

**An Ounce of Prevention:
Understanding the barriers and motivations to HIV testing among
women in Trinidad and Tobago**

by

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ABSTRACT

AN OUNCE OF PREVENTION:

Understanding the barriers and motivations to HIV testing among women
in Trinidad and Tobago

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Ever since its discovery in Trinidad and Tobago in 1983, HIV/AIDS continues to pose a significant threat to the government's vision for national development. Despite significant progress being made, many challenges exist including the feminization of the epidemic with women representing more than half of all new infections. This thesis explores the barriers and motivational factors impacting on behavioural change among women in Trinidad and Tobago as it relates to Voluntary Counselling and Testing (VCT) for HIV. The epistemological approach taken was based on social constructivism and interpretivism. The methodology included semi-structured interviews with 31 participants, a visual ranking survey with 241 respondents and observation. The findings reveal that the barriers and motivations impacting on women's uptake of VCT are highly interconnected and so consistent, targeted cues to action and strong community level support are crucial in order to increase women's likelihood of action and sense of self-efficacy.

AN OUNCE OF PREVENTION

For Amelia,
Everything I do, I do for you

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TABLE OF CONTENTS

Abstract	ii
Dedication	iii
Acknowledgements	iv
List of Figures	viii
List of Tables	ix
Chapter One: Introduction to the Study.....	1
1.0 Background and Rationale	1
1.1 Connecting the researcher to the research – An insider’s perspective	5
1.2 Research Goal and Objectives	5
1.3 Significance of the Research	6
1.4 Organization of the thesis	7
Chapter Two: Literature Review and Conceptual Framework.....	9
2.0 Introduction	9
2.1 The HIV epidemic	9
2.1.1 Where do we stand? – A global perspective	9
2.1.2 HIV in the Caribbean	12
2.2 HIV in Trinidad and Tobago	16
2.3 HIV and women	21
2.4 Behaviour change – A theoretical overview	27
2.4.1 Introduction	27
2.4.2 Communication and Behaviour Change Strategies for HIV Prevention	30
2.4.3 Health Belief Model	32
2.4.4 Health Decision Model	35
2.4.5 Precaution Adoption Process Model	36
2.4.6 AIDS Risk Reduction Model	39
2.4.7 Community Readiness Model	43
2.5 Conceptual framework	47
2.6 Summary	49
Chapter Three: Methodology.....	51
3.0 Introduction	51
3.1 Epistemological Approach	51
3.2 Site description – Trinidad and Tobago	52
3.3 Research design	56
3.4 Methodology	57
3.4.1 Observation	57
3.4.2 Key Informant Interviews	59
3.4.3 Visual ranking survey	60

AN OUNCE OF PREVENTION

3.5 Qualitative Data Analysis	61
3.6 Quantitative Data Analysis	62
3.7 Limitations	63
Chapter Four: Results.....	66
4.0 Introduction	66
4.1 Respondent profile	66
4.2 Barriers	69
4.2.1 Community level barriers	70
4.2.2 Intrapersonal level barriers	76
4.2.3 Interpersonal level barriers	79
4.3 Motivations	83
4.3.1 Intrapersonal level motivations	84
4.3.2 Interpersonal level motivations	87
4.3.3 Community level motivations	89
4.4 Cues to Action	92
4.4.1 Types of cues	92
4.4.2 Contribution to barriers	95
4.4.3 Seasonality of messaging	97
4.5 Summary	98
Chapter Five: Discussion of Findings.....	100
5.0 Introduction	100
5.1 Barriers and motivations and associated links	100
5.2 The importance of civil society and community level interventions	109
5.3 Exploring the cues to action	113
5.4 Putting the pieces together – the conceptual framework revisited	120
5.5 Summary	122
Chapter Six: Summary, Conclusions and Recommendations.....	125
6.0 Introduction	125
6.1 Final Summary and conclusions	125
6.2 Recommendations	130
6.2.1 Recommendations for the structure and delivery of the VCT program	130
6.2.2 Recommendations at the community level	133
6.2.3 Recommendations for improvements to the cues to action	135
6.3 Future Research	137
References.....	139
Appendix 1	144
Appendix 2	146

AN OUNCE OF PREVENTION

Appendix 3a	147
Appendix 3b	149
Appendix 4	151

List of Figures

Figure 2.2: The Health Belief Model

Figure 2.3: The Precaution Adoption Process Model

Figure 2.4: The AIDS Risk Reduction Model

Figure 2.4: Diagrammatic representation of the conceptual framework

Figure 3.1: Map and Geographic location of Trinidad and Tobago

Figure 3.2: Regional corporations and municipalities of Trinidad and Tobago

Figure 4.1: Distribution of respondents according to age

Figure 4.2: Distribution of respondents according to location

Figure 4.3: Percentage of Respondents per identified barrier

Figure 4.4: Percentage of respondents per identified motivation

Figure 5.1: Spheres of influence illustrating the interconnection between the barriers

Figure 5.2: Spheres of influence illustrating the interconnection between the motivations

Figure 5.3: Revised diagrammatic representation of the conceptual framework

List of Tables

Table 2.1: Estimated number of people living with HIV and adult prevalence rates

Table 2.2: Stages of Community Readiness

Table 3.1: Grouping of Municipal Corporations according to location

Table 4.1: Distribution of respondents according to specified attribute values

Table 4.2: Community level barriers

Table 4.3: Intrapersonal level barriers

Table 4.4: Interpersonal level barriers

Table 4.5: Intrapersonal level motivations

Table 4.6: Interpersonal level motivations

Table 4.7: Community level motivations

Table 4.8: Cues to action

Table 6.1: Recommendations for improvement of VCT program structure and delivery

Table 6.2: Community level recommendations made by study participants

Table 6.3: Recommendations for improvement of the cues to action

Chapter One: Introduction to the Study

1.0 Background and Rationale

In September 2000, world leaders came together at the United Nations Headquarters in New York and unanimously adopted the Millennium Declaration, which signified their unified commitment to a statement of values, principles and objectives for the international agenda for the 21st century. Among other things, this document set out a series of time-bound targets, with a deadline of 2015 that have become known as the Millennium Development Goals (MDGs). One of these goals, MDG 6, specifically addresses the tremendous global impact of HIV and AIDS and it stipulates the target of halting and reversing the spread of the disease by 2015. Significant progress has been made since the adoption of the Millennium Declaration, which has resulted in greater access to evidence-informed HIV prevention, testing and counselling, and treatment and care services in low and middle-income countries. As the health sector response has improved and capacity at all levels has increased, HIV programs have become more effective and efficient and this has resulted in a stabilization of the global incidence of HIV and, in many countries that exhibit generalized epidemics, the incidence has actually begun to decline (Joint United Nations Programme on HIV/AIDS [UNAIDS], United Nations Children's Fund [UNICEF], World Health Organization [WHO], 2011). Despite these gains however, a number of countries, still exhibit alarmingly high HIV prevalence rates, which indicates that there is still much work to be done in order to achieve the targets set out by MDG 6.

The Caribbean region is second only to sub-Saharan Africa in terms of adult HIV prevalence rates, with countries such as the Bahamas, Haiti, Jamaica and Trinidad and

AN OUNCE OF PREVENTION

Tobago exhibiting the highest prevalence rates in the region (World Factbook, 2014).

With a population of only approximately 1.3 million, the adult prevalence rate in Trinidad and Tobago is estimated to be 1.6% as of 2012 and exceeds 5% in the most at risk populations (World Factbook, 2014; Office of the Prime Minister, 2012). HIV and AIDS continue to pose a significant threat to the government of Trinidad and Tobago's vision for national development. Through a coordinated multisectoral response, significant progress has been made in the fight against the spread of the disease including a decrease in the number of newly diagnosed infections, the expansion of HIV testing and treatment sites, and a significant reduction in the number of AIDS related deaths, but many challenges still exist (Office of the Prime Minister, 2013).

One major issue is the feminization of the HIV epidemic in Trinidad and Tobago, particularly among youth between the ages of 15 to 24 (Office of the Prime Minister, 2012). In the Caribbean region as a whole, young women are approximately 2.5 times more likely than young men to become infected (UNAIDS, 2009). In 2010, UNAIDS estimated that approximately 53% of adults living with HIV in the Caribbean were women, making the Caribbean the only region in the world besides sub-Saharan Africa where there are more adult women living with HIV than men (WHO, UNAIDS & UNICEF, 2011). This increased vulnerability is largely due to biological as well as social, economic, legal and cultural factors and many of the existing AIDS strategies do not adequately address the unique needs of women and girls (UNAIDS, 2009). According to UN Women's Executive Director Phumzile Mlambo-Ngcuka in her message in commemoration of World AIDS Day 2013:

AN OUNCE OF PREVENTION

Today women and girls remain hard hit by HIV. Every hour, 50 young women are newly infected ... we should also recognize that empowering, engaging, and supporting women and girls are among the most effective means to reduce HIV infections ... Our approach must be comprehensive: empowering women and girls as agents of change, protecting them, and making political and financial commitments to address their needs. By working together to empower women and other groups affected by HIV to take action themselves, we can accelerate our progress and get closer to ending AIDS (UN Women, 2013).

Many countries in the region, including Trinidad and Tobago, have recognized the need for increased resource allocation and capacity building to address the needs and rights of women and girls as part of their HIV responses. This is further promoted by MDG 3, which addresses the need for promoting gender equality and empowering women. The Trinidad and Tobago National HIV/AIDS Strategic Plan, 2013-2018, explicitly states, “Tackling gender inequity, gender violence and improving safe sexual behaviours are key to preventing new HIV infections in Trinidad and Tobago” (p. 20).

Despite this recognition on the part of the government of the need for greater focus on women and girls, reality paints a very different picture. There are currently very few interventions in the country that specifically target women and girls and address their unique needs. From 2004 to 2010, most of the prevention interventions that were executed nationally targeted both males and females as a group. In Trinidad, only seven interventions specifically targeted women, while 21 targeted men (Noguera-Ramkissoon, 2011).

AN OUNCE OF PREVENTION

With regards to HIV testing, the Prevention of Mother-to-Child Transmission (PMTCT) program is noted to be the most successful and well-integrated program within both the public and private health sectors with over 95% of pregnant women in the country accepting counselling and testing for HIV. On the other hand, the Voluntary Counselling and Testing (VCT) program, which targets the general population, including women who are not pregnant, has not been as successful (Pan-American Health Organization [PAHO]/WHO, 2010). As of 2008, only 41.3% of women in Trinidad and Tobago had been tested for HIV and of that number, over 50% can be attributed to the PMTCT program (Network of NGOs of Trinidad and Tobago for the Advancement of Women, 2010; PAHO/WHO, 2010). These statistics clearly illustrate a serious shortcoming in the VCT program and in the prevention initiatives as a whole in reaching women. If over half of the total women that have been tested for HIV in Trinidad and Tobago accessed the service through the PMTCT program, then what happens to those women who are not pregnant or have not had children? Why are they hesitant to access the counselling and testing services voluntarily and what factors would motivate them to access the service? Also, if a woman tests for HIV, during pregnancy or otherwise, and is found to be negative, what would stop her from engaging in repeat testing at a later date and what would motivate her to do so?

Given the unique cultural nuances of Trinidad and Tobago, it would be beneficial to identify the barriers that are contributing to the low rates of testing among women through the VCT program and the factors that would motivate them to action. This exploratory study aims to identify some of these barriers and motivating factors and

AN OUNCE OF PREVENTION

provide some recommendations for a behaviour change strategy that would effectively respond to these barriers and motivate more women to undertake HIV testing.

1.1 Connecting the Researcher to the Research – An Insider’s Perspective

Being a citizen of Trinidad and Tobago and a woman, greatly influences the epistemological approach that was used for this study because it emphasizes both a gender and cultural perspective. My intimate knowledge of the culture, politics, social norms and issues surrounding gender inequality in Trinidad and Tobago provided me with an insider perspective that allowed for deeper analysis of the factors impacting on women’s decisions to get tested for HIV. It also allowed me to easily build rapport with the study participants because I was not viewed as an outsider but as a fellow citizen. In addition, having worked in the field of HIV prevention in Trinidad and Tobago, I am familiar with some of the challenges faced by the organizations that impede their ability to effectively execute sustainable prevention interventions.

1.2 Research Goal and Objectives

The overall goal of this study was to explore some of the factors impacting on the decisions of women in Trinidad and Tobago to access testing for HIV through the Voluntary Counselling and Testing (VCT) program.

The research will seek to achieve the following objectives:

1. To identify the barriers that women between the ages of 18 to 49 years face that discourage them from accessing the counselling and testing services offered through the VCT program.

AN OUNCE OF PREVENTION

2. To identify the motivating factors that influence the decisions of women, between the ages of 18 to 49 years, to seek counselling and testing for HIV.
3. To explore how the current cues to action either contribute to or respond to the barriers and motivations identified in objectives 1 and 2.
4. To make recommendations for changes to the structure and delivery of the VCT program and the current behaviour change strategy in order to effectively respond to the barriers that women face and provide stronger cues to action that would motivate them to access the program.

These objectives are presented with major research questions in Appendix 1.

1.3 Significance of the Research

According to Deblonde et al. (2010), there exists substantial literature on the factors that are associated with rates of HIV testing however, “the body of literature addressing barriers that are critical to effective HIV testing is relatively sparse” (p. 30). Barriers such as fear, stigma and discrimination, low perception of risk and lack of knowledge surrounding the efficacy of current treatments have been identified among the general population (Schwarcz et al, 2011). However, there is a gap in the literature when it comes to the barriers that affect women specifically, especially within the Caribbean. Similarly, research on the reasons why women in the Caribbean decide to undergo an HIV test is also very limited. By exploring the barriers and motivations that women in Trinidad and Tobago experience with regards to HIV testing, this study aims to not only contribute to the literature on the subject but also to look at how these identified barriers and motivations can be used to influence behaviour change among women in the country

AN OUNCE OF PREVENTION

when it comes to HIV. The results of this study can also provide program planners, not only in Trinidad and Tobago but also in other countries that have high Caribbean immigrant populations, with an insight into some of the factors that hinder and help behaviour change among Caribbean women with regards to HIV testing.

1.4 Organization of the Thesis

This thesis is organized into six sections. This first chapter provided a brief overview of the background and rationale of the study, the researcher's insider perspective and its influence on the epistemological approach, the goal and objectives as well as the significance of the research. Chapter two provides an overview of the HIV epidemic on a global and regional level as well as providing some background on HIV in Trinidad and Tobago specifically. It also looks at the impact that HIV has on women and the factors that make women vulnerable to the disease. The chapter concludes with an overview of the process of behaviour change, some of the major behaviour change theories and the conceptual framework that was used to guide the study. Chapter three outlines the epistemological approach that was used for the study, a description of the site and the methodology used to obtain data related to the barriers and motivations that impact on women's decisions to access VCT in Trinidad and Tobago. The fourth chapter presents the findings that emerged from the analysis of the data. It highlights the major barriers and motivations that were identified by the study participants and the cues to action that are currently being used to elicit behaviour change among women in the country. Chapter five elaborates on the findings presented in the previous chapter and discusses the major themes that emerged from the analysis. Chapter six, the final

AN OUNCE OF PREVENTION

chapter, concludes the thesis and presents some recommendations to help improve the success of the VCT program and recommendations for future research.

Chapter Two: Literature Review and Conceptual Framework

2.0 Introduction

Since its discovery approximately thirty years ago, HIV has continued to pose an increasing threat to the international community and to the livelihoods of people around the world. Due to the significant progress that has been made in terms of the global health sector response to HIV however, the annual number of people newly infected with HIV is on the decline but continued collective action and a stronger multisectoral response is still needed in order to achieve the Millennium Development Goal of halting the spread of the disease (UNAIDS, UNICEF, WHO, 2011).

This chapter begins with an overview of the HIV epidemic from a global perspective and then provides an overview of the situation in the Caribbean and a current look at HIV and its impact in Trinidad and Tobago. A review of the vulnerability and impact of HIV on women from a general perspective and also from the perspective of women in Trinidad and Tobago is then provided. The concept of behaviour change is then discussed before finally providing an overview of five different theoretical models of behaviour change which are often used as frameworks for many HIV prevention initiatives. The theoretical models pave the way for an explanation of the conceptual framework that was designed to guide the study.

2.1 The HIV epidemic

2.1.1 Where do we stand? - A global perspective

It cannot be denied that since its discovery in the 1980's, there has been significant progress on a global scale in the fight against HIV/AIDS. In 2000, the global

AN OUNCE OF PREVENTION

community took a major step by acknowledging the necessity of an effective response to the disease. Through this unified action, Millennium Development Goal (MDG) 6 was born. A decade later, at the 2011 High-Level Meeting on HIV and AIDS, UN Member States came together to review the progress made and to once again demonstrate their commitment to combatting the disease. They endorsed the 2011 UN Political Declaration on HIV/AIDS, which set a series of targets for 2015 (UNAIDS, 2013).

As stipulated by the 2011 UN Political Declaration, MDG 6 has three main targets, the first two of which specifically deal with HIV/AIDS: (1) Halt and begin to reverse, by 2015, the spread of HIV/AIDS; (2) Achieve universal access to treatment for HIV/AIDS for all those who need it; and (3) Halt and begin to reverse, by 2015, the incidence of malaria and other major diseases (UN Department of Public Information, 2013). As of 2012, there were approximately 35.3 million people living with HIV globally. Although this number is an increase from previous years, it is important to acknowledge the fact that more people are receiving antiretroviral therapy today. Globally, there were approximately 2.3 million new HIV infections, which shows a decline of 33 percent since 2001. The number of deaths due to AIDS has also declined from approximately 2.3 million in 2005 to 1.6 million in 2012 (UNAIDS, 2013).

Despite these gains however, there is still progress to be made if the MDG targets are to be met by 2015. Between 2001 and 2012, the annual number of new HIV infections among adults and youth decreased by 50 percent or more in 26 countries but there are still a number of countries that have not met that target. In addition, according to recent surveys in sub-Saharan Africa, decreases in condom use and/or increases in the numbers of sexual partners have been reported which illustrates that there is still work

AN OUNCE OF PREVENTION

that needs to be done in order to ensure that the number of new infections continues to decrease in these countries. With regards to transmission related to sex work and men who have sex with men, trends in prevalence indicate that efforts to reduce transmission among these high-risk groups are insufficient. Globally, the HIV prevalence rate among injection drug users remains high thus illustrating the need for continued efforts on this front (UNAIDS, 2013).

Prevention of mother-to-child transmission continues to make marked progress with an average of 62 percent of coverage in 2012 and there was decrease of 35 percent in the number of children newly infected with HIV however, progress still needs to be made to increase access to treatment for pregnant women and children. As it stands, they are currently less likely to receive antiretroviral therapy than treatment-eligible adults (UNAIDS, 2013).

Women continue to experience gender inequalities, which result in lack of autonomy, lack of power within relationships which impact on their ability to negotiate safe sex practices, economic dependency on their partners, harmful gender norms and gender based abuse and violence, which increase their vulnerability to HIV. For instance, studies have found that women who have experienced intimate partner violence were 50 percent more likely to be living with HIV but despite that statistic, less than half of the countries globally allocate funds for women's organizations. Integration of HIV and sexual and reproductive services is still insufficient and few countries have scaled-up initiatives to engage men and boys in their national responses to deal with gender issues (UNAIDS, 2013).

AN OUNCE OF PREVENTION

Another issue that still remains a major obstacle to an effective response to HIV and AIDS globally is stigma and discrimination. National surveys report that discriminatory treatment of people living with HIV is still common including discrimination when it comes to access to health care. Punitive laws and practices still exist with approximately 60 percent of countries reporting having laws, regulations or policies, which create barriers to HIV prevention, treatment, care and support (UNAIDS, 2013).

2.1.2 HIV in the Caribbean

The first cases of AIDS in the Caribbean region were reported in Haiti in 1981. By 1982, cases were also identified in Jamaica and Bermuda and by 1987 all of the countries in the Caribbean had reported at least one case of AIDS (UNAIDS, 2010). According to Calleja et al. (2002), in the 1990's, HIV prevalence rates in the Caribbean region among the general population and vulnerable groups, such as men who have sex with men, injection drug users and female sex workers, was on a slow but continuous increase. Calleja et al. (2002) also noted that most of the countries in the region that exhibited generalized epidemics were located in the Caribbean and the primary mode of transmission was heterosexual contact.

As of 2008, it was estimated that there were between 210,000 and 270,000 people living with HIV in the region, 182,000 of which were reported on the island of Hispanola. In the English-speaking Caribbean, Jamaica is reported to have the highest number of people living with HIV (28,400 as of 2012). Table 2.1 shows the estimated number of

AN OUNCE OF PREVENTION

people living with HIV and adult prevalence rates in 2012 in the different countries in the Caribbean.

Currently, the spread of HIV has slowed in the Caribbean. However, in certain countries, such as Trinidad and Tobago, HIV prevalence has continued to rise with the UN estimating that the prevalence rate in the country could potentially increase from the current 1.6% to 2% by 2015 particularly among the most at risk populations, which includes women (Noguera-Ramkissoon, 2011; UNAIDS, UNICEF, WHO, 2011; World Factbook, 2014).

Table 2.1: Estimated number of people living with HIV and adult prevalence rates among select Caribbean countries in 2012

Country	Estimated PLHIV	Adult HIV Prevalence
Bahamas	7,000	3.3%
Barbados	1,500	0.9%
Belize	3,100	1.4%
Cuba	4,700	0.1%
Dominican Republic	45,000	0.7%
Guyana	7,200	1.3%
Haiti	146,000	2.1%
Jamaica	28,400	1.7%
Suriname	4,000	1.1%
Trinidad and Tobago	14,300	1.6%

Source: World Factbook, 2014

As of 2010, HIV remains the leading cause of death among people between the ages of 20 and 59 in the Caribbean. Men who have sex with men and sex workers are

AN OUNCE OF PREVENTION

among the most vulnerable populations in the region and very often prevention interventions do not reach these groups. As a result, prevalence rates remain very high among these populations. Colonial laws still exist which criminalize sexual behaviours and orientations and add to the issue of stigma and discrimination and barriers to health care (UNAIDS, 2010).

Gender inequalities persist in the Caribbean region and the economic climate, poverty and the new information age have all contributed to changes in patterns of sexual behaviour and further increased the vulnerability of women to HIV beyond the biological vulnerability that already exists. As a result, the number of women living with HIV is increasing with an estimated 50 percent of people living with HIV in the region being women in 2008, as compared to 35 percent in 1990. The statistics are alarming. In countries such as Belize, Guyana and Trinidad and Tobago, 59 percent of people living with HIV in 2008 were women (UNAIDS, 2010).

Governmental responses to the HIV epidemic have produced some successes in dealing with the issue. All of the countries in the region have established national coordinating bodies and most have developed National Strategic Plans on HIV/AIDS to help coordinate and guide efforts however there are still some challenges with regards to implementation in the areas of policy and stigma and discrimination. Monitoring and evaluation also continues to be a challenge (UNAIDS, 2010).

In order to fully understand the HIV epidemic in the Caribbean it is necessary to look at some of the key social and cultural factors that drive it. For one, cultural constructions of masculinity and femininity in the Caribbean tend to impose obligations and restrictions on men and women leading to risky sexual practices such as early age of

AN OUNCE OF PREVENTION

sexual initiation, multiple partnering and transactional sex. According to Bombereau and Allen (2008), the median age of first sex is reported to be in the early to mid teens and in some cases, even earlier with boys. Some youth report being forced to have sex the first time that they had sexual intercourse. The age at sexual initiation among girls is generally lower than boys and some girls report first sex with significantly older men. These findings are important because studies have found that youth who become sexually active at an early age are more likely to engage in risky sexual behaviours, such as multiple partnerships, thus increasing their vulnerability to contracting HIV. Girls who are sexually initiated by an older man are particularly vulnerable since older men are usually sexually active for longer and so are more likely to be infected. Issues such as expected gender roles, sexual abuse and peer pressure add to the vulnerability of young people and are of particular importance when considering interventions (Bombereau & Allen, 2008).

The second factor driving the epidemic in the region is the economic environment and gender inequalities, which increase women's vulnerability to the disease.

Transactional sex is a common occurrence among men and women, particularly women, who put themselves at increased risk by engaging in multiple partnerships, not using condoms and trading sex for money or other economic resources. Multiple partnership arrangements are also very common in the region with a large proportion of men reporting concurrent partnerships and women reporting serial relationships. This point again ties into Caribbean gender norms where being "a man" is closely tied to the notion of having many partners. This is also considered proof of heterosexuality, which is

AN OUNCE OF PREVENTION

important to most Caribbean men because homosexuality is still very taboo in the region and in many countries considered to be illegal (Bombereau & Allen, 2008).

The third factor at play is young people and women's exposure to sexual abuse which puts them at increased risk for HIV on both a physical and psychosocial level. Surveys conducted in the region reveal sexual abuse at first sex between 4 percent and 38 percent. According to the World Health Organization, violence increases a person's vulnerability through four main mechanisms: (1) Forced sex or rape without a condom increases risk; (2) Condom negotiation is more difficult in scenarios where violence is a problem; (3) Sexual violence, particularly child sexual abuse, encourages the adoption of risky behaviours in adolescence and adulthood; and (4) Children who are victims of violence or witness violence between their parents are more likely to perpetuate the cycle later in life (Bombereau & Allen, 2008).

The fourth factor driving the epidemic is unstable and unsupportive family environments and the fifth is an unsupportive policy environment which serves to undermine the progress that is being made with regards to stemming the spread of the disease. Issues such as the criminalization of homosexuality and sex workers, weak policies where sexual abuse is concerned and accessibility issues when it comes to treatment, care and support for people living with HIV undermine the efforts that are being made to halt the spread of the disease in the region (Bombereau & Allen, 2008).

2.2 HIV in Trinidad and Tobago

Ever since the first case of AIDS was reported in 1983, the government of Trinidad and Tobago has sustained a national response in an effort to combat the spread of the

AN OUNCE OF PREVENTION

disease. In 2012, the estimated number of people living with HIV/AIDS in the country was 14,300, which represents an HIV prevalence rate of 1.6 percent and, among the most at risk populations, the prevalence rate exceeds 5 percent (Office of the Prime Minister, 2012; World Factbook, 2014). It is important to note that these rates only represent the public health sector and some key private labs that report to the public health laboratory and so the rates stated may actually be an under-estimation of the true prevalence in the country (Office of the Prime Minister, 2012).

The government views HIV as a serious threat to the country's development and to the quality of life of its citizens. As stated in the HIV and AIDS National Strategic Plan 2004-2008/10, "the impact of the disease lies in its ability to undermine economic growth through its effect on human, physical, and social capital" (p. 12). The NSP states that the very nature of the disease is that it tends to affect the most productive members of society and so at the macroeconomic level, the impact is felt in terms of productivity losses due to a decrease in the labour supply of the country (Office of the Prime Minister, 2003). Since the establishment of the National AIDS Coordination Committee (NACC) in 2004, several prevention initiatives have been implemented in an effort to mitigate the negative effects of the disease with the priority being expanding prevention initiatives, which includes HIV testing, expanding care and treatment of HIV and AIDS and targeting communities and most at risk populations, which are identified as men who have sex with men, sex workers, substance users and youth (NACC, 2010).

During the 1990s, significant advances in HIV testing technologies were made and this included the advent of rapid test technology that allowed for the decentralization of HIV testing to non-laboratory settings. In the early 2000s, many countries, including

AN OUNCE OF PREVENTION

Trinidad and Tobago, adopted the goal of universal access to anti-retroviral therapy (ART) and in 2003, the World Health Organization's 3 by 5 Initiative emphasized the importance of HIV testing as the "entry point" to all other HIV services and this led the way for HIV testing to become a major focus of prevention initiatives (Duke et al., 2010).

The first major national prevention program that was introduced in Trinidad and Tobago was the Prevention-of-Mother-To-Child-Transmission (PMTCT) program and this provided HIV testing for all women who attended public antenatal clinics (Duke et al., 2010). Currently, this is the most successful HIV testing program that exists in the country as the percentage of women giving birth at public health care facilities who had been tested for HIV was 93% in 2009 as compared to 14% in 2000 (PAHO/WHO, 2010). The success of this program is due in part to increased health promotion activities, such as the implementation of the Provider Initiated HIV Counselling and Testing (PITC) approach, health education sessions in the clinics, group counselling and outreach sessions, the implementation of a national PMTCT policy and the establishment of a steering committee to help guide the efforts (PAHO/WHO, 2007).

The implementation of the PMTCT program opened the door to the establishment of the national Voluntary Counselling and Testing (VCT) Program. This program was implemented on a phased basis from 2004-2005 and provided greater access to HIV testing for the general population and in 2008, the National HIV Testing and Counselling Policy was adopted. In comparison to the PMTCT program however, the VCT program has not been as successful in reaching the general population (PAHO/WHO, 2010).

Over the years, a coordinated multisectoral response involving the government, Civil Society Organizations (CSOs), trade unions, the business sector and international

AN OUNCE OF PREVENTION

organizations, has been promoted and there have been some successes of note. Trinidad and Tobago has seen a steady decrease in the number of newly diagnosed infections from 1448 in 2008 to 1077 in 2011 and a considerable decrease in the number of infants being born with HIV to HIV positive mothers. The National HIV and AIDS Workplace Policy has been adopted, a Human Rights Desk has been established to investigate cases of HIV related discrimination and a legislative review of national laws and their impact on people living with HIV and high risk groups has been conducted (Office of the Prime Minister, 2013). Additional policies were also formulated in 2010 including the Post Exposure Prophylaxis Policy and the Health Sector Workplace Policy. The number of sites providing HIV testing and counselling services increased from 28 in 2009 to 31 in 2010 and there has been a steady increase in the number of persons tested at same day sites. There has been also been an increase in the provision of free anti-retroviral treatment which has in turn led to a reduction in the number of AIDS related deaths (Office of the Prime Minister, 2012). Appendix 2 is an example of a promotional poster developed by the HIV & AIDS Coordinating Unit showing a complete listing of the HIV same day counselling and testing sites.

In an effort to build capacity among the Regional Health Authorities in the area of HIV rapid testing and counselling, the HIV & AIDS Coordinating Unit in collaboration with the Trinidad and Tobago Health Training Centre and the Centre for Disease Control (CDC) conducted a Training of Trainers workshop in 2011. This resulted in eleven rapid test trainers and five training assistants who subsequently conducted a training session in 2012 to successful train eighty six health care providers as HIV rapid testers (Ministry of Health HIV/AIDS Coordinating Unit, 2012).

AN OUNCE OF PREVENTION

There are two major testing events, which are organized by the Ministry of Health each year, the Caribbean Regional HIV/AIDS Testing Day, which is observed in June, and World AIDS Day on December 1st. During these events, the public health authorities and NGOs scale up testing efforts by conducting outreach sessions at business places, transport hubs, tertiary institutions and other public spaces in the cities and by increasing HIV communications and messaging at that time. In 2012, both the Caribbean Regional HIV/AIDS Testing Day and World AIDS Day campaigns were quite successful with established targets for the campaigns being met (Ministry of Health HIV/AIDS Coordinating Unit, 2012).

Despite these successes, some challenges still remain. HIV and AIDS remains the eighth leading cause of death in Trinidad and Tobago and three new cases of HIV infection are reported every day. There are significant gaps in the epidemiological and behavioural data and so the true picture of the epidemic is not known. There are also gaps in knowledge about the prevalence and risk among vulnerable populations due to discrimination, which prevents their access to testing, treatment and care. In addition, treatment sites are not fully integrated into health services, which in turn leads to accessibility issues (Office of the Prime Minister, 2013).

Another major challenge was the closure of the NACC in March 2011 in order to make way for the establishment of a new statutory body. To date, the new autonomous Coordinating agency has not been established but an Interim HIV Agency was established in 2013 to oversee the implementation of the National Strategic Plan, 2013 - 2018. The closure of the NACC presented some challenges to progress and reporting during that period of time and it also presented challenges for civil society groups namely

AN OUNCE OF PREVENTION

a decrease in funding and support for prevention interventions, care, advocacy and testing (Office of the Prime Minister, 2013).

Civil Society Organizations (CSOs) in Trinidad and Tobago, which include Non-Governmental Organizations (NGOs), play a key role in the national HIV response. In fact, most of the activities that have been implemented between 2008 and 2010, which target most at risk populations, such as women, were implemented by CSOs. In 2005, the NACC commissioned a study to assess the capacity needs of NGOs working in the field of HIV prevention and it was noted that amongst the NGOs, most have limited human resource capacity and financial capacity in order to effectively implement and sustain HIV prevention initiatives. From 2006 to 2008, the NACC increased funding to NGOs to implement a number of HIV prevention activities, however, this funding has steadily declined and with it, the number of activities (NACC, 2011).

There has been a significant increase in awareness of the modes of transmission of HIV in over 77% of the general population however this knowledge has not translated into improved behavioural change among the population as the number of new infections continues to rise each year. The primary mode of transmission in Trinidad and Tobago is heterosexual contact and despite the increase in awareness, only an estimated 1.89% of the population has ever received an HIV test (NACC, 2011).

2.3 HIV and women

According to UNAIDS (2009), young women and girls are particularly vulnerable to HIV and many of the existing AIDS strategies do not adequately address their unique

AN OUNCE OF PREVENTION

needs and rights. De Bruyn (1992) states that the increased impact of HIV/AIDS on women in developing countries can be linked to four main reasons.

The first is the existence of stereotypes that lead women to be blamed for the spread of HIV/AIDS or not recognized as potential patients therefore leading to delayed diagnosis and/or treatment, stigmatization, loss of income and violations of human rights. When the first cases of AIDS were reported in the 1980's, the stereotype that existed was that it was a disease that only affected homosexual men and this stereotype still persists, although to a lesser extent today. This therefore can impact on a woman's diagnosis of HIV because her symptoms may not be recognized early. The stereotype that AIDS is a prostitutes' disease was even more widespread and this stereotype often leads to women being blamed for the spread of the disease and being subjected to stigmatization (De Bruyn, 1992).

The second reason is various factors which are related either directly or indirectly to gender, such as biological and health-related factors, certain sexual practices and lack of access to information, thus placing women at increased risk for HIV transmission. Berer and Ray (1993) explain that per exposure and if all other risk factors are equal, the transmission of HIV from a man to a woman is biologically more likely than the reverse scenario. The virus load in the ejaculate of an infected male, especially one who is also infected with other sexually transmitted diseases, is particularly heavy and so the likelihood of HIV transmission to the female partner is high (Persson, 1994). In addition, if men generally have more sexual partners than women, then it can be argued that more women will potentially be exposed to the virus. Age is yet another factor that puts women at greater risk. In general, women tend to have sexual relationships with men

AN OUNCE OF PREVENTION

who are older than them and, in certain cultures, such as that of Trinidad and Tobago, the age gap can be in excess of 10 years or more. As previously mentioned, in these types of relationships, it is likely that due to the age difference, the man would potentially have had more of a chance to be exposed to HIV because they may have had more sexual partners in the past. Related to this issue, is the belief by some men that they can avoid becoming infected, or even cure their current HIV infection by engaging in sexual intercourse with virgins (Berer and Ray, 1993).

The third reason is the increased social and psychological consequences of HIV/AIDS for women (De Bruyn, 1992). For example, if a woman's husband dies of AIDS she may be ostracized from her community due to stigma and discrimination and may not be able to marry again. This will therefore also impact negatively on her and her children's economic future if she was financially dependent on her husband (Berer and Ray, 1993).

The fourth reason is that women's socio-economic status and lack of power often makes it difficult for them to undertake preventative measures (De Bruyn, 1992). Berer and Ray (1993) explain that unequal gender roles in many cultures often leaves women at an economic, social and physical disadvantage and thus decreases their level of safety in sexual relationships. Gender based violence among both married and unmarried women is a very common reason as to why women are unable to negotiate condom use in sexual relationships, even when they know that they are at risk for HIV infection. In some countries, forced prostitution among both adult women and girls adds to their risk of exposure and their vulnerability. Girls in particular, whose families sell them into the sex trade because of poverty are at an increased disadvantage when it comes to negotiating

AN OUNCE OF PREVENTION

safe sex practices not only due to their young age, but also due to inexperience (Berer and Ray, 1993). Power imbalances and economic dependency can also affect women's access to available information about HIV and AIDS especially in developing countries where educational and literacy levels are often low. Prevention campaigns, particularly those that rely on printed materials, are often not as effective with these women. In addition, for women living in very rural areas, the effectiveness of media, such as radio and television, as a vehicle for prevention messaging is also debatable (Persson, 1994).

Embedded within the four reasons outlined previously, are two issues that need particular attention. The first issue is that of gender based violence, which is associated with increased risk of HIV transmission in women. In a study conducted by Jewkes, Dunkle, Nduna and Shai (2010) which looked at whether intimate partner violence and relationship power inequity increases the risk of HIV infection among women in South Africa, it was found that women in the study who experienced violence within a relationship and had high gender inequity had an increased incidence of HIV infection. The threat of violence from a partner can inhibit a woman's ability to negotiate condom use. In addition, violence is also believed to increase the risk of infection through high-risk sexual encounters such as rape or coerced sex. When it comes to HIV testing, the threat of violence can be a major deterrent for a woman seeking a test because if she tests positive, the woman may be blamed for introducing HIV into the relationship (Green and Ruark, 2011).

The second issue that needs consideration is the intersection of HIV risk and marriage. Many women become infected with HIV within the confines of marriage and many scholarly articles, media reports and AIDS organizations acknowledge that

AN OUNCE OF PREVENTION

marriage and other long-term monogamous relationships do not necessarily reduce a woman's risk of contracting HIV (Green and Ruark, 2011). Green and Ruark (2011) argue that although the evidence shows that many women contract HIV through marital sex, women's lives are complicated and they are not always passive victims and there are a few cases where the woman brings the infection into the marital home. Nevertheless, marriage and the issue of infidelity, whether it is on the part of the man or the woman, is of particular importance when discussing HIV risk.

Given the impact of HIV and AIDS on women and girls, UNAIDS (2009) recognizes the need for increased resource allocation and capacity building in order to create enabling environments which uphold women's human rights and addresses their needs as well as provides a strong focus on comprehensive prevention approaches to HIV, sexual and reproductive health and violence against women. They argue that by incorporating human rights and gender equality into the global HIV response, women and girls will not only have the knowledge and power to protect themselves from HIV infection, but they would also have the ability to advocate for themselves and take on roles as leaders and policy makers who can drive change (UNAIDS, 2009).

The reasons for women's increased vulnerability to HIV infection, as expressed by De Bruyn (1992), are very evident when examining the HIV epidemic in Trinidad and Tobago. In this country, key issues such as violence against women, unequal gender roles which result in financial dependency on male partners, stigma and discrimination, poverty and unemployment, multiple partnering, risky sexual behaviour especially as it relates to transactional sex, and inconsistency in prevention messages all feed into the increased vulnerability of women to HIV and has driven the rise in the epidemic among

AN OUNCE OF PREVENTION

women and girls in the country (Network of NGOs of Trinidad and Tobago for the Advancement of Women, 2010). Of the average 1400 newly reported infections each year, women represent more than 50%, particularly between the ages of 15-24 years and as such, they are recognized as one of the most at risk populations. However, it must be noted that there are very few HIV interventions taking place in the country that specifically address the unique needs and rights of women and girls (Noguera-Ramkissoon, 2011).

When examining some of the key indicators of gender equity and HIV vulnerability as outlined by the Millennium Development Goals, statistics in Trinidad and Tobago further support the need to focus on women when it comes to HIV programming. The statistics show that as of 2010, 72% of women were not using contraceptives, 82% who were in a union were not using condoms, less than half of the women in the country had received an HIV test, approximately 25% of young women between the ages of 20-24 years had partners who are at least 10 years older than themselves and domestic violence and sexual abuse amongst children was prevalent (Network of NGOs of Trinidad and Tobago for the Advancement of Women, 2010). In addition, labour force data from 2007-2009 illustrates that more men than women are employed in the non-agricultural sector and that women tend to hold jobs in the wholesale and retail, restaurant and hotel, financing, insurance, real estate and business services and community, social and personal services sectors. Very often, the wages in these sectors is lower than that of other sectors thus increasing the financial dependency of women on men (Joint UN Team on HIV and AIDS and United Nations Development Programme [UNDP], 2010).

AN OUNCE OF PREVENTION

The increased susceptibility of HIV infection among women in Trinidad and Tobago can also be linked to other social issues such as the existence of prostitution among children, human trafficking and debt bondage and the fact that Human, Family, Life Education (HFLE) has only been introduced in some schools in the country and the emphasis is placed on abstinence as a means of prevention as opposed to condom use (Network of NGOs of Trinidad and Tobago for the Advancement of Women, 2010).

Another practice that is very prevalent in the country is that of concurrent relationships and multiple partnering, especially as it relates to transactional sex. A study on Juvenile delinquency that was conducted in Trinidad in 2008, found that a number of young girls tend to engage in sexual competition for the attention of older taxi drivers. These girls exchange sex for financial and/or material benefits (known as the “maxi taxi man” syndrome) and often they do not relate or understand that their behaviour is consistent with that of commercial sex workers and therefore puts them at increased risk for HIV transmission (Joint UN Team on HIV and AIDS and UNDP, 2010).

2.4 Behaviour Change – A Theoretical Overview

2.4.1 Introduction

In the fight to halt and begin to reverse the spread of HIV, the concept of behaviour change has become a central focus in prevention interventions. The process of behavior change is complex and very often, even when people are provided with information to help them to make decisions to either avoid risky behaviours or adopt new behaviours that can improve their health, they don't necessarily act on the information

AN OUNCE OF PREVENTION

that they receive. Even if they do make a change, it is often not sustained in the long term (Fan, Conner, & Villarreal, 2007).

Several different factors can have a significant influence on behaviour change and thus can impact greatly on the type of intervention that is developed when dealing with a specific health issue. The concept of the ecological perspective, which is a multilevel, interactive approach to examining the influences on health-related behaviours and conditions, provides a comprehensive understanding of the different levels of influence (McKensie, Neiger, & Thackeray, 2009). As identified by McLeroy, Bibeau, Steckler and Glanz (1988), there are five levels of influence and it is important to have an understanding of these levels when looking at behaviour change theories because certain theories work better in some situations than in others (as cited in McKensie et al., 2009).

The five levels of influence are:

1. Intrapersonal or individual factors (e.g. individual knowledge, attitudes, beliefs and personality traits)
2. Interpersonal factors (e.g. primary groups such as family, friends, and peers)
3. Institutional or organizational factors (e.g. rules, regulations, policies and informal structures)
4. Community factors (e.g. social networks and norms)
5. Public policy factors (e.g. local, state and federal policies and laws)

(McKensie et al., 2009)

When it comes to program planning however, the five levels are often condensed into three – intrapersonal, interpersonal and community – because in practice when addressing

AN OUNCE OF PREVENTION

the community level, it is usually necessary to take the institutional and public policy factors into consideration (McKensie et al., 2009).

Behaviour change theories can also be categorized by the approach that they use to explain behaviour. There are two distinct categories of theories, continuum theories and stage theories. Continuum theories identify the variables that influence action, such as perceptions of risk and precaution effectiveness, and combine them in a prediction equation that would indicate the likelihood that a person will take the recommended preventative action. Stage theories, on the other hand, are comprised of an ordered set of categories or “stages” into which a person can be classified and the theory then identifies factors that could promote movement from one “stage” to the next (McKensie et al., 2009).

When it comes to HIV prevention, sexual behaviour change has been associated with HIV decline in a number of countries, particularly in generalized epidemics, and epidemiological evidence suggests that primary behaviour change must occur in order to halt HIV transmission. HIV prevention interventions that utilize a behaviour change approach focus on what persons can do to either change or maintain their behaviour in order to avoid or reduce their risk of contracting the disease. These approaches also recognize the fact that not all persons have control over their sexual behaviour. Factors such as poverty, illiteracy, instability and displacement, and gender disparity can all have an impact on a person’s ability to practice abstinence, faithfulness, consistent condom use and to undertake HIV testing (Green & Herling Ruark, 2011).

For the purposes of this paper, a brief overview of some of the behaviour change strategies aimed at HIV prevention that health planners commonly utilize will be outlined

AN OUNCE OF PREVENTION

followed by a discussion of five behaviour change theories that may serve to provide a sound theoretical framework for determining the logical and affective calculations that go into the decision-making process, especially as it relates to HIV testing.

2.4.2 Communication and Behaviour Change Strategies for HIV Prevention

Several different strategies have been employed in an effort to predict and modify individual behaviours with varying degrees of effectiveness depending on the population that is being targeted by the intervention. These include one-on-one counselling, the use of exemplary role models, narratives with cultural and social links, personalized messages and testimonials . Behaviour change can also be influenced by knowing someone that is affected or has died from the disease, or by receiving reminders, prompts and/or cues to action, particularly through different forms of mass media. As previously explained, different strategies have yielded different results and often public health agencies would utilize a combination of approaches in an effort to maximize the reach of their campaigns (Kwan, Mechael, & Kaonga, 2013).

Perhaps the most widely used strategy globally is the implementation and promotion of Voluntary Counselling and Testing (VCT) for HIV, with the counselling aspect being the main vehicle for behaviour change (Fan et al., 2007). Whether a person receives a positive or negative result to an HIV test, it has implications for their life and behaviours going forward. A positive result has significant physical and psychosocial implications for an individual and a negative result can be interpreted as a validation of current sexual behaviours, which may put them at risk for contracting the disease later on. Pre- and post-test counselling therefore provides an ideal opportunity for a trained health

AN OUNCE OF PREVENTION

professional to provide the person with a personal risk assessment and to impart information about reducing their risk going forward and in the event of a positive outcome, care, support and referrals can be provided (Fan et al., 2007). The success of one-on-one counselling as a part of VCT has been shaky to say the least. As cited in Mattson and Basnyat (2008), “the lack of a genuine, personalized approach to HIV test counselling sessions and the parental and assuming tone often heard in the dialogue ... may explain why HIV test counselling has been criticized as ineffective for encouraging clients to practice safer sex” (p. 139). Mattson and Basynat (2008) suggest that a more agency-promoting, client-centered approach to VCT that adapts to the need and challenges of each individual client would be more effective.

Another approach that has been employed extensively, especially over the past few years, is the use of mass media as a vehicle for behaviour change. Due to their ability to reach large and diverse audiences in a cost effective way, mass media campaigns can be an effective tool in the fight against HIV. These mass communication strategies are utilized at the local, regional and national levels and employ the use of many different forms of media, such as radio, television, the Internet and mobile phones (Palmgreen, Noar, and Zimmerman, 2008).

Palmgreen et al. (2008) suggest the following seven core principles to guide the conduct and evaluation of an effective mass media campaign:

1. Conduct formative research to gain a comprehensive understanding of the target audience, behaviour and how they may react to the campaign messages.
2. Use theory as a conceptual foundation. Theories can help in the design of the campaign by suggesting important theoretical determinants as the focus for

AN OUNCE OF PREVENTION

messages, variables for audience segmentation and variables to be used in evaluation of the campaign.

3. Segmenting the audience into meaningful subgroups.
4. Targeting the messages to the audience segments.
5. Placement of messages in channels that are widely viewed by the target audience.
6. Conducting a process evaluation and ensuring high message exposure.
7. Using a sensitive outcome evaluation design that reduces threats to internal validity.

(Palmgreen et al., 2008, p. 224)

Regardless of the type of communication approach that is utilized as part of a behaviour change intervention for HIV prevention, one thing is certain, a variety of methods should be utilized in order to effectively reach the target audiences and to maximize the effects of the campaign.

2.4.3 Health Belief Model

As stipulated in the principles outlined by Palmgreen et al. (2008), the use of theories as a conceptual foundation for guiding the design of prevention interventions is crucial. One such theory, the Health Belief Model, which was initially developed in the 1950's by social psychologists Hochbaum, Rosenstock and Kegels to identify screening determinants for tuberculosis and participation in other programs to detect and prevent disease, is one of the most frequently used theories in health behaviour applications. It functions on the premise that beliefs about susceptibility and severity of a health concern

AN OUNCE OF PREVENTION

and beliefs about the efficacy of preventative action will predict the likelihood of action (Simmons-Morton, McLeroy and Wendel, 2012) (See Figure 2.2).

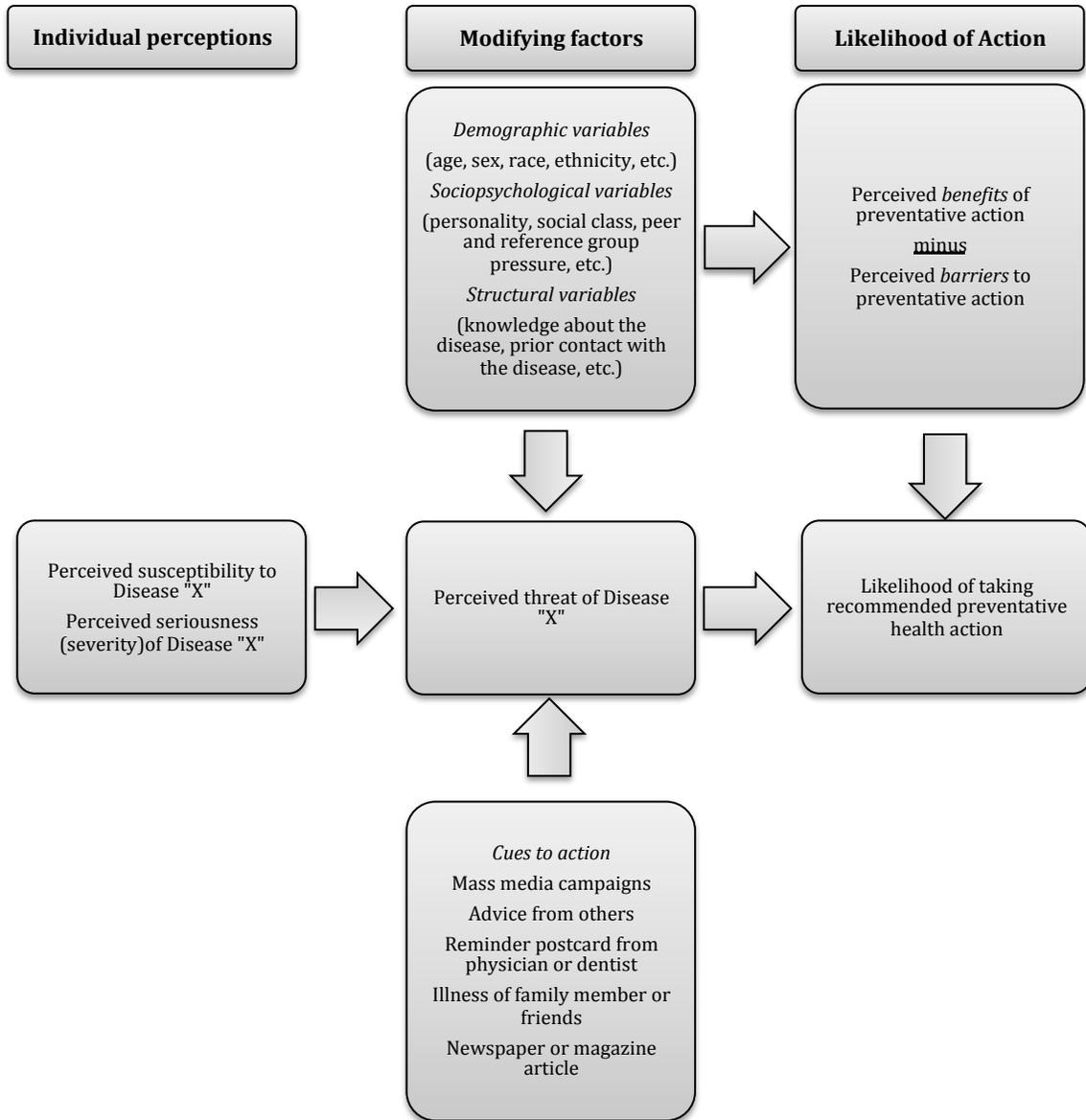


Figure 2.2: The Health Belief Model as presented by Becker, Drachman and Kirscht (1974) (as cited in McKensie et al., 2009)

The health belief model is classified as a continuum theory and it falls under the intrapersonal level of influence because it focuses on factors within the individual

AN OUNCE OF PREVENTION

(McKensie et al., 2009). It takes into consideration modifying factors such as gender, ethnicity, age and geographic location which may modify perceived threat. It also considers the impact that barriers and cues to action, which includes information and messaging about perceived threats or barriers and benefits of particular actions, have on the likelihood of action (Simmons-Morton, McLeroy and Wendel, 2012).

The health belief model identifies the following three main variables to explain health-related action.

1. Perceived susceptibility – The belief that one is susceptible to a serious health problem or illness. The theory posits that a person who does not consider themselves to be “at risk” for a disease will not change a health-related attitude or action in order to protect themselves from contracting that disease. For example, teenagers very often underestimate their risk when it comes to contracting HIV (Fan et al., 2007).
2. Severity of the threat – An individual’s assessment of the severity of the threat. Even though a person may acknowledge that they may be at risk for a particular disease, if they believe that the severity of the threat is low, there will be little incentive to take preventative measures. For example, if a person does not understand or accept that HIV is a serious threat to their health, they will be unlikely to take preventative action such as using a condom during sex or taking an HIV test (Fan et al., 2007).
3. Perceived benefits of preventative action – A person’s evaluation of the effectiveness of the recommended health-promoting or preventative action. For example, in the case of HIV testing, if a person does not have confidence in the

accuracy of the test or they do not feel that knowing their status will be beneficial to them, they will be unlikely to undertake a test (Fan et al., 2007). If the action is considered to be beneficial and perceived barriers can be overcome, then the person is more likely to take action. Perceived barriers include the concept of self-efficacy. Self-efficacy is an important concept when planning health interventions, particularly for priority populations in need of long-term lifestyle behaviour changes. Not only must a person feel that change will be beneficial to them, but they must also consider themselves to be competent enough to overcome perceived barriers to taking action (McKensie et al., 2009).

The health belief model is useful to consider for the purposes of this study because it can help to explore how the attitudes and beliefs of women in Trinidad and Tobago regarding HIV and the efficacy of HIV testing influence their decision to get tested. It can also help to explore how perceived barriers can impact on the decision to get an HIV test and how the information and messaging can be tailored to provide appropriate cues to action to motivate women to access the service.

2.4.4 Health Decision Model

The health decision model (Fan et al., 2007) can also be classified as a continuum theory but unlike the health belief model, it falls under both the intrapersonal and interpersonal levels of influence. The health decision model is actually a reformulation of the health belief model that incorporates the social variables of experience, knowledge, and interaction. It posits that health decisions are often made in the context of other

AN OUNCE OF PREVENTION

people, with other people's views taken into consideration. In addition to the variables of perceived susceptibility, perceived severity, and evaluation of action that constitute the basis of the health belief model, the health decision model also acknowledges that health-related decisions are also made based on an individual's past experiences with other people who are important in their life, their knowledge of other people's views and opinions and their current interactions with other people (Fan et al., 2007).

These interpersonal variables are especially important in the context of HIV. For instance, the decision to undertake a preventative action, such as condom use, is not only an individual decision, but also made jointly with another person. If the woman wants to use a condom and the man does not, the decision can be difficult to resolve. In the case of HIV testing, if a woman's peers have a positive view of testing and she has a social network that encourages knowing her status, she will be more motivated to access the service. Once all of the intrapersonal variables have also been satisfied, her likelihood of action will increase even further (Fan et al., 2007).

2.4.5 Precaution Adoption Process Model (PAPM)

Developed by Neil D. Weinstein and Peter M. Sandman in 1992, the Precaution Adoption Process Model (PAPM) is a stage theory that falls under the intrapersonal level of influence and is most applicable for use with the adoption of a new precaution or the abandonment of a risky behaviour that requires action. This model aims to explain the decision-making process and the stages that a person goes through in moving from "deciding to act" and actually taking action (McKensie et al., 2009). Unlike the health belief model and the health decision model, which are both static and linear in their

AN OUNCE OF PREVENTION

approach to the behaviour change process, the precaution adoption process model is more fluid and dynamic. It recognizes that when making a health-related decision, different factors come into play in different ways and at different times. As a result, a person may move forward from one stage to another only to go back when encountered with a factor that may hinder their decision, and then eventually move forward again. For most people, the decision-making process is a complex sequence of stages and this model takes that into account (Fan et al., 2007).

Stage theories like the PAPM, have four principle elements and assumptions (McKensie et al., 2009):

1. A category system to define the stages
2. An ordering of the stages
3. Common barriers to changes that people face in the same stage
4. Different barriers to change that people face in different stages

These assumptions form the basis for all stage theories and are incorporated into the following seven stages that comprise the PAPM model (McKensie et al., 2009) (See Figure 2.3):

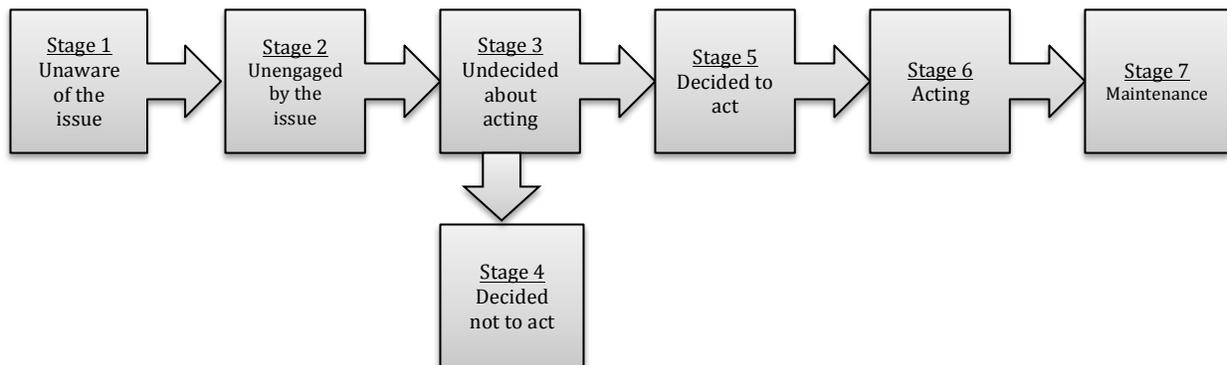


Figure 2.3: The Precaution Adoption Process Model (replicated from McKensie et al., 2009)

AN OUNCE OF PREVENTION

1. Stage 1 – Unaware of the issue: At some initial point, a person is unaware of the health issue. For example, a woman residing in the most rural area in Trinidad who has never heard of HIV or the risk of HIV transmission.
2. Stage 2 – Unengaged by the issue: When the person first learns about the issue, they are no longer unaware but they may not be engaged by it. Following from the previous example, the woman attends a health fair and is told about HIV but she does not think she is at risk and so she does not give it a second thought.
3. Stage 3 – Undecided: The person is engaged by the issue and is considering their course of action. For example, the woman acknowledges that she may have engaged in risky behaviour that may put her at risk for HIV so she is now considering whether she should get tested or not. At this point in the decision-making process, the woman may either decide to act or decide to take no action.
4. Stage 4 – Decided not to act: The person decides not to take action and the process ends.
5. Stage 5 – Decided to act: The person decides to take action. For example, the woman decides to take an HIV test.
6. Stage 6 – Acting: After making the decision to take action, the person actually follows through with their decision and takes action. For example, the woman gets tested for HIV.
7. Stage 7 – Maintenance: If appropriate for the action, this stage indicates that the behaviour is maintained over a long period of time.

AN OUNCE OF PREVENTION

There are several issues that can impact on a person's progress from one stage into another. Media messages about the hazard and precaution can influence a person to move from stage 1 to stage 2. Communication from a partner or personal experience with the hazard can influence a person to move from stage 2 to stage 3. Beliefs about the likelihood and severity of the hazard, personal susceptibility and precaution effectiveness and difficulty, as well as behaviours and recommendations of others, perceived social norms and fear and worry could all influence a person's progress from stage 3 to stage 4 or 5. Finally, between stages 5 and 6, time, effort, and resources needed to act, detailed "how to" information, reminders and other cues to action and assistance in carrying out the action can all have an impact. As such, it is important to consider all of these factors when designing a behaviour change intervention (McKensie et al., 2009).

As is evident by the example previously presented, the PAPM is a useful model to consider for this study because it can provide an understanding of the stages involved in the decision-making process of women when it comes to getting tested for HIV. It also helps to outline some of the factors that can have an impact on a woman's progress from one stage into another.

2.4.6 AIDS Risk Reduction Model (ARRM)

The AIDS Risk Reduction Model (ARRM), which was developed in 1990 by Joseph A. Catania, Susan M. Kegeles and Thomas J. Coates, provides a framework to explain and characterize people's behaviour change efforts when it comes to HIV transmission. It is a stage theory that incorporates constructs from the health belief model, efficacy theory as well as other social psychological problem solving models, and

AN OUNCE OF PREVENTION

it falls under both the intrapersonal and interpersonal levels of influence. The ARRM consists of three distinct stages (See Figure 2.4) (Catania, Kegeles, & Coates, 1990):

1. Behaviour labeling – Recognition and labeling one’s behaviours as being high risk for the transmission of HIV.
2. Commitment to change – Making a commitment to reduce high-risk behaviours and increase behaviours that are low risk.
3. Taking action – Seeking and enacting strategies in order to achieve these goals.

The ARRM posits that in order to avoid becoming infected with HIV, a person must first recognize that their behaviour puts them at risk for contracting the disease. Labeling their behaviour as risky would not necessarily lead to behaviour change unless the person makes a commitment to change their actions. This process of commitment may require deciding if their actions can be changed and it may also involve a cost-benefit analysis to determine whether the benefits of change will outweigh the costs. Finally, the person may need to seek solutions through self-help, a social support system or professional help in order to enact the change. This goal of this stage may be more difficult to achieve relative to the other stages because it may also involve overcoming external and psychosocial barriers that hinder the person’s ability to enact change as well as any negotiations with sexual partners who may not be at the same stage of the behaviour change process (Catania et al., 1990).

AN OUNCE OF PREVENTION

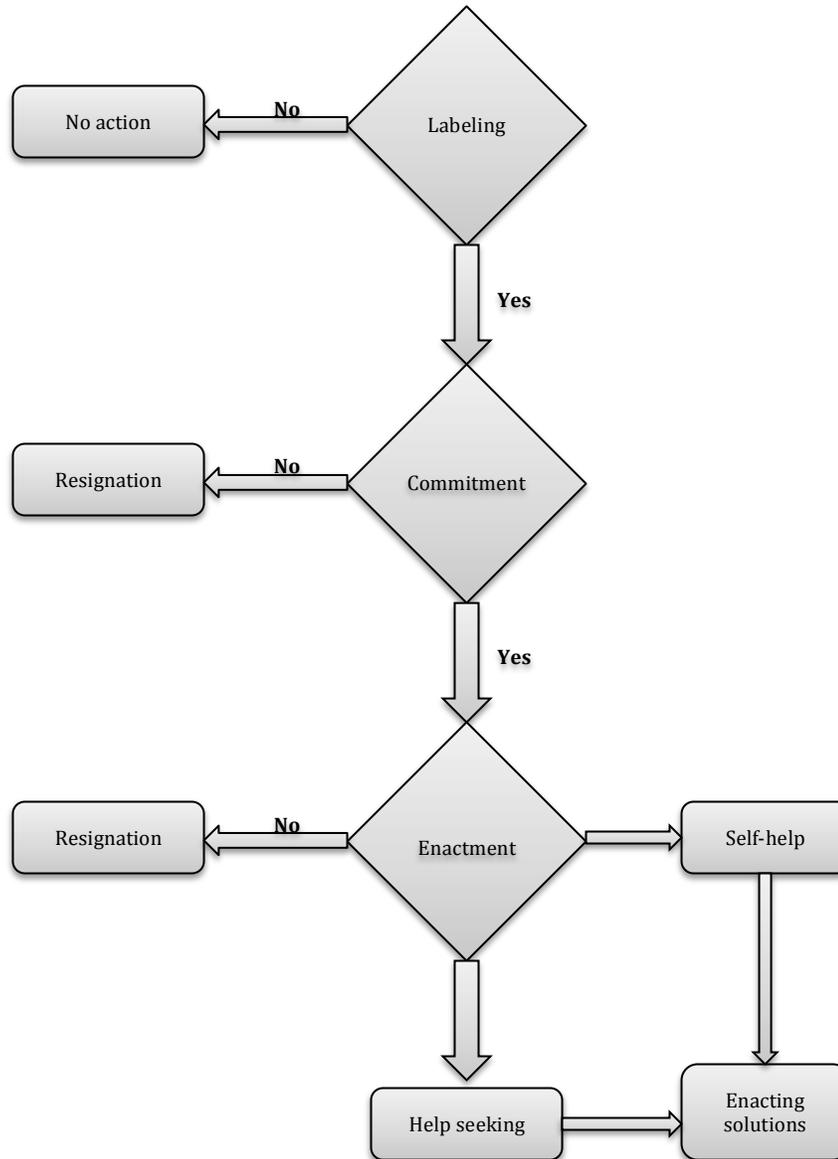


Figure 2.4: The AIDS Risk Reduction Model (replicated from Catania et al., 2009)

There are several variables that influence a person's achievement of goals and movement from one stage to another and these variables affect the change process differently at different stages. In stage 1, there are three variables that can have an impact on a person's acknowledgement that their behaviours put them at risk. The first is

AN OUNCE OF PREVENTION

knowledge of the sexual activities that are associated with HIV transmission, the second is the person's perception of their susceptibility to the disease and the third is their belief that contracting HIV is undesirable to them. The ARRM hypothesizes that once these three conditions exist, the person will likely label their behaviour as risky. It is important to note that social networks can also have a significant impact on the labeling stage by either condemning high-risk behaviours or downplaying the threat of the disease. Stigma and discrimination can also play a negative role if the person feels that they will be discriminated against for admitting that their behaviour puts them at risk for HIV (Catania et al., 1990).

Stage 2, which is the decision-making stage, can be very complex because it usually involves changing several sexual behaviours that may put the person at risk and it also involves making these changes across different sociosexual contexts. It is at this point in the process that the person will conduct a cost-benefit analysis to determine if it would be beneficial for them to commit to change and their perception of their own self-efficacy will come into play. If the benefits outweigh the costs and the person believes in their ability to perform the necessary actions to reduce their risk of contracting HIV, then they would be more likely to commit to change. Of course, knowledge about HIV and social influences also play a role and can impact a person's commitment (Catania et al., 1990).

Finally in stage 3, the person may pass through three phases in their effort to enact change. The first phase is information-seeking in which the person will begin seeking ideas from various sources, which may include the opinions of other people, on ways in which to change their risky behaviour. The second phase is obtaining remedies in which

AN OUNCE OF PREVENTION

the person may decide on self-help techniques or they may decide to seek help from friends or professionals. The final phase is enacting solutions. These three phases may occur concurrently or a person may skip phases 1 and/or 2 and go directly to enacting the solutions. At this stage, variables such as perceived barriers, which could include a person's self-esteem, past experiences and the influence of social networks, can have a major impact on a person's willingness to seek help and also on their ability to enact the solutions. Of particular importance is the ability to engage one's partner in safe sex practices in order to mitigate risk (Catania et al., 1990).

Apart from the variables outlined previously, internal motivators such as aversive emotional states and external cues to action such as those from public health campaigns can also have an impact on a person's movement from one stage to another in the decision-making process (Catania et al., 1990).

Given its specificity to behaviour change as it relates to HIV, the ARRM is highly applicable to this study as it takes into consideration the unique nuances that exist when it comes to HIV. This theory may help to provide further insight into the decision-making process that women go through when it comes to testing for HIV and the factors that impact on their movement through each stage of the process.

2.4.7 Community Readiness Model

When looking at the health interventions that have historically been employed to induce behaviour change as it relates to HIV, most of them have been based on "intraindividual" counselling models (Kelly, 2005, p. 89). Face-to-face counselling typically focuses on risk-reduction education with consideration to psychosocial factors

AN OUNCE OF PREVENTION

such as beliefs, perceptions, planning and goal setting to change behaviour, and skills training. Although these types of interventions are an integral part of HIV prevention strategies and can produce significant results, they are not sufficient enough to make sustainable change on a large scale. These types of interventions often do not adequately take into account the social, community and interpersonal factors that influence a person's ability to enact behaviour change when it comes to HIV prevention and maintain that change over a long period of time (Kelly, 2005). According to Kelly (2005), "successful long-term maintenance of HIV-protective behaviour is likely only when peer group social norms, relationships, the environment, and public health policies also support a person's behaviour-change efforts. This requires that we change communities, the social environment, and social norms, not just counsel individuals" (Kelly, 2005, p. 89).

Unlike the four models previously mentioned that focus primarily on individual behaviour change, the Community Readiness Model is a stage theory that focuses on change at the community level. This model, which emerged in the 1990s, provides a framework for evaluating a community's capacity to implement prevention strategies. It acknowledges that every community is unique and ever-changing and although two communities may be faced with similar issues, they may not necessarily be at the same stage of readiness to enact change (McKensie et al., 2009).

The assessment of community readiness is done by conducting interviews with key informants within the community about what is happening in the community. Based on the results of these interviews, the community is placed in one of nine stages of readiness as defined by the model (See Table 2.2): (1) No awareness; (2)

AN OUNCE OF PREVENTION

Denial/Resistance; (3) Vague awareness; (4) Preplanning; (5) Preparation; (6) Initiation; (7) Stabilization; (8) Confirmation/Expansion; and (9) High level of community ownership. Depending on the stage of readiness that the community is assessed to be in, different strategies are suggested in order to help move the community from one stage to the next with the ultimate goal being a change in community norms, behaviours and attitudes as it relates to HIV (McCoy, Malow, Edwards, Thurland, & Rosenberg, 2009).

Table 2.2: Stages of Community Readiness (replicated from McCoy et al., 2009)

Stages	Description	Goal
Stage 1: No Awareness	Issue not generally recognized by the community or leaders as a problem.	Raise awareness of issue.
Stage 2: Denial/Resistance	At least some community members recognize that it is a problem, but there is little or no recognition that it might be a local problem or resistance to addressing it.	Raise awareness that problem exists in community.
Stage 3: Vague Awareness	Some may feel that there is a local problem, but there is no immediate motivation to do anything about it.	Raise awareness that community can do something.
Stage 4: Preplanning	There is clear recognition that something must be done, and there may even be a committee. However, efforts are not focused or detailed.	Raise awareness with concrete ideas to address problem.
Stage 5: Preparation	Active leaders begin planning in earnest. Community offers modest support of efforts.	Gather information with which to plan efforts and/or programs.
Stage 6: Initiation	Enough information is available to justify efforts, and activities are underway.	Provide community-specific information.
Stage 7: Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced.	Stabilize efforts/programs.

AN OUNCE OF PREVENTION

Stage 8: Confirmation/Expansion	Standard efforts are in place. Community members feel comfortable in using services and support expansions. Local data regularly obtained and utilized to evaluate effectiveness of efforts and guide expansion.	Evaluate, expand and enhance services.
Stage 9: High level of community ownership	Detailed and sophisticated knowledge exists about prevalence, risk factors and causes. Staff members are highly trained. Effective evaluation is in place and utilized routinely to monitor effectiveness and need for change.	Maintain momentum and continue growth.

The Community Readiness Model is important to consider for this study because as Kelly (2005) states, community-based HIV prevention approaches seek to change the norms, collective self-efficacy and behaviours in the overall population as opposed to simply those of the individual. Models such as the Health Decision Model, the Precaution Adoption Process Model and the AIDS Risk Reduction Model all recognize that a person is much more likely to enact change when they are surrounded by a social network of support. As such, it can be deduced that by strengthening a community's capacity to deal with a health issue, the individual will feel more supported to change their own behaviours. In the case of a woman making the decision to get tested for HIV, if her community accepts and understands HIV and has supports in place to deal with the issue of HIV, it is possible that she will be more likely to change risky behaviours in the long-term and undertake regular HIV testing.

2.5 Conceptual Framework

The theoretical models presented in the previous section provide a sound framework for understanding the decision-making processes of individuals and the different factors that can impact on long-term, sustainable behaviour change. Two concepts that are common to most of the models, the concepts of barriers and motivations, require further exploration in the context of this study because the models do not adequately explain the complexity of the issues that impact on women's decisions to access VCT in Trinidad and Tobago. This study aims to help fill the gap in the literature with regards to the barriers affecting women in the country when it comes to getting tested for HIV and the factors which would motivate them to do so. The study also intends to demonstrate that when it comes to making the decision to get tested, simply weighing the barriers against the motivations is not enough to drive a woman to act. The impact of internal motivators and cues to action are incorporated into the models, particularly the AIDS Risk Reduction Model, because of the strong influence that motivating factors can have on a person's likelihood to enact change but the conceptual framework that will guide the study hypothesizes that in order for a woman in Trinidad and Tobago to make the decision to get tested for HIV, community level support is also critical.

The first concept that will be explored is the concept of barriers. At the individual level, Deblonde et al. (2010) identified low risk perception and fear as key barriers that directly influenced the uptake of HIV services, including testing. Fear of diagnosis and the consequences that a positive result might have on their lives, relationships and future, uncertainty as to the perceived ability to cope with a positive result and fear of dying

AN OUNCE OF PREVENTION

have been all been identified as reasons for not getting tested for HIV (Deblonde et al., 2010). Schwarcz et al. (2011) also cited fear of stigma and discrimination as a major barrier. In a study conducted by Mitra et al. (2006), women from HIV endemic countries who emigrate to Canada often experience decisional conflict when it comes to HIV testing and some question the importance of an HIV test. Other identified barriers include barriers at the health care provider level, such as varied attitudes when it comes to HIV testing among health care providers and lack of confidentiality, and barriers at the institutional and policy levels, such as lack of resources (Deblonde et al., 2010; Mitra et al., 2006).

The second concept that is of considerable importance when it comes to HIV testing is the concept of motivations. Musheke et al. (2013), identified deterioration of health or the death of a spouse/partner or child and a key motivator for women in sub-Saharan Africa to get tested for HIV. In Thailand, antenatal testing, testing for social reasons such as for a job application and premarital testing have also been identified as factors which motivate women (Le Coeur, Collins, Pannetier & Lelièvre, 2009).

The conceptual framework for this study suggests that when it comes to behaviour change, a woman's motivations to get tested for HIV must outweigh the barriers to testing that she faces in order for her to progress through the stages of the decision-making process. Cues to action and community level support are also necessary in order to "tip the scale" when it comes to making the decision to get tested for HIV and that will in turn lead to an increased likelihood of action and increased self-efficacy (See Figure 2.5).

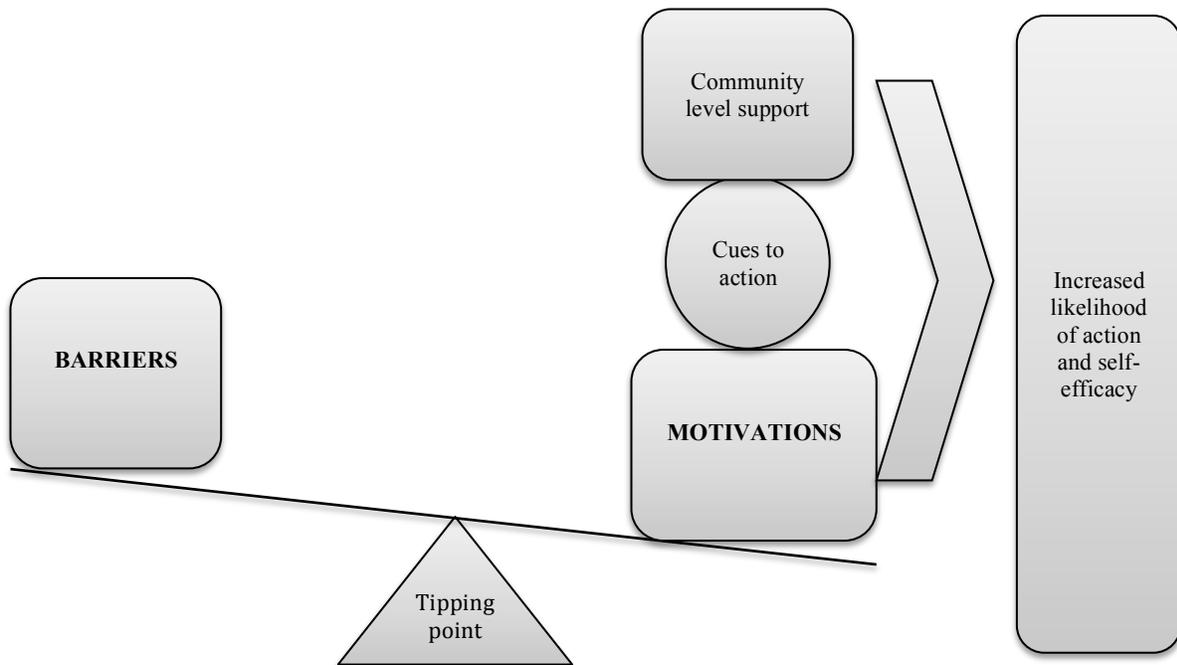


Figure 2.5: Diagrammatic representation of the conceptual framework

By identifying the barriers and motivations that women in Trinidad and Tobago face when it comes to HIV testing, the cues to action can be improved in order to respond to the barriers and further strengthen the motivations. This information can also help in stages 5 through 9 of the Community Readiness Model because program planners can potentially use the information to ensure that interventions are appropriately designed.

2.6 Summary

As seen in the review of the literature, HIV/AIDS continues to be a major stumbling block for many developing countries such as Trinidad and Tobago. Although great strides have been made on a global level to mitigate the impact of the epidemic, there is still a lot of work to be done. Greater focus needs to be placed on stemming the

AN OUNCE OF PREVENTION

spread of the disease among the most at risk populations and women in particular.

Despite the fact that many countries are committed to addressing the needs and rights of women and girls as part of their HIV responses, there still appears to be a gap between rhetoric and reality. The number of women newly infected with HIV continues to rise and so it is evident that more targeted behaviour change interventions are needed and more emphasis needs to be placed on tackling the issues that make women more susceptible to HIV infection. With regards to HIV testing, there is also a need for addressing the barriers that women encounter that discourage them from accessing HIV testing services. A review of some of the theoretical models of behaviour change that are often used to design HIV prevention initiatives, illustrate the importance of identifying the barriers that women face when making the decision to get tested for HIV and the motivating factors that can provide that much needed cue to action.

Chapter Three: Methodology

3.0 Introduction

This chapter provides an explanation of the epistemological approach, the methods of data collection and the approach to data analysis used in the study. The research methods employed are described in detail and the limitations of the study are highlighted. The chapter also provides some background information about the history, geography and culture of Trinidad and Tobago.

3.1 Epistemological Approach

The epistemological approach of this research is based on social constructivism and interpretivism and it was both exploratory and descriptive in nature. The overall goal and objectives sought to understand the viewpoints of women in Trinidad and Tobago with regards to HIV counselling and testing. According to Creswell (2009), social constructivism seeks to address the process of interaction between individuals and to focus on the contexts in which people live and work so as to understand their historical and cultural settings. “The goal of the research is to rely as much as possible on the participants’ views of the situation being studied” (Creswell, 2009). Social constructivism was appropriate for this research because it emphasizes the impact that social interactions and culture have on the assimilation of knowledge. This is particularly important in the context of this study because the social, economic and cultural setting of the country directly influences the viewpoints of women in Trinidad and Tobago with regards to HIV testing. In addition, as seen in the various theoretical models previously discussed, social interactions have a significant impact on behaviour change.

AN OUNCE OF PREVENTION

Similarly, interpretivism is a strategy whereby actors' meanings and actions are interpreted according to their own subjective frame of reference and this includes not only linguistic interpretations, but also includes observation techniques (Williams, 2000). Interpretivism was appropriate for this study because this approach helped to develop subjective meaning behind the viewpoints and experiences of women in Trinidad and Tobago. It is important to acknowledge the fact that being a Trinidadian woman and having intimate knowledge of the culture and social norms within the country would definitely influence my interpretation but by employing a mix of the social constructivist and interpretivist approaches, I was able to gather deeper meaning behind the viewpoints and experiences of women in Trinidad and Tobago as it relates to HIV testing.

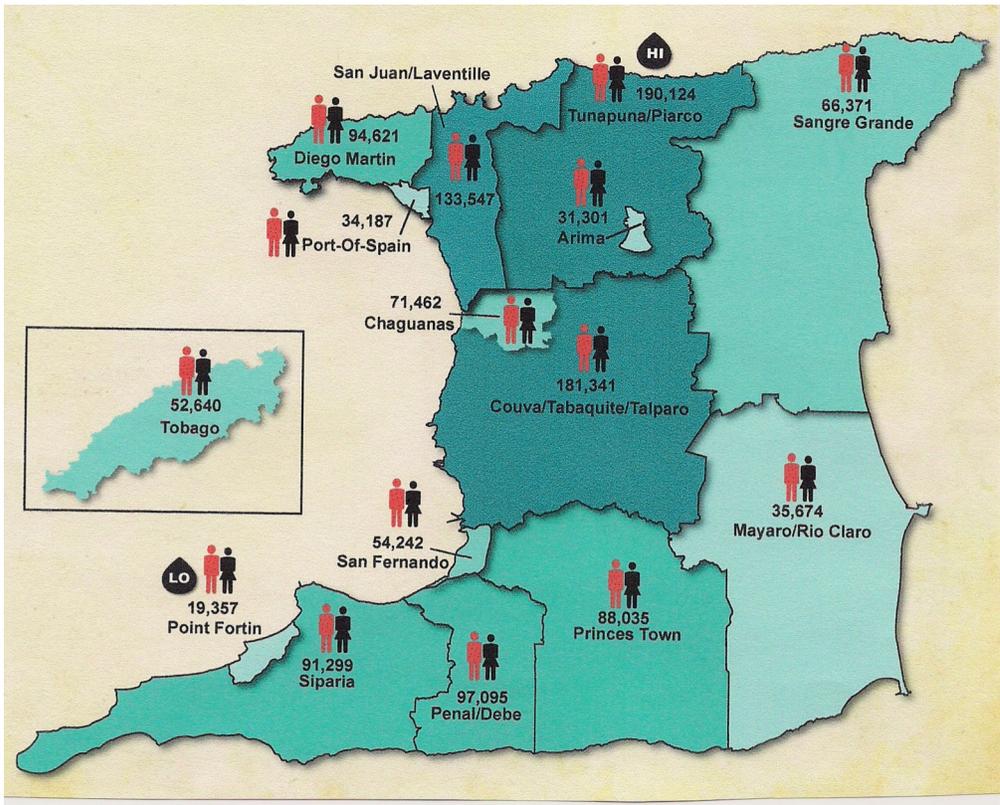
3.2 Site Description – Trinidad and Tobago

The twin island Republic of Trinidad and Tobago is located in the southern-most part of the archipelago of islands known as the Caribbean (See Figure 3.1). Trinidad was first discovered in 1498 by Christopher Columbus and was ruled by the Spanish until 1797 when the British assumed rule. During the 17th and 18th Centuries Tobago was ruled by the Dutch, French and British until finally in 1814, Tobago officially became a British colony of the Windward Island group. In 1889, Tobago was joined to Trinidad administratively and ten years later it became a joint Crown colony. It was not until 1962 that Trinidad and Tobago gained independence and in 1976 became a Republic (Central Statistical Office, 2010). Trinidad and Tobago is arguably one of the most prosperous islands in the Caribbean due in large part to its booming petroleum and natural gas industry.



Figure 3.1: Map and Geographic location of Trinidad and Tobago (Source: County Profile: Trinidad and Tobago, Commonwealth Local Government Forum)

Trinidad and Tobago was historically divided into eight counties and these counties were further subdivided into Wards. Currently, there are 14 municipal corporations in Trinidad that oversee local government activities and the Tobago House of Assembly, which governs Tobago. Port-of-Spain is the country's capital and the third largest municipality after San Fernando and Chaguanas (See Figure 3.2).



Municipal Corporations/Parish (Tobago):

Arima	Point Fortin	San Juan-Laventille
Chaguana	Port-of-Spain city	Sangre Grande
Couva-Tabaquite-Talparo	Princes Town	Siparia
Diego Martin	Mayaro/Rio Claro	Tunapuna-Piarco
Penal-Debe	San Fernando city	Tobago

Figure 3.2: Regional corporations and municipalities of Trinidad and Tobago showing population distribution (Source: Central Statistical Office & UNDP, 2012)

With a population of approximately 1.3 million, Trinidad and Tobago is a true melting pot of cultures. Aside from the African, Spanish, British, Dutch and French

AN OUNCE OF PREVENTION

descendants, Trinidad and Tobago also saw the arrival of Chinese immigrants beginning in 1806 and East Indians in 1845. As of 2000, the national population comprised 37.5% people of African descent, 40.0% East Indian descent, 0.6% Caucasian, 0.3% Chinese, 20.5% Mixed, and 0.3% Other (Central Statistical Office, 2010). This diverse mix of ethnicities has created a truly multi-cultural nation and has influenced every aspect of the “Trinbagonian” culture from art, cuisine, dance, music and festivals. The official language is English but Caribbean Hindustani (a dialect of Hindi), French patois, Spanish and Chinese can also be heard (World Factbook, 2014).

Religion plays a very large role in the culture of Trinidad and Tobago and has a significant influence in the lives of the people that live there. The main religious denominations are 26% Roman Catholic, 25.8% Protestant comprising of Anglican, Baptist, Pentecostal, and Seventh-Day Adventist, 22.5% Hindu, 5.8% Muslim, 5.8% other Christian and 10.8% a mix of other religions (World Factbook, 2014).

Many of the festivals celebrated in Trinidad and Tobago are religious observances such as the Hindu celebration of Divali, the Roman Catholic celebration of Easter and the Muslim festival of Hosay, but perhaps the largest festival celebrated is Trinidad’s carnival. Carnival is celebrated every year on the Monday and Tuesday before the Roman Catholic observance of Ash Wednesday and is Trinidad and Tobago’s biggest tourist attraction. It is known for the colourful costumes, music, dancing and festivities. The atmosphere at carnival time is highly sexually charged and is a contradiction of sorts when compared to the highly religious culture of the country. As a result of the high level of sexuality exhibited during the carnival season, the government and many CSOs plan HIV/AIDS campaigns and prevention initiatives at that time.

3.3 Research design

The data was collected by using a combination of 3 different data acquisition methods in order to have a stronger inferential value. Two qualitative methods and one quantitative method were employed and these methods were reviewed and received ethics clearance through the University of Guelph Research Ethics Board prior to the commencement of the study. Acquiring data using a combination of different methodologies allows for triangulation of the results, which helps to increase validity and reliability. The three methods that were employed were observation at testing sites, in-depth interviews with key informants and a visual ranking survey with women in the general public. The data acquisition using the three methodologies was conducted simultaneously due to time constraints. The research matrix (see Appendix 1) illustrates how the data collected through the various methods was used to respond to the research questions and satisfy the objectives of the study.

For the purposes of this study, Trinidad and Tobago was divided into five regions, North, South, East, Central and Tobago, which corresponded to groupings of the municipal corporations according to their location within the island. These regional labels were purposefully chosen because Trinidadians generally use these regional labels in everyday conversation to describe where they live on the island. Table 3.1 shows how the municipal corporations were grouped.

Table 3.1: Grouping of Municipal Corporations according to location

North	South	Central	East	Tobago
Diego Martin	San Fernando	Chaguanas	Arima	Tobago
Port-of-Spain	Point Fortin	Couva/Tabaquite/Talparo	Tunapuna/Piarco	
San Juan/Laventille	Siparia		Sangre Grande	
	Penal/Debe			
	Princes Town			
	Mayaro/Rio Claro			

NGO testing sites were primarily used for the purposes of this study as opposed to sites located within public health centres because access to public health centres would have been limited due to governmental policies and regulations and this would have hampered the process of observation. NGOs play a major role in the national HIV response and are governed by the national HIV Testing and Counselling policy and so were a valuable source of information. By establishing a rapport with a number of key NGOs working in the field of HIV prevention in Trinidad, complete access to their facilities was acquired as well as permission to accompany them on outreach activities.

3.4 Methodology

3.4.1 Observation

The first method of data collection that was used is observation, which was conducted at two different HIV testing sites and during four different outreach activities that were being conducted by three different NGOs respectively. The two testing sites were located in the North and the outreach activities took place at two different testing sites in the South, during a public health fair in the North and during an annual public event in the South. Observation at the testing sites was conducted over the course of two

AN OUNCE OF PREVENTION

full days while observation at the outreach activities took place on four separate days for the full duration of time that the NGO staff were facilitating the outreach session.

According to Palys (2009), this method of data collection is highly flexible and can be used within a wide range of research contexts and is consistent with all research objectives including both exploratory and descriptive. It allowed for the collection of data in a “real-world context”.

A mix of the participatory and observational roles was employed with a limited level of participation in which program staff were asked questions in order to clarify any information that was collected and to gain further insight regarding the services provided, the delivery of those services and types of communication and messaging that was being used as part of the program.

Detailed field notes were taken and samples of the Informational, Educational and Communication (IEC) materials that were being distributed at the testing sites and during the outreach activities were collected and photos of the facilities at the testing sites and any messaging on display was taken outside of operating hours and did not include any people so as to provide a visual component to the observational data while still maintaining the privacy of the program participants. Once the initial observations were noted, a slightly more structured observational process with limited participation was employed where program staff was asked questions in order to gain more clarity on the data as it was being collected.

3.4.2 Key Informant Interviews

In-depth semi-structured interviews were conducted with thirty-one key informants (n=31) so as to gain a general understanding of the VCT program, its successes and shortcomings, the current BCC strategy, recommendations for improvement and insight into the experiences of women accessing the programs including major barriers and motivations. Key informants were recruited using non-random keystone sampling and included HIV program managers, VCT counselors and testers, and major stakeholders such as NGO staff, members of Faith-based Organizations, academic researchers and representatives from other national and international organizations and governmental ministries working in the field of HIV prevention. The interviews were conducted until saturation was achieved. The interviews took place in person at various locations across Trinidad and via Skype for those participants located in Tobago and overseas. A funneling technique was employed whereby broad, open-ended questions were asked initially and then successively narrower, more structured questions followed (See Appendix 3a and 3b for interview guides). An alphanumeric labeling system was employed so as to protect the identity of the participants and the interviews were digitally recorded and then later transcribed. Field notes were also taken during the interviews in order to capture any observations such as subtleties in body language that may be missed by an audio recording. The length of time taken for the key informant interviews ranged from 14.57 to 67.10 minutes.

3.4.3 Visual Ranking Survey

The final method of data collection that was employed was a visual ranking survey. This survey was used as a means of having women in the general public rank the top five barriers that women in Trinidad are experiencing when it comes to HIV testing and the top five motivations that would push a woman to take a test. The barriers and motivations that were listed on the ballots were identified from existing literature on barriers to HIV testing and also from analysis of the field notes that were taken during observation and some of the key informant interviews. Extra space was provided on the ballot so that participants could include additional information if they wanted.

A total of 241 surveys were completed (n=241). The sample was purposefully selected with no replacement during two separate public outreach activities that were being conducted by two different NGOs. During the public outreach sessions, the NGOs set-up booths to provide IEC materials related to female sexual and reproductive health, HIV/AIDS and STIs, answer questions and conduct demonstrations to members of the public. One NGO also offered HIV testing on the spot. Women approached the booths on their own and once they were there, they were asked to participate in the study.

The participants were recruited using non-random haphazard sampling starting from the 3rd woman who approached the NGO booth during the activity. The sample only included women between the ages of 18-49 years and was stratified by age into 7 year cohorts of women beginning at age 18 and ending at age 49. The sample only included women starting at age 18 because that is the legal age of consent and ending at 49 because the majority of cases of HIV in Trinidad and Tobago fall within this age range.

AN OUNCE OF PREVENTION

The visual ranking survey consisted of four questions, which were presented in the form of a ballot (consisting of both text and images) to make the exercise more visual in nature and ensure that literacy issues did not deter the respondents from wanting to participate (See Appendix 4). The first two questions were demographic in nature specifically their age, so as to determine what age cohort the woman fell into, and the location of the country in which they live. The third question pertained to barriers that they may have been experiencing regarding HIV testing and the fourth pertained to motivations to get tested. Each participant recorded their responses by hand directly on the ballot and then folded their ballot and inserted it into a locked ballot box.

As an incentive to participation in the study, all participants were offered a snack as a means of thanking them for participating.

3.5 Qualitative Data Analysis

Data collected from the semi-structured key informant interviews and observation was analyzed using NVivo 10 software. A combination of open codes and a priori codes were used based on the concept of the ecological perspective as described in section 2.5. As identified by McLeroy, Bibeau, Steckler and Glanz (1988), the five levels of influence that have an impact on health related behaviours are the intrapersonal, interpersonal, institutional or organizational, community and public policy. According to McKensie et al. (2009), these five levels are often further condensed into three – intrapersonal, interpersonal and community levels of influence. These three levels of influence were used as a priori codes and open codes were added based on the responses of the key informants. Finally, selective codes were used to categorize the data under broad themes.

AN OUNCE OF PREVENTION

In NVivo 10, the term “node” is used to represent a collection of references about specified themes, persons, places or other areas of interest, so for the purposes of this study, the nodes were used to represent the identified codes. The software provided a count of the number of sources that were coded to a node and the frequency of references. As the interview transcripts and observation field notes were reviewed, responses and observations were placed in an appropriate node and the reference was verified against other responses within the node to ensure consistency. Photos that were taken as part of the observation process were also coded and placed into corresponding nodes.

Once the initial coding process was completed, the interview transcripts and field notes from the observation process were reviewed again and axial codes were used to examine the connections among the codes and explore the relationships that emerged.

3.6 Quantitative Data Analysis

The results of the visual ranking survey were analyzed using SPSS software. Frequency statistics was the primary method of analysis that was used to determine the number and percentages of women that selected each available response on the survey. There were a number of surveys where the participant did not select a response for a question and so both the barriers and motivations sections of the survey had missing values. Any survey where the participant selected more than one response in a section was removed from the data set.

The chi-square test for independence was attempted to determine whether there was any significant association between age and the identified barriers, age and the

AN OUNCE OF PREVENTION

identified motivations, location and barriers and location and motivations however, due to the missing values, there was insufficient data to perform the tests.

3.7 Limitations

There are a number of limitations that need to be taken into consideration with this study. One of the biggest limitations is that the results may not be generalizable to the entire population of Trinidad and Tobago due to the fact that data from the observation and visual ranking surveys was only collected in Trinidad and not in Tobago. Only two of the interviews were conducted with key informants from Tobago and although some of the other key informants were able to provide some information on the situation in Tobago, it is possible that the data collected may not be reflective of the situation in both islands.

Time, logistical and financial constraints also presented an issue especially when it came to observation at the testing sites and the outreach events. Due to the busy nature of the testing sites, the hours of operation and the time that the NGO staff allotted at each outreach event, the observation periods were relatively short so the data collected may not be representative of an average day at the sites or at an outreach event. The program staff was able to provide additional details to provide a better understanding of what was being observed but it may not provide a complete picture. In addition, observation was only conducted in the North and South of Trinidad and so the data collected in this method may not be representative of the entire island or Tobago. Time constraints also affected the design of the visual ranking survey because the survey had to be conducted before all of the interviews were completed and analyzed and so the barriers and

AN OUNCE OF PREVENTION

motivations that were used for the ranking exercise had to be identified based on existing literature and the field notes from observation and the interviews that had already been completed. As a result, some women may not have identified with the response options that were provided on the survey. An additional open section for comments was provided on the survey in an attempt to mitigate this limitation.

The third limitation that needs to be considered is although the structure and delivery of the VCT program at NGOs are designed based on the national HIV testing and counselling policy and NGOs are recognized as playing a major role in the national HIV response, the organizational structure is very different to that of the public health clinics and so the behavior change strategy may be different and any institutional level barriers that may be identified in the study, may not be applicable to the public health service and likewise, institutional level barriers that may apply to the public health service may be missed. Data collected through the key informant interviews helped to fill in some of the gaps but it may not give the full picture from the side of the public health service.

The fourth limitation that needs to be highlighted is that participants completing the visual ranking survey may have experienced recall error particularly in those participants who responded based on their past experiences of getting tested and, in those that had never been tested for HIV, their response to the question of motivation would have been based on speculation. It is hoped that triangulation of the data sets helped to overcome the effect of this limitation.

The final limitation that needs to be considered is researcher bias. Given the fact that I am a national of Trinidad and Tobago and have lived and worked there in the past,

AN OUNCE OF PREVENTION

a slight degree of personal bias may present a limitation for the study. On the other hand, the fact that I am Trinidadian allowed me to build rapport with the study participants very easily and possibly provided a level of comfort for them allowing for more open dialogue. This limitation therefore could possibly be also considered a research strength and it was acknowledged and monitored throughout the data collection process and the analysis.

Chapter Four: Results

4.0 Introduction

This chapter provides an overview of the study findings. The findings are based on the results of the semi-structured key informant interviews, observation at the testing sites and outreach events and the visual ranking survey that was conducted with women in the general public.

The chapter begins with an overview of the respondent profile from the interviews and the survey. The second section presents the barriers, as identified by the interview and survey participants, that women in Trinidad and Tobago face which negatively impact on their decisions to get tested for HIV. The third section presents the motivations that help to encourage women to access VCT and the final section discusses the cues to action that were identified by the study participants, how some of them contribute to the barriers that women face and the seasonality of the messaging.

4.1 Respondent Profile

The study sample was comprised of a total of 272 (n=272) participants of which 31 participated in the semi-structured key informant interviews and 241 participated in the visual ranking survey.

The 31 interview participants were classified according to gender, location and employment profile. Table 4.1 illustrates the distribution of the respondents according to the specified attribute values for each classification.

Table 4.1: Distribution of respondents according to specified attribute values (n = 31)

Classification	Attributes	Number of respondents
Gender	Female	22
	Male	9
Employment Profile	VCT Tester/Counselor	7
	NGO	11
	FBO	3
	Public Stakeholders	10
Location	North	17
	East	8
	Central	0
	South	4
	Tobago	2

Of the 31 participants, over 70% were female. More than half of the sample was located in the North of Trinidad while only 2 participants were located in Tobago. There were no participants from Central Trinidad. The participants were also classified according to their employment profile and the attributes for this classification consisted of staff from Non-Governmental Organizations (NGO), staff from Faith-based Organizations (FBO), public stakeholders and VCT testers and/or counsellors. There was almost an equal distribution of NGO participants and public stakeholders, while FBO staff comprised the smallest number of participants. Five of the nine male participants were NGO staff, two were VCT testers, one was a staff member at an FBO and one was a public stakeholder. Of the female participants, nine were public stakeholders, six were NGO staff, five were VCT testers and/or counsellors and two were FBO staff.

The sample for the visual ranking survey, as previously stated, was purposefully selected to only include women between the ages of 18-49. The participants were stratified into cohorts of 7 years and were also classified according to their location

AN OUNCE OF PREVENTION

within the country. Figures 4.1 and 4.2 present the distribution of the respondents by age and by location.

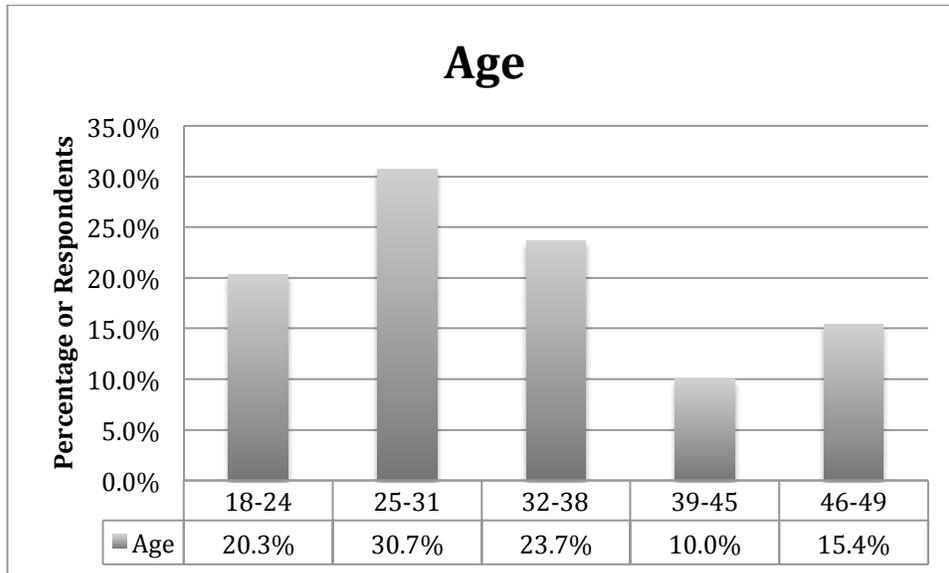


Figure 4.1: Distribution of respondents according to age (n=241)

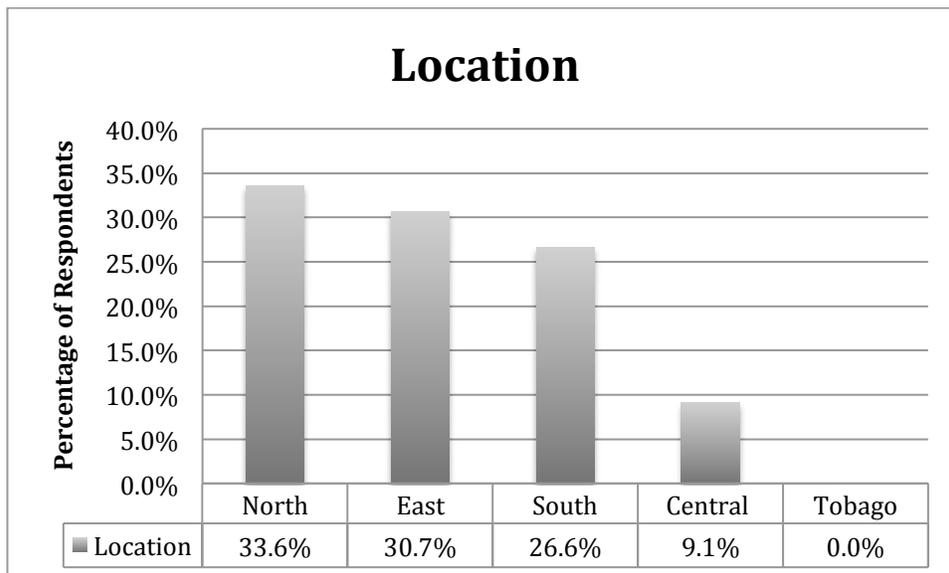


Figure 4.2: Distribution of respondents according to location (n=241)

AN OUNCE OF PREVENTION

Over 50% of the participants were under 31 years of age with most falling between the ages of 25 to 31 years while just over 25% of the sample were over the age of 39. Most of the respondents were located in the North of Trinidad. The outreach events that the researcher attended both took place in Trinidad and so consequently, there were no respondents from Tobago. In North and East Trinidad, the largest proportion of respondents (58% and 63.5% respectively) fell between the ages of 25 and 38 years while in Central and South Trinidad more than half of the respondents (63.7% and 50.8% respectively) fell between the ages 18 and 31 years.

4.2 Barriers

The qualitative data obtained during the semi-structured interviews and during observation at the testing sites revealed a number of barriers that could potentially have a significant impact either directly or indirectly on women's decisions to get tested for HIV. As previously noted, these barriers were then categorized as community level, intrapersonal level or interpersonal level barriers. Five barriers identified from existing literature and from analysis of the field notes from some of the semi-structured interviews were then selected for use in the visual ranking survey and the results of the survey can be seen in Figure 4.3.

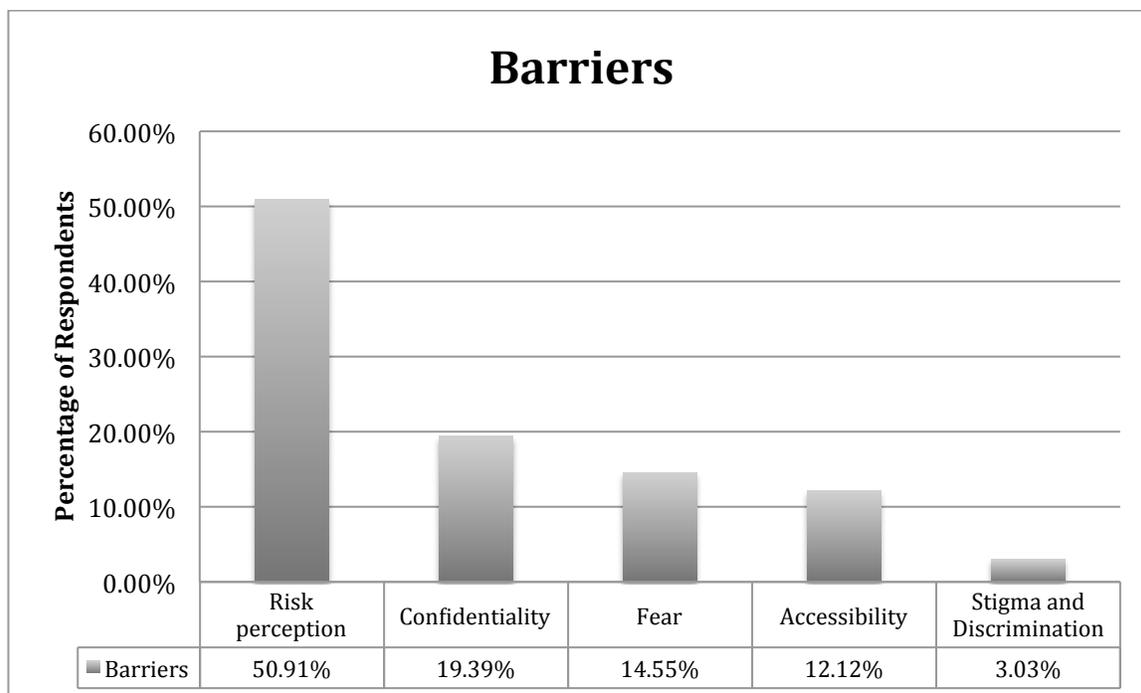


Figure 4.3: Percentage of Respondents per identified barrier

4.2.1 Community level barriers

All 31 of the participants in the semi-structured interviews identified barriers to testing at the community level, particularly barriers at the institutional and organizational level. Table 4.2 outlines the identified barriers and the frequency of references.

Table 4.2: Community level barriers

Identified Barrier	Number of Respondents	Frequency of References
Institutional and Organizational barriers:		
• Accessibility	27	113
• Confidentiality	27	79
• Lack of Resources	21	48
• Poor customer service	13	26
• Judgment	11	34
• Structure of the program	5	13
Culture and religion	20	57
Policy and laws	6	9
TOTAL	31	379

AN OUNCE OF PREVENTION

Overwhelmingly, barriers related to accessibility were mentioned most often during the interviews. The quantitative data collected during the visual ranking survey with women in the general public however, ranked accessibility fourth among the reasons why they would not access a VCT test. Only 12.12% of survey respondents selected accessibility as the main barrier impacting on their decision to get tested for HIV.

Of the 31 interview participants, 27 noted that despite the fact that the number of VCT sites in Trinidad and Tobago has increased over the years, accessibility to testing still remains a big challenge as women still have difficulty accessing HIV testing when and where they want it. As one participant explained,

If I was in this community and I said I want to go get a rapid test today and I need it to be free, or I don't want to go to the Health Centre to do it, where am I going to go? I wouldn't know where to tell someone to go and, to me, that's unfortunate because in most places it's just a lot easier. People know you could go there or that organization does it. In Trinidad, it's just not really the same.

VCT is still primarily offered through the public health system, with the exception of one NGO that routinely offers it as part of their services. Several participants noted that test availability is also a big issue when it comes to women accessing testing for HIV because once a woman makes the decision to get a test, she is often faced with inconveniences, such as test availability, that are outside of her control and that may make her rethink her decision. In addition, many of the testing sites are not located in rural areas so access to testing for people that live in the more remote areas of the country is limited.

One major issue that was highlighted by more than half of the participants is the fact that many of the testing sites only offer VCT on specific days of the week and during working hours (8:00am to 4:00pm) when women are unable or unwilling to access a test.

AN OUNCE OF PREVENTION

This fact is further supported by the promotional poster in Appendix 1 which shows the days and times available for VCT at the public health clinics. Data collected during observation at the NGO testing sites also supports this fact but it must be noted that one of the sites opened at 7am and closed at 12:30pm which would provide women with a small window of time before working hours to access the services. It could be argued however, that one hour may not be sufficient time for a woman to get the test done and then proceed to work, particularly if their place of work is not located close to the clinic. Participants explained that although the test itself may only take approximately 15 minutes to do, there are often long wait times at the public health sites and so the entire process could take as long as three hours depending on how busy the clinic is and other factors such as shortage of staff. This is a major deterrent for women because they often don't have the time to devote to the process. As one participant stated,

Women work, women have responsibilities. Because testing isn't accommodating to these responsibilities, whether the woman is working in an office or the informal economy, it is not flexible. This is the main barrier.

It is important to note that many of the aforementioned barriers are related to testing at the public health sites and the option exists for women to access testing at the Family Planning Association of Trinidad and Tobago (FPATT), which is the only NGO that is currently able to routinely provide VCT. Women can also access HIV testing through private health facilities. The major barrier that women potentially encounter when accessing testing through these channels is the issue of cost. In Trinidad and Tobago, HIV testing is offered free of charge at all public health facilities but there is a cost for it at private health facilities and at FPATT. At least 8 participants mentioned the

AN OUNCE OF PREVENTION

issue of cost as a possible barrier for women accessing a test particularly for those women who are economically disadvantaged. As one participant explained,

[Those women] are probably less inclined to get a test because that is probably not on their priority of things to do. They don't see the need for it. They're probably just trying to figure out how to live day-to-day, how to make a dollar to buy [food for] their children, particularly if they're single parents. How to mind their children and take care of themselves.

There were a few participants however, who felt that cost was not a significant barrier for some women as one participant noted, "Cost can be barrier to some but someone who can afford it will pay willingly because they feel like they are getting a higher quality of service."

The final issue related to accessibility is that of language. One participant who worked on a project involving sex workers, many of whom were Spanish speaking, explained that many of them are unable to access HIV testing not only because of their tenuous immigration status, but also because many of the health care providers do not speak their language.

Confidentiality was also identified, during the interviews, as one of the main barriers experienced by women in Trinidad and Tobago when it comes to testing for HIV. 27 of the 31 participants mentioned confidentiality as a barrier however the frequency of references was a bit lower than that of accessibility. The quantitative data from the surveys ranked confidentiality second (19.39% of respondents) as a barrier to getting tested for HIV.

Issues surrounding confidentiality and by extension, privacy, can be categorized as real or perceived and more often than not, participants highlighted perceived issues surrounding confidentiality as a barrier to women getting tested for HIV. Several

AN OUNCE OF PREVENTION

participants explained that many women do not think that the public health service is confidential enough and so they are reluctant to access VCT at the public clinics, particularly clinics that are located within their communities. This was highlighted as a major barrier especially affecting people living in rural communities as compared to people living in more urban settings and larger cities as one participant explained,

What we've found is a number of women... from those rural areas, they leave and go to Port-of-Spain or San Fernando to remove that stigma of being seen and judged because it's a small community therefore, you know, if you're living in Port-of-Spain, you're one in a million, in a rural area, everybody knows you, knows who you're related to, probably who you're going out with, so all of that people take into consideration if you were to go get a test because you're known, whereas in a [big] city, you'll be faceless.

One participant from Tobago noted that confidentiality is also a major issue in the communities on that island because of how small they are. Participants highlighted the issue of confidentiality as a barrier for both younger and older women alike.

Confidentiality, as it relates to the setting of the clinics and operational procedures was also identified. The setting of many of the clinics are such that VCT is performed in a separate room to other health services, so participants noted that even though there may not be a sign indicating that the room is designated for HIV testing, the perception that everyone in the clinic will know what you are going for still presents a barrier for women. Observational data at one of the clinics supported this finding. The VCT room was located at the back of the clinic and was specifically designated for HIV testing and so the confidentiality of the clients going into the room for VCT could potentially be compromised.

Another institutional and organizational barrier that was identified during the semi-structured interviews was lack of resources, which includes human, material and

AN OUNCE OF PREVENTION

financial. In terms of human and material resources, at least five participants explained that inadequate staffing and supplies is sometimes an issue, and this has a direct impact on the availability of testing. In terms of financial resources, several participants indicated that the sustainability of the VCT program is negatively impacted by the lack of adequate funding.

Other institutional and organizational barriers that were identified by interview participants, but to a lesser degree of frequency, were issues related to poor customer service on the part of health care providers, particularly within the public health service, judgment by health care providers and the overall structure of the VCT program as a whole. As one participant explained, “One of our barriers is that our health services don’t see... customer relations as part of their operations and we still have judgment-laden perceptions and judgment-laden language and judgment-laden behaviour creeping in.” That participant went on to further explain that one woman’s negative experience not only impacts her decision to get tested for HIV, but when she tells her friends about her experience, it has a snowball effect and as a result, several women would be hesitant to access the service. The responses from participants revealed that judgment on the part of the health care providers is problematic for both young women and older women alike.

At the community level, culture and religion was also identified by 20 of the 31 participants as a barrier impacting on women’s decisions to access VCT. Several participants explained that the topic of sex is still very much taboo in Trinidad and Tobago and as a result, women are hesitant to access testing for HIV because it would mean admitting to themselves and the health care provider that they are sexually active. One participant said it best,

AN OUNCE OF PREVENTION

We live in a society that is very contradictory. One, we are a very religious society that speaks to abstinence, faith, even though our statistics don't necessarily reflect that especially if you look at single parent households and the number of divorces. And then on the other hand, we have the whole carnival culture which speaks to having multiple partners and so forth, so people are not very open about their sexuality and what they do so by going to a medical professional, they are almost disclosing what they've been doing, they could be ashamed.

Another aspect of the culture that impacts on women's decisions to access testing is the fact that preventative health care is often not high on the list of priorities, particularly for young women as one participant explained,

That is not something we are taught to do. Health seeking behaviour is something for the aged, because that is when you experience deterioration per say.... I think that for younger women, that's not the priority. The priority is on looking good and having fun and health issues are the last thing on your mind.

The final barrier that was identified at the community level was that of policy and laws particularly with regards to the laws surrounding sex work and immigration policies that impact on the accessibility of health care for sex workers and illegal migrants. Two participants highlighted the fact that sex work is illegal in Trinidad and Tobago and as a result, women that are involved in the sex trade are often hesitant to access HIV testing. In addition, illegal migrants, especially female sex workers, are unwilling to access VCT because of their tenuous immigration status and the fear of possible deportation.

4.2.2 Intrapersonal level barriers

Of the 31 interview participants, 30 identified barriers at the intrapersonal level. Table 4.3 presents the frequency of the responses for each identified intrapersonal level barrier.

Table 4.3: Intrapersonal level barriers

Identified Barrier	Number of Respondents	Frequency of References
Fear	21	49
Knowledge and awareness	20	46
Beliefs and attitudes	17	39
Risk perception	15	26
Socioeconomic	15	25
Lack of confidence in health care system	5	9
TOTAL	30	194

Approximately 67% of interview participants mentioned fear as the most significant barrier that women experience which impacts their decision to undergo HIV testing. One participant explained,

VCT seems to inspire fear in people. I remember the first time I went for a test... I know about HIV, I was terrified. I knew all about it and I knew there was little risk of my having been infected but just the whole nature of going in to be told whether you have it or not was a terrifying experience for me, far less for a woman who is far more vulnerable, doesn't have my options just in case she were to come out as infected. So, you know, it's a terrifying experience for women.

Participants mentioned issues such as fear of knowing and the idea that “what I don't know, can't hurt me”, fear of a positive result, fear of dying, fear of needles, fear that they would not be able to cope if they are HIV positive, fear of both society's and their partner's judgment and reaction and fear of violence at the hands of their partner. One participant mentioned that for older women, “some of them tell you outright, ‘At this age, I don't want to know.’” Another participant mentioned that for married women, religious women and women that are viewed as “virtuous” in their community or family, they are afraid to be tested because they are afraid of what other people will think if they knew that they went for an HIV test. A number of participants also explained that for married

AN OUNCE OF PREVENTION

women, or women that are in long-term monogamous relationships, there is also the fear that their partner will think that they don't trust them or that their partner will blame them for being unfaithful.

Lack of knowledge and awareness also ranked relatively high (64.5% of interview participants) in terms of the frequency of responses. Participants mentioned issues such as lack of knowledge about HIV as a whole, for example, how it is transmitted and the affect that it has on the individual, families and society, myths and misconceptions around HIV and not knowing where to go and get tested, why testing is necessary, the process of getting tested and treatment options if they are found to be HIV positive. One participant stated that for young women, under the age of 20, "they get information from among themselves and most times wrong information." Another participant explained the knowledge gap between older and younger women,

Most of the young people now, at least 30 years and under, have been born into HIV, so for them, that's their reality. That's the world that they are operating in. For us [older women], we didn't know anything about this and all we know, boy, this thing come to lick away people and kill people. So I think the young people's view of the whole HIV situation is sometimes a little different than through the adult eye.

Issues such as low literacy rates and lack of exposure to information, particularly in the more rural communities, were also mentioned and at least 3 participants felt that access to information is higher in the more urban cities than in rural communities.

Other barriers at the intrapersonal level that was also mentioned were barriers associated with beliefs and attitudes (54.8% of respondents). This included a sense of invincibility and the idea that "it won't happen to me", particularly among young women, the belief that HIV is a death sentence and so they would rather not know, the notion of sex and HIV/AIDS as a taboo topic, naivety and denial, particularly when it comes to

AN OUNCE OF PREVENTION

their partner, and religious beliefs. One participant felt that older women sometimes have a more blasé attitude when it comes to HIV and feel that they don't need to do a test. For more economically depressed communities, one participant explained that there is an attitude of fatalism and the feeling that it “doesn't really matter anyway”.

Low risk perception, which is often related to lack of knowledge and awareness, was also mentioned as a barrier at the intrapersonal level but based on the frequency of responses among interview participants it ranked fourth. This contrasted sharply with the results from the visual ranking survey, which ranked risk perception the highest among barriers that women face when it comes to HIV testing. Approximately 50% of the survey respondents selected risk perception as the main barrier to their getting tested for HIV. On the other hand, only 14.55% of survey respondents selected fear as their main barrier. Low risk perception appeared to be a barrier for both younger and older women alike.

Other barriers mentioned at the intrapersonal level were socioeconomic barriers, particularly when it impacted on women's ability to pay for an HIV test at an NGO, and one participant mentioned lack of confidence in the health care system as a barrier.

4.2.3 Interpersonal level barriers

Barriers at the interpersonal level had the lowest frequency of mentions by interview participants however the margin of difference between the three levels was small. Table 4.4 presents the frequency of the responses for each interpersonal level barrier that was identified.

Table 4.4: Interpersonal level barriers

Identified Barrier	Number of Respondents	Frequency of References
Partner related	26	53
Stigma and discrimination	22	38
Lack of social support	10	16
TOTAL	29	107

At this level, partner related barriers were mentioned most often by interview participants. 83.9% of respondents mentioned issues related to the relationships between women and their partners as being a barrier to women getting tested for HIV. Of those respondents, over 60% mentioned the issue of trust as a major barrier. Several participants explained that very often the question of infidelity and trust usually hampers the woman's decision-making process when it comes to VCT because the woman is afraid that if she is found to be HIV positive, her partner may accuse her of being unfaithful, even if he was guilty of infidelity himself, or he may accuse her of not trusting him. As one participant explained,

What complicates that is the whole acquiescence of “horning” [cheating] in Trinidad. That has implications for HIV testing because you're saying to your partner you want for him to be tested or you want to be tested yourself, then there's a bell, “Ok, you don't trust me” or you're doing something wrong. It becomes a whole domestic issue.

Tied into that, as some participants explained, is the idea that by getting tested, the woman has to overcome her own denial and acknowledge the fact that her partner may have been unfaithful and so many women just don't want to know. For married women and women in long-term relationships, participants noted that blind trust in their partner often presents a barrier as many times the woman believes very strongly that they don't

AN OUNCE OF PREVENTION

need to be tested because their partner is faithful to them. For older women one participant explained,

The older women, as they cross into their 40s and 50s and so on, they become a little more closed in. They are ashamed to talk if their spouse has been unfaithful or if they even had a relationship and they need this testing because they feel that the seniority – At their age, they should be a certain way. They don't want everybody to know. Everything was going good for so much [sic] years and there's a little shame on the family.

Gender based violence was also mentioned by 10 respondents as a partner related barrier. Participants mentioned issues such as fear of violence, particularly if the woman's partner feels that she has been unfaithful or if she is found to be HIV positive. One participant noted that, for women who are victims of intimate partner violence, getting tested for HIV is probably low on her list of priorities and she may not even want to think about it. Participants mentioned that women that are victims of incest or sexual abuse also experience barriers to testing simply because they may not have control over their own sexuality or as one participant explained,

Women who do not have control over their sexuality, I am talking specifically about women who have been victims of sexual abuse in childhood or victims of assault, you find that they really don't want to know. They are very fearful because of the stigma attached with not only one, the virus, but two, having been a victim of rape or having to disclose now a history of sexual abuse which has compromised their ability to make choices within relationships.

Another participant noted that this issue also affects women who are involved in the sex trade because some of them can't leave the brothel to access testing and sometimes they face violence at the hands of the brothel manager and clients so they would rather not know.

AN OUNCE OF PREVENTION

Another interpersonal level barrier that was mentioned by participants was that of stigma and discrimination. 70% of interview participants felt that stigma and discrimination, whether perceived or real, was a significant barrier for women accessing testing for HIV because many women would rather not know their status so as to avoid facing discrimination in the event that they are HIV positive. Some interview participants also explained that stigma extends beyond being HIV positive to just simply getting tested because women don't want to be labeled as promiscuous. They noted that fear of discrimination limits women's accessibility to testing sites, particularly public sites, because women don't want to be seen accessing testing. It was also a major driver for women's hesitance to access testing within their communities, especially in rural communities, because they don't want anyone to know. Participants mentioned stigma and discrimination as a barrier for both younger and older women alike. At least 2 participants felt that stigma and discrimination, although still a barrier for women, has been reduced over time as a result of awareness campaigns and general education in the public. It is important to note that this finding contrasted with the findings of the visual ranking survey because stigma and discrimination ranked the lowest among survey respondents. Only 3% of survey respondents felt that stigma and discrimination was a barrier to their getting tested for HIV.

The final interpersonal level barrier that was mentioned, but at a lower frequency, was lack of social support. This barrier is linked to fear and stigma and discrimination because as participants explained, women may be afraid to get tested for HIV because they may be worried that, should they get a positive result, they may be ostracized. They may also be hesitant to get a test if they do not have the support of their partner, family or

AN OUNCE OF PREVENTION

friends. Participants mentioned that peer pressure is a barrier for young women in particular because, without the support of their peers, they may be reluctant to get a test. One participant also mentioned this as a barrier for migrant sex workers because they often lack the social support to both encourage testing and also to provide help in the event of a positive result.

4.3 Motivations

The respondents in the semi-structured interviews identified a number of different reasons why women decide to access VCT. Like the barriers, the motivations were categorized according to community, interpersonal and intrapersonal level motivations and five of the most frequently mentioned motivations based on existing literature and some of the interviews were selected for the use in the visual ranking survey. The dominant finding of the survey was that peace of mind was ranked as the number one motivation for women to get tested for HIV. 86.38% of respondents selected peace of mind as their response. The survey results for the other four identified motivations can be seen in Figure 4.4.

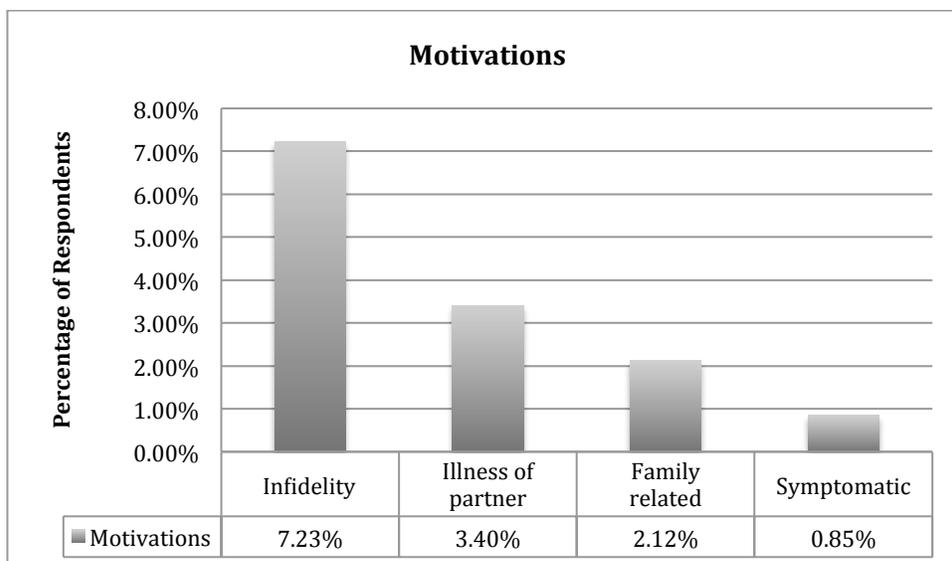


Figure 4.4: Percentage of respondents per identified motivation

4.3.1 Intrapersonal level motivations

Motivations at the intrapersonal level were identified by 30 of the 31 participants in the semi-structured interviews. The frequency of the responses for each identified motivation at this level can be seen in Table 4.5.

Table 4.5: Intrapersonal level motivations

Identified Motivation	Number of Respondents	Frequency of References
Risk perception	16	27
Knowledge and awareness	14	21
Peace of mind	14	21
Attitudes and beliefs	14	21
Symptomatic	13	20
TOTAL	30	110

Over 50% of the participants identified risk perception as a major motivation for women to decide to get tested. Participants indicated that if a woman knows that she is at risk of

AN OUNCE OF PREVENTION

infection due to unprotected sex, whether planned or not, if the condom that they were using during intercourse burst, if they suspect or heard that their partner was being unfaithful or that they themselves were unfaithful, they would be more likely to seek an HIV test. Some participants also indicated that for some women who know that their lifestyle puts them at greater risk for infection, such as women who have concurrent partners or those that engage in transactional sex, they would also be more likely to get tested and these women are also more likely to be repeat testers. One participant noted that for women over the age of 25, they would be more likely to acknowledge a slip in judgment that may have put them at risk and therefore would seek out a test as a result.

Knowledge and awareness was also identified as a motivator for women by approximately 45% of participants. Participants noted that once a woman is aware of her risk, the treatment options that are available for HIV and the fact that HIV is not a death sentence, she is more likely to get tested, as one participant stated, “When you have enough information to realize that you’re at risk, it could motivate you to want to find out if it is true.” Several participants indicated that this motivation tends to be seen more with younger women because they are more knowledgeable about HIV than the older generation and so are more likely to be willing to test as explained by one participant,

I find that younger people are getting tested more. I think because of exposure. Younger people meaning 18 to 30 younger women. We look at our bodies differently I think, we’re taking a great deal of agency of our own bodies and how we protect ourselves and things like that. It’s a different generation.

Another participant indicated that women that have a higher level of education and women that are more empowered tend to be more willing to get tested. At least 2 participants stated that there is a certain level of awareness and normalization that has

AN OUNCE OF PREVENTION

been achieved in society and one other participant indicated that there has been more education in the workplace due to the workplace program and so that can also help to motivate women to access VCT.

Peace of mind was also identified as a motivator for women by approximately 45% of participants. Most participants indicated that many women “just want to know.” Participants explained that this motivation is driven by the desire to know if they are “clean”, to empower themselves, to know that they can continue their current behaviours, whether risky or not, to know their health status so that they can seek treatment if necessary. One participant also indicated that some women seek a test because they know that they are likely infected and they just want confirmation. As previously indicated, peace of mind ranked as the number one motivation selected by women who participated in the visual ranking survey. It is important to note that this motivation is closely linked to many of the other identified motivations and so this may explain the reason why the majority of women identified it as their main reason for wanting to get an HIV test.

Participants also identified the motivation of beliefs and attitudes that may drive a woman to get tested. Several participants noted that women who are more empowered, those that are more independent and open-minded and those with fewer inhibitions, particularly younger women, are more likely to get tested for HIV. One participant explained that women who are more comfortable with their sexuality and have like-minded peers would also have a higher likelihood of action. Most of the participants indicated that women in general exhibit a higher interest in health and health seeking behaviours and so they are more likely to get tested.

AN OUNCE OF PREVENTION

The final intrapersonal level motivation that was identified by just over 40% of participants was being symptomatic. Several participants indicated that many women may seek an HIV test or may be referred by a health care practitioner if they are experiencing symptoms, which may or may not be related to an STI, or just symptoms of being unwell. Participants explained that for those women, they know that something is not right with their bodies and they want to know the cause. This motivation ranked lowest (0.85% of respondents) in the visual ranking survey.

4.3.2 Interpersonal level motivations

Motivations at the interpersonal level were identified by just over 87% of interview participants. Table 4.6 presents the frequency of the responses for each interpersonal level motivation that was identified.

Table 4.6: Interpersonal level motivations

Identified Motivation	Number of Respondents	Frequency of References
Partner related	21	37
Peer influence	10	14
Family related	8	12
Job or insurance	5	7
Social support	2	3
TOTAL	27	73

The dominant finding of the semi-structured interviews is that women are most likely to undergo testing for HIV due to reasons related to their partner. Approximately 67% of the interview participants mentioned partner related motivations as the main reason why women decide to test. This finding was supported by the findings of the

AN OUNCE OF PREVENTION

visual ranking survey in that infidelity and the illness of a partner were the most frequently selected responses by participants after peace of mind.

The majority of interview participants explained that the most common reason why women decide to get tested for HIV is because of infidelity, whether real or imagined, on the part of their partner or if they themselves have been unfaithful. Participants also explained that some women might test because they are entering into a new relationship or ending one or if they are getting married. One participant identified partner persuasion as a possible motivator. Another participant explained that some women decide to get tested so that they can make a decision about a relationship. The final partner related motivation that was identified by a number of participants is the illness of a partner, where the woman finds out that either her current or a past partner has HIV or has died of AIDS. Participants identified this motivation as a driver for both younger and older women regardless of their location within the country.

Another motivation that was identified by participants was that of peer influence. Participants explained that some women, especially youth, may decide to get tested because of peer support or because they accompanied a friend who was getting tested and then they decided to get tested as well. One participant explained, with regards to testing that occurs during outreach events,

Some of them may be walking in groups and they may have one person who will motivate them, “I am going to do it” and you see the others follow. They’ll say, “I don’t really want to be here you know, but my friend say she doing it.”

Two participants stated that the motivation of peer influence is often seen in work environments when testing is being done at a workplace as part of an outreach event.

AN OUNCE OF PREVENTION

Family related motivations were also mentioned by participants but less frequently than the other previously mentioned interpersonal level motivations. These included pregnancy or the possibility of future pregnancy, and responsibility to family, including parents and children. As one participant stated,

So you're worried about your health because at the end of the day, you're all your child has or your mother or your aunt. So I think it's a sense of responsibility to, not even to self, but to family.

The findings of the visual ranking survey also ranked family related motivations just below partner related motivations.

Other interpersonal level motivations that were identified by participants were job or insurance related, where an HIV test is required for a job or insurance application, and social support particularly among women in a community group as one participant explained,

Women will talk about their health, their headaches, their menstruation, even if they're close friends, they'll talk about their sexual — sex lives, whatever it is, so they have that kind of network where you kind of share and can listen and support testing. And we've found that, not just specific to Trinidad, but in general, social support is one of the major factors for both condom use and testing. For men it's important too, but for women it's definitely that social support. It's a huge motivation.

4.3.3 Community level motivations

The third category of motivations that were identified by interview participants is that of community level motivations. Approximately 77% of participants mentioned motivations at this level and the frequency of responses for each identified motivation can be seen in Table 4.7.

Table 4.7: Community level motivations

Identified Motivation	Number of Respondents	Frequency of References
Cues to action	20	40
Accessibility	18	69
Confidentiality	7	10
Customer service	6	7
TOTAL	24	126

Of the community level motivations that were identified, cues to action ranked the highest. Just over 64% of participants identified cues to action as a major motivation for women deciding to get tested for HIV. The majority of participants identified face-to-face interactions in the form of counselling or as part of an outreach event or educational program as a major motivator for women as one participant explained,

I think there's definitely something to be said about face-to-face programs in terms of success, so actually having behaviour change or getting your message across. That's why you see that people do line up to get tested if you're doing an outreach visit... So there really is something about, in Trinidad, being right there, you know.

One type of face-to-face interaction that was specifically mentioned by several participants as a strong motivator for women is the strategy of Provider-Initiated HIV Testing and Counselling (PITC). Participants also mentioned cues to action such as outreach events, like health fairs or testing booths, particularly those that take place on an internationally recognized day like World AIDS Day or during carnival season, as providing motivation for women. A few participants felt that mass media campaigns also help to motivate woman by raising public awareness and just getting the information out to them however, one participant felt that cues to action as a motivation was more frequently seen among women in urban cities simply because they tend to have more exposure to them.

AN OUNCE OF PREVENTION

The second community level motivation that was frequently mentioned by participants was accessibility. Of the 18 participants that identified accessibility as a motivation, 16 stated that when testing is offered through a mobile clinic or at an outreach event, particularly when testing is being offered outside of working hours or on weekends, women are more likely to get tested. One participant offered this example,

I believe too, for working people, when we are out in the Square, it's easy for them to get it and they don't have to ask for time off, and that sort of thing, to go and get it and it's right there. For some people, they come down to shop, "Oh, they're doing VCT, well they're right here so let me go and do it."

At least 10 participants stated that women's uptake of VCT is also higher when there is no cost for the test. Several participants explained that the introduction of rapid testing and same day testing has been a very strong motivator for women simply due to the convenience that it provides. According to a few participants, the expansion of the VCT program to include several more testing sites has also provided additional motivation for some women because of the convenience of having more locations available to access testing. One participant mentioned that women are also motivated when testing is offered through their workplace. At least 2 participants mentioned that the convenience of walk-in clinics is also a strong motivator for women.

Perceived confidentiality was also mentioned by a few participants as a motivator for women. Some participants explained that women tend to feel that the VCT service that is offered through NGOs is more confidential than that of the public health service and so that motivates them to access testing. A few participants also explained that women from rural communities are more motivated to access testing at locations outside

AN OUNCE OF PREVENTION

of their community because they feel that it would be more confidential and nobody that they know will see them going for a test.

The last community level motivation that was identified by a few participants was customer service. Participants explained that when women feel that the service that is being offered is welcoming and friendly, or if they get that sort of feedback from other women, they are more likely to make the decision to get tested for HIV.

4.4 Cues to Action

In-depth analysis of the qualitative data from the semi-structured interviews and observation at the testing sites and outreach events revealed a number of themes that focused on cues to action. Table 4.8 presents the frequency of the responses according to theme.

Table 4.8: Cues to action

Qualitative codes	Number of Sources	Frequency of References
Types of cues	52	138
Seasonality of messaging	21	37
Contribution to barriers	12	41

4.4.1 Types of cues

Of the 31 interview participants, 28 provided examples of different cues to action that are currently employed as part of the behaviour change strategy. As previously mentioned, face-to-face interactions, in the form of counselling or during an outreach event or educational session, was highlighted by several participants as the main cue to action that they employ when attempting to elicit behaviour change among women. Participants felt that this type of cue was the most effective means of reaching women.

AN OUNCE OF PREVENTION

One participant mentioned the use of street theatre as a way of providing cues to action during outreach events and she also stated that the use of theatre is also sometimes employed during educational sessions, particularly with youth.

Closely related to face-to-face interactions is Provider-Initiated HIV Testing and Counselling (PITC), which participants explained is a Ministry mandated approach that has been adopted over the past few years. Participants felt that PITC was crucial for increasing women's uptake of VCT services as one participant explained,

The provider initiated piece is so important because you have situations for example, just talking with young women, I was quite impressed to learn that a number of young women are, you know, taking on family planning practices... when I asked those women how many of them had done an HIV test, most of them hadn't and for me that's a major concern because if women are coming into family planning settings and if they are you know, accessing pap smears etc. etc., to me a natural complement to making that comprehensive and complete would be having an HIV test.

Several participants stated that they often used videos and other informational and educational materials such as posters, pamphlets and flyers. This was further supported by observational data collected at the testing sites where the researcher noticed several posters on topics such as HIV in general, HIV prevention and testing, and issues such as confidentiality, stigma and discrimination and abstinence. Videos were being played in the waiting rooms at both testing sites and pamphlets and flyers were available for people to take at the testing sites and on the tables during the outreach events. Most of the materials were targeted to the general public however there were some that were targeted specifically towards women and some towards young women in particular (18 to 24 years). Two posters targeted the working female.

AN OUNCE OF PREVENTION

Interview participants had varied opinions about the effectiveness of some of the different cues that were being used. At least 2 participants felt that the videos that they use in their waiting rooms were very effective and often prompted women to ask questions and, in so doing, open the door to talk about testing. Three of the participants did not think that pamphlets and flyers are effective for reaching women, as one participant from Tobago remarked,

You see the literature, Tobago, the Caribbean as a whole, we are not a reading society, so even though you have all this wonderful material, nicely done up, people just take them and put them down and they don't use them.

Several participants talked about the use of media, in the form of radio and television advertisements, public service announcements and mass media campaigns, to provide cues to action but most of the participants felt that the media messages were targeted more to the general public and youth as opposed to being targeted to women or to different age groups of women. This was highlighted by the following quote from one participant,

It's the above-line media, which used to be some radio ads, some bus ads, some TV ads, and then there's the below-line marketing which is the BCC [Behaviour Change Communication] outreach that used to take place. And specifically to women? Not really outside of PMTCT [Prevention of Mother-to-Child Transmission], it's sort of general population, more focused on youth and popularity messages than it is for women per say. Other than, obviously, women get targeted from the material at Family Planning, but again, the sad story is that you don't hear about it much in the last years.

Several participants stated that no major mass media campaigns have been executed over the past few years, specifically after the National AIDS Coordinating Committee (NACC) was closed and before the Interim HIV Agency was established. It is important

AN OUNCE OF PREVENTION

to note that during the period of field research, the researcher did not observe any cues to action in the media or in general public spaces. The only time that the researcher observed any information or messaging on HIV/AIDS was at the testing sites and at the NGO booths during the outreach events that were attended.

4.4.2 Contribution to barriers

Of the 31 interview participants, 12 mentioned ways in which the current means of communication, information and messaging contribute to the barriers that women experience with regards to testing for HIV. Of these participants, five mentioned issues surrounding lack of accessibility to information particularly for women in more rural areas as one participant explained,

I am just thinking of like say, farm workers, female farm workers, they are out in the field whole day, they're coming home, what exposure are they getting really to the information? If they don't have a TV? If they listen to the radio? Maybe not. Who's doing outreach to them? They are kind of shut off.

Lack of accessibility to information was also mentioned by one participant in relation to older women who are more confined to the home. That participant explained that older women, such as those, experience less accessibility to information than younger women. Another participant explained that because of the fact that most of the information and communication around HIV and HIV testing is in English, migrant sex workers whose mother tongue is not English also have difficulty accessing information.

Several participants mentioned that sometimes the actual messages that are being conveyed could present barriers for some women. Participants explained messaging surrounding abstinence is often not well received in the general public because it can

AN OUNCE OF PREVENTION

create a value clash for some women that hinder their decision-making process when it comes to HIV testing. As one participant explained,

The first method is abstinence, which goes along with this whole notion of morality and to be a moral woman means you abstain until you're married, right? So, of course, that's problematic in terms of the real issues and the barriers that we have with information and with minimizing the anxiety that we have around getting tested.

One participant mentioned that some of the messages that are conveyed are not culturally appropriate and so do not resonate with women at all,

A lot of them are very bland, very stereotypical and sometimes very mismatched to the culture. We've had messages on getting tested that talk about if you've had a one-night stand... one night stands are not a part of Caribbean culture. We have one weekend stands, one week stands, carnival "friend", summer relationships. Our line of thought around "hooking up" is not big on one-night whatever. We're big on seasonal whatever. You have a Christmas "friend", a carnival "darlin'", you have an Easter "friend", you have a travel "friend"... there are more of these kinds of scenarios, which is the dominant realistic ethic than there are one night stands.

A few participants explained that the messaging is not targeted enough towards women, particularly older women and married women.

At least 8 participants mentioned issues related to the appropriateness messengers that are often used to convey messages to women in the public. As one participant stated,

The messengers are important. Who carries the message is important. I know, for instance, in the past they've used a lot of icons like people in the music world and so on but very often you hear people saying that they are also associated with negative kinds of behaviours that you wonder if people take them seriously.

Some participants explained that using these types of icons tend to be more effective when targeting young people but it does not resonate as well with older women.

4.4.3 Seasonality of messages

Of the 31 interview participants, 21 felt that the messaging around HIV and HIV testing was very seasonal in Trinidad and Tobago. Participants explained that most of the national campaigns tend to be focused around internationally recognized days such as World AIDS Day and Caribbean Regional HIV/AIDS Testing Day and also during the carnival season and this has serious implications in terms of sustainability. Participants felt that the communications and messaging around HIV and HIV testing should be more intense and all year round because women need to be exposed to cues to action on a more consistent basis. As one participant stated,

I don't feel there is a sustained program of messages. You know, it's around World AIDS Day, you start to get a barrage of messages but when World AIDS Day is done, you don't see nothing [sic], you don't hear nothing, all the cups are given out, all the pencils are given out, all this money spent on giving out tokens but after that, a lull. I don't think that that's how it should be, you have to wait until World AIDS Day or any days that we commemorate issues around HIV. It has to be a sustained thing if we really want to make an impact on the population and make a difference and get them to start to think differently.

Most participants agreed that the national campaigns that are done on those special days are quite effective and that there is generally very good uptake of VCT, particularly at outreach events. However, participants felt that more emphasis needs to be placed on other times of the year in order for the behaviour change strategy to be more effective. A few participants explained that other than outreach events that some NGOs and some public health clinics may attend during the course of the year, there generally has not been a sustained national campaign or communication strategy on HIV prevention and testing since the NACC was disbanded.

4.5 Summary

In summary, the qualitative and quantitative data revealed the key barriers and motivations that women in Trinidad and Tobago experience at the intrapersonal, interpersonal and community levels, which impact on their decisions to access HIV testing. With regards to barriers, the qualitative data identified community level barriers as having the greatest impact on women, followed by barriers at the interpersonal and intrapersonal levels. The quantitative data, on the other hand, identified intrapersonal level barriers as the most important. This illustrates a slight disconnect between the barriers that providers and stakeholders view as having the most significant impact on women's decision-making process when it comes to VCT, and what women in the general public view as affecting them the most. The top five barriers that were identified are institutional and organizational barriers, in particular accessibility and confidentiality, fear, partner related barriers, low risk perception and stigma and discrimination. Other key barriers that were identified were lack of knowledge and awareness, beliefs and attitudes and culture and religion. Most barriers affected both younger and older women alike however, barriers such as peer pressure, was identified as affecting younger women more often while older women experienced barriers such as knowledge and awareness more frequently. Women living in more rural areas experience the barriers of accessibility, confidentiality, knowledge and awareness and stigma and discrimination more often than women who live in more urban settings.

Both the quantitative and qualitative data identified motivations at the intrapersonal level as having the most significant impact on women's decisions to access VCT. The top five motivations that were identified were partner related motivations,

AN OUNCE OF PREVENTION

peace of mind, cues to action, accessibility and risk perception. For younger women, higher levels of knowledge and awareness were identified as helping to motivate them to want to get tested for HIV. It is important to note that there were no motivations identified as playing a significant role in helping older women to make the decision to access testing. For women living in more rural areas, perceived confidentiality was identified as a major driver for them to get tested.

Finally, the chapter presented the major themes identified with regards to cues to action. A number of different types of cues are currently being employed, with varying degrees of effectiveness, as part of the behaviour change strategy in Trinidad and Tobago when it comes to HIV and HIV testing. Face-to-face interactions, which include Provider-Initiated HIV Testing and Counselling (PITC), were identified as being the most effective cue to action. Other cues to action that were identified include the use of information and educational materials as well as mass media campaigns. Participants identified issues related to the appropriateness of the messages and the messengers as well as the seasonality of the messaging as having an impact on the behaviour change strategy.

Chapter Five: Discussion of Findings

5.0 Introduction

This chapter will present an in-depth look at the major themes that emerged out of the findings of the study. The chapter is divided into four main parts. The first section will discuss the barriers and motivations that were identified by the study participants and explore the linkages that exist between them and across the levels of influence. The second section will explore the role that civil society and community level interventions play in the HIV prevention efforts in Trinidad and Tobago. The third section will critically examine the cues to action and some of the issues surrounding them that were highlighted in the study findings. Finally, the chapter will show how the findings support the conceptual framework that was used to guide the study and it will include a redesign of the conceptual framework to incorporate the interconnection between the barriers and motivations.

5.1 Barriers and Motivations and Associated Links

As is evident by the findings of the study, the barriers and motivations that women in Trinidad and Tobago experience with regards to VCT are numerous and complex and as stated by Musheke et al. (2013) “It is worth pointing out that the factors influencing uptake of HIV testing are not mutually exclusive... they are inextricably linked and may coalesce or reinforce one another to influence uptake of HIV testing” (p. 11). When examining the identified barriers and motivations these interlinkages become increasingly apparent and as such, the ecological perspective, which, according to Rimer and Glanz (2005), “emphasizes the interaction between, and the interdependence of

AN OUNCE OF PREVENTION

factors within and across all levels of a health problem”, helps to provide a deeper understanding of these linkages (as cited in McKensie et al., p. 163).

When it comes to the barriers that discourage women in Trinidad and Tobago from getting tested for HIV, the interconnection across the three levels of influence – the intrapersonal, the interpersonal and the community – can best be described as spheres of influence where a woman may experience one or more of the barriers at a given time. These barriers may influence one another or may be connected to one another across the levels of influence, and so further decrease the likelihood that she will access VCT (see Figure 5.1).

Fear was identified as one of the major barriers that impact on women’s decisions to access VCT and based on the explanations given by study participants, fear is highly interconnected with many of the other identified barriers. In an example given by Vermund and Wilson (2002), a woman may decide to forego HIV testing because of fear of rejection and blame from her partner and/or family if she should receive a positive result. The authors further explain that the psychological obstacle of fear may be based on the sociological aspects of lack of economic or social power and further tied to issues surrounding lack of empowerment. Social and religious norms may also play a role (Vermund & Wilson, 2002). For women in Trinidad and Tobago, fear is often compounded by many of the aforementioned factors. A woman who is economically dependent on her partner may be afraid to get tested for HIV because she may be afraid to lose the financial support that her partner may offer, if rejection occurs. This highlights the interaction between fear and socioeconomic barriers because not only is there the risk of rejection, but women who lack economic power may not even view

AN OUNCE OF PREVENTION

testing for HIV as a priority or feel that it is important, thus highlighting the connection between fear and lack of knowledge and awareness.

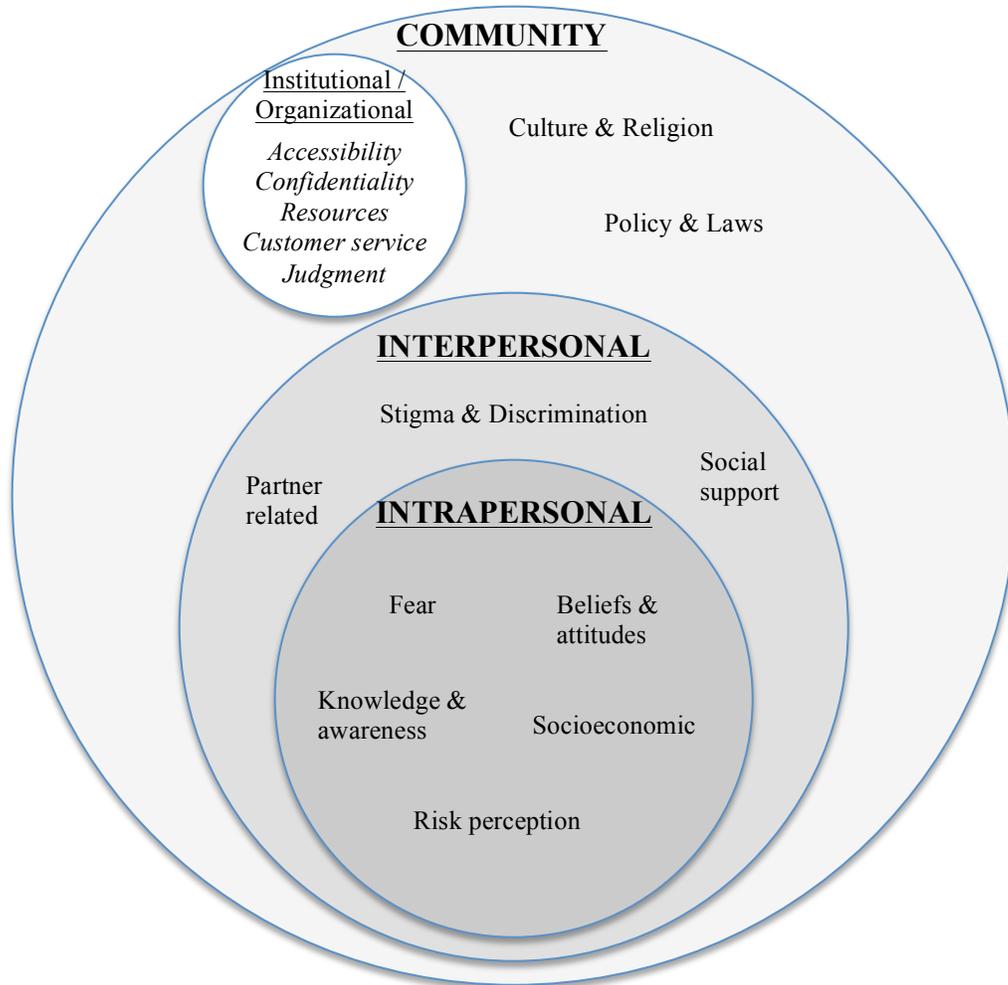


Figure 5.1: Spheres of influence illustrating the interconnection between the barriers that impact on women’s decisions to access VCT in Trinidad and Tobago

In addition, they may not be able to afford to pay for a test, thus illustrating how barriers related to accessibility come into play. Participants also indicated that women may also experience fear due to gender-based violence and again, this is often related to

AN OUNCE OF PREVENTION

economic dependency and lack of empowerment. Fear of rejection and fear of stigma and discrimination may also extend to family and friends in which case, the barrier of lack of social support may also impact the decision to access VCT. According to Musheke et al. (2013), social capital is crucial for survival in the absence of strong formal safety nets and, as a result, HIV testing behaviour is strongly influenced by social relationships. Thus, even if a woman acknowledges the importance of getting tested for HIV, the desire to preserve social relationships will impact on her decision to get tested (Musheke et al., 2013).

The barrier of low risk perception is also highly interconnected with several other barriers. As Musheke et al. (2013) explain, “Individuals engage in intense activity of experience-sorting and interpretation as they situate themselves in terms of danger. This lay assessment is informed by individuals’ knowledge of own and partner’s sexual behaviour and observations and experiences of health” (p. 11). If a woman lacks the knowledge and awareness to understand her risk of infection, she will not see testing as important. This is also connected to cultural barriers because as study participants explained, in Trinidad and Tobago, preventative health seeking behaviours are often not top-of-mind for the lay person. Many women only seek health care when there is a decline in health status or during pregnancy. In addition, a woman’s assessment of her risk may also be linked to her beliefs surrounding marriage and religion. Married women often feel that they are not at risk for HIV because marriage is often viewed as a safe sexual space however, research has shown that this is often not the case as many married women face the risk of HIV infection due to infidelity (Reddy, 2011). As the findings reveal, in Trinidad and Tobago, many women who are married or in long-term

AN OUNCE OF PREVENTION

relationships trust their partners implicitly and as a result they do not feel that they are at risk for infection. This may be further reinforced by religious beliefs that may strengthen women's conviction that marriage is not associated with risk of contracting HIV.

Institutional and organizational barriers are also strongly interconnected and may impact on barriers experienced at the other levels of influence. According to Gilson, because health systems are social institutions, service uptake is heavily influenced by people's perceptions of and experiences with the health care system (as cited in Musheke, 2013). Despite the fact that the VCT program in Trinidad and Tobago has been expanded over the past few years thereby increasing the number of sites that offer same-day testing, many women, particularly women from rural communities, still experience accessibility issues related to time constraints and lack of convenience when it comes to VCT. Many women prefer to get tested outside of their communities due to a perceived lack of confidentiality and so if the location or available times for testing is not convenient for them, they are unlikely to access testing. These women are often afraid that their partners, family and/or community members will find out that they are getting tested for HIV and stigma and discrimination may ensue. This illustrates the interconnection between accessibility, confidentiality and stigma and discrimination. In addition, many women feel that NGO or private clinic settings are more confidential and so would feel more comfortable accessing VCT at those locations however, there is currently only one NGO routinely offering VCT services on a daily basis so access is limited and for women that experience socioeconomic barriers, these options are not viable for them because they may not be able to afford to pay for the service. Accessibility can also be impacted by barriers related to lack of human, material and financial resources and these barriers

AN OUNCE OF PREVENTION

can also impact on the quality of service. For instance, lack of resources may impact on the attitudes of the health care providers on duty and their frustration may in turn be transferred to the clients. Study participants also highlighted judgment on the part of health care providers as an issue and this may be connected to stigma and discrimination, thus further impacting on the quality of service and care for women. Finally, accessibility is often impacted by policies and laws, which may limit access to VCT for certain members of society, such as migrant sex trade workers.

Similar to barriers, motivations to get tested for HIV are also interconnected. Figure 5.2 illustrates the spheres of influence for motivations. At the intrapersonal level, peace of mind is an overarching motivation that was identified by study participants as a key driver for women in Trinidad and Tobago to get tested for HIV and it is highly connected to several other motivating factors across the levels of influence. A woman may decide to get tested for HIV because, for example, she wants the peace of mind of knowing her status whether positive or negative, she may want the peace of mind of knowing that she will be there for her children and her family in the future or she may use her status as confirmation of her partner's fidelity. Peace of mind can also be connected to risk perception in that, a woman who has adequate knowledge about HIV and HIV transmission may know that she is at risk for infection and may want undertake a test for confirmation. This also illustrates the relationship between risk perception and knowledge and awareness. These two motivations may also relate to the motivations of symptoms because although a woman may not have a full understanding of the signs and symptoms, or lack thereof, of HIV and other sexually transmitted infections, knowing that she is at risk and having an awareness of her body and the fact that she is

AN OUNCE OF PREVENTION

experiencing ill health may drive her to seek medical attention. At that point, cues to action from her health care provider may help her to decide to get tested for HIV.

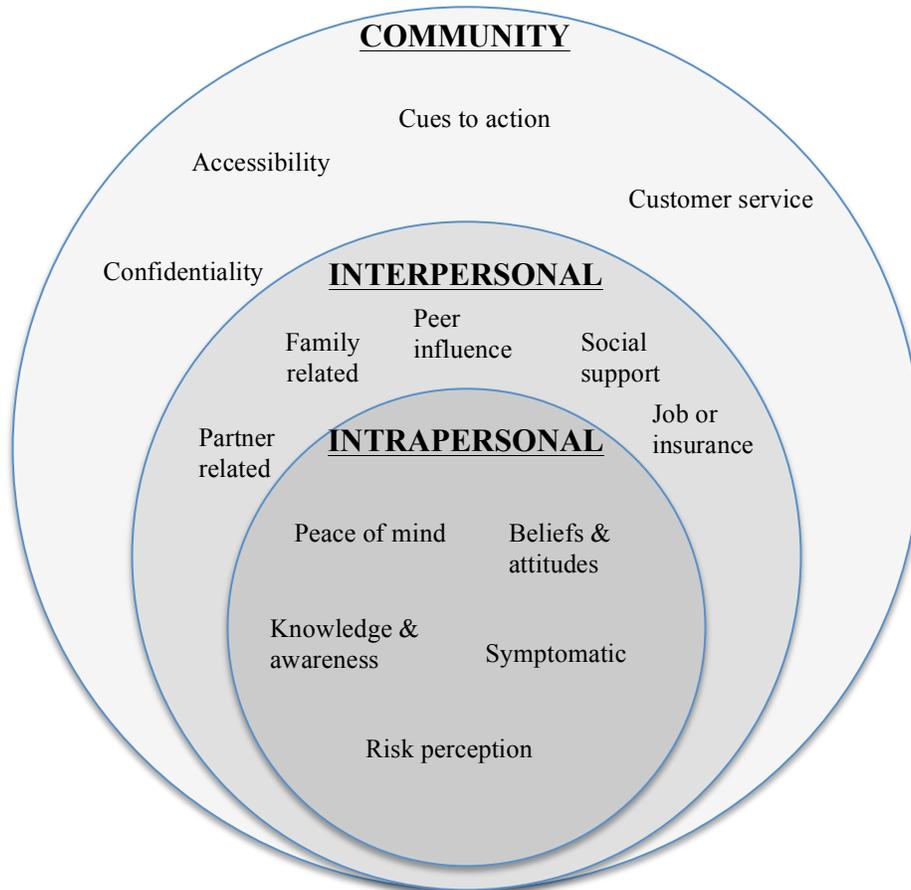


Figure 5.2: Spheres of influence illustrating the interconnection between the motivations that drive women's decisions to access VCT in Trinidad and Tobago

The motivation of knowledge and awareness extends beyond knowledge surrounding HIV and its transmission. Participants explained that women who are more highly educated are more likely to get tested for HIV. This finding is further supported by a study conducted by Singh, Luseno and Haney (2013) among married women in

AN OUNCE OF PREVENTION

Kenya, Zambia and Zimbabwe, which found a consistent positive association between education and testing, particularly among young women aged 15 to 24. Education, which is a key input for the attainment of gender equality, and empowerment go hand-in-hand because as women's knowledge increases, their opportunities for better employment may also increase and this can help to improve their socioeconomic status (Singh et al., 2013).

As previously discussed, participants noted that women who are more empowered and autonomous are more likely to undergo testing for HIV. Empowerment, and by extension gender equality, is strongly linked to the attitudes and beliefs of women because as women become more empowered they gain a greater sense of self-efficacy. According to social cognitive theorist Albert Bandura (1989), "Among the mechanisms of personal agency, none is more central or pervasive than people's beliefs about their capabilities to exercise control over events that affect their lives. Self-efficacy beliefs function as an important set of proximal determinants of human motivation, affect and action" (p. 1175). Bandura (1989) explains that as people's sense of self-efficacy increases, the stronger their commitment to their goals will be and the more likely they will be to persist when faced with obstacles. This is key when examining the motivation of beliefs and attitudes of women in Trinidad and Tobago, because as women's beliefs around self-efficacy increases, they would not only be more likely to commit to getting tested for HIV, but they will also be more likely to persevere when they encounter barriers which may threaten to deter them from their decision.

At the interpersonal level, partner related motivations are also heavily interconnected with motivations across other levels of influence. Participants explained that many women opt to get tested for HIV because they suspect that their partner has

AN OUNCE OF PREVENTION

been unfaithful or because a current or past partner has tested positive for, or died from, HIV. As a result, a woman perceives her risk as high and may undergo testing in order to confirm her own status. It is important to note however that although a high perception of risk may encourage testing, for some women who perceive themselves as already being infected with HIV, they may not see the value of getting tested until their health status declines and they need to access health care (Musheke et al., 2013). In cases such as these, family related motivations might help to prompt women to seek testing due to pregnancy or other family responsibilities. Participants also mentioned that some women are encouraged to test by a partner, family member or friend and so this illustrates the possible linkages between partner related motivations, family related motivations, peer influence, social support and cues to action.

Cues to action, particularly in the form of face-to-face interactions were identified as a powerful strategy for encouraging women in Trinidad and Tobago to seek testing for HIV because it can give health care providers an opportunity to address some of the barriers that women face that deter them from accessing VCT and provide the motivation that they may need to act accordingly. Cues to action such as mass media campaigns, can also help to increase knowledge and awareness around HIV and HIV prevention.

As with the barriers, the motivations of accessibility, confidentiality and customer service are all interconnected. Participants noted that many NGOs and public health centres conduct outreach events in various locations during the course of the year thus increasing women's accessibility to VCT because they basically "bring the testing to the people". Interestingly, although a perceived lack of confidentiality is a major barrier impacting on women's access to VCT at public health clinics due to the fear that

AN OUNCE OF PREVENTION

someone that they know may see them, participants indicated that the uptake of testing at public outreach events, particularly during key times of year such as World AIDS Day, is often very high. Participants explained that these outreach events draw large numbers of people, and long lines of people (both male and female) waiting to be tested can be seen. This suggests that the combination of the cues to action associated with event-based testing, accessibility, peer influence and social support help to overcome the barrier of lack of confidentiality.

Finally, it is important to examine the intersection of the barriers and motivations. There are several barriers and motivations at each level of influence that overlap. At the intrapersonal level, knowledge and awareness, risk perception and beliefs and attitudes act as both barriers and motivations, at the interpersonal level social support and partner related issues overlap, and at the community level, the institutional and organizational issues of confidentiality, accessibility and customer service overlap. This is important to consider because the intersection of these barriers and motivations can create decisional conflict for women who may experience these issues. For instance, a woman who suspects that her partner has been unfaithful may be highly motivated to get tested but if she is concerned that getting tested may create marital discord, she may not want to do so. In a case such as this, additional motivations would be necessary to help her overcome this decisional conflict and increase her likelihood of action.

5.2 The Importance of Civil Society and Community Level Interventions

The interconnection of the barriers and motivations highlights the importance of additional influences when it comes to behaviour change among women in Trinidad and

AN OUNCE OF PREVENTION

Tobago regarding testing for HIV. The critical role that civil society and community led interventions play in the HIV prevention efforts in Trinidad and Tobago was evident in the study findings. Civil society, which includes NGOs, FBOs, community groups, charities, voluntary organizations, people living with HIV and other key populations, professional organizations, research institutes and think tanks, are at the core of the fight against HIV globally and their importance cannot be overlooked (UNAIDS, 2012; Malinowska-Sempruch, Bonnell, & Hoover, 2006). In fact, the government of Trinidad and Tobago's Medium Term Policy Framework 2011-2014 highlights the need for a comprehensive multisectoral response to the HIV epidemic, "Combatting the HIV and AIDS epidemic will require a collaborative effort from the Government, private sector and civil society to reduce the incidence of HIV and improve the levels of treatment and care for people living with HIV" (as cited in the National HIV and AIDS Strategic 2013-2018, p. 10). However, the study findings reveal that although members of civil society are currently involved in community level interventions, their involvement is often hampered by lack of resources (human, financial and material), and lack of political will to strengthen their capacity to effectively elicit behaviour change among women and increase uptake of HIV testing. Participants noted that funding is inadequate and so the sustainability of programs is affected. This can in turn affect the credibility of civil society organizations (CSOs) among women because there is no consistency in the programming. Efforts that may have been successful in the short-term cannot be sustained without resources and so the long-term effects cannot be evaluated.

Participants also noted that although efforts have been made to train members of civil

AN OUNCE OF PREVENTION

society in the provision of HIV testing, governmental policies and bureaucratic “red tape” have hindered the expansion of HIV testing at NGO sites.

One area in which CSOs have been particularly active is in community level interventions. According to DiClemente, Crosby and Wingood, (2005), the definition of what constitutes a community is often debated but broadly speaking a community may be defined by a geographic location, shared social institutions, interactions or interests, shared sociological characteristics such as education or income, or internal strata such as age, gender, disease status or risk behaviour. Community level HIV prevention interventions are programs which are aimed at identifying and changing the underlying forces within a community that make HIV prevalent among specific subgroups and they are designed to elicit behaviour change. There are two pathways that these types of interventions utilize which encourage behaviour change, direct intervention effects and indirect intervention effects. Direct intervention effects are those that are produced by utilizing methods in individual-level programs, such as outreach programs, while indirect intervention effects are those that are produced by methods that do not involve direct interaction with behaviour change agents. It is the combination of both of these pathways that creates the most powerful effect on behaviour change (DiClemente et al., 2005).

Based on the study findings, a combination of both direct and indirect methods are utilized in Trinidad and Tobago however, there appears to be a heavier reliance on direct, face-to-face interactions than on indirect interventions. Most of the study participants identified individual level interventions, such as one-on-one counselling and outreach based programs, as a commonly employed strategy for increasing uptake of

AN OUNCE OF PREVENTION

VCT and there is no denying its effectiveness. However, it must be noted that these types of interventions may only be effective in addressing certain barriers that women face with regards to VCT testing, particularly those that occur at the intrapersonal and interpersonal levels. Barriers and motivations such as knowledge and awareness, fear and beliefs and attitudes can be addressed to a certain extent during an individual encounter with a behaviour change agent, but cues to action received through indirect interventions would greatly help to reinforce the information received and motivate a woman to make the decision to get tested for HIV. Direct interventions can also be particularly effective in helping to connect women who are facing other socio-environmental issues, to other community organizations through a referral network. The biggest limitation with individual-level interventions is the fact that they are usually not developed on a large enough scale to effect change within a large proportion of the population (DiClemente et al., 2005). Participants explained that outreach programs are conducted in larger cities more often and so women living in more rural communities would not have access to these types of interventions on a consistent enough basis to elicit behaviour change, particularly when they are faced with a combination of barriers that may be impacting on their decision to access VCT. As such, it is important to have a better balance between both the direct and indirect pathways in order to reach more women and provide the motivation to access VCT.

One key aspect of a successful community level intervention is that of community involvement. Community involvement offers several key benefits, not only in terms of the effectiveness of the HIV prevention interventions but also for the community volunteers and activists themselves. According to DiClemente et al. (2005),

AN OUNCE OF PREVENTION

community involvement helps to ensure “buy in” and build trust with community members and it allows for greater dissemination of the components of the intervention. On an individual level, the community volunteers and activists develop a sense of community, a positive sense of self and they become more conscious and educated on the risks of HIV and on preventative behaviours (Ramirez-Valles, 2002). Thompson and Kinne (1990) state that the rate of success of community interventions greatly increases when they are part of a community initiative rather than being designed from the outside (as cited in DiClemente et al., 2005). Based on the findings of the study, community engagement is often limited in Trinidad and Tobago and participants indicated that community members are usually not involved at every level of the design and implementation phases of interventions. The need for community involvement is further highlighted by the study findings which, as previously discussed, suggest a slight disconnect between what providers and stakeholders view as important and what women in the general public view as important. By engaging community members in every aspect of the intervention planning and execution process, it will help to ensure that the intervention addresses the specific needs and issues affecting the target community and will help to increase community capacity and ownership in the process.

5.3 Exploring the cues to action

Another key component to the behaviour change process is the use of appropriate cues to action. Cues to action are broadly defined as the specific stimuli that act to spur an individual to adopt a prescribed health behaviour (Mattson, 1999). According to Mattson (1999), “a central focus on cues to action is important because

AN OUNCE OF PREVENTION

individual beliefs and perceptions about health and illness are socially constructed and contingent upon social interaction. Because HIV/AIDS is primarily transmitted through social interaction... prevention actions are likely influenced by communication cues regarding these interpersonal actions” (p. 244). There are two distinct types of cues, internal cues, which are intrapersonal in nature and are comprised of perceptions, social cognition or physical health cues, and external action cues, which are generally communicative in nature and involve external messaging from media and interpersonal interactions (Mattson, 1999). Based on the findings of the study, cues to action for women in Trinidad and Tobago comprise a mix of both internal cues (i.e. symptoms of illness which drive a woman to get tested) and external cues (i.e. mass media campaigns, informational and educational materials and interpersonal interactions within social circles and with health care providers). When it comes to behaviour change strategies the focus is generally on designing appropriate external cues to action that can either directly influence a change in health behaviours or that can feed into the internal cues to strengthen them and spur action.

With regards to the cues to action, there were three main themes that emerged from the findings of the study, Provider-Initiated HIV Testing and Counselling (PITC), the need for innovation and sustainability of cues. Each of these themes will be discussed individually and will help to provide a general overview of the strengths and weaknesses of the cues to action that are currently being used in Trinidad and Tobago.

When it comes to cues that are received through interpersonal interactions, Provider-Initiated HIV Testing and Counselling (PITC), where individuals attending health care facilities are routinely offered an HIV test and counselling, was one of the

AN OUNCE OF PREVENTION

most frequently mentioned approaches utilized by health care providers in Trinidad and Tobago. In fact, participants explained that this strategy has been mandated by the Ministry of Health in an effort to increase uptake of HIV testing. There are two different approaches to PITC, the “opt-out” approach where the client must specifically decline the HIV test if they do not want to be tested, and the “opt-in” approach where the client must actively decide to be tested. The study findings suggest that the “opt-in” approach is used most often with clients seeking VCT in Trinidad and Tobago while the “opt-out” approach tends to be used more often for pregnant women being tested through the Prevention of Mother-to-Child Transmission (PMTCT) program. These findings fall in line with the recommendations put forth by the Centres for Disease Control in 2006 where the “opt-out” approach was recommended specifically for all pregnant women (Fields & Kaplan, 2011). In 2007, however, WHO and UNAIDS presented guidelines for PITC which recommended the “opt-out” approach, including simplified pre-testing information, in all health facilities which extended the use of “opt-out” testing beyond pregnant women. These guidelines, recommend using the “opt-out” approach as a standard part of medical care for all patients attending health facilities in a generalized epidemics, such as in Trinidad and Tobago. The guidelines do state however, for highly vulnerable populations, an “opt-in” approach may require consideration (World Health Organization & UNAIDS, 2007).

Given these recommendations, it is necessary to examine which approach would be best as a cue to action for women in Trinidad and Tobago who are not pregnant in order to encourage greater uptake of VCT. There are certain ethical considerations that need to be highlighted when examining the “opt-out” approach. According to Fields and

AN OUNCE OF PREVENTION

Kaplan (2011), opt-out testing has been proven to increase rates of testing, especially within prenatal settings however, there are questions as to whether it constitutes true informed consent. In addition, there is a certain degree of coercion that infringes on women's reproductive rights and sense of autonomy. "The nature of opt-out testing could lead to women being tested without their knowledge of the test or a true understanding of its implications. In such a case it might be significantly more traumatic for the patient to receive a positive result and for the provider who now must give it" (Fields and Kaplan, 2011, p. 738).

When examining the identified barriers that women in Trinidad and Tobago face, such as fear, the threat of gender-based violence, lack of autonomy and power, lack of empowerment, lack of social support and stigma and discrimination, it can be argued that the "opt-out" approach to HIV testing and counselling may in fact not be the best approach for this population. This therefore supports the current strategy that is being used by most health care providers when it comes to VCT for women. It cannot be denied that in certain circumstances, the "opt-out" approach does warrant serious consideration however, given the complexity of psycho-social issues that many women in Trinidad and Tobago face, it is imperative that women are counseled adequately to ensure that informed consent is given and that there is a support system available if she receives a positive result.

Considering the limitations of PITC, study participants highlighted the need for greater innovation when it comes to designing cues to action. Based on the findings of the study, most of the cues to action that are currently being used in Trinidad and Tobago can be classified as "traditional" methods, namely face-to-face interactions (which would

AN OUNCE OF PREVENTION

include one-on-one counselling), informational and educational materials (e.g. literature and posters) and mass media (e.g. radio and television advertisements and public service announcements). These types of cues have been used for many years globally as part of HIV prevention interventions with varying degrees of effectiveness. As previously mentioned, the study findings suggest that in Trinidad and Tobago, face-to-face interactions are considered to be the most effective strategy for women of all ages and locations within the country. Several participants indicated that the use of literature, for example pamphlets and books on HIV, is often not very effective, because although people are generally quite enthusiastic about collecting reading materials, there is no way to determine if they actually read them. Participants also highlighted the use of mass media campaigns, which vary in effectiveness depending on how widely they are disseminated and how well the messaging is designed. The most frequently mentioned campaign by study participants was the “What’s Your Position?” campaign which was implemented as part of the National Strategic Plan 2004-2008. In a study conducted by Jurawan et al. (2009), this campaign was found to be highly effective in promoting awareness and knowledge of HIV, HIV prevention strategies and testing.

When designing cues to action, it goes without saying that certain cues are more effective with certain subsets of the population than with others so it is necessary to employ a mix of communication formats. For instance, the study findings suggest that for women in more rural settings, such as those that live and work on farms, radio and television advertisements may not be as accessible to them as they are to women in more urban settings since they may not have access to these technologies on a regular basis. In

AN OUNCE OF PREVENTION

these cases, regular face-to-face interactions in the form of outreach may be more appropriate.

For younger, more modern women and women who have access and are more technologically savvy, the findings suggest that there is a need to employ more innovative cues to action in order to reach them. For instance, over the years, with the advent of globalization and greater technological advances in the country, more and more women have access to cellular phones, internet and cable television. In fact, there were a number of participants who remarked in passing that they don't watch the local television stations, unless they were looking at the local news. This illustrates the fact that television advertisements, for example, about HIV testing that may be aired on local stations may not necessarily reach these women on a regular enough basis to have an impact. Thus, it is necessary to employ more modern approaches when designing cues to action for this subset of the population.

The internet provides unique opportunities for health communication. Internet-based interventions (IBIs) are generally self-guided, interactive interventions that aim to assist individuals with behaviour change and they can offer a dynamic, engaging multimedia experience with on-demand access to information. They can help to overcome barriers such as distance, convenience, disability and stigma, particularly in the case of HIV. The disadvantage of these types of interventions however, are that complex sites can be difficult for users to navigate and, especially in the case of economically disadvantaged users, they may not have regular access to the Internet (Buller & Floyd, 2012). Social media via the Internet has become increasingly popular as a means of communication for HIV prevention as it can help to connect users around health and

AN OUNCE OF PREVENTION

social issues and can potentially provide a community for discussion and education around the issue of HIV (Taubenheim et al., 2012).

Mobile technologies have also recently become very popular in health interventions with mobile phones being used for dissemination of preventative health information, diagnosis, and treatment including appointment reminders and medication compliance. These types of behaviour change interventions can involve either direct or indirect messaging to either target a desired change or influence the adoption of a safe sex practice or the reduction of a risky behaviour (Kwan et al., 2013). An example of its application is Freedom HIV/AIDS which was a highly successful mobile games-based initiative developed in India in 2005. The initiative was designed to create information, awareness, and behaviour change among Indian youth on issues related to sex, HIV/AIDS, discrimination, testing and treatment (Quraishi, Quraishi & ZMQ Software Systems, 2013).

The final theme that emerged from the findings of the study was the lack of sustainability of the external cues to action, particularly media messaging. Health promotion planners recognize that the process of behaviour change is not linear and that even if an individual decides to adopt or change a health behaviour, there is always the possibility of regression where the entire decision-making process has to begin again. For individuals that actually make the prescribed change in their behaviour, relapse is also a possibility (McKensie et al., 2009). This again highlights the importance of regular cues to action, which can help reinforce the desired behaviour change.

Study participants highlighted that in Trinidad and Tobago, the messaging surrounding HIV and HIV testing is very seasonal in nature. Most of the mass media

AN OUNCE OF PREVENTION

campaigns tend to be focused on internationally recognized days such as World AIDS Day, and Caribbean Regional HIV/AIDS Testing Day and also during the carnival season but outside of those times, there is a considerable lull in terms of the messaging. This has serious implications for the behaviour change process for women because constant cues to action are necessary in order to increase women's sense of self-efficacy and help them to progress to the maintenance stage of the process. It is also important to remember that, as previously discussed, the barriers and motivations that women in Trinidad and Tobago encounter are multiple and highly interconnected and so regular cues to action that address these issues are critical because a woman may experience one or more barriers at any given time during the behaviour change process. If she is constantly bombarded with cues to action that address the barriers that she faces and provide motivation, she will be more likely to adopt testing as part of a preventative health care routine and most importantly, to maintain it.

It is important to acknowledge that sustaining cues to action such as mass media campaigns require a great deal of resources and so the government's proposed multisectoral approach, which includes civil society, is very important. Civil society organizations in Trinidad and Tobago, such as NGOs and FBOs, help to provide the interpersonal cues to action, such face-to-face interactions during outreach events and educational sessions, and so they help to fill the gaps when the media messaging is low.

5.4 Putting the Pieces Together – The Conceptual Framework Revisited

As previously discussed, the conceptual framework that was described in Chapter 2 builds on the concepts of barriers and motivations as identified by the theoretical

AN OUNCE OF PREVENTION

models of behaviour change which guided the study, namely the Health Belief Model, the Health Decision Model, the Precaution Adoption Process model, the AIDS Risk Reduction model and the Community Readiness Model. It was hypothesized that the barriers to getting tested for HIV must be outweighed by a woman's motivations in order for her to progress through the stages of the decision-making process and decide to act. It was also hypothesized that cues to action and community level interventions are also crucial in order to tip the scale and increase her likelihood of action and sense of self-efficacy.

The findings of the study clearly support the conceptual framework but with one change. The complexity of the interconnections between the barriers and motivations was not taken into consideration when the framework was initially designed. Figure 5.3 shows the redesigned conceptual framework.

The findings do however, support the hypotheses in that they illustrate that when it comes to getting tested for HIV, a woman's barriers must be outweighed by her motivations. The findings show that a woman may encounter several barriers at once and in order for her to overcome those barriers, there must be more factors motivating her to persevere in her actions. The study findings also show that because of the linkages of the barriers and motivations, regular cues to action and community level interventions are necessary to help strengthen the motivations and therefore push her to make the decision to get tested for HIV.

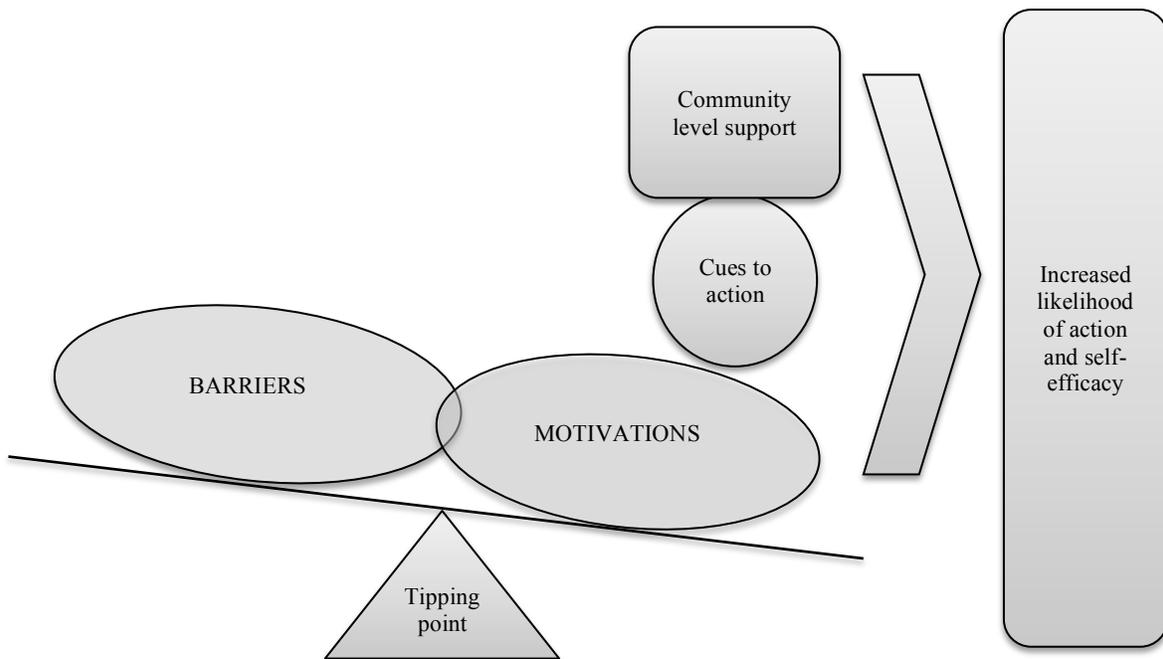


Figure 5.3: Revised diagrammatic representation of the conceptual framework

5.5 Summary

In conclusion, this chapter provided an overview of the major themes that emerged from the findings of the study. The identified barriers and motivations that impact on women's decisions to access VCT are strongly interconnected and so it illustrates the complexity of the decision-making process that women undergo when it comes to getting tested for HIV. The interconnection of both the barriers and the motivations occurs across all three levels of influence, the intrapersonal, the interpersonal and the community and they all influence one another. Women may experience several barriers and once and so further hindering their decision-making process. The findings showed that there is also some overlap between the barriers and motivations whereby

AN OUNCE OF PREVENTION

some issues can create both a barrier and a motivation for women, depending on how it is experienced.

The second theme that was explored was the importance of civil society's role and community led interventions in combatting the HIV epidemic in Trinidad and Tobago. Although the government advocates for a multisectoral response to HIV prevention efforts, which includes civil society, lack of resources and lack of political will hamper the ability of CSOs to implement long-term sustainable initiatives. The findings show that CSOs have been especially active in community level interventions however, community involvement, which is an essential component of any effective intervention, is relatively limited. A combination of both direct and indirect interventions are employed in Trinidad and Tobago however, the findings suggest that there is a heavier reliance on direct intervention approaches, particularly on individual level interventions such as face-to-face counselling.

The final theme that was explored was the cues to action. Within this theme, three issues were examined, the use of Provider-Initiated HIV Counselling and Testing (PITC), the need for more innovative cues to action and the lack of sustainability when it comes to the cues to action. The findings of the study illustrate that health care providers generally utilize the "opt-in" approach to PITC when dealing with women who are accessing VCT. Given the complexity of the psycho-social issues that women in Trinidad and Tobago face that not only increase their vulnerability to HIV infection, but also create barriers when it comes to getting tested, the "opt-in" approach is probably best. This approach is not without its limitations however, and so the need for more innovative cues to action is highlighted. In addition to the current types of cues, which

AN OUNCE OF PREVENTION

include the more traditional methods and mass media campaigns, there is a need to explore the use of more technology-based methods such as the use of social media, the Internet and mobile phone technology. The study findings also highlighted the seasonality of the messaging in Trinidad and Tobago and the need for greater sustainability when it comes to the cues to action in order to constantly provide motivation for women to not only get tested, but to make testing a part of their regular health care routine.

The chapter concluded by revisiting the conceptual framework that was used to guide the study. The study findings support the hypotheses that were initially presented however, the initial conceptual framework did not take into consideration the linkages between the barriers and motivations and so the conceptual framework was redesigned to accommodate this finding.

Chapter Six: Summary, Conclusions and Recommendations

6.0 Introduction

This chapter provides a summary of the key findings of the study as it relates to the barriers and motivations that women in Trinidad and Tobago experience which impact on their decision to access Voluntary Counselling and Testing (VCT) for HIV. It also provides some recommendations for the structure delivery of the VCT program, recommendations at the community level and recommendations for improvements to the cues to action. Finally, it concludes with some suggestions for future research.

6.1 Final Summary and Conclusions

HIV continues to be a major obstacle for many developing nations and in Trinidad and Tobago, and the Caribbean as a whole, the disease disproportionately affects women. The literature has shown that behaviour change is a critical component in the fight against HIV and so it is important to consider the factors impeding behaviour change among women, especially when it comes to being tested for HIV. HIV testing is a key tool in preventing future infections and in ensuring early diagnosis for women that are already infected.

The overall goal and objectives of this study was to provide some insight into the factors impacting on women's decisions to access HIV testing through the Voluntary Counselling and Testing (VCT) program in Trinidad and Tobago and to present some recommendations for improvements to the program as a whole. The findings of the study illustrate the complexity of the factors impacting on the decision-making process of women regarding VCT and employing the ecological perspective helped to provide a

AN OUNCE OF PREVENTION

deeper understanding of the interaction and interdependence of the factors across all three levels of influence, the intrapersonal, the interpersonal and the community. Numerous barriers were identified by the study participants with the top five barriers being institutional and organizational barriers, in particular accessibility and confidentiality, fear, partner related barriers, low risk perception and stigma and discrimination. The top five motivations were identified as being partner related motivations, peace of mind, cues to action, accessibility and risk perception. A deeper examination of the barriers and motivations, illustrated that many of them were inextricably linked and often compounded one another to influence a woman's uptake of VCT. The linkages and interconnection of the barriers and motivations can best be described as "spheres of influence" where a woman may experience one or more barriers and motivations at each level of influence. It was also evident that some of the barriers and motivations overlap thus potentially creating decisional conflict for a woman who may be experiencing the same issue from both sides of the spectrum.

The interconnection of the barriers and motivations illustrate the need for additional external motivating factors which can provide an additional push for a woman to make the decision to get tested. Community level support in the form of community led interventions is critical for providing that additional motivation. The key role that civil society plays in HIV prevention cannot be stressed enough. Civil society organizations (CSOs) operate at the grassroots level and can often reach members of the population that the government cannot reach as easily and as such, their involvement in the national HIV response is crucial. The study findings show that although the government of Trinidad and Tobago advocates for a multisectoral response including civil society, more work

AN OUNCE OF PREVENTION

must be done to create an enabling environment which would facilitate their involvement. Many CSOs lack the resources and capacity to create and sustain HIV prevention interventions in the long term.

CSOs have however, been very active in community level interventions. The study findings suggest that there is an imbalance between the direct and indirect approaches to prevention interventions that are being implemented in the country which would limit their scale and reach. Although direct interventions such as outreach programs have proven to be quite well received among women in Trinidad and Tobago, there is a need to implement more indirect approaches. Community engagement is also relatively limited where community members are often not actively involved in the design and implementation of interventions which could lead to a disconnect between what the community feels is important and what health planners feel is important.

The importance of appropriate and timely cues to action was also highlighted in the findings. Cues to action for women in Trinidad and Tobago comprise a mix of both internal cues and external cues. One of the most widely used external cues that is employed is Provider Initiated HIV Counselling and Testing (PITC) and the study findings illustrate that the “opt-in” approach to PITC is generally utilized by health care providers when it comes to VCT. Considering the complexity of issues that women in Trinidad and Tobago face with regards to gender inequality, such as lack of autonomy, lack of power within relationships, lack of economic power and gender based violence, it appears that the “opt-in” approach is probably best. This approach may not be as effective as the “opt-out” approach, but it limits issues surrounding informed consent and coercive techniques that may infringe on women’s autonomy and reproductive rights.

AN OUNCE OF PREVENTION

Other cues to action that are employed include more traditional means of communication such as literature, posters, and the use of media in the form of radio and television advertisements and public service announcements. The study findings show that lack of accessibility to the cues to action is often a problem for women living in rural areas and for older women that are confined to the home. In addition, migrant sex workers also experience issues surrounding accessibility to information because many of them don't speak English, which is the official language in Trinidad and Tobago. Issues surrounding the appropriateness of the messages and the messengers used to convey the messages were also highlighted. The findings show that messages which advocate abstinence were generally not as effective because they have the potential to create a moral dilemma for women thus further hampering their decision-making process. The findings also illustrated the need to ensure that the messages match the cultural reality and that the messengers that are used to convey messages are appropriate for the target audience. Finally, the need to employ more technology-based cues to action was also highlighted, especially when targeting younger, more modern women.

The final theme that emerged from the findings was the lack of sustainability of the cues to action. The findings show that cues to action in Trinidad and Tobago are very seasonal in nature, occurring mainly around key international days and carnival. In order for a woman to progress through the stages of behaviour change, constant cues to action, which incorporate the barriers and motivations, are necessary.

In consideration of the methodologies that were employed for this study, it is important to emphasize the benefits of a mixed method approach. By utilizing a combination of both qualitative and quantitative methodologies a deeper understanding of

AN OUNCE OF PREVENTION

the structure and delivery of the VCT program as a whole, the challenges that civil society organizations face when it comes to prevention interventions and the viewpoints of women in Trinidad and Tobago as it relates to HIV testing was possible. This approach was especially useful when exploring the interconnections between the barriers and motivations and the implications of these linkages on behaviour change. Given the limitations of the visual ranking survey however, it is recommended that the methods should be sequenced so that the visual ranking survey is conducted after the qualitative data is collected and analyzed and the sample size for the survey be increased. This would help to address some of the limitations faced.

In terms of the use of NVivo 10 for the analysis of the qualitative data, it is important to highlight that the use of a priori codes as opposed to inductive coding, was especially useful when employing this data analysis tool. Having a predetermined coding framework provided initial labels for the nodes that were used to classify the data in the software and then as the data analysis progressed these nodes were refined and emergent codes added.

In conclusion, women in Trinidad and Tobago are faced with several complex, interconnected barriers and motivations that hamper their decisions to get tested for HIV. The inclusion of consistent, targeted cues to action which address the barriers and motivations as well as strong community level support are critical in order to help women progress through the behaviour change process and increase their likelihood of action and sense of self-efficacy.

6.2 Recommendations

The findings of the study highlighted a number of areas where improvements can be made in order to address some of the barriers that women in Trinidad and Tobago face and provide much needed motivation to increase their likelihood of getting tested for HIV. The sections that follow will present recommendations for the improvement of the structure and delivery of the VCT program, recommendations at the community level and recommendations for improvements to the cues to action. The study participants also provided suggestions for improvements and these have been thematically summarized and will be presented in each section as well.

6.2.1 Recommendations for the Structure and Delivery of the VCT program

The barriers and motivations that were identified in the study highlighted the need for certain improvements to the structure and delivery of the VCT program. Table 6.1 summarizes the suggestions made by the study participants.

Table 6.1: Recommendations made by study participants for the improvement of the structure and delivery of the VCT program

	RECOMMENDATIONS
Accessibility	<ul style="list-style-type: none"> • Increase the number of testing sites, especially in more rural areas • Increase the times available for testing, especially on weekends and outside of normal working hours • Secure sponsorship to cover the costs of tests, especially for young people and economically disadvantaged women • Increase the number of NGO testing sites • Create more welcoming and friendly spaces for women • Increase the number of non-traditional testing sites • Provide more testing methods such as home test kits
Structure and delivery	<ul style="list-style-type: none"> • Need to integrate and decentralize the system • Integrate HIV testing into general health care • Improve legislation and policies which affect vulnerable groups, such as sex workers and illegal migrants

AN OUNCE OF PREVENTION

	<ul style="list-style-type: none"> • Improve the flow of the clinics • Increase knowledge sharing between VCT sites • Scale-up rapid testing
Resources	<ul style="list-style-type: none"> • Increase the number of staff in clinics and for outreach • Increase the number of full-time VCT testers • Ensure that all clinics have adequate testing supplies
Quality of care	<ul style="list-style-type: none"> • Focus more on quality of care instead of number of tests • Provide training on customer service for all VCT staff • Ensure that all staff are sensitized to help reduce stigma and discrimination • Spend more time with clients • Scale-up PITC and monitor its implementation • Focus more on post-test counselling to address behaviour change and provide more support to the newly diagnosed • Ensure that there are mechanisms in place for follow-up of clients • Ensure adequate continuation of care for persons who are HIV positive • Improve monitoring and evaluation of the system as a whole • Ensure that there are mechanisms in place to deal with other issues that women might be facing

Considering the fact that the institutional/organizational barriers of accessibility and confidentiality were identified as two of the major barriers that women face, one of the key recommendations for national decision-makers would be to improve the integration of VCT into existing health services whereby women can access VCT at any health clinic in the country, on any day, at any time and the test can be performed in any examination room. This level of integration will help to address issues of accessibility because it will increase the number of clinics offering the service, the number of days and the times at which testing for HIV can be done. Integration will also help to address the barrier of lack of perceived confidentiality because by eliminating the specification of VCT days and times and VCT clinics or rooms, a woman who is attending a health facility can feel comfortable that no one will know what service she is accessing. In addition to integration, extended operating hours during the week and on the weekends

AN OUNCE OF PREVENTION

should be considered so as to increase accessibility for women who are unable to access VCT during working hours.

Although free-standing VCT services, such as those which currently exist in the country, have the advantages of a dedicated staff, space and times for VCT, according to Manjok et al. (2010), the disadvantage is that stigma often decreases client attendance and the levels of stress among staff is often high. Integrated VCT services on the other hand, are less costly to operate and cross-referral of clients is easier. One of the main disadvantages to this type of clinic is that staff may not be as committed to the VCT program as there may be competing interests in the presence of other health programs (Manjok et al., 2010). Sensitizing and providing adequate training to the staff at integrated clinics to combat issues of stigma and discrimination and competing interests, can help to alleviate this disadvantage.

Another important consideration when integrating VCT into existing health services is to ensure that staff are consistently utilizing PITC with every client that accesses the clinics. PITC will be a crucial cue to action in integrated clinics because if HIV testing and counselling is not consistently offered to every woman coming in for other services, opportunities to encourage uptake of VCT will be missed. It is recommended that a mechanism for monitoring the use of PITC should be implemented at clinics and staff should be adequately trained in the use of this approach to ensure that informed consent is obtained from women that decide to get tested for HIV.

6.2.2 Recommendations at the Community Level

At the community level, there are a number of key recommendations that can help to strengthen the capacity of communities to deal with the issue of HIV, address the barriers that women face and sustain HIV prevention interventions. Table 6.2 highlights the recommendations by study participants.

Table 6.2: Community level recommendations made by study participants

	RECOMMENDATIONS
Community engagement	<ul style="list-style-type: none"> • Increase community involvement in the design and implementation of programs • Increase the links with community groups such as youth groups, women's groups and other community organizations • Work with community leaders to sensitize the community about the benefits of testing • Host more community meetings to raise awareness and engage community leaders • Build community capacity
Partnerships	<ul style="list-style-type: none"> • Engage civil society more • Engage members of the private sector more • Engage Parent-Teacher Associations to increase "buy-in" with parents • Engage men/partners more • Develop stronger partnerships with NGOs • Increase communication and knowledge sharing between stakeholders
CSO involvement	<ul style="list-style-type: none"> • Work with CSOs to implement interventions at the community level • Provide CSOs with adequate funding and other necessary resources • Build the capacity of CSOs to do testing, outreach and other community level interventions

The first key recommendation is to create an enabling environment that will facilitate greater involvement of civil society organizations (CSOs) in every aspect of the national HIV response, which would include the provision of VCT services and community level interventions. The vital role that CSOs play in combatting the HIV epidemic has already been highlighted and the study findings show that many women in Trinidad and Tobago prefer to access VCT services at NGOs. There is only one NGO currently offering VCT as part of its regular services so this further demonstrates the need

AN OUNCE OF PREVENTION

to expand VCT services to more of these types of organizations. In order to enable their involvement, it is crucial for donors and/or the government to allocate more resources, which includes both financial and material resources, to CSOs so that they can effectively implement and sustain HIV prevention interventions. In addition, CSOs should be utilized to expand mobile outreach services, particularly to the more rural areas of the country in order to improve accessibility for women in these areas. It is recommended that mobile VCT services should be integrated into a package of general health services so as to address issues of confidentiality and thereby motivate more women to access the service. A strong referral network of partner organizations is also crucial in order to ensure that women who access the mobile services can be referred to other social services if it is necessary.

Another key recommendation is to implement more community-led interventions. As previously discussed, community involvement greatly increases the rate of success of prevention initiatives because it not only creates a sense of ownership for the community but it also promotes collective self-efficacy and behavioural change in the whole community population (Kelly, 2005). It is recommended that health planners utilize a health theory such as the Community Readiness Model to guide intervention activities at the community level. This type of model will help planners to identify which stage of readiness the target community is at and will help guide the activities to create more sustainable change.

6.2.3 Recommendations for Improvements to the Cues to Action

The final recommendations are aimed at improving the cues to action for behaviour change. Table 6.3 presents the suggestions made by the study participants.

Table 6.3: Recommendations made by study participants for the improvement of the cues to action

RECOMMENDATIONS	
Outreach and education	<ul style="list-style-type: none"> • Increase community based mobile outreach, particularly in rural and high-risk areas so as to address issues surrounding accessibility at the same time ensuring that issues surrounding stigma and discrimination and confidentiality are taken into consideration • Integrate mobile testing into a broader package of health, such as women's health, or sexual and reproductive health • Increase outreach in workplaces • Engage schools more and conduct more educational sessions for young people • Incorporate education around HIV and testing into parenting workshops and marriage preparation courses • Utilize peer educators and youth educators more
Communication methods	<ul style="list-style-type: none"> • Utilize more modern forms of communication, such as social media, particularly for youth • Employ behaviour change communication and social marketing principles into intervention planning while ensuring that issues surrounding confidentiality and security are highlighted • Simplify written materials and make them more visual.
Messages	<ul style="list-style-type: none"> • Greater focus on women and gender as a whole • Address the barriers in the messaging and make the messaging relevant to the woman's experience • Integrate the social determinants of health into messaging more • Highlight the importance of getting tested, what it means to get a positive test, what to do if your partner wants to get a test • Explain the process of getting tested so that women know what to expect. • Focus messages on issues of empowerment. Address issues such as self-esteem, preventative health care, long-term goal setting etc. • Use catchy slogans, songs or symbols that people will associate with testing and easily remember • Use local "heroes" and "sheroes" to convey messages, this would include not only the local artistes but national heroes, athletes, community and religious leaders etc. • Tie messaging around HIV into messaging about chronic disease to help normalize it more and highlight the fact that it is not a death sentence • Obtain and advertise testimonials about testing and testing facilities from trusted sources such as community leaders and PLHIV
Sustainability	<ul style="list-style-type: none"> • Ensure sustainability of messaging, not only during key international days and carnival • Scale-up outreach during low periods of media messaging so that communication about HIV and testing is more consistent

AN OUNCE OF PREVENTION

The first key recommendation is the incorporation of the barriers and motivations that women experience into every aspect of communication programs. The study findings illustrate that women in Trinidad and Tobago experience a number of complex and interconnected barriers and motivations across all three levels of influence that impact on their decision to get tested for HIV. As such, it is crucial for health planners to consider these barriers and motivations when designing cues to action. It is important to not simply target women as a homogenous group because as is evident by the findings of the study, women of different ages and from different locations within the country are sometimes impacted by certain barriers more so than others. As a result, cues to action should be targeted to sub-groups of women, for instance, younger women versus older, and women living in rural areas versus women living in the city. As previously discussed, a better balance between indirect and direct intervention approaches is recommended and planners should employ more technology-based modes of communication such as social media, the Internet and mobile phones, particularly when targeting younger women.

Another key recommendation is to ensure that cues to actions are sustained throughout the course of the year as opposed to placing the emphasis mainly on key international days and around national festivals. It is acknowledged that mass media campaigns are very costly to sustain at a large scale over extended periods of time so it is recommended that mobile outreach programs be increased so as to help fill the gap when media messaging is low.

The final recommendation for communication planners is to place more emphasis on women's empowerment when designing cues to action for behaviour

AN OUNCE OF PREVENTION

change. Gender inequality is a major problem in Trinidad and Tobago with many women experiencing issues such as lack of sexual power within partner relationships, lack of financial power, gender based violence and lack of autonomy, and all of these issues not only make them more vulnerable to HIV infection, but also impact greatly on their decisions to access VCT. As discussed, a strong sense of self-efficacy is necessary for women to progress through the decision-making process and to ultimately maintain behavioural changes and so messages that focus on gender equality, challenge patriarchal norms and promote empowerment are key.

6.3 Future Research

Literature on the barriers and motivations that women experience which impact on their decisions to get tested for HIV is relatively sparse. This study was designed to not only help fill the gap in the literature surrounding this topic, but to provide some insight into the issues that women in Trinidad and Tobago face when it comes to accessing VCT. Further research into this topic would greatly assist other countries struggling with low rates of success of their own VCT programs and will help to guide their designs of HIV prevention interventions.

One suggestion for future research is to replicate this study in other islands within the Caribbean and to conduct a comparison of the barriers and motivations that women face when it comes to HIV testing in other countries in the region and the cues to action which are employed by different countries. This will help to not only highlight similarities and differences in the factors impacting on behaviour change among women in the region, but it will also help with knowledge sharing when it comes to the

AN OUNCE OF PREVENTION

approaches to behaviour change that the different countries utilize to motivate women to access VCT.

It is also highly recommended that research should be conducted on the barriers and motivations to accessing VCT among heterosexual males in the Caribbean. The existing literature on the subject as it relates to men, is heavily focused on at-risk male populations, such as homosexual males and men who have sex with men, but little exists on the topic as it relates to heterosexual males, particularly in the Caribbean. The findings of this study pointed to the fact that women access health services more often than men and so this has serious implications for the success of the VCT program. In addition, issues surrounding masculinities and male patriarchy in the Caribbean may also play a role in men's decisions to get tested for HIV. Identifying the barriers and motivations impacting on men's decisions to access VCT, will not only help health planners to design interventions that address the issues that men face and provide much needed motivation to increase their uptake of VCT, but it may also indirectly help to break down the partner related barriers that women face.

References

Bandura, A. (1989). Human Agency in Social Cognitive Theory. *American Psychologist*, 44(9), 1175-1184.

Berer, M., & Ray, S. (1993). *Women and HIV/AIDS: An International Resource Book: Information, Action and Resources on Women and HIV/AIDS, Reproductive Health and Sexual Relationships*. London: Pandora Press.

Bombereau G., & Allen C. F. (2008). *Social and cultural factors driving the HIV epidemic in the Caribbean: a literature review*. Caribbean Health Research Council. Retrieved from http://http://hiv.health.gov.tt/site_media/media/filer_public/2013/01/21/2008_socio-cultural_factors_driving_the_epidemic.pdf

Buller, D. B. & Floyd, A. H. L. (2012). Internet-Based Interventions for Health Behavior Change. In Noar, S. M. & Harrington, N. G. *eHealth Applications. Promising Strategies for Behavior Change* (pp. 59-78). New York, NY: Routledge.

Central Statistical Office. (2010). *Pocket Digest 2010*. Port of Spain, Trinidad: Central Statistical Office.

Central Statistical Office & United Nations Development Programme (UNDP). (2012). *Trinidad and Tobago Human Development Atlas 2012*. Port of Spain, Trinidad: Central Statistical Office.

Creswell, J. W. (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (3rd Ed.). Lincoln, NE: SAGE Publications Inc.

Garcia Calleja, J.M., Walker, N., Cuchi, P., Lazzari, S., Ghys, P.D., & Zacarias, F. (2002). Status of the HIV/AIDS epidemic and methods to monitor it in the Latin America and Caribbean region. *AIDS*, 16(suppl 3), S3-S12.

DeBlonde, J., De Koker, P., Hamers, F.F., Fontaine, J., Luchters, S., & Temmerman, M. (2010). Barriers to HIV testing in Europe: a systematic review. *European Journal of Public Health*, 20(4), 422-432.

De Bruyn, M. (1992). Women and AIDS in Developing Countries. *Social Science & Medicine*, 34(3), 249-262.

Duke, V., Samiel, S., Musa, D., Ali, C. Chang-Kit, C., & Warner, C. (2010). Same-visit HIV testing in Trinidad and Tobago. *BMC Public Health*, 10(185).

Fan, H. Y., Conner, R. F., & Villarreal, L. P. (2007). *AIDS Science and Society* (5th ed.). Sudbury, MA: Jones and Bartlett Publishers, Inc.

AN OUNCE OF PREVENTION

Fields, L., & Kaplan, C. (2011). Opt-out HIV testing: An ethical analysis of women's reproductive rights. *Nursing Ethics, 18*(5), 734-742.

Green, E. C. & Ruark, A. H. (2011). *AIDS, Behavior, And Culture. Understanding Evidence-Based Prevention*. Walnut Creek, CA: Left Coast Press, Inc.

Jewkes, R. K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet, 376*, 41-48. doi: 10.1016/S0140-6736(10)60548-X

Joint UN Team on HIV and AIDS in Trinidad and Tobago and UNDP Regional Centre in Port-of-Spain. *Women's Empowerment HIV and the MDG's: Hearing the Voices of HIV Positive Women*. Trinidad and Tobago.

Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). *UNAIDS guidance for partnerships with civil society, including people living with HIV and key populations*. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2236_guidance_partnership_civilsociety_en.pdf

Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). *Global Report. UNAIDS report on the global AIDS epidemic 2013*. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

Jurawan, K., Dindial, D., Hosein, S., King, D., Sahadeo, A. & Mungrue, K. (2009). An evaluation of intervention strategies for HIV/AIDS in Trinidad and Tobago (2000-2007). *Freund Publishing House Ltd., 21*(4), 581-589.

Kelly, J. A. (2005). The State of the Art in Community HIV Prevention Interventions. In Trickett, E. J., & Pequegnat, W. (Eds.), *Community Interventions and AIDS* (pp. 88-104). New York, NY: Oxford University Press, Inc.

Kwan, A., Mechael, P., & Kaonga, N. N. State of Behavior Change Initiatives and How Mobile Phones Are Transforming It. In Donner, J. & Mechael, P. *mHealth in Practice. Mobile technology for health promotion in the developing world* (pp. 15-31). London, UK: Bloomsbury Publishing Plc.

Le Coeur, S., Collins, I. J., Pannetier, J., & Lelièvre, E. (2009). Gender and access to HIV testing and antiretroviral treatments in Thailand: Why do women have more and earlier access? *Social Science & Medicine, 69*, 846-853.

Malinowska-Sempruch, K., Bonnell, R., & Hoover, J. (2006). Civil society – a leader in HIV prevention and tobacco control. *Drug and Alcohol Review, 26*, 625-632.

AN OUNCE OF PREVENTION

Mattson, M., & Basnyat, I. (2008). Infusing HIV Test Counselling Practice with Harm Reduction Theory. In Edgar, T., Noar, S. M., & Freimuth, V. S. (Eds.), *Communication Perspectives on HIV/AIDS for the 21st Century* (pp. 137-167). New York, NY: Taylor & Francis Group, LLC.

McKensie, J. F., Neiger, B. L., & Thackeray, R. (2009). *Planning, Implementing, & Evaluating Health Promotion Programs. A Primer* (5th ed.). San Francisco, CA: Pearson Education, Inc.

Ministry of Health HIV/AIDS Coordinating Unit (HACU). (2012). *Annual Report 2012*. Port-of-Spain, Trinidad and Tobago.

Mitra, D., Jacobsen, M.J., O'Connor, A, Pottie, K., & Tugwell, P. (2006). Assessment of the decision support needs of women from HIV endemic countries regarding voluntary HIV testing in Canada. *Patient Education and Counselling*, 63, 292-300.

Monjok, E., Smesny, A., Mgbere, O., & Essien, E. J. (2010). Routine HIV Testing in Health Care Settings: The Deterrent Factors to Maximal Implementation in Sub-Saharan Africa. *Journal of the International Association of Physicians in AIDS Care*, 9(1), 23-29.

Musheke, M., Ntalasha, H., Gari, S., Mckensie, O., Bond, V., Martin-Hilber, A., & Merten, S. (2013). A systematic review of qualitative findings on factors enabling and deterring uptake of HIV testing in Sub-Saharan Africa. *BMC Public Health*, 13(220), 1-16.

Network of NGOs of Trinidad and Tobago for the Advancement of Women. (2010). *The Establishment of a National Coalition on Women, Girls and AIDS*. Trinidad and Tobago.

Noguera-Ramkissoon, N. A. (2011). *HIV Prevention Interventions in Trinidad and Tobago: Mapping of Work Conducted in HIV Prevention from 2004-2010*. Trinidad and Tobago.

Office of the Prime Minister. (2003). *Five-year National HIV/AIDS Strategic Plan. January, 2004 – December, 2008*. Trinidad and Tobago.

Office of the Prime Minister. (2012). *Global AIDS Response Progress. Trinidad and Tobago Country Progress Report, January 2010 – December 2011*. Trinidad and Tobago.

Office of the Prime Minister. (2013). *National HIV/AIDS Strategic Plan, 2013-2018*. Trinidad and Tobago.

PAHO/WHO and CAREC. (2007). *Evaluation of the National Services for Prevention of Mother to Child Transmission of HIV and Syphilis: TRINIDAD and TOBAGO*. Trinidad and Tobago.

AN OUNCE OF PREVENTION

PAHO/WHO. (2010). *Report on the Evaluation of the National Health System Response to HIV and STI in Trinidad and Tobago*. Trinidad and Tobago.

Palmgreen, P., Noar, S. M., & Zimmerman, R. S. (2008). Mass Media Campaigns as a Tool for HIV Prevention. In Edgar, T., Noar, S. M., & Freimuth, V. S. (Eds.), *Communication Perspectives on HIV/AIDS for the 21st Century* (pp. 221-252). New York, NY: Taylor & Francis Group, LLC.

Persson, E. (1994). The threat of AISS to the health of women. *International Journal of Gynecology & Obstetrics*, 46(1994), 189-193.

Quraishi, S., Quraishi, H., & ZMQ Software Systems, India. Freedom HIV/AIDS. Mobile phone games for health communication and behaviour change. In Donner, J. & Mechael, P. *mHealth in Practice. Mobile technology for health promotion in the developing world* (pp. 146-161). London, UK: Bloomsbury Publishing Plc.

Ramirez-Valles, J. (2002). The positive effects of community involvement for HIV risk behaviour: a conceptual framework. *Health Educaiton Research*, 17(4), 389-403.

Reddy, S. (2011). Young women's understandings of (future) marriage: Links to sexual risk and HIV prevention. *Agenda* 87(25.1), 38-42. doi: 10.1080/10130950.2011.575581

Schwarcz, S., Richards, T.A., Frank, H., Wenzel, C., Chin Hsu, L., Chin, C.J., ... Dilley, J. (2010). Identifying barriers to HIV testing: personal and contextual factors associated with late HIV testing. *AIDS Care*, 23(7), 892-900.

Singh, K., Luseno, W., & Haney, E. (2013). Gender equality and education: Increasing the uptake of HIV testing among married women in Kenya, Zambia and Zimbabwe. *AIDS Care*, 25(11), 1452-1461.

Taubenheim, A. M., Long, T., Wayman, J., Temple, S., McDonough, S., & Duncan, A. (2012). Using Social Media to Enhance Health Communication Campaigns. In Noar, S. M. & Harrington, N. G. *eHealth Applications. Promising Strategies for Behavior Change* (pp. 205-220). New York, NY: Routledge.

UNAIDS. (2009). *Operational Plan for UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV*. Geneva.

UNAIDS Joint United Nations Programme on HIV/AIDS. (2010). *The status of HIV in the Caribbean*. Trinidad and Tobago: UNAIDS.

UNAIDS, WHO, UNICEF. (2011). *Global HIV/AIDS Response. Epidemic update and health sector progress towards Universal Access*. Geneva, Switzerland. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130_UA_Report_en.pdf

AN OUNCE OF PREVENTION

UN Department of Public Information. (2013). *We Can End Poverty. Millennium Development Goals and Beyond 2015. Fact Sheet*. Retrieved from http://www.un.org/millenniumgoals/pdf/Goal_6_fs.pdf

UN Women. (2013). *Message of UN Women Executive Director Phumzile Mlambo-Ngcuka in commemoration of World AIDS Day 2013*. Retrieved on February 3, 2014 from <http://www.unwomen.org/en/news/stories/2013/12/world-aids-day>

Vermund, S. H., & Wilson, C. M. (2002). Barriers to HIV testing – where next? *The Lancet*, 360, 1186-1187.

Williams, M. (2000). *Research Design: Quantitative, Qualitative and Mixed Methods Approaches* (2nd Ed.). London, UK: SAGE Publications Inc.

World Health Organization & UNAIDS. (2007). *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities*. Retrieved on April 9, 2014 from http://www.unicef.org/aids/files/PITCGuidance2007_Eng.pdf

World Health Organization, UNAIDS & UNICEF. (2011). *Global HIV/AIDS Response. Epidemic update and health sector progress towards Universal Access. Progress Report 2011*. Retrieved on April 14, 2014 from http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130_ua_report_en.pdf

World Factbook. (2014). *Country Comparison: HIV/AIDS – Adult Prevalence Rate*. Retrieved on April 14, 2014 from <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2155rank.html?countryname=Trinidad%20and%20Tobago&countrycode=td®ionCode=cam&rank=30#td>

World Factbook. (2014). *Trinidad and Tobago*. Retrieved on January 30, 2014 from <https://www.cia.gov/library/publications/the-world-factbook/geos/td.html>

Appendix 1**Research Matrix**

Objectives of the Study	Research questions	Sources of data/ Method of data collection
<p><i>Objective 1:</i> To identify the barriers that women between the ages of 18 to 49 years face that discourage them from accessing the counselling and testing services offered through the VCT program.</p>	<p>1.1 What are the top five barriers that women face which discourage them from accessing the service?</p> <p>1.2 Are certain barriers experienced more frequently by certain age groups?</p> <p>1.3 Are certain barriers experienced more frequently in certain locations within the country?</p>	<p>Observation Key informant interviews Visual ranking survey</p>
<p><i>Objective 2:</i> To identify the motivating factors that influence the decision of women between the ages of 18-49 years to seek counselling and testing for HIV.</p>	<p>2.1 What are the top five motivating factors that influence women's decisions to seek counselling and testing for HIV?</p> <p>2.2 Are certain motivations more powerful in certain age groups?</p> <p>2.3 Are certain motivations experienced more frequently in certain locations within the country?</p>	<p>Observation Key informant interviews Visual ranking survey</p>
<p><i>Objective 3:</i> To explore how the current cues to action either contribute to or respond to the barriers and motivations identified in objectives 1 and 2.</p>	<p>3.1 What types of cues to action are currently being used as part of the behaviour change strategy?</p> <p>3.2 Do the information and messages currently being used contribute to or respond to the identified</p>	<p>Observation Key informant interviews Visual ranking survey IEC materials</p>

AN OUNCE OF PREVENTION

	<p>barriers that women face, which discourage them from accessing the service?</p> <p>3.3 Does the current messaging that is being used provide appropriate and timely cues to action to help motivate women to access the service?</p> <p>3.4 Do the information and messages being conveyed take into consideration any age related or regional differences among women as it relates to the barriers and motivations?</p>	
<p><i>Objective 4:</i> To make recommendations for changes to the structure and delivery of the VCT program and the current behaviour change strategy in order to effectively respond to the barriers that women face and provide stronger cues to action that would motivate them to access the program.</p>	<p>4.1 How can the structure and delivery of the VCT program be improved in order to address the identified barriers and provide greater motivation for women to access the program?</p> <p>4.2 How can the behaviour change strategy be improved in order to effectively respond to the identified barriers and motivations and increase the likelihood of action?</p> <p>4.3 What key changes can be made to the information and messages to help women with their decision-making process?</p> <p>4.4 What changes can be made to improve the cues to action to ensure that they respond to the barriers and motivations and make the program more attractive to women?</p>	<p>Observation Key informant interviews Visual ranking survey</p>

Appendix 2

Promotional poster showing HIV same day counselling and testing sites (Source: Ministry of Health HIV/AIDS Coordinating Unit, 2012)

 **Ministry of Health**
Republic of Trinidad and Tobago

HIV SAME DAY COUNSELING & TESTING SITES

It's Better Together
TAKE THE LEAD
Get Tested

There is no reason to be unaware

NORTH WEST RHA

- Aranguez H/C** (638-2120) - Tue. 9am-2pm
- Barataria H/C** (638-2124) - Tue. 9am-2pm
- Barataria Wellness Centre** (638-8562) - Thur. 9am
- Carenage H/C** (632-1860) - Thur. 10am-2pm
- El Socorro H/C** (638-5218) - Wed. 10am - 6pm
- George Street H/C** (623-5155) - Mon. - Fri. 9am-3pm
- Maraval H/C** (629-2043) - Thur. 10am - 6pm
- Morvant H/C** (675-4068) - Thur. 9am - 4pm
- Petit Valley Adolescent Centre** (637-3284) - Mon. - Fri. 9am-2pm
- San Juan H/C** (638-3618) - Fri. 9am - 12 pm
- Santa Cruz H/C** (676-7400) - Thurs. 1pm - 3pm
- St. James DHF** (622-1142) - Mon. 9am-2pm
- Success Laventille H/C** (623-6434) - Wed. & Thur. 9am-2pm
- Woodbrook H/C** (622-2045) - Tue. 9am-12:30pm

NORTH CENTRAL RHA

- Arima DHF** (667-2276) - Mon. - Fri. 8:30am - 3:30pm
- Blanchisseuse /Brasso Seco H/C** (669-4118)- Mon. - Fri. 9am
- Chaguanas DHF** (672-1517) - Fri. 8:15am-12noon & Mon.-Thur. 8:15am - 2:30pm
- Tacarigua H/C** (662-4819) - Mon. - Fri. 8:30am- 3:30pm

EASTERN RHA

- Mayaro DHF** (630-1258/59) - Mon. - Fri. 8am- 4pm
- Rio Claro H/C** (644-2236) - Fri. 9am
- Sangre Grande H/C** (668-2509) - Fri. 8am- 3pm
- Toco H/C** (670-8277) - Thur. 8am - 12noon
- Valencia H/C** (667-8197) - Tue. & Thur. 9am - 2 pm

SOUTH WEST RHA

- La Brea** (648-7562) - Mon. - Fri. 8am- 4pm
- Marabella H/C** (658-0470) - Mon. - Fri. 8am- 4pm

TOBAGO RHA

- Canaan H/C** (639-8829) - Mon. Wed and Fri. 8am - 4:00pm
- Scarborough H/C** (660-7000) Mon. & Thur. 8am

OTHER TESTING SITES:

- Queen's Park Counselling Centre & Clinic North** (625-2944 / 625-2117) - Mon. - Fri. 8am- 3pm
- Family Planning Association of Trinidad & Tobago** (Cost \$70. Walk in or by appointment)
 - **Adolescent Centre** (627-3444) Sat. 8:30am-12 noon & Tue. 1pm-4pm
 - **FPATT Port of Spain** (623-5169) Mon., Wed., Fri. 10am-2pm OR 7am-12 noon
 - **FPATT San Fernando** (652-3065) Mon.-Fri. 8am-2pm
- University of the West Indies Health Clinic (by appointment only to staff & students)** 662-2002 Ext. 4195

Developed by the Ministry of Health HIV & AIDS COORDINATING UNIT

TREATMENT: If you have been tested and found to be HIV positive, treatment and support is available to improve the quality of your health and prolong your life. Free medication and support can be accessed by health provider referral to any of our national treatment sites

For more information call the National AIDS Hotline at 800-4HIV/625-2437

Youtube: TrinidadHealth | FACEBOOK: Ministry of Health - Trinidad and Tobago | Twitter: @moh_tt | Website: www.health.gov.tt

Appendix 3a

Interview guide for key informants at NGO testing sites

1. Describe the VCT services that you offer at your organization.
 - How successful has your organization been in attracting women to use the services?
 - What would you say are some of the major issues impacting on the success of the program?
 - What approaches have you tried to motivate women to use the service?
 - What feedback, if any, have you received from women who have accessed the program?

2. Describe the current Behaviour Change strategy that is being used by your organization
 - What means of communication have you used that target women specifically?
 - What are the key messages that you have conveyed to women specifically?
 - What baseline research, pre-testing and/or community engagement, if any, was done when developing the Information, Communication and Education materials that are currently being used?
 - Describe the monitoring and evaluation plan that your organization has in place.

3. What would you say are some of the main barriers that you think women experience which would stop them from wanting to get tested for HIV?
 - Do you think any of these barriers are experienced more often by certain age groups? If so, which ones and what age groups? If not, why?
 - Do you think that certain barriers are experienced more often by women living in certain regions of the country? If so, which ones and in what regions? If not, why?
 - Of the barriers that you identified, what do you think are the top three barriers?

4. Other than pregnancy, what would you say are some of the main reasons that women decide to get tested for HIV?
 - Do you think any of these motivations are experienced more often by certain age groups? If so, which ones and what age groups? If not, why?
 - Do you think that certain motivations are experienced more often by women living in certain regions of the country? If so, which ones and in what regions? If not, why?

AN OUNCE OF PREVENTION

- Of the motivations that you identified, what do you think are the top three motivations?
5. Do you think that the current means of communication or messages about HIV testing address the barriers and motivations that you identified?
 - If so, how do they address the barriers and how do they motivate women? If not, why don't you think so?
 - How do you think they can be improved in order to address the barriers and provide motivation?
 - Do you think that the current means of communication or messages about prevention contribute to the barriers in any way? If so, why?
 6. What changes do you think should be made to the structure and delivery of the VCT program in order to address the barriers that women face and to motivate them to get tested for HIV?
 7. What changes do you think should be made to the BCC strategy in order to effectively respond to the barriers that women face and provide cues to action which would motivate them to access the program?

Appendix 3b

Interview guide for key informants – Stakeholders

1. Can you tell me a little bit about the national VCT program here in Trinidad and Tobago?
 - How successful has the program been in attracting women to get tested for HIV?
 - What approaches have been tried to motivate women to use the service?
 - What do you think are some of the greatest shortcomings and successes of the program?
 - What would you say are some of the major issues impacting on the success of the program?

2. What means of communication have you seen or heard that targets women specifically?
 - What are the key messages that you have seen or heard being conveyed to women specifically?
 - Do you think that the current BCC strategy that is being employed has been effective in motivating women to access the VCT service? Why or why not?
 - Do you think that the current Information, Education and Communication materials adequately addresses some the issues that women in Trinidad and Tobago face with regards to HIV? Why or why not?

3. What would you say are some of the main barriers that you think women experience which would stop them from wanting to get tested for HIV?
 - Do you think any of these barriers are experienced more often by certain age groups? If so, which ones and what age groups? If not, why?
 - Do you think that certain barriers are experienced more often by women living in certain regions of the country? If so, which ones and in what regions? If not, why?
 - Of the barriers that you identified, what do you think are the top three barriers?

4. Other than pregnancy, what would you say are some of the main reasons that women decide to get tested for HIV?
 - Do you think any of these motivations are experienced more often by certain age groups? If so, which ones and what age groups? If not, why?
 - Do you think that certain motivations are experienced more often by women living in certain regions of the country? If so, which ones and in what regions? If not, why?

AN OUNCE OF PREVENTION

- Of the motivations that you identified, what do you think are the top three motivations?
5. Do you think that the means of communication or messages about HIV testing address the barriers and motivations that you identified?
 - If so, how do they address the barriers and how do they motivate women? If not, why don't you think so?
 - How do you think they can be improved in order to address the barriers and provide motivation?
 - Do you think that the means of communication or messages about prevention contribute to the barriers in any way? If so, why?
 6. What changes do you think can be made to the structure and delivery of the VCT program in order to address the barriers that women face and help them make the decision to get tested for HIV?
 7. What changes do you think should be made to the current BCC strategy in order to effectively respond to the barriers that women face and provide cues to action which would motivate them to access the program?

Appendix 4

Please answer each question by placing an "X" in the box for your response

1. How old are you?

18 - 24 years old
 25 - 31 years
 32 - 38 years old
 39 - 45 years old
 46 - 49 years old

2. Where do you live?

North or West Trinidad or POS
 East Trinidad
 Central Trinidad
 South Trinidad
 Tobago

3. Please select the statement that best describes how you feel about getting tested for HIV?

 I do not think I am at risk for HIV <input type="checkbox"/>	 I am afraid to find out my status <input type="checkbox"/>	 I am worried about what other people will think or say <input type="checkbox"/>	 I don't think the process is private or confidential <input type="checkbox"/>	 The location or hours of operation of the clinic are not convenient for me <input type="checkbox"/>	Other: (please specify) _____ _____ _____ _____
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4. Why would you (or did you) want to get tested?

 I just want to know my status <input type="checkbox"/>	 Pregnancy <input type="checkbox"/>	 My partner or I was unfaithful <input type="checkbox"/>	 I feel sick <input type="checkbox"/>	 My partner or ex, friend or family member has HIV <input type="checkbox"/>	Other: (please specify) _____ _____ _____ _____
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