HOUSEHOLD DECISION MAKING AND VOLUNTARY COUNSELING AND TESTING AMONG WOMEN ANTTENDING ANTENATAL CLINIC IN NIGERIA

BY

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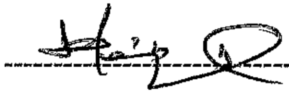
CERTIFICATION

This is to certify that **UBAH SOMTOCHUKWU CHIEMEKA** of department of demography and social statistics, Faculty of Social Sciences, carried out a Research on **Household Decision Making and Voluntary Counseling and Testing among Women Attending Antenatal Clinic in Nigeria** in partial fulfillment of the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision.



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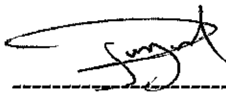

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DEDICATION

This work is dedicated to almighty God for his infinite mercy, guidance and also to my parent, for their support and making it possible for me to undertake this research.

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My sincere and utmost appreciation goes to God Almighty who gave me the grace and strength for success of this project.

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ABSTRACT

Background: The study is household decision making and voluntary counseling and testing among women attending antenatal clinic in Nigeria was conducted using data from 2013 Nigeria Demographic and Health Survey (NDHS). Voluntary counseling and testing is one of the best interventions to prevent mother-to-child transmission of HIV, but despite the proven benefits of VCT. The uptake of VCT in Nigeria still remains low.

Objective: The study is to ascertain the prevalence of voluntary counseling and testing, the perception of women on voluntary counseling and testing, and how household decision influence voluntary counseling and testing among women attending antenatal clinic in Nigeria.

Methods: The study was a cross sectional and descriptive study with both quantitative and qualitative component. The study involved women age 15-49 that are married and living together with their partner.

Results: In the quantitative result, women that are educated, wealthy, and working are more likely to receive voluntary counseling and testing. Women who decide alone on their health are more likely to receive voluntary counseling and testing than women who decide together with their partner. In the qualitative data, it was found out that fear was the main factor that can reduce the uptake of voluntary counseling and testing.

Conclusion: It is recommended that involvement of male partner should be part in voluntary counseling and testing process to reduce the fear of get tested.

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Background to the Study

HIV/AIDS is no doubt one of the greatest scourges of mankind in the 21st century. In fact, it is regarded as the 6th highest cause of death globally, with 36.9 million individuals globally infected (CNBC, 2014). It is also the main cause of death in Africa (WHO, 2014). HIV/AIDS is a constantly recurring infection which has a long period between exposures to infection. Demographic figures reveal that the pandemic affects mostly individuals within the reproductive age group of 15 to 49 (WHO, 2012), with many infected individuals in Nigeria especially pregnant women not aware of their HIV status. Globally, 17.1% of infected persons do not know their statuses. Around 22 million people do not have access to HIV treatment while 1.8 million children find HIV treatment inaccessible (UNAIDS, 2014). WHO (2014) reported that sub-Saharan Africa is the most HIV-contaminated area, with 25.8 million individuals are infected (WHO, 2014). Infected people however need to be reached with voluntary counseling and testing for HIV services. Voluntary Counseling and Testing (VCT) is one of the best methods used in ensuring that women do not transmit the infection to their child or partner. Despite the proven benefits of VCT, many women are unwilling to have HIV tests (Adelaiye, 2005).

With regards to mothers and their unborn children, 73% of the 1.5 million pregnant women living with HIV globally have access to antiretroviral therapy (ART) to prevent mother-to-child transmission of HIV or to their partner. This has assisted in reducing new HIV infections among infants by 58% from 2000 to 2014 (UNAIDS, 2014). Most of the infants or children living in sub-Sahara Africa were infected through by their HIV-positive mothers during

pregnancy or breastfeeding (WHO, 2014). UNAIDS (2015) report on Nigeria about HIV/AIDS informs that about 3.5 million Nigerians live with HIV/AIDS, with just 593,000 of them on antiretroviral drugs (ARVs). The HIV prevalence rate in Nigeria is 3.1% (UNAIDS, 2015). HIV positive pregnant women are estimated to be around 190,000, with 52,500 of these women on Anti-retroviral drugs (ARVs). Nigeria is unable to treat about 70% of these pregnant women while 12% of all infected children have access to treatment too (UNAIDS, 2015). In Nigeria approximately 180,000 people died from AIDS and there has been a decline in deaths of HIV/AIDS from 2005 up till 2015 (UNAIDS, 2015).

The fundamental target of ANC as indicated by NDHS is to guarantee ideal wellbeing result for the mother and her baby. Knowing your HIV status is vital for helping individuals make particular choices about embracing more secure sex practices to decrease their risk of contracting or transmitting HIV. In Nigeria men and women matured from 15-49 that have heard of HIV/AIDS is 96% for men and 93% for women. The awareness of HIV/AIDS is high in urban area than the rural area 13% of men and 12% of women said they would care for a family member with HIV/AIDS (NDHS, 2013).

The most effective way for preventing HIV infection is through primary prevention of transmission from mother-to-child during her child bearing age and secondly through the prevention of unwanted pregnancy among HIV infected women. Accessible, active and appropriate VCT services are essential for conducting a successful prevention of mother-to-child transmission programs. VCT services educate, notify, and help uninfected person or persons to remain uninfected and those that are infected to be able to receive support programs, care programs and plan for future and the prevention of mother-to-child transmission of HIV or transmission to others. Through VCT, knowing your HIV status may enable infected person or

persons to access appropriate treatment. Moreover women who are aware of their HIV status, that are infected are in a better position to make decision on their own about their reproductive health and also through VCT, HIV infected pregnant women can access specific interventions such as antiretroviral prophylaxis and counseling on infant feeding and their own health and through VCT there is reduction in mother-to-child transmission (Sadiya, 2012).

Decision-making against women is marked by a culture of silence. Some cultures do not permit married women to use a contraceptive method for sex with her husband or partner, even when she suspects a Sexually Transmitted Infection (STI). Women are expected to be submissive to their husband. A non-submissive wife can be beaten or affected emotionally. Some cultural beliefs also preclude sexual partner or men from accompanying their wives to antenatal clinics. Those men who accompany their wives ANC clinics are perceived to be weaklings. Women with high-income households, high level of education than their husbands and from a wealthy family tend to have a stronger influence on decision making and also can go for VCT service without deciding with the partner. Antenatal care aims to improve maternal and infant health. Regular attendance of ANC will keep the baby and the mother safe and prevent mother-to-child transmission of HIV (PMTCT) (Hasbullah, 2013).

1.2 Statement of Research Problem

HIV/AIDS has been one of the major causes of death in Africa. A significant volume of studies exist on how to find cure, prevent, sustain and prolong human life. Agencies, organizations, government and non-governmental bodies have invested massively in the fight against HIV/AIDS both in human labour, financial, resources and materials. Despite their efforts, HIV/AIDS has continued to increase at a geometric rate. This has been exacerbated by poor

family education, poor HIV information, poor family planning and lack of voluntary counseling and testing service to educate or guild the reproductive age group to normal and a healthy life. Many poor families cannot afford antennal care services, so they indulge in home medication. In addition, the high cost living in Nigeria has necessitated that most women spend most of their time working, finding means to survive and sustain their families to the detriment of their health (Abimbola et al., 2015).

HIV/AIDS affects mostly the reproductive ages between 15 and 49. This is known from the fact that most of youths are aware and not conscious about the consequence and risk in HIV. Most women are aware about HIV but don't find interest when talking about it to their sexual partner. Most women find it difficult to go for voluntary counseling testing (VCT) and even if they do; they refuse or don't collect their HIV test result. Some women refuse to go for VCT because they don't want to disclose their HIV test result to their partner or family members or being stigmatized, while some don't go at all because of fear. The prevention of HIV infection from mother to child remains low in Nigeria. Many pregnant women believe that they are not at risk of HIV infection and do not know about the benefits of treatment and interventions available to prevent HIV transmission to their infants. Some of them do not know their HIV status (Adelaiye, 2005; Sadiya, 2012). Africa women lack decision power as regards the safety and health of their children. Therefore it is difficult for HIV infected women to receive social support and medical support (Uthman, 2009).

Behal (2011) reported that some pregnant women are not confident to decide whether to go for voluntary counseling and testing for HIV or seek PMTCT services because of the fear of being HIV positive. However, some pregnant women do home medication because they find it difficult to attend antenatal care to get VCT services due to reasons such as poverty, distance

from a hospital, clinic and good health facilities. Some women fear to get tested due to their husband reaction and due to discrimination, stigmatization from friends, community members or people hearing they are HIV-positive. Moreover, cultural beliefs that a man or husband is the head of the household to make decision on his own without the wife point of view, which makes women to be powerless in decision making (Behal, 2011).

1.3 RESEARCH QUESTION

1. What is prevalence of voluntary counseling and testing among women attending antenatal clinic in Nigeria?
2. What is the perception of women on voluntary counseling and testing?
3. Does household decision making influence voluntary counseling and testing among women attending antenatal clinic in Nigeria?

1.4 RESEARCH OBJECTIVES

The aim of this research study is to ascertain

1. The prevalence of voluntary counseling and testing among women attending antenatal clinic in Nigeria.
2. The perception of women on voluntary counseling and testing.
3. The household decision making influence on voluntary counseling and testing among women attending antenatal clinic in Nigeria.

1.5 Justification for the Study

In Nigeria, practices to ensure the prevention of mother to child transmission (PMTCT) and treatment of HIV seems to be low. There should be increase in HIV program, so as to increase the knowledge of the people about HIV test, the consequences and benefits (UNAIDS, 2014). People avoid HIV test because of fear of knowing their HIV status, stigma, physical abuse, emotional abuse, blame, fear of divorce in marriage or death if found to be HIV positive. Voluntary counseling should address these factors and emphasize confidentiality, care, treatment, prevention, and improve communication skills for disclosure and decision making among couples. If Nigeria provides good health facilities, most especially in the rural areas, and when people are educated about HIV/AIDS, the incidents will invariably reduce (Adelaiye, 2005). Pregnant women should be empowered to take part in decisions at the household, having the ability to refuse unsafe sex. Pregnant women should attend VCT services for HIV test, so as to be informed and come about with a solution to the prevention of mother-to-child transmission (PMTCT) of HIV. Voluntary counseling testing can ensure pregnant women to receive adequate antenatal care, testing for HIV, and antiretroviral ARVs where needed, with full support from their partners (Domitilla et al., 2013).

1.6 Definition of Keywords

AIDS: This means Acquired Immune Deficiency Syndrome of illness which result from a specific weakness or damage of the immune system. The immune system defends the body against infections tumors and diseases. This immune deficiency is cause by a virus called Human Immuno-deficiency Virus (HIV) (UNAIDS, 2005).

VCT: It means voluntary counseling and testing. VCT is a process when a person or persons chooses to undergo HIV/AIDS counseling so that they can make an informed decision about whether to be tested for HIV or not and also to be treated, supported, and care for (KwaZulu-Natal Department of Health, 2001).

Antenatal Care: is the care a woman receives from healthcare professionals during pregnancy. She will be offered a series of appointments with a midwife, or sometimes with a doctor who specializes in pregnancy and birth (an obstetrician). They will check that the mother and baby are well, give useful information to help have a healthy pregnancy including healthy eating and exercise advice (National Health Service, 2015).

MOTHER-TO-CHILD TRANSMISSION (MTCT) OF HIV: It is a situation whereby an HIV infected pregnant woman can transmit the virus to her child during labour, delivery, and also during breastfeeding. It has been found that the risk of an HIV infected mother transmitting the infection to the infant is 20% to 45% in the absence of intervention, the rate during pregnancy may be 5% to 10%, at labour and delivery 10% to 20% and 5% to 20 % during breast feeding (Abubakar, 2014).

Household Decision-Making: is decision being made or carried out between one or more people who live in the same dwelling. The person or persons decides what should be done at the household, manages the household finances, and buys the food items for the house (Miranda, 2005).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A study of the determinants of women's empowerment and HIV status in sub-Saharan Africa observed that increased woman vulnerability to HIV stems from limited access to health care and lack of autonomy to make decisions concerning sexual health and education. In addition, cultural practices that entrust men to make most of the household decisions deny women decision-making power and make them submissive. Consequently, their participation in household decision making is low (Miller, 2011). According to Maman et al., (2002) the lack of financial autonomy, control of household income, women's incapability to negotiate for condom use, low educational level for both companions and low income at household are factors that prevent women from using voluntary counseling and testing for HIV services. Gender differences in decision-making concerning using voluntary counseling and testing (VCT) services deepen the gulf. Men make decision on their own to seek VCT services independently while women are compelled to talk about testing with their companions before getting access to the VCT service, thereby creating a potential barrier to access to voluntary counseling and testing (Maman et al., 2002). The primary concept of voluntary counseling and testing include pre-test counseling, HIV testing, and post-test counseling. Voluntary counseling and testing for HIV services should be provided with confidentiality, correct HIV test results, prevention, care, support and treatment. VCT can help in increasing the use of condom and preventing of sexually transmitted diseases {STDs}. VCT is an exclusive process that enables pregnant women to examine their attitude and knowledge of HIV and be able to notify them on how to prevent acquiring HIV virus and mother

to child transmission of HIV. VCT helps them to decide whether or not they should be tested. Pregnant women should be offered VCT and also support to strengthen their decision making for HIV testing during antenatal care (Kamengaa et al., 2001).

2.2 Women's Participation in Household Decision-Making

Decision making can be a complicated process, and the ability of women to make decisions that influence their personal circumstances is a vital aspect of their empowerment (NDHS, 2013). In Nigeria, currently married women who make independent decisions on how to spend their money that they earn is 70%. Women participate in the three types of household decisions such as their own health care, participating in large household purchases, and visits to family or relatives. Women resident in urban areas are more likely to participate in all three types of decisions than rural women. Women are considered as tools to be used by men. They are seen as objects that can be controlled, and used for pleasure. In Nigeria, a man will beat his wife and still expect his wife to ask for forgiveness. In Nigeria, women who participate in household decision-making have higher income, come from a wealthy family and are well educated. Women that are educated, have higher income and wealthy than their husband have strong influence on decision making. They have the right to decide on their reproductive health (NDHS, 2013). It is expected for both partners to have equal rights and opportunities to participate fully in all aspects and at all levels of household decision making. In Nigeria the number of women that make most of the decision in Nigeria is low e.g. in the leadership sector of Nigeria it has being found that males are mostly in power than the females. In some culture in Nigeria women are being discriminated

from household decision making, like some women are found to be house wife, which makes them powerless in decision making (Igbuzor et al., 2016).

2.3 Benefits of Voluntary Counseling and Testing

Voluntary Counseling and Testing (VCT) is a confidential process between the individual and HIV counselor or care provider aimed at making personal decision to prevent HIV infection or to enhance the person to be able to cope with stress related to HIV/Aids. It is particularly expedient because it brings about reduction and awareness in HIV. It is made accessible for women of reproductive age. VCT services are important for HIV prevention and care. Knowledge and acceptance of HIV status can facilitate behavioral change, enables early access to support and care, enable early access prevention of mother-to-child transmission, enable early access to social support and financial support service, help in personal decisions about future pregnancies, and help in the use of condom for safe sex. VCT enhance the quality of life of people living with HIV to care, support them and also planning for future care. Counseling helps them to decide whether to be tested or not. All mothers should be offered VCT for HIV during antenatal care (Adelaiye, 2005; Sadiya, 2012). VCT serves as an entry point to prevention, care, treatment and support, and enables people to confidently understand their HIV status and learn about supportive behaviours for protecting and preventing further spread of HIV. Through VCT, there is reduction of HIV transmission to potential mothers. VCT also enables the reduction of unintended pregnancies among women and women living with HIV. Through VCT, there is reduction of mother-to-child transmission of HIV. VCT ensures the provision of care, treatment, and support for mothers and their infants, partners and families (WHO, 2010)

Importance of voluntary counseling and testing

1. VCT helps people to know their HIV status either positive or negative.
2. VCT helps in preventing the spread of HIV.
3. VCT allows the women to have access to medical care when tested positive.
4. VCT educates people who tested negative and how to live positively without infecting others.
5. VCT provides critical information about HIV and the testing process.
6. VCT gives information about how HIV is transmitted and how the women can protect themselves from infection.
7. VCT also educates the public to know that HIV testing should be done regularly (NACA, 2015).

2.3.1 Disclosure of HIV Status

Disclosure is when an individual or person's HIV test status is revealed to another person. VCT helps individual or couple to disclosure their HIV result and improve communication skills. According to Sadiya (2012), disclosure of HIV result between antenatal client and their sexual partners raise awareness of the risk of infection and its being discuss between the two sexual partners on how control it, which brings about reduction in HIV risk. Secondly disclosure of HIV result is important for antenatal client and their sexual partners, because both partners discuss on the use of contraceptive method, which brings about reduction of unintended pregnancies. Thirdly, it brings about HIV infected woman participation of PMTCT program, care and treatment (Sadiya, 2012). Disclosure of HIV status to sexual partners is ultimate prevention goal and control of transmission from one person to another. It can be achieved through VCT. Through VCT disclosure of HIV status is an important prevention goal for number of reasons

such as; Disclosure increase social support, risk reduction and awareness of HIV risk to couple or partners which can lead to untaken of HIV test, through these it lead to great up take of VCT services and changes the behavior of partners or couples (WHO, 2010)

WHO (2010) outlined four approaches of women disclosure of HIV status. These are that it:

1. Initiates discussions among sexual partners that can lead to behavior change;
2. Enables HIV-infected women to begin to discussing the use of contraceptives with sexual partners;
3. Enables HIV-infected women to gain support from partners for participation in PMTCT programs; and
4. Enables HIV-infected women to gain support from partners for participation in treatment and support programs (WHO, 2010).

2.3.2 Prevention

Prevention is when an individual or person stops something from happening or arising. The prevention of transmission from mother-to-child of HIV is to reduce the risk of passing the infection to the infant. Prevention is one most important strategy in reduction or circulation of HIV Aids. HIV can be transmitted through breast feeding, blood, vaginal fluid, semen, rectal fluid, and during pregnancy (AIDS info, 2015)

2.3.3 Treatment

VCT serves as an entry point to treatment. Through VCT, a health care provider gives advice to HIV infected person, talk about the foods they need to maintain their body and gain weight,

regular take of medicines, and keeps an eye on their weight and advice their relatives or sexual partner to be encouraging and loving. Antiretroviral therapy (ART) prescribes for HIV infected people. HIV infected person that is on ART is recommended to take a combination of HIV medicines, called HIV regimen every day. Antiretroviral therapy (ART) can't cure HIV, but it succumb it and helps HIV infected person to live longer. ART reduces the risk of HIV transmission and prevent HIV from multiplying. HIV attacks the body cells, HIV destroy the CD4 cells (white blood cells that fight infection) of the immune system. Loss of CD4 cells open the body to any kind of diseases, it makes it hard for the body cells to fight off infections (Adelaiye, 2005) and (Sadiya, 2012).

2.4 Challenges Antenatal Clients Face in Voluntary Counseling and Testing Services

One of the challenges that HIV infected antenatal client face during VCT services is fear to disclosure their HIV status to their sexual partners or being found to be HIV positive. Numbers of challenges from disclosure of HIV status are; stigma, discrimination, blame, divorce, physical abuse, emotional abuse, loss of economic support, and can also lead to loss of protective care or guardianship of children. It can also lead to lack of communication skills between two sexual partners and lack of relative support. These risks may lead antenatal clients to choose closure of their HIV test result with their sexual partners, family, and friends. This in succession, lead to lost chance for the prevention of infection to their partners and infants, and also loss of access VCT services such as prevention, care, treatment, and support. Moreover there is also loss of consider access to financial, social, psychological, and legal support. It is difficult for Antenatal

clients whose sexual partner or partners are unaware of their HIV status to participate and adherence to VCT programs.

The negative outcome of VCT may be harsher for women than for men. This is because women are financially and socially powerless, frequently reliant on their sexual partner economic status and because there is less societal acceptance for women believed to have many sexual partners than men. Many antenatal clients disclose their HIV result because they want social and economic benefit, but sometimes it does not occur. Most women reported negative consequences from disclosing their result. For instance, women disclose their HIV status to their sexually partner expecting support, but find themselves being abandoned, rejected, and discriminated and be may be accused of infidelity. These consequences may be even more obviously insignificant for women who often experience discrimination, stigma, and rejection. It is because their sexual behavior is not according to what is accepted traditionally towards the women. They may be seen as prostitute or unfaithful wife, and their HIV result only makes it worst and treat them as insignificant. Despite the messages from health education program and HIV messages about HIV/AIDS on how to support and care for HIV infected person economically and socially, family members or sexually partner may develop the attitude of avoidant behavior or they pretend. For these consequences, the reason for going to VCT service will low and many women will not consider going for VCT services at all (Sadiya, 2012) and (Adelaiye, 2005).

Osumba (2009) stated that VCT is a facility and a service based on intervention that is render to pregnant women as part of their routine investigation during antenatal care. This serves as a hindrance to put to use of voluntary counseling and testing services, as not all pregnant

women use ANC services. The researcher found out that there are some obstacles that prevent pregnant women from utilization of VCT in ANC. The reasons are: single motherhood, short intervals between pregnancies, low level education, high parity, under age mother, absence of accessible and appropriate antenatal care services, scarcity of village health workers, long waiting at the clinics, long distances to the antenatal care and physical barriers like poor means of transportation, high cost of living which leads to high cost of transport and hospital charges, poor roads, poverty, gender disparities, and bad attitude towards antenatal clients (Osumba, 2009).

2.5 INTERVENTIONS THAT CAN BE USED TO IMPROVE VCT SERVICES

Sadiya (2012) outlined interventions that can be used to improve voluntary counseling and testing services;

2.5.1 VOLUNTARY COUNSELING AND TESTING SERVICES LEVEL INTERVENTIONS:

Voluntary counseling and testing services should establish a system for safe record keeping, counselors should be trained to understand women perception towards VCT and the intersection of confidentiality, guild, and the consequences and also educate women on the benefit of VCT so as to strengthen women understand about it. HIV counselor should develop a screening on domestic violence or referral tools to identify women at risk of negative consequences so as to pinpoint women who may feel discriminated or may feel stigmatized from family members or

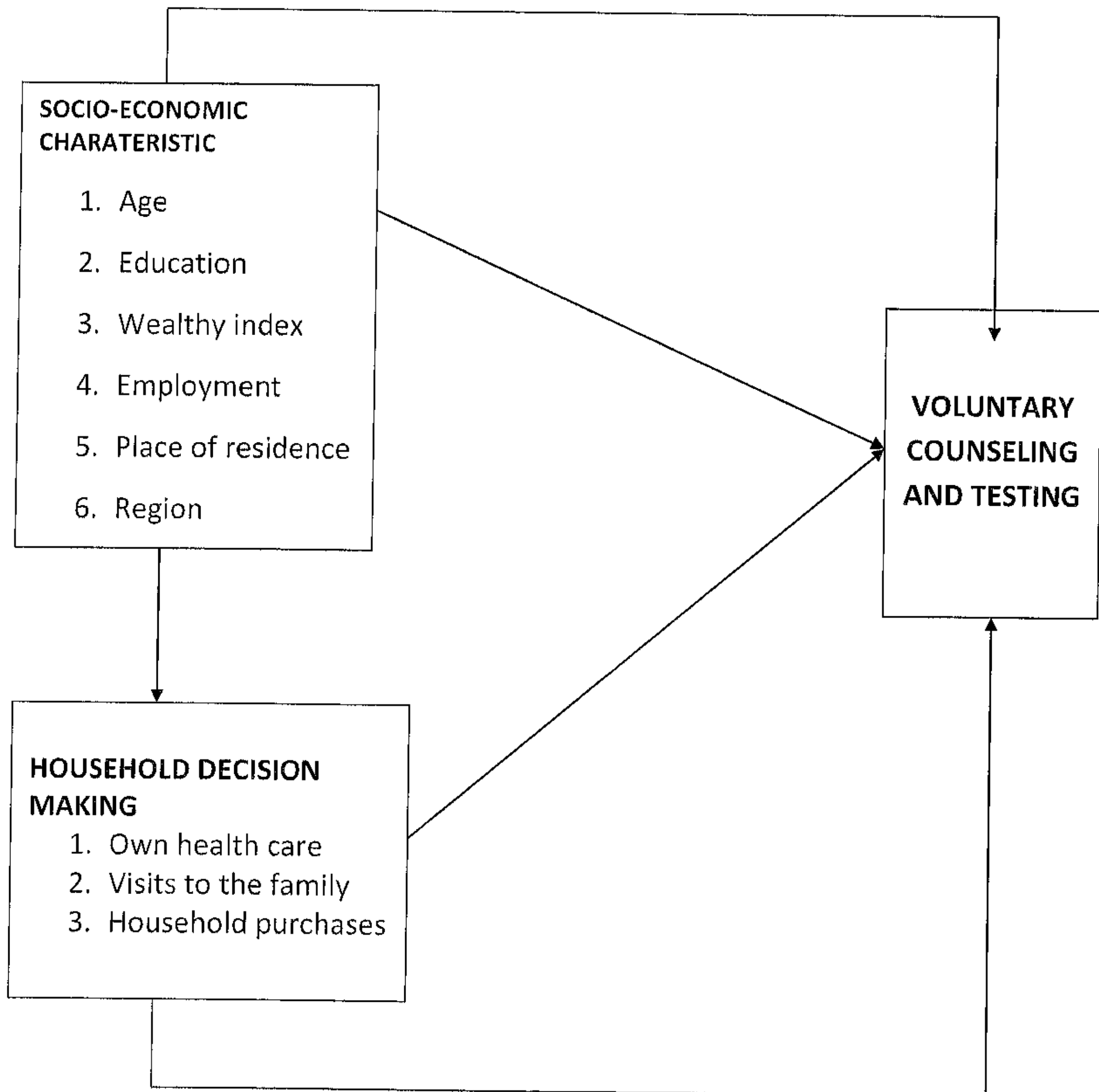
sexual partner, if found to be infected with HIV and also provide a stable and continuously supportive group counseling, to help reduce stigma (Sadiya, 2012).

2.5.2 POLICY MAKER LEVEL INTERVENTIONS:

A policy should be made for couples to go for VCT service together so as to promote partners communication and establish an appropriate and professional standard ANC service for voluntary counseling and testing. Policy should be made to address decision making differentials in gender relation (Sadiya, 2012).

2.5.3 Male involvement: Male involvement is a key strategy in addressing female involvement in VCT services. This is because it brings about reduction in negative consequences. Men make most of household decision making in many relationship. Women in most cases accept testing when they have discussed it with their partner. In Nigeria, there is the likelihood to blame women for household misfortunes. Encouraging women to go for VCT with their partners can soften this gender inequity. A system or policy should be used to reduce inequality between partners. Counseling should be done between couples or both partners, but some cultures don't facilitate counseling between couples or partners. Some ANC services do not welcome men as part of their setting. In Nigeria, because of men's perception, most men want to feel they are the superior to the women and so do not accompany their wives to ANC. VCT among partners can increase testing for HIV, communication between partners, reduces stigma, and reduction of HIV transmission. Male involvement is necessary, because it increases women involvement in seeking ANC to receive VCT. Men have the basic need that a woman needs, either physical or emotional (Sadiya, 2012).

2.6 CONCEPTUAL FRAMEWORK



The first assumption is that women aged from 15-49 who participate in household decision-making decide to go for voluntary counseling testing, not just for antenatal care (ANC). What determines this assumption are women that participate in VCT service are women that are well

educated, older in marriage, employed, and comes from a wealthy family tend to have a stronger influence on decision making, and also having the ability to make decision on their own health, visit the family and contribute equally or higher in household purchases.

The second assumption is that women aged from 15-49 whose voluntary counseling and testing for HIV are done when they were pregnant are provided as part of antenatal care. In Nigeria it is compulsory for a pregnant woman to get tested during her antenatal care. Pregnant women are eligible to attend ANC, just that not all pregnant woman are able to attend ANC due some reason, such as insufficient money, no nearby clinic especially in the rural areas, stigmatization from people, family members, friends, and fear of divorce. Pregnant women that age from 15-19 may not go for antenatal care services because they may feel discriminated and the chance to receive VCT will be low, and also women that are unemployed, not wealthy and not educated. Moreover, in Nigeria, WHO (2010) reported that stigma leads to secrecy and denial that tends to hinder openness about the HIV and prevents people from seeking voluntary counseling and testing for HIV (WHO, 2010).

The ANC was considered in the conceptual frame work because it is necessary for all pregnant women in Nigeria to attend ANC and will receive or go through voluntary counseling and testing as part of their routine check to prevent mother-to-child transmission of HIV. In ANC services where there are no voluntary counseling and testing services, pregnant women are referred to other clinic to get tested because it compulsory. In order to attain the objective of this study on household decision making and VCT among antenatal client, this study has to explore the relationship between women's socioeconomic characteristics and VCT. It also means that participation in household decision making stimulates women's desire for VCT services. VCT

serves as prevention, care, treatment, closure and disclosure of result and control of HIV epidemic (WHO, 2004).

Staveteig et al. (2013) observed VCT is a key strategy in providing care and preventing of HIV transmission. People that have tested and found to be HIV positive, testing is the first stage for care and control. It also prevents transmission of infection to their sexual partners and children. It helps in disclosure of result between sexual partners. Also for people who are HIV negative, the VCT is an opportunity to strengthen prevention efforts and reduce stigma (Staveteig et al., 2013).

2.7 RESEARCH HYPOTHESIS

H_0: There is no significant relationship between household decision making and voluntary counseling and testing among antenatal client in Nigeria.

H_1: There is significant relationship between household decision making and voluntary counseling and testing among antenatal client in Nigeria.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Background of the Study Area

3.1.1 Nigeria: A General Background

Nigeria is on the west coast of Africa. The country's 2006 population and housing census placed the country's population at 140,431,790. Nigeria had about 374 ethnic groups, with Hausa, Yoruba, and Igbo as major ethnic groups. The country has a tropical climate with wet and dry season. The dry season occurs from October to March with a spell of cool, dry, and dusty Harmattan wind felt mostly in the north in December and January. The wet season occurs from April to September. Agriculture was Nigeria's main economy before the discovery of crude oil in January 1953. Nigeria was famous for export goods like cocoa, palm production (oil and kernel), groundnut, and timber. Nigeria is country bless with many resources (NDHS, 2013).

3.1.2 History

Nigeria came to existence in 1914 through amalgamation of northern and southern protectorates. Before then, there were various ethnic groups such as Benin kingdom, Igbos, Ibibios, Ijaws, Tivs, Oyo, Hausa-Fulani empires, Nupe, and Jukun. Nigeria gained independence in October 1960 and became a federation. Lagos was made the capital of Nigeria. Nigeria became a republic on October 1, 1963. Presently Nigeria is made up of 36 states and a Federal Capital Abuja. Nigeria is made up of six geopolitical zones: North West, North East, North Central, South West, South South, and South East (NDHS, 2013).

3.2 Study Design

The study used both quantitative (using 2013 NDHS women's dataset) and qualitative research tools (in-depth interview). It was a cross-sectional study, using primary qualitative data from IDIs and KIIs, and secondary quantitative data from the 2013 NDHS. The individual recode dataset was used.

3.3 Dependent Variable: VCT means voluntary counseling and testing.

3.4 Independent Variables: Household decision making,

3.4.1 Control Variables: Socio economic characteristic (age, education, wealth index, occupation, residence, and region).

3.5 Data Collection Methods

3.5.1 Quantitative Method

The sample design included women age 15-49. The target population for the research is antenatal clients that are married and living together with their partner in Nigeria. Using NDHS data, with the samples size of 18,507 women that were attending ANC and marital status was used, focus was placed on married women and women living together with their partner (n=27,274) and they were included because of the study's focus on household and ANC. To measure women's household decision making, three variables have been developed: women's decision making on their own health care, visits to the family or relatives, and household purchases and my VCT will be received counseling after testing for HIV.

Data analysis was conducted using STATA software to process data from NDHS 2013 individual recode. The data was analyzed at three levels: Univariate (the frequency distribution of the dependent, independent and the control variables); Bivariate (a chi-square was used to identify the factor associated with the dependent variable and independent variables); and, multivariate (logistic regression model was employed to establish the relationship between dependent variable, independent variables and control variables).

3.5.2 Qualitative Method

An in-depth interview guide was used to obtain qualitative data. The sample design included women age 15-49. The target population for my research is women in Oye-Ekiti (Rural area) and Ado-Ekiti (Urban area) using a sample size of 10 women in my study, that is 8 IDIs and 2 KIIs for health workers in ANC facility was used to obtain relevant information from the respondents. The data analysis is the qualitative data information from IDIs and KIIs were retrieved by playing back the tapes and editing the notes documented. Permission was obtained from respondents to participate in the study and after full explanation of the purpose of the study. They were given the chance to opt out if they wish. All information obtained was treated with utmost confidentiality.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

4.1 Results of Quantitative Study

Table 1: Uni-variate Analysis on Socio Economic Characteristics of Women Respondents

VARIABLE	FREQUENCY	PERCENTAGE
AGE		
15-19	2,010	7.46
20-24	4,122	15.30
25-29	5,667	21.03
30-34	4,693	17.42
35-39	4,234	15.71
40-44	3,233	12.00
45-49	2,987	11.09
Total	**26,946**	**100.00**
EDUCATION		
No education	12,390	45.98
Primary	5,519	20.48
Secondary	6,941	25.76
Higher	2,096	7.78
Total	**26,946**	**100.00**
OCCUPATION		
Not working	7,498	27.83
Working	19,448	72.17
Total	**26,946**	**100.00**
WEALTH		
Poor	11,677	43.33
Middle	5,166	19.17
Rich	10,103	37.49
Total	**26,946**	**100.00**

RESIDENCE		
Urban	9,316	34.57
Rural	17,630	65.43
Total	**26,946**	**100.00**
REGION		
North Central	4,157	15.43
North East	5,213	19.35
North West	8,250	30.62
South East	2,314	8.59
South South	3,263	12.11
South West	3,749	13.91
Total	**26,946**	**100.00**
MARITAL STATUS		
Married	26,403	96.81
Living with partner	871	3.19
Total	**27,274**	**100.00**

Table 1 above indicates that the age range of the respondents is between 15 and 49. 21.03% of the respondents within the age bracket of 25 and 29. The lowest population of respondents was those between the ages of 15 and 19 as they constituted 7.46% of the study population. The Table also shows that 25.76% of the women had secondary education while 7.78%, the lowest category identified in the consideration of educational status, had higher educational level. 72.17% of the respondents were working class. In the wealth index, 43.33% of the respondents were classified as poor while 19.17% were in the rich category. 65.43% of the respondents were from rural area. The table also shows that most of the women were from North West region (30.62%) and the lowest is 8.59% of the South East region.

Table 2 Respondents' Household Decision Making, ANC Visits and Voluntary Counseling and Testing

Table 2 provides a summary of the findings on the percentage of women who received voluntary counseling testing. It also gives the percentage realization in the four categories of household decision-making indicators. 73.98% of the women informed that they received counseling after testing for HIV (VCT). The three indicators of women's household decision making were mostly 'decided by their husband or partner alone'; decision on respondent's health care (59.82%), decision on respondent's visits to the family or relatives (50.97%), and decision on large household purchases (60.26%) and the least in the three indicators of women's household decision making were 'decided by the woman alone'.

VARIABLE	Frequency	Percentage
Decision on women's health care		
Respondent alone	1,762	6.54
Joint decision	8,985	33.34
Husband/partner alone	16,118	59.82
Someone else	63	0.23
Other	18	0.07
Total	**26,946**	**100.00**
Decision on respondent visits to the family or relatives		
Respondent alone	2,274	8.44
Joint decision	10,883	40.39
Husband/partner alone	13,734	50.97
Someone else	44	0.16
Other	11	0.04
Total	**26,946**	**100.00**

Decision on large household purchases		
Respondent alone	1,721	6.39
Joint decision	8,898	33.02
Husband/partner alone	16,239	60.26
Someone else	63	0.23
Other	25	0.09
Total	**26,946**	**100.00**
Received counseling after tested for AIDS during antenatal care		
No	1,365	26.02
Yes	3,880	73.98
Total	**5,245**	**100.00**
Antenatal Visits During Pregnancy		
no antenatal visits	6,379	34.47
<4 antenatal visits	3,849	20.80
>4 antenatal visits	8,279	44.73
Total	**18,507**	**100.00**

4.1.2 Bi-Variate Analysis

Chi-square was used to check if there is a significant relationship between VCT as the dependent variable, household decision making as the independent variable and also socio-economic characteristics as the controlling variable.

Table 3: Bi-Variate Result on Voluntary Counseling and Testing and Socioeconomic Characteristics

Socioeconomic	YES		NO		TOTAL		Chi-square	P-value
AGE		%	%				**8.7372**	**0.189**
15-19	96	(2.47)	42	(3.08)	138	(2.63)		
20-24	615	(15.85)	192	(14.07)	807	(15.39)		
25-29	1,040	(26.80)	397	(29.08)	1,437	(27.40)		
30-34	975	(25.13)	328	(24.03)	1,303	(24.84)		
35-39	717	(18.48)	270	(19.78)	987	(18.82)		
40-44	319	(8.22)	103	(7.55)	422	(8.05)		

45-49	118	(3.04)	33	(2.42)	151	(2.88)		
Total	**3,880**		**1,365**		**5,245**			
EDUCATION							**12.1484**	**0.007**
No education	572	(14.74)	208	(26.67)	780	(14.87)		
Primary	813	(20.95)	253	(23.73)	1,066	(20.32)		
Secondary	1,821	(46.93)	614	(25.22)	2,435	(46.43)		
Higher	674	(17.37)	290	(30.08)	964	(18.38)		
Total	**3,880**		**1,365**	**5,245**				
OCCUPATION							**1.5277**	**0.216**
Not working	869	(22.40)	328	(24.03)	1,197	(22.82)		
Working	3,011	(77.60)	1,037	(77.60)	4,048	(77.18)		
Total	**3,880**		**1,365**	**5,245**				
WEALTH							**8.9871**	**0.011**
Poor	558	(14.38)	194	(14.21)	752	(14.34)		
Middle	776	(20.00)	224	(16.41)	1,000	(19.07)		
Rich	2,546	(65.62)	947	(69.38)	3,493	(66.60)		
Total	**3,880**		**1,365**		**5,245**			
RESIDENCE							**2.9682**	**0.085**
Rural	1,630	(42.01)	537	(39.34)	2,167	(41.32)		
Urban	2,250	(57.99)	828	(60.66)	3,078	(58.68)		
Total	**3,880**		**1,365**		**5,245**			
REGION							**123.6735**	**0.000**
North Central	692	(17.84)	302	(22.12)	994	(18.95)		
North East	720	(18.56)	159	(11.65)	879	(16.76)		
North West	531	(13.69)	189	(13.85)	720	(13.73)		
South East	678	(17.47)	156	(11.43)	834	(15.90)		
South South	494	(12.73)	305	(22.34)	799	(15.23)		
South West	765	(19.72)	254	(18.61)	1,019	(19.43)		
Total	**3,880**		**1,365**		**5,245**			

Table 3 provided information which revealed that the uptake of VCT is much higher at 26.80% among women between age 25-29 than among other age groups. The least in the uptake of VCT is 15-19 with 2.47%. There is no significant relationship between the age group and receive counseling after testing for HIV (chi-square = 8.7372, P = 0.189). Women with secondary education (46.93%) were more likely than women with other levels of education to receive counseling after testing for HIV. In addition, women with no educational background were the

least to receive counseling with 14.74% of the total respondents. We thus conclude that there is a significant relationship between education and the receipt of counseling after testing for HIV (chi-square = 12.1484, P = 0.007).

The uptake of VCT is much higher among women who are working (77.60%). Therefore, there is no significant relationship between occupation and receive counseling after testing for HIV (chi-square = 1.5277, P = 0.216). The level of 'receive counseling after testing for HIV' is higher among women from rich category (65.62%) and the lowest in the level of 'receives counseling' is the poor category (14.38%). We thus infer that there is a significant relationship between wealth index and the receipt of counseling after testing for HIV (chi-square = 8.9871, P = 0.011).

Table 3 also indicates that the level of 'receive counseling after testing for HIV' is higher among women from urban areas (57.99%). It is therefore safe to infer that there is no significant relationship between residence and the receipt of counseling after testing for HIV (chi-square = 2.9682, P = 0.085). However, in observing the relationship between regions of residence and the uptake of VCT, we identified that the South West with 19.72% had the highest regional uptake of VCT. The South South however had 12.73%, making it the least to receive counseling. There is a significant relationship between residence and receive counseling after testing for HIV (chi-square = 123.6735, P = 0.000).

Table 4: Bi-Variate Result on Voluntary Counseling and Testing and Household Decision-Making

Household indicator	YES	%	NO %		TOTAL		X_2	P-value
Decision on women's health care							**30.9786**	**0.000**
Respondent alone	301	(7.76)	122	(8.94)	423	(8.06)		
Joint decision	1,717	(44.25)	707	(51.79)	2,424	(46.22)		
Husband/partner alone	1,852	(47.73)	533	(39.05)	2,385	(45.47)		
Someone else	10	(0.26)	3	(0.22)	13	(0.25)		
Other	0	(0.00)	0	(0.00)	0	(0.00)		
Total	**3,880**		**1,365**		**5,245**			
Decision on respondent visits to the family or relatives							**32.7625**	**0.000**
Respondent alone	372	(9.59)	176	(12.89)	548	(10.45)		
Joint decision	1,937	(49.92)	733	(53.70)	2,670	(50.91)		
Husband/partner alone	1,568	(40.41)	453	(33.19)	2,021	(38.53)		
Someone else	3	(0.08)	1	(0.07)	4	(0.08)		
Other	0	(0.00)	2	(0.15)	2	(0.04)		
Total	**3,880**		**1,365**		**5,245**			
Decision on large household purchases							**3.7046**	**0.447**
Respondent alone	323	(8.32)	119	(8.72)	442	(8.43)		
Joint decision	1,751	(45.13)	648	(47.47)	2,399	(45.74)		
Husband/partner alone	1,793	(46.21)	593	(43.44)	2,386	(45.49)		
Someone else	12	(0.31)	4	(0.29)	16	(0.31)		
Other	1	(0.03)	1	(0.07)	2	(0.04)		
Total	**3,880**		**1,365**		**5,245**			

Table 4 indicates that in the uptake of VCT in decision-making of respondents, 'own health' is mostly decided by the husband or partner alone (47.73%). There is a significant relationship between decision making of respondent own health and receive counseling after testing for HIV (chi-square = 30.9786, P = 0.000).

In the uptake of VCT in decisions on respondents, 'visit to the family or relatives' is mostly joint decision between the woman and the husband or partner, totaling 49.92%. There is a significant relationship between decision on respondent visits to the family or relatives and receive counseling after testing for HIV (chi-square = 32.7625, P = 0.000). With regard to the uptake of VCT in decision on large household purchases, 46.21% stated that this is mostly decided by the husband or partner alone. There is no significant relationship between decision on large household purchases and receive counseling after testing for HIV (chi-square = 3.7046, P = 0.447).

Table 5: Checking the Prevalence of VCT among Women that Attended Antenatal Care

ANTENATAL WOMEN VISIT	YES	NO	Chi-square	P-value
			13.6975	**0.001**
< 4 ANC visit	943 (75.48)	272 (24.52)		
> 4 ANC visit	2,742 (73.04)	1,012 (26.96)		
TOTAL	**3,685 (74.16)**	**1,284 (25.84)**		

The prevalence of VCT among ANC clients in Nigeria is 74.16%. 74.16% of antenatal clients received counseling after testing for HIV. There is a significant relationship between antenatal client and receive counseling after testing for HIV (chi-square = 13.6975, P = 0.001).

4.1.3 Multi-Variate Analysis

Logistic regression was used to examine the relationship between the three indicators of women's household decision-making and socioeconomic characteristics with VCT. This analysis indicates the level of significance for each household decision making indicator's association with VCT, and the indicators is divided into three. In Indicator 1, decision on women's health care; in Indicator 2, decision on large household purchases; in Indicator 3, decision on

respondent visits to the family or relatives. The first three indicators addressing household decision making variables independently while controlling variables are: (age, education, wealth, employment, residence, and region) are variable of socio-economic characteristic. All indicators were run together to examine their combined association with VCT.

Table 6

VCT	Odds Ratio	P>|z|	[95% Conf. Interval]	
Age				
15-19 (RC)	1.0			
20-24	1.479721	0.060	.9840032	2.225171
25-29	1.250613	0.267	.8428996	1.855538
30-34	1.475578	0.057	.9886422	2.202345
35-39	1.299807	0.206	.8655884	1.951849
40-44	1.527221	0.061	.980201	2.379517
45-49	1.790132	0.037	1.036678	3.091196
Residence				
Rural (RC)	1.0			
Urban	.8073916	0.007	.6906535	.9438615
Wealth				
Poor (RC)	1.0			
Middle	1.426618	0.003	1.125923	1.807618
Rich	1.267738	0.047	1.003111	1.602177
Education				
No education (RC)	1.0			
Primary	1.386252	0.007	1.095415	1.754306
Secondary	1.41096	0.003	1.124063	1.771082

Higher	1.160322	0.267	.8924846	1.508538
Occupation				
Not working (RC)	1.0			
Working	1.196616	0.026	1.021205	1.402158
Region				
North Central (RC)	1.0			
North East	2.220962	0.000	1.748393	2.821261
North West	1.204113	0.126	.9491655	1.527539
South East	2.001077	0.000	1.594001	2.512112
South South	.6043613	0.000	.4919392	.742475
South West	1.443414	0.001	1.171883	1.77786
Decision on Women's Health Care				
Respondent alone (RC)	1.0			
Joint decision	.8458632	0.239	.6400493	1.117859
Husband/partner alone	1.507909	0.006	1.122417	2.025798
Someone else	1.526654	0.596	.3197095	7.289971
Other	1			
Decision on Large Household Purchases				
Respondent alone (RC)	1.0			
Joint decision	.9409319	0.671	.7103548	1.246353
Husband/partner alone	.5894234	0.000	.444908	.7808804
Someone else	.6959915	0.600	.1794055	2.700053
Other	1			
Decision on Respondents' Visits to Family or Relatives				
Respondent alone (RC)	1.0			
Joint decision	1.484204	0.001	1.166939	1.887727
Husband/partner alone	1.784371	0.000	1.166939	1.887727
Someone else	2.794307	0.431	.2167728	36.01998

Other	1

(NDHS, 2013)

Table 6 shows that women aged between 20 and 49 have greater odds of attending voluntary counseling and testing compared to respondents between ages 15 to 19. These odds are 1.48 (20-24), 1.25 (25-29), 1.48 (30-34), 1.30 (35-39), 1.53 (40-44), and 1.79 (45-49). Age 20-44 are not statistically significant ($P>0.05$; $0.060 > 0.05$, $0.267 > 0.05$, $0.057 > 0.05$, $0.260 > 0.05$, and $0.061 > 0.05$. The sole exception was found among respondents with the age bracket of 45 and 49 as this was observed to be statistically significant ($P<0.05$; $0.037 < 0.05$).

In terms of location, Table 6 shows that residents in rural areas (1.24) have greater odds of attending voluntary counseling and testing compared to the reference category of urban areas. Rural areas are statistically significant ($P < 0.05$, $0.007 < 0.05$). In the consideration of wealth, it was noted that the Middle and the Rich categories were more likely to attend voluntary counseling and testing compared to respondents within the Poor category. These odds are 1.43 (Middle) and 1.27 (Rich). The Middle and the Rich categories are statistically significant ($P < 0.05$, $0.003 < 0.05$, and $0.047 < 0.05$).

All educational levels – primary, secondary and tertiary – positively influenced the likelihood of respondents to attend voluntary counseling and testing compared to the reference category of no education. These odds are 1.39 (Primary), 1.41 (Secondary) and 1.16 (Higher) education. Both primary and secondary education are statistically significant ($P < 0.05$, $0.007 < 0.05$, $0.003 < 0.05$), expect higher education that is not statistically significant ($P > 0.05$; $0.267 > 0.05$).

Occupational status was also found significant. Working women were 1.20 more likely to attend voluntary counseling and testing compared to the reference category of not working. Women working are not statistically significant (P < 0.05, 0.026 < 0.05).

The North East (2.22), North West (1.20), South East (2.00), and South West (1.44) were more likely to attend voluntary counseling and testing compared to the reference category of North Central. Only the South South (0.60) has a lesser odd of attendance at voluntary counseling and testing. The North East, South East, South South, and South West are statistically significant (P < 0.05), only North West are not statistically significant (P > 0.05; 0.126 > 0.05).

Decisions on Women's Health Care

The findings on the decision-making of women on issues that affect or influence their health care are discussed here. Women who make decisions on health care with their husbands or partners were 0.85 less likely to attend voluntary counseling and testing compared to the reference category of women who can make personal decision on their health care. Women who decide with their husband or partner on their health care are not statistically significant (P > 0.05).

Women whose husbands or partners make decision on their health care were 1.50 more likely to attend voluntary counseling and testing compared to the reference category of women who can make personal decision on their health care. Women who their husband or partner makes decision on their health care are statistically significant (P < 0.05).

Women who decide with someone else on their health care are 1.53 more likely to attend voluntary counseling and testing compared to the reference category of women who can make personal decision on their health care. Women who decide with someone else on their health care are not statistically significant (P > 0.05).

Decisions on Large Household Purchases

Women who decide with their husband or partner on large household purchases are 0.94 less likely to attend voluntary counseling and testing compared to the reference category of women who can make personal decision on large household purchases. Women who decide with their husband or partner on large household purchases are not statistically significant ($P > 0.05$).

Women whose husbands or partners make decision on large household purchases are 0.64 less likely to attend voluntary counseling and testing compared to the reference category of women who can make personal decision on large household purchases. Women whose husbands or partners make decision on large household purchases are statistically significant ($P < 0.05$).

Women who decide with someone else on large household purchases are 0.70 less likely to attend voluntary counseling and testing compared to the reference category of women who can make personal decision on large household purchases. Women who decide with someone else on large household purchases are not statistically significant ($P > 0.05$).

Decisions on Respondent's Visits to Family or Relatives

Women who decide with their husband or partner on visits to the family or relatives are 1.48 more likely to attend voluntary counseling and testing compared to the reference category of women who can make personal decision on visits to the family or relatives. Women who decide with their husband or partner on their visits to the family or relatives are statistically significant ($P < 0.05$).

Women whose husbands or partners make decision on visits to the family or relatives are 1.78 more likely to attend voluntary counseling and testing compared to the reference category

of women who can make personal decision on visits to the family or relatives. Women who their husband/partner decides on their visits to the family or relatives are statistically significant. ($P < 0.05$)

Women who decide with someone else on visits to the family or relatives are 2.79 more likely to attend voluntary counseling and testing compared to the reference category of women who can make personal decision on visits to the family or relatives. Women who decide with someone else on their visits to the family or relatives are not statistically significant ($P > 0.05$).

4.2 Qualitative Analysis

Data for the qualitative part of the study was collected from ten women respondents. Eight in-depth interviews and two key informant interviews were held (Urban area as Ado and Rural area as Oye). The respondents were encouraged to express themselves with the assurance of confidentially of information. The respondents of the in-depth interview were coded R1 to R8 while those of the key informant interviews were coded K1 to K8.

4.2.1 The Prevalence of VCT among Antenatal Clients

The respondents all received counseling after testing for HIV. The uptake of VCT is 100% among the respondents.

4.2.2 Perception of Women on Voluntary Counseling and Testing

All the respondents indicated awareness of VCT. They informed that HIV testing is offered as part of antenatal investigation to all pregnant women who were also counseled on the benefits VCT to them and their unborn child. The respondents stated that they held discussions of their results with a health provider or HIV counselor. Most of the respondents said VCT as part of

ANC was where many pregnant women were offered HIV test and subsequently counseled on the benefit and how to prevent transmission from mother-to-child. They all subscribed to the continued inclusion of VCT in ANC.

> *Voluntary counseling and testing as part of antenatal care is compulsory, testing for HIV was not optional. If you don't test, you won't attend any antenatal section, so everyone had to test and then after that you will be advice on what to do next. R3, Age 29, Urban area, Higher education, Working, and Middle category*

> *It is an important aspect of antenatal care. It actual makes pregnant women to know their status when they come in for antenatal care and HIV counseling is the ability to listen to the client and advice them on the necessary things to do and not to do as in regard to the safety of the woman and the unborn child. K1, Age 35, Rural area, Higher education, Working, and Middle category*

All the respondents were happy about VCT and would recommend it to others to know their status and the safety of their child and their husband and also they will be advice on what to do and not do.

> *I would recommend VCT to other, because when I was informed of my status. I was then advice on what to do and not do and how to prevent get it. R5, Age 27, Rural area, Higher education, Working, and Middle category*

> *Yes, I would recommend it to others because it better one knows his/her status and the necessary advice to give the person so as not to transmit it to other people. K1, Age 35, Rural area, Higher education, Working, and Middle category*

All the respondents opted for VCT as part of antenatal. VCT as part of ANC increases the chances of pregnant women getting tested. The experience of the respondents during ANC was similar. This hovered over the fear of testing and wondering what will be the outcome of the result.

> *The experience women face during antenatal care is that, there is a general believe that ones you are being told to do HIV test. There is a kind of increase in heart beat, what will come out of it. There is a sense of fear because you*

don't know what the test result will be. K2, Age 42, Urban area, Higher education, Working, and Rich category

When I came for my antenatal check, I was offered to test for HIV. My heart was panting. I was afraid, thinking what will be the outcome of the result. But thank God when I was called in, to discuss about my result, the HIV counselor told me I am negative. I was so happy R7, Age 26, Urban area, secondary education, Working, and middle category

4.2.3 Influence of Household Decision-Making on Voluntary Counseling and Testing among Antenatal Clients

Decision--making at household level among the respondents and their partner is one sided. Their husbands/partners were most often the decision makers of the three types of household decision making. A sizeable portion of the respondent informed that decision making at household level (decision on respondent health, decision making on respondent visit to family and relatives and decision making on large purchases) were decided by their husband/partner. They were usually influenced by their husbands. The uptake on VCT has an increase when it is decided by their husband or decided together. The interview revealed that women who decide on their health care are more likely to opt for VCT and also women who decide with their husband together on their health care are less likely to opt for VCT.

Household decision making is decided between the respondent and her husband. For instant, when I told my husband about opting for voluntary counseling and testing for HIV. He didn't agree with me, but after persuading him, so that I will know my status, I will know how to take care of myself. He then agrees with me and we didn't have any problem. R5, Age 27, Rural area, Higher education, Working, and Middle category

Decision making on my health care is decided by me alone. Decision making on large purchases in the house is actually decided between me and my husband. Decision making on my visit to my family are decided between me and my husband.There is no big deal in it; I will opt for voluntary counseling and testing for HIV and inform him later. K2, Age 42, Urban area, Higher education, Working, and Rich category

Decision making on my health care, large purchases and my visit to my family is decided by my husband. God forbid, I won't tell my husband that I opt for voluntary counseling and testing for HIV, because he will beat me and start to assumed that I have cheated or am suspecting him of having HIV. R6, Age 24, Rural area, Primary education, Not working, and poor category

4.3 Discussion

Voluntary counseling and testing for HIV is a relevant tool or certain in a way to access care and prevent transmission from mother-to-child. VCT in Nigeria is complex and also personal reason. It entails educating the person on the benefit of testing. In Nigeria VCT has being a part of routine investigation during antenatal care, so as to know their HIV status and how to prevent transmission of infection to child or partner. The uptake of VCT in Nigeria is very low because of some factors. The ways women make choices about receive VCT vary across different age groups, wealth index, residence, educational background, occupation and region in Nigeria.

The present study concentrated on married women and women that are living with their partner as a variable of marital status as the household decision making between a man and a women. The age distribution is from 15-49. The mean age is 30-34. The largest age group identified in this study was between 25 and 29. The uptake of VCT is low among age 15-19 and 45-49, because women of age 15-19 may feel discriminated when going for VCT or they are not aware of the benefit of VCT while women that age from 45-49 is low in the uptake of VCT because chance of getting pregnant is low and also that goes with women that are not educated, poor, and from rural. This goes in line with Domitilla et al (2013) which observed that women who were educated, working, from urban area, and with the middle and rich category of wealth have a high uptake of VCT. Women who decide with their husbands/partners increase the chance

of VCT as observed by Sadiya (2012) who also asserted that communication between couples increase the uptake of HIV testing.

The study also shows that the dependent variable household decision making has an influence on VCT. Household decision making is my strongest variable. In the three types of women's household decision making, women who make personal decision and women who their husband or partner decide for them on their own health are more likely to receive VCT than women who discuss it with their husband or partner, women who make personal decision on large household purchases are more like to opt for VCT women who their husband or partner decide for them and women who discuss it with their husband or partner and also women who their husband or partner decide for them and women who discuss it with their husband or partner on visit to the family and relatives are more likely to opt for VCT than women who make personal decision.

The NDHS shows that the prevalence of VCT among women attending ANC in Nigeria is high, but the number of women that received counseling after testing for HIV is low. This finding is additional supported by the result of the in-depth interview. The entire respondent received counseling after testing for HIV. The uptake of VCT was made compulsory among women attending antenatal care.

The perception of women towards VCT shows that women that are educated, women that are in the middle or rich categories and women that are working have influence on VCT. Majority of the respondents said they are aware of VCT and main purpose of VCT was to know their HIV status (Adelaiye, 2005). This finding is additional supported by the result of my in-depth interview. All respondents were aware of VCT.

It is an important aspect of antenatal care. It actual makes women to know their status when then come in for antenatal care and HIV counseling is the ability to listen to the client and advice them on the necessary things to do and not to do as in regard to the safety of the woman and the unborn child. K1, Age 35, Rural area, Higher education, Working, and Middle category

Decision making can be a complicated process, and the ability of women to make decisions that influence their personal circumstances is a vital aspect of their empowerment (NDHS, 2013). The level of household decision making among married women and women living with their partner varies across the types of household decision making; in decision making on the woman health care, visit to family and relatives, and large purchases in the household are mostly decided by their husband or partner. This finding is corroborated by the in-depth interview conducted. Most of the respondents informed that their husband decides on all household decision making:

Decision making on my health care is decided by my husband. Decision making on large purchases in the house is decided by my husband. My husband decides on my visit to my family. R6, Age 24, Rural area, Primary education, Not working, and poor category

Household decision making in Nigeria is often one sided with the men seen as the decision maker. Sadiya (2012) observed that, because of societal norms, most men want to reiterate their superiority to the women. They are thus dominant while women are submissive (Sadiya, 2012). In the three types of household decision making; decision making on the woman health care, decision making on visit to family and relatives, and decision making on large purchases. Women who decide with their husband or partner on the three types of household decision making have greater chance to opt for VCT. This finding is additional supported by the result of the in-depth interview conducted. Majority of the respondents that decided with their husband on every aspect of decision making are more like to receive VCT.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of findings of the study. It then provides a conclusion and further gives recommendations for future researchers.

5.1 Summary of Findings

From the analysis done, it is perceptible that the study presented a useful forum for knowing the level of household decision making and voluntary counseling and testing among women attending antenatal clinic in Nigeria. In this research a qualitative and quantitative analysis was adopted. In this study, the hypothesis was tested and was found that there is relationship between household decision making and voluntary counseling and testing among women attending antenatal clinic. The women in this study are aware of VCT and its benefit. Most of the women accepted VCT as part ANC. There was high uptake of VCT among women that were educated.

5.2 Conclusion

The research study presents a nationally statistics of women's household decision making and voluntary and test among partners living together and married women age 15-49 in Nigeria. The uptake of VCT is low in Nigeria and the predominant factor was observed to be non participation of women in household decision making. Fear has being one of the main reasons that reduces the chance to opt for voluntary counseling and testing for HIV during ANC. Discrimination and stigma from husband/partner and family member are other reasons. Couples or partners were not educated about the benefit of VCT and there is poor family planning and health program in the country. The means of informing people is poor or not very effective.VCT is still a challenge in

Nigeria, therefore more effort should be render on educating women on the benefit of VCT, especially women that are not working, women that married early and women from rural area. The government should empower the women by encouraging them to participate in household decision so as to increase the chance of up taking VCT and also women should be educated about the benefit of VCT.

5.4 Recommendations

It is recommended that the government should empower the women in order to increase the chance of participation in household level which will enable them in the uptake of VCT. Antenatal client should be educated more on the benefit of VCT. Communication between patients and counselor should be to encourage the uptake of VCT and give patients physical and emotional support they require. Antenatal care services should develop a screening on their patient to identify women at risk of negative consequences, form an ongoing women support group and also encourage male involvement which help in reducing stigma and discrimination. Counselors should be trained to understand women's perception of VCT and the intersection of confidentiality, guild, and the consequences.

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APPENDIX

HOUSEHOLD DECISION MAKING AND VOLUNTARY COUNSELING AND TESTING AMONG WOMEN ATTENDING ANTENATAL CLINIC IN NIGERIA

IN-DEPTH INTERVIEW GUIDE

Socio economic characteristic of respondent: Age, Resident, Educational level, Occupation (working or not working) and Wealth index.

1. Are you aware of voluntary counseling and testing?
2. What do you know about VCT as part of ANC?
3. Do you think VCT is an important part of ANC? Probe if not, why do you disagree with VCT?
4. Did you receive VCT as part of your ANC package? What was the experience like?
5. Do you participate in decision making of household level; who makes decision on household purchases, who makes decision on your own health care, and who makes decision for you to visit the family or relatives? Do you decide alone, or you decide with your husband/partner, or your husband/partner decides for you.
6. Can you opt for VCT without notify your husband and what do you think will be reaction of your husband?
7. Are you happy about this VCT? Would you recommend to others to embrace it or not?