AN ASSESSMENT OF PREGNANT WOMEN’S ATTITUDES TOWARDS HUMAN IMMUNO-DEFICIENCY VIRUS (HIV) COUNSELING AND TESTING IN URBAN ZIMBABWE: A STUDY OF RUJEKO MATERNITY CLINIC IN DZIVARASEKWA HIGH DENSITY SUBURB, HARARE.

BY

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ABSTRACT

The purpose of this study was to assess the attitudes pregnant women have towards Human immune-deficiency virus (HIV) counseling and testing. The study’s objectives were to determine the basic characteristics of the respondents, to identify attitudes of pregnant women aged between 15-49 years, identify aspects of the policy on HIV counseling and testing and to draw recommendations on attitudes pregnant women have on HIV counseling and testing for policy makers and planners to review the policy, If need be. The main purpose of this study was to assess the attitudes of pregnant women towards HIV counseling and testing in urban settings. The study location was Rujeko maternity clinic in Dzivarasekwa High Density suburb of the City of Harare. With regard to the study methodology, its design was mainly qualitative and purposive sampling was used to select 8 pregnant women who had visited the clinic in their first pregnancy for ante-natal care. 5 key informants were drawn from the clinic staff and included the Matron, Sister-in-Charge and 3 maternity nurses/ counselors. The respondents were purposively selected at the reception area as they came in to register for ante-natal care. Consent to participate in the study was sought and Focus Group Discussions were conducted. It is from the focus group that those respondents who wished to be interviewed individually were selected for In-depth interviews where an interview was used, observations made and themes were drawn. Socio-demographic characteristics such as age, marital status, religion, location, level of education attained, nature of employment, ethnicity and number of pregnancies one had also determine how pregnant women perceive being tested for HIV. The results of this study showed that pregnant women developed positive attitude towards HIV counseling and testing because of their abundant knowledge about HIV and the benefits associated with being tested while pregnant. Most women who were or intended to become mothers were more concerned about the health of their born and unborn children despite the aversive experiences they go through during ante-natal care. The other results from this study are that pregnant women developed negative attitude towards HIV counseling and testing because of the coercive approach by service providers. The non-involvement of men and their traditional domineering status in most patriarchal societies stimulate the development of negative attitude towards HIV counseling and testing among pregnant women. It was also found out that maternity staff at Rujeko clinic was over-loaded with work since they were double-tasked working both as maternity nurses and as counselors. It is because of fatigue that they end up failing to offer quality services to the pregnant women. Pregnant women spent the whole day registering for ante-natal care at Rujeko clinic. Pregnant women felt offended and disrespected by poor service delivery. This study recommended that HIV counseling and testing at Rujeko clinic be done by the book. Both enough human and appropriate infrastructure should be provided at Rujeko clinic. In conclusion, this study showed that pregnant women’s positive and negative attitudes towards HIV counseling are shaped by several factors which are not limited to social, cultural and psychological issues. It is strongly believed that the findings and recommendations of this study shall be useful tools for policy makers and policy planners in improving the uptake of HIV counseling and testing among pregnant women for the achievement of a zero HIV transmission from mother-to-child and towards the achievement of a free HIV generation in Zimbabwe.
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invaluable input.
DEDICATION

To

My parents Andrew Ginasio and Maria

And

My wife Gau and our daughters Ledwina, Ashley, Amanda and Lindiwe.
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DEFINITION OF KEY TERMS

**Assessment** refers to the act of appraisal or evaluation of objects, events or persons. An **attitude** is a tendency to respond positively or favourably or negatively or unfavourably to certain objects, persons or situations. **Confidentiality** refers to keeping private information about someone, particularly information obtained in the course of employment or duties. **Counseling** refers to an interpersonal interaction between a counselor trained in the techniques of counseling and a client(s) presenting with a problem, that enables the client to talk about, cope and deal with the problem presented in an atmosphere of trust, acceptance and confidentiality. **Epidemic** refers to an outbreak of disease on a scale not normally seen in a given population. **Ethics** are a set of morals, standards or principles used to guide the practice of various professions. **Informed consent** pertains to having an agreement with or permission from a person, e.g. for a medical procedure, after they have clearly understood the meaning of the procedure. **Pregnant** is a word which relates to having a child or other offspring developing in the body. **Testing** refers to a particular process or method for trying or assessing events, objects or persons.
Appendix. D

Focus Group Discussion on the assessment of pregnant women's attitudes towards HIV Counseling and Testing at Rujeko Maternity Clinic

Discussion Guide

1. How do you rate your knowledge and beliefs on HIV Counseling and Testing and MTCT?

2. How do you rate the process of HIV Counseling and Testing at Rujeko Maternity clinic?

3. Can you explain the reasons why pregnant women sometimes decline to have HIV tests?

4. Who makes the decision for pregnant women to be tested for HIV?

5. What can be done to improve the acceptability of HIV Counseling and Testing among pregnant women?

Thank you for participating.
Chapter 1

1.1 Introduction

This chapter will provide an overview of the subject under study.

Background to the study

With an estimated 33.2 million people living with the Human Immunodeficiency Virus (HIV) in 2007, the world today faces one of the greatest health crisis (MOHCW, 2007). In 2007, alone, the epidemic led to an estimated 2.5 million new HIV infections and claimed an estimated 2.1 million lives the world over. An increasing burden is being placed on women and children who are experiencing growing rates of AIDS related illnesses and death in many settings (MOHCW, 2007).

In sub Saharan Africa, over 60% of all adults living with HIV are women. 370 000 children below the age of 15 years were newly infected with HIV mainly through Mother-To-child Transmission (MTCT) in 2007 (MOHCW, 2007). In Zimbabwe 152 000 children are living with HIV, 72 000 children are in need of Antiretroviral Therapy (ART), and 1 000 000 children are estimated to be orphans due to the death of parents because of Acquired Immuno-deficiency Syndrome (AIDS) (MOHCW, 2009). The adult population HIV prevalence in Zimbabwe was estimated at 15.6% at the end of 2007. It means that 1 in 6 adults aged between 15 – 49 years of age in Zimbabwe are living with HIV of which 60% are women (MOHCW, 2007).
The Human Immuno-deficiency Virus (HIV) globally including Zimbabwe is mainly transmitted through unprotected sexual intercourse with an infected partner (92%), from mother (parent) to child during pregnancy, during delivery and during breast-feeding (7%), and through sharing or using sharp needles or objects that would have been used by an HIV positive individual (1%). To date a cure for HIV has not been found. Emphasis is being placed on preventing the transmission of HIV, managing and caring for those affected and infected with HIV (MOHCW, 2007).

The Joint United Nations Programme on HIV/AIDS (UNAIDS), in response to the HIV/AIDS epidemic recommended routine HIV screening for all pregnant women with a view to prevent the vertical transmission of HIV from mother to child (UNAIDS, 1997). Zimbabwe is a signatory to the United Nations conventions and protocols, as it is a member to the United Nations. Hence, it adopted the policy of routine HIV counseling and testing for pregnant women. High uptake of HIV screening among pregnant women will result in the reduction of vertical transmission of HIV and if the women are positive they will adopt the available feeding options and care services.

According to Sengupta (2003) in the developed world, particularly in the United States, a new policy on prenatal HIV testing recommends routine HIV testing in which all pregnant women would be screened for HIV with no requirement of separate, written informed consent, and pre-test counseling. This policy is a departure from the opt-in testing guidelines where the right to opt-out is upheld. Zimbabwe has demonstrated its commitment to the fight
against HIV/AIDS through the enactment of the HIV/AIDS policy in 1999. This policy highlights prevention of mother- to-child-transmission of HIV (PMTCT) as one of the key strategies of fighting the HIV pandemic. The core interventions for PMTCT now include routine offer of HIV testing and counseling to all pregnant women presenting at health institutions, family planning counseling and services to prevent unintended pregnancies among HIV positive women, ARVs to those HIV positive women in need of treatment as well as safe obstetrical practices and infant feeding, education and counseling (MOHCW, 2007).

The guiding principle number ten (10) of the Zimbabwe National HIV/AIDS policy states that individuals and couples considering marriage or bearing children should have access to accurate information about HIV infection and pregnancy and voluntary counseling and testing. Guiding principle eleven (11) of the Zimbabwe National HIV/AIDS policy states that breastfeeding should continue to be encouraged unless there are viable options to ensure appropriate infant and child feeding for women who know their HIV status (MOHCW, 2007). An Infant Feeding Policy was also enacted and it aims at reducing the risk of HIV transmission through breast milk and it provides for the counseling of HIV positive women on safe infant feeding options.

The Reproductive Health Policy framework provides for the integration of key elements of the PMTCT intervention into the health delivery system with the ultimate goal of delivering an expanded and comprehensive package of care. The key elements of the interventions include; primary prevention of HIV
infection of women of childbearing age and their partners, prevention of unintended pregnancies in HIV infected women, prevention of HIV from an infected mother to the infant, voluntary counseling and testing (VCT) to all pregnant women, offering an antiretroviral regimen and counseling and support for safe infant feeding. The other element involves follow-up of the infected mother, child and family with a view to strengthen community psychosocial support mechanisms and the evolution of quality of services, coverage and assessment of the outcome and the impact of the interventions (MOHCW, 2007).

The study site was Rujeko Maternity Clinic, located in the high density suburb of Dzivarasekwa in the north-western district of Harare Province and approximately 8 kilometers from the City Of Harare Main Post Office. Dzivarasekwa has a population of about 97111 and an annual population growth rate of 1.1 %( Central Statistical office, 2002). The maternity clinic caters for all pregnant women in and around Dzivarasekwa.

Rujeko Maternity clinic is administered by the City of Harare, City Health Department. It is located in the North Western District of the City of Harare. It has a large catchment area catering for clients from areas including Dzivarasekwa, Kuwadzana Phase 3, Tynwald, Marlborough, Mabelreign, Bluff Hill, Westgate, Mount Hampden, Zvimba, Westlea, Lenana Park, Ashdown Park and Bloomingdale.
During the colonial era, the area was known as Gillingham and it sheltered indigenous black and foreign domestic workers who worked for the white settler community in the northern and central districts of the then Salisbury, now Harare. Most of the residents are of Malawian origin. The main language used in Dzivarasekwa is Shona although some of the residents speak Chewa. The literacy rate is 64% for men and 49% for women (National projection census, 2002). The majority of women in Dzivarasekwa sustain their lives from vending horticultural products, such as vegetables, tomatoes, chills, potatoes, onions and pumpkins. A small proportion of the female population in Dzivarasekwa is formally employed.

Averages of 160 pregnant women register for antenatal care at Rujeko Maternity Clinic each month. The PMTCT programme is delivered at the maternity clinic. Counseling and testing guidelines are followed in the PMTCT programme. Chersich, et al (2008) observes that few women are aware of their HIV status. Thus the PMTCT programmes provide women with an opportunity to get tested and subsequently know their status, and ultimately find ways of improving their health status and that of their children.

2.2 Conceptual Framework

Merchant and Lala (2005) report that the HIV epidemic is showing a shift towards women and children and that the increasing seroprevalence among women will result in an increase in mother-to-child transmission (MTCT) of HIV. The vast majority of children living with HIV acquire the infection through vertical transmission.
The same authors go on to state that the transmission of HIV from an infected mother to her child can be reduced to less than 2% by intensive interventions in the antenatal, intranatal and post natal periods. To achieve this low rate, primary prevention of HIV infection in parents-to-be, early identification of seropositivity in pregnant women, prevention of HIV by appropriate therapy, special interventions in maternal management during labour, appropriate care and follow-up of the newborn child, all play an important role. In the absence of any intervention, rates of MTCT of HIV vary from 15 to 30% in the developed countries and can reach as high as 30 to 45% in developing countries. The difference is mainly attributed to attitudes towards HIV counseling and testing among pregnant women (Merchant and Lala, 2005). It is possible to achieve a zero percent transmission rate of HIV from mother-to-child if all pregnant women are screened for HIV and when those who test positive to HIV are put on Anti- Retroviral Therapy (ART). The risk of a mother passing the virus to an unborn child is reduced if she is on ART. The main interventions for decreasing MTCT of HIV include ART, elective lower segment caesarean section, vaginal disinfection and immunotherapy (Merchant and Lala, 2005).

Attitudes play an important role towards the success or failure of most projects and programmes. The characteristics of pregnant women which include their age, education, and marital status, level of education, religion, and number of pregnancies, location and source of income and information influence their attitude formation towards HIV counseling and testing. The pregnant women’s knowledge, beliefs, perceptions and opinions including
benefits about HIV counseling and testing and MTCT also influence their attitude formation towards HIV counseling and testing.

The revised recommendations for HIV counseling and testing among pregnant women have witnessed a shift from voluntary counseling and testing (VCT) to routine counseling and testing (RCT) (Branson et al, 2006). Voluntary counseling and testing upholds the individual’s right to self determination as the individual makes a personal decision to either proceed to be tested or not. On the other hand, routine counseling and testing where pregnant women are offered HIV counseling and testing as a standard of care gives less room for individuals to choose not to be tested. Statements such as ‘Eliminate new HIV infections in children keep mothers alive’ are coercive in nature because most pregnant women will be subtly persuaded to comply with the testing. While coercion yields good results of having pregnant women tested, it creates long lasting negative effects in them. The universal policy on HIV counseling and testing among pregnant women provides that the women have the right to consent to HIV testing. In practice it is difficult to marry the policy of RCT with informed consent. This implies that women are forced to comply with HIV testing. In addition, pregnant women may develop negative attitudes towards HIV counseling and testing as a result of cultural and traditional factors where maternity issues are regarded as a domain for women leaving out men, yet it takes both of them to procreate. In most patriarchal societies women consult men on issues that require crucial decisions. Such practice may lead women to develop negative attitudes towards HIV counseling and testing as they may find it unnecessary to seek
permission for them to be tested for HIV, but because of fear of being denied socio-economic support, stigma and discrimination, blame, abuse and divorce women end up seeking permission from their husbands to be HIV tested. They are left with no other option but to consult their husbands before visiting the antenatal clinic for HIV counseling and testing.

It is important to assess the attitudes of pregnant women on HIV counseling and testing with a view to improve service delivery and concurrently prevent vertical transmission of HIV from mother –to-child

1.2 Statement of the problem
The Human Immuno-deficiency Virus (HIV) has led to loss of innocent lives particularly among children who acquire the virus from their HIV positive mothers. Vertical transmission of HIV is among the major causes of high mortality among children.

In Zimbabwe HIV prevalence among pregnant women aged between 15-19 years is about 27% which makes them an exceptionally vulnerable group for infection (MOHCW, 2007). Overall, the infant mortality rate was projected to be 20% higher and the child mortality rate 75% higher in 2005 as a result of HIV transmission from mother-to-child (MOHCW, 2007). Efforts to prevent vertical transmission of HIV through PMTCT programmes are being paralysed by the negative attitudes pregnant women develop towards HIV counseling and testing.
In Zimbabwe, health service providers have been instructed to ensure 90% uptake of routine HIV counseling and testing (RCT) among pregnant women. This approach has shifted from voluntary counseling and testing (VCT) where individuals decide on whether to opt-in or opt-out to HIV testing. The routine counseling and testing policy has been transferred and regurgitated from the developed countries to the developing countries without contextual considerations. In Zimbabwe, it has been observed that the implementation of RCT infringes upon the rights of pregnant women since; it is difficult to apply the principles of counseling and informed consent at the same time.

In Zimbabwe, some women do not register their pregnancies preferring home and bush religion-guided deliveries. Such behaviour is totally against the general aims and objectives of the national HIV policy provisions of Zimbabwe and it leads to the development of underdevelopment through a high infant mortality rate.

Some women have to seek for permission from their husbands or partners before considering HIV screening. In addition, some pregnant women are afraid of being stigmatized and discriminated against for testing HIV positive. Detailed information about testing from competent, trained and skilled professionals should be provided to pregnant women before HIV testing is commenced. It is because of the foregoing among other reasons that HIV counseling and testing has not been acceptable by all pregnant women. This study, therefore, intends to assess the attitudes of pregnant women towards HIV counseling and testing, with a view to identify and inform policy makers
on HIV counseling and testing practices as this can lead to the achievement of a zero vertical transmission of HIV from mother-to-child.

1.2 Justification of the study
It has been noted that between 40 and 80 percent of women who attend antenatal clinics accept voluntary counseling and testing while between 10 and 60% of HIV infected women get nevirapine and less than half their babies get tested after birth (Thom, 2007). Thus, there is great need to establish positive attitudes of pregnant women towards HIV counseling and testing. Zulueta and Boulton (2007) carried out a study on routine antenatal HIV testing and informed consent in the United Kingdom (UK) and found out that there was a challenge in applying the principles of counseling and informed consent at the same time. The same study which was conducted at Komfo Anokye Teaching Hospital, Kumasi, Ghana could be replicated in Zimbabwe. It was found out that more pregnant women have positive attitudes towards HIV testing where the opt-out policy is used. It is important to promote access of pregnant women to the benefits of HIV testing. Thus, there is need to carry out the same study under local (Zimbabwean) conditions. Other such studies where also carried-out in Sudan and Uganda. Thus, there was also need to include aspects of their studies to determine the attitudes of pregnant women on HIV testing and counseling in Zimbabwe hence it would promote standardization of practice among African countries.

The intended beneficiaries through this study primarily included mothers and their unborn children as they are assured of good and sound health through
early identification, screening and treatment for any possible opportunistic infection and HIV. The other intended beneficiaries include fathers of the unborn babies as they are supposed to be socially, economically and psychologically prepared to know how to manage their families both as bread winners and final decision-makers in most African households. Eventually, communities, the Zimbabwean nation and the world at large would immensely benefit from having populations who are free from HIV.

Practitioners or professionals dealing with the welfare of women and children particularly regarding HIV counseling and testing of pregnant women, would be guided by the findings of this study and probably enable them to improve service delivery.

The current study was intended to inform planners and policy makers on the attitudes of service end-users with a view to improve relevant policies and best practice.

1.3 Aim
To assess pregnant women’s attitudes towards HIV counseling and testing.

1.4 Objectives
1. To determine the basic characteristics of the respondents, for example, age, marital status, number of children, number of pregnancies, level of education, source of income, religion, ethnicity and location, etc.

2. To identify the attitudes of pregnant women aged between 15-49 years of age have towards HIV Counseling and Testing.
3. To identify specific aspects of Government policy on HIV counseling and testing in pre-natal care settings.

4. To draw recommendations from the findings of the study on attitudes pregnant women have on HIV counseling and testing and inform best practice policy makers and planners to review the policy, if need be.

1.5 Summary

This chapter has presented a general overview including the problem definition, significance, aim and objectives of the study. The next chapter will review the relevant literature to the study.
CHAPTER 2

Literature Review

2.1 Introduction

This chapter provides a conceptual and theoretical framework of attitudes in relation to HIV counseling and testing after giving a definition of attitudes. An overview of HIV counseling and testing among pregnant women also viewed as the Prevention of mother-to-child transmission of HIV (PMTCT) will be provided globally, in the developed countries, in the developing countries, regionally and in Zimbabwe. The pregnant women’s attitudes towards HIV counseling are also discussed and some studies carried out in other countries will be cited.

Scholars from different schools of thought define an attitude in a variety of ways. Myers (1992:551) defines an attitude as “a favourable or unfavourable evaluative reaction toward something or someone exhibited in one’s beliefs, feelings, or intended behavior.” McConnell and Philipachalk (1992) refer to an attitude as a consistent way of thinking about, feeling toward or responding to some aspect of one’s environment or toward oneself.

Morgan and King (1996) contend that an attitude is a tendency to respond positively or favourably or negatively or unfavourably to certain objects, persons or situations. Social psychologists have traditionally assumed that people’s evaluation of social policies and other entities in their social environment have major consequences. Attitudes have been postulated to
motivate behaviour and to exert selective effects at various stages of information processing, for example, attention, perception, and retrieval (Eagly and Chaiken, 1970). Attitudes are based on people’s opinions, beliefs, culture and experiences.

Oppenheim (1992) views an attitude as a state of readiness, a tendency to respond in a certain manner when confronted with a stimulus. Most of an individual’s attitudes are usually dormant and are expressed in speech or behaviour only when the object of the attitude is perceived. Attitudes are reinforced by beliefs (cognitive component) and often attract strong feelings (the emotional component) which may lead to particular behavioural intents (the action tendency component) (Oppenheim, 1992).

Attitudes develop from the influence of culture, family, peers, one’s personality, the information he/she receives, the statements and attitudes of authorities he/she is exposed to and the small informal groups or primary groups to which he/she is a member. Thus, pregnant women, as social animals, are likely to develop attitudes towards HIV counseling and testing (Oppenheim, 1992).

The HIV/AIDS pandemic has made people to develop attitudes towards it. HIV counseling and testing was globally introduced as a means of preventing the transmission of HIV from mother-to-child (PMTCT). Merchant and Lala (2005) observe that the majority of HIV positive children acquire the infection through vertical transmission. In many countries, HIV is primarily sexually transmitted
and the majority of infections occur during the reproductive ages (Strachan et al, 2004). Many countries have developed policies aimed at reducing MTCT. Benefits of the PMTCT programmes have been outlined and concerns continue to be addressed.

2.3 Theoretical Framework

Attitudes have three components namely the cognitive, affective and behavioural or conative (Michener et al, 2002). The cognitive component includes our thoughts, beliefs and ideas about something. The affective component refers to feelings or emotions that something evoke, for example, fear, sympathy or hate. The behavioural or cognitive component refers to the tendency or disposition to act in certain ways towards something. Emphasis is on the tendency to act, not the actually act, thus what we intent and what we do may be quite differently (Michener et al, 2002).

2.3.1 THEORIES OF ATTITUDE FORMATION AND CHANGE

Traditional theory of attitudes

According to Schaefer (2006) religion and the family are social institutions with organized patterns of beliefs and behaviour that are centred on basic human needs. The same author further states that societies have cultural universals which play functionalist roles which include the replacement of personnel through sexual reproduction, teaching new recruits to learn and accept its values and customs, preserving order and providing and maintaining a sense of purpose when people must feel motivated to continue
as members of a group or society. Thus the attitudes of pregnant women towards HIV counseling and testing are influenced by their cultural values and customs. In addition, religion as a unified system of beliefs and practices relative to sacred issues provide an explanation for events that seem difficult to understand such as HIV/AIDS and what happens beyond the grave (Schaefer, 2006). Religion encourages people to view personal misfortunes as relatively unimportant in the broader perspective of human history or as part of a disclosed divine purpose. Religion influences the attitudes of people toward events, objects and things (Schaefer, 2006).

Schaefer (2006) observes that authority patterns in the family on who rules are determined by the traditional gender distinctions which have given men a dominant position over women. Patriarchy expects males to dominate in family decision making. Thus most pregnant women in patriarchal families are expected to consult their husbands before they consider to be tested for HIV.

**Social influence**

Authorities play an important role in shaping the attitudes of people towards their enrolment in programmes. Since people have relatively few first hand facts upon which to base their beliefs, they often find themselves trusting authorities instead of facts (Morgan and King, 1966). People are forced to rely on the statements of experts, authorities or eyewitness reports. Medical experts who include doctors, nurses, laboratory personnel and HIV counselors shape the views of pregnant women on HIV. Expertise as power based on special knowledge, training and skill enable people to follow the
advice of experts (Sears et al, 1991). Logical arguments given by experts persuade people to develop positive attitudes towards what they say, hence the content of the message produces the desired effect of meeting their goals. Such specialization of knowledge has been essential in the development of complex civilization. However, the obstacle to forming correct beliefs and opinions is the tendency of some authorities to deliberately distort the facts in order to have people believe what they want them to believe (Morgan and King, 1966). Legitimate authority as the power based on the influencer’s right or authority to make a request enables those in authority to ask other people to act in a certain way. Social roles such as teacher-student, Social Worker-client, and health-patient practitioner often dictate the legitimate rights and responsibilities of people in a relationship (Sears et al, 1991). In HIV counseling and testing, very few facts are said about the side-effects of antiretroviral drugs. Less, if any, mention is made on ARV toxicity during counseling. Thus the attitudes of pregnant women toward HIV counseling and testing may be influenced by those people in authority, namely the maternity clinic staff. In addition, consent is likely to be theorized as it is not always practically sought when HIV testing pregnant women, thus, coercion is likely to be applied in some occasions. According to Sears et al (1991) the bases of social power that yields compliance is embedded through rewards, coercion, expertise persuasion/information, referent power and legitimate authority. Coercion can range from actual physical threats to threats of punishment or subtle signs of disapproval, hence it is power based on providing or promising a negative outcome.
SOCIAL (OBSERVATIONAL) LEARNING THEORY

Social/Observational Learning is based on modeling when people observe the behavior of others. If they are getting reinforced for certain behaviors or the expression of certain behaviors or the expression of certain attitudes, this serves as vicarious reinforcement and makes it more likely that we too will behave in this manner or express this attitude.

Morgan and King (1996) observe that sociologists believe that primary groups such as the family, friends and associates have an important effect on people’s beliefs and attitudes. It is through social influence that people comply with requests without paying much attention to the content of the explanation (Sears et al, 1991). It is usually through these primary group channels that cultural factors and authorities shape our view of the world about us. Thus, pregnant women learn from the experiences of their friends and associates about HIV counseling and testing. It is through social learning that they develop attitudes on the PMTCT programmes.

The Theory of Reasoned Action (TRA)

The Theory of Reasoned Action postulates that behavior is driven by beliefs, attitudes, intentions, expectations and social norms. Individuals have attitudes and beliefs that shape their intentions to engage in behavior (Sears et al, 1991). The Theory of Reasoned Action suggests that people behave according to their conscious intentions which are based on their rational
calculations about the potential effects of their behaviour and how people would feel about it (Sears et al, 1991). Where pregnant women believe that they benefit from being screened for HIV, they develop positive attitudes towards HIV counseling and get tested. The TRA says that a person’s behavior is determined by his/her attitude toward the outcome of the behavior and by the opinions of significant others in the person’s social environment. Thus, pregnant women whose spouses support and accompany them to antenatal clinics develop positive attitudes towards HIV counseling and testing. However, the effects of pmtct interventions are invisible, and are based on medical concepts that are alien to traditional cultures. This is one of the many reasons why some pregnant women develop negative attitudes towards HIV counseling and testing. This is more evident in some religious sects where they shun modern approaches towards the management of ailments. This theory is related to the social learning theory when people’s behaviour is influenced by public theory. Even the behaviour of pregnant women over personal and national programmes and projects are shaped by expectations of the society they live in.

2.3.2 GLOBAL OVERVIEW OF PMTCT

Merchant and Lala (2005) observe that the HIV epidemic is showing a shift towards women and children and that the increasing seroprevalence among women will result in an increase in MTCT. The vast majority of HIV positive persons acquire the infection through vertical transmission. The discovery of successful interventions that interrupt this transmission has been one of the greatest successes in AIDS research. In America and the rest of the
developed world, such programmes are heavily funded and well supported by all stakeholders. However, these approaches are not always possible in developing countries wherein 95% of vertical transmission occurs (Merchant and Lala, 2005). Several challenges remain and these include the means to find the most cost effective and feasible intervention to achieve zero percent transmission of HIV from an infected mother to the child.

Until 2002, over 4.3 million children have succumbed to the AIDS epidemic worldwide and in 2003 an estimated 7 million children under the age of 15 years become infected with HIV (Merchant and Lala, 2005). The vast majority, over 90% acquired the infection through MTCT. The main interventions for decreasing MTCT include antiretroviral therapy, elective lower segment caesarean section, infant feeding and other interventions such as Vitamin A prophylaxis, vaginal disinfection and immunotherapy (Merchant and Lala, 2005). Indeed, MTCT of HIV is a global problem which required global intervention strategies. The main purpose of HIV counseling and testing among pregnant women is to prevent the transmission of the HIV virus from the mother to her child. Chippindale and French (2001) observe that counseling in HIV and AIDS has become a core element in a holistic model of health care in which psychological issues are recognized as integral to client management. The prevention of HIV transmission and the support of those directly and indirectly affected by HIV can be achieved by changes in behaviour. Thus, counseling is aimed at changing clients’ attitude towards the PMTCT programmes. One to one prevention counseling has a particular contribution in that it enables frank discussion of sensitive aspects of a
patient’s life and such discussion may be hampered in other settings by the client’s concern for confidentiality or anxiety about a judgmental response (Chippindale and French, 2001). Furthermore, when clients know that they have HIV infection or disease, they may suffer great psychosocial and psychological stresses through fear of rejection, social stigma, disease progression and the uncertainties associated with future management of HIV (Chippindale and French, 2001). Good clinical management requires that such issues be managed with consistency and professionalism and counseling can both minimize morbidity and reduce its occurrence. All counselors in this field should have formal counseling training and receive regular clinical supervision as part of adherence to good standards of clinical practice. Such an approach will enable pregnant women to develop positive attitudes toward HIV testing and subsequently achieve zero percent MTCT of HIV.

Prevention counseling is aimed at determining whether the lifestyle of an individual places him or her at risk, help to identify the meaning of risk behavior, enable the individual to understand the risks and to define true potential for behavior change and assist the individual to achieve and sustain behavior change (Chippindale and French, 2001). Thus, good counseling assists people to make informed decisions such as whether to have an HIV test and also help people to cope better with their HIV positive result and to help reduce HIV transmission.
2.3.3 HIV Counseling and Testing Among Pregnant Women in Developed Countries

UNAIDS (1997) observes that most of the research and achievements in HIV and AIDS were developed in the United States of America. The Expert Panel on Prevention of Mother to Child Transmission of HIV was launched by the US President’s Emergency Plan for AIDS Relief (PEPFAR) in 2003. It receives funding from the fiscus. The US Global AIDS coordination aims to reach 80% of pregnant women through PMTCT programmes. Bennet (2007) notes that routing antenatal HIV counseling and testing was recommended for pregnant women. In 1999 the United Kingdom (UK) government instructed health authorities to implement the policy of offering and recommending an HIV test to all pregnant women. In order to reflect contemporary ethical and legal practices such a policy attempts to marry the public health aims of maximizing uptake of testing with a commitment to respect the choices of patients by requiring informed consent before they participate in screening (Bennett, 2007). Thus, in the case of UK policy, health professionals are instructed to recommend the HIV test to all pregnant women in order to achieve the target of a 90% uptake but at the same time those implementing the policy must ensure that it is up to each woman to choose whether or not she is tested and she should not be pressurized into a decision either way. All testing for infections and conditions in pregnancy should be with the woman’s knowledge, understanding and consent (Bennet, 2007). Superficially, this attempt to combine public health goals with respect for the autonomy of pregnant women seems the most ethically acceptable route available to policy makers. However, a qualitative study by Zulueta and Boulton (2007) on
exploring the practicalities of informed consent in routine antenatal HIV testing revealed that routine antenatal HIV testing and informed consent represent an unworkable marriage (Zulueta and Boulton, 2007).

Research has shown that where testing is offered on an “opt-out” rather than “opt-in” basis, the uptake will be much greater. One UK study compared an opt-in approach to antenatal HIV testing (in which women had to make any choice to be tested) with an opt-out approach (Zulueta and Boulton, 2007). It found out that the uptake of opt-out testing (88%) was more than double that of opt-in testing (35%). It is argued that even if some of the increase in uptake is due to increased knowledge and changing attitudes (the opt-in study was in 1996-7 and opt-out study in 1998), the magnitude of the increase suggest that the approach to testing is important (Zulueta and Boulton, 2007).

The fundamental aim of routine testing is to secure the testing of not only women who would have elected to be tested, but also those women who would not have specifically chosen to be tested. It seems inevitable that pressure will be put on women to accept the test. Midwives may feel it is their duty to persuade women to accept the test, particularly when they are instructed for a 90% uptake. Thus, a significant degree of pressure is put on women to accept testing.

In order for consent to be valid, the individual must have adequate, accurate information (Zulueta and Boulton, 2007). The UK General Medical Council guidelines on consent to screening emphasize that the standard level of
information required for informed consent for HIV screening should include a discussion of the uncertainties and risks attached to the programme (Zulueta and Boulton, 2007). However, given the time constraints and need for a high uptake of screening, a one-sided view of the positive consequences of HIV testing is given.

In the year, when routine antenatal HIV counseling and testing was introduced in the UK, it was estimated that 380 babies were born in the UK to HIV positive mothers. Before routine testing was introduced, it was thought that around three quarters of HIV positive women did not know at the time of their delivery that they were HIV positive. If 90% of pregnant women rather than around 25% was aware of their HIV status, risk-reducing interventions such as the use of Zidovudine, birth by caesarian section and not breastfeeding could be offered to many more women, with the result that some children might be spared infection (Zulueta and Boulton, 2007).

Sengupta (2003) conducted a study to determine the attitudes of United States pregnant women on routine HIV testing in prenatal settings. The study explored that 93% had been tested for HIV while pregnant but only 55% were offered that test and 47% were given pretest counseling (15,1%) were given information about the importance of HIV testing during pregnancy). When asked about the new policy, 63% liked it but 49, 3% said pregnant women need to be explicitly told that HIV testing is part of routine prenatal care. 60% were concerned that it lacked pretest counseling (Sengupta, 2003).
2.3.4 HIV Counseling and Testing Among Pregnant Women in Developing Countries

The World Health Organisation (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF in partnership with Health ministries of developing world governments and other organisations are spearheading HIV/AIDS programmes in developing countries. The same approach to HIV testing and counseling that is practiced in developed countries is implemented in developing countries.

Nasr et al (2003) conducted a study to determine the knowledge and attitudes toward HIV voluntary counseling and testing services among pregnant women attending antenatal clinic in Sudan. Respondents’ knowledge about HIV and MTCT were tested. In addition, their willingness toward HIV testing was reported. Out of the 1005 women investigated, 79% had basic knowledge about HIV. Those who were resident in Khartoum and whose age was above 25.1 years and their education level was secondary and above, were found to be more knowledgeable about HIV. More than half of the respondents were aware of MTCT. Older, educated and working mothers were found to be more knowledgeable about MTCT. Willingness to undergo the HIV test was demonstrated in 73, 8% of the respondents. However, only 30% had the test done. Older women and Muslims had a higher acceptance of VCT. The need to increase the level of education and health awareness about HIV and MTCT was realized.
In Ghana, a study on pregnant women’s knowledge of and attitudes to HIV counseling and testing at Komfo, Anokye Teaching Hospital, Kumasi revealed that HIV/AIDS is recognised as a life threatening condition but knowledge about MTCT was lacking (Agyei et al 2002). The majority of women who had done the test did so as a pre-requisite for church blessing of their marriage. The study also showed that HIV counseling and testing would be acceptable especially when anonymity is ensured and drug treatment is available for mother and child should the pregnant women test positive for HIV (Agyei et al, 2002). The Ghana PMTCT policy was derived from the United Nations General Assembly Special Session (UNGASS) whose declaration of commitment stated that the proportion of infants infected with HIV should be reduced by 20% by 2005, and by 50% by 2010. This goal was to be reached by ensuring that 80% of pregnant women who receive antenatal care have access to HIV prevention services (Agyei et al, 2002). The study also showed that people may not perceive themselves to be at risk and use denial as a coping mechanism. In addition, the study showed that women may also seek partner consent prior to testing and spousal affects uptake of PMTCT services in Ghana (Agyei et al, 2002).

In their study on low impact of a community-wide HIV counseling and testing, programme on sexual behavior in rural Uganda, Kipp et al (2001) reported that research in both the developed and developing countries has not clearly proven the effectiveness of HIV counseling and testing in reducing risk behaviour. Information about voluntary HIV counseling and testing programmes comes from developed countries. Thus, the information may be
inadequate or inappropriate to addresses the socio-cultural and medical needs of people of the developing world.

In countries, where human rights are not respected, HIV testing is more likely to lead to breaches of confidentiality, discrimination, quarantine and violence (Kipp et al, 2001). A study in Kenya reported increased violence and loss of security for pregnant women who shared information about their HIV positive serostatus with their spouses. Those who shared information with their partners were replaced with another wife while some were beaten and some committed suicide (Kipp et al, 2001). Other studies show similar adverse effects of HIV counseling and testing where HIV infected persons who disclosed their status to their partners where blamed, physically abused, abandoned, or divorced (Kipp et al, 2001). Protection from discrimination is of particular concern, because those at greatest risk of being HIV infected belong to groups already stigmatized by the society. Persons with HIV infection have experienced loss of employment, housing and health insurance and have, on occasion, been refused treatment by health care workers (Kipp et al, 2001). In contrast with the doubtful benefits of HIV counseling and testing services, the social risks to the tested individual are real. This leaves a glaring need to assess the attitudes of pregnant women on HIV counseling and testing in Zimbabwe.

In addition, to the findings of the study by Kipp et al in Uganda, it was reported that those individuals who were unwilling to have an HIV test thought that the test was not necessary and perceived themselves as not being at risk of HIV
infection. Those who tested found that practical advice was given during the counseling session. Most respondents (90%) felt that HIV counselors should have certain skills, be trained and should pass on examinations after a training session (Kipp et al, 2001). These revelations show that the respondents would have developed attitudes towards counselors and the counseling process.

In rural Malawi, Kasenga et al (2009) conducted a study on the implications of policy changes on the uptake of a PMTCT programme. The objective was to study how the demand for antenatal care, HIV testing and hospital delivery was influenced by policy changes among pregnant women in rural Malawi. It was established that HIV and testing among pregnant women increased from 82.6% to 98.8% after the introduction of routine (opt-out) HIV testing. After the introduction of free maternity services, ANC attendance increased by 42% and the ratio of hospital deliveries to ANC attendances increased from 0.50:1 to 0.66:1. Of the HIV tested ANC attendees, 52.6% who tested positive delivered at the hospital and got nevirapine at the time of delivery (Kasenga et al, 2009). It was concluded that increasing maternity service availability and uptake can increase the coverage of PMTCT programmes. Barriers such as economic constraints that prevent women in poor communities from accessing services can be removed by making maternity services free.

Meiberg et al (2005) carried out a study in Limpopo Province, South Africa to identify psychosocial correlates of HIV counseling and testing with an emphasis on the association between fear of AIDS-related stigma and
willingness to have an HIV test. The results showed that respondents had different levels of knowledge about HIV counseling and testing and that AIDS was still strongly associated with death. Results further demonstrated that HIV/AIDS related stigma is still a serious problem in South Africa. The main benefit for HIV counseling and testing was knowing ones HIV status, whereas the main barriers for testing were fear of being stigmatized and fear of knowing ones HIV positive status.

2.3.5 HIV Counseling and Testing Among Pregnant Women in Zimbabwe

The HIV/AIDS challenge is complicating an already complicated development agenda in Zimbabwe and other countries in Southern Africa. Zimbabwe has seen a reversal of its gains in life expectancy among children who die before their fifth birthday as they succumb to HIV/AIDS. USAIDS (2005) observes that the East, Central and Southern Africa Health Community (ECSA-HC) member states are implementing interventions for PMTCT. The ESCA-HC with funding from USAID commissioned a review to assess the progress made towards putting in place programmes, policies and guidelines for PMTCT within the member countries. UNAIDS reported that more than 76% of all the women living with HIV/AIDS were found in the region and that 76% of young people aged between 15 to 24 years of age who were living with HIV/AIDS in the East, Central and Southern African region were female. According to guiding principle 10 of the Zimbabwe National HIV/AIDS Policy 1999, individuals and couples considering marriage or bearing children should have access to accurate information about HIV infection and pregnancy and voluntary counseling and testing. HIV can be transmitted from mother to her child during pregnancy, delivery and through breast milk. The risk of HIV
transmission from mother to child is significant. Many children with HIV related illness develop AIDS early in life and die before they reach the age of five years. Child bearing is a very important event for every Zimbabwean yet the desire of the couple with HIV infection to have children needs to be balanced with the possibility of having an infected baby who has a high risk of dying within the first five years of life.

GOZ (1999) drew-up strategies which include the encouragement of women and couples considering pregnancy to seek voluntary counseling and testing for HIV, give information and offer counseling to HIV positive women and their partners in order to enable them to make informed decisions about planning pregnancy, ensure full information is available to all couples contemplating pregnancy and to emphasise the importance of primary prevention of HIV transmission among young people through appropriate behavior change.

Guiding principle number 13 states that people with HIV/AIDS have the right to choose the type of care they want and should have access to accurate information regarding orthodox and traditional medicine. Public awareness about the known benefits and limitations of the different sources of care should be made widely available to enable people to make informed choices (GOZ, 1999). Guiding principle 16 states that counseling services should be made accessible to all people affected by HIV/AIDS (GOZ, 1999). This can be achieved through providing appropriate training in HIV/AIDS counseling and established minimum standards required for such training. Guiding principle 18 observe that access to information and counseling necessary for
informed consent to HIV testing should be ensured as a fundamental human right (GOZ, 1999). This can be achieved by obtaining informed consent from the client before doing an HIV test, providing pre and post test counseling and this service must be offered by people with the appropriate technical and professional ability, encouraging couples envisaging marriage routinely to have HIV counseling and testing and present results to each other (GOZ, 1999:16).

The risk of discrimination and stigmatization is high in respect of HIV/AIDS and is being encountered in many spheres of life. To achieve full human and constitutional rights for people with HIV/AIDS, measures are needed to eliminate stigma against PLWHA. Thus, guiding principle 22 notes that all symptomatic people living with HIV infection should be treated as any other healthy individual with respect to education, training, employment, housing, travel, health care and other social amenities and citizenship rights (GOZ, 1999). People with HIV/AIDS should be treated as others who may have chronic or life threatening conditions.

Guiding principle 38 notes that gender violence in any form and setting is unacceptable and should be prescribed by law (GOZ, 1999 p. 31). Men usually dominate in violent encounters. Resultantly, some aspects of gender violence are culturally condoned because they are perceived as within the bounds of what is expected of men in their interaction with women in different situations. This violence denotes men’s way of asserting and reasserting their control over women and their anger and disapproval of women’s real or perceived
resistance to this control. Those different power relationships have a bearing on the transmission of HIV and should be dealt with effectively.

The foregoing Zimbabwe National Policy on HIV/AIDS reflects the country's commitment towards the prevention of transmission of HIV and the promotion of social justice towards accessing HIV/AIDS services. Zimbabwe has almost the same health related experiences like other African countries. In a study titled “The Characteristics of Pregnant Women Attending PMTCT of HIV Programme at Bulawayo City Clinics in Zimbabwe”, Sibanda (2008) observes that a woman's access to health care in physical, social and psychosocial contexts depends on her health beliefs and her socio-economic and demographic background. Thus, routine HIV counseling and testing is largely acceptable to pregnant women where the HIV test results are given on the same day the test is done, where benefits to those tested positive are readily available, and to those women who are educated (Sibanda, 2008).

In addition, pregnant women develop positive attitudes towards pretest counseling because of their previous interactions with health care systems which exposed them to information and associated benefits. Furthermore, positives attitude to pretest of HIV and counseling among pregnant women who reside in urban areas and who are less poor can be explained by the fact that they have more access to information about HIV issues through the print and electronic media and therefore they are more aware of the benefits of HIV counseling and testing (Sibanda, 2008). Women with three or more
pregnancies develop positive attitudes towards pre-test counseling because of their previous experience with health systems.

The development of negative attitudes in pregnant women towards HIV counseling and testing has been attributed to several factors and among them is lack of intervention services. Musarurwa (2011) noted that over 300 000 people living with HIV in Zimbabwe were failing to access ARVs owing to inadequate funding of the Government-run programme. Such situations deter would-be beneficiaries of HIV counseling and testing from enrolling into the HIV testing programme. In the same vein, Gova (2011) in an article in the Sunday Mail `In-Depth` dated 24-30 July, titled `HIV stigma taking too long to shake off` observes that people who test positive to HIV are finding it difficult to disclose their status because of fear of stigma from their environment. Therefore, the stigmatization of HIV may create negative attitudes towards HIV testing among pregnant women.

In a related study on factors associated with low male involvement in the PMTCT programme in Mutare Rural District, Ngwerume (2006) observes that women are left alone in HIV counseling and testing in prenatal settings. Most educated women seek permission from their male partners to test for HIV than less educated women. The subordination of women by men in most settings indirectly affects the attitude of testing among pregnant women. WHO in Ngwerume (2006) posits that the pregnant women are mostly seen alone in HIV counseling and testing services associated with PMTCT.

As alluded to somewhere above, the attitudes of pregnant women influence an uptake of PMTCT programmes in Zimbabwe. Even when a clinic offers
counseling to every pregnant woman, the reality is that not all of them accept. In an article in *The Herald* 5 July 2011 entitled ‘Bush camp delivers death, not children’, Chimuka and Cheru-Mupambawashe observed that a makeshift Johane Masowe maternity camp in Dema, Seke composed of expectant mothers who did not opt to enroll for the PMTCT programme. This scenario calls for the need to improve the efficiency of PMTCT services by addressing issues of accessibility, clinic resources, testing methods, fear and distrust, disclosure and discrimination, drug effectiveness, treatment for mothers including pregnant women, feasibility of replacement feeding and male visits to antenatal clinics (Meursing and Sibindi, 2000). The foregoing aspects influence the attitudes of pregnant women towards HIV counseling and testing.

### 2.3.6 Summary

This chapter has reviewed the literature on pregnant women’s attitudes on HIV Counseling and Testing. A theoretical framework of attitudes in relation to the development of positive and negative attitudes towards HIV Counseling and Testing among pregnant women was given. A Global, regional and Zimbabwean overview of HIV Counseling and Testing among pregnant women was given.

Studies have shown that age, level of education, occupation, ethnicity, location, marital status, knowledge experience about HIV and PMTCT, among other factors, influence the pregnant women’s attitudes towards HIV counseling and testing. In addition, the counseling given, reaction of the
health staff, availability of services after testing, the testing methods, reaction of male partners and receiving a positive HIV result and also the need to consult male partners influence the attitudes pregnant women would develop towards HIV counseling and testing.

In light of the above, the next chapter will reflect on the methodology to provide a comprehensive assessment of pregnant women’s attitudes towards HIV Counseling and Testing at Rujeko Maternity Clinic in Dzivarasekwa, Harare.
CHAPTER 3

METHODOLOGY

3.1 Introduction
This study sought to assess pregnant women’s attitudes towards HIV Counseling and Testing in urban Zimbabwe. Pursuant to this main goal, this chapter presents the study process of assessing pregnant women’s attitudes towards HIV counseling and testing. This study considered only residents of Dzivarasekwa. This chapter outlines the location of study, population of respondents, research design, sampling, data collection methods, feasibility, limitations of the study and ethical considerations. It then discusses methodological procedures used in the study and it gives justification for the use of those methods. Observations were also used by the researcher during data collection.

3.2 THE LOCATION OF STUDY
As earlier stated in chapter 1, the study site was Rujeko Maternity Clinic, located in the high density suburb of Dzivarasekwa in the North-Western district of Harare Metropolitan Province and approximately 8 Kilometers from the Harare Main Post Office.

3.3 RESEARCH DESIGN
Nachmias and Nachmias (1992) refer to research design as a logical model of proof that guides the researcher in the various stages of the research. It also
allows the researcher to draw inferences concerning causal relations among the variables under study. There are various research designs and each one of them is dependent on the nature of the problem under investigation. This study is mainly qualitative in its design although it includes quantitative research aspects. However, Tashakhori and Teddlie (1998) argue that there is no one method that fully addresses all aspects in social research. Bryman (1996) posits that quantitative and qualitative research studies are combined to produce a general picture of the subject under study.

Maxwell (1996:17) observes that qualitative studies offer an understanding of the meaning, for participants in the study, of the events, situations they are involved in and of the accounts that they give of their lives and experiences. Qualitative research is the most ideal when dealing with people with life threatening conditions as their accounts bring to the fore their perspectives, thus helping to bridge the gap between their experiences and the images other people including professionals, have of what it actually means. This research sought to assess the attitudes pregnant women living in Dzivarasekwa have towards HIV counseling and testing. Qualitative research allows for in-depth description and expression of the subjective feelings, emotions and meanings respondents attach to the phenomenon under study. Qualitative research gives the researcher an understanding of the particular context within which the respondents act and the influence that this context has on their actions (Maxwell, 1996). This approach is the most ideal in assessing pregnant women’s attitudes towards HIV counseling and testing. It allows the researcher to see the phenomena under study through the eyes of the respondents. In this study, the researcher collected data through Focus
Group Discussions (FGDs), in-depth interviews and through observations made during the interviews. In addition, data was also collected from the available and current literature.

3.4 TARGET POPULATION

Nachmias and Nachmias (1982) concur that a population is the aggregate of all cases that conform to some designated set of specifications. This study targeted 160 pregnant women from Dzivarasekwa high density suburb who came to attend ante-natal clinic at Rujeko Maternity Clinic. As earlier stated, an average of 160 pregnant women register for ante-natal care at Rujeko Maternity clinic every month. As such these women became the study target population. These women were identified at the reception as they registered for maternity services. The ages of these women ranged between 15 and 49 years of age. Five (5) key Informants were drawn from the clinic staff members who work in the antenatal clinic.

3.5 SAMPLING

Mason (2003) defines sampling as a strategy of selecting a smaller section of the population that will accurately represent the patterns of the target population at large. Purposive sampling is a form of non-probability sampling in which settings, persons or events are deliberately selected in order to provide important information which is difficult to obtain from other choices (Maxwell, 1996).

Only pregnant women from Dzivarasekwa high density suburb were selected for inclusion in the study. This study intended to assess the attitudes of
pregnant women from Dzivarasekwa towards HIV counseling and testing. Thus, the researcher purposively chose those pregnant women from Dzivarasekwa for inclusion in the study. It is from the reception area that the researcher identified those pregnant women who expressed their consent to be included in the study. It is from these willing pregnant women that a Focus Group Discussion was constituted and discussions were held. The researcher began with Focus Group Discussions and this is from where 8 pregnant women were purposively selected for in-depth interviews. Pregnant women who had visited the clinic for the first time the during course of the current pregnancy were identified from the focus group. Those pregnant women who were in the advanced stages of their pregnancy and ready to deliver babies were excluded from the study. A focus group discussion guide was used during the focus group discussions. A standardized pre-tested, structured interview schedule was administered in English by the researcher since all the respondents were able to speak English. Individual interviews covered topics concerning the respondents’ characteristics such as education, age, occupation, religion, ethnic group, number of pregnancies, household size, opinions and knowledge about HIV and AIDS and MTCT of HIV, experiences about routine counseling and testing in the antenatal clinic, issues of whether they were accompanied by their partners or not, feeding options and treatment of HIV infected mothers. Observations about the respondents were made during interviews and themes were drawn from the observations and the responses from the respondents were noted of respondents were made.
Of the 160 pregnant women who were attended to each month at the Clinic, some were visiting the clinic for the first time. A sample of 8 pregnant women was purposively selected for the purpose of this study. This is because qualitative research is intensive and time-consuming when collecting data and therefore demands the use of small samples. Patton (1990) concurs with the view that purposive sampling is best used with small numbers of individuals or groups which may well be sufficient for understanding human perception, problems, and contexts which are the main justification for a qualitative audience research. Banda (2010) concurs with Auckson (2004) that between 5-10% of a target population is representative enough and this is referred to as The Rule of the Thump. In addition, in-depth interviews require that the researcher allocate him/herself enough time to listen attentively to the respondent, clearly hear the voices of the respondent and be able to observe both verbal and non-verbal cues. The 8 pregnant women who attended the antenatal clinic for the first time were identified at the reception and tracked down through Routine counseling and testing (RCT) HIV and through routine antenatal assessment.

Key informants who included the clinic matron, sister-in-charge and 3 maternity nurses, who conduct HIV Counseling and Testing, were included in the study. The key informants were the professionally appointed, experienced, permanent and available staff members who were willing to assist the researcher in this study.

This study was conducted from the beginning of April to the end of July 2011.
3.6 DATA COLLECTION

This study draws its conclusions from data based on four months of ethnography from April to July 2011. Data collection techniques and instruments applied in the research process are discussed below;

Focus Group Discussions (FGDs):

FGDs make explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in the group (Maxwell, 1996). Individuals become individuated while working in groups as they freely relate their feelings and emotions. In this study, as indicated earlier, pregnant women were identified from the reception where those willing to participate in the study signed consent forms before they were put in a group of ten (10) for discussions on HIV counseling and testing. The researcher was able to see and hear the voices of the respondents during the discussions. It is from the FGDs that the researcher purposively identified those pregnant women who had visited the maternity clinic for the first time in the current pregnancy and considered them for in-depth on-on-one interviews.

In-depth interviews:

Qualitative methods allow the researcher to tap into individual women`s understanding, emotions, and actions in the world and explore issues in the women`s own voices (Muzvidziwa, 2001). Themes were drawn from the respondents` experiences as they narrated them. It was easy to assess whether the pregnant women had either positive or negative attitudes towards HIV counseling and testing from the in-depth interviews.
Some researchers usually use the Likert scale to measure attitudes. In this study the researcher drew themes from the respondents’ own words. In addition, the researcher had adequate time to conduct in-depth interviews with the pregnant women. The researcher used a structured interview schedule to unravel pregnant women’s experiences, feelings, perceptions and opinions towards HIV counseling and testing. The interview schedule also captured quantitative data in the form of the socio-demographic characteristics of the pregnant women. The researcher found that employing qualitative methods is useful in developing an understanding of the attitudes of pregnant women in his sample.

**Key informant interviews:**

Key informants may be viewed as the practitioners or professionals who can be relied upon for information because of the deeper knowledge, understanding and experience they have over a particular subject or process. In this study, key informants at Rujeko Maternity clinic included the clinic matron, the nursing sister-in-charge and three maternity nurses/ counselors. It is for the above reasons that the key informants were chosen and included in this study. An interview guide was used to gather data concerning the attitudes of pregnant women on HIV counseling and testing. The key informants had an opportunity to express their informed views on why pregnant women had positive and negative attitudes towards HIV counseling and testing. Their views were captured and recorded by the researcher without amendments.
3.7 FEASIBILITY
Clearance to conduct the study was obtained from the Director of City Health Services and the researcher once worked at the clinic. This made entry to carry out the study feasible.

3.8 DATA ANALYSIS
Both quantitative and qualitative data was analysed manually without the aid or use of a computer programme. This is because the sample was too small for the researcher to consider computer based analysis of the collected data.

3.9 LIMITATIONS
The study focused on one maternity clinic hence the findings cannot be generalized to other maternity institutions. In addition, HIV and AIDS is a sensitive area of study hence some responses may not be accurate.

3.10 ETHICAL CONSIDERATIONS
Basically, ethics refer to the principles of conduct which are adopted by various professions in an endeavour to protect the dignity and rights of society. Kumar (1996) observes that there are certain behaviours in research such as causing harm to individuals, breaching of confidentiality, using information improperly and coercing people into participating in studies. Such practices are considered unethical in any profession because human beings need to be respected and given the value they deserve. Thus, in most social science research, respondents need to provide their consent to participate, be
assured that confidentiality and their privacy was upheld and that they should volunteer their participation rather than to be coerced to participate.

**Informed consent**

When persons involved in research risk a limitation of their freedom, they must be asked to consent to this limitation (Nachmias and Nachmias, 1982). Pregnant women may not be at liberty to discuss issues concerning their pregnancy and anything related to pregnancy. Discussions on sexual issues in most Zimbabwean communities are regarded as taboo more so if the person who is asking questions is not related to the respondent. Thus, they need to be fully informed about the study, its purpose, procedure, benefits and the duration of participation. In addition, an instruction that the women are free to withdraw their consent and to discontinue their participation at any stage of the study without prejudice was given. The idea of informed consent derives from cultural values and from legal considerations. Informed consent rests upon the high preference given to freedom and self-determination which allows an individual to decide whether to participate in a research project or not (Nachmias and Nachmias, 1982). Informed consent involves the elements of voluntarism and competence. Pregnant women are able to volunteer their participation when they become fully aware of the study and when mentally and physically competent to decide on whether to participate or not. The respondents in this study consented to participate by signing written consent forms.
Following approval by the relevant authorities, each responded was given a comprehensive explanation about the purpose of the study, expected duration of participation, and the procedure used to collect information before the FGDs and interview and informed consent was sought. Respondents were asked to sign consent forms before participating in the study.

Privacy

The right to privacy refers to the freedom of the individual to pick and choose for him/her the time, extent and circumstances under which to share or withhold from others, his/her attitudes, behaviours and opinions. The researcher indicated to the pregnant women that he would respect their privacy by not forcing them to discuss those issues they regard sensitive especially when they are not prepared.

Confidentiality

The participants were told that the information they provided would be treated as confidential. All information given by the participants was not publicly revealed. The researcher signed a consent form in full view of the participants acknowledging that he upheld the principle of confidentiality in the research process.

3.11 SUMMARY

This chapter has reflected on the methodology that was used to unravel pregnant women’s attitudes from Dzivarasekwa towards HIV Counseling and Testing. Pre-tested instruments which include the interview schedule for
pregnant women, informed consent form, interview guide for key informants, and focus group discussion guide were produced. The chapter also looked at the location of the study, research design, target population, sampling, data collection, feasibility, data analysis, and limitations of the study. Ethical considerations of informed consent, privacy and confidentiality were discussed.

The next chapter will present research findings and the discussion of the study findings.
CHAPTER 4

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 Introduction

This chapter presents results from research findings derived from Focus Group Discussions (FGDs) In-depth interviews (IDIs) with respondents and from Key Informants. The FGDs and IDIs were conducted with the purposively selected 8 pregnant women who had visited Rujeko Maternity Clinic for the first time in the current pregnancy. Key informants composed of the clinic staff. After the presentation and analysis of the data, a discussion of the research findings will be given.

4.2 Characteristics (socio-demographic) of the respondents

The pregnant women enrolled in the study were living in urban areas and their ages ranged between 15 and 49 years of age. These respondents were all married and most of them belonged to the Muslim religion while some were Christians. Of these women the majority (6) of them had attained secondary education while a few (2) of them had attained primary education. These women had at least one previous pregnancy and their husbands were aged between 23 and 50 years of age. All (8) respondents resided in rented accommodation in Dzivaresekwa high density suburb. Out of these respondents most belonged to the Chewa ethnic group from Malawi while some were Shona speaking from Zimbabwe. The (5) key informants composed of 3 female and 2 male mature adults whose ages ranged from 42 – 50 years of age. They were trained and professional nurse counselors-cum-
midwives whose work experience ranged between 10-20 years of age. The foregoing characteristics together with other attributes of the respondents in this study could have influenced their attitudes towards HIV Counseling and Testing, as shall be illustrated below.

4.3 PREGNANT WOMEN AGED 15-49 YEARS OF AGE ATTITUDES TOWARDS HIV COUNSELLING AND TESTING

According to Morgan and King (1996) pregnant women develop attitudes towards HIV counseling as a result of a variety of factors which include their knowledge, experiences and opinions, associated benefits and concerns. The same authors go on to explain that the socio-demographic characteristics of pregnant women also influence their attitude formation. This study explored these factors and the results are presented, analysed and discussed below.

4.3.1 Table 1: Age as a characteristic measurement of attitudes

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

This study found that the new antenatal attendees aged between 15 to 49 years of age were likely to have positive attitudes towards HIV counseling and testing. Strachan et al (2004) observe that HIV is primarily transmitted sexually and the majority of infections occur during the reproductive ages of 15-49 years of age.

This finding is in agreement with the results of a study by Kasenga et al (2009) in Malawi which established that readiness to test for HIV was higher
among women of child-bearing age between 15 to 49 years of age. It is quite possible that the pregnant women were less fearful of accepting HIV testing because this approach was offered as part of the standard of care given to all women visiting the clinic for antenatal care. The 30-39 age groups had the most respondents attending antenatal clinic. This finding is apparent as it could suggest that the pregnant women developed positive attitudes towards HIV counseling and testing as a result of the socialization process pregnant women go through to become responsible mothers. It could be that the women wanted the best for their babies by avoiding the transmission of HIV.

The above finding is supported by the social learning theory which posits that learning is based on modeling when people observe the behavior of others. Thus, pregnant women develop positive attitudes towards HIV counseling and testing because of their maturity of purpose and environmental influence towards their behaviour.

4.3.2 Table 2: Education as a Characteristic measurement of attitudes

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>Primary</th>
<th>Secondary</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

This study showed that all of the respondents had attained some form of education particularly secondary school education and were more likely to develop positive attitudes towards HIV counseling and testing than those women who had attained primary education or less educated. The majority (6)
had attained secondary school education while two (2) had attained primary school education.

This finding is consistent with the findings of Ngwerume (2006) in a study in Mutare where he found that educated and married pregnant women were more likely to develop positive attitudes towards HIV counseling and enroll for PMTCT programmes. It goes to show that education enables individuals to comprehend and accept new programmes beneficial to them without much difficulty. Schaefer (2006) observes that education performs a rather conservative function in transmitting the dominant culture and schooling, exposes each generation of people to the existing beliefs, norms and values of their culture.

### 4.3.3 Table 3: Religion as a Characteristic measurement of attitudes

<table>
<thead>
<tr>
<th>RELIGION</th>
<th>Christian</th>
<th>Muslim</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

This study also found that the majority (5) of pregnant women who belong to the Muslim religious sect are more likely to develop positive attitudes towards HIV counseling and testing. 3 pregnant Christian women from other religious sects had positive attitudes towards HIV counseling and testing.

This finding concurs with findings of a similar study in Kumasi, Ghana conducted by Agyei et al (2002) which showed that pregnant women from the Muslim religious sect were more likely to opt-in for HIV testing than pregnant women from other religious sects. In a similar study in Khartoum in Sudan,
Nasr et al (2003) found out that older Muslim women had a higher acceptance of HIV counseling and testing. In Zimbabwe, The Zimbabwe Herald dated 5 July 2011 reported that bush deliveries were still common and rampant among some members of the Apostolic (Masowe) church. It can be inferred that the Islamic/Muslim belief in cleanliness and purity allows Muslim women to deliver in clean environments and watching the purity of their off-spring through preventive or response to HIV counseling and testing. This finding is contradictory to the fact that the Apostolic (Masowe) church members do not use modern technology in maternity.

The traditional theory of attitudes explains the role played by religion towards influencing pregnant women to develop positive attitudes towards HIV Counseling and Testing. Schaefer (2006) explains that religious societies have cultural universals which play functionalist roles which include the replacement of personnel through sexual reproduction, teaching new recruits to learn and accept its values and customs, preserving order, providing and maintaining a sense of purpose where people must feel motivated to continue as members of a group or society. The same author goes on to view religion as a unified system of beliefs and practices relative to sacred things which provides an explanation for events that seem difficult to understand such as HIV infection and what happens beyond the grave. Thus religion influences those pregnant women who believe in God to have positive attitudes toward HIV Counseling and Testing. Thus the outcome of HIV tests and what happens thereafter is left under God’s control as religious pregnant women opt-in for HIV testing.
This study revealed that the majority of women (5) aged between 30-49 years of age had two or more pregnancies had positive attitudes towards HIV counseling and testing.

These results are similar to study findings of Bulawayo PMTCT City clinics by Sibanda (2008) who agrees that pregnant women develop positive attitudes towards pretest counseling because of their previous interactions with health care systems which exposed them to information and associated benefits.

This finding is in agreement to the functionalist and social learning theories of attitudes which state that people hold positive attitudes because these attitudes help them to achieve their basic goals. People develop favourable attitudes towards things that aid or reward them (Morgan and King, 1996). In this perspective, the women may have developed positive attitudes due to the high expectation among most women to deliver healthy babies and mostly to fulfill the mothers’ roles and functions.

According to Michener (2002) attitudes meet psychological functions which include the value expressive function and the ego-defensive functions. The
value expressive function refers to expressing basic values and reinforcing self image. If a pregnant woman views herself as a responsible mother-to-be, she can reinforce that image by adopting motherly beliefs and values. The ego-defensive function is when some attitudes serve to protect people from acknowledging basic thoughts about themselves or the harsh realities of life. They serve as defence mechanisms where people with feelings of inferiority may develop attitudes of superiority. In most African patriarchal societies women are viewed as being inferior to men but when it comes to child-rearing issues, women are perceived to be superior to men. Thus, it can be inferred that women who have had more than two pregnancies develop positive attitudes toward HIV counseling and testing.

4.3.5 Table 5: Source of information as a characteristic measurement of attitudes

<table>
<thead>
<tr>
<th>SOURCE OF INFORMATION</th>
<th>Radio</th>
<th>Television</th>
<th>Newspapers</th>
<th>Social Gatherings</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUMULATIVE NUMBER</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

This study showed that all (8) pregnant women had access to various forms of information. This led them to develop positive attitudes towards HIV counseling and testing. The pregnant women in this study had access to the radio, television, newspapers and they also had information on HIV from social gatherings which include churches, weddings, and funerals and even through gossiping.

This finding concurs with the research findings by Zulueta and Boulton(2007)
in the UK where they found out that the uptake of routine counseling and
testing had doubled in 1996-7 as a result of increased knowledge and
changing attitudes among pregnant women.

This finding also agrees to the study findings in a study by Nasr et al (2003) in
Khartoum in Sudan which report that willingness to test for HIV is based on
the amount of information pregnant women have about HIV. In her study of
HIV counseling and testing in Zimbabwe Bulawayo City clinics, Sibanda
(2008) reported that a woman’s access to health care in physical, social and
psychosocial contexts depends on her health beliefs, socio-economic and
demographic background.

Pregnant women who can afford to buy or access newspapers, televisions
and radios expose themselves to a myriad of information about HIV. Exposure
to information helps individuals to develop in-depth knowledge about various
subjects including HIV. Lack of adequate exposure to information concerning
HIV counseling and testing could lead to the development of negative
attitudes among pregnant women.
4.3.6 Table 6: Source of Income as a Characteristic measurement of Attitudes

<table>
<thead>
<tr>
<th>SOURCE OF INCOME</th>
<th>Self Employed</th>
<th>Formally Employed</th>
<th>Unemployed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

This study revealed that willingness to test for HIV among pregnant women is determined by their sources of income. The majority of the respondents (5) were self employed as vendors and could afford to pay the user fees required at the clinic while (2) of the respondents though unemployed were able to harness the required user fees and enrolled for HIV counseling and testing at the clinic and (1) of the respondents was formally employed and also enrolled for HIV counseling and testing at the clinic. These respondents showed their positive attitude towards HIV counseling and testing. This finding confirms the study findings in Khartoum, Sudan by Nasr et al (2003) who found that willingness to test for HIV is determined by individuals’ sources of income. The study also found that women who are better paid in formal employment prefer to get HIV tested in private rather than public health settings. It is through common cause that individuals of high social status and of a sound economic base prefer to get medical assistance from private practitioners where they get service equivalent to the value of their money and where they feel they get individual attention than from public institutions. It can be inferred that pregnant women from the so-called ‘affluent’ families may not enroll for antenatal care at Rujeko Maternity clinic.
4.3.7 Table 7: Location as a Characteristic measurement of Attitudes

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DENSITY</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dzivarasekwa</td>
<td>High</td>
<td>8</td>
</tr>
</tbody>
</table>

This study showed that all the respondent pregnant women resided in Dzivarasekwa. Their attitudes towards HIV counseling and testing are to an extent probably influenced by the area they reside. This study revealed that pregnant women who reside in more affluent urban settings, who are relatively poor, have physical access to health settings and have access to various forms of media are more likely to develop positive attitudes towards HIV counseling and testing.

This finding is in agreement with study findings in Khartoum, Sudan by Nasr et al (2003) who reported that most of the people who went for HIV testing were living closer to the testing clinic than those living far away from it. It can be inferred that among other factors, proximity to the antenatal clinic cuts travel costs thereby making the services more affordable and subsequently enabled the pregnant women to develop positive attitudes towards services offered at the clinic.

The social learning theory helps to explain why there can be differences in the attitudes by location. Sears et al (1991) observe that primary groups such as the family, friends and associates have an important effect on people’s beliefs and attitudes. It is through social influence that cultural factors and authorities shape our view of the world about us. Thus, where we stay and the people
whom we associate with influence our views and perceptions on objects, events and situations.

4.4.1 Respondents’ Rating of their Knowledge and Beliefs about HIV Counseling and Testing and MTCT

When asked on how they rated what they knew and believed about HIV counseling and MTCT, all the 8 respondents rated their knowledge and beliefs about HIV Counseling and Testing highly. Among them Mai Chamunorwa (not her real name) said that;

`Nowadays each and every pregnant woman is now aware about the importance of being tested for HIV as this is essential for the good health of the mother and the unborn child`.

On answering the same question, Amai Phiri said the following in Chewa:

`Ndizofunikira kuti ndiziseje amoyo wanga pamodzi ndiwamwana`, literally in English meaning that it is important to prioritise one’s unborn child’s health together with one’s health as a mother.

VaChihera, VaMagumbo and VaMaphosa (not their real names) among other respondents responded with the same sentiments, in the same words, thus:

“HIV is the virus that lowers the body’s defense system and AIDS refers to a host of diseases that one suffers from when one’s body has been infected and weakened by HIV. An HIV positive mother can transmit HIV to her baby during pregnancy, delivery or when breastfeeding.”
The respondents had knowledge on how a pregnant woman could prevent the transmission of HIV to her baby. The respondents’ knowledge about HIV/AIDS and MTCT may have enabled them to develop positive attitudes towards HIV counseling and testing. The participants to the study were knowledgeable about the benefits of HIV counseling and testing. From among the respondents, VaMaphosa had the following to say;

`HIV counseling and testing is essential for the prevention of vertical transmission of HIV from mother to child (PMTCT), early identification and referral to More Efficacious drug Regimens (MER), promotion of individual, family and societal well-being, the promotion of public health, an increased chance of babies being born HIV negative and promotes continuum of care`.

These perceived benefits outweigh the side effects of ARV drugs and subsequently pregnant women develop positive attitudes towards HIV Counseling and Testing.

Sears et al (1991) in their theory of reasoned action, observe that individuals have attitudes and beliefs that shape their intentions to engage in behaviour and pregnant women develop positive attitudes towards HIV counseling and testing in situations where they believe they would benefit. The pregnant women in this study showed positive attitudes towards HIV counseling and testing in pregnancy. This finding concurs with the findings in an article entitled “PMTCT Bringing –Hope to HIV-Positive Women” in The Zimbabwe Sunday Mail’s In –Depth section dated July 3-9 2011 which showed that there is an increased uptake of HIV counseling and testing among pregnant women in Zimbabwe. The increase on the number of women
being tested can be attributed to the associated benefits and knowledge of PMTCT.

This finding also confirms the study findings in the UK by Zulueta and Boulton (2007) who reported that the increase in the uptake of the opt-out policy suggest that the clients maybe realizing the benefits probably due to the knowledge they have acquired through antenatal education, and pre-test counseling on HIV.

This finding is also similar to the study findings in the USA by Merchant and Lala (2005) who reported that the main interventions for decreasing MTCT of HIV include antiretroviral therapy, elective lower segment caesarian section, infant feeding, vitamin A prophylaxis, vaginal disinfection and immunotherapy.

The theory of reasoned action explains that behavior is driven by expectations and attitudes and social norms (Sears (1991). In situations where pregnant women believe that they benefit from being screened for HIV, they develop positive attitudes towards HIV counseling and testing. In addition, the functionalist theory posits that through knowledge, people seek some degree or order, clarity and stability in their personal frame of reference (Michener et al, 2002). Knowledge is meant to exclude the use of stereotypes on MTCT of HIV. Thus, the purpose of acquiring knowledge on PMTCT enables pregnant women to develop positive attitudes and make informed decisions towards HIV counseling and testing. Knowledge is an important determinant for the
development of positive attitudes hence good quality HIV counseling and testing is important for the success of PMTCT efforts.

This finding on the effects of knowledge on attitude formation is similar to the study findings in UK by Zulueta and Boulton (2007) who reported that increased knowledge on HIV increases the positive perception of HIV counseling and testing.

On the other hand, this finding is different from a similar study finding which was conducted in Sudan by Nasr et al (2003). The study showed that the pregnant mothers did not have enough, if any, knowledge about HIV and PMTCT. The same author goes on to explain that most health and other humanitarian programmes were affected by the war which was being waged at the time of the study in Sudan. Therefore, it became impossible to access most areas as most developmental programmes were affected by the war. Therefore, war and political instability result in high levels of illiteracy and underdevelopment thereby hindering the rolling out of welfare programmes.
When asked on how they rate the manner they were handled by the clinic staff and the time they spent at the clinic, this study found out that the majority (6) respondents expressed that the handling they received from the clinic staff was good while the minority (2) respondents stated that the handling they received from the clinic staff was average. The majority (7) of the respondents expressed that the time they spent at the clinic was average, and this can be inferred to mean bad while (1) respondent stated that the time she spent at the hospital was good.

Commenting about how they were handled at the clinic, Amai Chimwemwe from among the respondents had this to say:
`We received a warm welcome from the clinic staff from the time we entered the clinic. We were immediately taken for group information counseling and we felt respected throughout the session. Even for those who inwardly did not want to be tested, they would end up wanting to be tested because of the good manner the counselor talked to us. I personally liked the way we were received despite the long time we spent at the clinic. These people really know what they are doing`.

Good reception makes the programme more acceptable by the intended beneficiaries as they become confident with the processes involved. This study further shows that HIV counseling and testing is more acceptable by pregnant women even when it consumes a lot of time, where the counseling is provided by well trained, professional and experienced personnel. This finding is in agreement with study findings in the USA by Chippindale and French (2001) who reported that all counselors should have formal counseling training and receive regular clinical supervision as part of adherence to good standards of clinical practice.

This finding is in agreement with research findings of a study in Bulawayo by Sibanda (2008) who reported that RCT was largely acceptable to pregnant women where HIV test results are given on the same day the test is done and where benefits to those who tested positive are readily available. At this clinic the researcher observed that pregnant women who come for enrolment of antenatal care for the first time with the current pregnancy spent almost the whole day following the processes at the clinic. On being asked to comment on the time spent enrolling for antenatal care at the clinic, VaChihera from among the respondents had the following to say:
‘Kure kwegava ndokusina mitsvubvu’, literally meaning that the time spent at the clinic was very long but it was worth while considering the ultimate benefits’. The same responded added in Chewa language that ‘Ndizofunikira kuti ndikire thawi’, literally in English meaning that it is worthwhile to wait for long periods to have an HIV test’

This finding is also supported by the theory of social influence which states that rewards, coercion, expertise, referent power and legal authority enable people to comply with the needs of those people in authority (Sears et al, 1991).

This finding supports research findings of a study in Uganda by Kipp et al (2001) when they reported that HIV counselors should have certain skills, be trained and should pass an examination after training. Thus, good counseling will enable pregnant women to develop positive attitudes towards HIV counseling and testing.

4.6.1 Table 9: Findings on the Reasons Pregnant women develop Negative Attitudes towards HIV Counseling and Testing

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number of responses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of stigma and discrimination</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Fear of disclosure</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Fear of divorce</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Fear of knowing HIV status</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Fear of failing to access HIV services</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

This study showed the reasons why pregnant women develop negative attitudes towards HIV counseling and testing. 7 respondents expressed fear
of stigma and discrimination, 6 respondents expressed fears of divorce, 6 expressed fear of knowing their status and 6 expressed fear of failing to access services after testing positive to HIV. When asked the reasons for declining HIV testing while pregnant, Amai Phiri had the following to say:

`One has to be very careful before considering to have an HIV test because there is a danger for one losing her marriage, friends and relatives and one can fail to access the much talked about services. Sometimes it is frightening to know one’s status because one may not know what will exactly happen to you in future especially when you disclose your status`.

The above findings are similar to other studies conducted in KwaZulu Natal in South Africa by Meiberg et al (2005), in Kenya by Kipp et al (2001), in Ghana by Agyei et al (2002), in Uganda by Kipp et al (2001) and in Malawi by Kasenga et al (2009) in which women who disclose their HIV positive status to their “unprepared” husbands can be subjected to blame; stigma and discrimination, verbal, physical and psychological abuse and sometimes divorce. This therefore calls for the need for couple counseling in pregnancy and counseling males at their homes or work places in order to promote male participation in antenatal programmes.

On the other hand, this finding is in agreement with the study findings in Limpopo province, South Africa by Meiberg et al (2005) and by Kipp et al (2001) in Kenya. Meiberg et al (2005) reported that HIV counseling and testing in the Limpopo province of South Africa carried a lot of stigma and discrimination as people became afraid of being tested for HIV.
Studies in developed countries have different findings. In their study on the reaction to disclosure of HIV positive results Merchant and Lala (2005) alluded to the acceptance of the results by men in the UK. Acceptance of HIV positive results was attributed to increased knowledge on HIV among men in the UK.

Kipp et al (2001) reported that in Kenya, HIV positive women who disclosed their status to their husbands were physically abused or divorced. The above scenarios showed that there was lack of knowledge on HIV among the majority of men in some African countries. There is need to increase HIV awareness campaigns among men with a view to enable them to develop positive attitudes and participate in HIV related programmes.

4.7.1 Table 10: Findings on who makes the decision for HIV Counseling and Testing.

<table>
<thead>
<tr>
<th>Mode of decision-making</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consult Parents</td>
<td>1</td>
</tr>
<tr>
<td>Consult Husband</td>
<td>6</td>
</tr>
<tr>
<td>Own Decision</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
</tr>
</tbody>
</table>

This study revealed that the majority (6) of pregnant women consulted their husbands before they get tested for HIV while the minority (1) consulted parents and (1) made her own decision to have the HIV test. Seeking and
being granted permission to go for HIV testing guarantees the women morale, financial and all the support they required during and after receiving the test results.

From among the respondents, Amai Chimwemwe commented in Chewa stating that:

`Tima enera kuti tipatsidwe lamuro kuchokera kwazi bambo antu, kuti tipite kokaezedwa matenda a HIV. Ifeyo tipite kokaezedwa azibambo atu amatikaripira kapena kutimenya kapena kutikana, kapena kutipa. This in English translates as, One has to seek permission from ones husband before considering to have an HIV test to avoid being physically abused by one’s husband. If one gets an HIV test without the knowledge of one`s husband one may be physically assaulted, divorced, blamed or even killed when one`s husbands comes to know about the test`.

On being asked if their husbands accompanied them to the clinic after giving their wives permission to be HIV tested, the majority of the participants reported that their husbands do not accompany them to the maternity clinics for cultural and economic reasons. Among participants in the Focus Group Discussions, Amai Phiri had the following to say:

“Arume vedu vanotya kusekwa nevamwe varume vachinzi vakadyiswa” This in English translates as, “Our husbands are afraid of being laughed at by their male friends as they would be labeled as to have been given “love potions .If you seek for permission to get tested for HIV you are granted the permission but our husbands do not accompany us to the clinic. They give many excuses and claim to be busy at work until one delivers the child”.
This finding is similar to those studies in African countries including Kenya by Kipp et al (2001) where women seek for permission to be tested for HIV. If granted the permission, they would be guaranteed of economic and psychosocial support from their male partners. The same study by Kipp et al (2001) also shows that males do not accompany their wives to the maternity clinic even when they are aware of the benefits of PMTCT.

In the developed countries there are policies which promote male participation in maternity issues. In addition, the developed world culture tries to uphold gender balance and equality in roles between men and women. Such a development has seen men being able to apply for paternity leave with the aim of assisting their expecting wives.

The finding of this study is similar to study findings in Zimbabwe by Ngwerume (2006) who reported that pregnant women are mostly seen alone in HIV counseling and testing. This finding can be attributed to the socialization of men in the African culture coupled with gender imbalance between African men and women (Muzvidziwa, 2000).

Despite the fact that it takes two to have a child, women are left alone to take care of the pregnancy until a child is born. In addition, males have a culturally determined domineering role over women. Women are not allowed to make some decisions even on the pregnancy they carry. Women are put in a dilemma when the maternity/antenatal policies require that they have an HIV test on the one hand and when their husbands do no give them permission to get tested on the other hand.
The Cognitive dissonance theory supports the above study finding. Michener et al (2002) observes that cognitive dissonance occurs where feelings of tension arise when an individual is simultaneously aware of two inconsistent cognitions such as when he/she acts contrary to his/her attitude or when he/she makes decisions favouring one alternative despite reasons favouring another. Therefore pregnant women may develop negative attitudes towards HIV counseling and testing despite the benefits associated with having the HIV test.

4.8.1 Table11: Findings on the respondents` views and Perceptions on HIV Counseling and Testing policies as implemented at Rujeko clinic.

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating (Good)</th>
<th>Rating (Average)</th>
<th>Rating (Bad)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Counseling and Testing</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Voluntary Counseling and Testing</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Involvement of men in maternity issues</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

This study revealed that the majority (6) of the respondents had positive attitudes towards routine counseling and testing while the minority (2) expressed negative attitudes. The majority of the respondents (6) revealed
negative attitudes towards voluntary HIV counseling and testing while the minority (2) expressed positive attitudes towards voluntary HIV counseling and testing. The majority (6) of the respondents felt that men and pregnant women should be routinely tested for HIV whenever they seek medical attention rather than waiting to be tested when they get pregnant. All (8) respondents expressed their negative attitude towards the non-involvement of men in maternity issues despite the provisions of National Reproductive Health Policies. On being asked on the applicability of the HIV Counseling and Testing Policies as applied at Rujeko clinic, one key informant had this to say:

‘The revised recommendation on HIV counseling and testing of pregnant women (RCT) policy is not compatible with the principle of informed consent. There is a subtle element of coercion for the pregnant women for testing. The options for opting-out are neither here nor there. This is because the PMTCT programme funders expect a 90 to 100% uptake each month thereby forcing service providers to tell the pregnant women that they will not be attended to on delivery if their HIV status is unknown. Such statements are coercive in nature and against the principles of counseling and informed consent’.

Coercion on the other hand, can bring about positive results of compliance, but the above mentioned stigma and discrimination may have lasting negative effects to the subjects.

This finding is in agreement to the study findings of a study in the UK conducted by Bennet (2007) who reported that health practitioners are
instructed to recommend HIV testing to all pregnant women in order to achieve 90% uptake at the same time ensuring that each woman chooses to either opt-in or opt-out.

However, given the time constraints and need for high uptake screening, a one-sided view of the positive consequences of HIV testing is given. This is because the counselors will be inundated with so much work to do.

4.9.1 Findings on the views Key Informants have about HIV Counseling and Testing at Rujeko Maternity Clinic

On being asked about their view on the HIV counseling and testing among pregnant women at Rujeko clinic the key informants in this study revealed that:

‘Pregnant women who visit the antenatal clinic for the first time in the current pregnancy are treated separately from others. They spend almost the whole day at the clinic because the process is very long’.

This study is different from study findings conducted in Ghana by Agyei et al (2002) where it is reported that HIV counseling and testing process among pregnant women is short and services are readily available.

The key informants further expressed their concern over the non-involvement of men in PMTCT. They indicated that the negative attitudes of most men towards HIV testing influence the low uptake of HIV testing among pregnant women. Thus, most participants
were concerned about the male attitudes on HIV counseling and testing particularly when their female partners are pregnant.

Lack of proper counseling infrastructure and shortage of staff was an issue raised by key Informants. They further explained that counseling space does not promote confidentiality and privacy which leads to more affluent clients opting for delivery at private hospitals and clinics. Shortage of staff was another issue identified by key Informants which hinders proper counseling as most sessions are done hurriedly. Shortage of staff (counselors and midwives) was expressed as a concern by key informants and the pregnant women. This finding is similar to other studies conducted in rural Malawi by (Kasenga et al, 2009), Ghana by (Agyei et al 2002), and Uganda by Kipp et al, 2001) which reported for the need for the training and deployment of more professional staff at maternity clinics.
4.10: Suggestions on what could be done to improve the acceptability of HIV counseling and testing among pregnant women at Rujeko Clinic

Table 12

<table>
<thead>
<tr>
<th>What can be done to make HIV counseling and testing among Pregnant women become acceptable at Rujeko clinic</th>
<th>Number</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simplifying the health information/education given during counseling.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Continuous education of men on HIV transmission and on the benefits of being HIV tested.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Intensification of workplace HIV/AIDS programmes.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Demystifying HIV with a view to discard dysfunctional socio-cultural and traditional beliefs.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Giving more time to counseling before testing.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Recruitment, appointment and motivation of qualified and competent maternity personnel at the clinic.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Involving men from the day of initial ante-natal registration.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Provide adequate and appropriate infrastructure for counseling.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Emphasize couple counseling in pregnancy.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Show respect for the pregnant women.</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

All the participants in this study were of the view that the foregoing issues be addressed in order to improve the acceptability of HIV Counseling and Testing among pregnant women at Rujeko Maternity clinic.

These findings concurs with study findings in the USA by Branson et al (2006) who reported that pregnant women need to be provided with simple and detailed information about HIV testing in pregnancy. This approach will enable
pregnant women to develop positive attitudes toward HIV counseling and testing.

Branson et al (2006) also reports that health care practitioners in the USA are encouraged to structure counseling and testing procedures to facilitate confidential, voluntary participation and to include basic information regarding the medical implications of the test. This finding is in disagreement with the findings of this study which revealed that issues of informed consent are only theories which are never applied in practice. From among the respondents Amai Chimwemwe had the following to say:

‘Chirongwa chakanaka fani asi tibateiwo sevanhu, tapota. Tinopedza uva rese tiri pano nenzara tichinzi endi apa neapa, kuitwa kunge pwere. Chinonetsa vanotibatsira vacho vashoma basa rakawanda kuvadarika’. Literally meaning in English that they want to be treated with human worth and dignity and not as small children. They spent the whole day at the clinic without anything to eat. They attributed the problem to shortage of manpower at the clinic.

All (8) of the respondents indicated the need for couple counseling in pregnancy and possibly enact a policy which allows men to go on paternity leave each time their wives fall pregnant thereby allowing them to provide all the support needed by their pregnant wives. This finding is similar with the study findings in Kenya by Kipp et al (2001) who report that there is increased violence and loss of security for pregnant women who shared their HIV positive status with their spouses. Those who shared information with their partners were replaced by another wife while some were beaten and some committed suicide. Thus couple counseling and testing is designed to address
such social and communication barriers by encouraging the participation of males in PMTCT programmes.

Most of the study participants expressed the need to assign more personnel on HIV counseling and testing and also for the provision of space/rooms which promote privacy and confidentiality (FGDs, IDIs, and key Informants). This finding is in agreement with study findings by Bennet (2007) in the UK which reports that the principle of informed consent should be upheld when screening pregnant women for HIV. This will display some form of respect for the pregnant women and also improve their self-esteem.

4.11 SUMMARY

The findings of this study demonstrated that routine HIV counseling and testing seemed to be largely acceptable to the pregnant women in Dzivarasekwa in Harare, Zimbabwe.

This study has demonstrated that the characteristics of pregnant women have a bearing on the choices they made for themselves. Being married, of child-bearing age, educated, relatively poor, living in urban settings, having access to various forms of media, among other variables, influenced pregnant women to have positive attitudes towards HIV counseling and testing.

This study established that RCT policy has become more acceptable among pregnant women in both the developed and developing countries. However, few service users are familiar with the aspects of HIV policies. This study also
revealed that it is difficult to simultaneously uphold the principles of informed consent and routine counseling and testing in HIV counseling and testing.

This study has also brought to the fore the fact that attitudes are based on knowledge, experiences, beliefs, opinions, benefits and concerns. Sociological and psychological theories of attitudes can be applied to assess pregnant women’s attitudes towards HIV counseling and testing.

This study has highlighted to the policy makers, the need for male involvement in PMTCT programmes. There is also need for the provision of adequate supply of drugs, enough number of counselors and midwives, proper infrastructure for counseling and good counseling training skills for the practitioners. The next chapter will present recommendations and conclusions to the study.
CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the conclusions of a research study that set out to assess the attitudes of pregnant women towards HIV counseling and testing in urban Zimbabwe and particularly at Rujeko Maternity Clinic in Dzivarasekwa high density suburb of the City of Harare. This chapter is divided into two sections. The first section will provide a summary of the study and the second section presents recommendations to the study findings.

5.2 Summary of Findings

This study found out that socio-demographic characteristic which include age, marital status, level of education attained, religious affiliation, location, ethnicity, nature of employment, number of pregnancies influence the formation of either negative or positive attitudes towards HIV counseling and testing among pregnant women. Being mature, married, educated to at least up to secondary school level, belonging to Muslim religious sect, residing in Dzivarasekwa and having had more than one pregnancy were factors associated with the development of positive attitudes towards HIV counseling and testing among pregnant women.

Another finding from this study is that the majority of pregnant women had adequate knowledge concerning HIV and the associated benefits of HIV counseling and testing in pregnancy also developed positive attitudes towards
HIV counseling and testing.

This study revealed that good reception at Rujeko clinic enabled pregnant women to develop positive attitudes toward HIV counseling and testing. This could be so because the clinic is manned with well trained, professional and mature personnel.

This study established that most pregnant women developed negative attitudes towards HIV counseling because their husbands decided for them on whether to have an HIV test or not. Most women sought permission to have an HIV test from their husbands. Failure to seek permission for having an HIV test resulted in the pregnant women being blamed by their husbands especially if their test results were HIV positive. The sought permission assured the pregnant women economic and psycho-social support through-out the pregnancy period.

This study showed that most pregnant women resisted HIV counseling and testing because of fear of disclosing their results to their husbands if they came out to be positive, fear of knowing about the HIV positive result itself, fear of being battered, divorced, stigmatized and discriminated against and fear of failing to access the much needed HIV preventive and control services in the community.

This study found out that the HIV counseling and testing process at Rujeko Maternity clinic was very long. This was because there was a severe shortage of professional staff at the clinic. Long processes as a result of staff shortage led in some pregnant women to developing negative attitudes.
towards HIV counseling and testing as they expected short processes. They felt belittled and under valued by spending the whole day enrolling for antenatal care at the clinic.

This study found out that there was a great mismatch between the international blue-print on HIV counseling and testing in pregnancy and what was practiced on the ground. The study found out that it was difficult to uphold the principle of informed consent together with the principle of routine counseling and testing. A subtle element of coercing women to be HIV tested was identified.

Another finding of this study was that pregnant women developed negative attitudes towards HIV counseling and testing because of the non-involvement and non-enforcement of male participation in ante-natal care programmes.

In conclusion, this study found out that social factors included traditional and cultural and psychological factors influence the formation of either positive or negative attitudes towards HIV counseling and testing among pregnant women attending antenatal care at Rujeko maternity clinic.

5.3 Recommendations
The recommendations were derived from an outcome of the research findings and the discussions and suggestions from the respondents in the study. These recommendations were on particular issues.
5.3.1 Simplifying information on HIV

The health information on HIV was overloaded with medical jargon to the extent that even health practitioners labour to comprehend. It is therefore prudent to simplify the health information in HIV counseling like what has been done in Ghana where it is reported that patients with different levels of education are able to grasp the simplified information on HIV.

5.3.2 Continuous education for men on HIV

This study inferred that the negative attitudes of men towards HIV counseling and testing could be attributed to lack of knowledge. It is, therefore, recommended that continuous education of men through various forms of media such as electronic, print, political party rallies, church service gatherings be applied with a view to change their attitudes towards HIV counseling and testing.

5.3.3 Intensification of workplace HIV/AIDS programmes

The participants in this study reported that men who did not accompany their wives to the clinic for antenatal care claimed to be busy at work. They further reported that most men claimed to have regular HIV tests done at their workplace.

It is from the foregoing that recommendations are made to have workplace HIV/AIDS programmes intensified. These programmes should also have a special focus on HIV counseling and testing in pregnancy.
5.3.4 Demystifying of HIV

This study observed that socio-cultural and traditional beliefs led men to blame and abuse their wives if found to be HIV positive. It is, therefore, recommended that these beliefs be discarded through the enforcement of the whole population in participating in antenatal care programmes and through the provision of current policies and information on HIV transmission and management. Even schools can play a significant role in demystifying HIV through effecting changes of the curricula in crèches, primary, secondary and tertiary institutions to inco-operate HIV issues.

5.3.5 Involvement of men in maternity issues

This study observed that men were not involved in maternity issues despite the fact that it takes a man and a woman to bear a child. The national health reproductive policy clearly articulates the role of men in maternity issues but these are not enforced. The non-involvement of men in maternity issues stimulates the development of negative attitudes towards HIV counseling and testing among pregnant women.

It is from the foregoing that recommendations are made to ensure the involvement of men in maternity issues particularly from the day their pregnant wives come to the clinic to enroll for antenatal care.

5.3.6 Encouraging couple counseling

This study found out that all pregnant women in this study were counseled alone without the participation or involvement of their husbands yet it takes a couple to bear a child.
It is therefore necessary that couple counseling be recommended with a view to engage men and discard the negative views that pregnant women develop through the non-involvement of men in HIV counseling and testing in their wives’ pregnancy.

5.3.7 Provide enough time for counseling

This study revealed that pregnant women felt that the time spent by the counselors providing HIV counseling is too short. It was a general feeling among the study participants that time allocated for counseling should be enough to enable them to ask questions and that the counseling sessions should not be hurriedly done or adjourned.

It is recommended that counseling be given more time as it forms the base towards the development of attitudes towards HIV testing. Pregnant women should be allowed time to internalize and reflect on the information given to them during counseling.

5.3.8 Recruitment and appointment of adequate maternity personnel

This study showed that the maternity staff was double-tasked as maternity nurses and as counselors. The researcher observed that the counselor could abruptly end or adjourn a counseling session to attend a client in advanced labour to deliver a child.

Over-loading staff with work could bring in them burn-out, severe stress resulting inefficiency and poor relations with clients.

It is therefore recommended that qualified staff be recruited and appointed to
assist pregnant women develop positive attitude towards HIV counseling and testing. This would also promote high standard of service delivery.

5.3.9 Provision of adequate and appropriate infrastructure for counseling

This study revealed that the counseling rooms at Rujeko clinic were designed as waiting and store rooms and is too small and unsuitable for conducting counseling sessions. Biestek (1957) observes that confidentiality is an essential principle that should be considered on a one-to-one interaction. It is therefore recommended that proper counseling rooms be provided to allow for proper and professional counseling that which upholds the worth and dignity of clients.

Training of more staff is strongly recommended.

5.3.10 Show respect for the pregnant women

This study revealed that the HIV counseling and testing process which pregnant women went through at Rujeko clinic was dehumanizing and did not value them as major players in the creation and perpetuation of human species.

It is recommended that counseling particularly in pregnancy be done by the book because it forms the basis by which the world can achieve a zero transmission of HIV from mother to child and also achieve an HIV free generation.
5.4 Areas for further study

The researcher recommends the following areas for further research:

1. Challenges faced by HIV positive women suffering from multi-drug resistant tuberculosis.

2. Adolescents living with HIV/AIDS.

3. Elderly people living with HIV/AIDS

5.5 Conclusion

In conclusion this study found out that those pregnant women developed attitudes towards HIV counseling and testing through the influenced of their socio-demographic characteristics. Socio-cultural and psychological factors also influenced the formation of attitudes towards HIV. Pregnant women developed positive attitudes towards HIV counseling because of the vast knowledge they had from various forms of media, the benefits associated with HIV testing and the desire among all female species to become responsible mothers. This happened despite the gruesome process pregnant women go through in enrolling for ante-natal care this study found out that the policy on routine counseling and testing was incompatible with the principle of informed consent.

Pregnant women developed negative attitudes towards HIV counseling and testing because of the non-involvement of their husbands in maternity issues and because of the negative manner they were handled by their husbands and the service providers.
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Appendix A: Consent Form for Respondents and Key Informants

My name is Belamino K Chikwaiwa and I am a Master of Social Work student with

the University of Zimbabwe, School of Social Work. I intend to carry-out a study on

the assessment of pregnant women`s attitudes towards HIV counseling and testing

as practiced at Rujeko Maternity clinic.

You have been selected to participate in the study because of your knowledge about the subject under review.

Any information that is obtained in this study will remain private and confidential. The information will only be used for academic purposes and improving HIV counseling and testing services at Maternity Clinics.

Your decision whether to participate or not in this study will not prejudice your future relations with the researcher or the Maternity Clinic staff.

If you have any questions, please feel free to seek clarification. It is your right not to choose to respond to questions that you view as being too personal.

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE
.YOUR SIGNATURE INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE AFTER HAVING READ THE INFORMATION PROVIDED ABOVE.

Interviewee Signature: Date:

Interviewer’s Signature Date:
Appendix B

Respondent Code Number:

An assessment of pregnant women’s attitudes towards HIV counselling and testing in urban Zimbabwe: A study of Rujeko maternity clinic in Dzivarasekwa, Harare.

Introduction

My name is Belamino Chikwaiwa. I am a Master of Social Work student with the University of Zimbabwe, School of Social Work. I intend to carry-out the above mentioned study at this (Rujeko) Maternity clinic. The study is purely for academic purposes, However, it can be used to improve service delivery and policy particularly on HIV Counselling and Testing of pregnant women.

Confidentiality will be observed as the interviews will be done on a one –on-one basis in a private room where no names will either be asked or recorded. I therefore seek for your permission to allow me to have an interview with you.

A. Interview schedule for pregnant women.

1. Demographic characteristics

1.1 Age in years

1.  15-20
2.  21-24
3.  25-29
4.  30-34
5.  35-39
6.  40-44
7.  44-49

1.2a Marital status

1. Single
2. Married
3. Divorced
4. Separated
5. Widowed
6. Cohabiting
7. Other (specify) __________

1.2b If married, partner’s age years
1. 20 and below
2. 21-24
3. 25-29
4. 30-34
5. 35-39
6. 40-44
7. 45-49
8. 50 And above

1.2c. Number of children__Alive_____Dead_______

1.2d What is the size of your household? ___________________

2. Can you write and read a letter? Yes, with difficult, no

3. What level of education did you attain 1. none
2. Primary
3. Secondary
4. Tertiary

2. Traditional
3. Muslim
4. Other (specify)

5. How many pregnancies have you had? ______________

6. What is the source of your information about HIV and AIDS? 1. Radio
2. Television
3.
4. Internet
5. Health
6.

Newspapers
7. What is your occupational status?
1. Unemployed
2. Student
3. Domestic worker
4. Professional
5. Self employed
6. Other (specify)

Other (specify)
8. Ethnicity
1. Shona
2. Chewa
3. Ndebele
4. Other (specify)

13. Zimba 14. Other
10. What type of accommodation do you use
   1. Rented/leased
   2. Owner
   3. Family owned

2. Respondents rating of their Knowledge and beliefs about HIV & AIDS and mtct
2.1 How do you rate your understanding of HIV counseling and testing and Mother-to-child-transmission of HIV?
   1. Very poor
   2. Poor
   3. Average
   4. Adequate
   5. Highly adequate

3. Respondents’ rating of HIV counseling and testing at Rujeko Maternity clinic
How do you rate the manner you were handled and the time you spent trying to register for ante-natal care at Rujeko clinic?

   The manner I was handled was:
   1. Very bad
   2. Bad
   3. Average
   4. Good
   5. Very good

   The time I spent at the clinic was:
   1. Very short
   2. Short
   3. Average
   4. Long
   5. Very long
4. Reasons pregnant women develop negative attitudes towards HIV counseling and testing

Can you state the reasons why one would decline to have an HIV test?

5. Decision to get tested for HIV?

In your family, who makes the final decision for you to get tested for HIV?

6. Respondents’ views and perceptions on HIV counseling and testing policies as implemented at Rujeko clinic

How do you view the manner in which routine and voluntary counseling and testing policies are implemented at Rujeko clinic?

Rating:
1. Very bad
2. Bad
3. Average
4. Good
5. Very good

How do you perceive the manner in which men are involved in ante-natal care?

Rating:
1. Very bad
2. Bad
3. Average
4. Good
5. Very good

7. Key informants’ views about HIV counseling and testing at Rujeko clinic
What are your views with regards to HIV counseling and testing among pregnant women at Rujeko clinic?

8. Participants’ suggestions on improving the acceptability of HIV counseling and testing at Rujeko clinic

What are your suggestions towards improving the acceptability of routine counseling and testing among pregnant women at Rujeko clinic?

Thank you for your participation
Appendix C

An assessment of pregnant women’s attitudes towards HIV counseling and testing in urban Zimbabwe: a study of Rujeko maternity clinic in Dzikavarasekwa high density suburb in Harare

B. Interview guide for key informants

1. Age

   Years

2. Marital status

3. Professional qualifications

4. Appointment

5. Are you a trained HIV & AIDS counselor yes or no?

6. Years of experience as a counsellor in an antenatal setting.

7. Have you been tested for HIV yes or no?

8. In your opinion what are the benefits of HIV counselling and testing in pregnancy.

9. What policies do you apply when testing pregnant women for HIV?

10. What do you think are the concerns of pregnant women towards HIV counseling?

11. What do you think hinders the improvement of the uptake of HIV testing among pregnant women?

12. Suggest any possible ways of improving the uptake of HIV counseling in pregnancy.

Thank you for your participation