

**ACCEPTANCE, ACCESSIBILITY AND UTILISATION OF VCT SERVICES
BY WOMEN USING CONTRACEPTIVES AT CITY OF JOHANNESBURG
MUNICIPAL CLINICS**

by

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for the degree of

MASTER OF PUBLIC HEALTH

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DECLARATION

I declare that **ACCEPTANCE, ACCESSIBILITY AND UTILISATION OF VCT SERVICES BY WOMEN USING CONTRACEPTIVES AT CITY OF JOHANNESBURG MUNICIPAL CLINICS** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



Name
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18 May 2015

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ABSTRACT

Background: The South Africa's reproductive health policy put more emphasis on dual methods in preventing unwanted pregnancies, sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) transmission. Regardless of such policies, the uptake of voluntary counselling and testing (VCT) services remains a personal choice.

Aim: The purpose of the study was to determine the accessibility, acceptance and utilisation of VCT services by women on hormonal contraceptives.

Methods: About 134 women obtaining hormonal contraceptives were interviewed in a cross-sectional study. Descriptive and logistic regression analysis was applied to analyse the study data.

Results: Respondents displayed positive attitudes towards Human Immunodeficiency Virus (HIV) testing. Unavailability and poor access to in-house VCT services was found to be a barrier for use of these services.

Conclusion: There's a need for provider initiated counselling and testing (PICT) strengthening and integration of VCT services into family planning.

Keywords: Hormonal contraceptives, human immunodeficiency syndrome, provider initiated counselling and testing, voluntary counselling and testing.

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Dedication

I would like to dedicate this work to the following:

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
MDGs	Millennium Developmental Goals
PMTCT	Prevention of mother-to-child HIV infection
SADC	Southern African Development Community
SPSS	Statistical Package for Social Sciences
STIs	Sexually transmitted infections
VCT	Voluntary counselling and testing
UNAIDS	United Nations Programme on HIV/AIDS
Unisa	University of South Africa
UNPF	United Nations Population Funds
WHO	World Health Organization

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In South Africa, hormonal contraceptives (pills and injections) have been reported to be the most common form of method used by women. This form of contraception is seen as a method of choice because of the reported efficacy and safety as compared to other methods, which also depends on consistent and correct use. The introduction of the national contraception and fertility policy came at the right time when South Africa needed a strategy to improve and promote Voluntary Counselling and Testing (VCT) within this population of fertile women. Under this policy women coming for contraceptives are encouraged to go for voluntary counselling and testing-provider initiated (Wand & Ramjee 2012:[376]). Effective implementation of this policy could possibly improve accessibility of VCT services leading to acceptance and adequate utilisation by this population of women.

South African guidelines and policies support the accessibility and promotion of the use of VCT services by all citizens. This is echoed by the National Contraception Policy Guidelines, which promotes the provision of effective counselling and education regarding the use of dual protection method to prevent pregnancy and Sexually Transmitted Infections (STIs), including Human Immunodeficiency Virus (HIV). It is for this reason that the VCT services should form an integral part of the reproductive health programme with health care providers playing a vital role in implementing this (South Africa 2012:19).

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

Young South African women and girls are at high risk of unintended pregnancy and HIV. Unplanned pregnancies particularly among the youth still remain high indicating that most young people are continuously engaging in unprotected sex (Seutlwadi, Peltzer, Mchunu & Tutshana 2012:[43]).

1.2.1 Source of the research problem

Most women opt for hormonal contraceptives due to their partners' attitude towards the use of condoms. This was confirmed by six of 10 women attending Jeppe's Town Clinic in 2011. Seutlwadi et al (2012:[44]) state that communication among partners about condom use is determined by factors such as the level of education of both partners and occupational status. The statement of this kind has left the researcher with unanswered questions of which this study will try to address.

Hormonal contraceptives do not protect against STIs and HIV. This means that hormonal contraceptive users are at high risk of acquiring HIV and contracting STIs. In this case, the assumption is that the dual method is still regarded as an effective method in the prevention of STI's and HIV. South Africa's own reproductive health policy put more emphasis on the use on dual methods in preventing unwanted pregnancies, STI and HIV transmission (Myer, Mathews & Little 2002:[119]). Regardless of having such policies in place, the intake of VCT services remains a personal choice.

In a recent study conducted in four provinces in South Africa, the results had shown a decline in the use of contraceptives which was evidenced by high rate of unwanted pregnancies (Seutlwadi et al 2012:[43]). In 2007, the contraceptive prevalence rate by young sexually active people of ages between 18-24 was at 52.2%. Before they reach age 17, half of all teenage girls are already sexually active. The Department of Health also reported that 35% of South African women get pregnant or already have given birth by the age 19. This is a public health concern since half of the mentioned population were on contraceptives (Lince-Deroche, Hargey, Holt & Shochet 2015:[73]). The researcher's concern is not only based on the HIV prevalence rate, but in consideration of the reported high rate of unwanted pregnancies. The rate of unwanted pregnancies adversely affects and put severe strain on the current prevention of mother-to-child transmission (PMTCT) which only commence during pregnancy (Lince-Deroche et al 2015:[73]).

1.2.2 Background to the research problem

Policies and guidelines in most countries continue to treat family planning, STIs and HIV/AIDS services as unrelated areas of intervention. Too much attention has been given to the HIV/AIDS pandemic resulting in less interest to family planning especially in HIV/AIDS high prevalence areas like Africa. The relationship between the three areas is obvious, hence the need to integrate these services. Concentrating on PMTCT programme only, cannot take away the burden of the disease. This is because, the same women utilising the PMTCT service are sexually active and fertile and might have been on hormonal contraceptives (Strachan, Kwateng-Addo, Hardee, Subramaniam, Judice & Agarwal 2004:[5]).

The risk for unplanned pregnancies and HIV infections are not in different domains, hence concentrating on one may lead to fragmentation of services. Ideally, women should use condoms as both a method of contraception and for protection against HIV transmission, or even consider the use of condoms along with other contraceptive methods. But this is not happening; they either use one of the options available. It is imperative for policy makers to recommend contraceptive methods that do not increase women's vulnerability to HIV infection (South Africa 2012:19).

If reproductive health services, care and treatment of HIV and STIs are combined with education in all suitable settings, the opportunities and aims to reach people living with HIV will increase with greater impact on reducing further transmission. The attainment of this relies on the availability of all the adequate and relevant information. This means that women on contraceptives should know and understand all the available choices and services within the reproductive health system (Shapiro & Ray 2007:70).

1.3 RESEARCH PROBLEM

The problem statement represents the expression of a distracting, disturbing and problematic area that requires investigation with the aim of providing understanding. Here the nature of the problem being addressed in the study is identified, including its context and significance (Polit & Beck 2004:73).

South African women are enrolled in one of the commonly used reproductive health programme in which they receive hormonal contraceptives. The contraception prevalence rate is currently at 65%. The researcher has observed that half of the women seen in family planning clinics are not married and sexually active. Seven of 10 women in family planning in Jeppe's Town Clinic in 2010 did not know their HIV status and had no intention to test for HIV and this remains the same even in 2013. The family planning programme focuses mainly on prevention of unwanted pregnancies and the risk of contracting HIV and other sexually transmitted diseases is often ignored. The South African National Contraception and Fertility Planning Policy and service delivery guidelines recommend that HIV testing be part of contraceptive services (South Africa 2012:71). The implementation of this is crucial hence the study is aiming to assess how accessible are VCT services and if these are accepted and utilised when offered.

The majority of people with the highest incidence of new HIV infection including women on hormonal contraceptives are unaware of their HIV status. These women need access to sympathetic HIV counselling and testing. The question of accessibility and acceptability of such still remains a problem that is overlooked by both health care workers and patients (Shapiro & Ray 2007:69).

1.4 AIM OF THE STUDY

1.4.1 Research purpose

The purpose of the study was to describe the accessibility, acceptance and utilisation of VCT services by women on hormonal contraceptives obtained from municipal clinics in the City of Johannesburg Municipality area.

1.4.2 Research objectives

The study aimed at accomplishing the following objectives:

- To determine the accessibility of VCT services to women receiving contraceptives from Jeppe's Town, Malvern, Albert Street and Rossetenville Clinic.

- To determine the level of acceptance and utilisation of VCT services by women using hormonal contraceptives.

1.4.3 Research questions

- Are the VCT services made available to women on contraceptives?
- If these services are offered, are they easily accepted by the people being offered to?
- Are these services adequately utilised by women using hormonal contraceptives?

1.5 SIGNIFICANCE OF THE STUDY

A research problem should possess a sense of significance to health care and public health. The study should show a potential of meaningfully contributing to public health and health care (Polit & Beck 2004:70).

Hormonal contraceptives prevent unwanted pregnancies but do not prevent HIV and other sexually transmitted diseases. Recommendations based on this study's findings could enhance early detection of HIV positive women and could help to encourage regular HIV testing and counselling. In addition, the results could assist in advising policy makers on the importance of integrating HIV/AIDS and family planning services. This study endeavoured to identify and quantify accessibility, acceptance and utilisation of VCT services by women obtaining hormonal contraceptives from the City of Johannesburg's municipal clinics.

1.6 DEFINITIONS OF KEY TERMS

Acceptance: to take willingly something that is offered determined by factors such as age, gender, educational level race and other social factors (Shrestha 2010:8).

Accessibility: it is the extent to which services can be reached by people in need of the specific services and indicates how equitable the distributions are within the population (Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa 2002).

Contraception: a process or technique for the prevention of pregnancy by means of medication, device or method that alters one or more of the process of reproduction in such a way that sexual union can occur without conception (Mosby's Medical Nursing and Allied Health Dictionary 2002:300).

Family planning: the control of the number of children in a family by means of contraception (Compact Oxford English Dictionary for Students 2006:359).

Reproductive health: is the state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and its functions and processes (International Conference on Population Development 1994).

Women: adult human female (Compact Oxford English Dictionary for Students 2006:1194).

Voluntary counselling and testing (VCT): refers to an intervention that includes both voluntary pre- and post-test counselling and voluntary testing. People, of their own free will, opt for VCT, and it provides them with an opportunity to confidentially explore and understand their risks and to learn about their test results (Common Wealth Regional Health Community Secretariat 2002).

Utilisation: level at which a particular service is used (Stanhope & Lancaster 2000:G31).

1.7 OPERATIONAL DEFINITIONS

1.7.1 Independent variables

Contraception: for the purpose of this study, contraception refers to all the oral and injectable family pregnancy prevention methods administered and supplied by the family planning clinics participating in the study during data collection.

Voluntary counselling and testing (VCT): for the purpose of this study, this refers to voluntary seeking and using of counselling and testing for HIV by women using hormonal contraceptives.

1.7.2 Dependent variables

Accept: In this study, acceptance will be measured by the willingness of women using hormonal contraceptives to use VCT services.

Accessibility: For the purpose of this study, accessibility refers to the availability of VCT services to women attending contraceptive clinics participating in this study.

Utilisation: In this study, utilisation refers to the pattern in which VCT services are used by women on contraceptives.

Women: In this study, women are referred to as females receiving contraceptives from the participating clinics.

1.8 RESEARCH DESIGN

Quantitative research refers to a formal, objective, systematic process to describe and test relationships and to examine the cause-and effect between variables. The study was conducted in a non-experimental nature aimed at observing the phenomena as they occur without intervening (Polit & Beck 2004:162).

1.8.1 Descriptive correlational study

The main aim of the correlational study is to describe relationships among variables rather than supporting inferences of causality (Babbie & Mouton 2012:80; Polit & Beck 2012:226).

In this study, the researcher intended to describe the relationship between acceptance, accessibility and utilisation of VCT services by women using hormonal contraceptives in the selected clinics in the City of Johannesburg Municipality area.

1.8.2 Cross-sectional study

Cross-sectional designs are used for time-related purposes and are appropriate for describing the status of the phenomena at a fixed point in time (Babbie & Mouton 2012:92; Polit & Beck 2012:184).

The researcher applied the following procedures to ensure compliance with the principles of a quantitative, non-experimental cross-sectional study:

- The researcher measured three variables; which are the acceptability, accessibility and utilisation of VCT services by women using hormonal contraceptives; the quantitative paradigm will be suitable to measure and answer the questions posed.
- Data were collected at a single point and no follow-up will be done.

1.8.3 Research paradigm

A paradigm is a certain way of viewing a phenomenon in the world. Paradigms are often characterised in terms of the how they respond to basic philosophical questions. When applying a quantitative method, deductive reasoning is used to generate hunches that are tested in the real world. This requires that, findings are grounded in reality rather than the researcher's personal beliefs (Polit & Beck 2012:11).

The researcher adhered to principles of positivism by applying the following in the study:

- To promote empiricism of the study, the researcher applied the relevant quantitative research process during data gathering.
- Quantitative methods were applied in collecting and analysing the data.
- Structured data collection methods were used to ensure objectivity. This will be done by applying a standardised schedule interview.
- Conclusions supported by statistics are provided to verify the findings.

1.9 RESEARCH METHOD

1.9.1 Population

The population is referred to an entire group of people that is of interest to the researcher. It is the larger pool of from which the research sampling elements are drawn (Polit & Beck 2012:273; Terre Blanche et al 2006:133). The population for this study will include all women using contraceptives in South Africa. The target population refers to all women receiving hormonal contraceptives from the municipal clinics within the City of Johannesburg Municipality area. The accessible population includes all women receiving family planning services from the participating clinics during the data collection phase of this study.

In this study, the population of sites included all clinics where women can obtain hormonal contraceptives. The target population for this study also included all 14 clinics where the women are obtaining hormonal contraceptives in the City of Johannesburg Region F.

1.9.2 Sample and sampling technique

Sampling is a process used by the researcher to select cases to represent the entire population in order to make inferences about the entire population. A sample is selected during this process which is a subset of population elements from which data will be collected (Polit & Beck 2012:275).

Non-probability sampling is a sampling procedure distinguished by lack of random sampling procedure (Stommel & Wills 2004:300). The sampling technique used in this study was convenience sampling. The researcher selected eligible women attending the participating contraceptive clinics on the days when data were collected at the specific clinics and requested them to participate in the study.

1.9.2.1 Site sampling

Only four accessible clinics were used, which were within the researcher's reach. In order to select the clinics, convenience sampling based on geographic area was used.

In the City of Johannesburg Municipality area, the four accessible clinics are Jeppe's Town Clinic, Malvern Clinic, Albert Street Clinic and Rossetenville Clinic.

1.9.2.2 Data source sampling

The respondents were women between the ages 18-35 obtaining hormonal contraceptives from public health clinics in the Johannesburg Metropolitan area. They were selected from the four participating clinics. The sample frame comprised a clinic register listing all women who receive hormonal contraceptives from the participating clinics during the data collection phase.

1.9.3 Data collection

A structured plan that indicates what information should be gathered and how to gather it is necessary to answer the proposed study questions. An approach of structured data collection methods will be used (Polit & Beck 2004:318).

The researcher interviewed women attending family planning clinic in each of the selected facilities. Structured interviews were conducted using questionnaires. The researcher personally conducted interviews with the help of a trained research assistant to ensure that the respondents understood the questions and that the women's actual responses were recorded.

1.9.4 Data analysis

Statistical data analysis assisted the researcher in making sense of quantitative information. The procedures involved allowed the researcher to summarise, organise, evaluate and communicate numeric information. The statistics are either descriptive or inferential (Polit & Beck 2004:451).

The services of a private statistician were sought to ensure accurate data analysis.

1.9.4.1 Descriptive statistics

Descriptive statistics are of high value when the main aim is to describe and synthesise data. The researcher will use descriptive statistics to describe the characteristics of the sample and the relationship among all the study variables, which are acceptance, accessibility and utilisation (Polit & Beck 2004:451).

Descriptive statistics and logistic regression were used to present the data. Association between variables such as age, marital status, educational background, acceptance and utilisation of VCT services and presented in tables and graphs.

1.10 SCOPE OF THE STUDY

The scope of this study is mainly to look at the acceptance, accessibility and utilisation of VCT services by women on contraceptives in the City of Johannesburg Municipality area.

1.11 LIMITATIONS

Limitations are defined as problems, obstacles or restrictions that may decrease the generalisability of the study findings (Grove, Burns & Grey 2013:598).

1.12 STRUCTURE OF THE DISSERTATION

The study consists of five chapters on which different topics will be covered as stated below.

Chapter 1 outlines the introduction, background information and overview of the study.

Chapter 2 focuses mainly on the work that has been done by other researchers and writers. A comprehensive literature review that was conducted is further discussed in order to accomplish the aim and objectives of the study.

In chapter 3 a clear and detailed description of the design and method used was given.

Chapter 4 discusses the procedures use for data collection a management, analysis and the description of research finding.

Chapter 5 presents the conclusion and recommendations based on the study findings are discussed in this chapter.

1.13 CONCLUSION

Comprehensive approach in reproductive health can be a possible answer in reaching the millennium developmental goals (MDGs). The study is aiming to answer some questions the researcher has regarding treatment and care of women receiving hormonal contraceptives from the public health clinics.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this chapter is to review the relevant studies pertaining to accessibility, acceptance and utilisation of Human Immunodeficiency Virus (HIV) voluntary counselling and testing (VCT) services by women using hormonal contraceptives.

2.2 THE BURDEN OF HIV/AIDS

2.2.1 Globally

According to the United Nations Programme on HIV/AIDS (UNAIDS 2013) Report, there has been a decrease in the global HIV incidence. Only 2.3 million new HIV infections were reported in 2012, which was recorded as the lowest number since the mid-to-late 1990s, when the estimation of people acquiring HIV every year was at 3.5 million. More than 26 countries have reported the decline by more than 50% in HIV infections between 2001 and 2012 and only a decline of about 25% by 17 countries (UNAIDS 2013:[3]).

The report attributed this decline to the availability of treatment in most countries which has reduced AIDS-related deaths. Increase resources and improved commitment from most countries political leadership has made it easier for health agencies to try and curb the virus (UNAIDS 2013:[3]).

2.2.2 SADC Region

The Southern African Development Community (SADC) still remain the area that is mostly affected by the HIV epidemic. Thirty four percent (34%) of people living with HIV worldwide are from the SADC countries. The SADC continues to implement a number of interventions aimed at mitigating the epidemic. The interventions include: condom promotion and distribution, behaviour change communication, HIV counselling and

testing, safe medical circumcision, mainstreaming HIV/AIDS across all sectors, prevention of mother to child HIV transmission (PMTCT), treatment and home-based care (SADC 2012).

Prevalence rate vary between the SADC countries to less than 1% and 40%. It is worrying that with all the interventions in place SADC countries such as Botswana, Lesotho, Malawi, Namibia, Mozambique, Swaziland, South Africa and Zambia still have adult HIV prevalence of above 10%. The mostly affected populations are those in urban areas than those in rural areas. In the entire SADC region, women still occupy 53% of the total population living with HIV. This indicates that gender still plays a big role in HIV infections (SADC 2012). For the purpose of this study, more attention will be given to HIV within the South African context as outlined below.

2.2.3 South Africa

According to Statistics South Africa (Stats SA) 2013 estimation, 10% of the South African population is HIV positive. This has increased through years though the death rates due to HIV have drastically decreased due to an extended availability of HIV treatment in the country. According to this report, the total number of people living with HIV has increased from 4 million in 2002 to 5, 26 million in 2013. The worrying revelation of the report is that approximately 17% of South African women in ages between 15 and 49 are living with HIV (Stats SA 2013).

The HIV prevalence showed that 469,000 new infections occurred in South Africa during 2012. This is believed to have attributed to the easy availability of antiretroviral treatment (ARVs) and the belief that the disease is no longer lethal. Another revelation of this survey is that among adults aged 15 to 49 year, the new infections were 1.7 times higher in females than in males (Shisana, Rehle, Simbayi, Zuma, Jooste, Zuma, Zungu, Labadarios & Onoga 2014:xxiv).

2.3 VCT SERVICES IN THE SOUTH AFRICAN CONTEXT

The strategic objective 2 of the national strategic plan on Human-immunodeficiency virus (HIV), sexually transmitted infections (STI) and Tuberculosis (TB) require maximisation of opportunities for testing and screening to ensure that everyone in South

Africa is tested for HIV and screened for TB at least yearly (South African National Aids Council 2011). It is for this reason the South African HIV counselling and testing (HCT) programme aims to provide universal access to good quality, effective HIV counselling and testing and referral services to all people living in the country (South Africa 2010: 75).

VCT provides people an opportunity to know their HIV status. The process allows for quality counselling and support aimed at helping people to cope with positive or negative results. Knowing one's status is believed to serve as a strong motivating factor to behavioural modification (United Nations Population Funds (UNPF) 2002).

2.3.1 HIV testing models

Maintaining awareness of one's status through regular HIV testing is considered to be an important entry point to a comprehensive package of care for HIV/AIDS prevention and treatment (Shisana et al 2014:xxxvi). Currently, there are two HIV counselling and testing models used in South Africa health care facilities. Those are VCT and provider initiated counselling and testing. Couple testing is still piloted in some African countries.

2.3.1.1 *Voluntary counselling and testing (VCT)*

VCT refers to an intervention that includes both voluntary pre- and post-test counselling and voluntary testing. Out of one's own free will, a person opts for VCT, and it provides them with an opportunity to confidentially explore and understand their risks and to learn about their test results (Common Wealth Regional Health Community Secretariat 2002). VCT means an individual seeks HIV counselling and testing where confidential services are offered. Services are rendered in confidence. The primary focus is mainly on preventing HIV acquisition through risk assessment, risk reduction and testing (Makhunga-Ramfelo, Chidarikile, Farirai & Matji 2011:[2]). The model relies entirely on the client to initiate and request an HIV test. Though the model has been used for the past years, it did not necessarily improve VCT acceptance and utilisation.

2.3.1.2 Provider initiated counselling and testing

Provider initiated HIV counselling and testing means an individual may be coming to seek medical and care and the health care worker recommends HIV counselling and testing without coercion. The primary focus is to identify those who are infected and linking them to prevention, care and treatment services (Makhunga-Ramfolo et al 2011:[3]). The model has proven to facilitate uptake of HIV counselling and testing and can be applied in all health settings. Health care workers are able to use this opportunity to educate and remove misconceptions and fears about HIV testing.

2.3.1.3 Couple testing

Couple testing means sexual partners are offered HIV counselling and testing together. Couple testing renders an opportunity for partners to know and disclose each other's HIV status. It promotes commitment to a relationship and increase uptake of and adherence to treatment and formation of new social networks. However, this model also has its own repercussions, which includes verbal abuse, blaming each other, cessation of sexual relations and sometimes abandonment. Couple testing does not always lead to safe sex as per expectation; this is mainly attributed to gender power relations (Matovu, Denison, Wanyenze, Ssekasanvu, Makumbi, Ovuga, McGrath & Serwadda 2013[12]; Musheke, Bond & Merten 2013:[13]).

2.4 ACCESSIBILITY OF VCT SERVICES

In the past few years, policy shifts in South Africa has made HIV prevention and treatment interventions to be more available and accessible. HIV counselling and testing is a gateway to accessing all the available interventions. Despite the availability of these services, HIV testing remains low in South Africa (Doherty, Tabana, Jackson, Naik, Zembe, Lombard, Swanevelder, Fox, Thorson, Ekstrom & Chopra 2013:[2]).

Makhunga-Ramfolo et al (2011:[1]) state that there are many missed opportunities for HIV diagnosis in clinical settings. This is attributed to the fact that patients are not routinely offered HIV counselling and testing. Provider initiated counselling and testing was introduced to ensure accessibility of HIV counselling and testing and ensure that it becomes a standard of care in all consultations with health providers.

The researcher has observed that despite the emphasis of provider initiated counselling and testing as standard of care, not so much has been done for women using contraception. This population of women has been subjected to the promotion of dual protection with studies around this topic only relying of self-reported use of dual protection.

As noted by Makhunga-Ramfolo et al (2011:[2]), the availability of HIV rapid tests and receipts of results on spot has drastically increased access to HIV diagnosis. The rapid tests allow for the test to be done and clients provided with the results immediately. The nurse-patient relationship offers a great opportunity to offer patient centered care, allow for better decision making. This also gives an indication that the introduction of provider initiated counselling and testing can be easily introduced on women using contraceptives by the health care workers working in this section, thus increasing accessibility.

2.5 ACCEPTANCE AND UTILISATION OF VCT SERVICES

A study conducted by Matovu et al (2013) found that people who had tested for HIV before were more likely to do another HIV test. This is attributed to the fact that prior testing increases one's confidence and reduction of fears associated with the receipt of VCT. Despite having VCT services available free of charge, there is still much reluctance in utilising them to full capacity (Matovu et al 2013:[7]). Based on this statement it is clear that acceptance and utilisation of VCT services relies entirely on previous experiences.

2.5.1 Barriers to acceptance and utilisation of VCT

South Africa has the highest HIV prevalence of about 12%. However, many South Africans do not know their HIV status and the uptake of VCT has been unacceptably low (Makhunga-Ramfolo et al 2011:[1]).

HIV care and management has improved in South Africa but that does not eliminate the stigma attached to the disease. In most areas in the country, HIV/AIDS still appear as an epidemic of ignorance, fear and denial. Despite all the information and services

available in the country, people still fear to be seen seeking HIV counselling and testing in facilities that provides the service. There are a number of reasons to this, one is the fear of receiving positive results and having to disclose to the partner. The fear of disclosure is caused by that HIV is still associated with immoral behaviour and promiscuity (Meiberg, Arjan, Hans, Onya, Herman & Schaalmama 2008:[52]).

Fear of stigmatisation remains the most common barrier to utilisation of VCT services. There is still fear of family rejection after disclosure of positive results. The stigma further continues to a community level whereby HIV is still seen as a disease resulting from acts of promiscuity. The stigma advances even among health workers who are regarded as judgemental by patients. The evidence shows that fear of knowing one's status is a vital determinant of VCT services utilisation among South Africans (Meiberg et al 2008:[52]).

Meiberg et al (2008:53) indicate that people are fearful to have an HIV test because of the risks they might have taken in the past. The study found that people prefer not to know their HIV status, thus avoiding facing the reality of dying sooner. This leads to most of them being pushed to HIV testing when they feel very sick. It is vital for women using contraceptives on their reproductive age to know their HIV status which will lead to successful PMTCT programme.

Another dimension that needs to be explored further by the South African Health system is couple testing. Women may feel at ease to utilise and accept VCT services when their partners are also being tested. Rujumba, Neema, Byamugisha, Tylleskar, Tumwine and Heggenhougen (2012:[6]) state that disclosure of status by pregnant women who tested HIV positive to their partners was a terrifying experience. These women expressed fear of being abandoned and possible domestic violence if they were to report their positive results to their partners. The fears expressed by the women who participated in this study could be a possible contributory factor of poor intake of VCT services.

2.6 FAMILY PLANNING: HORMONAL CONTRACEPTIVES

A country with high HIV prevalence like South Africa requires having a well-developed reproductive health system. For an improved reproductive health, a safe and effective

contraceptive use may be a solution to some of the country's reproductive health problems. Some studies on hormonal contraception and HIV have shown association between hormonal contraceptive use and the risk of developing HIV and also influence the risk of developing cancers (Urban, Banks, Egger, Canfell, O'Connell, Beral & Sitas 2012:[2]).

The most commonly used contraceptive method worldwide is hormonal contraceptive. These come in a form of oral or injectable methods. Injectable contraceptives are mainly given as progestagen-only depot preparation, which is known as Depo-Provera. There are a number of oral contraceptives currently being used. Though they are known for their effect in preventing unwanted pregnancies, they are still not safe or offer protection against sexually transmitted diseases and HIV (Urban et al 2012:[2]).

2.6.1 Women using hormonal contraceptives and HIV

In a survey done by Human Sciences Research Council (HSRC) presented at the 6th AIDS Conference 2013, the indication was that being young and unmarried increased the risk of acquiring HIV infection among South African women (Rehle & Shisana 2013). This confirms the need to have women on contraceptive, particularly those that are unmarried to be encouraged to test for HIV.

Hormonal contraceptives are highly effective in the prevention of unwanted pregnancies; however, they do not protect users against sexually transmitted infections (STIs) and HIV. Majority of people including women using hormonal contraceptives are unaware of their HIV status. These women are in need of an effective intervention in terms of sympathetic HIV counselling and testing (Myer, Mathews & Little 2002:[119]; Shapiro & Ray 2007:70).

In general, women are at the greater risk than men in acquiring HIV. This is due to their anatomy and physiological structure which is usually exposed to pathogens during sexual intercourse. Young women are even reported to be even at the greater exposure because of their cervical ectopy. About 20 prospective studies on hormonal contraception and HIV done in South Africa and other countries had findings that hormonal contraceptives increase susceptibility to HIV-1 infection by promoting cervical ectopy, going further to increase women vulnerability to STIs and causing disturbances

in the structure of the vaginal epithelium and flora of the genital tract (Ramjee & Wand 2012:[749]; Ramjee & Daniels 2013:[2]).

After considering 20 different study results on relationship between HIV acquisition and hormonal contraceptives, of which some of them found no statistical significant association between hormonal contraceptives use and HIV acquisition, the World Health Organisation (WHO) released a statement in which the following was decided:

- Unrestricted use of hormonal contraceptives
- Promotion of dual protection (male and female condoms)
- Consideration and implementation of other HIV prevention measures
- Access to a wide range of contraceptives for couples (USAID 2013:[3]; WHO 2012:[4])

2.6.2 The use of dual protection by women using hormonal contraceptives

It is beyond the scope of this study to prove whether hormonal contraceptives do increase vulnerability to HIV-1 or not. The researcher intends to base the study solely on women using contraceptives' sexual practices especially condom use and HIV counselling and testing services use patterns.

In a country like to South Africa where HIV prevalence is high, relying on self-reported dual protection use might not be a solution. There are other structural factors that have to be taken into consideration. Maharaj (2006:[31]) states that the main challenge in reproductive health programme is ensuring the use of dual protection. Emphasis should be put more on consistent condom use and the role this plays in preventing pregnancy and HIV acquisition. In her study done in Durban, Maharaj (2006:[31]) found that general attitude towards condom use in KwaZulu-Natal was positive among young people. However, these results were reported based on self-reports which could have been biased by socially acceptable responses given by the respondents. As indicated by Musheke et al (2013:[8]), HIV testing, whether positive or negative results are received does not always guarantee behavioural change with regards to safe sexual practices.

Myer, Morroni, Mathews and Little (2002:[120]) indicate that the decision on whether the condom was used during sex relied on men. Women perceived condoms as a means of protecting men from infection by their female partners. This was further reiterated by Rujumba et al (2012:[4]), indicating that pregnant women who were tested HIV positive during antenatal visits found it hard to share their result with partners. The reasons for reluctance to participate in VCT were fear to be blamed for promiscuity or that they might be having multiple sexual partners. Women are still inferior in making sexual decisions; men are still making almost all sexual decision including that of using dual protection. It is for that reason we need to promote health education that will explore all the available HIV prevention methods for both men and women using hormonal contraceptives.

2.7 INTEGRATION OF VCT SERVICES TO FAMILY PLANNING

The National Contraception Clinical Guidelines (2012) seek to include and integrate HIV testing as part of the contraceptive services. The aim of this is to assist women using contraceptives to make fully informed fertility decisions once they are aware of their HIV status. Prevention of mother-to-child (PMTCT) has to commence here by allowing access to appropriate contraception and fertility services (South Africa 2012:72).

2.7.1 HIV services as an entry point for family planning

The need for the development of integrated services in reproductive health is obviously high. Counselling on the choice of contraception method and the need for HIV prevention has to be emphasised.

Ramjee and Wand (2012:[752]) state that condom use among partners of women using contraceptive seems to be low, hence the need to establish comprehensive programmes that will facilitate the integration of the family planning and HIV prevention services. There is a need to take on other strategies and to educate women and health care workers on promoting the importance of dual contraceptive use during counselling and how this can benefit women in preventing unwanted pregnancies and HIV-1.

Family planning providers should encourage women to utilise HIV counselling and testing services. These should include HIV risk assessment, provision of HIV

counselling and testing and availability of both male and female condoms to promote dual protection. VCT and family planning programmes help the clients in avoiding unwanted consequences of their sexual behaviour, which is HIV and unwanted pregnancies; integrating these two will increase coverage and efficiency (Gillespie, Bradley, Woldegiosrgis, Kidanu & Karklins 2009:[866]; Nougá & Ayalew 2010:2; South Africa 2012:71; WHO 2009:6).

HIV counselling and testing services, prevention of mother-to-child transmission (PMTCT) and family planning have similar aims of reaching sexually active people, prevention of unintended pregnancies, HIV and STIs and promoting safe, healthy and responsible sexual behaviour. Integration offers the opportunity for increased knowledge of dual method use and dual protection. VCT services as an entry point to family planning could enhance and support PMTCT programmes. If these services are combined, clients will appreciate that integration addresses their needs in one venue (Nougá & Ayalew 2010:4).

2.7.2 HIV interventions for women

Based on the studies discussed above, emphasising the vulnerability of women to HIV, there has been a number of interventions to address and assist to curb infection rate to this population. A core part of HIV/AIDS prevention and treatment programme is VCT, even in an area like family planning clinic. It is for that reason that the use of VCT services by women using contraceptives is vital.

Ramjee and Daniels (2013:[5]) state that counselling and testing provides with the platform to identify people who are HIV positive and require treatment and care and those that are negative to educate and promote HIV prevention. They further explain that HIV counselling and testing does not only render a chance to know one's HIV status but to ensure proper education on behavioural modification interventions aimed at obtaining proper care and treatment. Based on this report, women using hormonal contraceptives could benefit from VCT services if these are properly integrated. Continuous personalised risk reduction may assist these women and their partners in addressing issues relating to stigma and discrimination against HIV/AIDS.

Medley (2009) in Ramjee and Daniels (2013) further acclaims the benefits of peer education interventions that were implemented in some developing countries as they have shown improvement in HIV knowledge and condom use. These were further supported by studies done in the same developing countries which reported outcomes that showed improvement in condom usage and reduced risky sexual behaviour (Ramjee & Daniels 2013:[6]). Women using contraceptives may possibly benefit from such intervention once they offered HIV counselling and testing and education.

Social interventions that are aimed at changing the social norms that worsens women vulnerability to HIV needs to be implemented in all disadvantaged areas. In this case, women will be empowered and learn independence so that they are able to make own decisions about their reproductive wellbeing (Ramjee & Daniels 2013:[6]). While working as a nurse in a clinic, a researcher was made aware by some clients that they were pushed to using hormonal contraceptives by their partners' attitude towards condom use. Such statements exacerbate the need for more women behavioural and structural interventions in the fight against HIV/AIDS.

2.8 CONCLUSION

In this chapter, the following was discussed: the burden of HIV globally, the SADC region and South Africa. VCT services in a South African context were further explored looking and discussing different types of HCT models. Different literature on utilisation of VCT services was explored including accessibility of these services. In this chapter, the researcher looked at the literature and importance on integrating family planning into VCT services and the available HIV interventions for women.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

The purpose of this chapter is to outline the design and methods used to answer the research questions and meet the research objectives.

3.2 RESEARCH DESIGN

Quantitative research refers to a formal, objective, systematic process to describe and test relationships and to examine the cause and effect between variables. The study will take a form a non-experimental nature aimed at observing the phenomena as they occur without intervening (Polit & Beck 2004:162).

3.2.1 Descriptive correlational study

The main aim of the correlational study is to describe and examine relationships among variables rather than supporting inferences of causality. This design has an ability to facilitate the identification of different relationships in a situation in a short time (Babbie & Mouton 2012:80; Grove et al 2013:225; Polit & Beck 2012:226).

This researched used a descriptive correlational study design in order to describe the relationship between acceptance, accessibility and utilisation of VCT services by women using hormonal contraceptives in the selected clinics in the City of Johannesburg Municipality area. The relationship between the three variables will be measured in the following way:

- Acceptance – the researcher will describe the perception and attitudes of these women towards provider initiated counselling and testing (PICT).
- Accessibility – this will be described in terms of how accessible the services are and if they are user friendly to promote and allow women to use them without spending more time in the facility.

- Utilisation – this variable will describe and determine if accessibility and acceptance has an effect on the frequency of VCT services utilisation by women using contraceptives based on observation and the responses from the respondents.

3.2.2 Cross-sectional study

Cross-sectional designs are used for time-related purposes and are appropriate for describing the status of the phenomena at a fixed point in time (Babbie & Mouton 2012:92; Polit & Beck 2012:184).

The researcher applied the following procedures to ensure compliance with the principles of a quantitative, non-experimental cross-sectional study:

- The researcher aimed at measuring three variables; which are the acceptability, accessibility and utilisation of VCT services by women using hormonal contraceptives; the quantitative paradigm was identified as suitable to measure and answer the research questions posed.
- Women from different age groups, educational level and marital status were interviewed.
- Data were collected at a single point and no follow up was done.

3.2.3 Research paradigm

Grove et al (2013:702) describe the paradigm as a certain way of viewing the phenomena in the world. Paradigms are often characterised in terms of the how they respond to basic philosophical questions. When applying a quantitative method, deductive reasoning is used to generate hunches that are tested in the real world. This requires that findings are grounded in reality rather than the researcher's personal beliefs (Polit & Beck 2012:11).

The study aimed at conforming to the positivist perspective principles. This implies the relationship between the researcher and the knowledge itself. Positivism is characterised by verification of truth, the existence of objective reality independent of

human observation, empiricism, quantification and deductive reasoning (Polit & Beck 2012:13; Terre Blanche et al 2006:6).

The researcher adhered to principles of positivism by applying the following in the study:

- To promote empiricism of the study, the researcher applied the relevant quantitative research process during data gathering.
- Objectivity was maintained to avoid contaminating the data.
- Quantitative methods were applied in collecting and analysing the data.
- Structured data collection methods were used to ensure objectivity. This was done by applying a standardised schedule interview.
- Conclusions supported by statistics will be provided to verify the findings.

3.3 RESEARCH METHOD

3.3.1 Sampling

Sampling is a process used by the researcher to select cases to represent the entire population in order to make inferences about the entire population. A sample was selected during this process which was a subset of population elements from which data were collected (Polit & Beck 2012:275).

According to Grove et al (2013:363), when convenience sampling is applied, respondents are included in the study because they happened to be available during data collection. Non-probability sampling method was used to answer the study questions. Convenience sampling was used to select the study respondents. The study sites or the selected clinics did not have a formal booking system for the clients during data collection hence the convenience sampling method was selected for the study. The researcher selected eligible women attending the participating contraceptive clinics on the days when data were collected at the specific clinics and request them to participate in the study.

3.3.1.1 Population

The population is referred to an entire or a particular group of people that is of interest to the researcher. It is the larger pool of from which the research sampling elements are drawn (Grove et al 2013:351; Polit & Beck 2012:273; Terre Blanche et al 2006:133). The population for this study included all women using contraceptives in Gauteng Province. The target population refers to all women receiving hormonal contraceptives from the municipal clinics within the City of Johannesburg's Municipality area.

3.3.1.1.1 Target population

Grove et al (2013:351) describe target population as the entire set of individuals who meets the sampling criteria.

In this study, the population of sites included all clinics where women obtained hormonal contraceptives. The target population for this study included all 14 clinics where the women were obtaining hormonal contraceptives in the City of Johannesburg Region F.

3.3.1.1.2 Accessible population

Accessible population is only the portion of the target population that the researcher can easily access (Grove et al 2013:351). The accessible population included all women receiving family planning services from the participating clinics during the data collection phase of this study.

3.3.1.2 Sampling criteria

Grove et al (2013:352) describe sampling criteria as a list of characteristics essential for membership or eligibility in the target population.

3.3.1.2.1 Site sampling

Only four accessible clinics were selected and used. These clinics were within the researcher's reach. In order to select the clinics, convenience sampling based on geographic area was used. In the City of Johannesburg Municipality area, the four

accessible clinics are Jeppe's Town Clinic, Malvern Clinic, Albert Street Clinic and Rossetenville Clinic.

3.3.1.2.2 Data source sampling

The respondents were women between the ages 18-35 obtaining hormonal contraceptives from public health clinics in the Johannesburg Metropolitan area. The women were selected from the four participating clinics. The sample frame comprised a clinic register listing all women who were receiving hormonal contraceptives from the participating clinics during the data collection phase.

3.3.1.3 Ethical issues related to sampling

Participating in the study should never place respondents at a disadvantage or even expose them to danger (Polit & Beck 2012:153; South Africa 2006:18).

- **Right to self-determination**

All the eligible respondents were given a fair chance to decide whether they would like to participate in the study or not. Refusal to participate was respected by the researcher and this did not interfere with the way these clients were treated in the facility. Study respondent willingly participated in the study, no form of coercion or manipulation was used.

- **Right to full disclosure**

Information leaflet that had all the details about the study were handed out to all the prospective respondents (see Annexure D). Further explanation and information were given through discussions to ensure that all the prospective respondents' questions were responded to adequately.

- **Right to fair treatment**

Selection of study respondents was done based on the study objectives and requirements. No incentives were given to get more respondents for the study. No

cultural, racial and ethnic group was excluded based on their background. Respondents who declined to be part of the study and those who decided not to continue with the interview were given a fair chance to do so.

3.3.1.4 Sample

A sample is a group of people or elements which are included in the study and meeting the selection criteria (Grove et al 2013:351). The sample size calculation was informed by the number of family planning clinic clients seen in each facility per month. The sample size was calculated using formula for finite population where population is less than 50000 (Freedman 1997).

ss = sample size

z = z value

p = percentage of population picking a choice expressed as decimal

c = confidence interval expressed as decimal

$$ss = Z^2 \times p \times (1-p) / C^2$$

$$ss = 1.96^2 (0.5) \times (1-p) / 0.05^2$$
$$3.84 \times 0.25 / 0.0025 = 384$$

$$\text{New ss} = 1 + ss - 1 / \text{population}$$
$$= 1 + 384 - 1 / 2400 = 1.16$$
$$= 384 / 1.16 = 331$$

A final sample size of 331 was arrived but since this a research study of limited scope, the researcher only interviewed a total of 134 women.

3.3.2 Data collection

Data collection is defined as the process in which respondents are selected and have data gathered from these respondents (Grove et al 2013:523). A structured plan that indicates what information should be gathered and how to gather it is necessary to answer the proposed study questions (Polit & Beck 2004:318).

In a quantitative study, the most widely used data collection method is structured self-report which involves a formal, written instrument. The questionnaire or self-administered questionnaire is used when respondents are required to complete the instruments themselves (Polit & Beck 2012:297).

In this study, the questionnaires were used for data collection. This was to aid in facilitating the interviews, in this case the questions were read and posed and interpreted by the researcher.

3.3.2.1 Data collection approach and method

Structured interviews are defined as verbal communications with respondents that allows the researcher to implement exercise control over the content and responses of the interview to obtain essential and relevant data for the study (Grove et al 2013:422).

The study was conducted in Johannesburg in the Gauteng Province which is known for its diversity in terms of culture and language. The participants were approached immediately after they have been attending to by the nurse in the family planning clinic on their way exiting the clinic. A brief explanation of the study in the language they understood was given to all prospective respondents. After agreeing to take part in the study, all respondents were made to sign a consent form and their right to terminate the interview at any given time was explained. Though the dominating languages were isiZulu 50%, Sotho 30%, Xhosa 12% and with only 8% English speaking participants, all questions were in English and were translated to the respondents' languages to ensure that they are understood. The researcher being a local resident was able to translate the questions for all the local respondents who were speaking other languages than English.

The researcher interviewed women attending family planning clinic in each of the selected facilities during data collection. Questionnaires were used for data collection. The researcher personally conducted the interviews to ensure that the respondents understand the questions, questions are asked in the same pattern and that the women's actual responses are recorded. The four PHC clinics offer their services only five days a week. The services provided include provision and administration of contraception and family planning. In all four clinics, family planning clinics are deemed

as a special service that is offered what is referred to as “fast lane” status. Under this plan, the family planning clients have their own separate queue. In this queue, family planning clients are registered and seen immediately. About five clients are seen in a very short space of time of about ten minutes.

In order to accommodate this kind of operation, the researcher would introduce himself to all the prospective study respondents while waiting and request to talk to them once they have been seen by the nurse rendering the service.

The interviews were conducted in a private or screened area provided by the clinic manager or staff for each respondent. The process started from explaining the purpose of the study, and the rights of the prospective respondent were explained. After the discussion, the prospective respondents were asked if they would still continue with the study and the right to terminate it at any given time during the interview was explained.

3.3.2.2 Development and testing of the data collection instrument

The questionnaire was developed in English (see Annexure E). A pilot study that which constituted a total of 10 respondents was conducted to test the data collection instrument. The pilot study was conducted in Jepee’s Town Clinic (Which was one of the participating clinics) in order to test the data collection tool.

3.3.2.3 Characteristics of the data collection instrument

The questionnaire required self-reporting by the index respondent and no proxy respondents were used in the study. Basic demographic information which comprised of age, level of education and marital status was included in the questionnaire. All the questions included were aimed at addressing all the study variables.

3.3.2.4 Measures to ensure reliability and validity of the instrument

The researcher conducted face to face interviews using the questionnaire to enhance honesty in responding to questions and to ensure that questions are interpreted and understood in the same way by the respondents.

In order to ensure face validity in this study, the questionnaire was examined by other researchers, the departmental head including the supervisor to ensure its validity. Content validity was ensured by pre-testing the questionnaire during pilot study which was conducted in Jeppee's Town Clinic. The questionnaire was printed in English and translated to individual respondent's languages for uniform understanding.

3.3.2.5 Data collection process

Prospective respondents were asked to participate to the study when they were already leaving the clinic. After consenting to participation, respondents were assisted in completing the questionnaire by the researcher.

3.3.2.6 Ethical considerations related to data collection

- **Scientific integrity of the research**

The study has been approved by the University of South Africa's Health Studies Higher Degrees Committee in the College of Human Sciences (see Annexure A).

- **Informed consent**

The researcher obtained informed consent from all the respondents. The kind of questions and the purpose of collecting data were explained (see Annexure D).

- **Right to full disclosure**

The researcher disclosed all the needed information regarding the study and the use of the collected data to all prospective respondents. No covert data collection method was used in any part of the study.

- **Right to privacy**

The questions contained in the questionnaires were structured in a way that was only intended to answer the research questions. Respondents' privacy and anonymity were maintained at all times. Data collected was kept in a locker where only the researcher

had access. Names were not used or written in the questionnaires and only questions aimed at addressing the research questions were asked.

- **Site**

An application to conduct this study in Region F was submitted to the City of Johannesburg municipality health research committee (see Annexure B). Data collection was only done at the receipt of approval (see Annexure C).

3.3.3 Data analysis

Statistical data analysis assisted the researcher in making sense of quantitative information. The procedures applied allow the researcher to summarise, organise, evaluate and communicate numeric information. The statistics are either descriptive or inferential (Polit & Beck 2004:451).

The researcher used descriptive statistics in order to present the data. An association between variable such as age, marital status, educational background, acceptance, accessibility and utilisation of VCT services will be presented on a data matrix.

The results were analysed using the Statistical Package for Social Sciences (SPSS) version 21. The information was presented in frequency tables, bar charts and pie charts for all variables in order to determine the distribution of variables. Cross tabulation was also done to determine the relationship between the predictor variables and the response. The threshold for statistical significance was considered as p value $< .05$ for all statistical analyses.

3.3.3.1 Descriptive statistics

Descriptive statistics are of high value when the main aim is to describe and synthesise data. The researcher will use descriptive statistics to describe the characteristics of the sample and the relationship among all the study variables, which are acceptance, accessibility and utilisation (Polit & Beck 2004:451).

Descriptive statistics were used to present the data. Association between variables such as age, marital status, educational background, acceptance and utilisation of VCT services will be presented on a data matrix.

3.4 INTERNAL VALIDITY OF THE STUDY

Internal validity refers to an extent to which the effects discovered or the study findings are a true reflection of reality rather than from an effect of extraneous variables (Grove et al 2013:199; Joubert & Ehrlich 2007:117).

Content validity: in order to ensure face validity in this study, the questionnaire was examined and tested by other researchers, the departmental head including the supervisor to ensure its validity. Pilot study conducted on ten respondents was conducted to pre-test the questionnaire and ensure content validity.

Face validity: the questionnaires were developed in English but adequate measures were taken to ensure that questions were asked and translated into a respondent's preferred language. The researcher as a Gauteng resident and a professional nurse, is familiar with the cultures and spoken languages in the area.

3.4 EXTERNAL VALIDITY OF THE STUDY

According to Grove et al (2013:202) and Stommel and Wills (2004:52), external validity is mainly concerned with the degree to which the findings of the study can be generalised beyond just the sample used in the study but the population at large.

Inconsistent validity: women from different ethnic groups and age groups were interviewed to ensure that the results can be generalised to a larger population.

Selection bias: convenience sampling was used to select eligible respondents based on their availability during data collection. Women were not excluded because of their age or race but were requested to participate based on meeting the selection criteria.

Subject attrition: a cross-sectional study design was applied to answer the study questions. This resulted in the elimination of dropout and loss to follow up of respondents.

3.5 CONCLUSION

The chapter was aimed at explaining the research design and methods used to answer the study questions. The researcher further explained and reiterated the ethics observed when sampling and data collection processes were applied.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF RESEARCH FINDINGS

4.1 INTRODUCTION

The previous chapter dealt with the research design and methodology. This chapter presents data management, analysis and the discussion of the study findings. It consists of two sections, with descriptive analysis presented in Section A and logistic regression in Section B.

4.2 DATA MANAGEMENT AND ANALYSIS

The study data was collected from the four primary health care (PHC) clinics in Region F within the City of Johannesburg Municipality. The data were collected by the researcher assisted by the part-time research assistant. The services of a statistician were sought for data analysis.

4.3 RESEARCH RESULTS

4.3.1 Section A: Descriptive analysis

4.3.1.1 *Demographic profile of study respondents*

Table 4.1 Demographic profile of study respondents (N=134)

Facility	n	%
Jeppe's Town	40	29.9
Malvern	35	26.1
Albert Street	38	28.4
Rosettenville	21	15.7
Date of birth		
18–20	4	3.0
21–25	37	27.6
26–30	60	44.8
31–35	33	24.6

Facility	n	%
Level of education		
Grade 7 and below	11	8.2
Grade 8–11	55	41.0
Matric	60	44.8
Tertiary	8	6.0
Relationship status		
Not in a relationship	2	1.5
Living with the partner	81	61.9
In a relationship but not living with partner	51	38.1

All 134 respondents were women obtaining hormonal contraceptives from public clinic in the geographic area of the Johannesburg Metropolitan area, Region F. Most of the women obtained their hormonal contraceptives in Jeppe's Town clinic 40(29.9%) followed by Albert Street 38 (28.4%). Just under half (44.8%) of the study respondents were between 26-30 years while 3% of the respondents were between 18 - 20 years of age. It can be seen from table 4.1 that the vast majority of the respondent's highest academic qualification was matric (44.8%). The current finding contradicts with the findings by Seutlwadi et al (2012), which indicates the predictors of contraceptive use as having higher education (Seutlwadi et al 2012:[44]). About 81 (61.9 %) were living with the partner most of the time in which most of them were cohabiting conforming to Ramjee and Wand (2012) study which found that about 81% of women using hormonal contraceptives who participated were cohabiting (Ramjee & Wand 2012:750).

4.3.1.1.1 Employment status

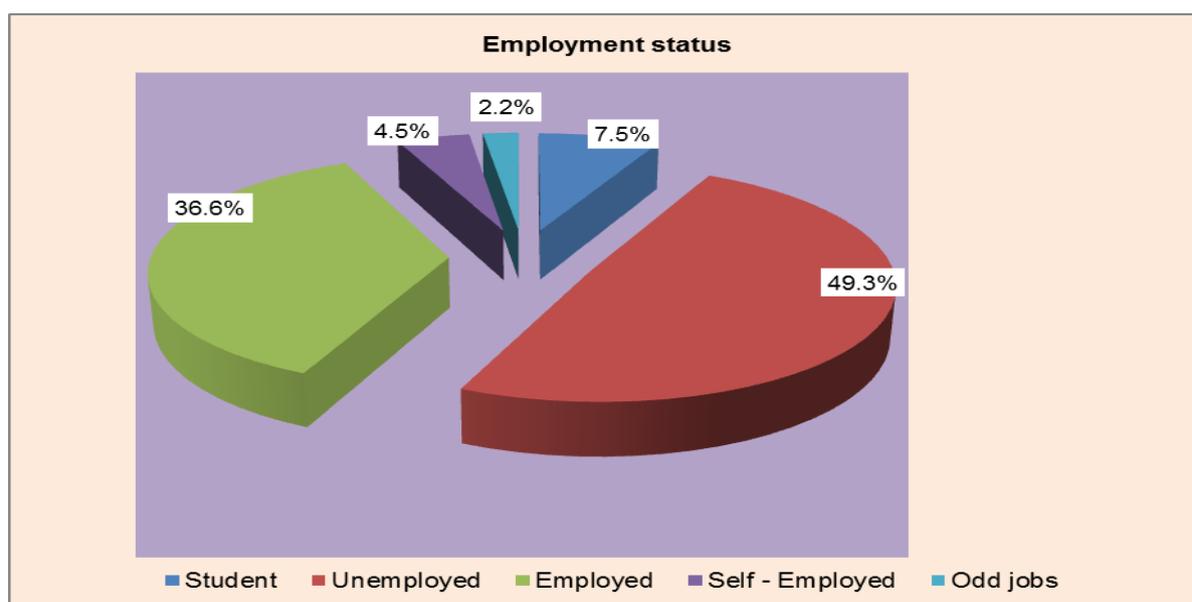


Figure 4.1 Distribution of employment status (N=134)

Figure 4.1 shows that with regards to employment status, the majority (49.3%) reported they were unemployed. Most women obtaining contraception in these facilities did not reach matric in their schooling years hence the high level of unemployment. The finding concurs to the previous study conducted in Durban, which indicated that 85% of hormonal contraceptive users reported to be unemployed (Ramjee & Wand 2012:750). It is good to see that despite the challenge of being unemployed, these women are able to attend family planning clinics.

4.3.1.1.2 Marital status

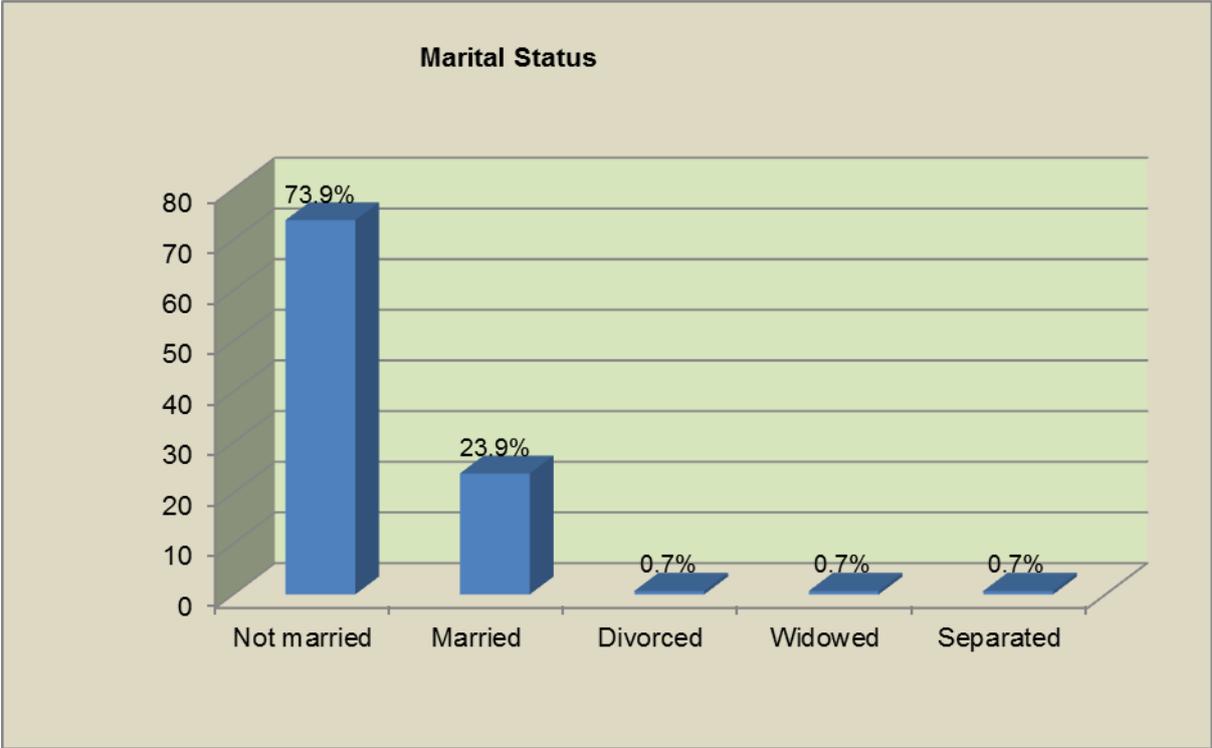


Figure 4.2 Marital status (N=134)

In this study, married was defined as those who are legally married. A very high proportion of the respondents 99 (73.9%) were not married and 32 (23.9%) were married the remaining 0.7% were divorced, widowed and separated (see figure 4.2). The finding was in the expected direction based on the researcher’s observation made in 2011 that almost half of the women seen in the family planning clinics are not married. The finding creates an area of concern when referred to a risk factor analysis done from different large scale HIV prevention trials (Matovu et al 2013:[11]; Ramjee & Daniels 2013:[1]).

4.3.1.2 Condom use

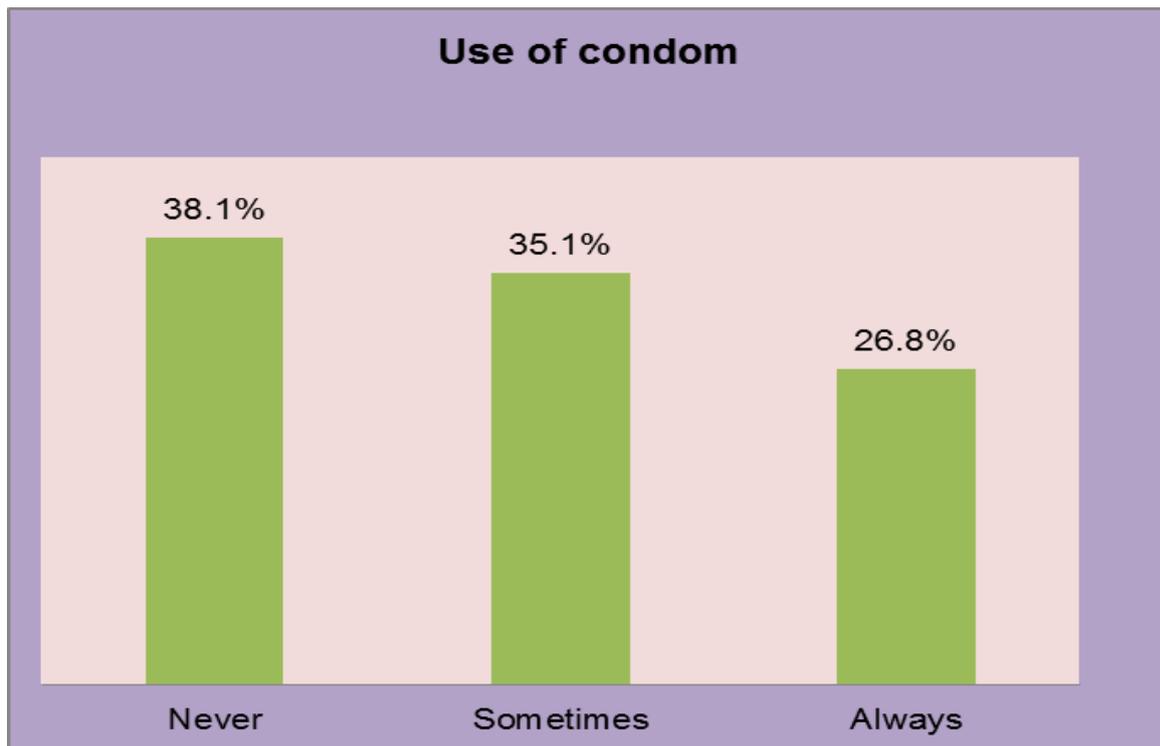


Figure 4.3 Distribution of condom use (N=134)

In this study, the total of 51 (38.1%) of respondents cited to not using condoms as a method of protection and only rely on hormonal contraception for prevention of pregnancy, while 41 (35.1%) reported to be using condoms sometimes or when convenient to do so. The results confirm Marahaj (2006) findings that as the relationship moved from casual to serious, condom use become unnecessary (Maharaj 2006:[31]). The data also allude to the finding from a previous studies which revealed that having higher education and better accessibility of condoms was a predictor for consistent condom use (Myer et al 2002:[120]; Seutlwadi et al 2012:[44]). The findings also concur with the findings in the previous survey, where 36% of respondents reported to have used condoms at last sex (Shisana et al 2012:73).

4.3.1.3 Services offered in the family planning clinic and uptake

Table 4.2 Distribution of contraception (N=134)

Variables	Number	Percentage
Hormonal contraception method used		
Oral	25	18.7
Injectable	109	81.3
Reason for using hormonal contraception		
Partner refuses to use condom	42	31.3
Just taking caution in case the condom breaks or not used	81	60.4
Own preference since she doesn't want to use condom	11	8.2
Were you offered HIV voluntary counselling and testing by the nurse who attended you in the family planning clinic?		
Yes	12	9.0
No	122	91.0
Sexually transmitted disease screening (probe if they were asked about symptoms)		
Yes	50	37.3
No	84	62.7
Were you given condoms today or your previous visit?		
Yes	7	5.2
No	127	94.8
Who issued the condoms?		
Nurse in the family planning room	8	6.0
HIV counsellor	37	27.6
I took them from the condom container	89	66.4

Table 4.2 shows that hormonal contraceptive method used was injection 81.3%. The majority of the respondents reported their reason for using hormonal contraception as just taking precaution in case the condom breaks or not used 81 (60.4%) and 40 (31.3%) reported that the partner refuses to use condoms. This finding alludes to the finding from the study done by Ramjee and Wand (2012), in which the respondents reported that the decision in whether to use a condom or not relied on men. The study also suggests that the partners of women on hormonal contraceptives are less likely to use condoms as compared to those who do not use contraceptives (Ramjee & Wand 2012 [752]). It is not surprising that most respondents in this study reported that their partners refuse to use condoms when considering the previous study results that alluded the same finding (Le-Deroche et al 2015:[80]).

A very high proportion of respondents 66 (49%) did not complete their matric. The data confirm the findings of a populations based survey done in South Africa, which states that condom use and communication is determined by the level of education and occupation status of both partners (Seutlwadi et al 2012:[44]).

When respondents asked whether they were offered HIV voluntary counselling and testing by the nurse who attended them in the family planning clinic, approximately 91% were not offered HIV counselling and testing. The data suggest that the issue of provider initiated counselling and testing is often not considered during consultations. This finding confirms the researcher’s observation that the nurse-patient relationship becomes that of nurse and a woman who does not want to fall pregnant leading to the ignorant of other health determinants.

The majority of the respondents in this study 62.7% reported to have not been screened for sexually transmitted diseases (the question was posed by probing if they were asked about symptoms). In this study, 94.8% were not issued with condoms during their visit. About (66.4%) respondents reported to have collected condoms from the condom dispenser and were never issued by the nurse. According to these findings, the integration between family planning and VCT services still lags behind in our health system (Gillepsie et al 2009:[868]).

4.3.1.4 Frequency of HIV testing

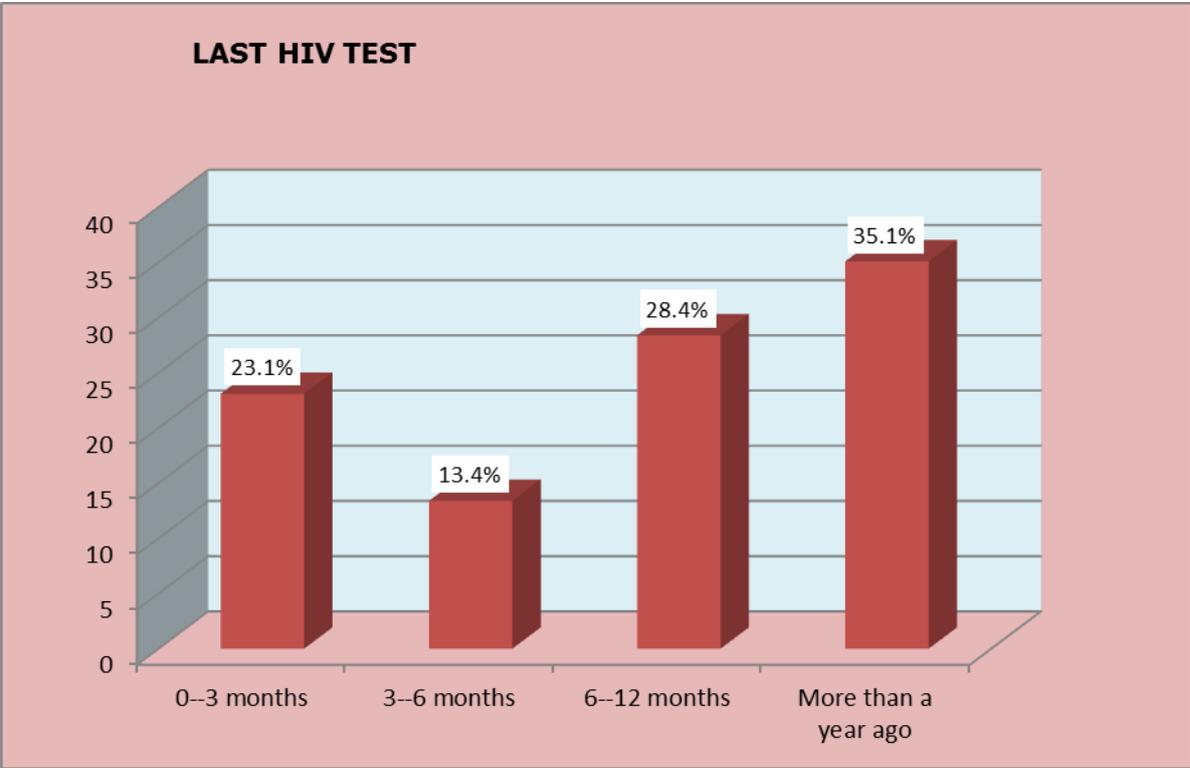


Figure 4.4 Distribution of HIV test (N=134)

When the respondents were asked when last they had HIV test, 35.1% reported to have done their last HIV test in more than a year ago. This was followed by those who reported to have tested 6–12 months ago 28.4% (see figure 4.4). These results contradict with the findings by Matovu et al (2013), that one of the predictors of HIV counselling and testing uptake was prior receipt of any form of HIV testing service (Matovu et al 2013:[10]). It is worrying to note that 35% of the respondents last had their HIV test in more than a year ago, which possibly means they do not know their current HIV status. The data concur with Meiberg’s (2008:[53]), that many of the respondents reported they would go for HIV testing when they feel really sick.

4.3.1.5 Determinants for HIV testing

Table 4.3 HIV testing patterns and reasons (N=134)

Variables	Number	Percentage
Was there a reason for you to do the test the last time you did it?		
I did voluntary since I wanted to know my status	88	65.7
I was advised by the nurse in the family planning clinic	6	4.5
I was encouraged by the nurse who gave health education in the waiting area	7	5.2
I was pregnant and advised to do it at the clinic	33	24.6
Results		
Reactive	18	13.4
Non – reactive	103	76.9
Not willing to share	13	9.7
Where did you do the HIV test		
In this facility	51	38.1
In another government facility	75	56.0
Private	8	6.0
Would you consider an HIV test if requested to do so by the nurse in the family planning clinic? (This question is for respondents who currently do not know their HIV status). Do not ask if reported to have tested reactive.		
Yes	102	76.1
No	12	9.0
N/A	20	14.9
Do you know where you can have an HIV test done in this facility?		
Yes	67	50.0
No	67	50.0

The questions were asked based on the last HIV test irrespective of the when was the test done. Table 4.3 shows that majority of the respondents in this study 88 (65.7%) reported to have voluntary undergone HIV testing since they wanted to know their status as oppose to 13 (9.7%) advised and encouraged by the clinic staff. The data allude to the study findings by Le-Deroche et al (2015:[78]) in which 53% had an HIV test to know their status and 35% through the PMTCT programme. Contrary to

expectations, the majority of the respondents in this study that were willing to share their last HIV test results reported to have tested negative for HIV102 (76.9%), 18 (13.4%) to have had their result recorded as positive and only (9.7) were not willing to share their last test results. The researcher envisaged reluctance in sharing the results by the respondents due to the stigma attached to HIV.

The larger proportion 75 (56%) of the respondents had their last HIV test done in another facility other than the one from which they obtained the hormonal contraceptives. The data collected in this study shows that the majority 102 (76.1%) would consider an HIV test if they were requested to do so by the nurse (PICT model) in the family planning clinic. Another finding was that half of the respondents 67 (50%) did not know and half 67 (50%) knew where they can have an HIV test done in the facility where they were obtaining their hormonal contraceptives on the interview day. In the study conducted by Lince-Deroche et al (2015:[78]), the respondents reported to have knowledge of the VCT services provided by the clinics. However, in this study, most respondents verbalised not to have an idea of where to get VCT services in the facility from which they obtained the hormonal contraceptives. The result is evidenced by the highest number of respondents having had their last HIV test in another facility. Considering this data, strengthening of PICT is necessary in the family planning clinic. The finding also contradicts with the survey conducted by Shisana et al (2012:81), where 92.3% responded affirmative in knowing the closest place where they could obtain an HIV test.

4.3.1.6 Acceptance of HIV test as mandatory

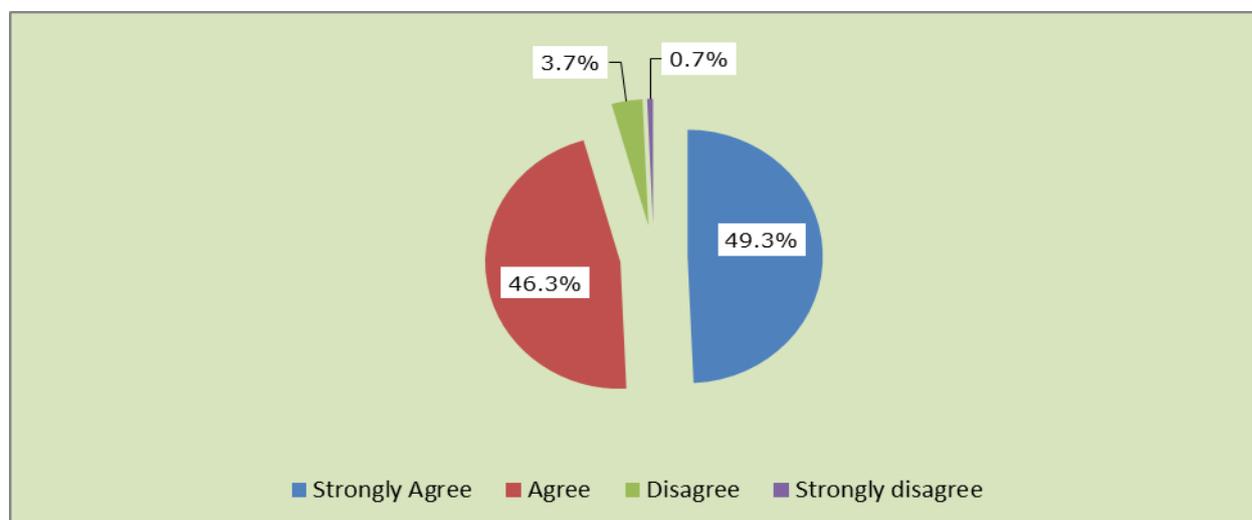


Figure 4.5 Distribution of women using hormonal contraceptives (N=134)

Figure 4.5 shows that majority of respondents strongly agreed (49.3%) and agree (46.3%) that HIV testing should be mandatory for all the women using hormonal contraceptives. Only few (4.4%) of the respondent did not agree with HIV testing being mandatory to women using hormonal contraceptives. It is a good sign to know that most women strongly agree with incorporating the VCT services into family planning. The PMTCT programme has done tremendously well in offering HIV counselling and testing to all antenatal clients. About 25% of the respondents did their last HIV test through the PMTCT programme, which indicates that women are more inclined to accept VCT services if they would be made available and offered during consultation.

4.3.2 Section B: Linear regression

4.3.2.1 STI screening as a determinant for being offered HIV testing

Table 4.4 HIV test offered by STI screening (N=134)

Response	Yes	No	Total
Yes	8	4	12
	5.97	2.99	8.96
	66.67	33.33	
No	42	80	122
	31.34	59.70	91.04
	34.43	65.57	
Total	50	84	134
	37.31	62.69	100.00
$\chi^2 = 4.855$ (p=0.027)			

Approximately 67% respondents who were offered HIV counselling and testing were significantly screened for sexually transmitted disease with (p=0.027, $\chi^2 = 4.855$). The results show an association between STI screening and referral for HIV testing. The group of women who had reported symptoms and were screened for STI were likely to be tested for HIV. This is an indication that STI screening outcome might have prompted for further investigation. This finding further puts more emphasis on integration and comprehensive care under one roof.

4.3.2.2 Previous HIV test as a determinant for an offer to HIV

Table 4.5 HIV test offered by last HIV test (N=134)

Response	3 months	3-6 months	3-12 months	More than a year	Total
Yes	7	1	3	1	12
	5.22	0.75	2.24	0.75	8.96
	58.33	8.33	25.00	8.33	
No	24	17	35	46	122
	17.91	12.69	26.12	34.33	91.04
	19.67	13.93	28.69	37.70	
Total	31	18	38	47	134
	23.13	13.43	28.36	35.07	100.00
$\chi^2 = 10.05$ (p=0.018)					

The results shows that 7 (58.3%) were significantly tested between 0–3 months ago and were significantly offered HIV voluntary counselling and testing by the nurse who attended them in the family planning clinic ($\chi^2 = 10.05$, p=0.018). The data confirm that the last or previous test was not considered where HIV testing was offered. This also highlights the need to fix the gaps in the provision of sexual and reproductive health services.

4.3.2.3 Association between HIV testing and the reason for test

Table 4.6 HIV test offered by reason (N=134)

Response	Voluntary	Advised by the nurse	Encouraged by the HIV counsellor	Pregnant (PMTCT)	Total
Yes	5	2	2	3	12
	3.75	1.49	1.49	2.24	8.96
	41.67	16.67	16.67	25.00	
No	83	4	5	30	122
	61.94	2.99	3.73	22.39	91.4
	68.03	3.28	4.10	24.59	
Total	88	6	7	33	134
	65.67	4.48	5.22	24.63	100.00
$\chi^2 = 8.83$ (p=0.032)					

The results shows that there is an association between reason for HIV test and HIV voluntary counselling and test offer by the nurse who attended you in the family planning clinic, $\chi^2=8.83$ ($p=0.032$). The data illustrate that respondents who voluntarily requested an HIV test were likely to be tested than those that did not. Other variables were not associated with HIV voluntary counselling and testing by the nurse who attended them in the family planning clinic, $p > 0.05$.

4.4 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

4.4.1 Acceptance of VCT services to women using contraception

The study data revealed that a majority of women 102 (76.1%) responded positive when they were asked if they would consider an HIV test if asked by the nurse in the family planning room. When asked if HIV testing should be mandatory for all women using contraception, the majority of respondents gave a positive response with 49.3% strongly agreeing and 46.3% agreeing to this. Based on this data, these women were willing to do an HIV test. The pattern of HIV testing by the respondents somehow contradicts with these responses with about 35.1% having had their last HIV test in more than a year ago. Despite this contradiction, the data show that most of the tests were done voluntarily to know one's status 88 (65.7%), with 33 (24.6) routinely done for prevention of mother-to-child HIV transmission (PMTCT). This illustrates the acceptability of routine testing.

4.4.2 Accessibility of VCT services to women using contraception

The results presented in this chapter had variables that were aimed at measuring the level of accessibility of VCT services by women using contraception in the City of Johannesburg Municipality clinics.

In all the four facilities where the study was conducted, the family planning services are treated and regarded as "fast lane". The latter gives the family planning clients an advantage of not sitting and wait in other long clinic queues but their own special queue. In some instance, the nurse was observed collecting cards of all those on oral contraception, she would then come back with the oral contraceptives wrapped in each

visit card and the next appointment written. The practice was seen very limiting in terms of addressing other issues that the client might have. It also prevented a nurse from engaging with clients in discussing issues of safe sex, the use of dual protection and the importance of constant HIV testing (PICT). The practice was seen by the researcher as limiting accessibility of VCT services to clients that really require such. This exacerbates the need of PICT, which allows the health care worker to treat the client appropriately by identifying those who need early treatment or wellness programme interventions (Makhung-Ramfolo et al 2011:[2]).

Based on the above observation, it did not come at a surprise to have 67 (50%) of respondents reporting not to know where to do an HIV test in the facility where the hormonal contraceptives were obtained. An indication of poor access to VCT services was further observed as these are required to form an integral part of the family planning services.

A proportion of women who had done their last HIV test in the facility where the hormonal contraceptives were obtained was lower 51 (38.1) than those who had their last HIV test done in another facility other than where the hormonal contraceptives were obtained 83 (62.0%). This concurs with the findings of the study previously conducted in Ethiopia, which found that integration of family planning into VCT programmes was likely to be efficacious (Gillespie et al 2009:[868]). Integration of services could easily ensure accessibility of services when needed without sending a client to another room within the health care facility.

4.4.3 Utilisation of VCT services to women using contraception

Utilisation was further explored in terms of HIV testing patterns based on the last HIV test and knowledge of one's status.

Although the proportion of those who strongly agreed on having an HIV test as mandatory for women using hormonal contraception, about 35.1% reported to have had their last HIV test in more than a year ago and 28.4% in more than six months ago. This illustrates the very low utilisation of VCT services by women obtaining hormonal contraception in the participating clinics. Voluntary HIV testing is not seen as important by most of the family planning clinic clients.

The statistics of this nature are worrying when considering the self-reported inconsistent condom use as those who reported to use it sometimes recorded 38.1% and those who never recorded 35.1%. This finding might have different explanations to it: the respondents perceived themselves of being at low risk of contracting HIV, having no control over the risk of contracting HIV or the fear of disclosing the HIV positive status to the partners as these have been a reasons in other studies (Meiberg et al 2008[53]; Rujumba et al 2012:[7]).

Condom distribution is considered a big component of the HIV counselling and testing and prevention programme. The proportion of self-reported condom use as always 42 (36.9%) was lower than those who reported never uses condoms 51 (38.1%) and uses condoms sometimes 41 (35.1%) respectively. This finding is consistent with the study done by Maharaj (2006), which found that the use of two prevention method was uncommon among young people (Maharaj 2006:[31]).

The finding also concurs with that from the previous study where it was found that partners of women using hormonal contraception were less likely to use condoms (Ramjee & Wand 2012:[752]).

The data collected from this study reveals that most women, that is, 33 (24.6%) had their last test during pregnancy through the PMTCT programme. Though the study was unable to state whether any of the respondents has ever refused PMTCT HIV routine testing, but the results show that routinely conducted medical investigation are more likely to be accepted and utilised.

4.5 CONCLUSION

This chapter presented the data analysed from the questionnaires, tables and graphs. Reference was also made to literature. Different aspects were analysed in order to answer the research questions and meet the objectives. The following chapter will present, research findings, conclusions and recommendations.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the conclusions based on the study results on acceptance, accessibility and utilisation of VCT services by women using contraceptives in the City of Johannesburg Municipality clinics. Following data analysis and interpretation, conclusions and recommendations were made.

5.2 RESEARCH DESIGN AND METHOD

The interpretation of the study findings will be made in reference to the study objectives as outlined below. In this study, the researcher is trying to describe the relationship between acceptance, accessibility and utilisation of VCT services by women using hormonal contraceptives in the selected clinics in the City of Johannesburg Municipality area. The principles of a quantitative, non-experimental cross-sectional study were applied to meet the study objectives.

In this study, the population of sites included all clinics where women can obtain hormonal contraceptives. The target population for this study included all 14 clinics where the women are obtaining hormonal contraceptives in the City of Johannesburg Region F.

Convenience sampling method was used to select eligible women attending the participating contraceptive clinics on the days when data were collected at the specific clinics and were requested to participate in the study. Structured interviews were conducted using a structured interview schedule; the researcher personally conducted the interview with the assistance of trained research assistance to ensure that the respondents understand the questions and that the women's actual responses are recorded.

5.2.1 The purpose of the study

The purpose of the study was to describe the accessibility, acceptance and utilisation of VCT services by women on hormonal contraceptives obtained from municipal clinics in the City of Johannesburg's Municipality area.

5.2.2 Study objectives and the research problem

The study conclusion will be discussed in relation to its objectives and the research problem as outlined in chapter 1. The intention of this chapter is ensure that the findings are discussed further with more emphasis placed on acceptance, accessibility and utilisation of VCT services by women using hormonal contraception.

5.3 CONCLUSIONS

5.3.1 Marital status

It is clear that the population of women using hormonal contraceptive are often unmarried based on the study data in which 99 (73.9%) were unmarried. This is regarded as one of the predisposing factors among women (Rehle & Shisana 2013). The high number of cohabiting women in the study is worrying especially when considering the low and inconsistent self-reported use of condoms for HIV prevention. The risk factor analysis suggested that being under the age of 25 years, having had one sexually transmitted infection in the past and being unmarried were associated with high risk of sero-conversion. Unfortunately, it is the same group with non-marital relationships that are usually reluctant to test for HIV due to fear of a positive result.

5.3.2 Condom use and distribution

A high proportion of women reported that they were not using condoms at all 51 (38.1%). About 42 (31.3%) cited the partners refusal of condom usage. This illustrates that women are still not decision makers where sexual decisions are made in the relationship. Despite 89 (66.4%) having collected condoms from the condom container at the clinic, it is clear that these condoms are not consistently utilised with 35.1% reporting to be using condoms sometimes and 26.8% self-reported consistent use. The

family planning nurses are not doing much in terms of condom distribution with only 8 (6.0%) having been offered with condoms. Based on these findings, the use of dual protection is very low. The finding contradicts with the study done by Lince-Deroche et al (2015:[79]) where 50.6% reported to have used condoms at last sexual intercourse. Based on these findings, the use of dual protection appears to be very low.

5.3.3 HIV testing patterns

VCT intake by women using hormonal contraception was found to be inconsistent, with 35% having had their last HIV test in more than a year ago and 28.4% in more than six months ago. The data were collected based on self-recalled information and estimation which might not be accurate. The intake was observed high in those that undergone routine PMTCT HIV test at 24.6%. This was alluded by 49.3% and 46.3% who strongly agreed and agreed respectively in having HIV testing mandatory for women using hormonal contraception.

5.3.4 Integration of HIV testing into family planning services

Most women reported their last HIV test was done in more than a year ago but the data show that those that voluntarily opt for HIV testing are more likely to be tested than those who do not $\chi^2 = 8.83$ ($p=0.032$). This is a clear gap in the implementation of the PICT model in the family planning clinics. Another finding was that 75 (56.0%) reported to have done their last HIV test in another facility other than the one from which they were obtaining their contraceptives. Based on the findings, it is clear that the integration of such vital services remains a challenge. Prevention of pregnancy and that of diseases are still addressed separately irrespective of the given role of condom in both situations. The data show that utilisation of VCT services is highly dependent on the availability of such continuous education and reinforcement. If VCT services are made available to women using contraception, the likelihood of utilisation will be high.

5.4 RECOMMENDATIONS

Family planning nurses need to put more focus on conducting risk assessment including STI screening for every client. Distribution and demonstration of use for both male and

female condom is required to improve consistent and correct condom use. Health systems strengthening needs to be cascaded to the facility level to ensure that the South African contraception guidelines are implemented correctly and efficiently. Capacity building in terms of provider counselling and testing is a necessity for all family planning nurses and facility HIV counsellors. All family planning clinics must have all the HIV testing commodities available to facilitate the one stop shop model. An integrated approach will improve acceptance by allowing women to make informed choices of having their HIV test done in the same room where they have obtained their contraception. The study results discovered inaccessibility as one of the barriers to HIV testing by this group of women. Integration of VCT services into family planning is highly recommended in order to improve accessibility leading to improved utilisation of these services.

5.5 CONTRIBUTIONS OF THE STUDY

The study will assist in creating HIV prevention awareness especially with special attention given to prevention messaging targeting hormonal contraceptive users. The study results will allow the programme managers and planners to develop strategies that will ensure that the contraception guidelines, HCT policy and the NSP are integrated and implemented effectively.

5.5.1 Integration of VCT into family planning

The study will further contribute toward the following:

- Creating awareness on the need to strengthen women health of hormonal contraceptive users.
- Develop an approach to create awareness about dual protection use
- Strengthen provider initiated HIV counselling and testing in family planning clinics.

5.6 RECOMMENDATION FOR FUTURE RESEARCH

This study was conducted in only one province; it is recommended that future research should be conducted in other provinces to further explore accessibility, acceptance and utilisation of VCT services by women using hormonal contraceptives.

5.7 LIMITATIONS OF THE STUDY

The study was restricted to only four facilities. This was a cross-sectional study and relied on self-reported behaviour than observed. The study may be limited to generalisability to other districts and provinces because the sample was drawn from one metro district, thus future studies can be done in other districts. The desire to stick to a socially acceptable behaviour in terms of condom collection, use and HIV testing might have influence on the reported use.

5.8 CONCLUDING REMARKS

In spite of the study limitations, the results have proven the need to strengthen family planning services. The main highlight is the importance of integration of HIV counselling testing into family planning.

“It is critically important that women at risk of HIV infection have access to and use condoms, male or female, and where appropriate, other measures to prevent and reduce their risk of HIV infection and sexually transmitted infections” (WHO 2012).

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Annexure A

Ethical Clearance from the Health Studies Higher Degrees Committee, Unisa

**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

HSHDC/294/2013

Date: 10 December 2013 Student No: 4433-058-8
Project Title: Acceptance, accessibility and utilization of voluntary counseling and testing (VCT) services by women using hormonal contraceptives in the City of Johannesburg's Municipal Clinics.
Researcher: Bandile Ernest Ndlazi
Degree: Masters in Public Health Code: DLMPH95
Supervisor: Dr TE Masango
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved

Conditionally Approved

PP
Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

L. Roets

MM Moleki
Ex Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure B

Letter seeking consent from the City of Johannesburg Municipality

PO Box 937

Kelvin

2054

13 June 2014

The City of Johannesburg

Health department

Region F

Sir/Madam

Application for permission to conduct a study in the City of Jhb Region F

My name is Bandile Ndlazi, currently studying MA Public Health with UNISA. With your permission, I would like to conduct a study in your region. This will be done in four of your clinics that were selected by the researcher. With your permission, the following facilities are requested to participate, Malvern Clinic, Albert Street Clinic, Jeppe's Town Clinic and Rosettenville Clinic.

The study topic is acceptance, accessibility and utilization of voluntary counseling and testing services (VCT) by women on contraceptives.

The aim of the study is to describe and quantify acceptance, accessibility and the use of VCT services by women on contraceptives. The target population will be women attending the family planning clinic between the ages of 18-49.

There are no risks associated with being involved in the study and participation is by choice. No direct benefits to the patients and nurses, but the study will make recommendation to improve the quality of care being rendered by our clinics. The

study has been reviewed and approved by the UNISA's Departmental Higher Degrees Committee of the Department of Health studies.

The researcher can be contacted on 0820876752 or the researcher's supervisor Dr TE Masango on 012 429 3386.

Yours faithful

Mr Bandile Ndlazi

Annexure C

Letter of approval: City of Johannesburg Municipality



a world class African city

Enquiries: C Fraser
Tel. +27(0) 11 407 7437
Tel. +27(0) 11 407 6340

PO Box 52144
Braamfontein
South Africa
2017

8 July 2014

Dear Mr. Ndlazi

APPROVAL TO CONDUCT RESEARCH WITHIN THE JOHANNESBURG HEALTH DISTRICT

Permission has been granted to you to conduct research within the Johannesburg Health District.

Topic: Acceptance, accessibility and Utilisation of Voluntary Counselling and Testing (VCT) services by women using hormonal contraceptives in The City of Johannesburg's municipal clinics

Please contact the following person(s) before you commence with your project and to gain access to the clinics:

Region	Regional Health Manager	Contact No.	Cell phone
F	Mr Oupa Montsioa	011 681 8130	082 467 9423

Should you have any queries please do not hesitate to contact our department.

We look forward to your Final Research Report.

Thank you

DR. R. BISMILLA
Executive Director
City of Johannesburg
Health Department

Annexure D

Respondent's information leaflet

Respondent's consent form

Respondent's information leaflet

Study topic: *Acceptance, accessibility and utilization of voluntary and counselling (VCT) services by women using hormonal contraceptives at the City of Johannesburg's municipal clinics.*

Introduction

Good day, my name is **Bandile Ndlazi**. I am a researcher currently doing Master of Public Health degree with the University of South Africa.

Reasons for doing the study

HIV transmission is the most common problem in South Africa, especially amongst women. The aim of the study is to assess the accessibility, acceptance and use of the voluntary counselling and testing services by women using hormonal contraceptives in the City of Johannesburg municipal clinics.

• Procedures when taking part

- If you consent to be part of the study:
- There are some questions that you will be asked and the request is that you answer in an honest way as possible.
- All the information given will be treated with high confidence (your personal particulars will not be shared in any way).
- You will be asked about the service you receive/receiving when attending the family planning clinic.
- You will also be asked about your HIV testing patterns.
- This is a once off interview.

Risks of taking part

Your participation in this study will pose no risk to your health. It will never affect or change the way you are currently receiving treatment in this facility or any other.

Benefits of taking part

You will not directly benefit from taking part in this study. However, the results will help us understand how we can improve women's health especially of those on hormonal contraceptives like you.

Refusal to participate

You have the right not to participate in the study. This will not affect or change the way you are currently receiving treatment in this facility or any other.

Protection of information

Your consent form and your answered questionnaire will be stored separately in a safe and locked area to ensure that the information given cannot in any way be referred back to you.

Questions about the study

In case you have any questions and concerns about the study, feel free to contact Mr Bandile Ndlazi on 082 087 6752/ Dr T Masango 012 429 3386

Annexure E

Data collection instrument

Title: *Acceptance, accessibility and utilization of voluntary and counselling (VCT) services by women using hormonal contraceptives at the City of Johannesburg's municipal clinics.*

Questionnaire

Facility/Clinic:

Thank you for your participation. You are reminded that there are no right or wrong answer and requested to respond in an honest way as possible.

1. Date of birth: dd/mm/year. Age.....

2. Level of education

.....

3. Employment status

- Student
- Unemployed
- Employed
- Self employed
- Odd jobs

4. Marital status

- Not married
- Married
- Divorced
- Widowed
- Separated

5. Relationship Status

- Not in a relationship
- Living with the partner most of the time
- Living with the partner some of the time
- In a relationship but not living with the partner

6. Use of condoms

- Never
- Sometimes
- Always

7. Hormonal Contraceptive method used

Oral

8. Period having been on contraceptives More than a year
- 3- 6 months
 - 6- 12 months
9. Reason for using hormonal contraceptives
- Partner refuses to use condoms
 - Just taking caution in case the condom breaks or not used
 - Own preference since she doesn't want to use condoms
10. Were you offered HIV voluntary counselling and testing by the nurse who attended you in the family planning clinic?..... Yes/ No
11. Sexually transmitted disease screening (probe if they were asked about symptoms)..... Yes/ No
12. Were you given condoms today or your previous visit?..... Yes/ No
13. Who issued the condoms?
- Nurse in the family planning room
 - HIV counsellor
 - I took them from the condom container
 - None
14. When last did you have an HIV test?
- 0- 3 months
 - 3- 6months
 - 6- 12 months
 - More than a year ago
 - Never had one

15. Was there a reason for you to do the test the last time you did it?

- I did voluntary since I wanted to know my status
- Was advised by the nurse in the family planning clinic
- Was encouraged by the nurse who gave health education in the waiting area
- I was pregnant and advised to do it at the clinic
- Other

(specify).....
.....

16. Are you willing to share the last results?..... Yes/ No.

If yes..... Reactive/ Non-Reactive

17. Where did you do the HIV test?

- In this facility
- In another government facility
- Private Doctor
- Other.....

18. Would you consider an HIV test if requested to do so by the nurse in the family planning clinic? (this question is for respondents who currently do not know their HIV status). Do not ask if reported to have tested reactive.

Yes/ No and kindly explain why?

.....
.
.....
.
.....
.

19. HIV testing should be mandatory for all the women using hormonal contraceptives?

- Strongly Agree
- Agree
- Disagree
- Strongly disagree

20. Do you know where you can have an HIV test done in this facility?

- Yes/ No

END. THANK YOU

Annexure F

Letter from the editor

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

18 May 2015

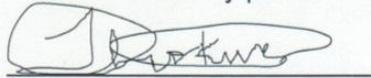
TO WHOM IT MAY CONCERN

This letter serves to confirm that I have edited and proofread Mr B. E. Ndlazi's mini-dissertation entitled: **"ACCEPTANCE, ACCESSIBILITY AND UTILISATION OF VCT SERVICES BY WOMEN USING CONTRACEPTIVES IN THE CITY OF JOHANNESBURG'S MUNICIPAL CLINICS."**

I found the work easy and enjoyable to read. Much of my editing basically dealt with obstructionist technical aspects of language which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors Group and also a Language Editor at Bureau of Market Research at the University of South Africa.

Thank you.

Hereunder are my particulars:



Jack Chokwe (Mr)

Bureau of Market Research (Unisa)

Contact numbers: 072 214 5489 / 012 429 3327

jmb@executivemail.co.za

Professional
EDITORS
Group