
Extended

HIV voluntary counselling and testing (VCT) is one of the strategies in HIV prevention and is being promoted in countries where the pandemic is rampaging. Studies have reported that the number of people using HIV testing and counselling services quadrupled in the past five years in several countries (Sangiwa et al 1998, RH Matters, 2000, Bollinger et al 2004, IUSSP 2007). However, little is known about whether and to what VCT is effective in stimulating behaviour changes.

This paper attempts to provide answers to four interrelated questions about the impact of VCT on behavioral changes in sub-Saharan Africa. These questions are (i) what are the levels and patterns of access to and utilization of VCT in sub-Saharan Africa? (ii) What are the observable patterns of behavioral changes in terms of safer sex practices and sexual activity? (iii) How much of reported behavioral changes are attributable to the utilization of VCT? (iv) What gaps exist between behavioral changes and use of VCT? This paper forms a part of an on-going 27 countries-study of sexual behavior, behavioral changes and poverty in sub-Saharan Africa using the demographic and health surveys. The main objective of the study is to examine how effective the VCT is in stimulating behavioral changes among individuals who have experienced VCT in selected sub-Saharan African countries. These are countries with 2000 rounds of DHS conducted by Macro International.

Data

This present study utilizes secondary data from demographic and health surveys of four sub-Saharan African countries representing four sub-regions in the continent. These are 2004 Cameroon Demographic and Health Survey representing Central African region; Lesotho 2004 DHS [Southern Africa], 2003 Kenya Demographic and Health Surveys [East Africa] and 2003 Nigeria Demographic and Health Survey (NDHS) representing West Africa. The surveys were jointly conducted by the National Statistical organizations and Macro International USA. The demographic and health survey is a nationally representative sample of urban and rural areas in which a probabilistic 2-stage sampling design was employed. The research design and methodology for individual countries are well described in their full reports.

Using structured questionnaires, detailed information pertinent to marital and sexual behavior of respondents was collected. In addition to the broad questions asked in the survey, relevant questions were asked about HIV testing and behavioral changes. On testing, the relevant questions are “.....have you been tested to see if you have the AIDS virus? Was it asked for, offered and accepted or required? Did you get the results of the test? On behavioral changes, the questions are “Since you heard of HIV/AIDS, have you changed your behavior to prevent getting AIDS?” The responses to this question were re-categorized into six categories to include delayed sex, abstinence, condom use, reduction in number of sex partners, fidelity and others. Other relevant information collected included age, gender, education, occupation, parity, partner’s education, type of place of residence

and household socio-economic status, HIV/AIDS awareness and perception, and some community variables.

Multinomial logistic technique is used to analyse the role of HIV VCT in behavioural changes. Separate models are fitted for the six types of behavioural changes. The dependent variable in each model is abstinence. Thus the probabilities of adopting each behavioural change method to sexual abstinence are estimated as a function of selected explanatory variables. Preliminary findings indicate that there is relationship between VCT and behavioral changes across the countries in some countries while in others, the relationship disappears when other variables like AIDS awareness is introduced. There is a gap in behavioral changes between HIV testers and non-testers. Diverse patterns of the relationship between VCT and behavioral changes are found. For instance, in some countries, receipt of test result is more significant predictor of behavioral changes than testing only. There are variations by gender and marital status as the role of VCT in promoting behavioral changes vary among men and women depending on their marital status and age. Respondents in marital union reported more likelihood of fidelity, while non-married reported limiting sexual partners and condom use. Women irrespective of their ages and marital status showed more likelihood of behavioral changes than men. There are a number of interaction effects, though. Further analysis of the 27 countries is on-going and will be completed before the conference. Various policy and program implications arising from the findings will be discussed.