

**PERCEPTIONS AND EXPERIENCES OF PREGNANT WOMEN  
TOWARDS HIV VOLUNTARY ANTENATAL COUNSELLING AND  
TESTING IN OSHAKATI HOSPITAL, NAMIBIA**

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**KEY WORDS:**

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## **ABSTRACT**

HIV infection has become one of the greatest complications of pregnancy in some developing countries. Namibia, with a population of only 1,8 million people, is ranked among the top five countries in the world, in terms of HIV/AIDS infections. In 2004, the National HIV prevalence ration among pregnant women was 19,8% (MOHSS, 2004). In the absence of ARV medicine intervention, transmission could vary between 30-45%. The identification of infection through voluntary counseling and testing (VCT), especially during pregnancy, is critical not just for guiding treatment but for future prevention as well. Namibia is experiencing a low uptake of VCT by pregnant women in all hospitals, which are implementing the Prevention of HIV from mother-to -child (PMTCT) strategy. Out of 5220 pregnant women who attended antenatal services in two pilot hospitals, only 10% of them agreed to be counseled and tested between March 2002 – March 2003 (MOHSS, 2003:7). This research was conducted in Oshakati Hospital, which is one of the first pilot hospitals for PMTCT.



The study focused on perceptions and experiences of pregnant women who opted in against those who opted out of voluntary antenatal HIV counseling and testing. The pregnant women's perceptions and experiences were assessed in order to gain insight into their views towards voluntary antenatal counseling and testing.

A qualitative, descriptive and comparative study was used regarding participants who opted in and opted out. A purposive random sampling was used to collect data from the participants. The study sample comprised six focus group discussions (FGD) of pregnant women who were attending antenatal services at this hospital. Each FGD consists of six pregnant women. Three FGD were women who opted in and other three FGD were for those who opted out. The semi-structure FGD guide was used to guide the discussions. The discussions were audio recorded, transcribed and analyzed, using thematic content analysis.

Based on the findings of the study, the knowledge of pregnant women who opted in was relatively good comparing with those who opted out. Despite the recognition of the benefits of VCT, it was evident that women were reluctant to use the VCT service because of reasons that include fear of being stigmatized, abandoned and discriminated against. The women's participation in the existing services of voluntary antenatal counseling and testing was influenced by their partners. The women are often being blamed for spreading the disease in the family. Due to stigma and discrimination women were afraid to disclose their status in order to avoid rejections by their partners, family and society.

It was also found that there were misconceptions surrounding the knowledge of the causes and prevention of vertical transmission. These misconceptions should be talked about. The distance was another factor, which hampered the participation of pregnant women in the programme. Other reasons for non-attendance given by the participants included dissatisfaction with some of the nurses' attitudes, ignorance about the service as well as reluctance to be tested.



Participants appreciated some aspects of VCT rendered, but suggested improvement in areas they felt were lacking. Areas of concern included partner involvement, community education, improving confidentiality and extension of services to the rural places / clinics.

The study makes number recommendations, among others improved partner communication on the issues of HIV/AIDS as it will encourage sharing of confidentiality and responsibility.

## DECLARATION

I declare that “The perceptions and experiences of pregnant women towards voluntary antenatal counseling and testing in Oshakati Hospital, Namibia” is my own work and that all the sources that I have used have been indicated and acknowledged by means of complete references.

Signed by:

---

Aini - Kaarin Toivo



This \_\_\_\_\_ date of \_\_\_\_\_ 2005

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## ABBREVIATIONS

AIDS =	Acquired Immunodeficiency Syndrome
ANC=	Antenatal Care
ARV=	Antiretroviral Therapy
CDC=	Communicable Disease Clinic
FGD =	Focus Group Discussion
GOVT=	Government
MOHSS =	Ministry of Health and Social Services
MMR =	Morbidity and Mortality Report
MTCT =	Mother to Child Transmission
PMTCT =	Prevention of HIV from Mother to Child Transmission
VCT =	Voluntary Counseling and Testing
WHO =	World Health Organization
UNAIDS =	Joint United Nations Programme on HIV/AIDS
SAFAIDS =	Southern Africa HIV/AIDS Action
SIAPAC =	Social Impact Assessment and Policy Analysis Cooperation

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## **CHAPTER 1: ORIENTATION OF THE STUDY**

### **1. 1. INTRODUCTION**

HIV/AIDS has become the most significant public health problem worldwide. In 2003 the global epidemic killed more than 3 million people, of whom 2.3 million were in sub-Saharan Africa (MOHSS, 2004). The largest source of infection is HIV transmission from infected mother-to-child. Scientific data now confirm that HIV can be transmitted from an infected mother to her child in utero, during delivery and through breastfeeding (WHO, 2001). The Ministry of Health and Social Services (MOHSS) report (2004) revealed that one in five pregnant women is HIV infected in Southern African countries.

In Namibia, the first four cases of HIV were reported in 1986. Since that year, the HIV/AIDS cases have increased rapidly and become the leading cause of death from 1996. AIDS was responsible for 26% of all reported deaths, and for 46% of deaths in the 15 - 49 year old group in 1999 (MOHSS, 2004). The number of HIV deaths has increased up to 80% in the three preceding years (MOHSS, 2004). By 31 December 2003, the accumulative number of HIV/AIDS cases, 136,068 was reported by the MOHSS (2004). In Oshakati, HIV infection among pregnant women was 30, 4% according to sentinel-sero survey for 2002 (MOHSS, 2002).

It is against this background that voluntary HIV counselling and testing should be available and accessible to all pregnant women, in order to reduce the vertical transmission. Currently, most pregnant women do not know their HIV status (WHO, 2000). This is because they fear to receive positive results. It is now high times to promote, provide and improve the access to VCT (Voluntary Counseling and Testing) in areas intervention to reduce MTCT are planned.

The Ministry of Health and Social Services in Namibia introduced the Prevention of mother to child HIV transmission (PMTCT) programme in 2002. It was piloted in two hospitals, Oshakati and Katutura. Since the implementation of this programme, the uptake has not increased as it was expected. From 1 March 2002 – September 2002, about 1834 pregnant women attended the ANC (Antenatal Care) for the first time at Oshakati Hospital. The numbers of pregnant women who enrolled for the programme and agreed to be tested during that period was considerably less, 462 (25,2%) (MOHSS, 2003).

It is because of these reasons that the study was conducted, to compare the perceptions and experiences of pregnant women towards voluntary antenatal HIV counselling and testing. The results will be hopefully used to improve the implementation of VCT among pregnant women in the Oshakati District.

## **1.2. BACKGROUND INFORMATION**



Namibia is located in the southwest part of Africa. It has a surface of 824 285 square kilometres. It shares its borders with Angola and Zambia to the north and northeast, Zimbabwe to the east, Botswana to the southeast, South Africa to the south and the Atlantic Ocean to the west (NDHS, 1992). Namibia has a population of 1,825 854 people, where females outnumber men by 51% to 49% (NDHS, 2002). More than half of the population (58%) lives in the northern part of the country. About 33% of the population lives in urban areas, whereas the remainder (67%) live in rural areas or commercial farms. Approximately two people occupy one square km. The population density appears to be low; some parts of the country are unliveable because of the Namib desert. Namibia is a culturally diverse and multi – ethnic society. Administratively, the country is divided into 13 regions.

Oshana is the smallest region (5290 square km) with a population of 166, 836 people. The population density is 32 persons per square km (Gov. of Namibia, 2001). The region

has only one district (Oshakati), but comprises of three towns [Oshakati, Ongwediva and Ondangwa], which are all governed by municipality councils. The region is situated in the centre of the northwest and shares borders with the following regions: Oshikoto to the east, Omusati to the south and west Ohangwena to the north.

The economy of the region is mostly centred in its three fast growing towns, where many companies and industries have sprung up. The rural community relies on subsistence agriculture that includes cattle farming and small business enterprises. The economy was calculated at just over 1670U\$ per capita (Gov. of Namibia, 2001).

The majority (80%) of the community has access to public transport, however the remainder, 20% have some difficulties reaching a nearby health facility, either due to long distances or impassable roads caused by water during the rain season. (Gov. of Namibia, 2000). There are means of communication at all health facilities in the region; radio communication or telephone. The public telephone system is also being expanded to many places in the region. The mobile phone is almost reaching more than 60% of the population in the region.

The region has 148 educational facilities of which, 32 are pre school units, 107 are primary schools, 6 secondary schools, a technical college and a boarding school for the deaf and the blind. There is also a college of education and a university branch of the University of Namibia.

There are 15 health facilities; one intermediate hospital with a capacity of 750 beds, 4 health centres, 10 clinics and 24 outreach points. All health facilities have registered nurses offering the antenatal services. All health facilities are rendering antenatal services, but so far only Oshakati Hospital is providing PMTCT services. Other health facilities are just disseminating information to pregnant women and those interested are referred to Oshakati hospital to be enrolled in the programme.

### **1.3. PROBLEM STATEMENT**

Statistics obtained from the records of the ANC in Oshakati Hospital showed that only 21% of HIV positive pregnant women were identified in the programme. Between April and September 2002, 520 pregnant women visited the ANC for the first time and only 179 (43.42%) pregnant women agreed to be tested. Out of that number 149 (83,24%) pregnant women tested HIV positive while 30 (17%) tested HIV negative and 1(0,22%) pregnant woman was doubtful. In 2003, 790 women visited the antenatal clinic for the first time but only 163 (21%) pregnant women agreed to be tested. The total number of 99 (61%) pregnant women enrolled tested HIV positive while 64 (39%) pregnant women tested negative. The involvement of partners in the VCT (voluntary counseling and testing) is considerably low. The data shows that from March 2002 – September 2003, 35 (12%) male partners enrolled in the programme. However, out of 35 male partners tested, only 31 (88,5%) came back for post test counseling (MOHSS: 2003).

From the above statistics, it can be assumed that voluntary HIV counseling and testing services are under utilized. In spite of the prevailing opportunity i.e. high ANC attendance and hospital deliveries, the uptake of the programme has been low. This can also create an assumption that women have negative attitudes towards VCT during pregnancy. Therefore, the researcher was interested in the perceptions and experiences of pregnant women towards antenatal VCT. So far, no study has been conducted on the perceptions of pregnant women towards voluntary antenatal counseling and testing among pregnant women in Namibia. Consequently, the study results will be used as baseline information which will assist MOHSS to develop amicable strategies, which will improve the uptake of voluntary antenatal counseling and testing among pregnant women.

### **1.4. PURPOSE OF THE STUDY**

The purpose of the study was to compare the perceptions and experiences of pregnant women who opted out and opted in towards voluntary antenatal HIV counselling and testing in Oshakati Hospital in Namibia, in an attempt to gain insight into what the contributing factors to women's low uptake of VCT during pregnancy were.

## **1.5. OBJECTIVES AND AIM OF THE STUDY**

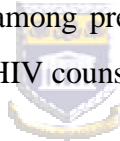
### **1.5.1. AIM:**

The aim of the study was to compare the knowledge, attitude, experiences and beliefs towards voluntary HIV counseling and testing among pregnant women who opt in against those who opt out of the voluntary antenatal HIV counseling and testing.

### **1.5.2. OBJECTIVES**

1.5.2.1. To identify groups of pregnant women who opt in and those who opt out regarding voluntary antenatal HIV counseling and testing.

1.5.2.2. To compare knowledge about vertical transmission of HIV and voluntary antenatal HIV counseling and testing among pregnant women who opt in against those who opt out of the voluntary antenatal HIV counseling and testing.



1.5.2.3. To compare the attitude towards voluntary antenatal counseling and testing among pregnant women who opt in against those who opt out of the voluntary antenatal HIV counseling and testing.

1.5.2.4. To compare the beliefs of pregnant women who opt in against those who opt out of the voluntary antenatal HIV counseling and testing towards testing towards voluntary antenatal counseling and testing.

## **1.6. DEFINITIONS USED IN THE STUDY**

**Opt in testing** : Acceptance of HIV test

**Opt out testing:** Declining of HIV test

**Perceptions:** Impressions or interpretations based on the understanding of something

**Experiences:** Events regarded as affecting one, the facts or processes of being so affected.

**Confidential:** Information shared during counseling must not be shared with others.

**Uptake of HIV:** Quantity of pregnant women enrolled in the PMTCT Programme

**PMTCT:** Prevention of HIV transmission from the mother to the child

## 1.7. OUTLINE OF THE STUDY



Chapter 1: Orientation to the study includes the introduction to the study, formulation of the problem, purpose of the study, objectives of the study, abbreviations and definitions of terms.

Chapter 2: A review of the relevant literature (global situation, HIV infection among pregnant women in Africa, women's risk of HIV infection and factors influencing the uptake of voluntary antenatal counselling and testing).

Chapter 3: The research methodology; study design, study sample, data collection procedures, data analysis procedures and ethical considerations overview will be discussed in this chapter.



Chapter 4: The methods used to analyse data, presentation of findings and interpretation of the results will be outlined in this chapter.

Chapter 5: Summary of findings, conclusions and recommendations will be presented in this chapter.



## **CHAPTER 2: LITERATURE REVIEW**

### **2.1. INTRODUCTION**

This chapter will review the literature related to this study. It includes the ideas and findings of other researchers on what is known about the research problem and what still needs to be researched. Literature in this study includes the global situation, the previous study undertaken to determine HIV infection among pregnant women in Africa, socio-cultural factors, factors contributing to the uptake of Voluntary Antenatal HIV Counselling and Testing, attitude of pregnant women towards VCT and stigma, discrimination and confidentiality.

### **2.2. Global Situation**

The MTCT is the most significant source of HIV infection in children under the age of 15 (UNAIDS, 2000:81). Since the beginning of the pandemic, more than 3 million children have died before their 15<sup>th</sup> birthday (UNAIDS, 2000). In 2001 alone, 580 000 children below the age of 15 died and the new infections in 2001 were 800 000 (UNAIDS, 2002). Ninety percent of them have been born in Africa. However, the number of cases in other parts of the world, especially in Asia and South East Asia appears to be rising (UNAIDS, 2002). MTCT occur during pregnancy, labour and delivery, or through breastfeeding. Without treatment, the risk of MTCT is estimated at 5-10% during pregnancy, during labour, delivery and through breastfeeding is at 10-20% (*SAfAIDS*, 2004).

The rising number of children places an enormous burden on both families and health systems. For many years, little has been known about PMTCT. Recently, important effective and affordable interventions have been developed to reduce the vertical transmission. The United Nations agencies recommended three pronged strategies to prevent transmission of HIV to infants:

- Primary prevention of HIV among parents to be

- Prevention of unwanted pregnancies among HIV infected women
- Provision of antiretroviral drugs to HIV infected pregnant women and their infants, safe delivery practices, and counseling and support for safer infant feeding practices. (WHO, 2001).

### **2.3. HIV infection among pregnant women in Africa**

Today, developing countries have reduced the rate of HIV transmission to babies by a combination of interventions, VCT and provision of antiretroviral therapy. The importance of HIV testing during pregnancy is to ensure that a mother and her child benefit from the therapies that prevent and treat HIV infections.

In Africa the HIV infection rate ranges from 20% to 30% among pregnant women tested anonymously at antenatal clinics (UNAIDS, 2002). In Botswana the median of HIV prevalence rate among pregnant women was 38, 5% in urban areas but in 2001, it had risen to 44, 9% while Zimbabwe climbed from 29% in 1997 to 35% in 2000 (UNAIDS, 2002). In Uganda the HIV prevalence rate has fallen from 29.5% in 1997 to 11, 5% in 2000 (UNAIDS, 2002).

In Namibia, the HIV prevalence rate among pregnant women is 22% (MOHSS, 2002). The prevalence ranges differently from region to region; for example: Katima Mulilo 43%, Oshakati 30% and Opuwo 9% (MOHSS, 2002). However according to the preliminary results of the 2004 sentinel surveillances survey, the results declined for the first time from 22% to 19,8% (MOHSS, 2004). The most sexually active age groups (15-43years) have also experienced decline in HIV prevalence.

It is more advantageous to integrate VCT with maternal health services in order to increase the uptake of VCT during pregnancy. In countries where PMTCT is integrated with maternal health services, the uptake is quite good (UNAIDS, 2002:130) and can also contribute to the reduction of HIV infections. In Thailand, the integration of PMTCT into

maternal and child health services reduced the MTCT transmission by 20% (MMR, 2001).

#### **2.4. Women's risk to HIV infection**

The study's focus is on the perceptions and experiences of pregnant women towards VCT, but it is also important to contextualise the women's vulnerability to the risk of HIV infection. Jackson (2002) states that all over the world the women's rights are violated every day because many cannot earn a living wage, or cannot afford basic necessities. Again, in many cultures they are not recognised. These can make them more vulnerable to infections and illnesses. There are several biological, economical and socio-cultural factors contributing to the increase of vulnerability of women to HIV. In Zimbabwe women cannot question their husband's extramarital affairs, because of the risk of violence or being subjected to abuse (Measuring et al 1999 cited in Nashandi, 2002; p. 16). Less than 25% of Zambian women agreed that a woman could not refuse to have sex with her husband even if he was known to be violent, unfaithful or infected with HIV (SAfAIDS, 2002).



In Namibia, women have limited abilities to protect themselves against HIV infections because they do not have control over their sexual activities. This is because they are economically depended on men (Nengomasha et.al, 2004). Several studies in Namibia show that women cannot initiate the use of condoms with spouses and often cannot refuse sexual advances of their partners (LeBeau et. al.1999; Iipinge and LeBeau. 1997).

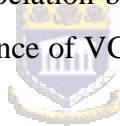
A study conducted by Fox (2002: 327) in Northern Namibia (cited in Nengomasha et al, 2004, p. 9) revealed that men decide when to have sex, but women have no right to refuse sex whether they are pregnant or menstruating. Ovambo women in Namibia are expected to play shy, may not initiate sexual activities and have to play a role of satisfying the sexual needs of their male counterparts (Becker and Hinz, 1997). As a result they cannot protect themselves from HIV – infections, which become a threat to the public. However,

recent data from the Windhoek area indicate that women who are educated and economically independent are now beginning to demand condom use for partners they suspect of being unfaithful (LeBeau, 2002:19).

## **2.5. Factors influencing the uptake of Voluntary Antenatal HIV Counseling and Testing.**

### **2.5.1. Knowledge about PMTCT/VCT during Pregnancy.**

VCT is an essential entry point to PMTCT services. WHO (2001) recommended that an opportunity should be given to all pregnant women to know their HIV status in order to save lives of hundreds of thousands of newborns. However, in many developing countries there are many factors hampering the uptake of VCT during pregnancy. Some literatures indicate that lack of knowledge hampers the uptake of VCT during pregnancy. A study conducted in the South West of Nigeria on clients' perspective towards antenatal HIV screening indicated that there is an association between uptake and knowledge (Fasubaa, 2001). It revealed that the high acceptance of VCT is only coming from pregnant women who are knowledgeable about HIV.



In Addis Ababa, Ethiopia, a study identified the factors that hampered the use of VCT services such as lack of appropriate knowledge, psychological, cultural and economic factors as well as lack of appropriate care and support services for the people living with HIV/AIDS (International Conference on AIDS, 2002). These factors need to be tackled in order to increase the uptake.

### **2.5.2. Male domination**

The women's choice of accepting the test is influenced by their partners. This was proven in Botswana and Zambia where the women feared to be seropositive because they would be blamed by their husbands for bringing the virus into the family (Jakson, 2002). This could be the reason why women do not have the courage to refuse sex. Therefore, the involvement of men from the beginning could increase the acceptance of the results.

LeBeau (2002b) found that many women do not enforce condom use or challenge their sexual partners when they believe these partners have been unfaithful because they fear violent reprisals from their sexual partners.

An exploratory study conducted in Uganda among pregnant women discovered that some pregnant women were unwilling to take the HIV test because they were concerned about the negative attitudes from the husbands if they happened to find out about their status and feared to be known being HIV positive (Pool et al, 2001). They decided not to take the test. It seems that women experienced male dominance. They cannot take the test without getting the go ahead from their partners. A qualitative study done in Dar es Salaam, revealed that women preferred to seek permission from their partners prior to testing in order to avoid violence (Horizons, 2001). A similar study showed that if husbands happened to know that their wives went for HIV test, the conflict would arise as a result. Women were also afraid to be abandoned by their husbands (Horizons, 2001). The study further revealed that the husbands who were asked for permission so that their wives could take the HIV test, refused. Those who went without permission got involved in conflicts with their husbands, and were even abandoned. (Horizons, 2001).

### **2.5.3. Attitudes of pregnant women towards VCT**

It is important to know the attitudes of pregnant women towards antenatal VCT. This may contribute to the success of the programme. At Ndola clinic in Zambia, a report revealed that after VCT services were introduced, community members chose not to be tested because they felt that VCT was a source of stress (Horizon, 2003). The implications of a positive test result for pregnant women are, therefore, enormous. Pregnant women drop out of the PMTCT programme for many reasons; including fear and denial of HIV, lack of partner support and poor quality care. In Zimbabwe pregnant women did not want to be tested because they could get high blood pressure and stress; their husbands could blame them for bringing the disease into the house, and divorced them (ICASA, 2003). In Botswana the reasons for refusal of VCT were physical violence from partners and fear of stigma and discrimination (Nyablade et al, 2001).

A study conducted on operational issues in preventing MTCT of HIV1 in Abidjian, Cote d'Ivoire has shown that the uptake of VCT was well accepted; however some left before counseling sessions commenced and the reason was unknown, though some were not counseled due to language barriers (WHO, 2001).

#### **2.5.4. Stigma, discrimination and confidentiality**

Stigma and discrimination associated with HIV and AIDS are great barriers to preventing further infections and providing adequate care, support and treatment (SA/AIDS, 2002). Being tested positive during pregnancy increases worries among pregnant women regarding the well being of their babies and stigmatization by the health workers, family members and the entire community. Interagency Coalition on AIDS and Development's report stated that the participation in prevention and treatment of HIV programmes, including VCT is hampered by social stigma, anger, depression and denial (Interagency Coalition on AIDS and Development, 2001). People may be discouraged from attending sites of a perceived stigma or attending a site known to be associated with HIV activities. This was proved by the report produced in South Africa, which confirmed the sentiment that pregnant women did not take VCT because of long waiting times, and people would see them (McCoy et al: 2002). The issues of confidentiality may affect acceptance of the HIV test. Most women do not want to take the test; they are afraid of stigmatization.

An exploratory study on attitudes of pregnant women towards antenatal voluntary counseling and testing for HIV among pregnant women conducted in rural south west of Uganda revealed that women feared to be tested because the nurses would refuse to care for them or kill them in order to reduce the infections (Pool, 2001). Another study conducted in Dar es Salaam, Tanzania on the implications of HIV voluntary antenatal counseling and testing found that a serious barrier to disclose the HIV results to partners is fear of a violent reactions by male partners and that HIV infected women are at increased risk of partner violence (Horizons, 2001).

A qualitative study conducted in Namibia on the experiences and coping strategies of women living with HIV/AIDS women who were interviewed revealed that people who tested HIV positive experienced various feelings after receiving the HIV results (Nashandi, 2002). The feelings included shock, fear, guilt and suicidal thoughts.

In Uganda, the attitudes of VCT for HIV among pregnant women in South-West Uganda were examined; the study result revealed also that they were not sure whether the nurses would keep their results confidential. The women did not accept the test because they thought that nurses would gossip about them and the story would spread into the community up to their partners (Pool, 2001). In Abidjan, women's reasons for not participating in the follow-up visits before starting the treatment were examined. The women said that they could not come for the test because of the attitude of the social workers and long waiting hours (Painter et. al, 2004). A qualitative study conducted in some selected areas in Namibia revealed that knowing one's HIV status, leads to loss of hope, discrimination and emotional shock (SIAPAC, 2003).



According to Jackson (2002:175) people fear that they can get HIV through normal social contact with an infected person. As a result the people with HIV have been thrown out of family houses, sacked from employment, denied access to services and excluded from all sorts of social gatherings and events. They had to endure the stigma, rejection and isolation in addition to their agony of facing a life threatening condition.

The HIV positive women felt that they were stigmatized with regard to their sexuality: HIV positive women should not engage in sexual activities and should not have children (SAfAIDS, 2002). Therefore, disclosure helps fight self-stigmatization, empowers and enhances self-worth. The only way of making progress against stigma and discrimination is to replace shame with solidarity; and fear with hope (SAfAIDS, 2002).



## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1. INTRODUCTION**

In this chapter, the process and methods used to conduct the study will be explained. It covers the following: the procedure used in selecting the participants for the interviews, study design, setting of the study, sampling design, study population, data collection and analysis, validity and rigour and ethical consideration.

### **3.2. Research design:**

A comparative descriptive study design was utilized to conduct this study. It allowed the researcher to compare the perceptions and experiences regarding voluntary antenatal HIV counseling and testing between the pregnant women who opted in and those who opted out.

The study was of qualitative nature. Qualitative research designs “focus on qualitative aspects (meaning, experience and understanding from the new point of view of the research subjects and in the context in which the acting takes place” (Brink, 1999: 119). Therefore the study was aimed to gain in-depth information by testing pregnant women’s understanding, views, attitudes, and experiences towards voluntary antenatal HIV counseling and testing. “Qualitative research approach values participants perspectives and seek to discover these perspectives” (Marshall & Rossman, 1995:39).

### **3.3. Setting of the study**

Namibia is located in the southwest part of Africa. It has a surface of 824 285 square kilometres with a population of 1,825 854 people, where females out-number men by 51% to 49% (NDHS, 2000). Namibia is a culturally diverse and a multi – ethnic society. It is divided into thirteen political regions. Oshana is the smallest of all the thirteen regions (5290 square km) with a population of 170 817 people. The region has only one intermediate hospital, Oshakati, with a capacity of 750 beds. Oshakati hospital is situated

in the north western part of Namibia in Oshakati district. The PMTCT programme is located at the ANC department of Oshakati hospital, where 3 full time HIV counselors as well as 4 doctors are working in turns for the programme control. The hospital is conducts the ANC services three times a week. Wednesday is for first visits, Thursday and Friday for follow-ups. The average of 120 pregnant women is seen for the first visit per month.

All pregnant women receive group counseling during their first visit. After the group counseling, they are expected to take the HIV test on a voluntary basis. Some take the test soon after the counseling session, while others go back to make a decision. After some weeks some come back for the test, but the rest choose not to; they decline. Those who accept the test are called pregnant women opted in and those who decide not to take the HIV test are called pregnant women opted out. Therefore the study participants interviewed had already received information about voluntary counseling and testing.



### **3.4. Study population**

Brink (1999:132) defines study population as the entire groups or persons or objects that are of interest to the researcher. The study population were the pregnant women attending antenatal services at Oshakati Hospital ANC clinic, and who visited this health facility during the period of the study, September 2004. Therefore, Oshakati hospital antenatal clinic was selected as the area of the study. “Study population is the entire set of objects and events or group of people which is the object of research and about which the researcher wants to determine some characteristics” (Bless & Higson-Smith, 1995: 95).

### **3.5. Sampling**

Purposive sampling was used to select the participants. This is a type of non-probability sampling in which subjects are selected because they are identified as knowledgeable regarding the subject under investigation. The investigator establishes certain thought to be representative of the target population and deliberately selected subject according to

the criteria (Burns & Groove, 1993; Dempsey & Dempsey, 1996; Bailey, 1997). The study sample was drawn from pregnant women who attended antenatal services at this hospital between the age of 15 - 45. The study sample comprised 6 focus group discussions (FGD) of pregnant women who opted in and those who opted out. Each group consisted of six pregnant women. Since there was already a system in place, which is registering pregnant women, those who opt in and out, that register was used to select the participants. The nurses at ANC clinic assisted in selecting the potential participants for the proposed study.

The characteristics of the study sample of the participants were:

Pregnant women who opt in

Pregnant women who opt out

Attending ANC at Oshakati Hospital

Speaking Oshiwambo

Voluntarily willing to participate in the study

Come for follow-ups



### **3.6. Data collection:**

Data were collected from the 13 -30 September 2004 in Oshakati Hospital ANC clinic. To collect data, focus group discussion (FGD) interview guide (Appendix I) was used as an instrument. A focus group is defined by Krueger (1994:6) as a carefully planned discussion designed to obtain perceptions of a defined area of interest in a permissive, threatening environment. The key principle in the formation of the focus group is homogeneity, which is determined by the purpose of the study.

Each FGD consisted of six pregnant women, which lasted for at least one (1) hour, was used to compare perceptions, attitudes, beliefs and experiences of pregnant women who opted in and opted out of voluntary antenatal HIV counseling and testing. 3 FGD were for women who opted in and the 3 other FGD were for those who opted out. The aim of

FGD was to produce the thick in-depth information on perceptions, attitude, beliefs and experiences towards VCT. Pregnant women shared their experiences and how they perceived VCT. The researcher asked probing questions until saturation of information was reached. It could enable the interviewees to organize their own descriptions with emphasis on what they themselves thought was important in their situation, in their own words (Kvale, 1983:193).


The PMTCT and ANC nurses assisted the researcher in identifying the participants. The researcher gave the sister in charge a copy of the inclusion criteria to study participants, which was utilized to select the participants from the clients who were attending ANC clinic. The discussions were conducted after the purpose of the study was explained, and written consent obtained (Appendix II). The discussion was conducted in the Oshiwambo language and later transcribed into English. The discussions were recorded on a tape recorder; while at the same time notes were also taken. A quiet and isolated room was provided where the interviews took place.



### **3.7. Data analysis**

“Data analysis is the process of bringing order, structure and meaning to the mass of collected data” (Marshall & Rossman, 1995: 111). Immediately after the completion of the discussions, the data were analyzed. Thematic content analysis was used to analyze the data. Content analysis is the process of identifying, coding and categorizing the primary patterns in the data.” (Patton, 1990:381). The taped information was listened to and transcribed. The transcriptions were read carefully, jotting down ideas as they came to mind. A list of all topics was made and similar topics were clustered together to form categories. The topics were turned into categories and subcategories. The results of the groups were compared and analyzed. The systematic comparison during discussions between two groups on all topics was done. The predetermined themes of interest are as follows: Knowledge about vertical transmission, knowledge about VCT during pregnancy, attitudes of pregnant women towards VCT, stigma, discrimination, confidentiality and disclosure of HIV results.

Table: Categories and Sub-categories of themes of perceptions and experiences of pregnant women regarding voluntary antenatal counseling and testing.

1. Category: Knowledge about vertical transmission
Sub-category: Causes of Vertical transmission
Prevention of vertical transmission
2. Category: Knowledge about Voluntary Antenatal HIV Counseling and Testing
Sub-category: Understanding of Voluntary Antenatal HIV Counseling and Testing
Awareness of availability of Voluntary Antenatal HIV Counseling and Testing
Source of information
Benefits of Voluntary Antenatal HIV Counseling and Testing
3. Category: Attitude towards Voluntary Antenatal HIV Counseling and Testing
Sub-category: Reasons for accepting of HIV test
Protect mother and baby
Receive treatment
Behavioural change

Sub-category: Reasons for declining of HIV test
Attitudes of husbands
Attitudes of health workers
Fear of death and to be known with HIV
Committing suicide
4. Category: Confidentiality, Stigma and discrimination
Disclosure of HIV results
Reactions of family members
6. Category: Desired improved Voluntary Antenatal HIV Counseling and Testing
Sub-category: Need for education
Male involvement
Compulsory test
Need for health workers to keep results confidential

### 3.8. Validity and Rigour

Rigour was ensured through credibility, transferability, dependability and confirmability (Health System Research Reader, 2004). Trustworthiness is the method of ensuring rigour in qualitative research (Guba & Lincoln in Krefting, 1991: 215)

**Credibility:** Krefting (1991:215) defines credibility as the truth obtained from the discovery of human experience as it is lived and perceived by informants. In this study, credibility was maintained through prolonged engagement, persistent observation, triangulation, peer debriefing and member checks. The researcher built trust by explaining to the participants the aim of the research, utilization and dissemination of the information and its use. The researcher kept the daily notes and included the non verbal reactions of the participants.



**Transferability** refers to how the research finding can be generalized or transferred from the representative sample to the whole population. The transferability was ensured through the provision of thick description. Because of the sensitive nature of the topic, the FGD were carried out to compare and gain in-depth information regarding VCT.

**Dependability:** The research methodology was fully explained. The field notes and the cassettes were kept safe in a locked cupboard. The study supervisor directed the researcher to prevent ambiguities.

**Confirmability** was achieved by tape recording the raw data and field notes taken by the researcher. The categories, interpretations and final report were produced.

### **3.9. ETHICAL STATEMENT**

Burns & Groves (1993:89) write that conducting the research ethically goes from the identification of the research topic to the publication of the study results.

Ethical clearance was obtained from the University of Western Cape Ethical Committee and permission to proceed while approval was given by the Ministry of Health in Namibia. The study was explained to the participants and a written consent, in the vernacular, Oshiwambo and English was obtained from each respondent on a voluntary basis.

Respondents' dignity, privacy and confidentiality were assured throughout the study. Due to the sensitive nature of HIV, anonymity was ensured and the notes and tapes were kept in a safe storage. The information provided was treated confidentially for the purpose of the study only. Co-operation of the respondents was ensured during the study. The interviewees were assured that they were free to ask questions or terminate their participations in the study at any time.

Chapter 4 will present an analysis and discussion of the participants' perceptions, knowledge and experiences in breast-feeding women living with HIV/AIDS. The responses they encountered will guide the policy makers on supporting their needs.

## CHAPTER 4: RESULTS AND DISCUSSIONS

### 4.1. INTRODUCTION

In the previous chapter, the methodology followed in conducting this study was discussed. In this chapter analysis of data will be discussed according to identified themes, categories and subcategories.

The focus group discussions were conducted within the period of three weeks, 13 – 30 September 2004. All the participants met the inclusion criteria: pregnant women who opt in and opt out, attending antenatal services in Oshakati Hospital ANC clinic. Six focus group discussions were conducted. The participants consisted of 36 pregnant women: 18 were pregnant women who opted in and 18 were pregnant women who opted out. Of the 36 participants 16 were married and 20 were not married.

The semi structured FGD guideline was used to collect the data as well as probing techniques during discussions. Data gathering was based on the personal expressions of the women. The FGD's were conducted within the Oshakati Hospital ANC clinic. The venue was conducive. One isolated room was allocated where discussions were conducted. There was no noise or disturbances experienced.

**Table: Demographic Profile of the study participants**

Characteristics variable	Number of participants	Percentages of participants
<b><u>Age</u></b>		
16 – 20yrs	5	13.(%
21-25 yrs	10	27,8%
26-30yrs	5	13,9%
31-35yrs	6	16,7%
36-40yrs	7	19,4%
41-47yrs	3	8,3%
<b><u>Marital status</u></b>		
Single	20	55,6%
Married	16	44,4%



<b><u>Education level</u></b>		
No schooling	1	2,8%
Grade 6	4	11,5%
Grade 7	3	8,3%
Grade 8	2	5,6%
Grade 9	5	13,9%
Grade 10	11	30,6%
Grade 12	8	22,2%
Tertiary Education	2	5,6%
<b><u>Occupation</u></b>		
Teacher	1	2,8%
Pastor	1	2,8%
Cashier	2	5,6%
Seller	2	5,6%
Housekeeper	1	2,8%
Security	1	2,8%
Clerk	4	11%
Unemployment	24	66,7%
<b><u>Parity</u></b>		
Primigravinda	15	41,7
Para 2	14	38,9%
Para 3	3	8,3%
Para 4	2	5,5%
Para 6	1	2,8%
Para 8	1	2,8%

The majority of the participants, 27%, were in the age group of 21-25 years. However, age did not have any direct bearing on the analysis of the data. In relation to marital status, 44,4% of the participants were married. With relation to education 72,2% participants had some form of secondary level education and 5,6% have tertiary education. Interestingly, 66,7%, women were unemployed and they financially depended either on their husbands or parents.

The results of the FGD have been reported using the following 6 main categories of themes and further divided into sub-categories:

1. Knowledge about vertical transmission
2. Knowledge about Voluntary Antenatal HIV Counseling and Testing
3. Attitude towards Voluntary Antenatal HIV Counseling and Testing
4. Confidentiality, stigma and discrimination
5. Desired improved Voluntary Antenatal HIV Counseling and Testing

Each discussed by the 2 main groups of participants, that is, those who opted in and those who opted out of the HIV test during pregnancy.



## **PREGNANT WOMEN WHO OPT IN AND OPT OUT OF THE HIV TEST**

This section describes data from groups of pregnant women who opted in and opted out of the HIV test during antenatal visits. The participants participated in the FGD had already received information when they visited the ANC for the first time. This was about their follow up visits. There was already a register which registering all pregnant women attending ANC. In the register it indicate that the pregnant women had enrolled in the PMTCT programme or not.

### **4.2. Knowledge about vertical transmission**

#### **4.2.1. Causes of vertical transmission**

Generally the participants who opted in were aware that vertical transmission occurred transmitted through three main ways: during pregnancy, during delivery and through breast milk. They had demonstrated clear knowledge that HIV is transmitted through breast milk. They indicated that there were two feeding options which the pregnant women would consider if they were HIV positive: exclusive breast feeding for the first four months or formula feeding. They felt that those who could afford to buy formula milk could use formula feeding, since breastmilk contained HIV. The following statement confirms:

*“The nurses informed us that women should exclusively breastfeed, and no water must be given to the baby until it is four months old. After that women should stop breastfeeding and start giving the baby other types of food”.*

This is in line with the study conducted in rural South Africa on acceptability of perinatal, voluntary HIV counseling and testing and interventions, to reduce mother to child transmission of HIV, which revealed that a large majority of pregnant women knew that MTCT occurs in utero, and through breastfeeding, and a smaller proportion knew that transmission also occurs around the time of birth (Wilkinson, 2004). Pool, et al (2001) reveal that most of the pregnant mothers in rural south-west Uganda were aware that vertical transmission occurs during delivery because of blood contact.

The participants who opted in knew that vertical transmission can be caused through unprotected sexual intercourse. They discouraged pregnant women not to have sexual intercourse during pregnancy until they stopped breastfeeding. They said:

*“If a pregnant woman is practicing unprotected sex, she can transmit HIV to her baby. It is good if she does not have sex during pregnancy and while she breastfeeds in order to protect her baby. The men are not reliable”.*

The majority of participants who opted in felt strongly that if a woman had sores on her nipples she could infect her baby. This is an indication that they had knowledge about the causes of vertical transmission.

*“I am very sure that if you are breastfeeding your baby and you have sores on your nipples – if the child sucks the blood coming from the nipples, which can cause HIV, you can infect your baby”.*



According to Jackson (2002), if the mother develops mastitis, a painful inflammation of a breast, an abscess or a cracked, bleeding nipple, she must feed the infant only with the other healthy breast and seek urgent treatment for the condition.

It is highlighted in the literature review by a study carried out in the South West of Nigeria on clients' perspective towards antenatal HIV screening, that there is an association between uptake and knowledge (Fasubaa,2001). It further reveals that the high acceptance of VCT is only coming from pregnant women who are knowledgeable about HIV.

The participants who opted out were aware that vertical transmission is caused from mother to child. They were not specific or knew more causes of vertical transmission like those who opted in. They only knew that a mother can infect her baby through breast milk. This was evident in the following account:

*“The HIV infected mother who breastfeed the baby can infect her child. It is better to give soft porridge, “etete” (thin porridge) or formula milk”.*

Even though the participants who opted in demonstrated the knowledge about causes of vertical transmission, there were misconceptions surrounding its causes. Like those who opted out some participants who opted in also believed that a mother and baby shared the same blood.

*“The mother can infect the baby with HIV because the mother and the baby share the same blood. Infection can also take place at birth, when the umbilical cord is cut”.*

Some participants who opted out believed that if the mother had sores on the mouth or all over the body, she could infect her baby.

*“If the mother has sores on the mouth or all over her body, she can infect her baby*



Similarly, in Abidjan pregnant mothers felt that a mother could pass the virus to the unborn baby because they shared the same blood. It was felt that contamination between the mother and the baby had already happened, so there was no hope of saving it (Painter et al, 2004). This is in line with findings by Pool, et al (2001) which revealed that most of the pregnant mothers in rural south-west Uganda indicated that a baby could get infected at birth when the umbilical cord was being cut.

It appears that there are misconceptions among women who opted out, which need to be cleared. Misconceptions can be barriers that lead to low uptake of the HIV test. More emphasis needs to be placed on the causes of vertical transmission.

#### **4.2.2. Prevention of vertical transmission**

The participants who opted in were aware that vertical transmission can be prevented if pregnant women, whose blood tested HIV positive, receive antiretroviral drugs during the

onset of labour and the baby is also given after delivery. They felt that having unprotected sex with an infected man while breastfeeding may lead to HIV transmission to the mother, who in turn can infect the baby. They recommended that mothers should practice safer sex during pregnancy and breastfeeding in order to prevent vertical transmission.

*“I will not never have sex with my husband during pregnancy till I stop breastfeeding in order to prevent HIV transmission to the baby. Sometimes you might be negative because the men are not reliable you will be infected during that time although you were negative”.*

The participants who opted in mentioned that mothers should choose the feeding practice such as total replacement feeding (use formula feeding) from the start or exclusively breastfeed for the first four months, and then abrupt weaning at four months to reduce vertical transmission.



The participants who opted out stated that vertical transmission could be prevented, if pregnant women took ARV drugs. However they did not know when to take them. This probably showed that the information obtained was inadequate and unclear. They heard about the PMTCT messages, but it could be that messages were not clear to them. The following are examples:

*“You can get ARV drugs when you are pregnant and continue taking them for 6 weeks after delivery”.*

*“The drugs will also prolong the lives of the pregnant women”.*

This is congruent with the findings from Ipinge et al (2004) which indicated that knowledge about prevention among women is low and unclear to enable them to adequately protect themselves. The same study stated that some community members do not know details about the mode of transmission of HIV. This can be the contributing factor to low uptake of VCT.

Surprisingly, participants who opted out felt that it is risky to have sex during pregnancy, but after breastfeeding women can just continue having unprotected sex in order to please their husbands. They only want to protect the baby but not themselves (mothers). After breastfeeding, they cannot refuse sex, because it is not culturally accepted although they know that they will put their lives in danger. Therefore, they preferred not to be enrolled in order to avoid problems. They also felt that even if they were enrolled in the programme they would face problems such as rejection, especially when they choose between two feeding options. The options are either exclusively breastfeeding for four months and start with weaning from four month and stop breastmilk but only formula milk from birth.

Interestingly, participants who opted out mentioned that some traditional practices should be avoided in order to prevent HIV transmission from the mother to the baby. They gave an example:

*“Sometimes, when a child is sick, it is believed that the mother is the cause. As a result, a small part is cut off the vagina of the mother and the blood is given to the child to lick. They put some blood on the hands of the baby. This practice should be discouraged”.*

It was noted from the study that there are some cultural practices which lead to the spread of HIV from mother to the child. These should be considered and discouraged when giving information on HIV/AIDS. The Aids Law Unit (2000) stated that the cultural and traditional practices that militate against the effective preventive action should be identified and steps should be taken to address them.

Interestingly, both groups were equally knowledgeable that mixed feeding is likely to transmit HIV to the baby after birth. They prefer HIV positive women to choose between the following two feeding options: exclusive breastfeeding for the first four months and after that the mother can stop breast feeding, and introduce weaning feeding or formula

feeding in order to prevent transmission of HIV after delivery. The following statements are accounts of this:

*“But I heard that you should only give bottle milk or breast milk, if you mix food there is a big chance of infecting the baby”.*

*“What is really good is that mothers should not give any other food, only breastmilk in order to prevent vertical transmission”.*

According to Sexton, (2000: 3) an infant may become infected with the HIV virus during pregnancy (risk of infection is 5 – 10%) labour and delivery (risk is 10 – 20%), and through breast-feeding (risk is thought to be 10 – 20%) in untreated women who continue to breast-feed after the first year. According to Coutsoydis et al., 1999 (cited in Jackson, 2002:161) exclusive breast-feeding has been shown to have a lower risk of HIV – transmission than mixed feeding.



Although the levels of knowledge among pregnant women who opted in is good, information campaigns targeting the misconceptions should be reinforced to both groups. All the groups did not mention all the preventive strategies of vertical transmission which are recommended by WHO. These are: primary prevention of HIV among parents-to-be, preventing unwanted pregnancies in women with HIV, terminating pregnancy where this is legal and preventing HIV transmission from HIV-positive women to their infants (Jackson, 2002).

### **4.3. Knowledge about voluntary antenatal HIV counseling and testing**

#### **4.3.1. Understanding of voluntary antenatal HIV counseling and testing**

The participants who opted in had good understanding of voluntary antenatal HIV counseling and testing. They described it as the voluntary willingness of pregnant women to go for HIV test during pregnancy without being forced

*“It is when a pregnant woman decides to go for the test on a voluntary basis and when nobody is forcing them to take the test”.*



It is good for the women to know about the existence of the service in order to make use of it. It was highlighted in the literature that the awareness can lead to the acceptance of the HIV test (Pool, 2001).

The participants who opted out knew about voluntary antenatal counseling. However the study revealed that they were not aware that after the HIV test,(if the results are positive) one could be referred to the infection control clinic for the blood to be tested for CD 4 cells count. The participants who opted out further explained that antiretroviral drugs were available at some hospitals and private pharmacies but were expensive. The availability of antiretroviral drugs that were freely available at hospitals was not well known to this group.

In Namibia, the procedure is, as soon as pregnant women tested HIV positive they will be referred to the CDC (Communicable Disease Clinic) for CD 4 cell count test. If the CD4 cell count is 300 or below, then one should start with the ARV treatment (MOHSS, 2003).



#### **4.3.2. Awareness of availability of Voluntary antenatal counseling and testing**

The participants who opted in knew that voluntary antenatal HIV counseling and testing was available at some selected health facilities. They knew of many locations where to get an HIV test, with almost all of them mentioning a health facility and others such as new start centres, youth centres and private doctors.

*“You can go to the big hospitals, because smaller hospitals are not doing it. Private doctors, youth centres and New Start Centres also offer this service.”*

In contrast, the majority of the participants who opted out mentioned that they were not aware of the availability of this service. They did not hear or had no idea about the existence of the voluntary antenatal counseling and testing service until they were informed when they started antenatal services. They further explained that they only

knew that pregnant women would be tested for three specimens such as blood group, hemoglobin and syphilis.

*“Yes I know that a pregnant woman can only be tested for the three bloods things: blood group, hemoglobin and for syphilis. But, the day I started the ANC, it was the first time I heard that they would test us for HIV on a voluntary basis.*

*“Like me, I have not heard about it before. I am from Ombalantu, Omatelekela village. I just happened to hear about it when I came to start the ANC. This thing is new to me”.*

The lack of knowledge may hinder an individual from taking effective action. One cannot expect people to accept the test if they are not aware of the programme. Therefore, the campaign needs to be conducted to create awareness in the entire community.

#### **4.3.3. Sources of information**



The group who opted in received information regarding voluntary antenatal HIV counseling and testing from the hospitals/clinics, radio, TV, community meetings done by homecare givers and booklets. These were reflected by the respondents as follows:

*“I heard about voluntary antenatal counseling and testing over the radio, hospitals and from the people from Catholic Aids Action and TKMOAMS who are doing house to house visits”.*

It can also be assumed that sources of information are inadequate at some places. Ipinge et al (2004) indicated that most sources of information were only available in urban areas in Namibia. Campaigns should be planned to target the entire population.

#### 4.3.4. Benefits of voluntary antenatal HIV counseling and testing

The participants who opted out knew the benefits of voluntary antenatal HIV counseling and testing. Overall, these participants felt that the voluntary antenatal HIV counseling and testing was beneficial. They knew what the benefits of HIV test were: to have healthy babies, change sexual behaviour, and get drugs that prolong their lives. It also appeared that participants who opted in had more information than those who opted out. Their opinions are described below:

*“It is good to be tested. I can be able to know my HIV status and I can have a healthy baby even if I am HIV positive, because I can get Nevirapine that will protect my baby not to be infected”.*

*“I can start using a condom with my partner, especially if I am negative and he is positive. My husband might sleep around with other women, if I know my status; I will not sleep with him without using a condom”.*



This is in line with the Interagency Coalition on AIDS and Development report which says that more than 90 percent of all the persons with HIV have never been tested and are not aware that they are infected. Those who know that they are HIV positive are likely to make informed decisions with respect to sexual practices ([www.icad-cisd.com](http://www.icad-cisd.com), 2001).

Although the participants who opted out knew that it was good to be tested during pregnancy in order to save the lives of their babies, they felt that they would not do that. They felt that they were not yet ready to receive their results because it would cause physical and emotional abuse by their husbands and families. They stated:

*“It is good to know where you are standing so that you can receive drugs that help the baby. I am not ready to go for the HIV test”.*

It was found in Dar es Salaam, Botswana and Zimbabwe that women prefer not to tell their partners because of fear to be blamed or physically violated (Jackson ,2002).

#### **4.4. ATTITUDE TOWARDS VOLUNTARY ANTENATAL HIV COUNSELLING AND TESTING**

##### **4.4.1. Reasons for acceptance of HIV test**

###### **4.4.1.1. Protect the mother and the baby**

Participants who opted in indicated that one of the reasons of accepting the HIV test was that they wanted to protect themselves and the lives of their babies. They wanted to have healthy babies and to receive treatment to prolong their lives.

*“I can have a healthy baby even if I am HIV positive”.*

This sentiment was supported by Fasubaa et al (2001) in a study conducted in South West Nigeria which assessed pregnant women’s opinions on the issue of antenatal HIV screening. The study indicated that the women who accepted the test did so because they wanted to prevent the HIV transmission from the mother to the baby. The women revealed that accepting the HIV test was beneficial to the mothers, babies, close family members and community.



The participants who opted out knew that the baby’s life would be protected. They thought that the drugs that the pregnant women received at the onset of labour would prolong their lives. However, the information was not clear to them, whether they would also benefit from this programme. For example:

*“The drugs which the pregnant women received during the onset on labour will help the baby not to be infected and prolong the life of the mother”.*

It is clear that the women who opted out had inadequate information. They seemed to mix information on drugs that prevent vertical transmission and those that prolong their lives Highly Active Antiretroviral treatment (HAART). It is very necessary for women to be informed about all the benefits regarding PMTCT. The benefits are: reducing the vertical transmission, changing sexual behaviour, receiving HAART; and preventing infections and re-infections. This is in line with the Interagency Coalition on AIDS and Development report which stated that health workers should be skilled in counseling

women and their partners about condom use and changes in behaviour to promote safe and responsible sexual practices ([www.icad-cisd.com](http://www.icad-cisd.com): 2001).

#### **4.4.1.2. Receive treatment**

It was very interesting to note that only the group who opted in demonstrated that they wanted to know their status and if they tested positive they would also be referred to the Communicable disease clinic (CDC) and receive antiretroviral treatment in order to prolong their lives. They knew that HIV is not curable; but lives can be prolonged. They explained:

*“It is good. I know that it will not cure me but I can be able to know my HIV status in order to start treatment for HIV to prolong my life”.*

According to the study conducted by Fasubaa (2001) the women take the test because they would like to obtain the treatment that will prolong their lives.



#### **4.4.1.3. Behavioural change**

Some participants who opted in indicated that behavioural change was also one of the factors that motivate people to go for HIV test in order to make correct decisions. They indicated that they intended to adopt safer sexual behaviours after the HIV test. These include: abstaining from sex and condom use if they were positive, to prevent re-infections. They were confident that if they happened to test HIV negative, they would start using condoms with their partners since the men did not seem reliable.

*“If I know my status, I will not sleep with my husband without using a condom especially if I am negative and he is positive. Men are naughty. My husband can sleep around with other women without using a condom and when he comes home he would do it without a condom”.*

*“It will help me to take correct decisions. If I tested positive, I will not have sex anymore because of re-infection. If the test is*

*negative, I will tell my husband to change his behaviour not to be infected”.*

This appeared showing that the group that opted in had good knowledge about the whole concept of the benefits of VCT. This is consonant with what was found by the UNAIDS (2001) report which revealed that, studies in different countries show a remarkable decrease in the rate of transmission from an HIV positive partner to the negative partner when both know their HIV status (Jackson, 2002). The study conducted in Dar es Salaam proved that couples describe the testing as a preventive measure used before one engages in an unprotected sexual intercourse as well as in marriage and pregnancy (Horizons, 2001). In Kampala, the youth went for the test in order to adopt safer sexual behaviour after the HIV test (Horizons, 2001).

The participants who opted out mentioned that one of the reasons, which could motivate pregnant women to take the test, was that they would do it out of concern about their own health and previous sexual behaviours.

*“If a woman is concerned because she had unprotected sex she may think of going to take the test. A person can go for the HIV test if she realized that her health is going down”.*

A study conducted in Zambia, Kenya and Spain indicated that the youth seek the HIV test because they are worried about their own health and that of their partners (Horizon, 2001). The study further indicated that there is no point of having the blood drawn if you do not have the disease or suspect that you have HIV. The study conducted in Zambia revealed the same that pregnant women took the test because they wanted to confirm their HIV status and were also worried about their health (ICASA, 2002).

Some participants who opted out expressed their feelings that they could not take the test because they knew that if they tested HIV positive; they would not be able to discuss safe sex or introduce condom use to their partners. They felt that as Ovambo women, they were not allowed to discuss or to refuse sex with their husbands although they knew that

it would be risky. They strongly believed that they would not introduce condom use to their husbands, for fear of being accused of having sexual affairs with other men.

*“I cannot tell my husband to use a condom although I know that he might be infected with the HIV virus, otherwise he will think that I have affairs with other men”.*

This belief is documented in several studies conducted in Namibia, which confirm that women cannot necessarily initiate the use of condoms or refuse sexual advances of their partners (LeBeau et al, 1999; Iipinge and LeBeau. 1997). However, recent data from the Windhoek area indicate that educated and economically independent women are now beginning to demand condom use with partners they suspect of being unfaithful (LeBeau 2002,19). From the discussions, it was clear that participants who opted out seemed to accept that men should have more girlfriends. A study conducted in Ohangwena Region indicated that it was generally accepted that a real man was someone who had many girlfriends and many children (Nengomasha et al, 2004).



#### **4.4.1.2. Reasons for non-acceptance of HIV test**

##### **4.3.2.1. Attitude of husbands**

The participants who opted out agreed that they could not take the test because they were afraid of their husbands who might hear about their results. They were very much concerned about their husband's reaction. They strongly believed that their husbands would react badly and start blaming them for bringing the disease home. They also felt that their husbands could leave them or kill them if they happened to find out that they tested HIV positive. They were very sure about the consequences. They knew that their husband would run away. In most cases women suffer the consequences, especially when they are financially dependent on their husbands.

*“My husband is intimidating me! For example one day I told him of my intention to go for the test. He said: “If you go there (hospital) and tested positive, you should not come back home. If you come here, I will kill you and then kill myself”.*

*“Mmm! We fear to be blamed by our husbands and their families. I will also be scared to tell my husband, because he will not accept the test. After delivery he may not name the child. If you go for the test you must expect anything, life or death. Men are crazy. They can even kill you and then kill themselves”.*

Similarly, Fasubaa et al (2001) found out in Nigeria that women did not take the test, because they were afraid of the reactions from their partners. This probably indicates that the imbalance of power between men and women is what places women at risk of violence from male partners and limit their ability to take preventive measures. The study conducted in Dar es Salaam stated that if husbands happened to know that their wives went for HIV test, a conflict would arise as a result. Women were also afraid to be abandoned by their husbands (Horizons, 2001).

The participants who opted out felt that they could not tell their husbands; otherwise the story would spread to other people especially to their family members. They preferred not to tell them to avoid inconveniences such as physical violence and also bad words from the husband’s relatives. They could not take the test without getting the go ahead from their partners. This was proved by all women; married and single. They would rather consult their parents, or someone they trusted to keep the results confidential. They mentioned the following:

*“I told my husband once that I would go for the HIV test. He said that he would kill me if I went for the test. Therefore I did not go because I know that he will kill me”.*

It seems that women experienced male dominance. The women fear domestic violence because of their HIV status. Generally, women have limited ability to protect themselves against HIV infections and they do not have control over their sexual activities. Ovambo women in Namibia are expected to act shy, may not initiate sexual activities (Beker, 2002:2) and are subordinated to their husbands. They cannot protect themselves from



HIV infection, which has become a threat to the public. It seems that the physical and emotional abuse experienced by the women prevent them from discussing and taking the test. Because of male dominance, women can hardly take decisions on their own. It was found in Dar es Salaam that the husbands who were asked for permission so that their wives could take the HIV test, refused and those who went without permission became involved in conflicts with their husbands, and were even abandoned (Horizons, 2001).

However, the majority of participants who opted in had expressed confidence and trust in their husbands that they would support them and keep test results secret. They knew that their husbands would understand the situation. Some had already discussed with their partners to be tested and permission to go ahead was granted.

*“I will tell my husband because he is the only one I trust in my life. In my case I discussed it with him and he agreed”.*

However, some participants who opted in found it difficult to negotiate the HIV test with their husbands because they did not know how they would react. On the other hand they felt that it was still good to know their status in order to make correct decisions. They also felt that it was their right. Those who discussed with their partners did not experience any violence. Their partners allowed them to go for the test. Even the pregnant single women who opted in indicated that they would ask for permission, first from their partners. It seems that they trusted their partners more than other people.

*“Ahaa! You must be careful. Informing your husband is not easy, you should expect anything life or death. That is why you hear many women being killed by their boyfriends because they disclosed their status to them, but I felt that it is my right to know my status in order to make right decisions”.*

A qualitative study done in Dar es Salaam, revealed that women preferred to seek permission from their partners prior to testing in order to avoid violence (Horizons, 2002). This is in line with the study conducted in Zimbabwe, which revealed that only 30 out of 600 women had managed to bring their partners to be tested (Baggaley, 2000). In

Namibia only 11% men came for the test (MOHSS, 2003). A similar situation was also revealed in South Africa where less than 50% of HIV - positive women felt able to tell anyone regarding their status and of these, only a minority could discuss it with their partners (Jackson, 2002:148).

#### **4.4.2.2. Attitude of health workers**

It was very interesting to note that only participants who opted out mentioned that, one of the main reasons for not accepting the test during pregnancy was because of the attitude of health workers. They described the nurses as rude, who did not keep people's results confidential. They were not supportive. They strongly believed nurses revealed the results of the clients to others, hence many of them were not reliable and they could not be trusted. They felt that this was one of the factors driving people away from VCT. They explained the attitudes of health workers as follows:

*“Sometimes people are scared because some nurses are shouting at us. They gossip also, and tell people in the community about our results”. Counseling sometimes is not done properly. If a nurse is informing you about positive results, you start crying, but she would say, ‘I am not the one who gave you the virus’. They are not supporting us”.*

*“Yes, some nurses do talk. The story will spread. They do gossip and tell people in the community about the results”. They further added that: “If the counselors do not talk, where do the rumours come from?”.*

According to Pool et al (2001) women in Uganda did not accept the test because they thought that nurses would gossip about them and the story would spread into the community until they reach their partners ears. They were not sure whether the nurses would keep their results confidential. In Abidjan, women said that they could not do the test because of the attitude of the social workers and long waiting hours (Painter et al, 2004). Health workers need to be informed and equipped with skills to communicate effectively with their clients.

Some participants who opted out further explained that even if women did not reveal their status, people could also suspect them, if they see them sitting at the PMTCT clinic. They would start observing whether their mood would be normal or not. Mood normally changes because of the concerns and worries. They explained:

*“If people see you going into room 6 they will start suspecting that you are HIV positive. They will just observe your mood to see whether it has changed or not. If it changes then that is a sign that you are HIV positive”.*

Research results revealed that the location can also hamper the service. Similarly, it was found among pregnant women in Abidjan that they were bothered by the location where tests were taken. Everyone who came to that clinic knew what was going on. As soon as a pregnant woman was seen coming from that office, it was known right away that she was sero-positive (Painter et al, 2004).



The majority of participants who opted in were confident that nobody would find out unless they disclosed their status themselves. They expressed their satisfaction with the attitudes of the health workers. They were confident that their results would be kept confidential and nothing would be leaking from the PMTCT clinic. They further explained that the nurses would give them support even after their results were made known, especially when tested HIV positive.

*“I do not think that the people will find out. In the counseling office you are there only with the counselor, they will not find out. They do keep information confidential”.*

*“Yes, if my results are good then I will be happy and tell everybody, that I am AIDS free, but if my results are bad I will not tell anybody. The mood will change. I will blame myself and won't even talk to them. The people will start then suspecting something”.*

The law in Namibia makes provision that the persons living with HIV/AIDS have the right to confidentiality and privacy about their health and HIV status. Information about HIV status may not be disclosed to the third party without the consent of the person living with HIV/AIDS, unless legally required (AIDS LAW UNIT, 2000).

#### **4.4.2.3. Fear of death and to be known as HIV positive**

Some pregnant women who opted out had a problem regarding the test, because they were scared of the positive result. They revealed that it would bring death nearer. They also did not want to be known as the people living with HIV/AIDS. The assumption that can be drawn from the statements is that those who opted out think that, not knowing what is actually wrong is less anxiety provoking than knowing the actual problem, which may create anxiety. Therefore, for them it was better not to be tested in order to avoid stress or even provoke it. They explained:

*“It is bad if a person does not accept the results. She will become more concerned, worried and she will die soon because of the stress. It will probably raise many thoughts, especially if you see AIDS patients suffering in the hospital. It is not good. They are suffering a lot. The pain is the problem. I cannot imagine undergoing the same problems of pain. It makes me mad and confused”.*

*“I don’t care about the test. “Tashiya ka Shilondelwa. Shoka tashi ya nashiye” (If something is coming, it does not need provocation. It will come). I came in the world to go, not to stay. This disease has come to kill people not animals ...(laughing) ”.*

The concern given above is reflected by the study conducted in Zimbabwe, that revealed that pregnant women would develop high BP and stress if they were found to be HIV positive (ICASA, 2002). Fasubaa et al (2001) also indicate that the women could not take the HIV test because they were afraid of the outcome of the results. In Ndola district, Zambia, women perceived VCT not as a source of important information about

one's health and options, but rather as a source of stress (Horizons, 2003). Vetten et al (2001:19) cited by Nashandi (2002) explains that women who kept their status secret experience "stress and guilt", since they were aware of the consequences of their secrecy. Baggaley et al (1998) reported about the early negative reactions among clients at Kara Counseling and Training Trust in Lusaka. For example, many people who did not want to be tested gave the following reasons: combination of hopelessness, stigma and denial (Jackson, 2002). *SAfAIDS* (2004) report stated that the shame of getting the HIV positive results has often led many women to choose not to disclose their status or even seek assistance such as counseling and treatment.

In contrast, during the discussions the participants who opted out had concerns about their children who would be left behind. They did not trust their husbands with the responsibility of taking care of the children. They preferred not to go for the test in order to remain oblivious to their HIV status.

*"People are afraid of death, especially when they have children. They are asking themselves: Who is going to take care of my children when I am gone? You know that men don't care about children. We women are born to take care of the children, unlike men. These are the things that we are concerned about".*

The concern above echo the sentiment reflected in studies conducted in some selected areas in Namibia that confirms that often knowing one's HIV status, is often associated with loss of hope, discrimination and emotional shock (SIAPAC, 2003).

#### **4.4.2.4. Committing suicide**

It was very interesting to note that among both groups, who opted out and opted in, some women had similar feelings that if their results were positive they would kill themselves. They further stated that to be HIV positive, one was almost dead and there was no future. This is evident from the following accounts:

*“Fear to be tested HIV positive. After the test you will not be the same. You will start thinking about many things. If the result is HIV positive, then I will kill myself. Especially when you look at people who are sick, they are really suffering. One can just decide to kill herself”.*

In Namibia, suicide has been regarded as a solution to problems by some people especially after receiving the results. Nashandi (2002) expressed the same sentiment that people who tested HIV positive experienced various feelings after receiving the HIV results. The feelings included shock, fear, guilt and suicidal thoughts.

#### **4.5. CONFIDENTIALITY, STIGMA AND DISCRIMINATION**

##### **4.5.1. Disclosure of HIV results**

The majority of the participants who opted in were confident that they would disclose their status to their partners. They further indicated that they were willing to ask their husbands if they were ready to receive the results. The main reasons to disclose the result to their partners were to get support and care and to be free from worries about the HIV. They trusted their husbands and were sure that they would keep results secret. They also felt that they would inform their pastors in order to get support and to be counseled. They would also be prayed for.

*“I will tell my partner. If you tested positive, you will be free, and you can even talk about your status and people will support you, but if you are not tested you are always concerned about your health”.*

*“I will tell the pastor of my church. He will pray for me. If one day I don't feel good and start thinking about bad things I will go to him to pray for me. He will support me”.*

It was found in Dar es Salaam that women trusted their community members such as priests who helped them to disclose their HIV sero status and to counsel their husbands to go for HIV test (Horizon report: 2001). Similarly, in rural South Africa pregnant women

disclosed their HIV status to their family members or partners who proved to them to be cooperative and supportive. (Nashandi, 2002).

In contrast, the majority of the participants who opted out were not in favour of informing their partners about the outcome of their HIV results. It would be difficult to tell their partners because of fear of being confronted with physical violence due to their HIV status. They feared of being killed and chased away. They would only inform their husbands if they tested negative, because should the result be positive, their reactions would be scary.

*“Some of the women are not really having a good relationship with their husbands. They are staying in one house, but everyone is doing whatever they want. HIV positive results in a relationship like this will never be accepted. A man can beat you up and tell his relatives, then the story spreads”.*

This is line with the study conducted by Nashandi, (2002:28) which reveals that women who are HIV infected would not disclose their status because they are afraid of being abandoned, rejected, or disowned by their families.

Another similarity that was raised by some participants who opted in and opted out was that they preferred to tell their parents, friends or family members they trusted would keep results confidential. Some preferred not to tell anybody because they did not trust anybody. Even their mothers would tell everybody about the results. They explained how difficult it is:

*I will not tell my husband, it is better to tell my parents. They will advise me on how to behave. I will not tell my partner, because he will kill me. He warned me already that I should not go for the test, otherwise he will kill me”.*

*“I will not even tell my mother that I tested positive. She will tell other people that she is not sleeping well because “Kauna” is HIV positive. You know, most mothers can*

*understand only if you are married because they usually blame husbands for infecting their wives. But some of us are not married, they will say: “It is your own doing because you were sleeping around and now you are sick. Just go where you got the disease from. It is better to keep quiet”.*

Nashandi's (2002) study indicates that the participants do not feel pressured to reveal their status to their partners, but instead to family members. They prefer the partners to find out for themselves in order to avoid physical and emotional abuse. According to Pool et al (2001) the women in the study were worried of disclosing their status to their partners because it could lead to separation, abuse and abandonment. Horizon's report (2001) revealed that in Zambia the majority of women who shared their results with their partners were given support and understanding. In some sub-Saharan Africa countries, such as Zambia and Uganda, AIDS counselors have adopted the concept of shared confidentiality among the relevant family members and even local chiefs and other appropriate community members (Jackson, 2002: 209).



In contrast, participants who opted out felt that this programme was done as kind of forcing people to be tested although they were not ready. Therefore, some participants were not sure who they would tell if they were to be tested. Pregnant women need to be prepared well in advanced regarding what should be done. They should get a chance to think before they take decisions.

*“Mmm, may be I will tell my husband but I don't know that I will be tested. I just came to attend ANC and the nurses told us that we will be tested for HIV. If you decline then they will refer you to one nurse who will ask why you don't want to take the test. This is kind of forcing people. But at the VCT centre, people talk to you and ask you whether you would like to take the test or not. If you don't they will leave you. Like in my case I refused, but I don't think that those who took the test will come back for their results”.*



Horizon (2001) revealed that women preferred to get early explanations before the test in order to prepare themselves.

#### **4.5.2. Reactions from the family members**

Both participants who opted in and out were concerned that the family members would react negatively. They would be blamed and discriminated against by their family members, especially the unmarried ones. Therefore, it was difficult to inform their family members because they were afraid of being stigmatized and abused. Pregnant women who opted out indicated that the unmarried women would suffer more, because they would be verbally abused by their family members and accused of being whores. They further explained that they would only understand if the infected women were married. They felt that if they disclosed their status they would be rejected by everybody. They decided that to keeping quiet was a better solution.

*“The relationship between you and your family will break.  
They will stigmatize and discriminate against you. Everyone  
in the house will know about your status”.*

This is supported by the findings of Nashandi (2001) which indicate that people living with HIV experienced negative responses on a daily basis from family members: they teased them and gossiped about them. As a result, a lot of fights occurred among the family members. Another study in Addis Ababa, Ethiopia, identified the factors that hampered the use of VCT services such as lack of appropriate knowledge, psychological, cultural and economic factors as well as lack of appropriate care and support services for the people living with HIV/AIDS (ICASA, 2002).

Participants who opted out further explained that it was high time for people stopped discriminating against others because of their status. More people were infected; therefore there was no need to discriminate against each other.

*“It is like that but I don’t think that in the future people will continue talking or blaming others because nowadays every house is affected by this disease.*

In Namibia people living with HIV are protected. There is a policy in place that provides people living with HIV/AIDS the rights to dignity and privacy (2002). This means that people living with HIV should be treated with respect and their status should be kept confidential unless the patient gives the permission.

#### **4.6. SUGGESTIONS FOR IMPROVEMENT**

Participants were requested to point out areas that need improvement.

##### **4.6.1. Need for education**

Interestingly, nearly all participants who opted in and opted out said that there should be training programmes to educate women and men on the issues of PMTCT. Some participants were not aware of the PMTCT programme, they just happened to know about it when they started the ANC services. If men were also educated, they would allow their partners to go for the test freely.

*“Nurses should educate the people to let them understand the benefits of VCT. The community meetings should be for both men and women because here people are really talking about the advantages of the HIV test during pregnancy and in general. The men don’t like to attend such meetings, they are left behind. At the end of the day they will end up preventing their wives to go for the HIV test”*

*“People really need to be educated in order to overcome their fear. Now they are very much scared about how their husbands will react.”*

Participants who opted out suggested that education was needed because the information regarding the programme was not clear enough. They found that accessibility to the

information of PMTCT was found to be a problematic area. They felt that community education was needed in order to know what to expect before one started with ANC.

*“Health educators should inform us well, because the message is not really clear that we will be tested when we are coming to the ANC. If you are clean, it is OK but if you are not then it will really bring death nearer / closer. It is very difficult to take a decision in a short time if you did not think about it before”.*

They hope that the training will educate the women to know the importance of VCT so as to clear the myths and misconceptions towards voluntary antenatal counseling and testing. They want to see more information giving sessions on PMTCT especially VCT.

#### **4.6.2. Male involvement:**

Pregnant women who opted in and out felt that the involvement of partners in the VCT was needed in order to reduce the fears among pregnant women for them to come freely for the test. They also felt that partner communication should be encouraged so that they discuss these issues in order not to blame each other. Education should also include men because they are the ones who do not allow women to take the test. They should be educated in order for them to support their wives and also take the HIV test themselves. This could reduce stigmatization and violence against women.

*“The pregnant women should discuss the VCT with their husbands at home and go together for testing. If that happens men will no longer blame women for the results”.*

*“It is also better to let men understand the issue of testing because they are the ones who are not allowing us as women to be tested or not to come for our results”.*

This is inline with the guideline of the PMTCT in Namibia that encourages pregnant women to be routinely counseled and tested for HIV infection at their first ANC visits, and their sexual partner(s) should be tested as well (MOHSS, 2004).

#### **4.6.3. Compulsory test**

Pregnant women who opted in suggested that it should be compulsory for all pregnant women to be tested for HIV during pregnancy in order to reduce HIV prevalence rate among children.

*“All pregnant women should only be tested whether they like it or not in order for them to be helped. The time they come to deliver, they will find their results at the maternity department for them to receive the drugs. Drugs will help their babies and reduce deaths”.*

The group who opted in further explained that the situation will improve because currently there are many hospitals that are offering this service. In the past only bigger hospitals used to do it.

*“We are happy, because, now most of the hospitals are offering HIV tests. Earlier, only some hospitals used to do it and people were willing to be tested but the services were not available. In some cases those who wanted had probably difficulties to travel long distances because of financial constraints.*

#### **4.6.4. Need for the health workers to keep the information confidential**

The participants who opted out suggested that nurses should try not to reveal the HIV status of the clients. Currently, according to some of the participants, nurses seem to reveal information to the community. This makes people unwilling to take the test because the nurses will tell everybody. They further said that people who are working at the counseling office should be selected or take an oath to keep all the information confidential.

*“People should not be told to disclose their status. They should not be forced to tell their families”.*

*“At counseling offices, there should be reliable people. Everything discussed should remain in the office. If it continues like, this none will use that service any more.*

According to the MOHSS policy on HIV/AIDS confidentiality, notification, reporting and surveillance (2002), health workers should keep patients' information to themselves and the health workers who breach legal and ethical duty to maintain confidentiality will be subjected to professional disciplinary measures. This policy should be fully implemented. Therefore, making counseling and testing as a routine ANC service can help reduce the stigma associated with both HIV and HIV infection.



## **CHAPTER 5: SUMMARY OF FINDINGS AND RECOMMENDATIONS**

### **5.1. INTRODUCTION**

In the previous chapter the findings of the study were presented and discussed in detail. In this chapter the summary of the study and findings is presented. Conclusions are also drawn on which recommendations are based. This study focused on a group of pregnant women attending antenatal clinic in Oshakati Hospital. It dealt with the perceptions and experiences of pregnant women who opted in and out regarding voluntary antenatal counseling and testing.

### **5.2. SUMMARY OF FINDINGS**

The study first attempted to assess the knowledge and perceptions of pregnant women towards voluntary antenatal counseling and testing. It identified some encouraging aspects as well as underlying shortcomings of the MTCT programme.

The results of the study suggested that there was some uncertainty surrounding vertical transmission, and the women's understanding of HIV/AIDS was low. All participants should have known the causes and the preventive measures of vertical transmission. Only some participants had some knowledge, but most of them, especially those who opted out did not. There are misconceptions that need to be cleared. This emphasizes a need for greater community education and reinforcement of this information through MTCT programme. Education will provide communities the opportunities especially women to explore and ensure greater understanding.

The study revealed that the women who opted in and out were aware of what voluntary counseling and testing was, its accessibility as well as its benefits. Participants indicated that the benefits of voluntary antenatal counseling and testing were:

- the promotion of an early uptake of care and support services,
- changes in behaviour to prevent infecting others with HIV/AIDS
- to prevent re-infection with HIV/AIDS. It also identified various sources of information that are addressing the issues of VCT during pregnancy.

On the other hand, the results demonstrated that not all women were aware about the existence of this service. The hope is for the sources of information to be seriously looked at. Planning is needed so that information is able to reach the entire population, but not to be limited in certain areas only.

The results further indicate that women who opted in and out demonstrated that their knowledge about the benefits of voluntary antenatal counseling and testing was almost the same. This is good, therefore the information that has already been gained need to be reinforced. On the other hand, those who opted out just need encouragement to take the test. They do not need to fear anything, since the people infected with HIV/AIDS may remain healthy for many years even without ARV therapy, as long as they are looking after their health.

A major concern that has been identified in the literature review and confirmed by the results of the study is the negative attitudes of health workers that prevent women from taking the tests. The women were concerned that nurses would reveal their HIV status. They thought that they would be stigmatized in the community if their HIV status was revealed. It was indicated in various studies that women could not take HIV test due to negative attitude of health workers.

It also became evident that women were not willing to take part in the testing programme because of negative reactions from their family members. The participants explained why they would not disclose their results. They were certain that they would not get support from families regarding basic necessities such as shelter, food etcetera. Unmarried women were said to be more stigmatized than married ones, because society regarded them as irresponsible and wild.

The results of the study show the reasons pregnant women gave for not taking the test, amongst others: fear to be blamed for bringing the HIV in the family, rejection, intimidation and harassment. This led to women feeling responsible for the disease.

It was evident that women have limited control over their sexual activities and prevention of infections. This was indicated in the literature that women tend not to practice safe sex although they know about their status. The imbalance of power between women and their partners is what places women at risk of HIV and limits their ability to take preventive measures.

The study also revealed how some participants showed their willingness to adopt safe behaviours such as abstaining from sex during pregnancy and using of condoms. In Kenya, Kampala and Uganda, women gave the same sentiment that they went for the test in order to change their behaviour (Horizons, 2001).

The study results revealed that education and male involvement are needed as a way of improving the VCT services. This will help women to gain support and cooperation from their male partners. In her study, Nashandi, 2002 (Stebel's study,1993) confirmed that the participants appeared to have adequate knowledge about the preventive measures, but without adequate personal support and cooperation from their male partners, nothing will really change.



It was evident that the environment was not conducive, since Room Six was known as an HIV office. Everyone who visited that room could be suspected of having HIV. This is causing stigma among the community. Consequently, the integration of VCT in the maternal health services would help to reduce barriers of testing such as stigma, discrimination and isolation or abandonment among women who are seeking the voluntary antenatal counseling and testing services.

As of now, voluntary antenatal counseling and testing is not offered at many places. This means that some women cannot benefit from PMTCT interventions. Making the voluntary antenatal counseling and testing more available and accessible can help to break the cycle of silence, myths and misconceptions. It may also assist in the normalization of having an HIV test.



Another reason that was given was fear of being known to live with HIV. This is an interesting point, because one would expect any client to be more anxious to know their HIV status rather than stay away and remain ignorant. This is so because of the belief that if one is ignorant of having an illness, depression and quick deterioration in one's general health status will be prevented.

The result also indicated that the women did not get sufficient time to think whether they would take the test or not, since they were expected to take the HIV test at the first antenatal visits. The counseling needs to improve. Some participants revealed that women were reluctant to take voluntary antenatal counseling and testing because they were not the ones benefiting.

It was also revealed that some women might commit suicide if they happened to know of their HIV status. This was shown in various studies that the women would kill themselves if they test HIV positive. Some studies indicate that the risks and the likelihood of suicide is 36 times greater in HIV infected individuals.



It was evident that the distances would also hamper the uptake of the HIV test. Therefore, expanding this service would provide more opportunities for pregnant women to exploit.

### **5.3. RECOMMENDATIONS**

The recommendations of the study are based on the suggestions made by the participants during the focus group discussions.

- Stigma and discrimination has been identified as a barrier to the acceptance of voluntary antenatal counseling and testing. Therefore, there is a serious call for interventions, which deal with violence against women and men over women's sexualities in communities. The men should be educated about the importance of voluntary antenatal counseling and testing and PMTCT in particular. It will encourage partners to share the burden of HIV status and reduce stigma and

discrimination. This cannot change overnight; therefore it remains a challenge to society at large to change their perceptions.

- Community education about the importance of voluntary antenatal counseling and testing and PMTCT should be strengthened. It will encourage community involvement and the reduction of stigma and discrimination in the society. It will also improve the knowledge about the benefits of voluntary antenatal counseling and testing. Information and education empower individuals to make correct decisions concerning health care.
- Since the health workers are the important support system for pregnant women with HIV/AIDS, they should keep the information regarding the HIV results confidential and provide care and support to those who are HIV positive.
- Voluntary antenatal counseling and testing should be available and accessible at all health facilities that are offering antenatal services. It would allow all pregnant women to benefit from the available interventions designed to reduce HIV infection among children.
- Effective communication and cooperation should be encouraged between partners. It will increase the male involvement in the programme and ensure that men know the importance of voluntary antenatal counseling and testing. Male involvement will allow both partners to accept and share their results (negative or positive results).
- Cultural practices should be discouraged in order to prevent HIV transmission from the mother to the baby.
- A policy on stigma and discrimination should be effectively implemented. It will help to reduce and eliminate the stigma and discrimination attached to HIV/AIDS.
- Voluntary antenatal counseling and testing services should be extended to all hospitals, health centres and clinics that are offering antenatal services.

#### **5.4. CONCLUSIONS**

Voluntary counseling and testing enable individuals to make informed choices regarding the HIV test and take appropriate action. It was evident that participants were able to state the benefits of voluntary counseling and testing. They also gave their views why there was a low acceptance of voluntary antenatal counseling and testing. It is important to remember that individual's views vary. As such their voices may give insight on how to design and deliver appropriate interventions that meet the needs of women and their families.

This study also provides useful information about voluntary antenatal counseling and testing. Constraints which hindered the implementation of voluntary antenatal counseling and testing were identified, and recommendations to facilitate the application of principles were made.



## 6. REFERENCES

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**APPENDIX 1**  
**INTERVIEW GUIDE**

**THE PERCEPTIONS AND EXPERIENCES OF PREGNANT WOMEN  
TOWARDS VOLUNTARY ANTENATAL HIV COUNSELING AND  
TESTING AT OSHAKATI HOSPITAL IN OSHANA REGION, NORTHERN  
NAMIBIA**

**VENUE:** OSHAKATI HOSPITAL ANC AND PMTCT CLINIC

**SERVICE ATTENDED:** ANTENATAL CARE AND PMTCT SERVICES

**DEMOGRAPHIC DATA**

Age

Parity

Marital status

Occupation

Education level



**A. KNOWLEDGE ABOUT VERTICAL TRANSMISSION**

1. What do you think are the causes of HIV from the mother to the baby?
2. What can be done to prevent vertical transmission of HIV?
3. How can pregnant women know whether they are HIV infected?

**B. VOLUNTARY ANTENATAL HIV COUNSELING AND TESTING**

4. Do you know what voluntary antenatal HIV counseling and testing is? Where did you hear it from?
5. Where do you receive information regarding VCT during pregnancy?
6. Where can you go to be tested?
7. What is good / what is not good as far as voluntary HIV counseling and testing is concerned?

**C. ATTITUDE TOWARDS VOUNTARY ANTENATAL HIV COUNSELING AND TESTING**

8. In your view what makes pregnant women to be tested / not to be tested?

**D. CONFIDENTIALITY AND DISCLOSURE OF HIV STATUS**

9. If you tested positive, who will you tell? Why?  
10. Who would you consult before being tested? Why?

**E. STIGMA AND DISCRIMINATION**

11. If you get tested, do you think that people will find out? Why?  
12. What do you think, your partner or family members will react if they happen to know that you want to go for the HIV test?  
13. What do you think your partner or family members will react if they happen to know that you tested HIV positive?

**F. SUGGETIONS FOR IMPROVEMENT**

14. What do you think should be done to get more people tested?

THANK YOU FOR YOUR TME AND PARTICIPATION IN THE DISCUSSIONS.

**APPENDIX II**

**CONSENT FORM**

**PERCEPTIONS AND EXPERIENCES OF PREGNANT WOMEN TOWARDS VOLUNTARY ANTENATAL HIV COUNSELING AND TESTING IN OSHAKATI HOSPITAL IN NAMIBIA.**

I, ----- am conducting a study about **Perceptions and experiences of pregnant women towards voluntary antenatal HIV counseling and testing in Oshakati Hospital in Namibia.** I will appreciate your participation in this study. The discussion will take at least one (1) hour to complete. Whatever information you provide will be kept strictly confidential and will not be viewed or discussed by other people. Your identity will not be made known to other people.

You may ask questions during the discussions if you wish. You can refuse to answer any questions without giving any reasons and you are also free to withdraw at anytime during the interview if you don't want to continue anymore.



Do you agree to participate in this study?

Yes/No

Signature of the interviewer: -----

Date:                                 /         /         /

Signature of the interviewee: -----

Date:                                 /         /         /

Thank you for your participation in this study.

**APPENDIX III**

Enquiries: K. Toivo  
Tel: 065-220740/220675  
Fax: 065-221338/220303

P.O. Box 971  
Oshakati  
18 July 2004

The Permanent Secretary  
Ministry of Health and Social Services  
Private Bag 13198  
Windhoek  
NAMIBIA

**RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY  
IN OSHAKATI DISTRICT.**

Dear Dr. K. Shangula

I am a distance Master Degree student at the University of the Western Cape. As a requirement for the study, I am expected to do a research study. The site is Oshakati Intermediate Hospital. The title of the study is, “The perceptions and experiences of pregnant women towards voluntary antenatal HIV counseling and testing at Oshakati Hospital in Oshana Region, Northern Namibia”. The target population will be pregnant women who opt in and opt out of HIV counseling and testing.

Therefore, I humbly request your good office to grant me permission to conduct my study. Included is a copy of the research proposal, which has been approved by the Research Committee at the University of the Western Cape.

Your kind response will be highly appreciated.

Yours sincerely

.....

A.K. TOIVO

## APPENDIX IV

Enquiries: K. Toivo  
Tel: 065-220740/220675  
Fax: 065-221338/220303

P.O. Box 971  
Oshakati  
18 July 2004

The Regional Director  
Private Bag 5538  
OSHAKATI

### **RE: APPLICATION FOR CONDUCTING A RESEARCH STUDY IN OSHAKATI DISTRICT**

Dear Dr N.T. Hamata

I am a distance Master Degree student at the University of the Western Cape. As a requirement for the study, I am expected to do a research study. The site is Oshakati Intermediate Hospital. The title of the study is, “The perceptions and experiences of pregnant women towards voluntary antenatal HIV counseling and testing at Oshakati Hospital in Oshana Region, Northern Namibia”. The target population will be pregnant women who opt in and opt out of HIV counseling and testing.

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Your kind response will be highly appreciated.

Sincerely yours.

-----  
A. K. TOIVO

## APPENDIX V

Enquiries: K. Toivo  
Tel: 065-220740/220675  
Fax: 065-221338/220303

P.O. Box 971  
Oshakati  
18 July 2004

The Senior Medical Superintendent  
Intermediate Hospital Oshakati

### **RE: APPLICATION FOR CONDUCTING A RESEARCH IN INTERMEDIATE HOSPITAL OSHAKATI.**

Dear Dr. K.V. Amutenya

I am a distance Master Degree student at the University of the Western Cape. As a requirement for the study, I am expected to do a research study. The site is Oshakati Intermediate Hospital. The title of the study is, “The perceptions and experiences of pregnant women towards voluntary antenatal HIV counseling and testing at Oshakati Hospital in Oshana Region, Northern Namibia”. The target population will be pregnant women who opt in and opt out of HIV counseling and testing.

Therefore, I humbly request your good office to grant me permission to conduct my study. Included is a copy of the research proposal, which has been approved by the Research Committee at the University of the Western Cape.

Your kind response will be highly appreciated.

Yours sincerely

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A. K. TOIVO