

An evaluation of the attitudes and understanding of HIV/AIDS  
that underpins the decision to comply or not comply  
with prenatal HIV/AIDS testing.

BY

MOTLATSI QUEEN KEKANA

SUPERVISOR

PROFESSOR CHARLES MALCOLM

The logo of the University of the Western Cape, featuring a classical building facade with columns and a pediment, with the text "UNIVERSITY of the WESTERN CAPE" below it.

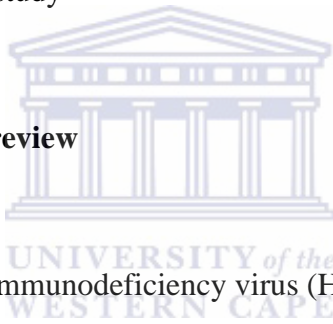
UNIVERSITY of the  
WESTERN CAPE

Full-thesis in fulfillment of the requirement for the degree of M.A in Research  
Psychology in the Department of Psychology, Faculty of Community and Health Science,  
at the University of the Western Cape

May 2007

Key word: Human Immuno-Deficiency Virus, Acquired Immuno-Deficiency Syndrome,  
HIV/AIDS test, Pregnant women, Qualitative, Stigma, Isolation, Discrimination, Social  
support, Compliance.

| <b><u>CONTENTS</u></b>   | <b><u>PAGE</u></b> |
|--|--------------------|
| Abstract   | i                  |
| Acknowledgement  | iii                |
| <b>CHAPTER ONE: Introduction</b>                                   | <b>1</b>           |
| Background information leading to HIV/AIDS testing stigma problems | 1                  |
| Statement of the problem   | 5                  |
| Purpose of the study   | 8                  |
| Significance of the study  | 8                  |
| Aims of the study  | 8                  |
| Conclusion   | 9                  |
| <b>CHAPTER TWO: Literature review</b>                              | <b>10</b>          |
| Introduction   | 10                 |
| The human immunodeficiency virus (HIV)                             | 10                 |
| HIV/AIDS testing   | 11                 |
| Value of HIV/AIDS testing  | 13                 |
| Stigma   | 14                 |
| <i>Depression</i>  | 16                 |
| <i>Suicide</i>   | 17                 |
| <i>Anxiety disorder</i>  | 17                 |
| <i>Post traumatic stress disorder (PTSD)</i>                       | 17                 |
| Perceived stigma within family structure Towards HIV/AIDS testing  | 18                 |
| Health promotion and the prevention of HIV/AIDS                    | 22                 |



|   |    |
|---|----|
| Programmes for HIV/AIDS-positive pregnant women                       | 23 |
| <i>Reducing mother to child transmission HIV/AIDS (MTCT)</i>          | 25 |
| <i>Reducing MTCT while breastfeeding</i>                              | 27 |
| HIV/AIDS test policy  | 28 |
| <i>Draft national policy on testing for HIV/AIDS</i>                  | 28 |
| <i>Circumstances under which HIV testing may be conducted</i>         | 28 |
| <i>Informed consent, pre-test counseling and post-test counseling</i> | 29 |
| Behavioural theories  | 31 |
| <i>Health belief model</i>  | 32 |
| <i>Social cognitive (or learning) theory</i>                          | 32 |
| <i>Social learning theory a applied to HIV/AIDS</i>                   | 33 |
| <i>Theory of reasoned action</i>                                      | 41 |
| <i>Trans theoretical model</i>  | 43 |
| <i>AIDS risk reduction model</i>                                      | 44 |
| <i>Innovative theory</i>  | 44 |
| <i>The Precaution Adoption Process Model (PAPM)</i>                   | 46 |
| Conclusion  | 47 |

### CHAPTER THREE: **Methodology**

|                         |    |
|-------------------------|----|
| Introduction            | 48 |
| Qualitative methodology | 48 |
| <i>Instrument</i>       | 49 |

|  |    |
|--|----|
| <i>Participants</i>                                    | 51 |
| <i>Procedure</i>                                       | 52 |
| <i>Data Analysis</i>                                   | 53 |
| <i>Familiarization and Immersion</i>                   | 53 |
| <i>Inducing themes</i>                                 | 54 |
| <i>Coding</i>  | 54 |
| <i>Elaboration</i>                                     | 55 |
| <i>Interpretation and checking</i>                     | 55 |
| Reflexivity  | 55 |
| Ethics   | 57 |
| Conclusion   | 58 |
| <b>CHAPTER FOUR: Results of the research</b>           | 59 |
| Introduction   | 59 |
| Knowledge of HIC/AIDS test                             | 60 |
| <i>Non-adhering pregnant women to HIV/AIDS test</i>    | 60 |
| <i>Adhering pregnant woman to HIV/AIDS test</i>        | 62 |
| Attitudes towards HIV/AIDS testing                     | 64 |
| <i>Non-adhering pregnant women to HIV/AIDS Testing</i> | 64 |
| <i>Pregnant women who adhered to HIV/AIDS testing</i>  | 66 |
| Barriers towards HIV/AIDS testing                      | 70 |
| <i>Stigma</i>  | 70 |
| <i>Isolation</i>                                       | 73 |



UNIVERSITY of the  
WESTERN CAPE

|  |     |
|--|-----|
| <i>Discrimination</i>                  | 75  |
| <i>Family support</i>                  | 78  |
| Belief system towards HIV/AIDS testing | 81  |
| Conclusion                             | 83  |
| CHAPTER FIVE: <b>Summary</b>           | 84  |
| Recommendations                        | 87  |
| Limitations of the study               | 89  |
| Conclusion                             | 89  |
| REFERENCES                             | 91  |
| Appendix A                             |     |
| Consent Form                           | i   |
| Appendix B                             |     |
| Interview guide                        | ii  |
| Appendix C                             |     |
| Interviews                             | iii |



## ABSTRACT

This study aimed to explore the attitudes to HIV testing among a group of black, low socio-economic status pregnant women from Gugulethu, South Africa. The key research interest was to evaluate the attitudes and understandings of HIV/AIDS that underpin the decision to comply or not comply with prenatal HIV testing. Theories of health behaviour concur that the extent to which an individual will engage in a given health behaviour, such as HIV test compliance, will be a function of the extent to which a person believes she is personally susceptible to the particular illness and her evaluation of the severity of the consequences of contracting the disease. The present study focused on the attitudinal and cognitive factors that differentially mediate compliance/non-compliance with HIV/AIDS testing in a sample of expectant mothers presenting at the maternity obstetric unit (MOU) at Gugulethu day hospital. Ten HIV testing compliant and ten HIV testing non-compliant women were interviewed with respect to their compliance/non-compliance decisions. It was expected that certain attitudinal factors would mediate the decision processes of the sample. The results indicate that social stigma, perceived discrimination, anticipated isolation, and expected gender violence on disclosure of HIV positive status were the key perceptions that discouraged the non-compliers from accessing the HIV testing service. The compliers also harboured such apprehensions but these were outweighed by their views that their unborn children would benefit, in the long-term, from their accessing the test outcomes and consequent treatment regimens. Further, recognized that life-sustaining treatment would be available for both themselves and their children if they tested HIV positive. Attached greater value to the benefits of childbearing than the negative impact of anticipated stigmatization and ostracization. They also had

greater confidence in guarding their test status from others. Enhanced knowledge of HIV/AIDS was not a factor that promoted compliance. The findings suggest that MOU testing programmes factor in the strong stigma fears of attendees and that pre-test counselling directly address these fears and behavioural strategies to manage disclosure of test status in an attempt to increase HIV testing compliance rates.



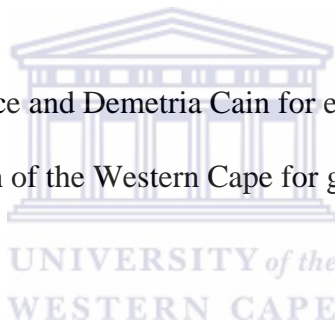
## Acknowledgement

I wish to direct my words of appreciation and gratitude to my supervisor Professor Charles Malcolm. Who at all times extended his kindness to accommodate and improve my skills on my academic writing. Not forgetting his effort to search for scholarship towards my studies. Confidence that he had in me. good Mentor that he has been. Thank you so much.

I would like to thank my two beautiful girls, Thato and Boitumelo for the support they have given me and appreciation they have shown while I was writing this Thesis.

My appreciation to Renee Pearce and Demetria Cain for editing my thesis

Thanks to Department of health of the Western Cape for giving me permission to conduct the study at Gugulethu MOU.



Thanks to Gugulethu MOU Sister Jam jam for providing me with a space to conduct the study

Lastly thank my spiritual counsellor Lenah Lebelo

Above everything thanks to GOD who is the author of my life, and that he has made it possible for me to be still living and achieving what I have achieved.



# CHAPTER ONE

## 1 Introduction

In chapter one there will be an exploration of the conditions that influenced the decision to research on pregnant women's compliance and non-compliance to HIV/AIDS test. There are however identified matters that encouraged the subject in question. Reasonable intentions to conduct the study are indicated. Briefly eluded the significance of the study and lastly pointed out the direction it will follow in achieving objective for the study.

## 1.2 Background of the problem

Since the commencement of the HIV/AIDS pandemic more than twenty-five million adults on the African continent have been infected. More than half of them have been women, and it's calculated that as many as 1 million children in Africa have been infected through mother-to-child-transmission, (UNAIDS,2005).In South Africa HIV/AIDS has however reached an alarming new level, with estimated 10% of the population now infected with HIV/AIDS virus. A medical survey of 17,000 women attending pre-natal clinics confirmed that South Africa has the highest rates of infection in the whole world, (UNAIDS, 2005). Medical interventions now offer the potential of reducing this vertical transmission that is particularly salient in developing countries. These interventions, which focus on the antenatal administration of anti-retroviral drugs, have as an implicit programme component, the identification of HIV-positive women via systematic HIV-counselling and testing among pregnant women.

The process of attempting to test pregnant women raises many challenges in developing country settings, e.g. observational studies that had been conducted in East Africa have indicated that HIV-positive pregnant women are less likely to return to collect their test results than those uninfected. As the results testing can have a deleterious effect on prenatal intervention strategies that require antenatal HIV-screening (LippinCott, William & Wilkins, 1998).

A study was conducted from January 1995 to October 1996 at antenatal public clinics in the Yopougon district of Abidjan and in Bobo-Dioulasso at the Social Security and the Farakon Health Clinics to evaluate attitudes of pregnant women towards HIV testing in two West African cities. Compliance/ non-compliance with HIV testing and failing to return for results were considered two aspects of a negative attitude towards HIV testing. The orientation towards HIV testing was evaluated in terms of advantages and disadvantages. (Cortoux, 1998). Each woman attending these clinics with a pregnancy of seven months or less, living within 10 kilometres of the health centre and aged 18 years or more received HIV pre-test counselling and was offered free HIV serological testing over 9 724 pregnant women were offered HIV testing through the pre-test counselling (5 766 in Abidjan and 3 958 in Bobo-Dioulasso). Pregnant women at these two clinics were mainly between the ages of 18 – 29 years, with little education were predominantly housewives and were living with their partners. On average they had more than three pregnancies including the current one.

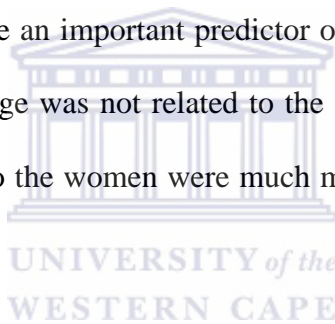
Women from Bobo-Dioulasso, who were less educated and from a more traditional culture and environment, had a tendency to coming back for their HIV test results because they considered themselves at low or no risk of contracting the HIV virus.. They usually suspected thin people as infected since they consider HIV as a ``slim disease''. If you were found to be infected with the HIV virus and as a woman you were regarded as a prostitute or promiscuous (Cortoux, 1998). Pregnant women had a tendency of not coming back for their HIV test results as identified by the research done in Abidjan where women testing HIV-positive were three times more likely to fail to show up for the test results than women testing negative. And, findings indicated that HIV infected women perceived themselves at risk of infection by virtue of their accounts of past sexual behaviour and the risks associated with their unfaithful regular partners. Women from Abidjan knew that there was a possibility that they had contracted HIV virus due to their perceived sexual behavioural patterns they engaged in previously however; they were sceptical of their HIV negative results, and decided to stay away and not fetch their HIV test results. Whereas pregnant women from Bobo Dioulasso considered themselves free from contracting HIV/AIDS virus. They associated HIV/AIDS with prostitute or promiscuous.

According to Cortoux, (1998) pregnant women in Abidjan who did not return for their HIV/AIDS test results, self-evaluated as being at higher risk. Their non-return was likely predicated on a perception of a possible positive status threatening their domestic security and physical safety. Cortoux, (1998) suggested that the non-return was further underpinned by the fact that stigmatisation and discrimination against people living with

HIV virus is still common in their area of their residence and that social norms from religious communities could influence their interest to partake in HIV virus screening from their blood since the way of contracting HIV/AIDS virus are associated with human behaviour that are in most cases not condoned by religious norms and beliefs.

Pool et al. (2001) explored the attitudes of south Ugandan women attending maternity clinics to voluntary counselling and testing during pregnancy. It was a qualitative study using focus group discussions. Almost all women canvassed indicated a willingness to take an HIV test in the event of pregnancy and to reveal their HIV-status to maternity staff. They were anxious, however, about confidentiality and there was a widespread fear that if their status was known, maternity staff might refuse to assist when the time came to deliver. This perception of stigmatisation applied more to traditional birth attendants than to bio-medical staff. Study participants also voiced rumours of medical staff intentionally killing HIV-positive patients in order to stem the spread of the epidemic. They were also concerned that if their husbands became aware of their HIV-positive status they could be blamed and separation or domestic violence might result. Thus, although voluntary counselling and testing during pregnancy was acceptable in principle, there were factors counteracting this such as fear of breach of confidentiality and fears of stigmatisation and discrimination during delivery. The authors state that community sensitisation would be necessary and male partners would preferably need to be involved in available intervention are to be acceptable and utilized (Cortoux et al., 1998; Fielding & Lee, 1998; Miles & Humbermon, 1994; Strauss & Corbin, 1998).

Another key study was conducted in Edinburgh, which is another area of high HIV prevalence amongst childbearing women in the United Kingdom. Here, prevalence of HIV-infection peaked at 1:250 deliveries in 1986 (Johnstone et al., 1998). Differential methods of offering the HIV test to pregnant women were implemented. Results indicated a similar uptake rate of approximately 35% for all methods. The authors concluded that the level of information given to women had no effect on uptake (Simpson et al., 1998). In an attempt to explain uptake, demographic and situational variables were examined and it was found that intention to be tested for HIV amongst pregnant women was predicted by being young and single (Meadors., 1993). Also, the midwife who offered the test was found to be an important predictor of uptake (Simpson et al., 1998). That is the midwife's knowledge was not related to the uptake rate but her attitude and the knowledge she conveyed to the women were much more important predictors (Boyd et al., 1998).



These findings are consistent with the view of Morteal & Johnston (1990) who highlighted the importance of health professionals' attitude, not knowledge, when trying to explain the relationship between health professionals' actions and patients' behaviour. In general, attitudes and beliefs towards testing may be influenced by demographic characteristics, but it is attitudes and beliefs that are most amenable to change and which are thus the focus of most psychological research into determinants of uptake of screening tests.

### **1.3 Statement of the problem**

2000 children are born with HIV/AIDS virus in sub-Saharan everyday. Most are from South Africa and the infection is through MTCT (UNAIDS, 2006). It was during the political chaotic time in 1982 that the first cases of HIV were diagnosed in South Africa, and for the first few years of the epidemic the reported incidence was mainly amongst white gay men. Following the same trends seen in other countries, as the number of cases increased, the virus began spreading to other population groups.

In 1992 the prevalence rate was reported as 2.4% based on antenatal testing. A governmental response to AIDS came when former president, Nelson Mandela's address formed the National AIDS Convention of South Africa (NACOSA), although there was little action from the government in the following few years. Then NACOSA started developing a national strategy to cope with AIDS. In 1993 the prevalence rate was reported as 4.3% based on antenatal testing. The Health Department reported that the number of recorded HIV infections increased by 60% in the previous two years and the number was increasing in 1993. A survey of women attending health clinics in South Africa indicated that 322,000 people were infected. (Berry and Frederickson, 2003)

In 1994 the prevalence of pregnant women was 7.6% based on antenatal HIV/AIDS testing. There was criticism, that the governmental AIDS plan, however intended, was poorly thought-out and disorganised. The South African organisation Soul City was formed, developing media productions with the intent of educating people about health issues, including HIV/AIDS. In 1995 South Africa had a 10, 4% rate of HIV virus

infected pregnant women. In 1996 the number increased to 14, 2%. It was estimated at a 17% infectious rate to pregnant women in the following year.

In 1998 the prevalence increased to 22%. In 1999 the percentage increased to 22, 4%. It was in this time when the President of South Africa, Mr Thabo Mbeki together with the minister of health Dr Manto Tshabalala-Msimang acknowledged the seriousness of the epidemic in South Africa they therefore encouraged condom use and they demonstrated the condom use especially to the youth since it is the group that is most hit by the HIV virus. They introduced HIV/AIDS reduction education programs that mainly focussed at the youth of South Africa (Berry and Fredriksson, 2003).

In 2000 the prevalence was reported as 24.5% and this was based on antenatal testing. At the International AIDS conference in Durban, the South African President in 2001 the prevalence was reported as 24.8% based on antenatal testing. South Africa's Constitutional Court ordered the government to make Nevirapine available to pregnant women to help prevent the transmission of the virus to infants. Despite international drug companies offering free or cheap AIDS treatment, the Health Ministry still refused to provide these drugs on a large scale. In 2002 the prevalence was reported as 26.5% based on antenatal testing and it increased to 27.9 in 2003 (Berry and Fredriksson, 2003)

A nationally defined target for the uptake of HIV testing amongst pregnant women has not been established. As a rule of thumb, however, for any site managing HIV a testing rate of 80% can be considered to be doing "very well" (a testing rate of >95% would be

unrealistic, and would suggest possible ``coercion'', as opposed to encouragement). 60% - 80% can be classified as doing ``reasonably well'' while those below 60% need to be targeted for extra support (Berry and Fredriksson, 2003).

The above mentioned statistics clearly empirical evidence that HIV/AIDS is taking its toll and some of the prevention campaigns have not manage to slow down the rate of new infection (about 1600 a day in South Africa people are infected by HIV/AIDS virus).

#### **1.4 Purpose of the study**

The purpose of the study was to research knowledge, attitudes and barriers towards HIV/AIDS testing among a group of black, low socio-economic status pregnant women from Gugulethu. To create a platform, that will allow pregnant women in Gugulethu to express their complete thoughts and feelings on subject of HIV/AIDS testing. That will after data analysis, inform department of health's decision in creating interventions or programmes that will encourage pregnant women towards compliance to HIV/AIDS testing. The purpose of the study was also to get information that will lead to life improvement for black women in Gugulethu. Get pregnant women to talk and know that their words have power to change their unfavourable situations and conditions.

#### **1.5 Significance of the study**

Very little research has been inducted to date in South Africa on compliance with HIV/AIDS testing. The results emerging from this study will possibly help the Department of Health to evaluate their existing MOU-practices, programmes and inform



a best practice model for effecting compliance with HIV pre-test counselling and testing at primary and secondary health care settings within the Western Cape Province. 80% of people living in South Africa do not know about their HIV/AIDS status, it is therefore important to know the reason why people do not get tested.

### **1.6 Aims of the study**

- To evaluate pregnant women's attitudes towards HIV/AIDS testing
- To investigate the barriers to HIV/AIDS testing compliance
- To evaluate pregnant women's knowledge on HIV/AIDS testing

### **1.7 Conclusion**

**This chapter had indicated the importance of conducting a study of this nature especially in the Gugulethu area. The participants, their residential area and how they will benefit from this study has also been explained. Prevalence of HIV/AIDS in women has been identified through antenatal clinics statistics reports. The Primary objectives of the study are also explained. There is information on similar research studies done in other parts of the world. Behavioural theories are included following their understanding and beliefs based on human behaviour. Charge potential Policy on HIV/AIDS testing is also explained.**

## **CHAPTER TWO**

### **2 LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

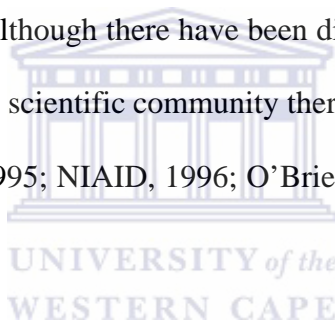
This chapter informs the reader on research done on subject of HIV/AIDS in areas of Southern Africa and surrounding countries. The definition of HIV/AIDS, the way it progressed and where it is suspected to have originated. Different ideas and methodologies of authors and theories from medical, social and psychological fields on the subject of HIV/AIDS are indicated. The possible patterns of thinking that might influence people's decision on whether to comply or not to comply with Health professionals prescribed medication is highlighted.

#### **2.2 The human immunodeficiency virus (HIV)**

HIV- the human immunodeficiency virus is the virus that causes the syndrome known as AIDS, or acquired immune-deficiency syndrome. HIV is normally contracted through sex. HIV can weaken the immune system to a point where the body is likely to develop opportunistic infections, which are illnesses that a healthy immune system would normally fight off, such as TB, pneumonia, Kaposi's sarcoma etc. An HIV infected person develops AIDS when he/she has developed one of the many opportunistic diseases, a major drop in T cells or CD 4 count. A healthy person has between 500 and 1,500 CD4 cells in a millilitre of blood. When a person with HIV has fewer than 200 T cells, that means he or she has progressed to AIDS. (AIDS FACTS, 2004) There are two types of HIV that have been identified; HIV-1 and HIV-2. According to AIDSFACTS, HIV-1 takes between 3-5 years to finish its devastating blow on the immune system to

manifest full blown AIDS. With HIV-1 it takes 5-10 years to destroy the body's immune system.

The incidence of HIV and AIDS was first noted in 1979-1980 in New York and San Francisco in the United States. A cluster of rare diseases began to present with recurring frequency. These diseases were typically pneumonia caused by the protozoan *Pneumocystis carinii* and Kaposi's sarcoma (a type of malignant cancer). Most of the initial cases occurred in homosexual men, followed by haemophiliacs and recipients of blood transfusion. The disease syndrome became known as AIDS, or the acquired immune deficiency syndrome (Whiteside & Sunter, 2000). In 1983, the virus that causes AIDS was identified as HIV. Although there have been disputes in recent years over HIV being the cause of AIDS, in the scientific community there is no doubt that it does (Weiss & Jaffee, 1990; Darby et al., 1995; NIAID, 1996; O'Brien & Goedert, 1996; Nunn et al., 1997).



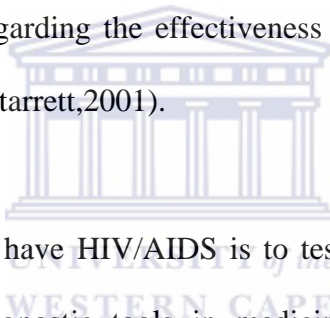
### **2.3 HIV/AIDS testing**

Voluntary counselling and testing (VCT) is an important part of South African's HIV/AIDS prevention strategy. It prepares individuals for HIV/AIDS testing and acceptance of HIV/AIDS test results. Once an individual knows of his/her HIV/AIDS test results, it encourages him/her to modify sexual behaviour to prevent further infections. If found to be HIV/AIDS positive individuals are introduced Anti retroviral treatment. VCT caters for different groups such as pregnant mothers and young people (UNAIDS 2005).

People who are recommended or who requested HIV/AIDS testing usually receive information such as:

- Information regarding the HIV/AIDS test, its benefits and consequences
- Risk for transmission and how HIV/AIDS can be prevented.
- The importance of obtaining HIV/AIDS test results.
- The meaning of the test results.
- Where to obtain further HIV/AIDS services and information on prevention.

There are other useful things they need to demonstrate during VCT. Description or demonstrations of how to use condom correctly; information regarding risk-free and safer sex options and description regarding the effectiveness of using clean needles, syringe and other drug paraphernalia (Starrett,2001).



The only way to know if you have HIV/AIDS is to test. HIV antibody testing is now among the most accurate diagnostic tools in medicine. HIV/AIDS tests detect the antibodies that the body produces to fight HIV/AIDS virus once the infection has occurred. Positive results mean that you have HIV virus in your body. When a person is infected with HIV virus, it means you have a potential of infecting other people. There are different types of HIV/AIDS testing tools:

- There is a standard HIV Blood test. This is the common means of HIV/AIDS testing. A nurse will draw a blood sample, which they send to the laboratory for screening. Results are generally available within few days, depending on the testing site.

-Rapid HIV test. The nurse draws a blood sample, which is processed at the testing location. The test requires only a drop of blood and the test can be obtained in 20 minutes and the test has the accuracy of 99.6 percent

- Oral test. A person is swabbed with a tiny brush on the side of his/her mouth and the nurse send the sample to the laboratory for screening. Results are generally available within few days depending on the testing site.

-Urine test. The person getting tested provides a urine sample, which is send to the laboratory. Results are available in few weeks, (Rabkin, 1994)

#### **2.4 Value of HIV/AIDS testing**

The immune system of the female parent undergoes a complicated change during pregnancy. One arm of the immune system called CMI (Cell-mediated immunity) becomes weaker during pregnancy. The body need CMI to fight certain microbes that tend to “hide” inside the cells for example bacteria that cause TB and related infections and, the parasite that cause brain infection (Toxoplasmosis) (Clark and Kendall, 1994). Hence it is advisable for pregnant woman to visit antenatal clinics early in their stages of pregnancy to screen infections that can disable their immune system and leave their body defenceless. Today, people are learning to live with HIV/AIDS, rather than preparing to die from it. There are more people getting tested, and they are revealing their diagnosis. Through their courage, they are breaking of stereotypes and stripping away the stigma that is often attached to HIV/AIDS. Most hopefully, pregnant woman with HIV/AIDS know that their babies can be born free from the disease, (Bush, 2005)

Some of the values of HIV/AIDS testing are to:

-Early diagnosis and consistent care from a health care professional are essential to best treat HIV/AIDS.

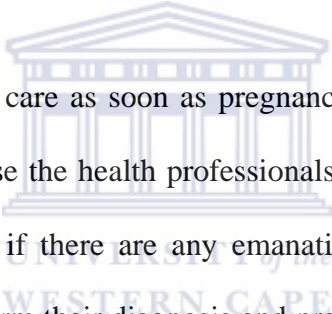
- Pregnant woman can give birth to a HIV/AIDS free baby.

- If your HIV/AIDS test results is positive, many things can be done to help you cope with HIV/AIDS positive status

-A doctor can keep an eye on your health, so that he/she can put you on antiretroviral if you fall ill. That can slow down the HIV/AIDS virus fast progression.

- If you know that you are HIV/AIDS positive, you can take steps to protect other people.

-You will be help to find support and resources within your community, (AIDSFACTS, 2004).



It is advisable to start prenatal care as soon as pregnancy is suspected. Prenatal care is critical during this time, because the health professionals can check on the health of the developing baby and examine if there are any emanating problems. If any, they will however have a chance to confirm their diagnosis and prescribe the correct medication to attend to the problem. For women who are living with HIV/AIDS, prenatal care is one of the most important steps to a healthy pregnancy and safe delivery. Pregnancy does not affect the course of the HIV/AIDS disease. It will never make HIV/AIDS worse or better. During pregnancy, there is a normal drop in CD4+cell count that usually rebound after birth to pre-pregnancy level. After HIV/AIDS positive results, a viral load test is done to determine the amount of HIV/AIDS virus in the blood. Pregnant woman with high HIV/AIDS viral loads or low CD4+cell counts are more likely to pass the HIV/AIDS virus on to their babies. When HIV/AIDS viral load is high, drug treatment is administered to reduce HIV/AIDS viral load. It can be reduced into an undetectable

level. If a mother's viral load is undetectable when she goes to labour, the risk of transmission is almost zero (Project Inform, 2005). All this can happen, if one decides to do HIV/AIDS testing early when she/he suspects exposure to the risk of contracting HIV/AIDS or when women suspect pregnancy.

## **2.5 Stigma**

Stigma and discrimination play a significant role in the development and maintenance of the HIV/AIDS epidemic. It is well documented that people living with HIV/AIDS experience stigma and discrimination on an ongoing basis (Skinner and Mfecane, 2004). This impact goes beyond individuals infected with HIV/AIDS to reach broadly into society. This type of stigma delays the engagement of people with HIV/AIDS testing and access to prevention and treatment facilities for HIV/AIDS. Stigma drives HIV/AIDS out of the public sight that however reduces the pressure for behaviour change. Stigma also introduces a desire not to know one's own HIV/AIDS status and that delays testing and accessing treatment. At an individual level stigma undermines the person's identity and capacity to cope with the disease. Fear of discrimination limits the possibility of disclosure even to potential important sources of support such as family and friends. Stigma impacts on behaviour change as it limits the possibility of using certain safer sexual practices. Behaviour such as wanting to use condoms could be seen as a marker of HIV/AIDS, leading to rejection and stigma, (Skinner & Mfecane, 2004)

Disclosure of HIV/AIDS status to others is often an emotionally charged subject. Rabkin (1994), describe two extreme responses when people learn that they are HIV/AIDS

positive. One response is that the individual desires to withdraw, isolate him/herself and refuse to tell anyone. The opposite of that is “tell the world”; and neither of the two is adaptive. He however indicated factors that will affect the decision to disclose or not to disclose as:

- The potential for prejudice and stigma
- The possibility of having the integrity of one’s sexual relationship called into question or of losing a relationship.
- The potential of being labelled an unfit parent
- Vulnerable to violence, particularly for woman who wish to disclose to their partners.
- Reaction from family and the fear of hurting the parents
- Shame, particularly for members of same cultural community.
- loss of friendships
- Loss of health insurance
- Fear of employer’s reaction, (Remien & Wilson, 1994)

Kalishman and Simbayi (2003) conducted a study in Cape Town to investigate attitudes, stigma and HIV/AIDS counselling in a black township. Their research results revealed that, people who are living with HIV/AIDS are believed to be dirty, cursed and untrustworthy. They however need to be shameful of their behaviour, the need to feel guilty and they are considered to be weak. There was also an indication that uninfected people will occasionally refuse to share a meal with a person living with HIV/AIDS. People are not prepared to share a room with someone with HIV/AIDS. They would not talk to someone they knew to have HIV/AIDS. Van Dyk and Van Dyk (2003) in their



study conducted in South Africa have revealed that, people have a deep mistrust of health care professionals and feared discrimination and rejection by health care workers, as well as by sexual partners and communities. Their participants indicated that, they do not know how to disclose their HIV-positive status. They were also concerned about testing that does not include treatment and/or follow-up support. They also expressed anxiety about the psychological turmoil they anticipated after an HIV/AIDS-positive test.

### ***2.5.1 Depression:***

Clinical depression is the most commonly observed psychiatric disorder among HIV infected and affected. Multiple risk factors for depression diagnosis of the HIV/AIDS infected itself may lead to sadness and fear of stigmatization. Stigmatization is something they cannot avoid because the HIV/AIDS infected result in wasting, weakness, pain, confusion and negative feelings. Sadness and grief are normal response of depression. There are times when people denies the diagnosis, even though people deny the diagnosis, diagnosis still need to be done and treatment should be strongly recommended(Links & Bonks,2000).

### ***2.5.2 Suicide.***

Social alienation from family and friends, loss of job and income, and chronic physical disorders that are infected with HIV/AIDS think of suicide some time. Suicides are committed by those who are depressed at the point when they experience intense sadness (Links & Bonks, 2000).

### ***2.5.3 Anxiety Disorder***

Anxiety is a common symptom in patients with HIV/AIDS infection. When the anxiety is severe it might result in anxiety disorder. These disorders include adjustment disorder,

panic disorder, and post-traumatic stress disorder. The practitioners need to be aware of the differences among the specific disorders treat or refer patient and help them receive optimal care. People with historically major depression and those with limited social support are people experience severe anxiety during the course of HIV/AIDS infection (Link & Bonks, 2000).

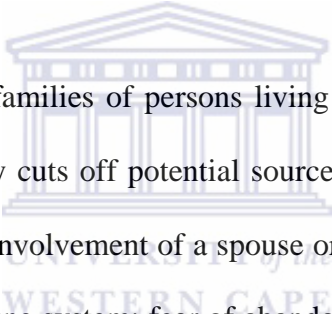
#### ***2.5.4 Post traumatic stress disorder (PTSD)***

Although chronic illness itself is a traumatic experience leading to PTSD, co-occurs with an individual's HIV/AIDS status. Trauma can affect both psychological and physical functioning. Physical effects of trauma have been related to significant health problems, suppression of the immune system and increased susceptibility to infections. The psychological aspects manifest themselves in increased risk-taking behaviour, such as substance use, risky sexual activity. Patients with PTSD may suffer from depression and feeling angry. Patients with HIV/AIDS may also be depressed to a point that it manifests in disease-management problem such as disputing with medical personnel and/or medication non-adherence, (Links & Bonk, 2000).

#### **2.6 Perceived stigma within family structures towards HIV/AIDS testing**

On the socio-cultural level, the impact of HIV/AIDS has also challenged and broadened traditional notions of what constitutes a family. Many of those affected by the disease live in non-traditional arrangements, prompting reconsideration of who is and who functions as a family. Family members are defined as “individuals who by birth adoption, marriage, or declared commitment share deep personal connections and are mutually entitled to receive and obligator to provide support of various kinds to the extent possible, especially in times of needs” (Levine, 1990). Operationally, the family includes the

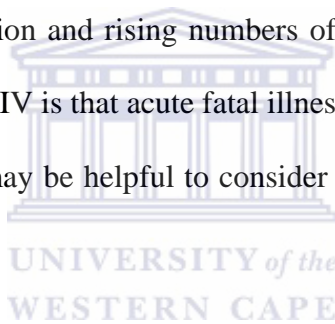
spouses, partners, children, parents, siblings, friends and caregivers of the person with HIV/AIDS (Bonuck, 1993:78). In terms of family systems theory, families are social systems. Consequently, the effect of a family member's infection will reverberate throughout that system and over time (Bonuck 1993:87). According to Bonuck (1993:79), the psychosocial impact of HIV and AIDS on families usually begins with the disclosure of HIV-positive status may be how spouses and partners first learn of the affected partner's bisexual, drug-using or commercial sex activities. Consequently, together with the prospect of being infected themselves, the partner's previous image of family life and/or pattern of denial may be shattered.



Reactions to, and feelings, of families of persons living with HIV/AIDS include social stigma and isolation, as secrecy cuts off potential sources of support; fear of contagion, which may limit intimacy and involvement of a spouse or parent; fear of infecting others or straining their lowered immune system; fear of abandonment, as caregivers are unable to keep up with the physical and emotional demands of care giving, and of watching a loved one suffer and deteriorate; guilt by family members for having estranged themselves from the ill individual because of his or her gay or drug-using lifestyle, of from having been spared from infections, and psychological physical fatigue (Bonuck, 1993:08-81). Caring for an individual with HIV-related disease is usually time consuming, burdensome and unpredictable, and may place an unbearable strain on the family martial system.

In South Africa, it has been postulated that the majority of HIV/AIDS infected and affected people will be assisted and absorbed by the extended family network. Even if this has been true in the beginning of the pandemic, it is now becoming clear that the increasing numbers of those is overburdening the extended family; infected and affected.

Many households are being run by the very old who have no or littler means of financial support. In addition, the number of households headed by children themselves is increasing rapidly. Whether this will lead to the ultimate demise of the extended family is not clear; however there is the need for community and governmental interventions to alleviate the financial desperation and rising numbers of AIDS orphans. A major factor affecting families living with HIV is that acute fatal illness may occur in several members of the same family. Hence it may be helpful to consider the different sub-populations of persons likely to be affected.



Katy Salmon (2004), explains how in Nairobi living with illness caused by HIV or AIDS is hard enough. But when one adds hostility and discrimination, the burden of facing the life threatening illness becomes far greater. According to the research results, the worse treatment comes from medical practitioners themselves. Quoting one of her participants, Katy Salmon (2004), indicated that the participant explained in a sad tone of voice that when she was admitted as a HIV positive patient at one of the hospitals in Nairobi they had a separate bathroom for HIV positive people. She went and used the 'normal' bathroom and the nurse came and dragged her out and started shouting at her and there

were many women in the bathroom at that time of the commotion. She explained the act humiliating her.

Eunice Odongo (2004), who is an HIV positive counsellor, working for women fighting AIDS in Kenya (WOFAK), indicated that it is twenty years since the first case of AIDS were reported at the United States of America. AIDS has killed close to twenty two million people worldwide. While millions of Africans have died people's attitudes towards the disease have barely changed. Many people still believe that it is only immoral people that get infected by HI virus. She says people are ashamed to be associated with AIDS. Mentioning 'WOFAK' as a place people will not want to be associated with, since it mostly handle HIV/AIDS related issues. So whoever visits the facility is suspected of being HIV positive, therefore people who visit the facility are stigmatised. Eunice Odongo (2004), finds the language that people use very offensive as well. The media in Nairobi calls people living with HIV 'victims' or 'sufferers'. She believes that people need to be sensitised that there are people living with HIV, they are not victims. They are not statistics. They are people.

Eunice Odongo (2004), explained that members of the family after comprehending your HIV positive status are the once who are going to cast you out of the house or discriminate you. They sometimes force you to stay in a servant's quarters, let you use your own cutlery and food without sharing. When you have land and you are HIV positive, after your death the family members come and grab the land because your wife does not deserve the land because she is going to die and follow you soon. The belief that

HIV positive people are not fit for work is not just an insult, but it also leaves them destitute. Employers will soon realise that it pays to keep their HIV positive staff healthy, rather than let them die. There are people who have capacity to run the organisation. If they leave them to die, the organisation might not do well, says Eunice Odongo (2004).

For women, the stigma is even greater than it is for men. Both in the community and their own homes, they are frequently blamed for infections and are at risk of violence. They are forever feared that they can be killed if they are found to be HIV-positive. The goal of VCT is to ensure that those who test positive receive counselling about stigma and ART. ART must be made more available, counselling services must also improve and increased information about all aspects people living with HIV/AIDS might encounter. Women should be able to confront or challenge their fear of violent if they disclose a positive status to partners who they consider to be ill tempered and violence if informed about sensitive issues like revealing an HIV positive status. Make referrals for young girls who are seen to be battling with their HIV positive status to structures that specialises with the area she is battling in. A parent should be called in if the HIV positive person allows that. That would encourage adherence to drugs because there will be someone to remind her to take medication. Studies in Brazil and South Africa show that counselling, coupled with support from other HIV-positive patients, makes it more AIDS patients will stay on drug therapy. For couple, having men and women together increase the chances for both of succeeding (UNAIDS/UNFPA/UNICEF, 2006).

UNAIDS (2004), indicated that people living with HIV/AIDS are often seen as shameful. In some cases HIV/AIDS is linked to 'perversion' and those infected by HI virus will be punished. In some societies HIV/AIDS is seen as a result of personal irresponsibility. Sometimes, HIV/AIDS is believed to bring shame upon the family or community. Following are factors that are indicated as contributors to HIV/AIDS- related stigma:

- HIV/AIDS is a life-threatening disease
- People are scared of contracting HIV
- The disease's associated with behaviours that are already stigmatised in many societies.
- People living with HIV/AIDS are often thought of as being responsible for becoming infected.
- Religious or moral beliefs that lead some people to believe that having HIV/AIDS is the results of moral fault (such as promiscuity or 'deviant sex') that deserved to be punished.

### **2.7 Health Promoting and the Prevention of HIV/AIDS**

The promotion of health is a complex and multi-disciplinary endeavour. The contribution of psychology to this field hinges on the attempt to explain behaviour and mechanisms of behavioural change or modification. A large amount of the early work conducted in health education was based on psychological theories of mass communication and, more specifically, the link between knowledge, attitude and behaviour. It was promised that should an individual have sufficient information, this would bring about a change in attitude, which was predictive of a change in behaviour (Bennett & Hodgson, 1992).

This direct link between attitude and behaviour modification has not only been challenged in recent years, but has also been disproved. Evidence of this is clear in the

many failed health promotion campaigns that operate on this premise – the safe sex, antismoking and anti-drug campaigns to name but a few (Bannett & Hudgson, 1992).

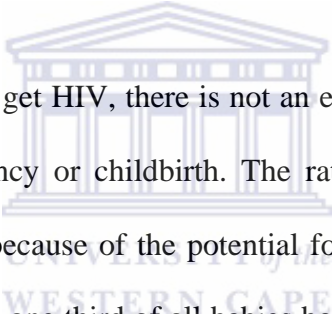
The failure of current HIV prevention campaigns to curb the spread of the disease has raised serious questions about the prevention strategies being employed. It is argued that these strategies are not accomplishing their goals, as they are being used in settings far removed from those in which they were originally designed (Air-hihenbuwa & Obregon, 2000).

### **2.8 Programmes for HIV/AIDS positive pregnant woman**

African progress in the fight against HIV/AIDS is best measured in hope. Only a few years ago, people viewed an HIV/AIDS diagnosis as a death sentence. They were assured of shame and isolation. Today people who are living with HIV/AIDS have hope. They have hope that they will see their children grow up. They have goals and dreams for their lives, regardless of HIV/AIDS infection. The hope that they will see a generation free from HIV/AIDS and no child will be made an orphan by HIV/AIDS. There is mother to mother-to-be program in Khayelisha. The program is organised by several organizations that forms programs that serves to meet the needs of mothers. This program offers medical and emotional support and economical opportunity to improve the lives of mothers who are living with HIV/AIDS. Last year, the mothers program served 2,500 women; and after they have expanded this year, they expected to reach 25,000 women in 2006, (Bush, 2005).



Mother- to- child transmission prevention programmes were introduced by the Department of Health in 2001. The aim of the project is to reduce the transmission of the disease from mother to children. Mother-to-child transmission (MTCT) is when an HIV/AIDS positive woman passes the HIV/AIDS virus to her unborn baby. There is an approximate 30% chance that if a pregnant woman is HIV positive the baby will be infected during pregnancy or labour. A further 10 to 20% of babies born to HIV positive mothers will become infected through breastfeeding. It is estimated that in 2004, almost 550 000 children in Africa became infected through MTCT (UNAIDS Global report, 2004).



Like all other ways that people get HIV, there is not an exact number known for the risk of transmission during pregnancy or childbirth. The rate of infection from mother to foetus is, however, very high because of the potential for exposure to large amounts of blood. It is estimated that about one third of all babies born to HIV-positive mothers will get the virus during pregnancy or delivery. The risk for transmission depends on factors such as the stage of HIV infection a mother is at-women who are at early and later stages of HIV infection are at higher risk for transmitting the virus to their baby-and whether she is receiving anti-HIV medications; anti-HIV drugs can significantly reduce the risk for transmission during pregnancy.(Kalichman,2005).

Babies born to HIV-positive mothers can get the virus in a variety of ways. While in the womb, the foetus is protected by the placenta, which forms a barrier between the maternal and foetal bloodstreams. For infection to occur during pregnancy, it is necessary

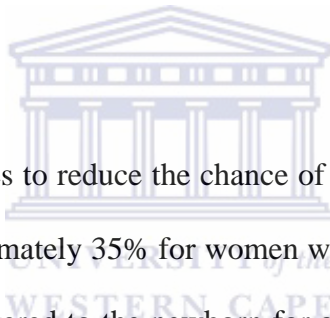
for the placenta itself to first become infected before the virus can be passed on to the foetus. Infection is also possible during labour and delivery, when large amounts of the mother's blood bathe the newborn as he or she passes through the birth canal. Finally, a mother can infect her infant during breast feeding because HIV has been found in mother's milk. Cracks in breast nipples can also allow the mother's blood to mix with her milk, further increasing the risk for infection. (Kalishman, 2005).

### ***2.8.1 Reducing mother to child transmission HIV/AIDS (MTCT)***

An HIV-positive women needs to reduce the chances of transmitting HIV to her baby. Therefore she must know her HIV status. Voluntary counselling and HIV/AIDS testing is the only gateway to knowing your status. It is important that a pregnant woman is given the most up-to-date information so that she can make informed choices about being tested to know her HIV status and what she can do to reduce the risk of mother-to-child transmission (MTCT). One important thing to remember is that the lower the mothers' viral load, the less the chances of the baby becoming infected. It is, therefore, important to keep the viral load down in all ways possible. This is the possible way to reduce the chance of the baby becoming infected while in the womb during pregnancy. It is also important to remember that the body's response to any infection is to produce more white blood cells to fight it. As HIV is produced in white cells it means that more HIV is produced. It is essential for pregnant women to avoid any infection, like STIs, or to be treated for infection as soon as possible. This would mean that she should only engaged in protected sexual intercourse. If the pregnant woman is found to be HIV positive she should consider taking antiretroviral medication since it has the power to reduce viral load significantly. (Page, 2006).

### ***2.8.2 Reducing MTCT during pregnancy and during birth***

There are different antiretroviral drug treatments available that lower the risk of mother-to-child transmission during pregnancy. Each patient who has tested HIV positive and has a CD4 count below 200 should be referred to HAART for assessment so that accurate and relevant HIV/AIDS drugs could be administered based on the progression the HIV virus has made in the body. Each patient who has a CD4 count above 200 will receive double therapy regimen of AZT. At 34 months it will be dispensed every two weeks and AZT and Nevirapine at delivery. (PMTCT protocol Western Cape Province 22 September 2003).



There are a number of strategies to reduce the chance of MTCT during birth: The risk of infection is reduced by approximately 35% for women who receive AZT only at the time of delivery, with AZT administered to the newborn for a week after birth. A single dose of Nevirapine given to the mother when labour begins and to the baby after the birth halves the chances of HIV transmission. As this method is very cheap and easy to administer, it is the most effective way to reduce the risk of MTCT. It is the most widely used method in South Africa. Preventing unnecessary cutting, examinations of rupturing of membranes reduce the amount of contact the baby has with blood and infected body fluids. Keeping labour time to a minimum reduces the time that the head of the baby is in contact with the birth canal where infection can occur, and therefore reduces the risk of MTCT. Caesarean sections are very effective in reducing MTCT but they are often not available and may be too expensive. (Page, 2006).

### ***2.8.3 Reducing MTCT while breastfeeding***

Normally breastfeeding is by far the best way to feed a baby. It is simple and provides the baby with all the nutrients necessary for its development. Breast milk also contains antibodies from the mother and these help the baby to fight off infections. Babies that have not been breastfed are more likely to suffer from malnutrition and other life-threatening diseases. If a mother is HIV positive, however, there is a risk that a child will be infected through the breast milk. The alternative to breastfeeding young babies is feeding them formula milk but this method is expensive and more complicated than breastfeeding. Mothers who have not disclosed their HIV status are often in households where they are pressurised to breastfeed. This is because of the stigma of people associating formula feeding with being HIV positive. The World Health Organisation has said that the following methods are the two best alternatives for preventing MTCT with breastfeeding: Breastfeeding exclusively for six months and then stop breastfeeding and provide formula feeding exclusively. Reducing the risk of MTCT depends on a number of factors, including the mother's viral load and the quality of counselling the mother receives. The danger of mix feed should be explained accurately and in strong terms. Mothers who are HIV positive should know that mix feed will cause more harm than good to the baby, because formula milk has chemicals that can interfere with the lining of the baby's stomach and that can give access to the HI virus. They should comply with the feeding instruction as indicated by nurses or as stipulated on formula container. In South Africa, pregnant women who are uncertain about their HIV status are offered voluntary counselling and testing. Those women who are found to be HIV positive receive information on the best options for infant feeding. (Page, 2006).

## **2.9 HIV/AIDS test Policy**

### **2.9.1 DRAFT NATIONAL POLICY ON TESTING FOR HIV/AIDS**

On 10 December 1999 the Minister of Health published her intention to determine a National Policy on Testing for HIV in terms of section 2 of the National Policy for health Act 116 of 1990. It must be remembered that the South African Law

Commission already published a National Policy of HIV Testing and informed Consent in 1997 – nothing, however, came of this.

### ***2.9.2 Circumstances under which HIV testing may be conducted***

(i) Testing for the HIV virus may be done only in the following circumstances:

Upon individual request, for diagnostic or treatment purposes, with the informed consent of that individual. On the recommendation of a medical doctor that such testing is clinically indicated, with the informed consent of the individual. As part of HIV testing for research purposes, with the informed consent of the individual in accordance with national legal and ethical provisions regarding research.

(ii) As part of screening of blood donations, with the informed consent of the individual and the accordance with statutory provisions regarding blood donations.

As part of unlinked and anonymous testing for epidemiological purposes undertaken by the national, provincial or local health authority or an agency authorised by any of

these bodies, with informed consent, provided that HIV testing for epidemiological purposes is carried out in accordance with national and ethical provisions regarding such testing.

(iii) Where an existing blood sample is available and an emergency situation necessitates testing the source patient's blood (example when a health care Worker has sustained a risk bearing accident such as a needle-stick injury), HIV testing may be undertaken without informed consent but only after informing the source patient that the test will be performed, and providing for the protection of privacy. The information regarding the result may be disclosed to the health care worker concerned but must otherwise remain confidential and may only be disclosed to the source patient with his or her informed consent.

Where statutory provisions or other legal authorisation exist for testing without informed consent.

(iv) Routine testing of a person for HIV infection for the perceived purpose of protecting a Health care worker from infection is impermissible regardless of consent.

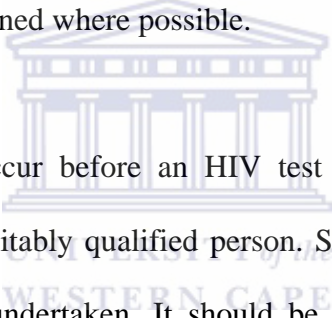
HIV testing of an employee in the workplace is prohibited unless justified by an order of the Labour Court, in accordance with the Employment Equity Act 55 of 1998, section 7 (2).

(v) Proxy consent may be given where the individual is unable to give consent.

### ***2.9.3 Informed consent, pre-test counselling and post-test counselling***

Testing for HIV infection at all health care facilities must be carried out with informed consent, which includes pre-test counselling. The information regarding the result of the test must remain fully confidential, and may be disclosed in the absence of an overriding legal or ethical duty only with the individual's fully informed consent.

In the context of HIV/AIDS, testing with informed consent means that the individual has been made aware of, and understands, the implications of the test. Consent in this context means the giving of express agreement to HIV testing in a situation devoid of coercion, in which the individual should feel equally free to grant or withhold consent. Written consent should be obtained where possible.



Pre-test counselling should occur before an HIV test is undertaken. It should be a confidential dialogue with a suitably qualified person. Such pre-test counselling should occur before an HIV test is undertaken. It should be a confidential dialogue with a suitably qualified person, such as a doctor, nurse or trained HIV counsellor, undertaken as a means of passing on information and gaining consent. Posters, pamphlets and other media (including videos) may be used in making information on HIV/AIDS available, but cannot be regarded as a general substitute for pre-test counselling.

A doctor, nurse or trained HIV counsellor should accept, after personal consultation, an individual's decision to refuse pre-test counselling and HIV testing. Psychological competence in understanding and dealing with the diagnosis of a life-threatening condition, rather than educational or social status, should be the yard-stick for this

decision. Such a decision should only be made on a case-by-case basis and should be recorded in writing. A doctor, nurse or trained HIV counsellor should also ensure that post-test counselling takes place as part of the process of informing an individual of an HIV test result. Where a health care facility lacks the capacity to provide a pre-test or post-test counselling service, a referral to a counselling agency or another facility with the capacity to provide counselling should be arranged before an HIV test is performed, and when an HIV test results are given.

## **2.10 Behavioural theories**

As HIV/AIDS transmission is propelled by behavioural factors, theories about how individuals change their behaviour have provided the foundation for most HIV/AIDS prevention efforts worldwide. These theories have been generally created using cognitive-attitudinal and effective-motivational constructs (Kalishman, 1998).

Psychological models of behaviour can be categorised in three groups. There are those that predict risk behaviour, those that predict behavioural change and those who are predicting maintenance of safe behaviour. These theories and models generally do not consider the interaction of social, cultural and environmental issues as independent of individual factors (Auerbach, 1994). Although each theory is build on different assumptions they all state that behavioural changes occur by altering potential risk-producing situations and social relationships, risk perceptions, attitudes, self efficacy beliefs, intentions and outcome expectations (Kalichman, 1997). Central to HIV prevention interventions based on psychological-behavioural theory is the practice of targeted risk-reduction skills. These skills are generally passed on to individuals in a



process consisting of instruction, modelling, practice and feedback (Kalichman, 1997).

The psychological theories and models that have been most instrumental in the design and development of HIV prevention Interventions are briefly described below.

### ***2.10.1 Health Belief Model***

The Health Belief model, developed in the 1950s, holds that health behaviour is a function of individual's socio-demographic characteristics, knowledge and attitudes.

According to this model, a person must hold the following beliefs in order to be able to change behaviour: perceived susceptibility to a particular health problem (“am I at risk for HIV?”), perceived seriousness of the condition (“how serious is AIDS; how hard would my life be if I got it?”), belief in effectiveness of the new behaviour (condoms are effective against HIV transmission), cues to action (witnessing the death or illness of a close friend or relative due to AIDS), perceived benefits of preventive action (“if I start using condoms, I can avoid HIV infection”) and barriers to taking action (“I don't like using condoms”). In this model, promoting action to change behaviour includes changing individual personal beliefs. Individuals weigh the benefits against the perceived costs and barriers to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions often target perception of risk, beliefs in severity of AIDS (“there is no cure”), beliefs in effectiveness of condom use and benefits of condom use or delaying onset of sexual relations.(Rosenstock,1974).

### ***2.10.2 Social cognitive (or learning) theory***

Learning can be defined as the process leading to relatively permanent behaviour change or potential behaviour change. In other words, as we learn, we alter the way we perceive our environment; the way we interpret the incoming stimuli; therefore the way we interact or behave (Watson, 1878-1958). The central idea behind behaviourism is that only observable behaviours are worthy of reaching for since other abstractions such as a person's mood or thoughts are too subjective.

Skinner (1904-1990), who is considered to be a radical behaviourist because of his belief, also argues that internal states could influence behaviour just like external stimuli.

Social learning theory focuses on the important roles played by sensational, symbolic, and self-regulatory process in psychological functioning and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants (Bandura, 1977). The central codes of belief of the social cognitive theories are:

- Self-efficacy – the belief in the ability to implement the necessary behaviour (“I know I can insist on condom use with my partner”).
- Outcome expectancies - beliefs about outcomes: Such as the belief that using condoms correctly will prevent HIV/AIDS infection.

Programmes built on SCT integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy. Specifically, activities focus on the experience people have in talking to their partners about sex condom use and HIV/AIDS testing, the positive and negative beliefs about adopting condom use (Greenberg, 1996).

### ***2.10.3 Social learning theory as applied to HIV/AIDS***

Social learning theory includes the notion of expected consequences as primary in explaining behaviour. The more positive the consequences are the more likely people are to engage in that particular behaviour (Bandura, 1977). What remains perplexing in the case of HIV/AIDS prevention is the fact that the consequences of behaviours, such as unprotected sex, are known to be adverse in the extreme, and yet people still engage in such behaviour. Various theories have been espoused to try and account for this finding. In this respect Bennett and Hadgson (1992) suggest that short-term gratification may be a greater motivating factor than the perception of a distant threat.

In addition, it is also suggested that self-control is a necessary component in regulating behaviour. Self-control involves actively bringing the consequences of an action to mind. This is a difficult task, as these consequences often lie dormant in the minds of individuals (Bennett & Hodgson, 1992). Also under states of intense sexual arousal, self-control is arguably compromised.

With regard to HIV/AIDS, the concept of modelling and self-efficacy are the most commonly used components of social learning theory. Modelling is based on the imitation of other people's behaviour, and positive role models are often included in prevention and awareness campaigns. Self-efficacy refers to "one's perceived ability to adopt a recommended behaviour" (Airhihenbuwa & Obregon, 2000:7).

It is suggested that this model is relatively successful in individualistic cultures, such as the United States. In collectivistic cultures, however, success is severely limited. This is because the theory is essentially individualistic in nature. It relies on individuals to take responsibility for their action as unitary entities (Airhihenbuwa & Obregon, 2000). In countries like South Africa, where extended families are the norm, and power differentials within relationships exist to the detriment of most women, the implication is that individual decisions are a violation of the norm and often incur severe consequences in the form of domestic violence or loss of financial support.

Another psychological factor associated with behavioural adherence is social support. Generally speaking, people who feel they receive the comfort, caring and help they need from other individuals or groups are more likely to follow medical advice than patients who have less social support (Dimatteo & Dinicola, 1982). Over the past few decades, research efforts have been invested in the examination of the beneficial effects of social support on health and well-being. There is now a greater deal of evidence that the availability of social support is associated with a reduced risk of mental illness and physical illness and even mortality (Schuwarzer & Lippin 1989a, 1989b). Social support has been defined as information from others that one is loved and cared for, esteemed and valued, and part of a network of communication and mutual obligation (Cobb, 1976). Such information can come from a spouse, a lover, and children, friends or social and community contacts such as churches or clubs.

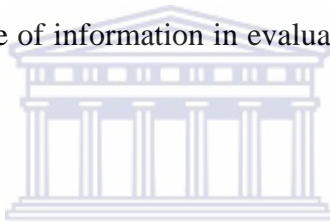
The measurement of social support has been approached from two perspectives, which differ in the way they conceptualise social support. One conceives of social support in terms of the structure of the target person's interpersonal relationships or social network. The second conceives support in terms of the function that these relationships or networks serve for him/her (Cohen & Wills, 1985).

Structured measures assess the existence or quality of social relationship. This information is relatively objective and easy to obtain. It can sometimes be gathered by observation or from behavioural records e.g. marriage records, organizational membership, etc. Even if it is based on self-reports, information about whether a person is married, lives alone or belongs to a church, is simple to collect and usually fairly accurate (House & Kahn, 1985). A standardized procedure for measuring various social network characteristics like size and density has been developed by Stoke (1983) and is known as a social network list. There is consistent evidence that low levels of social relationship are associated with the increased risk of mortality (Berkman & Syme, 1979; Blazer, 1982; House et al. 1982).

Functional measures of social support assess whether interpersonal relationships serve particular functions. Various typologies of support function have been proposed (Strobe & Stroebe, 1987). Most distinguish between emotional, instrumental, informational and appraisal support:

- Emotional support – Involves providing empathy, care, love and trust

- Instrumental support – consists of behaviour that directly helps the person in need, for example, individuals give instrumental support when they help other people to do their work, take care of their children or help them with transportation
- Informational support – involves providing people with information, which they can use in coping with their problems
- Appraisal support – is closely related to informational support. It also involves the transmission of information, but in this case it is information that is relevant for person's self-education. Thus, by comparing oneself to another person, one may use the other as a source of information in evaluating oneself (Dunkel-Schetter & Bennett, 1990).



There are a number of psychological and biological processes through which social support might influence an individual's health, e.g. a person who is integrated into a large social network of family and friends is subjected to social controls and peer pressure that influence normative health behaviour; depending on whether this pressure promotes healthy and unhealthy behaviour pattern. Social integration could have a positive or negative impact on health (Cohen, 1988).

Most of the psychological processes that link social support to psychological well-being and health may be mediated by self-esteem, i.e. the positive or negative belief and evaluations that the individual holds towards him or her. It is widely accepted among

clinical, personality and social psychologists that a positive and stable self-esteem is important for individual's well being (Epstein, 1999).

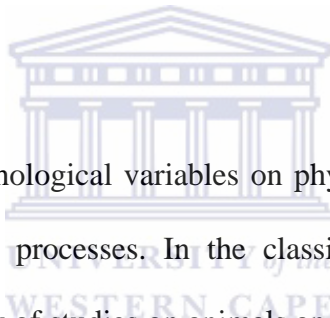
Tajfel (1978), emphasized the social groups to which we belong are major determinants of our definition of self and form the basis of social identity. Social identity refers to the part of people's self-concept, which derives from their knowledge of their memberships of various social groups, together with the emotional significance attached to these memberships. Thus, being embedded in a large interpersonal and social network may contribute positively to social identity and self-esteem (Tajfel, 1978).

Social membership may also fulfil a number of support functions that are beneficial for individual self-esteem. There is therefore broad agreement among the helping professions concerning the central role of emotional support for self-esteem and psychological well-being. Bernard (1968) has graphically described that one of the major functions of positive, expressive talk is to raise the status of the other, to give help, to reward, in ordinary human relations; it performs the stroking function. As infants need physical caressing or stroking in order to live and grow, and even to survive, so do adults need emotional or physical stroking or caressing to remain normal.

Group members also serve substantiating functions that are important for the individual's interpretation of reality. Success or failure in responding to situational demands depends not merely on one's skills, but also on whether or not one is able to assess these abilities

and the environmental demands realistically. Thus, people often fail, because they overestimate their ability or underestimate the difficulty of the task.

According to Festinger (1954), the assessment of the validity of one's belief about reality and about one's own level or ability, frequently depend on social comparison processes, particularly when objective criteria are lacking. Social comparison processes are also important for the education of the appropriateness of one's emotional reactions, particularly in novel and emotional situations (Schachter, 1959) such processes are therefore likely to play an important role in the perception and evaluation of bodily symptoms.



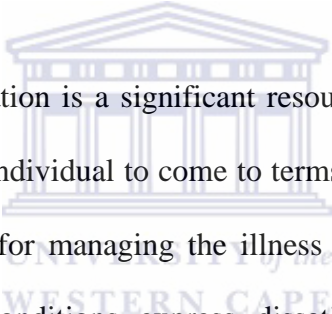
The impact of social and psychological variables on physical health must ultimately be transmitted through biological processes. In the classic book *‘‘The Broken Heart’’*, Lynch (1970) reported a variety of studies on animals and humans which suggest that the mere presence of an especially affectionate physical contact with a similar non-threatening organism, can tremendously reduce cardiovascular and other forms of physiological reaction.

There is also evidence that social support influences the neuroendocrine responses, which have been suggested as a possible mediator of the relationship between social support and coronary heart disease and between social support and immune functions (Cohen, 1988). Suggestive evidence of a link between social support and immune functions comes from studies showing that individuals with high score on a loneliness scale exhibited some



suppression of the immune system when compared with individuals who scored low on this scale (Kiecolt-Glase 1984; Glaser, 1985).

Since loneliness is negatively correlated with perceived social support, these findings tend to support the assumption that low levels of social support are associated with the impairment of immune functions. Schwarzer and Lippin (1989a, 1989b) found that social support has not only significantly related to mortality but also to self-report measures of health status, physiological reactivity (e.g. blood pressure, heart rate) and most strongly to depression



For the chronically ill, information is a significant resource for managing their lives. It reduces uncertainty, helps the individual to come to terms with the illness and allows for the development of strategies for managing the illness in everyday life. Nevertheless, many people with chronic conditions express dissatisfaction with the amount of information they are able to obtain about their disorder. For example, families of many patients who have suffered strokes, complain about the lack of information about the condition (Eleanor, 2004).

The proliferation of information of the Internet and the World Wide Web has made significant strides in increasing the availability of information to those with access to the appropriate technology. Although beneficial, this method of procuring knowledge can also be dangerous and detrimental to patient care. Information on the Web is not reviewed and any person with the technological know-how can post information, which

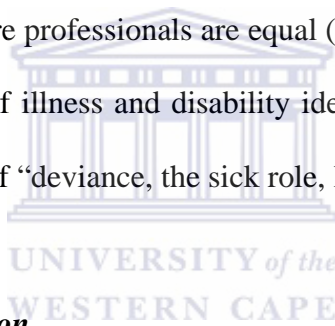
is then freely available. Incorrect information is thus common, as are alternative treatments and healing methods. These can lead patients to reflect traditional medical care and question the validity of information provided by health care practitioners. Additionally, discussing this information with health care practitioners can often lead to interpersonal problems, as many practitioners dislike having their epistemic authority challenged or being “second-guessed” by their patients. Practitioners may see the continual discussion of information from the Web as time consuming, threatening and even disrespectful (Eleanor et al., 2004).

It is also possible that patients may misunderstand complex information available on the Web and may experience increased anxiety as a result, or may be instilled with false hope or a false sense of security. The best way to manage these problems is to provide patients with as much information as they require gaining a sense of control over their illness or disability. In addition, practitioners may consider distributing a list of recommended web sites that patients could visit if they felt the need to read and learn more (Eleanor et al.,2004)

In recent years there has been a shift of emphasis from repairing damage caused by disease to a focus on education and understanding about living with chronic illness and disability. In this sense, information, advice and support are among the most important interventions health care professionals have to offer, their goal being to help the patient live as normal and satisfying a life as possible within his or her family and community. Such help needs to be approached with care and sensitivity, and information and support

provided within the context of a professional relationship (Locker, 1997). Spiro (1998) recommends humanising modern biomedicine with hope, empathy and caring. He believes that “doctors can cure diseases but that healing is a gift patients give themselves” (Mouradian, 2001).

Furthermore, patients need to be offered choices, and not have them made by others on their behalf. This means ensuring that individuals are helped to be independent and not encouraged into dependency. In this regard, the rise in patient consumerism, the patient’s rights movement, and easy Internet access to medical information all subtly reinforce the idea that patients and health care professionals are equal (Mouradian, 2001). In addition to the themes in the experience of illness and disability identified by Locker (1997), there are also the interacted themes of “deviance, the sick role, labelling and stigma”.



#### ***2.10.4 Theory of reasoned action***

The theory of reasoned action, advanced in the mid-1960s by Fishbein and Ajzen, is based on the assumptions that human beings are usually quite rational and make systematic use of the information available to them. People consider the implications of their actions in a given context at a given time before they decide to engage or not engage in a given behaviour and that most actions of social relevance are under volitional control (Ajzen, 1980). The theory of reasoned action is conceptually similar to the health belief model but adds the construct of behavioural intention as a determinant of health behaviour. Both theories focus on perceived susceptibility, perceived benefits and constraints to changing behaviour. The theory of reasoned action specifically focuses on

the role of personal intention in determining whether behaviour will occur. A person's intention is a function of two basic determinants:

- (1) Attitude (toward the behaviour), and
- (2) 'Subjective norms', i.e. social influence. 'Normative' beliefs play a central role in the theory, and generally focused on what an individual believes other people, especially influential people, would expect him/her to do. For example, for a person to start using condoms, his/her attitude might be "having sex with condoms is just as good as having sex without condoms" and subjective norms (or the normative belief) could be "most of my peers are using condoms; they would expect me to do so as well". Interventions using this theory to guide activities focus on attitudes about risk-reduction, response to social norms, and intentions to change risky behaviours.

The main value of this theory is that it accounts for the variables that can intervene between an attitude and its corresponding behaviour to change the direction of the person's actual behaviour. This goal is accomplished by focusing attention on the individual's attitude towards the behaviour and not the subject of the behaviour. For example, the attitude is about whether or not to use a condom, not on whether or not the individual likes condoms. Therefore a woman may choose not to use condoms not as a result of her dislike of condoms, but rather as a result of her fear of her partner's reaction to the suggestion of using condoms.

This theory also assumes that individuals are rational in their decision-making. This presumption may not be entirely accurate, or relevant when referring to HIV/AIDS, as

AIDS related behaviours are heavily influenced by emotion, originating from both the individual and society at large (Michel-Johnson & Bowen, 1992).

### ***2.10.5 Trans theoretical model***

In this model, behaviour change has been conceptualized as a six stages or continuum related to a person's readiness to change. People are thought to progress through these stages at varying rates, often moving back and fourth along the continuum a number of times before attaining the goal of maintenances. Therefore, the stages of changes are better described as spiralling or cyclical rather than linear. According to this theory, tailoring interventions to match a person's readiness or stages of change are essential. This model was developed by Prochaska, Clemente (1990).

Pre-contemplation, contemplation, preparation, action, maintenance and relapse. With respect to HIV/AIDS testing, the stages could be described as:

- (1) Has not considered testing for HIV/AIDS (precontemplation)
- (2) Recognizes the need to test for HIV/AIDS (contemplation)
- (3) Thinking about testing for HIV/AIDS in the next months (preparation)
- (4) Consider testing for HIV/AIDS now (action)
- (5) Use condom after HIV/AIDS test (maintenance)
- (6) slipping-up with respect to condom use (relapse)

In order for an intervention to be successful it must target the appropriate stage of the individual or group. For example, awareness rising between stage one and two.

Groups and individuals pass through all stages, but do not necessarily move in a linear fashion (Prochaska, 1992). As with previous theories, the stages of change model emphasizes the importance of cognitive processes and uses Bandura's concept of self-efficacy.

### ***2.10.6 AIDS risk reduction model***

The AIDS risk reduction model, developed by Catania et al (1990), uses constructs from the health belief model, the social cognitive theory and the diffusion of Innovation theory (a social model described below) to describe the process individuals (or groups) pass through while changing behaviour regarding HIV risk. The model identifies 3 stages involved in reducing risk for HIV transmission, including:

- (1) Behaviour labelling
- (2) Commitment to change
- (3) Taking action.



In the first stage, knowledge about HIV transmission, perceived HIV susceptibility, as well as aversive emotions influence how people perceive AIDS. The commitment stage is shaped by four factors: perceptions of enjoyment, self-efficacy, social norms and aversive emotions. Again, in the last stage, aversive emotions, sexual communication, help-seeking behaviour and social factors affect people's decision-making process (Catania, et al 1990). Programmes that use the AIDS risk reduction model focus on:

- Clients' risk assessment
- influencing the decision to reduce risk through perceptions of enjoyment or self efficacy
- Clients' support to enact the change (access to condoms, social support).

### ***2.10.7 Innovative theory***

These theories explain how new ideas or behaviour is spread through a population. The theory describes different types of people in a population, such as early adopters and opinion leaders.

This theory, postulated by Rogers (1983), examines health promotion from a societal level. It states that behaviour modification could be achieved by understanding the pattern and acting of absorption of any new innovation in society e.g. HIV testing. Initially, the uptake of the innovation, such as the drive to promote condoms, exhibits slow progress. The people who take up the innovation at this early stage are typically high in economic status and not characteristic members of the society from which they originate. These people do not have a tremendous impact on the mass uptake of the innovation, but they serve to influence a select group of people who are more characteristic of the general society. This select group of people is called the early adapters. They are usually community leaders; they are role models who command respect and have good communication systems. The uptake of the innovation increases rapidly as this group of people begins to accept the innovation. Only a small number of people ultimately fail to adopt the innovation, or do so very slowly (Rogers, 1983).

It is evident that opinion leaders and positive role models have been widely used in most societies to help people to choose HIV/AIDS testing. Leaders have not only spoken out about the disease, but many HIV infected leaders have also disclosed their status with the aim of normalising the disease and encouraging prevention. Despite this inundation of positive opinion leaders, the incidence and prevalence of HIV continue to rise. The

diffusion of innovation model has been criticised for being too linear, and for making the basic assumption that the innovation itself is always considered positive and responded to with adherence to prevention messages. (Airhihenbuwa & Obregon, 2000)

### **2.10.8 *The Precaution Adoption Process Model (PAPM)***

Weinstein and Sandman (1992) have refined the trans-theoretical model to explain why some people find it easier than others to move through stages of health promotion. PAPM is based on the assumption that people pass through seven discrete stages on the way to adopting precautionary health behaviour.

Weinstein et al., (1998) suggests that although (PAPM) is similar to the trans-theoretical model, it has unique features. It distinguishes first between people who are unaware of a health issue, and those who are aware of the issue but have not considered its personal significance. He defines those people as having an ignorant and optimistic bias, since they don't know anything about the health aspects of the problem (ignorance) and those who know and have heard about the aspect of the problem that may be dangerous, but still don't think anything can happen to them personally (optimistic bias). Secondly, it differentiates people who have decided not to act (no change). However, these are the people who think their behaviour needs to change to improve their quality of life, but still think that it won't happen now, maybe later, because of the environmental influence, and those who are not acting because they have not considered the issue (ignorance and optimistic bias).



Perceptions of personal vulnerability to the health threat e.g. are believed to be important in determining whether a person decides to take precautionary action. Move from stage 3 (where individuals engage themselves to make a decision about the problematic behaviour) up to stage 5 (when a person has intentions to change and willingly decides to avoid the aspects which seduce them to engage in that unpleasant behaviour). Situational obstacles are thought to play a large role in moving from an intention to act. Then up to stage 6, when someone implements his/her chosen quality of life.

## **2. 11 Conclusion**

There are appropriate options given under specific models that indicate that individuals should be cognitively and emotionally able to understand and remember what they are to do. People should be given the opportunity to be involved in choosing, starting, managing and maintaining control of the HIV/AIDS virus. The medication should however be seen as a form of benefit. Individuals need to justify their behaviour. Patient's beliefs should be examined and corrected if necessary.

Innovation has indicated that behaviour modification could be achieved by understanding the pattern and acting of absorption of any new innovation in society. The more HIV infected leaders disclose their status the higher the chance of normalising the disease and encouraging prevention. Bandura, from his social learning theory, indicated that modelling is encouraged to demonstrate the good or worthiness of imitating behaviour. Positive role models should be included in prevention and awareness campaigns. The reasoned actions model maintains that, the goal can only be

accomplished when focusing on the individuals' attitude towards the subject. Social support is one of the most needed elements to encourage adherence. People who feel they receive the comfort, caring and help they need are more likely to follow medical advice than people who have less social support.



## **CHAPTER 3**

### **3. Methodology**

#### **3.1. Introductions**

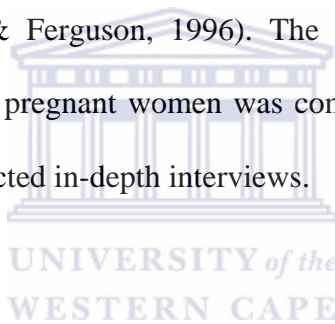
This chapter outlines the methodology followed to design and interpret the present study's results. Interviews were the primary data collecting source. The interview is considered a specialised pattern of verbal interaction. Twenty pregnant women who visited the clinic for the first time were recruited to participate in the study. The aim of the study was to recruit ten pregnant women who come to the clinic with the aim of antenatal examination and HIV/AIDS testing and ten who come only for antenatal examination and intentionally do not want HIV/AIDS testing. The chapter indicates is also indicated the procedure that was followed to collect data and analyse it. The reflexivity and proper research ethics were followed to avoid harm to the twenty participants and there are reported on.

#### **3.2. Qualitative methodology**

An interview is used as a form of qualitative data collection technique, since the subject of HIV/AIDS is an emotional subject. Interview is an open way of explaining and communication you're feeling to someone. It might help pregnant women heal their soul, accept life threatening conditions and come to terms with reality while explaining their views on the subject in question. Pregnant women in their health hazards felt accommodated welcomed and felt free to express themselves. Interviews also encourage people to freely express their feelings and understand aspects and factors that might affect their everyday life, be it physically, mentally or socially. Qualitative methodology is considered a suitable method of inquiry to understand people's compliance or non-

compliance with health promoting behaviour. Behavioural theories don't always predict people's behaviour, which is often controlled by different factors and these may change (Straub, 2002). So in interviews respondents are better situated to fully explain their reasons for following their present patterns of behaviour.

The most salient reason for using interviews methods is that it offers the opportunity to explore participants' perspective in their own terms. An interview approach is appropriate for exploring the views of individuals whose assumptions differ from those of the mainstream culture, and who therefore, have a particular need to speak and be heard (Reviere, Berkowitz, Carter & Ferguson, 1996). The main reasons for accepting or refusing HIV/AIDS testing by pregnant women was considered to be best accessed via sensitively arranged and conducted in-depth interviews.



### **3.2.1 Instrument**

Interviews occupy an important place in the behavioural and social sciences. Kahn and Connell (1975) define the interview as specialized pattern of verbal interaction initiated for a specific purpose, and focused on some specific content area. What it means to be healthy or ill must always be interpreted against the socio-cultural background. At the same time, health and illness are intensively personal, affecting individual bodies and intimate spaces. For anyone who seeks to study such experience the interview is a very powerful tool (Mathieson, 2002).

Given the sensitive nature of the topic, in-depth and semi-structured interviews as a form of qualitative inquiry were utilised in the study to elicit the desired information. Semi-structured interviewing as a more open and flexible tool allows the researcher to record perspective that is not usually envisaged by researchers. This use of semi-structured interviews allows for an exploration of a large unrehearsed area of women's experience (Banister et al., 1994; Kirkwood, 1993)

Pregnancy is a condition that interferes with pregnant women's hormones. Pregnant woman with hormonal imbalances due to pregnancy and having to explain her perceptions and opinions about HIV/AIDS testing it seems as if one is asking a lot from the pregnant women. The interview might be a reasonable way and if correctly conducted might ensure people that are being accepted, listened to and understood. In an interview people explain and express their feeling and thoughts with ease and in the process their self-esteem is boosted (Maccoby, 1980). In this study interviews were the preferred methodology of collecting data since there was no guarantee that subjects were literate, and the researcher could be able to probe and even clarify responses when there was misunderstanding or confusion.

Audiotape individual interviews were the primary data collecting source. This research method was selected, as it is a good technique to draw out and transmit information from the interviewee to the interviewer. After it is recorded it will help the interviewer to carefully listen to the audiotape and transcribe the interviews accurately and successfully.

It also helps the interviewer/researcher to understand the closed models of individuals, families, organization, institutions and communities (Holstein & Gubrium, 1995).

### **3.2.2 Participants**

Twenty pregnant women were selected to participation in the study. The participants were pregnant women between the ages 18 – 30 attending the Maternity Obstetric Unit at Gugulethu Health Clinic (MOU) for the first time. The clinic offers antenatal services to pregnant women only. They offer PMTCT therapy to women who are found to be HIV/AIDS positive after HIV/AIDS testing. Joining PMTCT program is optional. The sample comprised of ten pregnant women who were attending the clinic for the first time and who come with the intention of doing HIV/AIDS test as part of antenatal package. Ten other pregnant women were the group that come only for antenatal assessment only.

This is a qualitative study and the researcher chose to select a convenient sample. While pregnant woman were waiting for their turn to be attended by the health workers, the researcher was given a chance to explain the purpose of the study and answer questions asked by the pregnant woman. After the presentation, the researcher invited all women who are interested in participating in the research. Recruiting ten women who are for HIV/AIDS testing and against HIV/AIDS testing was not easy, because woman were not

divided from outside the room to indicate that they are for or against the HIV/AIDS test. Those who entered the room after the researcher had obtained the number wanted for the adhering or the non-adhering, groups was not turned away the researcher have asked them questions but did not probe since she had the sample required. So it means on the day were the researcher had uneven numbers, she had then increase the number to six instead of four, to get two who agreed to test for HIV/AIDS and two who disagreed to test for HIV/AIDS for the day. Four or six pregnant women were recruited everyday for five days to participate in the research study. Interviews were administered between seven and nine, lasting between 20 and 30 minutes. Every participant who entered the room was informed of the process of the data collection before the interviews. They then signed a consent form to demonstrate acceptance to participate in the research study. They were informed that the information that they have shared with the researcher was not going to be available to the clinic staff. It was only going to be seen by the researchers' supervisor at the University and the recorded tapes would be destroyed immediately after the transcription. The questions were written in English and translated into Xhosa during interview. The reason first time visitors were interviewed at that time of the morning was to avoid selecting participants after the health talk given from 09h00 that informs pregnant women about preventing mother-to-child HIV virus transmission (PMTCT). The present study was not established to evaluate (PMTCT), but to ascertain pregnant women's prior knowledge, attitude and perception of HIV/AIDS before they get the information about (PMTCT) at the clinic.

### **3.2.3 Procedure**

Permission to conduct the study was obtained from the Director of the MOU, Mowbray in the Western Cape. The researcher obtained permission by form of a letter. The data was obtained through audio tape recordings during November 2003 at Gugulethu MOU. The researcher talked with seventy women in an open hall, explaining the purpose and the objective of the study and the women asked questions in the process. After explanation the women willingly stood up and joined the researcher in the counselling room. There was no appointment for the next day. They had to listen to the presentation and decide thereafter to come for interview or not. They were given time to ask questions to verify issues they did not understand during presentation of the study in the hall. The participants signed a consent form to show their readiness to participate in the study. Doors and windows of the interview room were closed at all times to prevent people from the hall hearing details of the conversation. Interviews were administered for approximately 20- 30 minutes. Each interview was tape recorded and transcribed verbatim.

#### **3.2.4 Data Analysis**

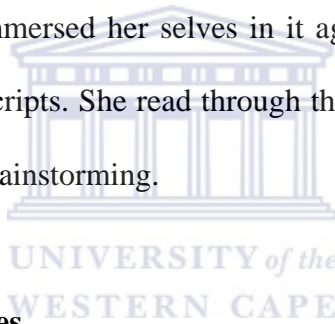
In the data analysis thematic content analysis was used following five steps as suggested by Terreblanche and Durrheim (2002). Each tape-recorded interview was transcribed verbatim. A qualitative thematic analysis was carried out on the data to gain an understanding of the participants' psychological world. A thematic analysis is a coherent way of organising or reading interview material with regard to specific research questions. These readings are then organised under thematic headings or categories in an



attempt to do justice both to the research question as well as the view of the participants (Banister et al., 1994).

#### **3.2.4.1 Step 1: Familiarisation and Immersion**

Data gathering in interpretive research is not just a mindless technical exercise, but involves the development of ideas and theories about the phenomenon being studied, even as the researcher makes contact with gatekeepers and set up interviews. So by the time the researcher comes to data analysis he/she should already have a preliminary understanding of the meaning of the data. In the present data analysis the researchers has taken research material and immersed her selves in it again, working with the text e.g. field notes and interview transcripts. She read through the text many times over: making notes, drawing diagrams and brainstorming.



#### **3.2.4.2 Step 2: Inducing themes**

In this step, the researcher looks at material and tries to work out what the organising principles are those “naturally” underlie the material. There are no hard and fast rules about what sort of themes or categories are best.

1. First, the researcher tries to use the language of the interviewees or information, rather than abstract theoretical language, to label the categories.
2. Second, the researcher attempts to move beyond merely summarising content, and thinks in terms of processes, functions, tensions and contradictions.

#### **3.2.4.3 Step 3: Coding**

During coding the researcher develops themes and she codes at the same time. That was done in the present study by marking different sections of the data that is relevant to one or more of emergent themes. The Researcher coded a phrase, a line, a sentence, a paragraph, identifying these textual “bits” by virtue of the content material that pertains to the themes under consideration. The context of the text might refer to a discrete idea, explanation or event, and any textual “bit” might be labelled with more than one code if it refers to more than one theme. The researcher used coloured marker pens to highlight pieces of text when coding, so that the researcher was able to identify themes and their origin. (Sehlapelo & Terreblanche, 1996). In coding the researcher broke down a body of data into labels, meaningful pieces, with the view of later clustering the “bits” of coded material together under the code heading and further analysing them both as a cluster and in relation to other clusters. In practice, thematising and coding blend into each other, because the themes that researchers is using tend to change in the process of coding as the researcher develops a better understanding of them and how they relate to other themes.

#### **3.2.4.4 Step 4: Elaboration**

At this stage, the researcher is likely to find that there are all sorts of ways in which extracts that you grouped together under a single theme actually differ, or that there are all kinds of sub-issues and themes that come to light. So elaboration has helped researcher explore themes more closely. This is also an opportunity to revise the coding system. This is however a sign of thorough analysis, (Terreblanche & Kevin Durheim, 2002).

#### **3.2.4.5 Step 5: Interpretation and Checking**

In this stage the researcher put together interpretation and tries to address weak points; to see if he/she can find examples that contradict some or other points in the interpretation and checks if there are parts of the interpretation that are just summarised and nothing more. The researcher needs to ascertain if there are no instances of over-interpretation or during interpretation. This is a good opportunity to reflect on researchers own role in collecting data and creating the interpretation.

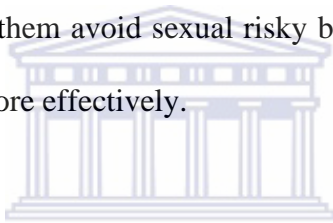
### **3.3 Reflexivity**

Reflexivity on the research process as well as investment in the research process is essential. The methodology employed in this study not only allowed the women to discuss their lives in their own voice, it also allowed the researcher, to practice the self-reflexivity necessary for revealing her biases as well as the nature of her understanding.

HIV/AIDS is a sensitive subject that carries lots of emotion. Given the opportunity to interview pregnant women at the Gugulethu maternity obstetric unit has enabled the researcher gain an insider view of what it is like to suspect that one might have contracted the HIV/AIDS disease, and to be aware of the complex decision that compliance/non compliance entails. To understanding what it means and feels to pregnant women who decide against medical treatment is considered helpful when found to be HIV positive. In the researchers mind she thought it was good and a must for pregnant women to take the HIV/AIDS test, since there are health benefits to it. It was

only after the researcher has conducted the interviews that she realised that there was a rational explanation to both HIV/AIDS test compliancy and non-compliancy.

The present research has actually prompted the researcher to use the research to improve the situation and position of women in our society. There were women who asked question after the interview. They were encouraged to seek more information about HIV/AIDS from professional institutions to empower them with the information that will actually help them better understand the epidemic. They will therefore possibly share that accurate information with their families and communities and they will also possibly adopt behaviour that will help them avoid sexual risky behaviour or if they are positive, be able to manage their lives more effectively.

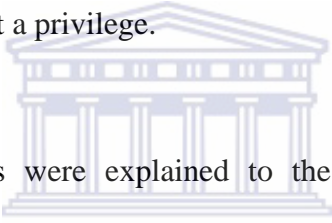


While reading the transcripts of the interviews the researcher had great difficulty in identifying salient themes especially since each and every one seems so significant to her. Terreblanche's (2002) five steps of analysis were used as a framework to analyse data appropriately. It was a great opportunity and experience to work with the medical professional staff of Gugulethu (MOU), and watch patients accessing their services.

### **3.4 Ethics**

The proposal for this study received approval from the Research and Ethics Committee at University of the Western Cape. In health research, where the health and lives of people participating in the study may be at stake, ethical considerations play a decisive role in research planning and the execution thereof. The objective of the study was explained in detail to the pregnant women individually to give them space enough to ask

questions on research aspects they did not understand. They were ensured that their information was safe and the recorded tapes would be destroyed once the transcription process is done. Xhosa was the language used during interviews. The reason for the participants signing the consent form was explained and there was mutual understanding between the researcher and the participants before signing it. All were informed of their rights to withdraw from the interviews if they felt or thought that their rights were being infringed or if they feel uncomfortable answering research questions. Since they were recruited before they receive the clinic services, they were ensured that even if they withdraw from the study, they would get the clinic services as always. Their access to clinic treatment is their right not a privilege.



The confidentiality procedures were explained to the participants. They were also informed that no one will access the information they have shared with the researcher even clinic staff. The only person who will get to read their interviews is thesis supervisor and their identity would be protected since their names would not be mentioned. They were assured that whatever was said in the interview room would never be a topic of social conversation, or discussed outside of a professional setting

### **3.5 Conclusion**

This chapter has outlined the detailed information on how the present research study was conducted and was interpreted. People who participated, the area they come from and their background are indicated. The next chapter interprets and explains the research

findings and, thereafter, compares the interpreted results between the pregnant women who adhered with HIV/AIDS testing to the group of pregnant woman who did not adhere to HIV/AIDS testing. Different theories are considered to better explain the why, how and what encouraged or triggered their particular behaviour with respect to HIV/AIDS testing.



## **CHAPTER 4**

### **4.1 Results of the research**

#### **4.1.1 Introduction**

The present study compares two groups. One group constitutes ten pregnant women who adhered to HIV/AIDS testing. The other group constitutes of ten pregnant women who did not adhere to HIV/AIDS test. Therefore the interpretation will compare the response sets of the two groups, in part to ascertain the motivational difference between the two groups.

The aims of the present study as indicated in chapter one is (i) To evaluate the two groups of pregnant women's knowledge on HIV/AIDS. (ii) To evaluate the two groups of pregnant women's attitudes towards HIV/AIDS testing. (iii) Investigate barriers to HIV/AIDS testing adherence. This chapter will inform us, as to whether aims of the study as indicated in chapter one have been achieved or not. To investigate the relevance to the objective, the process of interpretation of the results will be followed. That will include the participants' quotations, different behavioural theories and the researchers' opinions. Themes will be interpreted in the following order. These themes emerged from the thematic analysis of the data:

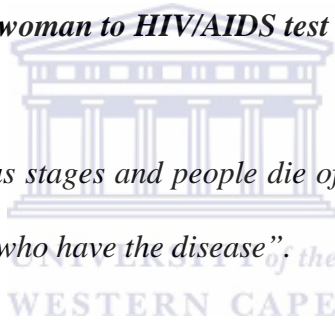
- ◆ Knowledge of HIV/AIDS
- ◆ Attitudes towards HIV/AIDS testing
- ◆ Barriers towards HIV/AIDS testing
- ◆ Belief system towards HIV/AIDS testing

## **4.2 Knowledge of HIV/AIDS test**

Acquiring information is a good practice; since it can help you make a good judgement in any situation one is facing in anytime of their life. One of the present study objectives was to evaluate pregnant women's knowledge of the subject of HIV/AIDS. In their different informed understanding on the subject of HIV/AIDS, pregnant women expressed themselves as follows:

### ***4.2.1 Non-adhering pregnant woman to HIV/AIDS test***

*“HIV/AIDS is a disease that has stages and people die of it especially those who engage in unprotected sex with people who have the disease”;*



The participant knows that HIV is a disease that progresses to AIDS through stages. HIV takes between 3-5 years to finish its devastating blow on the immune system to manifest the full blown AIDS, (AIDSFACTA, 2004). There is hope for those who take care of themselves after their HIV/AIDS positive diagnoses. People who are engaging themselves in unprotected sex are at risk of contracting HIV/AIDS virus. There is an indication of appeal from the participants that, it is important to change the sexual behaviour when one is diagnosed with HIV/AIDS to avoid re-infecting or infecting other people with HIV/AIDS virus. They should have the belief, in the ability to implement the necessary behaviour, self-efficacy (Bandura, 1977). Knowing how to use a condom and



use it correctly and knowing that they can insist on condom use with their partners. It is also suggested that self-control is a necessary component in regulating behaviour. Self-control involves actively bringing the consequences of an action to mind (Bennett & Hodgson, 1992)

*“I think when you are still in good healthy condition you have HIV, but when you start developing sores, loose weight and appetite and develop unusual things on your body then you have AIDS”.*

There is an understanding that, a person can live with an HIV/AIDS virus and still look fine. Living with HIV virus is not a thread or a dead sentence. It only imposes threat when symptoms that define AIDS diseases manifest. There is also a fair understanding of the symptoms associated with the AIDS disease. HIV/AIDS can weaken the immune system to appoint where the body is likely to develop opportunistic infections, which are illness that a healthy immune system would normally fight off. Such as TB, pneumonia, Kaposi's etc (AIDSFACTS, 2004)

*“From what I have heard, HIV is a virus that access your body through sexual intercourse and it can stay in your body for five to seven years before it can develop into AIDS.”*

There is a view that HIV Virus is a virus that does not harmer ones body after accessing it. It can also stay in your body for quite some time before it can completely get

your immune system under its control. Healthy person has between 500-1,500 cells in a millilitre of blood. When a person with HIV/AIDS has fewer than 200 T cells, that means he or she has progressed to AIDS. (AIDS FACTS, 2004). Reducing the amount of T cells from 1,500 in a millilitre of blood depends on your body's ability to fight infections. Sex has been mentioned as the main way the HIV/AIDS virus access the body.

#### ***4.2.2 Adhering pregnant woman to HIV/AIDS test***

*“I don't know what to tell you about HIV/AIDS. What I can tell you is that HIV/AIDS kills.”*

There is an expression of no hope when a person is diagnosed with the HIV/AIDS virus. Her explanation of “kill” might mean that when diagnosed with the HIV/AIDS virus and you do not look after yourself, with good nutrition, healthy sexual behaviour, accepting the disease, and exercise, one might well die soon and if the person does not know how to access the ART, community services and support groups if she is diagnosed with HIV/AIDS. Weinstein (1998) indicated that there are people are unaware of health issues, and those who are aware but have not considered its personal significance. He considered those people as ignorant and optimistic bias.

*“AIDS is a traumatising disease one cannot easily accept. I am so scared of it and I don't participate in HIV/AIDS discussions. HIV/AIDS is a killer disease; it can only be controlled if it is found in its early stage.”*

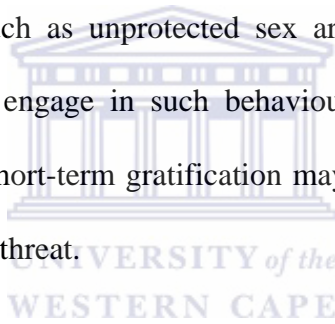
The participant explains her fears of the disease. Clinical depression is the most commonly observed disorder among infected and affected (Links & Bonks, 2000) There

is however a sense of understanding the importance of HIV/AIDS testing, and the consequences of testing in the early stages of the HIV/AIDS virus. Early diagnosis and consistent care from health care professional are essential to best treat HIV/AIDS. Pregnant women can give birth to an HIV/AIDS free baby (AIDSFACTS, 2004).

*“HIV/AIDS is a sad story, we have to live with the fear for this disease but we are married we are expected to bear children to honour our culture. What I can tell you is that HIV/AIDS is a deadly disease. We get it during sexual intercourse.”*

Situational obstacles are thought to play a large role in moving from an intention to act (Weinstein, 1998). The participant has mentioned that it is importance to fall pregnant and bear children in their culture but she did not think of unprotected sex with the person whom you do not know his HIV/AIDS status as something that expose her the to risk of contracting the HIV/AIDS virus. Prochaska and Diclemente (1990) have indicated in the Tran theoretical model, precontemplating is the time when people do not consider taking protective behaviour towards risky situations. In this sample participant honours her culture by exposing herself to contracting HIV/AIDS virus. According to Festinger (1954), the validity of one’s belief about reality and about one’s own level of ability frequently depend on social comparison processes. Social comparison processes are also important for the education of the appropriateness of one’s emotional reactions, particularly in novel and emotional situations (Schachter, 1959).

Pregnant woman from Gugulethu MOU, have responded as people who have a reasonable understanding of the subject of HIV/AIDS. Surprising the group that did not adhere to HIV/AIDS testing have given their answers in a more informed way than the pregnant woman who adhered. Therefore this might mean that woman who did not adhere to HIV/AIDS testing had a better knowledge on the subject of HIV/AIDS than the woman who adhered. Social learning theory includes the notion of expected consequences as primary in explaining behaviour. The more positive the consequences are the more likely people are to engage in that particular behaviour (Bandura, 1977). What remains perplexing in the case of HIV/AIDS prevention is the fact that the consequences of behaviour such as unprotected sex are known to be adverse in the extreme, and yet people still engage in such behaviour. In this respect Bennett and Hadgson (1992) suggest that short-term gratification may be a greater motivating factor than the perception of a distant threat.



### **4.3 Attitudes towards HIV/AIDS testing**

The second aim of the present study was to evaluate the attitudes of the total sample of twenty pregnant women towards HIV/AIDS testing. In most part, of the country people who are diagnosed with these diseases are still living in fear. The ten pregnant women who refused to take the HIV/AIDS test perceived the HIV/AIDS test as an exercise that will expose them to a status and identity that is considered unwanted, not accepted and death is inevitable. They have responded as follows:

#### ***4.3.1 Non-adhering pregnant woman to HIV/AIDS testing***

*“Hey sister, a person goes to the clinic and is given small brown tablets. They are vitamins, but they die while eating those vitamin tablets. There is nothing good now. I thought vitamins can heal but they don’t, I don’t know what to believe.”*

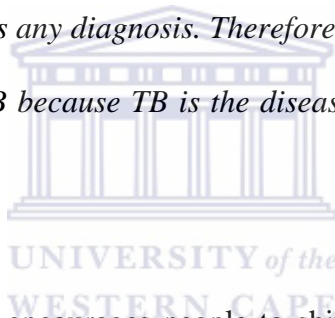
There is a perception of misleading information given about the tablets people living with HIV/AIDS get from the respective health clinics. There is a belief that vitamin tablets can cure HIV/AIDS, or, as this respondent indicates, there is an expectation that vitamin tablets improve the health condition of HIV/AIDS infected. The respondent did not mention ART as a therapy known to delay progression of HIV to AIDS. Weinstein (1998) defines people who think like the above mentioned participant as having ignorant and optimistic bias thoughts, since they do not know anything about the health aspect of the problem and hold onto over optimistic outcome expectations.

*“You know it is so funny, that each time they introduce HIV/AIDS new drugs it yields worse symptoms than the one introduced before. So I don’t think people should think of getting a cure anytime soon.”*

Reading the above mentioned statement there is a possibility that, people are living in areas where many people are known to be HIV/AIDS positive and are under medication. Therefore the HIV/AIDS medication is really reaching people who are living with the virus who need the treatment. People who are living with HIV/AIDS might have other opportunistic infections due to their compromised immune systems, so the symptoms that are said in the above statement might be the side effects of other treatment rather than the

symptoms that indicate the onset of the disease. There is also a sense that, since there is no treatment good enough to cure the HIV/AIDS virus then we might as well keep away from testing for HIV/AIDS with the hope to get cured. Skinner's (1904) internal state could influence behaviour just like external stimuli. Bandura (1977) argues that sensational, symbolic, and self-regulatory process in psychological function and human behaviour continuously interact between cognitive, behavioural and environmental determinants.

*“Why should we bother because TB, cancer and AIDS symptoms are the same? There is no way anybody can prophesies any diagnosis. Therefore if we are HIV/AIDS positive we can still claim that we have TB because TB is the disease that is usually reported when someone passes away.”*



The stigma around HIV/AIDS encourages people to shift the focus and prevent people from learning appropriate information on medical and social aspects. Weinstein (1998), believes that there are people in life who are not prepared to act regardless of the seriousness of the problem they are facing. These are people who think their behaviour needs to change to improve their quality of life, but still think that it won't happen now, maybe later, because of the environmental influence.

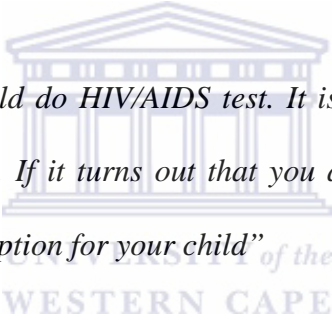
#### ***4.3.2 Pregnant woman who adhered to HIV/AIDS testing***

*“People say that when you are pregnant and maybe HIV/AIDS positive, the doctor and the nurses can be able to see that you are infected with the HIV virus through HIV/AIDS*

*test. If you are found to be HIV/AIDS positive, there is a medication that will prevent your unborn child from getting the HIV/AIDS virus. I think pregnant woman need to do HIV/AIDS test to avoid MTCT. Maybe our unborn children can survive”*

There are different antiretroviral drugs treatments available that lower the risk of mother-to-child transmission during pregnancy. Each patient who has tested HIV/AIDS positive and has a CD4 count below 200 should be referred to HAART for assessment so that accurate and relevant HIV/AIDS drug should be administered based on the progression the HIV/AIDS virus has made in the body. Each patient who has a CD4 count above 200 will receive therapy regiment of AZT. At 34 months it will be dispensed every two weeks and AZT and Nevirapine at delivery (PMTCT protocol Western Cape Province 22 September 2003). There is a concern for both the child and the mothers' good health, and it is not impossible to achieve that. There more positive the consequences are, the more likely people are too engaged in that particular behaviour (Bandura, 1977). It appears the woman who tested can perceive the positive consequences and value those above negative consequences. There is a good explanation for the value of testing for HIV/AIDS. There is also a need to for pregnant woman to test in the early stages of their pregnancy because HIV/AIDS positive pregnant woman can be enrolled into a Preventing Mother-to Child transmission program and that will reduce a number of children who are born with HIV/AIDS virus. Early diagnosis and consistent care from health care professionals are essential to best treat HIV/AIDS. Pregnant woman can give birth to a HIV/AIDS free baby. The doctor can keep an eye on your health, so that he/she can put you on antiretroviral if you fall ill. That can slow down the HIV/AIDS virus progression. (AIDSFACTS, 2004) They can even learn safer ways of parenting

HIV/AIDS negative children. For instance breastfeeding exclusively for six months and then stopping breastfeeding and provide formula exclusively. The danger of mix feed should be explained accurately and in strong terms. Mothers who are HIV/AIDS positive should know that mix feed will cause more harm than good to the baby's stomach and that can give an access to the HIV/AIDS virus (Page, 2006) How to interact with the environment to prevent themselves from re-infecting themselves or infecting other people. Is important health behaviour, their children might survive the HIV/AIDS virus during delivery. Most of all the children might survive the physical, psychological and emotional trauma that comes with being HIV/AIDS positive.



*“I think pregnant woman should do HIV/AIDS test. It is unselfish gesture because you must think of the unborn child. If it turns out that you are HIV/AIDS positive you will have time enough to decide adoption for your child”*

There is an expressed feeling that, the unborn babies needs to be protected from HIV/AIDS by their mothers. HIV/AIDS testing is the only way one can know, if he/she is infected with the HIV/AIDS virus or not. HIV/AIDS antibody testing is now amongst the most accurate diagnostic tools in medicine. HIV/AIDS test detect the antibodies that the body produces to fight HIV/AIDS virus once the infection has occurred (Rabkin, 1994). Preventing the unborn child from contracting HIV/AIDS is the best gift the HIV/AIDS positive can offer to her unborn child who is by all means depending on to the mother. To get the correct adoption is one of matters that pregnant woman thought as good gesture for the child if and only if the parent can die before the child grow and



mature to a level of living independently. There is a feeling that the woman are prepared to learn more about HIV/AIDS than what they know. There is also an understanding that one does not die immediately after HIV/AIDS positive diagnosis. It takes between 5-10 years for HIV to finish its devastating blow on the immune system to manifest the full blown AIDS (AIDSFacts, 2004). There are good positive thoughts expresses by pregnant woman than self punishing thoughts.

*“I think pregnant woman need to do HIV/AIDS test because when you are HIV/AIDS positive there is a medication to prevent your unborn child from getting HIV/AIDS infection. Even in the womb there are changes that they can be cured”*

There is still a challenge with the information people disseminate amongst each other. When a person is infected with HIV/AIDS virus, there is no way that it can be cured. One important thing to remember is that the lower the mothers' viral load, the less the chances of the baby becoming infected (Page, 2006). People seem to test with unendorsed hope and when their belief does not prevail, from their frustrations they interpret HIV/AIDS testing as a lie. There is a good sense of testing but there is inaccurate information on what happens to the unborn child who is already infected by HIV/AIDS virus while in the mothers' womb. An HIV/AIDS infected person has a potential of infecting other people around them. A pregnant woman has a potential to infect their unborn children (Kalishman, 2003). Testing for HIV/AIDS is still encouraged for the benefit of the mother and the unborn child.

The two groups had different attitude towards HIV/AIDS testing. Pregnant woman who adhere to HIV/AIDS test had a positive attitude towards HIV/AIDS test, while the non-adhering had a negative attitude towards HIV/AIDS test. Both groups attitude derived from the drug that is used on people who are HIV/AIDS positive to delay the first progression of HIV to AIDS. Woman who adhered to HIV/AIDS test sees testing for HIV/AIDS as something that will remedy their frustrations because; if they are HIV/AIDS positive they will access medication that might prolong their life. Catania (1990) defined them as people who are aware of their risk of contracting HIV/AIDS virus. Who have influence their decision to reduce risk through perceptions of enjoyment or self efficacy. They support to act the change. They however their unborn children might be born free from HIV/AIDS virus. Pregnant woman who did not adhere reported sees HIV/AIDS test as something that will expose them to HIV/AIDS drugs, the drug that will cause them more frustrations so they decide to keep away from HIV/AIDS test and pretend that they are ok. It is the intention of the individual that most strongly associated with behaviour. By determining and influencing intention (Ajzen & Fishbein, 1980)

#### **4.4 Barriers towards HIV/AIDS testing**

##### ***4.4.1 Stigma***

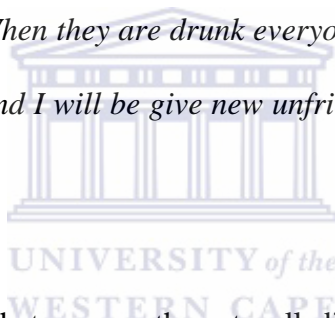
From the previous heading of PMTCT we have learned on how pregnant women who found to be HIV/AIDS are assessed, and in rolled in the PMTCT programme.

Family support is one aspect that encouraged pregnant women to do HIV/AIDS test.

The ten pregnant women who did not adhere to HIV/AIDS testing have explained their

fears as to why is HIV/AIDS testing their nightmare. Stigma, isolation and discrimination are words that were mentioned by pregnant women who did not comply with HIV/AIDS testing. Stigma can be defined as the identification and recognition of a bad or negative characteristic (Kelly, Adler & Abraham, 1999). The primary concern from pregnant women who did not comply with an HIV/AIDS test was that, they will be called names if they are found to be HIV/AIDS positive. They have responded as follows:

*“I am living within the extended family and my parents are selling liquor. They are also drinking the liquor. Disclosing my HIV/AIDS positive status to them will only invite frustrations and humiliation. When they are drunk everyone who drinks at the tavern will know of my HIV/AIDS status and I will be give new unfriendly names. That is my biggest fear.”*



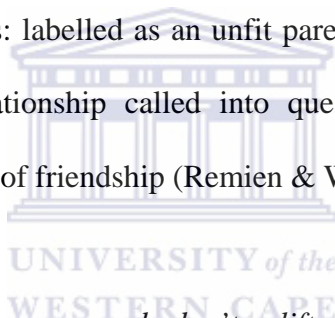
People live in environments that expose them to all different types of stigmatisation. There is a fear of testing for HIV/AIDS because they might have difficulties keeping their HIV/AIDS positive status a secret. Rabkin (1994) believes there are always extreme responses when people learn that they are HIV/AIDS positive. One is that the individual desire to withdraw, isolate and refuse to tell anyone the second person might wish to tell the world and neither of the two is adaptive. He however indicates factors that will affect the decision to disclose or not to disclose as: the potential for prejudice and stigma In this case the external force, like fear of being frustrated by her family and humiliation decide against HIV/AIDS testing. Family members are the very people that she is scared of, as her things they can divulge her HIV/AIDS positive status to people and maybe in a

negative way. There are number of psychological and biological processes through which social support might influence an individual's health, e.g. a person who is integrated into a large social network of family and friends is subjected to social controls and peer pressure that influence normative behaviour health behaviour; depending on whether this pressure promotes health and unhealthy behaviour pattern. Social integrations could have a positive or negative impact on health (Cohen, 1998). There is an understanding that it is important that, people should do HIV/AIDS test but due to their terrorising environment it will always be difficult for her to choose HIV/AIDS test.

*“I sometimes make love with my partner with blood present and he does not want to use a condom that is one thing that makes me scared of taking HIV/AIDS testing the chance of my test results coming out HIV positive exist. He might blame me for infecting him even if he might be the one who infected m with the HIV/AIDS virus he can tell his family and be blamed for the infection and even give me names.”*

There is a good understanding, on ways in which a person can be infected from HIV/AIDS. Sex with blood present is even seen as an extreme risk of HIV/AIDS infection. Due to inability to negotiate safe sex, women find themselves exposed to risky sexual behaviour even if they suggest using a condom. Their partners will always decline the request. Women may choose not to use condoms not as a result of her dislike of condom, but rather as a result of her fear of her partner's reaction to the suggestion of using condom (Ajzen & Fishbein, 1980). To avoid violence women will always succumb to that sexual risky behaviour situations. They even decide to stay away from HIV/AIDS

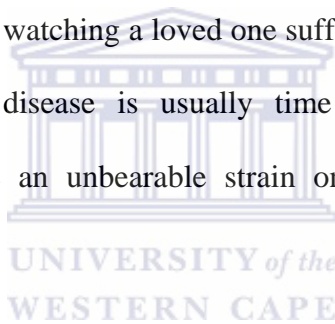
test, because they are going to be people who are responsible to deliver bad news to their partners and that alone can trigger violent behaviour. People have a deep mistrust of their sexual partners and community. They do not know how they can disclose their HIV/AIDS positive status. They are also concerned about testing that does not include treatment and/or follow-up support (Van Dyk, 2003). They even have a fear of being disowned by their partners and their family if they are HIV/AIDS positive. They will be seen as a promiscuous woman who brought the deadly disease to the family. How will they then provide the needs of the baby? Disclosure of HIV/AIDS to others is often an emotional subject. There are possible factors that can affect you when you choose to disclose your HIV/AIDS status: labelled as an unfit parent, the possibility of having the integrity of one's sexual relationship called into question or losing a relationship, vulnerable to violence and loss of friendship (Remien & Wilson, 1994).



*“We are living in a community where people don't uplift people who are down. If I can do the test and my HIV/AIDS test results come out positive, I will be the hottest township gossip. People will exaggerate my health condition and I will be left alone. I will have no friends. I might not be allowed to use or share things that I am presently sharing with my families or friends.”*

People spend most of their times in their communities. Community is a place that influences and directs most part of people's behaviour. In the case of HIV/AIDS, most part of the community sees it as a bad thing that only happens to people who deserve it. That is confirmed by the way they interpret the condition of people living with HIV/AIDS. Van Dyk (2003) in the study done in South Africa has revealed that, people have a deep

mistrust of health care workers, as well as sexual partners and communities. There is also a fear that, when they are HIV/AIDS positive they will be isolated their family and their free participation will be restricted. Thing that she need to use will be kept separately. She should first get permission to access things that she used to access before she was diagnosed with HIV/AIDS virus. Reactions to, and feelings, of families of persons living with HIV/AIDS include social stigma and isolation, as secrecy cuts off potential sources of support; fear of contagion, which may limit intimacy and involvement of a spouse or parent; fear of infecting others or straining their lowered immune system; fear of abandonment, as caregivers are unable to keep up with the physical and emotional demands of care giving, and of watching a loved one suffer and deteriorate. Caring for an individual with HIV-related disease is usually time consuming, burdensome and unpredictable, and may place an unbearable strain on the family soldierly system. (Bonuck, 1993).



#### ***4.4.2 Isolation***

In more extreme cases of continuous frustration, as in chronic disease, unemployment or prison confinement, many people loose hope, become resigned and apathetic, and adapt them to a restricted way of life. Such broken individuals thus protect themselves from the bitter hurt of sustained frustration by becoming passive recipients of whatever life brings them. Similarly, in extreme form of alienation, the individual may become non-involved and apathetic, feeling isolated, bewildered, and without hope (Carson et al., 1998).

*“I think it is difficult to be pregnant and be HIV/AIDS positive. It is possible that your neighbours, boyfriend and family members can completely change your identity. Keep you at a distance and never wish to share anything with you ever again. I think it is quite too much for the pregnant woman to handle.”*

Carrying an unborn child and being HIV/AIDS positive, is a greatest challenge pregnant woman has ever faced. There is a sense of frustration, that while facing the challenge of being HIV/AIDS positive and be pregnant the woman still have to face the challenge of deciding mechanism that will help unjust to the new identity the community and family will impose to them. Clinical depression is the most commonly observed psychiatric disorder among infected and affected. Multiple risk factors for depression diagnosis of HIV/AIDS infected itself may lead to sadness and fear of stigmatization. Stigmatization is something they cannot avoid because the HIV/AIDS infected result in wasting, weakness, pain, confusion and negative feelings. Sadness and grief are normal response of depression (Links & Bonks, 2000). The worst of all is the gap that will be created between because of HIV/AIDS. That seem taxing to the pregnant woman. On the socio-cultural level, the impact of HIV/AIDS has also challenge and broadened traditional notion of what constitutes a family. Many of those affected by the disease live in non-traditional arrangements, prompting reconsideration of who is and who function as a family (Levine, 1990).

*“I am scared to do HIV/AIDS test because if my results can come out positive it will be difficult for me to go to church because in my church they believe, that people who are HIV/AIDS positive have sinned against God. Therefore God is punishing them.”*

She preferred to stay away from HIV/AIDS test, because if she can test HIV/AIDS positive she will be removed from all church services. The church believes, that people who are infected with HIV/AIDS virus are been exposed by GOD as sinners who engaged in sex before their marriage. Hence they should be removed from all that is considered GOD services and properties. They think GOD will not listen to their prayers. People who are living with HIV/AIDS are seen as outcasts. Kalishman and Simbayi (2003) their research study revealed that, people who are living with HIV/AIDS are believed to be dirty, cursed and untrustworthy. They however need to be shameful of their behaviour, they need to feel guilty and they are considered to be weak.

#### **4.4.3 Discrimination**

A process complementary to generalization is discrimination; which occurs when the individual learns to distinguish between similar stimuli and to respond differently to them. The ability to discriminate maybe brought about through selective reinforcement (Carson et al., 1988). In the real world, people living with HIV/AIDS do suffer discrimination (Kalishman, 2002). Pregnant woman have expressed their possible fears of being negatively discriminated against by their employers. There are those who think government is discriminating against people living with HIV/AIDS.



*“Sister, government is delaying administration of (ART) and arresting the process of rolling out, where as other people suffering from other diseases like Diabetes and high blood pressure are given their medication without fighting, the HIV patient does not have immediate access to appropriate medications.”*

There is a concern of imbalances when coming to drug distribution by health professionals. They mention that as a strong and justifiable wall of excuses that will prevent them from testing for HIV/AIDS, because they think that even if they can test for HIV/AIDS now it will take them some time before they could be rolled into structures that distribute HIV/AIDS drugs. People are concerned about testing that does not include treatment and/or follow-up support (Van Dyk, 2003). This means that, people who tested for HIV/AIDS and are HIV/AIDS positive they will suffer the anxiety while waiting trail to access HIV/AIDS drugs. People who do not know their HIV/AIDS status will have less anxiety. Anxiety disorder is a common symptom in patients with HIV/AIDS infection. When the anxiety is severe it might result in anxiety disorder. These disorders include adjustment disorder, panic disorder, and post-traumatic stress disorder. The practitioners need to be aware of the differences among the specific disorders treat or refer patient and help them receive optimal care. People with historical major depression and those with limited social support are people might experience severe anxiety during the course of HIV/AIDS infection (Link & Bonks, 2000)

*“I don’t want to do this HIV/AIDS testing, because that will be the end of my marriage. My neighbours’ husband has left his wife and children. The wife was damned after she*

*has disclosed her HIV/AIDS positive status to her husband. The husband has beaten her up and left her for another woman”*

Disclosing a HIV/AIDS positive status to their partners, will be the end of their financial support, there will be with no shelter for them, and there will be no social and emotional support. In countries like South Africa, where extended families are the norm, and power differentials within relationship exist to the detriment of most woman, the implication of that individual decision are a violation of the norm and often incur severe consequences in the form of domestic violence or loss of financial support (Dimatteo & Dinicola,1982).

*“My husband is a breadwinner and we rely on him for everything. So if I can report that I am HIV/AIDS positive that would destabilise the family and he might beat me up. In my home we don’t talk about condom so how am I going to prevent my self from contracting HIV/AIDS. I cannot negotiate condom use and I cannot disclose a HIV/AIDS positive status to my husband”*

She decided to stay away from activities that will make her bring home information that will offend her Partner. Reporting HIV/AIDS positive status might mean that she will forfeit every supply and support, she was getting from the partner. That can still lead to violence and divorce. Woman are more stigmatised than men. It happens in their community and in their own homes. They are frequently blamed for infections and are at risk of violence, they even feared that they can be killed if they are found to be HIV/AIDS positive (UNIAIDS/UNFPA/UNICEF, 2006). To use a condom is something

that is not done in their household and that type of discussion is not encouraged. Behaviour such as wanting to use condoms could be seen as a maker of HIV/AIDS, leading to rejection and stigma, (Skinner & Mfecane, 2004). So if the partner is HIV/AIDS positive it means the woman is positive too. The pregnant woman's challenge is that even if they have HIV/AIDS testing resources at their exposure they will never use them because they do not want to be the people to will report HIV/AIDS positive status. Due to the frustrations, humiliation and abandonment HIV/AIDS report might bring.

#### ***4.5 Family support***

Social membership may also fulfil a number of support functions that are beneficial for individual self-esteem. There is therefore broad agreement among the helping professions concerning the control role of emotional support for self-esteem and psychological well-being. Bernard (1968) has graphically described that one of the major functions of positive, expressive talk is to raise the status of the other, to give help, to reward, in ordinary human relations; it performs the stroking function. As infants need physical caressing or stroking in order to live and grow, and even to survive, so do adults need emotional or physical stroking or caressing to remain normal.

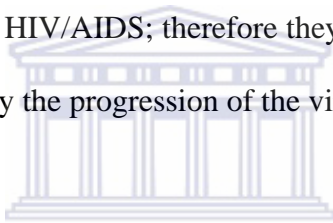
*“You know what I used to be scared when we talk about HIV/AIDS. But now I say thanks to governments educational programs because it is through those programs that my family learned of HIV/AIDS. Personally I did not know much about HIV/AIDS I was surprised to hear that my family advising me to do HIV/AIDS test. They told me that a person might be diagnosing with HIV/AIDS virus and live long. I am doing this*

*HIV/AIDS test today knowing that even if the test results can be positive my family will accept me and support me”*

There is an indication that, there are more people who watch and listen to HIV/AIDS programmes. They listen with the intention to benefiting and assisting people who need information about HIV/AIDS. There is also a sense of interest and desire to communicating information of HIV/AIDS between parents and children. Rogers (1983) has indicated that behaviour modification could be achieved by understanding the pattern and acting of absorption of any new innovation in society. In this case parents who are probably seen as role models encourages their pregnant children to do HIV/AIDS test and assured them the parental support they will receive if diagnosed HIV/AIDS positive. HIV/AIDS virus positive status is viewed as a report to inform individuals about the presence of HIV/AIDS virus in the body not as something that can kill you immediately after the diagnoses. There is now a greater deal of evidence that the availability of social support is associated with a reduced risk of mental illness and physical and even mortality (Schuwarzer & Lippin, 1989). Social support has been defined as information from others that one is loved and cared for, esteemed and valued (Cobb, 1976).

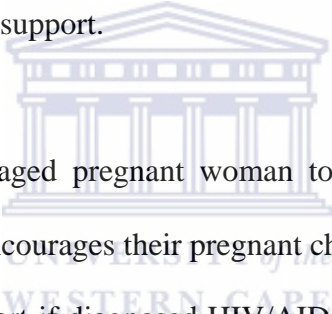
*“I am encouraged by my parents to do HIV/AIDS test, that when I am tested positive I should get ART and follow a correct diet so that I could live longer and take care of my baby. I have engaged in unprotected sex, some times during menstruation because in my culture is sad to die without a child. You must have a child who will carry your name when you are dead. Who will turn you parent sad loss in to happiness.”*

There is a good relationship between parents and children. They have taken their discussion to the highest level. They are discussing HIV/AIDS matters that were previously considered a taboo. The parents have made it their responsibility to talk with their children about HIV/AIDS. That encourages children to take part in HIV/AIDS testing during antenatal clinic visit. There is an information support; it involves providing people with information. One can however use in coping with their problems (Strobe & Strobe, 1987). Menstruation period is known as a period that exposes people to high sexual risk infection. There is knowledge of sexual intercourse during menstruation as a highly possible way to contract HIV/AIDS; therefore they wish to test for HIV/AIDS and use nutrition's and ART to delay the progression of the virus.



The pregnant woman who adhered to HIV/AIDS test have expressed their reasons on why did they adhered to HIV/AIDS test and so did the pregnant woman who did not adhere to HIV/AIDS test. The main reasons that discouraged the pregnant woman to test were; there is a fear of testing for HIV/AIDS because they might have difficulties keeping their HIV/AIDS positive status a secret. Potential prejudiced and stigmatisation. In the extreme cases, frustration and humiliations they will get from family members and community. Family members are the very people that they are scared of, as they things they can divulge their HIV/AIDS positive status to people and maybe in a negative way. . Due to inabilities to negotiate save sex, woman fined themselves exposed to risky sexual behaviour even if they suggest using a condom.

They decide to stay away from HIV/AIDS test, because if they are HIV/AIDS positive they will have to go and report the HIV/AIDS positive results, and that alone can trigger violent behaviour. Most part of the community sees HIV/AIDS as a bad thing that only happens to people who deserve it. They think they can not afford to carry a big belly and still unjust to the new identity the community and family will impose to them when they are known to be HIV/AIDS positive they think that even if they can test for HIV/AIDS now it will take them some time before they could be enrolled into structures that distribute HIV/AIDS drugs. Disclosing a HIV/AIDS positive status to their partners, will be the end of their financial support, there will be with no shelter for them, and there will be no social and emotional support.

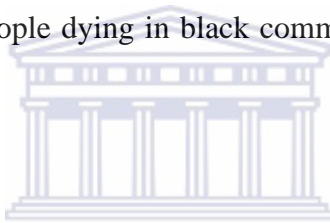


The main reasons that encouraged pregnant woman to test are; the parents who are probably seen as role models encourage their pregnant children to do HIV/AIDS test and assured them the parental support if diagnosed HIV/AIDS positive. There is knowledge of sexual intercourse during menstruation as a highly possible way to contract HIV/AIDS; therefore they wish to test for HIV/AIDS and use nutrition's and ART to delay the progression of the virus.

#### **4.6 Belief system towards HIV/AIDS testing**

*“White people don't like black people and Wouter Basson is one of many. It has being reported that he contaminated water with chemicals that cause different disease to the areas of black people. He has however poisoned corn meal, flour and sump since those are black people's basic foods. So that he will kill people in numbers”*

There is a belief that, white people are out there to reduce a number of black people in South Africa. There is still a belief that people can be infected by HIV/AIDS through HIV/AIDS virus contaminated water and poisoned flour, corn and sump. This therefore means that people can still be infected through water and food staff, not only through sexual intercourse and body fluid exchange. Even if one does not have sex, she/he will be HIV/AIDS infected anyway because she/he needs to eat. It might also mean that every black person who stay in black townships whether sexually active or not, they need to do HIV/AIDS test. HIV/AIDS test, according to this belief should be encouraged to black community more than any other area in South Africa. This belief seems to have emanated from the evident number of people dying in black community due to HIV/AIDS related diseases.

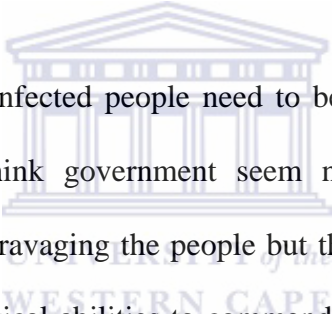


*“I am looking at the two sisters who are shouting instructions as they are drawing the blood from pregnant woman. They are even sharing a small table with all the instruments they are using to draw blood. There is a possibility that they can infect the uninfected with the HIV/AIDS infected blood. So looking at that scenario, I do not think that I can do HIV/AIDS test.”*

There is a fear that, nursing sisters have a potential of infecting pregnant woman with HIV/AIDS virus. That decision was influenced by the nursing sisters table arrangement and the amount of equipments they keep on that table. The simultaneous way of verbal and hand communication. There is a belief that, when a sister draw blood and talk at the same time that might interfere with the Nurse focus and lead to a possible use of same

injection to two different pregnant woman. It is possible that, there are HIV/AIDS infected people who still believe that they are infected due to the sisters' negligence. That type of health practice still cause people to delay or avoid HIV/AIDS test. People in South Africa have a deep mistrust of health care professionals (Van Dyk, 2003).

*“The government is not interested in searching for a HIV/AIDS cure. People living with HIV need to wait until they are near death before they can be put on treatment. The President even believes that HIV does not cause AIDS. So people are caught up in that political debate”*



People believe that HIV/AIDS infected people need to be given ART before HIV virus progresses to AIDS. They think government seem not to pay more attention on HIV/AIDS as a disease that is ravaging the people but they see it as a topic enough for the politicians to test their political abilities to command an attention. In that process of debate people are dying. So there is no need for a person to test for HIV/AIDS while looking healthy because you are not going to find the treatment anyway, you can only test for HIV/AIDS when you look sick because that is the time people infected with HIV/AIDS get drugs. Individuals weigh the benefits against the perceived cost and barriers to change. For change to occur, benefits must outweigh cost (Rosenstock, 1974)

#### **4.7 Conclusion**

Pregnant women from Gugulethu in South Africa expressed their insecurities and their sexual risky behaviour that exposes them to sexually transmitted diseases. The way they



are being discriminated by the way socialization. They are prevented from initiating condom during sex. They are exposed to HIV/AIDS infection in honour of culture. Propagated fear of stigmatisation, discrimination and isolation governs their lives. Parents are mentioned as leading role models to fight the spread of HIV/AIDS. Summary of the study, recommendations and limitations are discussed in the next chapter.

## **CHAPTER 5**

### **5 1 Summary**

Pregnant woman from Gugulethu MOU in Cape Town have responded as people who have a better understanding of the subject of HIV/AIDS. Although the group that did not adhere to HIV/AIDS testing have given their answers in a more elaborate way than the pregnant woman who adhered. Therefore this might mean that women who did not adhere to HIV/AIDS test had a better knowledge on the subject of HIV/AIDS than woman who adhered to HIV/AIDS. The present study does not however suggest knowledge as the accurate measurement that could decide and encourage HIV/AIDS testing adherence. There are factors that have encouraged pregnant woman who adhered to HIV/AIDS testing even though they did not have more information about HIV/AIDS, and that is their immediate family members who are their parents.

Pregnant woman who adhered to HIV/AIDS test had a positive attitude towards HIV/AIDS testing, while the non-adhering had a negative attitude towards HIV/AIDS test. Both groups attitudes derived from the drug (ART) that is used on people who are HIV/AIDS positive to delay the first progression of HIV to AIDS. Woman who adhered

to HIV/AIDS test said HIV/AIDS test is a way that will lead them to accessing ART if they are discovered to be infected with HIV/AIDS virus. Catania (1990) defined these pregnant women as people who are aware of their risk of contracting HIV/AIDS virus. Who have influence their decision to reduce risk through perceptions of enjoyment or self efficacy. They support to act the change.

Pregnant woman who did not adhere reported HIV/AIDS testing as something that will expose them to HIV/AIDS drugs, the drug that will cause them more frustrations because it do more harm than good, like reviling more side effects that are unbearable. Therefore be stigmatized due to those side effects. Hence they decide to keep away from HIV/AIDS test and pretend that they are ok. It is the intention of the individual that most strongly associated with behaviour. By determining and influencing intention (Ajzen & Fishbein, 1980).

The pregnant women who adhered to HIV/AIDS testing have expressed their reasons as to why they adhered to HIV/AIDS testing and so did the pregnant woman who did not adhere to HIV/AIDS test. Other reasons that discouraged the pregnant woman to test were; it might be difficult for them to keep their HIV/AIDS positive status a secret. Family members are the very people that they are scared of, as they things they can divulge their HIV/AIDS positive status to people and maybe in a negative way. By report my infection of HIV/AIDS as something that has been attracted by my behaviour.

Pregnant women have indicated their inability to negotiate safe sex, and that however exposed them to the high risk of contracting HIV/AIDS virus. Their negotiation on condom use raises a suspicion of promiscuity or maybe that is a polite way of informing a partner of their HIV/AIDS positive status. Hence they decide to stay away from HIV/AIDS test that will even save them from reporting any HIV/AIDS status. Pregnant women, have indicated that often that not a report of HIV/AIDS positive status triggers violent behaviour. HIV/AIDS positive status is only accepted when it is reported by a male counterpart and only if he has received a good counselling on how can a person get infected from HIV/AIDS. Women are still seen as HIV/AIDS possible carriers. Their community still sees HIV/AIDS as a bad thing that only happens to people who deserve it. . Disclosing a HIV/AIDS positive status to their partners, will be the end of their financial support, there will be with no shelter for them, and there will be no social and emotional support for them.

Pregnant women have indicated that they can not afford to carry a big belly and still adjust to the new identity the community and family will impose to them when they are known to be HIV/AIDS positive

The other reasons that encouraged pregnant women to test are; their parents who are probably seen as role models that have shared information with their children on how HIV/AIDS drug therapy can prevent an unborn child from contracting HIV/AIDS virus and delay the fast progression of HIV to AIDS. They were even assured they will get their parents support if diagnosed HIV/AIDS positive status.

There is a belief that, white people are out there to reduce a number of black people in South Africa. There is still a belief that people can be infected by HIV/AIDS through HIV/AIDS virus contaminated water and poisoned flour, corn and sump. This therefore means that people can still be infected through water and food staff, not only through sexual intercourse and body fluid exchange. Even if one does not have sex, she/he will be HIV/AIDS infected anyway because she/he needs to eat. It might also mean that every black person who stay in black townships whether sexually active or not, they need to do HIV/AIDS test. HIV/AIDS test, according to this belief should be encouraged to black community more than any other area in South Africa. This belief seems to have emanated from the evident number of people dying in black community due to HIV/AIDS related diseases.

There is a belief that, nursing sisters have a potential of infecting pregnant woman with HIV/AIDS virus. That decision was influenced by the nursing sisters table arrangement and the amount of equipments they keep on that table. Their talking shifted their focus from the work at stake to their communication that can make them infect people with HIV/AIDS. It is possible that, there are HIV/AIDS infected people who still believe that they are infected due to the sisters' negligence. This type of health practice still causes people to delay or avoid HIV/AIDS test. People in South Africa have a deep mistrust of health care professionals (Van Dyk, 2003).

People believe that HIV/AIDS infected people need to be given ART before HIV virus progresses to AIDS. They think government seem not to pay more attention on HIV/AIDS as a disease that is ravaging the people but rather see it as a topic enough for

the politicians to test their political abilities to command an attention. In that process of debate people are dying. So there is no need for a person to test for HIV/AIDS while looking healthy because you are not going to find the treatment anyway, you can only test for HIV/AIDS when you look sick because that is the time people infected with HIV/AIDS get drugs.

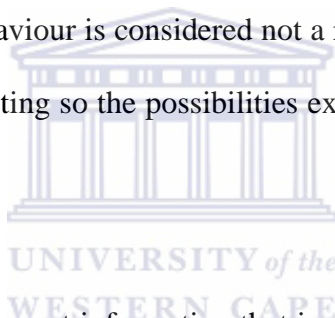
## **5.2 Recommendations**

The present study was a qualitative study. It had a small sample size. Therefore it might generate more information if the sample size could be increased. It can also be rolled over to other Maternity obstetric units in Cape Town. Look if the results obtained from Gugulethu MOU can be the same results if the are obtained in Delft an area that is predominately colourt people living there and Constantia where is an area that is predominately whites and determine if the HIV/AIDS testing experience in those areas are the same as the experience in black community or not.

The group sessions run in the clinics are highly informative about benefits of management but does not sufficiently address fears of stigma, social ostratization, discrimination and gender violence. Management of the pregnancy and breastfeeding are done comprehensively. The post-natal management information is focused on material and child health and not on the issues of sexuality management. Woman are given condoms and trained how to use them but the problem comes when they have to part that information with their partners. I think they should be trained on how to report save sexual management process to their partners and how to manage aggression if presented

by the partner during initiation of condom use. In most household condom is normally used if it is introduced by the male figure. When introduced by female it raises suspicions of promiscuousness and possibility of being HIV/AIDS positive.

Couple counselling should be encouraged, not only when they have to test for HIV/AIDS. There should be places in health structures, NGOs and private places where they encourage couple to attend counselling. To inform them on all sexually transmitted disease and how can that be transmitted because STIs are infections that expose people to contracting HIV/AIDS. They should be informed on what it is considered a sexually risky behaviour and what sexual behaviour is considered not a risky behaviour. The situation is very tense during HIV/AIDS testing so the possibilities exist that people might miss some of the important information.



There is also an element of incorrect information that is shared among people. There is a need to identify that information and when disseminating information it should be indicate as incorrect information and supplement it with correct information.

### **5.3 Limitations of the study**

This study aimed to explore pregnant women's adherence and non-adherence to HIV/AIDS test. Although the overall aim of the research was achieved, some women were short and brief in answering the questions. I however think it is because of the sensitivity of the topic and the stigma around it. There might have been less trust on the researcher.

The recruitment was done in an open hall, where all pregnant women were waiting to be assisted by maternity clinic staff. The office where the researcher was conducting the research was direct opposite to that hall. Therefore whoever entered that office after the presentation was of interest to talk about HIV/AIDS. There was maybe speculation about their HIV/AIDS status. The other suspected limitation could be the noise done by pregnant women who were waiting outside in the hall. Since the researcher is not an eloquent Xhosa speaking, the researcher had to use the street wise Xhosa (slang). Due to noise the researcher had to repeat each and every questions that could might have sounded like a different question..



#### **5.4 Conclusion**

The desire to conduct the research of this nature has been reported. Hence the aim of the present study has been successfully achieved. There was enough literature that helped to inform the researched data in discovering accurate and reliable research results. Methodology was identified to pick the voices that needed to be noticed and addressed and to again clean the unimportant information that was not relevant to the objective of the study. There was a careful interpretation of the results that produced the results that will invite intervention from the Government and attract other researchers to expand and extend more investigations on areas that the present study did not manage to reach. That will be guided by the recommendations that are done in chapter five.

## References

Ajzen I, Fishbein M (1980). Understanding attitudes and predicting social behaviour. Prentice-Hall, Inc., Englewood Cliff: New Jersey

Berry, S & Frederickson, J (2003). National HIV and prevalence survey of women attending Public Antenatal Clinic. 2001-2002 Summary Report. Department of Health <http://www.avert.org/safricostats.htm>

Boyd & Johnstone (1999). What do pregnant women think about the HIV test? Department of General Practice, UMDS, 5 Lambeth Walk, London. Vol.11, pp. 21-29.

Brannon, L. & Feist, J. (2000). *Health psychology*. (4<sup>th</sup> Ed) Ontario: Wadsworth.

Bunton, R. & Macdonald, G. (1992). *Health Promoting: Disciplines and diversity*. New York: Routledge.

Carson, R.C. (1988). *Abnormal Psychology and modern life*. Eighth edition. Socott, Fireman and company: London.

Cartoux, M. (1998). Attitudes of pregnant women towards HIV testing. *A Journal of Gower Academic Journal in London*, 12(17), 2337-2344.



Cartoux M. (1999). HIV testing and counselling in African pregnant woman in the context to reduce mother to child transmission. XI international conference on AIDS Vancouver, July 1996 (abstract ThC411).

Catania J. et al., (1990). Towards an understanding of risk behaviour: an AIDS Risk Reduction Model (ARRM). Health Education Quarterly.

Clarke AG, Kendall MD. The thymus in pregnancy: the interplay of neural, endocrine and immune influences. Immunology Today 1994; 15(11):545-551.

Cochman D.S. (1998). Health Behaviour; Emerging Research Perspective: New York: Plenum Press.

Cohen M (1992). Prevention in AIDS in the World: A global report. Mann, Harvard College.

Chuenyane, G. (Sowetan, 16 July 2001). *Pregnant women refusing AIDS test.*

Creswell, J. C. (2003). Research design: qualitative, quantitative and mixed methods Approaches. (2<sup>nd</sup> Ed.). Sage Publication: London.

Denzin, K. & Lincoln, S. (1994). Handbook of Qualitative Research. Sage Publications: London.

Derek, R. & Lyn, Q. (2002). Changing Health Behaviour-intervention and research with social cognitive models. Philadelphia: Open University Press.

De Vos, A.S. (1998). *Research at Grass Roots: A primer for the caring professions*.

Pretoria: J.L. van Schaik.

DiClemente R, Wingood G (1995). A randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American Women. *JAMA* vol 274 (16): 1271-1276.

Gillian, N. (1994). *Health Psychology, a lifespan perspective*. Switzerland: Harwood academic publisher.

Henning, E. (2004). *Finding your way in qualitative research*. Pretoria: Van Schaik.

Institute of Medicine Health and Behaviour (2000) *the interplay of Biology, Behavioural and Societal influences*. Washington, DC: National Academy Press.

Johnstone, F. (1990). Women's knowledge of their HIV antibody state. *British Medical Journal*, 300, 23-24.

Johnstone, F. (1998). Uptake and acceptability of HIV testing: a randomised controlled trial of different methods of offering the test. *British Medical Journal*, 316, 262-267.

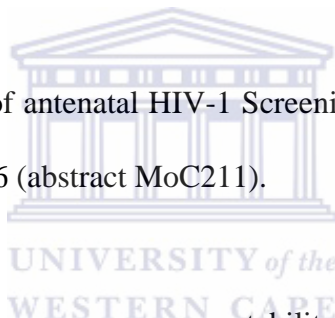
Joint United Nations Programme on HIV/AIDS, 'Report to the United Nations Secretary General on Progress towards implementation of the Declaration of Commitment on HIV/AIDS draft, July 2003.

Kalishman, S.C. (1997). *Answering your questions about AIDS*. Washington DC: American Psychology Association.

Kalishman, S.C. (2003). *The inside story on AIDS: Experts answers your questions*. Washington, DC: American Psychology Association.

Kalishman S.C. & Simbayi L.C. (2004). Theory-based HIV risk reduction counselling for sexual transmission infection clinic patients Cape Town, South Africa

Kiari J. (1996). Acceptability of antenatal HIV-1 Screening. XI international conference on AIDS. Vancouver, July 1996 (abstract MoC211).



Kiare J. (2000). HIV testing in pregnancy: acceptability and correlates of return for test results. *A Journal of Gower Academic Journals in London*, 14(10), July 2000, 1468-1470.

Klein L.(1991) Determination of acceptance of routine voluntary human immunodeficiency virus testing in an inner-city prenatal population. *Obstetrics & Gynaecology* 1991, 78:678-680.

Larsson, G (1990). Screening for HIV in pregnant women: a study of maternal opinion. *AIDS Care*, 2,223-228.

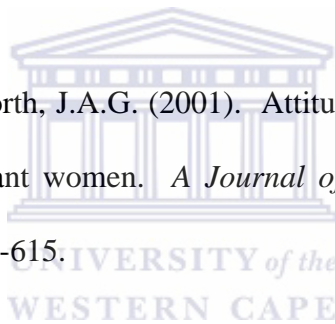
Marks, F.D. (2002). *The Health Psychology Reader*. London: Sage.

Pike, S. & Foster, D. (1995). *Health promotion for all*. Tokyo: Churchill Livingstone.

Projects inform. (2005). Pregnancy and HIV disease: issues that positive women may face when they are pregnant. [www.womenchildrenhiv.org](http://www.womenchildrenhiv.org)

Page, J. (2006). *Working with HIV/AIDS*. South Africa. JUTA and company LTD.

Pool, R., Nyanzi, S. & Whitworth, J.A.G. (2001). Attitude of voluntary counselling and testing for HIV among pregnant women. *A Journal of Medical Research Council in South West Uganda*, 13(5), 605-615.



Prochaska J, et al., The Tran theoretical model of change HIV prevention: a review. *Health Ed Quarterly* vol. 21 (4): 471-486.

Prochaska J and Clemente C (1990). Stages for change in the modification of problem behaviours. *Progress in Behaviour Modification*, (1992). Eds. Michel Hersen, Ridhark Eisler and Peter Millerp. Sycamore: Sycamore Publishing Company.

Reyd, D. (1995). Difference in HIV/AIDS testing. *Abingdon*. Issue: 7 (supply 1), Feb. 1995: 539-546,

Rosen stock, M. (1974). The health belief model and preventative health behaviour. *Health Education monographs*, 2,354-86.

Rogers. (1983). *Diffusion of Innovations*. Third Edition. New York, NY: The Free Press.

Sherr, L. (1989). HIV Testing in Antenatal Clinics: the impact on women. *AIDS Care*, 1,165-171.

Sherr, L. (1996). Antenatal HIV testing – which way forward? *A Journal of Carfax in Oxon*, 1(1), 99-111.

Silverman, D. (1997). *Qualitative Research: Theory, method and practice*. London: Sage.

Simpson, W. (August, 1998). To test or not to test? What makes pregnant women decide to take an HIV test? *A Journal of Carfax in Oxon*, 3(3), 327-335.

Smith, R. (1992). Preventing of HIV among childbearing women and women having termination of pregnancy, *British Medical Journal*, 304, pp, 1082-1085.

Smith, R. (1996). Antenatal screening for HIV in Scotland. *Answers*, 23, AM-20, No.96/08.

Strauss, SA. 1990. AIDS and Employment: Some key Issues. *Aids Analysis Africa*

*Southern African Edition, 1(1).*

Stroebe, W. & Stroebe, M. (1993). *Social Psychology and Health*. Amsterdam: Open University Press.

Terreblanch, M. & Durheim K. (2002). *Research in practice; applied methods for the social practice*. Cape Town: University of Cape Town.

UNAIDS (2001). *HIV/AIDS and Communication for Behaviour and Social Change: Programme Experience, Examples and the Way Forward*. Geneva: UNAIDS.unaids.org/bestpractice/summary/wp/index.html

UNAIDS/WHO. (2000). *Report on the global HIV/AIDS epidemic June 1998*, Joint United Nations Programme on HIV/AIDS; World Health Organisation 1998. UNAIDS/98.10 – WHO/EMC/VIR/98.2 – WHO/ASD/98.2.

US, Department of health and Human services, Public Health Services, Centre for Disease Control and prevention National Centre for HIV, STD, and TB Prevention, UNAIDS Joint United Nation programmes on HIV/AIDS, “AIDS Epidemic December 2001” and “ Report on the global HIV/AIDS Epidemic December 2001” World Health Organization 2002 Health report.

[www.globeafrica.com/health/hivstats.htm](http://www.globeafrica.com/health/hivstats.htm)

Watson, J. & Platt, S. (2000). *Researching Health Promotion*. New York/London:  
Rutledge.





# UNIVERSITY *of the* WESTERN CAPE

## DEPARTMENT OF PSYCHOLOGY

Private Bag X17, Bellville 7535, South Africa. Telephone: (021) 959-2283/2453.

Fax: (021) 959-3515. Telex: 52-6661

### TO WHOM IT MAY CONCERN

### INFORMED CONSENT

I ..... hereby agree to participate in a research study that is being conducted by MOTLATSU QUEEN KEKANA as part of her masters degree programme. I am aware that the research is on pregnant woman's attitudes to HIV/AIDS testing.

I understand that the information that I provide will be kept in the strictest confidence and that I will remain anonymous in the research report. I am a voluntary participant in this research and understand that I may withdraw from the study at any point.

.....  
PARTICIPANTS SIGNATURE

.....  
DATE OF INTERVIEW

*A Place of Quality, A Place to Grow*



## **INTERVIEW QUESTIONNAIRE**

1 What are HIV and AIDS?

2 What is HIV from AIDS?

3 How is HIV/AIDS transmitted?

4 What is HIV/AIDS test?

5 What does it do?

6 What do you think about HIV/AIDS testing?

7 What do you understand by being HIV positive?

8 What do you understand by being HIV negative?

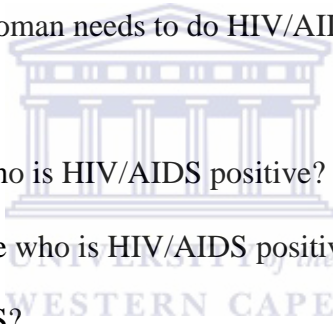
9 Do you think that pregnant woman needs to do HIV/AIDS test?

10 If yes/no why?

11 Do you know of anybody who is HIV/AIDS positive?

12 Have you ever seen someone who is HIV/AIDS positive?

13 Is there a cure for HIV/AIDS?



**Race – Black (Xhosa)**

**Gender – Female**

**Age – 24 yrs**

**Place – Gugulethu MOU**

**Q – Question**

**A – Answers**

**Non-adherent**

**Q:** Please tell me your understanding of HIV/AIDS?

**A:** “HIV/AIDS is a disease that has stages and people die of it especially those who engage in unprotected sex with people who have the disease.

**Q:** What do you know about HIV/AIDS testing?

**A:** I don't know if I am right, but I heard that it tracks down HIV/AIDS virus from your blood and it help people to know if they have the HIV virus or they don't.

**Q:** Have you done an HIV/AIDS test before?

**A:** No.

**Q:** Are you intending to do it today?

**A:** No.

**Q:** What are your reasons to refuse the test today?

**A:** I am living within the extended family and my parents are selling liquor. They are also drinking the liquor. Disclosing my HIV/AIDS positive status to them will only invite frustrations and humiliation. When they are drunk everyone who drinks at the tavern will know of my HIV/AIDS status and I will be give new unfriendly names. That is my biggest

fear.

**Q:** What does HIV/AIDS testing tells you?

**A:** It tells you that you have HIV/AIDS virus or not.

**Q:** How do you feel when facing HIV/AIDS testing?

**A:** Thank God I won't face it. Facing a test is not my problem.

**Q:** What do you think HIV/AIDS test does?

**A:** You know it is so funny, that each time they introduce HIV/AIDS new drugs it yields worse symptoms than the one introduced before. So I don't think people should think of getting a cure anytime soon.

**Q:** Anything else?

**A:** I think it is difficult to be pregnant and be HIV/AIDS positive. It is possible that your neighbours, boyfriend and family members can completely change your identity. Keep you at a distance and never wish to share anything with you ever again. I think it is quite too much for the pregnant woman to handle.

**Q:** Do you know someone who is living with HIV virus?

**A:** No.

**Q:** What do they mean when they say someone is HIV positive?

**A:** You do have HIV virus.

**Q:** HIV negative?

**A:** It means you don't have HIV/AIDS virus.

**Q:** Do you think pregnant women should do HIV/AIDS testing?

**A:** speaking for myself I think pregnant woman should not

**Q:** Do you know of anyone who is HIV positive?

**A:** No, I only see them on TV programs.

**Q:** What do you think of those people?

**A:** Nothing serious but I know they are going through hell. Their self-esteem and confidence is paralysed due to prejudice and stigmatisation.

**Q:** Can HIV/AIDS be cured?

**A:** Not that I know of. I think it can only be managed with western and African traditional medication.



**Race – Black (Xhosa)**

**Gender – Female**

**Age – 25 yrs**

**Place – Gugulethu MOU**

**Q – Question**

**A – Answer**

**Adherent**

**Q:** What do you know about HIV/AIDS?

**A:** I don't know what to tell you about HIV/AIDS. What I can tell you is that HIV/AIDS kills.

**Q:** How is it transmitted?

**A:** By sleeping with someone without the use of condom.

**Q:** What else

**A:** I think that is all I know about HIV/AIDS transmission

**Q:** What do you understand of HIV/AIDS testing?

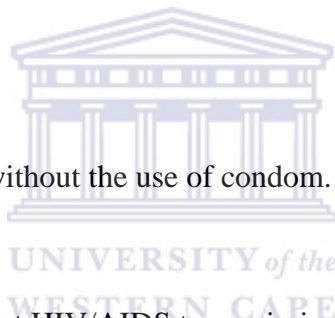
**A:** I know that people are testing but I have never tested HIV virus before.

**Q:** OK.

**A:** I have come to test.

**Q:** What do you know of HIV testing?

**A:** People say that when you are pregnant and maybe HIV/AIDS positive, the doctor and the nurses can be able to see that you are infected with the HIV virus through HIV/AIDS test. If you are found to be HIV/AIDS positive, there is a medication that will prevent your



unborn child from getting the HIV/AIDS virus. I think pregnant woman need to do HIV/AIDS test to avoid MTCT. Maybe our unborn children can survive.

**Q:** Is it a must?

**A:** No, you are not forced it is up to you.

**Q:** Is this your first HIV test?

**A:** Yes, this is my first day and time.

**Q:** What do you think HIV/AIDS testing does?

**A:** I am not sure but it helps nursing sisters to determine if you have HIV/AIDS or not

**Q:** What kind of problem are you talking about?

**A:** I say maybe if I have it and I know I have it, and then I can talk about it.

**Q:** How do you feel when facing testing since this is your first day?

**A:** If the results turn to be positive, I will definitely be scared. But I think as time goes by I will come to terms with it and however accept that I have it and I won't change.

**Q:** What do you think will make you feel that way?

**A:** I have told myself that I will accept it if I will be found HIV positive.

**Q:** What do they mean when they say a person is HIV positive?

**A:** You have it.

**Q:** HIV negative?

**A:** You don't have it.

**Q:** Do you think pregnant woman need to take HIV tests?

**A:** I think pregnant woman should do HIV/AIDS test. It is unselfish gesture because you must think of the unborn child. If it turns out that you are HIV/AIDS positive you will have

time enough to decide adoption for your child.

**Q:** Can a pregnant woman infect their unborn baby while in the womb?

**A:** I am not sure.

**Q:** What compelled you to come and does the HIV test?

**A:** I am encouraged by my parents to do HIV/AIDS test, that when I am tested positive I should get ART and follow a correct diet so that I could live longer and take care of my baby. I have engaged in unprotected sex, some times during menstruation because in my culture is sad to die without a child. You must have a child who will carry your name when you are dead. Who will turn you parent sad loss in to happiness.

**Q:** Have you seen someone who is HIV positive?

**A:** No.

**Q:** How do you feel about infected people?

**A:** I think they are like everybody else.

**Q:** Why do other women refuse to test?

**A:** I think they don't want to know their status maybe because they cannot handle it or accept it.

**Q:** Is there a cure for HIV/AIDS?

**A:** I don't think so

