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**REASONS FOR POST-CONCEPTION HUMAN IMMUNODEFICIENCY
VIRUS (HIV) TESTING AMONG PREGNANT WOMEN IN GABORONE,
BOTSWANA**

By

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A black and white photograph of a quill pen in an inkwell and several rolled-up scrolls of parchment. The quill is in a square glass inkwell in the upper right. Three scrolls of parchment are arranged diagonally across the page, with the largest one in the center. The word "DEDICATION" is printed on the top left scroll.

DEDICATION

I dedicate this study to

- **The most important person in my life, my daughter Jennifer Katso Makgopa and**
- **All the young people world-wide, who are faced with tough sexuality decisions in this HIV and AIDS era.**

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EXECUTIVE SUMMARY

Free voluntary counselling and testing (VCT) for Human Immunodeficiency Virus (HIV) by the international community and many African states is the entry point into HIV and Acquired Immunodeficiency Syndrome (AIDS) prevention, care, treatment and support. It is therefore worrisome that despite the Botswana government's multiple HIV preventative strategies, of the 56% Batswana who tested for HIV in 2008, only 34% know their status (National AIDS Coordinating Agency, Central Statistics Office & Ministry of Health, 2009:4). Among those who were tested, women outnumbered men, but even these women only had their HIV-status tested *when they were already pregnant* or when one of their children was suspected to have contracted AIDS, an observation that Hamblin and Reid (1991:4) has made years ago.

Ethical standards were followed to conduct a study, the purpose of which was to explore and describe the reasons why women in Gaborone only volunteered to go for VCT of HIV when they were *already pregnant*, instead of doing so *before* they conceived.

An exploratory, descriptive, qualitative and contextual design was used. Participants who met the sampling criteria were interviewed and data was audio-taped before transcription and analysis. An independent coder was involved to confirm the themes and sub-themes before relevant literature was searched. Strategies of trustworthiness were adhered to in the study (Lincoln & Guba, 1985:289-331).

Findings revealed that the most significant reason for participants not testing for HIV prior to pregnancy was fear of consequences of an HIV-positive result, such as stigma and discrimination against them by their partners, families and communities should they test HIV-positive. Another reason was the socio-cultural beliefs, norms and values expressed in different forms. However, once they fell pregnant, they had themselves tested because their fear of losing their babies to HIV overruled their fear of being ostracised by anybody else.

Based on the findings, guidelines were formulated to assist midwives and HIV and AIDS counsellors to facilitate uptake of VCT of HIV prior to pregnancy among childbearing women and men from as young as +15 years. Conclusions were drawn and recommendations made concerning midwifery practice, education and possible further research on this topic on a larger scale.

KEY WORDS: Batswana; Botswana; Conception; HIV; HIV/AIDS counsellor; Midwife; Motswana; Pre-conception; Post-conception



OPSOMMING

Gratis vrywillige berading en toetsing (VBT) vir Menslike Immuniteitsgebrekvirus (MIV) deur die internasionale gemeenskap en baie Afrika-state is die intrepunt in die voorkoming, versorging, behandeling en ondersteuning van MIV en Verworwe Immuniteitsgebrek Sindroom (Vigs). Dit is dus kommerwekkend dat, ondanks die Botswana-regering se veelvuldige MIV-voorkomende strategieë, van die 56% Batswana wat in 2008 vir MIV getoets is, slegs 34% hul status ken (National AIDS Coordinating Agency, Central Statistics Office and Ministry of Health, 2009:4). Van dié wat hulself laat toets het, het die vrouens die mans in getal oortref, maar selfs die vrouens het hul MIV-status laat toets *nadat hulle reeds swanger geraak het* of wanneer een van hul kinders Vigs opgedoen het, volgens 'n waarneming wat Hamblin en Reid (1991:4) 'n geruime tyd gelede gemaak het.

Etiese standaarde is gevolg om 'n studie te doen, waarvan die doel was om die redes waarom vroue in Gaborone slegs sover kom om vir VBT van MIV te gaan wanneer hulle *alreeds* swanger is, in plaas daarvan om dit doen *voor* hulle swanger raak, te verken en te beskryf.

'n Ondersoekende, beskrywende, kwalitatiewe en kontekstuele ontwerp is gebruik. Onderhoude is gevoer met deelnemers wat aan die steekproefkriteria voldoen het en die data is op oudioband vasgelê voordat dit getranskribeer en ontleed is. 'n Onafhanklike kodeerder was betrokke om die temas en subtemas te bevestig voordat toepaslike literatuur bestudeer is. Strategieë vir betroubaarheid is in die studie nagekom (Lincoln & Guba: 1985:289-331).

Bevindinge het getoon dat die belangrikste rede vir deelnemers om nie hulself vir MIV voor swangerskap te laat toets nie, was vrees vir die gevolge van 'n MIV-positiewe uitslag, soos die stigma en diskriminasie teen hulle deur hul lewensmaats, gesinne en gemeenskappe indien hulle MIV-positief sou toets. Nog 'n rede was die sosiokulturele opvattinge, norms en waardes wat in verskillende vorms verwoord is. Wanneer hulle egter swanger raak, laat hulle hulself toets omdat die vrees om 'n baba aan MIV te verloor soveel sterker is as die vrees om deur ander verstoort te word.

Gebaseer op die bevindinge is riglyne geformuleer om vroedvroue en MIV- en Vigs-beraders te help om die opname van VBT van MIV voor swangerskap onder kinderbarende vrouens en mans van so jonk as \pm 15 jaar te fasiliteer. Gevolgtrekkings en aanbevelings is gemaak oor verloskundepraktyk, voorligting en moontlike verdere navorsing oor hierdie onderwerp op 'n groter skaal.

SLEUTELWOORDE: Batswana; Botswana; Bevrugting; MIV; MIV/Vigs-berader; Vroedvrou; Motswana; Voor-bevrugting; Na-bevrugting



LIST OF ACRONYMS

ACHAP:	African Comprehensive HIV/AIDS Partnerships
AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Antenatal Care
ART/ARV:	Antiretroviral Therapy/ Antiretroviral(s)
BAIS:	Botswana AIDS Impact Survey
BNSF:	Botswana National Strategic Framework
BOTUSA:	Botswana/United States of America
CDC:	Centre for Disease Control
DENOSA:	Democratic Nurses Association of South Africa
HBC:	Home-based Care
HIV:	Human Immunodeficiency Virus
HRU:	Health Research Unit
IEC:	Information, Education and Communication
IPPF:	International Planned Parenthood Federation
I-TECH:	International Training & Education Centre on HIV
MCH/FP:	Maternal Child Health and Family Planning
MDG:	Millennium Development Goal
MOH:	Ministry of Health
MTCT:	Mother-to-child transmission of HIV
NACA:	National AIDS Coordinating Agency (Botswana)
NEPAD:	New Partnership for Africa's Development Dialogue
PLHIV:	People Living With HIV and AIDS
PMTCT:	Prevention of Mother-to-Child Transmission of HIV
PSI:	Population Services International
SADC:	Southern African Development Community
SRH:	Sexual and Reproductive Health
TBA:	Traditional Birth Attendant
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNGASS:	United Nations General Assembly Special Session

UNDP: United Nations Development Programme
UNFPA: United Nations Population Fund
UNICEF: United Nations Children's Fund
VCT: Voluntary Counselling and Testing
VHC: Village Health Committee
WHO: World Health Organization



CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND OF THE STUDY

Concerns that the world, especially Africa, could be losing the war against HIV and AIDS should never be underestimated. The reasoning behind this concern is that no disease, environmental condition or situation around the world had up until now attracted so much attention and resulted in the spending of so many millions of money in three decades and yet with such limited progress. Fredriksson and Kanabus (2005:1) are some of the researchers who have observed that many countries in Sub-Saharan Africa have until now failed to bring the epidemic under control. For example, the Botswana AIDS Impact Survey (BAIS) III of 2008 revealed that Botswana's prevalence rate has increased from 17.1% in 2004 to 17.6% in 2008 despite their multi-sectoral and multi-level response efforts (National AIDS Coordinating Agency (NACA), Central Statistics Office (CSO) & Ministry of Health (MOH), 2009:1).

In contrast with the above statement, the Southern African Development Community (SADC) HIV and AIDS Unit (2004) reported that most SADC member states are recording stabilised prevalence rates among the youth due to increased condom use and an increase in VCT of HIV and antiretroviral treatment (ARV). This positive feedback is received from countries that developed their national strategic plans, policies and programmes. Some amended their legal frameworks to prevent the spread of HIV, to mitigate its impact and to provide care and support to those infected and affected by HIV and AIDS.

The battle against HIV and AIDS started with the United States of America and Europe diagnosing their first cases of HIV as early as 1981 among homosexual men, injection-drug users and haemophiliacs (Essex, Mboup, Kanki, Marlink & Tlou, 2002:1). The disease, however, was diagnosed among heterosexuals in Botswana by 1985 although the campaign against AIDS only started in 1987 (ACHAP, NACA & UNAIDS, 2008:8). These authors

indicated that by December 2007, an estimated 33.2 million people were living with HIV globally; among them 22.5 million adults and children from Sub-Saharan Africa.

As part of Sub-Saharan Africa, South Africa has about 5.5 million people infected with HIV, of which 240 000 are children under the age of 15 years (Shu-Acquaye, Mbanya & Chungong, 2008:4). These authors continue to report that Swaziland has the highest prevalence in the world (33.3%), hence half of the beds in that country's health facilities are said to be occupied by People Living with HIV and AIDS (PLHIV). Tanzania's prevalence among hospitalised patients was estimated at 33%, making HIV infection the main cause of illness leading to hospitalisation (Fredriksson & Kanabus, 2005:1).

In Botswana, National AIDS Coordinating Agency (NACA) (2003-2009:16) and NACA (2008:1) estimated that 296 360 of the 1.7 million Batswana are living with the HI virus, out of which 140 000 are women and 14 000 children. The majority of these HIV-infected women are said to be of childbearing age, that is, 15–49 years old. They constitute over 35% of Batswana adults aged 15–49 who are reported to be HIV-positive, and yet most of them are unaware of their positive status (NACA, 2003-2009: 15 -16).

According to Fredriksson and Kanabus (2005:2), prolonged undiagnosed HIV leads to lengthy hospital stays, staff shortages and staff burn-out in hospitals as patients tend to be admitted at a later stage of illness when their chances of survival are limited. This contributed to 2.3 million people dying of AIDS in sub-Saharan Africa, accounting for three quarters of the total global toll of 20 million AIDS deaths in 2002 which has now increased to 25 million since the epidemic started (Essex et al., 2002:200 and Shu-Acquaye et al., 2008:4).

In response to these documented deaths, most governments put in place almost similar measures to contain the pandemic. The Botswana government started by declaring HIV and AIDS a national emergency and by 2005 this government had responded by putting in place the following preventative measures: 16 operational VCT centres in urban areas and major villages with two mobile caravans to reach remote areas in the north and south of the country; 634 Prevention of Mother-to-Child Transmission of HIV (PMTCT) sites countrywide since

1999; peer education in schools and workplaces; mass media educational efforts and inclusion of HIV/AIDS in the curricula of lower and higher learning institutions, e.g. Talk Back and HIV seminars for exiting graduates. Care and support included palliative treatment (ARVs now accessed in 29 sites in major hospitals and satellite clinics since 2002); Home-based Care (HBC) in all villages and orphan care programmes for the infected and affected children countrywide (NACA, UNDP, ACHAP & CSO, 2005:2, 247; NACA, 2003-2009:1-2 and NACA, 2008:4). Routine VCT of HIV was also introduced in all health facilities in 2005.

In addition to these programmes, the Botswana government has also put into place structures to plan for and monitor the services with assistance of development partners. For example, the NACA Department, under Office of the President, plans, monitors and reports on HIV prevention, treatment, care and support activities country-wide at technical level. Then there is the District Multi-Sectoral AIDS Committees (DMSAC) that carry out NACA activities on the ground involving all government ministries, non-governmental and private sectors (NACA & CSO, 2004:247). Traditional leaders, faith-based organisations and the community also became involved to curb the spread.

Studies and surveys were carried out by the same governments to determine whether the programmes were utilised and whether they were effective in curbing the spread of HIV/AIDS (NACA, ACHAP & CSO, 2005:245-247). Simpson, Johnstone, Boyd, Goldberg, Hart, Gormley and Hamilton (1999:3) reported that there was mounting evidence that VCT of HIV among pregnant women in antenatal care (ANC) clinics was in growing demand.

A study in Rwanda, among a large group of childbearing women who received voluntary HIV counselling and testing, reported a significant increase in condom use, while Uganda was reported to have managed to stabilise its HIV prevalence through VCT. Kenya and Tanzania's VCT of HIV and AIDS service was also reported to be in demand though not always accessible (Sweat, Gregorich, Sangiwa, Furlong, Balmer, Kamenga, Grinstead & Coates, 2000:113-121).

Although Botswana has challenges like acute shortage of trained personnel for programmes like ARVs (Fredriksson & Kanabus, 2005:2), the following positive factors have been identified as per Ministry of Health and UNICEF Botswana (2002:3- 4) and NACA, ACHAP & CSO (2005:245–247):

- The rate of condom use was found to be very high after VCT (70% for women and 77% for men).
- The public was aware that AIDS can be avoided (98.4% for women and 96.7% for men).
- There was an increase in uptake of VCT of HIV by pregnant women after introduction of ARV therapy (the number of women counselled during ANC in January 2000 increased from 4 000 to nearly 24 000 in December 2001).
- The number of people receiving Zidovudine (AZT) increased from 221 to 2 244 in the same time period.
- Of the 7 000 ANC attendances in one of Botswana's districts, 60% received VCT while 46% of them accepted the test and 56% of the tested ended up taking AZT.

From these data, it is evident that the Botswana government and other countries have come a long way in trying to combat the scourge of HIV and AIDS by informing the people and putting mechanisms in place to curb the spread of this disease. This is why the researcher was perplexed as to why women volunteer to go for HIV testing *post*-conception instead of *prior* to conception if the information and systems are in place.

1.2 STATEMENT OF THE RESEARCH PROBLEM

Despite positive findings that women do utilise VCT of HIV services in larger numbers than men both in Botswana and at regional level, it is worrisome that they do so *post*-conception (post-exposure to HIV infection).

VCT of HIV, regardless of whether it is done by males or females, is considered a cost-effective component of national HIV prevention and thus governments and non-governmental organisations (NGOs) have tripled their efforts in providing this service

globally (Ministry of Health (MOH)-Botswana, BOTUSA-CDC and International Training & Education Centre on HIV (I-TECH), 2004:58). Moreover, the cost involved in preventing one from becoming infected with HIV through VCT is likely to be substantially *less* than the cost of treatment for that one person, not to mention the non-economic costs like physical suffering or the psycho-social impact that being infected has on the individual, his/her family and community (Sweat et. al., 2000:113-121).

Studies were done in Kenya and Tanzania on the cost-effectiveness of VCT of HIV and the results from both countries reported that VCT of HIV is not only cost-effective economically, but also provides the individual with the opportunity to protect him/herself and others and to plan for the future (Sweat et al., 2000:113-121). MOH-Botswana, BOTUSA-CDC & I-TECH (2004:58) also agreed that knowledge about one's HIV status allays anxiety; that early detection of HIV improves medical and psychological support for the infected and that it promotes behaviour change for both the negative and the positive. Therefore the researcher believes it is beneficial for women and their partners to test for HIV prior to pregnancy.

NACA (2008:6) also reiterates that HIV testing lays the foundation and serves as an entry point for utilisation of other national response programmes, particularly care, treatment and support. This author also subscribes to the fact that, to some extent, timeous testing for HIV triggers behaviour change as the negative may strive to remain negative while the positive may take deliberate measures to live positively and delay onset of treatment, as well as avoiding possible re-infection.

When reviewing the effectiveness of PMTCT of HIV and ARV programmes in Botswana (programmes that one cannot utilise unless they have undergone VCT), Dr Randall from the University of California concluded that Botswana's adult HIV mortality rate has declined significantly since the roll-out of free ARV therapy (8% in 2003/04 and 20% in 2004/05); hence a decline in absenteeism at work, expenses on funerals and fewer people being on Home-based care. An overall decline in HIV prevalence among pregnant women at ANC sites has also been noted; from 37.4% in 2003 to 33.4% in 2005 (NACA, ACHAP, BOTUSA & UNAIDS, 2005: 30). This shows that volunteering for VCT of HIV can be lifesaving as

these same authors estimated that the implementation of a comprehensive HIV prevention package could avert 29 million (63%) of the 45 million new infections expected to occur between 2002 and 2010. It is not only about the life of the individual or their significant other, but goes all the way to save the economy both in the home and at country level because treatment and care of the infected and affected is expensive.

The problem however remains that, even though VCT of HIV is confirmed to be a beneficial strategy for preventing HIV in Botswana and elsewhere, and that indeed women increasingly utilise the service more than men, the researcher has observed that many still only do it when they are already pregnant (first-time HIV-testers). An anonymous report (Anon¹. 2004:35) confirms this observation by stating that increasing numbers of women in Botswana discover their HIV status at ANC clinics when they went to register their pregnancies. The following question is thus asked: *What are the reasons for VCT of HIV post-conception among pregnant women in Gaborone, Botswana?*

1.3 RESEARCH GOAL/OBJECTIVES

The purpose of this study is to explore and describe the reasons why women in Gaborone volunteer to go for HIV testing when they are *already* pregnant, as opposed to doing so *before* they conceive. Understanding their reasons will help in the formulation of guidelines which will assist midwives and HIV/AIDS counsellors in facilitating the uptake of voluntary pre-conception HIV testing among childbearing women from an early age.

1.4 DEFINITION OF KEY CONCEPTS: Batswana; Botswana; Conception; HIV; HIV/AIDS counsellor; Midwife; Motswana; Pre-conception; Post-conception

Batswana: Plural of Motswana which refers to citizens of Botswana.

Botswana: A country officially called Republic of Botswana; landlocked by South Africa on the south and south-east; Zambia and Zimbabwe on the north-east and Namibia on the north and west (Microsoft® Encarta® Encyclopedia, 2003).

Conception: Refers to union of an ovum and a spermatozoon to begin a new life or the act of becoming pregnant (Freshwater & Maslin-Prothero, 2005:143)

HIV: Is a membrane-enveloped member of the Retroviridae family of viruses (commonly known as retroviruses), classified in the subfamily of lentiviruses because of their slow gradual action. Human infection with HIV results in a complex clinical disease known as Acquired Immune Deficiency Syndrome (AIDS) (Willis, 2002; Microsoft® Encarta® Encyclopedia, 2003).

HIV/AIDS counsellor: A professionally trained social worker or a trained lay counsellor who is assigned to work in health facilities to offer individual clients or couples voluntary counselling and testing of HIV with the aim of enrolling them in PMTCT of HIV or ARVs.

Midwife: In Botswana midwife refers to a Registered Midwife who is registered in the Botswana Nursing and Midwifery Council Register of nurses and midwives after passing the examinations set from a curricula prescribed by the board (currently midwifery students undergo 18 months of training) (Nurses and Midwives Act of 1967:61:48 & 61:51).

Motswana: In the context of this study, a citizen of Botswana either by birth or naturalisation.

Post-conception HIV-testing: In the context of this study this refers to VCT of HIV by pregnant women, which is dependent on ANC services and is offered by government, parastatals or private sector.

Pre-conception HIV Testing: Also refers to VCT of HIV for non-pregnant women, which is independent of ANC services and is offered by government, parastatals or private sector as per this study's context

1.5 RESEARCH DESIGN AND METHODS

An exploratory, descriptive, qualitative and contextual study will be used to gain insight into, and understand reasons that prevented pre-conception HIV testing among women in Gaborone City Council clinics in Botswana (Creswell, 1994:162).

1.5.1 Population

Talbot (1995:241) defines a population as a group whose members possess specific attributes that the researcher is interested in studying. In this study, the population will be identified as pregnant women aged 21-49 years who had taken the HIV test for the first time during the current pregnancy, regardless of their HIV status outcome. The minors (<21 years) will be excluded due to the sensitivity of the study (being pregnant and taking an HIV test). The target population therefore will be HIV-tested pregnant women who attend ANC in Gaborone City Council clinics of Broadhurst 3, Block 9, Village (Extension 15) and Old Naledi.

1.5.2 Sampling

Sampling refers to selecting a group of elements (people, events or behaviours) with which to conduct a study, with certain sampling criteria that must be met (Burns & Grove, 2005:750). Purposive and convenient sampling will be used, whereby the researcher will consciously select and invite readily available pregnant women, who meet the sampling criteria and are willing to participate in the study (Brink, 2000:140 - 141). Purposive sampling helps to identify information-rich participants who can supply data required to answer the research question (Crowley in Mothibe, 2001:16).

In the interview room, the research goals and objectives will be further clarified to participants. Verbal informed consent will be obtained before interviews (written consent was not considered to ensure absolute anonymity). Appointments will be booked to interview those who had volunteered at a date and time of their convenience. Data will be collected from participants until saturation of data is obtained (Morse, 1991:135).

1.5.3 Method of data collection

In this study, phenomenological interviews will be used to collect data from selected participants. Interviewing involves verbal communication between the researcher and the participant, during which information is provided to the researcher (Burns & Grove,

2005:396). The researcher will thus seek the participants' verbal consent to interview them face to face and to record the interview on the audiotape. The tape will be placed in a non-obstructive (non-intimidating) manner for easy capturing of data by the interviewer (Morse & Field, 1999:77).

An interview allows the interviewer the opportunity to observe the correlation between the participants' verbal and bodily responses (more especially in this case where participants discussed their sexual and reproductive health and behaviours with a stranger). The researcher will be empathetic and understanding about the participants' feelings, their views about reality, their level of understanding and, above all, their values. Therefore questions will be rephrased or the interview stopped whenever the participants seem uncomfortable or emotional (Rubin & Babbie, 1998:374).

The researcher will conduct the interviews in Setswana, English or both, depending on the participant's preference. Safer topics such as demographic data will be discussed before the study's central question is addressed to help relax the participants (Burns & Grove, 2005: 396). The central question is **"Please share with me the reasons why you volunteered to undergo HIV testing when you were already pregnant and not before you fell pregnant."** Depending on the participants' response, this question shall be followed by non-invasive, relevant and probing sub-questions which will encourage participants to advance more detailed and useful information than they have volunteered in their first responses (Polit & Beck, 2006:507).

Brink (2000:158) says further probing increases detailed exploration into finding answers to the research question or the topic that is being discussed. The researcher will also utilise paraphrasing of remarks, responsive listening, minimal verbal response, reflecting, summarising, communicating and silence to elicit maximum information from the participants. Participants will finally be given a chance to ask questions to clarify whatever information will be of concern to them.

Field notes comprising of important observations like crying, hesitation, laughing or other non-verbal cues displayed by participants will be noted and will be made part of the data analysis. The researcher will also document reflective and personal notes that will include the researcher's personal experience, reflections and progress while in the field as well as the researcher's own feelings during the research process (Polit & Beck, 2006: 306).

1.5.4 Data analysis

Burns and Grove (2005:733) state that data analysis is conducted to reduce, organise and give meaning to raw data collected. The researcher will take the voluminous amount of data collected, transcribe it verbatim, translate it from Setswana to English and back into Setswana again to ensure trustworthiness of the transcription. The data will then be reduced into certain patterns, categories and themes by clustering and coding it; and finally interpret it by using Tesch's steps of analysis as outlined in Creswell (1994:155-156). Refer to *Chapter 2 for details of data analysis and Chapter 3 for analysed data.*

Field notes and observations will be analysed in conjunction with recorded interviews. The themes and sub-themes identified in the whole data will be discussed with the external coder to confirm whether they reflect the participants' input. The findings of the study will then be discussed by way of themes and sub-themes, with supporting local and international literature and quotes from respondents to substantiate the findings.

1.5.5 Literature control

Literature control will be done to place the findings of the study in the context of what was already known. Thus, conclusions from different researchers who conducted relevant studies related to reasons why pregnant women volunteer for HIV testing after they have fallen pregnant will be discussed. The discussion will be done in relation to findings of this study to strengthen its trustworthiness, and by comparing and combining both findings the current trends will be determined. Phenomenologists believe that literature should be reviewed after

data collection and analysis so that the information in the literature does not influence the researcher's openness about the current study (Burns & Grove, 2005:95).

1.5.6 Trustworthiness

Lincoln and Guba's (1985:290) criteria for establishing the trustworthiness of qualitative data will be used in this study. It includes using the criteria of credibility, transferability, dependability and confirmability (Polit & Beck, 2006:511), all of which shall be discussed in depth in **Chapter 2**.

The trustworthiness of this study has been achieved by having two supervisors throughout the process and it will be further achieved by availing the collected raw data and relevant supporting documents to the external reviewer for discussions and validation if necessary.

1.6 ETHICAL CONSIDERATIONS

Ethical considerations in this study will include ethical conduct towards participants who are dealing with two sensitive issues – HIV and pregnancy. Fair identification of participants, precise collection of data and honest reporting will be adhered to.

The researcher will therefore obtain permission to conduct the research from the following stakeholders:

- University of Johannesburg's Ethics Committee and Higher Education Committee (see Annexure B - Clearance Reference Number 17/07).
- Botswana Government (Ministry of Health/Health Research Unit (HRU); Department of Health Sector Relations & Partnerships; Ministry of Local Government and Gaborone City Council clinics' management) (see Annexure D - Reference No: PPME- 13/18 US Vol II (12)).
- Participants (verbal consent to safeguard their confidentiality and partial anonymity).

The researcher will adhere to the following:

- The Botswana Attorney General Chamber's guidelines regarding patients' rights to privacy (BOTUSA, CDC & UNICEF handbook, 2002:70).
- Ethical standards of the Democratic Nursing Organization of South Africa (DENOSA, 1998:7), which calls for the recognition and protection of the human rights of the participants.
- The research guidelines of the University of Johannesburg (UJ) previously called Rand Afrikaans University (Rand Afrikaans University, 2001:1-4).
- The five human rights protection regulations (right to self-determination; privacy; anonymity and confidentiality; fair treatment and protection from discomfort and harm), based on the three principles of respect for persons, principle of beneficence and principle of justice as outlined in Burns and Grove (2005:176-208) – see details in Chapter 2).

1.7 VALUE OF RESEARCH

No research has yet been done to determine the reasons why women in Gaborone, Botswana do not go for pre-conception HIV counselling and testing. The researcher hopes to gain insight into this problem in order to contribute to a possible larger study, which may improve VCT of non-pregnant women through utilisation of written guidelines. The findings of this research will be communicated to all the relevant stakeholders in Botswana.

1.8 SUMMARY

This chapter introduced the topic "Reasons for volunteering for post-conception HIV testing among pregnant women in Gaborone, Botswana" and gave an overview of the topic under study. The research aimed at exploring and describing the reasons that led to pregnant women in Gaborone City Council clinics volunteering to go for HIV testing when they were *already* pregnant, the findings of which are to assist the researcher in formulating guidelines for midwives and HIV counsellors to improve uptake of VCT of HIV among women of childbearing age before they conceive, to help reduce the spread of HIV and AIDS in the process.

1.9 CHAPTER DIVISION

CHAPTER 1: OVERVIEW OF THE STUDY

CHAPTER 2: RESEARCH DESIGN AND METHODS

CHAPTER 3: DISCUSSION OF RESULTS AND LITERATURE CONTROL

**CHAPTER 4: DESCRIPTION OF GUIDELINES, RECOMMENDATIONS,
LIMITATIONS, CONCLUSION AND BIBLIOGRAPHY**



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CHAPTER TWO

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

In chapter two the focus is on the description and justification of the research design and methodology, the purpose of which is to achieve greater control of the study findings by focusing on improving the precision of measurement (Burns & Grove, 2005:40).

Also detailed in this chapter is a description of the population and sample selection, the trustworthiness of the interview guide and an explanation of how the data-collection and data-analysis procedures were carried out.

The purpose of this study was to explore and describe the reasons why women in Gaborone volunteered for HIV testing when they were *already* pregnant, as opposed to doing so *before* they conceived. Understanding their reasons assisted the researcher in formulating guidelines for **pre-conception HIV testing**, which might help midwives and HIV/AIDS counsellors to facilitate uptake of voluntary pre-conception HIV testing among childbearing women from a younger age.

2.2 RESEARCH DESIGN AND METHODS

2.2.1 Research design

The research design organises all the components of the study in a way that is most likely to lead to valid answers to the questions that have been posed (Burns & Grove, 2005:228). The method adopted for this study therefore was a qualitative, exploratory, descriptive and contextual design. This design was appropriate as it generated new knowledge since little was known about the phenomenon under study in Botswana (Burns & Grove, 2005:44).

This method helped the researcher to gain insight into and understand reasons why women in Gaborone volunteered for post-conception HIV testing, as opposed to pre-conception testing.

2.2.1.1 Qualitative approach

Qualitative researchers are interested in understanding how things occur and how meanings and interpretations are negotiated with human data, because it is the participants' realities that the researcher tries to construct (Mothibe, 2001:14). LoBiondo-Wood and Haber (2002: 498) elaborate further by reporting that qualitative research deals with human experiences; that it is often conducted in natural settings and uses data that are words or text rather than numerical in order to describe the experiences that are being studied. It therefore enables the researcher to build a complex and holistic picture through the analysis of words and by reporting specific views of the informants after conducting the study in a natural setting where human behaviour and events occur (Segeel, 2005:22). In this study, the researcher tried to understand and describe reasons why pregnant women in Gaborone volunteered for post-conception HIV testing, without attaching the researcher's own reasoning to their responses.

2.2.1.2 Exploratory

The study was exploratory because it sought to gain new insights to comprehend reasons why women volunteered to take an HIV test post-conception as opposed to pre-conception. Mouton and Marais (in Kgokgothwane, 1998:14) state that the researcher should be willing to study new ideas and possibilities and not allow predetermined ideas to direct the study. Hence the researcher should "tell it as it is" after exploring the reasons advanced by the participants.

2.2.1.3 Descriptive

The purpose of descriptive research is the exploration and description of phenomenon in real-life situations. This process allows concepts to be described and relationships identified that

provide a basis for further research and theory testing (Burns & Grove, 2005:44). The study was therefore descriptive, as the researcher will narrate what each individual woman stated as her reason for having gone for HIV testing when she was already pregnant. Mouton and Marais (in Kgokgothwane, 1998:14) also state that descriptive research provides an accurate portrayal or account of characteristics of a particular individual or group. Thus the researcher explored and described each individual woman's reasons regarding the phenomenon under study.

2.2.1.4 Contextual

The study was conducted with participants from different backgrounds in terms of place of origin, educational status, socio-economic status etc. In addition, the setting of the study (Gaborone city) also had an influence on their responses as they reside in different locations in the city which is basically divided into the elite and the lower class. One should thus appreciate how diverse their knowledge, values and attitudes towards pre-conception HIV-testing were. It is imperative to note that the context of the findings of this study is based on the fact that it is a qualitative study and that the findings are unique to this study. The researcher therefore has no intention of generalising the findings to a larger population. Instead, a description of the reasons why women in Gaborone did not take up pre-conceptual HIV testing is described within their specific context (Mouton, 2002:133).

2.2.2 DATA COLLECTION

The research method included the population sampling, data collection, data analysis, criteria for trustworthiness and ethical considerations.

2.2.2.1 Population

Talbot (1995:241) defines a population as a group whose members possess specific attributes that the researcher is interested in studying. In this study, the target population was identified as pregnant women, aged 21-49 years old, who had taken the HIV test during their current

pregnancy, regardless of their HIV status outcome. The accessible population therefore was a portion of this target population who met the inclusive criteria as stated in 2.2.2.3.

2.2.2.2 Sample selection and size

Sampling refers to selecting a group of elements (people, events or behaviours) with which to conduct a study, with certain sampling criteria that must be met (Burns & Grove, 2005:750). The researcher used purposive and convenient sampling techniques to conveniently select the available sample that meet the criterion because they help in identifying information-rich participants who supply data required to answer the research question (Crowley *in* Mothibe, 2001:16). The participants therefore were pregnant women who had taken an HIV test for the first time in their life during their current pregnancy and were attending maternal-child health services in the chosen Gaborone City Council clinics during the interview period.

The norm in Botswana is such that clients always assemble in the reception area of the health facility for morning prayers and health-related messages before the day's work starts. The researcher used these fora to establish rapport and develop trust among the potential participants, by addressing maternal-child health issues for some weeks before and after data was collected.

The strategy was meant to prevent the researcher from being seen as a stranger by the participants during data-collection, lest they felt intimidated. Feelings of intimidation and betrayal may emerge due to the fact that being HIV-positive and pregnant can be emotionally threatening, especially to women who test for the first time and are probably not ready to disclose their HIV status to anybody but their counsellors. Participants who met the inclusive criteria stipulated in 2.2.2.3 were invited to participate in the study as per article 2.2.2.4.

Data were collected in this manner until no new information was obtained (saturation of data), as Mothibe (2001:16) states that qualitative research's adequacy of the sample refers to information adequacy and not the number of participants.

2.2.2.3 Inclusion Criteria

The inclusion criteria assist the researcher in remaining unbiased, and thus one avoids contamination of data by participants who do not possess the relevant characteristics for the study (Mothibe, 2001:18). The following criteria were used to select the participants:

- Pregnant women aged 21-49 years old because of their frequent sexual activity, increased expectation of fertility and being at risk of contracting HIV at the time of conception since most women have sexual relationships or marry in this age bracket (IPPF, UNFPA, Global Coalition on Women and AIDS & Young Positives, 2006:0). Pregnant women under 21 years of age were excluded from the study as they are regarded as minors in Botswana. Including them would have meant that the parents' permission had to be obtained before they could participate in the study. Due to the fact that their permission would be difficult to obtain, the researcher excluded them from this study.
- Confirmed post-conception HIV-test in the current pregnancy regardless of the HIV status (never tested before in her life).
- Attending ANC in the chosen Gaborone City Council clinics (Broadhurst 3, Block 9, Village (Extension 15) and Old Naledi for easy access to the researcher.
- Being a Botswana citizen and able to converse fluently in Setswana or English, because although non-Batswana are offered VCT, they are not offered free PMTCT or ARV in Government health facilities, the interviews were translated into English as the co-coder and supervisors speak and understand only English and no Setswana.
- Pregnant women who were voluntarily willing to participate in the study.

2.2.2.4 Method of data collection

Data collection in this study involved the researcher asking a single central question, listening to responses and asking further probing questions related to the study in the interview room. As participants narrated their reasons for taking post-conceptual HIV tests versus pre-conception testing, their responses were recorded for later transcription and

translation. The process is described under the following headings: phenomenological interview, field notes and the role of the researcher.

Phenomenological interviews: Interviewing involves verbal communication between the researcher and the participant, during which the researcher is provided with information (Burns & Grove, 2005:396). In this study, the researcher sought the participants' verbal consent to conduct the interviews and to audio-tape them. It was explained to the participants that the use of the tape was solely to capture all the data quickly and accurately during the interview process without interruptions or slowing down the participant, like when one takes notes. On being granted permission, the tape was placed on the table between the researcher and the participant in a non-obstructive (non-intimidating) manner for data capturing.

Segeel (2005:27) states that qualitative interviewing is an intentional way of finding out what people feel and think about their world. The researcher therefore interviewed the participants in Setswana or in English or both, depending on their language preference, to allow them freedom to describe their reasons without any language barrier. The responses were later transcribed verbatim and translated into English for understanding by the co-coder, the supervisors and ultimately the research consumers at large.

The researcher started the interview with safer topics such as demographic data, although these were obtainable from the ANC card, to help relax the participants before addressing the central question of the study (Burns & Grove, 2005:396). This also enabled the researcher to determine the participants' profile in order to match the level of the interview to the level of the participant, without distorting the real meaning behind the research study as the central question remained **“Please share with me the reasons why you volunteered to undergo the HIV test when you were already pregnant and not before you fell pregnant”**.

Depending on the participants' responses, this question was followed by relevant non-documented probing sub-questions and silence to encourage them to advance their reasons such that, at the end of the interview, the researcher had collected useful information that

attempted to answer the study's concerns. Brink (2000:158) says further probing increases detailed exploration into finding answers to the topic that is being discussed.

The researcher, however, observed the participants' bodily responses and non-verbal cues during the interview process, which in this study hinted at the participants' attitude or discomfort related to HIV and pregnancy as they are sensitive issues in Botswana. In instances where participants showed or voiced emotional discomfort, questions were rephrased, left unanswered or the interview abandoned to protect the participants from harm as Polit & Beck (2006: 87) has put forth that ethical researchers must be prepared to terminate their research if they suspect that continuation would result in injury, death or undue distress to study participants.

Field notes: As field notes are the most important aspect of data collection and analysis, the researcher scribbled them down as soon as each interview was over to capture observations such as contradictory statements, non-verbal cues, hesitations, nodding, crying, laughing etc displayed by the participants (Morse & Field, 1999:91-93). The researcher also documented personal notes, which included reactions, reflections and experiences during the course of the interviews. Creswell (1994:152) describes reflective notes as an opportunity for the researcher to record personal thoughts such as suppositions, feelings, intuition, biases etc, which can actually influence the findings of the study if they are not acknowledged and kept in check. All these notes contributed to a thick description of the study during data presentation as data analysis is derived from the notes and the recorded interviews.

Role of the researcher: The Environment: The interviews were conducted by the researcher in either a consulting room or in a secluded caravan with the notice 'Counselling - Do not disturb' to safeguard participants' confidentiality and privacy. The intention was also to minimise disturbances from both staff and other clients lest they interfered with the audio-recording and natural flow of the interview. Mays & Pope (1996:34) postulate that as much as setting has an effect on the content, it has to be ensured that participants are relaxed and can speak freely to avoid bias in the data provided.

The researcher as an individual: Polit and Beck (2004: 392) have identified common biasness among qualitative researchers during data collection through observation; hence it is ideal to include practice sessions in the training of researchers prior to data collection. These authors continued to stress that as qualitative researchers are primary instruments for data collection as well as creators of the analytic process; their training, qualifications and experience are important in establishing confidence in the data (Polit & Beck, 2006: 334). In this study therefore, the researcher's communication and interviewing skills were evaluated while she conducted four interviews that did not form part of the final interviews. An independent researcher, who is experienced in the phenomenological interviewing technique, analytically reviewed the interviews and made recommendations for improvement. Thereafter, the researcher collected the final data until saturation of data was obtained.

It was important for the researcher, however, to take a deliberate 'not knowing' stance to ensure that the actual interview sessions were approached with an open mind, instead of being influenced by what the researcher had come across in the preliminary interviews. Treating each participant's reasons as unique in order to obtain the full meaning of their descriptions of what led to their taking an HIV test post-conception instead of pre-conception was crucial in validating this study's findings.

The researcher employed non-invasive probing and paraphrasing of remarks, responsive listening, minimal verbal response, reflecting, summarising and communicating silence etc to elicit maximum information from the participants. Participants too were given a chance to ask questions to clarify whatever information was of concern to them. Honesty and openness in responding to the participants' concerns were maintained. Non-verbal cues, such as eye contact and nodding one's head to show concentration and appreciation of whatever the participant was saying, were utilised. The researcher strived to be empathetic and understanding about the participants' feelings as HIV and pregnancy are sensitive sexuality issues. Their views about reality were respected and their level of understanding, and above all their values were acknowledged, as the initiation of good rapport before data collection was important (Rubin & Babbie, 1998:374).

2.2.3 Data analysis

Qualitative researchers work with voluminous descriptive data which need to be understood before it is reduced into themes and sub-themes. As Mouton (2002:169) says, it's actually more important to understand the overall coherence and meaning of the data than the specific meaning of the parts of that data. The researcher therefore tried to understand each participant's story before packaging it with other related stories into categories and themes. Burns and Grove (2005:733) say that data analysis is conducted to reduce, organise and give meaning to raw data collected.

In this study, the researcher transcribed verbatim the recorded interviews after saturation of data. The interviews were then analysed together with field notes by clustering and coding them, then interpreting them using Tesch' method of open coding (Creswell, 1994:155). Kgokgothwane (1998:36) says that the researcher requires a significant degree of dedication to reading, intuiting, analysing, synthesising and reporting what has been discovered.

The researcher therefore adopted Tesch' steps of analysis as outlined in Creswell (1994:155) to analyse the recorded interviews as follows:

- Getting the sense of the whole – the researcher listened to the tapes and read transcriptions several times to gain accuracy of the information collected.
- One interview was chosen and read through, and while doing this, the researcher looked for underlying meanings in the information and kept on writing down any thoughts that came to mind in the margin.
- Having finished all the scripts, a list of all topics were made and similar topics were then clustered together and put into columns that were arranged into major and minor topics.
- The researcher looked at the list against the original data. Abbreviations of topics were done as codes, and these codes were written next to appropriate segments of the text to determine whether new categories would emerge.
- The researcher found the most descriptive wording for the topics and turned them into categories. Then the researcher strove to reduce the total list of categories by grouping

them into major topics that had related sub-topics underneath them, but at the same time the researcher avoided losing the original data.

- The researcher made a final decision on the abbreviations for each category and arranged the codes alphabetically.
- The data materials belonging to each category were assembled in one place and a preliminary analysis performed.
- The researcher recorded the existing data and then sought the services of an independent coder to compare her findings before carrying out the final analysis.

By engaging an independent coder who is familiar with analysing data according to Tesch's steps of analysis, the researcher wanted to compare her themes and sub-themes with those of the coder to confirm whether they reflected the participants' input and hence avoided bias. The researcher then came up with a description of the phenomenon that incorporates the participants' contexts (experiences, setting, cultural norms and family values, health services provided in Botswana etc), but is also in line with relevant national and international literature and research studies.

2.2.4 Literature control

Phenomenologists believe that literature should only be reviewed after data collection and analysis have been completed, so that the information in the literature does not influence the researcher's openness about the current study (Burns & Grove, 2005:95). In this study therefore, literature was searched post-analysis of the findings in relation to the themes and sub-themes that emerged from the study. Thus, studies from different researchers related to reasons why women volunteer for HIV testing when they were already pregnant were discussed, compared and combined with the current findings to determine the current trends. Guidelines were then formulated in line with the current findings to assist midwives and HIV counsellors to facilitate voluntary pre-conception HIV testing among childbearing women from an early age. In conclusion, controlling literature in this way places the findings of the study in the context of what is already known, and thus strengthens its reliability.

2.3 TRUSTWORTHINESS

Lincoln and Guba's (1985:290) criteria for establishing the trustworthiness of qualitative data were used in this study. It included using the criteria of credibility, transferability, dependability and confirmability (Burns & Grove, 2005: 426; Polit & Beck, 2006: 511).

2.3.1 Credibility

Credibility is a criterion for evaluating data quality in qualitative studies, referring to confidence in the truth of the data (Polit & Beck, 2006:498). The following questions may be asked: Do the findings of the study make sense? Are they credible to the people we study and our readers and do we have an authentic portrait of what we are looking at (Kgokgothwane, 1998:29). Lincoln and Guba (in Creswell, 1994:150-155) suggested the following techniques for improving and documenting the credibility of a qualitative research and the researcher thus adopted them:

- **Prolonged Engagement and Persistent Observation:** The researcher invested sufficient time in participants and their environment before, during and after data collection to attain an in-depth understanding of the participants' culture, language and their views about HIV testing. The researcher provided routine ANC services to prospective participants for some time before collecting data to establish rapport, develop trust among them and orientate herself to the current services surrounding the context of the inquiry. Close observation and concentration was maintained during the interview sessions to be able to pick up all the non-verbal cues from the participants. This assisted the researcher in testing for misinformation and distortion from the participants until saturation of data was obtained.
- **Triangulation:** Method triangulation was utilised more than other forms of triangulation. LoBiondo-Wood and Haber (2002:158) define triangulation as the expansion of research methods in a single study or multiple studies to enhance diversity, enrich understanding and accomplish specific goals. Multiple qualitative methods (recorded face-to-face interviews, observation and note taking) as suggested by Polit and Beck (2006: 333) were

used to collect data from multiple sites (different clinics, areas with different socio-economic levels), in an effort to identify the reason for women volunteering to test for HIV when they were already pregnant. Literature control, in which the findings were compared with what already exists, also added to triangulation of sources.

- **External Checks: Peer Debriefing:** The involvement of the two supervisors (Midwifery and Community Health experts), the independent coder who is an expert in interviewing skills (Community Mental Health), the Behaviour Change Intervention and Communication consultant from NACA office in Botswana and the researcher's colleagues from the conception of the study throughout the research process was beneficial in ensuring that this study is credible.
- **Member checking:** According to Polit and Beck (2006: 334), member check involve soliciting study participants' reactions to preliminary findings and interpretations which can be both be informal (ongoing as data is being collected) or formal (after data is collected and analyzed). The researcher thus provided feedback to the participants on the spot via replaying the tape so that they can confirm whether the tape has captured what they intended to say.

2.3.2 Dependability

Dependability is a criterion for evaluating data quality in qualitative data, referring to stability of data over time and over conditions (Polit & Beck, 2006: 498). Therefore the researcher endeavoured to account for the changes that may take place during the research process. This was achieved by having two supervisors throughout the process and will be further achieved by availing the collected data and relevant supporting documents to the external reviewer for an inquiry audit if necessary.

2.3.3 Confirmability

Confirmability refers to the objectivity or neutrality of the data, such that there would be a potential for congruence between two or more independent people about the data's accuracy, relevance or meaning (Polit & Beck, 2006: 430). These authors point out that it is not about the researcher's characteristics (objectivity or biases) but rather the characteristics of the data

itself. The researcher must therefore develop an audit trail so that any independent auditor can come to conclusions about the data, thus, ensuring the trustworthiness of the data and the meanings attached to them. The researcher is thus in possession of:

- the raw data (field notes and interview transcripts)
- data reduction and analysis products (theoretical notes, literature copies)
- process notes (notes from member check sessions)
- previous data collected and discarded and
- data reconstruction products (drafts of the final report).

2.3.4 Transferability

Lincoln and Guba's framework defines it as the extent to which findings from the data can be transferred or applied to other settings or groups. However, this lies with the potential user of the findings and not the researcher, depending on how sufficient the researcher has described their sample and design. To enhance this decision, the researcher:

- provided a thick descriptive data of the research setting or context and processes observed during the study; and
- nominated the sample by purposive sampling technique to permit judgement by independent investigators.

2.4 ETHICAL CONSIDERATIONS

Ethical considerations in this study included ethical conduct towards participants who are dealing with two sensitive issues – pregnancy and HIV. The researcher believe that when vulnerable human participants, such as pregnant women who may also be HIV-positive, are included in a research study like this one, utmost care has to be taken to avoid emotional assault on their already traumatised psycho-emotional being. Fair identification of participants, precise collection of data and honest reporting, as well as abiding by the ethical standards regarding conduct of research were thus adhered to

The researcher obtained permission to conduct the research from the following stakeholders:

- University of Johannesburg's Ethics Committee and Higher Education Committee (See annexure B - Clearance Reference Number 17/07).
- Botswana Government (Ministry of Health/Health Research Unit (HRU) (see Annexure D - Reference No: PPME- 13/18 US Vol II (12); Department. of Health Sector Relations & Partnerships; Ministry of Local Government and Gaborone City Council clinics' management).
- Participants themselves as per attached letters which were read to them.

The researcher adhered to the following:

- Ethical standards of the Democratic Nursing Organization of South Africa (DENOSA, 1998: 7), which call for the recognition and protection of the human rights of the participants.
- The research guidelines of the University of Johannesburg (UJ) which is former Rand Afrikaans University (Rand Afrikaans University, 2001:1-4).
- The 5 human rights protection regulations (right to self-determination; privacy; anonymity and confidentiality; fair treatment; and protection from discomfort and harm), based on the 3 principles of respect for persons, principle of beneficence and principle of justice as outlined in Burns and Grove (2005:176-208). For example, the following rights of the participants were observed:

Right to self-determination: It is based on the ethical principle of respect for persons. The researcher treated participants in this study as autonomous agents by informing them fully about the proposed study. It was pointed out that their voluntary participation or withdrawal from the study at any time will not jeopardise either their routine health services or that of their families in any way.

Right to privacy: Participants have the right to determine the time, extent and general circumstances under which personal information is shared with or withheld from another person, thus, the researcher in this study interviewed participants or requested appointments to interview them whenever it was convenient for them. They were informed that they could decline to answer some or all of the questions (in other words withhold some information or

withdraw) if they felt uncomfortable, as HIV and pregnancy are issues that may be too sensitive and personal to share freely with other people.

Right to anonymity and confidentiality: Complete anonymity could not be assured in this study as face-to-face interviews were done and the interviews were audio-taped. However, participants were asked for a verbal consent instead of a written one, to partially safeguard their anonymity. To ensure their confidentiality, information such as the identifying demographic data that could link them to the information they provided on tapes were not audio-taped. Moreover, the audiotapes used to collect data and the transcribed data were alphabetically labelled to avoid labelling them with their names. The tapes will be kept for three years in a locked safe and then they will be destroyed.

Right to fair treatment: This is based on the ethical principle of justice. Participants in this study were selected on the grounds of their being pregnant. In addition, HIV/AIDS is the current most challenging medico-social problem that should be addressed at an individual, family, community, national and international level and thus these participants were not selected based on some biased reasoning. On an individual level the researcher ensured that one clinic per a region of Gaborone city was utilised, to try and balance the inclusion criteria on the basis of socio-economic status of the participants as people of various economic statuses reside in different areas of the city. The language barrier was also surpassed by including participants who speak either Setswana or English.

Right to protection from discomfort and harm: This is based on the ethical principle of beneficence, which holds that one should do good rather than harm. Participants in this study were likely to be exposed to some inconvenience of time and possible temporary discomfort when answering the central question to the study: "Can you please share with me the reasons why you volunteered to undergo the HIV test when you were already pregnant and not before you fell pregnant?" However, participants who had to face the fact that they were pregnant and HIV-positive and were not coping well were counselled by the researcher and/or referred to the social worker in the clinic for further management. None of the participants incurred

any costs by participating in this study as they were interviewed when they were at the clinic for their routine ANC service.

2.5 CONCLUSION

This chapter introduced and described the research design and methods of data collection and analysis. Measures aimed at ensuring trustworthiness and ethical aspects were addressed. Chapter 3 will discuss findings of the study by way of themes and sub-themes in line with available relevant literature.



CHAPTER THREE

DISCUSSION OF RESULTS AND LITERATURE CONTROL

3.1 INTRODUCTION

The purpose of this study was to explore and describe the *reasons* why pregnant women in Gaborone volunteered to go for VCT of HIV when they were *already pregnant*, and not *before they conceived*. Chapter two described the research design and methods, trustworthiness of the study and the ethical principles. In this chapter, the researcher will present a narrative account of the study findings categorised into themes and sub-themes. For each theme and its sub-theme(s), a verbatim statement or more will be quoted from the interviews to highlight the responses of the participant(s). Relevant literature guided by the study findings will also be added throughout the text, as Poggenpoel (*in* Segeel, 2005:43) says that literature control is guided by data obtained from the interviews.

3.2 REALISATION OF DATA COLLECTION

The collection and analysis of data were implemented as follows: nine interviews were conducted in both Setswana and English, depending on the participant's comfort of wording, in four Gaborone government clinics. The participants' demographic data were collected and documented at the beginning of each interview, followed by audio-recordings of their responses to one central question: *"Please share with me the reasons why you volunteered to undergo the HIV test when you were already pregnant and not before you fell pregnant"*. The researcher discovered that most of the participants were more reserved than expected and therefore she made use of further probing, clarifying and summarising what they said to get maximum information from them (Burns & Grove, 2005:746). After nine interviews, saturation of data was reached.

The researcher took field notes to document non-verbal cues which normally complement the verbal responses. At the end of each interview the researcher re-played the tape for each

participant to ensure that what she captured was what the participant wanted to convey. Later the field notes and the transcribed information from the tapes were analysed. Three major interrelated themes and their sub-themes were categorised from these findings, as shall be presented in Table 1 below.

Literature similar to or related to these themes was searched and shall be presented below. Literature is intended to point out similarities and differences between the current study and the ones previously conducted in order to substantiate the findings accordingly. Verbatim statements from the actual interviews will also be added to enhance the discussion.

3.3 DISCUSSION OF THEMES AND SUB-THEMES

Major themes and sub-themes set out below seem to tie well with the four broad key determinants that reportedly drive the HIV and AIDS epidemic in Botswana, namely stigma and denial, socio-cultural determinants, socio-economic determinants and demographic mobility (National AIDS Coordinating Agency, 2003-2009:16).

Table 1: Table showing major themes and sub-themes identified in the study:

MAJOR THEMES	SUB-THEMES
Fear of consequences of an HIV-positive result	Loss of psycho-social and economic support: losing /being ostracised by partners/family/friends/society
	Breach of confidentiality
	Death: loss of own and baby's life
Socio-cultural beliefs, values and norms	Religious perspective
	Lack of safe sex principle: culture-related unplanned pregnancy
Maternal instinct of enhancing child survival	Protection of the baby through PMTCT-programme

3.3.1 MAJOR THEME 1: FEAR OF CONSEQUENCES OF AN HIV-POSITIVE RESULT

Many adults in Botswana (over 35%) aged 15-49 are HIV-positive and yet do not know their status (National AIDS Coordinating Agency, 2003-2009:16). The fact that all women interviewed in this research have never tested for HIV until they were pregnant confirms this sentiment. Most of the participants identified their major problem for failing to test for HIV before they conceived as fear of an HIV-positive result and the consequences thereof. Among others these consequences include fear of losing psycho-social and economic support from partners, being ostracised by family, friends and community, confirmation of the HIV diagnosis which is associated with death, socio-cultural believes and norms related to sexuality and sex. Another factor that featured was the commonly widespread 'no go area culture' where sex and sex-related issues are never discussed openly – even among spouses. This was evidenced by some women failing to convince their partners to go for HIV-testing before they conceived, let alone agreeing to fall pregnant in the first place. However, the discovery that their offspring were in danger of contracting HIV if they do not get tested and join PMTCT if necessary forced the women to test for HIV regardless of the said consequences.

Participants interviewed in this research study voiced being scared of HIV-positive results. One said *"I was so scared of my findings . . ."* Another participant reiterated the same fear by saying *" . . . to be honest, I got scared every time I wanted to come because I . . . I am still so-o s-c-a-r-e-d of my findings! This is why I decided to come and see you now before I get my findings since I heard you don't want our findings, so I came here while waiting for them because I am not sure how I am going to react after I get them if they are bad."*

According to these responses, it is evident that HIV and AIDS still invoke fear among individuals and the general community at large – to such a degree that some people prefer to be left in the 'dark' rather than know their HIV status *" . . . as long as people don't know your status, they actually don't mind even sharing a cup with you, but hei! Wait until anyone of them knows you are HIV-positive . . . everybody starts shying away from you so sometimes*

it's better to stay in the dark . . ." This scenario is observed in both developed and developing countries as in the United States of America, about a quarter of people with HIV have not yet been diagnosed and are unaware of their HIV-infection, simply because they have not had themselves tested for HIV; while in Burkina Faso, a study revealed that during active and intense pilot experiences and clinical trials of counselling and testing, the VCT uptake rate went as high as 80 – 90% – just like in other African countries (Pignatelli, Simpole, Pietra, Ouedraogo, Conombo, Saleri, Pizzocolo, De Iaco, Tall, Ouiminga, Carosi & Castelli, 2006:350). However, this percentage dropped to as low as 21.6% post trials. Reasons such as poor autonomy in the Burkina female population requiring male consent to accept the VCT proposal, social stigma of HIV/AIDS-infection, fear of not having access to effective treatment and denial of the existence of HIV were cited as contributing factors to this low rate.

In Botswana too, the researcher observed a similar situation whereby uptake of VCT among pregnant and non-pregnant women and men increased after introduction of routine HIV-testing in 2004. However, the figures did not remain high for long and currently people are being encouraged again to test through various strategies like 'Zebras for Life', 'Show you know your status by wearing a blue band' and 'Long Distance Bus Testing'. This reluctance to go for HIV-testing is evident even in this study as some women still fell pregnant without knowing their HIV status.

3.3.1.1 SUB-THEME 1: Fear of losing psycho-social and economic support from partners and/or family, friends and community

Under this sub-theme, the researcher will start by discussing participants' fear to lose psycho-social support and economic support from their partners, followed by fear to lose all forms of support from the family, friends and community.

Fear of losing psycho-social support from partner: Women in this research study pointed out that fear of losing their partners, especially if diagnosed as HIV-positive, has prevented them from testing for HIV before pregnancy, even though they knew HIV-testing is important for

survival. The fact sheet of the Southern African Development Community (SADC) (2004:2) reiterates this by reporting that the majority of people (including women) in the SADC region, which is by far the region worst affected by HIV and AIDS in the world, is aware of the effects of HIV and AIDS and how it can be prevented.

The problem as observed by Dube (2004:87) is that women's fears of the consequences of being tested HIV-positive can be related to the social construction of men and women (gender roles and responsibilities) as men are constructed by society as leaders, thinkers and decision makers, whereas women are to be silent, non-intelligent, obedient and faithful to their men. This social construction therefore makes women dependant on men to initiate and/or lead in everything – from issues of instilling discipline among children to being responsible for making decisions of whether the couple should or should not test for HIV. This was reiterated by one woman in the study who said “. . . *you have to be prepared to change your life if you decide to take an HIV test. You see, as for us married women, you know you can lose the very man you are married to even if he knows very well that it's him who has been sleeping around.*”

Many studies continue to associate this male-female-HIV disease phenomenon with gender inequality. NACA, UNDP, ACHAP and CSO (2005:16) report that the socially reinforced subordination of women underline many of their vulnerabilities and that their relatively weak position in making decisions about sex, their biological make-up, their socio-cultural roles and their lack of economic empowerment all make them more prone to HIV than men.

In this researcher's study, some women voiced that they suggested HIV-testing when their relationship was new and before they actually engaged in sexual activity, but when testing was not favoured by the partner, they practised safe sex but not for long. One of the participants reported falling pregnant with two different men, neither knowing their HIV status nor hers “. . . *I urged him (previous boyfriend) to come with me but he refused because he kept on giving me flimsy reasons . . . I just got stuck with my intentions which I never really fulfilled until now. In fact, even with this one (current boyfriend), I also tried to stick to testing before we slept together but owaii! we only talked about it, then used a condom quite a number of times and*

agreed to use it until we came for testing, but as you can see now, I had to do it today without him because in this clinic it's like you have to go to the caravan before the nurses massage you". Doyal, Naidoo and Wilton (1994:14) observe that most women feel that they do not have the right to assert their own needs and desires in a situation where the male partner's wants are seen to be paramount.

Other women participating in this study did not only fear being HIV-positive, but failed to test for HIV because they were scared of being wrongly accused of 'bringing the disease home', which is tantamount to emotional blackmail. One of them said ". . . *to be honest, I got scared every time I wanted to come because I . . . ah! You know men mos! . . . I thought maybe he knew he was positive that is why he refused to come with me. So because I thought if I come and the findings are... are...positive, he may say it's me who brought the disease home that's why I forced him into testing, I just got stuck with my intentions . . .*" According to Nayblade, Pande, Mathur, MacQuarrie, Kidd, Banteyerga, Kidanu, Kilonzo, Mbwambo and Bond (2003:15), women find themselves under a lot of pressure of not going for HIV-testing on their own, fearing to be viewed as having been unfaithful in their relationships. From general observation, if the woman is not blamed for being unfaithful, then she is blamed for suggesting that the man is promiscuous – something that women are not supposed to complain about, especially in some African cultures. In Botswana, for example, there is a Tswana saying "*When a man strays from home, his partner is not supposed to demand any explanations from him - Monna ga a botswe gore o tswa kae*".

Essex et al (2002:654) and Anon.² (2002:31) also stress that women fear to be blamed for sexual misconduct by their husbands. This is why they fail to negotiate for safer sex, let alone testing for HIV on their own. The tendency then is for male partners who want to be viewed by the society as faithful and 'clean' to opt to leave their HIV-positive female partners for HIV-negative ones or even for ones whose status they don't know, so that they are not associated with the partner's HIV-positive status.

Some male partners, however, do not opt to leave peacefully, but rather turn to violence against the women so that the women themselves end up leaving home to find safety somewhere else.

Essex et al. (2002:658) say physical violence, the threat of violence and fear of abandonment act as significant barriers for women who want to negotiate the use of a condom, discuss fidelity with their partners or leave relationships that they perceive to be risky. Shu-Acquaye et al. (2008:35-36) narrate a lived experience of a woman who was physically abused and emotionally blackmailed to admit having been unfaithful by a promiscuous husband who ultimately threw her out of their home just because she brought home a female condom from a women's meeting where they were taught about its use. Ruxin, Binagwabo and Wilson (2005:54) also report that fear of violence and the subordination of women to men in marriage or elsewhere make it very difficult for women to access AIDS service centres. In this study, physical violence was not cited by Gaborone women as the reason why they did not test for HIV, but fear of abandonment was part of their reasons.

Fear of losing economic support from partner: Women's fear to lose psycho-social support from their male partners post-HIV-testing is compounded by the fact that some women partially or wholly depend on men for economic support. In this study, one of the respondents stated that although she is employed, she needed her partner to support the family "*As for that man, I know I need him to help with this child . . . , I do work even though I am not getting enough . . .*"

According to Sherr (2000:309), a woman who is financially dependent on her partner to provide basic resources such as food and housing is vulnerable to her partner's decisions about sexual risk attitudes. NACA, ACHAP, BOTUSA and UNAIDS (2005:19) also reiterated this by stating that it is important to understand gender relations in the context of HIV and AIDS because men and women's power determine their ability to control whether, when and the terms on which to engage in sexual relationships and whom they are dependent on for food and shelter among other issues.

It is appalling to discover that the situation of economic dependence on men is forced upon women while they are still girls. During one of her HIV/AIDS public addresses in Botswana, Dr Kalilani, said it is the big men with cash, cars and cell phones who increase the HIV-infections because these young girls dare not ask the men to test themselves before they sleep

with them as these youngsters too are vying for economic gains, the same sentiment which was repeated by NACA (2006:10) that many of these relationships are predatory because older, better resourced men prey on sexually naïve or economically dependent girls. NACA further says that the continued rise in male dominance in sexual decision making and violence against women and girls, contribute directly to women's higher levels of HIV-infection at an earlier age. This is why NACA (2008:4) reported that HIV affects more women and girls than males because currently for every one (1) HIV-positive male, there are three (3) HIV-positive females of the same age group for age groups 15 years and above.

Ruxin et al. (2005:53) cited poverty as one of the things that can destroy people's freedom of making safer choices, because some people may remain in unsafe relationships or opt to do things that would not offend their partners and make them leave, such as suggesting an HIV-test. The researcher has also observed that the more dependant and helpless women become as they age or have more children, the more powerful men become, to such an extent that even if they do not openly command their partners not to test, their lack of interest in testing indirectly commands the women to follow suit. Like the researcher, these authors also have the opinion that lack of economic opportunities for women is a major cause of this situation as this research study showed that women continue to have unprotected sex with their partners in order to protect their relationships at the expense of their own lives.

Finally, Dube (2004:87) also argues that the issue of economic possession by males further stressed the fact that women are meant to be fearful, obedient and silent to such an extent that when men do not agree with something it cannot be done. This makes the researcher concerned about what the situation will be like for most women, especially in Africa in the current economic recession, because loss or lack of jobs is the order of the day for many. Oxfam and European Women's Lobby (2009) study on the impact of economic recession on women's poverty revealed evidence of precarious working conditions; increasing discrimination in the labour market with a subsequent shift to informal work; rising levels of poverty; reduced access to services; and rising levels of domestic violence, accompanied by cuts in vital support services (http://ec.europa.eu/employment_social/spsi)

The evidence clearly indicates that the recession is already having a significant negative effect on the lives of women, not only in relation to the labour market, but also in their homes. How then can women choose to test for HIV as and when they wish, without fearing the repercussions of losing economic support from their male partners?

It is evident from this study and the literature quoted that many women are dependent on men for financial support. Therefore, if we have to deal with this epidemic effectively, we need to understand and acknowledge gender relations as a very important tool in curbing the spread of HIV and AIDS in the context of pre-conceptual HIV testing.

Fear of being ostracised by family, friends and community (loss of psycho-social and economic support): In fighting HIV and AIDS, it is crucial to acknowledge that the moral fabric of importance of the extended family on the individuals' sex life, especially in Africa, will always be core to that individual's life decisions. The western nuclear type of family, influenced by the current cost of living, may slowly be chipping away at the extended family relationship, but sex and sexuality decisions remain controlled by family and community. . .
"Hei my sister! you know taking an HIV test is not a child's play. . . the painful part is that it just doesn't affect you alone. . . you can lose your relationship with people close to you . . . and those that call themselves your friends."

Peltzer, Skinner, Mfecane, Shisana, Nqeketo and Mosala (2005:28) state that medical recommendations made in certain health programmes are often difficult for women to implement as they are overshadowed by community norms, values and beliefs, and that partners, parents, in-laws, other family and community members influence most women's decisions on whether to partake in HIV prevention programmes. . . *"You know, when that nurse told us we go to the caravan first, I nearly went back home without registering because, like with my first partner, I started thinking 'what if I am positive and he runs away. . . ?"*
Peltzer et al., (2005:28) has observed that should women decide on their own to choose or adhere to certain recommendations not endorsed by families and communities, they risk going against social norms and hence may be stigmatised and discriminated against for life.

In this study, participants also reported that “. . . as long as people don't know your status, they actually don't mind sharing a cup with you, but hei! Wait until anyone of them knows you are HIV-positive . . .” The norm is that people always feel pity or empathy for others who are sick or somehow incapacitated, but the feelings are different for those infected or affected by HIV and AIDS. A study carried out in Zambia, Ethiopia and Tanzania discovered that in these countries, PLHIV were regarded by their families and communities as responsible for their deviant sexual behaviour (Nayblade et al., 2003:19). The same phenomenon was found to be common in the United States of America where HIV-positive people were also held responsible for their condition (Alexandrova, 2007:20).

Jonathan Mann, the former head of WHO's Global Programme on AIDS, identified stigma as a third epidemic in the history of HIV (Nayblade et. al., 2003:5). He further pointed out that stigma, blame and collective denial were potentially the most difficult aspects of HIV and AIDS to address, and yet addressing them was key to overcoming the disease. For example, when a person tests positive, he/she should actually be assisted to do something about it instead of being discriminated against, because it results in denial and blaming of partners. Failure to deal with positive findings has led to people dwelling on anger and spreading the disease further, while getting re-infected in the process.

Some health facilities proved to be no exception with UNAIDS and WHO reporting in Monageng and Makgopa (2002:33) that patients with HIV and AIDS in India were reported to be exposed to a frightening spectre of stigma, ignorance, neglect and ill treatment in private and public hospitals. This was due to the fact that nurses, doctors and other health care workers were seemingly overwhelmed by a collective fear of contagion (ICN, 2001 in Monageng and Makgopa (2002:33). In Botswana, a study done by Mukamaambo, Lesetedi and Mulinge (2001:27) also told of patients who were abandoned by their spouses as soon as they fell ill. One of them was abandoned completely by her spouse, relatives and even her children while others reported intimidation at the hands of the clinic staff just like those in India.

On close observation of this study findings and the literature presented, stigma and discrimination could be fuelled by two concerns: in the early days people discriminated against

others because of their knowledge deficit on HIV transmission, and now that most are supposedly fully informed they discriminate against others because they believe they were careless. The perception is that everybody is armed to protect themselves as there is a lot of information, education and communication (IEC) on HIV and AIDS available in health facilities, the media, kgotla meetings, schools etc nowadays. One participant stated *"I was so scared of my findings. You know, having HIV is such an embarrassment nowadays with all this information flying around..."*

Alexandrova (2007:20) reiterates that contracting HIV that could have been avoided at this stage may be viewed as voluntary and stupid. This type of stigma, however, does affect both men and women alike, but it is worse for women. Cohen and Durham (1993:242) have long reported that HIV-positive women's ability to cope with an already difficult situation (pregnancy) is severely tested by lack of community support.

According to Nayblade et al. (2003:28), stigma can also be manifested in treating the affected person differently, with the most common phenomenon being exclusion from family and community activities. HIV-positive persons are usually cut off from doing many of the family chores because of the belief that resting will help improve the person's health or even make the person feel that he/she is taken care of, but Akinade (2002:27) calls this form of stigma subtle stigma.

In research that Akinade did in Botswana, HIV-positive participants reported that some of the functions that they used to perform in society and in the family were withdrawn from them. They also decried that they were given special treatment at home, such as being marooned in comfortable rooms and provided with special and reserved utensils, crockery and beddings. For Akinade this is stigma painted with rich doses of love. Nayblade et al and others also add that this loss of role and loss of identity and livelihood do indeed reflect the families' stigmatisation of members who are living with the virus.

This kind of treatment from family members and the 'supposedly empowered' trained health workers on its own may scare people away from knowing their status. Another hitch can be

that women may be afraid of testing with the more anticipated suspicion that other people will know of their status by simply observing how they are treated if they are not ready to disclose their status. For example, those on a PMTCT programme are advised to formula feed when breastfeeding is so 'African'. In order to avoid potential disclosure when the family and community start asking questions and pointing fingers if they do not breastfeed their newborns, they will rather feed according to traditional practices and risk infecting their children than be discriminated against (Shapiro, Lockman, Thior, Stocking, Kebaabetswe, Wester, Peter, Marlink, Essex, & Heymann, 2003:221).

There are other people, however, who beat the odds by "coming out". A project representative in South Africa reported how she revealed her positive HIV status and started caring for children infected with HIV after she experienced her family's denial and rejection of her brother who died of AIDS (Marcus, 2004:11). It is therefore understandably challenging for one to do something if the consequences will include that they will lose family or community support, such as testing for HIV 'without a valid reason', unless they are empowered enough to deal with the consequences like this project representative.

In view of these circumstances, the researcher has thus come to appreciate that currently it is very difficult for women to opt for an HIV-test prior to pregnancy if they are most likely to be ostracised by their partners, family, friends and community should they test HIV-positive. It is evident then that there is still a lot of work to be done in empowering not only our women, but our communities in general, to be able to deal with stigma and discrimination against PLHIV from an early age.

3.3.1.2 Sub-theme 2: Breach of confidentiality

Confidentiality can be understood as an ethical decision made by a professional to not reveal to others what has been learned in private interactions with clients (Oagile, 1999:285). It has been made a regulation for medical practitioners as stipulated in Section 29 of the Botswana Medical Council Regulations (Professional Conduct) of 29 April 1988, which states that, "A practitioner shall not divulge, verbally or in writing, without the express consent of the patient, or, in the

case of a minor, without the express consent of his guardian or, in case of a deceased patient, without the consent of his next of kin or the executor of his estates, any information regarding the ailments of the patient.” This regulation is not unique to medical practitioners only, but also affects all health practitioners who deal with clients and patients on a day to day basis.

Although there is cause to believe that confidentiality is fully regulated in Botswana, some people still fear to go for HIV-testing with the suspicion that their confidentiality may be breached. For example, one of the respondents in this research did not go for pre-conception HIV-testing because she feared her parents may learn about her testing through her aunt who happens to be a health worker – *“So I couldn’t even think of going for HIV- testing before I got pregnant because I feared my parents will know that I am engaging in sex, more so that my auntie is a nurse. So I thought she has a way of knowing everybody who takes the tests because they use computers nowadays. So you see, even if I wanted to, like . . . yes. . . I had been toying with the idea before but I was scared my auntie will find out and tell her sister.”*

This response shows that the respondent did not trust either the health worker or the computerised system as she believed that all health workers can access patients’ information from any computer within the system. According to Fombad (2001:643-656), confidentiality is a critical factor in the management of HIV and AIDS diagnosis, treatment and prevention. He adds that the way in which the information of the infected person is handled is very important because the consequences of it becoming publicly known that a person is HIV-positive can be devastating as it could lead to social ostracism, rejection by family or friends and isolation at a time when support is vital. This fear of information reaching people that the client does not want it to reach can therefore obstruct people from finding out their HIV-status (Fombad 2001:649).

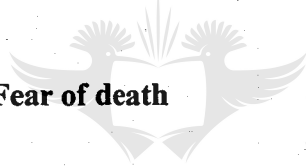
It should be noted from this sub-theme that fears of confidentiality being breached are influenced by the already discussed issues of stigma attached to HIV and AIDS. People most fear the consequences of others knowing their HIV-positive status as they are likely to stigmatise and discriminate against them. Fombad (2001:649) further emphasises that without the guarantee of confidentiality people will not come forward for testing, treatment and

counselling as they will be fearful of the repercussions that unauthorised disclosure of their status to the public will have on their lives.

In a study conducted by Kumar and Raizada (2008:82), Karen Leiter makes a statement to the effect that the very fear of being subjected to HIV-related stigma (as opposed to the actual experience of it), being abandoned by friends or being shunned at work was pervasive. In Botswana, for instance, 30% of women and men believe that testing positive and disclosure would lead to the break-up of their marriage or relationship.

Another study investigated the PMTCT approach and barriers to behaviour change, and highlighted the importance of ensuring confidentiality in testing, counselling and care (Peltzer et al., 2005:29). Midwives and HIV counsellors should therefore always be vigilant when dealing with sensitive issues like HIV and they should make a habit of assuring clients at every opportunity that unless the client consents, his/her information can never be divulged.

3.3.1.3 Sub-theme 3: Fear of death



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“Ah! Isn’t it you people who are the ones who always tell us that AIDS kills? I was scared I was going to die so young together with my child . . .”

AIDS has become the leading cause of death in Africa and it is said to be responsible for one in five deaths, which is twice as many as for the second leading cause of death in Sub-Saharan Africa (Essex et al., 2002:200). Willis (2002:56) agrees with these authors that AIDS is the leading cause of death for African and Hispanic women aged 19-40 and is the fourth leading killer for white women aged 24-44. Infant mortality rates are also reported to have increased as a result of perinatal transmission (Essex et al., 2002:654).

What makes AIDS complex is that it is deeply enmeshed with social and personal views, beliefs, fears and taboos around sex and death (Nayblade et al., 2003:15). This is not without reason because the presence of AIDS means that the household dissolves as parents die and children are sent to relatives for care and upbringing, especially if it is the mother who passes

away (Fredriksson & Kanabus, 2005:2). Worst still, there are more and more female-headed households, not just in Botswana but also in other countries, as Marcus (2004:8) reports that 71% of households with orphans in South Africa and 50% of those in Swaziland are female-headed.

In this study some participants reported that they tested for HIV post-conception because in addition to fear of ostracism by their families and the communities, they were scared of 'perceived' immediate and frequent sickness and death, as one of them said *"I know there are ARVs but isn't it that they don't really cure anybody. . . I thought I was definitely going to be frequently sick together with my baby . . ."*

The concept of HIV and death going hand in hand was hatched as long ago as the late 80s when the words HIV and AIDS were associated with a terribly contagious disease and dying, even by developed countries. When the UK started its HIV/AIDS campaign in 1987, it used on its leaflet and poster a slogan 'AIDS: Don't die of ignorance', while Malawi had a poster which read 'AIDS is killing Africa, Malawians Change Your Behaviour now! Let us save our country' (Willis, 2002:75).

Figure 1: AIDS awareness headlines in developed countries in the 1980

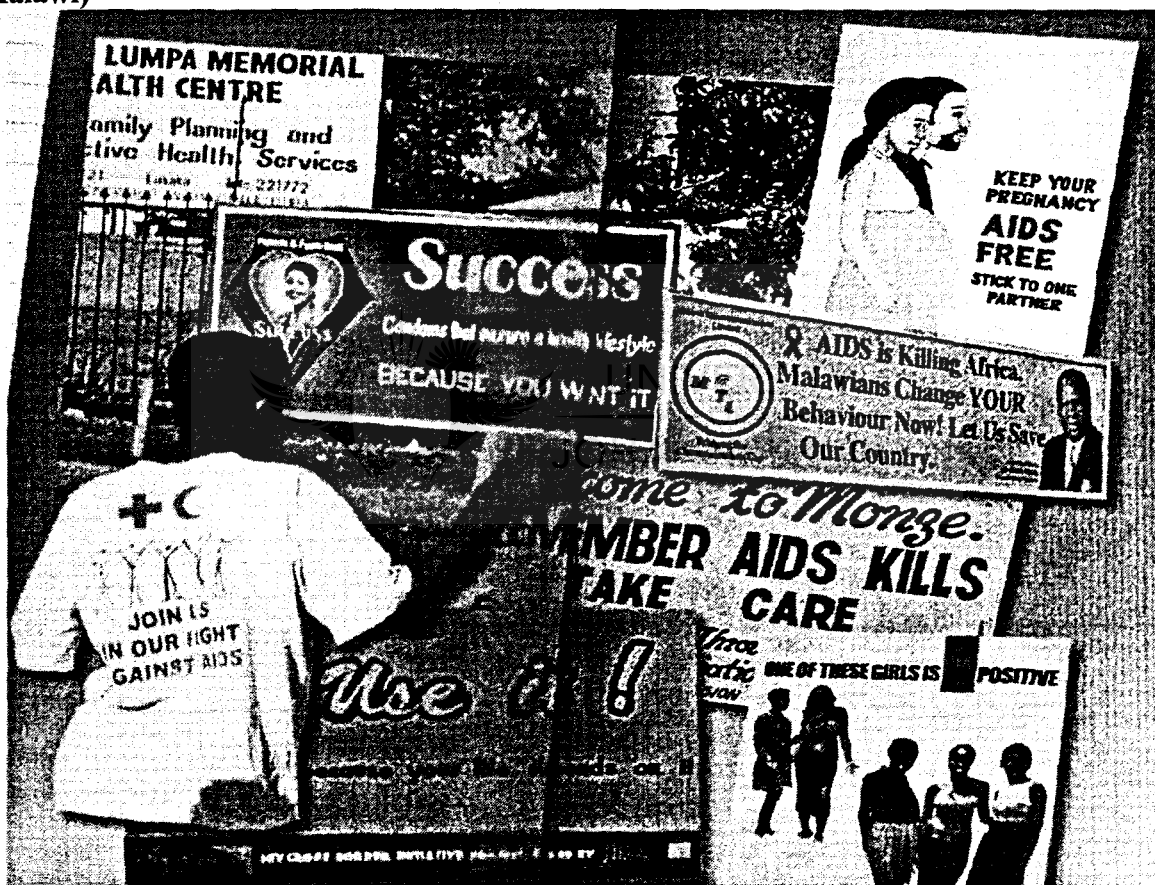


Van Bucher/Photo Researchers, Inc.

Adopted from Microsoft ® Encarta ® Encyclopedia 2003.

Botswana was no exception when it came to HIV prevention messages in the 90s in a bid to control this pandemic. However, some of them were terrifying and one of the messages was queried by PLHIV and the Human Rights organization in the country at some stage as it compared a person suffering from AIDS to a 'vehicle damaged beyond repair'. Another response in this study which echoed the fear-inducing messages was that "... you either do something now so that you get treatment ... or you delay and ... die earlier ..."

Figure 2: Fear-evoking HIV prevention messages in one of the developing countries (Malawi)



Adopted from Willis (2002:75)

Though most of these messages were true in practical terms, some were so scary that people did not want to be tested lest they were associated with HIV. They also didn't want to be associated with HIV-infected family members, friends or other community members and thus they segregated them. A situation analysis of stigma associated with HIV and AIDS in three

villages in Botswana revealed that community members sympathised with persons infected with HIV because they 'knew' being infected with HIV is a death sentence (Mukamaambo et al., 2001:26). The only hiccup however is that even though people fear contracting HIV, some still lack information on the disease process while others have no will-power to protect themselves and others – a situation which was revealed in this study - “. . . you insist on a condom today but then the next day you don't use it. . . How am I supposed to teach them about HIV when here I am, pregnant and not even sure of my partner's and my own status . . .”

However, with increased knowledge and understanding of the disease, most countries, including Botswana, adopted positive preventive and promotive messages like the one below (Figure 3). The unfortunate situation though is that some people still have that fear of sickness and death related to HIV, and thus they delay testing for HIV until when they have no choice, like when they are pregnant, as it was discovered in this study.

Figure 3: A road sign in Botswana written in Setswana: "AIDS: It's Your Problem Too, Help Prevent, Use a Condom"



Adopted from Microsoft ® Encarta ® Encyclopedia 2003.

3.3.2 MAJOR THEME 2: SOCIO-CULTURAL BELIEFS, VALUES AND NORMS: Religion and Culture-related Lack of Safe Sex Principle

In the context of this study, culture includes certain behaviours, norms, practices, attitudes, religious beliefs, customs, language and moral conduct; which are held dear by the people and are transferred from one generation to the next, either by word of mouth or non-verbally as it is rarely documented (Venes & Thomas, 2001:512).

However, as much as some cultural practices and beliefs are beneficial to our societies, some can be very costly as Essex et al. al. (2002:657) reported. They state that although public campaigns have generally created high levels of awareness and concern about HIV and AIDS among Africans, the major problem in most countries is the translation of this concern into responsible sexual behaviour, which is hampered mostly by cultural beliefs and myths. These same authors put forth that beliefs about HIV transmission and AIDS are rooted in cultural perceptions of the disease being a result of witchcraft or the breaking of social norms and taboos. For example, most adults in Botswana believe that AIDS is not a new disease; but an epidemic resulting from non-compliance with sexual taboos relating to widowhood as it affects young people who have supplanted traditional rituals like 'widowhood cleansing' by church-based ceremonies (Essex et al. al., 2002: 519; 657). However, these young people happen to be sexually active, which means the chances of them having unprotected sex are high and therefore they coincidentally become infected, lose partners to HIV and later also die.

In Botswana, Mac Donald (1996:20) cited the main factors of HIV transmission among women as the position they hold in society, particularly their lack of power in negotiating sexual relationships, cultural attitudes towards fertility and social migration patterns. Bond, Kreniske, Susser and Vincent (1997:24) also reported on how unfavourable women's position under customary law is in relation to issues of HIV and AIDS, a sentiment which has been reiterated by Essex et al. (2002:654) who wrote that Sub-Saharan Africa is not only unique in that there are more women than men infected with HIV, but the women are also exposed to increased risk of rejection, loss of security, stigma and violence. . . As one participant stated "*They are actually the ones spreading this disease because these men are all over with their 'small houses' . . . I mean you can imagine the risk they put us at. . . the next thing when they come*

home they refuse to use condoms hence we are scared too to test for HIV even though we know maybe some people think married women shouldn't be scared of HIV."

Knowledge of this vital information has led researchers like Shu-Acquaye et al (2008:42-43) to believe that understanding the people's culture and knowing how to operate in it is paramount to communicating information about AIDS, and that trainers and educators need to be "educated" about the people, their culture, politics and religion in order to be effective in conveying HIV prevention and protection programmes.

3.3.2.1 Sub-theme 1: Religious perspective

In this research study, Christianity was mentioned as one of the reasons why some women did not go for HIV-testing prior to pregnancy. It is evident that many Batswana have embraced and adopted Christian principles as their own, for example, conforming to strict norms of premarital abstinence and faithfulness in marriage (Benn, 2002:7). These principles were echoed in traditional Tswana culture when it was shameful to have premarital sex and bearing a child out of wedlock was taboo. Traditional culture thus contributed to youngsters abstaining from sex until they were married. This practice is currently being sought after in a bid to control HIV infection and single-mother families. It is, however, contradictory to the popular perceptions of media (especially the television), which promotes casual sex.

The researcher has found that the "no-sex-before-marriage" culture is not only difficult for young people, but it is also challenging and somewhat risky for some Christians as one of the respondents voiced that *"... in my case it was very difficult because you see; I am from a very strict Christian family. . . I mean we go to XXX church (names the church) and according to its beliefs, we are not supposed to have sex and let alone get pregnant before marriage. So I couldn't even think of going for HIV-testing before I got pregnant because I feared my parents will know that I am engaging in sex . . ."* The respondents were so fearful of what their parents will say such that they would rather not go for an HIV-test even if they knew it was indicated or beneficial for them.

Willis (2002:60) writes that 'the taboos and the stigma associated with HIV stop men and women from seeking treatment,' and further states that '... if a man comes here into an AIDS clinic, people will say he is running around and if it is a woman, they say she is loose and if anyone says they've got HIV, they will be despised'.

It is clear that stigma and discrimination still prevail around HIV and AIDS and it appears that Christians are perceived to be more affected as they are expected to be 'holy/pure'. This finding correlates with the findings of Willis (2002:75) who says in many societies sex is a taboo subject and some religious communities may feel inhibited from engaging in HIV preventive behaviours such as volunteering for HIV-testing, condom promotion or use and any other sex-related conversation as they believe this promote promiscuity.

Essex et al. (2002:657) argue that some strong cultural prohibitions against discussing sexual matters and expectations that virgins should be uninformed about sex, sexuality and even HIV and AIDS, lead to young people in the church not only getting pregnant but getting infected with HIV and other sexually transmitted disease as well because of their ignorance. Females are coerced to pretend to be virgins even if they are not, lest they are looked down upon or are ex-communicated from church should the church elders and their parents know they are sexually active. In some African countries, schools don't teach sexual and reproductive health and parents (especially fathers) are constrained by a culture that forbids them to talk to their own sons and daughters about sex. Thus the responsibility falls on the shoulders of health workers and youth organisations and even other ill-informed peers who lead others astray (IPPF, UNFPA, Global Coalition on Women and AIDS & Young Positives, 2006:1 & 2).

Most church leaders in Botswana also perpetuate the discrimination against HIV and AIDS and support the stance of pastors in the United States of America who have publicly declared that 'nature itself lashes back when we go against God', and that HIV and AIDS is a punishment from God for sin (Bongmba, 2007:22). Dube (2002:101) and Shu-Acquaye et al (2008:46) confirm that, indeed, some religious groups in Africa believe that AIDS is a divine punishment for those who have been sexually promiscuous. These authors blame this inappropriate public response to HIV and AIDS on cultural (religious) taboos that inhibit open discussions about the

epidemic simply because it spreads primarily through sexual contact. The silence and secrecy then will continue driving stigmatisation and discrimination of the infected and affected, the worst of them being those in the church.

Louw (2006:102) raises a concern that when an issue is supported by a specific theological interpretation, it tends to become a fixed perception. It then leads to the social prejudice gaining theological status with the danger of it robbing the person of his/her human dignity, and even denying some fellow Christians the opportunity to seek medical help, such as testing for HIV and to access education and treatment whether negative or positive. One participant remarked *"We don't really go to hospital for minor illnesses because we believe that 'Ntate – our Father' can cure us of any disease. It is just that this time I had to come for registration because delivery we do it in a hospital so I took the test because I found the opportunity."*

The researcher has discovered that some Christian women will rather be infected than be seen near testing centres, lest they are termed as 'promiscuous' by their families and church mates. On calling for a change in the church's thinking on HIV and AIDS, Archbishop Njongonkulu Ndungane of the Anglican Church in Cape Town observed that the stigma that society has created around the epidemic is causing people to die instead of living positively (Bongmba 2007:23). Bongmba argues that this perception by the churches has created a culture of shame and silence. In many instances, people find it better not to know their status or if they know, not to disclose even to those close to them because they are normally ashamed of themselves. Even the sex workers do not test for HIV due to fear and stigma of the results (Sharma & O'Malley, 2007:48). This makes Christians' fear the worst because of their 'perfect marriage designated-sex' principle in which sexually transmitted disease, including HIV, are taboo.

It is the researcher's opinion that the continuation of stigma surrounding sex and HIV by the Christian society therefore poses a great threat to many young lives in the church as these youngsters are usually naïve and ignorant about sexual and reproductive health issues, including HIV and AIDS (Essex et al., 2002:657). It can then be concluded that judging those who seek VCT of HIV as sinners will continue driving the HIV epidemic in the church as many Christians will avoid from testing centres in fear of being associated with sin, even if

they are sexually active. And this is regrettable because spirituality is supposed to provide a means through which people living with HIV and AIDS can be humanised and the various values associated with death and dying be explored (SADC, 2003:10).

3.3.2.2 Sub-theme 2: Lack of safe sex principle: culture-related unplanned pregnancy

Botswana provides maternal-child health (MCH) and family planning (FP) services for free to citizens and for a small fee for non-citizens. With the advent of HIV and AIDS, VCT and PMTCT/ARV programmes were integrated into these services. Condom use increased as a method of FP and protection from HIV compared to other methods. The Population Services International (PSI) representative in Botswana, Sournitro Ghosh, reported during one of their HIV presentations that condom use increased from 1% in 1988 to 72.9% in 2004 among 15-24 year olds. NACA, ACHAP, BOTUSA and UNAIDS (2005:5) also reported that condom use increased to 49% among the 25-49 year olds.

However, contrary to these positive reports, a concern has been raised that although the Ministry of Health is providing Botswana with condoms and PMTCT, it was worrisome that the numbers of people with HIV and babies born with it were still high (Daily News, August 31, 2007:10). This newspaper reported that of the 1 387 pregnant women who tested for HIV in 2005 in Central District, 701 turned out to be positive while in 2006, of the 1924 that tested, 741 were HIV-positive.

When looking into these reports of continuing HIV-infections and the findings of this study, the researcher concluded that it is possible that some people still lack knowledge on modes of HIV transmission, as one of the participants said *"Ah before I was . . . before I was pregnant I once asked my mother to take me there but she kept on saying she will until now. However, it was not a pressing issue because she showed me her findings and said to me "my child if I am still negative then you are negative, so stop worrying, or maybe you are telling me you are seeing someone?" I quickly said no and indeed I was still a virgin. So . . . so after I got pregnant that's when she advised me to do it so that I can know my status . . ."*

The participant and her mother's response show that they have no reason to believe that the participant needs an HIV test, as long as her mother is HIV-negative. This type of reasoning is common among some Batswana and it shows that people focus on HIV as being sexually transmitted only, while new HIV infections continue to be recorded (especially MTCT of HIV). Weister, Heisler, Laster, Korte, Tlou, Demonner, Phaladze, Bangsberg and Iacopino (2009) also observed that people do not test for HIV when they are of the opinion that they have not done anything that could infect them.

On the contrary, Mukamaambo et al. (2001:ii) and other researchers have documented a very high level of awareness, information and knowledge prevalent on HIV and AIDS aspects throughout Botswana among adults and youth; the problem is putting the information into action. This has been shown by one of the participants in this study who said *"You know, having HIV is such an embarrassment nowadays with all this information flying around . . ."*

This statement confirms that a lot of information has been disseminated so far – so much so that one actually feels embarrassed to be diagnosed with HIV when everybody is expected to protect themselves nowadays and yet they fell pregnant before testing for HIV. Another respondent said *'My reasons are that personally I really did not have plans to - - I did not know I will fall pregnant you know. . . , no, - really I had told myself that I will never bear a child because I have many children. . . , you see what I mean, then 'bang' you are pregnant . . .'*

This kind of response from a participant suggests that there is a worrying gap somewhere because this client has never tested for HIV before and yet has many children. The problem is that there is no guarantee that she would have tested for HIV if she had planned the pregnancy, based on the fact that she had failed to test in three previous pregnancies. She knew neither her status nor that of her past and present partner, and while this participant is struggling with all these decisions, what part did the partners play as they are also vulnerable to contracting HIV and having unplanned-for babies?

The problem of unsafe sex that normally culminates in unplanned pregnancies and HIV-infection among women and men seem to be uniform in many countries, and it normally affects

more women than men and younger women more than older ones. Dr Nomonde Xundu (Head of the HIV/AIDS unit in the Department of Health in South Africa) and Botha, a presenter on SAfm, discussed this phenomenon on SAfm during Gwala's show May 6, 2007. What surfaced is that mostly older men engage in empty, emotionless sexual relationships with young girls, enticing them 'with money, flashy cars and latest cell phones which automatically confuse and bamboozle their minds into unsafe sex'. Most youngsters who get into these unsafe sexual relationships come from poverty-stricken families which makes them very susceptible to material things and illusive relationships.

It should be noted that not all youthful sexual activity is the result of liberal sexual attitudes. Young women in Central and East Africa, for example, are more likely to have sexual intercourse before age 15 and to marry older men than similarly aged women in West Africa (Willis, 2002:55). This author continues to explain that the reasoning at times is that older men seek young girls in the belief that they are less likely to have HIV and, in turn, the infected infect the girls, impregnate them and transmit the virus to their babies. This happens because culturally and due to the immature thinking level of youngsters, they (youngsters) are neither capable of questioning any decision nor are they able to hold the older partners accountable. Hence they often become victims of unplanned pregnancies and HIV- infection.

On the other hand, the researcher believes that these very men are at risk too of being infected with HIV in these intergenerational sexual relationships, for example, in cases where the young girl is a virgin, but has been born with HIV, has been sexually abused before or has voluntarily been sexually active before that very older man approached her. One respondent explained it as follows " . . . *they run around with these small girls who are just after money such that. . . I mean you can imagine . . . my husband sleeps with Girl A, she'll just have him for gas, another married man for clothes, one for food, rent, you name it . . .*" . Willis (2002:55) supports this argument by saying that one in six young women in high school has experienced sexual intercourse with at least four different partners, which places the fifth man at risk of contracting HIV-infection.

At times, some male partners do not disclose their HIV-positive status, but at the same time refuse condom-use and end up knowingly infecting women with HIV while in the process impregnate them (IPPF, UNFPA, Global Coalition on Women and AIDS & Young Positives, 2006:1). This concern was raised in this study when one participant verbalised that as married women they were also scared of testing themselves for HIV because their partners are unfaithful and yet sometimes refuse condoms. Willis (2002:55) claims that 1 500 faithful wives are infected with HIV daily (this constitutes sixty to eighty per cent of women who have only one sexual partner and yet becomes infected). This practice is normally exacerbated by some cultures in which women are raised to believe that a man, especially in Africa, cannot be faithful to one woman, with polygamy often being the rule while monogamy is the exception (Shu-Acquaye et al., 2008:40, 43). Extra-marital, unplanned pregnancies for which normally no prior HIV-testing is done occur under these circumstances.

The Minister of Presidential Affairs and Public Administration in Botswana cautioned participants during a mid-term review of the 2003-2009 National Strategic Framework of HIV/AIDS in Botswana that the country was heading for disaster if the national response to the HIV and AIDS epidemic was left to continue unchecked (Daily News, 2007:2). He continued to say that there was need to check because of the sacrifices made towards the national response, as evidenced by the Government spending the largest amount (54%) of the country's budget on NACA, while 41% was shared among the forces and only 5% was left for other projects in the country. This shows that HIV is not only destroying lives, but has greatly destabilised other crucial developmental needs such as infrastructure, education and finance.

The researcher thus concludes that the situations that some of the participants in this study found themselves in, namely of unplanned pregnancies in unknown HIV-status, can be associated with factors like poor salaries or unemployment. Furthermore, some of our eroded cultural practices like respecting abstinence prior to marriage, fidelity of both partners, family and community social support and general safer sexual and reproductive health rights and practices are also additional factors that contribute to individuals' low self-esteem, who on occasion drink alcoholic beverages and end up pregnant or impregnating and at times infected with HIV - *"... their boyfriends were there ... I did not have a boyfriend then myself and I*

had never slept with anybody . . . we started drinking . . . ah! I don't really know what happened . . . in the morning I felt sore . . . They (her parents) were angry at first because when I told them I don't know who impregnated me they thought I was just being rude . . ." This participant did not know who impregnated her until later in her pregnancy, simply because she was drunk the day she conceived. These are situations that demand aggressive preventative strategies among the not yet infected but sexually active in Botswana.

3.3.3 MAJOR THEME 3: MATERNAL INSTINCT OF ENHANCING CHILD SURVIVAL

In this study, the researcher looked into reasons why participants volunteered for HIV-testing post-conception versus pre-conception. Themes one and two revealed that they feared stigma and discrimination which is still rife but hidden in Botswana. However, on being questioned further as to why they still tested post-conception despite this barrier, one of them said "*. . . to be honest, I was scared for this baby because I - I know if I am positive, I can infect him with this disease. So I couldn't bear the thought of seeing this God's thing suffering when nurses have told us that there is a chance that they may escape the disease if we join this PM - - PMTTC. . . Of course I was still scared but I had no choice now that I am pregnant.*"

This response was somewhat surprising because of the fact that the participants' urge to protect their young ones was greatest when they were already at a greater risk of contracting HIV. Could it be that these participants did not have adequate information on HIV-prevention, care, treatment and support prior to their pregnancies in this HIV and AIDS era? NACA (2006:2) affirmed that 92.7% of the population in Botswana knows about AIDS and 71.1% of women know that HIV-transmission from the mother to the unborn child can be prevented. It is thus alarming to acknowledge that participants in this study fell pregnant prior to testing for HIV although the majority of women in Botswana are said to understand the concept of PMTCT of HIV as NACA has it.

The researcher believes that women understand the concept of PMTCT of HIV differently, that is, they should undergo HIV testing 'after' they fall pregnant in case they need to enrol in

PMTCT of HIV. This was shown in this study because once the same participants who feared the consequences of an HIV-positive result discovered that they were pregnant, they ensured that they underwent VCT of HIV to access PMTCT and other interventions available in the country in case they were HIV-positive.

The Botswana Government started pilot-testing a PMTCT of HIV programme in two cities in April 1999 (Ministry of Health and UNICEF, 1999:14) and provided ARVs from 2002 (UNGASS, 2005:21 of 104). This was in response to 34% of paediatric hospital deaths which were reported to be HIV-related at Nyangabgwe Referral Hospital in Francis town, while Mushi (1999) also reported AIDS to be a leading cause of mortality in children in Gaborone. The majority of these children died before their first birthday, probably because approximately two thirds of them were infected before or during delivery, while a third became infected during breastfeeding and by other means (Clark, 2006:1). The latter reason brings some instability into the researcher's thinking because Shapiro et al. in Peltzer et al. (2005:29) say that as long as HIV remains highly stigmatised there is fear that ,although some women join PMTCT during pregnancy, some may breastfeed even if they are diagnosed positive.

Currently over 89.9% of HIV-positive pregnant women receive ARVs to prevent mother-to-child transmission of HIV countrywide and over 82.3% adults and children with advanced HIV-infection who need ARVs receive them (ACHAP, NACA and UNAIDS, 2008:19, 24). According to the researcher's observation, the majority of women and children who are currently enrolled on ARV treatment are those who had tested during pregnancy to enrol on the PMTCT programme.

Post-implementation of these programmes (PMTCT and ARV) positive responses were revealed by surveys conducted on their effectiveness. For example, during one of the National HIV Prevention Conferences held in Francis town, positive feedback was given about PMTCT to the effect that of the approximately 14 000 babies born each year to HIV-infected women out of the 40 000 live births, 5 700 of them would acquire HIV from their mothers in absence of interventions like PMTCT programme (NACA, ACHAP, BOTUSA and UNAIDS, 2005:16). The remark that was made by the then Health Minister Professor Tlou that ARVs are

a miracle was also observed in the reduction of mother-to-child transmission of HIV-infection rates from 37.4% in 2003 to 32.4% in 2006 among pregnant women (ACHAP, NACA & UNAIDS, 2008:11).

It is understandable that, under normal circumstances, once a female becomes pregnant the urge to protect, nourish and nurture the young one becomes priority in that female's life, regardless of circumstances. This study showed that participants surpassed their fears and tested for HIV for the sake of their babies since they knew that the PMTCT programme might save their babies and themselves, though it may be 'too little too late' for some.

3.3.3.1 Sub-theme: Protection of the baby through PMTCT

In this study, the majority of participants stated that they volunteered for HIV-testing post-conception because they wanted to protect their babies from contracting HIV (through the PMTCT of HIV programme). It should be appreciated that this response was more frequent than others because it always popped up first, or was added secondary to other reasons as to why women did post-conception HIV-testing. One respondent said "*I deeply thought of my baby and then I said . . . you either do something now so that you get treatment to protect him or you delay and lose him to HIV or even die earlier before you take care of him and his siblings.*" This response shows how this mother's concern was for her children and not herself.

Essex et al. (2002:659) observed that fear of social stigma, physical harm; isolation, loneliness and/or abandonment by loved ones, family and friends often compel people to keep their HIV-status a secret until the last minute. This study portrayed the same scenario with participants reporting that the same fear compelled them not to test for HIV until they had no other choice but to protect their babies. Despite their fears, however, they followed a Setswana proverb which says '*Mmangwana o tshwara thipa ka fa bogaleng*' – literally translated to mean 'if it means handling a knife by its sharp end, a mother will do just that to protect her baby'.

In another response, the participant said "*. . . I am still so-o s-c-a-r-e-d of my findings! . . . When that nurse told us we go to the caravan first, I nearly went back home without registering . . .*

but then I said 'my child's life is at stake here' and if Government can protect him, why am I disadvantaging him? I have learnt that PMTCT protects babies if their mothers are positive so I wanted to protect my baby too in case I am positive." Willis (2002:58) confirms that worldwide, approximately seventy per cent of babies born to mothers with HIV on PMTCT programmes will not be infected, and these women put all their hope on the chance that their babies may be among that 70%.

His Excellency, the former president of Botswana, Mr Mogae, also reported on Voice of America television during his state visit to America that the PMTCT programme in Botswana has been effective enough to reduce vertical transmission of HIV from 40% in 1999 to 6% in 2007 (Voice of America television interview, September 19, 2007). This suggests that the majority of babies born to HIV-positive women nowadays can be saved from acquiring the HI virus, if only individuals could take VCT of HIV at the right time, such as before they conceive. The current practice in Botswana is that most women take the HIV-test only when they have come to register for ANC services. This is not ideal because some women register later than 28 weeks of pregnancy, which is the appropriate time for starting the PMTCT of HIV treatment in Botswana.

In view of the literature and the study findings, the researcher has come to believe that the strategy of preventing MTCT of HIV and prolongation of lives by ARVs seems to be understood by an average Motswana woman. The researcher now also understands that the majority of the participants took HIV-testing during pregnancy, just to protect their offspring from HIV-infection despite the fear that initially barred them from doing so. . . *"Once you are pregnant 'Amen', you have to do it because if you don't, your child may get HIV from you and die while in fact you could have taken the test, if you are positive be given ARVs to help him stand a chance of not being infected."*

The women also knew that enrolling in the PMTCT programme was a gateway to ARVs, which will prolong their lives so that they can raise those very infants and their siblings, if any. A Burkina Faso study also suggests that however scary the repercussions of HIV-testing may have been for pregnant women in that country, they still tested so that if positive they could be

treated to avoid further unsuccessful childbearing, as the value of fertility in the Burkina context cannot be overemphasised – just like in most African countries (Pignatelli et al., 2006:350).

The Botswana Government is said to be spending approximately 650 million Pula per year on HIV-testing, provision of ARVs, treatment of opportunistic infections like tuberculosis, cancer, pneumonia and presenting sensitisation/review workshops, the amount which was to be increased to 838.4 million in 2008/2009 according to the Republic of Botswana Budget Speech (2008:25). The researcher therefore looked into saving these large amounts of money by targeting women prior to pregnancy, so that if they are positive only one person (the woman) or two (couple) can be provided with ARVs and treated for opportunistic infections, instead of three (couple and their baby).

Another factor which may save treatment costs is that, sometimes, people decide not to have children once they have been diagnosed with HIV, for example, one woman once described her diagnosis as premature death or ‘saying goodbye to a future with children’ (Hamblin and Reid, 1991). On being questioned whether they will undergo VCT again if they were to fall pregnant again, HIV-positive participants in Peltzer et al. (2005:37) reported that they will not, because they knew their status and had decided not to have another child. This ideology, however, should not be imposed on individuals as some health workers in the USA, India, Russia, Thailand and the Ukraine are reported to have put pressure on HIV-positive women to undergo abortion or sterilisation, regardless of the women’s choices (De Bruyne, 2003:155).

In Botswana, although everybody is made aware that it is every woman’s fundamental human right to have children if she wants to even if she is HIV-positive (NACA, ACHAP, BOTUSA and UNAIDS, 2005:19), the country is worried about some women who know their HIV-positive status and still fall pregnant without informing their partners about their status. The right thing to do for both men and women therefore is for everyone to protect the next person by giving them adequate and honest information about their status for them to make an informed choice prior to conception.

The current practice thus defeats the whole purpose of national HIV prevention as some men get infected unknowingly in the process of procreation, although they too are to blame because currently only 9% (ACHAP, NACA and UNAIDS, 2008:21) are involved, while a higher involvement would mean protection for more men. However, this also highlights the gaps in the PMTCT programme, when compared with pre-conception HIV-testing, as it seems to focus on protecting the child only and leaving out parents as per its main goal (ACHAP, NACA and UNAIDS, 2008:19). Even the United Nations recognised that the health of mothers was not given adequate attention in traditional PMTCT programmes (Peltzer et al., 2005:29), but that pre-conception HIV-testing can adequately fill that gap.

3.4 CONCLUSION

This chapter gave an account of the analysis and interpretation of data collected from pregnant women in Gaborone regarding their reasons for volunteering for post-conception HIV-testing versus testing prior to pregnancy. Themes and sub-themes that emerged from collected data were discussed, enhanced with verbatim quotes from the participants and by literature relevant to the findings.

Chapter 4 will consist of conclusions, guidelines, limitations and recommendations of the study.

CHAPTER FOUR

CONCLUSION, GUIDELINES, LIMITATIONS, RECOMMENDATIONS AND SUMMARY

4.1 INTRODUCTION

This chapter will present conclusions, guidelines, limitations, recommendations and summary of the study. The findings of the study were discussed in the form of themes and sub-themes in Chapter 3. Supportive literature and verbatim quotes from the interviews were integrated into the discussion to contextualise the findings. Recommendations will focus on midwifery practice, education and research.

4.2 CONCLUSION

Findings of this study have revealed that women in Gaborone are a part of the majority of people in this region who are aware of the effects of HIV and AIDS and of how to prevent being affected. In spite of this, HIV-infection rates have continued to soar among them due to the disparity that exists between their knowledge on the one hand and resistance to change behaviour on the other (Southern African Development Community (SADC), 2003:2).

The study revealed that most women know that HIV-testing is the gateway to accessing HIV prevention, care, treatment and support as evidenced by the fact that they tested for HIV when they discovered they were pregnant. Besides, literature has pointed out that timely VCT can save individuals, families and governments huge amounts of money which is currently used on the infected or affected. These funds could then rather be utilised for other basic needs like clothing, education, food, housing and government infrastructure and personnel development, especially in this era of economic depression.

However, fear of stigma and discrimination among people who test positive to HIV frustrate the efforts of massive campaigns for HIV prevention through VCT. This was evidenced by women in this study conceiving while ignorant of their own HIV-status and that of their partners. The reason for their reluctance is that they are scared of being ostracised by their male

partners, family, friends and community should they test positive. But the urge to protect their babies through the PMTCT programme then left the women with no other choice but to test post-conception.

The International Federation of the Red Cross and Red Crescent Societies (2007:29) argues however that HIV-testing and counselling services can only be useful if individuals can acknowledge what it means to be HIV-negative or positive, as people can improve their health and prolong their lives through prevention, treatment, care and support. It is important that our women understand this because although they underwent VCT of HIV to protect their babies, some did it after 28 weeks of pregnancy, which was late for starting an effective PMTCT regimen in Botswana. All of them also volunteered for HIV-testing after already exposing themselves or their partners to HIV-infection.

Through this study the researcher has come to be empathetic to both men and women, because although women are expected to make decisions to undergo the HIV-test for their own sakes, their reproductive health rights and responsibilities are still controlled by males (ignorant and naïve at times), as pre-determined by socio-cultural and economic factors. In addition, demographic factors like age, poor education, unemployment and other factors like early and multiple pregnancies also reduce women's chances of making informed decisions when it comes to HIV-testing prior to pregnancies.

The researcher strongly believes that individual women can still put more effort into making HIV prevention their personal responsibility if correctly empowered by midwives and HIV-counsellors, regardless of their circumstances. Peer-to-peer education among young women should be considered as a strategy to empower them as Pathfinder International (2006:10) says that young women tend to prefer receiving information on sexual issues from same-sex peers. The traditional system and the church should also be seriously engaged, as issues surrounding gender inequalities stem from these two systems. Pathfinder International (2006:21) says gender issues cannot be resolved by addressing them in training sessions; instead the great contribution of a gender perspective is the ability to discuss the differences between masculine and feminine constructions beyond the biological view of anatomy and relate these to culture

and history. In turn, these issues can then be connected to sexual and reproductive health (SRH) and HIV and AIDS among men and women.

It is thus imperative for the powers that be to use the same token (energy and resources) that has been used to encourage condom use, uptake of PMTCT programme, enrolment for ARVs etc from individual level to the nation at large, to now encourage pre-conception HIV-testing for both men and women if this war against HIV is to be won. This is especially important for a younger population like Botswana as 60% of its inhabitants are said to be younger than 45 years old, hence are still sexually active (NACA, 2003-2009:15). Botswana's youth also need to take a pro-active role in participating in existing programmes (outreach health services and income generating activities) to attain independence if we are to attain an AIDS-free generation. These programmes enhance informed decision making and positive behaviour, both of which are reported to have contributed to reduction in prevalence rates of HIV in Kenya, Uganda and Thailand.

In this study, the women reported being scared of losing their partners and hence they risked their lives and those of their partners by engaging in unprotected sex with partners who neither accepted VCT nor used condoms consistently. NACA, ACHAP, BOTUSA and UNAIDS (2005:19) reiterate that men and women's power determines their ability to control whether and when, and the terms on which to engage in sexual relationships and whom they are dependent on for food and shelter, among other issues.

Marcus (2004:9) says an individual struggle is unlikely to make significant inroads into the disease and its consequences if there is no clear and unequivocal commitment from respective governments that is purposely translated into practical and meaningful interventions on a significantly different scale. Thus, if one's behaviour has to be changed, one needs to be viewed within one's gender, demographic, economic, political, cultural, epidemiological and organisational context (SADC, 2003:2).

It is therefore vital to re-join hands and fight stigma and discrimination against PLHIV and empower women, men and especially the youth to make and share informed sex and sexuality decisions, since all of them are at risk of contracting HIV in the current practice. This is

especially important not just prior to pregnancy but prior to engaging in sexual activities of any nature as timely diagnosis means timely treatment and management.

4.3 GUIDELINES

The researcher formulated the following guidelines to assist in the quest for pre-conception HIV-testing for Batswana women:

4.3.1 Guideline 1: Embark on spearheading a family and community-centred approach towards HIV prevention, versus the common feminine-centred approach to address stigmatisation and discriminatory practices.

The following could assist in the constitution of a community-partnership programme:

- Midwives and HIV-counsellors should compile a community profile to assess and diagnose perceived or actual behaviours that constitute stigma and discrimination, such as social isolation of clients in homes, regardless of socio-economic status.
- Midwives and HIV-counsellors should identify communities at risk to address their identified needs (implement an educational community programme based on HIV prevention), for example, the monogamous San (Basarwa) and the polygamous Shona (Bazezuru) normally marry traditionally and start childbearing as early as 12 years. Families and communities should thus be educated to support pre-conception HIV-testing as women's decisions to participate in HIV prevention programmes (testing for HIV, disclosure of status and complying with drug treatment and infant feeding) are influenced by opinions of partners, family and community members.
- Midwives and HIV-counsellors should start marketing all SRH programmes (FP, MCH, VCT of HIV and PMTCT of HIV) with vigour to both men and women so that, should they intentionally or unintentionally fall pregnant, they would have done pre-conception HIV-testing together. This will change the mindset of service providers and recipients of care as currently most HIV prevention approaches are based on family planning and population strategies that tend to target women rather than men (SADC, 2003:9).

- Midwives and HIV-counsellors should be gender- and age-sensitive on recruiting, empowering and retaining Village Health Committee (VHC) members, Home-based Care (HBC) members and peer education members so that men, women and the youth can target their peers (men-to-men, women-to-women and youth-to-youth) with SRH education, including pre-conception HIV-testing at the workplaces of men, women and the youth, as well as at social gatherings like bars, parties, sports, weddings, funerals, church and homes. This will even empower male partners to care for their female partners in their own homes in cases of ill-health or during the lying-in period, instead of sending them away to other female caregivers which is otherwise condoned by Tswana culture.
- Midwives and counsellors should ask for slots in traditional *Kgotla* (ward) meetings and political gatherings to encourage adults to openly discuss SRH issues (including pre-conception HIV-testing) among themselves, so that they can be comfortable discussing it with their children at home, especially when they counsel them prior to marriage. The latest traditional initiation groups in Mochudi (*bogwera and bojale*) which is focused on males' circumcision coupled with responsible family life education for both men and women can be targeted to spread the concept of pre-conception HIV-testing. For parents who still find this difficult, promotional material in different languages can be written to hand out to them and to vulnerable sexually active groups to inform them of traditionally constructed misconceptions, myths and taboos.

4.3.2 Guideline 2: Provide holistic care which is culturally sensitive to all clients but based on the country's Constitution, policies, standards and patients' bill of rights regarding sexual and reproductive health issues, including HIV and AIDS

- Local and expatriate midwives and HIV-counsellors should be open-minded enough to be aware of their own and their clients' religious and traditional practices pertaining to SRH issues (inclusive of pre-conception HIV-testing) so that they can render holistic SRH care to all clients, regardless of their religious and traditional cultural backgrounds. This will assist them in encouraging harmless practices and diplomatically discouraging harmful ones. For example, breastfeeding is healthy for children of mothers who did pre-conceptual HIV-testing and have confirmed their negative status just before delivery while the same

practice may transmit HIV to the child if the mother is HIV-positive but did not have herself tested prior to delivery.

- The Ministry of Health, through experienced unit managers, should nurture a standard practice by supporting incoming employees (newly appointed midwives and counsellors as well as transfers) with induction, constituting relevant policies, the country's Constitution, regulations and guidelines regarding the handling of clients infected and affected by HIV and AIDS, regardless of whether they are fellow employees or patients, as HIV is a medico-legal and social problem and they might find themselves breaking the law due to ignorance.
- Through various committees in the health facility and the community, midwives and HIV-counsellors should educate and empower traditional birth attendants (TBAs) with IEC on pre-conception HIV-testing as there are still some women who opt for reproductive health-related massages at these traditional practitioners, whether pregnant or not, and some actually get delivered at home by these TBAs regardless of their HIV-status.
- Short or refresher courses on communication skills should be incorporated into midwives and counsellors' training and practice to enhance their approach to a culturally-sensitive communication about sex and sex-related issues, such as pre-conception HIV-testing between practitioners and their communities, and between adults and their children.
- Midwives and HIV-counsellors should participate in continuing education programmes to familiarise themselves with updated researched SRH information to better serve their clients holistically.

4.3.3 Guideline 3: Target religious leaders and their followers with sexual and reproductive health (SRH) education

- Midwives and HIV-counsellors should involve church leaders and followers in SRH workshops to empower them on facts relating to SRH issues and HIV, because they are part of the most vulnerable community members who are often overlooked.
- Midwives and HIV-counsellors should convince church leaders to make churches available as testing centres (a health and wellness day can be set up in different churches on different dates). This practice can be beneficial to those who are engaged in or had engaged in

premarital sex, the sexually abused or those young people who may have been born with the disease but were unaware or not disclosed to by their parents. All of them would have the benefit of pre-conception HIV-testing and could seek assistance in time.

- Midwives and HIV-counsellors can engage learned priests or their followers in HIV-related research and other topics on sexual and reproductive health to help disseminate accurate and appropriate information to other members.
- Midwives and HIV-counsellors belonging to different denominations should identify community members to form HIV-clubs and support groups, especially for single mothers in their organisations to inform their church mates on the importance of pre-conception HIV-testing as part of SRH services or as a pre-marital service.
- Midwives and HIV-counsellors should engage church leaders and followers in HIV counselling centres to de-stigmatise members going into the centres for counselling and testing or any other SRH service (this guideline should be nurtured until the church accepts it even in the future as some churches may not support it at the moment).

4.3.4 Guideline 4: Develop strategies to periodically help monitor and evaluate the quality of information, education and communication given to clients on pre-conception HIV-testing

- Midwives and counsellors should also make acquaintance with the outside world so that exchange visits can be arranged for them to copy or share the best practices regarding pre-conception HIV-testing with other countries (they will then implement what is relevant to their setting).
- Evaluation forms can be filled by individuals and couples after receiving the pre-conception HIV-counselling service from either the midwife or the counsellor.
- Periodic surveys can be conducted to determine the knowledge, attitudes and behaviours of clients towards the pre-conception HIV-testing service provided.

4.4 LIMITATIONS

This study looked into reasons why pregnant women in Gaborone city government health facilities volunteered to test for HIV when they were already pregnant and not before they conceived. In this study, the researcher encountered the following:

- The study' findings cannot be generalised as the study was qualitative in nature.
- The interviews were conducted using both Setswana and English; hence some meanings may have been lost during translation of the information into English as some Setswana words can have more than one meaning in English and vice versa.
- As the study was about sex-related issues of pregnancy and HIV, some participants may not have freely and honestly responded to the question asked due to variation in their demographic profile and cultural barriers relating to open communication about sex and sexuality issues.
- The researcher experienced cross-country challenges related to the execution of the research study and thus its completion was a challenge.

4.5 RECOMMENDATIONS



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4.5.1 Recommendations for Midwifery Practice

- Healthcare – A community-partnership programme should be established by midwives, politicians, traditional leaders and church leaders to increase knowledge and skills regarding HIV-testing and treatment.
- A comprehensive policy on pre-conception HIV-testing should be formulated, implemented, monitored and evaluated accordingly for Batswana to ensure that both men and women are empowered to make informed sexual and reproductive health decisions from an early age.
- Midwives and HIV-counsellors need to be engaged in continuing education programmes regarding knowledge and clinical skills related to HIV and cultural traditions, in order to render effective information, education and communication on HIV to all age groups.
- Politicians and the television media need to be approached to formulate clear strategies to market pre-conception HIV-testing at the appropriate time. It should be prior to initiating

the first sexual relationship with a new partner and maintaining HIV preventative behaviour throughout one's lifespan, as opposed to the current practice of encouraging clients to test in order to enrol for PMTCT of HIV when they are pregnant (already at a higher risk of being infected). The service should be offered simultaneously with all other SRH services starting from the teen years into late adulthood.

- Midwives and counsellors should encourage couple counselling to de-feminise pre-conception HIV-testing and overcome social taboos on discussing sexual matters in the home, across generations or even among women or men singly or as a group, as these taboos and stigma associated with HIV prevent men and women from seeking treatment (Willis, 2002:60). This can increase shared responsibility from family planning to HIV-testing and budding if ARVs have to be taken.
- All midwives and counsellors should be conscious of and respect their clients' cultural and religious beliefs and practices for them to render appropriate cultural and gender-sensitive HIV prevention education, care, treatment and support (Shu-Acquaye et al., 2008:42). In order to achieve this, the role players should receive in-service training on gender-sensitive and cultural-sensitive HIV education.
- The universal principles of precaution procedures to prevent HIV transmission through other methods should be discussed openly with clients, caregivers, family members and community groups (Mukamaambo et al., 2001:37), because it was found in this study that they had been ignored.
- At each contact opportunity all midwives and counsellors should assure clients of their right to privacy and confidentiality at all times, as in this study it was clear that they were scared of divulging any information due to lack of trust in the staff and the system. Clients should, at each meeting, be assured that divulging any information to family or partner(s) without their consent is punishable by law.

4.5.2 Recommendations for further midwifery research

- The researcher recommends that the study be expanded to the rest of the country (Botswana) to cover a larger population so that findings can be generalised to the whole country.

- A study can be conducted to determine the experiences of women who report to ANC without knowing their HIV-status and then are diagnosed as HIV-positive.
- A study can be performed in which the stance of church leaders regarding HIV-testing is determined, as part of a healthcare-religious partnership programme.
- A study can be conducted to determine the practicing midwives' attitudes and practices towards women who report to ANC without knowing their HIV-status.
- A study on knowledge, attitudes and practices of various community segments (men, non-pregnant women, Christians, youth etc) towards pre-conception HIV-testing can be done.
- A quantitative approach can be engaged to carry out this study to compare the results with those of qualitative approach.

4.5.3 Recommendations for midwifery education

- The current basic midwifery curriculum should incorporate and promote pre-conception HIV-testing over and above PMTCT as is the case at the moment in Botswana, so that student midwives can get used to offering pre-conception HIV-testing to clients as she would any other SRH service from training.
- Life skills coaching workshops/in-service training should be provided to both training and practising midwives so that they can efficiently and effectively assist young people when offering them SRH services in the current 'Youth Friendly Corners' in MCH/FP clinics.
- During training of midwifery students, traditional methods of family planning, such as abstinence, should be emphasised, followed by pre-sexual HIV-testing before one can use modern forms of family planning, just like Pap smear and urinalysis are done prior to issuing family planning commodities. This will contribute to pre-conception HIV-testing.
- Midwifery students should undertake research studies on topics like knowledge, attitudes and practices towards pre-conception HIV-testing among teens, the youth and older couples or those in intergenerational/extra-marital relationships.
- Student midwives should be encouraged to explore, identify and report rife cultural myths and taboos in Botswana pertaining to SRH services, so that research can be done to explore them. Then an evidence-based education be provided to the public to dispel the myths.

- Midwifery practitioners should subscribe to journals and make a habit of reading and attending conferences to familiarise themselves with updated researched midwifery information to better serve their clients holistically.

4.6 SUMMARY

In this study, the researcher explored and described the reasons why pregnant women volunteered to test for HIV post-conception, versus pre-conception in Gaborone City council clinics. Fear of stigma and discrimination from partners, family, friends and community was the core of their reasoning. However, once they discovered that they were pregnant, they went on to have themselves tested for HIV to protect their children from vertical transmission of HIV in case they were HIV-positive, despite the consequences of being found out.

Limitations of the study were discussed, followed by outlining recommendations for midwifery practice, midwifery research and midwifery education. Finally, guidelines that can improve the women and their partners' uptake of VCT pre-conception were also established.

The researcher discovered through this study that clients in Botswana understand the concept of PMTCT of HIV to mean testing for HIV post-conception in order to enrol in the PMTCT programme in case one is HIV-positive. This stance seems to be taken even by the rest of the world as the literature reviewed showed reports on PMTCT of HIV studies as those that have been done on women who were already pregnant. Women will be scared to test for HIV prior to pregnancy, but when they fall pregnant, they would come forth and test for HIV and join the PMTCT of HIV programme if need be. This shows that there is a need to re-orientate clients that pre-conception HIV-testing is more beneficial in PMTCT of HIV than post-conception.

The researcher thus intends to share the study findings with other health workers, the media, politicians, training institutions and community leaders through publishing it electronically and providing hard copies to a few institutions like Botswana Ministry of Health – Health Research Unit; University of Johannesburg and University of Botswana. Findings will also be disseminated verbally and otherwise during research conferences locally and internationally at

every opportunity. Consumers of healthcare services will be informed in health education 'morning talks' in Botswana health facilities and even in relevant gatherings such as in churches and at social gatherings.



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ANNEXURES:

ANNEXURE A: REQUEST LETTER FOR CONSENT FROM UNIVERSITY OF JOHANNESBURG (UJ) TO CONDUCT THE STUDY BY THE RESEARCHER



DEPARTMENT OF NURSING

Telephone: (011) 489 3651

Fax : (011) 489 2257

2007-02-28

Dear Sir/Madam,

REQUEST TO CONDUCT RESEARCH

UNIVERSITY
OF
JOHANNESBURG

I, BG Motseotsile, am currently a post-graduate student at the University of Johannesburg in the Republic of South Africa in the Midwifery Programme and would like to request permission to conduct a research study in the city council clinics.

The topic of my research is “REASONS FOR VOLUNTEERING FOR POST-CONCEPTION HIV-TESTING AMONG PREGNANT WOMEN IN GABORONE, BOTSWANA”.

The purpose of this study is:

To explore and describe reasons why pregnant women volunteer for post-conception HIV tests as opposed to pre-conception.

To formulate guidelines which will improve IEC and skill of midwives and HIV counsellors, hence facilitate uptake of pre-conception HIV-testing among women and men of childbearing age as opposed to the current post-conception testing.

I hereby ask for your permission to conduct interviews with pregnant women who meet the following inclusion criteria:

HIV-tested pregnant women, aged 21-49 years (regardless of their HIV status), attending ANC in Gaborone city council clinics of Broadhurst 3, Block 9, Gaborone West, Village and Old Naledi who did the HIV-test during pregnancy.

Those who are Setswana or English-speaking and are willing to participate in the study.

The researcher will adhere to the following ethical guidelines:

Participation in the research is voluntary and participants may decide to withdraw from the project at any given time, without any obligation.

The right to privacy of participants in this study will be protected by informing them of the study objectives and obtaining verbal consent, instead of written and that sharing of their information will happen on a voluntary basis except for the general grouped findings of the study.

Data will be collected by interviews and none of the participants in the study will be expected to reveal their HIV status. The interviews will be transcribed, after which the data obtained will be analysed.

The audio-recordings will be kept safe and after interpretation of the data they will be destroyed. The data will only be used for the purpose of this study.

Findings of the research will be made available to your institution once the study has been completed.

Your letter indicating approval for the interviews to be conducted can be addressed to me at the following address:

B.G. Motseotsile
P.O. Box 4087
Gaborone
BOTSWANA



Contact details:

+27 72 961 4505 (South Africa) and 092677 1658 132 (Botswana)

bgmotse@yahoo.co.uk

Regards

**BG MOTSEOTSILE
RESEARCHER**

**DW DU PLESSIS
DOCTOR AND SUPERVISOR**

**S BEUKES
DOCTOR AND CO-SUPERVISOR**

**ANNEXURE B: PERMISSION LETTER TO CONDUCT THE RESEARCH FROM
UJ TO THE RESEARCHER**



**FACULTY OF HEALTH SCIENCES
ACADEMIC ETHICS COMMITTEE**

02 MAY 2007

Clearance Reference Number: 17/07

TO WHOM IT MAY CONCERN

TITLE OF RESEARCH PROJECT: "Reasons for volunteering for post-conception HIV testing among pregnant women in Gaborone, Botswana"

RESEARCHER: Motseotile B

**SUPERVISOR: DR DW du Plessis
Dr S Beukes**

The Committee for Academic Ethics of the Faculty of Health Sciences of the University of Johannesburg evaluated the research proposal and consent letters of the above research project and confirms that it complies with the approved Ethical Research Standards of University of Johannesburg.

The study supervisor and researcher demonstrated their intent to comply with approved Ethical Research Standards during conduct of the research project.

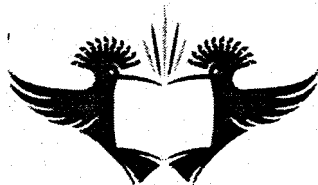
Attached please find the recommended changes to improve the quality of your proposal.

Changes must be submitted to the satisfactory of the supervisor/s.

Kind Regards

**MS M H Selolo
FACULTY RESEARCH ADMINISTRATOR.**

ANNEXURE C: REQUEST LETTER FOR PERMISSION FROM HEALTH RESEARCH UNIT IN BOTSWANA TO CONDUCT A RESEARCH STUDY



UNIVERSITY
OF
JOHANNESBURG

DEPARTMENT OF NURSING

Telephone: (011) 489 3651

Fax: (011) 489 2257

2007-02-28

The Health Research Committee
Health Research Unit
Private Bag 0038
Gaborone
Botswana



UNIVERSITY
OF
JOHANNESBURG

Dear Sir/Madam,

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I, BG Motseotsile, am currently a post-graduate student at the University of Johannesburg in the Republic of South Africa in the Midwifery Programme and would like to request permission to conduct a research study in the Gaborone city council clinics.

The topic of my research is "REASONS FOR VOLUNTEERING FOR POST-CONCEPTION HIV-TESTING AMONG PREGNANT WOMEN IN GABORONE CITY COUNCIL CLINICS, BOTSWANA".

The purpose of this study is:

- To explore and describe reasons why pregnant women volunteer for post-conception HIV-tests as opposed to pre-conception.
- To formulate guidelines which will improve IEC and skill of midwives and HIV-counsellors, hence facilitate uptake of pre-conception HIV-testing among women and men of childbearing age as opposed to the current post-conception testing.

I hereby ask for your permission to conduct interviews with pregnant women who meet the following selection criteria for inclusion in the study. The criteria for inclusion are:

- HIV-tested pregnant women aged 21-49 years (regardless of their HIV status) attending ANC in Gaborone city council clinics (Broadhurst 3, Block 9, Gaborone West, Village and Old Naledi) who did the HIV-test during pregnancy
- Those who are Setswana or English speaking and are willing to participate in the study.

The researcher will adhere to the following ethical guidelines:

- Participation in the research is voluntary and participants may decide to withdraw from the project at any given time, without any obligation.
- The right to privacy of participants in this study will be protected by ensuring that verbal consent is received to participate in the study, and informing them that the sharing of information will happen on a voluntary basis.
- Data will be collected by means of interviews and none of the participants in the study will be expected to reveal their HIV status. The interviews will be transcribed, after which the data obtained will be analysed.
- The audio-recordings will be kept safe and after interpretation of the data they will be destroyed. The data will only be used for the purpose of this study.
- Findings of the research will be made available to your institution once the study has been completed.

Your letter indicating approval for the interviews to be conducted can be addressed to me at the following address:

B.G. Motseotsile
P.O. Box 4087
Gaborone
BOTSWANA



UNIVERSITY
OF
JOHANNESBURG

Contact details:

+27 72 961 4505 (South Africa) and 092677 1658 132 (Botswana)

bgmotse@yahoo.co.uk

Regards

**BG MOTSEOTSILE
RESEARCHER**

**DW DU PLESSIS
DOCTOR AND SUPERVISOR**

**S BEUKES
DOCTOR AND CO-SUPERVISOR**

**ANNEXURE D: PERMISSION GRANTED BY THE MINISTRY OF HEALTH-
RESEARCH UNIT TO CONDUCT THE STUDY**

TELEPHONE: 3632000
FAX: 3914467
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD



MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE
BOTSWANA

REPUBLIC OF BOTSWANA

REFERENCE No: PPME-13/18 US Vol II (12) July 18, 2007

Baitlhatswi Gaolatlhe Motseotsile
P.O. Box 4087
Gaborone

**Permit : REASONS FOR VOLUNTEERING FOR POST-
CONCEPTION HIV TESTING AMONG PREGNANT WOMEN IN
GABORONE CITY COUNCIL CLINICS, BOTSWANA**

Your application for a research permit for the above stated research protocol refers. We note that you have satisfactory revised the protocol as per our suggestions. .

Permission is therefore granted to conduct the above mentioned study. This approval is valid for a period of 1 year effective July 18, 2007.

This permit does not however give you authority to collect data from the selected facilities without prior approval from the management of the facilities. Furthermore, consent should be obtained from all participants.

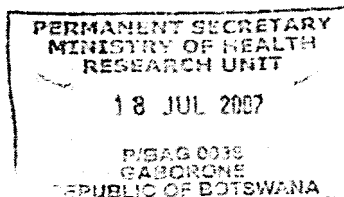
The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal will need to be resubmitted to the Health Research Unit in the Ministry of Health.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research Unit, Ministry of Health within 3 months of completion of the study.

Approval is for academic fulfilment only

Thank you,

S. El-Halabi
For/Permanent Secretary Ministry of Health



ANNEXURE E: REQUEST LETTER FOR RESEARCH SUBJECTS TO VOLUNTEER TO PARTICIPATE IN THE STUDY



UNIVERSITY
OF
JOHANNESBURG

DEPARTMENT OF NURSING

Telephone: (011) 489 3651

Fax: (011) 489 2257

2007-02-28

Dear Participant



UNIVERSITY
OF
JOHANNESBURG

PERMISSION TO CONDUCT RESEARCH

I, BG Motseotsile, would like to invite you to participate in my research project on reasons why pregnant women volunteer for post-conception HIV-tests as opposed to pre-conception. I hereby request your *verbal permission* that the information provided by you during these interview, may be used for the purpose of this study.

The topic of my research is: "REASONS FOR VOLUNTEERING FOR POST-CONCEPTION HIV-TESTING AMONG PREGNANT WOMEN IN GABORONE CITY COUNCIL, BOTSWANA". My supervisor is Doctor D du Plessis and co-supervisor is Dr S Beukes (University of Johannesburg, South Africa).

The objectives of this research are:

- To explore and describe reasons why pregnant women volunteer for post-conception HIV-testing as opposed to pre-conception.
- To formulate guidelines which will improve IEC and skill of midwives and HIV counsellors, hence facilitate uptake of pre-conception HIV-testing among women and men of childbearing age as opposed to the current post-conception testing.

Through your participation in this study you will be able to make a positive contribution to Midwifery. You have been purposefully chosen for this study. Your participation in the Research is voluntary and you may withdraw at any given time from the study. Measures will be in place to protect your anonymity and identity and all information will be dealt with in strict confidentiality. If the need arises, you will be accorded the necessary counselling by counsellors available in this clinic.

Information required will be collected through the conduction of an approximately **one-hour** interview and will be recorded on audiotapes. I hereby also request your permission to make an audio-recording of your interview. The audiotape/s will be safely stored and once the data have been analysed, they will be destroyed. A coding system will be used and your identity will not be revealed on the audiotape/s, thus further ensuring anonymity.

Your input in this research project is highly appreciated and the findings will be availed to you in combination with the others in a report form.

Contact details:

092 677 1658 132 (Botswana)

bgmotse@yahoo.co.uk

BG MOTSEOTSILE
RESEARCHER



UNIVERSITY
OF
JOHANNESBURG

DW DU PLESSIS
DOCTOR AND SUPERVISOR

S BEUKES
DOCTOR AND CO-SUPERVISOR

ANNEXURE F: TETLELELO YA GO DIRA PATLISISO



DEPARTMENT OF NURSING

Telephone: (011) 489 3651

Fax: (011) 489 2257

2007-06-07

Go Motsaakarolo

TETLELELO YA GO DIRA PATLISISO MO KA WENA

Kele, B G Motseotsile, ke go laletsa go tsenelela patlisiso e ke e dirang mabapi le mabaka a a dirang gore bomme ba ba itsholofetseng ba ithaopele go itlhatlhobela mogare wa HIV fa ba setse ba imile gona le pele ba ima. Ka jalo, ke kopa gore o mphe tetla ka molomo (o sa kwale gope) gore se o tla a se buang mo potsisisong e, se ka dirisiwa mo patlisisong e.

Setlhogo sa patlisiso yame ke **“MABAKA A GO ITHAOPELA ITLHATLHOBO YA MOGARE WA HIV GA BOMME BA BA SETSENG BA ITSHOLOFETSE MO KGAOLONG YA GABORONE, BOTSWANA”** : **“REASONS FOR VOLUNTEERING FOR POST-CONCEPTION HIV TESTING AMONG PREGNANT WOMEN IN GABORONE, BOTSWANA”**. Batlhatlheledi bame ke Doctor D du Plessis le Dr S Beukes (University of Johannesburg, South Africa). Maikaelelo a patlisiso yame ke:

- Go sekaseka le go nankolola mabaka a a dirang gore bomme ba ithaopele go itlhatlhobela mogare wa HIV ba setse ba imile gona le pele ga ba ima.
- Go tlhama kana go kwala dikaedi-seka-melawana (guidelines) tse di ka thusang baoki ba botsogo jwa bomme (midwives) le bagakolodi/basidilatlhaloganyo ba mogare wa HIV/AIDS go nonotsha dithuto, dipuisanyo (IEC) le boitsaanape jwa bone mabapi le itlhatlhobelo mogare pele ga motho a ima go na le jaaka go dirwa gompieno.

Go tsaya karolo ga gago mo patlisisong e go tla a dira phetogo e e maleba mo booking jwa botsogo jwa bomme. Ga o a tlhophiwa ka phoso, o tlhophilwe ka maikaelelo. Mme fela go tsaya karolo ga gago mo patlisisong e, ga go patike ka ebile o a letlelesega go tlogela nako

nngwe le nngwe fa o batla. Ke tla a dira gotlhe mo bokgoning jwame go sireletsa boleng jwa gago le tsotlhe tse re di buang e tla a nna sephiri se se ka se amanngweng le wena. Fa go tlhokafala, o tla a fiwa tshidilo-maikutlo ke basidila-maikutlo ba ba teng mo kokelwaneng e ya rona e.

Potsolotso ya rona mmogo e tla a tsaya selekanyo sa oura mme ebile ke kopa go e gatisa ka radio e e kapang mantswe (audio tapes). Dikapamantswe (audio tapes) tsa teng di bewa fa go sireletsegileng, mme ere go sena go sekasekwa puisanyo di senngwe. Re dirisa maemedi mo boemong jwa maina a gago, ka jalo gore o mang go ka se tlhalosege, se e le gone go leka gore o seka wa itsiwe ke ope gotlhelele mo dikapa-mantsweng.

Tsenyo-letsogo ya gago e botlhokwa thatathata mo patlisisong e, le maduo a yone o tla a itsisiwe ka go begelwa mo kokelwaneng ya gago a kopantswe le a ba bangwe.

Contact details:

092677 1658 132 (Botswana)

bgmotse@yahoo.co.uk

**BG MOTSEOTSILE
RESEARCHER**

**DW DU PLESSIS
DOCTOR AND SUPERVISOR**



UNIVERSITY
OF
JOHANNESBURG

**S BEUKES
DOCTOR AND CO-SUPERVISOR**

ANNEXURE G: DEMOGRAPHIC DATA AND STUDY QUESTION

1. Age / *Dingwaga*

Tick like this (✓) / *Tshwaya jaana*

21-25	
26-30	
31-35	
36-40	
41 and above	

2. Marital status / *Seemo sa lonyalo*

Tick like this (✓) / *Tshwaya jaana*

Married/ <i>Nyetswe</i>	
Single/ <i>Ga ke a nyalwa</i>	
Cohabiting/ <i>Nna mmogo</i>	
Divorced/Separated/ <i>Kgaogane</i>	
Widowed/ <i>Swetswe</i>	

3. What is your educational level? *O tsene sekolo go fitlha fa kae?*

Tick like this (✓) / *Tshwaya jaana*

None/ <i>Ga ke a se tsena</i>	
Primary/ <i>Se se botlana</i>	
Secondary/ <i>Se se golwane</i>	
Tertiary/ <i>Mmadikolo/Kholitshi</i>	

4. What is your employment status / *A o a bereka?*

Tick like this (✓) / *Tshwaya jaana*

Unemployed/ <i>Ga ke bereke</i>	
Temporary/Part time/ <i>Ke tshwareletse</i>	
Regular job/ <i>Ee ke a bereka</i>	
Self-employed/ <i>Ke a ipereka</i>	
Other/ <i>Sengwe fela</i>	
Explain/ <i>Tlhalosa</i>	

5. What is your main occupation? (If currently unemployed, state your most recent occupation)/*Tiro ya gago totatota ke eng? (Fa o sa tlhole o bereka, bolela tiro e o neng o e bereka mo bogaufing)* Tick like this (✓) / *Tshwaya jaana*

Professional/ <i>Ke modiri-mogolo ka tsela e e faphegileng</i>	
Office employee/ <i>Ke dira mo di-ofising</i>	
Student/ <i>Moithuti</i>	
Menial jobs/ <i>Ditiro tse di sa tlhokeng botsipa jo bo rileng (Hairdresser/ Loga/dira meriri; sales person/morekisi mo kgwebong; Self-employed/ Ke a ipereka; Labourer/Ke malaisa (Farming, Transport, Construction etc); Cleaner /Mophephafatsi wa dikago; Domestic help/Ke thusa mo lwapeng</i>	
Housewife/ <i>Mmalolwapa</i>	
Others...../ <i>Ke dira tiro ee sa kwalwang fa.....</i>	

6. What is your estimated monthly income / *O amogela bo bokae ka kgwedi?*

Tick like this (✓) / *Tshwaya jaana*

<i>Pula per month/Kamogelo</i>	
Allowance from home/institution	
< 499	
500 - 999	
1000 - 1499	
1500 - 1999	
> 2000	

8. Please share with me the reasons why you volunteered to undergo the HIV-test when you were already pregnant and not before you fell pregnant./*Ke kopa gore o mpolelele mabaka a a dirileng gore o ithaopele go itlhatlhobela mogare wa HIV o setse o imile/itsholofetse go na le pele ga o ima?*-----



UNIVERSITY
OF
JOHANNESBURG

ANNEXURE H: TRANSCRIPT OF AN AUDIO-TAPE INTERVIEW

KEY: R: RESEARCHER

P: PARTICIPANT

PARTICIPANT H

R: Can you please tell me the reasons why you volunteered to test for HIV when you were already pregnant and not before you conceived?

P: I wanted to know my status so that if I am positive I can join PMTCT. Isn't it that you guys advice us to do so nowadays?

R: Oh yes, yes. But can you tell me more about the reasoning behind you taking the test after you got pregnant as you did, as opposed to doing it before you got pregnant?

P: Oh ok! Hei my sister! you know taking an HIV test is not a child's play. You see, as much as I wanted to test myself all these years, I just couldn't be woman enough to come forth and test myself because I . . . I was so scared of my findings. You know, having HIV is such an embarrassment nowadays with all this information flying around, and you know the painful part is that it just doesn't affect you alone, it goes all the way to affect your children, you can lose your relationship with people close to you especially the one you sleep with and those that call themselves your friends. You know, as long as people don't know your status, they actually don't mind even sharing a cup with you, but hei! Wait until anyone of them knows you are HIV-positive, I mean . . . everybody starts shying away from you so sometimes it's better to stay in the dark until. . . I mean (shrugging her shoulders). . Yah . . . that time when you don't have a choice like now. You know, you have to be prepared to change your life if you decide to take an HIV-test, you see as for us married women, you know you can lose the very man you are married to even if he knows very well that it's him who has been sleeping around. They are actually the ones spreading this disease because these men are just all over with their

'small houses' nowadays although yes, we know it's not a new thing but in the olden days there was no HIV and actually there would only be one concubine where you can trace your man to, unlike nowadays . . . iyoo. . . they run around with these small girls who are just after money such that . . . I mean you can imagine the risk they put us at because say my husband sleeps with Girl A, she'll just have him for gas, another married man for clothes, one for food, rent, you name it and the next thing when they come home they refuse to use condoms hence we are scared too to test for HIV even though we know maybe some people think married women shouldn't be scared of HIV. I think this is where PMTCT comes in because you were asking me why test now. I deeply thought of my baby and then I said 'come on big girl, this poor soul is already on the way so you either do something now so that you get treatment to protect him or you delay and lose him to HIV or even die earlier before you take care of him and his siblings'. So by God's grace I bit my lower lip and did it, and yes thank God I am negative. I am so overjoyed I couldn't resist telling you even though you said I shouldn't, I mean with a man who drinks, I never thought I will still be negative this time. I am going to put my foot down now to remain negative even though they told me about the window period, hei why spoil my happiness by thinking the negative when I have hit this jackpot? Oh ma'm you must think I am a lunatic, you too. . why do you allow me to talk and talk and talk like this without stopping me? Anyway this is my big day my sister, I feel like telling everybody about it. It's such a relief I feel a big weight has been lifted off my shoulders, I was honestly scared. . . (Silence) . . .

R: No-o-o. Actually I am all ears. Like I said , I want to hear more from you guys to be able to understand the reasons why you have the 'fear' that you voiced before conceiving and yet you overcame it when you are now pregnant?

P: Yah. Like I said, it was “ha e sule e sule my sister – once it’s dead its dead my sister”. Once you are pregnant ‘Amen’, you have to do it because if you don’t, your child may get HIV from you and die while in fact you could have taken the test, if you are positive be given ARVs to help him stand a chance of not being infected. Another thing is that nowadays we see people living longer on ARVs, some whom we have even given up on have ‘4-cornered buttocks’ you won’t even believe they were once down so I believe I thought of that too and decided why can’t I be strong today and take this test so that I can be assisted to live longer? I mean you guys are so good to us, I mean our government is seriously spoiling us; imagine being given milk for free for the baby? I mean we honestly do not have any good reason why we shouldn’t join PMTCT because it’s like being given food in a silver platter while other people are suffering, except of course for this stupid fear that yes, with the counselling that we are given, we should be able to overcome. Imagine the poor XXXX (mentions one country)? I doubt if they get any of these services because they are actually struggling for food. . . . (Silence)

R: Yes, you are right. For now we still have better services than other countries. So you were saying your reason for testing during and not before pregnancy was that you were scared of the consequences of HIV-positive findings which include being embarrassment, being ostracised by family and friends but now you did it to protect your baby and prolong your life with ARVs in case you were positive?

P: My point exactly. I didn’t want my child to die of HIV when there are free services, not that he/she can’t die from other causes but HIV was not supposed to be one of them even though yes, I was scared. I know I should have tested but I couldn’t until now that I didn’t have a choice because of the baby. This baby actually helped me to do what I had wanted to do for so long but couldn’t bring myself to do it. You see with the previous children that I had, this disease was there but it wasn’t this cruel and probably because we just married, we were so

excited we never really thought of it whenever we wanted a child, unlike nowadays when you look around yourselves and you see how crazy men are, not that I don't really trust my husband but I have to be realistic my sister. And again I think nurses were not so pushy about it like now. I mean the messages were not everywhere like now and I think we were either too scared to care or too ignorant to take the heed like now. Hei mma I talked a lot, it's my turn now to ask you questions. There are certain things that I still do not understand. Can we turn the tables on you now?

R: Oh yes, yes. No let me thank you first for your valuable information. In case I have further questions to ask you, can I see you next week when you come for your next visit?

P: Yah no problem. Thank you too.

