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CHRISTIAN MARRIAGE COUNSELLORS' PRACTICES RELATING TO HIV COUNSELLING AND TESTING FOR INTENDING COUPLES IN IBADAN, NIGERIA

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Abstract

Introduction

HIV Counseling and Testing (HCT) is an indispensable strategy for controlling the spread of Human Immuno (HIV). Church-based Marriage Counselors (CMC) have pivotal roles to play in promoting its adoption among Intending Couples (IC) in their churches. However, the prevailing practices of CMC which can be relied upon for designing interventions for facilitating the adoption HCT have not been well explored. This study was, therefore, aimed at determining the practices concerning HCT among CMC in Ibadan South-West Local Government Area (LGA), Nigeria.

The cross-sectional study involved the use of a four-stage random sampling technique to select 660 CMC from churches which are affiliated to the Christian Association of Nigeria. A validated semi-structured questionnaire was used for data collection. Descriptive statistics and Chi-square test were used to analyse the data at $p=0.05$. Respondents' age was 45.0 ± 8.6 years, 60.3% were males, and most (99.4 %) were literate. Majority (88.0%) stated that pre-marriage courses for IC with infused HIV related topics existed in their churches. Majority (73.2%) of the respondents indulge in the practice of requesting intending couples to undergo compulsory HCT. Other medical requirements requested by churches before solemnizing a marriage included pregnancy test (27.1%), genotype testing (23.0%) and blood test (20.0%). Majority (58.3%) of the respondents revealed that they usually request IC to go to government-owned hospitals for their HCT. The practice of mandatory HCT for intending couples was significantly more common (93.5%) among respondents in non-indigenous churches than those indigenous churches (85.5%). There was no significant association between the practice of mandatory HCT for intending couples and nature of service rendered in church. The ways of handling situations in which one of the IC is HIV sero-positive included counselling of the IC (20.2%), leaving IC to decide on their own (19.2%), referral to a hospital (8.0%) and cancellation of wedding (5.7%). Some (37.0%) respondents reported that their churches had some forms of support for PLWHA in their churches; a combination of prayer and counseling (74.9%) topped the list of the forms of support provided by respondents for PLWHA. Most churches have an HIV component of the premarital counseling services provided for intending couples in their churches with some promoting mandatory HIV screening. However, intending couples are usually referred to formal health care facilities for such tests or screening. Multiple educational interventions which include training and supportive supervision are recommended to promote the adoption of ethically appropriate pre-marital counseling and referral of IC for testing in their churches.

Keywords: *Marriage counselors, HIV counseling and testing; Intending couples, Mandatory HIV testing, Disclosure of HIV test results*

Introduction

Acquired Immunodeficiency Syndrome (AIDS), caused by the Human Immunodeficiency Virus (HIV), is a life threatening but preventable disease condition (Obioha, 2008). The infection which has attained the status of a pandemic, is currently one of the world's most serious public health challenges (Adekeye, 2010). The challenges posed by HIV and AIDS have greatly hampered various aspects of development including the educational and health sectors as well as faith-based communities (UNAIDS, 2012). The UNAIDS (2012) adds that the disease condition has adverse social and economic effects on development where ever it is found.

Sub-Saharan Africa accounts for a disproportionate share of the HIV pandemic (UNAIDS, 2012). It has been reported for instance that the 1.9 million people who were newly infected with HIV in 2010 in sub-Saharan Africa accounted for 70% of persons who were infected by HIV infection worldwide (UNAIDS, 2011). The report of the 2012 National Reproductive Health Survey Plus (NARHS-Plus) showed that Nigerians were living with HIV/AIDS constituted about 3.4 % (FMOH, 2013). In Nigeria, the HIV/AIDS epidemic is fuelled primarily by heterosexual intercourse (UNGASS, 2010; NACA, 2012).

The HIV Counselling and Testing (HCT) strategy has been noted to be one of the effective public health interventions for preventing or controlling the spread of HIV worldwide (Merson, 2006; Obioha, 2008). The strategy entails providing counselling to individuals with a view to helping them make informed choices relating to being tested for HIV. A major issue stressed in the strategy is that the decision to get tested must be the choice of the individual; is also stressed that there must be assurance that the process would be confidential (USAID, 2010). The advantages inherent in HCT are numerous; these include the following: creating opportunities for people to determine whether they are infected or not; understanding the implications of their sero-status; and making informed choices about what to do (FMOH, 2007). In addition, the adoption of HCT provides individuals with the opportunity of taking decisions concerning the persons they would want to share their sero- status results with (USAIDS, 2010).

In Nigeria, the marriage institution is held in high regard and the marital union between a man and a woman is solemnized by various agencies; broadly these agencies include state, traditional and religious agencies. The HIV and AIDS can ruin the marriage institution. Therefore, the concern for preventing the epidemic from affecting it has made some religious organizations to make premarital HIV testing a condition which prospective couples must meet before they are joined together in marriage. Christian religious leaders, therefore, have key roles to play in the promotion of the adoption of HIV Counselling and Testing in Nigeria (Oluduro, 2010). In order to do this effectively Churches in Nigeria need to fully integrate HIV prevention and control programs into their health-related religious activities (Christian Health Association of Nigeria-CHAN, 2004). Churches in Uganda, Kenya and South Africa are known to have demonstrated leadership in the prevention of HIV and AIDS (Hartwig, Kissioki and Hartwig, 2006).

Churches in Nigeria have extensive networks of congregations across the country including the most remote areas. They can, therefore be used to reach their adherents with information and programmes relating to the prevention of the infection through the adoption of HCT. Ibadan, the largest city in West Africa, has numerous registered and unregistered churches. These churches are centres for the solemnization of a sizeable proportion of marriages and can thus help facilitate the adoption of HCT among intending couples in the city. A pioneering AIDS related study among Christian religious leaders' in the city has been conducted; it focused mainly on their knowledge and perceptions of the disease condition (Awopegba, 2009). An assessment of the Christian religious leaders' practices relating to HCT for intending couples was not included in the study. Field work activities by post graduate public health students have revealed that Ibadan South West Local Government Area (IBSWLGA), one of the five metropolitan Local Government Areas (LGA) in Ibadan, has a large concentration of churches of various denominations. It was noted, however, that the HCT related practices targeted at intending couples in the LGA were yet to be well investigated. This awareness led to the design and implementation of this study.

The results of this study are potentially useful for designing HIV- related interventions geared to towards involving Christian religious leaders in the promotion of HCT among intending couples. In addition, the results can throw light on issues that need to be taken into consideration while formulating policies relating to the involvement of Christian religious leaders in HCT programming targeted intending couples.

Methodology

Details of the study design, study setting, study population, sampling process, data collection instrument, data collection process as well as data and analysis have been presented elsewhere (Oshiname, Adegbola and Ogunwale, 2017.). A summary of these methodological issues are, however, presented in this paper in order to put the results contained in this paper in proper perspectives.

Study design and Study Setting

The study was a descriptive cross-sectional survey conducted in IBSWLGA, Oyo State Nigeria. The LGA comprises 12 political wards and it has a total population of 283,098 based on the 2006 (NPC, 2006). The LGA which is predominantly inhabited by the Yoruba is blessed with numerous churches of various denominations; there is hardly any neighborhood in the LGA without churches. However, however informal interviews with the leadership of the Christian Association of Nigeria (CAN) revealed that only 235 churches in the LGA were registered with CAN. The churches registered with CAN in IBSWLGA are grouped, for convenience, into four categories as follow: Catholic; African Instituted Churches/Indigenous churches; Pentecostal Churches; and Evangelical Church of West Africa (ECWA).

Many churches in the LGA provide pre-marital counselling for intending couples. The counselling services are mainly provided by church leaders and/or staff such as marriage counsellors, Pastors/Priests, Deacons and Deaconesses. Pre-marital counsellors are church officials who educate intending couples on a variety of issues which include the nature and demands of the marriage institution, parenting and social skills needed for marital life as well as the advantages and challenges of marriage.

Study Population

The study population consisted of male and female church officials such as Priest, Deacon/Deaconess, Elder, Pastor or other church officials mandated to provide pre-marital counselling services to intending couples. Church officials who were not directly involved in the provision of marriage counselling were excluded from the study. Churches that had never conducted any marriages or who declined to be involved in the study were also excluded.

Sampling process, data collection instrument and data collection process

A four-stage sampling technique procedure was adopted and this resulted in the selection of 660 Christian marriage counselors for interview. The first stage involved the stratification the 235 churches that registered with CAN into four districts in accordance with CAN's categorization of churches in the IBSWLGA. There was further stratification of the churches in each district into Indigenous Churches (IC)/African Instituted Churches and Non-Indigenous Churches (NIC); this constituted the second stage. In the third stage 50% of churches in each stratum (i.e. IC and NIC) in the four CAN districts was selected. This exercise resulted in the selection of 119 churches. The fourth stage was the identification and recruitment of church officials who provide pre-marital counseling services. In each selected church the presiding Pastor/Priest and any other associate Pastors, Church Deacons and Deaconesses and lay marriage counsellors were purposively selected. A minimum number of five and a maximum number of seven Christian officials who were associated with the provision of counselling services were purposively selected for interview. The investigators and Research Assistants (RAs) moved from church to church to interview eligible respondents until the sample size of 660 was achieved.

A validated semi-structured questionnaire was used for data collection. The instrument contained questions which elicit information relating to the following from respondents: socio-demographic information, pre-marital HCT practices, management or handling of sero-positive HIV test results and the typology of support provided for persons living with HIV/AIDS. The questionnaire was constructed in the English language and given to a language expert to translate to Yoruba. Subsequently the Yoruba version of the instrument was back-translated into English by another language expert; this was done with a view to ascertaining the accuracy of the translation exercise. Prior to its use the questionnaire was pre-tested in Ibadan North-West LGA among 66 church officials (i.e. 10 percent of the study sample size of 660). A total of six trained RAs were hired to assist in the data collection process.

Consenting participants were interviewed on one-on-one basis either in the church office or in a mutually acceptable venue in the church premises which guaranteed the privacy of respondents. Ethical approval of the proposal for this study was obtained from the Oyo State Ministry of Health Ethics Review Committee.

Data management and analysis

Copies of the administered copies of the questionnaire were collated and cleaned. A coding guide was developed and used to enter the data contained in the copies of the questionnaire into a computer using the SPSS software-version 20.0. Descriptive statistics such percentages, mean and Chi-square test were used to facilitate data analysis at $P=0.05$.

Results

Respondents' socio-demographic characteristics are presented in Table 1. Majority (60.3%) of the respondents were males and 85.9% of them were Yoruba. Their ages ranged from 27 -79 years with a mean of mean of 45.0 ± 8.6 years. Nearly all (99.4%) of the respondents were literate. A large majority (81.2%) of the respondents belonged to the indigenous churches. Almost two-third (65.0%) of the respondents served as marriage counselors alone, while some 35.0% of the respondents combine marriage counseling role with priestly responsibilities. As much as 77.3% of the respondents performed their marriage counseling role on part-time basis. The number of marriages usually solemnized in respondents' churches reportedly ranged from one to five per month with a mean of 1.35 ± 0.57 per month.

Table 1: Socio-demographic characteristics of respondents

Characteristics	N=660	
	No.	(%)
Sex		
Male	398	60.3
Female	262	39.7
*Age group (n=658)		
<40 years	175	26.6
40 – 49 years	309	47.0
50 – 59 years	126	19.1
≥60 years	48	7.3
Marital status		
Single ⁺	8	1.2
Married	633	95.9
Widowed	19	2.9

Highest educational qualification		
No formal education	4	0.6
Primary education	12	1.8
Secondary education	89	13.5
Tertiary education	555	84.1
Ethnic group		
Yoruba	567	85.9
Igbo	64	9.6
^Others	29	4.5
Typology of Christian faith:		
Indigenous	536	81.2
Non-indigenous	124	18.8
Position/role played in the church:		
Reverends/Pastors/Priests and marriage counseling	231	35.0
Marriage counselor only	429	65.0
Nature service rendered in church:		
Full time	150	22.7
Part time	510	77.3
Average number of wedding per month in church (n=567)^β¥		
1	395	69.7
2	154	27.2
>2	18	3.1

*Mean age of respondents=45.0±8.6 years, range=27-79 years

+ 0.9% were of them Rev. Father who adopt celibacy

^Others – Niger Delta ethnic groups – 3.7%; Middle belt ethnic minorities- 0.8%

^β Mean number marriage solemnized per month = 1.35 ± 0.57, range= 1 – 5.

¥Non responses were excluded from the analysis

Pre-marital counseling programme for intending couples

Table 2 presents information relating to pre-marital courses or counseling practices for intending couples in respondents' churches. The respondents were asked whether intending couples in their churches are usually mandated to undergo a pre-marital course or counseling in their churches. Most (88.2%) of the respondents' indicated that they had mandatory a pre-marital counseling programme for intending couple in their churches. The duration of the church-based pre-marital courses or counseling programme varies across churches. Some (31.9%) of the respondents conducted church-based pre-marital courses which lasted from 1-4 weeks (See table under reference for additional details). Few (14.7%) respondents often requested intending couples to undergo pre-marital courses or counseling programme that last more than 12 weeks in their churches. Sixty percent of the respondents who provided mandatory pre-marital courses or counseling services for intending couples in churches stated that their programmes included HIV related issues (including encouraging intending couples to undergo HCT).

Table 2: Pre-marital counseling practices/services for intending couple in respondents' churches
N= 660

Typologies of Pre-marital courses / counseling related practices:		Number	%
^β	<i>Mandatory pre-marital course or counseling for intending couple</i>		
	Yes	582	88.2
	No	78	11.8
	<i>Duration of church-based pre-marital courses in weeks (n= 498)^{β*}</i>		
	1 – 4 weeks	159	31.9
	5 – 8 weeks	121	24.3
	9 – 12 weeks	145	29.1
	>12 weeks	73	14.7
	<i>Inclusion of HIV related issues in pre-marital courses ^{*¥}</i>		
	Yes	346	59.7
	No	234	40.3

Mean=9.6±6.8; Median = 8 , Range- 1 – 28 weeks

¥ The HIV related issues included basic information on HIV, encouragement of intending couples to undergo HCT

* Non responses were excluded from the analysis

Table 3 shows that 67.8% of the respondents listed other church requirements, apart from HCT, which needs to be fulfilled by intending couples before they are joined in marriage. The listed requirements included pregnancy test (27.1%), genotype screening (23.0%) and blood group test (20.0%).

Table 3: Reported Church requirements, apart from HCT, which needs to be fulfilled by intending couples before they are joined in marriage.

N=448		
Church requirements ⁺	No.	%
Pregnancy test	138	27.1
Genotype screening or test	117	23.0
Blood group test	101	20.0
Legal freedom from local government and parents consent	66	13.0
Being a Christian and member of the church	55	10.8
Spiritual preparation (prayer, spiritual counseling & Baptism)	22	4.3
Gown inspection	9	1.8

*Multiple responses present

+Not necessarily compulsory

Pre-marital HIV Counselling and Testing practices in churches

A total of 73.2% of the respondents indulge in the practice of requesting intending couples to undergo compulsory HCT (See table 4 for details). The places where intending couples were requested to go for their HCT included Government Hospital (58.3%), private laboratory (17.4%) and Church Health facility (12.0%) (See table 4 for further details).

Table 4: Nature of HCT for intending couples in churches and places where intending couples go for HCT

	N=660	
	No	%
Nature of HCT for intending couples and places where intending couples go for HCT		
<i>Nature of HCT for intending couples who want to get married in churches (n= 570)</i>		
HCT made mandatory/compulsory	417	73.2
HCT made optional	153	26.8
<i>Places where intending couples are directed go (or are expect to go) for HCT (n=567)</i>		
Government hospitals	475	58.3
Private laboratory/ diagnostic centers	142	17.4
Church health facility	98	12.0
Private hospitals	93	11.4
Any centre decided by the couple	7	0.9

Table 5 shows the analysis of participants' church practice related to mandatory HCT for intending couples by selected respondents' characteristics. The practice of mandatory HCT for intending couples was significantly more common (93.5%) among those in non-indigenous churches than indigenous churches (85.5%). The practice of mandatory HCT for intending couples varied with the average number of wedding conducted per month ($p < 0.05$). The proportion of churches with one, two and more weddings per month that indulge in the practice mandatory HCT for intending couples were 85.1%, 89.6% and 100% respectively ($p < 0.05$). The proportion of practice of mandatory HCT for intending couples among participants who render full-time and part-time church services were 87.3% and 86.7% respectively. Overall, there was no significant association between the practice of mandatory HCT for intending couples and pattern of practice of counselling services. The proportions of practice of mandatory HCT for intending couples among churches whose duration of pre-marital counseling course were 1 – 4 weeks, 5 – 8 weeks, 9 – 12 weeks and more than 12 weeks were 91.2%, 90.9%, 91.7% and 89.7% respectively. Overall, there was no significant association between practice of mandatory HCT for intending couples and duration of pre-marital counseling course.

Table 5: Practice of mandatory HCT for intending couples by selected respondents' characteristics
N = 610

Selected characteristics	Practice of mandatory HCT for intending couple	Chi Square Value,
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				P value
	Yes N (%)	No N (%)	Total N (%)	
Pattern of counselling services rendered:				
Full time	131(87.3)	19 (12.7)	150 (100.0)	$\chi^2=0.045$
Part-time	442(86.7)	68(13.3)	510(100.0)	P=0.83
Religion denomination				
Indigenous churches	457(85.3)	79(14.7)	536(100.0)	$\chi^2= 6.04$
Non-indigenous churches	116(93.5)	8(6.5)	124(100.0)	P=0.014
Duration of pre-marital counseling course in respondents' church				
1 – 4 weeks	145(91.2)	14(8.8)	159(100.0)	$\chi^2= 0.25$
5 – 8 weeks	110(90.9)	11(9.1)	121(100.0)	P=0.97
9 – 12 weeks	133(91.7)	12(8.3)	145(100.0)	
>12 weeks	70(89.7)	8(10.3)	78(100.0)	
Average number of wedding per month in church				
1	336(85.1)	59(14.9)	395(100.0)	$\chi^2= 4.67^+$
2	138(89.6)	16(10.4)	154(100.0)	P=0.037
>2	18(100.0)	0(0.0)	18(100.0)	

*Non responses were excluded

⁺ Fisher Exact test was used since 1 cell had expected count less than 5

Table 6 presents respondents' reported ways of handling HCT results when either man or woman/lady is HIV positive. Many (35.3%) respondents disclosed that they did not request for the HIV test results of their clients while a smaller proportion (20.4%) of the respondents merely counselled the intending couples. Respondents who often leave the couples to decide what they wanted to do constituted 19.4%. Only a few (5.0%) respondents indicated they would go ahead to solemnize such marriages in their churches while 4.7% of the respondents would cancel the solemnization of the marriage proposal of such couples. On realising that both man and woman who intend to get married are HIV positive 36.9% would cancel the married proposal. Only 8.2% of the respondents reported that they would not prevent the solemnization of such a marriage. Respondents were asked whether they would disclose the HIV seropositive status of intending couples to the church congregation. All the respondents (n=654) who answered the question replied in the affirmative

Table 6: Ways of handling sero-positive HIV test results by church authorities and disclosure of HIV-sero positive status of intending couples to congregation

Variables	N=660	
	No.	%

Ways of handling HCT results which show that one of the intending partner is HIV positive*

We don't ask for their results	239	35.3
Counsel them about the situation	138	20.4
Leave them to decide what to do with the test result	131	19.4
Referral to nearby hospitals for appropriate counseling	55	8.1
Go ahead and solemnize their marriage	34	5.0
Cancel the marriage	32	4.7
It has never happened/ case never observed	28	4.1
Advise not to enter into the marriage	20	3.0

Ways of handling HCT results which show that both man and woman who intend to get married are HIV positive*

Cancel the marriage	254	36.9
Counselling and education	156	22.7
Left for them to decide	108	15.7
Referral to hospital for counseling	73	10.6
Marriage will still be solemnized	56	8.2
Advised to attend clinic regularly	32	4.7
It has never happened	8	1.2

Disclosure of HIV-sero positive status of intending couples to congregation (n=654) +

Yes	654	100.0
No	0	0.0

*Multiple responses present⁺

Non responses were excluded

Only 39 respondents indicated that their churches had ever cancelled a wedding programme on discovering that either man or woman was HIV positive. Table 7 presents respondents' pattern of practice of canceling wedding programmes by selected socio-demographic characteristics of respondents as a result of intending couples' HIV sero-positive status. The cancellation of wedding programmes on account of the HIV sero-positive status of intending partners was practiced by 6.8% respondents that was involved full-time practice and 5.8% respondents who were involved in part-time counselling services. Overall, there was no significant association between canceling of wedding programme on account of HIV sero-positive status of intending partners or couples and duration of pre-marital counseling course. A few (5.5%) of indigenous churches compared to 8.3% of non-indigenous churches indulge in the practice of canceling wedding programmes on account of the HIV sero-positive status of intending couples. Overall, there was no significant association between canceling wedding programme on account of HIV sero-positive status of intending partners and religion domination. The proportions of canceling wedding programme on account of HIV sero-positive status of intending couples and duration of pre-marital counseling course were 1 – 4 weeks, 5 – 8 weeks, 9 – 12 weeks and more than 12 weeks were 5.1%, 1.7%, 13.3%, 9.6% respectively. Overall, there was significant association between canceling wedding programme on account of HIV sero-positive status of intending partners or couples and duration of pre-marital counseling course. It was also noted that there was no significant association between the number of weddings consummated by churches and pattern of canceling marriages due to couples' sero-positive status (see table 7 for details).

Table 7: Practice of canceling wedding programme on account of HIV sero-positive status of intending partner or couples by selected respondents' characteristics

N = 610

Variables	Practice of cancelling wedding programme on account of HIV-sero positive status			Chi Square Value, P value
	Yes N (%)	No N (%)	Total N (%)	
Nature of service rendered in church				
Full time counsellor	10(6.8)	137(93.2)	147(100.0)	$\chi^2=0.187$ P=0.396
Part time counselor	29(5.8)	468(94.2)	497(100.0)	
Religion denomination				
Indigenous churches	29(5.5)	494(94.5)	536(100.0)	$\chi^2= 1.28$ P=0.289
Non-indigenous churches	10(8.3)	111(91.7)	121(100.0)	
Duration of pre-marital counseling course in respondents' church				
1 – 4 weeks	8(5.1)	148(94.9)	159(100.0)	$\chi^2= 14.7$ P=0.002
5 – 8 weeks	2(1.7)	117(98.3)	119(100.0)	
9 – 12 weeks	19(13.3)	124(86.7)	143(100.0)	
>12 weeks	7(9.6)	66(90.4)	73(100.0)	
Number of wedding per month in church				
1	21(5.4)	367(94.6)	388(100.0)	$\chi^2= 2.86^+$ P=0.198
2	14(9.3)	136(90.7)	150(100.0)	
>2	1(6.3)	15(93.8)	16(100.0)	

*Non responses were excluded

⁺ Fisher Exact test was used since 1 cell had expected count less than 5

There was a probe into the availability of any form of support for PLWHA in respondents' churches. Few of the respondents (37.0%) reported that they had some form of support for PLWHA in their churches. The nature of support listed by respondents included prayer cum counseling (74.9%), financial support (16.4%) and referral to the hospital 8.2% (See figure 1 for details).

N=219

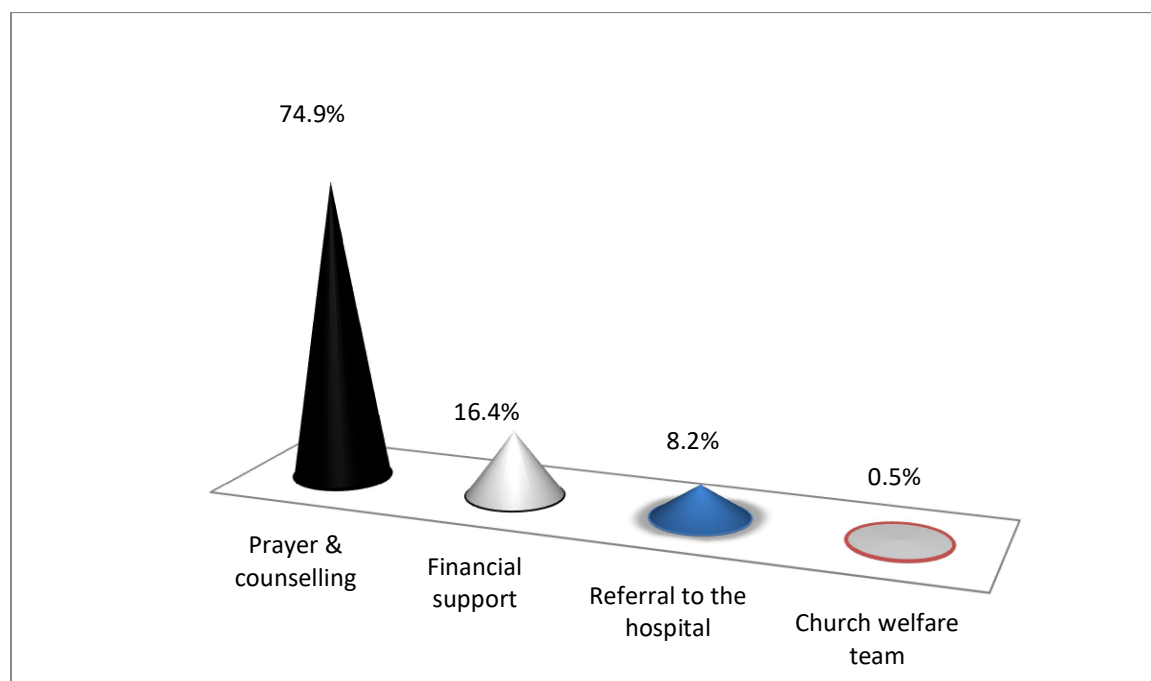


Figure 1: Nature of support provided by respondents' church for members who are living with HIV and AIDS.

Discussion

The mandatory practice of HCT for intending couples in churches observed in this study is in tandem with findings from some previous studies (Arunlogun and Adefioye, 2010; Umar and Oche, 2012). The study by Umar and Oche (2012) revealed the position of some Christian clerics relating to mandatory HIV test. They noted that some clerics insisted on intending couples undergoing mandatory premarital HIV testing before joining them together in marriage as this, according to them, is the surest way of preventing the transmission of HIV from the fiancé to the fiancée or vice-versa. Similarly, a study in Ghana showed that some religious leaders believed that their insistence on mandatory pre-marital HIV testing policy was genuine way of protecting those who are HIV negative from becoming infected (Luginaah, Yiridoe and Taabazuing, 2005). According to Durojaiye (2003), religious institutions often justified mandatory HCT for intending couples on the need to avert HIV transmission among intending couples and by so doing curb the spread of the epidemic in the society.

Some of the participants reported that they counseled intending couples based on the outcome of their HIV test. This report is similar to what was revealed in a previous study by Ansari and Gaestel, (2010), among religious leaders. According to Ansari and Gaestel, (2010) religious leaders counsel HIV positive individuals who experience isolation or discrimination; they added that the focus of their HIV related pastoral care include promotion of communication and social relationship as well as encouragement of HIV positive persons to challenge faulty beliefs.

This study revealed the various ways of handling sero-positive HIV test results by church authorities; these included counseling of intending couples, referral to hospital for counseling and leaving intending couples to decide what to do with their test results. Some Christian leaders counsel intending couples against continuing their marriage while few others decide to cancel the marriage of intending couples with sero-positive HIV test

results. A previous study carried out by Makele (2005) in Ghana, reported that Christian leaders' hold diverse views relating to the ways of handling sero-positive HIV test results of intending couples. According to Makele (2005) while some Christian leaders opined that marriage between discordant couples should not be permitted, some others opined that such marriages should be permitted only under certain protective precautionary measures which include permanent condom use, limitation of childbearing, and adoption of PMTCT measures. The practice of cancelling the proposed marriage of intending couples as a result of their sero-positive HIV test results could be as a result of inadequate knowledge and misconceptions relating to the on the prevention and management of HIV and AIDS. It could also be as a result of conflicts between cherished doctrinal issues and the some HIV prevention strategies such as those relating to condom use; this is an area which requires further exploration.

Advice and counseling are often the major forms of service provided for intending couples living with HIV and AIDS. This is in line with a study conducted by Agadjanian and Sen (2007) which showed that the major forms of support for persons living with HIV and AIDS are psychological supports such as advice, encouragement and tangible support in form of help with money, food, transportation, as well as personal physical care. These kinds of support should be sustained by Christian leaders in order to effectively address the psycho-social needs of person with HIV and AIDS. People tend to take refuge or seek for help in religious organizations they belong to especially in times of crises, diseases and deaths (Oluduro, 2010).

All the respondents in this study stated that they did not disclose the HIV and AIDS status of intending couples to their church congregations. A study conducted in Senegal, showed that both the Christian and Moslem religious leaders appeared to be divided on the issue of disclosure of HIV test results (Ansari and Gaestel, 2010). For instance, some stated that the HIV positive individuals need to make known their sero-status in order to access care and support services, while others were of the view that it was not necessary for an HIV positive individual to tell anyone; some persons strongly opined that HIV positive persons should do everything possible to get help while avoiding disclosure (Ansari and Gaestel, 2010).

Mandatory participation in HCT before marriages are consummated is the norm in some churches. Refusal to solemnize marriages on grounds of sero-positive HIV status against the freely expressed wish of intending couples could be termed discriminatory and the action has potential for reinforcing or perpetuating HIV related stigma. This is more so as it has been shown that HIV related stigma poses a barrier to HIV prevention efforts (Okechukwu, 2007; Monjik, Smesny and Essien, 2009). Appropriate educational interventions such as training and lobbying could be used to tackle the improper practice.

The issues relating to disclosure, informed consent, and measures for protecting confidentiality need be promoted by churches where HCT is a prerequisite for solemnizing marriages. Training relating to the ethics of HCT will help church leaders including marriage counselors to be implementing their HCT related policies in ethically acceptable ways. The essence of such a training programme should not be limited to decisions relating to solemnization of marriages alone. Rather the training programme should be used as an opportunity to upgrade Christian religious leaders' knowledge of the advantages inherent in adopting the test and adoption of prevention and control technologies such as Prevention of Mother-to-Child Transmission (PMTCT) of HIV. Trained religious leaders would then be in a position to be promoting PMTCT adoption, use of anti-retroviral drugs and uptake of practices for living positively with HIV among couples who want to go ahead with their marriage plans despite their HIV sero-positive status.

The churches in the study have diverse Christian religious doctrines that are promoted among their adherents. A common denominator among them, however, is that they all profess to be followers of Jesus Christ. The churches can network among themselves to be involved in HIV prevention in several ways with special reference to premarital HCT. This way they can share resources and ideas that work for preventing HIV among their intending couples. The social networking strategy can be used to promote information sharing and the replication of



innovative marriage counseling programmes among churches with special reference to church leaders including counselors.

Premarital HIV counseling activities of churches should involve individual and group counseling interventions for risk reduction. Identified HIV positive intending couples including discordant intending couples should not be left alone by church leaders and marriage counselors after knowing their HIV sero-status. Christian leaders and marriage counselors need to be supported by their churches to be providing outreach programmes as well. Support and care services such as follow-up counseling, management of opportunistic infections, interventions to prevent mother-to-child transmission of HIV, social support, and access to anti-retroviral (ARV) therapy must be given top priority. Marriage counselors' capacity need to be enhanced to be providing referral services to intending couples in terms of places where care and appropriate services needed for living positively with the disease condition could be accessed.

Christian religious organizations are increasingly becoming powerful institutions in Nigeria. They can use their resources and connections to advocate for policies aimed at standardizing pre-marriage counseling programmes with special reference to HIV and AIDS. A policy which fails to accept the marriage plans of intending couples contravenes people's fundamental rights because it is a violation of their right to make their own choice; such a policy is un-ethical. This concern should be addressed through advocacy for policy review in churches with un-ethical HCT related policies.

Conclusion

The findings from this study have thrown light on Christian marriage counsellors' practices relating to HIV counselling and testing for intending couples in Ibadan, Nigeria. Most churches have an HIV component of the premarital counseling provided for intending couples in their churches with some promoting mandatory HIV screening as part of their criteria for marriage solemnization. Other church requirements from intending couples included pregnancy test, genotype screening and blood group test. Intending couples are usually referred to formal health care facilities for such tests or screening. However, church leaders do not disclose the HIV and AIDS status of their infected church members to other people. This is a proper thing to do; disclosure of people's sero-negative status without their permission is a violation of their privacy and by that very fact un-ethical. The policy of not solemnizing marriages based on the sero-discordant status of intending couples exists in only few churches. It can be gleaned from this study that successful promotion of pre-marriage HCT in churches in the study area should be multi-dimensional and so multiple intervention strategies are required. The use of multiple educational strategies ensures that the weaknesses of one are reinforced by the strengths of the others. Appropriate training for Christian marriage counselors on ways of handling sero-positive HIV test results of intending couples are needed.

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