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Factors influencing sexually transmissible infection disclosure to male partners by HIV-positive pregnant women in Pretoria townships, South Africa: a qualitative study

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Abstract

Background: Sexually transmissible infections (STI) may increase the risk of mother-to-child transmission (MTCT) of HIV. However, diagnostic testing and targeted treatment of STI (STI-TT) during pregnancy is not standard care in South Africa.

Methods: A qualitative study was nested in a STI-TT intervention to investigate motivating and enabling factors associated with STI test results disclosure to sexual partners. A semi-structured interview protocol covered partner communication, HIV and STI disclosure, financial security and relationships dynamics. Interviews were conducted in participants' preferred language, audio-recorded, transcribed into English and analysed using a constant comparison approach. The study was conducted in two townships in Pretoria, South Africa.

Results: Twenty-eight HIV-positive pregnant women were interviewed. Based on the interviews, two disclosure experiences for women were identified – those with vulnerable experiences and those with self-enabling experiences within their partnerships. Vulnerable women discussed intimate partner violence (IPV) and fear of relationship dissolution as factors influencing their test result disclosure. Self-enabled women discussed their ability to talk with their partners about STI and HIV infections and the influence of multiple concurrent partnerships in the acquisition of HIV/STIs. Both groups of women were concerned about men's health behaviours, and all cited the health and development of their unborn child as a key motivator for test result disclosure.

Conclusions: Improved counselling and support for pregnant women to disclose their STI test results to their partners may improve the impact of STI diagnostic testing during pregnancy by improving partner treatment uptake and thus reducing the risk of re-infection.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

Keywords

STI disclosure; HIV; pregnancy; antenatal care; diagnostic screening of STIs

Introduction

Mother-to-child transmission (MTCT) of HIV remains a significant global health issue, with an estimated 235 000 children infected annually.¹ In South Africa, nearly 5% of new HIV infections each year are due to MTCT.² Key risk factors that contribute to in utero and intrapartum MTCT of HIV include late initiation on antiretroviral therapy (ART) due to delayed presentation for antenatal care (ANC), lack of access or adherence to ART and preterm birth.^{3,4} However, often less examined risk factors may include sexually transmissible infections (STIs).

Research involving HIV-infected, non-pregnant women suggests that co-infection with STIs may increase the risk of HIV transmission by increasing cervicovaginal viral shedding, while subsequent treatment of these STIs may reduce the risk of HIV transmission.^{5–10} Though STIs during pregnancy may increase the risk of MTCT of HIV during pregnancy and other adverse birth outcomes, the World Health Organization (WHO) continues to promote syndromic management of STIs during pregnancy.¹¹ As a result, extremely poor coverage of STI testing and targeted treatment (STI-TT) during pregnancy may be exacerbating adverse maternal and infant health outcomes via untreated STIs.^{4,12–14} Recent work by Mudau *et al.* revealed that 47.8% of HIV-infected pregnant women attending their first ANC visit in South Africa had an STI infection, of which 60% were asymptomatic.¹⁵ Given that 30.8% of pregnant women in South Africa are HIV-infected, implementation of diagnostic testing and treatment for STIs, as well as reducing re-infection by STI-infected male partners, must be considered a priority.¹⁶

However, several key social and relationship factors may inhibit STI and HIV testing, treatment and disclosure within partnerships, including men's and women's differential access to STI and HIV care.^{17–19} Men's barriers to health care include social constructions of their health and masculinity, as well as feeling unwelcome in clinics and negative interactions with nurses.^{17,18,20,21} Though women generally demonstrate higher rates of healthcare access compared with men, in some settings, their access is dependent on familial and partner decision-making.²² Moreover, women's ability to make independent health decisions and communicate with their partners about health matters are compromised in paternalistic relationships and communities where men have significant social and economic control over women.^{21,23} Studies indicate that women are less likely to disclose their STI or HIV infection to their partners out of fear of relationship dissolution or economic and/or emotional insecurity.^{24–28} Furthermore, because men infrequently attend healthcare clinics and are less likely to disclose an STI or HIV status to their partners, women are often blamed for bringing the STI into the relationship.²⁹ Consequently, fear of intimate partner violence (IPV) is a common factor that may prevent women from disclosing an STI diagnosis.^{27–29} Women may actually experience a range of social, physical or emotional

consequences, including the loss of additional resources like access to antenatal care when disclosing STI or HIV test results to their partners.^{25,30}

Although there are several inhibiting factors for STI testing and disclosure within partnerships, there is a lack of understanding of what enables and motivates HIV-infected pregnant women to disclose their STI test results to their partners. Consequently, we conducted in-depth qualitative interviews with women attending their test-of-cure (ToC) follow-up visit as part of a larger acceptability–feasibility study evaluating the integration of STI diagnostic testing and same-day treatment into ANC services in Tshwane Health District, South Africa. Here, we describe relationship factors that informed women's decision-making to disclose their STI results to their partners. However, all women had a shared perspective on men's behaviours that compromised their own health. It was their desire to give birth to a healthy baby that motivated all women to disclose their STI results to their partners. We conclude that even though all women disclosed their STI test results to their partner(s), interventions are needed to improve test result counselling and support, especially for women in multiple partnerships, and that disclosure counselling should build upon a motivation for healthy babies, which was a shared desire by women and the father of her child.

Methods

This qualitative study was embedded within a larger implementation study aimed at providing point-of-care (PoC) diagnostic testing for *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG) and/or *Trichomonas vaginalis* (TV), and same day STI treatment to HIV-infected pregnant women attending their first antenatal care visit at three public clinics in Tshwane District, South Africa.³¹ In this implementation study, women with a positive test result were given the option to either provide their partner a referral slip to present to a clinic for STI treatment or to take home with them a treatment packet to give to their partner. In addition, women were asked to return to the clinic 3 weeks post-treatment for a ToC visit. Subsequent rounds of treatment and ToC were provided until a woman had a documented negative test result or birth outcome. The qualitative study was conducted between May and October 2017.

Participant recruitment

Participant recruitment into the main study has been previously described.¹⁵ For the qualitative sub-study, eligible participants were those that tested positive for CT, NG and/or TV at their first ANC visit and returning for their ToC visit. All participants arriving for their ToC visit were invited to participate in an in-depth interview. Following participant voluntary consent for participation in our sub-study, participants were interviewed by trained study staff in a private space at the clinic.

Data collection

A semi-structured interview protocol was developed that consisted of six domains grounded in the literature.³² Interview protocol domains included: (1) partner communication norms; (2) STI disclosure to partner; (3) partner response to disclosure and treatment uptake;

(4) relationship decision-making; (5) HIV disclosure; and (6) financial independence.^{33–36} Interviews were conducted in the preferred language of the participants (e.g. English, seTswana or sePedi). Interviews were audio-recorded, translated and transcribed for analysis. During the translation and transcription process, a second researcher assessed all transcripts for correct translation and accuracy.³⁷ All interviews were 35–90 min in length. Qualitative data were supplemented and complemented by quantitative data collected during the main implementation study at enrolment.

Data analysis

A group of five researchers open-coded five initial transcripts based on their knowledge of the literature and the data collection process.³² This process was followed by group discussion of the five individually coded transcripts, which led to the development of a codebook that was used for all transcripts. Each code was assigned a positive and negative sign, where positive indicated preventative behaviour and negative indicated a risk behaviour. Transcripts were then randomly assigned and independently coded by two researchers based on the group-developed codebook. Once all transcripts were coded, quality assurance procedures ensured that all codes were used properly and documented in the codebook.³⁷ The coding team met to discuss the coded transcripts using the quality assurance outcome to ensure inter-coder reliability. Variance and discrepancies between coders were discussed by the team, and assignment of final codes was determined by consensus.^{18,38}

Utilising a constant comparison approach, data were analysed by the research team. This approach involved an iterative process of theme development as the researchers reviewed and discussed the transcript data over time. The coded transcripts were analysed as a whole and then these were analysed based on relationship characteristics to identify any potential differences in STI disclosure among women in this study.^{25,36,39} Meeting notes were taken, which included researcher discussions about code associations and emerging themes. This approach integrated memo writing to outline and refine factors that contributed to STI re-infection and prevention. Findings from the transcripts, notes and memo data were triangulated to: (1) assess consistency across data sources; and (2) identify major themes that developed from multiple discussions between researchers about data interpretation. The research team met every other week for 3 months to complete this analysis process. Finally, demographic data from the main implementation study were analysed to generate basic descriptive statistics on key relationship defining variables like partnerships, number of children and economic measures.

Data representation

Quotes from interviewers and participants are designated with an 'I' (interviewer) and 'P + number' (participant) respectively, where the number represents an individual participant's unique study ID.

Ethics approval

Ethical approval was obtained on 27 July 2017 from the University of Pretoria, Faculty of Health Sciences, Research Ethics Committee (Ref: 401/2015) and the University of California Los Angeles (Ref: 15–001351).

Results

We recruited 28 participants attending ToC visits for this qualitative sub-study. The mean age of participants was 28 years, 100% were Black African, 61% were unemployed, 14.3% did not have any children prior, 46.4% received a social grant to support their family and 22% had below matriculation schooling (i.e. less than high school diploma equivalency) (Table 1). Only 57.1% of participants knew their HIV status before their first ANC visit. With regard to partnerships, 25% of participants reported multiple concurrent partners and 50% reported that their partners had another partner. Among the 24 women who had a steady partner, 50% of them reported that their male partners lived with the participant.

Both vulnerable and self-enabled experiences influence partner communication

Through interviews, we examined women's experiences with communicating with their partners as a means to understand general relationship dynamics that may influence STI disclosure. Two distinct partnership communication experiences emerged: vulnerable and self-enabled. Some women described their male partners as violent, which limited communication occurring within their relationship. Another group of women described their ability to make independent decisions, including decisions to protect their health, with some describing their partners as equals, 'like blood', in regard to communication and decision-making. Each of these experiences are outlined below.

Vulnerability experiences

There were a proportion of women who described their fear and experience of being verbally and physically abused when attempting to communicate with their partner. As participant P88 explained: *'There is nothing I can do because when I talk, he talks bad with me and say hurtful words to me. So, I just use whatever [information] he gave me.'* In this quote, the participant outlines the verbal abuse that she receives from her partner. She states that she listens to his 'hurtful words' with the objective to attempt to find some useful information within his comments in order to make decisions to include health-related decisions. In addition to verbal abuse, women reported sexual abuse as well.

I: *'Can you say no to sex, if he wants to have sex with you?'*

P85: *'Yes, I do.'*

I: *'And then if you say no, what happens?'*

P85: *'Sometimes he understands and say 'ok, it's fine'. But sometimes he doesn't understand.'*

I: *'How?'*

P85: *'He just do it by force.'*

I: *'How does that make you feel?'*

P85: *'Sometimes if he does, it's by force. [He] makes me. In my mind come [I am thinking] that maybe he's the, he wants it that day, or sometimes I just say. 'Ah, ok, it's fine then. It is me who I'm wrong.'*

Here, the participant describes her inability to negotiate sex with her partner. 'Forced sex' occurs regularly in her relationship, and she describes that she often has an internal dialogue with herself that results in self-blame and prioritising the needs of her partner. Others characterised as vulnerable also described similar experiences with their partners, or described the fear of such experiences. Such dynamics inhibited them from conversing with their partners and fully disclosing their STI and HIV diagnoses.

Self-enabling experiences

Another proportion of women described their ability to make independent, self-enabling decisions, and described their partners as equals. For example, some women described their decision-making regarding sex within their relationship.

I: *'Ok, in your relationship with your partner, who initiates sex? Who would start with [asking to have sex], ok?'*

P62: *'Both.'*

I: *'Ok, it's from both of you.'*

P62: *'Yes.'*

I: *'How does it make you feel?'*

P62: *'Good (laughs) good.'*

I: *'Can you say no to sex?'*

P62: *'Ok, [I ask him], 'Tell me why [you want to have sex]' [because] today am not feeling well. [He asks], 'Why are you not feeling well? I don't have an answer.'*

I: *'If you say 'no', what happens?'*

P62: *'Mm...he feel angry, and he tell me maybe I give someone else [have sex with someone else] but it's not true.'*

This participant stated that she could initiate sex with her partner and that sex was a good experience for her and her partner. She can also say no to sex. Even though she may feel sick and her partner blames her for having sex with someone else, she does not change her mind about having sex with him. Some women describing self-enabling behaviour also described their ability to make independent decisions in their relationships. However, their ability to negotiate and initiate sex with their partners was not free of manipulative behaviours within

the relationship, such as blaming each other for having sex with someone else outside the relationship rather than respecting their partner's decision.

Most self-enabled women also outlined good communication with their partners as represented in the following statement (P30): *'If I have a problem...he calls then I'll say, 'Can I tell you something? and then he will agree, then I will just say whatever thing does not please me or I'm not happy with... Then, afterwards we discuss it. If he does not have enough airtime for that time then he'll tell me, 'Okay, let me buy airtime, let me buy free minutes, let's discuss this or let's meet...let's speak about this.'* Most self-enabled women described their ability to talk with their partners about most topics, and many described their partners as their best friend or an equal, 'like blood' as described earlier.

Different disclosure experiences for women based on (mis)trust

Women also described differential experiences with STI and HIV disclosure to partners. Among women who discussed being vulnerable in their relationship, they feared potential physical violence as a result of disclosure, *'I thought he was going to kill me. I thought he was going to strangle me, but he didn't. He was calm.'* Within this group, there was a lot of mistrust and blame as well:

'He only said, 'How did it come for you to get this HIV? Then, I said 'I don't know, I'm asking you? I don't sleep around', and he said, 'How do you know I sleep around? I said, 'I know because you have many girls out there.' Then, he said, 'We have to go for [HIV] testing again together at the doctor.' Then, I said, 'Ok, let's go.' He was tested negative, and I was tested positive. He said, 'You see, it's only you? I said, 'Ok, I'll go for the medicine.'

(P85)

In this situation, the participant described being angry with her partner and suspected that he infected her with HIV. She did challenge his assumptions about her fidelity, and in the end, he blamed her after they tested together and found out that he was not HIV-positive. After they tested, the participant does not describe any support from her partner, but only blame for being HIV-positive. Many vulnerable women only partially disclosed their test results to their partners out of fear of blame or other negative outcomes. As one participant (P56) stated, *'That's why I don't discuss everything with him [fear of relationship ending]. Like for, for, for example, he don't know my [HIV] status. He just knows about the STI, but he don't know about my status because he asked me whether they took blood test for me, and I said, 'Yes', but he didn't ask me what the results are.'* In this group, women often disclosed their STI diagnosis even though it resulted in fear of violence, but few women disclosed their HIV status out of fear of blame, violence and relationship dissolution. As another participant (P26) stated: *'I just thought that maybe by telling him the truth, it will apart us actually. It will depart us. That he will aloof himself from me.'*

Women who had more self-enabled behaviours, however, were more likely to fully disclose without much mistrust and blame occurring within the partnership. In the following two quotes, we show a process of partner disclosure and their STI education, treatment explanation and treatment uptake.

P66: *‘He was a bit afraid [after hearing that she had an STI and that he may have one too]. I told him, ‘I’ll open an internet.’ I showed him, okay, on Google, Chlamydia is this, Trichomoniasis is this...’*

I: *‘How did he respond to you asking him to take the treatment?’*

P66: *‘Yah, I told him at the clinic they said you must drink it. I have STI, and I told him ‘cause you know you—you have—you have other women—you sometimes sleep [with them] it means—is where you get the STI [due to sex with other women] and then you bring it to me and then he said: ‘Argh! It’s fine. Okay let me drink.’*

Self-enabled women described educating their partners about the specific STIs that they were diagnosed with and, as in this case, provided additional health education for them such as searching the Internet for medical information on these infections. Most self-enabled women disclosed their STI infection, explained the treatment to their partners and discussed why it was important to prevent re-infection especially during pregnancy. Further, as in the case above, the participant knows that her partner has other partners and acknowledges this with him without blame. Participant 66 also expressed concern that she was at increased risk for re-infection while being in a multiple concurrent partnership relationship. She explained this risk to her partner in order to motivate him to take the treatment, which he completed.

Self-enabled women often disclosed or had disclosed their HIV-positive status to their partner with independent decision-making, and the partner response was often supportive: (P85) *‘I told him, you see, you’re negative and I’m positive. Why don’t you go for another girl who are [HIV] negative. Then he just said, ‘No, I can’t go for another girl who are [HIV] negative because you’re my wife, you’re carrying my child.’ Then I said ‘Ok, it’s fine then.’* In this quote, the participant tells her husband to leave her for another woman because she is HIV-positive, suggesting that she believes either she is not worthy of being in a relationship with her husband given her HIV status or she is willing to be a single mom, if her husband does not want to be with her given her status. However, her husband reinforces his commitment to her after finding out that she is HIV-positive, which seems to change her mind about her suggestion of ending the relationship. Although a difficult conversation to have with any partner, and a common thought about ending a relationship for those just finding out their HIV-positive status, the key take-away message here is that the participant initiated this conversation with her partner and was able to make an independent decision.

Men are ‘in a different world’ within multiple concurrent partnership relationships

All women, in this study, however, shared a basic perception about men in general and their male partners, specifically: that men do not focus on their health and do not talk about health issues in the same way as women. Nearly all women stated that when they discussed their STI diagnosis, their partners were silent for a while: *‘You know men, sometimes like they are in a different world. He like was quiet for a moment.’* Also, men were described as not using clinics at all: (P47) *‘He was surprised when I told him to go to clinic. He doesn’t want anything to do with clinics.’* Furthermore, most women described men’s reluctance to go to clinic for care: *‘...because of men are scared of clinic, women can sometimes be scared but are forced to come to the clinic.’* Men were described as scared of and unwilling to seek care

at the clinic, whereas women, while also scared, had to go to clinic for antenatal care. As a result, many women stated that they brought the treatment home and told their partners to take it in order to prevent re-infection (P26): *'I took [the treatment] and I gave it to him...[I told him] whether we are positive or negative, but you just have to drink because we were diagnosed; that we have STI. So, we just have to do as we were asked to do [complete the treatment].'*

We found that only self-enabled women discussed concurrent multiple partnerships within their relationships. However, many women knew that their partners had other partners, as in this statement (P07): *'You can tell when people call him and he can't answer in front of you, you know it's the girlfriends calling him.'* A common concern for women was that they could be exposed to more STIs during their pregnancy (P88): *'So, I don't have a [another] partner, but he has many girlfriends outside. He must just be serious so we can live in peace together, and he must tell those people that he is sick [and] they must also get treatment.'* Among self-enabled women, many were fine with a multiple concurrent partnership arrangement, but they felt it was important for their partners to practice safe sex to prevent re-infection. As a participant explained (P35): *'After they tell me that I have [an] STI, I was telling [my partner] that we have to use condom so we can prevent this STI [re-infection]. Even if he's going outside [sleeping with another partner], he must use a condom so I... When I come to clinic... When they test me... I wanted to know that this STIs been over [not re-infected and treated].'*

'For the baby' is a motivator for treatment uptake

The key motivator for all women in this study, to get tested and complete treatment, was for the health of the baby and its development. As one participant stated (P26), *'Negative or positive, we just do it for the baby because... They took some samples [STI testing] actually, and then tests were done and they found out that we are [STI] positive. So, I had no choice but to do that [treatment] because for the sake of the baby.'* A woman explained that the father of her child also accepted treatment mainly to protect the baby.

'I was wondering because he is a person who don't like medication. So, I was wondering if he going to drink those pills or not. But, after I spoke to him, and then I forced him to drink, and he did just for the sake of the baby.'

(P26)

Women were concerned that their partners would not actually take the treatment. However, most women stated that their partners asked about, and expressed concern, for the baby's health and development. This concern motivated both men and women to accept treatment. In the end, most women, who disclosed to their partners and explained the treatment in relation to protecting the development of the baby, watched their partners take the medication without much resistance.

Discussion

Our nested qualitative study of HIV-positive pregnant women participating in an STI test-and-treat intervention outlines relationship factors influencing their STI and HIV disclosures to partners, which may influence STI re-infection risk during pregnancy.

Violence and blame limited STI disclosure for vulnerable women

Similar to previous studies, women in our study considered relationship dissolution when determining whether to disclose their STI test results to their partner.^{23,36,40} This fear was mostly documented among women who described additional vulnerabilities, such as emotional abuse, when discussing their disclosure decision-making. Though more self-enabled women may have considered relationship dissolution, this concern did not prevent them from disclosing their STI infection to their partners, and many of these women received support from their partners as result. Women outlining vulnerabilities were more likely to partially disclose (i.e. disclose their STI results, but not their HIV status) due to uncertainty in their relationship.⁴¹ Similar to studies^{29,36} regarding HIV disclosure, our findings on STI test results disclosure reveal considerable risk for women in relationships where fear of abandonment and violence is present.²⁹

In our study, vulnerable women were those who discussed a history of forced sex and emotional abuse from their partners. This is consistent with studies^{25,40} that report high rates of IPV in South Africa, where one in four women experience IPV in their lifetimes.³⁶ Though none of the women in our study reported any physical abuse during their time in the study, fear of physical violence was a significant factor. Specifically, fear of physical violence created additional stress and anxiety around disclosure that may have delayed time-to-disclosure, but it did not prevent women from disclosing their STI status to their partners.²⁶

In addition to fear of violence, trust and blame were common experiences for both men and women in relationships when STI and/or HIV infection enters the picture.^{42,43} Among more vulnerable women, they more often blamed their partners for their STI infection, with some women blaming their partners for their HIV infection as well. Women also reported that men blamed them for their STI and HIV infections after disclosure. At times, couples used the clinic to prove who infected whom first. In such situations, men used negative test results as a means of blaming women for bringing STIs into the relationship, which reinforced mistrust within the relationship. Further, this behaviour reinforces the idea that clinics are for women only; that men find themselves being invited to the clinic by women in order to ensure the health of women and children only rather than using clinics for his own health care.^{18,44,45} Nonetheless, when men didn't go to clinic, all the women perceived this behaviour to negatively affecting their health and the health of the baby, because men were perceived to have less understanding of STI risk and prevention that self-enabled women provided in their disclosure to them.

Self-enabled women communicating with their partners may motivate STI disclosure

For self-enabled women, the ability to disclose both their STI and HIV infection often led to conversations with their partners about STIs and their prevention.²¹ Self-enabled women described educating their partners about STIs, which led to some women having conversations with their partners about working together to keep each other healthy.³⁴ For self-enabled women, these conversations included open discussions with their partner about his other sexual partners and how to ensure STI prevention to protect their baby. Interestingly, even though 25% of women reported having another partner other than their main partner (the father of their child) in the past year, none of the women discussed if they disclosed their own multiple partners during conversations with their main partner. Yet, we found that self-enabled women desired to reduce STI re-infection risk by having direct conversations about multiple concurrent partners especially during pregnancy. More research is needed to unpack how self-enabled women's multiple partnerships influence their STI risk and prevention behaviours. However, our findings begin to unravel the assumption that men are the only partners to have other sexual relationships, with the additional assumption that these relationships may present higher STI transmission risk compared with the multiple partnerships that some of the pregnant women stated that they maintained. Further, previous studies have indicated that both women and men uptake and adhere to STI and HIV treatment in order to protect their unborn child.^{39,46} Similarly, in our study, concern for their unborn child was the common motivator for all women to disclose their STI status, and for some their HIV status as well. Also, most women stated that their male partners were motivated to accept STI and HIV treatment as a means to protect their unborn child. However, it is unclear if men or women discussed safe sex practices with other partners to protect their unborn child other than statements from women that they desired their main partners to do so. Ultimately, more research is needed to develop STI prevention interventions that engages and supports men and women who maintain multiple concurrent sexual partners.

Conclusions

The ability of HIV-positive women to disclose and discuss health-related concerns with a partner may reduce the risk of re-infection during pregnancy. Furthermore, their willingness (and ability) to discuss multiple concurrent partnerships with their partners may also reduce this risk by mitigating the ongoing transmission of STIs in their sexual network. While fear of IPV was a potential inhibitor of disclosure, the health of the unborn child was a strong motivator for both men and women to accept and complete treatment. In addition to disclosing their STI infection, women also educated their partners about STIs and the need to seek testing and treatment. This education step is likely an important factor for the ultimate outcome of decreased risk of re-infection. In order to fully recognise the benefits of diagnostic testing for STIs during pregnancy, co-delivery of interventions to support partner disclosure will be needed.

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Table 1.
Demographic characteristics of participants

ZAR, South African rand

	<i>n</i> (<i>N</i>)	%
Age, mean (range)	28.7 (22–39)	
Highest educational level completed		
Below Matriculation	15	53.6
Matriculation	10	35.7
Above Matriculation	3	10.7
Marital status		
No relationship	1	3.6
Married	3	10.7
Steady partner living with me	12	42.9
Steady partner not living with me	12	42.9
Partner's highest level of education completed ^A		
Below Matriculation	5	33.3
Matriculation	9	60.0
Above Matriculation	1	6.7
Employment status		
Employed full-time	6	21.4
Employed part-time	4	14.3
Self employed	1	3.6
Not employed	17	60.7
Partner's employment status ^A		
Employed full-time	10	66.7
Employed part-time	4	26.7
Self employed	1	6.7
Receives a social grant	13	46.4
Level of income		
None	1	3.6
<1000 ZAR per month	12	42.9
1001 – 5000 ZAR per month	9	32.1
5001 – 10 000 ZAR per month	6	21.4
Had a partner other than main partner last year	7	25.0
Partner has another partner		
No	9	32.1
Yes	14	50.0
Unsure	5	17.9
Prior knowledge of HIV status	16	57.1
Gestational age (mean)	17.8 weeks (6–32 weeks)	
No of children		
0	4	14.3

	<i>n</i> (<i>N</i>)	%
1	16	57.0
2	4	14.3
3	4	14.3
Sexual violence in the last 12 months	2	7.1
Physical violence in the last 12 months	2	7.1
Psychological aggression in the last 12 months	3	10.7

^A Data are from women who lived with a partner or who were married.