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University of KwaZulu-Natal

**The perceptions of HIV negative pregnant women
towards HIV preventive sexual behaviour in one of
the regional hospitals in Durban**

Sibongile Msebeni

**The perceptions of HIV negative pregnant
women towards HIV preventive sexual
behaviour in one of the regional hospitals in
Durban**

A dissertation submitted

to

**The School of Nursing at the University of
KwaZulu-Natal, Durban**

in

**Partial fulfilment of the requirements for the
Masters Degree in Nursing – Maternal and
Child Health**

By Sibongile Msebeni

**Supervised by Dr. B. R. Bhengu
Mrs. T. T. Myeza**

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Declaration

I declare that the research – the perceptions of HIV negative women towards HIV preventive sexual behaviour in one of the regional hospitals in Durban, is my own work. It is being submitted for Masters Degree in Nursing –Maternal and Child Health at The University of KwaZulu-Natal, Durban. It has never been submitted for any other purpose. All references used and/or quoted have been acknowledged by referencing.

Signature.....*Abusebeni*

Date.....*19. 4. 06*

This study has been approved for submission by the supervisors of the study, Dr. B. R. Bhengu and Mrs. T. T. Myeza

Signature.....*[Signature]*

Date.....*19. 04. 06*

Signature.....*[Signature]*

Date.....*24. 04. 06*

Dedication

This study is dedicated to my family.

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My husband Themba, my kids, Thamsanqa, Mngqobi and Nonjabulo for their support and care.

And lastly but not least God who has been with me from the beginning to the end of this study.

Abstract

Aim: The aim of the study was to explore the perceptions of the HIV negative pregnant women, after their HIV negative results, towards preventive sexual behaviour.

Methodology: A qualitative approach was used in exploring the perceptions of HIV negative pregnant women and describing their behaviour according to the findings. Fifteen participants were interviewed. Two semi - structured interviews were conducted with each participant, an initial interview and a verifying interview, for the purpose of saturation and verification. Each interview lasted for 20 – 30 minutes. The interviews were recorded and transcribed. Manual data analysis was used to identify categories and themes.

Findings: The study revealed that the participants knew what the negative status entailed. They were also aware that there is a chance of HIV negative person being infected by HIV virus if they do not engage in preventive sexual behaviour. Furthermore, they had also disclosed their HIV negative status to their partners and most of the partners refused to go for testing. Though the participants believed that it was necessary to use condoms even if they were HIV negative, most of them had not use condoms during their last sexual intercourse. Reasons for not engaging in preventive sexual behaviour were revealed by the study. Recommendations were suggested for clinical practice, nursing education, management and research.

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CHAPTER 1

INTRODUCTION

1.1 THE BACKGROUND OF THE STUDY

“HIV/AIDS has brought about a global epidemic far more extensive than what was predicted even a decade ago” (van Rensburg, 2004:276). It has destroyed the innocent hopes, desires and plans of people whose lives have been cut short. Furthermore HIV/AIDS has a tremendous impact on the medical, psychosocial, spiritual, educational and economic life of the infected person, his/her affected others and a community as a whole (van Dyk, 2001:iii).

The global HIV/AIDS epidemic killed more than 3 million people in 2003, an estimated 5 million acquired HIV, and 40 million people are living with HIV/AIDS around the world (UNAIDS, 2003:1). Current trends indicate that the global impact of HIV/AIDS on young people is set to worsen. Approximately 38%, of the estimated 40 million people living with HIV/AIDS worldwide, are under the age of 25. Teens and young adults between the ages of 15 and 24 constitute almost a third of those living with HIV/AIDS. Of the 5 million people who became infected with HIV, 58% were under the age of 25. The new infection rate amounts to almost 6 000 new infections per day, or approximately one every 15 seconds, in the age group of 15 to 24 (van Rensburg, 2004: 286).

Sub-Saharan Africa is the worst affected region in the world. According to the 2002 global and regional summary of the HIV/AIDS pandemic, 29.4 million people were living with HIV/AIDS; there were 3, 5 million newly infected and 2, 4 million died of HIV/AIDS in Sub-Saharan Africa alone. Two million women, more than the number of men, are infected with HIV. This skewed infection rate is caused by gender inequity, harmful cultural beliefs about masculinity and male sexual behaviour in the region. About a third of those who were living with HIV in 2001 were between 15 and 24 years of age, and most of them were unaware that they were carrying the virus (UNAIDS 2001:1). In 2002, 50% of approximately 14 000 new infections per day occurred in the age group 15 to 24 years (van Rensburg, 2004:277).

In 2001, the National Population Unit revealed that the first two AIDS cases in South Africa were diagnosed in 1982 and the first death was recorded in 1985. For the past seven years, there has been a growth in HIV infections in South Africa. By the end of 2001, an estimated 4,47 million adults and children in South Africa were living with HIV/AIDS, more than in any other country in the world. In 2001 some 2, 65 million women and 2, 09 million men aged between 15 and 49 years were estimated to be HIV positive (Department of Health, 2002a :11). In 2002, the prevalence rate in South Africa was 11, 4%, and between 15 and 49 years was estimated at 15, 6%. Currently 1 700 South Africans are infected with HIV each day, while 56% of all infected adults are women (van Rensburg, 2004: 279).

Based on a survey conducted in 2002, KwaZulu-Natal recorded the highest HIV prevalence rate among antenatal clinic attendees with a staggering 36, 5% of the patients testing positive. This was 3% higher than the rate recorded the previous year. Gauteng had the second highest HIV prevalence rate (31, 6%) among pregnant women in 2002, followed by Free State (28, 8%), Mpumalanga (28, 6%), North West (26, 2%), Eastern Cape (23, 6%), Limpopo (15, 6%), Northern Cape (15, 1%) and lastly Western Cape (12, 4%) (Department of Health, 2002a:6).

The antenatal survey that was conducted in October 2002 revealed that 26,5% of pregnant women were HIV positive. Women aged between 25 and 29 years are the most affected by HIV infection, with an estimated 34,5% of pregnant women in this age group being HIV positive. Those aged 30-34 years follow with 29,1% (Department of Health, 2002a:8)

One of the contributing factors of HIV/AIDS infection is gender inequity. The rights of an African girl are not recognised as much as those of boys. Girls are socialised to perform a subservient role. As she grows older, she lacks basic skills, such as the ability to communicate her wishes assertively, to solve the problems in social relationships, to think critically and creatively, to make decisions and negotiate, to resist the pressure and to cope with emotions and conflicts (Carnegie, 2000:3). For example, a woman may be scared to refuse intercourse or request a condom because she feels that a man is the only one who has a say on sexual matters.

Ignorance about HIV/AIDS is considered the crucial reason why the epidemic is out of control. Surveys reveal that although many people are aware of AIDS, they do not think that the risk applies to them. Despite almost universal awareness of the danger of HIV infection, 55%-65% of the South African population still have misconceptions and, as a result, demonstrate behaviour that exposes them to severe risk. People are reluctant to use condoms because they are surrounded by myths and misconceptions. For example, they believe that condoms from overseas bring AIDS with them (van Rensburg, 2004:293).

“Voluntary counselling and testing (VCT) is the process by which an individual undergoes counselling enabling him/her to make an informed choice about being tested for HIV” (UNAIDS 2000:3). This process is confidential. People who test sero-positive can have access to medical care, prevention/ treatment of opportunistic infections, emotional support and prevention of mother-to-child transmission (PMTCT) of HIV. Knowledge of their HIV serostatus can help people to make decisions to protect themselves and their sexual partners from infection. Counselling is also important when the HIV result is negative. The counsellor should motivate the client to adopt or continue with safer sex practices. (UNAIDS, 2000: 5). The study will be done within the VCT service in an antenatal setting. The researcher will be working together with HIV counsellors, the nursing and medical staff, and the participants.

For both the counsellor and the client, a negative HIV result is a tremendous relief. A client who is frequently involved in high-risk behaviour may think that she is ‘immune’ to HIV and that there is no need to continue with safe sex behaviour. There is a possibility that the

client is in the window period and that the antibodies to HIV are not detectable. The negative result may be false negative. During this period the client may infect or be infected if she practices unsafe sex. Even the repeat negative test does not yet warrant a person to behave in a risky manner because the chances of contracting the disease are still high (van Dyk, 2001:246).

The clients who test HIV negative should have counselling; guidance and support to help them remain negative (UNAIDS, 2000:5). Counselling of a client who has tested negative is very important. For most people, it is the only chance to talk to the person about his/her sexual practices and risky behaviours. While the client is likely to feel relief, the counsellor should emphasize the following points;

- The need for change in behaviour that can help the client to remain HIV negative, such as safer sex practices including condom use and other methods of risk reduction.
- The client has to adopt and sustain safer practices to prevent transmission of the disease to unborn babies and to prevent infection in the future.
- The counsellor should motivate the clients and provide encouragement for these behaviour changes (UNAIDS, 2000:5).

KwaZulu-Natal is offering interventions to prevent-mother-to-child-transmission (PMTCT). HIV positive women are counselled for PMTCT within the antenatal clinic setting. At 28 weeks of pregnancy, the woman is given a single nevirapine tablet which is taken when she goes into labour or when the membranes rupture. Sadly some women from the remote areas do not currently get these services.

Concentrating their efforts on the majority, that is, uninfected women has been the rationale for United Nations Population Fund's (UNFPA) strategic focus on pregnant women. It is one of the few occasions where a woman comes into contact with the health care system, therefore it is an opportunity to provide information on HIV prevention. This will help HIV negative women to remain free from infection and HIV positive women to be provided with treatment to ensure the PMTCT (United Nations Population Fund,2004:1).

The current national strategy to prevent or control the spread of HIV/AIDS is the HIV/AIDS and Sexually Transmitted Infections (STIs) Strategic Plan for South Africa for 2000-2005. The Strategic Plan aims at prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance. Other government departments have also developed policies for HIV/AIDS, for example, the Department of Labour protects job applicants from HIV/AIDS related discrimination. The provision of anti-retroviral drugs is an additional element to the strategy against HIV/AIDS (van Rensburg, 2004:308). The civil society organisations/non-governmental organisations perform the activities prioritised by the national policies and programmes. Those areas are: HIV/AIDS information; education and counselling to the community; condom distribution; employment of lay counsellors for voluntary counselling and testing (VCT); and home based care with the emphasis on nutrition, information and support for families (van Rensburg, 2004:308).

It is difficult to prevent or control the spread of HIV/AIDS because there are social, cultural and economical factors that accelerate the spread of virus. Behaviour change was established in early years when at risk groups were relatively well defined. They were categorized according to their sexual relationships and risk behaviour: for example, homosexual relationships and drug injecting users. The patterns were easily determined and specific interventions were promoted. For example, sharing a needle was targeted as risky behaviour and authorities promoted specific interventions that may make a difference. In Europe and the United States of America, drug users are allowed to exchange their used needles and syringes at health facilities for sterile equipment. Research studies conducted in the United States found that needle exchange programmes reduce HIV transmission without increasing the use of illegal drugs (van Dyk, 2001:149).

Kelly, Parker and Lewis (2001:2) argue that the targets are now larger and diverse. The target groups that are at risk as well as the relationships and behaviours through which the virus might be transmitted, are no longer isolated or targeted. For example, with HIV infection high risk is sex whether homosexual or heterosexual and interventions are not easy to define. The Centre for Disease Control and Prevention (CDC) in the United States cited in Leong (2002:1) reported that most women with HIV/AIDS are infected through heterosexual contact. “The high rate of heterosexual transmission of HIV/AIDS implicates the prevalence of traditional sexist thinking, fostering women’s continued dependence on men and continued sexual objectification of women” (Leong, 2002:1).

It has been postulated that malnutrition has an impact on the prevention and management of HIV/AIDS. Poor maternal nutrition is one of the factors that contribute to preterm deliveries and low-birth weight infants. These infants, whether HIV infected or not, fail to thrive. These children are less likely to be educated. The infected mothers have decreased ability to care for their children or ensure household food security. Their poor physical health may not allow them to practise breastfeeding, which assists in boosting the children's immunity, and makes them less prone to infections and minor ailment such as diarrhoea (Tomkins, 2005:8).

War is one of the social factors that fuel the spread of sexually transmitted infections and HIV. It affects health in a number of ways. The soldiers tend to have higher levels of HIV infections and STIs. Their deployment results in a huge growth in the prostitution industry and high incidence of rape. There is a greater rate of sexual activity in the general population due to stress and tension, thus accelerating the spread of the HIV virus. Wars also contribute to malnutrition, injury and the contamination of food and water supplies which all cause a deterioration in people's basic health. This may aggravate the early onset of AIDS in people infected with HIV. Furthermore, wars increase the need for health services. These services may not be functioning well because hospital, clinics, medical facilities, water and the sewerage system are also under threat. Doctors' and nurses' lives are in danger. It will therefore be difficult to sustain prevention programmes in times of war (FitzSimon and Whiteside, 1995:2).

1.2 Problem statement

While the HIV negative results are a pleasure, they may imply that the patient falls within the window period and exhibits a false negative. The client may think that she is 'immune' to HIV. Testing HIV negative while practicing unsafe sexual behaviour may tempt HIV negative women to be careless about their sexual behaviour. After testing negative, there is no continuity in the counselling process as recommended by UNAIDS (2000:5) Studies that have been done in the area concentrated on clients with positive results. UNAIDS (2000:5) has identified the need to counsel the HIV negative clients too.

Many women in South Africa test negative and then become positive within the following year. The latest Medical Research Council study on 1 200 HIV negative volunteers at community research sites in Durban area showed that, seven out of every hundred women became infected during one year (Sunday Tribune, 2004:5). This may also be the case for the HIV negative pregnant women: no research has been done on how they behave post testing. They may think that they are 'immune' to HIV if they have not been practising preventive sexual behaviour and have not contracted the disease. Therefore it is not known how they perceive the need for HIV preventive sexual behaviour post testing.

1.3 Purpose of the study

The purpose of the study is to explore the perceptions of the HIV negative pregnant women towards preventive sexual behaviour after receiving their HIV negative results.

1.4 Objective of the study

- To assess the knowledge of HIV negative women on what their negative status entails.
- To describe their preventive sexual behaviour before voluntary HIV counselling and testing.
- To describe how they can protect themselves from sexually transmitted HIV infection
- To establish the factors contributing to reported HIV preventive behaviour

1.5 Research questions

- What does an HIV negative test result mean to the pregnant woman who tested negative?
- Which patterns of sexual behaviour do HIV negative tested pregnant women reveal before testing?
- Are the HIV negative pregnant women aware of the need for HIV preventive sexual behaviour?
- What reasons do the HIV negative pregnant women give for their sexual behaviour?

1.6 Significance of the study

The findings of the study may convince practitioners of the need to counsel HIV negative people and also make recommendations on what the counselling should entail. It may be used to teach people that the HIV negative people need ongoing counselling and support. It may be used as an evidence for expanding the services for HIV negative people. This study

may be helpful in informing the curriculum of the students on targets for HIV counselling. The outcomes of the study, that is, the perceived sexual behaviour of HIV negative pregnant women may be included in the HIV education programme. It may form the basis for further research, for example, correlation studies on factors promoting people to stay negative.

1.7 Definition of terms

1.7.1 Perceptions –how the vulnerability and expectations of HIV preventive sexual behaviour is described by the HIV negative pregnant women in a particular setting.

1.7.2 Pregnant women – are those women who are less than 32 weeks pregnant.

1.7.3 HIV negative pregnant women – are those women who have, for the first time, undergone VCT and tested negative.

1.7.4 Knowledge – entails what the HIV negative status means to the participants of this study in terms of window period, false negative and transmission of HIV infection

1.7.5 HIV preventive sexual behaviour – these are efforts which individuals can undertake to prevent and /or control spread of HIV/AIDS;

-having one sexual partner

-Remaining faithful to one's partner

- Never assuming that the partner is faithful
- Using condoms to prevent sexually transmitted infections (STIs) and therefore HIV
- Always practicing safer sex, for example, oral sex on a man wearing a condom or a woman with latex barrier.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter will elaborate on the extent of HIV/AIDS infection, the national strategy to prevent or control the spread of HIV/AIDS, factors influencing sexual behaviour, the effects of HIV/AIDS on HIV negative people and theories of behaviour change.

2.2 The overview of HIV/AIDS

The 2003 statistics as calculated by UNAIDS revealed the worldwide impact of HIV at the end of 2002. At that stage there were 42 million people living with HIV/AIDS while 5 million people were newly infected with HIV. It also showed that AIDS deaths, worldwide, during 2002 numbered 3.1 million and new adults/adolescent HIV infections among women stood at 48% (Vorster, 2004:1)

South Africa seems to be the most affected country. “Southern Africa is a home of about 30% of people living with HIV/AIDS worldwide, yet this region has less than 2% of the world’s population” (UNAIDS 2003:2). There is a slight decline in prevalence among teenage pregnant women aged 15 – 19 years, consistently high HIV levels among 20 –24 year old pregnant women and rising levels among those aged 25 –34. The antenatal study conducted in October 2002 revealed that 26, 5% of pregnant women were HIV positive (Department of Health, 2002a:6).

Specifically, KwaZulu – Natal recorded the highest prevalence rate of 33, 5% among antenatal attendees in 2002. Gauteng followed with 31, 6%. The increase in HIV prevalence between 2001 and 2002 in the age groups 25 – 29 years and 30-34 years were statistically significant (Department of Health, 2002:6).

2.3 National strategies to prevent the spread of HIV/AIDS

2.3.1 Promotion and adoption of preventive sexual behaviour

To promote improved health seeking behaviour and the adoption of safe sex practices, the government has implemented life skills education in all primary and secondary schools and has also produced and disseminated informational, educational and communication material to various stakeholders. The numbers of trade unions that have implemented HIV/AIDS and sexually transmitted infections (STIs) strategies have also increased (Department of Health, 2000:18).

To broaden the responsibility for the prevention of HIV to all sectors of government and civil society, the Department of Health developed sector-specific policies and plans for the prevention of HIV/AIDS/ STIs (Department of Health, 2000:18), for example,

To implement HIV/AIDS prevention programmes for migrants by

- Developing a health programme with an HIV focus as part of the Maputo programme

- South Africa working in partnership with other Southern Africa Development Community countries.
- Implementing cross-boarder interventions, like VCT sites at boarder gates. (Department of Health, 2000:18).

To improve access to male and female condoms by:

- Condom distribution through non-traditional outlets was expanded
- Promoting acceptance, efficacy and use of condoms as a form of contraception among the youth. (Department of Health, 2000:18), for example, by means of HIV awareness initiatives like Soul City and Soul Buddies drama series in television channels SABC 1.

2.3.2 Improving the management and control of STIs

There is an evidence of the importance of STIs as a major determinant of HIV transmission. There are approximately 11 million STI episodes treated annually in South Africa, with approximately 5 million of these managed by private general practitioners. STIs pose an important public health problem. The Department of Health has developed guidelines to ensure effective syndromic management of STIs in the public and private sector and in addition has collaborated with traditional healers to improve health care seeking behaviour for STIs (Department of Health, 2000: 19).

The United Nations Population Fund (UNPF) focuses on preventing HIV infection among young people. It promotes safer sexual behaviour, empowering young women to refuse unwanted and unsafe sexual relations. The UNPF further supports the provision of 'youth friendly' reproductive health information, education and services. The youth may engage in unsafe sex because they are scared to go to a family clinic for condoms. They become pregnant and infected with HIV. Therefore 'youth friendly' reproductive health services act as the source of primary prevention of HIV/AIDS (UNAIDS, 2004:1).

Another programme that has been introduced is the use of youth to educate and support each other in order for HIV behaviour changes to occur. Evidence has reported that peer education programmes that are run by the youth, empower young people. According to Harrison, Smit and Myer (2000:287) as cited in van Dyk (2001:93), a successful peer education programme transfers the control of knowledge from the hands of the experts to the lay members of the community, thereby making the educational process more accessible and less intimidating.

2.3.3 Voluntary HIV counselling and testing (VCT)

UNAIDS (2000:3) defines VCT as the process by which an individual undergoes counselling thereby enabling him/her to make informed choices about being tested for HIV. The Department of Health has increased the number of VCT sites to increase access to VCT services. The decision to be tested is entirely the choice of an individual and the

process is confidential. VCT is an important entry-point to both HIV prevention and HIV related care (UNAIDS, 2000:3).

People who test HIV positive, are able to access medical care, ongoing emotional support and social support. People who test HIV negative can have counselling, guidance and support to remain negative. The counsellors need to discuss changes in behaviour that can help the client to stay HIV negative. For example, safer sex practices including condom use and other methods of risk reduction (UNAIDS, 2000:3).

VCT provides the opportunity for people to be aware of their HIV status. The quality of counselling and support helps them to cope with their positive or negative test result. The majority of adult people are HIV negative. Knowing that one is HIV negative can serve as a strong motivation to remain negative. For HIV positive people, they may become more motivated to adopt healthier lifestyles which can improve their health status and slow the progression of the HIV infection to AIDS (UNFPA 2004:1).

A study that was done in Uganda in 1992-1993 to describe the effects of VCT on risk reduction, revealed that there was an increase in condom use after VCT. It suggested highly responsible behaviours with casual partners, less so with steady partners. This could be an indication of the difficulty of introducing condoms into steady relationships or it could mean that many of the HIV negative steady partners maintained a monogamous relationship with a partner they knew or hoped was HIV negative. The study also reported that eleven percent of HIV positive people continued to put their steady partners at risk

(Jackson, 2002:187). The study revealed that VCT has some positive results or effects on HIV preventive behaviour though work still has to be done on steady partners.

A multi-site study was also conducted in Kenya, United States of Tanzania and Trinidad, which agrees with the study conducted in Uganda that there is behaviour change in individual following VCT. This study revealed that VCT significantly reduced risky sexual behaviour, that is, unprotected sex both with casual partners and among couples who have been counselled and tested together. The study also showed that VCT was cost effective compared to other HIV prevention interventions (UNAIDS, 2000:8).

A study was also conducted in Malawi to describe the motives and sources of information, to describe the sexual behaviour and identify the risk factors associated with HIV infection among those seeking VCT in one of the country's rural districts. It revealed that the majority of the individuals sought VCT after being encouraged by those who knew their status. Over 90% of VCT seekers reported having had sexual encounters and about half were practising unsafe sex. They also reported that they had no idea of the usefulness of condoms and that condoms were not accessible when they were needed. Most of positive patients were female, over 25 years of age and were farmers. The study concluded that there is a demand for VCT services and resources to make VCT available to all people, even to the less literate and remote rural populations (Zachariah, Spielmann, Harries, Buhedwa and Chingi, 2003:88).

2.3.4 Prevention of mother-to-child transmission (PMTCT)

The Department of Health has improved access to HIV testing and counselling in its antenatal clinics by developing counselling guidelines and training HIV counsellors. It has also improved access to comprehensive reproductive health services for HIV positive women. The clinical guidelines have been implemented to reduce the transmission of HIV during childbirth and labour (Department of Health, 2000:19).

The Centre for Disease Control and Prevention recommends routine HIV testing in all pregnant women regardless of risk and also the screening of infants if their mothers have not been tested. It has developed guidelines for the use of rapid HIV tests during labour and after delivery if the mothers did not undergo prenatal testing. The test requires less than one drop of blood from the finger prick and results are available in about twenty minutes (Gallant, 2004:2).

Most women today are HIV negative and they should remain so. Of the 200 million women who become pregnant, 99% are HIV negative (UNPFA, 2003:1). Since most of the pregnant women are HIV negative, the prevention of infection among pregnant women through provision of information, counselling and other services should be a priority (UNAIDS, 2004:1). That is why UNPFA is focusing on pregnant women and emphasising the mothers in PMTCT. If pregnant women remain HIV negative, the prevention of transmission to their children is ensured.

Research conducted at Chris Hani Baragwanath, Gray as cited in Cape Times (2000:5) revealed that women who breastfeed are twice as likely to transmit the virus to their babies. The risk is even higher for babies whose mothers are HIV negative during their pregnancy but contract HIV while they are breastfeeding. The enormity of the problem is projected by, the predicted doubling of deaths among children younger than five years in Southern Africa by the end of the decade (Cape Times, 2000:5).

Men should also be involved in preventing transmission of virus to the baby. According to Varga as cited in Cape Times (2002:6), lack of male involvement in the government's prevention of mother-to-child HIV transmission programme is undermining its success. Their involvement would ensure that men were also tested and so would not blame the women for HIV infection. They would also understand the need for safe feeding of their babies and for safer sex with their women. (Cape Times, 2002:6).

2.3.5 Addressing the issues relating to blood transfusion and HIV

In order to maintain safe blood transfusion services, national guidelines on HIV and blood transfusion have been implemented, for example, screening for HIV in donated blood. The implementation of these guidelines is monitored. The Department of Health has improved the recruitment of low-risk blood donors (Department of Health, 2000:20).

2.3.6 Appropriate post-exposure Prophylaxis (PEP)

Services for employees who have needle stick injuries, or any other occupational exposure such as rape, have been provided by the Department of Health. For exposure to blood and body fluids, the affected area is immediately cleaned with an antiseptic agent and eyes are rinsed with water. For large volume of blood and deep injury, the HIV status of the source patient and the health worker is determined following the guidelines of HIV testing. HIV post-exposure prophylaxis (PEP) is initiated promptly, preferably within 1-2 hours after exposure. The treatment is taken for four weeks if the source patient is positive. If the patient and the health worker are both HIV negative, the treatment is discontinued. The starter packs of recommended drugs should be available to prevent delays in starting treatment (Department of Health, 1999:4). This department has also ensured the supply of anti-retroviral drugs to treat occupational exposure in both the private and public sectors. Health workers have been taught the appropriate disposal of medical waste and sharps (Department of Health, 2000:20).

2.3.7 Nutrition interventions for the control of HIV/AIDS

Adequate nutrition is essential to maintain the immune system and allow physical activity and to achieve optimal quality of life. It is also required to optimise the benefits of antiretroviral drugs which assist to prolong lives of HIV infected people and prevent mother-to-child transmission. Initiatives have been launched to improve the nutritional status of women and children in the world. (Tomkins, 2005:8).

Tomkins (2005:10) argues that the studies in South Africa have shown the value of exclusive breastfeeding as opposed to mixed feeding in reducing mother-to-child transmission. The research done in Tanzania also revealed that multiple micronutrients containing large doses of vitamin C, E and B complex reduce the high prevalence of low-birth weight and prematurity among HIV infected women. Furthermore, paediatric infections like pneumonia and diarrhoea are reduced when micronutrients or vitamins are given to infected mothers (Tomkins, 2005:10)

2.4 The factors influencing sexual behaviour

2.4.1 The meanings and consequences of unsafe sex

The meanings and consequences of unsafe sex are different for people who are HIV negative and HIV positive. For an HIV negative individual, unsafe sex with an infected partner involves the possibility of becoming infected. For the HIV positive individual, unsafe sex with an uninfected partner involves the possibility of infecting another. The consequences of unsafe sex for HIV negative and HIV positive can be seen in the reasons why people have unsafe sex. “When people were asked why they thought uninfected men might have unsafe sex, the answer was that the HIV negative person has a low self-esteem, is depressed and grieving, and in short possibly, suicidal. The HIV positive person was seen as revengeful, demented, irresponsible and in short homicidal” (Johnston, 1995:1). It is surprising why an HIV negative individual can be suicidal.

An HIV negative status does not automatically motivate the HIV negative people to stay or remain negative. Scientists are locked in a life and death struggle to prevent thousands of Kwa Zulu-Natal women from becoming infected with HIV after alarming figures showed a dramatic increase in HIV in the past year. A South African Medical Research Council scientist (Ramjee as cited in Sunday Tribune 2004:5), said that researchers working at the three trial sites in and around Durban had been staggered by the infection results gathered during a recruiting process for the study volunteers.

Ramjee further maintains that young women between the ages 18 and 30 are becoming infected at a higher rate than the most at-risk groups in the world. The author said that of about 1200 HIV negative volunteers who were monitored at community research sites in the greater Durban area, 7% of the women became infected within one year. She said many more women were unwilling to be tested and were unaware of their status. The researchers have largely relied on the data emerging from antenatal clinics but none of the women in the study was pregnant and most were married or in stable relationships (Sunday Tribune, 2004:5).

The findings of the study by Rwakyaandela as cited in Cape Times (2002:6) agree with those of Ramjee. Rwakyaandela conducted a study on 390 women from Soweto who had tested HIV negative in early pregnancy. The study found that 5, 4% of these pregnant women who had initially tested HIV negative were then found to be HIV positive shortly before birth (Cape Times, 2002:6).

A structured interview about the risk factors for HIV/AIDS was conducted on women coming for antenatal care. The study revealed that 95,2% of pregnant women knew about HIV/AIDS. They also knew that it could be transmitted sexually (84,5%) and by sharing razor blades and injection needles (45,9%). However, only a few (23%) knew about mother-to-child transmission and transmission through breastfeeding. The study concluded that the majority of the paediatric HIV infections are contracted through vertical transmission. It also found that despite the women's knowledge of HIV/AIDS, they (85%) displayed a negative attitude towards AIDS patients (Etuk and Ekanen, 2005:101)

2.4.2 The effects of HIV/AIDS on HIV negative people

A study on the effects of HIV/AIDS on HIV negative gay men done in Toronto showed that:

- Many of these men had a negative outlook towards their future, believing that contracting HIV was inevitable. They feared that they would die of AIDS just like their friends had. Therefore, unsafe sexual behaviours might be attributed to the impact of multiple losses and grief.
- Many complained that the focus was directed towards HIV positive gay men at the expense of their own feelings and concerns as HIV negative gay men.
- Many men complained that they did not cope with their struggles as HIV negative gay men, therefore they needed support groups. One of the participants admitted that he did not cope, but he escaped by joking, going out or smoking grass (dagga).

- Several participants feared the possibility of growing old. One of the participants verbalised that he felt that since he was HIV negative, he would get old alone.
- HIV negative gay men believed that the AIDS Committee of Toronto should be providing more services, such as, counselling services and support discussion groups to HIV negative. These services should be offered as long as they are not provided at the expense of services to people with HIV (Maxwell, 1996b:1)

This author therefore concluded that HIV negative people needed ongoing counselling, guidance and support to help them remain negative.

2.4.3 The relationship between knowing one's HIV status and preventive behaviour

A second study was done by the Department of Health and Human Services in 1992-1993 on injecting drug users to analyse the effect of the knowledge of HIV serostatus on behaviours which prevent the transmission of HIV among European drug users. Results were compared to a similar study conducted three years back. The data was gathered during a respective multi-centre cross-sectional study of injecting drug users recruited in 11 European countries, specialised centres and on streets. This comparison revealed that condom use significantly improved only for drug users who knew their HIV negative serostatus. This study further confirms that there is a relationship between knowing your own HIV serostatus and the adoption of preventive behaviours. However, there were minor improvements in injecting drugs safely and using sterile injecting equipment after two years, indicating that the prevention of HIV transmission among drug users must be reinforced. This supports the idea of continuous counselling and ongoing support for the

HIV negative people (Schlumberger, Desenclos, Papaevangelou, Richardson and Ancelle-Park, 1999:1).

2.4.4 The impact of unrecognised HIV infection

A survey of young men was used to evaluate the impact of unrecognised HIV infection, the barriers to testing, and the reasons for not using condoms among black men having sex with men (BMSM). This survey done to 79 BMSM with unrecognised HIV infection revealed that 52% were not using condoms for one or more of the following reasons: 24% 'knew' that they were HIV negative, 20% 'knew' that their partners were HIV negative, or they thought their partners were at low risk for infection (35%); 43% also reported that they were not using condoms because they were not available. The findings in this report suggest that the majority of young infected BMSM were unaware of their infection (Morbidity and Mortality Weekly Report, 2002:1).

All those with unrecognised HIV infection, perceived themselves at low risk for being infected. They engaged in unsafe sex because of perceived low personal risks for HIV infection. Of those who had tested previously, 92% reported last testing HIV negative, and of these, 16% was found to be infected with HIV. Because 16% of young BMSM who reported being negative were found to be infected, people should be encouraged to use condoms consistently with all partners, including those who have tested negative previously (Morbidity and Mortality Weekly Report, 2002:1). This study supports HIV

prevention that indicates that one should never assume that one's partner is HIV negative or faithful.

A woman might be at risk for HIV infection and not know it, even if she has only one partner. "Women who believe that they are in a monogamous heterosexual relationship may be unaware that their sex partner is engaging in high-risk behaviour. It is therefore important to find out if the sex partner has been screened for HIV" (Gallant, 2004:6).

2.4.5 The socio-demographic factors influencing sexual behaviours

The London study, published in April 2004, found that the sexual risk behaviours of negative or untested gay men who completed a questionnaire about their sexual behaviour on the internet are significantly different from those of HIV negative or untested gay men completing the same questionnaire in community venues. The survey showed that men surveyed on-line were more likely to report high-risk sex behaviours than men surveyed off-line. It also found that there were significant social and demographic differences between gay men surveyed on-line and in the community (Carter, 2004:1). The conclusion is that the social and demographic factors have influence on sexual behaviours and that people are more likely to tell the truth when they can be assured of total anonymity.

2.4.6 Partner notification of HIV status reduces the spread of HIV/AIDS

Partner notification is the spectrum of public health activities in which sexual and injection equipment sharing partners of an individual with HIV are notified, counselled about the exposure and offered services. The partners can either be informed by the patient or health – care providers or other health worker with the patient’s consent. Partner notification programmes can make a positive contribution to prevention programmes, particularly for those who may be unaware that they are at risk of HIV, and as a result are not informed or aware of any need to practice preventive sexual behaviour (Canadian HIV/AIDS Legal Network, 2000:1).

A study to examine the effect of partner notification on sexual behaviours and partnership dissolution or formation was conducted. The participants were HIV positive persons interviewed to identify partner notification, partners notified of exposure, and HIV negative persons receiving HIV counselling and testing as controls. The participants were interviewed about their behaviours and relationships at three and six month intervals. Partnerships in which both the participant and partner receive partner notification were compared to partnerships in which only the subject received partner notification and to control partnerships. The findings of the study revealed that partnerships where both persons received partner notification were less likely to break up or acquire new partners and more likely to use condoms at follow-up. The study concluded that partner notification did not increase partnership dissolution or formation and was associated with higher

condom use, suggesting the value of partner notification in HIV prevention (Hoxworth, Spencer, Peterman, Craig, Johnson, and Maher, 2003:1).

The weight of the research to date is that notification of a person's HIV positivity assists in bringing about change in person's high-risk behaviour. In a study done in New York City where blood donors were notified about their HIV positivity, 60% decreased their high-risk sexual behaviour after notification. Other researchers found that notified HIV positive persons decreased their high-risk behaviours, compared to persons who are HIV negative or who have not been tested (Smereck, 1998:89). Therefore partner notification of HIV status would reduce the spread of HIV/AIDS.

2.4.7 Ignorance, denial, myths and cultural beliefs

Ignorance about HIV/AIDS remains profound and is considered a crucial reason why the epidemic has run out of control. Survey findings indicate that although many South Africans are becoming aware of HIV/AIDS, they do not think that the risk applies to them. They still hold misconceptions and, as a result demonstrate behaviour that exposes them to severe risk. Most of the people in rural areas blame the epidemic on witchcraft, instigated by a jealous neighbour. Some black South Africans believe that whites introduced the disease as a punitive measure against blacks after the demise of apartheid. These myths and misconceptions are currently hampering the progress of HIV programmes in rural clinics. Women and men who believe in these myths may not practice safe sex (van Rensburg, 2004:293).

Condoms are distributed for free at clinics, but they are not used because of myths and misconception about them. People say that the condoms carry HIV, build mistrust between partners, and reduce sexual satisfaction and many more reasons are given. The education campaigns are pitted against the power of cultural myths and sometimes, sheer ignorance (van Rensburg, 2004:293).

2.4.8 Gender inequity and female subordination

2.4.8.1 Subordination of females/women

African women are socialised to play the subservient role in their relationships with men, especially in matters of sexual relationships. Even when the woman is aware that she should use a condom to prevent the transmission of sexually transmitted diseases and HIV/AIDS, she is often confronted by an entrenched culture of male dominance that renders her powerless. Men have been known to beat their female partners if they refuse sexual intercourse or request that they use a condom. “Women who want their partners to use condoms have to fight deeply ingrained taboos because social norms dictate that ‘real men’ do not use condoms” (van Rensburg, 2004:287). The author further maintains that even when women know that their husbands are at risk of HIV, they may not raise the issue of safe sexual practices because that would mean that they look down upon their husbands and do not respect their husband’s manhood (van Rensburg, 2004:287).

2.4.8.2 Social status of a woman

Social expectations about women place all women at risk for HIV. According to Campbell, professor and AIDS specialist at California State University Long Beach, as cited in Leong (2002:2) women may engage in unprotected sex with men to attain social status, fulfil emotional needs and achieve economic stability. It is expected that woman should negotiate issues inherent in sexual relationships. This expectation ignores the fact that men and women do not have equal power relationships. It also ignores how women tend to celebrate and encourage displays of male virility through sexual acts (Leong, 2002:2).

2.4.8.3 Heterosexual exposure

The Centre for Disease Control and Prevention (CDC) in the United States cited in Leong (2002:1) reported that most women with HIV/AIDS are infected through heterosexual contact. This translates into continuing gender inequality. The common perception is that a woman's happiness and wholeness depends entirely on her affiliation with men. According to feminist poet and essayist Rich cited in Leong (2002:1), people are still trained to think that women need men as "social and economic protectors, for adult sexuality, and for psychological completion"; that the heterosexual nuclear family is the primary social unit; and that there is something so fundamentally abnormal or deviant about women whose primary affiliation and attachment is not to men. Society continues to perceive women as sexual objects to be used for control and consumption by men. "The high rate of heterosexual transmission of HIV/AIDS, thus, implicates the prevalence of traditional

sexist thinking, fostering women's continued dependence on men and continued sexual objectification of women'' (Leong, 2002:1).

Furthermore, in a number of countries in Africa and the Caribbean, HIV infection rates among young women is two to six times higher than among young men. The research that was done in Kenya's export industries found that women experienced violence and harassment as a normal part of their lives. Over 90% of those interviewed had experienced or observed sexual abuse at their workplace. Women face problems like discrimination, unequal property and inheritance laws, a lack of education, opportunities that limit women's income-earning possibilities and help perpetuate the inequality between men and women. The power imbalance in the workplace exposes women to the threat of sexual harassment. Certain types of work may increase the risk of HIV infection like sex workers and female domestic workers, especially those who live at their place of work (ILOAIDS, 2004: 1)

Women find limitations in their ability to negotiate in heterosexual relationships because they are highly dependent on men for social and economic support. This has serious implications in health education for the prevention of the spread of HIV/AIDS. The negotiations for HIV preventive sexual behaviour may not be feasible if women perceive that their male sexual partners will respond negatively. These women may find that participation in unprotected sex is a better option than an estranged relationship. Therefore the decision of an individual to engage or not to engage in preventive sexual behaviour depends on context or situation (Kelly, Parker and Lewis, 2001:12).

Strengthening gender equality can assist in the struggle against HIV/AIDS. Women need to be empowered to have better access to information, prevention care, support and services. This should start early in life by treating girl children same as boy children and in this way increasing women's status in the family and community. Women who are educated have better opportunities for access to resources when they are available. They also need to be empowered within their relationships. A decrease in dependency would also result in women being in a better position to negotiate safer sex (Willan, 2002:15)

2.5 Theoretical framework of the study

The theoretical framework for the study is sometimes called the conceptual context.

“Conceptual context is a formulation of what you think is going on with the phenomenon you are studying – a tentative theory of what is happening and why” (Maxwell, 1996a:25).

This section will discuss the models of behaviour change and their relevance to this study as each one of them emphasises one or more issues of behaviour change.

2.5.1 Models of behaviour change

The following models assist in understanding how behaviour change takes place. The four prominent models that will be discussed are rationality based theories of risk that is single and situated, theory of reasoned action, social learning theory and health belief model.

2.5.1.1 Rationality based theories of risk: single and situated

Single rationality based theory of risk

This theory assumes that the individual makes his/her own assessments or calculations of what is healthy or harmful. Avoiding the risk is viewed as a healthy choice, and is a rational and reasoned action. Risky behaviour is a result of unreasoned action and is irrational. For example, if an HIV negative individual continues to have sex with his/her HIV positive partner, this is irrational.

Critique

This theory is concerned with actions that are reasoned or unreasoned . It does not provide individuals with information to empower them so that they can make informed decisions about what is healthy or harmful. This theory is relevant to the study in that an individual makes her own decision about HIV preventive sexual behaviour.

Situated rationality theory of risk

The decision of an individual often depends on the context or situation. The benefits and consequences of risk- related behaviour are based on contextual factors. “A situated rationality would conceptualise such behaviour as being the product of rational decision-making based on situation, specific consequences and benefits associated with unsafe sex” (Kelly, Parker and Lewis, 2001:11). For example, the fear of losing a partner is seen as a

greater consequence than the risk of HIV transmission. An individual makes her own decision whether to engage in risky behaviour or preventive behaviour.

Critique

This theory focuses on context and situation. The decision that is taken is based on situation. This theory will be used to explore the situations or contexts that influence the decision-making. For example in African culture, a widow marries with her brother-in-law to retain her access to land, thus exposing herself to HIV infection because of situational reasons.

2.5.1.2 Theory of reasoned action

Adopting health protective behaviour depends on a person's strength of intention to perform the behaviour. The strength of the intention is based on the person's overall positive or negative attitude towards performing the behaviour, and on the perceived outcomes. The theory predicts that, for example, an HIV negative woman who values her negative status believes that she should practice protected sex (Kelly, Parker and Lewis, 2001:12).

Critique

This theory is mainly concerned with determination of a person and does not consider other influencing factors like gender inequity. Kelly, Parker and Lewis (2001:12) argue that in relation to the exchange of sex for money, the woman has no say over the man. No matter how determined a woman is to change her behaviour, she cannot if the man does not agree with her. For the HIV negative woman to stay negative, she has to be determined to continue or adopt HIV prevention behaviour. Therefore this part of theory will be included in the study.

2.5.1.3 Social learning theory

This theory recognises that to achieve self-directed change, people need to be given reasons to change their behaviour and also the means and resources to do so. For example, people are told that unprotected sex exposes them to HIV infection and that they need to protect themselves by using condoms. The condoms should be available and easily accessible. “In this way, it recognises that self-guidance, as well as ability to use these skills under trying circumstances” (Kelly, Parker and Lewis, 2001:13). HIV/AIDS education programmes designed in terms of this model include (1) basic knowledge, that is, how to conduct relationships with opposite sex and what abuse is; (2) attitude and values, that is, self-control, taking responsibility for one’s action and the right to say ‘no’; and (3) life skills, that is, assertiveness, negotiation skills and self-awareness.

Adopting health-protective behaviour depends on a person believing that he/she does not have/has the ability to change (self-efficacy). People practice unsafe sex because they doubt whether they can protect themselves against contracting HIV infection. For example, a woman who has discussed with her husband that they should use condoms and he refuses, means that she will not be able to change her sexual behaviour.

Critique

This theory concentrates on the purpose and reasons for changing risky behaviours and also the resources to do so. The weakness of this theory is that it is concerned with changing a person's behaviour, but does not consider her background or context. UNICEF (2000:1) argues that the women have been socialised to be submissive. This theory realised that these women need skills such as the basic knowledge, the right to say 'no' and life skills and need to use them effectively. This theory will be helpful in this study because it deals with the African women who need these negotiation skills.

2.5.1.4 Health Belief Model (HBM)

“The Health Belief Model is based on the premise that the perceptions of personal threats are necessary precursor to taking preventive action” (Kelly, Parker and Lewis, 2001:12).

Fisher and Fisher (2000:5) argue that

Vulnerability

- Perceived vulnerability is the perception that it is the joint function of perceived susceptibility and perceived severity. It motivates an individual to be ready to act.
- Perceived susceptibility involves one's subjective perception of the risk of contracting the threat in question;
- Perceived severity refers to the perception of both the physical (for example, death, and pain) and social costs (for example, effects on social relations, family life) of contracting a condition.

Expectations

- Perceived benefits of any action involve beliefs about the effectiveness of available options for reducing the threat of the disease.
- Perceived consequences of action refer to the negative aspect of a particular health action (for example, pain, side effects, stigma, and inconvenience).
- For the behaviour to occur or change to be initiated, the perceived benefits should outweigh the perceived costs of action (Kelly, Parker and Lewis, 2001:12)

Self-efficacy

Self-efficacy refers to perception that one is or is not capable of performing a certain behaviour. Some people doubt whether they can protect themselves from HIV infection and therefore engage in unsafe sex. Others may have tried to engage in safe sex but have failed. Providing these people with life skills such as assertiveness, negotiation skills and self-awareness will improve their self-efficacy.

Enabling factors

Enabling factors are helpful in promoting action. These stimuli might be internal or external. The internal stimuli (experiencing symptoms, bodily sensations), external stimuli (environmental happenings, for example, media messages) and other sources of information (counselling by a health care worker) can trigger preventive action.

Context

- Beliefs can be influenced by the socio-demographic characteristics (background or context), for example, age, sex, education, ethnicity and knowledge

2.5.2 Modification of the Health Belief Model to suit the study

Relevant issues/components have been extracted from previously discussed theories to modify the HBM to suit this study. Issues that have been added to HBM are as follows:

- The socio-demographic factors of the HBM and the contextual and situational factors of the Situated Rationality Theory of risk influence the decision of an individual.
- The Single Rationality Based Theory of Risk and Health Belief Model complement each other in assuming that an individual makes his/her own assessments of what is healthy or harmful.
- Adopting protective behaviour depends on a person's strength of intention (the Theory of Reasoned Action) and believing that he/she does not have the ability to protect herself/himself (HBM and Social Learning Theory).

- Social Learning Theory realised that people need life skills to empower them to make decisions or discuss sexual behaviour. These life skills have been added to HBM

2.5.3 The Modified Health Belief Model

This study will use the modified HBM to explore the perceptions of HIV negative pregnant women on HIV preventive sexual behaviour. The modified Health Belief Model will be discussed hereunder

Context

- Age – young women are exposed to ‘survival sex’ for food and shelter. African women in their twenties experience the highest HIV infection levels constituting on average about 50% of adult HIV positive population.
- Sex – refers to gender inequity and female subordination. A woman has no power to negotiate the use of condoms with her unwilling husband.
- Education – An illiterate woman is not able to read her HIV results, HIV/AIDS posters and pamphlets on HIV prevention. The number of learners in Grade 1 has decreased by 20% between 1998 and 2001 in KwaZulu- Natal, and is attributed to household impacts of AIDS (SAIRR 2001 b cited in van Rensburg, 2004: 299)
- Knowledge – Lack of education on HIV/AIDS. A study on the risk perceptions and the sexual behaviour of low income rural and nonrural African American women relationships indicated that rural women were about twice as likely than non-rural

women to report a lack of HIV counselling during pregnancy (AIDScience, 2002:1).

- Ethnicity – African culture incorporates a culture of male dominance that renders women powerless. A woman has no say over man, especially in matters related to sexual relationships.

This study will interview the African women whose beliefs might be influenced by these socio-demographic factors.

Perceptions

According to the Health Belief Model, it is assumed that if individuals:

- perceive themselves vulnerable to infection,
- perceive the consequences of infection to be severe,
- perceive the means and resources to be available and effective,
- perceive that there are few barriers to action and are able to protect themselves, then the likelihood of changing the behaviour or maintaining the safe sexual behaviour is greater. These perceptions are going to be used to explore the HIV preventive behaviour of HIV negative pregnant women.

Self-efficacy

Self-efficacy empower women to exhibit self-confidence, self-awareness, assertiveness and negotiating skills that enable them to discuss and negotiate on matters related to sexual

relationships. The study will attempt to determine whether HIV negative pregnant women are able or not able to protect themselves from the epidemic.

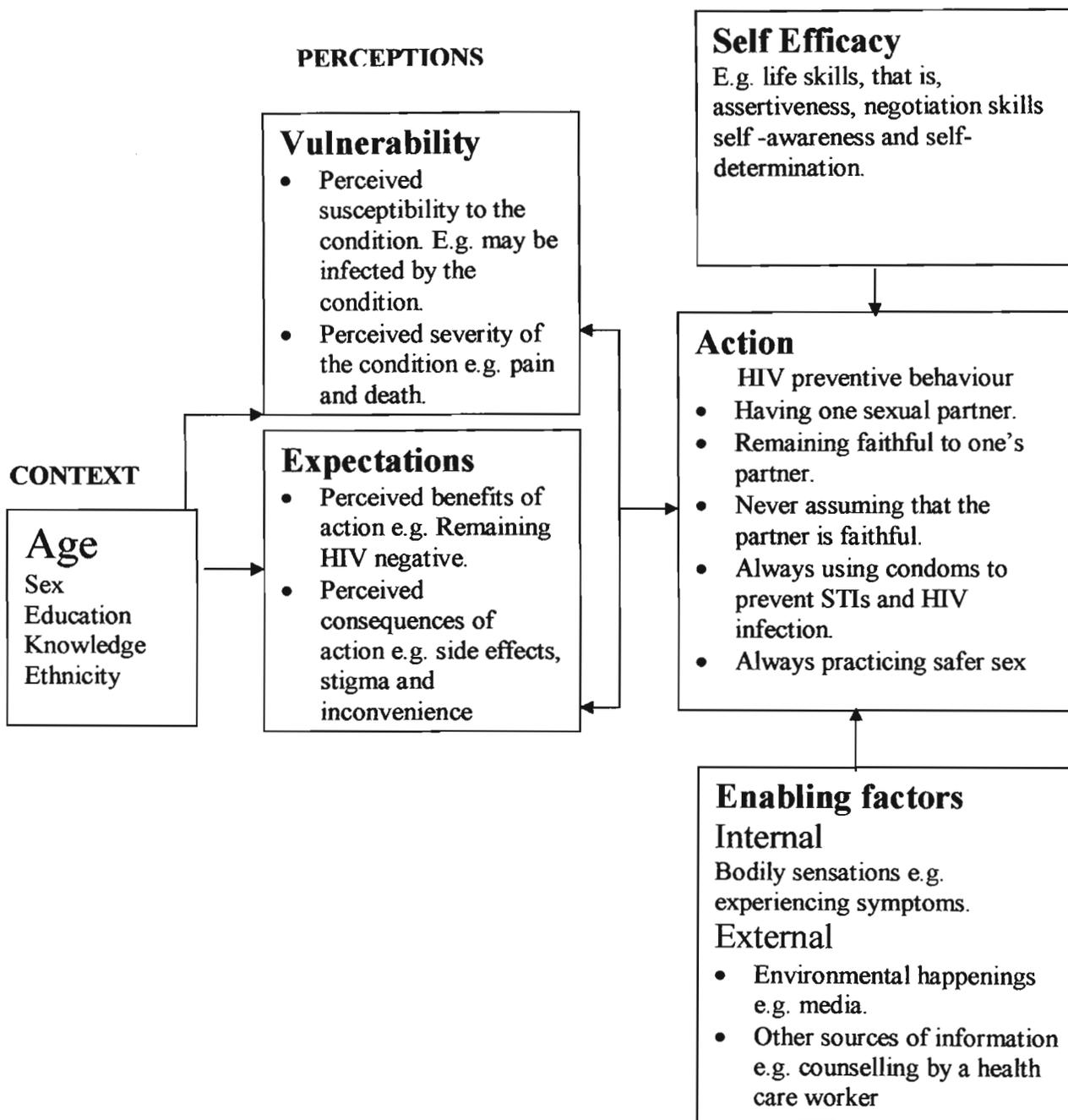
Enabling factors

These are helpful in stimulating an individual to engage in HIV preventive behaviour.

Enabling factors empower individuals with the necessary life skills to make the right health choices and to improve their quality of life. An individual develops responsible and effective coping skills that will enable one to prevent HIV infection (van Dyk, 2001:150).

Figure 2.1 illustrates the Modified Health Belief Model.

Figure 2.1: MODIFIED HEALTH BELIEF MODEL



Health Belief Model as modified using other models of behaviour change.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Research approach

Crotty (1998:3) defines methodology as the strategy, plan of action, process or design behind the use of methods to achieve the desired outcome. This study adopted a qualitative approach in exploring the perceptions of HIV negative pregnant women and described their behaviour according to the findings. Qualitative research captures and discovers meanings once the researcher becomes immersed in the data. Qualitative data documents real events, records what the people say and observes the specific behaviours (Neuman, 1997:328). The study recorded what the HIV negative pregnant women said about HIV preventive sexual behaviour.

3.2 Research design

An explorative design was used to explore the perceptions of HIV negative pregnant women on HIV preventive sexual behaviour. Blaikie (2000: 72) defines exploring as an attempt to develop an initial rough description or, possibly an understanding of some social phenomenon. He argues that exploratory research is necessary when very little is known about the topic being investigated. It is used to get a better idea of what is going on. Most studies that have been done concentrated on HIV positive people. This study has used the

exploratory design because very little is known about the perceptions of HIV negative pregnant women on HIV preventive sexual behaviour.

Basic demographic characteristics of a group of people, or some aspects of the behaviour or social relationships, may need to be known in order to design the study (Blaikie, 2000:73).

This study tried to find out if the socio-demographic characteristics of HIV negative pregnant women influence their HIV preventive sexual behaviour. Exploration usually precedes description. “Descriptive research seeks to present an accurate account of some phenomenon, the distribution of characteristics in some population, the patterns of relationships in some social context, at a particular time, or the changes in those characteristics over time” (Bulmer, 1986:66 cited in Blaikie, 2000:74). These descriptive accounts can include the characteristics of a social group or a demographic category.

3.3 The setting

The study was conducted at King Edward VIII Hospital. This hospital has been recently converted from a tertiary into a regional hospital. This is a regional hospital in EtheKwini metropolitan area (Refer figure 3.1). This hospital is the base hospital for KwaZulu-Natal health region which includes a number of districts. Furthermore, it is Level 2 hospital which is a referral centre for Level 1 hospitals and offers specialist care for the pregnant women who do not require Level 3 care, manages the severely ill pregnant women and makes advanced prenatal diagnosis (Department of Health, 2002b:15). In this hospital, about 271 antenatal cases report at the antenatal clinic per month. They report on a daily basis on weekdays. They have a VCT service, which starts with the group counselling

session and then one to one counselling. The women are tested on their first visit to the antenatal clinic. Those who volunteer come forward for testing. Rapid testing is done and the results are available on the same day. They are counselled after the test when the results are available.

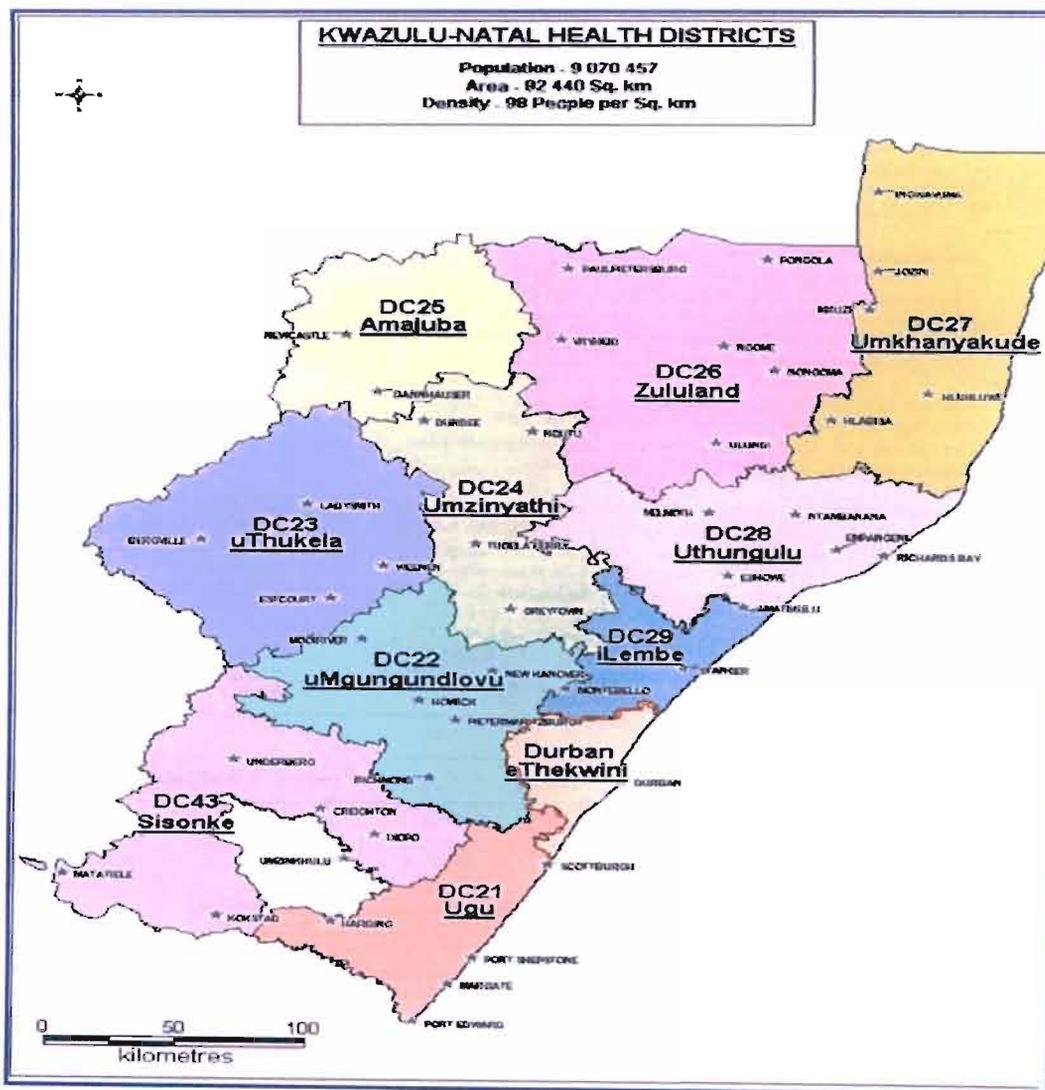


Figure 3.1 Map of KwaZulu-Natal health districts highlighting eThekweni Durban metro extracted from KwaZulu- Natal Department of health (<http://www.kznhealth.gov.za/mainmap.htm>).

According to the statistics, at antenatal clinic of the aforementioned hospital, 59% of the women test HIV negative. Table 3.1 gives detailed statistics of patients who volunteer for VCT and their outcomes over a year period.

Table 3.1: HIV STATISTICS OF FIRST VISITS ANTENATAL ATTENDEES AT KING EDWARD VIII HOSPITAL IN 2003

Month	Total number of first visits	Number of tested clients	HIV negative	HIV positive	Clients refusing testing
JANUARY	310	290 94%	170 55%	120 39%	20 7%
FEBRUARY	329	322 98%	192 58%	130 40%	7 2%
MARCH	329	318 97%	190 58%	128 39%	11 3%
APRIL	264	264 100%	155 59%	109 41%	-
MAY	312	307 98%	179 57%	128 41%	5 2%
JUNE	272	263 97%	174 64%	89 24%	9 3%
JULY	260	260 100%	155 60%	105 40%	-
AUGUST	231	231 100%	141 61%	90 39%	-
SEPTEMBER	240	240 100%	141 59%	99 41%	-
OCTOBER	281	281 100%	159 57%	122 43%	-
NOVEMBER	245	243 99%	132 54%	111 43%	2 1%
DECEMBER	175	175 100%	94 54%	81 46%	-
TOTAL	3248	3194 98%	1882 58%	1312 40%	54 2%

Number of first visits-3 248. Average 272. Weekly 68. Daily 14.

Number of clients who were tested for HIV – 3 194. Average 267. Weekly 66. Daily 13.

Number of HIV negative clients – 1 882 = 58, 9%. Average 157. Weekly 39. Daily 8.

Number of HIV positive clients – 1 312 =41, 1%. Average 109. Weekly 27. Daily 4.

Number of clients refusing testing – 54 =1.6%. Average 5 Weekly . Daily 1.

3.4 Sample and sampling technique

The sample population was pregnant women attending the antenatal clinic at King Edward VIII Hospital, who have undergone VCT and tested negative. Purposive sampling was used because the researcher chose only those participants that qualified under the selection criteria. The selection criteria included women who were less than 34 weeks pregnant so that the researcher would be able to meet them again for the second interview. They had volunteered for the VCT programme, signed the consent form, been tested and been found to be HIV negative. Three participants were interviewed for the pilot study. These were included in the main study for the saturation of data. In total, fifteen participants were chosen for this study.

3.5 Instrument for data collection

The researcher developed an interview guide that she believed would give the information that would answer the research questions. It had open-ended questions that allowed the participants to expand on how they behaved sexually (Refer Annexure A). An interview guide with probing questions was used to interview the participants in-depth in the following areas:

- Demographic background
- Knowledge on HIV negative status
- Patterns of sexual behaviour before testing

- Perceived need for HIV preventive sexual behaviour
- Reasons for their sexual behaviour

3.6 Data collection process

The researcher conducted semi-structured interviews to collect the data. Denscombe (1998:113) argues that with the semi-structured interview the interviewer is prepared to be flexible in terms of the order in which the topics are considered. The interviewee is allowed to develop ideas and speak more widely on the issues raised by the researcher. The answers are open-ended, and there is more emphasis on the interviewee elaborating on certain points of interest. The interviews were done in the morning, in a separate consulting room. Data was collected using the interview guide. Two interviews were conducted on each participant for the purpose of saturation and verification of data. The second interviews were conducted a month after the first interviews were done in both instances, the participants were individually interviewed.

The Sister-in-charge at antenatal clinic helped the researcher with the selection of participants. The researcher introduced herself to the participants and informed them about the purpose of the study. She sought the participant's permission to include them in the study and to be audio taped. All the participants agreed to be audiotaped except one and detailed notes were taken of her interview. The issues of confidentiality and anonymity were discussed before the interview. Pseudonyms were used to protect the names of the participants.

Using the interview guide, the researcher started with a question about their demographic background to put them at ease and make them feel relaxed. By the time the researcher asked the next round of questions that were very personal, the participants were talking and answering questions freely. Some asked questions that they did not have in mind during the HIV/AIDS lecture, before and after the counselling sessions. Field notes were taken to back up the audio taped recording. Each interview lasted 20-30 minutes. Transcribing interviews took two days. Photocopies of some transcripts were made for the supervisor to check.

The first interviews were conducted in a consulting room that had no roof. These consulting rooms were plank partitions with four walls and a door for privacy. There was a lot of noise. The researcher discussed her problem with the Sister- in charge of the clinic. She allowed the researcher to use another consulting room that was well constructed. The participants who were interviewed were between 20 and 30 weeks pregnant. These women came once a month to the antenatal clinic. The researcher had to wait a month to do second interviews.

3.7 Pilot study

Three women who qualified for the selection criteria were interviewed twice using the interview guide. Both interviews gave the same results. The aim was to verify whether the participants had understood the questions. The question that was asked was whether telling a partner about the HIV negative status influenced using/not using condoms was rephrased as “Did undergoing VCT and telling your partner about your HIV negative status,

influence your using/not using condoms’’. This was done because the researcher felt that the important issue here was that the participants had undergone VCT and were taught about condom use to prevent transmission of HIV infection. So, by asking this question the researchers wanted to find out whether VCT had motivated the participants to continue using condoms or to change their habit of not using condoms.

3.8 Trustworthiness

Trustworthiness is a qualitative way of expressing validity and reliability, which are measures of the research outcomes with respect to adherence to principles of qualitative approach and thoroughness in collecting data. The concepts used are credibility, dependability, confirmability and transferability (Burns and Grove 1995:136).

3.8.1 Credibility

Credibility refers to the authentic quality of the data, that is, whether the data reveals what the researcher was looking for. To meet this criterion the researcher gave a detailed description of the setting or context under study, sample, data collection instrument, data collection process and data analysis for the readers to assess the authenticity of the study (Burns and Grove, 1995:136).

3.8.2 Dependability

Dependability refers to the process of detailing the consistency, reasonable stability over time and convergence of accounts across methods. Factors for dependability include for example, informants, observations, contexts, connectedness to theory, data quality checks or audits and peer review of coding (Burns and Grove 1995:137). A quality check was done through presentation of the proposal and approval by the Research Committee of the School of Nursing. Interviews were done twice to verify the consistency of data with the participants.

3.8.3 Confirmability

Confirmability refers to achieving freedom from the researcher's biases by ensuring that the conclusion depends on the subjects and conditions of enquiry rather than on the investigator (Burns and Grove 1995:139). Over and above interviews being tape recorded, they were transcribed verbatim to ensure verification and audited by experienced research supervisors.

3.8.4 Transferability

Transferability refers to the findings of the research applied to other contexts. However, in qualitative studies, samples are too small to allow generalisation (Burns and Groves 1995:139).

3.9 Data analysis

Data analysis was done manually. The participants were given pseudonyms. The researcher identified codes for interviews as follows, 'T' for transcript; initial of the pseudonym, that is, A for Anele; the page number of the transcript; 'L' for line in the text and the number of the line. For example, Anele's transcript, first page and line 8 will be (TA1L8).

“There can be more than one area which the researcher has identified ‘as of interest’ and which has been allocated a unique code to represent an issue, a topic or meaning” (Denscombe, 1998:130). The researcher immersed herself in the data and began to identify units of meaning. These were either sentences or paragraphs extracted from the transcripts. These units of meaning were categorised according to themes. The themes were categorised as knowledge of implications of negative status, sexual behaviour before testing, perceived need for preventive sexual behaviour and reasons for their sexual behaviour. These were then fitted into the concepts of the chosen theory for interpretation.

3.10 Ethical considerations

The proposal of the study was submitted and approved by the Ethics Committee of University of KwaZulu –Natal (See Annexure C). Permission was obtained from the Department of Health (See Annexure D) and the Hospital Manager at King Edward VIII Hospital (See Annexure E).

The participants were informed about the purpose of the study, that participating in the study was not compulsory and that they were allowed to withdraw at any time from the study if they felt uncomfortable about answering the questions. They signed the informed consents (See Annexure B). They were assured that their names or personal details would not be written on interview schedule, however, a separate sheet of their names was kept under lock and key to facilitate the verification interviews. The pseudonyms were used in transcripts and discussion. The participants were interviewed individually in a consulting room to ensure privacy. When the interview was about to finish, the participants were thanked for their time. Confidentiality was observed.

3.11 Conclusion

In this chapter the process undertaken to conduct this study was presented. The process is also in keeping with exploration as the chosen research design. The process further describes the setting to the sample selected for this study. Measures to meet the ethical requirements for the study, including academic rigour were presented to avoid errors of conclusion and interpretation of the data.

CHAPTER 4

DESCRIPTION AND DISCUSSION OF FINDINGS

4.1 Introduction

During the interviews, the researcher started by asking participants about their demographic background. This helped in establishing a rapport between the researcher and the participants. By the time the researcher started asking them about their sexual behaviour, they were relaxed. The demographic data of the participants is shown in Table 4.1 below.

Table 4.1 Demographic data of the participants

Pseudonym	Age	Gestational age in weeks	Marital status	Living /separately	Level of education	Participant's employment	Partner's employment
Norma	36	28	Married	together	primary	domestic worker	driver
Qhuzu	23	28	single	separately	high school	unemployed	unemployed
Karabo	30	30	single	together	primary	unemployed	conveyer
Daisy	20	26	married	together	illiterate	unemployed	teacher
Eunice	19	28	single	together	high school	unemployed	employed
Philile	23	28	single	separately	tertiary	student	employed
Fezile	24	24	single	separately	high school	part-time	part-time
Bona	22	22	single	together	high school	unemployed	cook
Zethu	21	25	married	together	high school	unemployed	technician assistant
Julia	22	26	single	together	high school	sales administrator	warehouse supervisor
Rhoda	35	20	single	together	high school	unemployed	part-time
Sophie	31	24	single	together	high school	unemployed	panel beater
Thoko	33	30	married	together	high school	self-employed	self-employed
Anele	24	28	single	separately	high school	unemployed	student
Chwane	44	30	divorced	together	high school	quality controller	quality controller

4.1.1 Sample description

The gestational age of the chosen participants was between 20 and 30 weeks pregnant which meant the researcher would be able to meet them again for the second interview. The

age range of the participants was between 19 to 44 years and they were all younger than their partners except one who was older than her partner.. Most of the participants were not married but were living with their partners. Most of them had passed matric and were expected to have negotiation and communication skills about use of condoms. The majority of the participants were unemployed and depended on their partners for financial support.

4.2 Research findings

4.2.1 Data analysis

The collected data was analysed manually. The units of meaning were identified and categorised as their knowledge of the implications of their HIV negative status, their sexual behaviour before testing, their perceived need for preventive sexual behaviour and the reasons for their sexual behaviour. Themes were developed from these categories and were further fitted into the conceptual framework. The categorisation of themes is shown in Table 4.2 below.

Table 4.2 Categorisation of themes

CATEGORIES	A. Knowledge of implications of HIV negative status	B. Patterns of sexual behaviour before testing	C. Perceived need for preventive sexual behaviour	D. Reasons for their behaviour
THEMES	There is no HIV virus in my body	... had one sexual partner before pregnancy	... disclosed my HIV status to my partner	... do not see the reason for using condoms because I am married
	HIV negative test results can be false negative	... had one casual sexual encounter	... there is no need for him to be tested because I am HIV negative	He is the one who supports me
	... can wait three months before repeating test	... have never used any form of contraception	We were together when he was tested, he is HIV negative	He can beat me
	... can still be infected with HIV virus even if your repeat test result is negative	... was on a pill	It is necessary to use condoms even if you are HIV negative	We do not use condoms because we trust each other
		... have never used a condom in my life	We did not use condoms during our last sexual intercourse	The baby is not going to grow if he uses condoms

4.3 Discussion of findings

4.3.1. CATEGORY A: Knowledge of implications of HIV negative status

Theme 1: there is no HIV virus in my body (TQ1L8)

The participants knew what the negative status entailed. Most of the participants said that negative status meant that they had no disease, meaning that they did not have HIV/AIDS. “HIV negative test result means that I have no disease” (TF1L8). “There is no HIV virus in my body” (TQ1L8).

Theme 2: HIV negative test results can be false negative (TR1L10)

Most of the participants knew that there was a period, after infection before the antibodies were formed, when the HIV results could be false negative (TR1L10). They were aware that they were supposed to repeat the HIV test after three months to confirm their HIV negative status (TZL11)

Theme 3: ...to wait three months before repeating test (TJ1L14)

All participants, except two, knew that there is a chance of HIV negative person being infected by HIV virus if one does not engage in preventive sexual behaviour. They knew that even if the repeat test results were negative one could still be infected by the HIV virus (TQ1L11).

Theme 4: ...can still be infected with HIV virus even if your repeat test result is negative (TZ1L15)

The participants were aware that they could still be infected even if the repeat test results were negative.

4.3.2 CATEGORY B: Patterns of sexual behaviour before testing

Theme 1.1: 'I had one sexual partner before pregnancy' (TF1L15)

Each participant had one sexual partner before pregnancy. "I had one sexual partner before pregnancy" (TF1L15). They said that they were faithful to their partners.

Theme 1.2: '...had one casual sexual encounter' (TA1L18)

All the participants denied having casual sexual relationships before testing except one. The participant who accepted that she had once had casual sexual relationship (one night stand) had used protection during that sexual encounter. "I had one casual sexual encounter but I used a condom. It was just once and that was it" (TA1L18)

Theme 2.1: '...have never used any form of contraception' (TD1L12)

There were participants who had never used any form of contraception. Their partners did not allow them to use the family planning services. "I have never used any form of birth control; my first baby is two years old now, I did not use birth control in between pregnancies" (TD1L12).

Theme 2.2: ‘...was on a pill’ (TJ1L18)

Other participants were using some form of contraception, either a pill (TJ1L18) or injectables (TR1L17). The participants did not use dual contraception that is any form of contraception together with a condom. This is done to prevent sexually transmitted infections and HIV/AIDS.

Theme 3 ‘...have never used a condom in my life’ (TB1L13)

“I have never used a condom in my life” (TB1L13). None of the participants were using condoms during sexual encounters before testing.

4.3.3. CATEGORY C: Perceived need for preventive sexual behaviour

Theme 1: ‘...disclosed my HIV status to my partner’ (TS1L20)

All participants disclosed their status to their partners. “I disclosed my HIV status to my partner” (TS1L20). The partners were happy and relieved about the participants’ results.

Theme 2.1: ‘there is no need for him to be tested because I am HIV negative’

(TE1L20)

Most of the participants requested their partners to go for VCT. The partners refused to go for VCT because they believed that there was no need since the participants were HIV negative. “He says that there is no need for him to be tested because I am HIV negative” (TE1L20).

Theme 2.2: 'we were together when he was tested, he is HIV negative' (TP1L21)

Of those few whose partners had accompanied participants to antenatal clinic, they had all attended HIV lecture and undergone VCT. "We were together when he was tested, he is HIV negative" (TP1L21).

Theme 3.1: 'it is necessary to use condoms even if you are HIV negative' (TN1L23)

Some of the participants believed that it was necessary to use condoms when one was HIV negative. "It is necessary to use condoms even if you are HIV negative" (TN1L23).

Theme 3.2: 'we did not use condoms during our last sexual encounter' (TE1L21)

Though the participants believed that it was necessary to use condoms even if they were HIV negative, most of them did not use condoms during their last sexual intercourse. "We did not use condoms during our last sexual encounter" (TE1L21).

Theme 4; 'VCT did not influence our behaviour of not using condoms' (TD1L20)

"VCT and disclosing my HIV negative status to my husband did not influence our behaviour of not using condoms" (TD1L20). "Knowing that we are HIV negative, gives us freedom of not using condoms" (TCL24). Going through VCT did not change the sexual behaviour of most of the participants. Knowing that they were HIV negative did not motivate them to engage in preventive sexual behaviour. Only a few changed their sexual behaviour and were then always using condoms. Other participants claimed that their partners were HIV negative but they had never been tested. "He has not been tested because I am HIV negative; VCT did not influence us on not using condoms because 'we' are HIV negative" (TB1L19 and 22). They

assumed that since they were HIV negative it meant that their partners were HIV negative as well.

4.3.4. CATEGORY D: Reasons for their sexual behaviour

Theme 1: ‘...do not see the reason for using condoms because I am married’

(TZ1L25)

“I am not using condoms because my husband does not want them” (TS1L26). “I do not see the reason for using condoms because I am married” (TZ1L25). Women had been socialised to play a subservient role in their relationships with men, especially in matters related to sex.

Theme 2: ‘...he is the one who supports me’ (TN2L28)

Women chose to stay in a high-risk relationships rather than facing the greater economic risk of leaving the partner upon whom they were dependant. “The reason for not using condom is that it has to be a husband’s decision whether to use them or not; I cannot argue with him because he is the one who supports me, I am not working” (TN2L28).

Theme 3: ‘...he can beat me’ (TQ1L21)

Fear of violence reduced the ability of women to negotiate HIV preventive sexual behaviour. “The reason for not using condoms is that my boyfriend does not agree on using condoms. I cannot be able to say ‘condom or no sex’ because he can beat me” (TQ1L21).

Theme 4: 'we do not use condoms because we trust each other' (TE1L24)

“We do not use condoms because we trust each other” (TE1L24). Most of the participants trust their partners and are trusted by their partners. So there is no perceived need for preventive sexual behaviour. Very few participants believed that it was the right thing to use condoms. “The reason for my sexual behaviour, that is using condoms, is that I want to protect my baby and it is the right behaviour for protecting myself from contracting HIV” (TP1L25).

Theme 5: '...the baby is not going to grow if he uses condoms (TB1L25)

“We are not using condoms because my boyfriend says that the baby is not going to grow if he uses condoms. He needs to feed his baby” (TBL25). This myth prevented that couple from engaging in HIV preventive behaviour. “I believe that he is using condoms with other partners that are not staying together with him; it is different with me because we are staying together” (TK2L24). These myths and beliefs exposed the HIV negative pregnant women to HIV/AIDS.

4.4 Conclusion

This chapter discussed the findings according to the demographic background, knowledge on HIV negative status, patterns of sexual behaviour before testing, perceived need for HIV preventing sexual behaviour and their reasons for their sexual behaviour. Demographically, the participants' ages were ranging between 19 and 44 years and most of them were unmarried but living with their partners. It appeared that they knew the implications of not using condoms but most of them were not engaging in preventive sexual behaviour.

CHAPTER 5

SUMMARY OF FINDINGS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 Summary of findings

In this chapter findings of the study are discussed in the context of the Health Belief Model that guides the study.

5.1.1 HEALTH BELIEF MODEL

As discussed in the previous chapter, the Health Belief Model consists of the following concepts, context, perceptions, self-- efficacy, enabling factors and HIV preventive sexual behaviour.

5.1.1.1 Context

Age

Most of the participants were younger than their sexual partners. They had a problem discussing HIV preventive sexual behaviour with their partners because of the age difference. The partners told them how they should behave. “Young girls especially are often coerced, raped or enticed into sex by someone older, stronger or richer than

themselves. It is well known that older ‘sugar daddies’ often offer school girls gifts or money in return for sex’’ (van Dyk, 2001:21)

Sex

ILOAIDS (2005:1) argues that the greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. In a number of countries in Africa and the Caribbean, infection rates among young woman are two to six times higher than among young men. Many women experience sexual and economic subordination in their personal relationships at work, so cannot negotiate safe sex or refuse unsafe sex. Some of the participants were willing to use condoms but their partners were refusing to use them. They engaged in unsafe sex because of their lower socially imposed subordinate status to men to the extent that they had no say in sexual matters. “By and large, most men, however poor can choose when, with whom and with what protection if any, to have sex. Most women cannot’’ (AFROL, 2005:1).

Education

Education is a key defence against HIV infection, but girls are the first to be taken out of school to help with care or to earn much needed income (ILOAIDS, 2005:1).

Participants that had never been to school or those with lower primary education were not clear about what the HIV negative status entailed.

5.1.1.2 Perceptions

Vulnerability

“It is argued that an individual will engage in health behaviour, such as safe sex if, that individual perceives herself as vulnerable or susceptible to a health threat. The health threat is perceived as having serious consequences” (Kelly et al, 2001:12).

Most of the participants were aware that they could be infected with the virus even if they were HIV negative. But some participants did not seem to perceive HIV/AIDS as having serious consequences because they were not practicing safe sex. However, there were other influential factors that made them vulnerable, for example, failure to negotiate their choices about sex like condom use.

Expectations

The participants knew that HIV preventive sexual behaviour is the only way to avoid HIV infection. To some of the participants, their perceived consequences of actions were their fear of losing the economic support of their partners and their fear of violence. The participants could not engage in HIV preventive sexual behaviour because their perceived cost of action outweighed the perceived benefits. They decided on risking their lives by practicing unsafe sex rather than losing financial support from their partners. Poverty also forces women to resort to sex for survival or to continue in relationships with men who refuse to practice safe sex (ILOAIDS, 2005:2)

5.1.1.3 Self - efficacy

“It refers to the perception that one is, or is not, capable of performing behaviour. People may engage in high-risk behaviour due to the doubt as to whether they can protect themselves from HIV infection” (Kelly et al, 2001:13). Most of the participants could not personally perform the preventive sexual behaviour successfully and experience the expected positive outcome because their partners were the ones who decided on their sexual behaviour. They lacked life skills like assertiveness, communication, negotiation and refusal skills.

5.1.1.4 Enabling factors

Kelly et al (2001:12) argue that internal states, such as bodily sensations, and environmental happenings such as media, message or other sources of information (for example, health worker’s advice) can act as cues that trigger preventive action.

Internal factors

The participants were physically well and not suffering from any symptoms of HIV/AIDS because they were HIV negative. Since they were HIV negative, the researcher assumed that was the reason why most of them were not engaging in HIV preventive behaviour.

External factors

The participants were given a lecture on HIV/AIDS and counselled before and after their HIV test. The professional nurses and HIV counsellors provided the participants

with the information on HIV/AIDS. Even all this did not motivate most of the participants to engage in HIV preventive sexual behaviour.

5.1.1.5 HIV preventive behaviour

The participants did not engage themselves in HIV preventive sexual behaviour because they played a subservient role in their families and their partners were expected to decide on their sexual behaviour. Being married made them feel that there was no need for HIV preventive behaviour. They also depended on their partners financially therefore feared rejection in addition to fear of violence. They further assumed that their partners were faithful and trusted them. This is in keeping with Eldis's (2005:1) findings in which women had stayed in the relationships where they were aware that their husband were not monogamous mainly through fear of violence, and financial dependence on those men.

5.2 Recommendations

5.2.1 Recommendations for nursing practice

Since men are the ones who are regarded as heads of the families and who decide whether HIV sexual preventive behaviour is going to be practiced or not, they should be targeted during HIV awareness campaigns. Some of the women are willing to practice HIV sexual preventive behaviour but their partners refuse. The campaigns should concentrate on men. Men usually do not attend workshops for HIV prevention that are conducted for communities. They should be visited at their places of work,

shebeens and sport clubs where they are often gathered. The researcher recommends that a partner should accompany a pregnant woman, who is coming to the antenatal clinic for her first visit, so that they could be together at the HIV prevention lecture and VCT. Prenatal classes should be encouraged so that woman and man could share the responsibility of parenthood and HIV prevention.

Counselling should include life skills for women to enable them to protect themselves from violence and the subservient expectations of their society. Legislation should be enforced to protect women from violence, for example, the Domestic Violence against Women Act (Act no. 116 of 1998).

5.2.2 Recommendations for nursing management

It is evident that HIV negative people need ongoing counselling and support. The facilities needed to achieve this are for example, private rooms for counselling couples and qualified counsellors.

5.2.3 Recommendations for nursing education

Counselling of HIV negative people needs to be included in the curriculum of the basic nursing students. Girls have to be sent to school and not deprived of education. If they are educated they will have life skills such as assertiveness, negotiation skills and self-awareness. These skills have to be incorporated in HIV education so that every woman can develop them. They will then be able to negotiate about their sexual matters such as condom use with their partners.

It was observed that illiterate participants had never been to family planning clinics. Therefore, girls should be taught about sexuality early at school so that they have the knowledge about health services like family planning. Sexuality and HIV/AIDS awareness has to be taught as early as primary school because children engage in sex at an early age. This would enable them to make decisions about their sexual lives.

5.2.4 Recommendations for future nursing research

The findings of this study showed that most of the HIV negative pregnant women did not engage in preventive sexual behaviour. Their reasons were their fear of losing financial support, fear of violence and their lower status in the society. This may form the basis for further research, for example, correlation studies on factors promoting people to stay HIV negative.

5.3 Limitations of the study

The sample consisted of pregnant women therefore the findings may be biased because the participant did not represent the community. The participants were tested once for HIV during pregnancy and it is possible that the results were false negative. Therefore it would be interesting for a further study to follow the HIV negative clients over a long period. Sexual practices that a person engages in are a personal matter. It is a sensitive issue. The researcher was prying into the participant's private life. It was possible that the participants could tell the researcher what they thought was acceptable. For example, only one participant divulged that she once had casual sexuality relationship. All participants claimed that they had only one sexual partner

before pregnancy. This may not have been true. Generalisations cannot be made on this study because only 15 people, including those in the pilot study, were interviewed. Time was limited since the study was done as a requirement for degree purpose.

5.4 Conclusion

The study explored the perceptions of HIV negative pregnant women on HIV preventive sexual behaviour. The findings revealed that the HIV negative pregnant women perceived HIV preventive sexual behaviour as essential for prevention of HIV infection. However, this preventive behaviour is outweighed by their marriages, their economic/financial dependency on their partners and the trust for their partners. They decided not to engage in HIV preventive sexual behaviour because they did not want to lose their partners or husbands. They would rather get infected by HIV than lose the financial support of their partner. Lack of negotiation skills also contributed to non-protection from HIV infection. It is surprising that people who were fortunate enough to be found HIV negative did not value it but they continued to engage in unsafe sex practices. It shows that the HIV lectures and VCT did not change some of these participants nor did it motivate these participants to continue with HIV preventive sexual behaviour.



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Annexure A

Interview guide

INTERVIEW GUIDE

A. Background

Age – yours

-Partner's age

Married /single / divorced /widowed

Place of stay

Living together with the partner / living separately

Level of education

Type of employment –yours

-Partner's employment

B. Knowledge on HIV negative status

- What does HIV negative test result mean to you?
- Can HIV negative test result be false negative?
- What do you understand by 'window period'?
- Is there a chance of HIV negative person to be infected by the virus?
- Why is the repeat test important?
- How long do you have to wait before repeating test?
- Can you still be infected with HIV virus even if your repeat test result is negative?

C. Patterns of sexual behaviour before testing

- How many sexual partners did you have before pregnancy?
- Before pregnancy, what form of contraception were you using?
- Were you using condoms during sexual encounters before testing?
- Have you had any casual sexual relationships before testing?

D. Perceived need for safe sexual behaviour

- Did you disclose your HIV status to your partner?
- Has he been tested for HIV?
- If he has, did he disclose his status to you?
- If he has not, what is his reason for not testing?
- Did you use condom during your last sexual intercourse?
- When you are HIV negative, is it necessary / not necessary to use the condom?
- Telling your partner about your HIV negative status, did it influence your using / not using condoms?

E. Reasons for their sexual behaviour

- Why did you decide to have one partner / number of partners you have?
- Why are you and your partner using / not using a condom?

Annexure B

**(i) and (ii) Consent forms for those participating in the study
in English and Zulu**



THE SOUTH AFRICAN CENTRE
FOR EVIDENCE BASED NURSING & MIDWIFERY



THE JOANNA BRIGGS INSTITUTE

Appendix B (I)



UNIVERSITY OF
KWAZULU-NATAL

CONSENT FOR PARTICIPATING IN THE STUDY

I am a student at the University of KwaZulu-Natal doing a study on the Perceptions of HIV negative pregnant women on HIV preventive sexual behaviour. I am seeking your permission to participate in the study by allowing me to interview you on this.

Participating in the study is not compulsory. Your name will not appear anywhere in the documents and no one will have access to the information that you will give in this interview. You are allowed to withdraw at any time from the study if you are uncomfortable.

I _____ the undersigned was informed about the study and voluntarily agree to be a participant in the study.

Participant's signature / Thumbprint

Date

Researcher's signature

Date

School of Nursing, Howard College Campus

Postal Address: Durban, 4041, South Africa

Telephone: +27 (0)31 260 2499

Facsimile: +27 (0)31 260 1543

Email:

Website: www.ukzn.ac.za

Founding Campuses:

■ Edgewood

■ Howard College

■ Medical School

■ Pietermaritzburg

■ Westville



THE SOUTH AFRICAN CENTRE
FOR EVIDENCE-BASED NURSING & MIDWIFERY



THE JOHANNA BRIGGS INSTITUTE



UNIVERSITY OF
KWAZULU-NATAL

IFOMU YOKUVUMA UKUNGENELA UCWANINGO

Ngingumfundi wasenyuvesi yakwaZulu-Natal. Ngenza ucwaningo lwemibono yabantu abakhulelwe anatholakale bengenalo igciwane lengculazi kwimiphumela yegazi. Bengicela imvume yakho ukuba uphendule lemibuzo engizoyibuza ngalesisihloko.

Ukungenela ucwaningo akuphoqelekile. Igama lakho livikelekile ngoba alizuvela kulamaphepha ocwaningo futhi izimpendulo zakho azizukutshelwa muntu. Uvumelekile ukuhoxa kulolucwaningo noma yinini uma ungasathandi ukuqhubeka nalo.

Uma uvuma ngicela usayine ngezansi.

Mina _____ osayine lapha
ngiyavuma ukuthi ngazisiwe kahle mayelana nalolucwaningo. Ngiyavuma ngaphandle
kokuphoqwa ukuthi ngingene kulolucwaningo.

Ukusayina /Isithupha sokuvuma

Usuku

Ukusayina kukamcwaningi

Usuku

School of Nursing, Howard College Campus

Postal Address: Durban, 4041, South Africa

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Annexure C

Letter of permission – Ethics Committee of KwaZulu-Natal
University



THE SOUTH AFRICAN CENTRE
FOR EVIDENCE-BASED NURSING & MIDWIFERY



THE JOHANNA BRIGGS INSTITUTE



UNIVERSITY OF
KWAZULU-NATAL

RESEARCH ETHICS COMMITTEE

Student: Sibongile Msebeni

Research Title: THE PERCEPTIONS OF HIV NEGATIVE PREGNANT WOMEN ON HIV PREVENTIVE SEXUAL BEHAVIOUR IN ONE OF THE REGIONAL HOSPITALS IN DURBAN.

A. The proposal meets the professional code of ethics of the Researcher:

YES NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: [Signature] Date: 9.12.04

Signature of Supervisor: [Signature] Date: 9.12.04

Signature of Head of School: [Signature] Date: 09.12.2004

pp Signature of Chairperson of the Committee: [Signature] Date: 13/12/2004

School of Nursing, Howard College Campus

Postal Address: Durban, 4041, South Africa

Telephone: +27 (0)31 260 2499

Facsimile: +27 (0)31 260 1543

C:\Documents and Settings\Administrator\My Documents\ETHICS CLEARANCE FORM.DOC

Website: www.ukzn.ac.za

Founding Campuses:

■ Edgewood

■ Howard College

■ Medical School

■ Pietermaritzburg

■ Westville

Annexure D

Letter of permission – KwaZulu-Natal Health Services



DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

SPECIAL SUPPORT SERVICES

Natalia, 330 Longmarket Street, Pietermaritzburg, 3201
Private Bag X9051, Pietermaritzburg, 3200
Tel.: 033 395 3123, Fax.: 033 345 4433

ENQUIRIES : Ms N Sithole
REFERENCE : 9/2/3/R
EXTENSION : 3123

Miss Sibongile G Msebeni
University of KwaZulu-Natal
School of Nursing
Howard College Campus
DURBAN
4041

Dear Miss Msebeni

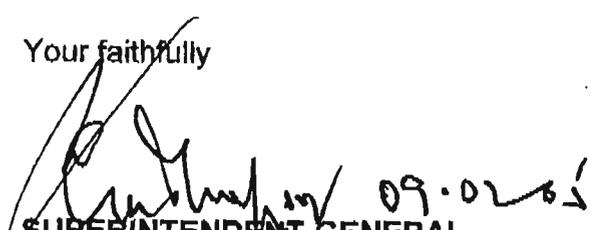
REQUEST TO UNDERTAKE RESEARCH AT KING EDWARD ON THE PERCEPTION OF HIV NEGATIVE PREGNANT WOMEN ON HIV PREVENTIVE SEXUAL BEHAVIOR

Your letter dated 24 January 2005 refers.

Kindly be advised that authority is granted for you to conduct research regarding "the perceptions of HIV Negative Pregnant Women on HIV Preventive sexual Behaviour", provided that the following is agreed to:

- (a) Prior approval is obtained from Head of the relevant institutions;
- (b) Confidentiality is maintained;
- (c) The Department is acknowledged;
- (d) The Department receives a copy of the report on completion; and
- (e) The staff and patients are not inconvenienced and service delivery not affected.

Your faithfully


09.02.05
SUPERINTENDENT-GENERAL
HEAD : DEPARTMENT OF HEALTH
Nnm/msebeni king edward



Annexure E

Letter of permission – King Edward VIII Hospital



DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

KING EDWARD VIII REGIONAL HOSPITAL

Private Bag X02
Congella DURBAN 4000

Enquiries: Mr AJ Seekola
Reference: KE 2/7/1 (6/2005)
Research Programming
22 February 2005

Sibongile Msebeni
School of Nursing, Howard College
University of KwaZulu-Natal
DURBAN
4041

Request to conduct research at King Edward VIII Hospital

Protocol: The perceptions of HIV Negative Pregnant Women on HIV Preventive Sexual
Behaviour in one of the hospitals in Durban.

Your application received on the 14 February 2005 is approved.

Please ensure the following:

- That King Edward VIII Hospital receives full acknowledgement in the study on all publications and reports and also kindly present a copy of the publication or report on completion
- Before commencement:
 - *Discuss your research project with our relevant Directorate Managers.
 - *Sign an indemnity form at Room 8, Hospital Manager's Complex. Admin Block..

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours Sincerely

Mrs ZG Zola
Acting Hospital Manager.

cc All Directorate Managers. A&E/ Critical Care/ General Surgery/ Internal Medicine/
O&G/ Orthopaedics/ Paediatrics/ Radiology/ Specialty Services Theatre



Annexure F

The full interview as prescribed

INTERVIEWEE NO. 1

First interview on 14.4.2005

Pseudonym: Karabo

30 weeks pregnant

A. Background

1. I am 30 years old.
2. Laughed... 'My boyfriend is 28 years old'.
3. I am single.
4. I stay at Lamontville.
5. We are living together with my partner.
6. I passed Standard 6.
7. I am not working.
8. My boyfriend is working as a conveyer at Jacobs.

B. Knowledge of implications of HIV negative status

9. HIV negative test results mean that I do not have HIV.
10. HIV negative test results can be false negative.
11. It was said that a person might be infected by the virus during pregnancy that is before delivery.
12. A repeat test is important for the unborn baby, but I am not sure how long do I have to wait before repeating test.
13. Whether a person can be infected/not infected even if one is HIV negative depends on one's or partner's behaviour.

C. Patterns of preventive sexual behaviour before testing

14. I behaved myself well before voluntary counselling and testing.
15. I had one sexual partner before pregnancy.

16. I have never had casual sexual relationships before testing.
17. I did not use any contraception before pregnancy. This is the fourth child.
Two are from my previous relationship and this pregnancy is the second baby in the current relationship.
18. We did not use condoms during sexual encounters before testing.

D. Perceived need for preventive sexual behaviour

19. After receiving the HIV test result, I told my partner that I was HIV negative.
20. He was so happy that I was HIV negative and said that it meant that he was HIV negative too.
21. My boyfriend does not want to use condoms. We did not use them during our last sexual encounter. I like to use them but he refuses to use condoms.
22. I think it is necessary to use condoms if one of the partners does not behave well.
23. Being HIV negative did not change our behaviour; we are still not using condoms.

E. Reasons for their sexual behaviour

24. I believe that my partner is using condoms with other partners that are not staying with him. With me it is different because we are staying together.
25. We do not discuss about sex with my boyfriend. He always tells me to behave myself well.
26. I decided to have one partner because I am scared of contracting HIV.