

**PERCEIVED KNOWLEDGE AND ATTITUDE OF WOMEN TOWARDS HUMAN
IMMUNODEFICIENCY VIRUS TESTING SERVICES IN MOPANI DISTRICT, LIMPOPO
PROVINCE**

BY

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Master of Public Health at the University of Venda**

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Declaration

I, Manganyi Tinyiko Hestine (11572873), declare that this mini-dissertation titled "**Perceived Knowledge and Attitude of women towards Human Immunodeficiency Virus Testing Services In Mopani District, Limpopo Province**" hereby submitted for the degree, Master of Public Health (MPH) at the University of Venda has not been submitted before by me at this or any other University, that it is my own work in design and in execution. All the sources that I have quoted and cited have been indicated, acknowledged and referenced

Signature: Manganyi Date: 29/07/2020

DEDICATION

The project is dedicated to my wife, Ms Ralithi Khuthadzo Claudia for being pillar of strength throughout this study. To my son, Rito Manganyi, follow the footsteps of your father.

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LIST OF ACRONYMS

AIDS:	Acquired immune deficiency syndrome
ART:	Anti-Retroviral Treatment
Azt:	Zidovudine
DoH:	Department of Health
HBM:	Health Belief Model
HCT	Human Immune Virus (HIV) counselling and testing
HIV:	Human immunodeficiency virus
HTS:	Human Immunodeficiency Virus Testing Services
MTCT:	Mother-to-child transmission of HIV
PHC:	Primary Health Care
PITC:	provider-initiated testing and counselling
PMTCT:	Prevention of mother-to-child transmission
STI:	Sexual Transmitted Infections
TB:	Tuberculosis
UNAIDS:	United Nations programme on HIV/AIDS
UNGASS:	The United Nations General Assembly Special Session
USAIDS:	United States agency for international development
UNICEF:	United Nations Children's Fund
WHO:	World Health Organization
ZDV:	zidovudine

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ABSTRACT

Background: Human Immunodeficiency Virus Testing Services has been identified as the key entry point to prevention, care, treatment and support services. It is where people learn whether they are infected, and helped to understand the implications of their HIV status, in order to make informed choices for the future.

Aim: The aim of the study was to assess Perceived Knowledge and Attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province.

Methodology: A cross-sectional quantitative descriptive study was conducted to assess the perceived knowledge and attitudes of women towards Human Immunodeficiency Virus Testing Services. The target population of this study were all pregnant women and those bringing their biological children for immunization to the local clinics within Sekgosese area in the Greater-Letaba Municipality. However, the researcher decided to stick to the original sample of 240 since the respond was positive and all questionnaire were fully completed. Data was collected using a questionnaire consisting of four sections; namely, demographic information of the respondents, perceived women's knowledge towards HIV testing services, perceived women's attitude towards HTS and perceived factors preventing women from undergoing Human Immunodeficiency Virus Testing Services in Sekgosese area. The questionnaires were constructed in English and translated into Northern Sotho by a language specialist. The questionnaire comprised of closed-ended questions and Likert scale questions. Validity and reliability were ensured. A pre-test was carried out to determine if the questions are clear and easy to understand. The data collected was analyzed using the Statistical Package for Social Sciences version 25.0. Cross-tabulations were done to analyze the relationships between variables; for instance, age and attitude of women towards Human Immunodeficiency Virus testing, marital status and attitude of women towards Human Immunodeficiency Virus by women. Data was presented in the form of graphs, tables and charts.

Results: Two Hundred and forty (240) questionnaires were distributed to respondents and they were all completed. The findings of the study indicate that the most respondents 94 (39.2%) were in the age bracket 21-30 years; 73 (30.4%) were in the age bracket 31-40; 40 (16.7%) were in the age bracket 15-20 and 33 (13.8%) were in the age bracket 41-49. The study results indicated that the attitudes of respondents about HIV testing and age have a significant association (P -value = 0.037). There was a positive relationship, as most of the respondents aged 21 to 30 years reported that women who get tested feel good/confident. The study results further indicated that the attitudes of respondents about HIV testing and level of education have significant association (P -value =0.000). The majority of the respondents who left school at secondary level reported that their loved ones would leave them if they had HIV.

Conclusions: The study revealed that majority of women in Sekgosese have good knowledge and attitude towards HTS. The study found that there is a significant association between age and the women's attitude towards HIV testing services. Furthermore, there is a significant association between marital status and HIV testing services.

Recommendations: There is therefore a need for collaboration among several stakeholders, such as the local municipality, Department of Health, Department of Social Development and Department of Basic Education. These stakeholders need to come up with strategies to encourage all community members to utilize HTS.

Key words: Attitudes, HTS, Knowledge, Perceptions, Women.

CHAPTER 1

1. INTRODUCTION AND BACKGROUND

1.1. Introduction

Human Immune Virus (HIV) counselling and testing (HCT) is now referred to as HIV testing services (HTS). The services include counselling (pre-test and post-test counselling), association to appropriate HIV prevention, treatment and care services and other clinical and support services; coordination with services to support quality guarantee and the delivery of accurate results (Department of Health, 2016).

HTS has been identified as the key entry point in the prevention, care, treatment and support services. It is where people learn whether they are infected or not and are helped to understand the implications of their HIV status and make informed choices for the future. HTS is now acknowledged as an efficacious and crucial strategy for both HIV and Acquired Immune Deficiency Syndrome (AIDS) prevention and care (Gatta & Thupayagale-Tshweneagae, 2012). HTS allow individuals to know their HIV status through pre-test and post-test counselling. Furthermore, HTS is client-initiated, as opposed to provider-initiated testing and counselling (PITC), where health care providers initiate discussion of HIV testing with clients who are seeking health care for other reasons. In addition, HTS can be provided through stand-alone clinics or offered through community-based approaches, such as mobile or home-based HIV testing. Finally, counselling for HTS may take place at the individual, couple, or group level (Gatta & Thupayagale-Tshweneagae, 2012)

HIV/AIDS is reported to be the major public health problem, as it has already claimed more than 35 million lives in 2016 and over one million people have died due to HIV-related diseases globally. At the end of 2016, there were 36.7 million people living with HIV and 1.8 million of new infections globally (WHO, 2017). Furthermore, 54% of the adults and 43% of the children who are living with HIV and are receiving Anti-Retroviral Treatment (ART). The rate of pregnant and breastfeeding women who are living with HIV is high at 76% (WHO, 2017). Nearly 12 million young people aged 15–24 years are living with HIV and AIDS globally; and more than 7000 young people become infected with HIV every day. Furthermore young people have limited access to information and services. In particular, young girls and young women are more

biologically vulnerable to HIV infection than mature women and men (Gatta & Thupayagale-Tshweneagae, 2012).

According to the World Health Organisation (WHO) (2019), Africa is the most affected region by HIV/AIDS in the world, particularly young women aged 15 to 24 years. New HIV infections for the East and Southern Africa Region were 800 000 in 2017, a 30% decrease since 2010. On the other hand, new HIV infections for West and Central Africa were 370 000, an 8% decrease since 2010. Nineteen million, six hundred people were living with HIV in the Eastern and Southern Africa Region in 2017. Among them 1,100,000 were adolescents, including 650,000 adolescent girls (WHO, 2019). Furthermore, 6.1 million people were living with HIV in the West and Central Africa Region in 2017 among them 440,000 were adolescents, with 250,000 adolescent girls. Lastly, twelve million, nine hundred thousand people in Eastern and Southern Africa were accessing treatment in 2017. This corresponds to 66% of the total estimated number of people living with HIV who have access to antiretroviral therapy, while 81% of the people living with HIV know their status and 52% of those on treatment were virally suppressed. Lastly 2.4 million people in Western and Central Africa were accessing treatment in 2017 (WHO, 2019).

In 2017, 59% of the infants (aged 0-14) living with HIV in Eastern and southern Africa were accessing antiretroviral therapy. In 2017, 26% of infants (aged 0-14) living with HIV in Western and central Africa were accessing ART (WHO, 2019). In 2017, 380 000 people died from HIV/AIDS-related illnesses in the Eastern and Southern Africa Region, corresponding to a 42% decrease since 2010. Adolescents (both genders) contributed to 22,000 among these deaths (6%). In 2017, 280 000 people died from HIV/AIDS-related illnesses in the West and Central Africa Region, corresponding to a 24% decrease since 2010. Adolescent (both genders) contributed 13,000 of these deaths (WHO, 2019)

Global action to fight HIV/AIDS has had a huge impact in the African Region. By the end of 2017, 15.3 million people living with HIV in the African Region had access to antiretroviral drugs (ARVs), representing 70% of the 21.7 million people accessing antiretrovirals (ARV) globally. WHO and the Joint United Nations Program on HIV/ AIDS (UNAIDS) have set the target of 90% for people living with HIV on ART reaching suppression of HIV by 2020 (ILO, 2019). However, the potential positive impact from the scale up of ART is under threat as a result of an increase in the prevalence of HIV drug resistance (HIVDR). As the prevalence of HIVDR in the African

Region increases, the impact on society, the economy and on health could be severe (ILO, 2019).

The global response to HIV and AIDS is at a critical juncture. Nowhere is this more evident than in the region of Sub-Saharan Africa. Of the global total of 34 million women and men living with HIV today, the vast majority of an estimated 23.5 million or 69 percent live in Sub-Saharan Africa. In addition, 92 percent of all pregnant women living with HIV and 90 percent of the world's children living with HIV live in this sub-region. Women are particularly the most affected, representing about 58 per cent of those living with HIV in the sub-region. Finally, 71% of all HV/AIDS-related deaths worldwide in 2011 were recorded in Sub-Saharan Africa (ILO, 2019).

The HIV epidemic is also having a severe impact on maternal deaths in South Africa. HIV data from antenatal clinics in South Africa suggest that the country's epidemic might be stabilizing. However, there is no evidence of major changes in HIV-related behaviour (USAIDS, 2014). The findings further reveal that every day in Africa, 1900 children acquire HIV infection from their mothers. In light of these high statistics, it is imperative for all pregnant women attending antenatal clinics to receive HTS. Uninfected women also benefit from such programmes because the programmes provide them with information to reduce the risk of acquiring HIV. For infected pregnant women, interventions can enable them to receive appropriate and timely help for their own health, as well as to reduce the risk of passing the virus on to their babies (USAIDS, 2014)

According WHO (2019), to reduce maternal transmission, high quality, appropriate information and counselling must be provided, to ensure that patients are able to make informed decisions before and after testing. Lack of adequate information and knowledge about HTS increases ignorance and promotes stereotypes about HIV/AIDS. In addition, women who acquire useful knowledge on Mother-to-Child Transmission (MTCT) are more likely to take the test. In other words, knowledge appears to be a precursor to reducing stigma. Health-related behaviour is influenced by the knowledge of the disease and necessary promoting actions to prevent or improve the condition, as well as people's beliefs, which may be positive or negative, towards the disease or health-promoting actions (USAID, 2014).

HIV risk perceptions are not stationary and can vary, depending on the context, time and knowledge of the person involved. Also, people, who are exposed to the same or a similar

situation may have different perceptions of risk at different stages. Many of the stigmas about HIV/AIDS began before people knew much about the disease (Barbra, Shillah & Ishmael, 2015). According to the United Nations, over 50 percent of men and women report discriminating against people living with HIV. These stigmas develop from misinformation and misunderstanding of the disease. Since the start of the epidemic, the media has played a role of shaping the public's perception by sharing stories, and helping people understand HIV/AIDS better. Several celebrities have also become spokespeople for HIV and AIDS (Donnenfeld, Pastuszek, Noah, Schick & Koren, 2017)

HIV/AIDS is reported to be a serious problem in South Africa, with an estimated national prevalence of 12.2 per cent in 2012. The HIV annual rate among persons aged 15 to 49 years is estimated at 1.9 per cent, and 2.3 per cent among teenagers and youth aged 15 to 24 years. The country has a generalized and growing HIV epidemic, with the highest number of people (6.4 million) living with HIV/AIDS in the world (Barbra, Shillah & Ishmael, 2015). The prevalence of HIV in South Africa remains high. This can be attributed to the rapid scale and success of the ART program. It is estimated that about three million people are on ART, making it the largest programme worldwide. HCT is now referred to as HTS, to embrace the full range of services that should be provided together with HIV testing. These services include counselling (pre-test information and post-test counselling), linkage to appropriate HIV prevention, treatment and care services as well as other clinical and support services. The South African Government has embarked on a deliberate effort to scale up HTS and strengthen its quality at all health facilities and non-health sites. With increasing availability of quality HTS and its uptake in all public health facilities in South Africa, the numbers of people taking an HIV test and becoming aware of their status has increased from 50 per cent in 2008 to 66.5 per cent in 2014. In addition, 92.3 per cent of South Africans are mindful of HTS and 66.2 per cent had actually utilized them in the past year (Department of Health, 2016)

As the HIV epidemic continues to grow, women are increasingly and excessively affected. HIV prevalence among women now exceeds half of the total prevalence in many countries particularly where the disease is prevalent. For many years interventions that focus on increasing women's access to HIV prevention, treatment and care were not prioritized (Barbra, Shillah & Ishmael, 2015). However, since the discovery of zidovudine (also known as AZT) to HIV positive women during pregnancy, the probability of mother-to-child transmission of HIV has been reduced. Prevention of mother-to-child transmission (PMTCT) programmes began to be

instituted globally and pregnant women have been a focus population for HIV testing. In addition, voluntary HIV HTS should be available and accessible to all pregnant women, in order to reduce the vertical transmission. However, currently, many pregnant women do not know their HIV status. This is because they fear getting positive results. This is because pregnant women have different perceptions on HIV /AIDS testing during pregnancy. Much has been done up to now by the South African Department of Health, in order to protect all unborn babies, including giving treatment to pregnant mothers just before birth, in order to protect the unborn child and treating the baby soon after birth; by giving the baby nevirapine. However, HIV/AIDS testing is voluntary to each individual (DOH, 2016). Never-the-less, pregnant women are encouraged to get HTS whilst they are pregnant, for the sake of their unborn baby. According to the Ministry of Health of South Africa, all pregnant women nowadays are expected to be tested, so that early measures can be taken to protect unborn babies (Barbra, Shillah & Ishmael, 2015).

There is a high demand for HIV Testing Services in South Africa. This is according to the study conducted on the challenges faced by lay counsellors in implementing HTS in the health facilities of Mopani District. The study population consisted of the health workers from the Greater-Tzaneen Municipality, Greater-Letaba Municipality and Ba-Phalaborwa. The study outcomes showed that the health workers are experiencing difficulties when implementing the HTS programme, clients who tested positive are reported to be denying their status (Ramalepe, Khoza & Maputle, 2015).

1.2. Problem statement

Despite the rapid implementation of HTS, the uptake of services for the prevention of HIV infection from mother to child remains low. The current study was initiated after the observations made by the researcher at Raphahlelo clinic, which showed that pregnant women do not want to get tested. The majority would take the test expecting the results to be negative. when the results turn out to be positive, they deny their status, while others stay at home until they are due for delivery. This leads to those refusing their status giving birth to children who are HIV positive. From December 2017 to May 2018 the Health workers at Raphahlelo Clinic referred 13 women who were pregnant and were refusing HIV Testing. The social workers provided counseling in order to convince them to undergo HIV Testing. A total of 10 accepted and three needed more time to think about going for testing. It is against this background that the researcher wanted to determine the perceived knowledge and attitude of women towards

Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province (Department of Health Mopani District, 2017).

1.3. Aim of the study

An aim is defined as a general statement and direction of a research (Gray, 2009). The aim of the study was to determine the perceived knowledge and attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province

1.4. Objectives of the study

The study was guided by the following objectives:

- 1.4.1. To assess women's perceived knowledge regarding HIV infection in Sekgosesa Area
- 1.4.2. To evaluate women's perceived attitude regarding HTS in Sekgosesa Area
- 1.4.3. To identify perceived factors preventing women from undergoing HTS in Sekgosesa Area

1.5. Significance of the study

The Department of Health may use the research results to plan and allocate appropriate measures and resources to HIV testing services to women. This may serve as a way of evaluating health promotion programme through public health education when the knowledge and attitudes of women towards HTS are known. The study might also benefit the women when their knowledge and attitude towards HTS are known and addressed, so that the majority of women utilize HTS services. The policy may be strengthened to provide better services in Primary Health Care facilities in relation to HTS. Upcoming researchers may use the study findings to compare the outcomes and propose the way forward. Finally, the uptake of HTS may increase, many lives might be saved and those who test negative will maintain their negative status.

1.6. Definition and operationalization of concepts

Knowledge:

Knowledge refers to the understanding of the topic by the women (Karunamoorthi, 2014). For the purpose of this study, knowledge refers to what women know about HTS.

Attitude

Attitude refers to feelings towards a subject and any preconceived ideas towards it (Karunamoorthi, 2014). In this study, attitude refers to the thoughts, and opinion, that women have about HTS.

HIV testing

HIV Testing refers to the process by which blood is analyzed for the presence of antibodies or antigens produced in response of HIV (NDoH, 2010). For the purpose of the current study, HIV testing refers to the tests conducted to find out if HIV is present in the body.

Women

Women refer to any female human or specifically, to mean an adult female human as contrasted with girl. (<https://en.m.wikipedia.org/wiki/women>). For the purpose of the study a woman is a female person who has received HIV testing services during pregnancy at the PHC facility.

HIV Testing Services (HTS)

HIV Testing Services (HTS) is a process by which an individual undergoes counselling to enable them to make an informed decision about being tested for HIV, assess their personal risk for HIV and develop a risk reduction strategy (USAID, 2012). In this study HTS refers to the services given to the women in order to convince them to undergo the HIV tests during pregnancy.

1.7. Outline of the dissertation

This dissertation is divided into six chapters, which are arranged as follows:

Chapter 1: Introduces the study, background of the study, problem statement, aim and objectives of the study, significance, and definition of key terms and theoretical model of the study.

Chapter 2: This chapter presents the literature review about HTS. The literature reviewed included HIV pandemic in South Africa, HIV/AIDS and women, knowledge about HTS, and perceptions about HTS.

Chapter 3: This chapter summarizes research approaches that were used in the gathering, collection, presentation and analysis of data.

Chapter 4: It outlines the study findings.

Chapter 5: This is a discussion based on the results of the study.

Chapter 6: It contains conclusions and suggested recommendations.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

This chapter presents the review of relevant literature. The researcher reviewed literature related to perceived knowledge and attitude of women towards HTS during pregnancy. The chapter includes aspects such as HIV testing services, the global HIV/AIDS epidemic, HIV/AIDS in Africa, HIV/AIDS in Sub-Saharan Africa, HIV and AIDS epidemic in South Africa, women and HIV/AIDS, Knowledge about HTS, attitude of pregnant women towards HTS, perceptions about HTS, challenges faced in implementing HTS during pregnancy, theoretical model and a summary.

2.2. HIV Testing Services (HTS)

HTS is the initiative which allows people to know their HIV status through pre-counselling and post-counselling. It is also known as the client-initiated approach, as opposed to provider-initiated testing and counselling, whereby the health care providers initiate discussion and HIV testing with patients who are seeking health for other reasons. HTS is offered at community clinics, community-based approaches such as mobile clinics or home-based HIV testing (USAIDS, 2012). Furthermore, HTS can be provided to individuals, couples or a group of people. This initiative was introduced to get people motivated, so that they could change behaviours, prevent transmission of HIV, reduce anxiety of possible infection, facilitate future disclosure of status and future planning, and improve access to HIV prevention and treatment services. The number of facilities offering HTS has increased by 35% since 2008; however, the majority of people globally are still unaware of their HIV status (USAIDS, 2012).

2.2.1. Knowledge of HTS by women

Research on the reasons shaping the acceptance of HTS amongst pregnant women attending antenatal care clinics used the unmatched case-control study design in Gurage Zone, Ethiopia. The study found that some of the respondents had not heard of HTS in general, and the main reason for non-use among those who did know about HTS included un-cooperative partners and self-trust, lack of information on HTS and lack of services or clinics nearby (Raymond & Smith, 2019). Providing HTS early during pregnancy allows pregnant women to benefit from all

the relevant prevention interventions, such as preventing the child and the pregnant women themselves and starting with ART. Pregnant women who test HIV positive will be provided with treatment and care, which will reduce or prevent the risk of HIV transmission to their infants. The package of care for pregnant women with HIV includes regular screening for Tuberculosis (TB) and Sexually Transmitted Infections (STIs), and referral and treatment, as necessary. Pregnant women testing HIV positive are linked to ART for PMTCT and HIV services. All pregnant women should retest for HIV at the time of the diagnosis of pregnancy, during every visit while pregnant, at delivery, and every three months during breastfeeding (Department of Health, 2016).

Women continue to account for an inconsistent percentage of new HIV infections among adults (aged 15 and older) in sub-Saharan Africa. This represented 59% of the 980 000 million [820 000 to 1 100 000] new adult HIV infections in 2017. In other parts of the world, men accounted for 63% of the 650 000 [590 000 to 750 000] new adult HIV infections in 2017. Globally, there were almost 90 000 more new HIV infections among men than women in 2017 (UNAIDS, 2018)

2.2.2. Factors that influence the utilisation of HTS

A study conducted in Ethiopia on factors contributing to HTS utilization among the youth found that few people did not have knowledge or about HTS and the majority reported that they had heard about HTS on mass media. The study also revealed that a significant number of people were not willing to utilize HTS services because they feared stigma and discrimination (Raymond and Smith, 2019).

2.2.3. Rationale for HTS

Gatta (2012) summarised the rationale for HTS in four points:

- ❖ HTS is an important point of entry for HIV and AIDS services including the prevention of transmission and management of HIV positive people.
- ❖ HTS allows people to know their status confidentially.
- ❖ HTS provides benefits to people who test positive as well as those who test negative.
- ❖ HTS offers a holistic approach that can address HIV in the broader context of peoples' lives.

2.2.4. The effectiveness of HTS for achieving prevention goals

The main goal of HTS is to change the conduct that puts people at risk of infection. HIV prevention has been conquered by people's behavioural involvement that seeks to impact behaviours, knowledge, attitudes, such as the awareness about condom use, sexual-health education, and teaching drug users about the dangers of sharing drug equipment (Gupta, Ogden, Parkhurst & Mahal 2008)

2.2.5. HTS goals

HTS's goals as explained by UNAIDS (2001), are as follows:

- ❖ HTS aims to prevent HIV transmission from a person who tested positive to someone who has not tested or a negative-tested person and also from HIV positive mother to the unborn child, by developing appropriate knowledge.
- ❖ Preventing HIV negative people from risks that may lead them to acquire HIV from infected people.
- ❖ Encouraging HIV positive people to take appropriate medical care, emotional care, counselling for positive living, psychosocial support and coping mechanisms.
- ❖ normalising HIV, challenging stigma, promoting awareness and supporting human rights
- ❖ Counselling for adherence to ARVs and preventive therapies, coping with adverse effects and adherence in MTCT interventions

2.3. The global HIV/AIDS epidemic

A massive human misfortune is unfolding in numerous less-developed countries because of the spread of HIV/AIDS. Of the 33.4 million HIV-infected people around the world, there are an estimated 22.5 million in sub-Saharan Africa: 6.7 million in South and Southeast Asia, 1.4 million in Latin America, and 665,000 in the United States. Globally, more than 14 million people have died of the disease, including 2.5 million last year (Gunnberg, Reid, Williams, Floyd & Nunn, 2015).

2.4. HIV/AIDS in Africa

HIV/AIDS is a major public health problem and has already caused death in many parts of Africa. Though Africa as a continent consists of about 15.2 percent of the world's population, of

the more than two thirds of the total infected worldwide, some 35 million people were Africans, of whom 15 million have already died (DOH,2016). Sub Saharan-Africa alone accounted for a projected 69 percent of all people living with HIV/AIDS and 70 percent of all AIDS deaths in 2015. The number of countries in sub Saharan Africa most affected by AIDS has raised death rates and lowered life expectancy among adults between the ages of 20 and 49 by about twenty years. Furthermore, the life expectancy in many parts of Africa is declining, largely as a result of the HIV/AIDS epidemic, with life expectancy in some countries reaching as low as thirty-four years (Raymond & Smith, 2019).

Many countries in North Africa have significantly lower prevalence rates, as their populations typically engage in fewer high risk cultural patterns that promote the virus spread in sub-Saharan Africa. Thus, Southern Africa is the worst affected region on the continent. As of 2015, HIV has infected at least 10 percent of the population in Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Eswatini, Zambia and Zimbabwe (Raymond & Smith, 2019)

2.5. HIV/AIDS in Sub Saharan Africa

Global trends in HIV infection reveal a general growth in HIV prevalence and extensive declines in HIV/AIDS-related deaths due to antiretroviral treatment. Sub-Saharan Africa is reported to be carrying an inconsistent burden of HIV, accounting for more than 70% of the worldwide burden of infection. However, success in HIV prevention in sub-Saharan Africa has the potential to impact on the global burden of HIV. Nevertheless, significant progress in scaling up (ART), sub-Saharan Africa accounted for 74% of the 1.5 million HIV/AIDS-related deaths in 2013 (Ayesha & Quarraisha , 2016).

Of the estimated 6000 new infections that occur globally every day, two out of three are reported to be in sub-Saharan Africa, with young women continuing to bear an unequal burden. Adolescent girls and young women aged 15-24 years are more vulnerable of HIV infection compared to their male peers (Ayesha & Quarraisha , 2016). Furthermore, there remains a gap in women-initiated HIV prevention, especially for women who are unable to negotiate the current HIV-prevention options of abstinence, behavior change, condoms and medical male circumcision, or early treatment initiation in their relationships. The possibility of an HIV/AIDS-

free generation cannot be realized unless the region is able to control and prevent HIV infection in young women (Ayesha & Quarraisha , 2016).

2.6. HIV and AIDS epidemic in South Africa

South Africa was reported to have the largest HIV epidemic in the world with 7.1 million people living with HIV. HIV is also high amongst the general population, at 18.9% (DoH, 2016). However, South Africa has made enormous progresses in getting more people to take HIV test for the past few years and it is now almost meeting the 90-90-90 (a concept introduced by the United Nations programme on HIV/AIDS that by 2020, 90% of those who are infected will be diagnosed, 90% of persons who are diagnosed will be on ART and 90% of those who receive ART will be virally depressed) targets, with 86% of people knowing their HIV status. The country has the largest ART programme in the world, which has undergone even more expansion in recent years with the implementation of test and treat guidelines (Ayesha & Quarraisha , 2016).

2.7. Women and HIV/AIDS

HIV usually spreads from one person to another during sex through unprotected sex with an infected person. Women are particularly vulnerable to get it during vagina sex than men. It is reported that one in four people in United States who are HIV positive are women (MedilinePlus, 2017). In addition, women living with HIV/AIDS experience some different problems from men, such as the following: difficulties such as frequent vaginal yeast infections, severe pelvic inflammatory disease and they are at risk of cervical cancer. Drug relations between some HIV/AIDS medicines and hormonal birth control and they are at risk of passing HIV to their children during pregnancy or during childbirth (MedilinePlus, 2017).

2.8. Knowledge about HTS

HTS is thus a crucial entry point to PMTCT services. WHO has recommended that all pregnant women should be given an opportunity to know their HIV status, so that they save lives of their new-borns. However, in many developing countries there are many factors preventing the uptake of HTS during pregnancy. This may be due to lack of knowledge about HTS and its benefits during pregnancy (Barbra, Shillah & Ishmael, 2015). Furthermore, there is an

association between uptake and knowledge, and high acceptance of HTS is only coming from pregnant women who are well-informed about HIV (Barbra, Shillah & Ishmael, 2015)

HIV/AIDS has become a public health problem and there has been an increased in number of awareness campaigns, in order to give information about HIV/AIDS around the continent and the world at large. The awareness varies with level of education and access to the information. However, the information is mostly passed to the public using mass media such as radio and television, as they reach many people at once. The incidence of HIV among pregnant women is a good indicator of the spread of the epidemic in the general population, as the level of HIV infection among pregnant women is similar to that in the general population of men and women aged 15 to 49 years (Addo, 2005). In 2001, the United Nations General Assembly Special Session (UNGASS) placed a clear emphasis on the effect of HIV/AIDS on maternal and child health. The final declaration of commitment from the assembly stated that the proportion of infants infected with HIV should be reduced by 20% by 2005, and by 50% by 2010. This goal was to be reached by ensuring that 80% of pregnant women who receive antenatal care have access to HTS. At the time of this survey, HIV Testing Services, PMTCT and ART were not available to antenatal attendants. There were however plans to introduce these programmes in KATH in the near future. This survey was therefore carried out to find out how many pregnant women knew about HIV/AIDS, MTCT and their attitudes to HTS (Addo, 2005).

Maternal transmission of HIV/AIDS should be reduced by providing appropriate information and proper counselling to patients, so that they can to make well and informed decisions before and after HTS. Lack of adequate information and impact knowledge about HTS makes people avoid testing, promotes stereotypes and increases stigma among people about HIV/AIDS. However, women who are well-counselled can acquire better knowledge on HTS and are more likely to take the test, thereby gaining more knowledge about HTS and reducing stigma and stereotypes. Women's decision to perform HTS is influenced by factors such as the level of knowledge they have that assist them in taking actions to prevent and improve the condition, as well as beliefs which may be positive or negative towards the disease (Dube & Nkosi, 2008).

2.9. Attitudes of pregnant women towards HTS

It is important to understand the attitudes of pregnant women towards antenatal HIV testing services. This may contribute to the success of the programme. After HTS services were

introduced many people chose not to be tested because they felt that HTS was a source of stress. The implications of a positive test result for pregnant women are therefore enormous (Adekemi, Oluyemi, Adhlakun & Abiola, 2018). Pregnant women drop out of the PMTCT programme for numerous reasons, including fear and denial of the HIV results, lack of partner support and poor quality care. In some parts of the world pregnant women did not want to be tested because they could get high blood pressure and stress and their husbands could blame them for bringing the disease into the house, and they could divorce them (Barbra, Shillah & Ishmael, 2015).

2.10. Perceptions about HTS

Although lack of knowledge prevents pregnant people from utilising HTS, the major obstacle is the reluctance to acknowledge that they are at risk. The correct and incorrect views of transmission and treatment of HIV/AIDS exist; they also document behaviours that differ with professional perspectives, such as doubting the existence of HIV, denying the dangers, the exaggerated concerns of those not at risk, failure to adopt protective behaviours, and stigmatization of victims (Adekemi, Oluyemi, Adhlakun & Abiola, 2018). Most of the people may take the HIV test but fail to return for the results due to fear. This may be not be surprising as HIV is viewed as life-threatening disease. Fear of HIV positive results is about social consequences of the illness, rejection by the loved ones, as well as discrimination and stigma attached to the disease (Obermeyer & Osborn, 2007)

There is something about HIV that has made it a more fertile terrain for apparently, irrational beliefs and behaviours. There is a mystery surrounding its origins, the uncertainty of prediction, or its association with human relationships, the point is that information about HIV is often confusing, has emotional implications, and cannot simply be reduced to its medical content (Adekemi, Oluyemi, Adhlakun & Abiola, 2018). Because of the stigma and discrimination attached to people living with HIV, people often decide not to take HTS because of fear. In Africa it was reported that two thirds of the respondents stated that they would take HTS, but the proportion of those who reported being tested was much lower, around 15% at some areas. Individuals may plan to inform partners and return for joint counselling but then change their minds (Valerie, Laramie, Stephenie, Chaudoir, I-Ching, & Michael, 2012)

The way in which stigma and discrimination is attached to HIV/AIDS prevents further infections and provide adequate care, support and treatment. If a pregnant women tests HIV positive, that increases the worries regarding the wellbeing of their unborn child and stigmatization by the health workers, family members and the community at large. Interagency Coalition on AIDS and Development reported that participation in HTS is hampered by social stigma, anger, depression and denial (UNAIDS, 2018). People may be discouraged from attending places of a perceived stigma associated with HIV activities because they may feel uncomfortable due to their HIV status. Thus, confidentiality in primary health care facilities may affect the women's acceptance of the HIV test. The majority of women therefore do not want to take the test because they are afraid of stigmatization (UNAIDS, 2018).

2.11. Perception of women on HTS during pregnancy

Perception leads to someone taking the decision to undergo or refuse to take the action, depending on the perceived risk. HIV risk perceptions are not stationary and can vary depending on the context, time and knowledge that the person has. People who are exposed to a similar situation may have different perceptions of risk at different stages of their life course (UNAIDS 2018). A person may for example, change from low perceived risk to high perceived risk or vice versa. With regards to HTS in pregnancy, a woman with low risk perceptions at one stage may advance to a high-level perceived risk as a result of information received about HTS. This means that a person may refuse HTS due to lack of information but end up accepting HTS after receiving adequate information about HTS during pregnancy (Barbra, Shillah & Ishmael, 2015). Women who might be feeling that they are infected and that there is something that they can do about it, might have high HIV/AIDS information levels and risk perceptions and opt for HIV testing. A second category of women might feel that they may be infected, but there is nothing they can do about it and they will not take the test due to lack of adequate information about HIV. The following criteria are important in assessing people's risk of perceptions: specific knowledge of transmission and prevention; for example, thinking that someone who looks healthy cannot have HIV and the ways to avoid contracting HIV (Barbra, Shillah & Ishmael, 2015)

Pregnant women who are in stable relationships or marriage believe that they are safe from contracting HIV and those who are still healthy may not associate themselves with HIV infection and they will not be ready to take an HIV test. Several studies have indicated that there is a

stigma involved in HIV testing services, which leads to a reluctance to have the test. In addition, there is a significant stigma attached to HIV infection, which contributes to women not seeking HIV testing. The stigma of HIV infection for women means rejection and exclusion by friends, partners or by their families. Also fear of stigma has discouraged pregnant women from being tested (Adekemi, Oluyemi, Adalakun & Abiola, 2018). The stigma on HIV also affects the child who is born HIV positive because his/her mother will be sick and she is responsible for her child's HIV status. It has been noted that once a woman discloses her HIV status, the public and friends tend to keep a distance as a result of stigma. Infected women are subjected to emotional trauma, gossip and finger-pointing about their HIV status. Many women thus perceived HTS as more beneficial to their unborn children than to the women themselves (Barbra, Shillah & Ishmael, 2015).

2.12. Challenges faced in implementing HTS during pregnancy

A number of challenges are being faced when implementing HTS during pregnancy. Firstly, women who accept HTS sometimes do not wait for their results, even though the results are usually available the same time or later on the same day (DoH, 2016). Furthermore, some of the women identified as HIV-positive refused antiretroviral prophylaxis. This problem appears particularly among those women who received HTS later in the pregnancy and there will be no time to cope with their HIV status. The follow up of HIV positive women is a major challenge and some women attend antenatal clinics once and then vanish without a trace. Others do not give birth in the PHC facilities and they miss antiviral prophylaxis and are therefore under modified obstetric care (Barbra, Shillah & Ishmael, 2015). This challenge is more common in rural areas and areas where women depended on spouses for transport to the facilities. The follow up of women and their babies after delivery is even more difficult. As a result, most women find it difficult to disclose their HIV status to their partners. They also report nondisclosure of the HIV status to the partner as creating serious problems in family planning. Some women may return with a second and third pregnancy after initial diagnosis of HIV, which was on the first pregnancy. In some cases, it is a great challenge to implement HTS because there are instances where one partner has started antiretroviral therapy without informing the other. Women who had not disclosed their HIV status to their partners would be more likely to get lost to follow up as they prefer not to be traced into their community (Barbra, Shillah & Ishmael, 2015).

2.13. Theoretical Model

The Health Belief Model (HBM) was used as the theoretical model of the current study. HBM is a conceptual model which is useful in labelling a person's behaviour in health promotion and disease prevention. HBM further defines the health behaviour of a person as an expression of his/her health belief (Dennill, King & Swanepoel, 1999). The Health Belief Model, according to the social psychologists helps to systematically clarify and predict preventive health behaviour, with special focus on the relationship between health behaviours, practices and utilisation of health services (Walker, 2004). This model (HBM) was developed in the 1950s, as an effort by psychologists to explain the lack of participation of in health broadcast and prevention programs, particularly for a free and appropriately located TB screening project, wherein few people took advantage of these opportunities (FHI, 2004).

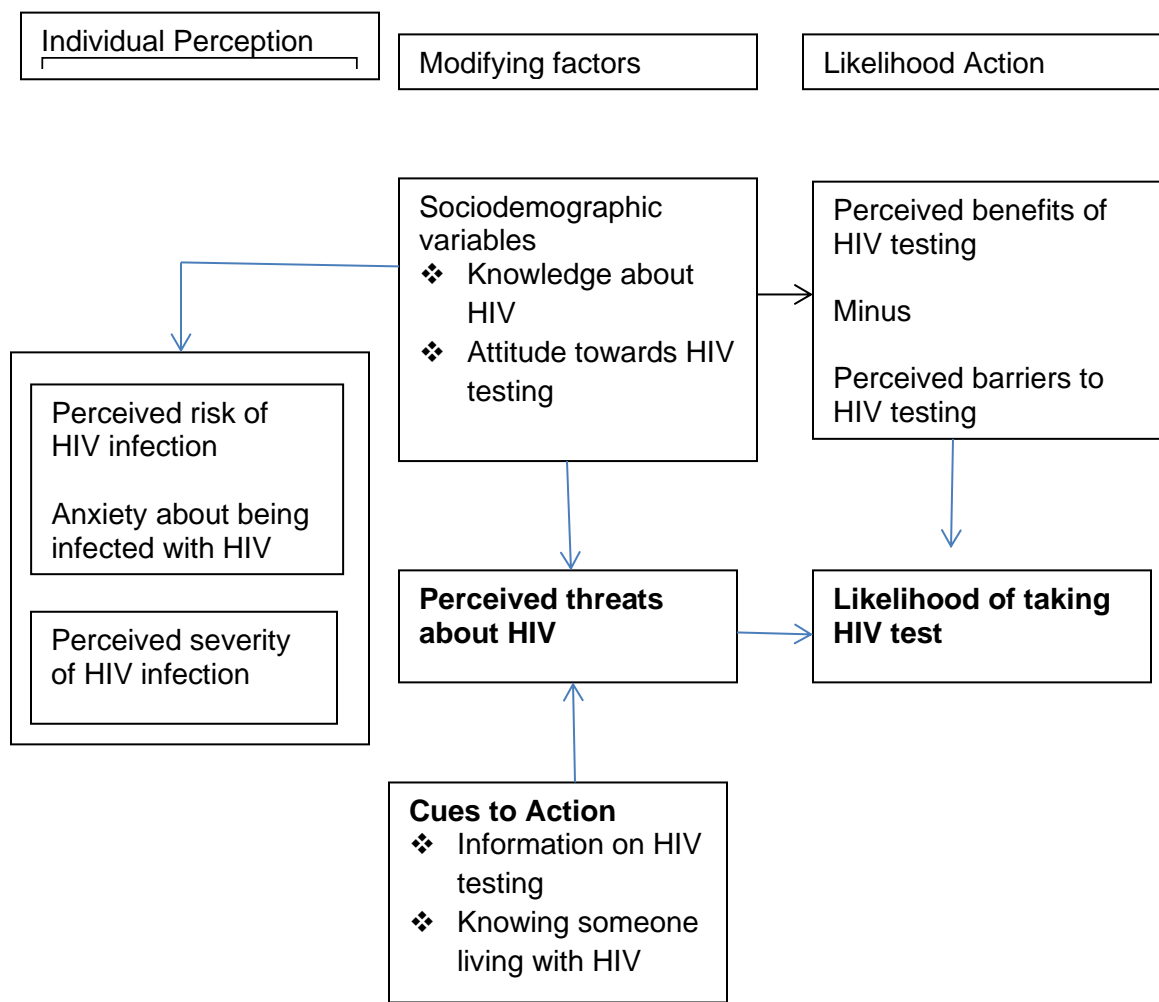


Figure 1: Health Believe Model

The three assumptions that will be applied in relation to this model are:

❖ **Perceived Susceptibility to HIV infection**

This is subjective assessment of risk of developing a health problem. The HBM predicts that people who perceive that they are vulnerable to a health problem will engage in behaviors to reduce their risk of developing the health problem. Individuals with low perceived susceptibility may deny that they are at risk for contracting a disease/illness (Champion & Skinner, 2008).

In this study women will not change their health behaviour unless they believe that they are at risk. Furthermore, they will seek HTS once they were informed of the seriousness of the disease. Also, those who does not think that they at risk of acquiring HIV from unprotected intercourse are unlikely to use condom and may also refuse to get tested.

❖ **Perceived Benefits of HIV Testing Services**

This is an individual's assessment of the value of engaging in a health-promoting behavior to decrease risk of disease. If an individual believes that a particular action will reduce vulnerability to a health problem or decrease its seriousness, then he or she is likely to engage in that behavior regardless of objective facts regarding the effectiveness of the action (Champion & Skinner, 2008).

If the women are informed about the benefits of HTS, they may take the decision to get tested so that they can protect their unborn children from getting infected.

❖ **Perceived Barriers to the uptake of HIV Testing Services**

Perceived barriers refers to an individual's assessment of the obstacles to change behavior. Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behavior. Therefore, the perceived benefits must outweigh the perceived barriers for behavior change to occur (Champion & Skinner, 2008).

Sometimes women might believe seeking HTS might be the sign of saying they have HIV and may refuse HTS because they are scared of the stigma attached to the disease.

2.14. Summary

The chapter was about the review of the literature on HIV testing Services. The chapter covered aspects such as the following: introduction, HIV testing services, the global HIV/AIDS epidemic, HIV/AIDS in Africa, HIV/AIDS in Sub-Saharan Africa, HIV and AIDS epidemic in South Africa, women and HIV/AIDS, Knowledge about HTS, attitude of pregnant women towards HTS, perceptions about HTS, challenges faced in implementing HTS during pregnancy and theoretical model.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

This chapter includes aspects such as the study design, study setting or area of study, study population and sampling, measurement instrument, pre-test of the instrument, validity and reliability, plan for data collection, data analysis and ethical considerations.

3.2. Study Design

The study used a quantitative descriptive cross-sectional design

3.2.1. Quantitative approach

Quantitative research is defined as a research that focuses on the results from the large number of people instead of focusing on the individuals (Grove, Gray & Burns, 2015). The study adopted a quantitative approach, as it provides high level of quantity as well as a high degree of reliability. A quantitative study was advantageous as it minimized the researcher's bias, as compared to a qualitative approach, where there is an interaction with the participants in the process of data collection. Therefore, describing the participants' responses in proportions, frequencies or percentages assisted to bring out the perceived knowledge and attitude of women towards HTS.

3.2.2. Descriptive study

The researcher attempted only to relate one variable to another and did not attempt to determine the cause. The researcher merely collected and analyzed data about a particular topic of interest, including knowledge and attitude. Then the researcher presented what was observed (LoBiondo-Wood & Haber, 2014). The researcher described the perceived knowledge and attitude of women towards HTS in Mopani District, Limpopo Province.

3.2.3. Cross-sectional studies

A cross-sectional study is a study that takes place at a single point and time. The researcher collected data from the study group at a single point and time rather, than at several points in

time (LoBiondo-Wood & Haber, 2014). The study is cross-sectional because it studied the perceived knowledge and attitudes of women towards HTS at the same point and time.

3.3. Study setting or area of study

The study was conducted at Sekgosese Area, which is found in the Greater-Letaba Municipality within Mopani District in Limpopo Province. Sekgosese Area has four clinics that render HIV/AIDS counselling during pregnancy namely, Mamaila Clinic, Raphahlelo clinic, Sephukhubje clinic and Pheeha clinic. Some of the people live close to the clinic while others walk for 3km to 10 km to get to the nearest clinic. The literacy level in the area is low due to the high number of school drop-out, mostly at high school level. This can have a negative effect on the knowledge about the phenomena. Sekgosese is deep rural area, with high a rate of unemployment, at 35% (Stats S.A. 2015). The population of the area is dominated by the youth, both male and female, who are at childbearing age, with few elderly people and children.

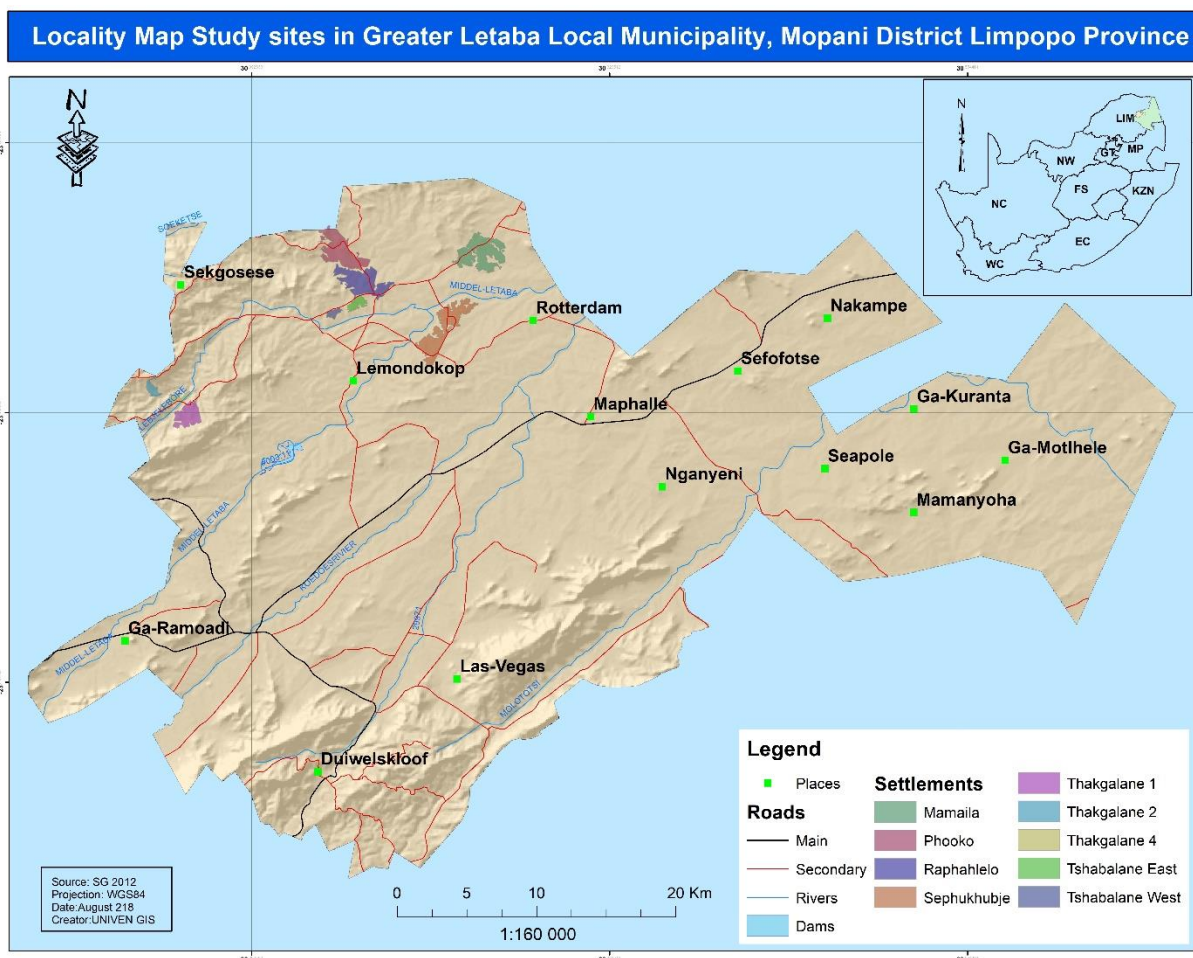


Figure 2: Study setting map (Geography Information System, 2018)

3.4. Study population and sampling

3.4.1. Population

A study population is that aggregation of element from which the sample is actually drawn/selected (Babbie, 2010). A population is the study's objects and consists of individuals, groups, organizations, human products, and events or the conditions to which they are expressed (Welman, Kruger & Michelle, 2005). The study population in this study were pregnant women and women bringing their children for immunization at the clinic at Sekgosese Area in Limpopo Province.

3.4.2. Sampling

3.4.2.1. Sample size

Slovin's (1960) formulas, as cited by Guilford and Frucher (1973), was used to calculate the sample size, where N is the total population, n is the sample size, and e is the level of error. In this study e is 0.05:

$$n = \frac{N}{1+N(e)^2}$$

$$n = \frac{599}{1 + 599 (0.05)^2}$$

$$n = 599 / (1 + 599 \times (0.05)^2)$$

$$= 599 / (1 + 1.5)$$

$$= 599 / 2.5$$

Sample size (n) = 240

The sample size was increased by 60 to make provisions for non-responses, constituting a sample size of 300.

3.4.2.2. Sampling of participants

The study used clinics at Sekgosesese area as units of sampling. There were about 599 clients in the clinics, of which 169 clients (28.21%) were in Raphahlelo clinic; 150 (25.04%) were in Mamaila clinic; 175 (29.21%) were in Sephubje Clinic, while Pheeha clinic had 105 (17.53%) clients, as shown in Table 1 below:

In this study convenient sampling was used to select clients for the study. Convenient sampling is sampling whereby any case in which any case which passes the researcher's path and has anything to do with the phenomenon is included in the sample until the desired number is obtained (Babbie, 2010).

Table 3.1: **Sampling frame and proportional distribution of sample**

Sekgosesese Clinics	Total Number of patients	Percentage	Sample
Raphahlelo Clinic	169	28.21%	68
Mamaila Clinic	150	25.04%	60
Sephubhubje Clinic	175	29.21%	70
Pheeha Clinic	105	17.53%	42
Total	599	100%	240

The study used convenient sampling method. The clinics were visited by the researcher and all participants who qualified to be on the study were requested to participate. In case of young women, permission was sought from the parents to give consent on behalf of the children. Each clinic constituted a percentage of the population, depending on the number of patients per clinic. The total number of patients in a clinic was divided by the sample size to find K value, that is $K = 599/240$. Even though the sample size was 240, the sample size was increased by 60 to provide for non-responses, constituting a sample size of 300. However the researcher decided to stick to the original sample of 240 since the respond was positive and all questionnaire were fully completed.

3.5. Measurement instrument

A questionnaire was used in this study. A questionnaire is defined as an instrument of data collection consisting of standardized series of questions relating to the research topic to be answered in writing by participants (Bless, Higson-Smith & Kagee, 2008). A questionnaire is defined as a document containing questions and other types of items designed to solicit information appropriate for analysis. Questionnaires are used primarily in survey research but also in experiments field research and other modules of observation (Babbie, 2010).

The researcher developed the questionnaire (Appendix A) focusing on the research topic and objectives, as he was interested on perceived knowledge and attitude of women towards HTS. The questionnaire consisted of four sections; namely, demographic information of the participants, perceived women's knowledge towards HIV infection in Sekgosesse Area, perceived women's attitude towards HTS in Sekgosesse Area and perceived factors preventing women from undergoing HTS in Sekgosesse Area.

The questionnaires were constructed in English and translated into the language that the participants understood well, namely Northern Sotho (Appendix A2) by language specialist. The questionnaire comprised of closed-ended and Likert-scale questions.

3.6. Pre-test of the instrument

Pre-test involves the researcher testing the instrument after designing it and having selected the sample population on the neutral population with the same characteristics as the population of the study (Bless, Higson-Smith & Kagee, 2008). A pretest entails administering the instrument to a limited number of subjects from the same population as that for which the eventual project is intended (Welman, & Mitchelle, 2005).

For the purpose of the study, the researcher did the pretest with 10 participants from Raphahlelo clinic as it was easily accessible to the researcher, the researcher administered the questionnaires to the clients. The aim was to check whether the questions were understandable or not. The participants on the pre-test did not form part of the main or final study. Furthermore, the results obtained during pre-testing were not used in the study. The results of the study were positive and some of those were used to amend the questionnaire to be more understandable to the respondents. The questions amended include the following: "why do u do HIV test" it was amended to "what are the benefits of having HIV test".

3.7. Plan for data collection

Data was collected by distributing questionnaires among participants. They were each given a chance to respond confidentially and independently in either English or the language that the participants understood namely, Northern Sotho. However, the researcher was also present to clarify and assist with completing questionnaires to those who were illiterate. The questionnaires were distributed to all pregnant women and those who were bringing their biological children for immunization in the selected clinics. Questionnaires were given to those who volunteered to participate on the study. The respondents spent between 45 to 60 minutes completing the questionnaire. The researcher ensured high response rate by handing out the questionnaires and then collecting immediately afterwards them. The participants were also provided with an envelope to put the questionnaires in and drop them in a box for the researcher to collect. Data was collected for the period of 12 days in all the clinics which were targeted.

3.8. Data analysis

Data analysis is defined as an ongoing process involving continual reflection about the data, asking analytic questions and writing memos throughout the study (Gray & Burns, 2015). Research data was analyzed using Statistical Package for the Social Sciences (SPSS) version 24.0. Descriptive and other relevant statistical tests such as the chi square test (to establish relationships or cross tabulation between two categorical variables) were performed/calculated and conclusions were drawn thereof. Cross-tabulations were done to analyze relationships between variables; for instance, age and attitude of women towards HIV testing services, marital status and attitudes of women towards HTS and level of education and attitudes of women towards HIV testing services. Results emanating from the analysis were represented in the form of tables, graphs and charts.

3.9. Validity and reliability of the study

3.9.1. Validity

Validity is the degree to which a research tool measures what it is supposed to measure or the extent to which findings correctly represent what is happening in the situation (Mohamad, Sulaimanb, Sern & Sallehd, 2015). For this study, content and face validity were established. Content validity was established by ensuring that the instrument is constructed in such a way

that it addresses the aims and objectives of the study. Face validity was also used to ensure validity by taking the research instrument to research supervisors for examination to see if it really measures what it is supposed to measure.

3.9.2. Reliability

According to Burn and Grove (2013), reliability involves the accuracy of the researcher's research methods and techniques and to what degree they may be maximised. Additionally, reliability is associated with accuracy, stability, consistency and the repeatability of the study. Test-retest method was used to measure the reliability of the measurement instrument. Reliability coefficient test was performed as a way of measuring consistency of the instrument and the degree of consistency was quantified based on the test results. The researcher administered the questionnaire (measurement instrument) twice, one week apart to some 10 people (these 10 people will not take part in the study) from the same designated area (setting).

3.10. Ethical considerations

Ethics in research refers to the responsibilities that researchers bear towards those who participate in the research, those who sponsor research and those who are potential beneficiaries of a research (Pilot & Beck, 2014). The researcher ensured that the work and practices do not cause harm to the participants. The ethics that guided the research were the following: informed consent, voluntary participation and no harm to participants (see Appendix C).

3.10.1. Permission to conduct research

The research proposal was presented at the Department of Public Health, School of Health Sciences and later to the University of Venda Higher Degrees Committee for quality assurance and approval. An application was made to the Research Ethics Committee of the University of Venda for ethical clearance to conduct the study (see Appendix C). After getting the ethical clearance from the Ethics Committee, permission was sought from the Department of Health (see Appendix D) and (Primary Health Care) PHC managers at Sekgosese Area to administer the questionnaire.

3.10.2. Voluntary participation

Voluntary participation refers to the participant's rights to freely subject themselves to the scouting inherent in research. Anyone involved in research should be willing to participate (Pilot and Beck 2014).

The researcher explained what the study is all about to the participants, so that the participants could decide on whether they would participate or not. The respondents therefore participated in the study voluntarily.

3.10.3. Confidentiality

Confidentiality means that individual identities of participants will not be linked to the information they provide and will not be divulged (LoBiondo-Wood & Harber 2014). The researcher ensured that the questionnaire did not include the personal information of the participants or anything that could link the participant with the information provided.

3.10.4. Anonymity

Anonymity is the step that researchers take to make sure that no one can link the information that participants provide with them (LoBiondo-Wood & Harber 2014). The researcher assigned a number to each questionnaire, instead of using names.

3.10.5. No harm to participants

The researcher should not use the real names of the respondents, to expose the respondents to unnecessary discomfort, deception or worse harm (Terre Blanche, Durrheim & Painter 2006).

The researcher ensured that the participants are not exposed to any physical or psychological harm. The researcher also ensured that the participants were well-protected in the proceedings of the study.

3.11. Plan for dissemination of results

The researcher will go back to the Primary Health Care PHC facilities where he conducted the study to give feedback about his findings. The researcher will first invite community

stakeholders, so that they can organise a gathering where the results will be presented and the health workers will also be there to give clarity where necessary. The findings will also be submitted to the Department of Health, so that they know where the problem lies, so that they adjust their HIV/AIDS counselling and testing.

3.12. Conclusion

In this chapter the research design and study design, study setting or area of study, study population and sampling, measurement instrument, pre-test of the instrument, validity and reliability, plan for data collection, data analysis and ethical considerations were discussed.

CHAPTER 4

PRESENTATIONS OF RESULTS

4.1. Introduction

This chapter presents the findings of the study. As described in Chapter 1, the aim of the study was to determine the perceived knowledge and attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province. The chapter is divided into four sections. These are the following: the demographic characteristics of respondents, women's perceived knowledge regarding HIV infection in Sekgosese Area and women's perceived attitude regarding HTS, perceived factors preventing women to undergo HTS in Sekgosese Area. Two hundred and forty questionnaires were distributed to respondents and they were all completed and returned; thus, the response rate was 100%.

4.2. Demographic characteristics of respondents.

Table. 4.1: Demographic information

	Frequency (n=240)	Percent (%)
Age		
15-20 years	40	16.7
21-30 years	94	39.2
31-40 years	73	30.4
41-49 years	33	13.8
Marital status		
Married	69	28.7
Single	137	57.1
Widowed	16	6.7
Divorced	18	7.5
Level of education		
Primary	17	7.1
Secondary	136	56.7
Tertiary	61	25.4
None	26	10.8

Employment status		
Employed	56	23.3
Unemployed	142	59.2
Self-employed	38	15.8
Pensioner	4	1.7
Distance between participants' house and the clinic		
Less than 3 km	112	46.7
3-5 km	72	30.0
5-10 km	31	12.9
Not sure	25	10.4
Transport fee from home to clinic		
R10	44	18.3
R20	79	32.9
None	104	43.3
R40	13	5.4

Descriptive statistical analyses were performed to obtain frequency distributions of demographic variables (see Table 2.1). Brief descriptions of each of these demographic characteristics are explained.

The findings of the study indicate that a few of the respondents, 94 (39.2%) were in the age bracket 21-30 years; 73 (30.4%) were in the age bracket 31-40; 40 (16.7) were in the age brackets 15-20 and 33 (13.8) were in the age bracket 41-49. The findings also revealed that the majority of respondents 137 (57.1%) are single and 69 (28.7%) are married. The study also revealed that the majority of respondents 136 (56.7%) left school at high school level while few 26 (10.8%) never attended school. The study further revealed that the unemployment rate is higher, with respondents who were unemployed at 142 (59.2%) and only 56 (23.3%) of the respondents were employed. The study also revealed that many of respondents 112 (46.7%) travelled less than 3 km to their nearest clinic, which is a walking distance for some, while 25 (10.4%) were not sure of the distance they travelled to the nearest clinic. Some respondents 104 (43.3%) do not pay any transport fee from their house to the clinic, 13 (5.4%) paid R40 from their homes to the clinic.

4.3. Women's perceived knowledge regarding HIV testing services

4.3.1. Knowledge about HTS

The respondents were asked whether they have heard about HIV/AIDS Testing Services (HTS) before today

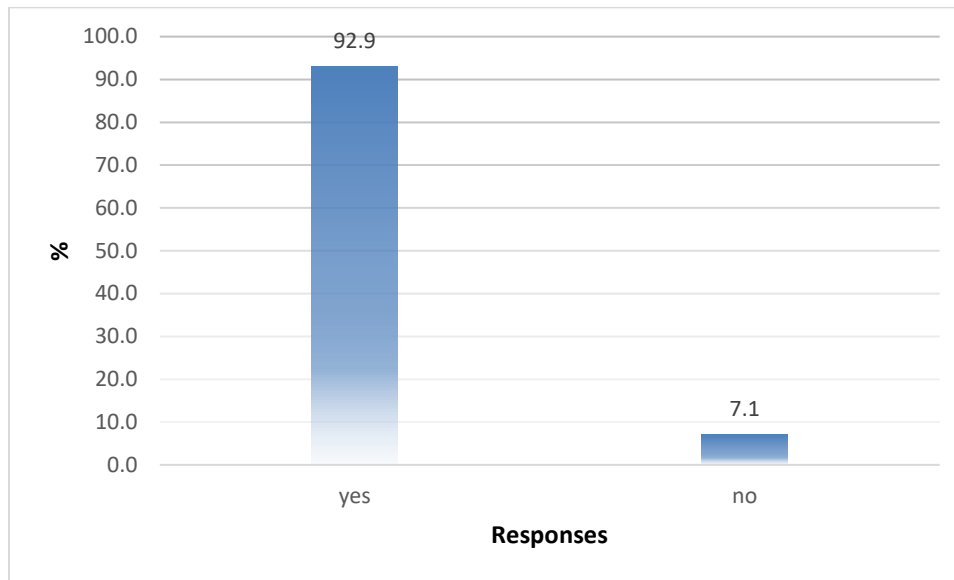


Figure 4.1: Knowledge about HTS (N=240)

The study revealed that the majority of respondents 223 (92%) have heard about HTS before the data was collected, and only 17 (7%) reported that they have never heard about HIV testing services, as shown in Figure 3.

4.3.2. Knowledge of where HTS is offered

The respondents were asked if they know where HTS is offered

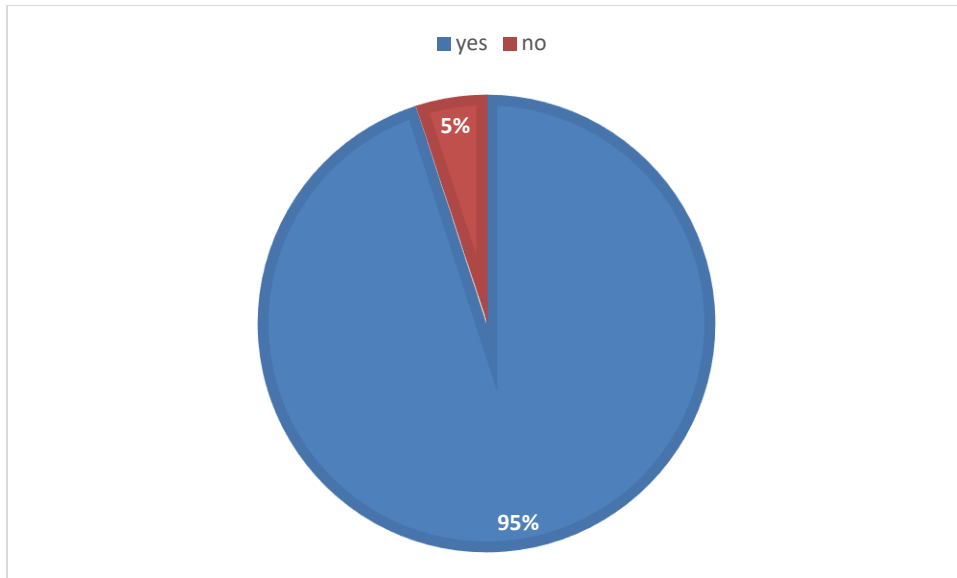


Figure 4.2. : Knowledge of where HTS is offered (N = 240)

The majority, 95% reported that they knew where HTS is offered, while 5% reported that they do not know where HTS services are offered, as shown in figure 4

4.3.3. Places where HTS is offered

Respondents were asked if they know the places where HTS is offered

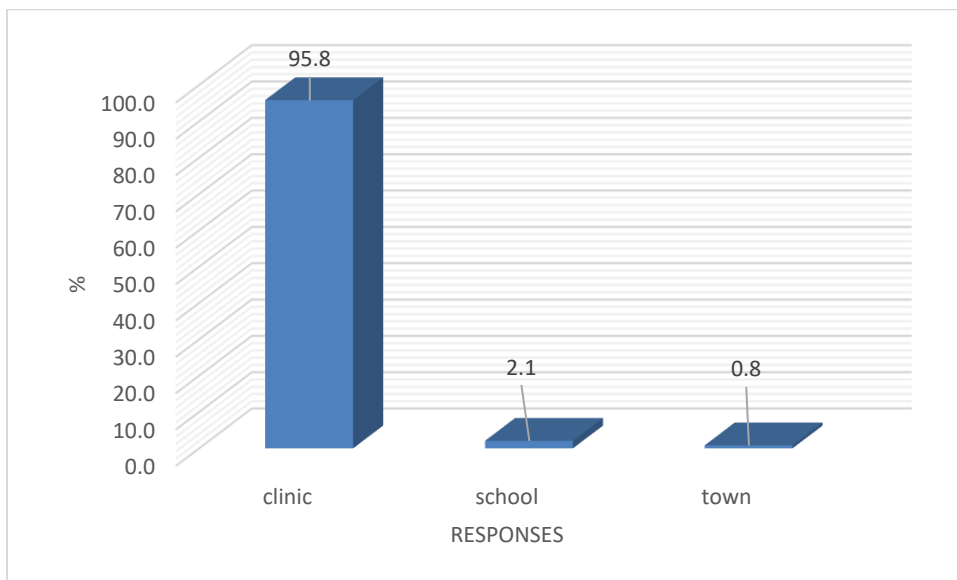


Figure 4.3: Places where HTS is offered (N=240)

In this study the majority of respondents (230 or 96%) reported that HTS is offered at clinics while 5 (2%) reported that they knew that it is offered at school, and only 3 (1%) reported that it is offered in town, as shown in Figure 5.

4.3.4. Where respondents heard about HTS

Respondents were asked where they had heard about HTS

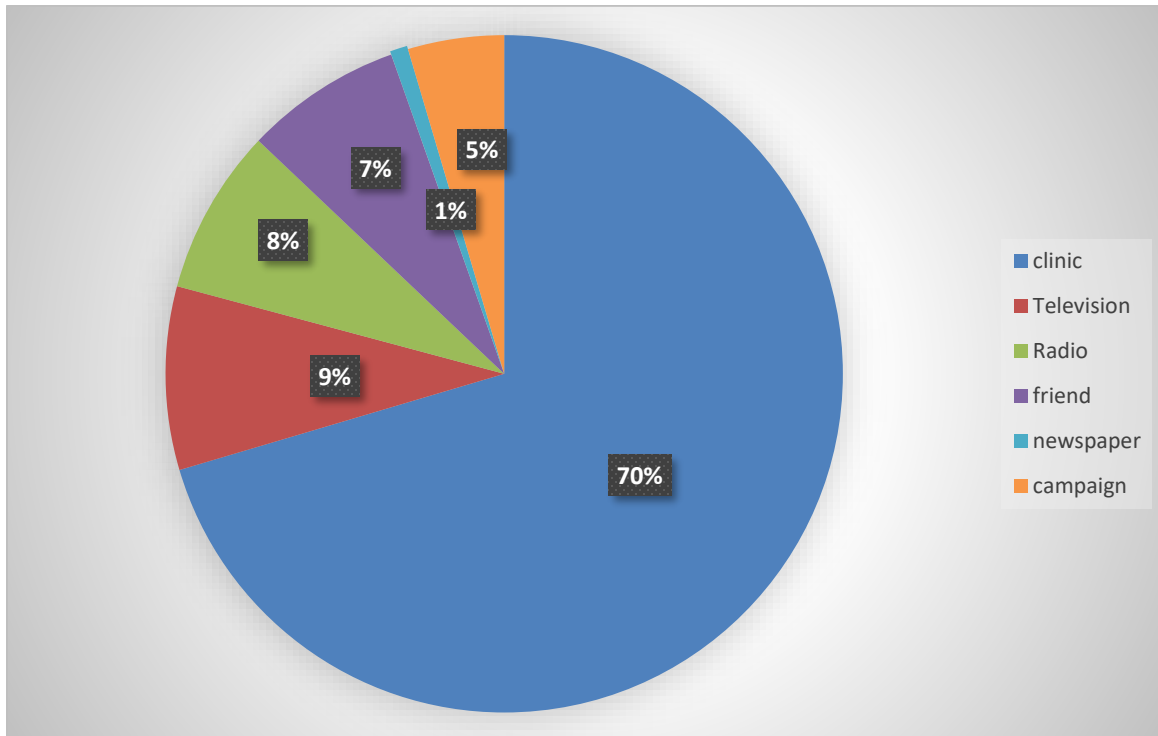


Figure 4.4: Where respondents heard about HTS (N=240)

The study revealed that the majority of respondents (169 or 70%) had heard about HTS at the clinic during their visits; 21 (9%) and 19 (8%) of the respondents indicated that they have heard about it on television and radio respectively; 18 (7%) reported that they had heard about HTS by their friends and only 2(1%) participants had heard about it from newspapers, as shown in Figure 6 above.

4.3.5. HTS is voluntary

Respondents were asked if they knew that HTS involves people to get tested voluntarily.

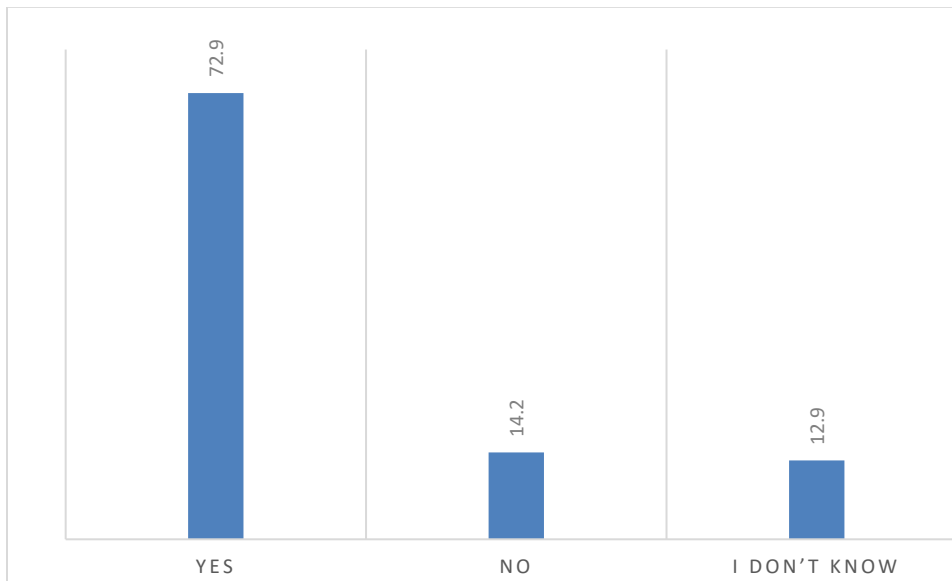


Figure 4.5: HTS is voluntarily N= 240

Out of the 240 respondents in this study, the majority (175 or 72.9%) reported that HTS involves people getting tested of their own will, while 34 (14.2%) disagreed with the question and only 31 (12.9%) reported that they do not know the answer (see Figure 7).

4.3.6. HTS prevents HIV

Respondents were asked if they knew that HTS is meant to prevent HIV

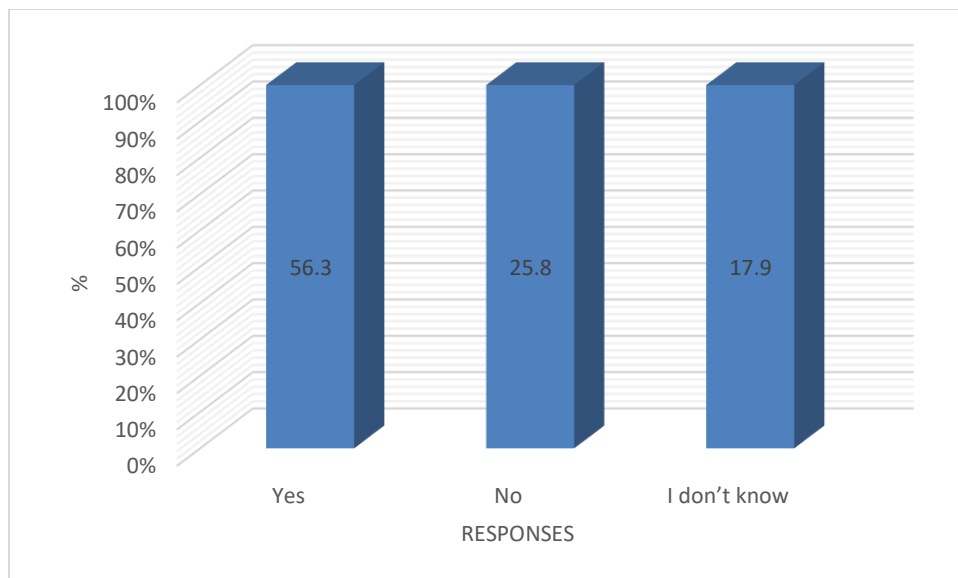


Figure 4.6: HTS prevents HIV (N= 240)

The study showed that the majority of respondents (135 or 56.3%) agreed that HTS is meant to prevent HTS, 62 (25.8%) disagreed that HTS can prevent HIV and 43 (17.9%) reported that they do not know whether HTS is meant to prevent HIV or not (see Figure 8).

4.3.7. Pre-test counselling, testing and post-test counselling

Respondents were asked if they know that HTS involves pre-test counselling, testing and post-test counselling

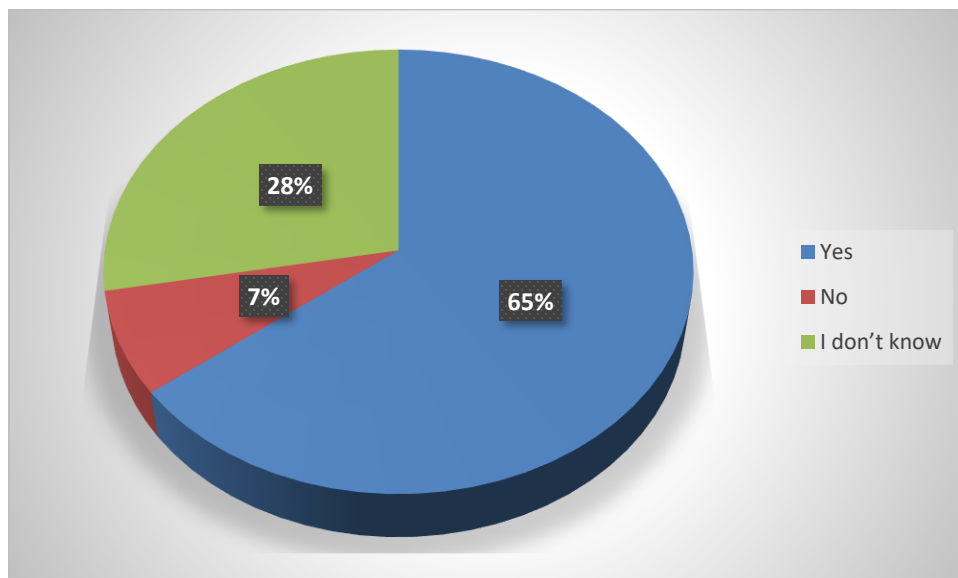


Figure 4.7: Pre-test counselling, testing and post-test counselling (N= 240)

The study revealed that 155 (65%) respondents reported that they know that HTS involves pre-test counselling, testing and post-test counselling, 18 (7.%) respondents disagreed with the question while 67 (28%) reported that they do not know that HTS involves pre-test counselling, testing and post-test counselling as shown in Figure 9.

4.3.8. HTS involves confidentiality

The respondents were asked if they know that HTS involves confidentiality

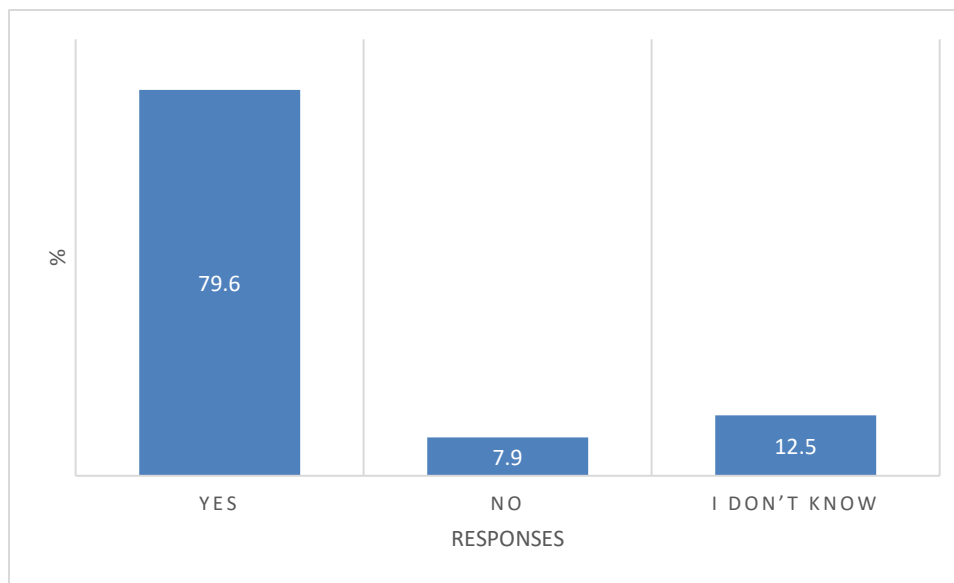


Figure 4.8: HTS involves confidentiality (N= 240)

The study revealed that the majority of respondents (191 or 79.6%) agreed that HTS involves confidentiality while 19 (7.9%) disagreed with the question and few (30 or 12.5%) reported that they do not know that whether HTS involves confidentiality or not as shown in figure 10.

4.3.9. HIV infection

The respondents were asked if they how a person get infected by the HIV virus

Table 4.2: Route of HIV infection (N= 240)

Sex	121	50.4
Body fluids	44	18.3
Blood contact	68	28.3
Mother to child	7	2.9

In this study, most of the respondents (121 or 50.4%) reported that a person can get infected by HIV virus through sex, 44 (18.3%) respondents reported that a person can be infected through body fluids, while 68 (28.3%) reported that through blood contact and few (7 or 2.9%) reported that an infected pregnant woman can transmit HIV to her unborn baby through mother-to-child transmission, as shown in Table 3.

4.3.10. Strategies for HIV prevention

The respondents were asked about the strategies of HIV prevention?

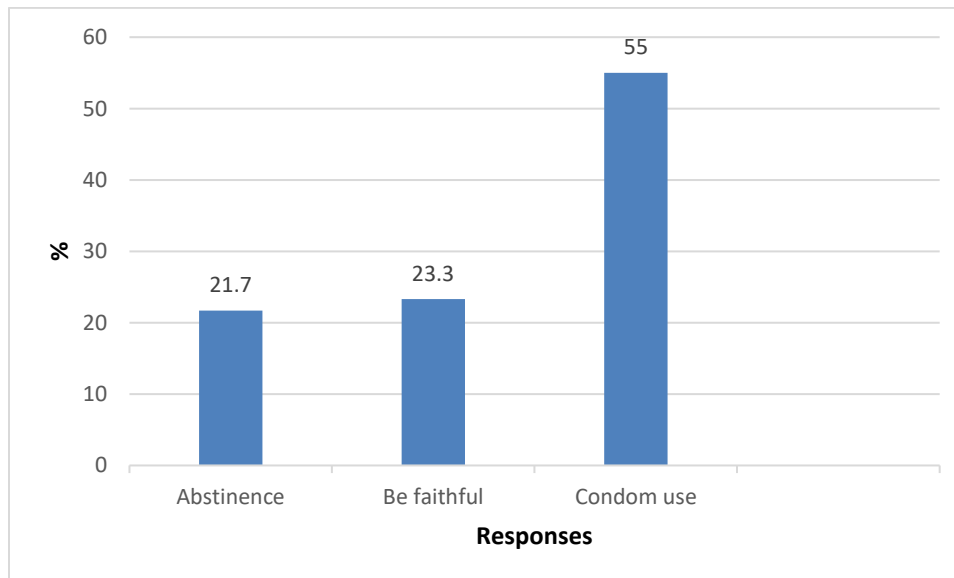


Figure 4.9: Strategies of HIV prevention (N=240)

In this study 132 (55%) selected condom use as their type of HIV prevention while 56 (23%) selected being faithful as their strategy for HIV prevention and 52 (22%) respondents indicated that abstinence is their strategy for HIV prevention, as indicated on the figure above.

4.3.11. HIV transmission to a child

The respondents were asked if they knew how an infected pregnant woman can transmit HIV to her unborn baby.

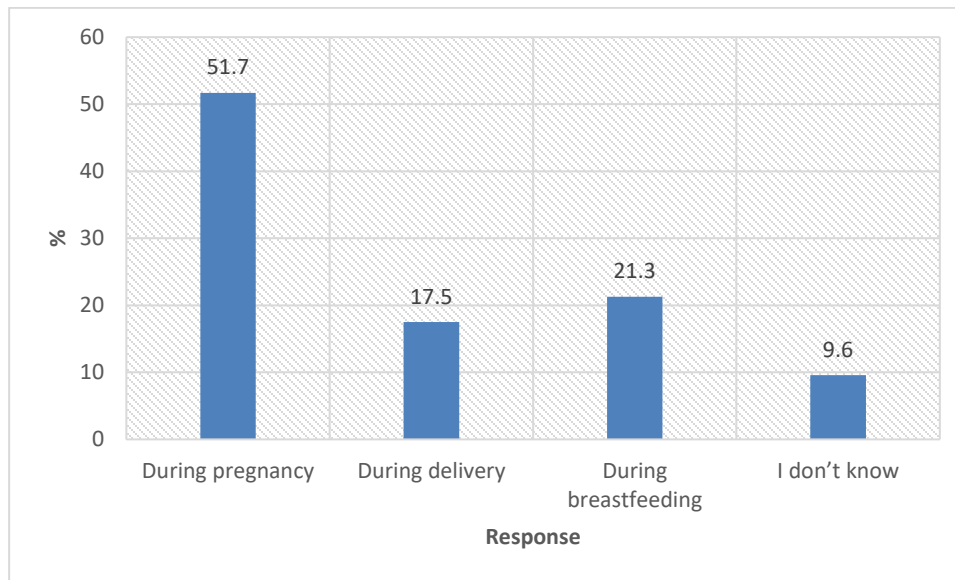


Figure 4.10: HIV transmission to a child (N=240)

In this study, the majority of respondents 124 (51.7%) indicated that a pregnant women can transmit HIV to her unborn child during pregnancy; 42 (17.5%), respondents indicated that a child could get infected during delivery; 51 (21.3%) believe that a child can be infected through or during breastfeeding, while 23 (9.6%) reported that they did not know how an infected pregnant woman can transmit HIV to her unborn baby, as shown in Figure 12.

4.3.12. Benefits of HTS

Respondents were asked if they knew the main benefits of having an HIV test.

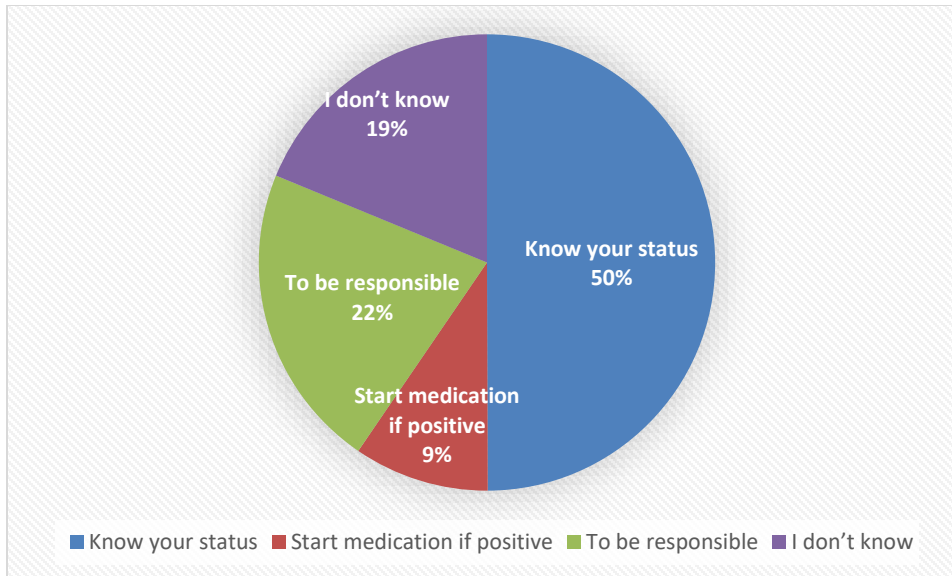


Figure 4.11: Benefits of HTS(N=240)

In this study the findings indicate that half of the respondents (120 or 50%) reported that the benefits of having HIV test is to know your status; 52 (22%) indicated that being responsible is the benefit of having an HIV test; 23 (9%) reported that if you test positive, the benefit is that a person will start medication immediately and 45 (19) reported that they did not know the benefits of having HIV test (see Figure 13).

4.3.13. Fears of having an HIV test

Respondents were asked if they knew the main course fear of having an HIV test

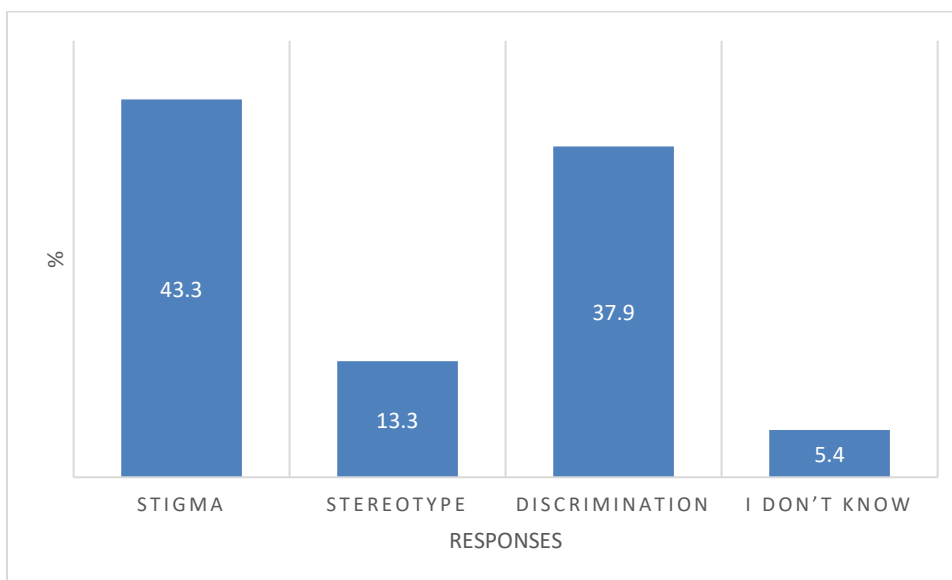


Figure 4.12: Fears of having an HIV test (N=240)

The diagram above indicates that many respondents (104 or 43%) reported that the fear of having an HIV test is caused by stigma, 91(38%) respondents reported that discrimination is the fear to have an HIV test while 32(13%) reported that the fear to undergo HIV test is stereotype and 13(6%) reported that they did not know what causes the fear of having HIV test, as shown in Figure 14.

4.3.14. HTS benefits for pregnant women

The respondents were asked if pregnant women benefit from HTS

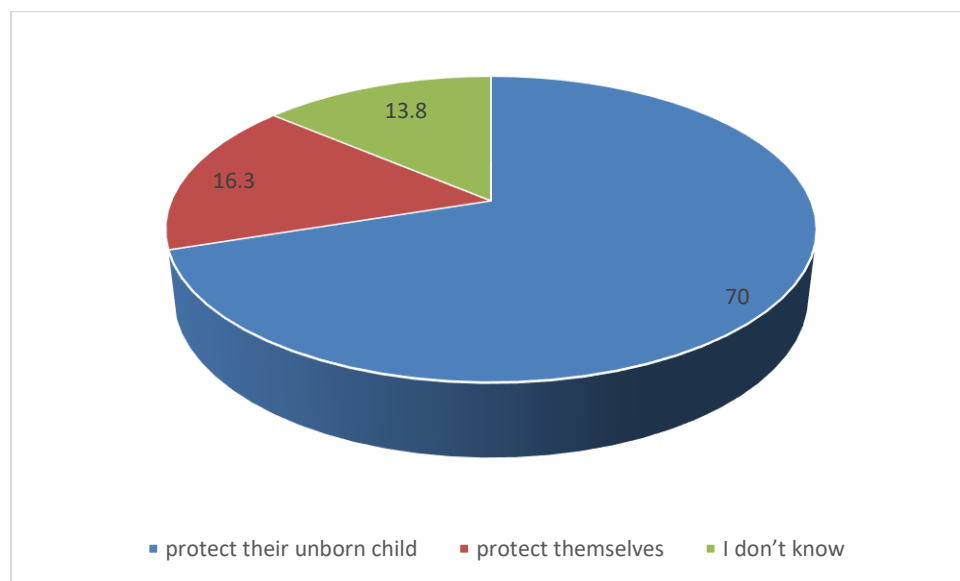


Figure 4.13: HTS benefit to pregnant women (N=240)

The study findings show that the majority of respondents (168 or 70%) reported that pregnant women protect their unborn children through HTS, 39 (16%) reported that they protect themselves and 33 (14%) reported that they do not know how pregnant women benefit from HTS (see Figure 15).

4.3.15. The benefits of HTS

The respondents were asked if they knew the benefits of HTS.

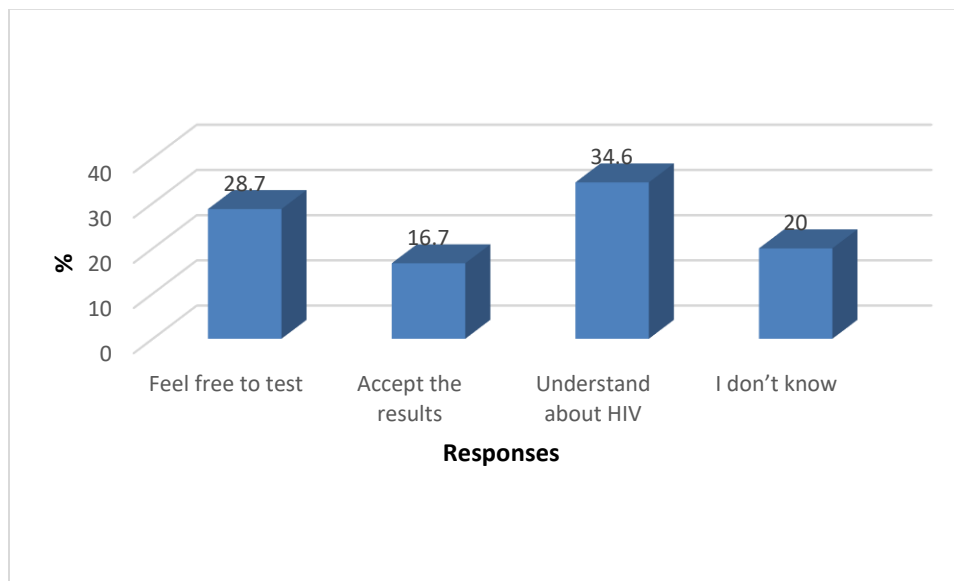


Figure 4.14: The benefits of HTS (N=240)

The study revealed that 83 (34.6) respondents reported that a better understanding about HIV is one of the benefits of HTS; 69 (28.7%) reported that feeling free to test is the benefit of HTS, 40(16.7) reported that one of the benefits of HTS is accepting the results, while 48 (20%) reported that they did not know the benefits of HTS, as shown in Figure 16.

4.4. Women's perceived attitude towards HTS

4.4.1. HIV testing feels good

The respondents were asked if they knew that women who get tested for HIV feel better

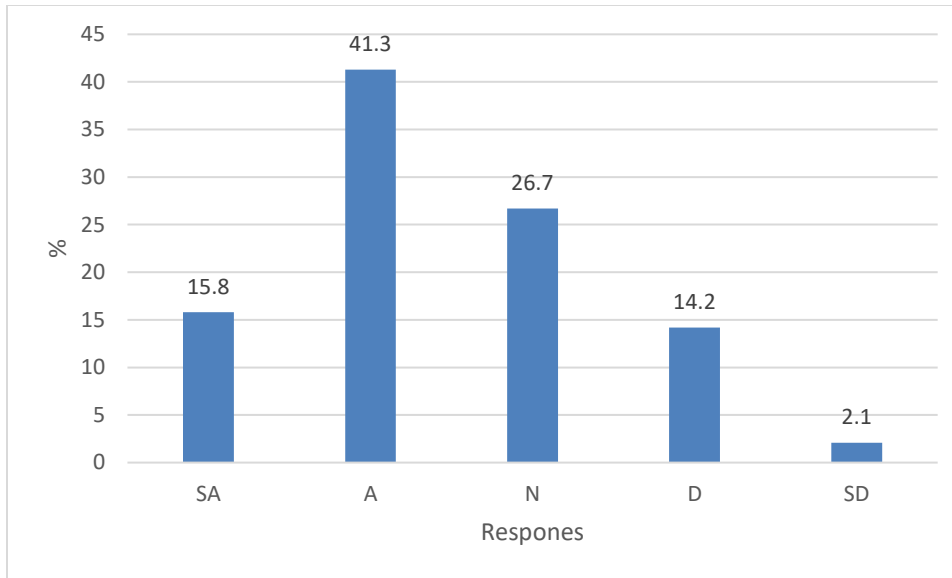


Figure 4.15: HIV testing feels good (N = 240)

The study revealed that few respondents (38 or 15.8%) and 99 (41.3%) respectively agreed that women who get tested for HIV feel good/confident; 34 (14.2%) and 5 (2.1%) respondents disagreed with the statement and only 64 (41.3%) were neutral, they did not agree nor disagree, as shown in Figure 17.

4.4.2. HTS prevent HIV

Respondents were asked if they knew that getting tested for HIV prevents women from getting HIV.

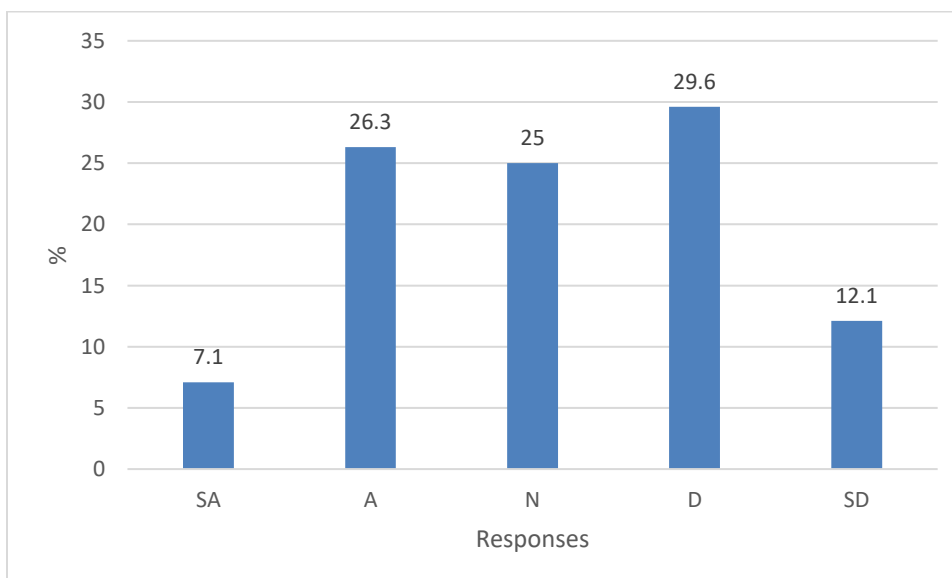


Figure 4.16: HTS prevent HIV (N=240)

Most respondents (90 or 29.6% and 12.1%) reported that they disagree with the statement that getting tested for HIV prevents women from getting HIV; 80 (7.1% and 26.3) agreed that HTS prevents HIV, 60 respondents (25%) were neutral, which means they were not sure about the statement.

4.4.3. People leave if a loved one is HIV positive

Respondents were asked if they agree that people in their life would leave them if they were HIV positive.

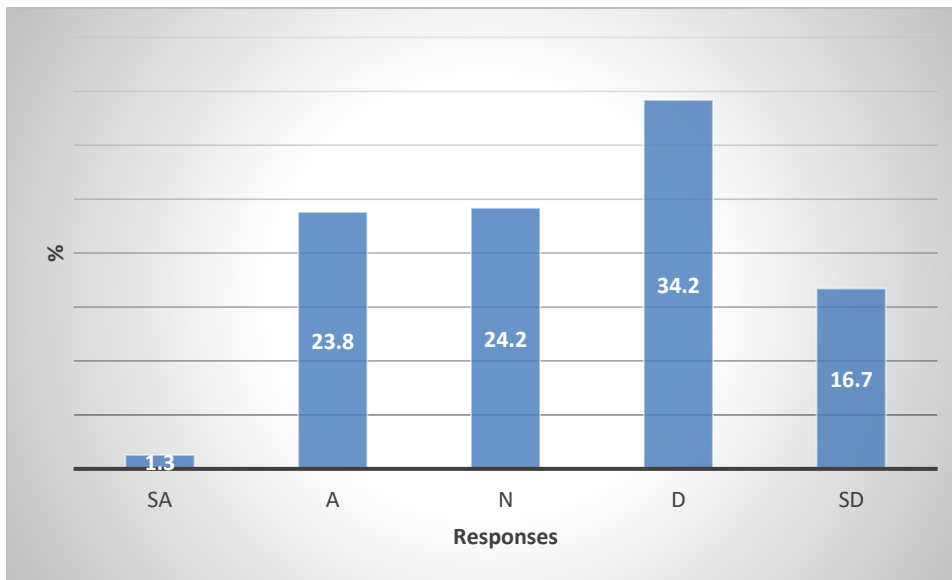


Figure 4.17: People would leave if loved one is HIV positive (N=240)

The findings showed that few respondents (3 or 1%) reported that they strongly agree that people in their life would leave them if they tested HIV positive, 57 (23.8%) also agreed that people in their life would leave them if they tested HIV positive, while 58 (24.2%) were neutral on the statement. Most of the respondents disagreed that people in their lives would leave them if they had HIV and their rate was at 82(34.2%), while 40(16.7%) strongly disagreed, as shown in Figure 19.

4.4.4. Hide HIV positive status

Respondents were asked if they agreed that women who tested HIV positive should hide it from others.

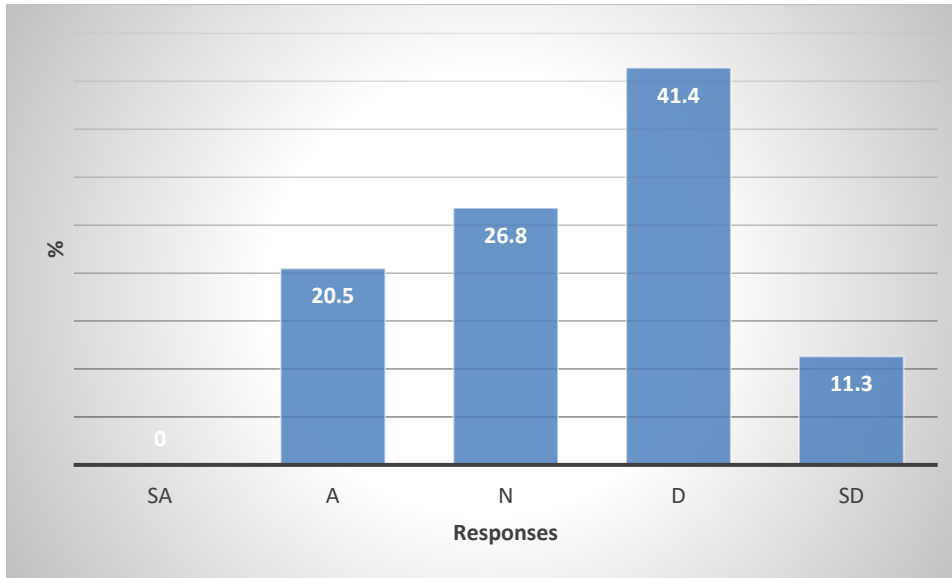


Figure 4.18: Hide HIV positive status (N=240)

The study revealed that no one strongly agreed that women who tested HIV positive should hide it from others; 49 (20.5%) agreed that they should hid from others, while 64 (26.8) respondents were neutral on this statement. Most of the respondents 99 (41.4%) and 27(11.3%) respectively disagreed with the statement and believed that women who test positive should not hide it from anyone (see Figure 20).

4.4.5. Women must not know their HIV status

Respondents were asked if they agree that women should not know if they have HIV.

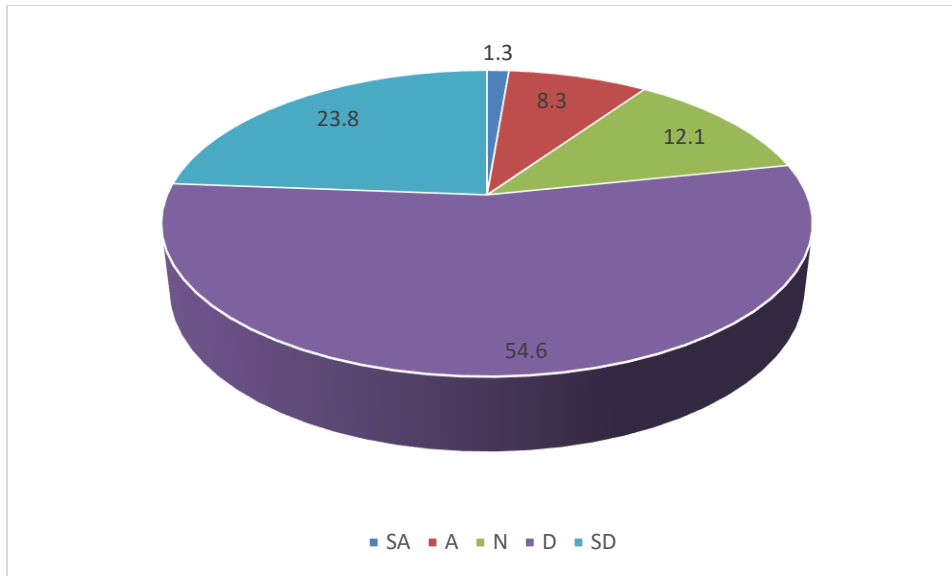


Figure 4.19: Women must not know HIV status (N=240)

The study revealed that only 3 (1.3%) of the respondents agreed that women should not know if they have HIV. 20 (8.3%) also agreed that they should not know their status; 131 (54.6%) disagreed with the statement.; 57(23.8%) strongly disagreed while 29 (12.1%) were neutral; as shown in Figure 21.

4.4.6. HIV positive women are dirty

Respondents were asked if they agreed that women who test HIV positive are dirty

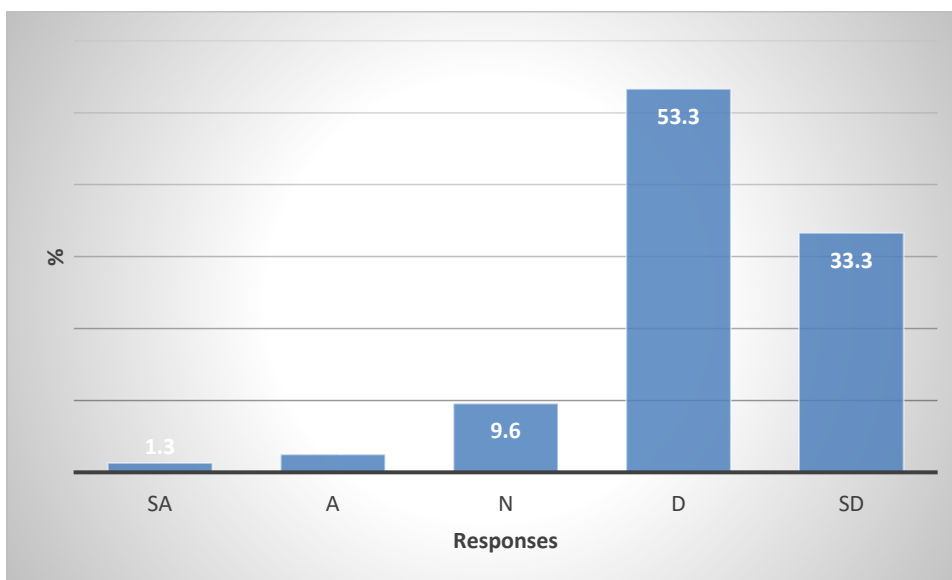


Figure 4.20: HIV positive women are dirty (N=240)

The study revealed that few respondents (3 or 1%) and 6 (2.5%) agreed that women who test HIV positive are dirty; 128 (53.3) and 80(33.3) respondents respectively disagreed that women who tested HIV positive are dirty, while 23(9.6%) respondents were neutral, as shown in Figure 22.

4.4.7. HIV positive women cannot be trusted

Respondents were asked if they agree that women who test HIV positive cannot be trusted

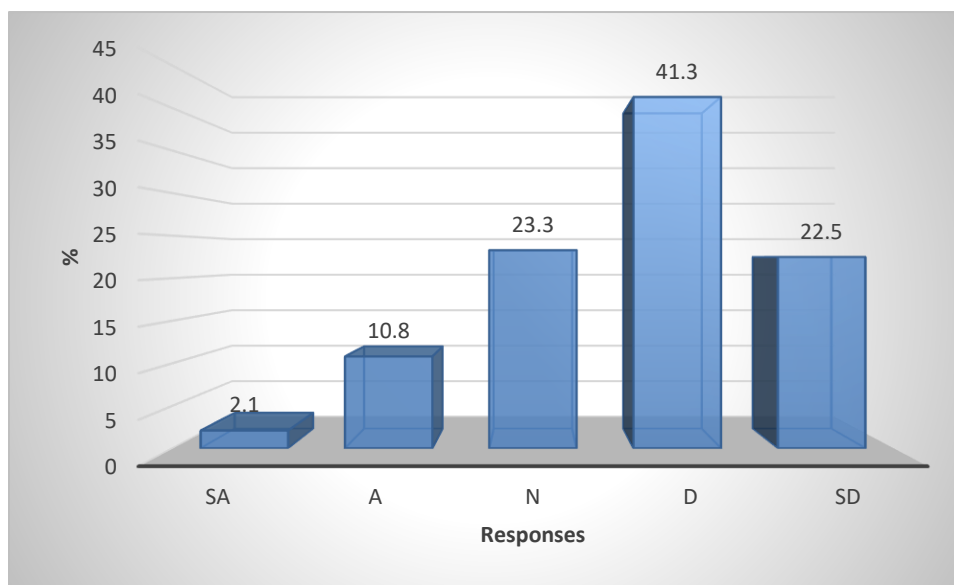


Figure 4.21: HIV positive women cannot be trusted (N=240)

The study revealed that fewer respondents agreed that women who test HIV positive cannot be trusted and 99 (41.3%) disagreed, 54 (22.5%) strongly disagreed that women who test HIV positive cannot be trusted while 54(23.3%) were neutral as shown in figure 23.

4.4.8. Women who are HIV positive should not feel guilty

Respondents were asked if they believe that women who test HIV positive have nothing to feel guilty about.

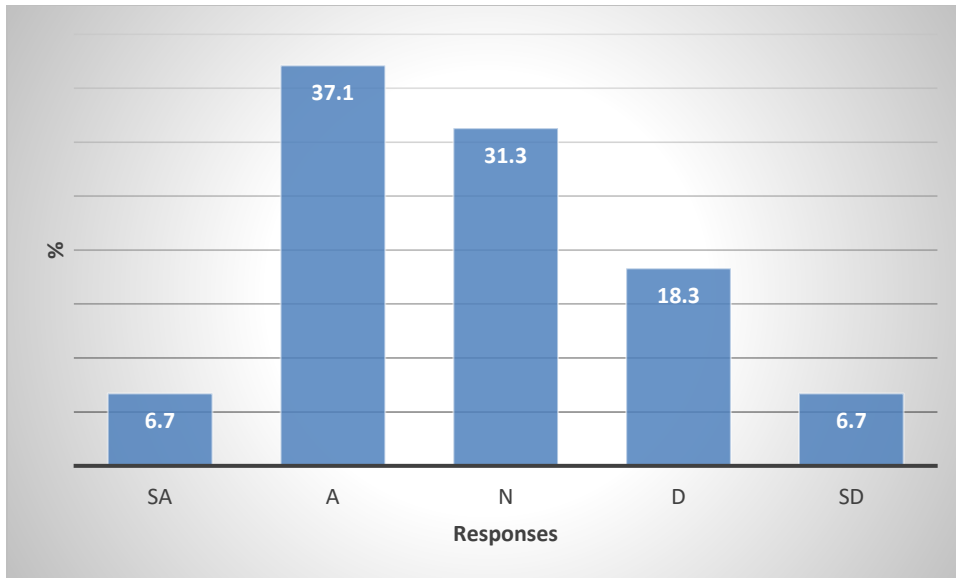


Figure 4.22: Women who are HIV positive should not guilty (N=240)

The study revealed that the majority of respondents (16 or 6.7%) strongly agreed and 89(37.1%) agreed that women who test HIV positive have nothing to feel guilty about; 44 (18.3%) and 16(6.7%) disagreed and strongly disagreed respectively that women who test HIV positive have nothing to feel guilty about, while 75 (31.3%) respondents were neutral.

4.4.9. HIV positive women are weak and foolish

Respondents were asked if they agreed that women become HIV positive by being weak or foolish.

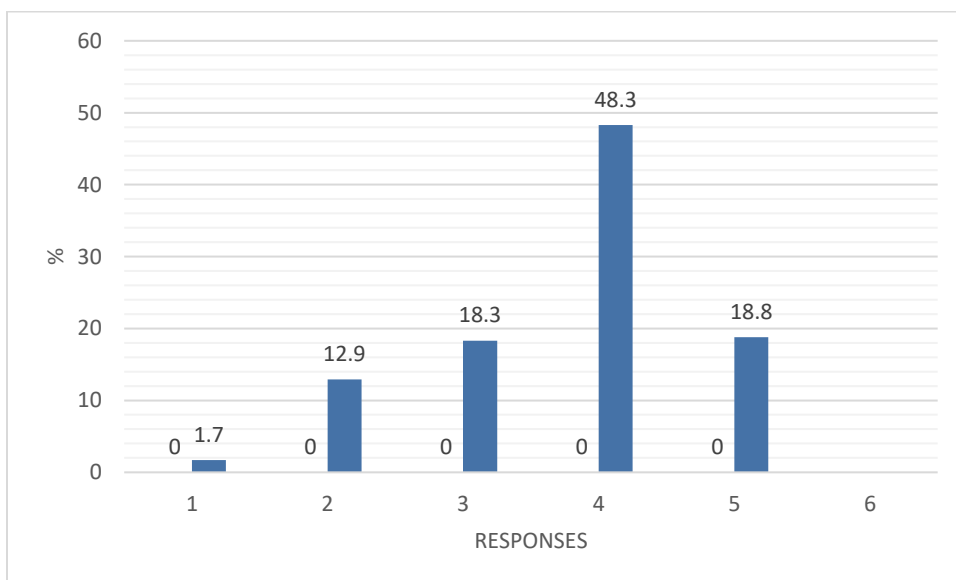


Figure 4.23: HIV positive women are weak and foolish (N=240)

The study revealed that only 4 (1.7%) and 31 (12.9) respondents respectively strongly agreed and agreed that women become HIV positive by being weak or foolish; 116 (48.3) and 45(18.8%) respondents disagreed and strongly disagreed respectively that women become HIV positive by being weak or foolish, while 44(18.3%) respondents were neutral (see Figure 25).

4.4.10. People who are HIV positive can work with children (N=240)

Respondents were asked if they agreed that it is safe for people who have HIV to work with children.

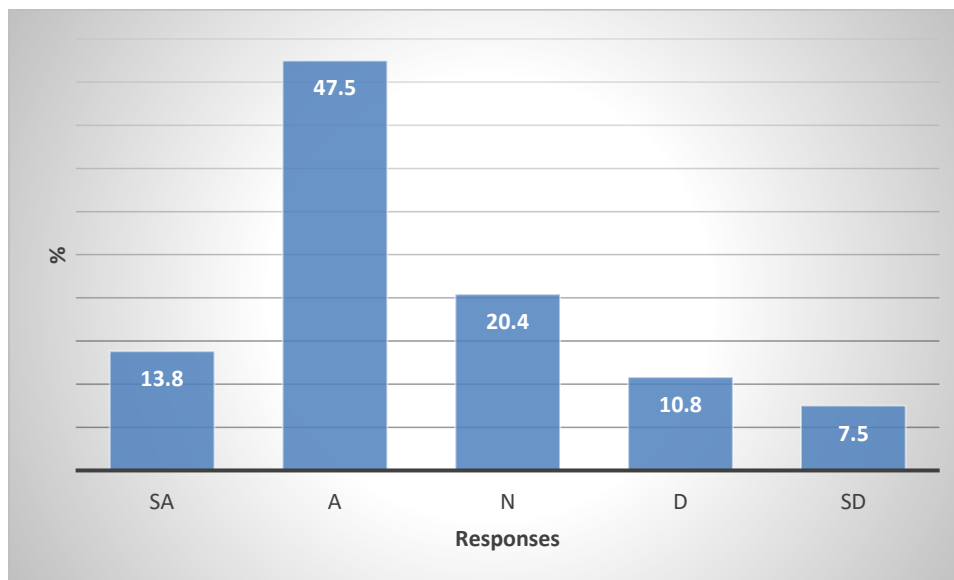


Figure 4.24: People who are HIV positive can work with children (N=240)

The study revealed that the majority of respondents 33(13.8%) and 114(47.5%) strongly agreed and agreed respectively that it is safe for people who are HIV positive to work with children. Only 26(10.8) and 8(7.5) respondents disagreed and strongly disagreed respectively that it is safe for women who are HIV positive to work with children (see Figure 26).

4.4.11. HIV positive women can give birth

Respondents were asked if that agreed that women who test HIV positive can still give birth to the healthy children.

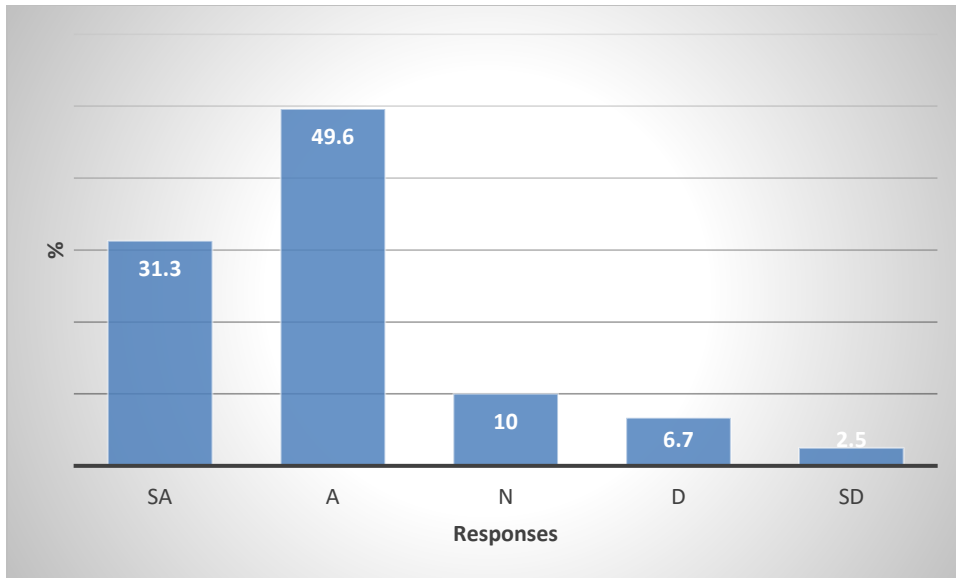


Figure 4.25: HIV positive women can give birth to healthy kids (N=240)

The study presented by the graph above revealed that the majority of respondents 75 (31.3%) and 119(49.6%) respondents strongly agreed and agreed respectively that women who test HIV positive can still give birth to healthy children. Few respondents 16(6.7) and 6(2.5) disagreed that women who test HIV positive can give birth to healthy children, while 24 (10%) respondents were neutral on this statement, as shown in Figure 27.

4.5. Perceived factors preventing women from undergoing HTS

4.5.1. Only pregnant women get tested

Respondents were asked if only pregnant women should undergo HIV testing services.

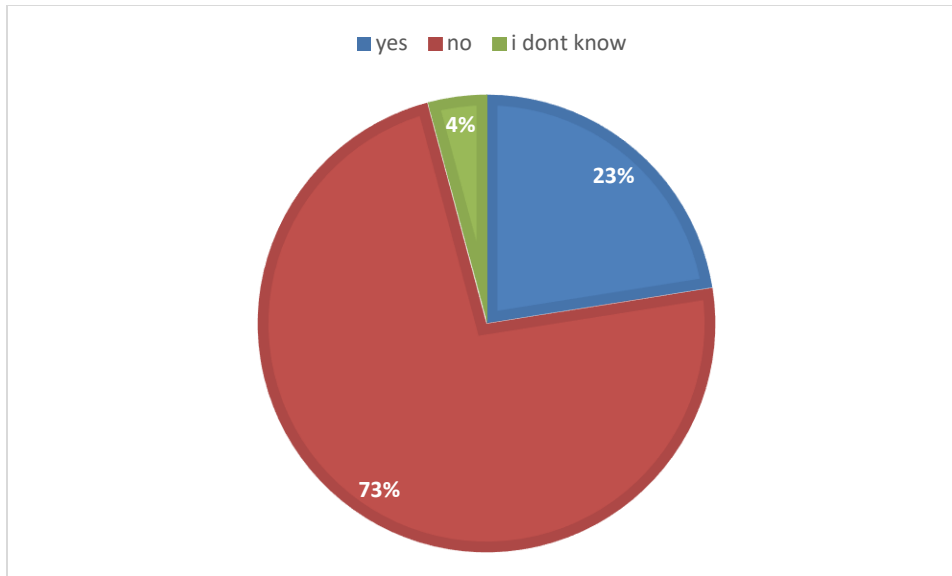


Figure 4.26: Only pregnant women should get tested (N=240).

The findings of this study revealed that majority of the respondents 176 (73%) disagreed with that only pregnant women can undergo HTS while 54 (23%) agreed that only pregnant women should undergo HTS. Only fewer respondents 10 (4%) reported that they do not know the answer as shown in figure 28.

4.5.2. Spouse's HIV status same as respondents

The respondents were asked whether a spouse negative test means the respondent are also negative.

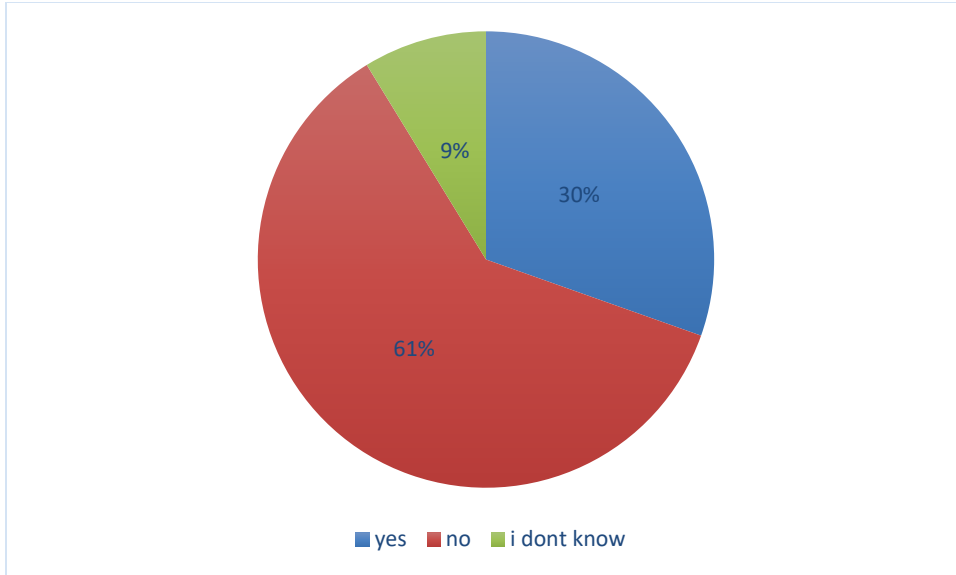


Figure 4.27: Spouse's HIV status same as respondents (N=240)

The study revealed that the majority of respondents 146 (61%) disagreed that if your spouse is HIV negative, you are also HIV negative, while 73(30%) reported that if your spouse is negative, you are also negative and 21 (9%) respondents reported that they do not know the answer, as shown in figure 29.

4.5.3. Confidentiality taken serious

Respondents were asked if they know that confidentiality is taken seriously in HTS

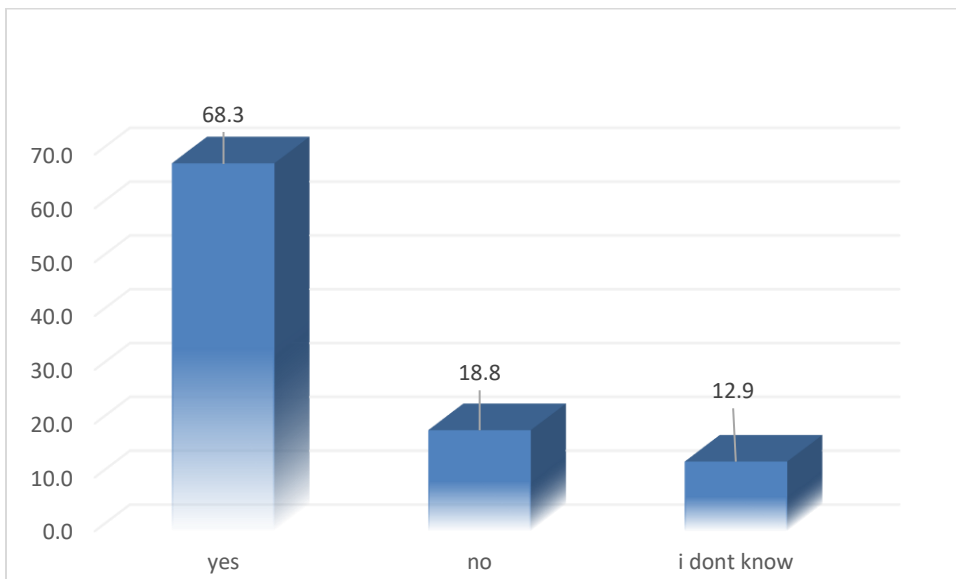


Figure 4.28: Confidentiality taken serious (N= 240)

The study revealed that the majority of respondents (164 or 68.3%) agreed that confidentiality is taken seriously in HTS few (45 or 18.8%) reported that indeed confidentiality is taken seriously in HTS and 31 (12.9%) are not sure or they did not know the answer, as shown in Figure 30.

4.5.4. Women who test positive are careless

Respondents were asked if they believe that women who test positive are not faithful and are seen as careless.

Table 4.3: Women who test positive are useless (N=240)

	Frequency	Percent
Yes	20	8.3
No	202	84.2
I don't know	18	7.5
Total	240	100.0

The majority of respondents 202 (84.2%) disagreed with the statement that said women who test positive are not faithful and are seen as careless, 20 (8.3) respondents agreed that women who test positive are not faithful and are seen as careless and 18 (7.5%) reported that they did not know the answer, as shown in Table 4.

4.5.5. HIV positive women will die shortly

Respondents were asked if they believed that women who test positive during pregnancy will die shortly.

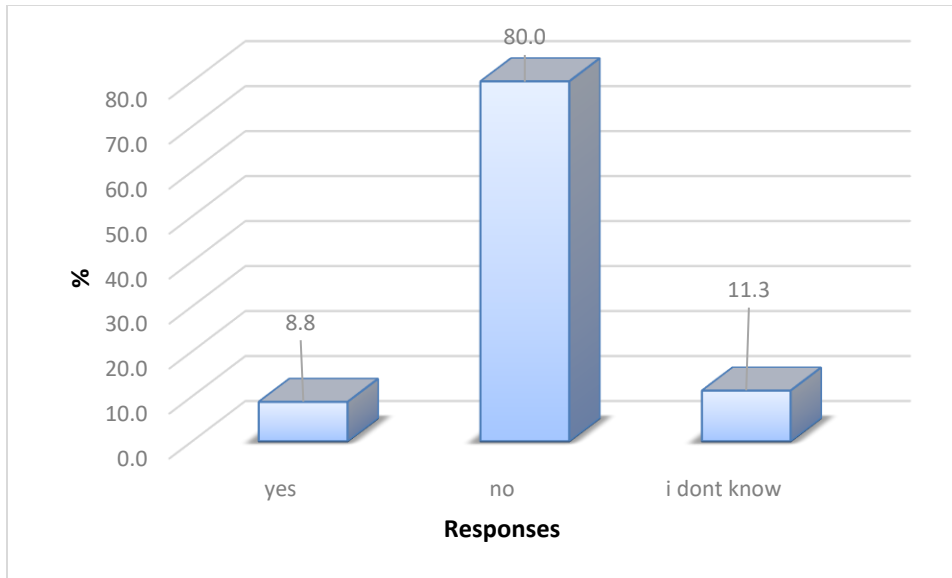


Figure 4.29: HIV positive women will die shortly (N=24)

The study revealed that the majority of respondents 192 (80%) disagreed that women who test HIV negative are going to die shortly; 21 (9%) reported that women who test HIV positive are going to die shortly and 27 (11%) reported that they did not know, as shown in Figure 31.

4.6. Association between attitude about HIV testing services and age, marital status and level of education.

The results indicated significant association between HIV testing and age (P-value = 0.037). There is a positive relationship, as most of the respondents aged 21 to 30 years reported that women who get tested feel good/confident. The study results also indicated that the attitudes of respondents about HIV testing and marital status have significant association (P-value = 0.024). There was a positive relationship, as most of the respondents who are single (57%) reported that a woman would rather not know if they have HIV. The study results further indicated that the attitudes of respondents about HIV testing and level of education have significant association (P-value = 0.000). The majority of the respondents who left school at secondary level reported that people in their life would leave them if they had HIV. The distribution of attitude about HIV testing services and age, marital status and level of education is shown on table 5.

Table 4.4: Relationship between attitudes, age, marital status and level of education

Variables				Age			P Value
		Frequency	%		Frequency	%	
Women who tested for HIV better get for feel	Strongly Agree	38	15	15-20 years	40	16.7	0.037
	Agree	99	41.3	21-30 years	94	39.2	
	Neutral	64	26.7	31-40 years	73	30.4	
	Disagree	34	14.2	41-49 years	33	13.8	
	Strong disagree	5	2.1				
Variables				Marital status			P Value
		Frequency	%		Frequency	%	
Woman should rather not know if they have HIV	Strongly Agree	3	1.3	Married	69	28.7	0.024
	Agree	20	8.3	Single	137	57.1	
	Neutral	29	12.1	Widowed	16	6.7	
	Disagree	131	54.6	Divorced	18	7.5	
	Strongly disagree	57	23.8				
Variables				Level of education			P Value
		Frequency	%		Frequency	%	
People in my life would leave me if I had HIV	Strongly Agree	3	1.3	Primary	17	7.1	0.000
	Agree	57	23.8	Secondary	136	56.7	
	Neutral	58	24.2	Tertiary	61	25.4	
	Disagree	82	34.2	None	26	10.8	
	Strong disagree	40	16.7				

4.7. Conclusion

This chapter presented, analyzed and interpreted the study results section by section. A summary of findings was also presented. The next chapter discusses the findings, and provides the conclusions, implications and recommendations based on the findings.

CHAPTER 5

DISCUSSION OF RESULTS

5.1. Introduction

The quantitative data instrument was designed based on the findings from quantitative approach and the instrument was divided into four sections; namely, demographic information of the respondents, women's perceived knowledge towards HIV infection, women's perceived attitude towards HTS, perceived factors preventing women from undergoing HTS. The aim of the study was to determine perceived knowledge and attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province. The objectives of the study were to assess women's perceived knowledge towards HIV infection, evaluate women's perceived attitude towards HTS and to identify perceived factors preventing women from undergoing HTS in Sekgosese Area.

5.2. Demographic characteristics of the respondents

Out of the 240 respondents, 136(56.7%) had reached the secondary level and only 61 (25.4%) had reached tertiary level and their ages ranged from 15 to 49 years. It is evident that the majority of respondents had some formal education. Education plays a crucial role in understanding better about HIV testing services. Educated women are more likely to seek testing pregnancy and understand that HIV can be transmitted by breastfeeding. They are also more likely to understand that mother to child transmission can be reduced by taking ARV's during pregnancy (Gem Report, 2013). Previous studies have linked the level of education of people to HCT utilization because the women might have more understanding of the benefits of such services and are more likely to respond to health-promoting messages (Olowokere, Adalakun & Komolafe, 2018). As the majority of the respondents had reached the high school level and others had managed to further their studies at tertiary institutions, it is evident that they were capable of learning more about HTS and its benefits.

The results on this study further revealed that majority of respondents (112 or 46.7%) travelled less than 3 km from their homes to the local clinics; 72(30%) travelled between 3 to 5km and 31 (12.9%) respondents traveled between 5 and 10km to reach the nearest clinic. It is clear that the majority of the respondents could easily access the clinic. The study also revealed that the majority of respondents (142 or 59.2%) were unemployed while 56(23.3%) were employed. The

study also showed that the majority of respondents (104 or 43.3%) walked to the nearest clinic and did not need a transport to reach the clinic. A study conducted by Olowokere et al (2018) on knowledge, perception, access and utilization of HIV counselling and testing among pregnant women in rural communities revealed that medical facilities that offer HTS during pregnancy are easily accessed by pregnant women in rural communities. HTS was available for free for the majority of women attending the antenatal clinic in the rural areas. Olowokere et al (2018) also indicated that in west Africa it had been reported that women were not accessing HTS despite its availability due to lack of knowledge.

5.3. Women's perceived knowledge towards HIV testing

The total number of respondents were 240 and 95% reported that they knew where HTS was offered, while only 5% reported that they did not know where HTS services were offered. Furthermore, 230 (96%) respondents reported that HTS was offered at the clinic, 5 (2%) reported that they knew it was offered at the school and only 3 (1%) reported that it is offered in town. The Department of Health (2016) on the national HIV testing services indicated that HTS can be offered in health facilities and community-based settings. The service can also be offered at mobile outreach campaigns, events, workplace testing, home-based testing, testing in educational settings and places of worship.

The Department of Health has done extremely well in impacting knowledge about HTS to the community members. This is because the majority of respondents knew where HTS is offered. The Department of Health in partnership with other department should expand HTS to institutions like schools and community activities (such as Sports tournament), where many youth are gathered.

In the current study half of the respondents (120 or 50%) reported that the benefits of having HIV test is to know your status; 52 (21.7%) respondents indicated that being responsible is another benefit of having an HIV test; 23 (9.6%) reported that if you test positive, the benefit is that a person will start medication immediately and 45 (18.8) reported that they did not know the benefits of having an HIV test. Olowokere et al (2018) on knowledge, perception, access and utilization of HIV counselling and testing among pregnant women in rural communities, indicated that HTS is of significant benefit to everyone who tests negative and to those who test positive. It reduces anxiety, promotes behavioral modification and enables early referral to care and

support, including access to antiretroviral drug therapy. HTS as a component of PMTCT in the antenatal setting is of significant importance in enabling HIV infected women to access ARV treatment, enabling women to make informed choices about future pregnancies. HTS also provides HIV infected women with the opportunity to seek early medical care for HIV related conditions, such as TB and other related diseases.

The results are not satisfactory, as it is well known that when a person gets tested for HIV, he/she will know their status. The Department of Health, in partnership with Department of Social Development, should therefore raise awareness in schools, community gatherings and churches to inform the people about the benefits, which include making an informed decision about their life, taking ARV treatment, if positive, and also maintain the negative status, if tested negative.

In the current study most of the respondents (121 or 50.4%) reported that a person can get infected by HIV virus through sex; 44 (18.3%) reported that a person can be infected through body fluids; 68 (28.3%) reported that by blood contact, while 7 (2.9%) reported that an infected pregnant woman can transmit HIV to her unborn baby through MTCT. Health Link (2019) reported that HIV infection is caused by the Human Immunodeficiency virus. A person can get HIV from contact with infected blood, semen or vaginal fluids. Most people get infected by HIV through unprotected sex with someone who is who has HIV. Another common way of getting it is by sharing drug needles with someone who is infected with HIV. The virus can also be passed from mother to her baby during pregnancy, birth or breastfeeding. HIV cannot survive outside the body. Therefore, HIV cannot be spread through casual contact, such as kissing or sharing drinking glasses with an infected person. The researcher is satisfied with the results presented by the respondents. The community should also be informed about other possible ways of HIV infection.

The researcher had expected more than 75% of respondents to report sex as their choice, as HIV is often associated with sex. The researcher feels the choices presented were limited and respondents might have had other ways that they knew of HIV transmission. The researcher would have loved to have had respondents mentioning what they knew rather than what they were provided to choose from.

This study also revealed that 132 (55%) respondents selected condom use as their strategy for HIV prevention, 56 (23%) selected being faithful as their strategy of HIV prevention, while 52 (22) respondents indicated that abstinence is their strategy for HIV prevention. Health Link (2019) reported that HIV is often spread by people who do not know they have it. Therefore it is safer and or advisable for people to protect themselves and others by practicing safe sex. Every person must use a condom every time they engage in sex until they are sure that their partners are not infected with HIV or other sexually-transmitted infections (STI). They further reported that people must have one sex partner at a time and that partner should also be faithful and do not have other sex partner. If people are not sure about their partner HIV status, the solution is to keep using condoms until they both get HTS.

More than half of the respondents reported condom use as the HIV prevention strategy. This shows that they are aware of the most recommended means of HIV prevention between people who engage into sex before they get tested and know their status.

The study further showed that the majority of respondents (135 or 56%) agreed that HTS is meant to prevent HTS, 62 (26%) disagreed that HTS can prevent HIV, while 43 (18%) reported that they do not know whether HTS is meant to prevent HIV or not. Kaler and Watkins (2011), on the manuscript titled "Asking God about the date you will die: HIV testing as a zone of uncertainty in rural Malawi", found that people who believe they have contracted the virus may also see the need for testing. This is caused by fear and the stigma attached to the virus.

Fifty-six percent of the respondents reported that HTS is meant to prevent HIV and the researcher had expected more than 80% to report that they know it is meant to prevent. HIV Health education should thus be provided within the communities and in media about the aim/purpose of HTS.

The study also revealed that 155 (65%) respondents indicated that they know that HTS involves pre-test counselling, testing and post-test counselling; 18 (8%) disagreed with the question and only 67 (28%) reported that they did not know. WHO (2019) in their article on HTS reported that HIV testing services should include the full range of services that should be provided together with HIV testing: counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment and care services, and other clinical and support

services; as well as coordination with laboratory services to support quality assurance and the delivery of correct results. However, there is still a gap in the knowledge presented by the respondents. All respondents were at some point introduced to HTS but some still did not know that it involves pre-test counselling, HIV testing and post-test counselling. The health care worker who provides HTS should thus make sure that patients seeking HTS understand what it means and involves, so that they know what they are signing.

5.4. Women's perceived attitude towards HTS

The study revealed that few respondents (3 or 1%) and 6 (2.5%) agreed that women who test HIV positive are dirty; 128 (53.3) and 80(33.3) respondents respectively disagreed that women who test HIV positive are dirty, while 23(9.6%) respondents were neutral. This study also revealed that fewer respondents agreed that women who test HIV positive cannot be trusted and 99 (41.3%) disagreed; 54 (22.5%) strongly disagreed that women who test HIV positive cannot be trusted, while 54(23.3%) respondents were neutral. The study further revealed that msome of the respondents (16 or 6.7%) strongly agreed and 89(37.1%) agreed that women who test HIV positive have nothing to feel guilty about; 44 (18.3%) and 16(6.7%) disagreed and strongly disagreed that women who test HIV positive have nothing to feel guilty about while 75 (31.3%) respondents were neutral. Kalichman and Simbayi (2013) in the article titled "HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa" reported that the HIV/AIDS stigma reflected negative beliefs about people living with HIV, such as dirty, cursed and untrustworthy. They are also stigmatized with behavior such as guilt and shame, and are also perceived as weak, and there is endorsement of social sanctions of people living with HIV such as they should not work with children thus they also experience isolation.

There are people who still believe that HIV is a death sentence and attached with stigma and stereotypes. Therefore, health education is still needed, so that people understand that HIV can infect a person in different ways and can also be managed through ARV's. Most people refuse HTS because they are scared of the stigma attached to HIV. As a result, they put their lives, together with their loved ones, in danger of being infected.

5.5. Perceived factors preventing women to undergo HTS

The study also revealed that the majority of respondents 176 (73%) disagreed that only pregnant women can undergo HTS while 54 (23%) agreed that only pregnant women should undergo HTS. Fewer respondents (10 or 4.2%) reported that they did not know the answer. UNAIDS, (2017) in the study on counselling and voluntary HIV testing for pregnant women in high HIV prevalence countries, indicated that young women and men consulting at the reproductive health services should all receive HTS about the sexual transmission of HIV and how to prevent it, as well as information about the transmission of the virus from mother to child. HTS should be provided to everyone who is in need. It should not be given only to pregnant women because they may infect their unborn children. There are people who still believe only pregnant women should undergo HTS, which is wrong: everyone should seek HTS regularly to ensure healthy living. More information about who and when people should get tested for HIV is still lacking.

The study also revealed that the majority of respondents 146(61%) reported that if the spouse is negative that does not guarantee the other partner is negative and 73(30%) reported that if the one spouse is negative then the other is also negative. Dube & Nkosi (2016) in their study on the acceptability, knowledge and perceptions of pregnant women towards HIV Testing in pregnancy, reported that 47.5% of the women believed that a person needs to practice safe sex when tested negative. The study also revealed that it is important to inform the woman that her negative results do not automatically indicate that her partner is negative. The researcher was not happy with the results as there are still women who believe they can take an HIV test for their spouses. At least 80% and reported that if the spouse is negative that does not guarantee that the other partner is also negative. This shows that most understand that every person needs to get tested for themselves.

This study also revealed that the majority of respondents (164 or 68.3%) reported that confidentiality is taken seriously on HTS; 45(18.8%) disagreed and 31(12.9%) reported that they do not know. UNAIDS, (2017) in the study on counselling and voluntary HIV testing for pregnant women in high HIV prevalence countries, reported that it is vital that clients understand that HIV test results will be entirely confidential. They must also know and believe that they have control over disclosure of their test results to themselves, to other health staff, or to their spouses, families or friends. The results will not be revealed to anyone else, including other healthcare

providers without the client's permission. Some of the respondents did not know that they have the right to get tested or not. However, the health care workers who provide HTS should initiate and show the patients the importance of testing and the benefits thereof.

The study further revealed that the majority of respondents (192 or 80%) disagreed that women who test HIV negative will die shortly, 21 (9%) reported that women who test HIV positive will die and 27(11%) reported that they did not know. Kaler & Watkins (2016) in the manuscript titled "Asking God about the date you will die: HIV testing as a zone of uncertainty in rural Malawi", reported that reluctance to test is connected to the perception that testing certainly leads to a positive diagnosis and also leads to death. This fear is in turn linked to overestimation of the transmissibility of HIV. Health practitioners who administer HTS have been addressing this concern that being tested does not mean having a death sentence pronounced. They also stress the benefits of HTS. Some of the respondents are still living with the stigma attached to HIV, hence they are scared of getting tested. They still believe that being HIV positive simply means that a person will die shortly, and that is incorrect.

5.6. Conclusion

The study was about perceived knowledge and attitude of woman towards HIV testing services in Mopani District, Limpopo Province. The researcher was interested in finding out the respondents' knowledge and attitude towards HTS. The study revealed that the majority of respondents have adequate knowledge and their attitude towards HTS is satisfactory.

Chapter 6:

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1. Introduction

This chapter presents the summary, conclusions and recommendations based on the study findings. This is based on the study findings that was presented and discussed in the previous chapter.

6.2. Summary of the study

The aim of the study was to determine perceived knowledge and attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province. A self-administered questionnaire was formulated in line with the study objectives, to collect data. The data was captured on Microsoft Excel spread sheet and transferred to Statistics Programme for Social Sciences. Recommendations have been drafted in line with the study objectives. The study reviewed previous studies with a view to establish academic gap which the present study sought to bridge. This was done through the literature review.

The first objective of the study was to assess the women's perceived knowledge of HIV testing services in Sekgosese Area. The study findings revealed that the majority of respondents are knowledgeable about HTS and they also know where it is offered. The study also revealed that the majority of respondents know that HTS involves pre-test counselling, HIV testing and post-test counselling, and that it involves confidentiality. The study further revealed that the majority of respondents know how a pregnant woman can transmit HIV to her unborn baby and the prevention thereof. The study also revealed that the majority of respondents know the benefits of having HIV test and the fears that women have towards HIV testing services.

The second objective of the study was to evaluate women's perceived attitude towards HTS in Sekgosese Area. The study findings revealed that the majority of respondents have adequate attitude towards HIV testing services. The majority of respondents reported that women who get tested for HIV feel good/confident; some reported that they disagreed that people in their lives

would leave them if they had HIV, and others disagreed that women should rather not know if they had HIV.

One of the objectives of the study was to identify the perceived factors preventing women from undergoing HTS in Sekgosese Area. The study findings revealed that the majority of respondents reported that everyone can undergo HTS, not only pregnant women. Other respondents revealed that it is not always the case that if your spouse test negative, then you are also negative. The study further revealed that the majority of respondents reported that confidentiality is taken seriously during HTS in a health facility. Finally the study revealed that respondents disagreed that women who test HIV positive will die shortly.

6.3. Limitations of the study

The study was limited to women in Sekgosese Area, in the Greater-Letaba Municipality in Mopani District within Limpopo province, South Africa. This is a deep rural area, where people are living in modern houses. Most of the houses are given to the people by the government, especially old people, unemployed, orphans and single mothers. Most of them own the houses ,though in some areas they are overcrowded. The researcher focused on pregnant women and women who had once received HTS during their pregnancies. The study concentrated on perceived knowledge and attitude of women towards HIV testing services. The area of Sekgosese is deep rural, with all age groups, but mostly people aged 15 to 40 years of age. In the area, there is approximately 15 000. The researcher selected a sample of about 10 people which was a manageable sample for the researcher. From the sample there were 7 women bringing their children for immunization and 3 pregnant women. The researcher used a smaller sample because it was easier to work on.

6.4. Conclusions

The study revealed that majority of women in Sekgosese have good knowledge and attitude towards HTS. The study found that there is a significant association between age and women's attitude towards HIV testing services, and there is significant association between marital status and HIV testing services. The aim of the study was to determine perceived knowledge and attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province. The study revealed that most study respondents disagreed that they are knowledgeable about HTS and they know where it is offered within their villages.

6.5. Recommendations of the study

Based on the above conclusions, the following recommendations were made about perceived knowledge and attitude of women towards HIV testing services:

6.5.1. Recommendations to Department of Health

- There is therefore a need of collaboration of several stakeholders such as the local municipality, Department of Health, Department of Social Development and Department of Basic Education, to come up with strategies to encourage every person to utilize HTS.
- The Department of Education in collaboration with department of Health should introduce subjects that address the need and/or benefits of HTS
- The Department of health should establish policies or guidelines which makes HTS compulsory to couples during pregnancy
- Married women should also be encouraged to bring their spouses when attending health facilities during pregnancy.
- Couples who visit the clinic for HTS should be given gifts for their unborn child. That will encourage couple testing.
- The Department of Health, working together with the Department of Social Development, should establish and implement an effective health promotion programme that will encourage people to utilize HTS.
- The Department of Health should employ more skilled staff members, especially medical staff and social workers, in PHC facilities. This will act as an incentive and will ensure that there is adequate staff to cater for the rural population; for example, professional nurses to carry out the necessary tests for ARV commencement, lay counselors to offer HTS and social workers to offer supportive and other welfare services.

6.5.2. Recommendations to future researchers

Additional studies are required, preferably qualitative studies, that seek to gain deeper insights on why certain women have poor knowledge of HIV and negative attitudes towards HTS.

Recommendations to policy makers

Policy makers and the media should educate women more about HTS and its benefits.

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APPENDIX A1: RESEARCH INSTRUMENT

PERCEIVED KNOWLEDGE AND ATTITUDE OF WOMEN TOWARDS HUMAN IMMUNODEFICIENCY VIRUS TESTING SERVICES IN MOPANI DISTRICT, LIMPOPO PROVINCE

INSTRUCTIONS

1. Answer all questions
2. Read carefully and understand before you answer

Record number			
Researcher's name			
Date of interview	Year:	Day:	Month:
Site Description			
Mamaila		District:	Mopani District
Raphahlelo		Municipality:	Greater Letaba Municipality
Sephukhubje		Respondent's Gender	Female
Thakgalang			

SECTION A: DEMOGRAPHIC INFORMATION

No:	Questions	Responses	Code
1.	How old are you?	15- 20 years: 21 – 30 years: 31 – 40 years: 41 – 49 years +:	1 2 3 4
2.	What is your marital status?	Married: Single: Widowed : Divorced:	1 2 3 4
3.	Level of education	Primary: Secondary:	1 2

		Tertiary:	3
		None:	4
4.	Employment	Employed:	1
		Unemployed:	2
		Self employed:	3
		Pensioner :	4
5.	What is the distance between your house and this clinic?	Less than 3 km:	1
		3 – 5 Km:	2
		5 – 10 Km:	3
		Not Sure:	4
6.	How much taxi fare do you usually pay between home and this clinic?	R10.00:	1
		R20.00:	2
		None:	3
		Other (specify) :	4

SECTION B: FACTORS PREVENTING WOMEN TO UNDERGO HTS

7.	Only pregnant women can undergo HIV testing services	Yes:	1
		No:	2
		I don't know:	3
8.	If your spouse tests negative, you are also negative.	Yes:	1
		No:	2
		I don't know:	3
9.	Confidentiality is taken seriously in HTS.	Yes:	1
		No:	2
		I don't know:	3
10.	Women who test positive are not faithful and are seen as useless.	Yes:	1
		No:	2
		I don't know:	3
11.	Women who test positive during pregnancy are going to die shortly.	Yes:	1
		No:	2
		I don't know:	3

SECTION C: KNOWLEDGE REGARDING HIV/AIDS TESTING SERVICES

12.	Have you ever heard about HIV/AIDS Testing Services (HTS) before today?	Yes: No:	1 2
13.	Do you know where HTS is offered?	Yes: No:	1 2
14.	If yes, where is it offered?	Clinic: School: Town:	1 2 3
15.	Where did you hear about HTS?	Clinic: T.V: Radio: Friend: Newspaper: Others(specify):	1 2 3 4 5 6
16.	HTS involves people get testing on their own will?	Yes: No: I don't know:	1 2 3
17.	HTS is meant to prevent HIV.	Yes: No: I don't know:	1 2 3
18.	HTS involves pre-test counselling, testing and post-test counselling?	Yes: No: I don't know:	1 2 3
19.	HTS involves confidentiality.	Yes: No: I don't know:	1 2 3
20.	How does a person get infected by the HIV virus?	Sex: Body Fluids: Blood Contact: Mother to Child: I don't know:	1 2 3 4

21.	What are the types of HIV prevention strategies?	Abstinence: Be faithful: Condom use: I don't know:	1 2 3 4
22.	How can an infected pregnant woman transmit HIV to her unborn baby?	During pregnancy: During Delivery: During Breastfeeding: I don't know:	1 2 3 4
23.	What are main benefits of having an HIV test?	Know your status: Start medication if positive: To be responsible: I don't know:	1 2 3 4
24.	What are the main fears of having an HIV test?	Stigma: Stereotype: Discrimination: I don't know:	1 2 3 4
25.	What do pregnant women benefit from HTS?	Protect the unborn child: Protect themselves: I don't know:	1 2 3 4
26.	What are the benefits of HTS?	Feel free to test Accept the results Understand more about HIV I don't Know	1 2 3 4

SECTION D: ATTITUDES ABOUT HIV TESTING SERVICES

27.	Women who get tested for HIV feel good/confident	Strongly agree..... Agree..... Neutral Disagree Strongly disagree.....	1 2 3 4 5
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28.	Getting tested for HIV prevents women from getting HIV.	Strongly agree..... Agree..... Neutral Disagree Strongly disagree.....	1 2 3 4 5
29.	People in my life would leave me if I had HIV.	Strongly agree..... Agree..... Neutral Disagree Strongly disagree.....	1 2 3 4 5
30.	Women who test HIV positive should hide it from others.	Strongly agree..... Agree..... Neutral Disagree Strongly disagree.....	1 2 3 4 5
31.	Women would rather not know if they have HIV.	Strongly agree..... Agree..... Neutral Disagree Strongly disagree.....	1 2 3 4 5
32.	Women who test HIV positive are dirty.	Strongly agree..... Agree..... Neutral Disagree Strongly disagree.....	1 2 3 4 5
33.	Women who test HIV positive cannot be trusted.	Strongly agree..... Agree..... Neutral Disagree Strongly disagree.....	1 2 3 4 5
34.	Women who test HIV positive have nothing to feel guilty about	Strongly agree..... Agree..... Neutral	1 2 3

		Disagree	4
		Strongly disagree.....	5
35.	Most women become HIV positive by being weak or foolish.	Strongly agree.....	1
		Agree.....	2
		Neutral	3
		Disagree	4
		Strongly disagree.....	5
36.	It is safe for people who have HIV to work with children.	Strongly agree.....	1
		Agree.....	2
		Neutral	3
		Disagree	4
		Strongly disagree.....	5
37.	Women who test HIV positive can still give birth to healthy children.	Strongly agree.....	1
		Agree.....	2
		Neutral	3
		Disagree	4
		Strongly disagree.....	5

APPENDIX A2: SEDIRISWA NYAKISISO

PERCEIVED KNOWLEDGE AND ATTITUDE OF WOMEN TOWARDS HUMAN IMMUNODEFICIENCY VIRUS TESTING SERVICES IN MOPANI DISTRICT, LIMPOPO PROVINCE

Ditaelo

1. Araba dipotsiso ka moka
2. Bala ka hlokomelo le kwesiso pelo o ka araba

Nomoro ya rekoto			
Leina la Monyakisisi			
Letsatsi la poledisano	Ngwaga :	Letsatsi:	Kgwedi:
Lefelo la tlhaloso			
Mamaila	Selete:	Mopani District	
Raphahlelo	Mmasepala:	Greater Letaba Municipality	
Sephukhubje	Bong bja diarabi	Mosadi	
Thakgalang			

Karolo ya A: Tshedimoso ya diarabi

No:	Dipotsiso	Dikarabo	khoutu
1.	O na le mengwaga ye mekae	15- 20 : 21 – 30 : 31 – 40 : 41 – 49 +:	1 2 3 4
2.	Seemo sa lenyalo	nyetswe: Ga ke a nyalwa: Mohlologadi..... Hlalane:	1 2 3 4
3.	Tsa thuto	Thuto ya tlase: Thuto ya ka	1 2

		godingwana:	3
		Thuto ya godimo:	4
		Ga gona:	
4.	Tsa mosomo	Soma:	1
		Hloka mosomo:	2
		3
		Boipereki:	
5.	Ke bokgole bjo bo kaakang go tswa ga geno go ya bookelong bjo.	Ka fase ga 3 km:	1
		2
		3 – 5 Km:	3
		5 – 10 Km:	4
		Ga ke na bohlatse:	
		
6.	Ga ntsi o patella bokae go tswa ga geno go ya bookelong ka tekisi.	R10.00:	1
		R20.00:	2
		Ga go na:	3
		Tse dingwe (e ba thwi)	4
		:	

Karolo B: Dilwana tseo di thibelago basadi go ya ditikong tsa HIV

7.	Ke fela basadi bao ba le go mmeleng bao ba dirago diteko tsa HIV	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3
8.	Ge molekane wa gago a ka hwetsa a se na tshwaetso go bolela gore le wena ga o nayo	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3
9.	Sephiri se tseelwa godimo ge go dirwa diteko tsa HIV	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3
10.	Basadi ba ba na go le tshwaetso ga ba tshepagale e bile ba bonagala ba hloka mohola	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3

11.	Basadi bao ba hwetsagalago ba na le tshwaetso ka nako ya boimana ba tla hlokofala	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3

Karolo C: TSEBO MABAPI LE DITIRELO TSA DITIKO TSA HIV/AIDS

12.	O keke wa kwa ka ditirelo tsa diteko tsa HIV peleng	Ee:	1
		Aowa:	2
13.	O tseba mo ditirelo tsa ditiko tsa HIV di dirwago gona	Ee:	1
		Aowa:	2
14.	Ge Karabo e le ee, gona di dirwa kae	Boekelong:	1
		Sekolong:	2
		Toropong:	3
15.	O kwele kae ka ga ditirelo tsa diteko tsa HIV	Boekelong:	1
		Thelebiseneng:	2
		Seyalemoyeng:	3
		Ka Mogwera:	4
		Koranteng:	5
16.	Ditirelo tsa diteko tsa HIV di dirwa ntle le kgapeletso	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3
17.	Ditirelo tsa diteko tsa HIV di nepilwe go thibela HIV	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3
18.	Ditirelo tsa diteko tsa HIV di akaretsa dikeletso tsa pele, ge go dirwa diteko le morago ga diteko	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3
19.	Ditirelo tsa diteko tsa HIV di akaretsa sephiri	Ee:	1
		Aowa:	2
		Ga ke tsebe:	3
20.	Motho a ka hwetsa jwang tshwaetso ya	Thobalano:	1

	kokwanahloko ya HIV	Seela sa mmele: Kopanelo ya madi: Go tswa go mme go ya ngwaneng: Ga ke tsebe:	2 3 4
21.	Ke mekgwa efe ya go thibela kokwanahloko ya HIV	Go tlogela: Go tshepagala: Go somisa dikgotlopo: Ga ke tsebe:	1 2 3 4
22.	Na mosadi yo a lego mmeleng a ka fetisetsa jwang tshwaetso go ngwana pele a ka belegwa.	Ge a le mmeleng: Ge a belega: Ge a nyantsha: Ga ke tsebe:	1 2 3 4
23.	Go mohola jwang go dira diteko tsa HIV	Go tseba seemo sa gago: ... Thoma go nwa dihlare : Go ba le maikarabelo: Ga ke tsebe:	1 2 3 4
24.	Ke eng tsa go tshosa ka go dira diteko tsa HIV	Dikgopolo di shele: O kwera: Kgethologanyo: Ga ke tsebe:	1 2 3 4
25.	Ditirelo tsa diteko tsa HIV di hola bjang basadi bao ba lego mmeleng.	Tshireletsa ngwana pele a belegwa: Itshireletsa: Ga ke tsebe:	1 2 3 4
26.	Ditirelo tsa diteko tsa HIV di mohola jwang	Lokologa g dira diteko Amogela dipoelo E ba le kwisiso ka HIV Ga ke tsebe	1 2 3 4

SECTION D: ATTITUDES ABOUT HIV TESTING SERVICES

27.	Basadi bao ba dirago diteko tsa HIV ba ekwa ga botse	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5
28.	Go dira diteko tsa HIV go tshireletsa basadi go fetelwa ke HIV	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5
29.	Batho bao ba lego kgauswi le nna ba tla ntlogela ge ke na tshwaetso ya HIV	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5
30.	Basadi bao ba nago le HIV ba tshwanetse ba khutisetse bangwe.	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5
31.	Go kagone ge basadi bao ba nago le tshwaetso ya HIV bas a tsebe	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana	1 2 3 4 5

		Ke gana ka maatla.....	
32.	Basadi bao ba nago le tshwaetso ya HIV ba ditshila	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5
33.	Basadi bao ba nago le tshwaetso ya HIV ga ba tshepegi	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5
34.	Basadi bao ba nago le tshwaetso ya HIV ga ba swanela go ipona molato	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5
35.	Bonsti bja basadi ba hwetsa tshwaetso ya HIV ka go ba ditlaela le bokowa	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5
36.	Go lokile gore batho bao ba nago le tshwaetso ya HIV ba some le bana	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana	1 2 3 4 5

		Ke gana ka maatla.....	
37.	Basadi bao ba nago le tshwaetso ya HIV ba ka belega bana	Ke dumela ka maatla..... Kea dumela..... magareng Ke a gana Ke gana ka maatla.....	1 2 3 4 5

Appendix B: LETTER OF INFORMATION

Title of the Research Study: Perceived Knowledge and Attitude of Women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province

I am Manganyi Tinyiko Hestine enrolled for Masters in Public Health specializing in Health Education and Health Promotion. My Main supervisor is Prof Lebeso R.T. who is a research professor and Dr. Mabunda J.T. from the department of Public Health.

Introduction

You are being asked to take part in this study with the above-mentioned title. You are selected as a possible respondent using convenient sampling technique. The study will be conducted at your respective clinic, where you received HTS and all of you who are present will be allowed to form part of the study. I humbly request you to read this form and ask any questions you may be having before agreeing to form part of the study.

Purpose of the study

The purpose of the study is to determine the perceived knowledge and attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province, The researcher is intending to publish this study afterwards and a copy will be submitted to your clinic, the district office and to the Department of Health.

Description of the study procedures

The questionnaires will be given to you by the researcher at your respected clinic. The completion of the questionnaire will take you approximately less than an hour. If you agree to take part in this study, you will be asked to complete a questionnaire which will have the following four sections:

Section A: Demographic information

Section B: Perceived knowledge of women towards HTS

Section C: Perceived attitude of women towards HTS

Section D: Perceived factors preventing women from undergoing HTS

Risks involved

Taking part in this study may sometimes pose unknown risks. For example, you may find that some of the questions you will find in the questionnaire may harm you or you are having a different view, but it is not the intention of the researcher.

Benefits

There are no monetary benefits for participating on the study. However, being a respondent in this study will give you an opportunity to make your own view regarding HIV Testing Services. It will also make your voice heard.

Reasons why participants may be withdrawn from the study

Participants who will not comply during data collection will be withdrawn, together with those who may not be able to participate due to illness.

Remuneration

Participants will not be compensated for participating in the study with either money or any other type of gratuity

Costs of the study

Participants are not expected to pay anything to cover the costs of the study as it is the responsibility of the researcher.

Confidentiality

The researcher will ensure that the questionnaire does not include the personal information of the participants or anything that can link the participant to the information provided.

Research related injury

In case of an injury, the researcher will not be responsible and every participant will have to take responsibility of her injury.

I, _____ having understood the above, as explained by the researcher, I do agree/disagree to be part of this study.

Date: _____

In the Event of Any Problems or Queries please contact my supervisor Prof Lebese R.T on 015 962 8207/071 561 8263 or Co-Supervisor Dr Mabunda on 082 842 6328. Please contact the researcher at 072 787 9100 or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof G.E. Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

Appendix C: CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, (Manganyi Tinyiko Hestine), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: ,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant

Date

Time

Signature

I,

.....

.....

.....

Manganyi Tinyiko Hestine, hereby confirms that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher

.....

Date.....

Signature.....

Full Name of Witness (If applicable)

.....

Date

Signature.....

Full Name of Legal Guardian (If applicable)

.....

Date.....

Signature.....

APPENDIX D: ETHICAL CLEARANCE CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:

Mr TH Manganyi

Student No:

11572873

PROJECT TITLE: Perceived knowledge and attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province.

PROJECT NO: SHS/19/PH/06/2304

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof RT Lebesa	University of Venda	Supervisor
Dr JT Mabunda	University of Venda	Co - Supervisor
Mr TH Manganyi	University of Venda	Investigator – Student

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2019

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee:

Name of the Chairperson of the Committee: Senior Prof. **G.E. Ekosse**

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION

2019 -04- 2 5



University of Venda

PRIVATE BAG X5050, THOHYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060

Private Bag X5050
Thohoyandou 0950

"A quality driven financially sustainable, rural-based Comprehensive University"

APPENDIX D: PERMISSION TO CONDUCT RESEARCH TO THE DEPARTMENT OF HEALTH

PERMISSION TO CONDUCT RESEARCH

P.O. Box 286
Munzhedzi
0948
22 May 2019

The Manager
Department of Health
Fidel Castro Ruz House
18 College Street
Polokwane
0700

PERMISSION TO CONDUCT RESEARCH


Sir/Madam

I am a Master of Public Health student at the University of Venda and engaged in a research project in Sekgosesa clinic, found in Mopani District. My research study is entitled: "Perceived Knowledge and Attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province". The aim of the study is to determine perceived Knowledge and Attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province.

I therefore request permission to conduct this research. You are further assured that data collected during the investigation will be highly confidential and will only be used for the purpose of my research.

Thanking you in anticipation.

Yours Faithfully



Manganyi T.H

APPENDIX D: APPROVAL LETTER BY THE LIMPOPO DEPARTMENT OF HEALTH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Ref : LP_201908_013
Enquires : Mrs PN Motimele
Tel : 015-293 6028
Email : Phoebe.Mahlokwane@dhsd.limpopo.gov.za

Hestine Manganyi

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

Perceived knowledge and attitude of women towards Human Immunodeficiency Virus Testing Services in Mopani District, Limpopo Province.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
 - a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
 - b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
 - c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
 - d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - e. The approval is only valid for a 1-year period.
 - f. If the proposal has been amended, a new approval should be sought from the Department of Health
 - g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated



Head of Department

27.09.19
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street, Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: <http://www.limpopo.gov.za>

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