Appraisal of HIV Counseling and Testing Services Provided for Pregnant Women in Selected Government Hospitals in Ibadan Metropolis, Nigeria

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Abstract
HIV counseling and testing (HCT) is a critical gateway to treatment, care, and support services. For pregnant women, it is to access prevention of mother-to-child-transmission (PMTCT) services. However, not much has been done to appraise this service from the perspective of the recipients in Nigeria. This study documents the appraisal of the HCT services received at the antenatal care (ANC) services in three government hospitals in Ibadan, Nigeria, from the perspectives of pregnant women. Data were collected using focus group discussion guide among purposely selected 40 (21 primigravida and 19 multigravida) pregnant women. Observation and inventory checklists were used to collect data on procedures and basic requirements of HCT. Content analysis was used to analyze the data. Participants were neither counseled nor given opportunity to voluntarily participate in HCT services as it was made compulsory before accessing ANC. Test results were reportedly handed over directly to participants without post-test counseling. Observation of HCT procedure showed that guidelines for counseling were not strictly adhered to. Inventory of facilities, staff, and materials revealed inadequate staffing, lack of a dedicated counseling room, and inadequate antiretroviral drugs and test kits. The HCT services as provided for pregnant women are fraught with procedural inadequacies. Training and supervision of health care workers as well as provision of resources are needed to address the situation.

Keywords
prevention of mother-to-child transmission, pregnant women, antenatal care, appraisal of HCT services, perception

Introduction
Mother-to-child transmission [MTCT] is the main cause of HIV infection in children (Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2006). Perinatal transmission has been reported to occur mostly because a significant number of women living with HIV do not receive prenatal care and not all women enrolled in prenatal care are offered voluntary counseling and testing [VCT] (Stoto, Almario, & McCormick, 1999). HIV counseling and testing (HCT) for pregnant women is therefore considered a key factor for successful prevention of MTCT [PMTCT] (Rutenberg et al., 2003).

HCT is usually integrated with antenatal care (ANC) at different levels of the health care system. However, the quality and uptake of the service vary, and it has been documented that even when HIV testing is offered as a part of ANC, many women are still tested for the first time only as they go into labor and thus do not get the full benefit from the PMTCT program (Morch, Thu Anh, Ha, & Hanh, 2006; Pai et al., 2008). VCT for HIV infection among pregnant women has been reported as a public health priority given the ability of potent antiretroviral therapy to prevent HIV infection in infants and preserve the mother’s health during pregnancy (Centers for Disease Control & Prevention, 1995, 1998; Newsman & Hoyt, 1998).

HIV testing has been proven to be a “critical gateway” to treatment, care, and support services. Knowledge of HIV
status can empower individuals and couples to take measures to prevent HIV acquisition or onward transmission. For those already infected, a positive test result is necessary to access treatment and, in the case of pregnant women, to access PMTCT services (Higgins et al., 1991; WHO; 2003). However, progress toward universal knowledge of HIV status is inadequate (Granich, Gilks, Dye, De Cock, & Williams, 2009). In 10 population-based surveys conducted in sub-Saharan Africa in 2007-2009, the median percentage of people living with HIV who knew their status was <40% (WHO, 2009). In Africa, the estimated percentage of people who know their HIV status ranges from <10% in Sierra Leone, Democratic Republic of Congo and Liberia to 40% to 56% in Kenya and South Africa. In 2009, an estimated 50% of pregnant women in Eastern and Southern Africa received an HIV test, up from 43% in 2008 (WHO, 2010).

For many years, HIV testing was delivered through a VCT model. A client-initiated approach, VCT guidelines stressed the importance of confidentiality, expressed voluntarism, and written informed consent. VCT relied on personal motivation to seek testing, which is influenced by a number of factors that might act as barriers to widespread testing (Leon, Naidoo, Mathews, Lewin, & Lombard, 2010). With <10% of key populations in low- and middle-income countries who may have been exposed to HIV accessing VCT and with evidence that many opportunities to diagnose patients with HIV were lost (Fetene & Feleke, 2010; Seipone, 2004), VCT was increasingly seen as inadequate (Fetene & Feleke, 2010; Nieburg, Cannell, & Morrison, 2005).

To address this problem in 2007, WHO issued guidance recommending the routine offer of HIV testing in clinical settings. Termed “provider-initiated testing and counselling” (PITC), this model supports recommending testing to all patients attending health facilities, including antenatal services, in countries with generalized epidemics and for those attending, for example, antenatal, tuberculosis, and sexually transmitted infection services in non-generalized epidemiological contexts (WHO, UNAIDS, 2007). PITC eliminates the need for lengthy pre-test counseling, replacing it with pre-test information that meets the minimum standard for informed consent (WHO, UNAIDS, 2007). Opt-out PITC is recommended; however, the guidance suggests that opt-in PITC should be considered for “highly vulnerable populations” (WHO, UNAIDS, 2007). PITC proponents highlight its potential impact on universal knowledge of HIV status, thereby its potential to reduce MTCT, HIV-related morbidity, and mortality (Leon, Colvin, Lewin, Mathews & Jennings, 2010), and its capacity to “normalise” HIV testing (Gruskin, Ahmed, & Ferguson, 2008). However, others have concerns that removing extensive pre-test counseling and written informed consent could lead to coercion and thus threaten the ethics and human rights of HIV testing (Bayer & Edington, 2009; Leon, Colvin et al., 2010). Prior to the WHO guidance, numerous countries had adopted the models of PITC in clinical settings, particularly in antenatal clinics in response to evidence of the effectiveness of antiretrovirals (ARV) in reducing MTCT and the urgent need to provide access to PMTCT services to pregnant women with HIV (Centers for Disease Control & Prevention, 2008; Seipone, 2004). Growing evidence suggests that adopting PITC in ANC reduces lost opportunities to test pregnant women for HIV and increases PMTCT uptake and coverage (Amornwichet et al., 2002; Chersich et al., 2008; Kharsany, Karim, & Karim, 2010; Weigel, Kamthunzi, Mwansambo, Phiri, & Kazembe, 2009).

Nigeria accounts for 13% of all HIV positive people and 19% of all AIDS-related deaths in sub-Saharan Africa with a prevalence of 3.2%; 3.4 million persons living with HIV; 51,000 new child infections and 190,000 HIV positive pregnant women; 52,500 HIV positive pregnant women receiving ARVs; 70% of HIV pregnant women not receiving ARVs; and 210,000 AIDS-related deaths and little decline in deaths between 2005 and 2013 (UNAIDS, 2014). Despite these figures, not much has been done to appraise the HCT services from the clients’ perspective in Nigeria. This study was therefore designed to bridge this gap by appraising the procedures and basic requirements of HCT services provided for pregnant women at the antenatal clinics of three government-owned hospitals in Ibadan Southwest Nigeria against the approved standard HCT service at the antenatal clinics.

Materials and Method

Study Design

The study was a qualitative one based within the phenomenological paradigm. A qualitative study method was chosen because of its usefulness in exploration of people’s perceptions, knowledge, and experiences. The focus group discussion (FGD) guide was used to ensure that similar topics were covered during the discussion as well as allowing participants to express their perceptions and lived experiences of the HCT services received during ANC. The observation and inventory checklists were used to triangulate the data from the pregnant women.

Study Setting

The study was carried out in three selected government-owned hospitals in Jericho and Yemetu areas of Ibadan. Ibadan was purposively selected because of the high number of clientele, and it houses the earliest institutions that pioneered the PMTCT program. For ethical reasons, the names of the hospitals have been coded, and these are JNH, GHJ, and AMTH. The JNH, a 36-bed hospital was established in 1927 to cater for the health need of the Caucasian residents in the Government Reservation Area before later expansion. The GHJ is a 26-bed hospital made up of three wards—the maternity, male, and female ward, whereas AMTH was founded in the year 1927 under the colonial administration as a General Hospital for the indigenous people of Ibadan and...
its environ. It later metamorphosed into a Teaching Hospital specializing in ANC services including HCT services.

**Sampling Method**

Sampling for this study was purposive based on whether the pregnant women were first-time mothers or not. Pregnant women attending antenatal clinic were approached after the usual clinic routine and were informed that a study was being conducted on pregnant women’s perception of HCT services received during ANC, and those willing to spare an hour to participate in the discussions were welcome. The clinic staff introduced the researchers, and the researchers briefly explained the objective of the research, which was to understand their perception of HCT services received from the clinic. The discussion groups were homogenized by whether they were carrying their first pregnancy or subsequent pregnancies.

**Data Collection Method**

**FGDs.** Pretested FGD guide was used for data collection. The FGD guide was developed in English, translated into Yoruba, the language of the study area, and re-translated into English language. Data collection was facilitated by the use of trained field assistants who were well versed in data collection after 1-day training.

Six FGDs were conducted: three for primigravida and three for multigravida women. Topics discussed were knowledge of HIV/AIDS and perceptions on HCT services. This was further aided by probing questions. Each focus group session began with a welcome, brief introduction of the research project, objectives, and setting of the ground rules. Ground rules covered issues of confidentiality of the discussion, the fact that the session was being recorded, and that there were no wrong or right answers. It was emphasized that all individual opinions and assertions were important and should be respected as well as the fact that participation was voluntary and individuals had a right to withdraw from the study at any time. After the introduction, the first question was posed and the discussion proceeded. Each participant was given an opportunity to speak until the information was saturated and no new ideas were emerging. The six field assistants worked in a team of two, and each team along with a researcher moderated and recorded the discussions. The researcher in the group moderated the discussion while the two field assistants acted as note takers and observers. The discussions were held in vernacular language. A short questionnaire on age and educational level was administered at the end of the discussions. A summary of the main views was made at the end. Each participant was given a 36 g biscuit and a bottle of non-alcoholic beverage for the time spent during the interview. None of the participants dropped out in the process of the discussion.

**Data Management and Analysis**

All the written and recorded materials were first transcribed in Yoruba language, the language in which the discussion was held. To validate the transcripts, there was a blind translation into English and then re-translation to Yoruba language. The analysis consisted of familiarization with the transcripts; formulation of emergent themes; coding of different themes; charting, cutting, pasting, and rearrangement of data under different themes; and interpretation and explanation of findings. The analysis did not make use of any qualitative data analysis software, as the tools provided in MS Word were sufficient for manual organization of data.

**Ethical Consideration**

Ethical clearance for the study was obtained from the Oyo State Ministry of Health Ethical Review Committee, and permission to conduct the study was granted by the heads of the hospitals used. The researchers ensured confidentiality and anonymity by not divulging names of the participants and safe storage of field notes and tapes. Participation in the study was on informed consent and voluntary basis, and the right to withdraw from the study at any time was guaranteed.

**Results**

**Demographic Characteristics**

Forty pregnant women comprising 21 (52.5%) primigravida within the age bracket 20 to 32 years with a mean age of 26 ± 3.5 years and 19 (47.5%) multigravida within the 24 to 39 years age group with a mean of 28.7 ± 4.2 years participated in the FGD. Highest proportion (32.5%) of these women had secondary school education.

**Knowledge of HIV/AIDS**

Participants were generally aware of HIV and AIDS. Knowledge of HIV/AIDS was measured by asking participants to say the meaning of the acronym HIV and AIDS, and list routes of transmission and preventive measures. Many of the pregnant women in the two groups stated that they do not know or have forgotten the meaning of HIV as they chorused “we don’t know it, we cannot recall.” Those who knew what the acronymn stand for said that Human Immune Virus, Human Immune Deficiency Virus. Participants were then asked for the full meaning of the acronym AIDS, and most gave the correct full meaning of the acronym AIDS as Acquire Immune Deficiency Syndrome.

Participants were then asked what the modes of transmission of HIV were. Modes of transmission listed included use of sharp instruments, blood transfusion, unprotected sexual intercourse, and blood and blood products. Preventive measures listed that cuts across groups included “by abstaining from sex,” “by being faithful to one’s partner,” and “if you
cannot abstain from sex, use condom.” Only the multigravida groups mentioned ensuring that screened blood is being transfused.

**HCT**

All participants had heard and were aware of HCT at one time or the other. Most common sources of information between the two groups of pregnant women were the media and hospital. Participants in both groups were quick to respond in a chorus answer that they had all done the HIV test, and a large majority also stated that their husband had done the test as well.

On the process of HCT, there were divergent opinions for the three study sites, and the responses among the multigravida were more comprehensive and sequential than those of the primigravida:

> When we came here, they did counseling for us, they told us the meaning of HIV and how it can be contracted. After that our blood was taken and tested and they told us to wait for the result. They said the result could be in three ways, it may be reactive (positive), non-reactive (negative), and invalid. Whosoever is reactive will be asked to wait and they will tell her all the rules and regulations, so that the unborn child will be free from HIV. Anyone with invalid result will be asked to come back after three months. Those with negative (non-reactive) results will be asked to come back to repeat the test after six months. After this, they will give us the results and tell us to go home. (A multigravida AMTH)

> When we first came here, before we were booked and given card, they collected our blood samples. If one is negative or non-reactive after doing the test, they will ask the person to go and if the person is reactive, she will be asked to come back later to see them. (Another multigravida AMTH)

> They took our blood samples and did the test for us. (Primigravida JNH)

> When we came to this clinic, they took our blood samples, they told us that the result may be in three ways; it may be reactive, non-reactive or invalid. Those that are non-reactive were asked to come after six months and also with their husbands. Those that have it were given drugs. (Primigravida AMTH)

> When they were asked about whether they were given opportunity to participate voluntarily in the HCT, all the participants irrespective of study site and gravida status responded that they were compelled to do the test.

> They compelled us to do it and that it is compulsory for us to do it that day. They didn’t allow us to go until we did it that day. (A multigravida AMTH)

> In fact, in Adeoyo here, anybody that refuses to do the test will not be attended to. Everybody must do it before being registered. (Another multigravida AMTH)

Perceived Benefits of HCT and Motivation for Uptake

Participants were asked of the benefits for undergoing HCT. Perceived benefits listed included prevention of transmission to the unborn child, protection of the future, and reduction of death in young persons. When asked about what motivated the participants to do HIV test, majority expressed self-motivation irrespective of site or group.

> I was encouraged to do it because one, I have been wanting to know my status since it is not only sexual intercourse that can cause it, there are so many things that we are hearing about it, and I believe that by doing it, I will be rest assured that I don’t have it. Two, I will be able to monitor and watch it, in order not to have it. (Primigravida group)

> It helps you to know your status, apart from knowing your status, it is also to prevent the baby in case you have it and to guide against the complication that may arise when you are giving birth because there is a way you will be guided during delivery if you have it, To be able to know the right quarter to go to and if you don’t have it, you will be able to avoid it. (Multigravida group)

Perception of the Quality of HCT Services

Both groups agreed that the HIV testing should be encouraged but still observed some things that were wrong about the HIV testing.

> As for me, I believe it should not be voluntary, but everybody should do it in order to avoid the spread of HIV, so that other people will not be infected and that if they can do the test for people and detect it, they will be able to counsel the person on what to do and what not to do. (Primigravida)

> When some people do it, they may be given positive result and when they go to another hospital, they will be given negative result. May be the technology was not strong enough in those days, I don’t know of now, but I have heard of people that were said to be positive in one hospital and when they went to another hospitals, they were tested negative. That is one of the things that are wrong with the test. The laboratory attendant, should be more careful because sometimes they mix up blood samples together, they will give this person’s result to that person. (Multigravida group)

Key recommendation made on how to improve HCT services was,

> There should be a kind of re-assessment of the laboratories, because at times, they will say you are positive when you are
negative, so they should be assessing the laboratories bi-annually so that there won’t be error in the result they give out. They should employ more trained and qualified personnel and not just anybody. They need advanced equipment so that there won’t be mistake. (Multigravida group)

Findings From Observation and Inventory Checklists

In all the three hospitals, observation showed that there was no opportunity for voluntary participation, no partner testing was done, and in two of the three hospitals, no form of counseling was done. At the only hospital where counseling was done, it was the group counseling that was done. Other observations are shown in Tables 1 to 3.

Record of inventory of staff showed that there were medical and laboratory personnel available. There were no trained counselors in two of the hospitals and the hospital that had received their training specifically for HIV, and it was on-the-job training. There were no designated rooms for counseling in all the centers. Details of the inventory for each hospital are found in Tables 4 to 6.

Knowledge of HIV/AIDS

Women attending antenatal clinics have been used in Nigeria to determine the national sero-prevalence data, and their views are important in appraising the service used in arriving at these data. This study has therefore appraised the quality of the HCT services provided at the antenatal clinics from the perspective of the recipients. Such information is important in ensuring that the testing guidelines are followed and to identify areas that need strengthening by the authorities and the National PMTCT program. For pregnant women to access HCT services for the PMTCT, it is important to know whether they understand the benefits and whether they view HIV as a threat to them and their unborn babies. The level of knowledge about HIV/AIDS exhibited by the participants in this study influences the context within which decisions are made about the PMTCT of HIV. The participants in this study showed a high level of knowledge about the major modes of transmission of HIV including the mother-to-child route. This is a confirmation of the 2013 Nigerian Demographic Health Survey (NDHS) (National Population Commission [NPC], Nigeria, and ICF International, 2014), which documented that knowledge of HIV has increased over the years and at variance with findings of earlier studies in Nigeria, Botswana, and Zambia (Arulogun, Adewole, Olayinka-Alli, & Adesina, 2007; Mukuka & Siyandi, 1999; Nyblade & Field, 2001; Orji, Sotiloye, Fawole, & Hunyibo, 2001).

Perceived Benefits and Motivation for Uptake

Most participants were aware of the availability of HCT services at the hospital with main reason for seeking an HIV test was cited as knowing one’s status. A multi-country study on the efficacy of HIV HCT demonstrates the important role of HCT as an HIV preventive strategy (the Voluntary HIV-1 Counselling and Testing Efficacy Group, 2000). It is encouraging to note that the participants were aware of the benefits of VCT.

Perception of the Quality of HCT Services

Although most participants were supportive of routine HIV testing, they were not pleased with the mandatory way in which it was done as well as the lack of counseling services.
This is at variance with the “opt out” approach recommended by WHO and UNAIDS (2007). The “opt out” approach had resulted in dramatic and sustained increase (28%) in rates of prenatal HIV testing in Alberta, Canada (Jayaraman, Preiksaitis, & Larke, 2003), with similar trends reported in the United Kingdom and the United States (Simpson, Johnstone, Goldberg, Gormley, & Hart, 1999; Stringer, Stringer, Cliver, Goldenberg, & Goepfert, 2001). It is therefore important for those monitoring the HCT services to ensure that the “opt out” approach is adhered to so that recipients are given the opportunity to express their right of choice after being well counseled and informed.

The appraisal revealed the sub-standard setup in the national policy on HIV and AIDS of 2009. The settings were more of normal antenatal settings. There was no counseling unit, no counselors, and no counseling skills for providing HCT. Staffing was inadequate, and majority of the health workers were not trained in the skills of providing HCT. There were laboratory backups though, but test kits were scarce and not current, most cases were referred to where confirmatory test could be done. The procedure was not in keeping with the HCT protocols.

### Recommendations

Based on the findings of this study, it is recommended that not only should there be adequate number of staff, but also the staff should be trained and retrained. Adequate training and

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**Table 2.** Observation of HIV Counseling and Testing Procedure at the Antenatal Clinic of General Hospital, Jericho, Ibadan.

| S/N | HIV counseling and testing procedures | Yes | No | Remark |
|-----|-------------------------------------|-----|----|--------|
| 1.  | Pre-test counseling                  | ✓   |    | General health talks on antenatal care only. |
| 2.  | Individual counseling               | ✓   |    | Not observed                  |
| 3.  | Small-group counseling              | ✓   |    | Not observed                  |
| 4.  | Large-group counseling              | ✓   |    | It was large group health talk on general antenatal care. No specific mention was made of HIV testing. |
| 5.  | Informed consent                    | ✓   |    | Not observed. It was that all pregnant women must do the test. Test was compulsory. |
| 6.  | Use of consent form                 | ✓   |    | Consent form not in use.      |
| 7.  | Voluntary participation in HIV testing | ✓   |    | No HIV testing is a criterion before accessing antenatal care. |
| 8.  | Post-test counseling                | ✓   |    | Not observed.                  |
| 9.  | Confidential release and disclosure of result | ✓   |    | No! Results were given to pregnant women themselves from the laboratory. |
| 10. | Referral services                   | ✓   |    | Referrals were on the basis of lack of ARV and confirmatory test kits. |
| 11. | Proper follow-up                    | ✓   |    | Not observed                  |
| 12. | Partner testing                     | ✓   |    | Not observed                  |

**Note.** ARV = antiretroviral.

**Table 3.** Observation of HIV Counseling and Testing Procedure at the Antenatal Clinic of Adeoyo Maternity Teaching Hospital, Ibadan.

| S/N | HIV counseling and testing procedures | Yes | No | Remark |
|-----|-------------------------------------|-----|----|--------|
| 1.  | Pre-test counseling                  | ✓   |    | Not one-on-one, but in form of information giving to a crowd of pregnant mothers on HIV/AIDS and testing. |
| 2.  | Individual counseling               | ✓   |    | Not observed                  |
| 3.  | Small-group counseling               | ✓   |    | Not observed                  |
| 4.  | Large-group counseling               | ✓   |    | Yes, a large group of about 35 pregnant women who came to book at the antenatal clinic. |
| 5.  | Informed consent                    | ✓   |    | Though they were informed and consented but it was obvious that no one wanted to be the odd person out of majority that wanted the test. |
| 6.  | Use of consent form                 | ✓   |    | Majority of the pregnant women were helped by the counsellors to fill the forms. |
| 7.  | Voluntary participation in HIV testing | ✓   |    | They all participated but it was not voluntary but it must be done in order to be registered and attended to at the ANC. |
| 8.  | Post-test counseling                 | ✓   |    | Also, it was on the large group basis because large majority were tested negative. |
| 9.  | Confidential release and disclosure of result | ✓   |    | Result was released based on the fact that majority tested negative |
| 10. | Referral services                   | ✓   |    | Not observed this day.        |
| 11. | Proper follow-up                    | ✓   |    | No one was followed up.       |
| 12. | Partner testing                     | ✓   |    | Not observed                  |
Table 4. Inventory of Basic Requirements for HIV Counseling and Testing Services at the Antenatal Clinic of Jericho Nursing Home, Ibadan.

| S/N | Requirements for HIV counseling and testing services | Yes | No | Remark |
|-----|----------------------------------------------------|-----|----|--------|
| 1.  | Staffing                                           |     |    |        |
| a.  | Doctors                                            | ✓   |    | Few doctors were attached to the antenatal clinic |
| b.  | Nurses/midwives                                    | ✓   |    | Nurses and midwives were available in good number |
| c.  | Laboratory scientists                              | ✓   |    | Only one laboratory scientist was available |
| d.  | Counselors                                         | ✓   |    | Nil available. Nurses and midwives carried out the duty when they give health talks on general antenatal care. |
| e.  | Others (specify)                                   |     |    |        |

2. Facilities and materials

| S/N | Requirements for HIV counseling and testing services | Yes | No | Remark |
|-----|----------------------------------------------------|-----|----|--------|
| a.  | Counseling section                                 | ✓   |    | Nil. Nurses in the antenatal clinic perform the health talk with the pregnant women. |
| b.  | Nursing rooms                                       | ✓   |    | Nil. |
| c.  | Laboratory backups                                 | ✓   |    | There is a laboratory back up. |
| d.  | Reagent kit for HIV testing                        | ✓   |    | Not adequate at all referrals to other centres were based on that. |
| e.  | Provision of ARV drugs                              | ✓   |    | Not available at all. |

Note. ARV = antiretroviral.

Table 5. Inventory of Basic Requirements for HIV Counseling and Testing Services at the Antenatal Clinic of General Hospital, Jericho, Ibadan.

| S/N | Requirements for HIV counseling and testing services | Yes | No | Remark |
|-----|----------------------------------------------------|-----|----|--------|
| 1.  | Staffing                                           |     |    |        |
| a.  | Doctors                                            | ✓   |    | Doctors were available. |
| b.  | Nurses/midwives                                    | ✓   |    | Nurses and midwives were available in good number. |
| c.  | Laboratory scientists                              | ✓   |    | Only one laboratory scientist was available. |
| d.  | Counselors                                         | ✓   |    | No counsellors at all. |
| e.  | Others (specify)                                   |     |    |        |

2. Facilities and materials

| S/N | Requirements for HIV counseling and testing services | Yes | No | Remark |
|-----|----------------------------------------------------|-----|----|--------|
| a.  | Counseling section                                 | ✓   |    | No counselling section. |
| b.  | Counseling rooms                                   | ✓   |    | No counselling room. |
| c.  | Laboratory backups                                 | ✓   |    | Available but not with adequate staff. |
| d.  | Reagent kit for HIV testing                        | ✓   |    | Available but grossly inadequate. |
| e.  | Provision of ARV drugs                              | ✓   |    | Not available at all. |

Note. ARV = antiretroviral.

retraining of health worker in skills of providing quality HCT services as well as supply of up-to-date equipment to meet the ever increasing demand of HCT are recommended. Also, an effective monitoring mechanism should be put in place to ensure that quality services are rendered. As there appeared to be a dearth of counselors from the findings of this study, there is the need to train more lay counselors and station them at clinics to provide counseling services at the facilities. Health promoters should harness the findings from this study as evidence for interventions to improve uptake of HCT services.

Nurses and midwives working in ANC have a huge responsibility to be patient advocates in HIV and AIDS care and management generally and more specifically with regard to HCT. The “force” or “obligatory” note found in this study did not reflect its confidentiality and voluntariness and should be given due attention. Positive results are difficult to divulge to patients who are forced to have testing done and may contribute to the spread of the virus.

Conclusion

Participants in our study were highly knowledgeable about HIV/AIDS, and HCT during ANC was considered a good initiative. Perceived benefits included prevention of transmission of HIV to the unborn child, protection of the future, and reduction of death of young persons. Knowing one’s HIV status was seen as the most important reason for HCT as such knowledge would help reduce HIV risk behavior.
Because most participants were highly supportive of antenatal HIV testing, introducing an “opt out” approach in all clinic setting is important to increase uptake. More importantly, arising from this study is the fact that program managers need to devise ways of constantly receiving feedback from the clients so as to improve the running of the program. Some clients may have some negative views about the program as evidenced in this study that might lead to poor HCT uptake. Unless mechanisms are put in place to receive those views, effective program functioning can be compromised.

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