FACTORS INFLUENCING UTILIZATION OF VOLUNTARY COUNSELLING AND TESTING OF HIV AMONG PREGNANT WOMEN IN LESOTHO

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DECLARATION

Submitted in partial fulfilment of the requirements for the degree of Masters in Population Studies, in the Graduate Programme in the Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal,
Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Population Studies in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Abstract

Voluntary Counselling and Testing for HIV is an effective and important strategy for prevention, care and support. The study examines factors affecting utilization of VCT among pregnant women in Lesotho. A combination of quantitative and qualitative methods was employed. The quantitative part of the study utilized the 2004 Lesotho Demographic and Health Survey data and the qualitative study drew on data from focus group discussions among women attending antenatal clinics in Maseru and Leribe. The majority of pregnant women have never been tested for HIV/AIDS. Married women were less likely to go for VCT as compared with those who are not married. The study also established that place of residence, education and marital status were significantly associated with knowledge of HIV/AIDS and ever been tested for HIV. Stigma and discriminations and fear associated with HIV testing were highlighted as the main factors hindering the use of VCT services among pregnant women. However, knowing one's status in order to access early treatment was the main reason for utilizing VCT. The VCT promotion programme for pregnant women in Lesotho has to focus on enhancing positive perception of VCT and alleviating perceived barriers related to the use of VCT services.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral Therapy
AZT	Azidothymidine
BOS	Bureau of Statistics
FAO	Food and Agricultural Organization
FHI	Family Health International
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
LDHS	Lesotho Demographic Survey
MoHSW	Ministry of Health and Social Welfare
MTCT	Mother-To-Child Transmission
PMTCT	Prevention of Mother-To-Child Transmission
PRB	Population Reference Bureau
SPSS	Statistical Package for Social Scientist
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZDV	Zidovudine

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

For more than a decade now HIV/AIDS has been a global challenge for all sectors of life, affecting and infecting families and becoming the leading cause of death in the world (UNAIDS/WHO, 2008). Africa especially sub-Saharan Africa has been mostly affected and devastated by the HIV/AIDS pandemic. According to UNAIDS (2008), by 2007 more than two thirds (67%) of all persons infected with HIV were living in the region and an estimated 1.9 million people were newly infected with HIV. Furthermore, sub-Saharan Africa continues to bear the greatest burden of disease, and represent 75% of the global AIDS death toll (UNAIDS, 2008). Southern Africa remains the epicentre of the global HIV epidemic and worldwide, 35% of people with HIV live in this sub-region and this region accounts for 38% of AIDS deaths globally (UNAIDS, 2008).

It has been estimated that most of the 37 million people worldwide living with HIV do not know that they are carrying the virus and the proportion is highest in countries worst affected by the epidemic (Ekanem and Gbadegesin, 2004). The first pillar of HIV prevention is voluntary counselling and testing (VCT) but despite the very high number of people already living with HIV/AIDS, it is estimated that less than 10% are aware they are infected, mainly because of the limited availability, access, and use of VCT (FHI, 2003). This fact greatly hinders efforts to respond to the AIDS epidemic, as people have to know if they are infected in order to access services. Therefore, encouraging VCT is a very important strategy in the fight against HIV/AIDS. Hence, the present study will shed more insights into the factors affecting utilization of VCT among pregnant women in Lesotho.

1.2 Background of Study

Lesotho has a population of approximately 1.8 million and one of the highest HIV prevalence rates in the world (PRB, 2006). The first case of HIV in Lesotho was identified in 1986 but by 2007 the HIV/AIDS prevalence rate had risen to 23.2% (PRB, 2006, Lesotho UNGASS report, 2008). By 2005, there were about 270,000, people living with HIV in Lesotho and by

2007 this number had increased to 290,000 (UNAIDS, 2006; UNAIDS, 2008). The HIV prevalence rate in Lesotho is high and each day there are about 62 new incidences of HIV and 50 AIDS deaths. Females continue to bear more burden of the disease than males (Lesotho, UNGASS Country report, 2008). Furthermore, in 2007 18,244 people died of HIV/AIDS in Lesotho (ibid).

According to UNAIDS (2006), the number of children aged 0-14 years living with HIV declined from 18, 000 in 2005 to 12,000 in 2007 and those orphaned by HIV increased from 97,000 in 2005 to 110,000 in 2007 (UNAIDS, 2008). Infants and young children, and the age group 30-50 are most heavily affected by HIV/AIDS in Lesotho (UNAIDS, 2008). The premature deaths and reduced fertility among the HIV positive have led to a decline in population growth rates and dramatically reshaped the population structure in Lesotho (UNAIDS, 2008).

In 1994, the HIV prevalence among antenatal clinic attendees in Lesotho was over 20% and by 2003 the HIV prevalence rose dramatically to 30% (UNAIDS, 2004). In 2005, the HIV prevalence was 28.8% in urban areas and 21.7% in rural areas (Lesotho National Human Development Report, 2007). There seems to be no significant change in HIV countrywide however, a recent sentinel surveillance report suggested a decline in HIV prevalence among pregnant women aged 15-24 attending antenatal clinics from 11% in 2005 to 8.9% in 2007 (Lesotho UNGASS report, 2008).

Mother-to-child transmission (MTCT) is the leading cause of HIV infection in children and if there are no preventive measures, approximately 30% to 45% of infants born to HIV positive mothers will contract the virus (WHO/UNAIDS/UNICEF, 2007; UNAIDS, 2001). MTCT accounts for the majority of HIV infections in children in developing countries and more than 90% of children living with HIV acquired the virus during pregnancy, birth or breastfeeding (UNAIDS, 2008). In addition, de Paoli et al. (2002) argued that, MTCT of HIV is an urgent and growing problem in developing countries. VCT in pregnancy is therefore regarded as the gateway for prevention of MTCT of HIV (Rogers et al., 2006). However, in Lesotho, it has been shown that the level of knowledge and understanding of the way the HIV virus is acquired and spread among the general population is low especially among vulnerable groups due to inadequate access to information and services (National AIDS Commission, 2006).

In Lesotho, transmission rates from mother to child are high and the Ministry of Health and Social Welfare (2004) estimates that about 7000 infants will be infected with HIV during pregnancy, delivery or breastfeeding. With the introduction of antiretroviral therapy in Lesotho, it is essential for pregnant women to know their status so as to prevent mother-to-child transmission (PMTCT) of HIV. Furthermore, VCT has long been a component of HIV prevention and care efforts in developed countries, but only recently it is being implemented in resource-constrained countries (FHI, 2003; Kippax, 2006). In countries with a high prevalence of HIV, governments have included VCT services as a major component of their national HIV prevention and care programs (FHI, 2001).

There has been a significant increase in the number of people who have ever been tested in Lesotho. In 2007 about 12% of the population have ever received testing for HIV in Lesotho representing a three fold increase since 2005 (Lesotho UNGASS report, 2008). Consequently, PMTCT uptake has also increased from 5% in 2005 to 31% in 2007 (Lesotho UNGASS report, 2008). Furthermore, the report showed that in 2006, 9,277 pregnant women were tested for HIV as compared with 5,459 in 2005 and a total of 2592 were found to be HIV positive of whom 2,224 received antiretroviral therapy (ART) for PMTCT. Similarly, in 2007, 23,965 pregnant were tested for HIV, of whom 5,539 were found to have HIV and 3,966 were provided with ART (ibid). The increase in HIV testing among pregnant women is due to the implementation of HIV Testing and Counselling (HTC) implemented by the government in most health centres. In 2007, there were about 161 health centres offering HTC in Lesotho (Lesotho UNGASS report, 2008).

1.2.1 Voluntary Counselling and Testing (VCT)

There are two methods of HIV testing, which are VCT and HTC. VCT is client initiated, where a person is the one who voluntarily decides to go for testing after getting the information about HIV while HTC is provider initiated where the provider is the one who decides that a person should be counselled and tested for HIV unless the person 'opts-out' (WHO/UNAIDS, 2007). However, for the purpose of this study the focus will be on VCT.

In the absence of a cure, it is important to promote interventions such as VCT since it is an important entry point for prevention, care, treatment and support (UNAIDS, 2000). Boswell and Baggaley (2002) describes VCT as a process whereby an individual or a couple undergo

counselling so as to make an informed choice about being tested for HIV after being assured of confidentiality. The three processes of VCT are pre-test-counselling, post-test counselling and follow-up counselling and support (UNAIDS, 2000).

HIV counselling should be offered before taking an HIV test. Ideally the counsellor prepares the client for the test by explaining what an HIV test is, as well as by correcting myths and misinformation about HIV/AIDS. The counsellor may also discuss the client's personal risk profile, including relationships and HIV prevention methods. The counsellor may also discuss the implications of knowing one's sero-status, and ways to cope with that new information. Informed consent is usually obtained from the client during this time.

The main goal of post-test counselling is to help clients understand their test results and initiate adaptation to their positive or negative results. If the person is HIV positive, the counsellor provides emotional support and discusses how the client will cope. During this session the counsellor must ensure that the person will have immediate emotional support from a partner, relative or friend. Furthermore, prevention of HIV transmission to uninfected or untested sexual partners must also be discussed. Moreover, counselling is also important even when the test result is negative. While the client is likely to feel relief, the counsellor must emphasize behavioural change that can help the client stay HIV negative, such as safer sexual practices including condom use and other methods of risk reduction (UNAIDS, 2000).

VCT services should offer continued counselling to people whether they are sero-positive or sero-negative. For sero-positive people, counselling should be available as an integral part of ongoing care and support services. Counselling, care, and support should also be offered to people who may not be infected but affected, such as, the family and friends of those living with HIV (UNAIDS/WHO, 2004).

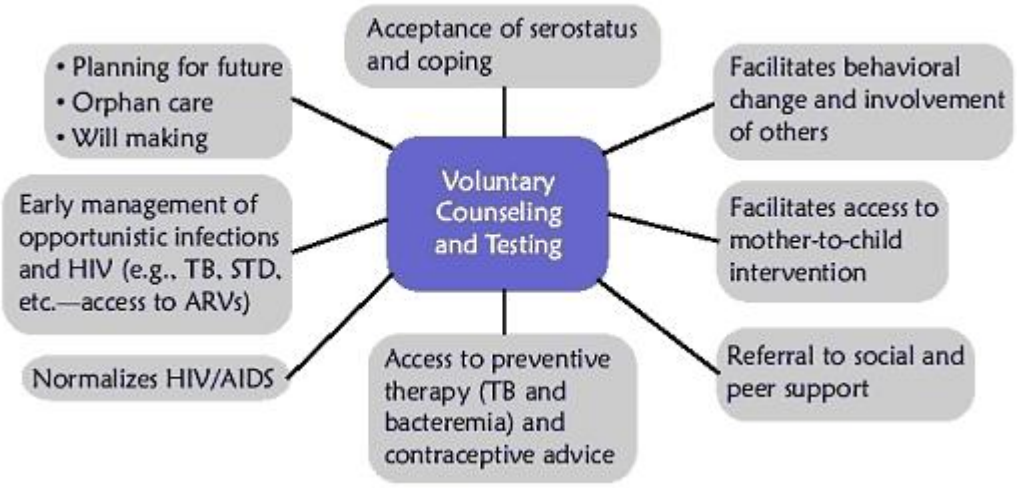
1.2.2 Importance of VCT as an HIV Intervention Strategy

VCT has many advantages to those who access it. Indeed, HIV testing has often been used as a diagnostic tool to confirm symptomatic AIDS but a growing number of studies attest to the value of VCT for HIV in largely healthy populations (UNAIDS, 2001). VCT provides people with the opportunity to receive information on HIV/AIDS, other sexually transmitted diseases (STDs), family planning, pregnancy and TB (Jackson, 2002). VCT for HIV have benefits

beyond the prevention of transmission from mother-to-child. Counselling prepares people physically and emotionally, prior to undergoing the test and ensures them of confidentiality (UNAIDS, 2000; Sozi et al., 2002). VCT gives hope to people who suspect or know that they are infected with HIV. For those who are HIV negative, they will be counselled on how to remain that way and for those found to be HIV positive they will be counselled on how to live positively with HIV/AIDS, without infecting others. Moreover, VCT services have been shown to contribute to an increase in safe behaviour at the individual level, and are likely also to reduce the ignorance, fear and stigma associated with HIV infection in the population at large (UNAIDS, 2001). In the community, VCT reduces stigma by changing the image of AIDS from illness, suffering and death, to living positively with HIV (Boswell and Baggaley, 2002). It also facilitates early referral and access to care and support services (Boswell and Baggaley, 2002; UNAIDS, 2000). Moreover, it enables planning for the future in such contexts as marriage, pregnancy and family planning (UNAIDS, 2000). VCT has also been known to enhance faithfulness among couples (Rehle et al., 2001). It helps reduces anxiety, increases individual's perception of their vulnerability to HIV and promotes behaviour change (Boswell and Baggaley, 2002).

VCT is a combination of two activities - counselling and testing - into a service that combines the benefits of both (UNAIDS, 2000). VCT for HIV is internationally recognized as an effective and important strategy for prevention, care and support (FHI, 2007). However, VCT services have been slow to gain acceptance in many countries, especially where HIV is heavily stigmatized and access to services and support for the HIV-infected is limited (UNAIDS, 2001). Figure 1.1 further explains the importance of VCT in curbing the spread of HIV/AIDS.

Figure 1.1: VCT as an Entry Point for HIV Prevention and Care



Source: UNDP, 2007

There is no cure for HIV however, WHO/UNAIDS (2003) argue that, the development of life-saving antiretroviral drugs has brought hope and has extended and improved the life for large number of people living with HIV/AIDS and transformed perceptions of HIV/AIDS from a fatal disease to a manageable chronic illness. The presence of HIV can be detected by undergoing an HIV testing. According to Evian (2000), HIV testing and counselling is one of the tools that can be utilized in combating the further spread of the AIDS epidemic through people determining their HIV status. HIV testing and counselling is considered a priority in most national HIV programs since it is regarded as a gateway to HIV/AIDS prevention, care, treatment and support intervention. In order to ensure access to HIV testing and counselling for a large sector of the population and to facilitate access to ARV treatment, achieve the Millennium Development Goals of combating the AIDS epidemic and improving health, there is a need for VCT services (UNAIDS, 2004).

In the fight against AIDS, VCT is an important entry point for prevention, care, treatment and support (UNAIDS, 2000). While there is no cure for HIV/AIDS, VCT allows people to know their HIV sero-status and prepare them for treatment, care and prevention for HIV (UNAIDS, 2000). Furthermore, with the introduction of ART in Lesotho it is essential for pregnant women to know their status so that they will be able to prevent the transmission of HIV from mother-to-child and also, for future prevention. Thus far, however, no studies have been conducted in Lesotho on factors influencing utilization of VCT among pregnant women;

hence the present study attempts to fill this gap. Furthermore, it is hoped that the study will help inform policies of the Ministry of Health and Social Welfare (MoHSW) in Lesotho related to VCT services among pregnant women.

1.3 Rational for the Study

The effectiveness of interventions to reduce mother-to-child transmission depends on a mother knowing her status, so that among other reasons she can be offered ARVs and infant feeding advice (de Paoli et al., 2002). Thus, knowledge of the availability of treatment options has changed the attitudes of people towards VCT (Ekanem and Gbadegesin, 2004). However, despite the recognized importance of VCT in national AIDS control programs, VCT services are still not fully developed in most resource-constrained countries and if available, these services are of limited quality and coverage and are often implemented by non-governmental organizations (FHI, 2001).

VCT has become an integral part of HIV prevention in Lesotho. As outlined in the Lesotho National Strategic Plan and Global Fund Proposal, VCT is expected to contribute to a comprehensive response towards the HIV/AIDS pandemic by promoting HIV prevention as a key public health goal (National AIDS Commission, 2003). Furthermore, VCT in Lesotho will reduce stigma, fear and anxiety about HIV/AIDS, increase community awareness, early diagnosis and referral, as well as the prevention of mother-to-child transmission (National AIDS Commission, 2003).

Thus, lack of testing may be hindering efforts to increase prevention coverage for pregnant women in need of HIV treatment (UNICEF, 2008). Obviously, pregnant and positive women are at high risk of passing HIV to their partners and unborn children (through perinatal transmission) and hence increasing the HIV prevalence rate. Furthermore, it is known that high risk sexual activity can increase the HIV prevalence especially if people do not have knowledge on how to prevent infection (National AIDS Commission, 2006). Hence, the focus of the Lesotho National Strategic Plan (LNSP) is to enhance prevention by increasing the quality of interventions through behavioural change communications strategies such as VCT. Indeed, the annual number of AIDS deaths have declined in the past two years from 2.2 million in 2005 to 2.0 million in 2007 globally, as a result of the substantial increase in access to HIV treatment in recent years; however, in Lesotho the level of HIV prevalence among

pregnant women is still increasing (UNAIDS, 2008). In this context, VCT has an important role to play. As a result, there is a need to investigate knowledge of and attitudes towards VCT services

1.4 Objectives of the Study

The main objective of the study is to shed more insights into factors facilitating or inhibiting VCT use among pregnant women in Lesotho. The specific objectives are:

- To examine the association between the socio-economic and demographic characteristics and VCT among pregnant women in Lesotho;
- To examine knowledge and attitudes of pregnant women towards VCT services;
- To identify barriers that prevent pregnant women from utilizing VCT Services.

1.5 The Conceptual Framework

One of the key objectives of VCT is to facilitate behaviour change in order to reduce the spread of HIV/AIDS (USAID, 2002). Studies have shown that in the context of HIV/AIDS the behaviour change strategies are based on several psychological theories (Ross and Deverell, 2004). Therefore, the present study will draw from empirical research and also look at different theories such as the theory of planned behaviour, theory of reasoned action, the health belief model and social learning theory relating to behavioural change in order to understand their effect on human behaviour and how they relate to the present study. Furthermore, the design of the study from questionnaire design to analysis and interpretation of both qualitative and quantitative data will draw on the theory of planned behaviour.

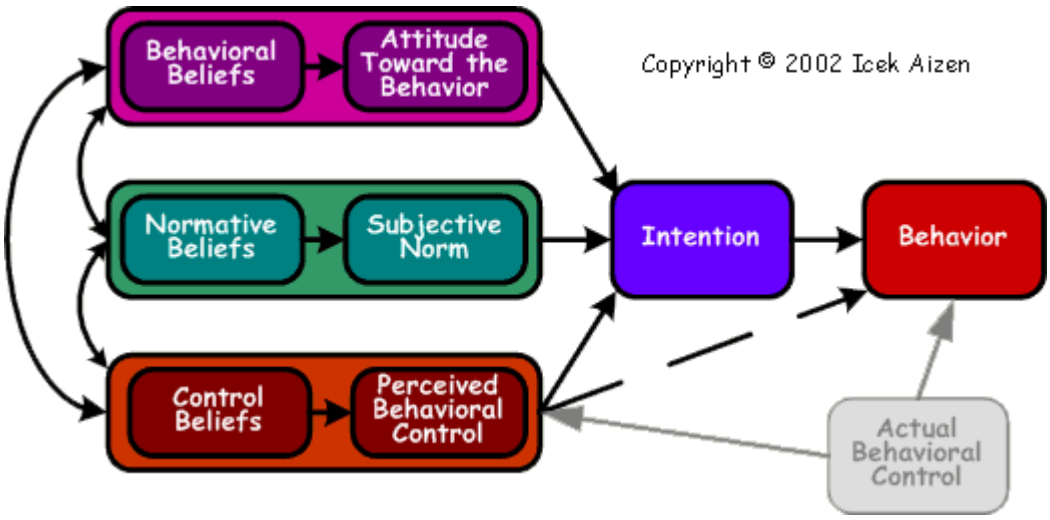
1.5.1. The Theory of Planned Behaviour (TPB)

Unlike other theories of health behaviour which focuses on one specific causal factor of behaviour or which does not look at the influence of others (normative belief) towards a certain behaviour, this theory takes into account the issue of behavioural intentions, attitudes toward behaviour, subjective norms and perceived behavioural control. In addition, the theory of planned behaviour has been used in many studies relating to behavioural change. For example, the theory of planned behaviour was found to be a valid model in the explanation of

condom use among South Africans (Boer and Mashamba, 2007). In Tanzania among primary school teachers the theory of planned behaviour was also found to be an effective model for behavioural change (Kakoko et al., 2006).

The theory of planned behaviour was initially developed by Fishbein and Ajzen in 1967 as the theory of reasoned action (FHI, 2002). According to Ajzen (1991), the theory of planned behaviour differs from the theory of reasoned action by the fact that the theory of planned behaviour has added the concept of perceived behaviour control in the model. According to the theory of planned behaviour, human behaviour is influenced by three main concepts: 'behavioural beliefs', 'normative beliefs' and 'control beliefs'. According to Croyle (2005), the theory of planned behaviour explores the relationship between individual's beliefs, attitudes, intentions, behaviour and perceived behaviour control (see Figure 1.2).

Figure 1.2: Conceptual Model of TPB



Source: Ajzen, 1991

In the theory of planned behaviour, intention is the most important determinant of behaviour and it is influenced by a person's attitudes (behavioural beliefs) towards performing certain behaviour, and by the person's belief (normative belief) that others would approve or disapprove of that behaviour (Croyle, 2005).

Behavioural beliefs combine a person' beliefs towards the outcomes of certain behaviour and the way the person evaluates the potential outcomes (Denison, 1996). Behavioural beliefs are about the likely consequences of the behaviour and whether it will be of a favourable or unfavourable behaviour. Deciding to have the test and choosing whom to disclose the HIV positive results can sometimes be frightening especially if a person lives in a community with a high HIV/AIDS prevalence and stigma. Furthermore, an HIV positive results can be shattering, it can also mean that one partner has been unfaithful and has been engaging in risky sexually behaviour and it is a reminder of one's mortality (Roberts, 2006). Therefore, people may find it difficult to disclose their HIV status to their partners even after they have been counselled.

For individuals to change their behaviour, they must have the intention to do so. However, the intention to change sexual behaviour depends on the persons' attitudes towards that particular behaviour for example, condom use. Research shows that among the 235 young people who took HIV tests in Kenya and Uganda, most intended to adopt safer sexual behaviours such as abstaining from sex, having one partner and using a condom after the HIV test (Horizons, 2001). In Thailand after the implementation of the "100% condom program" condom use reached more than 90% in commercial encounters (Hanenberg et al., 1994; Genuis and Genuis, 2004) and the proportion of men buying sex declined by 50% (Hanenberg et al., 1994). Likewise in Cambodia after instituting the same program condom distribution rose dramatically (Hearst and Chen, 2004). In different countries, such as Uganda, Zambia, Ethiopia and Dominic Republic reduction in sexual partners and commercial sex has been reported after VCT (Shelton et al., 2004).

Normative beliefs are a result of perceived social pressure or subjective norms and it is about the normative expectation of others. The intention to change behaviour also depends on the subjective norms of the individual. However, gender inequality and lack of power of women to suggest condom use in many African countries can inhibit the intention to change risky sexual behaviour. Furthermore, subjective norms are influenced by the 'beliefs of important reference groups, or individuals as well as by the desire to please these reference groups or individuals' (Van Dyk, 1999: 126). Therefore, in situations where condom use is not accepted by friends or partners and if it is also important to an individual to impress such people, it will be difficult for people to use condoms. For example, it can be difficult for HIV positive woman to opt for formula feeding since it is not accepted in most cultures. Furthermore,

testing positive is sometimes associated with the dissolution of marriage, physical abuse and neglect or disowning by the families especially for women. Therefore, in order for the behaviour to be effective it may be necessary to have peer groups or couple counselling. According to UNAIDS (2007), there is an increased emphasis on couple counselling in different countries especially where HIV/AIDS is high. Furthermore, empowering women with information and education is also a necessary step so as to influence others to change their sexual behaviour.

Normative beliefs and subjective norms are important in changing people's behaviour. Thus, power to control women sexuality by their partners is a key pillar of male dominated social relations (Campbell et al., 2006) and this can lead to more women being denied the use of VCT by their partners. Moreover, young girls may also fear to go for VCT because of the denial by their parents of their sexual desires and relationships (Campbell et al., 2006). However, studies have shown that many young people have mentioned that their peers are often advising them to go for VCT (Boswell and Baggaley, 2002).

Control beliefs refer to the presence of factors that may facilitate or inhibit the performance of the behaviour. This can give rise to perceived behavioural control which can change behaviour directly if it reflects actual control and whenever the certain behaviour is not under complete control by the individual (FHI, 2002). For example, some people go for VCT or change their behaviour if they personally feel at risk of contracting HIV infection or if they know someone with AIDS. In Uganda many mentioned that they know someone who has AIDS or someone who has died from it, and according to Macintyre et al. (2001), this is a strong prediction of behavioural change. The benefit of knowing one's status is to access early treatment, and this gives hope not only to individuals but to the whole population. For example, in Europe there was a 64% decline in the risk of dying within 10 years of developing HIV treatment and a similar decline was noticed in Australia and Brazil (Kippax, 2006). Furthermore, Kippax (2006) also highlighted that there are some positive benefits of life events following VCT, mainly in the form of increased emotional support for HIV positive individuals and couples. Hence, people can change their sexual risk behaviour after being tested for HIV. Furthermore, research has found VCT to be an effective strategy for facilitating behaviour change (FHI, 2007).

1.5.2 Review of Other Theories Related to the Study

The Theory of Reasoned Actions

According to Ajzen and Fishbein (1980), the theory of reasoned action assumes that people are rational and make decisions based on the information available to them. Thus, people can change their sexual risk behaviour after being tested for HIV. The theory provides a construct that links individual beliefs, attitudes, intentions, and behaviour (FHI, 2002). The report further argued that attitudes and norms shape a person's intention to perform behaviour and, a person's intention remains the best indicator that the desired behaviour will occur. In addition, VCT is being increasingly positioned as the 'gateway to prevention' as well as care, treatment and support (UNAIDS, 2001) therefore the argument is, if a person knows that he or she is HIV positive then as a responsible rational person he or she will not engage in unsafe sex, and if negative then he or she will act to remain so.

The Health Belief Model (HBM)

The health belief model is one of the most widely used conceptual frameworks for understanding health behaviour change strategies (Croyle, 2005). It was first developed in the 1950s by social psychologists working in public health services in the United States with the intention to find out why so few people were participating in health programs (FHI, 2002). The model focuses on the attitudes and beliefs of individual to predict and explain certain health behaviour (FHI, 2002). For example, HIV is a negative health consequence, and the desire to avoid HIV can be used to motivate sexually active people to practice safer sex.

According to the model, a person must hold certain behaviours in order to be able to change their behaviour, that is, 'perceived susceptibility' to a certain health problem, which means that a person must believe that he or she is at certain risk, furthermore, a person must believe in the seriousness of the health condition he or she is in, that is, he or she must believe that AIDS is serious and if he or she has it then his or her life will be in danger (Horizons, 2006). Furthermore, the report shows that there must be 'cues to actions', in order for a person to believe in the seriousness of the situations and hence change their behaviour, that is, a person might have witnessed a relative or a friend dying from AIDS. Likewise, for the model to be effective there should be 'perceived benefits of preventive action', which means, a person

must believe that if they start 'using condoms, they can avoid HIV infection, or believe that if they go for VCT they will be able to live a positive life if ever infected with HIV or live negatively without being infected'.

Social Learning Theory

The social learning theory assumes that individual's opinion, thoughts and behaviour are influenced by the social environments (family members, peers, colleagues) surrounding them (Croyle, 2005). The theory asserts that people learn not only from their own experiences, but by observing the actions of others and the benefits of those actions (Horizons, 2006). Furthermore, Bandura (1977) emphasized that learning would be exceedingly laborious, or even hazardous, if people had to rely solely on the effects of their own actions. Hence, most human behaviour is learned observationally through modelling, that is, from observing others on how new behaviours are performed. Furthermore, the theory states that providing information alone is not sufficient to change behaviour, rather sustained behaviour change requires the skills to engage in the behaviour and the ability to use these skills consistently (Croyle, 2005). For example, in order to reduce the spread of HIV the social learning theory posits that there is a need to educate people about HIV/AIDS and to show them the skills that can lead them to change their risky sexual behaviour. Moreover, people should be made aware what their risks of contracting HIV/AIDS are and hence be provided with necessary skills on how to prevent those risks. Furthermore, there is a need to show people how to use condoms, how to negotiate safer sex, and the importance of knowing one's HIV status. In addition, if ever the person is HIV positive, he or she should be made aware of the existence and importance of support groups.

Critique

The other theories (the theory of reasoned action, social learning theory and the health belief model) however, do not take into account the environment and economic factors that may influence health behaviour and do not incorporate the influence of social norms and peer influences on people's decision regarding health behaviour. Moreover, these theories do not take into considerations the tendency of individuals to change their behaviour and then their beliefs or attitudes about it. For example, studies on the impact of seat belt laws in the United States showed that people often changed their negative attitudes about the use of seatbelt as

they grew accustomed to the new behaviour (FHI, 2002). Parker (2004) also raised the fact that many theories do not take into account the socio-economic context, culture and gender imbalances that influences behaviour. Furthermore, the way people perceive their world or make sense of it is informed by their cultural context and not necessarily their own individual behaviour (Held, 1990).

1.6 Organization of the Dissertation

The study will comprise six chapters. The first chapter provides a background to the study with an emphasis on the aims and objectives of the research and the theoretical framework that guides the study. The second chapter is the review of the literature on VCT. The third chapter focuses on the methodology used for the study. The following chapters present the quantitative and qualitative findings respectively. The final chapter provides a discussion of the findings, the conclusions of the study and some recommendations for future research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A review of literature suggests that VCT is one of the most effective means of preventing HIV**,** however, there are many factors influencing utilization of VCT. There are a number of factors facilitating and inhibiting use of VCT services including distance to health facility, cost of the services, fear of knowing one's status, awareness of the risk of HIV infection, availability of antivetrovirals and perceived quality of care (Nuwaha et al., 2002; Kipitu, 2005). The focus of this chapter is on studies related to factors facilitating or inhibiting the uptake of VCT and the impact of VCT as a behavioural change strategy.

2.2 Impact of VCT as a Behavioural Change Strategy

The key objective of VCT is to facilitate behavioural change and thus reduce the spread of HIV infection. Furthermore, it is believed that people who undergo VCT for HIV usually change their behaviour; presumably as a result of counselling (Mola et al., 2006). Additionally, a meta-analysis conducted in 1999 examining the efficacy of VCT supported the intervention as an effective behaviour change strategy for persons infected with HIV (Wolitski et al., 1997). Knowledge of HIV status only boosts prevention if it leads to safer sexual behaviour, yet the fear of stigma and rejection could encourage people to delay or avoid disclosing their status to their regular partner and this underscores the importance of counselling (Maman et al., 2001). Thus, in such situations the effectiveness of VCT on behavioural change is sometimes contested.

In Rwanda, intensive counselling of discordant couples was successful in addressing acute psychological distress including threats of suicide and abandonment following HIV positive tests (Roth et al., 2001; Kamenga et al., 1991). Likewise, in Rwanda counselling increased condom use and reduced coercive sex among man who received VCT, while in a study done in Zambia condom usage increased from less than 3% to 80% (Shapiro and Ray, 2007). Similarly, research conducted in Kenya, Tanzania and Trinidad from 1995 to 1998 indicated a significant reduction in unprotected intercourse among couples receiving VCT compared with

those receiving only health information thus VCT was found to be the most effective way in changing people's behaviour, (Voluntary HIV Counselling and Testing Efficacy Group, 2000; Lichter, 2000). Other studies have also revealed that both men and women who have been counselled increased their condom use over time compared with those who were not counselled (Mola et al., 2006). Furthermore, from the seven studies that presented data on unprotected sex it was found that VCT recipients were significantly less likely to engage in unprotected sex (Denison et al., 2008).

According to a number of studies, VCT encourages people to disclose their HIV status thus reducing stigma (De Zoysa et al., 1995; King, 1999; Njagi and Maharaj, 2006). A study of pregnant women attending antenatal clinics in Lusaka found that after receiving VCT, women were increasingly broaching sensitive HIV-related topics with their partners (Horizons, 2003). Askew and Berer (2003) also found that in Kenya and Zambia pregnant women were able to discuss their HIV status with their partners, and this reduced stigma towards people living with HIV/AIDS.

In their review, Boswell and Baggaley (2002) observed that in three studies done in the United States of America VCT promoted a reduction in sexual partners among the majority of males. However, none of the females reported any decline in sexual partners. Nevertheless, the authors explained that the results of the study may be due to the fact that HIV testing with individual pre- and post-test counselling was offered at a public sexually transmitted infection (STI) clinic therefore the quality of counselling and ongoing care may not have been as consistent as at VCT sites. Similarly, a study among adults in developing countries reported behavioural change such as condom use, reduction in number of partners, and reduction in STIs after VCT (McCauley, 2004).

VCT may reduce reported risk behaviour and prevent new infections, notably among those testing positive and among discordant couples (Weinhardt et al., 1999; Kamenga et al., 1991; Allen et al., 1992; Allen, 2003; Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000; Pronyk et al., 2002). It is therefore evident from these findings that VCT can lead to behavioural change and hence contributes to reducing HIV/AIDS. Thus, VCT for HIV has been found to be effective in changing behaviour (Ekanem and Gbadegesin, 2004).

Moreover, overall trends show that reduction in risky behaviour have been noticed among young people in several countries, for example, the percentage of young people (ages 15–19) that became sexually active before their 15th birthday declined in seven countries (UNAIDS, 2008). In addition, the proportion of young women and men (ages 15–24) who had more than one partner in the previous 12 months decreased in 10 countries and condom use has increased among young people (ages 15–24) in 12 countries (UNAIDS, 2008).

While a review of the literature suggest that VCT is one of the most effective means of preventing HIV, research has shown that VCT interventions does not necessarily result in HIV/AIDS risk reduction behaviour. In a study done in six countries in Africa and two in Europe it was found that VCT did not encourage those who were infected to reduce their risk behaviour (Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). Hence, VCT was found not effective in primary prevention however, it was found to be an effective means of secondary HIV prevention, since it reduced the chances of an infected person infecting others (Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). In a study conducted in Uganda, Porter et al. (2004) observed that among couples who had not received the results of HIV tests, female HIV positive discordant (F+M-) couples were more likely to report the use of condoms than were male HIV positive discordant (F-M+) and concordant HIV negative (F-M-) couples. This pattern suggests that uninfected men suspected that their female partners were infected and took precautions to protect themselves from infection.

2.3 Factors Inhibiting VCT Uptake

2.3.1 Stigma and Discrimination

The stigma and discrimination associated with HIV/AIDS have powerful psychological consequences for how people with HIV/AIDS come to see themselves, leading in some cases to depression, lack of self-worth and despair (UNAIDS, 2002). Furthermore, stigma has been found to be the main obstacle in combating HIV/AIDS in the whole world (UNAIDS, 2002). Stigma and discrimination can also undermine prevention by making people afraid to find out whether or not they are infected, for fear of the reactions of others. In addition, fear of stigma and discrimination is known to discourage individuals from being tested for HIV and from disclosing their sero-positive status to sexual partners, family and friends (Weinhardt et al.,

1999). Stigma and discrimination may also cause those at risk of HIV infection and some of those infected to continue practicing unsafe sex because they do not want to raise suspicion about their HIV positive status (UNAIDS, 2002).

In a study conducted in Cape Town, South Africa it was found that stigma was the main reason people did not go for HIV testing (Kalichman and Simbayi, 2003). Similarly, women in India also expressed concern about stigma and discrimination (Rogers et al., 2006). A study investigating knowledge of PMTCT and barriers that might affect the acceptability of interventions for PMTCT in South Africa found that many pregnant women did not go for testing because they feared HIV positive results (Peltzer et al., 2007). Stigma and discrimination sometimes cause people with HIV/AIDS erroneously to be seen as some kind of 'problem', rather than part of the solution to containing and managing the epidemic (UNAIDS, 2002).

Fear of stigmatization is the main concern why people do not go for VCT in South Africa, hence, Van Dyk and Van Dyk (2003) found that 33% of people would go to clinics where nobody would know them. In trying to explore the relevance of social concepts such as stigma and denial to the transmission of HIV in South Africa, Petros et al. (2006: 67) found that "othering of blame of HIV" exist. People still believe that HIV can infect other people of different race, gender and religion and therefore persist to discriminate these 'other' people. These findings are an indication that stigma and discrimination against people living with HIV/AIDS are a major impediment to implementing HIV prevention and treatment programs (Rogers et al., 2006).

2.3.2 Accessibility of VCT Services

Accessibility has been found to limit VCT uptake in some places especially in the rural areas. Consequently, Kipitu (2005) noted that in studies done in Kenya, Tanzania, and Zimbabwe around 60% of adults wanted to know their HIV status, however, only 15% or less had access to VCT**.** Hankins (2000) also observed that the acceptability of VCT by pregnant women in the developing countries has increased to 69%, however, the main obstacle in the poorest settings is inaccessibility which restricts many HIV positive women from making informed decisions about their HIV status, such as, termination of pregnancy or taking of antiretroviral prophylaxis to reduce transmission of HIV to their babies. Besides cultural and social barriers

continue to be ignored and poorly understood in resource poor countries, such as India where VCT centres have been recently established primarily in urban settings (Rogers et al., 2006).

2.3.3 Fear of Abuse

Studies have shown that fear of their male partners' violent reaction is a serious barrier to women's disclosure of positive test results (Boswell and Bagalley, 2002). The authors further reported that in a qualitative study conducted in Dar es Salaam, Tanzania, young HIV positive women were more likely to report partner violence than young HIV negative women. Furthermore, in Zambia it was thought to be shameful for a woman to have HIV (UNAIDS, 2000) and these women often experience violence from their partners. Research from the Positive Women's Network in India indicated that HIV infection often leads to emotional abuse and stigma within the home and community (PWN+, 2004). Moreover, studies have reported that women are often accused of infidelity or forced from their home as a result of testing positive (Nath, 1997).

In the Rakai district in Uganda about 25% - 40% of couples, in which one or both partners is HIV infected, dissolve their union by divorce, separation, or widowhood each year (Porter et al., 2004). In some cases the women were willing to share their results with their partners, however physical abuse and the break-up of marriage after disclosure was mentioned (Horizons, 2003). Thus, fear of violence may be an impediment to utilization of VCT.

2.3.4 Disclosure of HIV Status

Studies show that HIV related stigma and discrimination are associated with not disclosing HIV status to sex partners, and non-disclosure is closely associated with HIV risk behaviours. In a study conducted in Cape Town in South Africa it was found that 42% of participants did not disclose their HIV status to the people they had sex with (Simbayi et al., 2007). Furthermore, it was also found that participants who had not disclosed their HIV status to their sex partners were likely to have multiple sex partners, HIV negative partners, or partners of unknown HIV status (Simbayi et al., 2007). Furthermore, it was found that not disclosing their HIV status to partners was also associated with other people having lost a job or a place to stay because of disclosing their HIV positive status (Simbayi et al., 2007).

In Baltimore, Rothenberg et al. (1995) found that among a sample of 136 health care providers serving HIV-infected women, 24% of providers had at least one female patient who experienced physical abuse after disclosing their HIV status to their partner. Similarly, in Kenya, among the women who disclosed their HIV status to their partners, some were chased out of their homes, while some were beaten (Temmerman et al., 1995; Gaillard et al., 2002). In Tanzania after disclosure of their positive results some HIV positive women said that their partner blamed them while others were abandoned by their partners (Maman et al., 2001). Women's barriers to HIV testing and positive status disclosure reflect the unequal and limited power that many women have to control their risk for infection (Maman et al., 2001). However, in some studies most VCT clients reported positive experiences with disclosure of their HIV status (USAID, 2003).

2.3.5 Lack of Confidentiality

Confidentiality is an important factor that may hinder utilization of VCT services. Before taking the HIV test people want to be assured of confidentiality. In South Africa, Njagi and Maharaj (2006) found that respondents felt that there was no privacy at the VCT facility especially in the waiting room since people could hear what was said when people were making appointments to go for VCT. Lack of confidentiality of test results was highlighted as the main barrier for not taking the HIV test among pregnant woman attending antenatal clinic in Eastern Cape, South Africa (Peltzer et al., 2007). A study in rural southern India found that although the majority of pregnant women were willing to go for VCT and would seek medical interventions to prevent MTCT of HIV if they were detected to have HIV, most were concerned about the confidentiality of their results (Rogers et al., 2006). In a study on the acceptability of VCT among Nigerian women attending antenatal clinics, Ekanem and Gbadegesin (2004) found that confidentiality was the major concern in undertaking the HIV test and most of the respondents would not want to undergo testing if results would be made available to their employers.

In rural Uganda all women were willing to take an HIV test during pregnancy, and to reveal their HIV status to maternity staff, however, they were anxious about confidentiality and feared rejection during delivery if their status was known (Pool et al., 2001). As such, the success of VCT in reaching women depends on utilization, trusting health services and empowering women to seek and access VCT services (Desai, 2005).

In South Africa, less trust in the health care system or fearing a breach of confidentiality and a lack of follow-up support after diagnosis was mentioned as the barriers for undertaking VCT (Van Dyk and van Dyk, 2003). In rural Uganda participants favoured VCT services and counsellors were seen as competent but participants argued that they preferred counsellors from a different community (Kipp et al., 2002). This shows that even though many people still regard counsellors as efficient and competent there is still mistrust when it comes to confidentiality. People prefer counsellors from a different community because they believe that they will not judge them or reveal their HIV status to other people.

2.3.6 Cost Effectiveness of VCT

If more people are willing to pay for VCT services this will lead to sustainability and potential service expansion (Admassu and Fitaw, 2006). In Lagos among antenatal clinic attendees, the cost of VCT ($3.00) was not the major concern, probably because of the benefits that knowledge of their HIV status could bring, however, appropriate pricing or subsidy on the cost of the test was desirable (Ekanem and Gbadegesin, 2004). However, the results reflected only antenatal clinic attendees' views in Lagos and these might be different from the general population or other antenatal clinic attendees in other parts of the country.

Sweat at al. (2000) found in a VCT cost-effectiveness study that although the respondents were willing to pay $1.64 in Kenya and $5.11 in Tanzania they still hoped to pay less. Furthermore, Baiden et al. (2006) argued that in sub-Saharan Africa the evidence shows that in order to sustain universal access to VCT for pregnant women there is a need for substantial subsidy. In addition, in the Navrongo study, Baiden et al. (2006) found that about 30% of pregnant women wanted the test to be offered for free. Similarly, in Ethiopia, Admassu and Fitaw (2006) found that 74% of the people in the study were willing to pay for VCT services, while only 13% in Kenya and 24% in Uganda were willing to pay for VCT services.

2.3.7 Collection of HIV Test Results

It is important for people to collect their test results in order to know their HIV status; however in some situations people often do not collect their results. A study among mineworkers in South Africa found that many people who took the HIV test did not return for the results of their test (Day et al., 2003). Among approximately two million people who took

HIV tests in America in 2000 almost one third of those with HIV positive results did not return for their test results (Centre for Disease Control, 2003).

Certain factors such as lack of pre-testing counselling and delayed test results have exacerbated failure to collect test results. For example, in Lusaka, Zambia, where rapid tests were used but results not available the same day, only 37 percent of women collected their test results; by contrast, at a rural clinic in Zambia, where the counsellors offered rapid HIV tests with results available same day as part of their one-day visit, almost all clients received their results (Horizons, 2003). In a randomized trial in Nairobi, Kenya among pregnant woman who were assigned to rapid testing (same-day results) and others to enzyme-linked immunosorbent assay (ELISA) testing (after 7 days results), rapid HIV testing was found to significantly increase the proportion of women receiving their HIV results (Malonza et al., 2003). In Zimbabwe, it was found that both men and women who received pre-test counselling were significantly more likely to return for their results than those who did not (Sherr et al., 2007). In Zambia, many people who are invited for voluntary counselling and testing of HIV fail to collect their test results because they change their mind during the waiting period (KARA Counselling and Training Trust, 1997).

Not returning for HIV test results is very wasteful especially as HIV testing is not free and this could cause governments huge some of money which could otherwise be used for something else. Moreover, this will also prevent the HIV positive person from getting necessary help. However, this wastage would be largely eliminated if same day testing was available, but if it is implemented, the counsellor must ensure that the client is able to cope with the positive test results. Furthermore, people must not be coerced into having a HIV test.

2.3.8 Fear of HIV Results

Some people associate being HIV positive as a death sentence therefore the fear of getting positive results may prevent them from going for VCT. According to Pool et al. (2001), in Uganda women feared HIV positive test result due to the rumour that medical staffs were killing HIV positive people in order to reduce the HIV prevalence. In a study done in South Africa, Njagi and Maharaj (2006) found that the majority of respondents did not go for VCT because of fear of a positive result. In Tanzania, 52% of women attending VCT did not disclose their HIV positive status because of fear of their partner's reaction (Maman et al.,

2001). In the study among mineworkers in South Africa, fears of being HIV positive, as well as concerns of colleagues' reactions were the most frequent responses for not testing for HIV/AIDS (Day et al., 2003). A study on the barriers to preventing HIV transmission from mother-to-child in the Eastern Cape, found that most pregnant women (92.4%) indicated that they have never had an HIV test because of fear of HIV positive results (Peltzer et al., 2007). In Ghana, the reason given by participants for being unwilling to get tested was fear of positive results (Holmes et al., 2008). Fear of testing HIV positive has exacerbated lack of utilization of VCT service. However, people still need to be taught the importance of knowing one's status because the perceived benefit of VCT far outweighs the fear of testing positive.

2.3.9 Doubting the Existence of HIV

Denial of the existence of HIV is also a major impediment to people accessing VCT. In a study in urban Mali, Castle (2003) found that the majority of people denied the existence of HIV and considered it to be a Western plot to encourage condom use in order to halt the growth of the African population. In the study to explore the relationship between HIV knowledge and testing in South Africa it was found that those who had been tested for HIV had more knowledge than those who had not (Haile et al., 2007). Furthermore, as the level of education increased so did the frequency of testing. In addition, knowing someone who has HIV/AIDS or someone who has died of the disease tends to increase testing behaviour (Haile et al., 2007).

2.3.10 VCT Services

In South Africa long queues at counselling units due to insufficient counsellors and lack of privacy could serve as a major obstacle to VCT uptake (van Dyk and van Dyk, 2003). Njagi and Maharaj (2006:120) mentioned that one respondent when responding to concerns about VCT services said, "When I visited the health centre I was told to come back after two days because they were fully booked". Furthermore, respondents also mentioned that waiting in long queues at the VCT facilities was the norm and respondents feared that if seen they could be discriminated and stigmatized by others. In Malawi, Stanley and Matinga (2004) also found that respondents were disappointed about the long wait at VCT centres and the incompetence of counsellors.

The quality of counselling is undoubtedly one key factor motivating women to take the HIV test. This was the case in countries such as India, Kenya, and Uganda, where antenatal clinics were counselling more than 90% of clients (Horizons, 2003). However, good counselling takes time, but it is often in short supply at many busy clinics where workers already provide antenatal, child health, and family planning services (Horizons, 2003). Therefore, there is a need to hire additional medical staff, or other available professional staff to become dedicated counsellors in order for counselling to be effective.

2.3.11 Age of Consent for VCT

Young people aged 15–24 years account for 45% of all new HIV infections in adults, and many still lack accurate or complete information on how to avoid exposure to HIV/AIDS (UNAIDS, 2008). As such the number of youths seeking VCT has been increasing, especially for pre-marital testing or after ending a relationship (Boswell and Baggaley, 2002). The AIDS Information Centre (AIC) in Uganda has reported an increase in the number of youth seeking VCT (Boswell and Baggaley, 2002). In Zambia, 14.6% of attendees at the Hope Humana VCT site in Ndola were 10 to 19 years old (Hope Humana, 2001). Uptake of VCT by young people aged 13-19 years is also reported to be increasing in Brazil and the United States (Boswell and Baggaley, 2002). However, parental consent is a barrier to uptake of VCT among young people in many countries, as some are being denied access to VCT and clinical care on the basis of age either based on provider judgment or policy restriction (Boswell and Baggaley, 2002). Thus, in some countries young people under the age of 18 require parental consent in order to undergo VCT. In Kenya and Zambia the legal age of consent for VCT uptake is 18 years, if younger than 18 the person must be married in order to undergo VCT without parental consent (Boswell and Baggaley, 2002; Obarzaucher and Baggaley, 2002). In Uganda it was reported that parents and the larger community do not encourage young people to go for HIV testing as this will be an indication that they are sexually active (Horizons, 2001).

However, in some countries young people do not need parental consent for HIV testing. In California in the United States, persons aged 12 years or older may undergo a test for HIV or other STI's without parental consent (State of California, Department of Health Services, 1997). In Brazil, adolescents over the age of 12 years have the same rights to health services as adults, and do not require parental consent to access services (Boswell and Baggaley,

2002). Thus, giving young people access to VCT services will increase uptake and further provide them with necessary skills to eradicate HIV/AIDS.

2.4 Factors Facilitating VCT Uptake

2.4.1 Desire to Know One's HIV Status

The major factors that would encourage women to go for VCT was being provided with HIV/AIDS information, wanting to know their HIV status and concern for the transmission of HIV from mother-to-child (Peltzer et al., 2007). In the study among university students in Durban, Njagi and Maharaj (2006) found that the desire to know one's status was the main reason for students seeking VCT services. The availability of ART has played a big role in increasing demand for VCT. In Haiti, people at first were not interested in VCT as they believed that it did not treat people however, after the introduction of ART, there was a 300% increase in VCT (Milosevich, 2005). Furthermore, the study observed that the introduction of AZT has led to a 90% increase in VCT rates among pregnant women in Haiti. According to Ekanem and Gbadegesin (2004) several studies have shown that those who knew about zidovudine (ZDV) therapy for pregnant women were more likely to have had an HIV test than those without such knowledge. In addition, researchers found that 20% of young people who undertook VCT in Kenya and Uganda reported that they were not sexually active but were simply seeking access to information (Boswell and Baggaley, 2002).

2.4.2 Perceived at Risk of HIV/AIDS

There are many different factors that may influence utilization of VCT services. Women with HIV are more likely to go for testing than HIV negative women as positive women are likely to get sick or lose weight and therefore feel compelled to go for the test (Sherr et al., 2007). However, in general, those who were at elevated risk through their sexual behaviour, sexual networks, relationship status or condom use, were failing to access VCT (Sherr et al., 2007).

Low perceived risk behaviour is also another factor that influences the decision not to go for VCT. In their study among college students in Kwazulu-Natal, Njagi and Maharaj (2006) found that respondent did not utilize VCT services because they felt that they were not at risk of contracting HIV mainly because they were not currently sexually active, consistently used

condom or never had sex. A study in Kenya found that young people considered HIV testing to be a tool used by doctors to diagnose a patient so that they could determine an appropriate treatment (Horizons, 2001). Furthermore, in the study done in South Africa, Njagi and Maharaj (2006:121) mentioned that one respondent said, "I have not experienced any symptoms [of being HIV positive] therefore I do not see the need for VCT".

In Zimbabwe it was found that education, including knowledge about HIV, and place of residence was the main determinants of VCT use rather than personal sexual risk behaviour (Sherr et al., 2007). Furthermore, people who perceived a high risk of HIV infection were more likely to be willing to undergo a HIV test. In their study on prevention of mother-to-child transmission of HIV in Uganda, Mpairwe et al. (2005) found that women who perceived themselves at high risk of HIV infection were more accepting of VCT. Also, in Zambia young people with a high perceived risk of HIV infection were more likely to be willing to be tested (Fylkesnes and Siziya, 2004).

2.4.3 Acceptability of VCT of HIV

Studies elsewhere have shown that the majority of prenatal women opted for VCT in consideration of their unborn children especially for fear of vertical transmission (Larson et al., 1990; Enosolease and Offor, 2004). The number of women who were willing to be tested in the study among Nigerian women attending antenatal clinic increased by 96% when told that VCT would assist in the PMTCT of HIV (Ekanem and Gbadegesin, 2004). The percentage of women who accepted HIV test after counselling ranges between 64% and 83% in 11 countries (Horizons, 2003). In addition, women attending antenatal care showed positive attitudes towards VCT due to their concern for the health of the expected baby, self–perceived HIV risk, and knowledge of medical interventions to reduce disease or prevent vertical transmission (Enosolease and Offor, 2004).

While the overall acceptability rate of VCT was 35% among tuberculosis patients in South Ethiopia (Jerene et al., 2007), Olanrewaju et al. (2007) found that in Nigeria the acceptance rate of VCT was high among pregnant women but utilization of PMTCT was remarkably low. Ekanem and Gbadegesin (2004) reported similar findings in Ibadan while de Paoli et al. (2004) reported that in Tanzania perceived personal susceptibility to HIV/AIDS and partner involvement were associated with greater willingness to accept VCT. Matovu et al. (2005)

also found that even though there was much greater initial willingness to go for VCT (93%) in Uganda, only 63% of the participants accepted VCT.

In a randomized study on the acceptability of VCT in Zambia, Fylkesnes and Siziya (2004) found that acceptability differed by age. Respondents who were young perceived themselves at risk of HIV infection and this was the main reason for testing while among those who were older, poor self rated health and declining general health status was the reason for testing (Fylkesnes and Siziya, 2004). In Ethiopia, Admassu and Fitaw (2006) found that the younger age group (15-19 years) was the most receptive group to VCT services compared with the other age groups. In Burkina Faso, the uptake rate of VCT among pregnant women was independently associated with age (Pignatelli et al., 2006). Similarly, in South Africa utilization of VCT services was positively associated with age (Hutchinson and Mahlalela, 2006). In contrast to the high acceptance of VCT among pregnant women found in other studies, Coulibaly et al. (1998) found in Abidjan that a large percentage of pregnant women refused to be tested for HIV. Some of the women did not consider pregnancy to be an appropriate time to do an HIV test.

2.4.4 Marriage and VCT

Studies suggest that marriage is not a safe haven against the risk of HIV infection especially for girls who marry at young ages. Bruce and Clark (2003) argue that girls who married before the age of 18 are more at risk due to unprotected sexual exposure, which is often with older partners who, by virtue of their ages, have an elevated risk of being HIV positive. Furthermore, Bruce and Clark (2003) argued that in Uganda there is an increase in VCT uptake among couples who are about to get married and the desire for young girls to go for VCT increases if they are to get married. Similarly, in Uganda the majority of people accepted VCT because they were planning to get married (27%) or because of a new relationship (84%), while some (35%) tested in order to plan for the future (Muller et al., 1992). The Kara Clinic in Zambia, for instance, reported an increase in number of youth seeking VCT before getting married or getting involved in a new relationship (McCauley, 2004).

2.4.5 Influence from Others

Studies suggest that influence from spouse, peers and family is a major factor impacting on the decision to go for VCT. In South Africa it was found that peer influence among university students was the motivating factor for others to attend VCT services (Njagi and Maharaj, 2006). Furthermore, studies done in other African countries have mentioned that recreational centres that have VCT facilities were also encouraging more young people to go for VCT. In the study conducted in Tanzania participants highlighted the importance of family, friends, peers and priests in encouraging HIV testing and disclosure of positive results (Maman et al., 2001). In Zambia, peer influence on VCT uptake was cited as a major contributing factor in increasing VCT uptake in youth centres in Zambia (Obarzaucher and Baggaley, 2002).

2.4.6 Couple Counselling

VCT for couples is a particularly powerful HIV prevention tool (Painter, 2001). Couple counselling and testing of HIV has been highlighted as reducing stigma and the fear of disclosing positive results to other partners. Disclosure has a number of important public health benefits, such as increasing social support for people who are sero-positive and reducing partner infection. Hence, in the community survey on VCT in Nakuru, Kenya the majority of respondents preferred couple testing (Irungu et al., 2008). In two antenatal clinics in Lusaka, Zambia, it was found that couple counselled women were more likely to accept HIV testing than women counselled alone (Semrau et al., 2005). Furthermore, studies have shown that the change in risk behaviour is particularly great for couples who know their HIV sero-status as they are able to make informed reproductive health choices together (Hope, 2004). In Tanzania the sero-concordant HIV negative couples encouraged couple counselling by indicating that VCT may be an important strategy to encourage negative couples to maintain their negative HIV status (Maman et al., 2001). Moreover, focus group discussion among people living with HIV in Nairobi Kenya revealed that many people are afraid to disclose their HIV status and they may opt for church pastors as common targets for disclosure (Miller and Rubin, 2007). This shows that people still fear disclosing their HIV status to their partners therefore couple counselling has the potential of reducing the stress and the hassle of disclosing HIV positive results to partners.

2.5 Summary

The review of the literature has revealed different factors associated with VCT. In the fight against HIV, studies have found VCT to be an important phenomenon, as it acts as a gateway for prevention, care, treatment and support (UNAIDS, 2000); however, it is evident from the different literature that there are obstacles pertaining to utilization of VCT.

The fear of testing HIV positive has caused people not to make the right decision, and perhaps to become reluctant to change the way they think and behave (Grant et al., 2001). Moreover, stigma attached to HIV/AIDS makes people scared of discovering or talking about their HIV status. The fear of being stigmatized plays an important role when people decide to go for VCT. Furthermore, the majority of women are less likely to go for testing especially in societies where gender inequalities exist, as they fear that if they are tested positive their partners might leave them. Thus, Basset (2002) also confirmed that usually it is difficult for women to deal with the knowledge of HIV infection, and to disclose their status to their partners. Furthermore, people might have the intention to go for VCT however; factors such as economic well being, availability and accessibility of services may undermine their intentions.

Moreover, it is evident that people do not only fear HIV/AIDS but they fear people living with HIV as the majority of people still discriminate against people living with HIV while not taking precautions in preventing HIV or utilizing VCT services. Since the beginning of the epidemic, 25 million people worldwide have died of HIV-related causes (UNAIDS, 2008) and these deaths represent an incalculable loss of human potential. HIV/AIDS is a reality and it is not just about numbers or statistics but it is about people losing their lives, children losing parents and families losing relatives. One death to a country or to the world is not much but to the family it is a great loss. Individually, each death is associated with enduring trauma in households and communities (UNAIDS, 2008).

However, the introduction of life saving drugs have brought hope and have normalized HIV from a fatal diseases to a manageable chronic disease and these have encouraged more people to go for VCT in order to know their status in advance. Furthermore, a review of the literature has highlighted success stories in countries like Uganda, Rwanda, Zimbabwe and Kenya. In these countries, there has been dramatic changes in sexual behaviour and decline in new infections leading to the global stabilization of HIV/AIDS (UNAIDS, 2008).

CHAPTER THREE

METHODOLOGY

3.1. Introduction

This chapter will focus on methods used to conduct the study. A combination of both qualitative and quantitative method was used. According to Jick (1979) this form of research study, where both qualitative and quantitative method is used, is usually described as the triangulation method. The quantitative data is in the form of numbers, and represent concepts that may take on greater or lesser values (Lynch, 1983). The quantitative data for the study relies on data from the 2004 Lesotho Demographic and Health Survey (LDHS). Qualitative data exist in the form of words, and it usually consists of detailed descriptions and direct quotations of situations, observed behaviours, attitudes, beliefs, and thoughts (Lynch, 1983). The qualitative data for the study was derived from the focus group discussions with pregnant women.

The study draws on both quantitative and qualitative data and this chapter will present the importance and limitations of both methods. The chapter will also highlight how data from both qualitative and qualitative methods was sampled, collected and analyzed. Lastly, the chapter will discuss the limitations of the study.

3.2 Study Settings

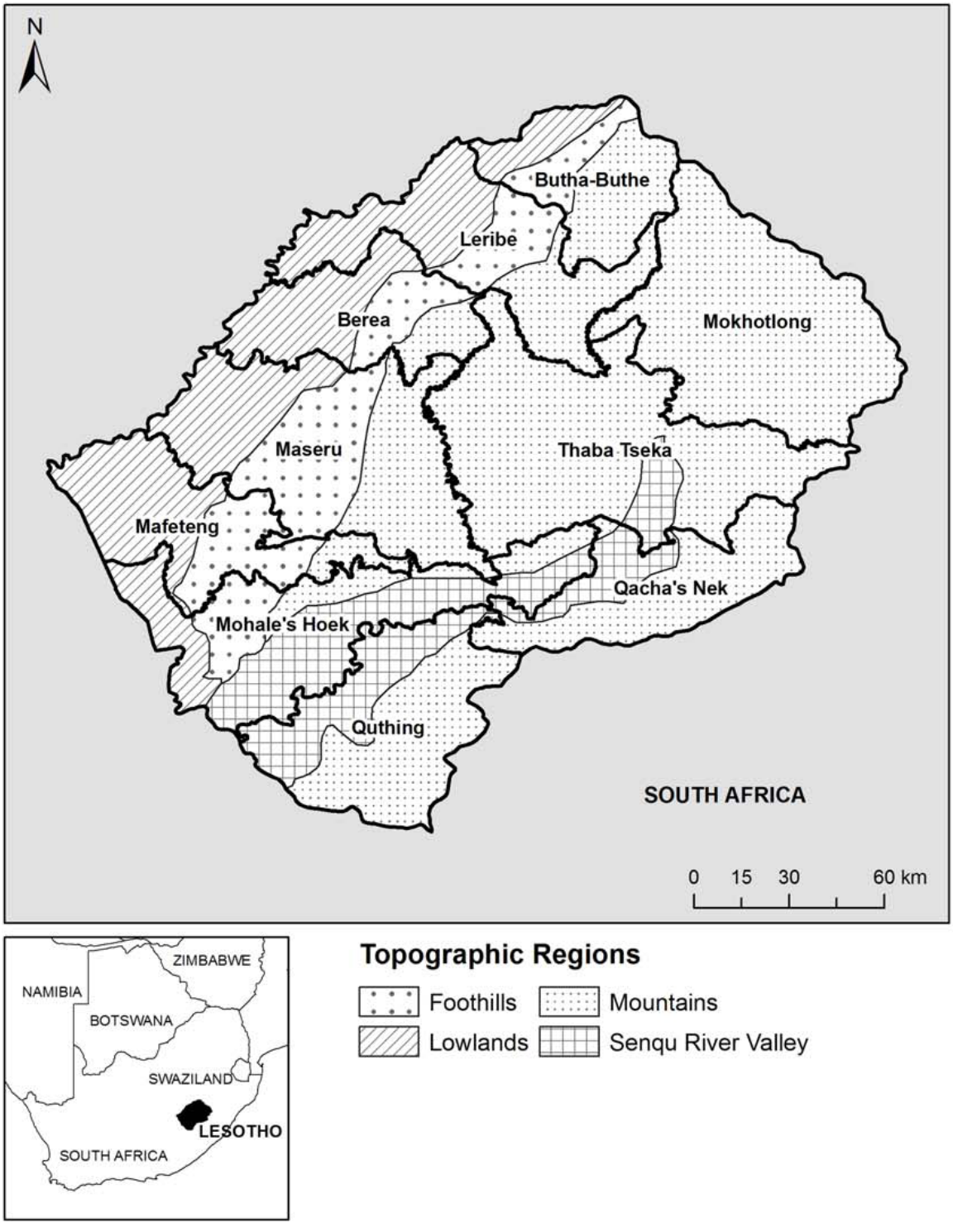
Lesotho is a small mountainous country fully surrounded by South Africa. The country's land area is approximately 30, 350 square kilometres, three-quarters of which is made up of highlands and the remaining one-quarter is lowlands. The country is divided into ten districts and further into four ecological zones: the Lowlands, Foothills, Mountains and Senqu River Valley. Lesotho can be distinguished by its high altitude terrain hence often referred to as "Mountain Kingdom" or "Kingdom in the sky". About 61% of the population resides in the urban areas while 32% in the rural areas (PRB, 2006). Currently the population is estimated to be 1.8 million (BOS, 2003). Due to the AIDS epidemic, life expectancy at birth has declined tremendously. Life expectancy is 35 years for males and 36 years for females (PRB, 2006).

Lesotho has two official languages, Sesotho and English. Lesotho gained its independence on the 4th of October 1966 and it is now ruled by both the King and the Prime Minister. The three largest religious organizations in Lesotho are the Roman Catholic Church, Lesotho Evangelical Church and Anglican Church of Lesotho.

The economy of Lesotho is heavily reliant on agriculture. However, like most of Southern African, the country has experienced a series of droughts in the past few years and an AIDS pandemic (as the most productive population get sick and die from the disease), which has led to acute shortages of food and severe famine in the country (Lesotho National Human Development Report, 2007). The majority (56%) of Basotho are poor and are living below US$2 per day (PRB, 2006). There is a high unemployment rate in Lesotho exacerbated by the high retrenchment rate of miners since historically Lesotho had been exporting labour to the South African mines (FAO, 2007). However, there has been an increase in number of women coming to work in the clothing industries in the two largest districts of Lesotho, Maseru and Leribe.

Water is one of the most important resource in Lesotho and it is often referred to as "Lesotho's white gold". The Lesotho Highlands Water Project (LHWP) which was established in 1986 is a multi-million-dollar project between Lesotho and South Africa designed to capture, store and transfer water from Lesotho to South Africa.

Figure 3.1: Map of Lesotho



Source: 2004 Lesotho Demographic Survey report

3.3 Triangulation Method

The triangulation method is broadly explained as the combination of methodologies in the study of the same phenomenon (Denzin, 1978). Some argue that qualitative and quantitative methods should be viewed as complementary rather than as rival and as such the effectiveness of triangulation rests on the premise that the weakness in each single method will be compensated by the counter-balancing strengths of another (Jick, 1979; Bryman, 1984).

In the present study the triangulation method will be used because of data limitations where some of the questions were not asked especially on attitudes and behaviour in the 2004 LDHS. Therefore, in this research the qualitative research will try and explain some of the findings from the quantitative research, while on the other hand it will be complimenting the results from the quantitative research. In addition, qualitative research could serve to verify and validate the data (Ulin et al., 2002). Furthermore, according to Rehle and Hassig (2003), the triangulation method has the potential of dealing with sensitive and personal issues and may also help in interpreting behaviours in a holistic manner. Therefore, this method was regarded as the best method for the study since the study deals with sensitive issues of sexual behaviour and HIV/AIDS.

3.4 Quantitative Methodology

There are many advantages in the use of quantitative data. With quantitative data it is easy to predict any association between large populations; therefore data can be analyzed with a high confidence level (Holland and Campbell, 2005). Furthermore, with quantitative data it is easy to predict the future and make inferences. Quantitative data provides data that can be aggregated and analyzed to predict the relationship between variables in the study (Holland and Campbell, 2005). Quantitative methods emphasize validity and reliability, thus data can be replicated, compared, and generalized (Young and Hagerty, 2007). In addition, data are seen as more objective and scientific due to the large number of cases studied and the researcher's less involvement with the subjects (Young and Hagerty, 2007). This method is less time consuming and hence allows the researcher to have a large sample.

On the other hand quantitative research has some disadvantages. In the quantitative study, the set of questions are limited due to predetermined categories and therefore it is not easy to study issues in depth or in detail (Patton, 2002). In addition, quantitative results are limited to the numerical descriptions rather than detailed human perceptions (O'Neill, 2006). Moreover, quantitative data collect a much narrower and sometimes superficial data set (O'Neill, 2006).

The present study relies on the 2004 LDHS. The 2004 LDHS is part of the worldwide MEASURE DHS. The survey was implemented by the Ministry of Health and Social Welfare and the Bureau of Statistics in Lesotho, in collaboration with the ORC Micro. This population based survey is the main source of data on the key demographic indicators in Lesotho. The 2004 LDHS was conducted using a representative sample of women and men of reproductive age. The specific objectives of the LDHS is to provide data at national and district levels on different indicators such as fertility, mortality and knowledge and behaviour related to HIV/AIDS (Ministry of Health and Social Welfare et al., 2005).

The 2004 LDHS used three questionnaires: a household questionnaire, a woman's questionnaire and a man's questionnaire. For the purposes of this study, only the woman's questionnaire will be used. Data was collected using the face-to-face interview technique where interviewers asked questions and recorded the responses from the respondent.

A representative probability sample of 9903 was selected. This sample represents the ten districts of Lesotho including urban and rural. All women aged 15-49 who were either permanent household residents in the 2004 LDHS sample or visitors present in the household on the night before the survey were eligible to be interviewed. The survey comprised a two-stage sample design. In the first stage, 405 clusters where selected from the enumeration areas list of the 1996 population census sampling frame and these included 109 clusters from the urban area and 296 from the rural area. According to Kirkwood and Sterne (2003), the sampling frame is a list or database of all individuals in the population. In the second stage, a listing of households was then carried out in each selected clusters and the households were systematically selected to be interviewed.

The 2004 LDHS sample comprised 7095 women. However, the present study was concerned with pregnant women and therefore the number of women who were pregnant in the sample was 3364. Since there was no variable in the study called 'pregnant' certain variables were

used as proxy and these were: women who were currently pregnant during the survey, women who had births in the last 5 years and women who had a pregnancy that miscarried, was aborted or ended in a stillbirth in the last 5 years. For VCT, the variable 'ever been tested' will be used as a dependent variable because it is stated in the 2004 LDHS that pregnant women received counselling and testing during their antenatal visit.

The quantitative data was analysed using SPSS (Version 15). In the first stage of data analysis descriptive statistics were produced. The background information of pregnant women who had ever been tested for HIV and those who have ever heard of HIV were analyzed as frequencies and percentages. The chi-squared test for independence was employed. Cross-tabulations were used to determine the statistical association between ever tested for HIV/AIDS (dependent variable) and other independent variables, such as socio-demographic and behavioural characteristics. The binary logistic regression analysis was used to determine the characteristics of women utilizing VCT services.

The present study is using secondary data which limits the researcher to the questions which were asked in the 2004 LDHS. As such, some of the variables which are very crucial to the present study, such as attitudes to VCT were not asked in the survey. Furthermore, there was no variable called 'pregnancy' therefore the proxy variables were used to get the total number of pregnant women therefore this could have biased the results.

3.5 Qualitative methodology

Qualitative research provides rich and in-depth information (Holland and Campbell, 2005; Bryman, 1984). Qualitative data deals with exploring people's life, everyday behaviour and it provides a deeper understanding of social phenomena than quantitative data (Silverman, 2003). Qualitative research embarks on discovery rather than on verifications as such it is likely to stimulate new leads that the quantitative researcher is unlikely to underpin, but which can be used as a basis for further research (Bryman, 1984).

Furthermore, qualitative research is a scientific way to understand the world from the point of view of the subject, to unfold peoples' experience and to uncover their lived world (Kvale, 1996). Qualitative research allows the participants to describe what is meaningful or important to them using their own words rather than being restricted to predetermined

categories; thus participants may feel more relaxed. In addition, interviewers have the flexibility to use their own knowledge, expertise, and interpersonal skills to explore interesting or unexpected ideas or themes raised by participants (Sewell, 2008). The advantages of using qualitative research was to get more in-depth responses about attitudes of pregnant woman towards VCT which were the variables that were not measured in the quantitative data of this study. Therefore, the focus group discussion was more advantageous because it is less time consuming.

The major disadvantage of qualitative research is that the sample is usually small because of its complexity hence the small group of individual interviewed cannot be taken as representative. For the current study the sample selected was small due to limited time and resources. In addition, qualitative interviews can be more subjective than quantitative interviews because the researcher decides which quotes or specific examples to report (Sewell, 2008).

The qualitative data derives from two focus group discussions. Each group comprised approximately five women. Galindo-Gonzalez and Israel (2008) describes the focus group interview as a planned, relaxed, naturalistic dialogue among a small group of people on a specific topic. Furthermore, focus group discussions are more advantageous than one-to-one interviews since they provide more information as they allow individuals to use the ideas of others in order to express and strengthen their views (Morgan, 1996). According to Patton (2002), the focus group must be a homogeneous group of people; therefore in the present study a group of pregnant women attending antenatal clinic were selected.

The focus group discussion guide was used to collect the qualitative data. The discussion included words such as ‘why’, ‘how’, ‘what’, ‘under’ and the questions were open-ended giving the respondents the opportunity to express their views. According to Lewis (2000), the questions should not be structured and should be open-ended so that the respondent can answer from a variety of dimensions. The focus group discussion guide was divided into different categories and sub-categories with seven themes relating to VCT

The focus group discussions were conducted in two districts in Lesotho: Maseru and Leribe. Maseru is the capital town while Leribe is one of the largest districts with a growing number of factory clothing industries attracting people from different places. According to the 2004

LDHS, Leribe and Maseru had the highest HIV prevalence rate (30.6% and 29.9% respectively), among women as compared to other districts. Therefore, two antenatal clinics were selected from Maseru (an urban area), and Leribe (a rural area). The health centre was the Queen Elizabeth II hospital which is in the city centre of Maseru and it is the only government hospital in town. This hospital attracts many people from different areas in Maseru and the surrounding areas. The Peka Health Centre is on the outskirts of Leribe districts and in the rural part of Leribe.

The study populations were all women attending antenatal clinics in two health facilities in Maseru and Leribe during the time of the study, that is, July 2008. A purposive sample of 10 pregnant women was selected from two antenatal clinics, that is, five from Queen Elizabeth II Hospital which is in Maseru - an urban area and the other five from Peka Health Centre which is in the rural area of Leribe. Often qualitative research uses purposive sampling and according to Patton (1990) purposive sampling entails that subjects are selected because of some characteristic of the sample which one already have in mind.

The focus group discussions were conducted in the first week of July 2008. The discussions took place in a quiet and isolated room provided by the antenatal nurses from both places who also assisted the researcher in identifying the participants. The women were told the importance of the study and asked whether they were willing to participate. Before the interview commenced the women were assured of confidentiality and told that the responses they provide will be used for the study purposes only. The respondents were further told that they were free to withdraw at anytime and also were free to refuse to answer any questions if they feel uncomfortable. Lastly, the respondents were asked to fill the consent form to show their willingness to participate in the study.

After all the questions from the respondents were answered and the consent form filled the discussion commenced. The discussions were recorded on a tape recorder while at the same time notes were taken. The discussion from each focus group lasted for about one hour and were conducted in Sesotho and later transcribed into English. The researcher acted as a moderator and used questions from the focus group discussion guide (see Appendix I) to facilitate the discussions. Each woman was given the chance to respond to the questions and express her views.

The responses from the focus group discussions were recorded with the consent of the respondent. Together with the notes made by the researcher the responses were later transcribed so that they could be coded and analyzed using the qualitative data analysis package (Nvivo). The data from the focus group discussion was analyzed using thematic analysis. Thematic analysis involves sorting data according to themes that have already been selected for the analysis of qualitative data. Furthermore, Patton (1990:381) describes thematic analysis as "the process of identifying, coding and categorizing the primary patterns in the data". As noted by Cassell et al. (2005:9), this is a useful organizational tool which allows the "researcher to index segments of the text to particular themes, carry out complex search and retrieval operations quickly and link research notes to coding". Direct quotations were also used to illustrate particular findings.

The focus group discussion was done in Sesotho and later translated in English. This could bias the results as some of the words are not easy to translate. The sample focused on women who attended antenatal care on the day of the focus groups only because of limited funds and time and this was also a major disadvantage as it excluded other pregnant women. Due to time constraints, it was not easy to use the quantitative results to identify the themes for the study. However, the themes were guided by the literature and other studies conducted which were relevant to the present study.

The ethical clearance to conduct the study was granted by the University of KwaZulu Natal Research Ethics Committee in South Africa and by the Ministry of Health and Social Welfare Research and Ethics Committee in Lesotho.

3.6 Summary

The chapter discussed the methods of data collection and data analysis. The study employed the triangulation method using both quantitative and qualitative methods. The quantitative data for the study was derived from the 2004 Lesotho Demographic Survey. The focus of the study was on women who were pregnant between 1999 and 2004. The total number of pregnant women sampled for this study was 3364. The qualitative method involved two focus group discussions comprising ten women attending antenatal clinics in Queen Elizabeth II Hospital in Maseru and Peka Health Centre in Leribe.

CHAPTER FOUR

QUANTITATIVE FINDINGS

4.1 Introduction

This chapter will present the findings from the quantitative data. The quantitative data draws on the 2004 LDHS. For the purpose of this study, the sample consists of all pregnant women aged 15-49 years. Firstly, in order to provide background information of pregnant women in the study the socio-demographic variables will be analyzed and presented. The selected socio-demographic variables of pregnant women include age, place of residence, marital status, education and religion. This chapter then discusses the main findings of the study with particular emphasis on ever tested for HIV/AIDS.

4.2 Socio-demographic Characteristics of the Sample

This section provides the socio-economic and demographic characteristics of pregnant women in the study. According to Table 4.1 the total number of respondents sampled was 3364. Those aged group 20-24 and 25-29 constituted about 29% and 22% of the sample respectively. The number of women who fall within the age group 45-49 comprised 3.2% of the total sample while those in age group 15-19 were slightly above 10%. The majority of respondents (79%) were from the rural areas and less than a quarter resided in urban areas. About 74% of the pregnant women were married. Almost 17% of respondents were neither married nor living together and about 10% were not married but living together. More than 60% of respondents had primary or no education and 33% had secondary or higher education. The majority of the women (46%) were Catholic. Almost 27% belonged to other Christian denominations and 18% were Evangelicals. Few belonged to other religious denominations.

Table 4.1: Percentage distribution of respondents by background characteristics

Age group	**N**	**%**
15-19	363	10.8
20-24	962	28.6
25-29	737	21.9
30-34	530	15.8
35-39	390	11.6
40-44	273	8.1
45-49	109	3.2
Place of residence		
Urban	694	20.6
Rural	2670	79.4
Marital Status		
Married	2480	73.7
Neither married nor living together	557	16.6
Not married but living together	327	9.7
Education		
Primary or less	2246	66.8
Secondary or more	1118	33.2
Religion		
Roman Catholic Church	1535	45.6
Lesotho Evangelical Church	588	17.5
Other Christian	906	26.9
Anglican Church	295	8.8
Other Denominations	33	1.0
All	**3364**	**100.0**

4.3 Awareness of HIV/AIDS

In the fight against the further spread of HIV/AIDS, awareness of the existence of HIV/AIDS is very important (Ekanem and Gbadegesin, 2004). Furthermore, knowledge of HIV will encourage more people to access VCT services in order to know their HIV status. This will help people to take the necessary precautions not to get infected or to infect others. In the study, respondents were asked whether they have ever heard of HIV/AIDS. Table 4.2 shows that the majority (90.6%) of respondents have ever heard of HIV/AIDS. However, a small number of respondents (9.4%) mentioned that they have never heard of HIV/AIDS.

Table 4.2: Percentage distribution of respondents who have ever heard of HIV/AIDS

Ever heard of AIDS	**N**	**%**
No	316	9.4
Yes	3048	90.6
All	**3364**	**100.0**

In trying to understand the characteristics of women who had ever heard of HIV/AIDS a chi-squared test was used. The results from Table 4.3 confirm that place of residence, age and level of education played a significant role in influencing knowledge of HIV/AIDS. The overwhelmingly majority of urban dwellers had ever heard of HIV/AIDS compared with rural dwellers. Age also showed a significant relationship with ever having heard of HIV/AIDS. Moreover, it was expected that respondents in the younger age groups especially those that are often mostly affected by HIV/AIDS would have been aware of the existence of HIV/AIDS. According to UNAIDS (2008), the age group 30-50 is mostly affected by HIV/AIDS in Lesotho. Hence, it is observed from the results that the highest percentages of people (94%) who have ever heard of HIV/AIDS were aged between 35 and 39 years. The age group 30-34 constituted about 93% of respondents who have ever heard of HIV/AIDS. The age group 20-24 had the lowest percentage of people who have ever heard of HIV/AIDS.

Education on the other hand was important in influencing knowledge of HIV/AIDS. Almost all the respondents with secondary or higher education (97%) have ever heard of HIV/AIDS compared with respondents with primary or no education (88%). Marital status on the other hand was significantly associated with ever having heard of HIV. Respondents who were neither married nor living together had the highest percentage (95%) of people who have ever heard of HIV/AIDS than other groups. Religion was not significant and did not show any association with ever having heard of HIV/AIDS.

Table 4.3: Percentage distribution of women who have ever heard of AIDS and their socio demographic characteristics

Characteristics	Ever heard of HIV/AIDS		Never heard of HIV/AIDS	
Location	**N**	**%**	**N**	**%**
Urban	689	99.3	5	0.7***
Rural	2359	88.4	311	11.6
Age group				
15-19	325	89.5	38	10.5***
20-24	845	87.8	117	12.2
25-29	676	91.7	61	8.3
30-34	491	92.6	39	7.4
35-39	365	93.8	25	6.4
40-44	249	91.8	24	8.8
45-49	97	89.0	12	11.0
Education				
Primary or less	1967	87.6	279	12.4***
Secondary or higher	1081	96.7	37	3.3
Marital Status				
Married	2229	89.9	254	10.1***
Neither married nor living together	527	94.6	30	5.4
Not married but living together	292	89.3	35	10.7

Note: * $\rho<0.10$ ** $\rho<0.05$ *** $\rho<0.001$

Studies have shown that knowing someone who has HIV or someone who has died from AIDS can change people perception towards HIV/AIDS, thus reduce stigma and the spread of HIV (Visser et al., 2007). In the present study, respondents were asked whether they know someone who has died of AIDS. The results are illustrated in Table 4.4. About 80% of respondents mentioned that they did not know any person who has died of AIDS. Only about 20% of the respondents revealed knowing someone who has died of AIDS.

Table 4.4: Percentage distribution of respondents who know someone who has died of AIDS

Know someone who died of AIDS	**N**	**%**
No	2671	79.4
Yes	693	20.6
All	**3364**	**100.0**

4.3.1 Knowledge of Means of Preventing HIV/AIDS

Knowledge of ways in which people could avoid getting HIV infection is very crucial. Moreover, when people go for VCT they are counselled on ways in which they could avoid getting HIV if ever they are negative. If positive they are also taught to use condoms during sexual intercourse in order to protect others from getting infected. As such, the respondents were asked whether using condoms during sexual intercourse or having one sexual partner who is faithful could prevent people getting infected with HIV. As illustrated in Table 4.5 about 59% of respondents were aware that using condoms during sexual intercourse could prevent people from getting HIV/AIDS. In contrast, the majority (74%) did not believe that having only one sexual partner could prevent people from being infected with HIV/AIDS.

Table 4.5: Percentage distribution of respondents and knowledge of means of preventing HIV/AIDS		
People can avoid HIV infections by;	**N**	**%**
Not using Condoms	1366	40.6
Using condoms	1998	59.4
All	**3364**	**100**
Not having one sex partner	2483	73.8
Having one sex partner	881	26.2
All	**3364**	**100**

In addition, there were some respondents who mentioned that during antenatal visits they were taught about ways in which they could prevent HIV/AIDS. This is an important initiative that could be used to inform people about prevention strategies that can be taken to reduce their risk of HIV infection. However, Table 4.6 shows that a great deal still needs to be done since about two thirds of respondents have never been taught about any strategies to prevent HIV.

Table 4.6: Percentage distribution of respondents who were taught about things to do to prevent HIV		
Taught how to prevent HIV/AIDS	**N**	**%**
No	2294	68.2
Yes	1070	31.8
All	**3364**	**100.0**

4.4 Awareness of Prevention of Mother-To-Child Transmission of HIV

The main factor that can encourage many people to go for VCT is the benefit of knowing one's HIV status. Prevention of HIV transmission from mother-to-child has been one of the main advantages for many pregnant to know their status (Rogers et al., 2006). Furthermore, if more people are aware of ways in which babies could get HIV infection from their mothers, more babies will be protected from getting HIV (WHO/UNAIDS/UNICEF, 2007). According to Table 4.7, the majority of respondents knew the three ways in which HIV can be transmitted from mother-to-child. However, there were still respondents who did not know that a child can get infected from mother during pregnancy (19.5%), delivery (24.8%) and breastfeeding (25.2%).

Table 4.7: Percentage distribution of awareness of MTCT of HIV

HIV can be transmitted from MTC during;	**N**	**%**
Pregnancy		
No	656	19.5
Yes	2708	80.5
Delivery		
No	835	24.8
Yes	2529	75.2
Breastfeeding		
No	849	25.2
Yes	2515	74.8
All	**3364**	**100**

4.4.1 Awareness of HIV life-saving drugs

In the present study respondents were asked if they knew about medication which can prevent mother-to-child transmission of HIV. In addition, the respondents were also asked whether they know of medication that is given to HIV positive people to prolong their lives. The responses are presented in Table 4.8. Slightly more than half of the respondents did not know of such medication that can be given to babies to avoid them getting infected from their mothers. However, about 53% of the respondents mentioned that they knew of medication given to positive people. It was disturbing to find that close to half of the respondents did not know about medication given to babies for PMTCT and to other HIV positive people.

Table 4.8: Percentage distribution of awareness of HIV life- saving drugs

Drugs to avoid MTCT of HIV	**N**	**%**
Drugs are not available	1765	52.5
Drugs are available	1599	47.5
Medication for people infected with HIV		
Medication is not available	1596	47.2
Medication is available	1768	52.6
All	**3364**	**100**

4.5 Awareness of VCT

VCT is a gateway for prevention, care, treatment and support (UNAIDS, 2000). VCT de-stigmatizes and normalizes HIV/AIDS (Boswell and Baggalley, 2002). Hence, it is an important strategy in the fight against HIV/AIDS. However, according to Table 4.9, the majority of respondents (80.5%) have never been tested for HIV. Only about 20% of the respondents have ever been tested for HIV/AIDS in the present study.

Table 4.9: Percentage distribution of respondents who have ever tested for HIV/AIDS		
Ever tested for HIV	**N**	**%**
No	2707	80.5
Yes	657	19.5
All	**3364**	**100.0**

Willingness to go for HIV testing shows that people understand the importance of knowing one's HIV status and therefore are willing to take responsibility for their lives. Table 4.10 illustrates that close to half of the respondents are willing to go for HIV testing. However, slightly above 50% of the respondents are still not willing to test for HIV. Numerous studies suggest that many people still do not want to go for HIV testing because of fear of positive results (Dyk, 2003). Similarly, some especially women fear physical abuse or abandonment by their husband if ever they test HIV positive (Maman et al., 2001; Pool et al., 2001). On the other hand, stigma and discrimination associated with testing HIV positive have been highlighted as the main reason many people are not willing to go for HIV testing (Rogers et al., 2006).

Table 4.10: Percentage distribution of respondents who want to be tested for HIV/AIDS		
Want to be tested for HIV	**N**	**%**
No	1644	48.9
Yes	1720	51.1
All	**3364**	**100.0**

4.5.1 Knowledge of a place to obtain HIV/AIDS test

In order for people to access VCT services they should be made aware of the existence of such places. In the present study, Table 4.11 shows that 67% of respondents knew a place to get an HIV/AIDS test while more than 30% did not know such places.

Table 4.11: Percentage distribution of respondents who know a place to obtain HIV/AIDS test

Know a place for HIV testing	N	%
No	1116	33.2
Yes	2248	66.8
All	**3364**	**100.0**

According to Table 4.12, knowledge of place for HIV testing is significantly associated with HIV testing. The majority of respondents (71%) who knew a place to get an HIV test have never been tested. Not surprisingly, respondents who did not know a place to get an HIV test did not test for HIV/AIDS.

Table 4.12: Percentage distribution of respondents who ever tested and knowledge of a place to obtain HIV/AIDS test

Characteristics	Ever tested for HIV/AIDS		Never tested for HIV/AIDS	
Place to get HIV/AIDS test	**N**	**%**	**N**	**%**
Don't know a place for HIV testing	0	0.0	1116	100***
Knows a place for HIV testing	657	29.2	1591	70.8

Note: * $\rho<0.10$ ** $\rho<0.05$ *** $\rho<0.001$

4.5.2 Socio-demographic Characteristics of Respondents who have Ever Been Tested for HIV/AIDS

The socio-demographic characteristics of individuals accessing VCT are pertinent in understanding why certain people would go for VCT while others would not. The chi squared test results shows that place of residence, marital status and education were significantly associated with ever been tested for HIV. On the contrary, age and religion did not show any association with ever been tested which means it did not matter which religion or age group a person belonged to in order for that person to test for HIV.

Table 4.13 illustrates that the majority of respondents have not tested for HIV. There were more rural dwellers compared with urban residents who have not tested for HIV. Furthermore, it can be observed from Table 4.13 that pregnant women with secondary or higher education (24.6%) are more likely to test compared with pregnant women with primary or no education (17%). The majority (24.2%) of the respondents who were neither married nor living together have ever been tested for HIV compared with about 20% of women who were not married but living together and 18% of women who were married.

Table 4.13: Percentage distribution of women who ever tested by socio demographic characteristics

Characteristics	Ever tested for HIV		Never tested for HIV	
Location	**N**	**%**	**N**	**%**
Urban	184	26.5	510	73.5***
Rural	473	17.7	2197	82.3
Age group				
15-19	65	17.9	298	82.1
20-24	189	19.6	773	80.4
25-29	161	21.8	576	78.2
30-34	102	19.2	428	80.8
35-39	82	21.0	308	79.0
40-44	42	15.4	231	84.6
45-49	16	14.7	93	85.3
Religion				
Roman Catholic Church	289	18.8	1246	81.2
Lesotho Evangelical Church	119	20.2	469	79.8
Other Christians	192	21.2	714	78.8
Anglican Church	52	17.6	243	82.4
Other Denominations	5	12.5	35	87.5
Education				
Primary or less	382	17.0	1864	83.0***
Secondary or higher	275	24.6	843	75.4
Marital Status				
Married	456	18.4	2024	81.6***
Neither married nor living together	135	24.2	422	75.8
Not married but living together	66	20.2	261	79.8

Note: * $\rho<0.10$ ** $\rho<0.05$ *** $\rho<0.001$

The results of the logistic regression show that place of residence and education are statistically associated with ever tested for HIV/AIDS. According to Table 4.14, the odds of testing for urban dwellers are higher than the odds of testing for rural dwellers (OR= 1.475; CI: 1.202 – 1.809). Furthermore, a highly significant association (P<0.001) between the odds of testing for urban and rural residents was noted. The odds of testing was higher for respondents who were neither married nor living together (1.171) than those who were married and those who were not married but living together. The results further highlighted that respondents who were married have less odds for testing (0.852).

Table 4.14 also illustrates that the odds of testing for respondents with secondary or higher education were higher than the odds of testing for respondents with primary or no education (OR= 0.695; CI: 0.578 – 0.835). The results show that respondents with primary or no education are less likely to go for HIV testing as compared to those with higher education and the results are highly significant (P<0.001) . The findings further confirm that there is a relationship between place of residence, marital status and education. However, no association was noticed between age and religion of respondents and ever having tested for HIV.

Table 4.14: Logistic regression coefficients of selected socio demographic variables on VCT

Location	Odds (B)	Odd Ratio	Confidence Interval (95%)
Urban	0.388	1.475***	1.202 – 1.809
Rural	1.000	1.000	1.000
Age group			
15-19	0.102	1.108	0.602 – 2.040
20-24	0.235	1.265	0.720 – 2.220
25-29	0.336	1.399	0.794 – 2.463
30-34	0.209	1.233	0.691 – 2.199
35-39	0.312	1.366	0.758 – 2.462
40-44	0.041	1.042	0.547 – 1.949
45-49	1.000	1.000	1.000
Religion			
Roman Catholic Church	0.393	1.481	0.571 – 3.845
Lesotho Evangelical Church	0.438	1.549	0.589 – 4.075
Other Christians	0.574	1.775	0.681 – 4.631
Anglican Church	0.250	1.284	0.476 – 3.467
Other Denominations	1.000	1.000	1.000
Education			
Primary or less	-0.364	0.695***	0.578 – 0.835
Secondary or higher	1.000	1.000	1.000
Marital Status			
Neither married nor living together	0.158	1.171	0.827 – 1.658
Married	-0.160	0.852	0.661 – 1.097
Not married but living together	1.000	1.000	1.000

Note: * $\rho<0.10$ ** $\rho<0.05$ *** $\rho<0.001$

4.6 Summary

This chapter presents the quantitative findings of the study. The results were three-folded as data was analyzed using distribution statistics, chi-squared test and binary logistic regression. First, frequencies and percentages were used to show the distribution of the data. Secondly, cross-tabulation was used to determine any association between the dependent variables and independent variables and lastly the odds of ever been tested and socio-demographic characteristics were established.

Knowledge of PMTC was overwhelmingly high and respondents were aware of three ways in which mothers could transmit HIV to their children. Respondents were also aware of the existence of HIV and the measures that could be taken to avoid infection. However, there were some of the respondents who have never heard of HIV/AIDS. The results also highlighted that there was a significant number of respondents who were willing to be tested for HIV.

The majority of women were married, resided in rural areas, had primary or no education and were within age group 20-24. On the other hand the chi-square results revealed that there was highly significance associations between ever tested for HIV and place of residence, education and marital status. Age and religion did not show any significance with testing.

CHAPTER FIVE

QUALITATIVE RESULTS

5.1 Introduction

The chapter outlines the main findings from the focus group discussion conducted with pregnant women in Lesotho. The women interviewed ranged in age from 21 and 37 years and they were all married. Level of education was relatively low with the majority reporting having only completed their primary school education. Few had secondary education and none of the women had a tertiary education. Most of the women were either working at a clothing factory or unemployed. The chapter attempts to highlight and explain some of the factors associated with utilization of VCT among pregnant woman in Lesotho. The findings will be presented according to particular themes.

5.2 Knowledge of VCT

Lack of knowledge about VCT can prevent people to access the services. It was evident from the present study that some women were not aware of VCT services and they confused VCT with the routine counselling and testing that is provided at antenatal clinics. When asked what they know about VCT the women found it difficult to explain the purpose and said, "*We know about it, it is just that we can't explain what it means but we know about it".* However, during the discussion it was clear that the women have attended HIV testing and counselling provided at the antenatal clinics which also has the same benefit as that of VCT. The responses they provided regarding the importance of knowing one's status revealed that they were aware of the significance of VCT. The women mentioned many advantages of going for VCT such as counselling to cope with positive results or if negative to maintain their negative status. They also stated that VCT allows individuals to more effectively manage opportunistic infections and in this way lead a healthier life. In addition, it also encourages individuals to seek treatment.

In short I can say VCT is very important especially to us Basotho, because it takes care of our health and if you know your status you can live for many years. It is also very important because you can be counselled in many things not only in HIV but on different factors of life

and VCT also helps people to accept their HIV status. I still think it is easy if you know the enemy you are fighting rather than fighting something you don't know (Rural FGD).

I think it is very important for people to go for VCT services because if people don't know their status, they can die easily but if they know their status they can take medication and live for a very long time (Urban FGD).

In contrast, there were some women from both focus groups who were clueless about the importance of VCT and had not even heard of it. However, the women were eager to learn about VCT and said if they were to be given information about VCT they would like to know its importance. Some mentioned that they would want to know about the causes of HIV. They also said that they would like to know why HIV kills so many people and why it is not curable. The majority of women in the study had never attended VCT services but they heard about VCT on radios, at schools, community gatherings, at the clinic and from HIV workshops. The women in the focus groups also stated that promotions and awareness campaigns can lead to more people knowing about VCT, thus increasing utilization. As such, the ways in which people gathered information about VCT was regarded as important since this will not only provide people with information on VCT but about HIV/AIDS in general.

5.3 Knowledge of Vertical Transmission

In order to prevent HIV positive mothers infecting their unborn children the participants emphasized the importance of knowledge of mother-to-child transmission of HIV by pregnant women. They described this method of vertical transmission of HIV as very essential as it affects both mothers and their unborn children. They further pointed out that mother-to-child transmission of HIV could occur through three main ways, that is, during pregnancy, breast feeding and delivery.

The women stressed that in order to prevent a baby from being infected with HIV a mother should avoid mixed feeding of bottle and breast milk. They indicated that HIV positive women could opt for exclusive breastfeeding until a child is six months. However, for those who could afford formula milk it was advisable not to breastfeed since breast milk may contain HIV.

I think the first thing is that when a woman is breastfeeding she has to give the child only breast milk and not mix it with formula feeding. She has to continue breastfeeding only until the child is ready to start eating food. It is when a child is six month that you should start giving her food (Urban FGD).

Other methods that could prevent a mother infecting her child, such as, an HIV positive woman not giving birth at home were also discussed. The main reasons raised were that positive women should not deliver by natural birth as she could infect the baby during delivery. The women also mentioned that HIV positive woman should be given AZT before delivery which will protect the baby from getting infected. The child on the other hand should also be given medication immediately after birth to prevent it from infection.

Another thing is that a woman has to use the pill that she will take during labour and this will prevent the child from being infected. This will prevent the child from getting infected because sometimes during birth a mother's pubic hair can scratch a child and the child can get infected (Urban FGD).

Also a woman should not give birth at home, but has to go to the clinic or hospital especially if she is infected so that she will be given a medication that prevents her from infecting the child (Rural FGD).

The participants further explained that a woman who is breastfeeding should use condoms during sexual intercourse. This is particularly important if she suspects that her partner has other sexual partners. As such, they maintained that while breastfeeding may protect them from getting pregnant, it cannot protect them from the risk of HIV infection from their sexual partners.

*If the woman who is breastfeeding is not using condoms she could infect the baby, because she will not know what her husband has been doing (*Urban FGD*).*

Although the above mentioned protective measures concerning PMTCT are taken as important there is still a need to reinforce the way in which pregnant women are getting information regarding PMTC and VCT. In both focus group discussions women did not mention all the preventive strategies of vertical transmission which are recommended by

WHO such as, primary prevention of HIV among parents-to-be, preventing unwanted pregnancies in women with HIV, terminating pregnancy where this is legal (Jackson, 2002).

5.4 Knowing One's Status

When asked what they think could make pregnant women to go for VCT, participants highlighted that the perceived benefits of knowing one's status was the most salient reasons that could influence pregnant woman to go for VCT. The women felt that it was important to know their HIV status in order to prevent HIV transmission to their unborn child and seeking treatment to prolong their lives. They also highlighted that knowledge of one's status can lead to women taking action to protect themselves against HIV infection. In addition, women who know their status could access treatment on time, and could also get support from peers, family and community support including support groups for people living with HIV/AIDS. As such, women regarded HIV testing as a means to plan for the future. Here are some of the reasons of knowing one's status that were mentioned by the respondents:

VCT has a double benefit especially during pregnancy as I will be able to protect my baby from getting infected while at the same time I will be taking medication which will help me to live longer and see my other children grow (Urban FGD).

If I know my status I will be able to protect myself from getting infected, and if I am already infected I can get medication. I would also like to have a healthy baby which is free from HIV so this would make me to go for VCT (Rural FGD).

Even though VCT is sometimes regarded as a diagnostic tool the benefit of knowing one's status early is worthwhile. Thus, the participants indicated that it is important that people access VCT early before they get sick.

Usually if a person is getting thin and also has TB or is sick all the time, that is the time that she may decide to take the HIV test, or if she does not decide then the doctor and the nurse will force her to go for a HIV test and sometimes it is too late (Urban FGD).

Numerous studies suggest that people go for VCT for different reasons such as the influence from peers, spouse or family, marriage, perceived risk of HIV and many other factors

(Nuwaha et al., 2002). However, in the present study the participants were not aware of these factors or did not mention them. It is important to make people aware of the importance of VCT so that these services could be utilized and hence assist in curbing the further spread of HIV/AIDS.

5.5 Fear of Positive Results

In trying to understand the reasons why pregnant women would not be willing to go for VCT the respondents were asked what they think could be the reason that could prevent pregnant women from attending VCT. The main reason most women mentioned was the fear of knowing one's status. Some respondents mentioned that being HIV positive and knowing that they are going to die is like getting a life sentence. The majority also mentioned that the stress of knowing that they are about to die is not healthy especially during this time when they are expecting their babies. The women believed that they are vulnerable and cannot cope with a HIV positive result. They also revealed that people usually do not want to go for testing because they believe that they cannot cope with positive results, while others think that knowing their status may kill them.

I would not want to stress myself about knowing my status, because the fear of knowing that I am HIV positive is going to kill me (Urban FGD).

I am very scared to know my status, even to think that I might be HIV positive. So I would rather not know. It is better that way! (Rural FGD).

I would say I don't want to stress myself about knowing my status especially now when I am pregnant as this will put more strain on my health and the baby. I can't go through that stress now (Rural FGD).

The responses reveal that the fear of a positive result is the main obstacle to knowing one's status. In addition, these responses suggest that some people are not aware of the availability of life-saving drugs which has made HIV like any other chronic diseases and prolongs people's lives. As such, many will die from HIV/AIDS. However, this could be prevented if people could overcome their fears and get tested so that they could be able to access antiretrovirals.

5.6 Stigma and Discrimination

It was noted from the study that stigma and discrimination are the main reasons many people would not want to go for HIV testing. The respondents stressed that people usually fear what others would think about them if ever their HIV status is known. They further describe stigma and discriminations as a major obstacle to VCT utilization. They believed that stigma and discriminations may deter the benefits of knowing one's status, thus leading to people believing that HIV is the disease for 'others'. In addition to stigma and discrimination, the respondents explained that adherence to antiretroviral may be compromised especially in situations where people have to hide their medication. This is confirmed by the following statement by one woman who observes "*I wouldn't want my friend to know that I am taking antiretrovirals I would rather not take them at all".* The other woman told a story about the negative consequences of not revealing their HIV status.

There is this woman who was taking antiretrovirals; however, she did not want anyone to know about them. So she changed containers and told her husband that she was on high blood pressure medication. But it was not long till people saw her at Sankatana [a hospital where people access HIV medication] and started talking. When the husband heard about his wife's HIV status, he was so furious that the woman had lied. The man threw the pills away and told her to stop going to Sankatana or taking the pills (Urban FGD).

Sometimes fear of stigma and discriminations force women to hide their antiretrovirals from their spouses and friends and pretend that the medications is used to control other diseases, such as, high blood pressure or diabetics which people consider as normal.

During the focus group discussion some of the women also stated the other reason pregnant women would be reluctant to attend VCT is because of fear of what other people would say if they found out that they are HIV positive. Fear of positive results together with the fear of losing friends and family has outweighed the fear of dying from HIV/AIDS. This suggests that some people seems to worry more about what others would say when they hear about their HIV status than worry about getting sick or dying from HIV/AIDS. This is disturbing because HIV positive people are most likely to need support from family and friends in order to cope with a HIV positive result, or will need care from family and friends when they are sick.

If ever your friend can find out that you are HIV positive she could stop visiting you, so it is better if you don't know your status (Urban FGD).

You know, where I am staying, if people suspect that you are HIV positive they start gossiping about you and some if they hear that you are sick they just come to see you and go back and laugh with their friends (Rural FGD).

Some women also noted that in many African cultures it is the norm for women to breastfeed, so if a woman decides to bottle feed her child everyone will start to become suspicious of her and start speculating that she is HIV positive. The association of HIV/AIDS with bad behaviour on the other hand has also exacerbated stigma towards those with HIV. This is because HIV/AIDS was first mistakenly associated with sex workers and homosexuality. Thus, people tend to believe that HIV positive people acquired the disease through immoral behaviour. Moreover, some people believe that HIV is a punishment from God.

We first knew HIV as a disease for people with bad behaviour only, but now we know that it is not true and everyone can get HIV (Urban FGD).

Some of the women observed that everyone is susceptible to HIV especially if the person has not been taking the necessary precautions to protect themselves. However, they mentioned that the main obstacle in accessing VCT is the association of HIV/AIDS with immoral behaviour. They described how most people believe that HIV is for those with bad behaviour. They believed that if this perception persists it will be unlikely that many people would reveal their HIV status. For example, they explained that it will be unlikely for an old man or woman to disclose their HIV positive status to their children; a Christian who is well known and respected in a society can never come out about his status; a young adolescent who is respected by the community because of her good behaviour will not be able to tell others that she is HIV.

5.7 Fear of Violence and Rejection

Once the woman has overcome the fear of testing she now faces the fear of disclosing the positive results to her partner. Some respondents are most fearful of their partners' reaction. They mentioned that negative results are easy to disclose however, if the results are positive

this often can lead to denial and blame. Most women rely on their husbands for financial support, as most are not working; however, positive women often face the consequences of being thrown out of the house. Some also face physical and emotional abuse. Some men still blame their wives for bringing the disease into the family. This is what one woman had to say about her husband.

My husband may throw me out of the house if he knows that I am HIV positive, I know because he told me (Rural FGD).

On the other hand, men may react irrationally due to fear or denial of positive results. This could be because they may not have been ready to hear the frightening news as they may not have been counselled on how to handle the HIV positive result. In such cases it is advisable for women to seek professional help before revealing their HIV positive status. The responses also show that male involvement and couple counselling and testing is essential in reducing the blame.

Lack of knowledge about HIV/AIDS and misconceptions could lead to more people being infected with HIV. The silence surrounding HIV/AIDS are the contributing factor towards lack of knowledge about this pandemic. If people could speak up about their positive status, others would be aware that AIDS exist. The responses also showed that people from rural areas are mostly disadvantaged as in most cases they do not get correct information regarding their health. This respondent clearly explained this by saying.

For example, if you go deep in the rural areas parents do not understand anything about HIV and if you go there trying to teach people about HIV they are saying you are the one who is teaching their children to have sexual intercourse. In the rural areas people still believe in witchcraft so if a person is told that she is HIV positive she does not accept it because she will think that she has been bewitched. This is killing so many people. Another reason is that people don't want to disclose their status because in the rural areas people think that people who have HIV are those who have been living a loose life, and having many partners (Rural FGD).

The respondents highlighted the importance of teaching people especially those residing in the rural areas about the impact of HIV/AIDS. They mention that people still lack correct information as some still associate HIV/AIDS with witchcraft or bad sexual behaviour. Furthermore, the women showed concern that this lack of knowledge about HIV/AIDS will continue to kill many people if there are no interventions.

5.8 Permission to Seek VCT

It was important to note that, when respondents were asked whether they need to seek permission from anyone before testing, the groups from both urban and rural areas overwhelmingly felt that they did not need permission to go for VCT. This was regarded as an important aspect, especially considering that VCT is a gateway to prevention, care and support and everyone has the right to access it. Moreover, it was important to highlight that the respondent had the right to decide about their health unlike in other places where women have to seek permission from their husbands to go to health facilities.

In order to investigate whether partners have any influence on their wives attending VCT women were asked how they think their husband would react if they go for VCT. Regardless of stigma and discrimination some respondents mentioned that their husband would not mind while a few felt that their husband would even encourage them to go for VCT. One woman from the rural group said, *"He will not have a problem, he is the one always advising me to go and do the test"*. The encouragement women receive from their partners to test for HIV could mean that their partners want to protect their unborn children from getting infected in case the woman is HIV positive. As such, the woman will be able to access PMTCT services. On the other hand, the man may also want to encourage his partner to test so that she will be able to access early treatment if she is HIV positive.

The respondents were also asked the reaction of their partners if ever they knew that they are HIV positive. The freedom to seek VCT without their husband's permission has made some women optimistic concerning their husband's reaction if ever they could learn that their wives were HIV positive. This woman said, "*My husband can understand and accept my positive results"*. The positive reaction and support by their husband towards HIV testing could encourage many women to seek VCT. This woman reported that her husband did not react

negatively to her, "*I always tell him after testing and I haven't seen him reacting in a bad way"*.

However, there were some women who felt that their husband may not take the positive test results lightly. They believed that fear; stigma and discrimination may make their husband scared if they find that their partners are HIV positive, and this may lead to negative consequence for them.

I think he can get scared, because it will be the first time he hears something like that (Rural FGD).

5.9 Disclosure of Positive Results

Some women revealed that disclosure of an HIV positive status will mostly likely be the hardest decision an HIV positive woman will have to take apart from doing the test and accepting the positive result. They mentioned that a person may not know how people will react towards her after learning her HIV status. Thus, the woman may risk losing her children, husband, family and friends. Sometimes she may even lose her job. Her children may be ill-treated at school and by the community because their mother is HIV positive. If pregnant the woman may be told to have an abortion and if she refuses she may be viewed as selfish and the nurses may even decline to help her during delivery. The woman could be faced with loneliness, stress and disappointment. Some women explained that when people disclose their status to certain people they may expose themselves to stigma while they were hoping for support. As such, stigma and discrimination may impact negatively on the person's health and in such situations, follow-up counselling and support as a component of VCT is very essential.

On the other hand, disclosure of positive results is very important as it encourages partners to protect themselves against HIV infections. Furthermore, disclosure of positive results is a big step for positive woman to take. In this study it was interesting to note that all the women were willing to disclosure their HIV status to their partners and family regardless of whether they were positive or negative. Nonetheless, the women were not willing to disclose their positive results to their community or any person who is not a member of the family, because

they feared stigma and discriminations. When expressing why they were not willing to disclose their status to other people respondents said,

Other people can talk about you everywhere and tell everyone that you are HIV positive and that is why I can't tell the relatives or anybody other than my family (Urban FGD).

People tend to believe that if you are positive that means you have been misbehaving but they don't even know their status themselves so I will never reveal my status to anyone (Urban FGD).

5.10 Risk and Prevention Behaviour

VCT promotes and facilitates behavioural change thus leading to acceptance of and coping with sero-status, prevention of mother-to-child transmission, and normalization and de-stigmatization of HIV/AIDS (UNAIDS, 2000). As such, women in both focus groups in the study were asked whether they believe that they were at risk of contracting HIV/AIDS. Most women from the rural areas pointed out that they were not at risk of HIV infection however, the following responses were observed from urban women.

Yes I think we are at risk because we are living in society where almost everyone is HIV positive so we might as well regard ourselves as positive (Urban FGD).

If you are pregnant it means you were not using condoms, and then yes I think pregnant women are at risk. Men do not want to test or use condoms so we cannot trust them (Urban FGD).

The responses show that these women believed themselves to be at risk of contracting HIV. The main reason they highlighted was that almost everyone is HIV positive hence they may as well regard themselves as HIV positive. However, what these people do not know is that there are benefits of VCT such as accessing early HIV medication and reducing stigma and discrimination to mention the few. Moreover, people may live in fear that they are HIV positive while in actual fact they are not. Furthermore, the responses show the despair that women often face due to the lack of power to insist on condom usage or to refuse to have sexual intercourse with someone with many partners or someone they suspect is HIV positive.

The women did not mention any behaviour that may put them at risk of contracting HIV apart from the fact that their husband can never be trusted. This further shows that people still persist in shifting the blame to others and not taking responsibility in protecting themselves against the risk of HIV infection.

Furthermore, there were also other negative responses with some women arguing that they did not believe that they were at risk of contracting HIV. Some women believed that they were safe from contracting HIV as they were faithful to their husband and they also trust their partners.

I have always been faithful to my husband and I also know that he is faithful too so I cannot get AIDS (Urban FGD).

I do not move around [do not have extra marital affairs] *so I know that I cannot have AIDS* (Urban FGD).

The belief that the respondents are not at risk of HIV infection because they are faithful to one partner could lead to many people getting infected. This implies that some partners may not be faithful and may have other sexual partners that their spouses do not know about. Therefore it is important that people protect themselves in all sexual encounters and also know their HIV status and that of their partners. Another woman told the story of a woman who was faithful to her husband but now has HIV.

My sister has been married for over twenty years. For the past twenty years she has been faithful to her husband. She never knew any man apart from her husband. Her husband has been working in the mines all this years and after been sent home because he is sick she discovered that he has AIDS. She was also confirmed HIV positive after she took an HIV test. She is so angry she cannot stop crying and she says 'how can he do this to me. I do not want to see him or take care of him; he has been unfaithful to me' (Urban FGD).

This is a sad story of a woman who has been faithful to her husband all her life but all of the sudden discovers that the man has been unfaithful. This conveys that marriage can no longer be regarded as a safe haven against the risk of HIV infection. Some women are at risk of HIV infection because of their partner's sexual behaviour.

To further investigate the role of VCT in facilitating behavioural change, women were asked whether they think VCT has the potential of changing risky sexual behaviour. It was evident that most respondents especially those from rural areas did not know the impact of VCT on behavioural change. However, there were some positive responses from other participants. These few participants were aware of the impact of VCT on behavioural change. They mentioned that at the antenatal clinics they were counselled on how to be faithful to one partner. They mentioned that the main objective of counselling is to make sure that people understand and accept the results. If the results are positive the counsellor ensures that the person is willing to protect other people from getting infected. Likewise, when the results are negative the counsellor emphasizes the importance of remaining that way by practicing safer sexual practices, such as using condoms and having one partner who is also faithful.

At the clinic we are taught how to protect ourselves by using condoms if we have more than one partner and also to be faithful to our husbands (Urban FGD).

Yes, after counselling people can start to change the way they lived before, like if they had many sex partners they can decide to have only one (Urban FGD).

I think it depends on an individual whether she was properly counselled, so yes people can change their behaviour about the way they think about HIV after being counselled. People can start to notice the importance of using condoms after being counselled (Rural FGD).

5.11 Accessibility and Availability of VCT Services

In the study the women were asked whether they think VCT services were accessible and available. Most women thought that VCT services were more easily accessible in urban areas than rural areas. They explained that most health facilities are mainly in urban areas while people from rural areas have to walk long distances to access these services. Furthermore, women from rural areas also highlighted that in some places VCT services are not offered everyday and sometimes there is a lack of testing facilities.

There are other places where counsellors are not available all the time and you will be told to come some other time (Rural FGD).

Services are not available everyday so there are times when you can't get VCT. Sometimes you find that some of the HIV testing equipments are not available and we have to wait until they arrive and they usually take time to arrive (Rural FGD).

The focus group discussions suggest that there is unmet need for VCT services especially in the rural areas. In these areas there are still some people who are not aware of HIV or VCT. Moreover, in these areas people continue to die everyday from something that they do not know while they sit and wait hoping that one day help will come their way.

5.12 Improving on VCT

VCT is regarded as the important strategy in changing people's risky behaviour and reducing the spread of HIV; however, its utilization is often low especially in many developing countries. Therefore, it is very important to improve awareness of VCT, so as to increase utilization. It is important to understand the point of view of the users on what needs to be improved so that many more people could access such facilities. As such respondents were asked what they think could be done in order to encourage more people to go for VCT.

Many respondents from both rural and urban areas think that talking about HIV/AIDS and people revealing their status to everyone may encourage others to want to know their status. They believed that people should consider HIV to be like any other chronic diseases such as high blood pressure or diabetes since this will normalize and de-stigmatize it. Furthermore, the participants believed that there is a need to publicize VCT on the radio, television, newspapers and in church. They also mentioned that VCT should be included in the school curriculum starting from primary level.

Talking about HIV can normalize it so that people can consider it to be just like any chronic disease like high blood, diabetes. So if people should talk about it everywhere all the time it can encourage many people to go for VCT and to know their status (Urban FGD).

It is important to talk about VCT everywhere - on the radio and everywhere and also to talk about HIV, even at church we can talk about HIV. Even at school I think teachers should include HIV in their curriculum (Urban FGD).

The women in the study suggested routine testing for everyone like it is being done for pregnant women. They further proposed that VCT services should be made available to everyone. They also noted the importance of breaking the silence surrounding AIDS so as to normalize it so that it is like any other chronic disease.

I think everyone should be forced to take the test like it is being done with pregnant women because if people are given the choice to decide to take the test they are not willing to do so (Rural FGD).

This confidentiality about AIDS is the one that scares people. We should break the silence and talk about HIV to everyone and let other people know that HIV is a reality and it exists. Why are we not scared to tell people that we have sugar diabetics but we are scared to say we have HIV? (Urban FGD).

5.13 Summary

This chapter presented the qualitative results from focus group discussions with women attending antenatal care in Maseru and Leribe. The findings of the study suggest that most women know about HIV testing and counselling which is provided at the antenatal clinic. The findings also imply that respondents are aware of the advantages of PMTCT. Fear and stigma and discrimination were the main obstacle to people accessing VCT services or disclosing their status. However, the importance of knowing one's status was regarded as most important since many people will be able to access early treatment of HIV.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter will summarise the results from both quantitative and qualitative data. The main objective of the study was to examine factors facilitating or inhibiting utilization of VCT among pregnant women in Lesotho. The chapter will also discuss some of the main conclusions and suggest some recommendations on how to improve VCT uptake among pregnant women in Lesotho.

6.2 Summary of Findings

HIV/AIDS have been spreading at an alarming rate causing untold suffering and death and creating profound development challenges. Many countries especially those from developing countries have suffered tremendously due to the loss of a large sector of the economically active population. In the fight against HIV/AIDS people have to know their status, so that they are be able to protect themselves and others from getting infected, thus knowledge of HIV/AIDS is essential in eradicating this pandemic. The results suggest that the vast majority of pregnant women in Lesotho have heard of HIV/AIDS. However, there are still others who have not heard of HIV/AIDS. Women with no education or primary school education and those from the rural areas were least likely to be aware of HIV/AIDS. This is consistent with a study conducted in Nigeria which found that education was strongly associated with knowledge of HIV/AIDS (Lliyasu et al., 2006).

Moreover, the quantitative results suggest that most women did not know of anyone who was living or has died of HIV/AIDS. Some people in the study mentioned that they have never heard of HIV/AIDS therefore it is possible that these people might have never seen anyone who has died of HIV or even if they saw someone with AIDS they might not have known that it was HIV/AIDS. It is also possible that stigma associated with HIV/AIDS has led people to hide their status and the cause of death of the deceased, thus leading to many not knowing anyone who has AIDS or someone who has died of AIDS. However, the silence surrounding

HIV/AIDS could lead to more people being infected. The women argued that if people could speak up about their HIV positive status, many people would be aware of HIV/AIDS.

Several studies have shown that knowing someone who has died from AIDS could encourage people to change their behaviour towards people living with HIV. Thus, people who knew someone with HIV or someone who has died of HIV were less stigmatizing than people who did not know anyone (Visser et al., 2007). The results implied that a great deal has to be done in Lesotho so that every person regardless of education or place of residence should know about HIV/AIDS in order to be able to work together to fight this epidemic.

On the other hand it was apparent that there were some respondents who were not aware of drugs which prevent babies from becoming infected with HIV by their mothers. In addition, some respondents did not know about antiretrovirals that may be given to HIV positive people to prolong their lives. Access to treatment is one of the benefits of knowing one's status thus helping people to lead a normal HIV positive life (UNAIDS, 2000). However, if people do not know about this medication many will continue to die from AIDS.

The results highlighted the socio-demographic characteristics influencing utilization of VCT. The bivariate and multivariate results revealed an association between VCT and place of residence, marital status and education. However, religion and age did not show any impact on utilization of VCT. These findings are in contrast to the studies conducted in rural Tanzania (Wringe et al., 2008), in Zambia (Fylkesnes and Siziya, 2004) in Ethiopia (Admassu and Fitaw, 2006) in Zimbabwe (Sherr et al., 2007) and in South Africa (Hutchinson and Mahlalela, 2006). These studies suggested that age was significantly associated with acceptance of VCT among women. With regard to religion, in Lesotho the majority of the population are Christians and other denominations constitute a small proportion and this could be the reason why religion did not influence the decision to go for HIV testing. This is unlike in Tanzania, where it was found that Muslims had higher odds of testing than other religions (Wringe et al., 2008).

Many countries that are affected by HIV are among the poorest in the world, therefore VCT is often not available in such countries because of lack of infrastructure and trained staff (UNAIDS, 2002). There was evidence in the present study to suggest that urban residents compared to those from rural areas were more likely to go for VCT. This could be due to less

or lack of accessibility and availability of VCT services in the rural areas. Qualitative results highlighted that in the rural areas VCT services are not provided on a daily basis and moreover, there is a lack of VCT facilities and this could affect VCT uptake in the rural areas. Therefore, in order to access the services people have to walk long distances, especially in the rural areas where there is no formal transportation. This could discourage many people especially if they have not developed any signs of any disease and still look healthy. As such, it was evident that the lack of availability and accessibility of VCT services has been an obstacle in accessing VCT services. However, these findings are in contrast with findings from South Africa where people would prefer to access VCT services in other places rather than their place of residence because of fear of stigma and discriminations (Dyk, 2003).

It has also emerged from the findings of this study that education had a strong significant effect on VCT. Thus, in particular, it was found that women with higher levels of education are more likely to test than those with no education or primary level. This was in contrast to findings from rural Uganda (Matovu et al., 2005) but similar to findings from Zimbabwe (Sherr et al., 2007; Wringe et al., 2008) which observed that VCT use increases with an increase in level of education. Therefore it is very important to disseminate information on the benefits of VCT and PMTCT beyond schools, so that everyone including those without formal education could benefit.

The findings of this study suggest that women who were not married were more likely to have HIV test than those who were married. A possible explanation for these findings is that women who are not married perceive themselves to be at high risk of contracting HIV. These findings are also consistent with findings from rural Tanzania where women who were not married had the highest odds for testing than those who were married (Wringe et al., 2008). In addition, the results from the present study further showed that only about 18% of respondents who were married have ever been tested. This could be due to the fact that married women consider themselves to be at low risk of HIV infection. This is a particular concern since different studies have found that marriage is a risk factor for HIV infection (Bruce and Clark 2003; Wringe et al., 2008; Glynn et al., 2001; Gregson et al., 2002).

It was also apparent from this study that many of the women surveyed did not perceive themselves to be at risk of HIV infection. This may be due to the fact that the majority of respondents (74%) were married and may have viewed themselves as faithful partners to their spouses. Moreover, the quantitative results also showed that the odds of married woman going for VCT were less than those who were not married. This suggests that respondents who are not married regard themselves to be at a greater risk of contracting HIV than the married. Some respondents from the focus group discussion believed that they were not at risk of HIV infection because they were in a monogamous relationship with one sexual partner. However, the quantitative results revealed that majority of respondents did not believe that having only one sexual partner could prevent people from being infected with HIV/AIDS. This could be because some partners may pretend to be faithful while they have other sexual partners without their partner's knowledge. Furthermore, the results also highlighted that about almost three quarters of the women in the study are married, thus showing that a significant proportion of women emerged as disadvantageous in terms of VCT services since married women are not accessing VCT services. The qualitative results also revealed that women who were married did not perceive themselves to be at risk of contracting HIV since most mentioned that they trusted their husband.

The majority of pregnant woman have never tested in Lesotho. This is also true for other studies that showed that most people from developing countries have never tested for HIV (WHO/UNAIDS/UNICEF, 2007). Many factors contribute to this lack of testing in Lesotho, for example the focus group discussion highlighted that respondents were not familiar with VCT services as they confused VCT with antenatal counselling and testing that is provided for pregnant women. Thus, even though this method of HIV testing has the same advantages as that of VCT the problem is that it is provided for pregnant women only, therefore, the population in general cannot benefit. Moreover, stigma and discriminations associated with testing HIV positive, the fear of an HIV positive result, the unavailability and inaccessibility of VCT services have been highlighted as factors inhibiting HIV testing in Lesotho.

It is very important to make health services (including VCT) accessible to everyone. However studies have highlighted that some women attending antenatal services still lack knowledge of MTCT and VCT (UNAIDS, 2002a). In the present study even though there were some respondents who were not aware of VCT services and were willing to learn about it, it was interesting to discover that respondents believed that they could get more information about

HIV/AIDS from VCT services. This is congruent with the findings from Boswell and Bagalley (2002) who mentioned that in Uganda young people attend VCT in order to get information about HIV. This shows that people still lack information about HIV/AIDS and if VCT services are accessible and available people will be able to learn from such services.

The study on the other hand also focused attention on the unmet need for HIV testing. The results also tally with findings from other studies which showed that pregnant women are willing to go for HIV testing after they are told the benefits of knowing one's status (Addo, 2005). As such, the services should be made available and accessible to everyone. However, willingness to go for VCT is different from taking a test as people may have awareness of VCT services but may end up not going for testing because of fear of HIV positive results. This was also evident from the present study where it was revealed that about 71% of respondents who knew a place to get HIV/AIDS test have never been tested.

The qualitative results revealed a general awareness of vertical transmission of HIV. This is unlike the study conducted in Nigeria where only 27% knew about vertical transmission of HIV (Adeneye et al., 2006). The women highlighted that testing for HIV was a very important aspect especially during pregnancy, as this would prevent babies getting infected by their mothers. Other studies have shown that women often feel obliged to go for VCT during pregnancy to avoid infecting their unborn children if ever they are HIV positive (Ekanem and Gbadegesin, 2004). In addition, the respondents remarkably explained PMTCT and its advantages. All three methods of HIV transmission from mother-to-child, that is, during pregnancy, delivery and breastfeeding, were thoroughly explained. Thus, the women showed a clear knowledge and understanding of PMTCT.

The respondents also highlighted the importance of avoiding mixed feeding of bottle and breastfeeding in order to prevent babies getting infected. They also stressed the importance of mothers not giving birth at home as another way of protecting babies from being infected with HIV by their mothers. However, there were some women in the study who did not know about PMTCT of HIV. This was also in line with the study in Thailand where pregnant women did not have proper knowledge about MTCT of HIV and these women were even opting for abortion if ever found to be HIV positive during pregnancy (Hyodo et al., 2000). This shows that there is still a great deal to be done in preventing mother-to-child transmission of HIV.

A number of factors concerning behavioural change after uptake of VCT have been identified. It was obvious from the findings of this study that the women were aware of the importance of VCT in facilitating behavioural change. The women mentioned that the main objective of counselling is to ensure that people are willing to protect others from infection. Thus, if negative they should remain that way by using condoms and having only one sexual partner. These findings were confirmed by the quantitative findings where about 59% of respondents who had tested for HIV knew that people should avoid getting infected with HIV by using condoms during sexual intercourse.

On the other hand, various obstacles to accessing VCT by pregnant women have been identified. The majority of women in the study have mentioned the fear of positive results, violence associated with testing positive and stigma and discriminations as some of the factors that may prevent VCT utilization. The fear of positive results limits access to VCT among pregnant women in the study. The women allowed their fear about HIV to prevent them from accessing VCT services and knowing their HIV status. Some of the women associated HIV positive result with a life sentence. They felt that they would not cope with an HIV positive result during their pregnancy as they were very vulnerable at this time of their life. Studies have shown that the fear of positive results has been the main reason most people give for not going for VCT (Pool et al., 2001; Maman et al., 2001). In the study conducted in South Africa the majority reported that they would not go for testing because they feared prejudice and rejection by their partners while others felt that knowing their status would lead to depression, despair and early death (Dyk, 2005). In addition, some studies have shown that the uptake of interventions to reduce MTCT has been hampered by, among other things, women's fear of being tested for HIV (Gillard et al., 2002).

Interestingly, there were some women who considered themselves susceptible to HIV due to the lack of power of women to negotiate safe sexual practices, including condom use. The women pointed out that they may know that their husbands are having other sexual partners but because of lack of power due to financial dependency on men they cannot confront their husband. Furthermore, the threat of physical abuse associated with testing positive can discourage women from going for HIV testing (Maman et al., 2001; Pool et al., 2001).

Disclosure of positive results can be the hardest decision a positive woman has to take. Studies have found that most women often experience violence from their partners after disclosure of positive results (Gaillard et al., 2002). Surprisingly, some women were willing to notify their husbands about their HIV positive result. This might be a confirmation of the fact that they consider their husbands to be the most likely source of their infection. On the other hand, the women may consider their spouses their primary source of psychological and social support and, thus, the importance of informing them. However, some women were not willing to disclosure their HIV status to the community due to fear of stigma and discrimination. Similarly, studies conducted in South Africa found that respondents were not willing to disclose their positive status to their community and friends because they feared stigmatization (Roberts, 2006; Peltzer et al., 2007).

Stigma and discrimination emerged as the main factor that may deter VCT utilization. In addition to stigma and discrimination, the respondents explained that adherence to antiretrovirals may be compromised especially in situations where they have to hide their medication. Moreover, partner's and other people's attitude have been described as one of the obstacles to the adoption of formula feeding by HIV-infected mothers. The women identified formula feeding as the hardest decision to take especially in the rural areas where breastfeeding is a norm. In addition, because of stigma and discrimination people who are HIV positive may compromise the lives of their partners by refusing condom use during sexual intercourse as they may not want their partners to suspect that they are HIV positive.

According to the theory of planned behaviour, people are often influenced by the intention to perform certain behaviour and by whether others will approve or disapprove of that behaviour. As such, stigma plays an important part when people want to access VCT services. This is because even if a person might have the intention to go for VCT and also want to disclose their HIV positive results but as long as stigma still prevails it will be difficult. As such, HIV related stigma and discriminations are the emerging phenomena which hinder the ongoing efforts to reduce the incidence of HIV infections. In order to reduce and avoid HIV-related stigma and discrimination, there is a need to unravel the concept of stigma and begin openness and stop the silence around HIV.

In order to encourage more people to access VCT services concerns were raised that people should stop hiding their HIV status as this will normalize and de-stigmatize it. It was also evident that women are willing to go for VCT if HIV can be considered like any other chronic diseases such as high blood pressure or diabetes. Overwhelmingly, the results revealed a need to create greater awareness of VCT using the mass media. In addition, it was argued that VCT should be included in the school curriculum starting from primary school level. Moreover, respondents suggested routine testing for the entire population as this will break the silence surrounding AIDS and normalize it.

6.3 Recommendations

The responses have shown that women have support from their husband to undergo VCT. However, the majority of respondents still fear going for HIV testing. From the results it is suggested that counselling should explicitly address physical and emotional violence that most women experience at the hands of their partners. Couple counselling and partner involvement in MTCT prevention programs is also highly essential and therefore recommended. This is because testing women only can increase their susceptibility to violence despite careful counselling. Promoting infant health should be the responsibility of both the mother and the father hence fathers should be encouraged to test jointly with their partners. Married women should be taught the importance of protecting themselves by using condoms. As such, married women should be equipped with life skills which will give them confidence to confront their spouses and to be able to negotiate condom use during sexual intercourse.

Mobile clinics for VCT are essential especially in the rural areas where it is not easy to access services. Moreover, it is recommended that there should be home based counselling and testing of HIV so that every person can benefit. The “know your status campaign” that has been implemented by the government of Lesotho should continue and be reinforced and supported financially so that every Mosotho should know his or her HIV status, as this is inevitable. There is a need to avoid home birth practices in order to increase PMTCT. However, in order to reach those women from the rural areas who give birth at home there is a need to reinforce quality home-based maternity care by traditional birth attendants (TBA) so that even children who are born at home are protected from MTCT of HIV.

Community education and awareness campaigns on VCT, PMTCT and HIV/AIDS are essential. Such education should involve everyone, including mothers-in-law and men, who have influence over breastfeeding practices. This will reduce the burden on women to disclose the positive results to other people including the husband. Moreover, information on the benefits of VCT and PMTCT should be disseminated beyond schools, so that everyone including those without formal education could benefit.

In order to reduce the fear of positive results as well as stigma and discrimination routine HIV testing and counselling of HIV is recommended. This will help people to consider HIV/AIDS like any other chronic disease. Moreover, the availability of life-saving drugs will give people more confidence to test for HIV/AIDS as they will know that there is hope after testing positive.

The researcher further recommends a thorough investigation of VCT with a larger sample which will include both man and woman and not pregnant women only. Moreover, further research on sexual behavioural change after VCT is also recommended.

6.4 Conclusion

The study has highlighted different key factors that influence utilization of VCT among pregnant women in Lesotho. It has also established that married women are in danger of contracting HIV as marriage is no more a safe haven for HIV. Hence, it is believed that the results will act as a guideline for policy makers for both Lesotho and other countries on policies relating to VCT services among pregnant women.

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Appendix I: Focus Group Discussion Guide

Focus Group Discussion Guide

Confidential Confidential Confidential Confidential

Factors influencing utilization of VCT among pregnant women in Lesotho

Demographic characteristics

Age

Marital Status

Educational level

Place of residence

Occupation

1. Knowledge of VCT

a. What do you know about VCT
b. Have you ever received information about VCT, *(if yes where)*
c. Have you ever attended VCT services
d. If you were to get information about VCT what would you want to know? (*Note to interviewer: You may need to probe to gather the information you need).*

2. Knowledge of vertical transmission

e. What do you think pregnant women can do to know their HIV status?
f. What do you think are the causes of HIV from mother-to-child?
g. What do you think can be done to prevent mother-to-child transmission of HIV?

3. Attitudes towards VCT

h. What do you think can make pregnant women to go or not to go for HIV testing? (*Note to interviewer :probe to get all the information)*

4. Attitudes towards confidentiality, stigma and discriminations

i. What do you think about the attitudes of counsellors towards pregnant women?

j. Do you think you can trust the counsellors about your HIV results? (*Note to interviewer :probe to get more information)*
k. Do you need to seek permission from anyone before testing *(If yes who and if no why)*
l. If you were to test positive who are you willing to disclosure your results to and why?
m. How do you think your family or husband will react if you go for HIV testing?
n. How do you think your family or husband will react if you tell them you are HIV positive?

5. Risk and prevention behaviour

o. Do you think pregnant women are at risk of contracting HIV and why? (*Interviewer: please probe to get more information).*
p. Do you think VCT services can help change people's risky behaviour, and how?

5. Accessibility and Availability of VCT services

q. In your own view do you think VCT services are available and accessible?

6. Improving on VCT

r. What do you think can be done to encourage more people to test for HIV?

THANK YOU VERY MUCH FOR YOUR TIME