Christian Marriage Counsellors' Knowledge and Perceptions of HIV Counselling and Testing for Intending Couples in Ibadan South West Local Government Area of Oyo State

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Abstract

HIV counselling and testing (HCT) is a key strategy for controlling HIV, an infection which remains one of the leading public health problems in sub-Saharan African nations, including Nigeria. Church-based marriage counsellors (CMCs) can play important roles in facilitating HCT adoption by intending couples (IC) who register for marriage solemnisation. However, knowledge and perception of CMCs relating to HCT, which could be used as baseline information for designing interventions to empower them to promote HCT among ICs, have not been sufficiently investigated.

This paper explored the knowledge and perceptions of HIV counselling and testing (HCT) for intending couples (IC) among Christian marriage counsellors (CMCs) in Ibadan South West Local Government Area (LGA) of Oyo State.

The cross-sectional study used a four-stage random sampling technique to select 660 CMCs from the Christian Association of Nigeria districts, denominational categories and parishes in the LGA. A pre-tested semi-structured questionnaire was used to collect data. Descriptive statistics and the chi-square test were used to analyse data at p=0.05.

Respondents' age was 45.0±8.6 years, 60.3% were male, 84.1% had tertiary education, 65.0% performed only CMCs roles; while 35.0% were pastors as well. Mean knowledge score was 9.3±2.6 and the proportions of respondents with poor, fair and good knowledge scores were 5.2%, 44.8% and 55.2% respectively. Respondents with no formal/primary, secondary and tertiary education who had poor knowledge of HCT were 31.3%, 10.1% and 3.6% respectively ($p<0.05$). The majority (84.7%) perceived mandatory HCT as morally justifiable, while 88.6% opined that churches should make HCT compulsory for ICs. Some (25.2%) respondents asserted that the sero-positive status of an individual who intends to get married should not be disclosed to his/her sero-negative partner.

Knowledge relating to HIV counselling and testing was generally high among the Christian leaders. However, those who had tertiary education were largely more knowledgeable about HCT. Some inappropriate perceptions relating to HCT which have ethical implications existed among the Christian leaders. Educational interventions that have potentials for upgrading respondents' knowledge of HCT and promoting appropriate ethical perceptions are recommended.

Keywords: Marriage Counsellors, HIV Counselling and Testing, Intending Couples

Introduction

The human immunodeficiency virus (HIV) remains one of the most serious infections and poses a serious challenge to public health (UNAIDS, 2012). Over the years, HIV and AIDS have brought immeasurable suffering and despair to humanity (Adekeye, 2010). The spread has had adverse

economic consequences for individuals and households (Odumosu and Okonkwo, 2006). The disease condition diminishes human capital and delays social and economic development (UNAIDS, 2012). In 2015, 2.1 million new HIV infections occurred worldwide, adding up to a total of 36.7 million people living with HIV (USAID, 2016). However, data from 160 countries has shown that AIDS-related deaths decreased by 43% at the end of 2015 (UNAIDS, 2016). Despite the progress recorded globally in HIV and AIDS, sub-Saharan Africa, with an estimated population over 10 percent of the world's population, has continued to record the greatest burden of the disease condition (UNAIDS, 2013; UNAIDS, 2016). The burden of the HIV and AIDS pandemic has been felt in all areas of life and poses serious challenges to various sectors and organisations, including faith-based organisations (Ajakaiye and Odumosu, 2002; Casale, 2005; Momoh and Ezugworie, 2010).

Nigeria, which is the most populated country in Africa, carries the second highest burden of HIV in Africa with about 3.4 million people infected (NACA, 2012; FMOH, 2013). It is second only to South Africa, which has a population of 6.8 million HIV-infected people (USAIDS, 2013). Nigeria has an increasing population of people living with HIV (NACA, 2012). The factors which drive the prevalence of HIV in Nigeria include low risk perception (NACA, 2012), multiple concurrent partners (NACA, 2012; John, Okolo and Isichei, 2014), informal transactional and inter-generational sex (NACA, 2012), and forced sex (Chinawa et al, 2013; Akinlusi et al, 2014). Other factors that could increase the prevalence of HIV include lack of effective services for managing sexually transmitted infections (STIs), poor quality and inaccessibility of health facilities (NACA, 2012), gender inequalities (UNAIDS, 2016), poverty (NACA, 2012) as well as HIV and AIDS-related stigma and discrimination (Monjok, Smesny and Essien, 2009; NACA, 2012). In addition, it has been noted that lack of knowledge and misunderstanding of the issues relating to HIV and AIDS have continued to undermine the fight against HIV and AIDs (Odimegwu, 2003).

Generally, there are numerous ways of spreading the infection (CDC, 2013). The leading route of HIV transmission is heterosexual intercourse, which accounts for over 80 percent of infections in Nigeria (NACA, 2012; NACA, 2014). Other factors or practices known to be implicated in the transmission of HIV include sharing of contaminated or infected sharp objects, use of contaminated body fluids including blood and sharing of

contaminated or infected intravenous equipment (MTCT). Sharing of contaminated or infected intravenous equipment is a major factor implicated in paediatric HIV/AIDs cases (WHO, UNAIDS and UNICEF, 2012; UNAIDS, 2012; CDC, 2013).

At present, there is no cure for HIV and AIDS and most control activities are aimed at preventing and reducing HIV transmission. Behaviour modification remains the most appropriate intervention in the prevention and control of HIV and AIDS (Obioha, 2008). These interventions include adoption of HIV Counselling and Testing (HCT), reduction of casual sex, proper blood screening before use and prevention of MTCT (Momoh and Ezugworie, 2010). Of these interventions, HIV counselling and testing constitutes one of the most effective technologies for the control of HIV worldwide (Merson, 2006; Ogunwale and Adewumi, 2014). It involves, in a nutshell, the laboratory or medical screening of a person's blood with a view to determining whether the person has HIV or not. The process involves counselling people before their blood is taken for HIV screening and after screening, people are again counselled irrespective of their sero-status.

It has been noted that pre-marital HIV counselling and testing is a major strategy for curtailing the spread of the virus (Laurice, 2002). It helps to reduce or prevent the spread of HIV through MTCT (UNAIDS, 2012). In Nigeria, many people including unmarried youths do not know their HIV status (NACA, 2012). This can be attributed to various factors including inadequate knowledge about the benefits of HIV counselling and testing, misconceptions about HIV and AIDS and high level of stigma associated with the disease (NACA, 2009).

Therefore, religious institutions have an important role to play in the prevention and control of HIV and AIDS (Awopegba, 2009; Oluduro, 2010). In many African countries such as Uganda, Kenya and South Africa, churches are in the forefront in the prevention of HIV and AIDS (Hartwig, Kissioki and Hartwig, 2006). This is so because they contribute to the shaping of social values and norms, and can influence public attitudes and national policies related to HIV prevention and control (Family Health International, 2005). The role of religious leaders within the context of HIV and AIDS prevention and control has gone beyond prayers, fasting and other religious obligations. Their roles should include promotion of juristic

regulations and social mobilisation for the adoption of effective HIV and AIDS prevention and control initiatives (Umeora and Esike, 2005).

Christian religious leaders have a large followership; they therefore have pivotal roles to play in the social marketing of HCT as well as other effective interventions in Nigeria. Their involvement in the care of persons living with HIV and AIDS can also not be overlooked (Oluduro, 2010; Asekun-Olarinmoye et al, 2013). In addition, churches are present even in remote areas, including villages and slums in various parts of Nigeria. They can be used to reach many people with information and programmes aimed at preventing the spread of the infection. Churches are popular centres for the solemnisation of marriage involving young people. They can thus help to facilitate the adoption of HCT among intending couples (IC). A prerequisite for the involvement of churches in the social marketing of HCT among intending couples, is the exploration of the knowledge and perception of Christian marriage counsellors (CMCs) who are key actors in the solemnisation of marriage. Investigations of this nature have potentials for yielding evidence-based information for planning HIV-related interventions.

There are however, a number of barriers to the active involvement of churches in HIV and AIDS control in Nigeria. These include lack of appropriate knowledge and misconceptions about HIV and AIDS among the clergy, high levels of stigma and discrimination, and inadequate care and support services for people living with, or affected by HIV and AIDS (Awopegba, 2009; Tiendrebeogo and Buykx, 2004).

This study which is a form of formative research, therefore, focuses on the investigation of the knowledge and perceptions relating to premarital HCT for intending couples among CMCs in churches or parishes in Ibadan South-West Local Government Area (LGA).

Methodology

Study Design and Study Area

The study was carried out in Ibadan South West LGA (IBSWLGA), Oyo State. Ibadan South West LGA, which was created in 1991, is one of the five LGAs in Ibadan metropolis. The LGA comprises 12 political wards with a population of 283,098 persons as at 2006 (NPC, 2006). About 90 percent of

all the inhabitants of the LGA are Yoruba. The other ethnic groups in the LGA include the Igbo and Hausa. Foreign nationals, especially the Lebanese, also live in the area. The LGA is also home to many public or civil servants. The common occupations in the area are trading and craftsmanship.

Ibadan South West LGA has 85 primary and 28 secondary schools. There are also a total of 19 health centres in the LGA. In addition, there are six state hospitals, numerous private healthcare facilities and one mission hospital (St. Anne's Anglican Hospital, Molete). The two major religions practiced in Ibadan South West LGA are Christianity and Islam.

There are over 500 churches in the LGA. However, only 235 were registered with the Christian Association of Nigeria (CAN) as at the time of the study. The churches registered with CAN in IBSWLGA are grouped into four districts based on location (CAN, 2012). Only churches recognized under the CAN Allied Matters Act of 1990 are allowed to register with CAN. Such churches include the Catholic, Anglican, African instituted churches or indigenous churches, pentecostal churches and the Evangelical Church of West Africa (ECWA). These churches, irrespective of category, provide pre-marital Christian education sessions for intending couples.

Study Population

The study population consists of Christian leaders operationally defined as individuals who hold leadership positions in churches and who are involved in the provision of pre-marital counselling services to ICs. This could be a priest, deacon/deaconess, elder, pastor or head of a religious department or an individual conferred with official responsibilities relating to counselling of intending couples in church settings. Churches that had not conducted any marriages as at the time of the study were excluded from the study. In addition, churches that declined to be involved in the study were excluded because participation in the study was voluntary.

Sampling Process, Data Collection Instrument and Data Collection Process

A four-stage sampling technique was used in selecting 660 Christian marriage counsellors for the study. In the first stage of the sampling process, all 235 churches registered under the Christian Association of Nigeria (CAN) were stratified into four districts based on CAN's categorisation of churches in IBSWLGA. For the second stage, churches in each district were further

stratified into indigenous churches (IC) or African-instituted churches and non-indigenous churches (NIC). The third stage involved the selection of 50% of all churches in each stratum (i.e. IC and NIC) across the four CAN districts. Overall, 119 churches were selected from all the 4 districts in the LGA. Selection/sampling of Christian leaders involved in pre-marital counselling programmes and services constituted the fourth stage. The presiding pastor/priest and any other associate pastors, church deacons/deaconesses and marriage counsellors were purposively selected. The research teams visited the selected churches and in each church a minimum of five and a maximum of seven Christian leaders were purposively selected and interviewed until the sample size of 660 was achieved.

Data collection was carried out using a validated semi-structured questionnaire. The design of the questionnaire was done after a review of related literature. The instrument contained questions that were used to elicit respondents' socio-demographic information, and a 13-point knowledge scale, which was used to assess respondents' knowledge of HCT. The instrument also contained questions on perceptions relating to pre-marital HIV counselling and testing. In order to ensure that good quality data were collected, the questionnaire, which was written in the English language was translated into Yoruba by an expert who was competent in both languages. The Yoruba version of the instrument was back-translated into English by another language expert to ascertain the accuracy of the translation. The questionnaire was pre-tested in Ibadan North-West LGA among 66 Christian leaders (i.e. representing 10 percent of the study sample size of 660). Copies of the pretested questionnaire were coded and Cronbach's alpha analysis of SPSS was carried out to determine the internal consistency of the items in the questionnaire. The Cronbach's alpha value obtained was 0.82. Eligible participants were interviewed one after the other, using either the Yoruba or English version of the questionnaire, depending on the preference of the interviewees.

Data Analysis and Management

Copies of the administered questionnaire were collated, cleaned and stored in a secure place. The responses were carefully reviewed and hand-coded. The coded responses in each questionnaire were entered into the computer using the SPSS software-version 20.0. Analysis of univariate data

was done with descriptive statistics, while bivariate analyses of test of associations between independent and dependent variables were done using the chi-square test at 0.05 level of significance. Based on the 13-point scale used to measure knowledge of HCT, scores of ≤ 4, >4 – 9, and ≥10 points were graded as poor, fair and good knowledge of HCT respectively.

Ethical Considerations

The protocol for the study was reviewed and approved by the Oyo State Ministry of Health Ethics Review Committee. Prior to the interview of each respondent, the nature, purpose and processes involved in the study were explained. Participants were assured privacy, confidentiality regarding volunteered information, and plans that had been made to ensure anonymity of information provided by them. Only participants who provided written informed consent were interviewed. Each participant was interviewed on a one-on-one basis in the church office. Where the church office was not conducive, a mutually agreeable venue within the church premises where privacy could be guaranteed was used. This was particularly necessary because HIV and AIDS-related issues are usually sensitive. In addition, this arrangement helped to protect the privacy of respondents and to provide an opportunity for free disclosure of information.

Result

The socio-demographic characteristics of the respondents are presented in Table 1. The majority (60.3%) of the respondents were male. Respondents' ages ranged from 27–79 years with a mean of 45.0 ± 8.6 years. Nearly all (95.9%) the respondents were married, 2.9% were widowed and 1.9% were never married (reverend fathers who adopted celibacy). The majority (84.1%) of the respondents had tertiary education; only few (0.6%) had no formal education. The respondents were predominantly Yoruba (85.9%) and 9.6% were Igbo. A large majority (81.2%) of the respondents belonged to the indigenous churches. Marriage counsellors with no pastoral responsibilities constituted 65.0%, while 35.0% were priests who were involved in marriage counselling for IC as well as pastoral assignments. Above three-quarters (77.3%) of the respondents rendered part-time services in their churches.

Table 1: Socio-demographic characteristics of respondents

N=660

Characteristics	No.	(%)
Sex		
Male	398	60.3
Female	262	39.7
Age group*		
<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: l		
Reverends/Pastors/Priests and marriage counselling	231	35.0
Marriage counsellor only	429	65.0
Nature of service rendered in church:		
Full time	150	22.7
Part time	510	77.3

*Mean age of respondents=45.0±8.6 years, range=27-79 years
+ 0.9% of them were Rev. Fathers who had adopted celibacy
^Others – Niger Delta ethnic groups – 3.7%; Middle belt ethnic minorities- 0.8%

Table 2 presents respondents' concept of HCT. Some (30.3%) of the respondents correctly described HCT as a test used to detect people's HIV status. Others (7.2%) gave incorrect description of the concept of HCT as a way of encouraging people to protect themselves from contracting the diseases while 0.2% of the respondents described it as a satanic way of promoting immorality through the use of condoms.

Table 2: Respondents' concept of HIV counselling and testing

N=502[+]

Concept of HCT	**No.**	**%**
A talk on prevention and management of HIV and AIDS and a simple blood test to know the HIV status*	125	24.9
A test to detect HIV status**	152	30.3
Encouraging people on how to protect themselves from contracting the diseases***	36	7.2
Awareness and the test to confirm one is free from the virus or not**	56	11.2
Giving information on causes and transmission of HIV and letting an individual make an informed decision***	73	14.5
Preventing people from having HIV/AIDS and helping those already infected to be able to manage themselves***	32	6.4
Places and centres which offer counselling services and testing services to people***	7	1.4
Satanic way of encouraging immorality by using condom***	1	0.2
Counselling done before and after going through the HIV test*	20	4.0

Notes: Correct options*; Partially correct options**; Wrong options***

+ Non responses were excluded

Respondents' detailed knowledge relating to HCT is highlighted in Table 3. Most (94.4%) of the respondents indicated that the only way of knowing whether a person is infected with HIV or not is to test the person's blood for the presence of HIV. Most (93.8%) respondents stated that HCT helps infected persons to accept their condition and live productive lives. Few (6.2%) of the respondents declared that HCT is only for persons who have HIV and AIDS.

Table 3: Respondents' knowledge relating to HCT

N=642[+]

Knowledge related statements	True No(%)	False No(%)	Not sure No(%)
The only way of knowing whether a person is infected with HIV or not is to test the person's blood for the virus	606(94.4)**	25(3.9)	11(1.7)
The only way of knowing whether a person is infected with HIV or not is to test the person's excreta or faeces	25(3.9)	563(87.7)**	54(8.4)
HIV counselling and testing does not create an opportunity for one to be receiving HIV and AIDS treatment	160(24.9)	427(66.5)**	55(8.6)
HIV counselling and testing does not create an opportunity for one to receive social support and care	138(21.5)	458(71.3)**	46(7.2)
HIV counselling and testing provides an opportunity for one to know whether or not to access HIV and AIDS related care	579(90.2)**	21(3.3)	42(6.5)
HIV counselling and testing helps infected persons to accept their condition and live healthy and productive lives.	602(93.8)**	14(2.2)	26(4.0)
Participating in HIV counselling and testing is a way of preventing HIV and AIDS in a community	603(93.9)**	20(3.1)	19(3.0)
Testing for HIV is mandatory or compulsory in Nigeria	220(34.3)	357(55.6)**	65(10.1)
Confidentiality or privacy is not ensured in HIV counselling and testing	112(17.4)	449(69.9)**	81(12.6)
HIV counselling and testing involves surgical operation on people so as to remove the part of the body infected with HIV	7(1.1)	613(95.5)**	22(3.4)
HIV counselling and testing is only for persons who are having HIV and AIDS	40(6.2)	586(91.3)**	16(2.5)

Correct option**

+ Non responses were excluded

Respondents' knowledge of the length of the "window period" for HIV is shown in Table 4. The majority (64.6%) of respondents stated correctly that the length of the window period for HIV is within 3-6 months, while 25.4% of the respondents indicated that the window period is 12 months.

Table 4: Respondents' knowledge on the length of the window period for HIV following infection

N=347+

Length in months	Proportion (%)
One month	7(2.0)
Less than 3 months	28(8.1)
3-6months	224(64.6)**
12 months	88(25.4)

Correct response**

+ Non responses were included.

Participants' mean knowledge score relating to HCT was 9.3± 2.6. Levels of knowledge on HCT are presented on Figure 1. The proportion of respondents with poor, fair and good knowledge scores were 5.2%, 44.8% and 55.2% respectively.

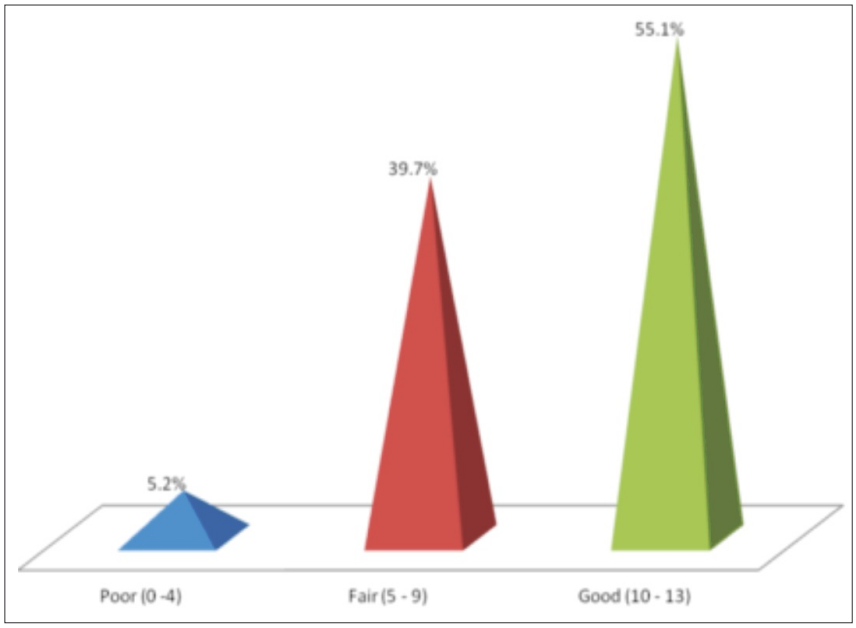

Figure 1: Respondents' level of knowledge on HCT

Table 5 shows the analysis of participants' knowledge of HCT by selected socio-demographic characteristics. Male and female participants with good knowledge of HCT were 54.0% and 56.9% respectively. Overall there was no significant difference in knowledge between males and females. More respondents who were younger than 40 years old (64.6%) had poor knowledge of HCT than respondents aged 60 years and above (58.3%). There was however no significant association between the age of respondents and level of knowledge of HCT. Poor knowledge of HCT decreased significantly in relation to level of education. For instance, participants with poor knowledge of HCT decreased from 31.3% among respondents with only primary education to 3.5% among those who had tertiary education. Overall, there was a significant association between level of education and knowledge of HCT. More respondents in indigenous churches (5.8%) had poor knowledge of HCT than those in non-indigenous churches (2.4%). There was however no significant association between typology of church and level of knowledge of HCT.

Table 5: Level of knowledge of HCT by selected demographic characteristics

N = 610*

Variable	Level of knowledge				Chi Square value, P value
	Poor N (%)	Fair N (%)	Good N (%)	Total N (%)	
Sex					
Male	19(4.8)	164(41.2)	215 (54.0)	398 (100.0)	χ^2= 1.09
Female	15(5.7)	98(37.4)	149(56.9)	262(100.0)	P=0.58
Age					
<40 years	113(64.6)	53(30.3)	9 (5.1)	175 (100.0)	χ^2= 4.54
40 – 49 years	175 (56.6)	121(39.2)	13 (4.2)	309 100.0)	P=0.58
50 – 59 years	71 (56.3)	48 (38.1)	7 (5.6)	126 (100.0)	
≥60 years	28 (58.3)	17 (35.4)	3 (6.3)	48 (100.0)	
Level of education					
+No formal/Primary	5(31.3)	3(18.8)	8(50.0)	16 (100.0)	χ^2= 41.8
Secondary	9(10.1)	48(53.9)	32(36.0)	89 (100)	P<0.001*
Tertiary	20(3.6)	211(38.0)	324(58.4)	555 (100)	
Typology of Church					
Indigenous	31(5.8)	212(39.6)	293(54.7)	536 (100.0)	χ^2= 2.35
Non-indigenous	3(2.4)	50(40.3)	71(57.3)	124 (100.0)	P=0.31

*Non responses were excluded

The study participants had several perceptions relating to pre-marital HCT services. Table 6 presents their perceptions about pre-marital HCT services. The majority of the respondents (87.0%) opined that pre-marital HCT could help reduce the spread of HIV infection in any community. The majority (88.0%) also averred that pre-marital HCT should be promoted by churches. Almost all (95.6%) of the respondents were of the view that a healthy-looking fiancé(e) can be a HIV carrier. Most (94.4%) of the respondents opined that it is good for everyone to go for HCT occasionally. Only a few (9.2%) of the respondents were of the opinion that pre-marital HCT for IC is not necessary because the results can put a stop to the marriage. A small proportion (7.7%) of the respondents also shared the perception that pre-marital HCT is not desirable because it can expose a person about to get married to stigma and discrimination if the test turns out positive.

Table 6: Respondents' perception relating to pre-marital HIV counselling and testing

N=660

Perception-related Statements	Agree No(%)	Disagree No(%)	No opinion No(%)
Pre-marital HIV counselling and testing cannot help reduce the spread of HIV infection in any community.	61(9.2)*	574(87.0)+	25(3.8)
Pre-marital HIV counselling and testing is not desirable because it can expose a person about to get married to stigma and discrimination	51(7.7)*	587(88.9)+	22(3.3)
Pre-marital HIV counselling and testing for intending couples is not necessary because the results can put a stop to the marriage	61(9.2)*	571(86.5)+	28(4.2)
Pre-marital HIV counselling and testing should be promoted by churches	581(88.0)+	66(10.0)*	13(2.0)
It is important for a man and a woman who are about to marry to know whether either of them has HIV or not.	639(96.8)+	12(1.8)*	9(1.4)
A healthy looking fiancé(e) can be a HIV carrier	631(95.6)+	18(2.7)*	11(1.7)
HIV counselling and testing is not necessary for Christians because Christians do not indulge in practices that lead to HIV infection	20(3.0)*	630(95.5)+	10(1.5)
HIV counselling and testing (HCT) is meant for the sexually active people, not committed Christians.	27(4.1)*	622(94.2)+	11(1.7)

Perception-related Statements	Agree No(%)	Disagree No(%)	No opinion No(%)
It is good for everyone to go for HIV counselling and testing occasionally	623(94.4) [+]	19(2.9)*	18(2.7)

[+] Perception that can favour the promotion of HCT targeted at intending couples

* Perception that can discourage the promotion of HCT targeted at intending couples

Perceptions relating to the ethics of HCT are presented in Table 7. The majority of respondents (84.7%) opined that mandatory HCT for IC is morally justifiable. The majority (88.6%) of the respondents also shared the opinion that HCT should be mandatory or compulsory in churches before joining ICs in marriage to prevent divorce later. About a quarter (25.2%) of the respondents indicated that the HIV positive status of a man or woman who intends to be married should not be disclosed to his/her partner by the church authorities.

Table 7: Respondents' Perceptions Relating to the Ethics of HCT

N=660

Perception with Ethical Implication*	Agree No(%)	Disagree (%)	No opinion No(%)
Mandatory or compulsory HIV counselling and testing for intending couples is morally justifiable	559(84.7) [β]	56(8.5) [α]	45(6.8)
Mandatory or compulsory pre-marital HIV counselling and testing is a violation of intending couples' human rights.	84(12.7) [α]	525(79.5) [β]	51(7.7)
Counselling of intending couples who are discordant (one is positive while the other is negative) by an officiating minister is an abuse of their human right	68(10.3) [β]	549(83.2) [α]	43(6.5)
The HIV positive status of a man or lady who intends to be married should not be disclosed to the partner by church authorities.	166(25.2) [β]	446(67.6) [α]	48(7.3)
HIV counselling and testing should be mandatory or compulsory in churches before joining intending couples in marriage to prevent divorce later	585(88.6) [β]	49(7.4) [α]	26(3.9)
The HIV status of either a man or woman should not prevent the solemnisation of their marriage	421(63.8) [α]	183(27.7) [β]	56(8.5)

[α]Ethically appropriate perception; β Unethical perception; *Multiple responses

Discussion

The study revealed that there were more male Christian leaders (60.3%) than female Christian leaders (39.7%). A study conducted by Awopegba (2009) in Ibadan and Kaduna similarly revealed that a higher proportion of the Christian religious leaders were male. This situation may be a reflection of the prevailing practice in most orthodox Christian religious groups, that preferentially bestows leadership positions on males or tend to reserve certain official religious responsibilities for the males.

The ages of the respondents ranged from 27 – 79 years with a mean of 45.0 ± 8.6 years. This is similar to what obtained in previous similar studies conducted by Awopegba (2009) and Umar and Oche (2012). The study conducted by Awopegba (2009) for instance, revealed that the ages of Christian religious leaders ranged from 20 – 80 with a mean age of 48.6±12.7. The finding of the study implied that religious leaders are often mature adults. Physical and psychological maturation are among the major factors that are often considered when appointing people to leadership positions in churches (West et al, 2015).

The majority of respondents had tertiary education. This is an emerging trend among Christian religious leaders in Nigeria. Religious leaders with tertiary education constitute an asset that could be easily used to promote adoption of HCT and other HIV prevention activities through churches and other frequently organized religious fora.

Most (81.2%) of the respondents were from the indigenous faith/churches compared he NICs which accounted for 18.8%. This is expected because indigenous churches are very aggressive in the spread of their doctrines and they do this by setting up churches in almost all available areas or spaces in communities. If their capacities for HIV prevention and control are developed, their zeal for the spread of their various denominational doctrines and winning converts could be used to spread factual information relating to HIV and AIDS in general and HCT in particular.

Almost all the study participants mentioned correctly that the only way of knowing whether a person is infected with HIV or not is to test the person's blood for the virus. The study by Amu and Ijadunola (2012) similarly revealed that almost all their respondents knew that a blood test

is required to confirm the presence of the HIV virus in a person. Respondents with tertiary education had better knowledge of HCT than their counterparts who had primary and secondary school education. A previous study by Masiye, Chama and Moono (2009) also showed that education significantly influences HCT-related knowledge. A logical conclusion that can be drawn from this trend is that people with higher educational levels are more likely to understand the benefits inherent in the test and thus have better privilege of being exposed to health promotion messages relating to HCT (De Walque, 2006). This finding implies that educational interventions and strategies are needed to facilitate HCT knowledge among less-educated religious leaders. Training strategy can be used as an opportunity to upgrade Christian religious leaders' knowledge of the advantages inherent in adopting HIV prevention innovations including Prevention-of-Mother-to-Child-Transmission (PMTCT) of HIV and the adoption of other HIV preventive and control technologies. Christian leaders who have knowledge and experience of HIV and AIDS prevention and management should be encouraged to train and empower other Christian leaders and church workers involved in the provision of marriage counselling and HCT-related services targeted at intending couples. Training programmes for church workers should be guided by well-designed educational curricula and delivered using multiple training methods.

The majority of participants were of the opinion that pre-marital HCT can help reduce the spread of HIV infection in any community. This is, undoubtedly, a reflection of their knowledge of the advantages of adopting HCT. This result is similar to the results of previous studies such as those of Makelele (2005) and Bwambale et al (2008) who noted that participants in their studies opined that pre-marital HCT is pertinent for HIV prevention and control. Bwambale et al. (2008) described HCT as an integral component of a comprehensive approach to the reduction of HIV to zero level. Therefore, religious leaders, including marriage counsellors, need to be targeted with educational interventions aimed at reinforcing their favourable perception of the test and modifying those perceptions that can discourage the adoption of HCT.

Some of the participants in this study were of the view that the HIV positive status of a man or lady who intends to get married should not be disclosed to his or her partner by church authorities. This perception raises

ethical concerns. Intending couples should be encouraged to voluntarily disclose their HIV status to each other in view of the incurability of AIDS today. The dilemma is that if an HIV-positive person hides his or her status from his/ her intending partner the innocent partner could get infected. In view of the highly infectious nature of HIV, the incurability and burden of AIDS that results, it could be argued that if an HIV-positive person is encouraged and counselled to disclose his/her positive HIV status to his/ her intending partner and he/she refuses bluntly to do so, then the CMCs who have the privileged information have an ethical and legal duty to warn and/or protect the innocent partner; failure to do this could amount to unethical and/or criminal conspiracy. The truth is that to "tell or not to tell" in situations like this is a dilemma which is characterized by ethical, legal, human rights and religious concerns. Religious leaders, especially marriage counsellors, need to be well schooled in respect of strategies and methods of resolving such ethical dilemmas in a manner that will ensure confidentiality of information, fairness to the intending couples and protection of their privacy within limits of ethical and legal bounds.

Many participants opined that the HIV status of either a man or lady should not prevent the solemnization of their marriage; this is an ethically acceptable practice. Preventing the solemnization of marriage as a result of the HIV-positive status of intending couples constitutes not only an ethical issue but also a human right infringement (Zou et al, 2009). If two persons who intend to get married are aware of each other's HIV-positive status and still want to go ahead with the marriage, then such a choice could be said to be based on informed decision; therefore, no obstacles should be put in their way. Ethically appropriate practices such as this can contribute to the de-stigmatization of HIV and AIDS. The findings in this study relating to Christian marriage counsellors perceptions that contravene ethical principles involved in HCT suggests the need for the adoption of training programmes and other behavioural change interventions which can be used to upgrade their knowledge of the rights of ICs. Training relating to the ethics of HCT can help Christian leaders and Christian marriage counsellors to implement their HCT-related policies in ethically-acceptable ways. Such training activities should be conducted periodically and delivered by those who are vast in HCT as well as the design and implementation of training interventions.

Policy interventions could be very useful in promoting the design, implementation and evaluation of HCT-related educational interventions for Christian religious leaders involved in the provision of HIV and AIDS related education and services. The Christian Association of Nigeria (CAN) and other allied bodies should formulate policies that provide support for HIV control and prevention. Policies formulated by religious bodies or organizations can help to improve the capacities of Christian leaders to render HCT-related services for intending couples across both indigenous and non-indigenous churches.

The doctrinal values of the churches under CAN in the study area are diverse. However, Jesus Christ constitutes the unifying factor among them. The common acceptance of Jesus Christ as the most fundamental basis of their faith can, therefore, be capitalized upon to promote partnership and unity among churches in respect of tackling HIV and AIDS as a common challenge.

Conclusion and Recommendations

Knowledge relating to HIV counselling and testing was generally high among the Christian leaders. Those who had tertiary education were however, significantly more knowledgeable about HIV counselling and testing. Generally, the majority of the respondents had positive perceptions relating to HIV counselling and testing. However, some participants were of the view that HCT should be made mandatory by churches for intending couples before joining them together in holy matrimony. This is a perception that needs to be addressed because of the associated ethical concerns. The perception is not in line with the principles guiding the ethical conduct of voluntary HCT or the goal of the test. Training and other relevant health education interventions should be used to upgrade church leaders' knowledge of the phenomenon and modify HCT-related perceptions among them which are unethical or inappropriate for preventing and controlling HIV and AIDS among intending couples.

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