FACTORS INFLUENCING THE ATTENDANCE OF VOLUNTARY COUNSELLING AND HIV-TESTING (VCT) AMONG WOMEN IN GLEN VIEW HIGH DENSITY SUBURB IN HARARE, ZIMBABWE

by

PRECIOUS MOYO

submitted in accordance with the requirements for
the degree of

MASTER OF ARTS

in the subject

SOCIAL BEHAVIOUR STUDIES IN HIV/AIDS

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR G E DU PLESSIS

NOVEMBER 2009

DECLARATION

I declare that: *"Factors influencing the attendance of voluntary counselling and HIV-testing (VCT) among women in Glen View high density suburb in Harare, Zimbabwe"* is my own work and that all the sources 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 of higher learning.

Precious Moyo:

Student number: 42548349

Signed:  **Date:** 20 November 2009

ACKNOWLEDGEMENTS

I would like to acknowledge the help of my supervisor, Dr Gretchen du Plessis. Without her consistent supervision; this dissertation would not have been successful.

SUMMARY

Voluntary Counselling and Testing (VCT) is vital in the management of HIV/AIDS as it is the first step in treatment, care and behavioural change. Entrenched economic and gender inequities drive an increasingly feminized HIV/AIDS pandemic. This study investigated factors influencing VCT attendance by women in the Glen View high density suburb in Harare. A survey methodology was followed using a semi-structured, self-administered questionnaire that was distributed to randomly selected women of reproductive ages in the area. The analysis showed that VCT usage is low and that factors such as fear of the consequences of testing positive for HIV, such as violence and rejection by male partners are to blame. Importantly, the findings suggest that if the vulnerability of women is not addressed, then increased VCT uptake and better reproductive health outcomes for women are also unlikely.

KEYWORDS:

AIDS, factors that limit HIV-testing uptake, Harare, HIV, reproductive health risks, VCT

TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

CHAPTER 2: LITERATURE REVIEW

CHAPTER 3: RESEARCH METHODOLOGY

TABLE OF CONTENTS (CONTINUED)

TABLE OF CONTENTS (CONTINUED)

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS AND ABBREVIATIONS

ABC	Abstain, Be Faithfull, use Condoms
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretrovirals
ART	Antiretroviral Treatment
ASSA	Actuarial Society of South Africa
CBO	Community-based Organisation
FBO	Faith-based Organisation
HAART	Highly Active Anti-Retroviral Therapy
HBC	Home-based care
HIV	Human Immunodeficiency Virus
KAPB	Knowledge, Attitudes, Practices and Beliefs studies
MOHCW	Ministry of Health and Child Welfare
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NIH	National Institutes of Health
NGO	Non-governmental Organisation
OI	Opportunistic infection
PITC	Provider-initiated Counselling and Testing
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSI	Population Services International
PSI/Z	Population Services International of Zimbabwe
SAFAIDS	Southern African HIV/AIDS Information Dissemination Service
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
TRA	Theory of Reasoned Action
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations' General Assembly
UNISA	University of South Africa
VCT	Voluntary Counselling and Testing

LIST OF ACRONYMS AND ABBREVIATIONS (CONTINUED)

WAG	Women's Action Group
WHO	World Health Organisation
ZNASP	Zimbabwe National HIV/AIDS Strategic Plan

CHAPTER 1
SITUATING THE RESEARCH PROBLEM

1.1 INTRODUCTION

This chapter discusses the following topics in detail: the research problem, the rationale and objectives of the study and research questions. The research approach and background to the study area and a description of the area studied are also outlined. Lastly presented is the definition of key terms.

1.2 BACKGROUND OF THE RESEARCH PROBLEM

Recent statistics from the Country Report for Zimbabwe by the United Nations' General Assembly (UNGASS 2008:21) indicate that at the end of 2007 there were 649 voluntary counselling and testing (VCT) centres for HIV in Zimbabwe. Despite these advances, the Zimbabwe Demographic and Health Survey (Central Statistical Office & Macro International 2000) and the UNGASS Country Report (2008:21) state that only 6,6% of women and 6,6% of men (between the ages of 15- to 49 years) in Zimbabwe were tested for HIV during the period 2005 to 2006. This is despite the fact that *"sentinel surveillance of pregnant women receiving antenatal care services at public clinics has been ongoing since 1990* [in] *Zimbabwe.*" (Ministry of Health and Child Welfare; Government of Zimbabwe 2004:6). Moreover, the Operating Procedure Manual of the New Start Centre (2004:6) states that in Zimbabwe: *"where VCT is available, uptake has been relatively low in some areas. Many people are reluctant to know their status due to the social stigma and discrimination associated with AIDS, unavailability of drugs for the management of HIV-related illnesses and limited psychosocial support for those that test HIV positive. Some, especially high risk groups such as commercial sex workers, have diagnosed*

themselves as HIV positive and see no reason to confirm their suspicions."

These poor uptake figures for VCT in Zimbabwe are not unique for the African continent as only 9% of men and 7% of women have been reported as ever having had an HIV test in surveys conducted in 25 African countries (UNAIDS 2007). Despite this general reluctance to test for HIV, the assumption is that women hardly go for VCT services in Harare as indicated in the Zimbabwean National HIV and AIDS Strategic Plan (Government of Zimbabwe. National AIDS Council, Ministry of Health and Child Welfare & UNAIDS 2006). Special efforts have been undertaken by the Zimbabwean Ministry of Health and Child Welfare (MOHCW) to empower women to refrain from risky behaviours and to get tested at VCT centres which are well established in the urban areas. In addition, efforts are made to increase VCT uptake to up to 75% of the total adult population for the period 2006 to 2010 according to the Zimbabwean strategic plan.

This raises the question: What are the reasons for the apparent VCT phobia in women? With the information that 5 700 people die daily from AIDS-related illnesses (UNAIDS 2007:10) women should be seen at the forefront of getting to know their status for the purpose of HIV prevention, care and treatment. It is assumed by the researcher that women are more likely to take the initiative to get tested since they are the ones mostly affected by the HI-virus. Statistics show that in Zimbabwe in 2005, 56% of the estimated number of people living with HIV were women (MOHCW 2004), but only 6.6% of the total population went for VCT that same year. UNAIDS (2007), concurs that in Zimbabwe, the HIV prevalence rate is high among pregnant women attending antenatal clinics, especially in mining and commercial farming areas.

At this stage, it is not clear whether VCT phobia is due to cultural practises, settlement patterns (with poor access to medical facilities), fear of stigma attached to HIV/AIDS, lack of knowledge of HIV/AIDS, fear of antiretroviral therapy (ART) or fear of the unknown. These questions prompted this investigation.

1.3 THE RATIONALE FOR THE STUDY AND THE OVERARCHING GOAL OF THE STUDY

Testing and education are the chief mechanisms to curb the spread of new HIV-infections. At the same time referring people living with HIV for treatment is also imperative. Thus it is important to understand the factors that determine whether an individual will decide to have an HIV test or not. In order to reduce the spread of HIV-infection, people at risk of infection need to adopt the necessary prevention methods so that they can protect themselves and their families. It is therefore vital to formulate strategies to investigate VCT uptake among women.

The statistics quoted earlier in this chapter show that a large number of women are not being tested for HIV. With the disproportionate impact of HIV on women compared to men, it is therefore important to assess the factors leading to the infectivity of the woman and possible reasons why they will not get tested for the HIV-virus or attend VCT and when tested refuse to collect their test results. The overarching goal of this study was to uncover from women in a high density residential area those factors that influence (i.e. enable or hamper) VCT uptake.

1.4 OBJECTIVES OF THE STUDY

Following from the goal as stated above, the objectives of this study were to:

1. Assess the knowledge that these women have about VCT.
2. Gain an understanding of the perceptions that women in the target research area have towards VCT issues.
3. Gain an understanding of the characteristics of women who have never visited a VCT site.
4. Understand why some women do not go for VCT, or go but do not collect their test results.

1.5 RESEARCH QUESTIONS

The following research questions flow from the stated research objectives:

1. In terms of the knowledge of VCT (objective 1), the question is: what sources of information are available to women in this area to educate them about VCT?
2. In terms of the women's perceptions of VCT (objective 2), the question is: what are the barriers that women face in accessing VCT services in the Glen View high density-suburb?
3. In terms of the characteristics of the target group regarding VCT (objective 3), the question is: what are the characteristics of the women in this area who went for VCT and why did they go?
4. In terms of the reasons for not using VCT or for neglecting to collect test results (objective 4), the questions are: what are the characteristics of the women in this area who did not go for VCT and why did they not go as well as what are the reasons why some women neglect to collect their test results after VCT?

1.6 THE RESEARCH APPROACH AND BACKGROUND TO THE STUDY AREA

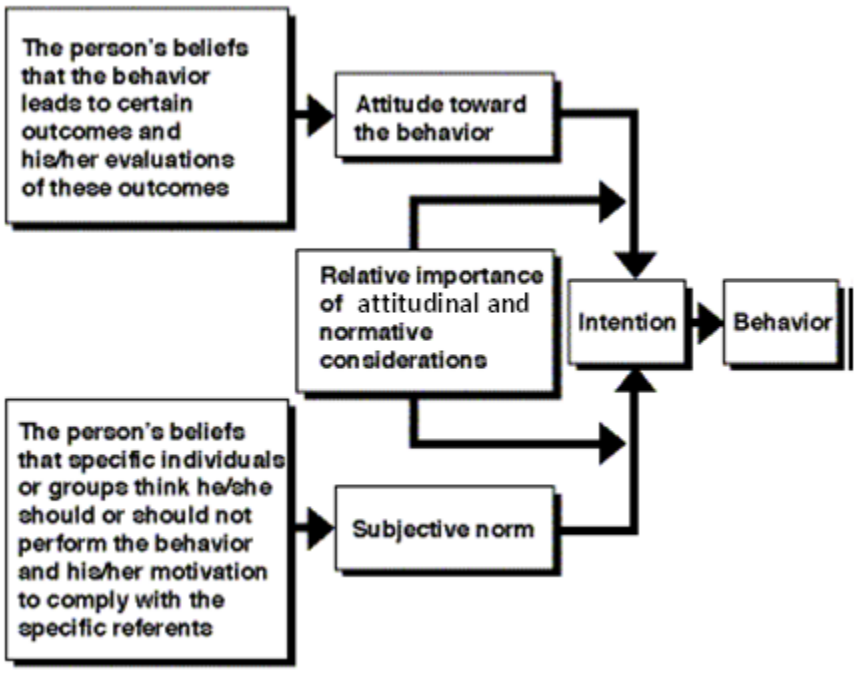
There are a number of theories that describe behavioural change in respect of HIV and AIDS. Research also indicates that people have concerns about the consequences of testing HIV-positive that go beyond the mere clinical management of the disease (Van Dyk & Van Dyk 2003; Reed 2005; Swanepoel 2006). The physical and mental concerns about HIV-testing and about knowing one's status thus demands the consideration of a range of personal, interpersonal, social and contextual factors. For the purpose of this study, the Theory of Reasoned Action (TRA) was used to describe and understand the dynamics of VCT uptake. According to Denison 1996 (quoting Azjen & Fishbein 1980), three central concepts in the theory are behaviour, intention and attitudes. Behaviour as used in the TRA refers to specific behaviour defined by a combination of four components, namely action, target, context, and time. Thus in terms of this study, VCT uptake can be regarded as the action component; women as the target; women of reproductive ages in a high density suburb as the context and whether the test is done timeously as the time component.

In the TRA "intention" refers to the intent or reason to perform a given behaviour and regarded as the best predictor that a desired behaviour will actually occur. Attitude and norms, described below, influence one's intention to perform a given behaviour. Attitudes in the TRA refer to a person's positive or negative feelings toward performing the defined behaviour which, in terms of this study, is VCT attendance. In Figure 1.1 below, the interrelatedness of these concepts and components are depicted. The theory is discussed in greater detail in Chapter 2 but it should be noted at the onset that the strict methodological prescripts of a TRA-inspired study with elicitation interviews were not followed in this study. Instead, inspired by the TRA and based on a review of the common factors that hamper or enable

VCT attendance, the researcher followed a survey-type baseline study.

.

Figure 1:1 Theory of Reasoned Action (TRA) Model



Source: Denison 1996.

The research was focused on women aged between 15- and 49-years of age since these are the reproductive ages. The Glen View high density suburb was chosen as the research site as it is home to middle to low income groups and the women inhabitants tend to be formally or informally employed. The researcher deliberately wanted to test the behaviour, intentions and attitudes of women with relatively higher levels of education and who were not economically destitute, but earned an income via formal or casual waged labour.

1.6.1. Background of VCT in Zimbabwe

According to Population Services International's (PSI 2003:7) Manual, research was carried out in 1998 to find ways to maximise the impact of VCT services in Zimbabwe. It was concluded that VCT services should offer *"anonymity, privacy, accessibility, affordability and*

professionalism". The first VCT centre known as the New Start Centre opened its doors to the public in March 1999 at Wilkins Hospital in Harare. The goal then was to contribute to the reduction of HIV transmission through behaviour change and the mitigation of the impact of HIV and AIDS by providing psychosocial support to those infected and affected.

Each New Start Centre was to work under the guidance of the Ministry of Health and Child Welfare and Population Services International of Zimbabwe (PSI/Z). Up to the end of 2007, 649 VCT centres were established in Zimbabwe (UNGASS 2008:21).

1.6.2 Background to the study area

Glen View high density suburb is situated about 14 km south west of the city of Harare. It is divided into 8 phases: Glen View 1 to Glen View 8 with a total of 8 500 lots. The population of the suburb is 200 000 people (Central Statistical Office 2004).

A city of Harare official, Mr. Steven Nyahore (2009), in a personal interview, gave the researcher a detailed history of Glen View high density suburb. The area was established in 1978 as a residential area consisting of four- to five-roomed houses available for rent and a self-help housing scheme. A total of 1 005 four- to five-roomed houses were earmarked for civil servants who at that time earned not more than $1 000 Zimbabwean dollars annually. The self-help housing scheme was a system whereby a person would buy a plot and build their own dwelling on it. The serviced stands comprised of ablution blocks on a 200m^2 lot, hence the township earned the nickname "The Toilet Town" (Nyahore 2009).

There were 500 larger plots of 400m^2 which were earmarked for African business people. The site had tarred roads, electricity, water and sewer systems. There were 9 plots set aside for primary schools, 3 plots for secondary schools, 6 plots for shopping centres, 2 for clinics and 2 for community halls. In addition, there were plots set aside for telephone exchanges, a post office and a district administration centre. Beneficiaries to these plots were taken from the housing waiting list of the City of Harare from which married people were selected to move into the so called “married accommodation” (Nyahore 2009).

Currently the residents of the area are middle to low income persons. Women of working class status employ housemaids to do household chores and to take care of young children while they are at work. Some residents own dwellings of their own while others are subject to monthly rental costs. This is referred to as the “lodging” system in Zimbabwe. The lodging system in most of Zimbabwe’s high density suburbs was aggravated by poverty, lack of accommodation, expensive accommodation and the “Murambatsvina” (Clean-up) campaign of 2005 which left small property “shacks” holders homeless and thus they sought alternative accommodation as lodgers (Nyahore 2009).

1.7 DEFINITIONS OF KEY TERMS

In this section, some of the key terms employed in the dissertation are defined.

1.7.1 AIDS

AIDS occurs when the body is not able to fight infections as the immune system is weakened by HIV and therefore the HIV-infected

person reaches the most advanced stage of HIV-infection (Van Dyk & Van Dyk 2003).

1.7.2 Confidentiality

It pertains to the treatment of the information which an individual has disclosed in a relationship of trust and with the expectation that such information will not, without permission, be divulged to others in ways that are inconsistent with the understanding of the original disclosure (Willig 2001).

1.7.3 Counselling

Counselling, as used in this dissertation, refers to a confidential dialogue between a counsellor and a client that empowers the client to make an informed decision about HIV testing (Van Dyk & Van Dyk 2003). Every person who takes an HIV test must receive counselling before the test and when the test results are available, regardless of the outcome of that test result. **Pre-test** counselling is designed to assist clients to assess personal risks and to identify practical strategies to cope with their tests results (Van Dyk & Van Dyk 2003). **Post-test** counselling is conducted when issuing the results, whether positive or negative (Van Dyk & Van Dyk 2003).

1.7.4 Voluntary Counselling and Testing (VCT)

A process, by which an individual undergoes counselling to enable him or her to make an informed decision about getting tested for HIV, assess his or personal risk and develop a risk reduction strategy (Van Dyk & Van Dyk 2003).

1.7.5 VCT uptake and VCT site

According to the Commonwealth Regional Health Community Secretariat (2002: iv) VCT uptake *"includes both voluntary pre- and post-test counselling and voluntary HIV testing".* The key word is 'voluntary': meaning that no form of coercion is applied to the person taking up VCT. The primary goal of VCT uptake is prevention of further HIV-infection implying that people need to know and understand their HIV statuses to engage in positive behaviour change. Zimbabwe has been able to promote the social marketing of VCT uptake by branding it a name "New Start" with a small fee charged. VCT is increasingly recognised as a key component for effective HIV/AIDS prevention and care efforts to combat the epidemic. The factors involved in this process are depicted in Figure 1.2.

A VCT site is a place where VCT services are delivered. There are five different types of VCT centres. Each of them is discussed below.

a) *Stand alone VCT centres* are typically comprised of facilities run by NGOs where the main service offered is VCT (PSI 2003).

b) *Franchised VCT*- involves service delivery by a variety of implementers, including local NGOs, Community based Organisations (CBOs) and Faith Based Organisations (FBOs). They have a united brand with standardised training and operating procedures (PSI 2003).

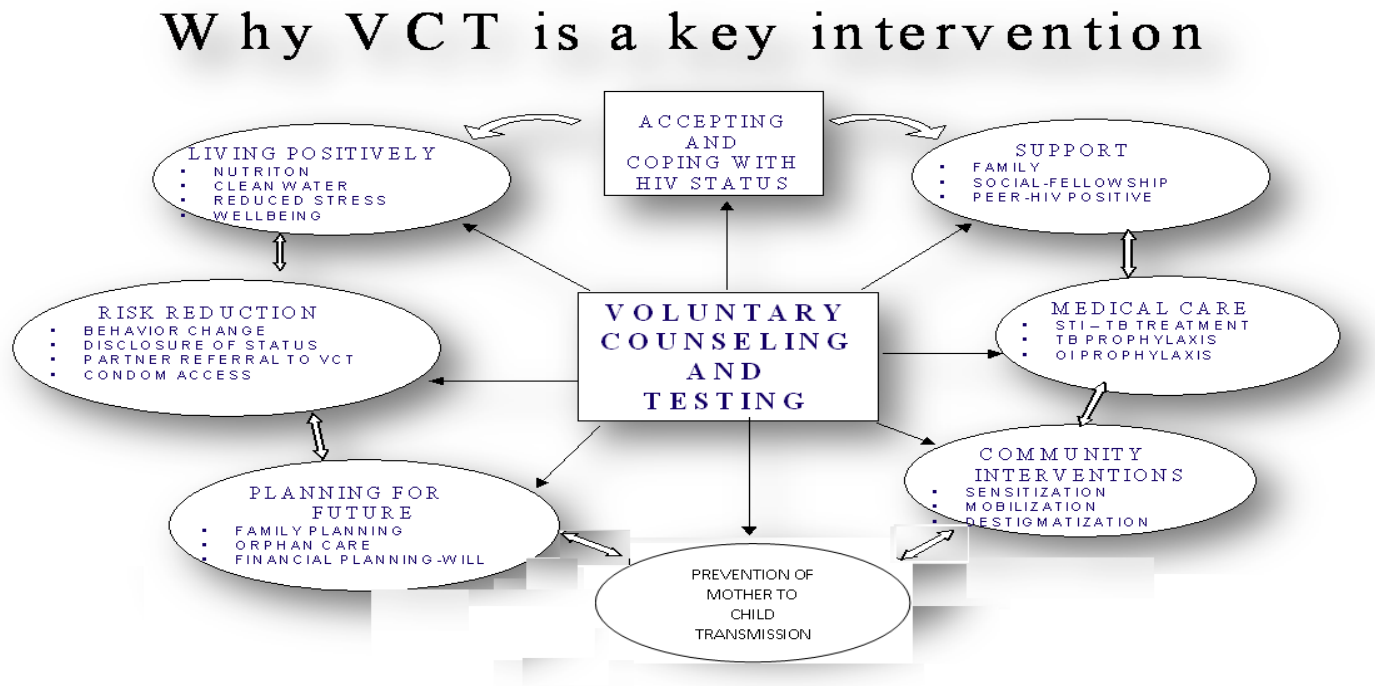


FIGURE 1:2 IMPORTANCE OF VCT UPTAKE

Adapted from Commonwealth Regional Health Community Secretariat (2002).

c) *Integrated VCT* refers to VCT co-located within existing health services. Two systems exist. In the first system, VCT services are delivered as part of the existing primary health care services and no additional staffs are trained or placed to manage those services. In the second system, a place (a separate room or venue) is co-located within an existing health facility where VCT services are offered by a full-time, dedicated staff (PSI 2003).

d) *Provider-initiated testing and counselling (PITC)* refers to HIV testing within the health facility provided at the direct request or recommendation of the health care provider. There are two types of PITC. **Routine testing** is where everyone is tested within a health service unless they refuse testing. AIDSMark (2009:30) notes that the World Health Organisation (WHO) recommends routine testing for all patients diagnosed with a sexually transmitted infection (STI) or tuberculosis (TB), all pregnant women and all patients in areas with high HIV prevalence rates. **Diagnostic testing** is where a doctor offers HIV testing when a patient shows signs and symptoms consistent with HIV-infection. Zimbabwe is currently in the process of advocating for PITC (PSI 2003).

e) *Mobile VCT* involves sending out a team of VCT counsellors and laboratory personnel to do VCT outside the normal VCT facility. The team sets up VCT services in the community and promotion of the mobile outreach service is done in advance by outreach workers and peer educators. The host organisation assumes responsibility for follow-up care and support, especially psychosocial support for people who test HIV positive (PSI 2003).

1.7.6 HIV tests and test results

HIV tests are performed on a blood sample collected from an individual. The test is used to diagnose HIV infection. HIV tests detect

the antibodies produced by the immune system in response to HIV, *"as it is much easier and (and cheaper) to detect antibodies than the virus itself"* (UNAIDS 2007).

HIV antibody tests can have three results:

(1) A negative result implies that the person is probably not infected with the HI-virus. However, it can take from 3 to 6 weeks and sometimes 3 months before antibodies show in a standard HIV test of a newly infected person. This is called the "window period". The window period in other words is the period between exposure and the time it can take to develop antibodies. If one takes an HIV test during the "window period" the results may not be a true reflection of one's HIV status (HIV/AIDS Dictionary: 2009).

(2) A positive result means that HIV antibodies are present and that a person is infected with HIV (HIV/AIDS Dictionary: 2009).

(3) An Indeterminate or inconclusive result means that the antibody test was neither positive nor negative. This may be as a result of recent HIV infection. In such cases the test will have to be repeated (HIV/AIDS Dictionary: 2009).

1.7.7 Barriers to VCT uptake

Barriers are the factors that hinder one from seeking VCT services. AIDSMark (2009:8) points out the mistake made in VCT, namely that *"social marketing is linking VCT services in people's minds with a positive result.*" Thus they conclude that people fear being diagnosed as HIV positive and that many people believe that there is no point to knowing one's status. Key barriers to seeking VCT services as described by AIDSMark (2009), based on international research, are detailed in the table below.

Table 1:1 Key international research findings on VCT

Main barriers to seeking VCT services:	**Key motivators for seeking VCT :**	**Perceived advantages of knowing one's status**
No cure/ treatment for AIDS virus sense of hopelessness if positive	Partner or child dies	Better quality of life
Fear of losing partner	Chronic or recurrent illness	Improved ability to plan for the future
Lack of perceived confidentiality at VCT centres	Plans to marry	Preventing spread of HIV
People do not perceive risk of infection or alternatively, strong fear of a definitive positive result	Plans to have a baby	Freedom from worries about AIDS
Unfamiliar with VCT or just do not know where to go	To achieve "peace of mind"	PMTCT
Believe that VCT is only for "sick" or "dying" or "promiscuous" people-highly stigmatised	Worried about partner's behaviour	Access to ARVs or other treatment

1.7.8 High-density area

The definition of what a high density area is, is contextual. According to Mbara and Maunder (1996) a high density residential district in Harare is a low income residential area located mainly to the south and south-western part of the city. This classification allows for most housing types and limited commercial and office use. The density per acre ranges from 8 to 25 houses. Most housing types are permitted in this type of settlement.

1.8 THE ORGANISATION OF THE DISSERTATION

This dissertation comprises of five chapters:

Chapter 1: Introduction to the study, background of the research problem, rationale and objectives of the study and research questions.

Chapter 2: Literature review.

Chapter 3: Describes and discusses the research design and methodology, sampling and data collection procedures, data analysis, ethical considerations and definition of terms,

Chapter 4: Research findings are discussed.

Chapter 5: Discussion of the findings, conclusion and recommendations.

1.9 CONCLUSION

This introductory chapter provides a brief contextualisation of the HIV/AIDS pandemic, paying attention to voluntary counselling and testing as mechanism to HIV/AIDS prevention and health service delivery. Further to this, readers are introduced to the research problem, the objectives and the questions that guided the study.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter focuses on a review of literature mainly on factors that influence VCT attendance among women. It also explores factors that render women vulnerable to HIV and AIDS. This review is organised in the following manner: firstly, an overview of HIV/AIDS in Sub-Saharan Africa is given, and then HIV/AIDS and women's vulnerabilities are discussed. This is followed by literature on VCT uptake and acceptance and of behavioural strategies used to promote VCT attendance.

2.2 OVERVIEW OF HIV/AIDS IN SUB-SAHARAN AFRICA

Globally there were 33 million people living with HIV in 2007 (UNAIDS 2008). The annual number of HIV-infections declined from 3 million people in 2001 to 2.2 million people in 2007 (UNAIDS 2008). Although there has been a global stabilisation in the number of new infections, Sub-Saharan Africa remains the region most heavily affected by HIV accounting for 67% of all people living with HIV and for 75% of all AIDS-related deaths in 2007 (UNAIDS 2008). Nearly 60% of women infected with HIV are in Sub-Saharan Africa. Women's share of HIV-infections is increasing in several countries including Zimbabwe.

The Government of Zimbabwe has continued to scale up the multi-sectoral response to HIV and AIDS based on the Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) (2006-2010) that was launched in July 2006. This plan builds on lessons learnt in implementing the National AIDS Policy of 1999 and the National HIV and AIDS Framework (2000 -2004). The strategic plan continues to highlight HIV and AIDS as an emergency that requires government and all

stakeholders to urgently mobilize the required resources in order to fight the epidemic (UNAIDS 2008). To date the overall HIV prevalence rate in Zimbabwe's adult population has decreased from an estimated 24.6% in 2003 to an estimated 20.1% in 2005 of the adult population (aged 15- to 49-years) to 15.1 % in 2007 and is currently at 13.7%. National HIV prevalence rate estimates in 2008 stated that among the estimated 1 085 671 people aged 15- to 49- years living with HIV, 60.0% are women (Ministry of Health and Child Welfare 2008).

2.3 HIV/AIDS AND WOMEN

The percentage of women living with HIV varies greatly across regions. In areas such as Europe and Oceania, Avert (2008) mentions that women account for a relatively low percentage of HIV infected persons. However, in regions such as Sub-Sahara Africa and the Caribbean, the percentage is significantly higher.

At the end of 2007, it was estimated that out of the 23 million adults living with HIV in Sub-Saharan Africa (SSA), 60% of these are women (UNAIDS 2008). However, the global proportion of men versus women who are infected has remained at approximately 50% since the late 1990s, thus putting the women in SSA at the epicentre of the problem. This is owed to the vulnerable status of women which is exacerbated by biological and social factors. Moreover SSA is where HIV is transmitted mostly heterosexually (Avert 2008). The epidemic has an adverse impact on women, which has been exacerbated by their role in society and their biological vulnerability to infection.

According to Chopra, Doherty, Jackson & Ashworth (2005:357), *"an expected 1 in every 10 women in Southern Africa can expect to become infected each year.*" They say that in South Africa, where HIV-test statistics are most complete for Southern Africa, annual rates of

sero-positivity have shown the most alarming and consistent rise year by year. Besides being at a greater risk of heterosexual transmission of HIV, women are biologically twice more likely than their male counterparts to be infected with HIV through unprotected heterosexual intercourse. Women are more likely to suffer lesions during sexual intercourse than men creating a direct route for infection. The fact that seminal fluid is deposited into the female body makes women more vulnerable (Basset & Mhloyi 1991). Women are also put at risk by a multitude of social factors that prevail in patriarchal societies and are perceived as catalytic in the spread of HIV.

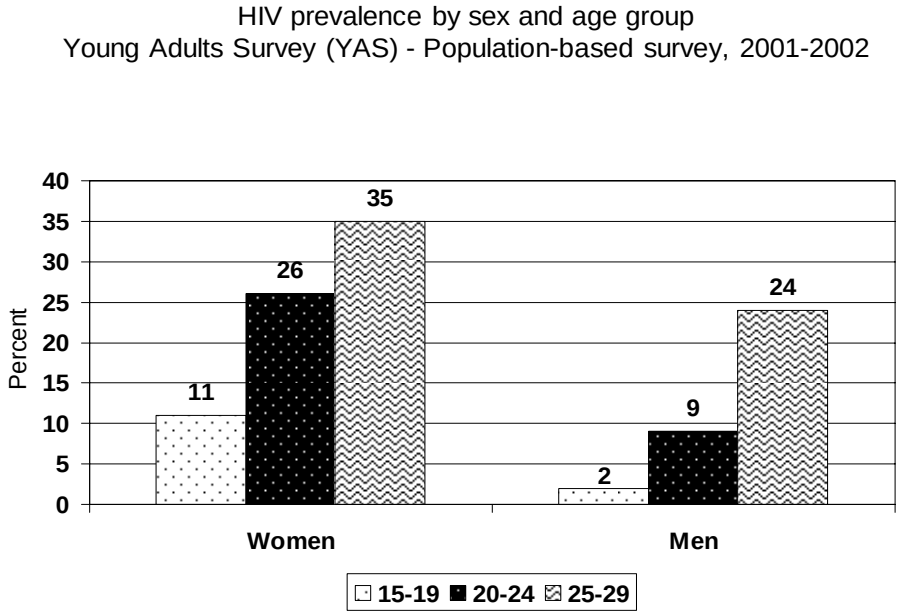
The nature of women's social roles as childbearing people means that they have to contend with issues such as mother-to-child transmission of HIV (MTCT) as well as with the responsibility of caring for AIDS patients and orphans.

HIV prevalence rates are reported to be declining in Zimbabwe, however the number of women infected with HIV has now surpassed the number of HIV-positive men. Figure 2.1 below shows a comparison of HIV prevalence rates in Zimbabwe between males and females.

In researching factors that predispose women to HIV-infection as part of a Systemic Counselling course with the Zimbabwe Institute of Systemic Therapy, Moyo (2007) discovered that cultural, biological, economic, educational and gender-related factors contribute to the rise in HIV infections among women. The Women's Action Group, (WAG 2007) mentions similar factors as driving HIV infection among women, and adds that women should be the ones at the forefront of VCT uptake.

Prevention of mother to child transmission (PMTCT) is also an issue that directly affects women and at the same time increases the spread of HIV. UNAIDS (2007) reports that at the end of 2007 about 2 million children living with HIV got infected pre-or post-natally via MTCT.

Figure 2.1 HIV prevalence rates amongst men and women aged 15-29



Source: Young Adults Survey Zimbabwe (2001-2002).

The graph above shows age differentials in HIV acquisition amongst young men and young women aged 15- to 29-years. As in the rest of SSA, the epidemic in South Africa disproportionately affects women. Young women (15– to 24-years) are four times more likely to be HIV-infected than are young men. In 2005, prevalence rates among young women was 17% compared with 4.4% among young men (UNAIDS 2006). In South Africa, one in three women aged 30– to 34-years were

living with HIV in 2005 as were one in four men aged 30– to 39-years, according to (Shisana Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste, Pillay *et al*. 2005). In addition, high infection rates were found among men older than 50 years, more than 10% of whom tested HIV-positive (UNAIDS 2006).

Other issues that directly affect women include economic deprivation, customary norms that prevent women from being able to negotiate safer sex, the use of condoms and multiple partnering that render women susceptible to infection. The following subheadings elaborate on the factors that predispose women to HIV infection.

2.3.1 Gender inequality

Women's increased risk is a reflection of gender inequalities (Ward 1993). In most societies, the rules governing sexual relationships differ for women and men, with men holding most of the power (Ward 1993). Leclerc-Madala (2001:533) argues that "*the growing popularity of virginity testing must be understood within a gendered meaning-making process consistent with commonly held beliefs that the epidemic is the result of women being sexually out of control ... virginity testing is an attempt to manage the epidemic by exerting greater control over women and their sexuality. In addition, virginity testing of girls helps to draw attention away from the role of men in the maturing epidemic, consideration of which has been conspicuously absent in the popular discourse on AIDS at all levels of South African society".*

Economic disempowerment has important implications for the sexual behaviour of women. Many women are dependent on their husbands financially, making it impossible for them to take major decisions in

their homes. Therefore many women are unable to negotiate for safer sex. This means that for many women, including married women, their male partner's sexual behaviour is the most important HIV-risk factor (Shagula 2006).

In most patriarchal societies men are the chief decision-makers in terms of matters such as who to marry and whether the man will have more than one sexual partner (Shagula 2006). This power imbalance means that it can be difficult for women to protect themselves from getting infected with HIV. For example, a woman may not be able to insist on the use of a condom if her husband is the one who makes the decisions. Avert (2008), reports in study of 400 women attending an STI clinic in Pune, India that:
25% were infected with STIs
14% were HIV positive
93% of those women were married
91% had not had sex with anyone other than their husbands.

The statistics above show the vulnerability of women with regards to gender issues. The case above indicates that the introduction of condoms in the matrimonial relationship may seem obvious as a preventive measure and protection mechanism for both partners. However, where women are not the chief decision-makers and where a woman's role is defined by her reproductive potential, the introduction of condom use in marriage may be problematic (Shagula 2006). It is not only male infidelity that renders women vulnerable to HIV-infection. Widespread violence against women represents a global human rights crisis and contributes to women's vulnerability to HIV. (UNAIDS 2008:72)

Gender inequality not only affects infection and vulnerability, but also extends to the issue of care-giving. In areas with few palliative care

facilities, when a person becomes sick due to HIV-infection, the care of that person usually falls on women (Shagula 2006).

2.3.2 Cultural factors

Women who are victims of sexual violence are at risk of infection with HIV. The forced nature of rape and lack of condom use associated with it aggravate the vulnerability of HIV infection among women. It is also stated that between *"100 and 140 million girls and women have undergone partial or total removal of the external female genitalia in the world"* (UNAIDS 2008:72). Addressing harmful cultural practices therefore reduces the risk and vulnerability of women and girls. Some nations have taken steps to alleviate some of these problems, such as legislation passed in Zimbabwe in 2007 that prohibits forced marriages. In Zambia "widow cleansing" was prohibited in 2005. UNAIDS (2008:72) states that widow cleansing is a practice whereby women whose husbands have died submit to sex with a village leader in order to be accepted into the community.

Deacon, Stephney and Prosalendis (2004:58) argue that HIV-testing and the disclosure of an HIV-positive status have become female burdens that further exacerbate women's vulnerability: *"Women who test first through antenatal services are often blamed for infecting the partner and because of the prevention of Mother-To-Child transmission programs, they are also often blamed for infecting the children as well. Disclosure often happens not by telling people of one's status but by using formula milk for children, suggesting the use of a condom, going to an AIDS or TB clinic or taking certain pills. Many of these kinds of activities are thus stigmatised by association and thus avoided, in spite of their possible health-giving properties, to avoid unintentional disclosure."*

2.3.3 Economic factors

Women who own property or control other economic assets have higher incomes, a secure place to live and greater bargaining power within their households (UNAIDS 2008:74). Such women can thus demand safer sex. Economically vulnerable women rely on their husbands or male partners for their upkeep and are therefore forced to submitting to their husbands and this may compromise safer sexual practices. They are not able to negotiate for safer sex for fear of rejection. Many researchers have found that economic impoverishment is the reason why some women enter into multiple sexual partnerships and barter sex for economic gain (Ngugi 1991; Schoepf *et al* 1990;). In such contexts, the provision of alternative income-generating opportunities and the general improvement of women's economic status through access to credit, skills training, employment, and primary and secondary education are needed (Gupta & Weiss 1993).

Gupta and Weiss (1993:405) argue: *"Concern is rising in many communities with regard to the 'Sugar Daddy' phenomenon, which involves young girls having sex with older men in exchange for money, gifts, or favors. When school girls in Zimbabwe were shown a picture of an apparently affluent man suggestively eyeing a young girl, the students acknowledged the existence of 'sugar daddies' in their community and one adolescent girl remarked: 'These days there is ESAP (the Zimbabwean Economic Structural Adjustment Program) so maybe this girl is not getting enough money from home, so she will be hoping to get a lot of money from a sugar daddy'."*

2.3.4 Biological factors

Biologically, women are more likely to be infected than man during unprotected vaginal intercourse with an infected partner (Ward 1993). This is because women have a larger surface area of mucosa exposed

to a man's secretions. During sexual intercourse, semen, which can stay in the vagina for hours after intercourse, also contains a higher concentration of HIV than vaginal secretions. This puts a woman at greater risk of HIV infection.

2.3.5 Educational factors

The Global Campaign for Education (2004) states that if every child receives a complete education, 700 000 new HIV-infections in young adults could be prevented every year. The 2008 UNAIDS report cites a study in rural South Africa which found that each additional year of educational attainment reduces the risk of HIV infection by 7%.

Educating woman make it easier for them to negotiate safer sex. It is not part of the Zimbabwean culture for women to discuss sexual issues with their sexual partners openly. However, HIV/AIDS forces policy makers to question those traditional norms which might expose women to the risk of HIV infection. It takes women's assertiveness, determination and creativity to face up to this challenge (Mhloyi & Mhloyi 2000).

2.4 VCT UPTAKE AND ACCEPTANCE

VCT services are essential for HIV prevention (WHO 2008). When an HIV-test was developed in the mid 1980s, it was accompanied with little counselling and testing. However, with the growing awareness of HIV infection and AIDS and the recent availability of antiretroviral therapy (ART), the scope of and reasons for VCT have broadened (WHO 2008). It is however important to note that there is an economic impact linked to the provision of ART. Nattrass (2004: 171) states that in South Africa, *"The public provision of HAART would cost a great deal in terms*

of direct costs accompanied with little counselling and testing. However, the growing awareness of HIV reduced demands on the health sector because of lower associated expenditure on AIDS related opportunistic infections"

UNAIDS (2008) reports that HIV surveillance in designated sites has expanded and improved considerably in SSA, leading to more reliable estimates relating to the HIV epidemic and its impact. This is a positive development for African countries including Zimbabwe. According to the Zimbabwean Ministry of Health and Child Welfare (2004), VCT is a voluntary (thus client-initiated) and confidential process by which a person can be counselled by a professional about the advantages and disadvantages of having an HIV-test done. This confidential procedure is decided upon voluntarily as the result of the test can be life changing. Through VCT a person is able to assess her personal risk and develop risk reduction strategies. Other benefits of VCT are that it promotes behaviour change, facilitates early referral for care, treatment and support, including access to ARV therapy and it is believed to reduce stigma in the community (UNAIDS 2008). Pre-test counselling enables the client to make an informed decision about whether to get tested or not. After the individual has been tested, he or she is counselled according to whether he or she is HIV positive or negative. With the intensification of care and treatment, VCT services are becoming more popular in Zimbabwe.

VCT comprises certain steps and these are outlined as below:

- *Step A*: Pre-test counselling takes place which lasts between 20 to 45 minutes. The client is told about the test and HIV disease. Ways to cope with an HIV-positive diagnosis are also explored.

- *Step B*: Actual testing is done after a consent form is signed. A sample of blood is collected from a finger prick and a blood collection tube. For rapid testing, results will be available in 20 minutes.

- *Step C*: Results are discussed and post-test counselling is done. The results are kept confidential. A negative test result will mean that the client will be advised on how to prevent infection in the future. A confirmatory test will be conducted after a 3 month window period. A positive result will result in the client getting counselled on how to manage his or her health.

Despite AIDS awareness campaigns launched in different communities in Zimbabwe, many people still depend on the visual confirmation of an AIDS test where they draw conclusions about the alleged HIV status of others (or their own) based on perceived signs and symptoms. Many women do not go for VCT for different reasons. Maman (2002a) suggests that violence is a risk factor pertaining to HIV infection. In her study on experiences of partner violence between HIV-positive and HIV-negative women, of the 340 women who were interviewed 3 months after they got tested, violent events were significantly higher among HIV-positive women than among HIV-negative women. This study was conducted in Tanzania and results can be compared to a similar study done in Uganda by Pool (2001). In this study, focus group discussions were conducted with 208 pregnant women about their attitudes towards VCT uptake. It was found that the women were concerned that if their husbands found out they were HIV positive they would be blamed for the infection.

In a cluster randomised trial in Zimbabwe on the uptake of workplace HIV counselling and testing, (Corbett, Dauya, Matambo, Bun Cheung, Makamure, Bassett, Chandiwana, Munyati, Mason, Butterworth, Faussett, & Hayes, 2006) found that a minor improvement in accessibility to testing can translate to a major difference in VCT

uptake. Their argument is that if VCT is availed where the people are then more people will go for testing. The researcher however observed that in Zimbabwe there are mobile VCT units that were set up by Population Services International Zimbabwe to make VCT accessible to more people (especially to those in the high density suburbs and rural areas), but people tend not to visit them. Factors that mediate VCT attendance include the age of the attendants, exposure to TB, the social conceptualisation of disease causation, pregnancy, access and provider-initiated testing. Each of these is discussed below.

- Age can be a contributing factor in VCT uptake. Young adults, in preparation for marriage, usually get tested so that they know their HIV statuses. Population Services International's New Start Centres in Zimbabwe encourage testing among young people and the current Imagine Africa Programme advocates for VCT among young people.

- Corbett *et al* (2006) state that household exposure to TB has influenced VCT attendance as the Zimbabwean national television service advocates for people with TB to get tested for HIV.

- Social conceptualisation and representation of HIV/AIDS testing have an influence on HIV tests uptake rates. Issues of stigma and discrimination prevent VCT uptake since people are labelled by society as deviants. In Uganda, Maman (2002b) found that women did not go for VCT because they feared violence from their husbands. They feared that if their husbands found out that they were HIV positive they would be blamed and separation or domestic violence might result.

- In a study by Shagula (2006) in Namibian's Tsumeb District, factors affecting VCT uptake in pregnant women were explored.

Fifty-one percent of the participants avoided VCT because they feared death and they thought that if they are diagnosed with HIV they would die soon. In her study, comments from a participant who refused to get tested and did not see any benefits in getting tested were, *"…you think about death always VCT uptake's not okay to know always that I am sick up"* (Shagula 2006:51). Forty-three percent of the respondents in Shagula's study (2006) feared stigmatisation, discrimination and rejection by the family and community if they were found to be HIV positive.

- In Zimbabwe, it was discovered that VCT attendance can be improved if the testing centres are closer to the target population. This was revealed in a study by Corbett *et al* (2006) on uptake of VCT in the workplace where they found that a high percentage (50%) of employees got tested when the testing centre was on site compared to that (20%) of employees who had to visit VCT centres off-site.

- Currently, the Zimbabwean government, through Population Services International is promoting a programme called Provider Initiated Testing and Counselling (PITC). This programme was based on the results of a study by Corbett *et al* (2006) on uptake of VCT in the workplace. They found that when a person who visited a clinic or hospital for any kind of treatment, was introduced to VCT during that visit, he or she were often inclined to agree to be tested. It is the researcher's contention that this programme is likely to increase the number of women who get tested as it is mostly women who visit such health centres.

2.4.1 Factors affecting VCT attendance

There are a number of factors that influence VCT attendance. No country wants to undermine basic human rights by instituting mass compulsory testing. VCT determines the success of Prevention of Mother to Child Transmission (PMTCT). It is also an entry point for treatment, care and support of HIV infected persons (Newell 2006). However the problem is that few (6.6%) people in Zimbabwe who are infected know their status (UNGASS 2008:21). There are service oriented and personal factors that affect VCT attendance.

2.4.1.1 Service oriented factors

These are factors that originate from the service provider as discussed below:

(a) Accessibility

Convenience and accessibility appear to have critical roles in the acceptability of community-based VCT. In a study by Corbett *et al* in Zimbabwe in 2006, it was noted that more testing was undertaken by workers who had been provided with an on-site VCT centre compared to those who had to visit an offsite VCT centre. Population Services International in Zimbabwe developed mobile VCT centres to help the community by providing VCT services at their doorsteps. This has socially marketed VCT to some extent instead of merely relying on testing by the private sector whose costs are not affordable to most Zimbabwean women.

(b) Confidentiality

A qualitative study that investigated VCT uptake by pregnant women in south-west Uganda revealed that pregnant women

were anxious about taking up VCT, due to the fear of a lack of confidentiality and the fear that maternity staff might refuse to assist them when the time came to deliver (Pool 2001).

2.4.1.2 Personal Factors

These emanate from the individual and they include:

(a) Knowledge

According to the Zimbabwe National HIV and AIDS Strategic Plan (2006), there is need to empower women in order to achieve normative and behavioural change with regards to attitudes toward VCT. One of the most powerful reasons to get tested is the knowledge that there is appropriate support, and treatment is available if the test is positive. Shagula (2006) states that the majority of women in developing countries are illiterate and that this contributes to them not understanding health-related problems. Promoting HIV/AIDS knowledge, awareness and compassion will result in people seeking VCT services.

(b) Stigma and discrimination

UNAIDS (2008) states that HIV-related stigma is a key reason why there is a need to empower women in order to achieve the kind of normative behavioural change that is necessary to address HIV and AIDS. Discrimination refers to actions based on stigma. HIV-related discrimination follows on stigma and it is *"unfair treatment of an individual based on his or her real perceived HIV status"* (UNAIDS 2008). HIV-related stigma and

discrimination undermine efforts to address HIV and AIDS by making people reluctant to be tested. If a person fears stigma and discrimination, he or she will not go for VCT. Fear of stigma and discrimination makes people living with HIV less likely to seek care and treatment, adhere to treatment and disclose their status to their sexual partners (UNAIDS 2008:77).

2.5 BEHAVIOURAL CHANGE

Attitudes towards VCT among women have to be changed in order to get a better response to counselling and testing. One aspect that favours preventive behaviour is when family members witness the illness of one member and their eventual death. HIV/AIDS awareness and VCT uptake becomes more internalised and the need to get tested intensifies as people will want to protect themselves.

Radical behavioural changes have to be witnessed among individuals and groups of people in order to promote VCT uptake. Behaviours can be modified by educating families and communities through different forms of media. A key success factor for the VCT programme is its ability to encourage people who are at risk of HIV infection to receive the service.

Goals for behaviour modification should include knowledge of HIV/AIDS, stigma reduction, access to VCT services, delay of onset of first intercourse, decrease in the number of sexual partners and increase in condom use. It is important therefore to highlight the advantages of VCT that if known by women, can result in them wanting to get tested. The advantages of VCT are bulleted below:

- Early treatment of HIV infection

- Prevention of new infections. A model of assumptions about sexual behaviour change following VCT was developed by the Actuarial Society of South Africa (Dorrington 2000). Nattrass (2004:103) states that this model predicts that a VCT intervention could prevent 356 000 new infections between 2001 and 2015.
- Sexual behaviour is positively modified. Nattrass (2004:103) says that by 2015, VCT would have resulted in a 16% reduction in unsafe sex between discordant couples. Couples can only learn of the discordance in their results through VCT uptake.
- The person can be enabled to live a longer, more productive life
- Prevention of the spread of HI-virus

In Zimbabwe much has been done to achieve behavioural change over the past two decades and recent reviews indicate that behavioural change has already started. Beyond awareness-raising and communication on Abstinence, Faithfulness, Condom use (ABC), there is a need to address underlying factors for multiple partnering including imbalanced gender relations (National AIDS Council 2008).

Social marketing is effective especially using the radio, television and newspapers as a medium of imparting information. Radio debates and programs can be scaled up addressing issues of VCT. Road shows can be utilized in imparting information on the importance of VCT.

2.6 BEHAVIOURAL CHANGE THEORIES

While much has been done to prevent the spread of the HIV-infections and to render services to those infected and affected by HIV and AIDS, there remains concern with regard to the desired impact of these interventions. This has resulted in calls from the global community (UNAIDS 2008) for an integrated and holistic approach to combat HIV and AIDS. An integrated approach recognises the multifaceted nature of the HIV/AIDS pandemic and its impact on individuals, communities and countries.

HIV-infection is transmitted through exposure to infected blood and unprotected sexual intercourse. Therefore programmes directed at curbing its spread were associated with a series of *Knowledge, Attitudes, Practices and Beliefs* studies (KAPB) intended to equip programme managers with data on local attitudes, knowledge and practices (Barnett & Whiteside 2006). The resulting programmes were based on individualistic views of health behaviour and more specifically on three main theories, namely the Health Belief Model, the Theory of Reasoned Action, and the Stages of Change Theory.

The researcher used the concepts and notions of the TRA in conjunction with the above described insights about factors that influence VCT as sensitising notions to plan her study, develop her questionnaire and analyse and interpret her data. In doing so, she is aware that researchers who use the TRA as the theoretical foundation of a quantitative study tend to follow a strict methodology of elicitation interviews which is followed by questionnaire construction and the strict measurement of very particular constructs developed from the TRA (Kakoko, Astrom, Lugoe & Lie 2006; Millstein 1996; Rossi & Armstrong 1999). However, her intention was not to measure the statistical strength between the different dimensions of the TRA or to use data as prediction for the behavioural intentions of the respondents, but instead to undertake a baseline survey of the knowledge, attitudes, perceptions and experiences of the sample in terms of VCT.

Women's access to health care depends on their attitudes, health beliefs and their socioeconomic and demographic backgrounds. An attitude is a hypothetical construct that represents an individual's like or dislike for a given idea, person or thing (Myers & McCaulley 1985). Attitudes can therefore be positive, negative or neutral (or ambivalent) in terms of a stance towards a person, event or object. According to Myers and McCaulley (1985) health beliefs form as cognitive responses (that is, as mental evaluations or knowledge acquisition) or emotional responses (that is, as the result of observational or experiential learning from the environment)

TRA postulates that individual behaviour is guided by beliefs, attitudes, intentions, expectations, and social norms. This implies that social actors have certain, measurable attitudes and beliefs that shape their intentions to adopt a given behaviour Chiroro, Mashu, & Muhwava, 2002 ; Valente 2002). Ajzen and Fishbein (1980) suggest that for a person to adopt and act out a given behaviour, he or she must first develop the intention to perform that behaviour. This behavioural intention is determined by the actor's attitude toward the behaviour and her or his subjective norm. Therefore in order to change behaviour, health promotion programmes have to first change attitudes and beliefs about the behaviour.

2.7 CONCLUSION

Although VCT is acceptable in principle, much still needs to be done to ensure confidentiality and allay women's fears of stigmatisation and discrimination. Community sensitisation will be necessary and male partners will have to be involved if interventions are to be acceptable. The Zimbabwean government boasts of many VCT sites, and Avert

(2009) states that *"every district now contains at least one site that provides the service"*. There is however a need to fully utilise every service centre. The broad aim of the study was to investigate the knowledge, attitudes and experiences of a sample of women regarding VCT decision-making. This chapter presented a description of VCT in Zimbabwe. Factors influencing VCT utilisation and the TRA were reviewed.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION.

This chapter focuses on the methods used in gathering data from the sampled interviewees. Moreover, the chosen research design, sampling design and sampling procedures, data collection procedures, data analysis, ethical considerations and details of the pilot study are discussed.

3.2 THE CHOSEN RESEARCH DESIGN

The study was explorative and descriptive in nature as the researcher endeavoured to understand, from the point of view of women living in the Glen View high density area, those factors (such as knowledge, attitudes, characteristics and practices) that enable or hamper their VCT uptake. The goal of the research was therefore compatible with a mixed design encompassing both quantitative and qualitative approaches. For this reason, a questionnaire was developed that could elicit responses on biographical information by answering questions to fixed-response items on the one hand and allow the respondents on the other hand to express their feelings and perceptions regarding issues through open-ended questions.

The questionnaire was designed to be answered by the selected respondents in their own time. According to Ovretveit, (1998:205) *"self administered questionnaires are used when evaluators want to collect data about specific topics,*" in this case: VCT uptake among women. This method was chosen because it was not as expensive and time consuming as personal face-to-face interviews. Another advantage of

self-administered questionnaires that has been considered by the researcher is that this allows the respondents some time to think and reflect on their answers and to respond confidentially and freely. In preparation for this, the researcher attended a workshop organised by UNISA on research methods in 2008.

3.3 QUESTIONNAIRE DESIGN

The first section of the questionnaire comprised of items soliciting responses to questions on biographical information. Demographic characteristics pertaining to the respondents were collected. One of the objectives of this study – as stated in Chapter 1 – was to ascertain the characteristics of women in the chosen research site that either have accessed VCT or have not.

Knowledge of HIV/AIDS was assessed in the section after the biographical items as another objective was to find data on the sources of information available to women to inform and educate them about HIV/AIDS and VCT. The third section of the questionnaire focussed on the challenges that women face in accessing VCT services in the Glen View high density suburb as well as establishing the reasons for VCT uptake, the reasons for not using VCT and the reasons for neglecting to obtain VCT test results.

Prior to the actual fieldwork, the questionnaire was pre-tested with a small group (twenty) of female volunteers at the researcher's workplace to check the clarity of the question items and responses. The mean age for the pre-test group was 32 years. This was an easy process since the researcher did not have to travel to look for participants. The volunteers contributed greatly to the construction of the questionnaires because they were experienced researchers. They highlighted some problems relating to skip patterns which the researcher had not noticed

when developing the questionnaire. Some response options were also changed based on their input which was very helpful.

When the researcher pre-tested the questionnaire, she realised how emotionally involved the women were with the issue of VCT and how sensitive some of the questions were. Some of the respondents in the pre-test thought that the researcher had the answers to all questions about VCT. This led to a discussion about the role of research in uncovering factors related to women and VCT.

3.4 SAMPLING DESIGN AND PROCEDURES

The researcher chose to employ a probability sample because she had a list of all dwelling in the area as a sampling frame. Practical problems in the fieldwork, however, meant that 14 of the randomly selected dwellings or visiting points had to be substituted (see below). Glen View's high density suburb accommodates 2 000 residential units. The researcher decided to use systematic random sampling and to select every 20^{th} dwelling unit in the area starting at a random point in the suburb. At each selected visiting point a woman aged between 18 and 49 years was asked to complete the questionnaire. If more than one woman in these age groups was available for participation in the study at the selected visiting point, their ages were recorded and the researcher randomly picked one. When there was no woman between the ages of 18 and 49 at the chosen visiting point, or where the inhabitants refused participation, the researcher moved on to the next visiting point. By using this method, 100 female respondents were eventually sampled for participation in the study.

Four of the visited dwellings did not have female participants fitting the selection criteria so the researcher moved to the dwelling directly adjacent to it to sample a respondent. In addition, twelve women at

selected dwellings refused participation so the researcher followed the same aforementioned procedure. The researcher managed to distribute all the 100 questionnaires.

3.5 DATA COLLECTION PROCEDURES

The tool for data collection for this particular study was a questionnaire containing fixed responses and open-ended question items developed from the literature reviewed and reported on in Chapter 2 of this dissertation. These self-administered questionnaires were presented in English as the respondents in the chosen study site are literate and able to read and respond in this language. No translation into vernacular language was required for this sample. The researcher chose the study site since she is familiar with the area.

The researcher personally delivered a questionnaire and a consent form to each selected woman at the selected dwelling unit. The researcher explained the goal of the study and asked women fitting the eligibility criteria to participate in the study by completing the questionnaire and by signing the consent form. Consent forms were immediately signed and collected by the researcher. The questionnaires were left with the selected female respondent and collected after a day by the researcher. This allowed each respondent to complete the questionnaire in their own time.

Access to this community proved to be relatively easy, as the researcher was familiar with the suburb and was known to be a former resident of the area. The selection of respondents, the handing out of consent forms and the collection of completed questionnaires took place from 7 June 2009 to 22 July 2009. After data collection was completed, the responses to the open-ended questions were coded, the codes were entered on the computer on a spreadsheet and the

data exported to SPSS version 16.0 and analysed. The results are presented in Chapter 4.

3.6 ISSUES OF RELIABILITY AND VALIDITY

Validity refers to the degree to which an instrument measures what it is intended to measure. Internal validity refers to the internal logic and consistency of the research and external validity is how far the can the findings of the study be generalised. (Punch 2005: 255). The questionnaire was developed from the relevant literature and pre-tested by a group of female volunteers not included in the study sample. These women were asked to comment on the clarity of each question item. The researcher's supervisor also reviewed the questionnaire before it was administered. Comments by the volunteer mock respondents and the supervisor were incorporated in the final questionnaire.

Reliability refers to the degree of consistency or accuracy with which an instrument measures those attributes that it is supposed to measure. The researcher feels that she addressed this issue by using self-administered questionnaires that were clear and simple so that bias could not be introduced by different interviewers who pose questions differently. However, self-administered questionnaires present the problem that the researcher cannot completely guarantee that the intended respondents completed the questionnaire by reading the question items in the same sequence or by completing it at all. To try to address this, the researcher asked each respondent to please complete the questionnaire in one sitting when she has the time to do so and to read and answer questions thoroughly. The selected women were also asked not to discuss the questions or her answers with anyone else and to keep the completed questionnaire confidential and on her person until the researcher returns to collect it. When collecting

the completed questionnaires, the researcher held a short debriefing discussion with each respondent asking her whether there was a question item that was unclear to her or whether she wanted to tell the researcher anything in person about the study or the questionnaire. With the respondent's consent, the researcher quickly paged through each questionnaire checking that all questions had been answered. Thus a first check of data quality was done in the field. For six respondents, the researcher found out that they ticked several responses on questions 22, 23 and 25, instead of only one. The researcher asked the respondents again which of the responses they considered important and edited the responses accordingly. This problem during fieldwork may influence the quality of the data.

3.7 DATA ANALYSIS

The signed consent forms and the completed questionnaires were kept in a safe and secure location at the researcher's residence before data analysis. Coding lists were developed for the open ended questions. The data was captured as a spreadsheet and analysed using SPSS 16.0.

3.8 ETHICAL CONSIDERATIONS

Written permission to conduct research was obtained from the Glen View Community District Officer, Mr. Steven Nyahore. In the preparation of the research protocol, the consent forms and data-gathering strategies, UNISA's policy on research ethics was taken into consideration and these documents were presented to the supervisors for approval. The ethical principles underpinning this study pertain to voluntary participation, no harm to participants, informed consent, anonymity and confidentiality and not deceiving subjects.

3.8.1 Voluntary participation

The participants were made aware that they had the right to decline participation in the study at the onset or at any point in time without any penalties. They were also told that they could decline to respond to any question item if they so wished.

3.8.2 Risks involved

At each selected visiting point a woman fitting the selection criteria was asked to sign an informed consent form and told that there were no foreseeable risks associated with participation in the study.

3.8.3 Informed consent

An informed consent form was designed and given to the woman to sign after reading it and prior to completing the questionnaire. The informed consent form summarised the study's goals and procedures. The signed consent forms were collected by the researcher and the questionnaire was left for the respondent to complete. The signed consent forms are locked away securely at the researcher's residence.

3.8.4 Confidentiality

Participants' names and addresses were not written on the questionnaires. Instead, the researcher noted the selected visiting points in her personal research journal and gave codes to each questionnaire so that she was able to collect the completed questionnaires from the correct addresses. The journal, the consent forms and the completed questionnaires were securely locked away. Participants were asked not to discuss their participation, the questions

or their answers with anyone else and to keep their completed questionnaires with them until the researcher came to collect them.

3.8.5 Provision of debriefing, counselling and additional information

The researcher debriefed each respondent upon collecting the completed questionnaire. She also left her details for respondents to contact her should they at a later stage wish to discuss the study or anything related to VCT.

3.9 CONCLUSION

The methodology employed in this research study has been discussed in this chapter. Quantitative research formed the basis of this study. The next chapter discusses the findings of the study. Qualitative research is a useful means of collecting sensitive data and understanding perspectives. The Research Design workshop organised by UNISA on 23-25 July 2008 helped the researcher to grow ethically and intellectually.

CHAPTER 4
FINDINGS

4.1 INTRODUCTION

In this chapter the findings of the study are presented and discussed. First, the demographic characteristics of respondents are discussed and then evidence about the levels of knowledge, the attitudes, beliefs and practices of the respondents regarding HIV and VCT and the experiences of women with VCT attendance is presented. The goal of this study was to uncover from randomly selected respondents in a high density residential area those factors that influence (meaning factors that enable and hamper) VCT uptake for women. More specifically, the objectives were to firstly assess the knowledge that these women had about VCT, secondly to gauge their perceptions towards VCT issues, thirdly to gain an understanding of the experiences that women go through when they visit a VCT site and fourthly to investigate why some women avoid VCT, or fail to collect their test results.

4.2 THE CHARACTERISTICS OF THE SAMPLE

A total of 100 respondents (all women) were randomly selected and asked to complete the questionnaires. It should be self-evident that in tables where the total number of cases in the analysis was 100, the frequency and percentage columns contain the same figures for each row in the table. In this section, findings on the age distribution, marital status, current employment status, level of education and access to forms of media are presented. This section depicts the background information and demographic variables of the sample.

4.2.1 Age distribution

The respondents' ages ranged from 18- to 49-years. This selection criterion was invoked as the researcher was interested in the knowledge, perceptions, attitudes and experiences of women of reproductive ages who were also able to give consent to participate in the project.

Table 4.1 Age distribution of respondents (N=100)

Age group	Frequency	(%)
18-20	17	17
21-25	14	14
26-30	26	26
31-35	22	22
36-40	12	12
41-45	6	6
46-49	3	3

The majority of the women were relatively young, aged 26-35years. As shown in Table 4.1, there were 26 respondents aged between 26- and 30-years and 22 respondents aged between 31- and 35-years.

4.2.2 Marital status

More than half of the sample of respondents (51%) were married in a monogamous relationship as shown in Figure 4.1 About two out of every 10 respondents had never been married.

4.2.3 Employment status

Figure 4.2 shows that 59% of the respondents were employed and that 40% were skilled labour whereas 19% were unskilled labour. Skilled labour in this case is defined as having a professional course to accompany the job such as in teaching, accounts and secretarial. Unskilled labour is defined as work that did not require any formal training. It included vendors, general hands, etc. About 2 out of every 5 respondents were unemployed at the time of data-gathering.

Figure 4.1 Marital status of the respondents (N=100)

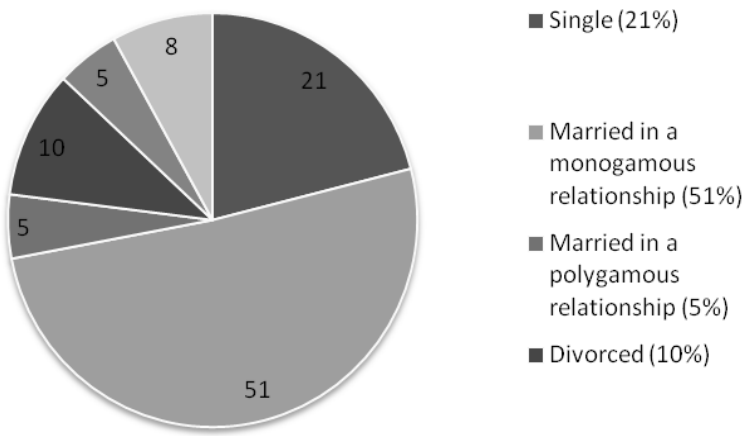
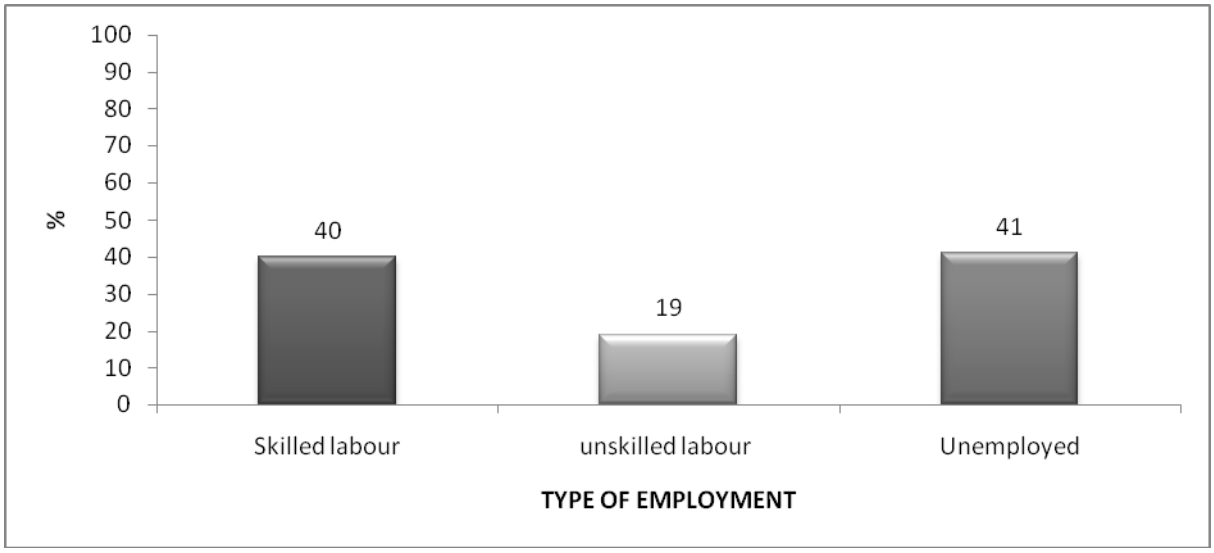


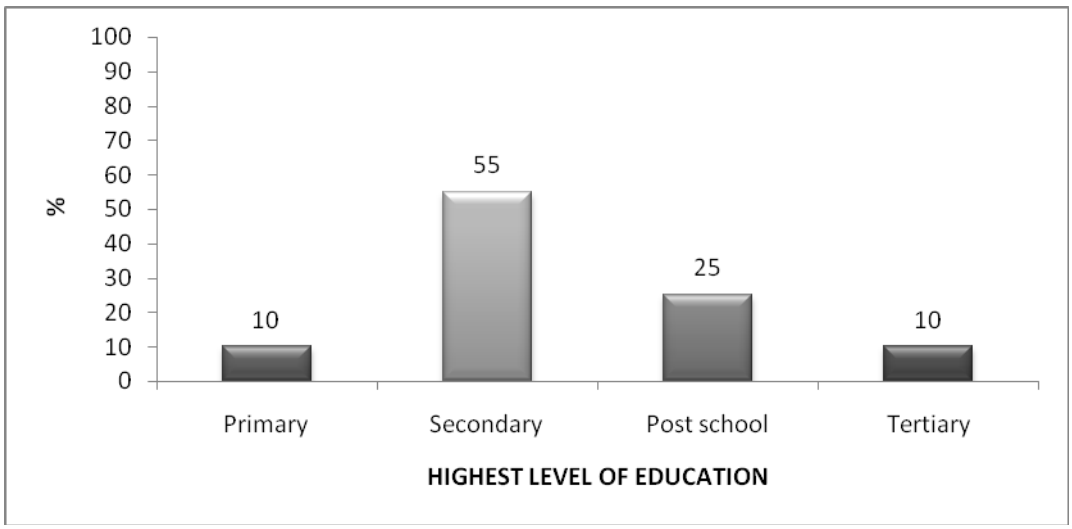
Figure 4.2 Employment status (N=100)



4.2.4 Level of education

Most women in the selected area were educated with a total of 90% having attained secondary school level at least up to Form 4 or Form 6 (see Figure 4.3). A quarter of the respondents had post-school qualifications and a tenth of the respondents had university level educational attainments.

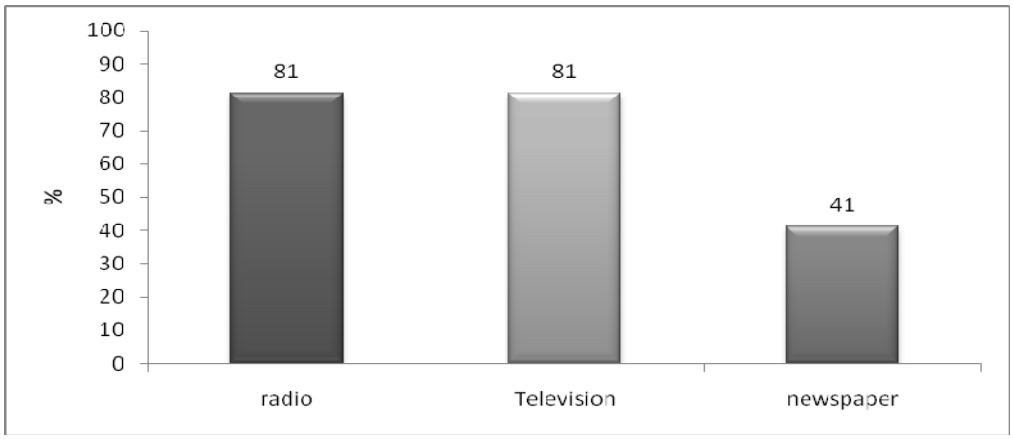
Figure 4.3 Highest level of education (N=100)



4.2.5 Access to forms of media

Figure 4.4 shows that most of the respondents had access to forms of media; the most common being radio and television which have both 81% of listenership and viewership respectively. Less than half of the respondents (41%) reported that they had access to newspapers. Given the fact that most of the respondents were literate, this lower reported use of newspapers can be concluded as having other reasons (such as costs or disinterestedness) aside from an inability to use this medium.

Figure 4.4 Access to forms of media (N=100)



Number of living children and number of dependents

Table 4.2 shows that 31% of the women did not have any children at the time of the data-gathering, whereas more than two thirds (69%) of the respondents had living children at the time of the survey. The mean number of own living children per respondent was 1,44 children. Only eight of the respondents were pregnant at the time of the survey, but almost 1 out of every 5 respondents (21%) took care of non-biological

children younger than 18 years of age in their homes. By including the current pregnancies and the foster children in the analysis, the mean number of children per woman increased to 1, 87.

Table 4.2 Number of children, current pregnancies and foster children

Number of living children	Frequency	%
None	31	31
1	23	23
2	28	28
3	9	9
4	7	7
5	2	2
Total	100	100
Mean number of living children	1,44	
% of respondents pregnant at the time of the survey	8	8
% of respondents who took care of children <18 years that were not their own biological offspring at the time of the survey	21	21
Mean number of children per woman including current pregnancies and fostered children	1,87	

4.3 KNOWLEDGE OF HIV TRANSMISSION AND PREVENTION

Figure 4.5 shows that overall; the respondents had good knowledge of how HIV is transmitted. All of the respondents knew that a mother can transmit HIV to her unborn baby; whereas 96% agreed that sharing a needle (syringe) with an infected person can transmit HIV virus; 96% concurred that unprotected sex with an HIV infected person results in

HIV transmission and 98% knew that if a person gets transfused with infected blood, HIV can be transmitted. As far as the first objective of this study is concerned, the research revealed high levels of accurate knowledge of HIV transmission among the women.

Figure 4.5 Knowledge of how HIV is transmitted (N=100)

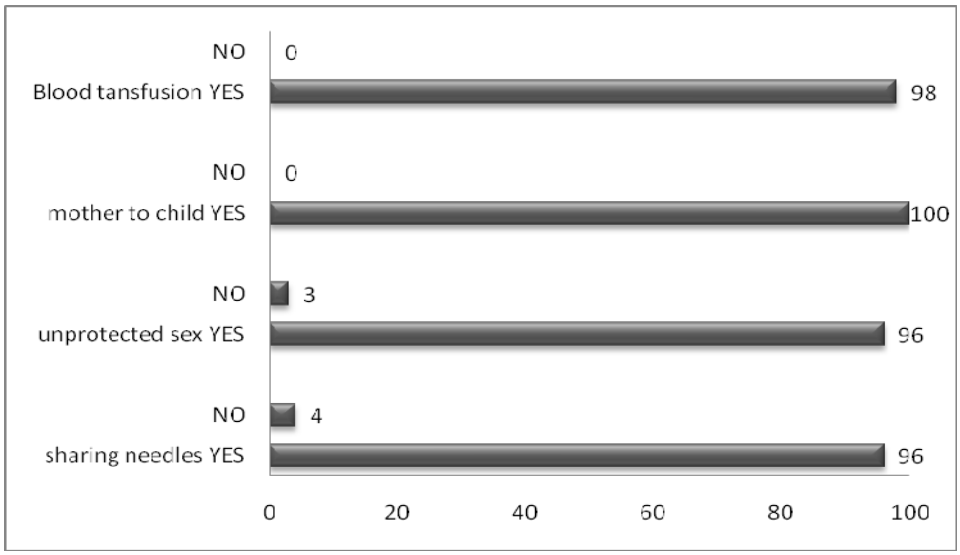
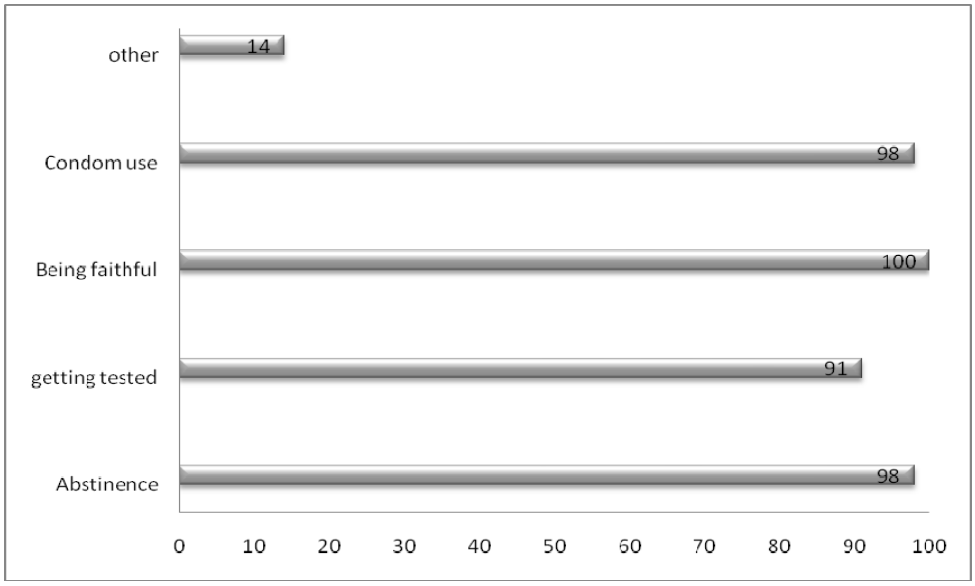


Figure 4.6 Knowledge of methods of HIV prevention (N-100)



As far as knowledge of how to prevent HIV-infection is concerned, Figure 4.6 shows similar high levels of knowledge as all of the respondents reported that being faithful to one uninfected partner is a good protective measure. Abstinence, condom use and getting tested were also identified as important factors in HIV protection as evidenced by the scores 98%, 98% and 91% respectively. Respondents could add their own perception of a good form of protection and 14% of them mentioned male circumcision.

4.4 KNOWLEDGE AND EXPERIENCES OF AND ATTITUDES TOWARDS VCT SERVICES

The researcher wanted to assess the respondents' perceptions of VCT issues and to find out what their VCT experiences were like. She also wanted to investigate why some women avoid VCT outright and why some go for testing but then fail to collect their test results. In the questionnaire, respondents were asked to mention the place where they would go to get tested for HIV. All of the respondents were able to give an answer to this question. As can be seen in Table 4.3, 61% of the women reported that they would get an HIV test at a VCT centre, 34% reported that they can have an HIV test at the clinic and 5% reported the hospitals as a place where one can get an HIV test.

Table 4.3 Where respondents would go to get an HIV-test (N=100)

Place	Frequency	%
VCT centre	61	61
Hospital	5	5
Clinic	34	34

Table 4.4 The distance between respondents' dwellings and the place they would visit in order to get an HIV-test or for VCT services (N=100)

Distance	Frequency	%
less than 2 km	34	34
2-4 km	23	23
5-6 km	14	14
More than 6 km	28	28
Would not go	1	1
Total	100	100

The majority (71%) of the respondents reported that they lived less than 6 kilometres from the nearest available point to receive VCT (see Table 4.4). Only 28% reported a distance of more than 6 kilometres between their dwellings and the nearest available point to receive VCT. One of the respondents indicated that she did not report a distance on the questionnaire as she would never go for VCT. Of the 28 respondents who lived more than 6 kilometres from the VCT centre, 93% indicated that they can afford transport to the VCT centre (see Table 4.5). These findings indicate that accessibility and affordability of transport to visit a VCT centre were not hindrances for VCT uptake.

Table 4.5 Whether respondents can afford transport to the place they would visit in order to get an HIV-test or for VCT services if the distance from the dwelling is more than 6 kilometres (N=28)

	Frequency	%
Yes, I can afford transport	26	92,9
No, I cannot afford transport	2	7,1
Total	28	100,0

As access to a service is more than knowledge of where to go for that service or the distance to that service, respondents were also asked to indicate what their sources of information about VCT were. As all of the respondents knew where to access VCT and the majority lived within reasonable walking distance (6 kilometres or less) from such a site, it was not surprising to find that they were also able to name more than one source of information about VCT. Respondents could name more than one source and these responses are reported in Table 4.6.

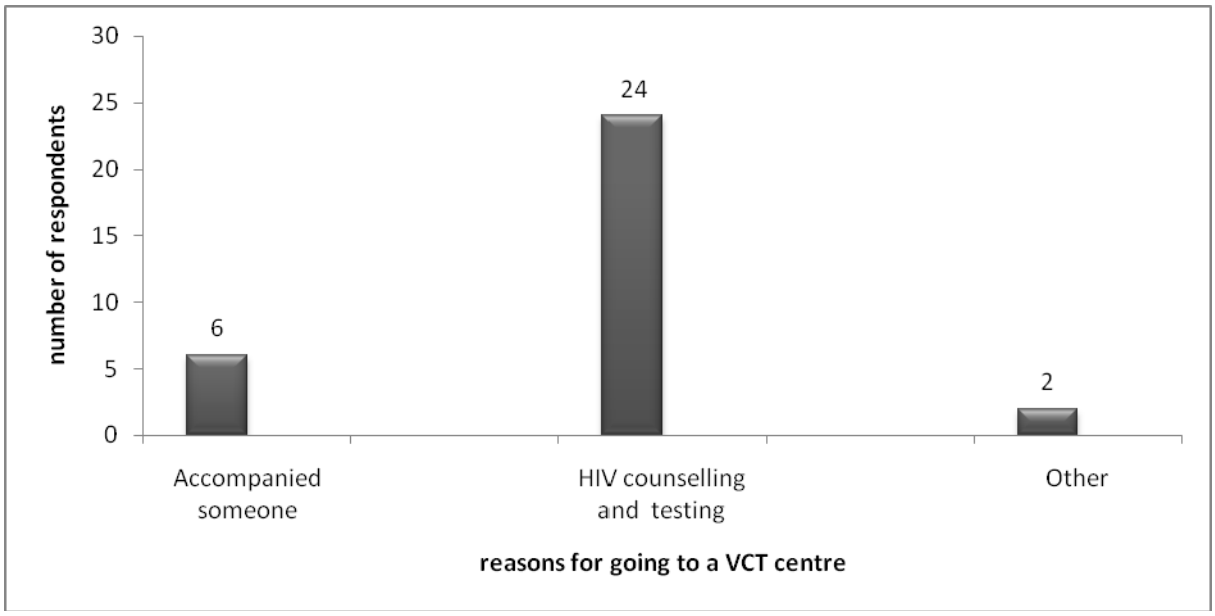
Table 4.6 Sources of information on VCT (N=100)

Source	Frequency	%
Radio	69	69%
Television	81	81%
Newspaper	36	36%
Antenatal clinic	61	61%

The most common source of information on VCT, mentioned by 81% of the respondents, was the television. The radio and the antenatal clinic were mentioned by 69% and 61% of the respondents respectively. Newspapers as a source of information were mentioned by 36% of the respondents and this lower reporting of this source is not surprising given than only 41% of the respondents reported that they have access

to newspapers. The reason that can be inferred to the low usage of newspapers can be linked to affordability or cost.

Figure 4.7 Reason for VCT visit (N=32)



The researcher also wanted to find out whether the respondents have ever visited a VCT centre. From a sample of 100 respondents, 32% reported to have visited a VCT centre. Out of these 32 respondents, 24 (75%) visited the VCT centre for testing, 6 (19%) accompanied someone else and 2 (6%) went there for other reasons (see Figure 4.7). This means that at the time of the research, less than a quarter (24%) of the sample had gone for HIV testing at VCT centres. This is a low utilisation rate of VCT given the youthful age of the respondents. All of the respondents who had ever visited a VCT centre for an HIV test reported that the staff observed confidentiality issues. A slightly higher proportion of the respondents (33%) reported having had an HIV test before (see Table 4.7). This means that although less than a quarter of the respondents have visited a VCT centre for HIV-testing, a third of them have never had an HIV-test, suggesting that 9% of the respondents have had an HIV test at a utility other than a VCT centre.

Table 4.7 Respondents who have ever tested for HIV (N=100)

Have you ever tested for HIV?	Frequency	%
Yes	33	33%
No	67	67%

Out of the 33 respondents who had reported that they have tested for HIV, 10 (31%) took the test because they wanted to get pregnant or were pregnant, 15 (50%) wanted to know their HIV status, 5 (15%) tested for medical reasons, 2 (6%) tested because their partners had tested positive for HIV and one respondent (3%) tested for other reasons (see Figure 4.8).

The researcher was also interested in the reasons why some women avoid HIV-testing. As reported earlier, two thirds of the respondents (67%) reported that they had never been tested for HIV. Their reasons for not getting tested are shown in Table 4.8.

Figure 4.8 Main reason for getting tested for HIV virus (N=33)

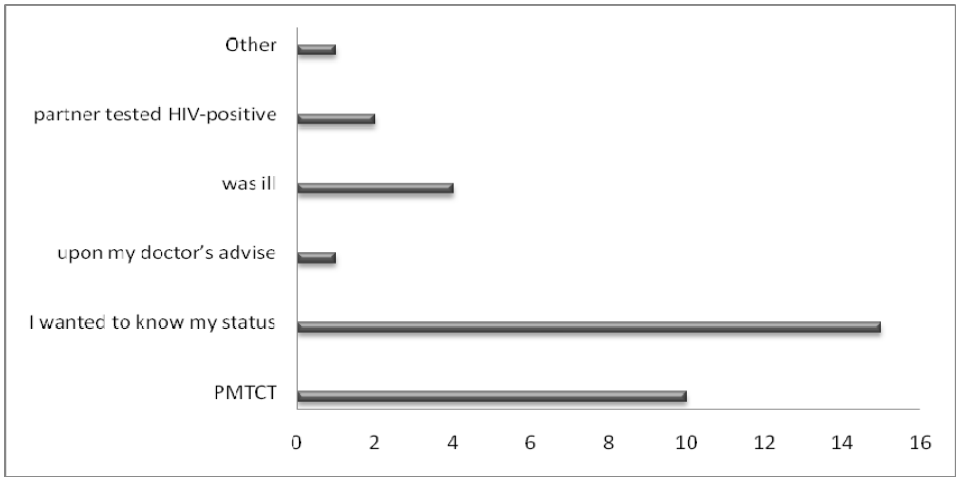


Table 4.8 Reasons why some respondents have never been tested for HIV (N=67)

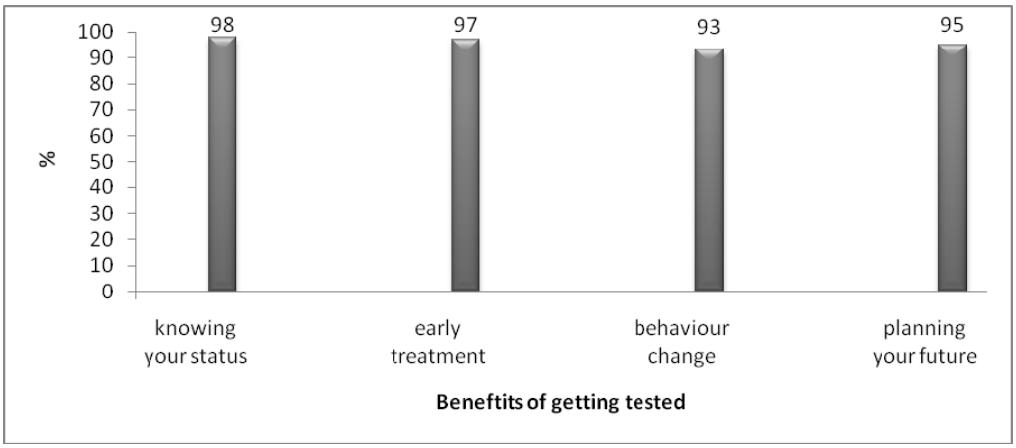
Reason	Frequency	%
Fear of stigma	27	40%
Fear of rejection by partner	31	46%
Assumes they know their status	5	8%
Fear of accusation of promiscuity by partner	29	43%
Perceived themselves as not at risk	28	42%
Fear of violent behaviour from partner	28	42%

Of the 67 respondents who had never been tested for HIV, the majority (46%) said that they feared rejection by their partners and 43% reported that they feared that their partners would accuse them of promiscuity. Fear of violent behaviour by a partner was reported by 42% of the respondents who have never been tested. It thus seems that the perceived reactions by close partners – whether that reaction was rejection, accusations of unfaithfulness or violence were the main deterrents for the women who have never had an HIV test. Fear of stigma and discrimination was mentioned by 40% of the respondents who have never tested. A fair proportion of the respondents (42%) reported that they have never tested because they perceive themselves as not being at risk for HIV and another 8% of the untested subgroup assumed that they already knew their status despite never testing. It is possible that this group of women overestimated their non-susceptibility to HIV and thus have put themselves at unnecessary risk by avoiding testing because of these untested assumptions of invulnerability.

As the researcher wanted to ascertain whether negative experiences at testing sites or VCT centres might influence women, a question was included in the questionnaire to test whether those women who have been tested would return to the same testing facility for follow-up testing or VCT. The majority of the respondents who got tested (27 out of the 33 or 82,8%) reported that they were willing to go back to the same centres for testing. Among the six who reported that they would not go back to the same centres, 4 of them reported that they had been transferred from where they got tested before; 1 said that the distance to that testing facility was too far (more than 200km) for her to return and another 1 indicated that the waiting time was too long.

All of the respondents were asked to indicate what they perceived to be the benefits of being tested for HIV. As shown in Figure 4.9, 98% of the respondents reported that the benefit was the relief associated with knowing one's status; 97% reported that testing provided the opportunity of early treatment; 93% said that testing can prompt behaviour change; and 95% of the respondents said that testing allowed the person to plan for the future. In an open question, the respondents were given the opportunity to list any other possible benefit to HIV testing that occurred to them and 8% of the respondents reported that HIV testing resulted in a reduction of anxiety. The responses thus seemed to indicate that the women valued the intrapersonal benefits of HIV-testing (reducing anxiety, setting one's mind at ease, planning for the future and enabling treatment and advice on behaviour change) but that the fear of the possible negative interpersonal consequences (partner's violence, rejection and accusations) deterred many from testing for HIV.

Figure 4.9 The benefits of getting tested (N=100)



The questionnaire also awarded the respondents the chance to express their general views regarding VCT uptake among women. As can be seen in Table 4.9, accordingly (44%) indicated that they fear rejection by their partners should they test as HIV-positive; 39% of the respondents felt that all women should go for VCT for PMTCT reasons (Newell 2006).

Table 4.9 General perceptions of VCT uptake among women (N=100)

Perception	Frequency	%
Women should be tested for PMTCT	39	39
Women fear losing their partners if they test positive	44	44
Women fear stigma and discrimination	12	12
Women should be tested before they engage in sex	5	5
Total	100	100%

4.5 RESPONDENTS' PERCEPTIONS OF FACTORS THAT HAMPER OR ENABLE VCT ATTENDANCE AND THE COLLECTION OF TEST RESULTS

To the question on what the respondents regard as the main reason why a woman would not get tested for HIV, the majority of the women responded that fear was the most common factor (see Figure 4.10). The notion of fear took on two dimensions, namely the fear of a positive test result (32% of the respondents regarded this as the main deterrent to testing) and fear of rejection by a partner (31% of the respondents regarded this as a main deterrent to testing). Lack of knowledge (23%) was also cited as a major reason for not having an HIV test. Other factors mentioned included fear of dying (5%) and fear of stigma and discrimination (7%).

As shown in Figure 4.11, to the question on what the respondents regard as the main reason why a woman would get tested for HIV, the majority (58%) replied that the intention to get pregnant would fuel such a decision; 23% indicated that a woman would get tested if she wanted to know her status; 10% said that testing would be prompted by the woman's ill health; 5% said that testing would only follow upon a doctor's advice; 2% felt that a woman would test for HIV upon her partner's advice and 2% said that a woman would test if her partner tested positive for HIV.

Figure 4.10 Reasons why respondents think other women do not get tested for HIV

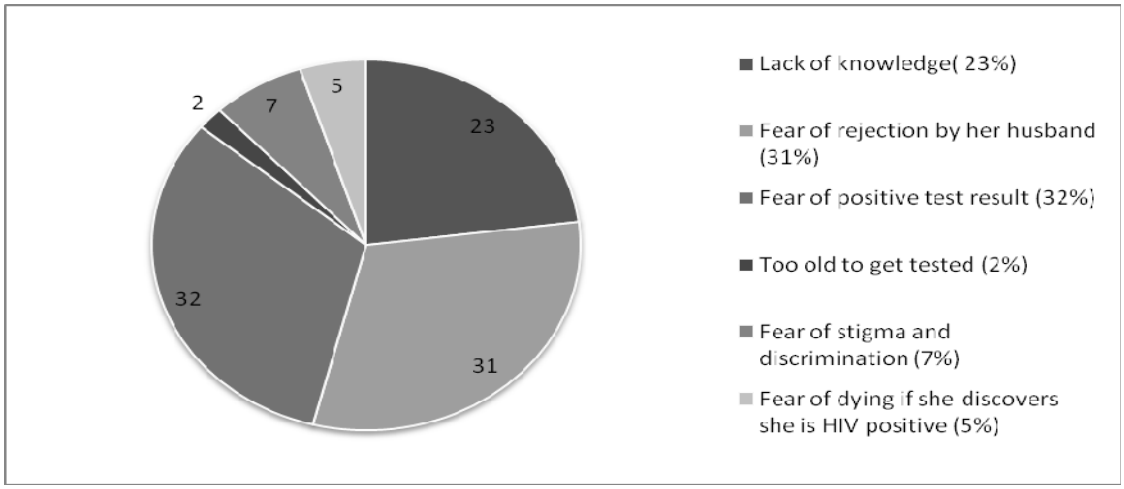
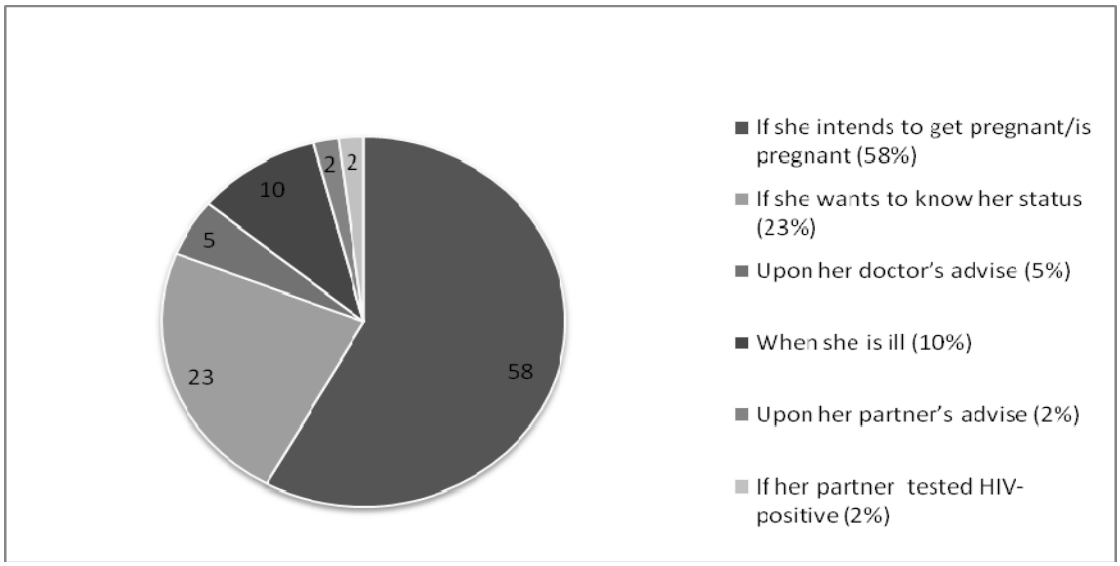


Figure 4.11 Reasons why respondents think why other women get tested



For the final part of gauging respondents' perceptions about other women's reactions to VCT, they were asked why they think some women would have the courage to have an HIV test but then fail to wait or return to get the test results. These responses are given in Table 4.10.

Table 4.10 Reasons reported by the respondents for why some women who get tested for HIV but do not collect their test results (N=100)

Reason	Frequency	%
Lack of knowledge	15	15
Fear of rejection by her husband	33	33
Fear of a positive test result	36	36
Fear of stigma and discrimination	13	13
Fear of violent behaviour from partner	3	3
Total	100	100

It was found that 36% of the respondents thought that women feared a positive test result; 33% thought that women feared rejection by their partners and 15% thought that lack of knowledge resulted in testers not waiting or returning for their results. In addition 13% of the respondents thought that the fear of stigma and discrimination was to blame for this and 3% said that women feared violent behaviour from their partners.

Table 4.11 Characteristics of respondents by HIV-test history

Characteristic	Has had an HIV-test		Has never had an HIV-test	
Age group				
18-20	(2)	11,8%	(15)	88,2%
21-25	(5)	35,7%	(9)	64,3%
26-30	(13)	50,0%	(13)	50,0%
31-35	(8)	36,4%	(14)	63,6%
36-49	(5)	23,8%	(16)	76,2%
Current marital status				
Single	(5)	23,8%	(16)	76,2%
Married (monogamous)	(25)	49,0%	(26)	51,0%
Other	(3)	10,7%	(25)	89,3%
Employment status				
Skilled labour	(16)	40,0%	(24)	60,0%
Unskilled labour	(9)	47,4%	(10)	52,6%
Unemployed	(8)	19,5%	(33)	80,5%
Highest level of education				
Up to secondary	(19)	29,2%	(46)	70,8%
Post school up to tertiary	(14)	40,0%	(21)	60,0%
Whether currently pregnant				
Yes	(6)	75,0	(2)	25,0%
No	(27)	29,3%	(65)	70,7%

When cross tabulating the variables on HIV testing by certain background characteristics of the respondents (see Table 4.11), it is revealed that the groups of women in the Glen View high density

suburb with non-testing percentages exceeding the 67% found for the entire sample are those women in the 18- to 20-year age groups, those who are divorced, widowed or in polygamous marriages, those who are unemployed and those with a lower level of education. (UNAIDS 2008:74) concurs with these findings when they it states that women who have a greater bargaining power within their households have a healthier sexual life with their partners. This notation is also supported by the Global campaign for education. However, contrary, to this notion, (AIDSMark 2009) revealed that barriers to VCT among women were associated with lack of perceived confidentiality at VCTs, unfamiliar with VCT and that VCT is only foe the ‘sick” and “dying” people.

4.6 DISCUSSION: SUMMARY AND INTERPRETATION

The findings of the biographical characteristics of the respondents revealed young women of which the majority reported to be married in monogamous relationships. These women were educated and reported good access to mass media such as television and radio. The majority of the respondents were mothers, foster mothers or expectant mothers and many had living children, a few were pregnant and some were fostering children at the time of the survey. The biographical picture of Glen View high density that emerges from this study thus depicts women who are at their peak ages and in the ideal positions in their life course to have particular reproductive health needs including the need to know their HIV status and to be informed about HIV and AIDS.

The study revealed that the respondents had an excellent understanding of how HIV is transmitted. This can be attributed to the fact that they reported fairly wide access to forms of mass media which educate them on HIV and AIDS issues. It thus seems evident that VCT

uptake and facilities in Zimbabwe are publicised through the mass media. The radio, television, newspapers and the clinic were cited as sources of VCT information, the first two being the most prominent. It can be deduced from these findings that women in Glen View suburb are particularly well informed about VCT.

One of the key questions guiding this study was what the barriers are that women face in accessing VCT services in the Glen View high density suburb. The study revealed that access was not a barrier to VCT uptake in Glen View as 61% of the women indicated that they could access such services at a VCT centre and 34% said that they could do so at a clinic. Of those who indicated that the VCT centres were far away from where they stayed, most reported that they can afford transport to visit such service sites.

Despite reported high levels of knowledge of HIV/AIDS and VCT and the apparent ease of access to VCT sites, which could imply a high uptake of VCT services, only about third (32% visited a VCT centre for an HIV test and 33% ever tested for HIV) of the respondents had taken up VCT services in Glen View high density suburb. This is in contrary to Aynalem and her co-worker's findings (2004) on why some pregnant women refuse HIV testing in America, where they discovered that 41% of them had not received general information on HIV/AIDS and how it affects pregnant women.

Two important reasons for VCT uptake were revealed namely the need to know one's status and the prevention of MTCT. Of the 33 respondents who were tested, half wanted to know their HIV status so that they could protect themselves by living positively as evidenced in this statement written by one of the respondents on the questionnaire: *"If females are tested, they know their status and can live positively."* This has also been the primary objective of the PSI New Start centres

opened in Zimbabwe. These centres encourage testing by advocating for behavioural change, for the development of individual self efficacy, for the destigmatisation of HIV and AIDS and for the eradication of misconceptions about how HIV is transmitted (MOHCW 2004:6)

A third of the respondents who tested for HIV did so as part of antenatal testing or because they planned to fall pregnant soon. Again one of the respondents wrote on the questionnaire: "*It is vital for women to know their HIV status especially if they intend to get pregnant for the sake of the baby so there are precautions that can be taken to avoid mother to child transmission."* Moreover most of the respondents reported that the main reason why most women test for HIV is for the PMTCT (Newell 2006). In this regard Shagula (2006:9) writes: *"Without* [HIV Testing and] *treatment, the rate of transmission during pregnancy ranges from 5 to 10 percent, during labour and delivery from 5 to 20% and during breastfeeding 10 to 20 %. Therefore the prevention of acquisition of infection in women and reduction of incidence of unwanted pregnancy in HIV positive women will aid global Prevention of Mother to Child Transmission of HIV (PMTCT) by decreasing the neonatal and maternal mortality rates.*

This strong support for PMTCT, however, was negated by the reported strong fears about the possible negative consequences of having an HIV test (Newell 2006). Foremost among these fears was a strong fear about the reactions of male partners – apprehension that the man might reject, blame or become violent towards a woman who has tested positive for HIV. An assumption that can be drawn from this finding is that most women in Glen View's high density suburb, despite being educated and well informed about VCT, still feel powerless and insecure when it comes to issues of reproductive health and to embracing the services for VCT that are made available to them.

These fears are not ill-founded and probably based on the respondents' personal experiences of what happens around them. Other researchers (Bujra 2000; Monaghan 2002) have found that male partners, instead of owning up to concurrent and multiple sexual partners that might expose them and their spouses to sexually transmitted infections and HIV, accuse their female partners of being promiscuous and unfaithful. SAFAIDS (2004) states that one in four women in Zimbabwe has reported experiencing sexual violence by an intimate partner. Moreover, 60% of all reported murder cases in Zimbabwe in 2004 were related to domestic violence and in many cases the cause of the violence was the disclosure of a positive HIV status by a woman to her male partner (SAFAIDS 2004).

Despite being literate, only 2 out of every 5 respondents in this study was found to be employed in skilled labour whereas 41% were unemployed and 19% employed in unskilled jobs such as street trading (vendors) and part time domestic work. It can therefore be assumed that the majority of the women in the study site were not economically independent. Such vulnerability might imply financial dependence on men which can make the negotiation for safer sex practices very difficult for these women especially given the finding that many of them also take care of their own or foster children.

Even though there is evidence that women in the study site were well aware of HIV and AIDS issues, responses revealed that some women fear being stigmatised should their HIV-positive status become known. One respondent wrote the following: *"Women do not want to be a laughing matter in the community if they know that they are HIV positive so they do not get tested".* The fear of stigma was, however, less reported as a deterrent to HIV testing among women than the fear of a positive test result and the fear of rejection by a partner.

4.7 CONCLUSION

In concluding this chapter, findings from the research study revealed pertinent themes regarding issues of fear vulnerability and male involvement in VCT uptake. Although these trends in the data should be treated with great circumspection due to the small sample size, it seems to confirm that women who are socioeconomically vulnerable (because they are younger, have a lower level of education, are divorced, widowed or in polygamous marriages and are unemployed) tended to be those who avoided HIV-testing. Reading against the findings of this study that the respondents regarded male reactions to a positive HIV test as a major deterrent against utilising VCT, it thus seemed that women who felt vulnerable might avoid testing. To this end, HIV testing, while it has its own specificities, follows traditional gender norms related to help-seeking and health seeking.

Of interest is the relatively large proportion of pregnant women who tested for HIV. PMTCT came out as a major driver for VCT among these women. Whereas this is certainly a positive finding in terms of PMTCT, it should also be considered that many other opportunities for testing are missed for non-pregnant women and for men. The scope should be widened to include other important variables.

CHAPTER 5
CONCLUSION

5.1 INTRODUCTION

This chapter highlights the limitations of the study, presents suggestions for further research and details recommendations for policy and practice. The purpose of this study was to describe the factors that influence VCT attendance among women in Glen View high density suburb. Furthermore, factors hindering VCT uptake and collection of tests results once tested were explored.

5.2 LIMITATIONS OF THE STUDY

The researcher originally planned to achieve a sample size of 200 women of reproductive ages, but this was reduced by a Glen View City Council official to 100. His reason for this suggestion was that given the time the researcher had to complete the dissertation, she would not be able to produce quality work. The researcher felt that this sample was too small for the purposes of generalising the results to a larger population, but she was unable to convince the official of this. However for planning purposes in Glen view, the results are useful. Access to financial resources and the time constraints on the researcher also made the expansion of the study difficult. Caution should be exercised in generalising the findings of this study to other contexts in Zimbabwe.

The researcher opted for self-administered questionnaires and used quantitative data collection methods. Given that HIV and AIDS are sensitive topics, the self-administered nature of the questionnaires could have resulted in respondents giving social-desirable responses.

The construction of the questionnaire and its pre-testing attempted to limited acquiescence in responses. Whereas it is the contention of the researcher that the set objectives of the study have been met, a qualitative method would have added the lived experiences of the women and add textured data.

5.3 SUGGESTIONS FOR FURTHER RESEARCH

The researcher recommends that further research be conducted to (1) ascertain why women fear a positive result and (2) gauge the gender-dynamics related to VCT-uptake. There have been notable developments worldwide in terms of treatment availability for HIV positive people but still some women fear HIV testing. . With the advent of combination ARV therapy, “fast facts” are that the HI-virus can be prevented from multiplying in the body of an HIV infected person, and then the body's immune cells - most notably the CD4 cells - are able to live longer and provide the body protection from other opportunistic infections (UNAIDS 2008).

Qualitative research should be conducted to gauge textured data on the lived experiences of women on violence and rejection as a result of HIV positive status disclosure.

5.4 RECOMMENDATIONS

Two sets of recommendations are made and these are discussed below:

5.4.1 Scaling up male involvement initiatives

In line with the Zimbabwean national behaviour change strategy of 2006-2010, there is need to scale up interventions that target men. In this way men can be better informed about HIV thereby encouraging

behaviours that would protect them and their female partners. Settings such as workplaces, beer halls, churches and homes could be utilised to engage men in discussions on protection against HIV-infection and on the prevention of violence against women who test HIV-positive. This form of social marketing is effective especially when using the radio and television as mediums of imparting information New Start Centre (2004). Radio debates and information, education and communication programmes can be scaled up to address issues such as couple counselling and testing. Road shows can be utilised to impart information on the importance and benefits of HIV testing.

Research should be conducted among men to ascertain their knowledge, attitudes and behaviour towards HIV/AIDS. Men should be educated about HIV/AIDS issues. Teachings on HIV/AIDS are mostly targeting women either during their community meetings or during antenatal visits at local clinics. Men from high density suburbs, who are assumed to frequent public drinking places after work, do not get the opportunity to hear HIV/AIDS information on radios and televisions, which have proved to be reliable sources of information dissemination regarding the disease.

5.4.2 Opening communication lines between partners regarding VCT

Respondents gave various reasons for not getting tested and most of these reasons seemed to stem from poor communication between sexual partners about reproductive health issues. There is need to encourage communication between partners so that there is understanding in the matrimonial home leading to couple counselling and testing.

The researcher further recommends that:

(a) Women should be empowered to refrain from risky relationships and work towards protecting themselves from HIV infection. This can be achieved through introducing some female controlled methods of HIV prevention that women can be use secretly such as for example certain microbicides.

(b) Legal support and sensitisation programmes should be established to ensure that the rights of women and girls are not violated. . Women's representation in AIDS Action Committees at all levels, including in leading positions, should be increased to enhance their decision-making power.

(c) A contribution should be made towards women's economic independence by integrating income-generating components into programmes such as home-based care (HBC) or allow a modest degree of profit-making from such activities as condom distribution.

(d) Educational tools that may assist in safer sex negotiation among women should be made more widely available, thus empowering women to get tested.

(e) The training of male primary counsellors certified to perform VCT services should be scaled up in order to significantly expand the uptake of VCT among men.

(f) Efforts should be put in place to make existing VCT services more male friendly and that VCT service providers should be trained on how to make their services more attractive to males.

(g) Mobile VCT units should be made available in industrial areas where men can easily access the services over lunch.

(h) VCT awareness should target beer halls since men frequent these places.

5.5 CONCLUSION

The government of Zimbabwe has continued to scale up the multi-sectoral response to HIV and AIDS based on the Zimbabwe National and HIV AIDS Strategic Plan (ZNASP2006-2010) that was launched in July 2006. This plan builds on lessons learnt in the implementation of the National AIDS Policy of 1999 and the National HIV and AIDS Framework (2000 -2004). The strategic plan highlights HIV and AIDS as an emergency that requires the government and all stakeholders to urgently mobilise the required resources in order to fight the epidemic.

The policy also highlights VCT as a central part of Zimbabwe's HIV and AIDS prevention strategy. With the number of VCT centres having increased significantly between 2004 and 2005 (ZNASP 2006), it is feasible to expect that these resources should be fully utilised in order to achieve the country's goals. Thus the mobilisation of communities and their leaders for normative and behavioural change, to complement and stimulate demand for the envisaged scaling up of essential service-based prevention programmes, such as counselling and testing is encouraged. Billboards and posters should be displayed and small print media disseminated to maintain knowledge and awareness of VCT issues in the recently introduced PITC will mean that a greater number of people might know their status, including men, thereby de-stigmatising the HIV positive issue.

The importance of enabling more women to access VCT services in Glen View cannot be overemphasised in the struggle to fight the epidemic. The nation will benefit as a result of VCT uptake. As it has

emerged that client- oriented and not service-oriented factors affect VCT attendance among women in the Glen View suburb, policy formulation and implementation should be targeted towards the clients.

LIST OF SOURCES

AIDSMark. 2009. *The social marketing approach to voluntary counseling and testing.* Washington DC: AIDSMark.

Ajzen**,** I & Fishbein, M. 1980. *Understanding attitudes and predicting social behaviour*. New Jersey: Prentice-Hall**.**

Avert. 2008. Women, HIV and AIDS. Available at: www.avert.org/women.htm (Accessed on 9 December 2008).

Avert. 2009. HIV and AIDS in Zimbabwe. Available at http://www.avert.org/aids-zimbabwe.htm (Accessed on 22 April 2009).

Aynalem, G, Mendoza, P, Frederick, T & Mascola, L. 2004, Who and why? HIV-testing refusal during pregnancy: implication for pediatric HIV epidemic disparity. *AIDS and Behavior* 8(1) 21-38.

Babbie, E. 1989. *The practice of social research. 5th Ed*. Belmont: Wadsworth.

Barnett, T & Whiteside, A. 2006. *AIDS in the twenty-first century: Disease and globalization*. Eastbourne: Palgrave McMillan.

Basset, MT & Mhloyi, M. 1991. Women and AIDS in Zimbabwe. The making of an epidemic. *International Journal of Health Services* 21(1):143-156.

Bujra, J. 2000. Targeting men for a change: AIDS discourse and activism in Africa. *Agenda* 44: 6-23.

Central Statistical Office. 2004. *Census 2002: Zimbabwe national report.* Harare: Central Statistical Office.

Central Statistical Office & Macro International Inc. 2000. *Zimbabwe Demographic & Health Survey 1999.* Calverton, Maryland: Central Statistical Office and Macro International.

Chiroro, P, Mashu, A & Muhwava, W. 2002. *The Zimbabwean male psyche with respect to reproductive health HIV, AIDS and gender issues.* Harare: Centre for Applied Psychology, University of Zimbabwe.

Chopra, M, Doherty, T, Jackson, D & Ashworth. A. 2005. Preventing HIV transmission to children: Quality of counselling of mothers in South Africa. *Acta Pædiatrica* 94: 357–363.

Commonwealth Regional Health Community Secretariat. 2002. *HIV/AIDS voluntary counselling and testing: review of policies, programmes and guidelines in east, central and southern Africa.* Arusha, Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa.

Corbett, EL, Dauya, E, Matambo, R, Bun Cheung, Y, Makamure, B. Bassett, MT, Chandiwana, S, Munyati, S, Mason, PR, Butterworth, AE, Faussett, PF & Hayes, RJ . 2006. Uptake of workplace HIV counselling and testing: A cluster randomised trial in Zimbabwe. Available at http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0030238 (Accessed on 24 July 2009).

Deacon, H, Stephney, I & Prosalendis, S. 2004. *Understanding HIV/AIDS stigma: a theoretical and methodological analysis*. Pretoria: HSRC.

Denison J. 1996. *Behavior change -- a summary of four major theories.* Available at ww2.fhi.org.en.aids.aidscap/aidspubs/bhres/bc4theo.html (Accessed on 24 July 2009).

Dorrington R. 2000. *The ASSA2000 suite of models*. Available at www.assa.org.za (Accessed on 24 July 2009).

Global Campaign for Education. 2004. *Learning to survive: how education for all would save millions of young people from HIV/AIDS.* Available at http://www.campaignforeducation.org/en/news/ (Accessed on 24 July 2009).

Government of Zimbabwe. National AIDS Council, Ministry of Health and Child Welfare & UNAIDS. 2006. *Zimbabwe national HIV and AIDS strategic plan 2006-2010.* Harare: National AIDS Council.

Gupta, N & Mahy, M. 2003. Sexual initiation among adolescent girls and boys: trends and differentials in Sub-Saharan Africa. *Archives of Sexual Behavior* 32(1):

Gupta, GR & Weiss, E. 1993. Women's lives and sex: Implications for AIDS prevention. *Culture, Medicine and Psychiatry* 17: 399-412.

HIV/AIDS Dictionary. 2009. Available at http://www.hivinfosource.org/hivis/hivbasics/dictionary/ (Accessed on 24 July 2009).

Kakoko, DC, Astrom, AM, Lugoe, Wl, Lie, GT. 2006. Predicting the intended use of voluntary AIDS counselling and testing services among Tanzanian teachers using the theory of planned behaviour. *Social Sciences & Medicine* 63(4): 991-999.

Leclerc-Madlala, S. 2001. Virginity testing: managing sexuality in a maturing HIV/AIDS epidemic. *Medical Anthropology Quarterly.* 15(4):533-552.

Maman, S. 2002a. Women's barriers to HIV–testing and disclosure: challenges for HIV-1 voluntary counseling and testing: *AIDS Care* 13 (5): 595-603.

Maman, S. 2002b. HIV-positive women report more lifetime partner violence: Findings from a voluntary counseling and testing clinic in Dar es Salaam, Tanzania. *American Journal of Public Health* 92 (8):1331-1337.

Mbara, TC & Maunder, DAC 1996. The initial effects of introducing commuter omnibuses in Harare. Harare: TRL Report 123.

Mhloyi, M & Mhloyi, GD 2000. *A manual for negotiating safe sex by married women.* Harare: UNIFEM.

Millstein, SG. 1996. Utilities of the theories of reasoned action and planned behaviour change for predicting physician behaviour: A prospective analysis. *Health Psychology* 15(5):398-402.

Ministry of Health and Child Welfare. 2004. *The HIV and AIDS epidemic in Zimbabwe.* Harare: MOHCW.

Ministry of Health and Child Welfare..2008. *National HIV and AIDS estimates for 2007.* Harare: MOHCW.

Ministry of Health and Child Welfare, Zimbabwe Family Planning Council, National AIDS Council (Zimbabwe) & US Centers for Disease Control and Prevention. 2004. *The Zimbabwe young adult survey 2001-2002*. Harare: Zimbabwe: Ministry of Health and Child Welfare and US Centers for Disease Control and Prevention.

Monaghan, LF. 2002. Opportunity, pleasure, and risk. An ethnography of urban male heterosexualities. *Journal of Contemporary Ethnography* 31(4): 440-477.

Moyo, P. 2007. An investigation into the factors that predispose women to HIV infection. Unpublished report written as part of the fulfillment of the requirements of the Certificate in Systemic Therapy at the Zimbabwe Institute of Systemic Therapy, Harare

Myers, IB & McCaulley, MH. 1985. *Manual: a guide to the development and use of the Myers-Briggs type indicator.* Palo Alto, CA: Psychologists Press.

National AIDS Council. 2008 *National behavioral change strategy for prevention of sexual transmission of HIV 2006-2010.* Harare: NAC..

National AIDS Council, MOHCW & UNAIDS. 2006. *Zimbabwe national HIV and AIDS strategic plan (2006-2010)*. Harare: Zimbabwe.

National Institutes of Health 2009: Online ethics training: Available at http://phrp.nihtraining.com/codes/11codes.php (Accessed on 11 May 2009).

Nattrass, N. 2004. *The moral economy of AIDS in South Africa.* Cape Town: Cambridge.

Newell, M. 2006. Current issues in the prevention of mother to child transmission of HIV-1 infection. *Transactions of the Royal Society of Tropical Medicine and Hygiene*.100(1):1-5.

New Start Centre. 2004. *Operating procedure manual.* Harare: The AIDS and TB Unit of the Ministry of Health and Child Welfare of Zimbabwe.

Ngugi, E. 1991 Education and counseling interventions. Paper presented at the 18th Annual NCIH International Health Conference, Arlington, Virginia, Atlanta.

Nyahore, S. 2009. Personal interview with the researcher.

Ovretveit, J. 1998. *Evaluating health interventions*. Buckingham:.Open University Press.

Pool, R. 2001. Attitudes to voluntary counseling and testing for HIV pregnant women in rural south-west Uganda. *AIDS Care* 13 (5): 605-615.

Population Services International. 2003. *Knowledge, attitudes, beliefs and practices on HIV/AIDS in Zimbabwe, 2003*. Harare: University of Zimbabwe.

Punch, KF. 2005. *Introduction to social research: Quantitative and qualitative approaches.* London: Sage Publishers.

Reed, C. 2005. *Workplace initiatives in South Africa: a case study approach.* Johannesburg: AIDS Law Project.

Rossi, NA & Armstrong, JB. 1999. Theory of reasoned action vs. theory of planned behaviour: Testing the suitability and sufficiency of a popular behaviour model using hunting intentions. *Human Dimensions of Wildlife* 4(3):40-56.

SAFAIDS News. 2004 *Gender and sexuality among married couples*. March 8(4): 10.

Schoepf, BG, Engundu, W, Wa Nkera, W, Ntsomo, P & Schoepf, C. 1990. Gender, power, and risk of AIDS in Zaire, in *Women and Health in Africa,* edited by M Turshen. Trenton, NJ: Africa World Press: pp 187-203.

Shagula, NM. 2006. Factors affecting voluntary counseling and HIV testing among pregnant women in Tsumeb Disctrict, Oshikoto Region, Namibia. South Africa: MPH thesis, University of the Western Cape.

Shisana, O, Rehle, T, Simbayi, LC, Parker, W, Zuma, K, Bhana, A, Connolly, C, Jooste, S, Pillay, V, *et al*. 2005. *South African national HIV prevalence, HIV incidence, behaviour and communication survey, 2005.* Cape Town: HSRC Press.

Swanepoel, P. 2006. Message strategies in corpus Dutch voluntary counselling and testing (VCT) campaign texts. *Journal of Language Teaching* 40 (1):241-249.

Thomas, JC. 2008. Behavioural strategies to reduce HIV transmission: how to make them work better. *Lancet* 372 (3): 669-84.

UNAIDS. 2006. *AIDS epidemic update.* Available at www.unaids.org: (Accessed on 17 March 2008).

UNAIDS. 2007. AIDS e*pidemic update.* Available at www.unaids.org/en/knowledgecentre/hivdata/EpiUdate/EpiUpdArchive/2007 (Accessed on 22 April 2008).

UNAIDS. 2008. *Report on the global AIDS epidemic.* Geneva: UNAIDS.

USAID. 2004. *Health profile: Zimbabwe.* Available at http://www.synergyaids.com/Profiles_Web/Profiles_PDFs/ZimbabweProfileDec2004.pdf (Accessed on 22 September 2008).

UNGASS. 2008**.** Country progress report: Zimbabwe Available at http://www.aidsportal.org/Article_Details.aspx?ID=7154 (Accessed on 22 September 2008).

Valente, TW. 2002. *Evaluating health promotion programs*. Oxford: Oxford University Press.

Van Dyk. AC & Van Dyk, PJ. 2003. What is the point of knowing? Psychosocial barriers to HIV/AIDS voluntary counselling and testing programmes in South Africa. *South African Journal of Psychology* 33(2): 118-125.

Women's Action Group. 2007. *WAG's role in the promotion of women's health in Zimbabwe.* Harare: WAG.

Ward, M. 1993. A different disease: HIV/AIDS and health care for women in poverty. *Culture, Medicine and Psychiatry* 17: 413-430.

Willig, C. 2001. *Introducing qualitative research in psychology: Adventures in theory and method.* Maidenhead: Open University Press.

World Health Organisation. 2005. *Zimbabwe country profile for HIV/AIDS treatment scale up.* Geneva: WHO.

World Health Organisation. 2008 *Fast facts about HIV treatment.* Geneva: WHO.

World Bank. 2004. *Education and HIV/AIDS. A sourcebook of HIV/AIDS prevention programmes*. Washington: World Bank.

*The Zimbabwe Young Adult Survey (YAS) 2001-2002***.** Harare: Central Statistical Office.

APPENDICES

APPENDIX A: Consent Form

APPENDIX A: INFORMED CONSENT

TITLE OF THE RESEARCH: Factors influencing VCT attendance among women in Glen View high density suburb in Harare

INVESTIGATOR: Precious Moyo, an MA Social Behaviour Studies in HVIV/AIDS student at University of South Africa under supervision of Dr Gretchen Du Plessis also of University of South Africa

INTRODUCTION: You are being asked to take part in a research study named above because you meet the criteria for enrolment into the study. This informed consent document gives you information about the study. You are free to decide not to take part in this study and you will not be prejudiced in any way. Please note that information obtained from this study may be used in future studies.

PURPOSE OF THE STUDY: It is important to understand the factors that determine whether an individual will decide to have an HIV test or not. In order to reduce the spread of HIV-infection, many people at risk of infection, particularly women, need to take the necessary prevention methods so that they protect themselves from heterosexually transmitted HIV. It is therefore vital to formulate strategies to investigate VCT uptake among women.

PROCEDURES: 100 randomly selected women will be asked to complete self administered closed ended questionnaires. The researcher will collect completed forms at an agreed date for data analysis. Completion of questionnaires will be done by the respondents at their households at any time convenient to her.

RISKS AND DISCOMFORTS: There are no risks or discomforts involved in this study.

CONFIDENTIALITY: Your research records will be kept confidentially to the extent permitted by UNISA law. You will be identified by a number only and your name will not be required. I will produce my student ID card to you when I distribute the questionnaire.

POTENTIAL BENEFITS: There are no direct potential benefits to you. This information will be useful for policy makers in the government departments. You will devote some of your time to completing the questionnaire.

CONTACT PERSON FOR PROBLEMS OR QUESTIONS: If you ever have questions about your rights as a research candidate please write to The Programme Coordinator, Unit for Social Behaviour studies in HIV/AIDS and Health, Department of Sociology, P O Box 392, UNISA 0003, or telephone +27122524116 South Africa.

SIGNATURE SECTION: If you have understood the consent form and are willing to participate in the research study, please sign below.

Respondent's name_____

Signature _____

Researcher's name_____

Signature_____

APPENDIX B: LETTER OF APPROVAL TO CONDUCT RESEARCH

11. MAY. 2009 12:36 Mail UZ UCSF PHILLIPS2 NO. 1302 P. 1/1

Researcher approved

825 McKenzie Way
Parktown
Harare

6 May 2009

The District Officer
Glen View District Office
Municipality of Harare
Glen View
Harare

RE: Request for permission to conduct research among women in Glen View high density suburb

My name is Precious Moyo and I am a second year student at UNISA. I am requesting for permission to conduct research in Glen View. I am studying for a Masters degree in Social Behaviour studies in HIV/AIDS. As part of fulfillment for the requirements of this degree, I am required to submit a dissertation. The topic of my dissertation is **Factors affecting VCT attendance among women in Glen View high density suburb.** The objectives of the study are to understand experiences and feelings that women go through when they visit VCT centres, to assess the knowledge that women have about VCT and to understand why some women do not go for VCT.

200 women will be randomly selected to answer self administered questionnaires relating to VCT uptake. Attached to this letter is the protocol version of my research project detailing study specific procedures.

Please let me know if you require any additional information to support this request.

Yours faithfully

Precious Moyo

→ D.O.: G/View District Office;
Sister-in-charge: G/View Polyclinic;

CITY OF HARARE
DEPARTMENT OF HOUSING AND COMMUNITY SERVICES
08 MAY 2009
P.O. BOX [illegible]

Please assist the researcher as much as you can.
Thanking you in anticipation.

APPENDIX C: QUESTIONNAIRE

Factors influencing VCT attendance among women in Glen View high density suburb in Harare, Zimbabwe.

Researcher's name	**Precious Moyo**
Respondent's number	
Date of interview	

The objectives of my study are to understand the experiences, feelings, knowledge and barriers to VCT uptake among women in Glen View. All respondents have been randomly selected, alternating between a young woman and an adult woman in each household. Before you respond to the questions, I would like to remind you that you will be asked sensitive questions about your life. Some of these questions may be difficult to answer, but I want to reassure you that all answers will be kept confidential and will be used for research purposes only. Your name does not appear on this questionnaire and, once all the answers have been captured, there is no link between you and the answer you have given. You are free to decline to respond to any questions if you feel so but please try your best to answer all questions. There are no right or wrong answers to these questions. Either a pen or pencil may be used to complete this questionnaire. I will collect the completed questionnaire at an agreed date.

Thank you.

SECTION A: BACKGROUND INFORMATION

Instructions: Please tick the appropriate box next to the answer option that applies to you.

1. In which age group do you fall?

(a) 18-20	1
(b) 21-25	2
(c) 26-30	3
(d) 31-35	4
(e) 36-40	5
(f) 41-45	6
(g) 46-49	7

2. What is your current marital status?

(a) Single	1
(b) Married in a monogamous relationship	2
(c) Married in a polygamous relationship	3
(d) Divorced	4
(e) Separated	5
(f) Widowed	6

3. Are you currently employed? Tick the answer box and write in the space provided.

(a) Yes Please write what kind of job you are doing in the space below: _____	
(b) No	8 8

4. What is your highest level of education? Tick the answer box and write in the space provided.

(a) Primary , *that means up to Grade 7*	1
(b) Secondary, *meaning Form 1 to from 6*	2
(c) Higher, *meaning post school*	3
(c) Tertiary, *meaning a university degree*	4

5. Do you have any children of your own? Tick the answer box and write in the space provided.

(a) Yes, if yes, how many(Please write number of children) _____	
(b) no	88

5.1 Are you currently pregnant? Tick the answer box and write in the space provided.

(a) Yes, if yes, how many months pregnant are you now?	
(b) no	88

5.2 Are you taking care of children (below the age of 18 years) who are not your own in your house/dwelling? Tick the answer box and write in the space provided.

(a) Yes, if yes, how many children do you take care of? Please write number of children)	
(b) no	88

6. What is your religion?

(a) Catholic	1
(b) Apostolic	2
(c) Pentecostal	3
(d) Protestant	4
(e) Traditional	5
(f) Other	6

7. Do you have any access to any of the following in your house?

	Yes	No
(a) radio	1	2
(b) television	1	2
(c) newspaper	1	2

SECTION B: KNOWLEDGE ON HIV TRANSMISSION AND PREVENTION

8. Can HIV (the virus that causes AIDS) be transmitted via: (Please tick all relevant boxes?)

	Yes	No	Don't know
(a) Sharing needles for injections with a person who has HIV?	1	2	3
(b) Having unprotected sexual intercourse with someone infected with HIV?	1	2	3
(c) During pregnancy and breastfeeding from an HIV-infected mother to her child?	1	2	3
(d) Via blood transfusion with HIV-infected blood?	1	2	3

9. How can a sexually active woman protect herself from getting infected with HIV? (Please tick all relevant boxes)

	Yes	No	Don't know
(a) Through abstaining from sex	1	2	3
(b) By getting tested for HIV	1	2	3
(c) By being faithful to one partner	1	2	3
(d) By using a condom each time she has sex	1	2	3
(e) Other (Please write other protection methods you know of)_____			

10. If you wanted to get an HIV-test, where will you go? Choose the main facility and tick the relevant box.

(a) VCT centre	1
(b) Hospital	2
(c) clinic	3
(d) Doctor's surgery/rooms	4
(e) Other (Please specify) 5	

11. What is the distance between your home and the place you will go to for an HIV-test or for VCT services?

(a) less than 2km (Go to Question 13)	1
(b) 2-4km (Go to Question 13)	2
(c) 4-6km (Go to Question 13)	3
(d) more than 6km (Go to Question 12)	4
(e) I would not go for an HIV-test or for VCT	5

12. If the distance your home and the place you will go to for an HIV-test or for VCT services is more than 6km, can you afford transport to go to the VCT centre?

(a) Yes	1
(b) No	2

SECTION C: EXPERIENCES OF VCT SERVICES

13. Where did you get information about VCT? Please mark all possible answers.

	Yes	No
(a) Heard about it on the radio	1	2
(b) Saw a programme about it on television	1	2
(c) Read about it in the newspaper	1	2
(d) Were told about it at the anti-natal clinic	1	2

14. Have you ever visited a VCT (voluntary counselling and testing for HIV) centre?

(a) Yes	1
(b) No if no go to 16	2

15. What was your reason for going to a VCT centre?

(a) Accompanying someone	1
(b) General Counselling	2
(c) Voluntary Counselling and testing go to 16	3
(d) Other	4

15.1. Do you think the staff observed confidentiality issues when you went for VCT?

(a) Yes	1
(b) No	2

16. What do you think are the benefits of getting tested for HIV? Tick all applicable.

(a) You can know your HIV status	1
(b) You can get treatment early	2
(c) You can reduce spreading the virus to others by change in behaviour	3
(d) You can plan for your future	4
(e) No benefits	5
(f) Other (please specify)_____	

17. Have you ever been tested for HIV virus?

(a) Yes	1
(b) No, if no go to Question 21	2

18. If yes how many months ago did you last get tested for HIV?

(a) 3-5 months ago	1
(b) 6-8 months ago	2
(c) 9-11 months ago	3
(d) 12 months or more ago	4

19. What was your MAIN reason for getting tested?

(a) I wanted to get pregnant/was pregnant	1
(b) I wanted to know my status	2
(c) It was upon my doctor's advise	3
(d) I was ill	4
(e) It was upon my partner's advice	5
(f) My partner tested HIV-positive	6
(g) Other (please specify)	

20. Would you go back to get tested for HIV again at the same centre you last tested at?

(a) Yes (go to 22)	1
(b) No, (go to 20.1)	2

20.1. If no at Question 20 why would you not go to the same VCT centre? Please write down your MAIN reason.

(a) lack of confidentiality./privacy	
(b) It's too far away	
(c) Waiting time is too long	
(d) The centre is located near my relatives	
(e) Other (please specify)	

21. Why have you never been tested for HIV? Please tick all relevant answer options.

	es	o
(a) I fear the stigma related to HIV and AIDS		
(b) I fear that my partner will reject me if I am positive		
(c) I already know my HIV status		
(d) My partner will accuse me of promiscuity		
(e) I do not think that I am at risk of being HIV-positive		
(f) I fear that if I am HIV-positive, I will become a victim of violence in my community		
(g) N/A I have been tested	88	

22. In general, what do you think is the MAIN reasons why a woman would have an HIV test?

(a) If she intends to get pregnant/is pregnant	
(b) If she wants to know her status	
(c) Upon her doctor's advise	
(d) When she is ill	
(e) Upon her partner's advise	
(f)If her partner tested HIV-positive	
(g) Other (please specify)	

23. In general, what do you think is the MAIN reasons why a woman would NOT have an HIV test?

(a) Lack of knowledge	
(b) Fear of rejection by her husband	
(c) Fear of positive test result	
(d) Too old to get tested	
(e) Fear of stigma and discrimination	
(f) Fear of dying if she discovers she is HIV positive	
(g) Fear of becoming a victim of violence against her if she has tested positive for HIV	
(h) Other (please specify)	

24. Have you ever heard of a woman who got tested for HIV but then did not collect her test results?

(a) Yes	
(b) No	

25. In general, what do you think is the MAIN reasons why a woman would have an HIV-test but then not collect her test results?

(a) Lack of knowledge	
(b) Fear of rejection by her husband	
(c) Fear of a positive test result	
(d) Fear of stigma and discrimination	
(e)) Fear of becoming a victim of violence against her if she has tested positive for HIV	
(f) Other (please specify)	

26. In general, what do you think about HIV testing among women? Give a brief explanation.

_____
_____
_____
_____
_____
_____
_____
_____
_____

THANK YOU VERY MUCH FOR YOUR TIME