

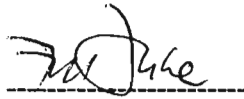
ACCEPTABILITY, KNOWLEDGE AND PERCEPTIONS OF PREGNANT
WOMEN TOWARDS HIV TESTING IN PREGNANCY AT ILEMBE DISTRICT

BY
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SUBMITTED IN PARTIAL FULFILMENT OF THE DEGREE MASTER
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DECLARATION

I hereby declare that this dissertation is my own work. Sources that were used have been acknowledged with complete references.



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Date: October 2005

Dedication

I dedicate this work to my late mother Mrs Tayi Dube, my husband Musa and my daughter Nandipha.

ACKNOWLEDGEMENTS

I would like to thank the Almighty God for strengthening me and helping me to complete this study.

My sincere gratitude goes to the Department of Health KwaZulu-Natal for granting me permission to conduct the study.

I am also thankful to the University of KwaZulu-Natal Ethics Committee for approving my study.

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I would also like to thank pregnant women attending the clinic at Sundumbili CHC who took part in the study, without them this study would not be a success.

I also thank my family, my daughter Nandipha and my niece Nokusa for their patience and support when I felt stressed due to the work involved in the study.

Lastly, my sincere gratitude goes to all the people who contributed to this study.

ABSTRACT

This research study aimed at investigating the acceptability, knowledge and perceptions of pregnant women towards HIV testing in pregnancy in Ilembe District.

An exploratory research design guided the study. A systematic random sampling was used to select forty pregnant women who were attending clinic for the first time in their current pregnancy.

Self-administered questionnaires with close-ended questions were used in the collection of data. The questions included the women's demographic details, their views towards HIV testing, knowledge and acceptability of HIV testing. Forty questionnaires were distributed and they were all returned. Quantitative method was used to analyse data.

The findings of the study revealed that women in the sample were relatively young (18-25) with the percentage of 45% and most of them were unmarried (90%). The majority of women (92.5%) said testing was a good idea and 85% said it is necessary. However only 52.5% said they will opt for HIV testing. Uptake of HIV testing was found to be low.

Eighty-seven and a half percent (87.5%) women were of the opinion that HIV testing in pregnancy was of benefit to the mother and her baby. Women in the study were found to have good understanding and good perceptions towards HIV testing in pregnancy, but this was not consistent with their behaviour. Meaning that in spite of their good understanding and good perceptions towards HIV testing in pregnancy, only a small percentage (52%) of respondents said they will opt for the HIV test. The researcher's expectations were one hundred percent response.

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F	Consent Form
G	Letter requesting permission to conduct the study at Sundumbili CHC
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Abbreviations

- | | |
|---------------------|---|
| 1.HIV | Human Immunodeficiency Virus. |
| 2. PMTCT | Prevention of Mother-to-Child Transmission. |
| 3. VCT | Voluntary Counseling and Testing |
| 4. WHO | World Health Orgaization |
| 5. STI s | Sexually Transmitted Infections |
| 6. AIDS | Acquired Immune Deficiency Syndrome |
| 7. FHI | Family Health International |

CHAPTER 1.

1.1. Background

AIDS is regarded as a serious health crisis because the majority of people are dying of complications related to HIV/AIDS. In a study by Piot (2005:1) the number of women living with HIV in Africa has skyrocketed to 20 million.

The World Health Organization estimates that vertical transmission is responsible for over 1, 5 million HIV infected children worldwide (Penn and Ahmed 2003:321). In South Africa, the Department of Health estimates that 5, 3 million South Africans were HIV positive by the end of 2002; and it is estimated that 91,271 babies were infected with HIV during 2002 via Mother to Child Transmission (Department of Health 2003:2). Recent findings reveal that every day in Africa, 1900 children acquire HIV infection from their mothers. (Ekoveri, Leroy and Viho 2004:697). The HIV epidemic is having a major impact on maternal deaths in South Africa (Moodley 2001:137). Non-pregnancy related infections have now become the leading cause of maternal deaths and HIV/AIDS is the major contributor to these deaths.

The National strategic framework for HIV/AIDS prevention in South Africa includes establishing numerous centres for HIV counselling and testing; training and employing lay counsellors and a public education campaign to encourage the use of testing services. However, little is known about women's knowledge and their perceptions towards HIV testing.

KwaZulu-Natal Province has recorded the highest HIV rate amongst antenatal attendees in 2002 with a rate of 36, 5% as compared to eight provinces in South Africa. The statistics show that an

estimated 34, 5% of pregnant women aged from 25-29 are HIV infected; thus making this age group the group with the highest prevalence rate (Department of Health 2003:4). HIV testing is not universal, meaning that it is not routinely done. According to Moodley (2001:28), this is due to poor infrastructure - particularly in rural areas- which leads to underestimation of the contribution of HIV/AIDS related infections to maternal deaths.

In light of these high statistics, it becomes imperative that all pregnant women attending antenatal clinics receive voluntary HIV counselling and testing (VCT). The benefit for uninfected women from such programmes is that it can provide them with information to reduce the risk of acquiring HIV. For infected pregnant women, interventions can enable them to receive appropriate and timely help for their own health and to reduce the risk of passing the virus on to their babies (Semprini and Fiore 2004:259).

Schochetman and George (1994:5) are also of the opinion that “availability of HIV testing and counselling for women is a prevention strategy for reducing the risk of prenatal HIV transmission.” In Northern KwaZulu-Natal where the researcher is working, some pregnant women who have tested HIV positive go to the extreme of erasing the code which identifies them as HIV positive. This leads to poor statistics being recorded, poor identification of pregnant women who are HIV positive and prevents their inclusion in the PMTCT programme. This programme for the Prevention of Mother to Child Transmission (PMTCT) of HIV was commenced in 2001 by the National Government in order to reduce the chances for the baby to contract HIV virus from the infected mother. (Doherty, Besser, Donohue, Kamoga, Stoops, Williamson and Visser 2003:5).

Few studies were done in Africa around HIV testing in pregnancy. These studies revealed many reasons which contribute to acceptance and non- acceptance of HIV testing by pregnant women. A

study conducted by Fransman (2000:1) of Child Health Unit in Khayelitsha (Cape Town), on knowledge and perceptions of pregnant women towards HIV testing concluded that most women attending antenatal clinic would opt for HIV testing. Those who did not opt into the programme did so for personal reasons, and the predominant reason is anxiety about the results (Exner, Hoffman, Parish, Leu and Ehrhard 2002:76).

In a study conducted in Malawi by Matinga (2003:7) it was found that women did not have information about HIV testing in pregnancy. The researcher argues that pregnant women are not well informed about the importance of HIV testing and they perceive HIV counselling and testing as labelling them HIV positive.

In a study conducted by Abdool-Karim (2000:96) amongst peri-urban and rural pregnant women in KwaZulu-Natal, revealed that women do not have knowledge on HIV/AIDS testing and their perception towards HIV testing is poor. The main reason for women not acting on their knowledge and perception of HIV risk, according to Abdool Karim (2000:22), is that most of them do not believe that they have the right to refuse to have sex.

Berer and Ray (1993:238), in their study found that many women would prefer not to be tested during their antenatal visits because of fear of positive results. In the study conducted in Northern KwaZulu-Natal in 1996, it was found that women faced rejection and increased violence from their male partners when they revealed their HIV positive status (Leclerc- Madlala 1999:75).

Therefore, the purpose of testing should be seen as a form of increased knowledge for the individual, and not just a way of public health services to find pregnant women who are HIV

positive. This study is looking at the knowledge and perceptions of pregnant women towards HIV testing.

1.2. Problem statement

Despite the rapid implementation of pilot health programmes, uptake of services for the prevention of HIV infection from mother to child remains low in South Africa (Ekoveri et al 2004:698). Many pregnant women believe that they are not at risk of HIV infection and do not know about the benefits of treatment and interventions available to prevent HIV transmission to their infants. Most women who refuse the HIV test are those who lack information concerning HIV testing (Budget Speech 2004:2) and having confidence that they are seronegative, afraid of their partners or afraid to know the test results (Berer and Ray 1993:239).

Studies reveal that there is a correlation between levels of knowledge about HIV testing to the possibilities of accepting the test. Fernandez, Wilson, Ethier, Walter, Gay and Moore (2000:467), found that acceptance was related to strong beliefs about the benefits of testing, and knowledge about vertical transmission and the woman's perception that she is at risk of HIV infection (Kiarie, Nduati, Koigi, Musia and John (2000:1468), Ho and Loke 2003:823).

Data from multitude of knowledge, attitudes, practices, and behaviour, (KAPB) studies, demonstrate that most women have a superficial knowledge of HIV testing (Goldman and Hatch 2000:424). They further maintain that poor knowledge can deter a woman from taking an HIV test. Therefore, it shows that pregnant women lack knowledge on HIV testing in pregnancy.

1.3. Purpose

The purpose of this study was to establish the knowledge and perceptions of pregnant women about HIV testing and ascertain the level of HIV testing acceptability.

1.4. Objectives

The objectives for conducting this study were:

- 1.4.1. To ascertain women's knowledge of HIV testing
- 1.4.2. To describe women's perception of HIV testing in pregnancy
- 1.4.3. To determine factors relating to acceptability of HIV testing by pregnant women.

1.5. Research Questions

This study wanted to address three questions.

- 1.5.1. What information do pregnant women have on HIV testing?
- 1.5.2. What factors influence the acceptability of HIV testing in pregnancy?
- 1.5.3. What are the perceptions of pregnant women towards HIV testing?

1.6. Significance of the study

The significance of this study was to find strategies that will make HIV testing in pregnancy more acceptable to pregnant women. Berer and Ray (1993:238) stress that, "the time to serve women is now; not when they are in their first trimester of pregnancy", meaning that HIV testing should also be available in other women's health services like primary health care services and reproductive regulation services.

There is hope that increased knowledge of HIV testing in pregnancy will allay anxiety in pregnant women thus increasing the number of women accepting HIV testing. The health sector may be able to plan and allocate the appropriate resources. This will serve as a way of evaluating health promotion programmes when the level of knowledge and perceptions of pregnant women are known.

1.7. Definition of terms

1.7.1 Pregnant women

In this study pregnant women will mean women attending antenatal clinic for the first time in their current pregnancy.

1.7.2. Knowledge

In this study will mean information and past experiences the women have had on HIV testing.

1.7.3. Perception

Louw and Edwards (1995:117) define perception as “the process through which one gives meaning to the information received through senses”.

1.7.4. Acceptability

In this study, acceptability will mean a positive attitude towards HIV testing.

This will be determined by the score of the questions. A score of 6-9 will mean that acceptability is high. A score of 5 and below will indicate low acceptability.

1.7.5 HIV testing

In this study, this term will mean testing undertaken by pregnant women to determine whether they have contracted HIV infection.

1.8. Theoretical Frame work

1.8.1. Introduction.

Williamson (1981:66) defines a theory “as a formulation of apparent relationships or underlying principles of certain observed phenomena which has been verified to some degree” According to Williamson (1981:66), the function of theories is to organize and explain the relationship of questions whose answers lead to new knowledge. This is consistent with what is said by Polit and Hungler (2001:145), that theories constitute the mechanism by which researchers organize empirical findings into a meaningful pattern. Polit and Hungler further maintain that the purpose of theories is to make scientific findings meaningful and generalizable.

The researcher used Health Belief Model (HBM) and Reasoned Action Theory to support rationale for conducting the study. The reason for using this theory and model is that the study centres around health related issues, and that people need to take reasoned action in order to stay healthy; for example, taking an HIV test for the prevention of mother to child transmission of HIV infection.

This model and theory were used by Rawjee (2002) in his case study of “an HIV/AIDS Awareness campaign Targeted at Young Adults at a Tertiary Institution” and by Dawad (2003), in his study of “Knowledge, Attitudes, Risk Perception and condom use among married men and women in Ntuzuma and Kwa-Dumisa, Kwa-Zulu Natal”.

The afore - mentioned are discussed below.

1.8.2 The health belief model.

Maiman and Becker (1974), formulated the Health Belief Model. The health belief model (referred to as HBM), attempts to predict health related behaviour in terms of certain belief patterns. It focuses on the perceptions and beliefs of individuals and in so doing, it tries to explain and predict health behaviours (Dawad 2003:8).

This model is based on the premise that the individual's health behaviour is a function of perceived threat and perceived benefit (Rawjee 2002:16). The model maintains that an individual's perception of susceptibility, severity, benefits barriers and the cures available would determine the possibility of the individual engaging in preventative health activity ([www. med.usf.edu/~kmbrown/healthbeliefmodeloverveiw .htm](http://www.med.usf.edu/~kmbrown/healthbeliefmodeloverveiw.htm). 21/02/04) , Rawjee (2002:16).

Perceived susceptibility refers to an individual's feelings of personal vulnerability to a condition (Dawad 2003:8, Rawjee 2002:16). This dimension refers to one's subjective perception of the risk of contracting a condition. In this study, it will be based on the pregnant women's perception of the risk of not taking an HIV test or taking an HIV test.

Perceived severity refers to an individual's concern about the seriousness of contracting an illness or leaving it untreated (Dawad 2003:8, Rawjee 2002:16).

This dimension varies from person to person and is made upon an evaluation of a consequence and possible social consequences. Women with perceived HIV risk are likely to accept the test. Those who believe that HIV is not their concern are more likely to decline HIV testing.

Perceived benefits refer to how an individual reacts to the message. This depends upon the individual's beliefs in the effectiveness of strategies that are designed to reduce the threat of illness. The course of action that a person chooses will be influenced by the beliefs regarding the action.

Finally, *perceived barriers* refer to the potential negative aspects of a particular health action which may act as barrier to undertaking the recommended behaviour. Barriers relating to the characteristics of a treatment may be perceived by an individual as being unpleasant, painful or upsetting (Rawjee 2002:16).

These characteristics may lead a person away from taking the desired action.

The health belief-model asserts that an individual's readiness to take action for her well-being stems from a perceived threat of disease coming from her susceptibility to the disease and its possible severity.

The cure to take action is a result of the individual's perception of the disease or the knowledge acquired. Other variables include demographic (age, educational standard, marital status), psychosocial variables that are responsible for an individual's perceptions and in so doing influence behaviour.

The application of this model is evident in HIV testing in pregnancy. Women opting for an HIV test, if found to be HIV positive, would be subjected to stigmatisation, violence from partners and social isolation. If the woman has adequate information about HIV testing and her perception is good towards it, she is likely to take the test (Rawjee 2002:17).

1.8.3. Theory of Reasoned Action

The theory of reasoned action (TRA) was developed in 1967 and it was revised and expanded by Ajzen and Fishbein in the 1970s. This theory is based on the premise that humans are rational and make systematic use of information available to them. According to Ajzen and Fishbein (1980:5) people consider the implications of their actions before they decide to engage or not to engage in a given behaviour.

The variables in theory are:

- Firstly, *behaviour*, which is defined by a combination of four components: action, target, context and time.

An example of this could be providing HIV counselling (*action*) to pregnant women (targets) in antenatal clinics (context) on their first visit in their current pregnancy (time).

- Secondly, *intention*. It is the best predictor of whether a desired behaviour will actually occur. Knowledge and norms influence one's intention to perform behaviour.
- Thirdly, *action*, which refers to a person's positive or negative feelings toward performing the defined behaviour.
- Fourthly *norms*, which refer to a person's perception of other people's opinions regarding the defined behaviour (Dawad 2003:12).

Each of the above variables is linked by a framework, which is provided by theory of reasoned action.

The behavioural and normative beliefs, which are referred to as cognitive structure, influence individual perceptions and subjective norms respectively. Thereafter, knowledge and norms shape a person's intention to perform behaviour and finally, a person's intention remains the best indicator that the desired behaviour will occur.

This can be illustrated diagrammatically:

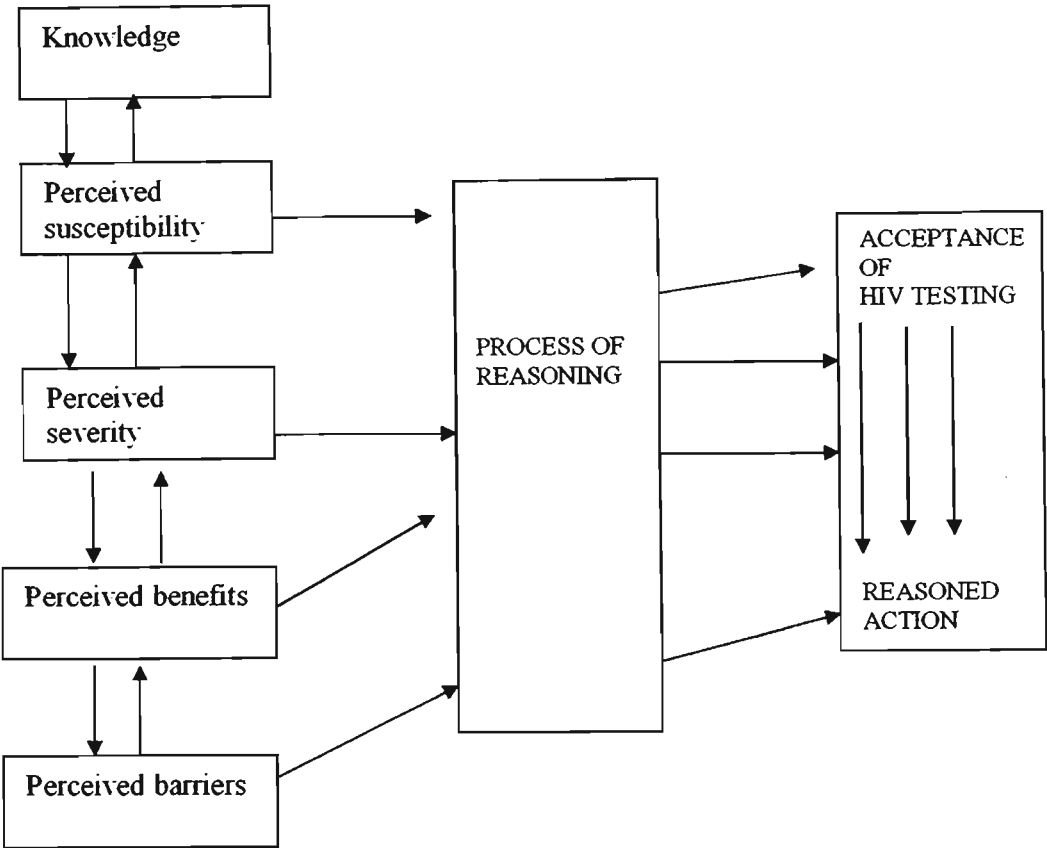


Figure 1: Adapted from Health Belief Model by Maiman and Becker (1974:336).

1.8.4. Summary

The above model and theory have similarities within them and the variables will be used to structure the arguments of this study. What the above model and theory put forward is that the higher the perceived risk, the more likely it will be for people to carry out protective behaviour; for example, taking an HIV test during pregnancy. Furthermore, the more knowledge that pregnant women have on HIV testing, or good perceptions, the higher the chances will be of them taking the test.

This implies that women’s behaviours will be shaped by the rational decisions that they make.

CHAPTER 2

2. Literature Review

2.1 Introduction.

Literature review has been done on routine antenatal care services, HIV testing and counselling, knowledge of HIV testing, perceptions of HIV testing, acceptability of HIV testing, factors of women's vulnerability and constraints related to low HIV testing uptake in antenatal settings.

The majority of studies show that pregnant women endorse the offer of HIV testing, but they are uncertain about personal uptake (Johnson and Johnstone 1993:21). Meaning that women offer to take HIV testing but they are not sure as to whether they really want to take the HIV test. They are also not sure how are they going to cope with the positive HIV test results.

2.2. Routine antenatal care services

The Department of Health in South Africa developed a National Policy on the provision of antenatal services. This was done to standardise the procedure for providing antenatal care in all provincial hospitals. Antenatal services in South Africa are routinely done and they are provided free of charge in all provincial hospitals. This has been in place since 1994 after the first elections of the Government of National Unity.

Routine antenatal care includes:

- **Medical history:** a detailed medical history is taken from a pregnant woman. This includes family medical history. The reason for taking this history is to identify any medical conditions the woman may have; any treatment she is currently taking and to exclude pregnancy risks related to medical conditions.
- **Physical examination:** a head to toe physical examination is done to exclude conditions that may have adverse effects on pregnancy and to the health of a woman while pregnant.

Conditions like varicose veins, spina bifida, cyanosis and pallor among others are checked.

If present, the woman is given the necessary treatment and care throughout her pregnancy.

- Blood testing. Blood is tested for anaemia. Any haemoglobin reading of less than 11g/dl in a pregnant woman is considered a low haemoglobin level. Blood is also tested for blood type, hepatitis B antigen, rubella and syphilis
(Department of Health 2002:23).

- Urinalysis is done to exclude abnormalities like glycosuria in cases of diabetes, proteinuria that is present when the woman is having gestational hypertension, for haematuria and for ketons in cases of keto acidosis.
- Tetanus toxoid vaccination to protect the unborn baby from contracting tetanus. Three doses at one-month interval are given to a woman if she is pregnant for the first time. In subsequent pregnancies, the woman is given a booster dose if the last dose was given in less than three years.
- Provision of vitamins and iron to boost the woman's haemoglobin.
- Health education on pregnancy related topics, nutrition and self-care.

HIV testing is not routinely done in most of the antenatal settings especially in Kwa-Zulu Natal because there must be informed consent and women must voluntarily take an HIV test.

2.3. HIV testing and counselling in pregnancy

HIV counselling and testing is a confidential process that enables individuals to examine their knowledge and behavior in relation to their personal risk of acquiring or transmitting HIV infection that helps them to decide whether or not they should be tested. The primary objectives of HIV Voluntary Counselling and Testing (VCT) are: to provide an opportunity for persons to learn

their HIV sero- status and if infected; (Sethosa and Peltzer 2005:31), to obtain referrals for medical and psychological care and to provide counselling, so that clients might change their behaviour to avoid infection, or if they are already infected, to avoid transmitting the virus to others.

The World Health Organization is of the opinion that HIV testing and counselling enables people to learn whether they are infected, understand the implications of their status and make more informed choices for their future (WHO 2001:1).

Devita, Hellman and Rosenberg (1998:325), view HIV testing as a motivation for people who engage in high risk-sexual behaviour to reduce or stop such behaviour. For Schochetman and George (1994:5), HIV testing for women is a preventative strategy for reducing the risk of perinatal HIV transmission.

According to Minkoff, DeHovitz and Duerr (1995:109), “ benefits of HIV testing include the collection of epidemiologic data on maternal and infant infection; informed decision making on termination of pregnancy; and method of infant feeding and the introduction of treatments”).

Epidemiological data is important so that adequate and appropriate services can be provided for women and their children.

Kilmarx, Hamers and Peterman (1998:28), view the benefits of HIV testing as a strategy to reduce high-risk behaviours of both HIV infection and HIV uninfected persons, and to provide referrals to medical and social services for those who are HIV infected. Tallis (1997:72), is of the opinion that HIV testing reduces the stigma attached to HIV because during counselling, the woman is given adequate information on HIV/AIDS and is not coerced into testing, but can make an informed decision.

Counselling is important in HIV infection because there are fears arising from uncertainty and incomplete knowledge. WHO (2001:1), stresses that inadequate information during HIV counselling may sometimes lead to a person opting out of HIV testing.

Pre-test counselling for HIV testing is not simply about whether to take the test or not; but also has a preventative role. Counselling sessions need to include patient education and informed consent. In Evlan's (1997:203), opinion, "the primary purpose of counselling and testing is to encourage informed decision-making and behaviour". It helps patients to adjust to their condition and prepare them for bad news (Bor and Miller 1992:105).

Counselling provides an opportunity to inform women about HIV and enables them to make informed decisions about testing, pregnancy medical care and relationships.

Further more, counselling is a means of influencing the pregnant women's compliance with follow up care and the adoption of safer sexual practices (Evlan 1995:195). Pre-test counselling needs to be highly skilled and sensitive (Bury, Morrison and Mclachlan 1992:127). They further maintained that during counselling, clients should not feel under any pressure from the counsellor to make a decision. Information given during counselling must be accurate and fairly presented, and include a realistic description of the medical care that is available for HIV related illnesses.

Berer and Ray (1993:242) are of the opinion that during counselling, pregnancy related transmission and its consequences should be explained. They further maintained that it is important to offer women the opportunity of bringing their partners with them to be tested in order to avoid problems in their relationships. The Department of Health in South Africa has developed

and provided educational tools and materials to all health centres to assist health educators in informing women about HIV/AIDS. What is interesting is that the information is provided in the language the women understand.

It is important for pregnant women to know through counselling they have access to necessary services they need; such as fertility regulation services; condoms to practise safe sex during pregnancy and breast-feeding; primary care services for HIV care for adults and children, on going counselling services for individuals needing for support and prevention of mother to child transmission (PMTCT) (Evlan 1997:203).

Factors such as the type of clinical setting, the prevalence of HIV in the community and the education level of clinical clientele will help determine the most appropriate way to provide basic information about HIV and the antibody test (Minkoff et al 1995:267).

2.4. Knowledge of HIV testing

To reduce maternal transmission, high quality, appropriate information and counselling must be provided to ensure informed decisions before and after testing. Lack of adequate information, knowledge about HIV testing and counselling increases ignorance and stereotypes about HIV/AIDS. Women who acquire better knowledge on Mother To Child Transmission are more likely to take the test (Ho and Loke 2003:823). According to Kalichman and Simbayi (2003:446), knowledge appears to only be a precursor to reducing stigma. People must be well informed about HIV/AIDS for the destigmatization of HIV/AIDS to be possible.

In a study conducted by Tharao, Massaquoi and Brown (2002:424), they concluded that women had little information or knowledge about HIV transmission, testing and treatment.

According to WHO (2001:1), knowledge of HIV infection is the main entry point for interventions that prevent HIV infections in infants and for disseminating information about HIV counselling and testing (Matinga 2003:5). HIV infected women who know their sero status are able to make informed choices about their reproductive lives.

Katzenellenbogen, Joubert and Abdool-Karim (1999:170), are of the opinion that individual health related behaviour is influenced by the knowledge of the disease and necessary promoting actions to prevent or improve the condition, as well as their beliefs, which may be positive or negative towards the disease or health promoting actions.

It is argued that the decision taken by a pregnant woman to take or not to take an HIV test, is based on her knowledge about HIV and her perceptions -which may be positive or negative- towards HIV testing. According to Valdiserri, Holtgrave and Brackbill (1993:868), socio demographic characteristics are likely to influence preferences for HIV counselling and testing in spite of adequate information that the person has. These socio-demographic characteristics include age, marital status and geographic placement. Ninan (2003:2), found that knowledge of HIV/AIDS is much lower among rural and less educated women. He/she found that only 18 percent of illiterate women have heard of AIDS as compared with 92 percent of women who had at least completed high school. This is consistent with what was found by Baylies and Bujra (2000:6), that women's lesser access to education and lower literacy levels, contribute to their more limited access to information about HIV.

In rural areas, public education will not reach most of women because of poor infrastructures such as roads. The other reason will be their thinking ability -because they think that they are in a monogamous relationship, seeking information on HIV/AIDS and testing for HIV will be seen for some women as unnecessary.

2.5. Perceptions on HIV testing.

Perception is the process through which one gives meaning to the information received through senses. This leads to the person taking the reasoned action or refusing to take the action depending on the perceived risk.

HIV risk perceptions are not stationary and can vary depending on the context, time and knowledge that the person has (Dawad 2003:19). People, who are exposed to the same or a similar situation, may have different perceptions of risk at different stages of their life course. That is, a person may change from low- perceived risk to high-perceived risk or vice versa.

With regards to HIV testing in pregnancy, a person with low risk perceptions at one stage may progress to a high level of perceived risk as a result of adequate exposure to HIV/AIDS information. This means that a person who was initially not interested in HIV testing -due to lack of information - will end up accepting HIV testing after receiving adequate information on HIV/AIDS and HIV testing in pregnancy.

Dawad (2003:19) stated that there are different categories or states of perceived risks which might lead to either low or high perception risk. Women, who feel that they might be infected and that there is something that they can do about it, might have high HIV/AIDS information levels and risk perceptions and they will opt for HIV testing.

A second category of women might feel that they may be infected, but there is nothing they can do about it and they will not take the test. The following criteria according to Dawad (2003:18), are important in assessing people's risk of perceptions: specific knowledge of transmission and prevention; for example thinking that a healthy looking person cannot have HIV; mother to child transmission and the knowledge of ways to avoid contracting HIV. These relate to people's own

interpretation of illness and severity (Dawad 2003:19): Pregnant women who are in stable relationships will think that they are safe from contracting HIV and those who are still healthy will not associate themselves with HIV infection and they will not be eager to take the test.

Several studies have indicated that there is a stigma involved in HIV testing which leads to a reluctance to have the test. In a study conducted by Leclerc-Madlala (1999:20), it was found that women are often blamed for spreading HIV infection and become targets for anger and violence from their partners. There is a great amount of stigma which is attached with HIV infection which contributes to women not opting for HIV testing. The stigma of HIV infection for women means rejection and ostracism, by friends, by their partner or by their families. (Oppenheimer and Reckitt 1997:389). Fear of stigma has deterred pregnant women from being tested (Herek, Capitanio and Widaman 2002:8).

This stigma further affects the child who is HIV positive because his/ her mother will be ill-treated as she is solely responsible for her child's sickness (Tallis 1997:63).

Women, according to Minkoff et al (1995:268), may fear their partner's reaction including abandonment, withdrawal of emotional or economic support or emotional or physical violence”

It has been noted that once the victim discloses her HIV status, public and friends tend to keep their distance to avoid the stigma. The victim is subjected to a lot of emotional trauma, gossip and finger pointing about her HIV status.

A study conducted by Leonard, Gahagan, Doherty, Hankins and Rehman in (2002:421), concluded that many women perceived HIV testing as being for the benefit of their unborn child rather than

for their own benefit. The reason for their perceptions may be due to the fact that most women are not offered testing until they become pregnant, and they regarded HIV testing as an exceptional test done out of concern for the baby and not necessarily considering their own risk factors.

Ho and Loke (2003:823), in their study found that women who had stable partners were more likely to decline the test because they thought that their chances of contracting a disease were minimal. According to their perceptions, they believed that single pregnant women are at risk because of a number of consorts. The perception that test results are not always kept confidential deters many people from seeking the HIV test (Jurgens 2004:4).

If perceptions are good, they can lead to women to take reasonable action to protect herself and the unborn baby. Poor perceptions in most antenatal settings have resulted in women not opting for an HIV test.

2.6. Acceptability of HIV testing.

The problem of HIV/AIDS is not only for underdeveloped countries. Developing and developed countries are experiencing the problem of acceptability of voluntary HIV testing as it was discussed by Cartoux, Meda, van der Perre, Newell, de Vincenzi and Dabis (1998:2489).

Goldman and Hatch (2000:425), are of the opinion that knowledge and good perceptions of HIV testing are a prerequisite for acceptability of HIV testing. Nakchbandi, Longenecker, Ricksecker, Latta, Heaton and Smith (1998:762), found that acceptance of HIV testing among pregnant women increased when testing was offered with counselling and that outreach and educational efforts substantially improve the acceptance of HIV testing.

Women have mixed views about accepting to test for HIV. In a study conducted in Florida in by Fernandez et al (2000:467), acceptance of HIV testing was found to be related to strong beliefs about the benefits of testing and knowledge about vertical transmission. Kiarie, Nduati, Koigi, Musia and John (2000:1468), found that women who perceive themselves as at risk of contracting HIV are more likely to accept HIV testing.

Women who declined the testing said they did so because they did not perceive themselves to be at risk for HIV (Fernandez et al 2000:467). Berer and Ray (1993:239), found that women who refused to take HIV test said, “they are afraid of blood being taken, afraid to know the test results, confident they were seronegative”. Exner et al (2002:80), found that most women did not accept HIV testing because it was too emotionally stressful; others reported that they did not want to know if they were HIV positive and others said they did not think that they at risk of HIV infection. Other reasons for women not having been tested were concerns about confidentiality.

According to Valdiserri et al (1994:868), socio demographic characteristics such as age and educational status are likely to influence preferences for HIV counselling and testing -even when the persons have adequate information about the availability of HIV testing. In a study conducted in Benin City by Enosolease and Offor (2004:89), it was found that older women are more likely to accept HIV testing than younger ones because they perceived themselves to be at risk. According to Cartoux et al (1998:2490), highly educated women and those who perceive themselves at risk of being already infected may be better able to analyse these risks and thus develop a negative attitude towards HIV testing.

In Fernandez et al (2000:468), acceptance rates can be increased when women understand the modes of vertical transmission and the belief that prenatal testing of HIV can promote the health of the mother and child.

2.7. Factors increasing women's vulnerability.

The majority of HIV infection is through heterosexual relationships and unprotected vaginal and anal intercourse with an HIV positive man. Male to female transmission (Farmer 1992:140), is more likely than female to male. The reason for this is that women have a greater biological vulnerability than men. This according to Evan (1977:193), Baylies and Bujra (2000:5), is due to the fact that a woman is a recipient partner during sex. Infected semen is deposited in the woman's vagina and remains there for some time, giving the virus an opportunity to gain entry into the body.

Vaginal lesions which occur during sexual intercourse, provide a point of entry for the HIV virus. Many women suffer from STI's and that makes them to be prone to HIV infection. STI's often go unnoticed or hidden in women and they may not seek treatment Baylies and Bujra (2000:5), Boyd-Franklin, Steiner and Boland (1995:100) Evlan (1997:194), for fear that someone might recognize them in the clinic and find out that they are 'sick'.

According to Tallis (1997:40), women's vulnerability to HIV infection is due to the fact that; " the virus is more concentrated in semen than in vaginal fluids and therefore women come into grater contact with the virus the mucous membranes of the vagina have greater permeability and a larger surface area than those of the penis".

Minkoff et al (1995:174, argue that “a pregnant patient is more susceptible to various viral, bacterial and fungal infections and is more prone to serious morbidity and mortality than non pregnant women”. Most new HIV infections are taking place in women in stable relationships (Abdool-karim 2000:19).

In addition, repeated infections of gonorrhoea, chlamydia and other reproductive tract infections through their association with infertility can sometimes lead to women toward greater sexual activity in an attempt to conceive. This can result in a woman being placed in an increased risk of HIV infection (Baylies and Bujra 2000:5). Younger women are especially vulnerable in part, Baylies and Bujra (2000:10), “because of the immaturity of their cervix and vulnerability to non consensual sex”.

Therefore, the gynaecological structure of a female exposes her to be easily infected by a male partner.

2.7.1 Status of women in society.

Women’s vulnerability to HIV infection is directly linked to their status in society and in the family. Women from low socio-economic communities are having less control over their sexual lives (Evlan 1997:194). Most women are unemployed and poor, and they may have to resort to selling sex for money in order to buy food and shelter. If a woman refuses sex or requests the use of a condom, men often suspect infidelity. Therefore, women risk abuse by refusing sex or requesting condoms. Women whose husbands or partners have sex with other partners are prone to infection. In this way, the HIV infection can be silently passed without a woman even knowing (Abdool-karim 2000:30). In the Arab culture, a man can have four wives. If he is infected, it means four women will become infected.

Most women are in positions of social, economic and emotional dependency (Ten Brummelhuis and Herdt 1996:31, Baylies and Bujra 2000:30, Abdool-Karim 2000:96). They are forced into unwanted sexual encounters because of life circumstances.

Abdool Karim (2000:19), argues that limited job opportunities and in some instances, the exclusion of women from the formal economy has forced women to explore other mechanisms of survival, including sex work.

Men from rural areas leave their homes and loved ones and migrate to urban areas to find employment. In the areas of employment they seek out young women and teenage girls for sex and intimacy

Violence directed towards women is also a contributing factor for the woman to contract HIV. In a study conducted in Rwanda by Mukamana (2004 : 67), it was revealed that their partners subject women to a lot of violence and abuse. During the Rwandan genocide, women were physical and emotionally abused. Some were subjected to repeated rapes.

Cultural influences can also contribute to a woman being infected by the HIV virus. In some cultures, young women are expected to have relationships with ,or marry older men who are more sexually experienced and more likely to be HIV infected.

At times, HIV positive men cheat women into marriage. Before getting married, a woman may plan to have an HIV test, but a man who knows that he is HIV positive and wants to get married, would ask his friend who is HIV negative to go for a test. The man will get married and infect the woman in while complying with the norms of fidelity. (Baylies and Bujra 2000:11).

Widow inheritance, which is still practiced in black culture, occurs when a woman who is at the time HIV negative, is forced by her in-laws to marry her HIV positive brother in law and thus infecting her.

Male dominance over women pervades every aspect of their lives such as family, religion, social, legal and institutional and influences their ability to protect themselves (Abdool- Karim 2000:30). Males will not listen to commands by women. The dominant power of males over women is also shown during counselling and HIV testing where women would not opt for the test and their reason is that they want to first consult their husbands or partners. Pregnant women studied by Brown, Vallabhaneni, Solomon, Mothi, McGarvey, Jackson, Putcha, Brenner, Mate and Cu-uvin (2001:393), refused HIV testing and said their husbands would have to decide.

Avoiding infection with HIV and other STIS is more complicated for women compared to men due to male dominance.

2.7.2 Women's culture of silence

The culture of silence involves a prescription of relative passivity for females, and the according of sexual decision making and initiative to men; along with a tolerance of men's greater sexual mobility both prior to and after marriage (Baylies and Bujra 2000:7). Women have less control negotiating safer sexual practises with their sexual partners and this may be due to the fear of violence associated with alcohol (Abdool Karim 2000:22), and they may find adherence to risk reduction guidelines, Lachman (1995:8) extremely difficult.

Johnson and Johnstone (1993:131) argue that women find it difficult to persuade their partners to initiate and sustain condom use. This, according to Ten Brummelhuis and Herdt (1996:101), is due to the fact that sexism has weakened a woman's ability to negotiate safe sexual encounters and they tend to have relatively little power in a heterosexual relationship (Wilton 1997:29)

Women are coerced into having sex with men by social expectations that accord men the power to choose sexual partners, and for women to be subserviently available (Ten Brummelhuis and Herdt 1996:88). They argue that "women's ability is dictated by the expectations surrounding spousal and maternal roles, the need to prove that they are normal women, attractive to men and able to procreate. There are social pressures on women to prove their fertility; barren women are pitied and mothers are respected" (ten Brummelhuis and Herdt 1996:83).

Many young women have lost their virginity outside the context of dating or engagement without their consent due to poor socio-economic status.

Besides cultural factors and the status of women in society, religious and social practices have contributed to a high number of HIV victims. For example, the accepted religious and social practises that allow men to enjoy multiple partners as wives, while strongly condemning women's expression of their sexuality, have been key factors in the spread of HIV (Ten Brummelhuis and Herdt 1996:86).

2.8. Constraints related to low HIV testing uptake in antenatal settings.

In other areas of South Africa, uptake of HIV testing in pregnancy is affected by other factors apart from factors that have been discussed.

2.8.1. Human resources shortage.

In most of the ante-natal settings in Kwa-Zulu Natal, HIV counselling is done by lay counsellors. During antenatal visits, all women are given group counselling which is routinely done. After that, individual counselling is given to every woman who has attended the clinic and this is when the woman can make an informed decision whether to take the test or not.

Informed decisions can only be made after thorough and accurate information has been given about HIV testing in pregnancy.

In other health facilities, there is still a shortage of lay counsellors. This shortage results in low uptake of HIV testing because the woman has to wait a long time for the service (Doherty et al 2003:72).

2.8.2. Inadequate physical structures

Most health facilities experience inadequate physical structures which make it impossible to provide for individual counselling. In some ante-natal clinics, wall partitioning of rooms is done in order to provide more space for counselling. Confidentiality in these settings cannot be guaranteed. Lack of confidentiality has turned the women away from HIV testing (Jurgens 2004:13).

According to Doherty et al (2003:37), the availability of space for private counselling influences the rate of testing uptake amongst ante-natal clients. The findings of the study by Exner et al (2002:11), showed that women were concerned about confidentiality, and that was a reason why they chose not to be tested.

2.8.3. HIV/ AIDS related stigma.

HIV/AIDS related stigma creates a barrier to seeking VCT. According to Kalichman and Simbayi (2003:446), AIDS related stigma promotes and fosters social isolation and discrimination against people with HIV/AIDS.

Black South African women have experienced discrimination during the apartheid era in terms of race and by gender (Kalichman and Simbayi 2003:446). It is not surprising then that pregnant women would avoid any test that will add another source of stigma and discrimination by family, friends and the community.

2.9. Summary

Most of the literature reviewed stresses the importance of providing adequate information on HIV testing so that the uptake of HIV testing is increased. The issues that have been examined are; routine ante-natal services, HIV testing and counselling in pregnancy, knowledge of HIV testing, perceptions of HIV testing, acceptability of HIV testing, factors of women's vulnerability and constraints related to low HIV testing uptake in antenatal setting. Increased knowledge of HIV testing in pregnancy is thought to be a motivator in shaping the women's perceptions so that they can take a reasonable approach and accept the HIV test.

CHAPTER 3

3. Methodology

This section covers and describes the design, population and sampling method, data collection, research instrument and data analysis.

3.1. Research Design

This is a quantitative study. Polit and Hungler (2001:167), describe a research design as a researcher's overall plan for obtaining answers to research questions or testing the research hypotheses. They further state that the design describes the way in which the researcher structures the research process.

The researcher used an exploratory survey to obtain facts in an attempt to describe and learn the perceptions and knowledge pregnant women have on HIV testing. An exploratory survey explores the characteristics of the target population and identifies what issues are important to their understanding of the topic (Katzenellenbogen et al 1999:170).

According to Polit and Hungler (2001:186), surveys collect information on people's actions, knowledge, intentions, opinions and attitudes. Surveys are also based on self-reports, that is respondents answer questions posed by the researcher. The advantages of survey research is that it is highly flexible, that is it can be applied to many populations, it can focus on a wide range of topics and its information can be used for many purposes (Polit and Hungler 2001:186).

Despite the advantages, survey design has a major weakness. The drawback is that it is very demanding on personal time and other resources (Polit and Hunger 2001:186). To overcome this, the researcher collected data in the clinic, which is in the area where the researcher is working.

3.2 Setting

The antenatal clinic where the study was conducted is at eNdondakusuka Municipality, Northern KwaZulu-Natal. This Community Health Centre is in District 29, which is Ilembe District (Annexure A). It is situated in Sundumbili Township which is 25km away from Stanger. This area is overpopulated due to the industrial area, which is 11km away. Most women attending this clinic have moved to the area to seek employment in the nearby industrial area. They are earning R90-00 to R150-00 per week, and the majority of the women have not completed high school. Most of their time is spent at work. The clinic conducts a weekly ante- natal clinic, which is held on a Monday. The average number of women that attend is 50 per week and 200 per month. Previously, ante- natal services in this Community Health Centre were conducted on Mondays and Wednesdays. There are two residential clinics in the area which began ante-natal care services in June 2004. This has decreased the number of antenatal attendees in this Community Health Centre. Out of 200 pregnant women who are seen per month, only 10% opt for HIV testing.

3.3 Population

The population surveyed was all pregnant women attending antenatal clinic for the first time in their current pregnancy in the selected clinic. The reason for testing pregnant women for HIV, according to Johnson and Johnstone (1993;16) is that reproduction and childbearing decision-making focuses on women.

3.4. Sampling method

This study used systematic sampling to draw its sample from the population. **The inclusion criteria** in to the study was that the pregnant woman should be attending antenatal clinic for the

first time in her current pregnancy. All pregnant women who come to the clinic are entered in the register for statistical purposes. The antenatal register was used as the sampling frame. The population elements for the day were listed in consecutive numbers. In the list, the researcher selected every third name and 20% was selected each Monday over four weeks meaning that there were 10 respondents each week making a total of 40 respondents in four weeks.

3.5. Data collection

Data was collected on each Monday over one month in November 2004. The researcher used self-administered questionnaires for collecting data with close-ended questions (Annexure B). No names were written on the questionnaires and data was coded.

The researcher sought assistance from two registered nurses with basic Degree in Nursing employed in the same institution to assist her with the collection of data at no cost. These nurses were on leave and the employer's time was not abused. The researcher ensured that she personally administered the questionnaires so that she, together with her assistants be able to help respondents who cannot read nor write to complete the questionnaire in a private room.

3.5.1. Instrument

The questionnaire was translated into Zulu since the majority of participants were Zulu speaking (Annexure C). The translated questionnaire was tested by an expert in the School of Nursing for content validity. Section A of the questionnaire covered demographic data such as age, educational level, parity and marital status.

Section B contained questions where the researcher was trying to ascertain knowledge of respondents. Section C and section D had questions where the researcher was trying to describe the respondents' perceptions.

3.5.2 Data collection process

The researcher met the pregnant women in the waiting area after they have registered their names with the clerks. The researcher introduced herself to pregnant women and explained to them the purpose of the visit. The researcher waited for them to receive health education and group counselling. After that antenatal examination was done and completed by the midwives.

Questionnaires were administered to the respondents after securing a written consent irrespective of whether the respondent was going to opt or not to opt for HIV testing. After individual counselling and all other routine antenatal tests, the respondent then attended to the questionnaire. It took approximately 20 minutes for each respondent to complete the questionnaire.

Data was collected in a private room adjacent to the waiting area. Only one participant was allowed in the room for confidentiality purposes.

3.6. Ethical consideration

HIV testing is a sensitive issue especially in pregnancy because the woman has to deal with stress associated with pregnancy and the knowledge of her HIV status. Before the study was conducted, the proposal was presented to the University of KwaZulu-Natal Research Ethics committee and it was approved (Annexure D).

Permission for conducting the study was sought from the Department of Health head office, Pietermaritzburg (Annexure E). Permission for conducting a study in the Sundumbili Community Health centre was sought from the Nursing Manager.

Explanation before administering the questionnaire was done to the respondents and verbal reassurance was given. Written informed consent was sought from the respondents before administering the questionnaires (Annexure F). Assurance was given to them that data cannot be traced back as it will be coded. They were informed that they can withdraw at any time from the study.

3.7. Validity.

Validity refers to the degree to which an instrument measures what it purports to measure (Polit and Hungler 2001:308). In this study the instrument actually measured knowledge, acceptability and perceptions of pregnant women towards HIV testing.

3.7.1 Content Validity

The research questions on the questionnaire cover the content of the research in terms knowledge, perception and acceptability of HIV testing.

Objective 1.

Section B of the questionnaire, questions 1-5 covered research questions on knowledge relating to testing for HIV during pregnancy.

Objective 2.

Section C of the questionnaire, questions 1-10 covered research questions on perceptions towards HIV testing in pregnancy.

Objective 3.

Section D of the questionnaire, question 1-10 covered research questions on acceptability of HIV testing during pregnancy.

3.8. Reliability

A group of five pregnant women, who did not form part of the study, were given a questionnaire to complete before they were given HIV counselling at the clinic. An appointment was made with the respondents to come to the antenatal clinic after a week so that they complete the questionnaire again with the same questions. The responses from the first questionnaire and the second questionnaire were the same and there was correlation. The pilot study was anonymous in nature.

Reliability of the measuring instrument, according to Polit and Hungler (2001:305), simple means the consistency of the instrument found when the same questionnaire is administered to the same respondent at a later stage (Katzenellenbogen et al 1999:172).

CHAPTER 4

4. Data Analysis

4.1. Introduction

Data was analysed using Statistical Package for the Social Sciences (SPSS) 11.5 for Windows.

Forty questionnaires were distributed and they were all returned because the researcher personally distributed and collected them. There were no questionnaires that were discarded as they were all correctly completed, that means there was 100% response rate.

The researcher used frequency distributions to describe the demographic profile of the respondents and to characterise women's acceptance, perceptions and knowledge of HIV testing in pregnancy.

4.2. Results.

4.2.1. Introduction.

The results were presented in graphs and tables. The numbers of responses were further interpreted in terms of percentages.

4.2.1.1. Demographic Characteristics of Respondents.

4.2.1.1. Distribution of respondents by Age.

The results in figure 1, revealed that most women were relatively young, between the age of 18-25 (45%, n=18). Twenty seven and a half percent (n=11) of women were between the ages of 31-40, 17.5% (n=7) were between 26-30, seven and a half percent (7.5%, n=3) were between 13-17 and with a relatively small number of women who are 41+ which is 2.5% (n=1).

Young women may have differing reasons for getting tested for HIV. One of the reasons according to Matinga (2003:1), is the suspicion of their partner’s infidelity.

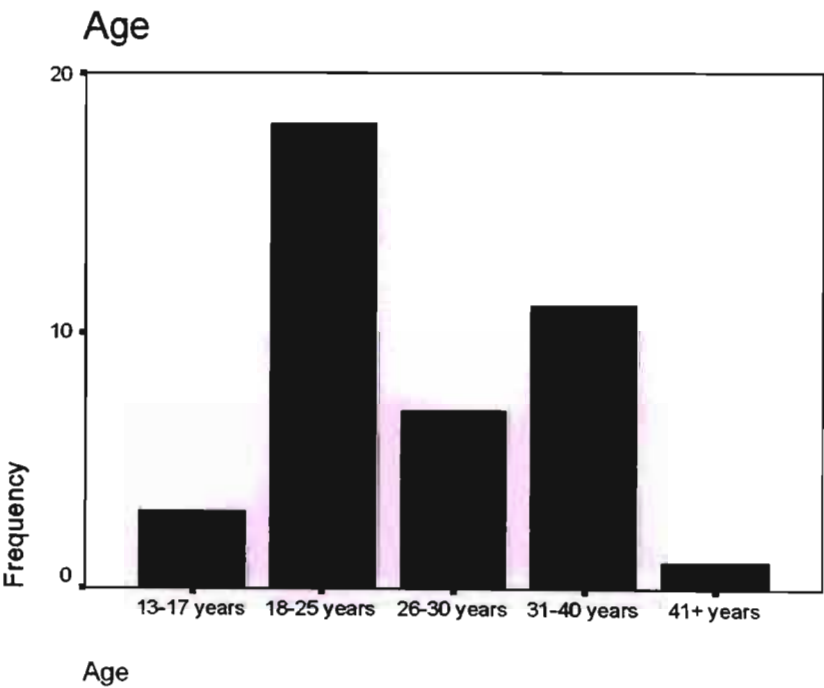


Figure 4.2. Age Distribution (n=40).

4.2.1.2. **Distribution of respondents by Marital Status.**

The highest proportion of respondents is unmarried (90%, n=36). There were only 7.5% N=3) married women in the sample (Figure 4.3). The sample consisted of many women who are single and they are young. The reason is that, they have limited information about reproductive and sexual health including HIV/AIDS and they engage themselves in sexual relationships at an early age (Baylies and Bujra 2000:10). Ho and Loke (2003:822), in their study found that unmarried women were more likely to be tested for HIV.

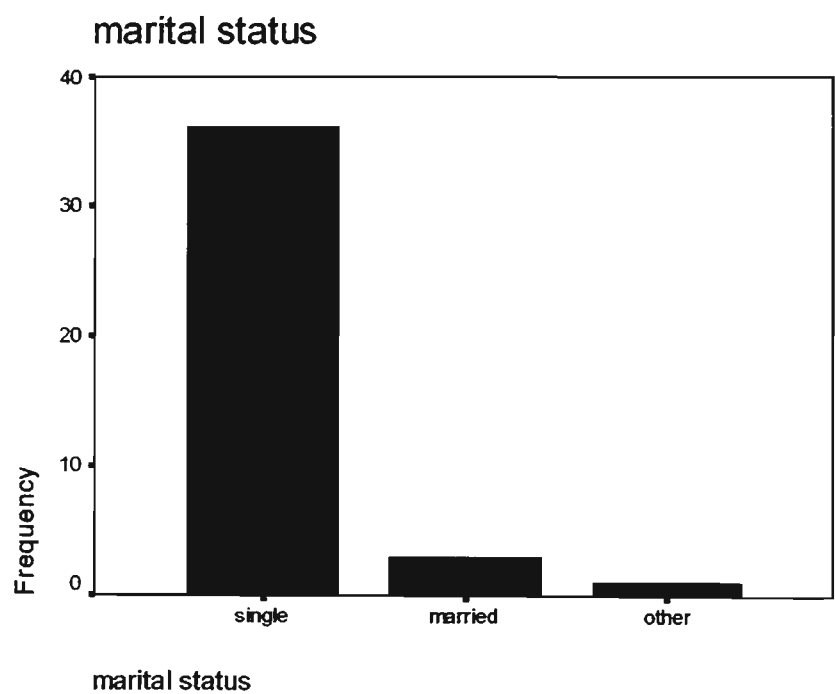


Figure 4. 3. Marital Status of Respondents. (n= 40)

4.2.1.3. **Distribution of respondents by Parity.**

Seventy percent (n=28) of respondents were of parity between p0-p2, 20% (n=8) were of parity between p3-p5. Only 10% (n=4) of respondents were between parity six and above (Figure 4.4).

There are twenty percent of women who are pregnant for the third to the fifth time and it might happen that they already knew that they are HIV positive. Sometimes testing positive for HIV seems to accelerate the women’s desire to get pregnant (Berer and Ray 1993:90

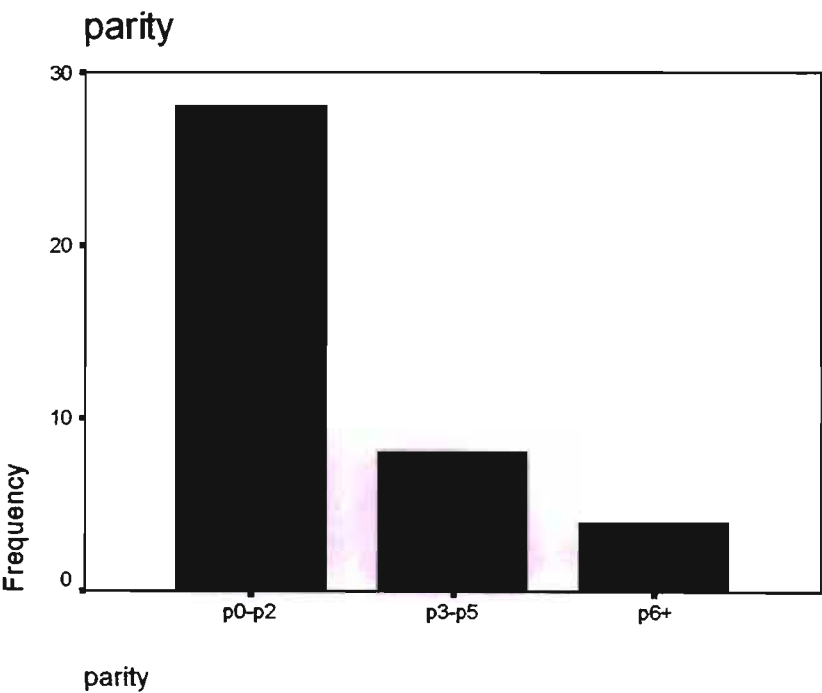


Figure 4.4. Parity (n=40)

4.2.1.4. Educational Attainment.

The results revealed that only 10% (n=4) of respondents has tertiary education with the highest proportion of the sample with secondary education which is 62.5% (n=25). There was only one respondent with no formal education (2.5%) (Figure 4. 5).

The sample consisted mostly of women with less education. The researcher is of the opinion that women with lesser education have less or no access to information.

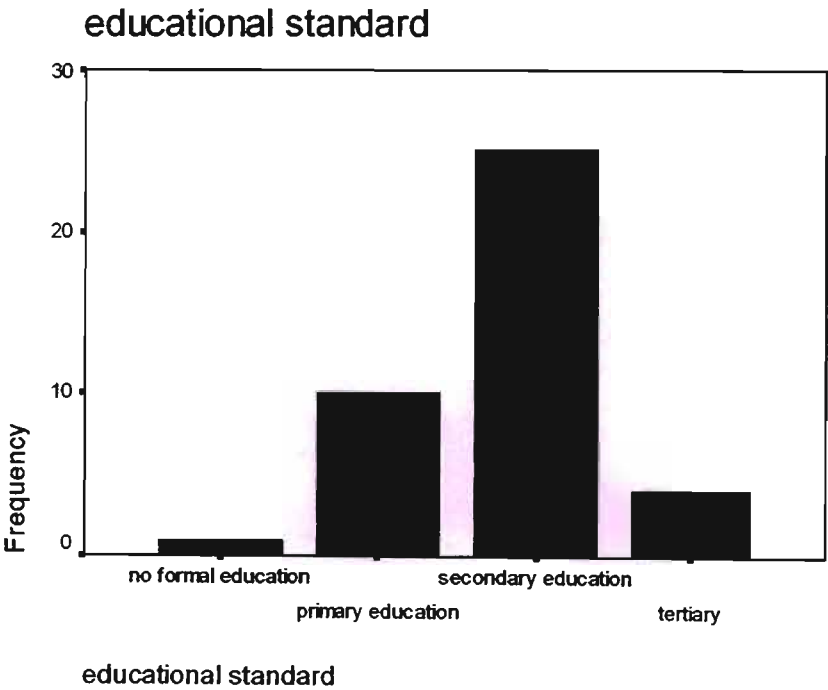


Figure 4. 5. Educational standard (N=40).

4.2.2. Knowledge of HIV testing.

4.2.2.1. Who should test for HIV?

Forty percent of women (n=16) were of the opinion that testing should be done by all women together with their partners whereas only 7.5% agreed that testing should be done by all women.

Women studied by Matinga (2003:11), felt that HIV counselling and testing process would be meaningful if couples are involved.

	Frequency	Percent
Pregnant mothers	9	22.5
All women	3	7.5
Mothers and partners	12	30.0
All of the above	16	40.0
Total	40	100.0

Table 4.1. Who should test for HIV? (n=40)

4.2.2.2. When should a person test?

Fifty five percent (n=22) respondents, responded by saying a woman should take a test when she likes, 27.5 %(n=11) said she should test during pregnancy and only 15% (n=6) said she should test when asked by a health worker. The majority of women in the study preferred not to be tested antenatally.

	Frequency	Percent
During pregnancy	11	27.5
When she likes	22	55.0
When asked by a health worker	6	15.0
Don't know	1	2.5
Total	40	100

Table 4. 2. When should a person test? (n=40).

4.2.2.3. If you have tested negative, what must you do?

Most women responded by saying that one need to practice safe sex when tested negative (47.5%, n=19). Thirty five percent (n=14) were of the opinion that, the person need to retest again so as to be sure and 17.5% (n=7) said the person need to be careful.

The responses of the respondents is consisted with what is said by Kennedy (2003:76) that discussion and counselling following a negative result should include information about the window period and the possibilities of further exposure.

	Frequency	Percent
Be careful	7	17.5
Practice safe sex	19	47.5
Retest again so as to be	14	35.0
sure	40	100.0
Total		

Table 4. 3. If you have tested negative, what must you do? (n=40)

4.2.2.4. If you have tested positive, what must you do?

The majority of respondents (45%, n=18) were of the opinion that the person must use a condom. Twenty percent were of the opinion that the woman must abstain from sex and another 20% said the woman must take medicine. The respondents were asked to specify the medicine and they said the woman should take AZT (comments not shown). Six percent (n=6) of respondents said the woman should inform partner.

Breaking the news of HIV positive test results to a person requires great sensitivity. It is important to use this opportunity to encourage behaviour change.

	Frequency	Percent
Take medicine---specify	8	20.0
Abstain from sex	8	20.0
Use a condom	18	45.0
Inform partner	6	15.0
Total	40	100.0

Table 4. 4. If tested positive, what must you do? (n=40).

4.2.2.5. Can you tell another person the importance of testing?

Seventy percent (n=28) of women said they can convey the message regarding the importance of testing to another person. Seventeen and a half (n=7) said they will not be able to tell another person and 12.5% (n=5) were not sure.

In order to increase the percentage of people to convey the message of the importance of HIV testing in pregnancy, all health sectors providing VCT services must make every effort to provide VCT services that the women see as clearly beneficial.

	Frequency	Percent
Yes	28	70.0
No	7	17.5
I am not sure	5	12.5
Total	40	100.0

Table 4. 5. Can you tell another person the importance of testing? (n=40).

4.2.2.6. Is testing a good idea, is it necessary?

The highest proportion (92.5%, n=37) were of the opinion that testing is a good idea and it is necessary (85%, n=34). Five % (n=2) were of the opinion that it is not a good idea and 12.5% (n=5) said it is not necessary. 2.5% (n=1) of respondents said they do not know whether testing is a good idea or is necessary.

Studies have indicated that pregnant women think the HIV test is important and acceptable. However having a positive attitude towards HIV testing does not automatically mean that the woman will accept the HIV test (Kennedy 2003:74).

	frequency	percent
Is testing a good idea?		
Yes	37	92.5
No	2	5.0
Don't know	1	2.5
Total	40	100.0
Is it necessary?		
Yes	34	85.0
No	5	12.5
Don' know	1	2.5
Total	40	100.0

Table 4. 6. Is testing a good idea and is it necessary? (n =40)

4.2.2.7. **Have you ever had an HIV test?**

Eighty five percent (n=34) of women have not had an HIV test. When asked if they would like to be tested, only 52.5% respondent by saying they would like to take the test and 32.5% (n=13) said they will no take the test (Table 2.10). This shows that the uptake of HIV testing in pregnancy is still low. Fifteen percent (n=6) said they have had the HIV test. In a study conducted by Exner et al (2000:8), one of the reasons for not having the test were concerns about confidentiality and afraid of their partner’s reaction (Berer and Ray 1993:239).

	Frequency	Percent
Yes	6	15.0
No	34	85.0
Total	40	100.0

Table 4. 7. Have you ever had an HIV test? (n=40).

	Frequency	Percent
Yes	21	52.5
No	13	32.5
Total	34	85

Table 4. 8. Would you want to be tested? (n=40).

4.2.2.8. If tested, did you tell anyone the results of the test?

Out of six respondents (15%) who said they have had a HIV test, 10% (n=4) said they told another person the results of the test and 5% (n=2) said they did not tell anyone. The study conducted by (Matinga 2003:11) revealed that the most preferred individual whom women wanted to share their test results was husband.

	Frequency	Percent
Yes	4	15.0
No	2	5.0
Total	6	15.0

Table 4. 9. If tested, did you tell anyone the results of the test?
(n=40)

4.2.2.9. If not, is it necessary to tell anybody?

Out of 85% women who have not had a test, 40% (n=16) said it is not necessary to tell another person the results of the test. Thirty five percent (n=14) are of the opinion that it is necessary to tell another person. Disclosure of HIV status is still feared by most of the people due to stigma attached to HIV. Ekanem and Gbadegesin (2004:96) in their study found that few women would undergo the HIV test if the results would be shared with relatives

	Frequency	Percent
Yes	14	35.0
No	16	40.0
Don't know	4	10.0
Total	34	85.0

Table 4. 10. Is it necessary to tell anybody? (n=40).

4.2.2.10. Should an HIV positive mother bear children?

Sixty two percent (n=25) of respondents are of the opinion that HIV positive mothers should not bear children whereas 32.5% (n=13) thought the HIV positive mother should bear children. The positive HIV test results are important for decision making regarding the number of children one should have.

	Frequency	Percent
Yes	13	32.5
No	25	62.5
Don't know	2	5.0
Total	40	100.0

Table 4. 11. Should an HIV positive mother bear children?

(n=40).

4.2.2.11. Must HIV testing routinely done?

Fifty five percent (n=22) of women said HIV testing must be routinely done, 22.5% (n=9) said it must not be routinely done and another 22, 5% said they don't know whether testing should be routinely done or not.

This shows that there are still woman who are afraid to take the test.

Most women felt that HIV testing should be routinely offered in the antenatal clinic. This is consistent with the findings of a study conducted by Kiarie et al (1999:1469), where women were of the opinion that HIV testing should be offered to all antenatal mothers.

	Frequency	percent
Yes	22	55.0
No	9	22.5
Don't know	9	22.5
	40	100.0

Table 4. 12. Must HIV testing be routinely done? (n=40).

4.2.2.12. Does testing benefit a pregnant woman?

Most respondents 87.5% (N=35) are of the opinion that testing does benefit a pregnant woman.

Only one respondent had a different view (2.55%) and said testing does not benefit the pregnant woman. The reason stated is that, if the woman is tested, sometimes testing causes misunderstanding in families.

Those who viewed testing as of benefit to the woman stated the following reasons:

- because HIV can be prevented from getting to the baby by using AZT
- for her babies health and hers
- gives mother a chance to have access to treatment
- it will protect the baby from getting HIV
- it will provide mothers with treatment early
- knows her results and protect the baby
- mother will get treatment to protect her unborn baby
- mother will know her status and decide whether to bear a child in future
- mother will loose her husband
- must get support and treatment
- she can get something to protect herself like tablets
- she gets protection
- she gets treatment to protect her baby during birth
- she knows that she must not breastfeed the baby
- so that she knows that she must not breastfeed
- to avoid mother to child transmission
- to get treatment
- to prevent HIV for unborn child
- to prevent the child from getting HIV
- will have access to treatment

4.2.2.13. Would you advise any other person to accept HIV testing?

Seventy two and a half percent (n=29) said they would advice any other person to take the test. Twenty-two and a half percent (n=9) said they would not and 5% said they do not know.

	Frequency	Percent
Yes	29	72.5
No	9	22.5
Don't know	2	5.0
Total	40	100.0

Table 4 13. Would you advise any other person to accept HIV test?

N=40).

4.2.2.14. Testing is a routine way of monitoring pregnant women.

Forty two and a half percent (N=17) of respondents agreed to the above statement, 22.5% (n=9) strongly agreed and 7.5% (n=3) strongly disagreed. (Results in table 4.14).

The majority women agreed to the statement. This is supported by Berer and Ray (1993:234) where they stated that; the aim for HIV testing is to find the prevalence of HIV infection and to estimate how many infants will be born with HIV.

	Strongly Agree		Agree		Not Sure		Disagree		Strongly Disagree		Total
	N	%	N	%	N	%	N	%	N	%	
Testing is a routine way of monitoring pregnant women	9	22.5	17	42.5	8	20	3	7.5	3	7.5	40
Testing is promoting condom use	15	37.5	17	42.5	2	5.0	6	15.0	0		40
Testing is for the safety of the unborn baby	22	55.0	11	27.5	3	7.5	4	10.0	0	0	40
Testing is for health workers to conduct research	4	10.0	10	25.0	13	32.5	10	25.0	3	7.5	40
Testing will provide mothers with earlier access to treatment	24	60.0	11	27.5	3	7.5	2	5.0	0		40
All women who receive prenatal care should be tested for HIV	19	60.0	14	35.5	4	10.0	2	5.0	1	2.5	40
Testing will minimize the number of HIV infected babies	15	37.5	20	50.0	3	7.5	0		2	5.0	40
Getting tested is emotional stressful	13	32.5	9	22.5	4	10.0	10	25.0	4	10.0	40
Testing is a way to decrease anxiety about HIV	9	22.5	19	47.5	6	15.0	5	12.5	1	2.5	40
Testing does not eliminate current or future risk of HIV infection	9	22.5	13	32.5	12	30.0	6	15.0	0	0	40

Table 4. 14. Perceptions of pregnant women. (n=40).

4.2.2.15. Testing is promoting condom use.

The majority of respondents (42.5%, n=17) agreed to the statement. Thirty-seven and a half (n=15) strongly agreed and 15% (n=6) strongly disagreed. (Results in table 4.14).

Although the majority of women thought testing is promoting condom use, they find it difficult to persuade their partners to initiate and sustain condom use (Johnson and Johnstone 1993:31

4.2.2.16. Testing is for the safety of unborn baby.

Every pregnant woman is concerned about the health and safety of her unborn baby. In this study 55% (n=22) respondents strongly agreed to the statement that testing is for the safety of the unborn baby. Twenty seven and half percent (n=11) agreed to the statement and 10% (n=4) did not agree with the statement. (Results shown in table 4.14).

The fact that only pregnant women are usually screened strongly suggests that HIV test is for the sake of the infant and not the women (Berer and Ray 1993:236).

4.2.2.17. Testing is for health workers to conduct research.

Respondents 32.5% (n=13) were not sure concerning this statement with a tie of 25% (n=10) of respondents who agreed to the statement and those who disagreed to the statement. (Results in table 4.14). Minkoff et al (1995:108) are of the opinion that pregnant women are often screened for HIV as a means of monitoring spread in the general population

4.2.2.18. Testing will provide mothers will earlier access to treatment.

Sixty percent (n=24) of respondents strongly agreed to the statement and 27.5% (n=11) agreed to the statement. The small proportion of 5% (n=2) disagreed to the statement. (Results shown in table 4.14).

4.2.2.19. All women who receive prenatal care should be tested for HIV.

The majority of respondents are in favour if the statement, 47.5% (n=19) strongly agreed and 35% (n=14) agreed to the statement. Only 2.5% (n=1) of respondents strongly opposed the statement and 10% (n=4) were not sure. (Results shown in table 4.14).

Berer and Ray (1993:237) found that forty six percent of the women tested first learned they had HIV from an antenatal test.

4.2.2.20. Testing will minimize the number of HIV infected babies.

Fifty percent (n=20) of respondents agreed to the fact that testing will minimize the number of HIV infected babies while 5% (n=2) strongly disagreed to the statement. (Results in table 4.14). Ho and Loke (2003:823) are of the opinion that HIV testing during pregnancy is for the health of the newborn.

4.2.2.21. Getting tested for HIV is emotional stressful.

The results in the table show that women are afraid to take HIV test as 32.5% (n=13) strongly agreed and 22.5% (n=9) agreed to the fact that testing for HIV is emotional stressful. Although there are people who are scared to take the test, it is interesting that there are some (25%, N=10) who disagreed to the statement. (Results shown in table 4.14). According to Exner et al (2002:01), the predominant reason for women not accepting HIV testing was anxiety about the test.

4.2.2.22. Testing is a way to decrease anxiety about HIV.

The results revealed that 47.5% (n=19) view HIV testing as a way to decrease anxiety about HIV. Twelve and a half percent (n=5) did not agree with the statement. (Results in table 4.14). The results are consistent with the findings of a study conducted by Exner et al (2002:10) where women felt that being tested for HIV was a way to decrease anxiety about HIV.

4.2.2.23. Testing does not eliminate current or future risk of HIV infection.

It is interesting to know that there are women who know that getting tested for HIV will not eliminate current or future risk of HIV infection. These findings are supported by Exner et al (2002:11) that HIV testing merely rules out prior infection. Results in the table show that 22.5% (n=9) strongly agree and 32.5% (n=13) agreed to the statement. Thirty percent (n=12) of respondents were not sure and 15% (n=6) disagreed with the statement. (Results shown in table 4.14).

CHAPTER 5

5. Discussion and Conclusion

5.1. Introduction.

Guided by the theoretical framework of the Health Belief Model and Theory of Reasoned Action, this study aimed to ascertain women's knowledge of HIV testing, describe women's perceptions towards HIV testing in pregnancy and determine factors relating to acceptability of HIV testing by pregnant women.

5.2. Key Findings

5.2.1. Age and Marital Status.

The sample in this study was found to be mostly young women between the age of 18-25 (45%) and most of them were unmarried (90%). The reason why there is high proportion of single pregnant women than married women is that the area where the study was conducted is an industrial area. The majority of young women migrate from their homes to seek employment in the low paid industries. Because they are financial dependent, they fail to control their sexual lives and they engage themselves in unprotected sex.

Enosolease and Offor (2004:88), in their study found that young women had multiple sexual partners and regularly practised unprotected sex. This increases their vulnerability to HIV/AIDS. The other reason is that, during these years (18-25) young women learn, explore and make decisions that will affect the rest of their lives including early and unintended pregnancies (USAID 2004:5). Enosolease and Offor (2004:88) further found that older women were more likely to

accept HIV testing than the young ones. This may be due to the fact that older women see themselves at risk of contracting HIV infection.

5.2.2. Educational Standard.

Most women in the study had attained secondary school education (62, 5%) and only 10% had attained tertiary education. The researcher is of opinion that pregnancy in young women limits their ability to complete their education. This is in line with the findings of Baylies and Bujra (2003:6) where they found that, women's lesser access to education and lower levels of literacy contribute to their limited access to information about HIV testing.

5.2.3. Willingness to test.

In this study, 52, 5% of women were willing to be tested out of 85% who had not been previously tested. This is considered as a low HIV testing acceptance. In a study conducted by Ho and Loke (2003:823), they found that, pregnant women refused the HIV test mainly because they have only one sexual partner who is trustworthy and infection with HIV is out of question.

The woman's reasoned action to accept the test emanates from Health Belief Model as they perceive themselves to be susceptible to HIV/AIDS.

Many women may be reluctant to be tested due to fears of domestic violence and stigma attached to HIV. Others reported concerns about confidentiality as a reason not wanting to be tested. The study conducted in Botswana by Matinga (2004:18), revealed that there is a correlation between levels of knowledge about HIV testing to the possibilities of accepting the test, (Budget speech 2004:2), as knowledge influences one's intention to perform behaviour.

According to this study, the poor response appeared in the population where only 15% reported to have ever been tested for HIV. This is likely to be influenced by past exposure to HIV testing in their previous pregnancies and by the acceptability of the voluntary counselling and testing provided.

5.2.4. Perceptions.

The majority of women (92, 5%) said testing was a good idea and 85% said it was necessary. However, not all women who said HIV testing in pregnancy is a good idea thought it was necessary because only 52, 5% said that they will opt for HIV testing.

This means that perceptions are not always consistent with behaviour. The simple explanation is that, there is still resistance to the acceptability of HIV testing amongst these women. Kennedy (2003:74), is also of the opinion that a woman's good perception to a test does not automatically mean that a woman will accept the test.

Exner et al (2002:7), Matinga (2003:7) found that women felt that being tested was a way to decrease their anxiety about HIV.

This is further supported by the findings of this study where the highest population (55%) of women felt that, getting tested for HIV is emotional stressful.

These findings highlight the importance of using pre-test counselling to directly address anxiety about testing. The researcher argues that voluntary testing maintains a women's relationship of confidence in her counsel or health worker and the woman is treated as a person in her own right.

Most of them had a feeling that HIV testing should be routinely done. The findings of this study are similar with the findings of the study conducted by Kiarie et al (1999:1469), where most women felt that HIV testing should be routinely offered in antenatal clinic because it reduces suspicions from spouses and friends.

They further found that, the contributing factor towards the women's acceptance of HIV testing is based on the women's perception of testing benefit for their babies or their own health.

5.2.5. Future Reproduction for an HIV Positive Woman.

Children are considered essential to self-fulfilment and to family happiness for African women, (Tallis 1997:19) and the value placed to children is extremely high.

The majority of women in the study (62, 5%) felt that an HIV positive mother should not bear children. The researcher argues that denying an HIV positive mother to bear children will be unconstitutional and it violates women's equality and their security as a person.

An individual woman's reproductive choices should be respected regardless of her HIV status. It is their right to bear children but counselling is very important so that they make informed choices. Women must decide on their own without pressure to have or not to have a test in their own time.

The identification of HIV infected women during pregnancy or before delivery ensures the appropriate management of the women and her child (Semprini and Fiore 2004:259).

It also allows the woman to consider the use of Antiretroviral therapy for herself and her baby, and to make an informed decision on the most appropriate type of birth (Kennedy 2003:67). The concern for every pregnant woman is to have a healthy baby.

5.2.6. When should testing be done?

The problem with testing a woman during pregnancy is the uncertainty as to whether pregnancy is the best time for a woman to find out she is HIV positive. Kennedy (2003:65) recommended that if

testing is done during pregnancy, it should be done at an early stage as possible because this will allow those women diagnosed as HIV positive the opportunity to be offered advice and treatment during antenatal care for their health and that of their babies.

5.2.7. Testing Negative.

The women in this study (47.5%) were of the opinion that a person need to practise safe sex when tested negative and 35% said a person need to retest again so as to be sure and 7% said a person need to be careful.

It is important to inform the woman that her negative results do not automatically indicate that her partner is negative. This opportunity must be used by the counsellor to encourage behavior change and to ensure that the individual realises the limitations of a negative results. Counsellors need also to explain that a negative test result can only rule out past risk and is not the end point of HIV prevention.

A study conducted by Exner et al (2002:11) on pregnant women, revealed that women's knowledge of their HIV status seemed to offer emotional reassurance but had no effect on their future choices.

A number of women according to Kennedy (2003:76) "will remain anxious following a negative result and they have been termed the worried well". These women may need additional counselling for their support throughout their pregnancy because they are in a dilemma on how they can maintain a negative HIV status and protect their unborn baby from HIV infection. They found it a challenge to convince their partners to use a condom when having sex as one way of preventing mother to child transmission of HIV.

5.2.8. Testing HIV positive.

The majority of respondents (45%) in this study were of the opinion that if a person has tested HIV positive, she must use a condom. Twenty percent said the person must take medicine. It is interesting to know that there are some people who are having knowledge about the availability of antiretroviral drugs. Condom use is not guaranteed in African women as confirmed by studies done which revealed that there is stigma associated with the use of condom by women. Francis-Chizororo and Natshalaga (2003:110) found that, 80% of women said they will have to first seek permission from their partners to use the female condom.

If a woman has tested positive, she should receive detailed counselling at the time the results are given and in follow up sessions. Counselling should include a description of the early clinical manifestations of HIV disease, the current understanding of the prognosis of HIV disease, the risk of prenatal transmission to the foetus and available interventions for preventing transmission (Faro and Soper 2001:492). According to Berer and Ray (1993:89), counselling for those with HIV encourage living positively, that is believing in the ability to stay well and carrying on with life.

5.2.9. Sharing the results with other people.

The findings of this study reveal that the majority of respondents are not comfortable with informing relatives or partners about the HIV test results. Ekanem and Gbadegesin (2004:95) in their study found that only few pregnant women would undergo the test if the results would be shared with relatives.

HIV positive women who communicated their results to partners suffered violence from their partners after counselling (Temmerman, Ndinya-Achola, Ambani and Piot 1995:970). Although a different view was explained by Sethosa and Peltzer (2005:39) that individuals who are aware that they are infected with HIV and who engage in sexual relationship have a social and legal

responsibility to disclose their infections to their partners. Sharing the results with partners will not improve HIV testing uptake, if according to dePaoli, Manongi and Klepp (2004:426), there is lack of sensitivity to the woman's fear of blame and rejection.

5.3. Recommendations.

5.3.1. Recommendations related to research.

- Further studies relating to “acceptability, knowledge and perceptions of pregnant women towards HIV testing in pregnancy” need to be done on a large scale so that results will be generalizable.
- Research amongst all women of child bearing age and elderly women on “acceptability, knowledge and perceptions of HIV testing in pregnancy” need to be undertaken so that results are applied to all groups of the women population..

5.3.2. Recommendations related to practise

- Mutual testing must be promoted which will support disclosure of HIV status and provides support.
- HIV testing should be integrated in Reproductive Health Services.
- Destigmatization campaigns to reduce stigma directed to women living with HIV.
- Improvement in physical structures, like provision of adequate counselling rooms.

- Provision and equal distribution of adequate HIV counsellors to decrease client's waiting time.

5.4. Limitations of the study.

- This was a small-scale study and the results cannot be generalized.
 - The instrument used did not try to find out the reasons from women for refusing HIV testing.
 - All study participants were only Africans and from one Community Health Centre.
- Therefore caution must be taken in generalizing the study results to other geographic regions and demographic groups.

5.5. Conclusion.

Choice of testing in pregnancy may be difficult to the pregnant woman due to stigma attached to HIV/AIDS. Most women fear to inform their partners about HIV positive results because of fear of rejection and physical harm. Couple counselling and enhanced partner involvement is recommended in the prevention of mother to child transmission programmes.

From the findings of this study it can be thus deduced that HIV testing acceptance is low in the setting where the study was conducted. The women's perceptions to HIV testing are good but they are not consistent with their behaviour. That means, the women's positive attitude to HIV testing was not transformed into actual behavior. Women showed good understanding and knowledge of

From the findings of this study it can be thus deduced that HIV testing acceptance is low in the setting where the study was conducted. The women's perceptions to HIV testing are good but they are not consistent with their behaviour. That means, the women's positive attitude to HIV testing was not transformed into actual behavior. Women showed good understanding and knowledge of HIV testing in pregnancy but their knowledge did not increase the uptake of testing. This might be due to the increase in awareness of vertical transmission of HIV.

Increasing knowledge about HIV transmission may decrease stigma surrounding HIV infection and help to improve acceptance rate to HIV testing in pregnancy.

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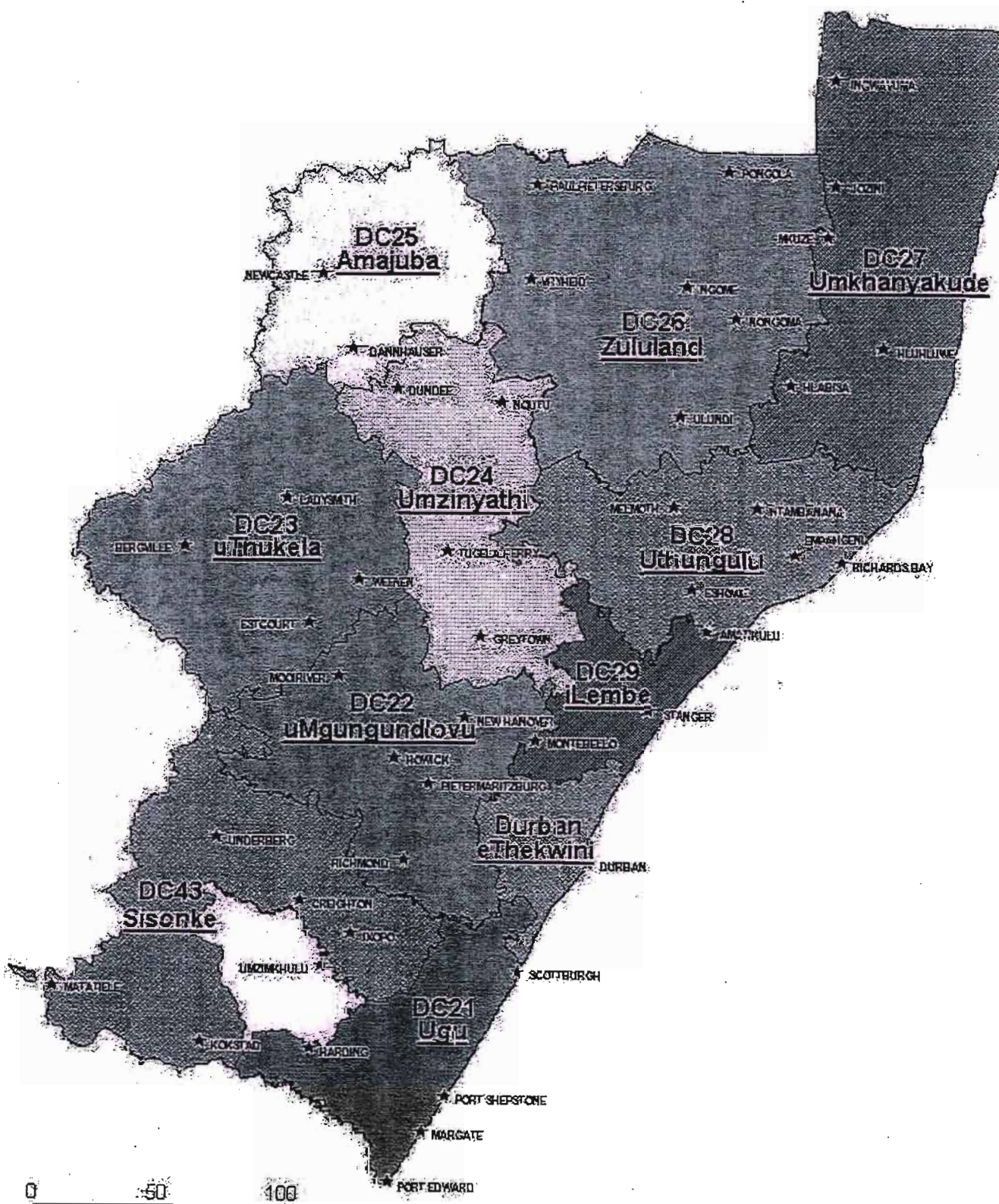
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ANNEXURE A

KWAZULU-NATAL HEALTH DISTRICTS

Population - 9 070 457
Area - 92 440 Sq. km
Density - 98 People per Sq. km



ANNEXURE B

QUESTIONNAIRE

SECTION A: DEMOGRAPHIC INFORMATION

PLEASE TICK IN THE APPROPRIATE BOX

Age

<input type="checkbox"/>	13-17 YRS
<input type="checkbox"/>	18-25 YRS
<input type="checkbox"/>	26-30 YRS
<input type="checkbox"/>	31-40 YRS
<input type="checkbox"/>	41 +

Marital Status

<input type="checkbox"/>	Single
<input type="checkbox"/>	Married
<input type="checkbox"/>	Divorced
<input type="checkbox"/>	Other (specify)

Parity

<input type="checkbox"/>	P0-P2
<input type="checkbox"/>	P3-P5
<input type="checkbox"/>	P6+

Educational standard

<input type="checkbox"/>	No formal education
<input type="checkbox"/>	Primary education
<input type="checkbox"/>	Secondary education
<input type="checkbox"/>	Tertiary

SECTION B

What do you know about testing for HIV during pregnancy?

Put a tick along the response which is most appropriate

QUESTION	RESPONSE	TICK
1. Who should test for HIV	(a) Pregnant mothers (b) All women (c) Mothers and partners (d) All of the above (e) Don't know	
2. When should a person test	(a) During pregnancy (b) When she likes (c) When asked by health care workers (d) Don't know	
3. If you have tested negative, what must you do	(a) Be careful (b) Practice safe sex (c) Retest again so as to be sure (d) Don't know	
4. If you have tested positive, what must you do	(a) Take medicine-----specify (b) Abstain from sex (c) Use a condom (d) Inform my partner (e) Don't know	
5. Can you tell another person about the importance of testing	(a) Yes (b) No (c) I am not sure	

SECTION C

What do you think about HIV testing?

	Yes	No	Don't know
1. Is testing a good idea?			
2. Is HIV testing necessary?			
3. Have you ever had an HIV test?			
4. If not, would you want to be tested?			
5. If tested, did you tell anyone the results of the test?			
6. If not, is it necessary to tell anybody			
7. Should an HIV positive mother bear children?			
8. Must HIV testing be done routinely?			
9. Does HIV testing benefit a pregnant woman? If so, how? Specify If not, why? Specify			
10 Would you advise any other person to accept HIV testing?			

SECTION D

How strongly do you agree or disagree with the following statements?

	Strongly agree	Agree	Not Sure	Disagree	Strongly disagree
1. Testing is a routine way of monitoring pregnant women					
2. Testing is promoting condom use					
3. Testing is for the safety of the unborn baby					
4. Testing is for health workers to conduct research					
5. Testing will provide mothers with earlier access to treatment					
6. All women who receive prenatal care should be tested for HIV.					
7. Testing will minimize the number of HIV infected babies					
8. Getting tested for HIV is emotional stressful					
9. Testing for HIV is a way to decrease anxiety about HIV					
10. Testing does not eliminate current or future risk of HIV infection					

Thank you for your cooperation!

ANNEXURE C

IMIBUZO

ISIGABA A: OKUPHATHELENE Nawe
FAKA UPHAWU (✓) EBHOKISANENI ELIFANELE.

Uneminyaka emingaki

	13-17 weminyaka
	18-25
	26-30
	31-40
	41+ weminyaka

Ushadile noma qha

	awushadile
	ushadile
	uhlukanisile
	Okunye(chaza)

Unezingane ezingaki

	Ayikho-zimbili
	Zintathu- kwezinhlanu
	Zingaphezu kwesithupha

Izinga lemfundo

	Awukaze uye esikoleni
	Wagcina emazingeni aphansi
	Emazingeni aphakeme
	Esikhungwewni semfundo ephakeme

ISIGABA B**Wazini nokuhlolwa igciwane le HIV kumuntu okhulelwe?**

Umbuzo	Impendulo	Uphawu(✓)
1. Ubani okufanele ahlolelwe igciwane leHIV	(a) abasifazaneabakhulelwe. (b) Bonke abesifazane (c) Omama nopathini babo (d) Bonke ababalwe ngenhla (e) anginalwazi	
2. Kufanele ahlolelwe nini umuntu	(a) ngesikhathi ekhulelwe (b) uma ethanda (c) uma ecelwe abasebenzi bezempilo (d) anginalwazi	
3. uma uhloliwe kwathiwa awunagciwane, kufanele wenzeni	(a) uqaphele (b) wenze ucansi oluphephile (c) uphinde uhlole khona uzoba nesiqiniseko (d) anginalwazi	
4.uma uhlolwe kwathiwa unegciwane, kufanele wenzeni	(a) udle imithi—(chaza) (b) ungayi ocansini (c) usebenzise ikhondomu (d) utshele uphathini wakho (e) anginalwazi	
5. ungamtshela omunye umuntu ukubaluleka kokuhlolwa igciwane le HIV	(a) yebo (b) cha (c) angazi kahle	

ISIGABA C

Yini oyicabangayo ngokuhlololwa igciwane leHIV.

	yebo	cha	angazi
1. ukuhlololwa igciwane leHIV kuyinto enhle?			
2. ingabe kunesidingo?			
3. wake wahlololwa igciwane leHIV?			
4. uma ungakaze, ungathanda ukuhlololwa?			
5. uma wahlololwa, kukhona owamthela umphumela?			
6.uma ungakaze, kunesidingo ukutshela omunye imuntu?			
7. owesifazane onegciwane kufanele yini athole abantwana?			
8. ukuhlololwa igciwane kufanele kube yinto eyenziwa njalo?			
9. ukuhlololwa igciwane, kuyamsiza owesifazane okhulelwe? Kumsiza kanjani? (chaza) Akumsizi kanjani (chaza)			
10. ungakwazi ukutshela omunye umuntu ukuthi avume ukuhlololwa igciwane leHIV?			

ISIGABA D

Uvumelana kangakanani nalezizitatimende ezilandelayo.

	Impela kuyikho	kuyikho	angina lwazi	Akuyi kho	Akuyikho impela
1. ukuhlolwa igciwane indlela yokuqapha abesifazane abakhulelwe					
2. kukhuthaza ukusetshenziswa kwamakhondomu					
3. kwenzelwa ukuphephisa ingane engakazalwa					
4. okwabasebenzi bezempilo ukuze benze ucwaningo					
5. kusiza abasifazane abakhulelwe ukuba basheshe bathole imishanguzo					
6. bonke abesifazane abahamba umtholampilo wabakhulelwe kufanele bahlolwe					
7. ukuhlolwa kunciphisa inamba yezingane ezizalwa zinegciwane					
8. ukuhlolwa igciwaneakuyon into emnandi					
9. ukuhlolwa kunciphisa uvalo ngeHIV					
10. ukuhlolwa akuvimbi ukuhaqwa yigciwane leHIV.					

SIYABONGA!

ANNEXURE D



RESEARCH ETHICS COMMITTEE

UNIVERSITY OF
KWAZULU-NATA

Student: FAITH NANA DUBE

Student No: 201507705 Qualification: MASTER'S DEGREE (COURSEWORK)

Research Title: THE ACCEPTABILITY, KNOWLEDGE AND PERCEPTIONS OF PREGNANT WOMEN ABOUT HIV TESTING IN PREGNANCY AT ILEMBE DISTRICT

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: 18 OCTOBER 2004

Signature of Supervisor: [Signature] Date: 18 October 2004

Signature of Head of School: [Signature] Date: 18 October 2004

Signature of Chairperson of the Committee: [Signature] Date: 25 October 2004

Faculty of Community & Development Disciplines

Postal Address: Durban 4041, South Africa

Telephone: +27 (0)31 260 3139

Facsimile: +27 (0)31 260 2458

Email: khanyid@ukzn.ac.za

Website: www.ukzn.ac.za

Learning Campuses:

Edgewood

Howard College

Medical School

Pietermaritzburg

ANNEXURE E

18 October 2004



THE SECRETARY
DEPARTMENT OF HEALTH KWAZULU-NATAL
P/BAG X 9051
PIETERMARITZBURG
3200

Dear Sir/ Madam

**Re: Permission to conduct research at Sundumbili Community Health Centre.
Topic: The Acceptability, Knowledge and Perceptions of Pregnant Women
About HIV Testing in Pregnancy At Ilembe District.**

Permission is hereby sought to conduct a study at the above named institution. I am studying towards Masters Degree in Maternal and Child Health through the University of KwaZulu-Natal. The research is the requirement for partial fulfillment of the degree.

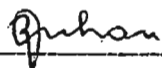
Enclosed please find the proposal.

Thanking you for granting me the permission.

F.N. DUBE

STUDENT

MS Z. Z. NKOSI


RESEARCH SUPERVISOR

**School of Nursing
Decentralised Programmes**

Postal Address: Durban 4041, South Africa

Telephone: +27 (0)31 260 2901

Facsimile: +27 (0)31 260 1543

Email: nkosizz@ukzn.ac.za

Website: www.ukzn.ac.za

Learning Campuses:

Edgewood

Howard College

PRIVATE BAG X 9051
PIETERMARITZBURG
3201

TELEPHONE
UTINGO (033) 3952111



330 LONGMARKET STREET
PIETERMARITZBURG
3201

FAX: 033 345 4433

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

10 NOV 2004

Ms Faith Nana Dube
University of KwaZulu -Natal
School of Nursing -- Decentralised Programmes
Howard College Campus
DURBAN
4041

Dear Ms Dube

APPLICATION TO CONDUCT RESEARCH ON THE ACCEPTABILITY, KNOWLEDGE AND PERCEPTIONS OF PREGNANT WOMEN ABOUT HIV TESTING IN PREGNANCY AT ILEMBE DISTRICT

Your letter dated 25 October 2004 refers.

Kindly be advised that authority is granted for you to conduct research regarding "the acceptability, knowledge and perceptions of pregnant women about HIV testing in pregnancy" at Ilembe District, 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.

Yours faithfully


27/11/04
SUPERINTENDENT-GENERAL
HEAD : DEPARTMENT OF HEALTH
NNM/Ilembe district dube

ANNEXURE F

INFORMATION DOCUMENT

Study title: Acceptability, knowledge and perceptions of pregnant women towards HIV testing in pregnancy at Ilembe District.

Greeting: I would like to thank you for participating in my research study.

Introduction: I, Faith Nana Dube, am doing research on the **Acceptability, knowledge and perceptions of pregnant women towards HIV testing in pregnancy at Ilembe District**. Research is just a process to learn the answer to a question. In this study we want to learn about the knowledge and perceptions of pregnant women towards HIV testing in pregnancy and how they affect acceptability of HIV testing.

Invitation to participate: I am asking for your permission to participate in this research study.

What is involved in the study: The study includes answering questions in the provided questionnaire. It should take approximately twenty minutes to complete the questionnaire. The study only involves pregnant women attending antenatal clinic for the first time in their current pregnancy at Sundumbili Community Health Centre.

Risks: I may inconvenience you in terms of time, but you are not compelled to fill the questionnaire.

Benefits: You may see the benefits of the study in terms of improved quality service provided in our antenatal Voluntary Counseling and Testing sites.
You will be kept informed about the process and the outcome of the study.

Participation is voluntary: Refusal to participate will involve no penalty or you cannot be denied the quality care that you are entitled to. You may discontinue to participate at any time.

Reimbursements: There is no reimbursement involved in this study but it is hoped that you will benefit from the findings.

Confidentiality: Efforts will be made to keep personal information confidential but absolute confidentiality cannot be guaranteed.

Should you have any questions you need to ask me, you may contact me at this number:

Work : 035-474840

Cell : 0827076340

ANNEXURE F

Declaration

I.....(full names of participant)
hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I have been informed that the interview is entirely voluntary and that even after the interview begins I can refuse to answer any specific questions or decide to terminate the interview at any point.

SIGNATURE OF PARTICIPANT

DATE

.....

ANNEXURE G

Box 3954
Sundumbili
4491
26 October 2004

THE NURSING MANAGER
SUNDUMBILI COMMUNITY HEALTH CENTER
SUNDUMBILI
4491

Dear Madam

**Re: Permission to conduct research at Sundumbili Community Health Centre.
Topic: The Acceptability, Knowledge and Perceptions of Pregnant Women
About HIV Testing in Pregnancy At Ntshong District.**

Permission is hereby sought to conduct a study at the above named institution. I am studying towards Masters Degree in Maternal and Child Health through the University of KwaZulu-Natal. The research is the requirement for partial fulfillment of the degree.

Enclosed please find the proposal.

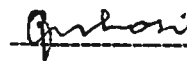
Thanking you for granting me the permission.

F.N. DUBE



STUDENT

MS Z. Z. NKOSI



RESEARCH SUPERVISOR

ANNEXURE H

**PROVINCE OF KWAZULU-NATAL
DEPARTMENT OF HEALTH**



**SUNDUMBILI CHC
PRIVATE BAG X 6032
MANDENI
4491**

TEL.: 032 454 1802

E-MAIL H010267@dohho.kzntl.gov.za
NURSING MANAGER'S OFFICE

FAX: 032 454 1802

DATE: 2004/11/03

ENQUIRIES: Mrs HARRIS R

TO : MISS NF DUBE
P.O. BOX 3954
SUNDUMBILI
4491

SUBJECT: PERMISSION TO CONDUCT RESEARCH

PERMISSION IS HEREBY GRANTED FOR YOU TO CONDUCT RESEARCH ON: THE
ACCEPTABILITY, KNOWLEDGE AND PERCEPTIONS OF PREGNANT WOMEN TOWARDS HIV
AIDS AT SUNDUMBILI CHC OBSTETRIC UNIT.

WISHING YOU SUCCESS IN YOUR ENDEAVOURS.

YOURS FAITHFULLY

Mrs HARRIS R
NURSING MANAGER

