DIE SWANGER VROU SE KEUSE TOT MIV-TOETSING

I GERRITS

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Opsomming

MIV infeksie neem steeds teen 'n sorgwekkende tempo onder swanger vroue in Suid-Afrika toe, ten spyte van reeds bestaande voorkomende intervensies wat daarop gemik is om MIV-oordrag te laat afneem. Vrywillige MIV-berading en -toetsing gedurende swangerskap is die kern-intreepunt tot die voorkoming van moeder-na-kindoordrag. (Department of Health, 2000:16; Birdsall, Nkosi, Hayiyiannis & Parker, 2004:3). 'n MIV-positiewe vrou word dikwels tydens haar swangerskap die eerste keer as sodanig gediagnoseer wanneer sy 'n voorgeboortekliniek besoek en tot MIV-toetsing instem (UNAIDS, 1997).

Die doel van hierdie studie was om te bepaal wat swanger vroue se ervaringe was ten opsigte van die voortoetsberading wat hulle ontvang het, en om die belemmerende en fasiliterende faktore wat 'n rol gespeel het in hulle keuse om MIV-toetsing te ondergaan, te verken en te beskryf. Beide swanger vroue wat MIV-toetsing geweier en dié wat daartoe ingestem het se ervaring van voortoetsberading is verken. Deur die belemmerende en fasiliterende faktore wat 'n rol speel in die swanger vrou se keuse om MIV-toetsing te ondergaan, te verstaan, kon aanbevelings aan die hand gedoen word om die opnamesyfer van MIV-toetsing onder swanger vroue te probeer verhoog.

Die populasie wat in hierdie navorsing bestudeer is, bestaan uit swanger vroue wat van voorgeboorteklinieke in die Potchefstroom sub-distrik gebruik maak. Doelbewuste steekproefneming is toegepas vir deelnemerseleksie met die hulp van tussengangers wat in die klinieke en die hospitaal werksaam was. Steekproefgrootte is bepaal deur middel van dataversadiging wat na 10 onderhoude bereik is.

'n Kwalitatiewe navorsingsontwerp is gebruik en data is versamel met behulp van semi-gestruktureerde onderhoude. Data-analise is gelyktydig met data-insameling uitgevoer. Tydens konsensusgesprekke het die navorser en medekodeerder eenstemmigheid bereik oor die hoof- en subtemas wat tydens data-analise na vore gekom het.

Op grond van bevindinge is tot die gevolgtrekking gekom dat belemmerende en fasiliterende faktore wat 'n rol speel in die ervaring van swanger vroue asook hul keuse om MIV-toetsing te ondergaan wel voorkom. Belemmerende faktore wat

geïdentifiseer is, is: vrees vir 'n positiewe status; vrees vir stigmatisering en diskriminasie; vrees vir die verlies aan ondersteuning; dat hulle nie die geleentheid gegun sal word om na te dink oor hul keuse om MIV-toetsing te ondergaan nie; gebrek aan die versekering dat vertroulikheid inderdaad gehandhaaf sal word; vrees daaroor om bewus te wees van 'n positiewe status, wat tot gevoelens van depressie en geestesongemak lei; en verskille tussen beraders en swanger vroue se persoonlikheidseienskappe. Fasiliterende faktore wat geïdentifiseer is, is: die begeerte om bewus te wees van hul MIV-status; die begeerte om die baba te beskerm; voldoende inligting en die belangrikheid van vertroue en ondersteuning.

Aanbevelings is vervolgens aan die hand gedoen om die MIV-beradings-en toetsingsdienste vir swanger vroue meer gebruikersvriendelik te maak en dit gevolglik vir die swanger vrou makliker te maak om tot MIV-toetsing in te stem. Deur aanbevelings op te volg sal moontlik tot gevolg hê dat meer swanger vroue se MIV-status gedurende baring bekend sal wees. Aanbevelings is aan die hand gedoen om swanger vroue tydens hulle eerste voorgeboortebesoek te beraad ten opsigte van MIV-toetsing en om tydens die tweede besoek die MIV-toets vir hulle aan te bied. Navorsingsbevindinge toon dat die meeste swanger vroue bedinktyd oor hul keuse rakende MIV-toetsing nodig het en om hulle daarop voor te berei. Die meeste swanger vroue het gevoel dat hulle moontlik tydens die tweede voorgeboortebesoek tot toetsing sou instem.

Sleutelwoorde: menslike immuniteitsgebrekvirus (MIV), verworwe immuniteitsgebreksindroom (VIGS), moeder-na-kindoordrag, vrywillige berading en toetsing, voortoetsberading, leke-beraders.

Summary

The prevalence of HIV infection in pregnant women is still on the rise despite existing preventive programmes aimed at reducing HIV-transmission. Voluntary counselling and testing during pregnancy is the key entry point in the prevention of mother-to-child transmission (Department of Health, 2000:16; Birdsall *et al.* 2004:3). Women are often diagnosed as being HIV-positive for the first time when they attend antenatal clinics and consent to HIV testing (UNAIDS, 1997).

The objective of this study was to determine the pregnant women's experiences of voluntary counselling and testing (VCT) and to explore and describe the impeding and facilitating factors that played a role in their choice whether or not to consent to HIV testing after having received pre-test counselling. By understanding the impeding and facilitating factors that play a role in the pregnant woman's choice to undergo HIV testing, recommendations could be made to possibly improve the uptake of HIV testing among pregnant women.

The population studied in this research consisted of pregnant women making use of antenatal clinics in the Potchefstroom sub-district. Purposive sampling was used to select participants with the assistance of mediators who were working in the local clinics and the hospital. The sample size was determined by data saturation, which was reached after 10 interviews.

A qualitative design was used and data was collected by means of semi-structured interviews. Data analysis was carried out simultaneously with data collection. In consensus discussions, the researcher and the co-coder reached consensus on the main and sub-themes. The main themes are the facilitating and impeding factors that play a role in the pregnant women's choice to undergo HIV testing.

Based on findings, it was concluded that facilitating and impeding factors that play a role in the pregnant woman's choice to HIV testing do indeed exist. Impeding factors identified were: fear of a positive status; fear of stigmatization and discrimination; fear of lack of support; lack of opportunity to consider their choice to undergo HIV-testing; lack of trust that confidentiality will indeed be honoured; fear of knowing possible positive HIV-status that can lead to feelings of depression and mental anguish; differences between counsellors' and pregnant women's characteristics.

Facilitating factors consist of the desire to be aware of own HIV status; desire to protect the baby; sufficient information and the importance of trust and confidentiality.

Recommendations were subsequently made to make HIV counselling and testing services to pregnant women more user-friendly in order to facilitate the pregnant woman in her choice concerning HIV-testing. Heeding these recommendations will possibly lead to more pregnant women's HIV status being known by the time they go into labour. Recommendations were made that pregnant women be counselled for HIV testing during their first antenatal visit and the HIV-testing being offered to them during the second visit. Research findings reveal that most pregnant women need time to consider their choice to undergo HIV testing and to prepare themselves for the test. Most pregnant women felt that they would possibly consent to HIV testing during their second antenatal visit.

Key words: Human immune deficiency virus (HIV), acquired immune deficiency syndrome (AIDS), mother-to-child transmission, voluntary counselling and testing, pre-test counselling; lay counsellors.

INHOUDSOPGAWE **Bladsy**

Aanhangsels

Lys van tabelle

DEEL 1
OORSIG VAN DIE NAVORSING

1.1 INLEIDING

In hierdie studie word die probleemstelling, doelstellings en aannames, soos deur die navorser gehuldig, eerstens bespreek. Daarna volg 'n indringende beskrywing van die navorsingsontwerp en -metode wat in hierdie navorsing gevolg word. Deel 2 bestaan uit 'n artikel "African Journal for Aids Research". Die studie word afgesluit met Deel 3 wat die gevolgtrekkings en aanbevelings bevat.

1.2 AGTERGROND EN PROBLEEMSTELLING

Vandat die eerste geval van Verworwe Immuniteitsgebreksindroom (VIGS) in 1986 aangemeld is, het die insidensie van MIV teen 'n sorgwekkende tempo wêreldwyd toegeneem. Volgens die mees onlangse verslag van die Wêreld Gesondheidsorganisasie (WGO) en die Joint United Nations Programme on HIV/AIDS (UNAIDS), naamlik die "Aids Epidemic Uptake" is gevind dat 33.2 miljoen mense wêreldwyd met MIV/VIGS leef (UNAIDS & WHO, 2007). Sub-Sahara Afrika verteenwoordig 68% van die wêreldpopulasie wat met MIV leef. Vyf komma vyf (5,5) miljoen Suid Afrikaners leef met MIV/VIGS en verteenwoordig 32% van die wêreldpopulasie wat met die toestand leef (UNAIDS, 2006). Dit plaas Suid-Afrika eerste op die wêreld-ranglys as die land met die meeste MIV-positiewe persone (UNAIDS/WHO, 2006:10; Avert, 2004). Die prevalensie van MIV word bepaal deur die toetsing van swanger vroue wat gebruik maak van openbare voorgeboorteklinieke (Brookes *et al.* 2004:1; Department of Health, 2004(b):1).

Volgens die mees onlangse verslag van die Departement Gesondheid, "National HIV and Syphilis Antenatal Sero-prevalence Survey in South Africa" is bevind dat 29.1% swanger vroue wat van openbare voorgeboorteklinieke gebruik maak, MIV-positief is (Department of Health, 2007:6). In die Noordwes-Provinsie is die voorkoms van MIV 29.0% (Department of Health, 2007:7). Volgens hierdie onlangse opname is daar 'n 1.1% verlaging in die voorkoms van MIV onder swanger vroue van 2005 tot 2006 (Department of Health, 2007:6). Die afname in die voorkoms van MIV word aan verskeie tendense wat in die verskillende ouderdomsgroepe voorgekom het, toegeskryf. Die afname in die insidensie van MIV onder vroue jonger as 20 jaar van

15.9% in 2005 na 13.7% in 2006 word volgens die verslag toegeskryf aan die impak wat intervensieprogramme op die voorkoming van nuwe MIV-infeksies het (Department of Health, 2007:17). In die 20 tot 24 jaar ouderdomsgroep is daar ook 'n verlaging in die insidensie van MIV opgemerk van 30.6% na 28.0% in 2005-2006. Alhoewel daar 'n nasionale verlaging in die voorkoms van MIV gemerk word is dit belangrik om te let op die insidensie van MIV in die Potchefstroom-distrik waar hierdie studie uitgevoer is. Volgens die kwartaallikse verslag van die Noordwes–Provinsie, se Departement Gesondheid, vir die Potchefstroom-subdistrik, het 1 306 swanger vroue gedurende die periode Desember 2006 tot Maart 2007 die plaaslike klinieke vir hul eerste voorgeboorteondersoek besoek. Ongeveer 4 073 swanger vroue het gedurende genoemde periode die klinieke vir hul opvolgbesoeke besoek. Uit hierdie kwartaallikse verslag blyk dit dat die insidensie van MIV onder swanger vroue wat getoets is gedurende Desember 2006 tot Maart 2007 in die Potchefstroom-distrik 49.1% was (Vana, 2007). Die hoë voorkoms van MIV onder swanger vroue in die Potchefstroom-distrik is kommerwekkend, en daadwerklike stappe moet gedoen word om die insidensie van MIV onder swanger vroue te laat afneem.

VIGS lewer 'n groot bydrae tot moederlike sterftes. Meer as 600 000 vroue sterf jaarliks tydens swangerskap en binne die eerste 6 weke na die geboorte van 'n baba (Neilson, 2005:375). Nege-en-negentig persent (99%) van hierdie sterftes kom in ontwikkelende lande soos Suid-Afrika voor. Ten spyte van voorkomende intervensies is daar steeds 'n verhoging in die moederlike sterftesyfer in Suid-Afrika (Maternal and Neonatal Program Effort, 2005). Meer as 2 600 vroue en jong meisies sterf jaarliks in Suid-Afrika weens swangerskapverwante komplikasies (AbouZahr & Wardlaw, 2004). In Suid-Afrika word 37,8% moedersterftes toegeskryf aan nie-swangerskapverwante infeksies, waarvan 20,1% aan VIGS toegeskryf word (Department of Health, 2004(b):12). Weens 'n hoë moedersterftesyfer van 165.5 per 100 000 geboortes per jaar, is die gesondheid van moeders sowel as die lewering van reproduktiewe gesondheidsdienste deur die Departement Gesondheid as prioriteite geïdentifiseer (Department of Health, 1998; 2002(b):4; Penn-Kekana & Blaauw, 2002:10). As gesondheidsdienste vir moeders beskikbaar, toeganklik, omvattend en geïntegreer is en inligting van hoë gehalte aan swanger vroue oorgedra word, is gesondheidsdienslewering meer optimaal. Swanger vroue kan sodoende in staat gestel word om na afloop van gesondheidsvoorligting ingeligte besluite te kan neem rakende hul gesondheid en reproduktiewe regte (Department of Health, 2004(b); Maternal and Neonatal Program Effort, 2005).

MIV raak nie net volwassenes nie; kinders raak ook geïnfekteer. Negentig persent (90%) pediatriese infeksies word toegeskryf aan moeder-na-kindoordrag (Luo, 2000:144; Birdsall *et al.* 2004), en is die mees algemene wyse waarop kinders met MIV geïnfekteer word (Walter *et al.,* 2000:70). MIV kan gedurende die swangerskapperiode of tydens baring en deur middel van borsvoeding oorgedra word. Ongeveer 5,4% Suid Afrikaanse kinders tussen die ouderdomme 2 en 18 jaar is met MIV geïnfekteer (Brookes *et al.* 2004:3). Minstens een derde van die babas van MIV-positiewe moeders wat nie antiretrovirale middels ontvang het nie, sal met die MI-virus geïnfekteer word (Brookes *et al.* 2004:3). Vir die voorkoming van perinatale oordrag van MIV/VIGS is dit van belang om bestaande intervensies rakende voorkoming van moeder-na-kindoordrag uit te brei.

Aangesien vrywillige MIV-berading en -toetsing die kern-intreepunt tot voorkomingsintervensies is, beklemtoon die Departement Gesondheid die belangrikheid van die implementering van toeganklike en vertroulike vrywillige beradings- en toetsingsdienste (Department of Health, 2000:16; Birdsall *et al. 2004:3*). 'n MIV-positiewe vrou word dikwels tydens haar swangerskap die eerste keer as sodanig gediagnoseer wanneer sy 'n voorgeboortekliniek besoek en tot MIV-toetsing instem (UNAIDS, 1997). Swanger vroue wat nie bewus is van hulle MIV-status nie, kan nie die nodige stappe doen ter voorkoming van moeder-na-kindoordrag nie. Vrywillige berading en toetsing tydens swangerskap bied aan die swanger vrou die geleentheid om:

- 'n ingeligte besluit te kan neem rakende vroeë toegang tot moeder-en-kindversorgingsdienste;
- ingeligte besluite te kan neem ten opsigte van die terminering van haar swangerskap in die geval van 'n positiewe status en die nodige stappe uit te voer om vertikale oordrag te voorkom indien sy sou besluit om met haar swangerskap voort te gaan; en
- ingeligte besluite te neem rakende babavoedingsopsies, seksuele praktyke en toekomstige swangerskappe, asook die verandering van haar lewenstyl in belang van haar eie gesondheid (Postma *et al.* 1999:1656-1660; Ades *et al.* 1999:271-278; Patrick *et al.* 1998:942-947; Department of Health, 2002(a):9).

Vrywillige beradings-en toetsingsdienste (VBT) is noodsaaklik vir MIV-toetsing en is ook 'n belangrike aspek in gesondheidsdienslewering aan MIV-pasiënte. As gevolg van die hoë werkslading en personeeltekort in die openbare sektor word die dienste van vrywillige leke-beraders benut om berading en toetsing te doen (McCoy *et al.* 2002:13). Alhoewel leke-beraders nie formele opleiding ontvang het nie, word hulle wel deur nie-regeringsorganisasies onderrig om saam met geregistreerde verpleegkundiges en in die geval van hierdie studie, die vroedvrou, te werk, om beradings- en toetsingsdienste aan swanger vroue te lewer (Rohleder & Swartz, 2005:397-406).

Benewens die MIV-toets self bestaan vrywillige beradings- en toetsingsdienste uit voortoetsberading waartydens die leke-berader of vroedvrou vertroulik en in privaatheid met die swanger vrou praat oor:

- die belangrikheid van MIV-toetsing tydens swangerskap;
- die impak van MIV op swangerskap;
- die implikasie van 'n positiewe of negatiewe uitslag op die swanger vrou; en
- die toetsprosedure en die verkryging van vrywillige ingeligte instemming (Department of Health, 2002a:9).

Natoetsberading word verskaf na afloop van MIV-toetsing en dit behels:

- die meedeel van die swanger vrou se MIV-status aan haar;
- die verskaffing van ondersteuning aan die swanger vrou ten opsigte van emosies wat moontlik kan voortspruit; uit óf 'n positiewe óf negatiewe resultaat;
- die identifisering van haar ondersteuningsnetwerke, sowel as die bekendmaking van haar status aan hulle; en
- die verskaffing van inligting rakende bestaande voorkomingsintervensies ten opsigte van die voorkoming van moeder-na-kindoordrag en die belangrikheid van 'n gesonde lewenstyl (Department of Health, 2002(a))

Gedurende 2001 het die "Health System Trust" in samewerking met die Departement Gesondheid die loodsprogram vir die voorkoming van moeder-na-kindoordrag in verskeie gesondheidsdienste geëvalueer. Tydens hierdie opname is 18 proefsetels in die openbare gesondheidsdienste in Suid-Afrika betrek om onder andere die persentasie swanger vroue wat van openbare voorgeboorte-gesondheidsdienste gebruik maak en tot MIV-toetsing instem, te bepaal. Daar is bevind dat net 56% van

die swanger vroue wat aan die program blootgestel was, wel tot MIV-toetsing ingestem het (Doherty *et al.* 2003:1). Tydens genoemde opname is bevind dat slegs 27% swanger vroue in die Noordwes-Provinsie tot toetsing ingestem het. Die toetssyfer in die Noordwes-Provinsie val dus onder die peil van 50%, soos aanbeveel deur die WGO (WHO/ UNICEF/ UNAIDS, 2001). Dis is duidelik dat daadwerklike pogings aangewend moet word om die toetssyfer in die Noordwes-Provinsie te verhoog.

Die vraag ontstaan waarom sommige swanger vroue MIV-toetsing weier en ander wel tot toetsing instem. Die sukses van vrywillige beradings- en toetsingsdienste word beïnvloed deur die beskikbaarheid van dienste, die omgewing waarin voortoetsberading uitgevoer word sowel as die gemeenskap se persepsie van MIV (McCoy *et al.* 2002:15). Volgens die verslag vind vrywillige berading en toetsing dikwels in ongunstige omstandighede plaas, wat 'n direkte invloed het op die swanger vrou se keuse ten opsigte van instemming tot toetsing.

Persoonlike faktore dra ook daartoe by dat swanger vroue nie tot MIV-toetsing wil instem nie. Uit verskeie studies wat internasionaal en nasionaal uitgevoer is, blyk dit dat persepsies met betrekking tot 'n lae infeksierisiko (Boyd *et al.* 1999:8) die noodsaaklikheid van die toestemming van hul mans (Cartoux *et al.* 1998:239) asook negatiewe persepsies ten opsigte van dienste wat gelewer word (Kalichman & Simbayi, 2003:442-447) 'n rol speel in die keuse van die swanger vrou om tot MIV-toetsing in te stem. Stigmatisering met betrekking tot MIV, gepaardgaande vrese vir diskriminasie sowel as openbaarmaking van 'n moontlike positiewe status aan 'n metgesel kan tot gevolg hê dat swanger vroue nie tot MIV-toetsing wil instem nie (Chesney & Smith, 1999; Hull *et al.* 1988; Maman *et al.* 2001:595; Pool *et al.*2001:606; Campbell & Bernardt, 2003:548; Birdsall *et al.* 2004:2). Persoonlike faktore wat 'n rol speel in die swanger vrou se keuse om nie tot MIV-toetsing in te stem nie, is nie in die navorsingsverslag deur die "Health System Trust" in Suid-Afrika aangeraak nie. Met hierdie onderhawige studie wil die navorser in die eerste instansie bepaal hoe swanger vroue in 'n semie-stedelike gebied in die Noordwes Provinsie MIV voortoetsberading ervaar, en wat die persoonlike redes daarvoor is dat sommige swanger vroue MIV-toetsing weier.

Die navorser se persoonlike ervaring is dat voortoetsberading in die vorm van groepsgesondheid-voorligting aan swanger vroue verskaf word. Tydens voorligtingsessies word die belangrikheid van MIV-toetsing beklemtoon, en die swanger vrou word bewus gemaak van voorkomingsintervensies om die risiko van moeder-na-kindoordrag van MIV te beperk. Dit wil egter voorkom of swanger vroue nie op hulle gemak is om hul bekommernisse en vrese met die beraders te bespreek nie, wat daartoe kan bydra dat daar steeds 'n groot aantal swanger vroue is wat nie na afloop van voortoetsberading tot MIV-toetsing wil instem nie.

Hierdie navorsing maak deel uit van 'n oorkoepelende projek oor MIV-toetsing tydens swangerskap waardeur gepoog word om vas te stel waarom die status van meer swanger vroue nie teen die einde van hul swangerskap nie bekend is nie (Minnie, 2005). Die doel van die onderhawige studie is om aanbevelings aan die hand te doen met die oog daarop om voortoetsberading vir swanger vroue meer doeltreffend te maak. Die aanbevelings sal moontlik tot gevolg hê dat die MIV-toetssyfer onder swanger vroue verhoog en dat meer moeders en babas voordeel trek uit die voorkomings- en behandelingstrategieë.

Aanvanklik is beplan om slegs swanger vroue wat nie tot MIV-toetsing ingestem het nie, by die navorsing te betrek. Die navorser wou bepaal wat die belemmerende faktore is wat 'n rol speel by swanger vroue se keuse om, na afloop van voortoetsberading, nie tot MIV-toetsing in te stem nie. Oor 'n periode van 9 maande heen is ongeveer 50 swanger vroue geïdentifiseer wat MIV-toetsing geweier het. Slegs 4 van hierdie vroue was bereid om in te stem om aan die studie deel te neem. 'n Moontlike verklaring hiervoor was dat MIV 'n sensitiewe saak is en dat swanger vroue nie op hulle gemak voel om daaroor te praat nie. Na gesprekvoering met kundiges is besluit om ander vroue wat wel tot toetsing ingestem het, in te sluit. Hierdie strategie sou die navorser in staat stel om meer onderhoude te kon voer en sou ook daartoe bydra dat ryker data verkry kon word. Die navorser wou bepaal wat die fasiliterende faktore was wat daartoe bygedra het dat hierdie groep vroue wel tot toetsing ingestem het en wat hulle ervaring van voortoetsberading was. Deurdat die redes verstaan word waarom swanger vroue tot MIV-toetsing instem, of dit weier, kan aanbevelings gedoen word om hierdie dienste in die lewering van optimale gesondheidsorg aan swanger vroue meer doeltreffend te maak, wat dan moontlik tot gevolg sal hê dat die status van meer swanger vroue bekend sal wees.

Uit bogenoemde bespreking en die navorser se persoonlike ervaring van hoe voortoetsberading tans plaasvind en weens die hoë persentasie swanger vroue wat nie tot MIV-toetsing instem nie, ontstaan die volgende vrae:

1. Wat is die ervaring van swanger vroue ten opsigte van voortoetsberading?

2. Watter belemmerende faktore dra daartoe by dat swanger vroue nie tot MIV-toetsing wil instem nie?

3. Watter fasiliterende faktore dra daartoe by dat swanger vroue wel tot MIV-toetsing instem?

1.3 NAVORSINGSDOELWITTE

1. Verken en beskryf die ervaring van swanger vroue ten opsigte van voortoetsberading.

2. Verken en beskryf belemmerende faktore wat daartoe bydra dat die swanger vroue nie tot MIV-toetsing wil instem nie.

3. Verken en beskryf fasiliterende faktore wat daartoe bydra dat swanger vroue wel tot MIV-toetsing instem.

1.4 PARADIGMATIESE PERSPEKTIEF

Die navorser se paradigmatiese perspektief word vervolgens bespreek. Dit verskaf die agtergrond van waaruit die navorsing vertrek. Die aannames word vervolgens in die metateoretiese, teoretiese en metodologiese stellings weergegee.

1.4.1 Metateoretiese aannames

Die navorser ondersteun die metateoretiese aanname, soos gestel in die Verplegingsteorie vir Mensheelheid wat oorspronklik ontwikkel is deur die Oral Roberts University Anna Vaughn School of Nursing (ORU, 190:136-142) wat gebaseer is op 'n Judeo-Christelike wêreldbeskouing en filosofie wat die Bybel as

bron van waarheid beskou en op die heelpersoon fokus. Orem se teorie vir selfsorg (George, 1990:92) is ook hier van belang, aangesien die navorser van oortuiging is dat die mens oor die potensiaal beskik om te leer en te ontwikkel om sy of haar volle potensiaal te bereik. Metateoretiese stellings vir hierdie navorsing berus op die begrippe die *mens, gesondheid, siekte, verpleging* en *die omgewing.* Hierdie begrippe word vervolgens kortliks bespreek.

1.4.1.1 Die mens

Die mens is 'n geestelike wese wat as eenheid van liggaam, psige en gees op 'n geïntegreerde biopsigososiale wyse funksioneer ten einde sy strewe na heelheid te verwesenlik. Die mens verkeer voortdurend in wisselwerking met sy omgewing.

In hierdie navorsing word die mens verteenwoordig deur die swanger vroue en die vroedvrou waar elkeen as geheel in wisselwerking met hul omgewing tree ten einde hul strewe na heelheid te bereik. Die mens beskik oor die potensiaal om te leer en te ontwikkel met die doel om fisiek, psigies of geestelik sy volle potensiaal te bereik (George, 1990:92).

As mens verkeer die swanger vrou in 'n volgehoue strewe na heelheid om haar gesondheid deur haar bewustheid of onbewustheid van haar MIV-status te bevorder. Die rol van die vroedvrou is om die swanger vrou in staat te stel om deur MIV-berading en -toetsing bewus te raak van haar MIV-status en haar sodoende te ondersteun en in staat te stel om vertikale oordrag van MIV te beperk. Gesien in die lig daarvan dat die mens oor die vermoë beskik om ingeligte besluite te neem wil die navorser bepaal watter belemmerende en fasiliterende faktore 'n rol speel wat tot gevolg het dat sommige swanger vroue MIV-toetsing weier of daartoe instem. Swanger vroue se keuse tot MIV-toetsing het tot gevolg dat hulle hul volle potensiaal kan bereik in hul strewe na heelheid.

1.4.1.2 Gesondheid

Gesondheid word deur die navorser beskou as 'n staat van geestelike, psigiese en fisieke heelheid. Die mens se kenmerkende wyse van interaksie met sy omgewing bepaal sy/haar gesondheidstatus.

Die navorser glo daarin dat die mens oor die vermoë beskik om optimale gesondheid te bereik deur besluite te neem wat tot voordeel vir sy/haar gesondheid sal strek. Volgens Orem se Selfsorgteorie word gesondheid gebaseer op die konsep *voorkomende gesondheidspraktyke* (George, 1990:98). Aangesien die mens(e) 'n selfversorgende wese met unieke behoeftes is, word daar gefokus op die instandhouding en bevordering van gesondheid. Orem se selfsorgteorie is van toepassing op hierdie studie deurdat die swanger vrou wat tot MIV-toetsing instem, haar in staat stel om voorkomende intervensies in werking te stel om moeder-na-kindoordag te voorkom en haar eie gesondheid te bevorder deur die verandering van haar leefwyse. Selfsorg is 'n self-geïnisieerde, doelbewuste aktiwiteit wat verantwoordelike gedrag bevorder. Deurdat die swanger vrou tot MIV-toetsing instem, neem sy die besluit om ingelig te wees oor haar MIV-status en dat sy sodoende besluite kan neem wat tot voordeel kan strek van haar toekomstige gesondheid en dié van haar ongebore baba. Optimale gesondheid word bereik deur die swanger vrou se doelgerigte optrede, byvoorbeeld instemming tot MIV-toetsing, inskakeling by die program vir die voorkoming van moeder-na-kindoordrag, om haar en haar baba se gesondheid in stand te hou, te herstel en te bevorder (Du Preez, 2004:11).

1.4.1.3 Siekte

Siekte word deur die navorser gedefinieer as 'n staat van fisiologiese en psigologiese ongemak wat veroorsaak word deur faktore wat in die interne en eksterne omgewing van die mens aanwesig is. Weiering tot toetsing kan nadelig wees vir die swanger vrou se gesondheid, want as sy nie bewus is van haar status nie, stel sy nie voorkomende intervensies ter beskerming van haar eie of haar ongebore baba se gesondheid in werking nie.

Volgens Minnie (2003:8) kan 'n moontlike MIV-positiewe uitslag, sowel as die bekommernis daaroor dat die virus na haar baba oorgedra word, as stressor in haar interne omgewing dien. Dit is die navorser se aanname dat swanger vroue wat nie tot MIV-toetsing wil instem nie, moontlik nie gekonfronteer wil word deur die ongemak en wete van 'n positiewe MIV-status (siekte) nie, en daarom verkies om nie ingelig te wees oor hul status nie. Dit wil voorkom of swanger vroue meer op hul gemak voel om nie bewus te wees van hul MIV-status nie. aangesien dit vir hulle die voordeel inhou van "gesondheid" eerder as om bewus te wees van 'n moontlike positiewe uitslag, naamlik "siekte". Deur bewus te wees van hul MIV-status kan

swanger vroue dit moontlik nadeliger ervaar as gevolg van stigma, vrees vir verwerping en bewustheid van die dood, teenoor die voordele wat ingeligtheid oor haar MIV-status vir haar inhou, soos toegang tot voorkoming van moeder-na-kindoordragprogramme, ondersteuning en verandering in leefwyse met betrekking tot MIV-toetsing.

1.4.1.4 Verpleging

Verpleging is die professionele optrede van die geregistreerde verpleegkundige en het ten doel om die pasiënt (swanger vrou) met akademiese kundigheid en kliniese vaardigheide te lei om optimale gesondheid te bereik deur interaksie en funksionele aktiwiteite wat gerig is op die bevordering, instandhouding en herstel van gesondheid. Vir doeleindes van hierdie studie verwys verpleging na die verskaffing van voortoetsberadings- en toetsingsdienste aan swanger vroue, sowel as die toesighouding oor leke-beraders in die lewering van voortoetsberading.

1.4.1.5 Die omgewing

Die mens verkeer deurlopend in wisselwerking met sy omgewing, hetsy intern of ekstern van aard. Faktore wat in die mens se omgewing aanwesig is, beïnvloed sy funksioneringswyse. Volgens die definisie van die Verplegingsteorie vir Mensheelheid (ORU, 1990:136-142) van die begrip *omgewing,* bestaan die interne omgewing uit liggaam, psige en gees. Die eksterne omgewing is fisiek, sosiaal en geestelik van aard.

Op liggaamlike gebied vind veranderinge in die vrou se liggaam plaas namate die fetus groei en die liggaam hom op die geboorte voorberei. Geestelik word die swanger vrou bewus van die lewe wat binne haar groei, van vrees vir die geboorteproses, van 'n moontlike positiewe MIV-status, van vrees vir verwerping deur haar familie, haar lewensmaat en die gemeenskap en van 'n vrees vir die dood.

Die sosiale dimensie word verteenwoordig deur die familie en die gemeenskap sowel as die rol wat die gesondheidspersoneel in haar lewe tydens haar swangerskap speel. Haar fisieke omgewing bestaan uit haar huishoudelike omgewing en bronne wat sy tot haar beskikking het vir die versorging en beskerming van haarself, haar ongebore baba en ander gesinslede. Die voorgeboortekliniek sowel as die hospitaal maak deel uit van die swanger vrou se omgewing waar voortoetsberading plaasvind.

Vir doeleindes van hierdie studie is die swanger vrou se intellek, emosies, waardes en etiese beginsels van belang, aangesien hierdie faktore 'n rol speel by haar keuse om tot MIV-toetsing in te stem en dit deel uitmaak van die interne omgewing. Voortoetsberading wat deur leke-beraders aan swanger vroue verskaf word, sowel as die omgewing waarin dit plaasvind, maak deel uit van die eksterne omgewing. In hierdie studie saldaar gefokus word op die belemmerende en fasiliterende faktore wat 'n rol speel in die interne en eksterne omgewing wat daartoe bydra dat swanger vroue na afloop van voortoetsberading toetsing weier of daartoe instem.

1.4.2 Teoretiese aannames

Teoretiese aannames behels die formulering van die sentraal teoretiese argument sowel as die omskrywing van sleutelterme van hierdie studie. Konseptuele omskrywings soos op hierdie studie van toepassing, word vervolgens beskryf.

1.4.2.1 Sentraal teoretiese argument

Kennis van die ervaring van die swanger vroue ten opsigte van voortoetsberading, en die kennis van belemmerende en fasiliterende faktore wat 'n rol speel in hul keuse ten opsigte van MIV-toetsing sal bydra tot die formulering van aanbevelings wat die toetssyfer vir MIV-toetsing onder swanger vroue moontlik sal verhoog sodat meer swanger vroue se MIV-status tydens geboorte bekend sal wees en meer moeders en babas voordeel kan trek uit intervensies ten doel om moeder-na-kindoordrag te voorkom..

1.4.2.2 Begripsomskrywings

Die begrippe wat sentraal staan in hierdie navorsing word soos volg omskryf.

MIV (Menslike Immuungebrekvirus)

MIV is 'n retrovirus wat VIGS veroorsaak deurdat dit 'n persoon se immuniteit afbreek. Die MI-virus kan slegs in lewende menslike selle reproduseer, oorleef en vermenigvuldig. Hierdie virus behoort tot die retrovirus-groep en word ingebou in die DNA van die gasheerselle, wat dan aanleiding gee tot 'n verskeidenheid kliniese tekens en simptome wat varieer van asimptomaties tot fatale toestande as gevolg

van immuniteitsgebrek (Merck, 1992:77). Die MI-virus val die immuniteitselle, naamlik die CD4-selle, aan. Hierdie selle word uitgewis en het tot gevolg dat die liggaam se immuniteitsisteem nie meer kan funksioneer om die liggaam teen eksterne patogene te verdedig nie (Van Dyk, 2001:7). Die verlaging van die CD4-telling (<200 selle/ml) het tot gevolg dat opportunistiese infeksies die liggaam oorneem (Van Dyk, 2001:11). Die liggaam vorm teenliggame in reaksie daarop om die virus te vernietig. Sodra hierdie teenliggaampies in die menslike bloedstroom gevind word, is die persoon MIV-positief. MIV word deur bloed, semen en vaginale vloeistowwe sowel as borsmelk oorgedra. Primêre oordrag geskied deur seksuele omgang, moeder-na-kind-oordrag en die gebruik van inspuitbare dwelmmiddels (Van Dyk, 1999:47).

VIGS (VERWORWE IMMUNITEITSGEBREKSINDROOM)

VIGS word veroorsaak deur die MI-virus. VIGS is die finale stadium van MIV. Indien die CD4-telling minder as 200selle/ml is, het die persoon VIGS. Die MI-virus verswak die persoon se immuunstelsel in so 'n mate dat dit patogene wat die liggaam binnedring nie kan beveg nie, en het tot gevolg dat die persoon sterf weens opportunistiese infeksies en sekere kankers (Van Dyk, 2001:5).

Moeder-na-kindoordrag

Moeder-na-kindoordrag verwys in hierdie navorsing na die oordrag van die MI-virus van 'n MIV-positiewe vrou na haar baba gedurende swangerskap of baring of deur borsvoeding (Minnie & Du Preez, 2004:19-3; WHO, 1998). Die terme perinatale en vertikale oordrag is sinonieme vir moeder-na-kindoordrag. Volgens Luo (2000) en Birdsall *et al.* (2004) is perinatale oordrag verantwoordelik vir 90% van pediatriese infeksies van MIV. Die Departement Gesondheid het die PMTCT (Prevention-of-mother-to-child-transmission)-projek in Suid-Afrika geïmplementeer waarvolgens intervensies gedoen word om die oordrag van die MIV van die moeder na die kind te probeer voorkom.

Vrywillige berading en toetsing (VBT)

Bogenoemde term verwys na voor- en natoetsberading sowel as MIV-toetsing self. Vrywillige berading en toetsing is noodsaaklik vir die lewering van voorgeboortedienste aan swanger vroue. Vrywillige berading en toetsing (VBT)

behels ook verdere begeleiding vir die MIV-positiewe vrou ten opsigte van die neem van ingeligte besluite om haar eie gesondheid te bevorder en om die nodige intervensiestappe te doen om moeder-na-kindoordrag van MIV te voorkom (Postma *et al.* 1999:1656-1660; Ades *et al.* 1999:271-278; Patrick *et al.* 1998:942-947).

Voortoetsberading

Voortoetsberading is 'n een-tot-eengesprek tussen die pasiënt en die berader of geregistreerde verpleegkundige. Tydens voortoetsberading tree beraders/verpleegkundiges in privaatheid met die swanger vrou in gesprek oor die belangrikheid van MIV-toetsing. Inligting rakende MIV wat verstrek word, behels:

- die impak wat MIV op swangerskap het;
- die implikasie van 'n positiewe of negatiewe uitslag vir die persoon se lewensgehalte; en
- die verduideliking van die toetsprosedure en die verkryging van vrywillige ingeligte instemming tot MIV-toetsing (Department of Health, 2002a:9).

Die Departement Gesondheid beklemtoon dat beradings- en toetsingsdienste toeganklik, privaat en vertroulik moet wees (Department of Health, 2000:16).

Beraders

Beraders word verteenwoordig deur die verpleegkundige, die vroedvrou of die leke-berader wat in gesondheidsorginstansies werksaam is. As gevolg van die swaar werkslading in veral die openbare klinieke word die dienste van leke-beraders benut. Leke-beraders is persone wat nie oor 'n formele beradingskwalifikasie beskik nie, maar wel opleiding ontvang het om onder toesig van geregistreerde verpleegkundiges/vroedvroue te werk (Pienaar, 2004:10). Hierdie beraders lewer voortoets- en natoetsberading aan swanger vroue.

Vroedvrou

Volgens die *International Confederation of Midwives* is 'n vroedvrou 'n persoon wat verloskundige program suksesvol voltooi het en geregistreer is om in die land van opleiding as vroedvrou te praktiseer. As vroedvrou moet sy oor die vermoë beskik

om toesig te hou, en om sorg en inligting gedurende swangerskap, baring en in die post-partumperiode aan vroue te bied. Die vroedvrou moet bevallings onafhanklik kan uitvoer en sorg aan die pasgebore baba kan gee. Sorg aan moeder en baba behels voorkomende intervensies, die identifisering van abnormale toestande in beide moeder en baba, die verskaffing van mediese hulp en die uitvoering van noodmaatreëls in die afwesigheid van mediese hulp. As vroedvrou is dit haar verantwoordelikheid om berading en onderrig aan vroue en hul familie sowel as die gemeenskap te gee. Hierdie verantwoordelikhede behels voorgeboorteonderrig en die voorbereiding op ouerskap en die verskaffing van inligting met betrekking tot gesinsbeplanning en kindersorg. Die vroedvrou mag praktiseer in hospitale en klinieke of in ander omgewings van gesondheidsorg wat geskik is vir die hantering van bevallings (ICM, 1992).

Die vroedvrou word verteenwoordig deur die geregistreerde verpleegkundige wat ook as vroedvrou by SARV geregistreer is. Vir doeleindes van hierdie studie word na die geregistreerde verpleegkundige verwys, en dit sluit die vroedvrou in. Die vroedvrou se rol is om heelheid by die swanger vrou sowel as haar ongebore baba te fasiliteer deur die implementering van veilige voor- en nageboortepraktyke sowel as toesighouding oor leke-beraders in die lewering van voortoetsberading. Vir die doeleindes van hierdie studie is dit die vroedvrou se verantwoordelikheid om toe te sien dat swanger vroue die geleentheid gegun word om ingelig te word ten opsigte van hulle MIV-status deur toegang te hê tot MIV-voortoetsberading. Swanger vroue met 'n positiewe MIV-status moet ingelig word oor voorkomende praktyke wat daarop gerig is om perinatale oordrag te voorkom.

1.4.3 Metodologiese aannames

Die navorsingsmodel van Botes (1995) word gebruik om die navorsingsproses te rig. Die toepassing van hierdie model kan die waarde van hierdie studie bevorder, aangesien dit spesifiek vir verpleegnavorsing ontwikkel is. Deur van hierdie model in die navorsingsproses gebruik te maak word die geldigheid en betroubaarheid van die navorsing verhoog (Botes, 1995:5). Volgens Burns en Grove (2005:3) is die doel van verpleegnavorsing om bewysgebaseerde sorg te verskaf wat tot gevolg sal hê dat die uitkomsgehalte vir pasiënte, gemeenskappe, gesondheidverskaffers en die gesondheidstelsel bevorder word. Bewysgebaseerde sorg is juis van toepassing op hierdie studie, aangesien die navorser beplan om uit die kennis van swanger vroue se ervaring van voortoetsberading en die geïdentifiseerde belemmerende en

fasiliterende faktore wat 'n rol speel in die swanger vrou se keuse om tot MIV-toetsing in te stem of om dit te weier, bruikbare en toepaslike aanbevelings te formuleer vir doeltreffende voortoetsberading om sodoende die toetssyfer vir MIV-toetsing onder swanger vroue te verhoog.

Die eerste orde verteenwoordig die verpleegpraktyk en navorsingsterrein van verpleging as aktiwiteit. Vir die doel van hierdie studie word die verpleegpraktyk verteenwoordig deur die openbare voorgeboorteklinieke in die Potchefstroom-distrik sowel as die kraamsaal in die Potchefstroom Hospitaal. Op hierdie vlak tree die vroedvrou en leke-berader tydens voortoetsberading in interaksie met swanger vroue.

In die tweede orde word op teorievorming en navorsing gefokus. Deur kennis te genereer oor die swanger vrou se ervaring van voortoetsberading en die belemmerende sowel as die fasiliterende faktore wat 'n rol speel in die swanger vrou se keuse tot MIV-toetsing, en die formulering van aanbevelings om voortoetsberading meer doeltreffend te maak sodat meer swanger vroue se MIV-status tydens baring bekend is, dien die tweede orde die eerste orde.

Die derde orde het betrekking op die filosofiese paradigma van navorsing. Metateoretiese aannames van die navorser ten opsigte van die mens (swanger vrou ,berader, omgewing en die vroedvrou), verpleging en siekte en gesondheid spruit voort uit die Verpleegteorie vir Mensheelheid (ORU, 1990: 136-142), Orem se teorie vir Selfsorg (George, 1990) en Christelike godsdiensbenaderings.

1.5 NAVORSINGONTWERP EN -METODE

Die navorsingsontwerp en -metode wat op hierdie studie van toepassing is, word vervolgens bespreek en sluit die navorsingsontwerp, navorsingskonteks, steekproef, data-insameling en data-analise in.

1.5.1 Navorsingsontwerp

'n Kwalitatiewe navorsingsontwerp is in hierdie studie gebruik aangesien die navorser swanger vroue se ervaring van voortoetsberading sowel as die belemmerende en fasiliterende faktore wat 'n rol speel in die swanger vrou se keuse tot MIV-toetsing wil

verken en beskryf. Omdat die doel van hierdie studie die verstaan van swanger vroue se keuse tot MIV-toetsing is, en die navorser belemmerende en fasiliterende faktore wil verken en beskryf wat 'n rol speel in die swanger vroue se keuse om wel tot toetsing in te stem of om dit te weier nadat hulle voortoetsberading ontvang het, is dit van pas dat die navorser gebruik maak van 'n fenomenologiese benadering (Burns & Grove, 2005:27). Uitkomste van die studie word gebaseer op die navorser se ervaring en interpretasie van die realiteit. 'n Fenomenologiese benadering is gepas om die betekenis van ervaring, in die geval die swanger vrou se ervaring van voortoetsberading, te ontdek soos dit deur die individu beleef en ervaar word (Burns & Grove, 2005:27; Fouche, 2004:273). Die uitkomste van die studie is op die swanger vrou se ervaring en interpretasie van die realiteit gebaseer.

Verkenning en beskrywing van ervaringe word veral aangewend om 'n relatief onbekende terrein te ondersoek en dit te beskryf deur 'n opname te doen onder persone wat hierdie ervaringe binne die praktiese konteks beleef (Mouton & Marais, 1992:44, 244). Deelnemers se ervaringe word vanuit hul persoonlike siening binne die spesifieke konteks bestudeer (Babbie & Mouton, 2004:272) 'n Kwalitatiewe navorsingsontwerp is gebruik en data is versamel met behulp van semi-gestruktureerde onderhoude. Die navorsingsontwerp is kontekstueel van aard want daar word nie gestreef na veralgemening nie.

1.5.2 Navorsingskonteks

Die navorsingskonteks word deur Mouton en Marais (1992:91-92) beskryf as die area, tyd, kultuur, individu en gemeenskap se oriëntasie ten opsigte van die omstandighede waarbinne die navorsing plaasvind. Hierdie studie word uitgevoer binne die konteks van die Potchefstroom-subdistrik. Aangesien die meeste swanger vroue wat van voorgeboorteklinieke gebruik maak, woonagtig is in die informele nedersettings rondom die Potchefstroom-subdistrik, is dit dan ook die navorsingsarea vir die studie. Die dominante etniese groep wat in die informele nedersettings voorkom, is die Tswana, maar mense wat die Xhosa-, Zoeloe- en Sotho- sowel as Kleurlingbevolking verteenwoordig, is ook hier woonagtig. Tans is daar agt openbare gesondheidsorg-klinieke in die distrik wat voorgeboortesorg-dienste lewer. Voorgeboortesorg-dienste word Maandae en Dinsdae by die onderskeie klinieke gelewer. Volgens die vierde kwartaallikse opname van die Noordwes Departement Gesondheid wat gestrek het van Desember 2006 tot Maart 2007, het 1306 swanger vroue die eerste keer voorgeboorteklinieke bygewoon en 4 073 swanger vroue hul

opvolgbesoeke. Gedurende hierdie periode het slegs 799 swanger vroue tot MIV-toetsing ingestem (Vana, 2007). Alhoewel daar 'n gemiddeld van tot 2 000 besoeke is, is dié nie noodwendig gelyk aan die aantal pasiënte nie, omdat swanger vroue die klinieke meer gereeld gedurende die latere periode van hul swangerskap besoek (Minnie, 2003:91).

Openbare primêre gesondheidsdiensklinieke is gebou in die verskeie informele nedersettings om toeganklikheid vir die publiek te fasiliteer. Hierdie geboue bestaan uit bakstene en is van lopende water, elektrisiteit en sanitasie voorsien. Die klinieke word deur die Departement Gesondheid en geregistreerde verpleegkundiges en leke-beraders beheer, en skoonmakers lewer dienste by die onderskeie klinieke. As gevolg van die hoë werkslading van die verpleegkundiges by die klinieke, gee die leke-beraders MIV-voortoetsberading aan veral swanger vroue. Die geregistreerde verpleegkundige doen die toetsing en verstrek die resultaat van die toets aan die swanger vrou en behartig dan verder ook die voorgeboortesorg van die swanger vroue.

1.5.3. NAVORSINGSMETODE

Die navorsingsmetode sluit die populasie, steekproef, data-insameling en data-analise in en word vervolgens bespreek.

1.5.3.1 Steekproef

Populasie

Vir doeleindes van hierdie navorsing bestaan die populasie uit alle swanger vroue wat in die Potchefstroom-subdistrik woonagtig is wat gebruik gemaak het van die openbare voorgeboorteklinieke vir voorgeboortesorg, ongeag of hulle ingestem of geweier het om MIV-toetsing te ondergaan.

Steekpoefmetode

Vir doeleindes van hierdie studie is deelnemers doelbewus geselekteer wat aan die seleksiekriteria voldoen (Brink, 2002:141; Burns & Grove, 2005:352; Strydom & Delport, 2003:334). Geregistreerde verpleegkundiges en leke-beraders wat in die openbare voorgeboorteklinieke en Potchefstroom Hospitaal werksaam is, het as

tussengangers opgetree om moontlike deelnemers te identifiseer. Aangesien MIV-toetsing 'n sensitiewe saak is, speel die tussengangers 'n belangrike rol deurdat deelnemers hulle ken en reeds 'n verhouding met hulle opgebou het.

Vir doeleindes van hierdie navorsing was die seleksiekriteria soos volg:

- swanger vroue wat vir voorgeboortesorg gebruik gemaak het en vir voortoetsberading gegaan het by openbare voorgeboorteklinieke in Potchefstroom en
- swanger vroue wat ingestem het om aan die studie deel te neem en dat onderhoude op band opgeneem kon word.

'n Brief (Aanhangsel A) is aan tussengangers gerig waarin die navorser hulle hulp versoek het met betrekking tot die seleksie van deelnemers. Nadat tussengangers ingestem het om tydens die studie hulp te verleen het die navorser persoonlik na die onderskeie klinieke en die hospitaal gegaan om seker te maak dat deelnemers aan die seleksiekriteria voldoen het alvorens hulle by die studie ingesluit is.

Die rol van die tussenganger was om:

- potensiële deelnemers te identifiseer;
- aan deelnemers te verduidelik wat die doel, voordele en belangrikheid van die navorsingsprojek is;
- aan potensiële deelnemers te verduidelik dat konfidensialiteit en anonimiteit regdeur die studie verseker sou word, en ook watter strategie toegepas sou word om dit te verseker;
- aan deelnemers die data-insamelingsmetode te verduidelik en hulle in te lig dat onderhoude ongeveer 'n halfuur sou duur en dat onderhoude op band opgeneem sou word;
- deelnemers in te lig dat hulle psigologiese ondersteuning na afloop van onderhoud sou ontvang indien hulle dit sou benodig;
- 'n tyd te reël vir onderhoude wat beide die navorser en deelnemer pas; en
- te reël dat 'n private vertrek met minimale steurnisse by die kliniek en hospitaal ten tye van onderhoudvoering beskikbaar sou wees.

Tydens die seleksie van deelnemers het hulle inligting ontvang rakende die doel van die studie en wat van hulle verwag sou word. Die inligtingsdokument (Aanhangsel B) het aan deelnemers die doelwitte van die studie verduidelik asook die versekering gegee dat vertroulikheid en anonimiteit te alle tye verseker sou word. Deelnemers is daarvan bewus gemaak dat deelname aan die studie vrywillig was en dat onderhoude op band opgeneem sou word indien hulle daartoe sou instem. Nadat deelnemers bogenoemde inligting ontvang het, het die navorser seker gemaak dat hulle die inligting verstaan het en aan hulle geleentheid gegee om onduidelikhede of bekommernisse uit te klaar.

Steekproefgrootte

Steekproefgrootte is bepaal deur dataversadiging (Morse, 1994:285) - as 'n patroon van dataherhaling voorkom en geen nuwe bevindinge geïdentifiseer is nie. Daar is aanvanklik gemeen dat 'n minimum van 6-8 onderhoude nodig sou wees voor dataversadiging bereik sou word.

1.5.3.2 Data-insameling

Vervolgens word die data-insamelingsmetode, proeflopie, die navorsingsomgewing,data-insamelingsproses, die duur van onderhoude en die rol van die navorser bespreek.

Data-insamelingsmetode

Data is verkry deur indiepte-onderhoudvoering wat gerig is deur twee van drie sentrale vrae. Die vrae was daarop gemik om die swanger vrou se ervaring van voortoetsberading te verken en te beskryf sowel as om te bepaal wat die belemmerende of fasiliterende faktore was wat 'n rol gespeel het in haar keuse, of sy ingestem het tot MIV-toetsing of nie.

Die volgende vraag is aan die deelnemers gestel:

"Wat was u ervaring van MIV-voortoetsberading?"

Aan vroue wat nie tot toetsing ingestem het nie:

"Watter belemmerende faktore het 'n rol gespeel in u keuse om nie tot MIV-toetsing in te stem nie?"

Aan vroue wat wel tot toetsing ingestem het:

"Watter faktore was fasiliterend ten opsigte van die keuse om tot MIV-toetsing in te stem?"

Tydens onderhoudvoering is van bepaalde kommunikasietegnieke, soos deur Greeff (2003:295) beskryf, gebruik gemaak:

- Uitklaring: Hierdie tegniek word gebruik om onduidelike stellings uit te klaar.
- Parafrasering: Die deelnemer se woorde word herhaal, met gebruikmaking van sinonieme.
- Rigting gee: 'n Oop vraag word gestel om die deelnemer aan te moedig om meer inligting te verstrek.
- Minimale verbale respons: Deur middel van minimale verbale respons van die kant van die navorser word die deelnemer aangemoedig om meer te praat.
- Reflektering: Die navorser verbaliseer die perspektief en bekommernisse van die deelnemer om te toon dat sy verstaan.
- Opsomming: Die navorser stel vrae wat verband hou met die onderhoudskedule met die oog daarop om vas te stel of sy verstaan wat die deelnemer sê.

Veldnotas (Voorbeeld in Aanhangsel C) is direk na afloop van die onderhoud opgestel en later getik en by die transkripsie van die onderhoud gevoeg. Dit stel die navorser in staat om gebeure wat tydens die onderhoud plaasgevind het, nie te vergeet nie, en dra by tot data-analise. Die tipes veldnotas word soos volg deur Wilson (1993:222-223) verduidelik:

- *Observasienotas:* Hierdie notas is van belang aangesien die doel daarvan is om die optrede van die deelnemer op enige gegewe tydstip gedurende die onderhoud te ondervang. Die inligting dui op gebeure tydens die onderhoud wat deur die navorser gesien en gehoor word, maar wat nie deel uitmaak van die onderhoud of die verbale kommunikasievaardighede soos genoem nie.

- *Teoretiese notas:* Die notas is 'n doelbewuste betekenistoewysing aan die observasienotas. Afleidings, aannames en interpretasies word aangewend met die oog daarop om 'n moontlike skema vir data-analise saam te stel.

- *Metodologiese notas*: Hierdie notas word gebruik om instruksies en wenke te gee en kritiek te lewer om moontlike toekomstige metodologiese benaderings te verbeter.

- *Persoonlike notas*: Die navorser/onderhoudvoerder se reaksies, gevoelens en ervaringe word verwoord ten einde die rykheid van die data aan te vul.

Proeflopie

Die navorser het 'n proeflopie van die hele data-insamelingsproses in die navorsingsveld onderneem om te bepaal of relevante data bekom sou kon word aan die hand van die vrae wat aan deelnemers gerig sou word (Strydom & Delport, 2003:337). Die proeflopie verskaf aan die navorser bruikbare en praktiese inligting rakende die nodigheid van veranderinge in onderhoudvoeringsvrae en -tegnieke. Soos reeds in die probleemstelling genoem, het die navorser oor 'n periode van 9 maande heen slegs 4 onderhoude kon voer met swanger vroue wat MIV-toetsing geweier het. Aangesien daar so min vroue bereid was om aan die studie deel te neem, het die navorser saam met haar studieleiers besluit om ook swanger vroue wat wel tot MIV-toetsing ingestem het, by die studie in te sluit, en dan te fokus op die faktore wat fasiliterend ingewerk het op die swanger vrou se instemming tot MIV-toetsing. Na die uitbreiding in die navorsingsvrae was daar meer swanger vroue wat bereid was om aan die studie deel te neem en het data-insameling vinniger plaasgevind.

Fisiese omgewing

Alle onderhoude het plaasgevind in 'n private vertrek ter versekering van privaatheid en konfidensialiteit. Die vertrek is so georganiseer dat dit verwyderd is van aktiwiteite in die kliniek of hospitaal, met geen telefone, goeie ventilasie, en skoon en hartlike omgewing om deelnemers op hul gemak en veilig te laat voel. Personeel is daaraan herinner dat onderhoude nie onderbreek moet word nie en 'n kennisgewing is teen die deur aangebring wat gelees het: "Moenie steur nie".

Die navorser en deelnemer het naby mekaar gesit met geen versperring tussen hulle nie. Twee gemaklike stoele, van dieselfde kleur en grootte, is oorkant mekaar geplaas om te voorkom dat deelnemers moontlik ondergeskik teenoor die navorser kon voel, wat tot gevolg sou kon hê dat verskille as negatief en diskriminerend ervaar sou kon word.

Data-insamelingsproses

Data-insameling het geskied soos breedvoerig onder Steekproefneming bespreek is. Nadat geïdentifiseerde deelnemers tot deelname ingestem het, is hulle by die studie ingesluit. Deelnemers is weer daarvan bewus gemaak dat hulle hulle aan die studie kon onttrek indien hulle psigologiese ongemak sou ervaar. Psigologiese ondersteuning was ook beskikbaar indien hulle dit sou benodig. Vertroulikheid en anonimiteit van deelnemers is deurgaans gewaarborg.

Duur van onderhoude

Daar is geen tydsbeperking geplaas op onderhoudvoering nie, aangesien die duur van die onderhoud bepaal was deur die situasie. Onderhoude het wel ongeveer 25 tot 35 minute geduur.

Rol van die navorser

Toestemming om hierdie navorsing te mag onderneem is van die volgende instansies verkry:

- Die Etiekkomitee van die Noordwes-Universiteit (Potchefstroomkampus) (Aanhangsel D),
- Die Distrikbestuurder van die Departement Gesondheid van die Potchefstroom-subdistrik (Aanhangsel E);
- Die Pasiëntveiligheidgroep te Potchefstroom Hospitaal (Aanhangsel F).

Doelbewuste seleksie van deelnemers het plaasgevind nadat die navorser afsprake met tussengangers wat in die klinieke en hospitaal werksaam was, gereël het. Tussengangers het die navorser aan potensiële deelnemers voorgestel. Data-

insameling is uitgevoer soos reeds in die paragraaf Steekproefmetode onder 1.5.3.1 bespreek.

Die navorser self is weekliks werksaam in die Verloskundige Eenheid en kom in aanraking met swanger vroue wat MIV voortoetsberading ontvang. Dit skep dus die geleentheid om self potensiële deelnemers te identifiseer.

Onderhoude, met die oog op data-insameling, is deur die navorser self gevoer. Oudiobande is deur die navorser self getranskribeer. Die navorser het oudiobande en veldnotas gemerk sodat inligting korrespondeer en het die data ook self met die samewerking van 'n medekodeerder geanaliseer.

1.5.3.3 Data-analise

Met die oog op data-analise is die oudio-kassetopnames van onderhoude verbatim getranskribeer. Data-analise is na afloop van die eerste onderhoud begin en vind gelyktydig plaas met data-insameling. Die aanvanklike data-analise rig die navorser met betrekking tot besluite rakende toekomstige data-insameling. Daar is gebruik gemaak van oop kodering om getranskribeerde data te analiseer (Burns & Grove, 2001:346; De Vos *et al.* 2002:342). Volgens De Vos *et al.* (2003:345) is oop kodering die proses waarvolgens data ondersoek, vergelyk, gekonsepsualiseer en gekategoriseer word. Tydens die proses van oop kodering word data afgebreek in diskrete gedeeltes waarna dit van naby ondersoek word om ooreenkomste en verskille te vergelyk en vrae te stel rakende die fenomene soos in die data weerspieël (De Vos *et al.* 2003:236). 'n Medekodeerder was behulpsaam met die kodering en het die data onafhanklik van die navorser gekodeer om die geloofwaardigheid daarvan te verseker (De Vos *et al.* 2002:342).

Data-analise is soos volgens die volgende analiseprotokol uitgevoer:

- Transkripsies is herhaaldelik deurgelees om vertroud te raak met die data wat verkry is, sowel as om 'n oorsig te kry van die onderhoude as geheel alvorens die onderhoude opgebreek is (De Vos *et al.* 2003:343). Gedurende die leesproses het die navorser aantekeninge gemaak rakende idees en konsepte wat na vore getree het.

- Elke transkripsie is in drie kolomme verdeel. Die linkerkantste kolom is vir begrippe, die middelste kolom het bevat die data bevat en die regterkantste kolom die persoonlike persepsies en idees.
- Transkripsies is weer eens gelees. Gesproke woorde en sinne is geselekteer en weer gelees. Treffende woorde is onderstreep.
- Die onderstreepte woorde en sinne is in die linkerkantste kolom geskryf as kategorieë, en persepsies en idees wat na vore gekom het, is in die regterkantse kolom geskryf.
- Deurdat die kategorieë in die linkerkantste kolom gelees is, word hoof- en subkategorieë duideliker en makliker geïdentifiseer.
- Hoof- en subkategorieë is gekodeer deur afkortings aan hulle toe te ken (Burns & Grove, 2001:597).
- Genoegsaam data is sodoende verkry om temas te identifiseer wat in die artikel beskryf word (De Vos *et al.* 2003:343). Die navorser het gesoek na menings en verbande tussen data en het patrone geïdentifiseer wat verduidelik en beskryf word.
- Data is in tabelvorm voorgestel waarin hoof en subkategorieë aangedui word. 'n Kort en duidelike oorsig word gegee van die geïdentifiseerde patrone en verkillende verskillende patrone kan vergelyk word (Gillham, 2003:64).
- Die tabel word weer gelees en gefinaliseer deur op kategorieë te besluit, indien nodig (Gillham, 2003:64).

Die medekodeerder het dieselfde analiseprotokol gebruik. Ooreenkomste en verskille in die kategorieë word bespreek en geïdentifiseer en 'n konsensusgesprek is gevoer om kategorieë te finaliseer en konsensus te verkry aangaande geïdentifiseerde temas (Polit & Hungler, 1997:380).

1.6 LITERATUURKONTROLE

Die doel van literatuurkontrole is om navorsingsbevindinge uit die literatuur te bevestig, asook om uniekhede ten opsigte van die bevindinge uit te lig wat verwant is aan die bestaande kennis in die MIV/VIGS-navorsingsveld (Fouché & Delport, 2003:268). Deur swanger vroue se keuse tot MIV-toetsing sowel as hul ervaring van voortoetsberading te verken en te beskryf is data verkry en bevestig deur dit met bestaande literatuur te vergelyk. Nuwe bevindinge wat in hierdie navorsing verkry is, is as unieke bevindinge uitgelig.

1.7 VERTROUENSWAARDIGHEID

Dit is die navorser se verantwoordelikheid om te verseker dat die studie aan die eise van vertrouenswaardigheid voldoen. Vir kwalitatiewe navorsing word die volgende kriteria aangewend om te bepaal of navorsing vertrouenswaardig is: geloofwaardigheid, oordraagbaarheid, vertroubaarheid en bevestigbaarheid (De Vos *et al.* 2002:351-352; Krefting, 1991:215-222).

1.7.1 Geloofwaardigheid (Waarheidsgetrouheid)

Waarheidsgetrouheid verwys na die vermoë van die navorser om vertroue in die waarheid van bevindinge en interpretasie te vestig. In kwalitatiewe navorsing word waarheidsgetrouheid verkry deur die ontdekking van persone se belewenis soos dit deur hierdie persone self beskryf word (Krefting, 1991:215). In die studie is moeite gedoen om die regte persone te selekteer om hulle ware ervaring vas te lê vir onderhoudvoering. Volgens Sandelowski (soos aangehaal deur Krefting, 1991:216) word 'n kwalitatiewe studie as geloofwaardig beskou wanneer deelnemers se belewenis so akkuraat is dat ander persone wat in 'n soortgelyke situasie verkeer of verkeer het onmiddellik die belewenis sal herken.

Kruisvalidasie is 'n kragtige strategie om waarheidsgetrouheid te verseker (Krefting, 1991:219). Deur in hierdie studie van kruisvalidasie gebruik te maak is 'n verskeidenheid perspektiewe bymekaar gebring om 'n gemeenskaplike bevestiging van data te verkry om te verseker dat alle aspekte van 'n verskynsel verken is. Die verkryging van 'n herhalende patroon in data word beskou as dataversadiging Deurdat kodeerders veldnotas en onderhoudtranskripsies korreleer, word foutiewe persepsies voorkom.

Interne geldigheid word bedreig deur waarnemingseffekte soos seleksie, regressie en mortaliteit (Woods & Catanzaro, 1988:137). Waarnemingseffekte kom voor waar die deelnemers data verswyg of verdraai as gevolg van die feit dat hulle daarvan bewus is dat hulle waargeneem word. Tabel 1.1 gee 'n uiteensetting van maatreëls wat getref word om waarheidsgetrouheid in hierdie navorsing te verseker.

Tabel 1.1 Maatreëls om waarheidsgetrouheid in hierdie navorsing te verseker

Kriterium	Strategie	Maatreëls gevolg in hierdie studie
Waarheidgetrouheid	Betrokkenheid van navorser	1. Die navorser was self betrokke by onderhoudvoering. Daardeur is sy in staat gestel om die voorkoms van wanopvattings te identifiseer, en om 'n vertrouensverhouding met deelnemers te vestig. 2. Bandopnames is deur die navorser self getranskribeer, wat direkte betrokkenheid by die data versterk het.
	Waarnemingseffekte	1. Deelnemers is van anonimiteit en konfidensialiteit verseker. 2. Konsensusgesprekke is gevoer tussen die navorser en medekodeerder om bevindinge uit te klaar. 3. Literatuurkontrole is uitgevoer om interpretasie van die navorser met bestaande literatuur en relevante navorsing te kontroleer.
	Status van die navorser	1. Die navorser se status is in die verslag aangedui en hou geen bedreiging in vir die deelnemers nie. 2. Deelnemers is nie ondergeskik aan die navorser nie. 3. Daar is van 'n onafhanklike medekodeerder gebruik gemaak vir kodering.
	Deelnemerseleksie	1. Tussengangers is geïdentifiseer om deelnemers aan die hand van gestelde kriteria te selekteer. 2. Deelnemers is op 'n onpartydige basis geselekteer. 3. Deelname was vrywillig, deelnemers kon hulle te enige tyd aan die studie onttrek.
	Mortaliteit	1. Transkripsies is onmiddellik na onderhoudvoering gedoen. 2. Veroudering van data is voorkom deur dit nie lank te laat lê nie.
	Navorsingsmetodologie	1. 'n Indigte beskrywing is gegee van die navorsingsmetodologie. 2. Oudiokassetopnames is verbatim deur die navorser self getranskribeer. 3. Kodering is deur die navorser en 'n onafhanklike medekodeerder gedoen.

1.7.2 Toepaslikheid (Oordraagbaarheid)

Volgens Krefting (1991:220) is kwalitatiewe, kontekstuele navorsing nie veralgemeenbaar nie weens die uniekheid van die situasie, en die verantwoordelikheid vir oordraagbaarheid berus nie by die navorser nie. Indigte beskrywing van die konteks en navorsingsproses word egter benodig om die konteks sodanig te beskryf dat verslaggewing ter insae sal wees indien ander navorsers die oordraagbaarheid sou wou beoordeel. In hierdie navorsing is die konteks in detail beskryf sodat die leser self kan besluit in watter mate dit ooreenstem met ander kontekste.

1.7.3 Konsekwentheid (Vertroubaarheid)

Vertroubaarheid van die navorsing dui op die stabiliteit of konsekwentheid van navorsingsdata. Guba (soos aangehaal deur Krefting, 1991:221) maak gebruik van die term ouditbaar om die redeneringsdraad van die navorser helder en duidelik kontroleerbaar te beskryf. Om hierdie studie ouditbaar te maak en vertroubaarheid te verhoog word 'n indigte beskrywing van die data-insamelingsmetode, data-analise en gevolgtrekkings gegee. Tabel 1.2 dui die maatreëls aan wat van toepassing is op vertroubaarheid.

Tabel 1.2 Maatreëls van toepassing op vertroubaarheid

Kriterium	Strategie	Maatreëls
Vertroubaarheid	Status van die navorser	1. Die navorser se status word in die verslag aangedui en hou geen bedreiging vir die deelnemers in nie. 2. Deelnemers is nie ondergeskik aan die navorser nie. 3. 'n Onafhanklike medekodeerder word vir kodering gebruik.
	Kontroleerbaarheid	1. Navorsingmetodiek word dig beskryf.
	Seleksie van deelnemers	1. Tussengangers identifiseer die deelnemers aan die hand van gestelde kriteria. 2. Oorspronklike bande en transkripsies word in veilige bewaring gehou en is beskikbaar vir oudit.

1.7.4 Neutraliteit (Bevestigbaarheid)

Bevestigbaarheid dui op die wetenskaplike eerlikheid wat die navorser tydens die navorsing aanwend. Daar word deurentyd gepoog om op 'n neutrale wyse met die navorsingsdata te werk om sodoende bevestigbaarheid van die navorsing te versterk. Guba se model (soos aangehaal deur Krefting, 1991:221) word gebruik om bevestigbaarheid van die navorsing te verseker. Tabel 1.3 dui maatreëls aan wat van toepassing is op bevestigbaarheid.

Tabel 1.3 Maatreëls om bevestigbaarheid van die navorsing te verseker

Kriterium	Strategie	Maatreëls
Bevestigbaarheid	Triangulasie	1 Onafhanklike kundiges neem deel aan die voorondersoek om die geskiktheid van die vrae te ondersoek. 2. Literatuurkontrole word vanuit 'n internasionale en nasionale soektog uitgevoer. 3. Veldnotas word direk na afloop van onderhoude afgeneem. 4. Konsensusgesprekke volg tussen die navorser en medekodeerder.
	Bevestigbare kontrole	1. 'n Onafhanklike medekodeerder is betrokke by data-analise. 2. 'n Voorondersoek word geloods en met kundiges bespreek. 3. Veldnotas en transkripsies maak deel uit van die navorsingsverslag. 4. Beide nasionale en internasionale navorsing word in die literatuurkontrole gebruik.

1.8 ETIESE ASPEKTE

Etiese aspekte wat in aanmerking geneem word, ooreenkomstig die riglyne wat deur Babbie en Mouton (2004:525), Brink *et al.* (2006:29-43), Burns en Grove (2001:196-208), DENOSA (1997) en International Council of Nurses (2000) gestel word, word volledig bespreek.

1.8.1 Toestemming om navorsing te doen

Toestemming om die navorsing uit te voer is van die volgende instansies verkry:

- Die Etiekkomitee van die Noordwes-Universiteit (Potchefstroomkampus) (Aanhangsel A),
- Die Departement van Gesondheid van Noordwes Provinsie (Aanhangsel B);
- Die Distrikbestuurder van die Potchefstroom sub-distrik en
- Die Pasiëntveiligheidgroep te Potchefstroom Hospitaal.

1.8.2 Reg op vertroulikheid en privaatheid

Erkenning word gegee aan die feit dat MIV/VIGS 'n sensitiewe onderwerp is en dat spesifieke etiese probleme kan onstaan indien die navorser etiese beginsels nie handhaaf nie. Aangesien vertroulikheid ten opsigte van MIV-status 'n sensitiewe saak is, is die deelnemers se MIV-status in hierdie studie nie vir die navorser van belang nie, maar wel waarom swanger vroue nie tot MIV-toetsing wil instem nie, of wel ingestem het.

Die navorser het 'n verantwoordelikheid teenoor die deelnemers om te verseker dat die navorsing op 'n etiese wyse uitgevoer word (Brink *et al.* 2006:32). Volgens Brink *et al.*(2006:33) vorm respek vir die deelnemer, regverdigheid en voordeel die grondslag vir die beskerming van die deelnemers se menseregte. Vertroulikheid word te alle tye verseker, onderhoude word in privaatheid gevoer en die deelnemer bly tydens die navorsing anoniem. Bandopnames word in veilige bewaring gehou. Geen persoonlike inligting word bekendgemaak aan ander persone wat nie deel van die navorsingsprojek uitmaak nie.

1.8.2 Ingeligte vrywillige instemming

Skriftelike ingeligte instemming word van deelnemers verkry alvorens hulle aan die navorsingsprojek deelneem (Bylaag C) (Babbie & Mouton, 2004:525; Brink *et al.* 2006:35; Burns & Grove, 2001:206). Deelnemers ontvang inligting in eenvoudig verstaanbare taal ooreenkomstig hulle kognitiewe vlak (Brink *et al.* 2006:37; Burns & Grove, 2001:208). Noodsaaklike inligting rakende die studie word op 'n inligtingspamflet (Bylaag D) aangebring sodat deelnemers weet wat die navorsing behels (Brink *et al.* 2006:36). Deelnemers het die reg op selfbeskikking (Burns & Grove, 2001:196; Brink *et*

al. 2006:31) en het ook die reg om hulle te enige tyd aan die studie te onttrek sonder dat daar teen hulle gediskrimineer word.

1.8.3 Reg op beskerming teen ongemak en skade

Die navorser en studieleiers hou deurlopend toesig gedurende die navorsingsproses om te verseker dat 'n balans gehandhaaf word tussen die betrokke voordele en risiko's.

Gedurende die navorsingstudie word deelnemers teen fisiese, emosionele, geestelike, ekonomiese, sosiale en wetlike ongemak beskerm (Brink *et al.* 2006:32). Deelnemers word verseker van ondersteuning deur 'n berader om haar sodoende teen emosionele ongemak te beskerm. Etiese aspekte ten opsigte van hierdie navorsingstudie word deur die navorser respekteer en daar word seker gemaak dat hierdie studie op 'n wetenskaplike eerbare wyse uitgevoer word. Die navorser deel resultate wat uit die navorsing voortspruit met ander wetenskaplikes, diensverskaffers en deelnemers sodat dit uiteindelik tot voordeel van die gemeenskap kan strek.

1.9 NAVORSINGSUITLEG

Die skripsie word in artikelformaat voorgelê en bestaan uit die volgende:

- DEEL 1:

OORSIG VAN DIE NAVORSING

- DEEL 2:

NAVORSINGSBEVINDINGE WORD IN ARTIKELFORMAAT WEERGEGEE: THE PREGNANT WOMAN'S CHOICE TO UNDERGO HIV TESTING

- DEEL 3:

GEVOLGTREKKINGS, TEKORTKOMINGE VAN DIE NAVORSING EN AANBEVELINGS MET SPESIFIEKE VERWYSING NA DIE VERHOGING VAN DIE OPNAMESYFER VAN MIV-TOETSING ONDER SWANGER VROUE

1.10 SAMEVATTING

In Deel 1 is die probleemstelling en navorsingsontwerp en -metode breedvoerig bespreek. Verder is die vertrouenswaardigheid en etiese aspekte van die navorsing ook uiteengesit.

In Deel 2 word die resultate van die navorsing in artikelformaat bespreek.
Die artikel word voorberei ooreenkomstig die instruksies van die tydskrif *African Journal of AIDS Research*.

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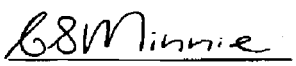
In die volgende stelling, bevestig die mede-outeurs hul rol in die studie en stem saam dat die artikel ingesluit word in die verhandeling.

Hiermee bevestig ek dat genoemde artikel in paragraaf 1.9 ingesluit word in die verhandeling. Ek gee hiermee toestemming dat die artikel gepubliseer mag word as deel van die M.Cur. verhandeling van Me. I Gerrits.



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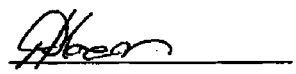

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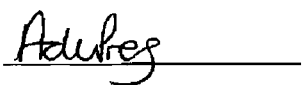

Me. A du Preez

DEEL 2

THE PREGNANT WOMAN'S CHOICE TO UNDERGO HIV-TESTING

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Article for submission to *African Journal of AIDS Research*.

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Mann, J. (1992) AIDS in the World. Cambridge Massachusetts, Harvard University Press.
Webb, D. (1998) The sexual and economic politics of reintegration: HIV/AIDS and the question of stability. In: Simon, D. ed. South Africa in Southern Africa. Reconfiguring the Region. Oxford, James Currey.
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THE PREGNANT WOMAN'S CHOICE TO UNDERGO HIV TESTING

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The pregnant woman's choice to undergo HIV testing

ABSTRACT

The prevalence of HIV/AIDS in pregnant women is still on the rise, despite existing preventive programmes. The pregnant woman's choice to consent to HIV testing plays an important role in implementing measures to prevent mother-to-child transmission.

The objective of this study was to determine pregnant women's experiences of voluntary counselling and testing (VCT) and to explore and describe the impeding or facilitating factors that played a role in their choice to consent to or refuse HIV testing after having received pre-test counselling.

A qualitative design was used. After purposive sampling, data was collected by means of semi-structured interviewing. Individual interviews were conducted with pregnant women in the local clinics as well as in the hospital. Open coding was used for analyzing the data.

Impeding factors identified consist of the following: fear of a positive status; fear of stigmatization and discrimination; fear of lack of support; lack of opportunity to consider their choice to undergo HIV testing; lack of trust that confidentiality will be honoured; fear of knowing possible HIV status, which could lead to feelings of depression and mental anguish; differences between counsellors' and pregnant women's characteristics. Facilitating factors were: desire to be aware of own status; desire to protect the baby; sufficient information and the importance of trust and support. Pregnant women still fear to know their HIV status. The fear of knowing their HIV status can possibly be aggravated by HIV stigmatization. Recommendations were formulated for counsellors and midwives to improve the uptake of HIV testing by pregnant women leading to more pregnant women's HIV status being known by the time of delivery.

Keywords: HIV/AIDS, HIV/AIDS counselling, lay counsellors, mother-to-child transmission, voluntary counselling and testing (VCT),

Introduction

More than 5,5 million South Africans are living with HIV/AIDS – 32% of the global number (UNAIDS/WHO, 2006). These statistics place South Africa as number one on the ranking list as the country with the most HIV infected people (Avert, 2004; UNAIDS/WHO, 2006). The prevalence of HIV in pregnant women consenting to be tested in the town in the North-West Province under investigation was 49,1% during December 2006 to March 2007 (Vana, 2007).

Voluntary counselling and testing (VCT) is the key entry point for the prevention of mother-to-child transmission (Birdsall, Nkosi, Hayiyiannis & Parker, 2004). The pregnant woman cannot take steps to prevent HIV transmission if she is not aware of her HIV status. A HIV positive woman is often diagnosed for the first time when she is attending the antenatal clinic after having consented to HIV testing (UNAIDS, 1997). Voluntary HIV counselling and testing during pregnancy affords pregnant women the opportunity to make informed decisions concerning their reproductive choices and health as well as interventions to prevent perinatal transmission of HIV.

A study has revealed that the success of voluntary testing and counselling is influenced by the availability of services, the environment in which counselling is rendered as well as the community's perception of HIV (McCoy, Besser, Visser & Doherty, 2002). According to this report, voluntary counselling and testing usually occurs in unfavourable conditions which have a direct influence on the pregnant woman's choice concerning whether or not to undergo HIV testing.

Personal factors also contribute to the pregnant woman's choice to refuse HIV testing. Recent studies conducted nationally and internationally indicate that perceptions of a low infection risk (Boyd, Simpson, Hart, Johnstone & Goldberg, 1999), the need to get consent from their partner (Cartoux, Msellati, Meda, Welfens-Ekra, Mandelbrot, Leroy, van de Perre & Dabis, 1998) as well as negative perceptions regarding services delivered (Kalichaman & Simbayi, 2003) all play a role in the pregnant women's choice regarding HIV testing. HIV stigma, the fear of discrimination and disclosure of their HIV status to their partners can

also contribute to pregnant women's refusal to be tested (Hull, Bettinger & Gallaher, 1988; Chesney & Smith, 1999; Maman, Mbwambo, Hogan, Kilonza & Sweat, 2001; Pool, Nyanzi & Whitworth, 2001, Campbell & Bernardt, 2003; Birdsall *et al.* 2004). Personal factors that play a role in the pregnant woman's choice to refuse HIV testing have yet not been investigated in these above-mentioned research reports.

According to the South African National HIV Survey of 2005, 45% pregnant women still refused HIV testing (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillau, 2005).. It is of importance to the researcher to explore the pregnant women's experiences of HIV pre-test counselling, as well as to examine the impeding and facilitating factors that play a role in the pregnant women's choice to consent to or refuse HIV testing and the role of those factors that influence the women who refuse testing. The researcher formulated recommendations that can improve the experience of voluntary counselling and testing so that more pregnant woman might become more willing to be tested and be informed about their status before they go into labour.

This study forms part of an overarching project in which all the factors affecting HIV testing during pregnancy are investigated.

Research questions

The following research questions arose from the problem statement:

- How do pregnant women experience HIV pre-test counselling?
- What are the impeding factors that play a role in the pregnant women's choice to refuse HIV testing?
- Which facilitating factors contribute to pregnant women consenting to undergo HIV testing?

These research questions led to the following objectives for this study:

Objectives

- To establish what the experiences of pregnant women are regarding HIV pre-test counselling.
- To explore and describe impeding factors which contribute to pregnant women refusing HIV testing.
- To explore and describe facilitating factors which contribute to pregnant women to consent to HIV testing?

Research design and method

A qualitative, explorative, descriptive contextual design was used for this study. Data was collected by semi-structured interviewing pregnant women who refused or consented to HIV testing after having received pre-test counselling, so as to achieve the research objectives. A qualitative approach is appropriate because the researcher was interested in understanding the pregnant women's experience of pre-test counselling and in exploring and describing the impeding as well as facilitating factors that contributed to the pregnant women's choice to undergo HIV testing.

The population studied in this research consisted of pregnant women living in a town in a semi-urban province. Participants consisted of pregnant women attending local antenatal clinics in the district as well as the local hospital for antenatal care whom received pre-test HIV counseling. Purposive sampling was used to select participants (Brink, Van der Walt & Van Rensburg, 2006; Strydom & Delport, 2003; Burns & Grove, 2005). Potential interviewees were identified by mediators working in the clinics and the hospital. When participants were selected, they were given information concerning the research and what was expected of them. This information explained the objectives of the research, the ways in which confidentiality was ensured and that the interviews would be recorded. Once participants had received the above-mentioned information and the researcher had ensured that they understood this information, they were

requested to sign a consent form. The sample size was determined by data saturation (Morse, 1994). Purposive sampling and data-collection in this study continued until a sufficient amount of data was obtained from the interviews to be able to draw valid conclusions. Originally it was planne to only interview pregnant women who refused HIV testing after receiving pre-test HIV counseling, but after only 4 women were willing to participate in the study in a period of 9 months it was decided to also include women who did agree to HIV testing. Ten interviews were conducted during this research – four with pregnant women refusing HIV testing, and six with women consenting to testing before data saturation was reached.

Data was collected from June 2006 to August 2007. The researcher conducted the interviews in private rooms at the local clinics and the hospital. Data was collected by means of semi-structured interviews. Participants were questioned on their experiences of HIV pre-test counselling, what factors contributed to their choice not to consent to HIV testing and which facilitating factors contributed to their choice to consent to testing after having received pre-test counselling. Interview strategies such as open-ended probes and reflection were also used. Each interview lasted between 25 and 35 minutes.

The researcher transcribed recorded interviews verbatim within three days after the interviews. Data analysis commenced after the first interview and was carried out simultaneously with data collection. Open coding was used for analyzing the transcribed data (Burns & Grove, 2001; De Vos, Fouché & Delport, 2002). An experienced co-coder analyzed the data independently according to an analysis protocol to ensure trustworthiness (De Vos *et al.* 2002). Consensus discussions were held regarding the main and sub-themes and the researcher and the co-coder discussed the coding themes, and consensus was reached on the main and subcategories in order to ensure trustworthiness of the data analysis (Polit & Hungler, 1997).

Discussion of Results

The experiences of pregnant women regarding HIV pre-test counselling were incorporated with the co-coder into sub-themes within the main themes namely impeding and facilitating factors. The data collected were confirmed by relating them to relevant literature.

The first objective was to explore the experience of pregnant women regarding HIV pre-test counselling. During data-analysis the sub-themes related to experiences of pregnant women regarding HIV pre-test counselling could be related to both impeding and facilitating factors influencing their choice to undergo HIV testing.

The second objective was to explore and describe impeding factors that played a role in the pregnant women's choice to undergo HIV testing. The following sub-themes were identified:

- Fear of a positive HIV status.
- Fear of stigmatization and discrimination.
- Fear of lack of support.
- Lack of opportunity to consider their choice to undergo HIV testing.
- Lack of trust that confidentiality will indeed be honoured.
- Fear that knowing possible positive HIV status can lead to feelings of depression and mental anguish.
- Differences between counsellor's and pregnant woman's characteristics.

The third objective was to explore and describe the facilitating factors that played a role in the pregnant women's choice to consent to HIV testing and the sub-themes were as follow:

- Desire to be aware of own HIV status.
- Desire to protect the baby.

- Sufficient information.
- The assurance of support

Results indicated that all the pregnant women were afraid of knowing their HIV status regardles, of whether or not they consented to testing. Various researchers found fear of stigmatization, fear of rejection by family, time needed for emotional preparation, perception of risk and the fear of not being able to cope with knowing their status contributed to the pregnant women's choice to undergo HIV testing (Parra, Doran, Aranda & Hernandez, 2001; Van Dyk & Van Dyk, 2003; Etiebet, Fransman, Forsyth, Coetzee & Hussy, 2004; Kebaabetswe, 2007). The limited number of pregnant women who refused HIV testing after they received pre-test counseling, who were willing to participate in this study may indicate that HIV still is a very sensitive issue.The main themes of impeding factors are discussed and confirmed by relating them to relevant literature.

Impeding factors contributing to the pregnant women's choice not to undergo HIV testing

The following impeding factors that played a role in the pregnant woman's choice to consent to undergo HIV testing after having received pre-test counselling, were identified during this research.

- **Fear of a positive HIV status**

When the subject of testing was raised, all women reported that they were afraid of being tested and knowing their HIV status. Women who refused testing after having received pre-test counselling were concerned about the possibility of knowing that they are HIV positive and the implication of a positive test result. This was confirmed by the following quotes: *"I was scared....I was really scared and afraid. I was afraid that I am going to know...." "I was afraid nè, if I am going to test, the test comes and says I am HIV positive." "I am afraid; yes I am afraid of that thing..."*

Similar findings are reported by Boyed *et al.* (1999), Campbell and Bernhardt (2001) as well as Etiebet *et al.* (2004) who point out that many participants expressed their fears concerning the consequences of testing and knowing that they are HIV positive as well as what the implication of a positive status will have on their lives.

- **Fear of stigmatization and discrimination**

Stigma is perceived as a major limiting factor in the primary and secondary prevention of HIV/AIDS. According to Holzemer and Uys (2004), it interferes with voluntary counselling and testing services. Herek *et al.* (1998) used the term 'AIDS related stigma' that meant "prejudice, discounting, discrediting, and discrimination that are directed at people perceived as having HIV or AIDS, and individuals, groups and communities with which they are associated." The fear of stigmatization and discrimination contributes to pregnant women not consenting to HIV testing.

Participants reported the following reasons for not wanting to be tested for HIV: *"The people talk a lot, they talk the whole day. They laugh at you." "Other people say that you are thin, you are HIV positive." " When you are sick, you can see them bleeding from their skin, they have diarrhoea, you can see that they are sick...." "She is not the same person...": "They think you got HIV from being naughty and that kind of stuff ..."* During interviews the researcher noticed that some pregnant women were also discriminating against people who they perceived to be infected by HIV, but to them their own beliefs were substantially more accepting. *"Because that person is really sick, and if I am positive, I do not want to look like her."* From the quotes above it is evident that stigmatization and discrimination prevail within the communities surrounding the sub-districts of the town studied.

Kebaabetswe (2007) mentions that pregnant women prefer not to be tested because they are afraid that by knowing their HIV status, other people will perceive that they are HIV positive.

Etiebet *et al.* (2004) also found that pregnant women believed that stigmatizing attitudes directed at HIV positive women were prevalent within their community. It could be concluded that participants who did not consent to HIV testing, held greater AIDS-related stigmas than those who consented to HIV testing. Some participants declined HIV testing because they do not wish to be associated with groups of people who they thought of being HIV positive. Negative attitudes and prejudice against people with HIV have a negative effect on HIV counselling and testing.

- **Fear of lack of support**

Most participants were dependent of a family member and needed to know that they would still be taken care of if the result was HIV positive.

Participants reported the following: *"Because they must be ready for whatever situation comes, my mother has to be ready because she is the only breadwinner at home, and my grandmother they must be ready." "How are they going to accept me...?" "They are afraid that there will be no one to care for them...", "I don't know how is going to be her reaction."* Due to the fear that they will be rejected, most pregnant women do not want to consent to testing or to disclose their HIV status.

According to Parra *et al. (* 2001) as well as Van Dyk and Dyk (2003) women do not disclose their status due to the fact that many pregnant women are subjected to violence, break-up of relationships with their partners and family, loss of security, shelter and food.

- **Lack of opportunity to consider their choice to undergo HIV testing**

Many pregnant women who attend antenatal clinics are being confronted with the thought of HIV infection for the first time, causing the pregnant women to feel uneasy with the idea of being tested for HIV. This can cause pregnant women not to feel ready to consent to HIV testing after having received pre-test counselling.

As mentioned before, most participants are dependent on family members for emotional and financial support. Participants felt the need to first discuss the possibility of consenting to HIV testing with their families. *"I want to go home and speak to my mother and family at home to tell them about HIV testing."* These women need to know that they will still be taken care of if they are HIV positive. Some women wanted to go and pray about their choice to undergo HIV–testing and to ask God to help them accept whatever the result of the test may be. *"This is my first appointment, I do not feel at peace...", "I do not want to take the test, this is my first time, I need time to go and think about it...", "...when I go home I will speak to my heart, pray to God whatever situation comes out I have to accept whatever and ask God to give me strength.", " The next time at the clinic I wanted to test.", "They must give me time to think about the test...they must give you a date to return to do the test."*

Cartoux *et al.* (1998) found that 41% participants who refused HIV testing after having received pre-test counselling needed to make a decision at home. No other literature could be traced stating that pregnant women need time to consider their choice to consent to or refuse HIV testing at home.

- **Lack of trust that confidentiality will indeed be honoured**

Some participants reported that they felt singled out and that they were uncomfortable with the way health care workers dealt with HIV counselling and testing because they felt that confidentiality was not provided for. Pregnant women reported that the counsellors wrote *"HIV testing"* on the back of their clothing in order to identify themselves as counsellors and that everyone in the clinic would know that you could go to them for counselling and testing. These women did not feel comfortable with this method because everybody in the clinic would know that you went for HIV counselling and testing when you went into a room with the counsellors. This practice of the counsellors caused pregnant women to think that their HIV results would not be treated confidentially. The fear of being stigmatized can also contribute to their feeling that provision was not made for confidentiality.

Another reason why participants needed to talk to the family first is that they were afraid that they would hear of their HIV status from someone else first. This is demonstrated by the following quotes": *"I want to go home and speak to my mother, and my family at home to tell about testing for HIV." "I must tell my mother, she must not hear it from other people.", "It is a matter of trust, people need to be honest."*

Participants and the community associate certain clinics with providing services to HIV positive persons. Visiting a clinic like this can lead to their status being publicaly known. *"They told me that I must go and get my treatment at the clinic where HIV positive people go."*

Confidentiality and trust play an important role in HIV counselling and testing. The lack of trust in the counsellor as well as the health care system is a barrier to the provision of comprehensive HIV counselling and testing to pregnant women (Van Dyk & Van Dyk, 2003).

- **Fear of knowing possible positive HIV status can lead to feelings of depression and mental anguish.**

Pregnant women often do not wish to consent to HIV testing due to psychological barriers such as feelings of fatalism, the inability to handle the psychological turmoil of an HIV positive test result and knowing one's HIV status (Van Dyk & Van Dyk, 2003).

Participants reported that they prefer not to consent to HIV testing due to the fact that knowing of a positive HIV status will make them feel hopeless, and that they are afraid of knowing that they are dying. Knowing that you are HIV positive would cause depression, despair and death (Van Dyk & Van Dyk, 2003). *"I see about my people when they get their results they get destroyed. They just blame themselves.", "That time I only think about death. Nothing else...", "I am going to stress myself, shu I am going to die. That is why I was afraid to test.".*

The fear of knowing that they might have an HIV positive status can cause self-stigma. Self-stigma associated with HIV causes feelings of shame, guilt, self-doubt, self-blame and feelings of inferiority (Boswell, Imakiku, Patient, Orr, & Toh, 2004).

Many of the participants know people living with HIV. They see what the disease is doing to the person they care for, and consenting to testing, and knowing their status will make them fear being confronted with the feelings of death and one's mortality. *"I have met a lady, eish...", so those things make me scared, if I think about those things, eish...", "They are sick, they bleed from their skins, they have diarrhoea, you see that they are not healthy..."*

- **Differences between counsellors and pregnant women's characteristics**

How pregnant women perceive the HIV counsellor may have an influence on their choice to undergo HIV testing. Most participants perceived the counsellors' attitudes as positive, and were satisfied with the way counsellors treated and respected their choice to undergo HIV testing.

The following quotes demonstrates above mentioned statement: *"Yes, the lady she was very nice to me...", "...she told me she is not going to force me to test, By the time I'm ready I'll tell her so that she can test me.", "They treated my nicely, we talked about these things and afterwards I feel better...".* In his study, Kebaabetswe (2007:359) reported that women are more likely to consent to HIV testing if the health care providers display a positive attitude.

Some women reported that they did not feel comfortable with the manner in which the counsellor dealt with the pre-test counselling. These women felt that the counsellors only wanted to know their status, and that they did not respect the patients' privacy and confidentiality. *"You feel like the person wants to know your status...", "I was not comfortable...", "It was very difficult for me to talk to her..."*

HIV and AIDS counselling is a stressful and emotionally demanding work and counsellors need to be more sensitive to pregnant women's needs and of how they may perceive them. Counsellors are involved in confidential and emotionally loaded topics with patients (Rohleder & Swartz, 2005) and need to respect the patients and their right to confidentiality. Kebaabetswe's (2007) study showed that negative attitudes of health workers were barriers to pregnant women's choices to participate in the prevention of mother-to-child transmission programmes.

Younger pregnant women reported that they experienced counsellors as being judgmental and not respecting them as individuals. One participant reported that the counsellor was telling them that it was wrong to have a baby at a young age, and scolded them for not being married. One participant did not feel comfortable with the counsellor being older than her. She reported that the huge difference in age made it difficult for her to trust and speak openly to the counsellor out of respect for the counsellor. *"It was very difficult for me to talk to her...", "She was great, but then the age factor....", "....with us black people we can't speak freely to somebody who is older than us.....we are raised to respect older people and you can't just say anything....."*

Two other participants also reported that in their culture respect for an older person is important, and that it is difficult to talk to a stranger and your mother about your sexuality and topics such as HIV. *"It is difficult because, you can't ask your mother these questions", "It is difficult in our culture to talk to elders". "We as children is not suppose to talk about these things..."* No evidence could be traced of similar findings in other studies of discomfort due to an age difference causing pregnant women to not consent to HIV testing although Malaudzi (2007) mentioned the cultural cloak of silence related to issues pertaining to sexual practices excisting in the Venda culture.

Facilitating factors contributing to the pregnant women's choice to undergo HIV testing

- **Desire to be aware of own HIV status**

The pregnant women who consented to HIV testing did so because they wished to be informed about their HIV status: *"Because I want to know my status.", "I must know my status if I am sick..."*

A study by Etiebet *et al.* (2004) indicated that 80% participants consented to being tested, mainly because they wished to be informed about their HIV status. According to these auther's, the reason that the pregnant women consented to HIV testing demonstrates that they were knowledgeable about HIV infection and that these women were offered voluntary counselling and testing services that was integrated into the routine antenatal clinic services.

Some participants in this study were aware of being offered the HIV test at the antenatal clinic as this quote demonstrates: *"...I usually hear people, they tell me that they went for counselling...."*

- **Desire to protect their baby**

Participants reported that they consented to HIV testing because they wanted to protect their baby. *"...because I was thinking about my baby...", "I tested because I was thinking of my child."*

Studies by Etiebet *et al.* (2004) and Boyd *et al.* (1999) conclude that pregnant women consented to HIV testing because they felt the need to protect their baby. Boyd *et al.* (1999) also state that even if the pregnant women did not know about the benefits of preventive measures that existed, they tended to think more positively about HIV testing. Pregnant women reported that they did not know that preventive measures could be taken to prevent vertical HIV transmission while they were still pregnant and their HIV status was known.

- **Sufficient information**

All participants received HIV pre-test counselling. Most women reported that they had received sufficient information explaining the importance of HIV testing during pregnancy. *"It was necessary for me to understand."*, *"They tell me about HIV and AIDS..."*, *"They explained to me what HIV testing is about, how they are going to do it and why..."*

Some participants mentioned that the counsellors gave then an information leaflet to read that was easily understood and interesting. A study conducted by Boyd *et al.* (1998) indicates that most women felt that information they received on the HIV information leaflets was easily understood and the information interesting.

Most participants were satisfied with the way counsellors treated them. "*They spoke to me nicely...*", *"The way they talked to me, they told me everything about HIV..."*.

It is evident from various studies that participants were satisfied with the way counselling services are offered and that the counselling helped them to consent to testing or, if they refused testing, they found the counselling very helpful (Etiebet *et al.* 2004; Kebaatetswe, 2007).

- **The assurance of support**

It came to the researcher's attention that trust played an importent role in the pregnant women's choice to consent to HIV testing. Pregnant women who refused or consented to HIV testing felt the need to first confide in their support system regarding the fact that they either consented to HIV testing or were considering it. As mentioned earlier, most of these pregnant women are dependent on a family member for the provision of food, shelter, security and emotional as well as physical assistance. Participants who were considering HIV testing preferred to first speak to their support system in order to establish

whether, in case of a positive HIV result, they would still be taken care of. *"I talked to the girlfriend of my brother, I talked to him and I talked to her that I will probably go....Ja, it was good for them talking to me and every problem I have, I go to them.", "I need to know if I am sick, so that I can tell my mother."*

Pregnant women who consented to HIV testing and became aware of their positive status felt the need to disclose their status to their support system. One participant wanted to inform her mother of her status because she was afraid that her mother would hear of it from someone else in their community, *"I must tell my mother so that she does not hear this from other people" This* shows that, although her HIV testing was done in privacy and it is supposed to be kept confidential, she still feared stigmatization and breach of confidentiality. No conformation for this finding could be found in the literature.

Conclusions

The researcher came to the following conclusions pertaining to impeding and facilitating factors that play a role in the pregnant women's choice to undergo HIV testing.

1. The main reason pregnant women refuse HIV testing after having received pre-test counselling is the fear of knowing that they might be HIV positive. This is evident in the fact that participants refused HIV testing after having received pre-test counselling.

2. Despite awareness campaigns regarding HIV and AIDS, stigmatization and discrimination against HIV-infected and -affected persons still continue. The fear of being stigmatized and discriminated against influences the pregnant women's choice to consent to HIV testing because they are experiencing the presence thereof within the communities they live in.

3. The fear of lack of support from their family contributes to the pregnant women refusing testing after pre-test counselling. Most pregnant women needed to be assured by their family that even if their HIV status were positive, they would still

be taken care of. Since most women in Africa come from resource-poor settings, it is of importance to them that they are assured of emotional and financial support. If a pregnant women knows that she will not have her family's support, if found to be HIV positive she will probably not consent to HIV testing.

4. Most women are not prepared to be tested for HIV directly after having received pre-test counselling, but need time to consider their choice to undergo HIV testing. Pregnant women need to prepare themselves spiritually and emotionally for consenting to testing and knowing their HIV status. Many women reported that they preferred to go home and consider the test they have been offered as well as what the implications would be should their status be positive. These women reported that they may consent to testing later during their pregnancy.

5. As a whole, most women experienced both the counsellors and the pre-test counselling to be positive. This can be an indication that the way in which pre-test counselling is currently being done is acceptable to pregnant women and that they feel comfortable with the counsellors. Although some women refused HIV testing, they were comfortable and satisfied with the counsellors, but were afraid of knowing their HIV status. Other women reported that they experienced the counsellors as not respecting their privacy and confidentiality. It was concluded that counsellors need to be reminded of the need to be sensitive towards the clients' needs, especially trust and confidentiality.

However, certain problems were identified. Some pregnant women reported that they felt uncomfortable with some counsellors. They perceived counsellors as judgmental, and felt that they were not respected as individuals. A unique finding in this study is the discomfort a young pregnant woman can experience if there is a huge age difference between herself and the counsellor. Older and younger generations do not discuss issues of sexual nature due to a cultural taboo.

6. The fear of knowing that you might be HIV positive can cause feelings of depression and mental anguish. Many pregnant women know someone who is either infected or affected by HIV. The reality of the disease and the fear of

knowing the fatal consequences the disease has on people, influence the pregnant women to rather not know their status and decrease the emotional discomfort they will have if they consent to HIV testing and found to be positive.

7. Participants who had consented to testing wished to know their status and to protect their baby. By knowing their HIV status they can take preventive measures to reduce vertical transmission if HIV positive. These women consented to testing although they were afraid of knowing their HIV status, but the motivation to take preventive measures to protect their unborn baby in case of a positive status encouraged them to consent to testing.

Recommendations

This study was aimed at understanding the experiences of pregnant women regarding HIV pre-test counselling, as well as the impeding and facilitating factors that play a role in the pregnant women's choice to undergo HIV testing. By understanding the reasons why some women consent to or refuse HIV testing after having received pre-test counselling, recommendations were made to improve the intake of HIV testing of pregnant women. By implementing these recommendations, pre-test counselling and HIV testing can be a more positive experience for pregnant women leading to more pregnant women's status being known.

Recommendations for the nursing practice

- **Motivating pregnant women to consent to HIV testing**

When pregnant women refuse HIV testing after pre-test counselling has been given, the counsellor and registered nurse can ask the women when it would be convenient to discuss HIV testing with them at a later stage and then arrange appointments for such discussions. If they still refuse testing, the benefits of PMTCT need to be explained to them once again. Pregnant women who persist in refusing being tested should, during each antenatal visit, be given the

opportunity to consent to testing, improving the possibility that their status will be known at their babies' birth.

- **Training counsellors to be sensitive to the pregnant women's needs**

Counsellors need to be more sensitive to the pregnant women's needs because HIV is a sensitive topic. Pregnant women need to feel respected and supported in their choice to undergo HIV testing. The role of the counsellor is to prepare pregnant women for HIV testing and to receive the test result; therefore it is important for the counsellor to develop trust relationships with pregnant women. Counsellors can experience work-related stress due to the high client flow and the mentally demanding circumstances that accompany HIV counselling. This can cause pregnant women to perceive the counsellor as judgmental and not sensitive to their needs. Sensitive counselling forms part of HIV counselling and testing. Counsellors work under direct supervision of the registered nurse or midwife. Registered nurses can do in-service training in counselling skills and send counsellors to workshops to enhance their counselling skills and interpersonal relationships with patients.

- **More counsellors available in clinics for delivering VCT services**

More than one counsellor should be available to deliver HIV pre-test counselling. By doing this, more clients can be accommodated and counsellors enabled to develop trusting relationships. Because some women prefer to first consider their choice to undergo HIV testing, they will feel more comfortable going to the counsellor that counselled her because they have already built a trusting relationship.

Many young pregnant women attend the antenatal clinics; therefore the need was identified that younger counsellors should be available at the clinic, since these women do not feel comfortable discussing their sexual relationships and uncertainties with the older counsellors.

- **HIV testing done during second or subsequent visits**

HIV testing does not need to be done directly after pre-test counselling, but can rather be postponed to the second or subsequent follow-up visit. Pregnant women are usually confronted with HIV testing during their first antenatal visit. By postponing the HIV test to the next visit, pregnant women are afforded the opportunity to consider their choice to undergo HIV testing and prepare themselves emotionally for consenting to testing during the next antenatal visit. HIV testing should be offered at each visit if the pregnant women persist in refusing being testing.

Recommendations for nursing education

Registered Nurses and midwives should continuously be involved in in-service training as well as self-study education programmes to obtain updated knowledge regarding nursing care practices as well as evidence-based practices such as:

Communication skills: These skills are essential, seeing that the registered nurse and midwife coordinate and supervise the counsellors' services and continuously interact with pregnant women in rendering health care services.

Sensitive counselling and developing trusting relationships with pregnant women: Counsellors and registered nurses as well as midwives should be educated in being sensitive to the pregnant women's needs, and to treat them with respect. This can be achieved by strengthening and implementing supportive interviewing techniques and role-play.

Specific knowledge: Counsellors and registered nurses/midwives should have specific knowledge of vertical transmission of HIV, of preventive practices available and of implementing them correctly. Continuous involvement in in-service training and the implementation of knowledge will cause PMTCT programmes to be more effective.

Recommendations for nursing research

Following the outcomes of this research, the following possibilities for future research are proposed:

- Research to establish the role age plays within different cultures with regard to rendering HIV counselling to young pregnant women.
- Explore the support pregnant women receive from their family when they consider HIV testing.
- Research to investigate the support an HIV positive mother, attending the PMTCT clinic, receives from her family.

Summary

In conclusion it can be pointed out that most pregnant women share similar concerns and fears regarding HIV testing. These concerns prevent a number of them from consenting to HIV testing during pregnancy. The limited number of pregnant women who refused HIV testing who consented to participate in this study may reflect that HIV still is a very sensitive issue. Many pregnant women still deny the possibility of infection, fear the stigma associated with infection, fear rejection by their family or partner and experience feelings of fatalism. Women who consented to participate in this research mainly expressed their concerns regarding knowing that they might be HIV positive, their fear of rejection by their families and of stigmatization and also indicated that they needed time to consider consenting to testing. Pregnant women seem to be satisfied with pre-test counselling services. Only one participant reported that the age difference between her and the counsellor as well as the fact that the counsellor was judgmental towards her had played a role in her choice not to consent to HIV testing. This was a unique finding for this research and no other literature could be traced regarding this phenomenon. Counsellors need to be more sensitive towards the pregnant women's needs. Reducing HIV stigmatization within communities still needs to be stressed. Although HIV awareness campaigns are

being launched, individuals still deny their risk of infection and they discriminate against individuals who are infected and affected by HIV and AIDS.

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DEEL 3.

GEVOLGTREKKINGS, TEKORTKOMINGE VAN DIE NAVORSING EN AANBEVELINGS MET SPESIFIEKE VERWYSING NA DIE VERHOGING VAN DIE OPNAMESYFER VAN MIV-TOETSING ONDER SWANGER VROUE

3.1 INLEIDING

Navorsingsbevindinge ten opsigte van die ervaring van swanger vroue ten opsigte van voortoetsberading sowel as die belemmerende en fasiliterende faktore wat 'n rol speel in die swanger vrou se keuse om MIV-toetsing te ondergaan word in artikelformaat in die voorafgaande hoofstuk bespreek. Bevindinge is deur direkte aanhalings ondersteun en met relevante literatuur bevestig. Aanbevelings is geformuleer wat kan meehelp om die opnamesyfer van MIV-toetsing onder swanger vroue in die Noordwes-Provinsie te verhoog. Eerstens, in die onderhawige hoofstuk, word die gevolgtrekkings rakende die faktore wat 'n rol speel in die swanger vroue se keuse om MIV-toetsing te ondergaan bespreek. Tweedens word die tekortkominge van die studie bespreek en derdens word aanbevelings wat uit die studie voortgespruit het, bespreek.

3.2 GEVOLGTREKKINGS

Die doel van hierdie studie was om te bepaal wat swanger vroue se ervaringe was ten opsigte van die voortoetsberading wat hulle ontvang het, en om die belemmerende en fasiliterende faktore wat 'n rol gespeel het in hulle keuse om MIV-toetsing te ondergaan, te verken en te beskryf en aanbevelings aan die hand te doen om die opnamesyfer van MIV-toetsing onder swanger vroue in die Noordwes-Provinsie te probeer verhoog. Die doelwit is bereik deur data te verkry uit semi-gestruktureerde onderhoude wat met swanger vroue gevoer is, dit te analiseer en met relevante literatuur te vergelyk. Na afloop van data-analise en konsensusgesprekke met die medekodeerder is subtemas onder die volgende temas geïdentifiseer: fasiliterende faktore, belemmerende faktore, ervaringe van swanger vroue. Die gevolgtrekkings waartoe gekom is ten opsigte van bogenoemde temas word soos volg bespreek.

3.2.1 Die ervarings van swangervroue ten opsigte van voortoets beraming

Die eerste doelwit was om swanger vroue se ervaring van voortoetsberading te verken en beskryf. Die sub-temas ten opsigte van die ervarings van swanger vroue ten opsigte van voortoetsberading het uitgekristaliseer as óf belemmerend óf fasiliterend ten opsigte van hul keuse om te besluit op MIV toetsing en is toe onder dié opskrifte bespreek.

3.2.2 Belemmerende faktore ten opsigte van die swanger vrou se keuse om nie tot MIV toetsing in te stem nie

Belemmerende faktore wat geïdentifiseer is wat 'n rol speel in die swanger vrou se keuse ten opsigte van MIV-toetsing, is verkry deur die volgende navorsingsvraag te stel: "Wat is die rede waarom jy nie tot MIV-toetsing wil instem nie?" Die temas wat hieruit geïdentifiseer is, is soos volg: Vrees 'n positiewe status, vrees stigmatisering en diskriminasie, vrees gebrek aan ondersteuning, gebrek aan geleentheid om na te dink oor keuse ten opsigte van toetsing, gebrek aan vertroue en vertroulikheid, vrees dat 'n positiewe status tot gevoelens van depressie en geestelike ongemak kan lei en verskille tussen beraders en swanger vroue se persoonlikheidseienskappe.

- **Vrees vir 'n positiewe MIV-status**

Vrees vir 'n positiewe MIV-status bring mee dat die swanger vrou nie instem tot toetsing en dus nie selfversorgend kan optree nie. Volgens Orem se Selfversorgingsteorie (George, 1990:98) kan so 'n swanger vrou dus nie haar gesondheid in stand hou en bevorder deur voorkomende gesondheidspraktyke nie. Indien sy nie bewus is van haar MIV-status nie, kan sy ook nie voorsorgmaatreëls tref om haar ongebore baba teen vertikale oordrag van die virus te beskerm nie. Deelnemers het ook gerapporteer dat hulle bang is vir die implikasie van 'n positiewe status op hul lewe.

- **Vrees vir stigmatisering en diskriminasie**

Een van die implikasies van 'n positiewe status is dat hulle stigmatisasie en diskriminasie kan ervaar. Deurdat hulle bewus is van hul moontlike MIV-posititewe status, kan swanger vroue blootgestel voel aan die reeds bestaande MIV-stigma en -diskriminasie wat in die gemeenskap heers. Swanger vroue verkies dan om nie die moontlikheid te vermy en ombewus te bly van hul MIV status. In die studie is gevind dat alhoewel

deelnemers bang is vir stigmatisering en diskriminasie, hulle self stigmatiseer teenoor persone wat hulle as MIV-positief beskou.

- **Vrees vir gebrek van ondersteuning**

Die meeste deelnemers is afhanklik van 'n familielid vir versorging. Deur ingelig te wees oor hul MIV-status, vrees swanger vroue dat hulle verwerp sal word deur die familie, wat direk verlies aan sekuriteit en finansiële en emosionele ondersteuning tot gevolg sal hê.

- **Gebrek aan tyd on na te dink oor keuse tot toetsing**

Die meeste swanger vroue voel nie gerus om direk na afloop van voortoetsberading tot toetsing in te stem nie. Deelnemers rapporteer dat hulle nie gereed voel om tydens die eerste voorgeboortelike besoek tot toetsing in te stem nie, en dat hulle eers met hul familie wil gaan praat oor hul keuse tot toetsing. Sommige deelnemers het die behoefte om te gaan bid voor hulle die besluit neem om tot toetsing in te stem. As swanger vroue die geleentheid gegun word om hulle emosioneel voor te berei sal hulle moontlik meer geneë voel om tydens hul volgende besoek aan die kliniek tot toetsing in te stem.

- **Gebrek aan vertroue dat vertroulikheid gerespekteer sal word**

Deelnemers in hierdie studie het gerapporteer dat hulle nie uitgesonder wil word vir toetsing nie. Baie swanger vroue is huiwerig om sekere klinieke te besoek omdat die gemeenskap daarvan bewus is dat MIV-positiewe persone antiretrovirale middels hierdie klinieke ontvang. Deelnemers vrees dat familielede te hore gaan kom van hul positiewe status deur dit van ander te hoor.

- **Vrees om bewus te wees van moontlike positiewe MIV status kan lei tot depressie en geestesongemak**

Gevoelens van depressie en geestelike ongemak wat gepaard gaan met 'n bewustheid van 'n MIV-positiewe status dra daartoe by dat swanger vroue nie tot toetsing wil instem nie. Deelnemers rapporteer dat hulle bang is vir die realiteit van hul sterflikheid wat versterk kan word deur intieme verhoudings met MIV positiewe persone.

- **Verskille tussen die beraders en swanger vroue se persoonlikheidseienskappe**

Sommige swanger vroue het beraders ervaar as minagtend en veroordelend, soos in die geval waar die jonger swanger vroue deur die berader veroordeel is omdat hulle nie getroud was nie en dat hulle na haar mening te jonk was om swanger te wees.

'n Unieke bevinding was dat jonger swanger vroue nie op hul gemak voel om met ouer beraders oor hul seksuele gedrag te praat nie. Die ouderdomsverskil het gevolglik 'n invloed gehad op hul keuse om tot toetsing in te stem al dan nie.

3.2.3 Fasiliterende faktore ten opsigte van die swanger vrou se keuse om nie tot MIV toetsing in te stem nie

Die derde doelwit was om die fasiliterende faktore wat 'n rol speel in die swanger vroue se keuse tot MIV toetsing te verken en te beskryf. "Waarom het jy ingestem tot MIV-toetsing?" Dit was 'n vraag wat tydens die onderhoude aan die swanger vroue gerig is. Hooftemas wat uit hul antwoorde gekristalliseer het, was dat hulle 'n behoefte gehad het daaraan om ingelig te wees oor hulle MIV-status en dat hulle hul ongebore babas teen vertikale oordrag van MIV wou beskerm. Die feit dat swanger vroue voldoende inligting deur middel van MIV-berading en in die vorm van inligtingspamflette ontvang het en dat hul verseker is van hul familie se ondersteuning, was ook fasaliterend in die swagner vrou se keuse om MIV toetsing te ondergaan. Omdat fasiliterende 'n positiewe bydrae tot die swanger vrou se keuse om MIV-toetsing te ondergaan lewer, is dit belangrik dat sodanige faktore versterk moet word. Daardeur sal meer swanger vroue moontlik tot MIV-toetsing instem.

- **Begeerte om bewus te wees van eie status**

Deelnemers wat ingestem het tot toetsing het gerapporteer dat hulle die behoefte gehad het om bewus te wees van hul eie status. Deelnemers het ook aangedui dat hulle daarvan bewus was dat MIV toetsing aangebied word tydens voorgeboortelike besoeke.

- **Begeerte om baba te beskerm**

Deelnemers het aangedui dat hulle bewus was van die voorkoming van moeder-na-kind-oordragprogram en dat hulle hul babas wou beskerm.

- **Voldoende inligting**

Meeste deelnemers het gerapporteer dat hulle genoegsame inligting by die voorgeboortelike klinieke ontvang het rakende die belangrikheid van MIV toetsing gedurende swangerskap.

- **Versekering van ondersteuning**

Deelnemers wat bewus was dat hulle familielede hulle sal ondersteun ten spyte 'n positiewe MIV status was meer gewillig om tot toetsing in te stem.

3.3 TEKORTKOMINGE

Ten spyte daarvan dat die studie 'n omvangryke bespreking gee van swanger vroue se ervaringe ten opsigte van MIV-toetsing en van die belemmerende en fasiliterende faktore wat 'n rol speel in hul keuse tot toetsing, kom beperkinge in hierdie studie tog voor. Eerstens is 'n klein steekproef by die studie betrek wat nie al die swanger vroue in die Potchefstroom–subdistrik verteenwoordig nie. Tweedens sou ryker data verkry kon word indien meer swanger vroue wat MIV-toetsing geweier het, by die studie ingesluit kon word. Navorsingsbevindinge is gebaseer op data soos verkry gedurende onderhoudvoering. Die feit dat die navorser self onderhoude gevoer het, en daarmee saam die verskillende taal- en kultuurgroepe onder die deelnemers, kon tot misverstande gelei het of dat deelnemers hulle nie bevredigend kon uitdruk nie.

3.4 AANBEVELINGS MET SPESIFIEKE VERWYSING NA DIE VERHOGING VAN DIE OPNAMESYFER VAN MIV-TOETSING ONDER SWANGER VROUE

Na aanleiding van die literatuurstudie, die navorsingsresultate en die gevolgtrekkings wat daaruit voortgespruit het, word die volgende aanbevelings aan die hand gedoen. In hierdie afdeling word aanbevelings vir die verpleegonderwys, verpleegnavorsing en die verpleegpraktyk uiteengesien.

3.4.1 Aanbevelings vir die verpleegpraktyk

Die sukses van die implementering van aanbevelings om instemming tot MIV-toetsing onder swanger vroue te verhoog berus by geregistreerde verpleegkundiges, vroedvroue en die beraders wat by die lewering van MIV-voortoets-beradingsdienste betrokke is.

- **Motivering van swanger vroue om tot MIV-toetsing in te stem.**

Die geregistreerde verpleegkundige en vroedvrou tree as fasiliteerder op wat betref die swanger vrou se besluitnemingsproses rakende haar gesondheid. Swanger vroue kan slegs ingeligte besluite neem as hulle oor voldoende inligting beskik. Swanger vroue moet ondersteun word in hul besluitneming rakende optredes wat tot voordeel van haar en haar baba se gesondheid sal strek om sodoende suksesvolle optimale selfsorg te bereik. Indien swanger vroue voortoets-berading meer positief ervaar kan dit bydra dat meer swanger vroue se MIV status bekend is tydens baring.

Die fasiliterende faktore soos geidentifiseer in hierdie studie, behoort versterk te word omdat dit as motivering kan dien om vroue aan te moedig om in te stem tot toetsing. Swanger vroue behoort voortdurend inligting te ontvang oor die voordele daarvan om bewus te wees van hulle MIV status. So kan hulle dan ingeligte besluite neem ten opsigte van maatreëls om moeder-na-kind-oordrag van MIV te voorkom.

- **Aanmoediging van beraders om meer sensitief te wees vir die behoefte van swanger vroue**

Beraders behoort meer sensitief te wees vir swanger vroue se behoeftes omdat MIV so 'n sensitiewe onderwerp is. Swanger vroue behoort te voel hulle word gerespekteer en ondersteun in hul keuse om MIV toetsing te ondergaan. Omdat beraders onder moeilike omstandighede van hoë pasiëntsyfers en emosionele uitputtende werk moet funksioneer, ervaar hulle dikwels spanning. Swanger vroue kan beraders as veroordelend en onsensitief teenoor hulle behoeftes ervaar. Omdat beraders onder toesig van geregistreerde verpleegkundiges werk moet die verpleegkundiges toesien dat die beraders die nodige opleiding ontvang en voortdurend opgeskerp word.

- **Meer beraders beskikbaar vir dienslewering**

As gevolg van die hoë werkslading moet meer beraders in die klinieke beskikbaar wees. Hierdeur kan meer swanger vroue geakkommodeer word, en beraders kan dan makliker vertrouensverhoudinge met swanger vroue opbou. Baie vroue het die behoefte om tuis te gaan nadink oor hul keuse om MIV-toetsing te ondergaan. As die swanger vrou die berader vertrou, gaan sy meer op haar gemak voel om vir toetsing terug te keer.

Jonger beraders behoort in klinieke beskikbaar te wees om jonger swanger vroue te beraad. Jonger

Toetsing tydens tweede of opvolgende besoeke

MIV-toetsing hoef nie direk na afloop van voortoetsberading te geskied nie. Swanger vroue wat voel dat hulle daaroor wil gaan nadink, moet die geleentheid gegun word om dit te doen. MIV–toetsing kan tydens die tweede besoek aangebied en gedoen word. Indien die swanger vrou steeds weier, moet haar besluit gerespekteer word. Dit is belangrik dat swanger vroue, indien hulle toetsing sou weier, die geleentheid gegun behoort te word om tydens elke besoek getoets te word, totdat hulle gereed voel en tot toetsing instem.

- **Vermindering van MIV stigmatisering en diskriminasie**

Geregistreerde verpleegkundiges en beraders moet saamwerk om MIV stigmatisering en diskriminasie te verminder deur veldtogte te hou waarin die gemeenskap betrek word. Deurdat die gemeenskap ingelig word van die voorkoming van MIV, behandeling, gesondheidsorg beskikbaar, ondersteuning en die MIV-positiewe persoon se regte kan daar sodoende gepoog word om diskriminasie teen MIV-positiewe persone te verminder en stigma te verminder.

- **Beskerming van konfidensialiteit**

Beraders en geregistreerde verpleegkundiges moet herinner word aan die belangrikheid van die beskerming van konfidensialiteit van die pasiënt. Kennisgewings moet aangebring word in die klinieke waarin daar verseker word dat konfidensialiteit van pasiënte se MIV status beskerm word en dat konfidensialiteit en vertoulikheid hul reg is.

Gemeenskappe kan betrek word by die beskerming van MIV-positiewe persone se regte deurdat hulle bewus daarvan gemaak word dat 'n persoon se MIV status konfidensieel is al het die MIV-positiewe persoon dit vertoulik bekend gemaak. Deurdat die gemeenskap bewus is van die MIV-positiewe persoon se regte kan dit sondoende ook bydra tot die vermindering van diskriminasie.

3.4.2 Aanbevelings vir die verpleegonderwys

- Om die opnamesyfer van MIV-toetsing onder swanger vroue te verhoog moet geregistreerde verpleegkundiges en vroedvroue selfs na hul basiese opleiding deurlopend betrokke wees by indiensopleiding en selfstudieprogramme om die jongste kennis te bekom rakende verpleegsorgpraktyke sowel as bewysgebaseerde praktyke. Aangesien MIV-toetsing die kern-intreepunt tot die voorkoming van moeder-na-kindoordrag is, word heelwat navorsing gedoen oor die faktore wat 'n rol speel by MIV berading-en-toetsing met betrekking tot swangerskap. Dit is belangrik dat reeds gekwalifiseerde verpleegkundiges en vroedvroue sowel as leerders wat basiese opleidingsprogramme volg, ingelig behoort word oor die jongste ontwikkelinge op die gebied van MIV-navorsing.

- Kommunikasievaardighede moet deel uitmaak van basiese MIV-beradingsopleidingsprogramme, aangesien die geregistreerde verpleegkundige toesig hou oor beraders en self by berading, gesondheidsvoorligting en verwysing van swanger vroue betrokke is. Die geregistreerde verpleegkundige moet die beraders onderrig in die aanwend van kommunikasievaardighede om doeltreffend met swanger vroue te verkeer ten opsigte van die verskaffing van voor-en natoetsberading. Kommunikasievaardighede wat versterk moet word is om oop einde vra te rig, reflektering, parafrasering en aanmoediging te gebruik. Hierdie tegnieke kan aangeleer word deur rolspel.

  Beraders, geregistreerde verpleegkundiges en vroedvroue behoort opgelei te word om sensitief te wees vir swanger vroue se behoeftes. So behoort hulle voortdurend daarop attend gemaak word om vroue in privaatheid te beraad, vertroulikheid te handhaaf en vertrouensverhoudings met hulle pasiënte op te bou. As swanger vroue in 'n vertrouensverhouding met die beraders en verpleegkundiges staan, sal vroue meer op hul gemak voel om na die kliniek terug te keer vir toetsing omdat hulle veilig voele en daar in hulle emosionele behoeftes voorsien word.

- Spesifieke kennis rakende vertikale oordrag van MIV is noodsaaklik. Beraders veral, moet oor voldoende en spesifieke kennis beskik rakende die oordrag va MIV, aangesien hulle die persone is wat voorteotesberading aan swanger vroue gee. Beraders behoort oor die vermoë te beskik om swanger vroue se vrae korrek te kan beantwoord en sodoende misverstande te voorkom. Deurdrat beraders oor die spesifieke kennis beskik, kan hulle die korrekte inligting aan die swanger vroue rakend die voorkoming van moeder-na-kindoordrag verstrek

3.4.3 Aanbevelings vir verpleegnavorsing

Verdere navorsing is nodig om te bepaal of aanbevelings daartoe sal bydra om die opnamesyfer van MIV-toetsing onder swanger vroue in die Noordwes-Provinsie sal verhoog. Na aanleiding van die resultate van hierdie navorsing bestaan die moontlikheid om verdere navorsing oor die volgende aspekte uit te voer:

- Navorsing om te bepaal wat die rol van ouderdomsverskille binne verskillende kulture is ten opsigte van die beskikbaarstelling van MIV-berading aan jonger swanger vroue.
- Navorsing om te bepaal watter ondersteuning swanger vroue van hul families ontvang wanneer hulle MIV-toetsing oorweeg.
- Navorsing om ondersoek in te stel na die ondersteuning wat MIV-positiewe moeders van hul familie ontvang as hulle voorkoming van moeder-na-kindoordrag klinieke besoek.

3.5 SAMEVATTING

Die navorser is van mening dat die navorsingsdoelstellings, naamlik dat swanger vroue se ervaring van MIV-voortoetsberading bepaal moes word, en die belemmerende sowel as fasiliterende faktore wat 'n rol speel in swanger vroue in die Potchefstroom-subdistrik se keuse ten opsigte van MIV-toetsing te verken en te beskryf bereik is en dat voldoen is aan die doel om aanbevelings te doen wat daartoe kan lei dat die opnamesyfer van MIV-toetsing onder swanger vroue kan verhoog.

Die gevolgtrekking kan gemaak word dat swanger vroue tyd nodig het om na te dink oor hul keuse ten opsigte van MIV-toetsing, aangesien 'n verskeidenheid belemmerende

faktore 'n rol speel in hul keuse om tot toetsing in te stem. Die meeste swanger vroue is tevrede met en gerus oor die wyse waarop voortoetsberading gedoen word; dus is daar nie aanbevelings gemaak om die wyse waarop dit uitgevoer word, te verander nie. Die motivering onder swanger vroue om wel tot toetsing in te stem spruit voort uit hul behoefte om ingelig te wees oor hul MIV-status en om hul babas te kan beskerm.

Aanbevelings is gedoen wat voortgespruit het uit gevolgtrekkings gebaseer op die navorsingsbevindinge. Aanbevelings is geformuleer met spesifieke verwysing na verpleegpraktyk, verpleegonderrig sowel as verpleegnavorsing. Verdere studies soos in die aanbevelings uiteengesit, is egter nodig om die geslaagdheid en doeltreffendheid daarvan te evalueer.

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Aanhangsel A

Toestemming om van die Etiekkomitee

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Mrs C S Minnie
Internal Box 520
Potchefstroom Campus
North-West University

Ethics Committee
Tel (018) 299 2564
Faks (018) 297 5338
E-Mail Ethics@nwu.ac.za

15 May 2007

Dear Mrs Minnie

APPROVAL FOR EXPERIMENTING WITH HUMANS (QUALITATIVE RESEARCH)

Hereby I wish to inform u that your project with the title "HIV testing during pregnancy" has been approved on 8 December 2004 with a project number 04K26.

Please use the number mentioned in paragraph 1 in all correspondence concerning the above mentioned project. Also note that it is expected from project leaders to complete an annual report in June which will be send to the Research Ethics Committee regarding ethical aspects as well as publications produced from the research.

Approval is valid for 5 years (according to a Senate Decision on 4 November 1992, art 9.13.2). For the continuing of projects after the expiring date of the project, new approval is needed for the project.

We wish you all the best with your research.

Kind Regards

RONEL PIETERSE
SECRETARIAT

Aanhangsel B

Toestemming van die Departement Gesondheid

NORTH WEST DEPARTMENT OF HEALTH

Healthy Living for All

North West Province

Republic of South Africa

3rd Floor Tirelo Building
Dr Albert Luthuli Drive
Mafikeng, 2745
Private Bag X2068
MMABATHO, 2735

OFFICE OF THE DDG

Enq: K. Mangonyane
Tel: (018) 387 5833/6
Tel (018) 387 5816
www.nwhealth.gov.za

29 August 2005

Ms C.S Minnie
North West University(Potchefstroom Campus)
North West Province

SUBJECT: Approval for Research: **HIV Testing in Pregnancy in the North West Province**

Approval is granted to conduct the above study in the North West Province, kindly make relevant arrangements with the management for suitable dates and times. Detail at the bottom of this letter has to be completed by you and returned to the Knowledge Management Directorate before your study may commence.

Regards

.....

O. Mongale
NWDOH Head of Department

The NWDoH will be furnished with final research report by

.....31/5/2007.....
Submission date of the final report

.....

C.S Minnie

Aanhangsel C

REQUEST FOR ASSISTANCE OF MEDIATORS

Dear Sir/Madam,

I am currently busy with my M.Cur degree in Midwifery and Neonatal Nursing science at the Potchefstroom University for Christian Higher Education. In order to complete this degree, as well as obtain my registration in advanced midwifery and neonatal nursing, I need to carry a research project into effect. I hereby request permission to undertake data collection at Potchefstroom Hospital during September to December 2006 My research forms part of an overarching research project on HIV-testing in Pregnancy in the North-West Province.

The topic of my research is: **THE PREGNANT WOMAN'S CHOICE TO HIV-TESTING.**

The purpose of my research is:

- To establish pregnant women's personal experience regarding HIV pre-test counselling,
- To establish other personal factors that contribute to pregnant women refusing HIV-testing,
- To formulate guidelines for HIV pre-test counselling that will promote the uptake of HIV-testing by pregnant women in the North West Province.

For purposes of this research, individual interviewing will be used in order to establish pregnant women's personal experience regarding HIV pre-test counselling as well as other personal factors that contribute to pregnant women refusing HIV testing in the North-West Province.

For purpose s of data-collection, the chief professional nurse in the ante-natal ward will be requested to act as coordinator. Her role will be as follows:

1. To act as mediator or to identify potential mediators, who in their turn can identify participants as set out below in the criteria for inclusion, namely:

    - Pregnant women who are hospitalized and who have refused HIV-testing after having received pre-test counselling;
    - Pregnant women who wish to voluntarily participate in the research;
    - Mediators who have full command of Afrikaans, English or Setswana.

2. Te engage in conversation with the mediators as soon as they have identified a participant, and to explain the purpose of the research with him/her so that, if this identified mediator gives consent to participate in the research, he/she can make an informed decision;

3. At specific hours, as agreed upon, when the researcher will be at the hospital to conduct interviews.

4. In order to protect confidentiality of participants, it will be necessary for interviews to be conducted in a private room at the hospital. Interviews will be conducted individually and last up to 20 minutes.

5. Assist the researcher in obtaining informed consent in writing from participants who have already verbally given their consent;

6. To act as interpreter for the researcher, should questions need further explanation in Setswana.

7. To inform the researcher if participants in the research possibly experience mental discomfort after having been exposed to interviewing. A psychology nurse will assist the participants if necessary.

Permission to conduct my research has been obtained from the District Manager of the North-West Department of Health, Mr O Mongale as well as the Ethics Committee of the Potchefstroom Campus of the North-West University, with number 04K26.

Anonymity and confidentiality of participants will be protected throughout the study. The research will be conducted under the guidance of knowledgeable academics in the School of Nursing at the Potchefstroom Campus of the North-West University.

I hope this request for conducting my research in Potchefstroom Hospital will be viewed favourably and that permission will be granted to conduct data-collection in your hospital and to obtain my registration in advanced midwifery and neonatal nursing. Should you require more information with regard to this research, you may contact me at the following numbers:

(Home): **********
(Cell) : **********

I appreciate your attention to my request.

Kind regards

Ilza Gerrits

Aanhangsel D

COVER LETTER FOR PARTICIPATION IN RESEARCH

Dear participant

I am currently busy with my M.Cur degree in Midwifery and Neonatal Nursing Science at the North-West University, Potchefstroom Campus. In order to complete this degree, I need to carry a research project into effect. I have acquired permission to do the research in the Potchefstroom district as part of the group research project on HIV-testing in pregnancy in the North-West Province and from the Ethics Committee of the North-West University (number 04K26).

The topic of my research is: **THE PREGNANT WOMAN'S CHOICE ON HIV-TESTING**

The purpose of my research is:

- To establish pregnant women's personal experience regarding HIV pre-test counselling;
- To establish other factors that contribute to pregnant woman refusing HIV-testing;
- To formulate guidelines for HIV pre-test counselling that will promote the uptake of HIV-testing by pregnant women in the North-West Province.

I hereby wish to obtain permission from you to participate in this research. Your participation will include that we meet for an interview, which will be recorded on a voice recorder and will last approximately half an hour. The interview will take place in a comfortable room where your privacy is ensured. Your name will not be in the research report or publication and all information you give to me will be kept strictly confidential.

Participation in this research is voluntary and you can withdraw at any stage without being discriminated against. If during any stage you feel uncertain as to the meaning of any questions, please ask me or the mediator to interpret and clarify questions.

If you experience any discomfort during or after completion of the interview, a support person will be available for counselling.

Thank you for your willingness and agreement to participate in this research project. You are kindly requested to sign the attached consent form or to give verbal consent to confirm that you are voluntarily participating in this research.

Yours sincerely
I. Gerrits
Contact no: **********

Aanhangsel E

VOLUNTARY INFORMED CONSENT FORM

RESEARCH TITLE: THE PREGNANT WOMAN'S CHOICE TO HIV-TESTING.

The researcher:

I have discussed the risks, benefits and obligations involved in this research project with the participant, and in my opinion the participant understands this information.

_____ _____

Researcher Date

The participant:

Hereby I give consent to voluntarily participate in the above-mentioned research project. I agree to participate in an interview that will be recorded on tape. I understand that my participation is voluntary and that I may refuse to participate or withdraw from the research project at any stage.

_____ _____

Participant Date

Aanhangsel F

Veldnotas

Observasienotas:

Deelnemer is 24 jaar oud. P0G1. Sy is getroud, het matriek voltooi en werk nie tans nie. Sy kom goed versorg voor, dra 'n netjiese sweetpak en is nie oorgewig nie. Die deelnemer kom fisies gesond voor. Was die vorige nag opgeneem met 'n diagnose van vals kraam. Deelnemer vir ontslag. Sy het vrywillig ingestem tot onderhoudvoering en was gretig om met my te gesels. Die deelnemer is Engels en Tswana magtig en het met gemak in Engels met my gekommunikeer. Die onderhoud is in privaatheid in die dokters se ruskamer by Potchefstroom Hospitaal gevoer nadat die deelnemer skriftelik vrywilliglik ingestem het om aan die navorsing deel te neem.

Teoretiese notas:

Die deelnemer het met gemak en vrymoedigheid met die navorser in gesprek getree. Gedurende die onderhoud het dit na vore gekom dat sy ongemaklik gevoel het tydens haar voortoets-berading aangesien die berader ouer as sy was en met tye veroordelend was teenoor haar. Die deelnemer meld dat sy ingestem het tot MIV-toetsing vir haar baba se onthalwe en dat sy in die verlede ook op verskeie geleenthede tot MIV-toetsing ingestem het en dat sy nie bang was om bewus te wees van haar status nie.

Metodologiese notas:

Die navorser het toestemming by die suster in bevel van die kraam afdeling gekry om die onderhoud in die dokters rus kamer te voer. Die vertrek is agter in die kraamkamers geleë en is goed belig en geventileer. Die navorser en deelnemer het teenoor mekaar gesit in gemaklike stoele. Personeel is ingelig dat onderhoude gevoer word in bogenoemde vertrek en dat hulle asb. nie die onderhoud moet onderbreuk totdat die gesprek afgehandel is nie.

Aanhangsel G

Uitreksel uit 'n onderhoud

N: X thank you for consenting to talk to me. I just want to remind you again that this conversation will be kept confidential between us, and that you are free to end this interview at any given time. As I have explained to you before, my research is on the pregnant woman's choice tot HIV testing. When you think back to the day you had your pre-test counselling, can you remember that?

D Yes, I can.

N How did you experience it?

D My experience was fine, but then you know with us black people, we, we can't speak freely to somebody who is older then us. So the counsellor, she was really, she was like almost my mothers age. So it was very difficult for me to talk to her. So I decided to take the test because I was thinking about my baby and my health, so I took it. But then, she was great but then the age factor, but you know because with us blacks nè, we are raised to respect older people and you can't say just anything.

N ok, so then

D I think it would have been better if she was at least around my age

N Ja, and maybe younger?

D Ja

N Ok, so I understand.....

D No, not younger because she was younger then me I would feel Ja, she is younger then me, but at least around my age.

N Ja, you would have felt more freely to express yourself and your worries, whatever was bothering you, nè?

D Ja

N Tell me X, you said the age difference it made it difficult for you, because you had that respect for the lady...

D Umm, I was thinking how am I going to talk to her about sex to her, I am not respecting her then.

N Ok, so then the age difference played a role, and you did feel uncomfortable discussing your sexual relationships with her.

D Most of the ladies at the clinic, some said they didn't take the test because they felt shy of that.

N ok,

D If she would have been a bit younger.....

N It would have made it better for you?

D Ja,

N Do you think um, because some women said when I asked them, they said the people tell them to test. Was it the same experience for you?

D No, they asked me if I want to test. And they told me if I took the test it would be better for myself and the baby to know my status for the baby's sake and all. And they gave me time to think that I wanted to take the test, they weren't forceful.

N So it didn't feel like they said you must take the test, it didn't feel like they are pressuring you to take the test?

D No.