UNIVERSITY OF KWAZULU-NATAL

AN ASSESSMENT OF THE ADMINISTRATION OF THE PREVENTION OF THE MOTHER TO CHILD TRANSMISSION PROGRAMME IN UMGUNGUNDLOVU DISTRICT – KWAZULU-NATAL

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DECLARATION

I, Lillian Nonhle MTUNGWA, declare that:

(i) The research reported in this dissertation, except where otherwise indicated, is my original research.

(ii) This dissertation has not been submitted for any degree or examination at any other university.

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ABSTRACT

This study assesses how the Prevention of Mother to Child Transmission programme (PMTCT) is administered and implemented under three public health clinics within uMgungundlovu Health District in the KwaZulu-Natal province of South Africa. The programme has a crucial role in reducing the mortality of babies owing to Mother to Child Transmission (MTCT) of HIV.

The study focuses on public health care processes aimed at the vulnerable population of women and children who attend public health care facilities. It was critical to investigate the extent to which the programme was accessible to all South Africans visiting public health facilities.

Qualitative research methodology was employed in this study. In- depth interviews were carried out in three public health clinics falling under uMgungundlovu Health District. These interviews were carried out with health care professionals based at the facilities: patients receiving health care services within the maternity, antenatal and postnatal sections as well as the PMTCT Coordinators or Managers responsible for the implementation of guidelines, policies and protocols within the KZN Department of Health (KZN DOH).

The findings of the study revealed that the three health care clinics possessed the PMTCT policies and protocols and the health care professionals knew how these had to be implemented though not in all three facilities. The majority of women received education on HIV/AIDS in all three facilities under study, and most knew how HIV was transmitted and how the transmissions could be avoided. About 90% of women who attended antenatal services were aware that an HIV positive mother could transmit the virus to her unborn child during pregnancy, birth, and through breastfeeding.

The research, however, established that there were a range of implementation challenges. This includes a lack of sufficient consultation rooms, lack of human resources and difficulties arising during delivery process when dealing with stigma associated with HIV/AIDS in some communities. Further, the research established that defaulting patients who failed to take their medication made a notable impact on the smooth implementation of the programme. It was suggested that all health care professionals involved should receive training in the administration of the PMTCT programme. This would help to ensure that all patients are

enrolled into the programme in time and that all staff knew how to implement the programme to the right people, and at the right time.

TABLE OF CONTENTS

CHAPTER 2: LITERATURE REVIEW

CHAPTER 3: RESEARCH METHODOLOGY

LIST OF ABBREVIATIONS AND ACRONYMS

AFASS	Affordability, Safety & Sustainability
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AZT	Zidovidine

ARV	Antiretroviral Therapy
BFHI	Baby Friendly hospital Initiative
BP	High Blood Pressure
DOH	Department Of Health
EBF	Exclusive Breastfeeding
EFV	Efavirenz
HAART	Highly Active Antiretroviral
HIV	Human Immune Virus
HCT	HIV Counselling and Testing
HSRC	Human Science Research Council
MTCT	Mother to Child Transmission
M2M	Mothers to Mothers
MCH	Maternal Child Health
MDRTB	Multi Drug Resistance Tuberculosis
MOH	Medical Officers of Health
NDOH	National Department of Health
NVP	Nevirapine
PCR	Polymerase Chain Reaction
PMTCT	Prevention of Mother to Child Transmission
PHC	Public Health Clinic
PLHIV	People Living with HIV
RTHC	Road to Health Card
SANAC	South African AIDS Council

SdNVP	Single-dose Nevirapine
STI	Sexually Transmitted Infections
TB	Tuberculosis
TAC	Treatment Action Campaign
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
XDR	Extreme Drug Resistance Tuberculosis

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

This chapter presents an overview of the study and the international and national statistics on HIV and AIDS. Against this background, the chapter discusses Public Administration and Management and how the generic processes of public administration provide a medium through which the government's responses to the pandemic are operationalised. This is done by highlighting how the work of three Public Administration theorists has influenced public administration practice. Further, the chapter provides an overview on the prevention of mother-to-child transmission (PMTCT) programme in South Africa as a case study to understand critical Public Administration processes and how these translate into practice.

1.2 BACKGROUND OF THE STUDY

Kapczynski and Berger (2009:4) state that children can contract HIV from their mothers before they are born, during delivery, or while breastfeeding. Collectively, these forms of transmission are known in the field as "mother-to-child-transmission of HIV" ("MTCT"). Mother-to-child transmission is the transmission of HIV from an HIV-positive woman during pregnancy, delivery or breastfeeding to her child (Department of Health, 2008). According to WHO (2014), the global community has committed itself to accelerate progress for the prevention of mother-to-child HIV transmission (PMTCT) through an initiative with the goal to eliminate new paediatric HIV infenction by 2015 and improve martenal, newborn and child survival and health in the context of HIV (WHO, 2014).

This study assesses the administration and implementation of PMTCT Programme in three public health clinics of uMgungundlovu Health District in KwaZulu-Natal. The study critically explores how the programme can best be implemented and is, as such, crucial to reducing the mortality of babies owing to mother-to-child transmission (MTCT) of HIV (Department of Health, 2008).

The study focuses on public health care processes of individuals in South Africa, especially the vulnerable population of women and children. The population comprised of pregnant women between 18-49 years of age who had visited antenatal sessions in public health clinics more than once and received education on HIV counseling and testing. In addition, nursing managers and PMTCT coordinators interested in and responsible for PMTCT protocols and guidelines were interviewed. It also examines the South African government's responsibility, through its Department of Health, to ensure that all South African citizens have access to health care services.

Consumers and the general public want to know about how the services they need are performing and what they are likely to experience. To this effect, the Monitoring and Evaluation unit under the presidencyof Jacob Zuma is tasked with ensuring service delivery to the public servants (President Zuma's State of the Nation Address, 2009).The South African government is guided by constitutional principles to ensure maximum delivery of its services. The interim Constitution of the Republic of South Africa (1993) authorised transformation of the country by giving all citizens the same rights and freedoms. It was replaced by the final Constitution of the Republic of South Africa, 1996 (Cloete, 1998), which is the supreme law of the country; no other law is above the Constitution.

A few studies have been conducted on PMTCT in KwaZulu-Natal. A study by Baek, Mathambo, Mkhize, Friedman, Apicella and Rutenberg (2007) evaluated the intervention on PMTCT known as mothers to mothers (m2m), which found that this intervention plays a major role in providing a continuum of care for HIV-positive women and infants. The women who participated in m2m intervention study had greater psychosocial well-being, greater use of PMTCT services and better PMTCT outcomes. The intervention, however, is still not available in all public health facilities in South Africa, but what can be learned from it is that if the Department of Health comes up with similar interventions there will be benefits from the PMTCT programmes (Baek et al., 2007).

In their study, Baek et al. (2007) found that PMTCT programmes found it difficult to follow up women after delivery to address issues such as infant feeding, family planning, infant health and women's health. In many countries, once women deliver, most do not return to the antenatal care (ANC) or maternal child health (MCH) clinics where they receive PMTCT services (Baek et al., 2007:4). Research shows that lack of participation in PMTCT-related

programmes during the postpartum period contribute to pediatric HIV infections. Infections could be reduced by improving follow-up by public health professionals of HIV-positive mothers and their infants and fostering their utilisation of health services (Baek et al., 2007:4). Thus, programmes on health education in communities could be expanded by the Department of Health in order to address this challenge and more mobile clinics provided in resource-limited settings.

A study conducted by the Human Science Research Council (HSRC) in 2011, in public health clinics under uMgungundlovu Health District found that women who participated in the programme had better PMTCT outcome. The main objective of the study was to test the effectiveness of PMTCT programme through Mentor Mother Intervention and health information materials supplied. The intervention focused on HIV-positive pregnant women receiving antenatal and postnatal care in public health clinics. It found that women who participated in the programme had better PMTCT outcomes, for instance, the ability to disclose their HIV-positive status to somebody, ability to encourage other people to test for HIV and to educate community members on positive living and healthy eating (Rotheram-Borus, Richter, van Rooyen, van Heerden, Tomlison, Stein, Rochat, de kadt, Mtungwa, Mkhize, Ndlovu, Ntombela, Comulada, Desmond & Greco, 2011). This shows that a properly planned and implemented health care programme stands greater chances of success.

The challenge is to ensure that the PMTCT programme is administered and implemented according to the Department of Health policy and guidelines at all times. This will ensure that all the public health clinics possess the PMTCT policies, protocols and guidelines and know how these have to be implemented, and constitutes the foundation of this research. First, however, it is important to understand the extent of the HIV pandemic nationally by outlining the pertinent statistics.

1.3 INTERNATIONAL AND NATIONAL STATISTICS ON HIV AND AIDS

At the end of 2010, an estimated 34 million people were living with HIV worldwide (UNAIDS, 2011). UNAIDS (2011), states that about 68% of all people living with HIV reside in sub-Saharan Africa, a region with only 12% of the global population. In 2010, 70% of new HIV infections were accounted for in sub-Saharan Africa in 2010.

Nigeria is the most populated country in sub-Saharan Africa, with an estimated population of 162,265,000 and it carries the second heaviest burden of HIV in Africa (NACA, 2012). The total number of new HIV infections in sub-Saharan Africa has dropped by more than 26% down to 1.9 million from the estimated 2.6 million at the height of the epidemic in 1997 (UNAIDS,2011). According to UNAIDS report, in 22 sub-Saharan countries, research has shown a decline in HIV incidence by more than 25% between 2001 and 2009. This includes some of the world's largest epidemics in Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe (UNAIDS, 2011).

At the end of 2009, women accounted for just over half of all adults living with HIV worldwide (UNAIDS, 2010). Estimates show that by the end of 2009, 33.3 million people were living with HIV globally. Adults living with HIV and AIDS were 30.8 million; 2.2 million were newly infected adults, 15.9 million were women and 2.5 million were children living with HIV and AIDS. In 2009, people who died owing to AIDS-related illnesses were 1.8 million and orphans between ages 0-17 years were 16.6 million (UNAIDS, 2010). In Sub-Saharan Africa, estimates show that by the end of 2009, 22.5 million adults and children were living with HIV and AIDS, of whom1.8 million were newly infected adults and children (UNAIDS, 2010). This state of affairs should be of concern to any democratic society that cares for its citizenry. It is, thus, imperative that appropriate policies and programmes be devised. Equally important is the need to ensure functional and responsive public administration machinery – a matter to which the discussion now turns.

According to the Global AIDS Report (UNAIDS, 2010:16), the overall growth of the global AIDS epidemic appeared to have stabilised. The annual number of new HIV infections has been steadily declining since the late 1990s and there has been fewer AIDS-related deaths owing to the significant scale up of antiretroviral therapy over the past few years). Although the number of new infections has been falling, levels of new infections overall have been high and globally deaths among children younger than 15 years of age have also been declining (UNAIDS, 2010:35).

Lau and Adamson (2004:402) state that the illnesses and deaths associated with the HIV and AIDS pandemic have major economic and social implications: poverty and hunger have increased; children have become increasingly vulnerable as a result of the epidemic; the

education sector has been weakened; people are suffering from AIDS related isolation, and life expectancy is decreasing.

The authors further state that in 12 out of 44 Sub-Saharan African countries, at least 10% of the population is infected with HIV and AIDS. Six Sub-Saharan African nations have HIV infection rates exceeding 20%. In countries with HIV infection rates over 10%, nearly 80% of deaths in young adults (age 25-45) will be HIV-related. Infection rates in young African women are much higher than in young African men. Rates for teenage girls are five times of those of boys of the same age and those in their early twenties; rates are three times higher in women (Lau & Adamson, 2004:403).

According to NACA (2012), children are affected by HIV/AIDS through mother to child transmission infection or through the loss of one or both parents from AIDS. The 2008 National Situation Assessment Analysis (SAA) on OVC showed that not only has HIV and AIDS been a major cause of death of parents, especially in households where both parents have died, but also before the loss of a parent, social and economic vulnerability has been worsened by serious illness of a parent or other adult member of the household (NACA, 2012).

A related process to public spending is that of policy implementation.Public health policies, similarly to other public policies, are implemented through the public administration process. To get an understanding of the success of implementation of HIV policies, or lack of it, requires an understanding of public administration and management processes, a matter which the discussion now turns to.

1.4 PUBLIC ADMINISTRATIONAND MANAGEMENT

Public Administration is recognised as a distinctive field of work because of the requirement that those who practice public administration in a democratic state have to respect specific guidelines that govern their conduct when carrying out their work (Cloete, 1998:91). Du Toit and van der Waldt (1999:13) state that “Public Administration is concerned with handling public matters and the management of public institutions in such a way that resources are used efficiently to promote the general welfare of the public”.

One of the defining tensions in the intellectual development of public administration is the tension between the field as a social science and as a professional activity undertaken in a political environment (Moyniham, 2006:78).

Public Administration is an activity serving the public and public officials or servants to implement policies devised by their superiors (Hughes, 2003:6). The action of public administration has to do with government institutions producing certain products and/services for the society. Various departments within governments are expected to render certain services to society because individuals cannot meet some of their own needs in specific situations (du Toit & van der Walt, 1999:8).

Boyne (2002:98) states that unlike private firms which are owned by the enterpreneurs or shareholders, public agencies are owned collectively by members of political communities. In private organisations, owners and shareholders have a direct monetary incentive to monitor and control the behaviour of managers. Additionally, managers are likely to benefit from better performance either because they own company shares or because their pay is linked to financial success (Boyne, 2002:98).

Public Management is regarded as an integral part of public administration, the activity and Public Administration discipline which is necessary to perform public duties effectively and efficiently (du Toit & van der Waldt, 1999: 15). In addition, the activity, and the discipline which is necessary to perform public duties effectively and efficiently (du Toit & van der Waldt, 1999:15).

Public managers have multiple goals imposed upon them by the numerous stakeholders that they must attempt to satisfy. Public organisations' goals are vague than those of private counterparts since organizational purposes are imposed through the political processes rather than selected by managers themselves (Boyne, 2002: 101)

1.5 GENERIC PROCESSES OF PUBLIC ADMINISTRATION

According to du Toit and van der Waldt (1999:64), there are six generic processes of public administration. These include policy-making, organising, financing, personnel provision,

determining work procedure and control.The six generic processes of public administration are critical in the running of any public institution efficiently.

1.5.1 POLICY-MAKING

Policy-making refers to the functions performed to obtain policies. It will always involve interaction between the public and the institution and officials who have to perform the policy-making functions. When human beings begin to live together in communities, they are no longer self-sufficient, a need for basic goods and services arise as human beings cannot live in communities with their families without them. Policy-making should always be seen as a function undertaken in an orderly manner, the function involved in obtaining information should be performed thoroughly to deliver information with which the matter to be decided upon can be quantified (Cloete, 1998:139).

In public health clinics, the district manager together with middle and upper management determine the administrative process of policy-making, organising, staffing, financing, determination of work methods and procedures and control. Cloete (1998:215) states that in public administration the policy will always triumph; it is much more than a decision and in order to arrive at policy level a number of decisions are made. The author further states that no aspect of public administration comes into action until a policy has been articulated announced and endorsed by legislation. The legislation in question should provide directions on how, when, where and by whom the policy should be implemented. According to du Toit and van der Waldt (1999:20), a number of functions are carried out to decide on a plan of action to achieve certain objectives. At the national level, for instance, the Department of Health provides guidelines for successfully administering and managing the Department of Health institutions and issues arising in different regions.

1.5.2 ORGANISING

Organising is known as a division of work and consists of categorising the grouping functions as well as allocating groups of functions to institutions and workers in an orderly pattern so

that everything the workers do will be aimed at achieving determined objectives (Cloete, 1998:165).

According to Cloete (1998:218), legislatures cannot perform the staffing functions themselves and have to arrange for this function to be performed by executive functionaries and executive institutions. Legislatures delegate their executive functions in staffing matters to the political executive office-bearers in charge of the executive institution. Organisation refers to activities or functions involved in creating and maintaining organisational units called institutions. This involves the formation of structures each responsible for a particular functional area, for example health or education, and grouping of certain functional activities within certain structures (du Toit & van der Waldt, 1999:14).

1.5.3 FINANCING

Most public institutions spend the largest part of their available money on personnel. Various staffing functions should be done efficiently. This will also be conducive to effective and efficient discharge of the functional activities of the administrative executive institution (Cloete, 1998:190). A provision is made at national level of how money is obtained and allocated to particular institutions and how it should be spent and controlled; not a single department can function without finances (du Toit & van der Waldt, 1999:15).

1.5.4 PERSONNEL PROVISION AND UTILISATION (STAFFING)

Gulick and Urwick (1937) and Stillman (1987:175), cited in Hughes (2003:31), indicate that staffing refers to recruiting and hiring of personnel who will carry out the crucial functions of the organisation.Personnel provision and utilisation refers to the process of making personnel available and placing them in suitable positions. In individual departments, this involves recruitment and selection of suitable staff members (du Toit & van der Waldt, 1999:15). All public institutions consist of officials, each of whom is responsible for a specific area of work function or duties. A number of specific areas are always combined to obtain larger units resulting in an establishment being formed, that is, a hierarchical structure of posts which constitutes the agency.

1.5.5 DETERMINATION OF WORK PROCEDURES

Drafting of specific functions to be followed is important in order to carry out certain actions. Delegation of tasks ensures accountability and responsibility amongst staff. These are found in legislation and regulations arising from legislation.

1.5.6 CONTROL

It is important to ensure that all functions are carried out effectively and efficiently in order to achieve set objectives, thus controls are exercised (du Toit & van der Waldt, 1999:15). The PMTCT programme is not different as its successful implementation greatly relates to how these six generic processes are operationalised with regard to the programme. These processes are informed by theorists of Public Administration who view them as the best way of implementing public policies efficiently and effectively. In the next section, three theorists are discussed in order to provide an insight into how they conceptualise the public administration process.

1.6 PUBLIC ADMINISTRATION THEORISTS

1.6.1 FREDERICK TAYLOR

Frederick Taylor was known as the father of scientific management who believed that there is "one best way" of accomplishing any given task (Hughes, 2003:27). Taylor believed work needed to be standardised and procedures made clear so that people would be able to follow instructions accordingly. This theorist also believed that people needed to be motivated in order to work an extra mile and above measurable standards, and had to be compensated for their hard work (Hughes, 2003:20-27). The Department of Health, through its policies, guidelines and protocols, aims at ensuring that the functions performed by health care professionals nationally are standardised. The staff need to know what is expected of them at work, what to do, when and how to perform their tasks.

1.6.2 WOODROW WILSON

Woodrow Wilson was of the view that there should be a strict separation of politics from administration (Hughes, 2003:24). Wilson believed that the evils of the spoils system resulted from the linking of administrative questions with political ones (Hughes, 2003:25).

According to Hughes (2003:45), management refers to the achievement of results and taking personal responsibility for doing so. Managers are responsible for proper planning and organization of work within the department and/organisation. They are responsible for ensuring that employees know what tasks need to be completed, how, when and by whom. Kroon (1990:8-9), however, states that it is the responsibility of all managers to apply management principles and create a working environment under which individuals can work together towards achieving organisations' objectives. He further states that, in public health care clinics and hospitals, managers are responsible for ensuring that the facilities are managed efficiently and effectively by ensuring policy and guidelines are adhered to at all times by health care professionals (Kroon, 1990: 8-9). Management in public health care facilities need to ensure that the programmes, which are supposed to be administered and implemented in their facilities are, in fact, being implemented according to national policy and guidelines (Kroon, 1990:8-9).

Like Frederick Taylor, who believed that "there is one best way" of accomplishing any given task (Hughes, 2003:27), the Department of Health in South Africa subscribes to the view that there should be protocols and guidelines in place within its department and that health care professionals be trained on how to implement these guidelines. This would then ensure that work in the Department of Health is standardized nationally (Department of Health, 2008). The Department of Health has a hierarchy of personnel who perform various functions at particular times in keeping with Weber (Hughes, 2003:21), who believed in separation of functional activities to various administrative units to ensure graded levels of authority in the implementing policy.

1.6.3 MAX WEBER

Max Weber's involvement with social theory and social questions always shaped his approach to religion, law, politics and history (Weber, 2009). Weber was interested in and concerned by the political and social implication of dependency on foreign labour.

Weber (cited in Hughes 2003:22) designed six principles for modern systems of bureaucracy. First, Weber argued that authority derives from the law and rules made according to law meaning that there is no other form of authority that could be followed. Secondly, Weber believed in strict hierarchical delegation of functions, for instance, on what tasks need to be performed, when, how and by whom and added that these needed to be determined by those in higher rank. Thirdly, Weber believed that an organisation is something of existence separate from the private lives of its employees and that written documents should be preserved so that reference is made if a similar incident were to occur in future (Hughes, 2003:22). Fourthly, he argues that the administration needs thorough training; as it is a field, which not anyone can be allowed into without proper training and experience. Lastly, Weber states that working for a bureaucracy is a full time occupation as opposed to it being a secondary activity (Hughes, 2003:22). In addition, office management is an activity that could be learned as it has general rules to be followed.

Weber's model replaced personal administration with an impersonal system based on rules. As with Taylor (Hughes, 2003:22), who treated individuals like robots, Weber did not acknowledge that human beings have personal problems, but believed that an organisation and its rules were much more important than individuals within it (Hughes, 2003:22).

The Department of Health has personnel who perform various tasks at different times according to their hierarchical ranks, and ensure that the protocols and guidelines are adhered to at all times. Members of staff are trained on the protocols and guidelines to ensure that they know what is expected of them and how to implement such protocols and guidelines effectively. In this regard, the PMTCT is no exception as its implementation comes with clear protocols and guidelines (Department of Health, 2008). It is the extent to which these are adhered to that this study in part, seeks to establish. Before that, however, a background to this programme is provided.

1.7 BACKGROUND ON PREVENTION OF MOTHER-TO-CHILD TRANSMISSION PROGRAMME IN SOUTH AFRICA

South Africa has made notable progress in improving access of mothers, children and women to health care and nutrition services since 1994. This was made possible by the introduction and implementation of primary health care (PHC) policies, including the restitution and building of PHC facilities as well as the introduction of the free health care policy for mothers and children less than six years of age (Department of Health, 2008).

According to Kapczynski and Berger (2009), at least 70,000 infants were infected with HIV as a result of MTCT in 1998. A universal PMTCT program using Nevirapine thus had the potential to prevent up to 35,000 pediatric HIV infections each year, if not more. The government however refused to implement such a program and the refusal was not based on cost effectiveness as the government's internal documents showed that the intervention was cost-effective. The refusal had to do with AIDS denialism from the president's side. There was a belief that AIDS was caused not by HIV, but rather by a situation which weaken the immune system, such as recreational drug use, malnutrition, and ARV medicines themselves (Kapczynski and Berger, 2007:7).
The TAC focused its energy on securing affordable prices forAZT and other HIV-related medicines. Its members marched, protested, met with drugcompanies, and intervened on the side of the government in a lawsuit brought by patent-based drug companies that challenged a law designed to reduce the prices of medicines in South Africa.These efforts met with significant success. In September 1999, the new Health Minister, Dr. Mantombazana ("Manto") Tshabalala-Msimang, told TAC that the government was committed to a PMTCT program, but that there were concerns about the safety and efficacy of Nevirapine.Despite mounting evidence to the contrary, Tshabalala-Msimang told Parliament in November 1999 that there was not enough information either on the affordability or on the appropriateness of using the ARV drugs (Kapczynski and Berger, 2007:11-12).

The first PMTCT policy was drafted in 2001 and implemented nationally in 2002 (Department of Health, 2008). In 2002, the PMTCT programme was limited to only 180 pilot

sites and women who stayed far from these sites could not access the programme (Chopra, Doherty, Jackson & Ashworth, 2005:358). PMTCT programmes have been implemented in South Africa at government-designated pilot sites and nationally, by order of a July 2002 Constitutional Court judgement ordering the government to make Nevirapine (NVP) universally available to HIV-infected pregnant women (Sherman, Jones, Coovadia, Urban & Bolton, 2004:289).

Chopra et al. (2005:358) note that after initial evaluations, these sites were given extra resources to employ lay counselors and conduct rapid HIV tests in antenatal clinics. Following a number of failed attempts to convince the Minister of Health to broaden the MTCT programme, the Treatment Action Campaign (TAC), together with the other two complainants, filed a notice of motion with the Pretoria High Court alleging that the Minister of Health as well as the Ministers of Health for all provinces were in breach of their constitutional and international obligations in failing to provide Nevirapine (NVP) to women outside limited pilot sites.

Kapczynski and Berger (2009), states that in 2001, after repeated attempts over a number of years to convince the government to provide comprehensive PMTCT services had failed, TAC filed a lawsuit contending that the government was violating the South African Constitution. They further state, with the help of women who have had bad experiences at public health clinics regarding access to Nevirapine during their pregnancy; TAC won what has become one of the most celebrated human rights cases in the world: Minister of Health & Others v. Treatment Action Campaign &Others. In its judgement, the Constitutional Court of South Africa held that the government's failure to develop and implement a comprehensive PMTCT program breached the express constitutional guarantee of access to health care services, in particular the state's positive obligation in respect of that right (Kapczynski & Berger, 2009:3).

The policy and guidelines for the implementation of the PMTCT programme were developed in 2008 with the aim of providing continued guidance towards a reduction in vertical transmission of HIV (Department of Health, 2010). The introduction of the PMTCT policy and guidelines by the South African government was aimed at standardising procedures, providing uniformity in public health facilities across all provinces as well as providing

health care professionals with necessary knowledge and skills to be able to carry out their functions effectively (Department of Health, 2008).

The Minister of Finance, Mr Pravin Gordon, announced in his 2010 Budget Speech that more money would be allocated for HIV and AIDS treatment and drugs and Dr Aaron Motsoaledi, Minister of Health, has made a number of policy shifts to also show his commitment to HIV and AIDS (AIDS Law Project, 2009). According to a report by Human Sciences Research Council on national survey (2008), when comparing HIV prevalence in 2005 with 2008 estimates for each of the nine provinces, KwaZulu-Natal had the largest reduction in HIV prevalence among children, from 7.9% to 2.8%. The survey also found that the decline was not only in KwaZulu-Natal, but nationally and could be attributed to programmes that address the issue of MTCT. HIV prevalence remains high for females in comparison to males and rises in the 25-29 year age group for females where one out of three females were found to be in 2008 (HSRC, 2009:63).

In all public health facilities, clinics and hospitals, managers are responsible for ensuring that facilities are managed efficiently and effectively in order to benefit the public as expected by the principles of Batho Pele. Managers have to ensure that the institutions have necessary personnel to carry out their tasks, sufficient human resources, and all the necessary programmes are being implemented accordingly as required by the policy and guidelines set out nationally (Kroon, 1995:8-9).

1.8 OBJECTIVES OF THE STUDY

The main objectives of the study were to:

- Assess the current situation regarding the administration, delivery and implementation of the PMTCT programme in three public health clinics in KwaZulu-Natal, specifically uMgungundlovu Health District.
- Establish if health care professionals had the PMTCT protocols and guidelines in their facilities and if they were trained on the policy and guidelines and assess if these protocols and guidelines were administered properly.

- Find out what challenges were encountered by health care professionals in implementing the PMTCT protocols and guidelines.
- Assess whether patients visiting the health care facilities received all the necessary information on PMTCT as is their democratic right.

According to Chopra et al. (2005), a study was conducted in 2002 to address mortality of babies in three different sites. In the study, findings revealed that the rate was 60/100 live births and counseling was part of the nurse's duties. In addition, there were three full-time PMTCT lay counselors one of whom specialised in feeding counseling. The second study, which was conducted in a peri-urban/rural site where infant mortality was 40/1000 live births, revealed that there were five lay counselors who were responsible for PMTCT counseling. The third study took place in the poorest rural area, which had 99/1000 live births and voluntary counseling and testing, was performed by midwives and two professional nurses (Chopra, et al., 2005:358).

1.9 RESEARCH QUESTIONS

The study had four broad research questions. The first type of questions were directed at health care professionals, while the second was targeted at patients (HIV-positive and pregnant women) visiting health care facilities. The third type of questions was aimed at patients (HIV-positive already delivered babies) with babies not older than 12 months old, and the fourth set was for the PMTCT coordinators.

The first question was aimed at gathering information from health care professionals on critical issues relating to:

- awareness of protocols and guidelines regarding practice and the form of such protocols and guidelines;
- processes through which the protocols were developed;
- training on protocol and guidelines;
- availability of and access to policies and guidelines;
- ability to implement the guidelines;
- existence of a PMTCT implementation plan;

- how the PMTCT protocols are implemented;
- challenges in implementing the guidelines; and
- solutions to implementation challenges.

The second question sought to establish whether patients (HIV-positive and pregnant women) were receiving essential care and information on HIV and AIDS while attending public health facilities and involved a number of questions focusing on:

- dissemination of HIV and AIDS information and how;
- opportunity to test for HIV and AIDS and rationale;
- administration of PMTCT drug to HIV positive participants;
- provision of information on implications of being an HIV-positive mother;
- provision of information on HIV and AIDS support for HIV-positive mothers; and
- basic information on transmission of HIV and AIDS from mother to child.

The third question was aimed at establishing if HIV-positive women who had delivered their babies received necessary care at PHCs when pregnant and questions concentrated on:

- opportunity to test for HIV and AIDS;
- administration of different bloods (CD4 count blood type and viral load);
- provision of information on important medication to be administered on HIV positive women;
- information on infant immunisation;
- information on HIV testing for infants; and
- provision of information on infant feeding options.

The fourth question was meant at garthering information from the PMTCT coordinators on:

- whether the PMTCT programme was run in their respective facilities;
- availability of PMTCT policy and guidelines in their facilities;
- workshops held at national level on PMTCT policy and guidelines amendments;
- provision of trainings on PMTCT;
- HIV and AIDS information and PMTCT provision to health care professionals
- Enrolments of eligible patients to PMTCT programme; and

- challenges encountered by health care professionals when implementing PMTCT programme.

1.10 STRUCTURE OF THE THESIS

Chapter One: Introduction and background

This chapter introduces the study and provides the national and international statistics as well as the overview of HIV and AIDS and PMTCT. This was done against the background of Public Administration theories. Furthermore, the chapter advances the rationale of the study, and problem statement.

Chapter Two: Literature review

Chapter two reviews previous studies on PMTCT programme, its implementation and administration. It also discusses the existing literature on PMTCT in South Africa, and globally as case studies.

Chapter Three: Research methodology

This chapter discusses the methodology used and focuses on the research problem, research design, data collection and processing of data collection.

Chapter Four: presentation and discussion

This chapter presents the findings of the study. It explores the challenges encountered by public health clinics when administering and implementing the PMTCT protocols and guidelines.

Chapter Five: Conclusions and recommendations

The chapter summarises the key issues and makes recommendations on how government policies can be formulated to assist in the effective administration and implementation of PMTCT guidelines and protocols.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a literature review on project implementation of HIV and AIDS and PMTCT. It reviews different studies conducted nationally and internationally. Furthermore, the chapter assesses the administration of the PMTCT programme in uMgungundlovu health district, KwaZulu-Natal.

According to du Toit and van der Waldt (1999:20), efficient administration in terms of the achievement of objectives, economical use of resources and reasonable and fair distribution of resources between groups and projects should be pursued at all times. The authors further note that there is no institution that can function efficiently or effectively without suitably trained personnel. One of the measures for increasing efficiency in public institutions would be to enhance the quality of personnel through creating opportunities which will result in a greater degree of professionalism among officials (du Toit & van der Waldt, 1999:20).

2.2 PUBLIC HEALTH SERVICES BEFORE AND AFTER1994

Coovadia, Jewkes, Barron, Sanders and McIntyre (2009:817) state that racial and gender discrimination, the migrant labour system, destruction of family life, vast income inequalities, and extreme violence have all formed part of South Africa's troubled past and all have affected health and health services. When apartheid came to an end in 1994, the health system faced massive challenges, many of which still persist.

Fourie (2006:88) states that the first AIDS-specific piece of legislation enacted by the National Party was the Human Tissue Act (65 of 1983), which was amended in 1990. This legislation allowed for the exclusion of certain groups of people from donating blood, particularly homosexual males (Fourie, 2006:88). The aim was to exclude those individuals who were thought to be risky donors and protect the rest of the population against their unsafe blood. Further, on 30 October 1987, the most significant AIDS-specific legislation of the apartheid government was announced. On that day, the Minister of Health and Population

Development published amendments to the Public Health Act (63 of 1977), which gave special powers to medical officers of health (MOHs) with regard to HIV-positive individuals. According to this amendment, a MOH who suspected someone to be the carrier of a communicable disease could instruct that person to subject himself/herself to a medical examination. A medical practitioner who treated a person suffering from a medical condition had to submit weekly reports on the patient to the regional director of health, and in schools, the principals were obliged to notify MOHs of the presence of an HIV-positive pupil or staff member (Fourie, 2006:88).

Between 1948 and 1994, poverty-related diseases persisted within the black population, maternal, infant and child mortality increased and the rate of tuberculosis (TB) and deaths due to TB became much higher in black and coloured population compared to the white population (Wilkison, Gouws, Sach, Abdool Karim, 2001:655-667). The authors further state that fees paid by the public to PHCs for consultation for children under the age six and pregnant women were abolished in 1997 as they were used to recover costs and discourage unnecessary attendance at the PHC (Wilkison et al., 2001:665-667).

Wilkison et al. (2001:666-668) point out that a number of Acts were further implemented, for instance The Choice on Termination of Pregnancy Act (92 of 1996), which legalised abortion and led to marginal declines in septic abortions and stabilisation in maternal mortality from septic abortions. In a study conducted at Hlabisa Health District to investigate the impact of the changes on clinic attendance patterns after the abolition of user fees, Wilkison (2001) found that the total number of consultations for curative care in the mobile unit almost doubled, while the number of consultations for preventive services fell. It was also found that the removal of user fees encouraged and increased access to curative services and that clinic congestion and reduced consultation times discouraged some women from attending for antenatal care and from bringing their children for growth monitoring and immunisation (Wilkison, 2001: 666-668).

The Department of Health (2008) PMTCT Policy and guideleines state that the PMTCT programme was implemented nationally in South Africa in public health facilities in 2002 . The aim was to reduce the mortality of babies dying owing to (MTCT) of HIV (Department of Health, 2008). The PMTCT policy and Guidelines further state that all pregnant women

attending the PHC should be informed of the PMTCT programme being run at their facilities and offered an opportunity to access the programme.

Some of the cornerstones for the PMTCT programme are: HIV counselling and testing (HCT), ARV drugs and treatment, feeding options, family planning and vaccination of infants (Department of Health, 2008). Wilkison et al. (2001:667-669) highlight that in 2004 the National Health Act legislated for a national health system incorporating public and private sectors. The authors further point out that the provision of equitable health-care services ensured the fulfilment of the rights of children with regard to nutrition and basic services and entrenched the rights of pregnant women and children to free care throughout the public sector if they were not on a medical scheme (Wilkison et al., 2001:667-669).

2.3 PREVENTION OF MOTHER-TO-CHILD TRANSMISSION PACKAGES

The national PMTCT programme offers voluntary counselling and testing, administration of NVP to mother and baby, provision of free milk formula for the first six months of life, and follow-up for infants on cotrimoxazole prophylaxis from six weeks of age to one year of age when their HIV infection status is determined using an HIV enzyme-linked immune sorbent assay (ELISA) test (Sherman, Jones, Coovadia, Urban & Bolton, 2004:289). The PMTCT policy and guidelines (Department of Health, 2008) states that pregnant women visiting public health facilities for antenatal services should be offered HIV and AIDS education, HIV counselling and testing, anti-retroviral drugs, infant regime, family planning, infant feeding methods and infant vaccination.

2.3.1 HIV AND AIDS EDUCATION

Education on HIV and AIDS is conducted at the waiting area in public health institutions, as patients are gathered and awaiting to receive their clinical servics. HIV and AIDS education involves topics like HIV infection, transmission and prevention, condom usage, abstenance and sexualy transmitted infections, to name a few.The South African PMTCT policy and guidelines states that public health facilities should provide information on HIV and AIDS and its transmission to all pregnant women attending antenatal services in a group or one on one (Department Of Health, 2008). A study conducted in Thyolo district in rural Malawi

between March 2002 and September 2003 found that all pregnant women attending the PHC received education on HIV and AIDS as well as other PMTCT information (Manzi, Zacharia, Teck, Buhendwa, Kazima, Bakali, Firmenich & Humbelet, 2005:1246).

A study which was conducted by Scott, Chopra, Conrad and Ntuli (2005:112) to assess the extent of inequalities in availability and utilisation of HIV services across South Africa found that VCT and PMTCT services in the urban sub-districts of Khayelitsha were much more accessible and used effectively and efficiently than those in poor sub-districts. The study also found that the number of people tested for HIV in poorer districts of Khayelitsha was lower than the number of those tested for HIV in urban sub-districts though there were trained staff and sufficient testing kits. In another study which was conducted by Skinner, Mfecane, Gumede, Hendaand Davis (2005), which looked at lack of transport as a hinderence in participating in PMTCT programme, it was found that transport was the barrier in accessing PMTCT services in rural areas of the Eastern Cape, specifically Flagstaff. Flafstaff district was found to be the poorest and least developed area in South Africa with limited public transport due to poor quality of the roads. Only one bus travelled in early hours of the morning and very late in the afternoon, which becomes a challenge when a pregnant woman goes into labour and requires visiting the clinic to access PMTCT services (Skinner et al., 2005:117-122). It was also found that very few villagers own vans, the only vehicles able to survive poor quality roads in the area. The distance from the clinic to the village is far, making it difficult and expensive for villagers to hire vans from neighbours in order to arrive at the clinic in time. In many cases, people die before they get to the clinic since they have to wait for long hours to get an ambulance (Skinner et al., 2005:117-122).

2.3.2 HIV COUNSELLING AND TESTING

HIV counselling and testing (VCT) is the most important component of PMTCT. A high quality of VCT is important for success, and if done well it will result in significant reduction in child mortality through decrease postnatal HIV transmission and improved infant feeding practices. However if done badly, it could lead to deaths from diarrhoea and other infections, increased drug resistance, and the spread of poor infant feeding practices into general

population (Chopra et al,2005). This shows the importance of ensuring that all pregnant women attending antenatal services at the clinic are offered with VCT.

The PMTCT policy and guidelines state that pregnant women visiting public health facilities for antenatal services should be offered HIV Counselling and Testing (HCT) as part of PMTCT package (Department of Health, 2008). There is increasing evidence that VCT reduces reported risk behaviour and prevents new infections. Measuring the quality of VCT in PMTCT programme, and the possible factors that influence quality, is therefore very important (Chopra et al., 2005). In his study in Kenya, Delva, Mutunga, Quaghebeur and Temmerman (2006:588-589) found that the topics regarding safe sex were covered vaguely during pre-test counselling whereas this group of pregnant women was at a higher risk of acquiring HIV infection in comparison to the average population. This shows how important it is to ensure that all relavant topics are covered in details during pre-test counselling when conducting VCT.

2.3.3 ANTI-RETROVIRAL DRUGS

When the PMTCT programme was implemented nationally in 2002 in South Africa, a single dose tablet known as Nevirapine (NVP) was issued by the registered health care professional to an HIV-positive pregnant woman at 34 weeks (Department of Health, 2008). The NVP tablet had to be swallowed by the woman when she experienced labour pains and the tablet could not be re- swallowed if labour was false. The baby born by a HIV-positive woman had to be given NVP syrup soon after birth (Department of Health, 2008). The PMTCT policy and guidelines state that pregnant women presenting in labour who are not on any anti-retroviral drugs (either unbooked or HIV status unknown) should be offered VCT in the first stage of labour; if found to be HIV-positive they should be given anti-retroviral drugs in the form of Nevirapine syrup (sdNVP) during labour (Department of Health, 2010).

According to WHO (2010), the initiation of ART is recommended to all HIV-positive and pregnant women who have the CD4 cell counts of ≤350 cells/mm3, irrespective of WHO clinical staging, and for all women in WHO clinical stage 3 or 4, irrespective of the CD4 cell count. All HIV-infected pregnant women in need of treatment for their own health should

start ART irrespective of gestational factors and age and should continue with it throughout pregnancy, delivery, during breastfeeding (if breastfeeding) and thereafter (WHO, 2010).

2.3.4 INFANT REGIME

According to WHO (2010), a short duration of antiretroviral prophylaxis (for 4-6 weeks) is indicated for infants born to HIV-infected women receiving ART to further reduce peripartum and postpartum HIV transmission, in addition to the protection received from the mother's ART regimen. WHO further states that regardless of infant feeding choice, infant prophylaxis provides added protection from early postpartum transmission, particularly in situations where women have started ART late in pregnancy, have less than optimal adherence to ART and have not achieved full viral suppression. The choice of infant prophylaxis should be guided by national programme considerations with regard to experience, availability, feasibility and potential toxicity (WHO, 2010).

The PMTCT policy and guidelines by the Department of Health (2008) state that ARVs given soon after birth to infants born to women who are HIV-positive have been found to be an effective strategy for reducing MTCT, whether maternal ARVs are received or not, and forms the basis of a post-exposure prophylaxis strategy (Department of Health, 2008). The policy further states that the administration of sdNVP and a 7-day course of AZT prescribed by a registered health professional (in line with the relevant legislation and regulations) to the infant have been shown to be effective in reducing MTCT (Department of Health, 2008).

Infants born to women who received optimal PMTCT or HAART should receive sdNVP soon after birth or within a 72-hour period. AZT prescribed according to regulatory requirements should be commenced soon after birth and administered for seven days (Department of Health, 2008). Infants born to women who received suboptimal PMTCT or HAART where no maternal ARVs were taken, or where maternal ARVs (PMTCT or HAART regimen) were taken for less than four weeks, or where women received only sdNVP their infants should receive sdNVP immediately after birth (Department of Health, 2008).

The standard national eligibility criteria for starting ART regimes for infants and children as stated in the treatment guidelines (2010), is that all children less than one year of age and

children one to five with clinical stage 3 and 4 can begin ART as well as those with CD4 less than 25% or absolute CD4 count less than 750 cells. Furthermore, children over age five to 15 years with clinical stage 3 or 4 and CD4 less than 350 cells can also be administered with ART (Department of Health, 2010).

2.3.5 FAMILY PLANNING

Family Planning or contraception is one of the cornerstones of the PMTCT programme. Women need to be advised on the advantages of birth spacing and the disadvantages of having many children, especially those who are HIV-positive and whose immune system is compromised (Department of Health, 2008).

A study conducted by Peltzer, Wei Chu and Dana(2008:975-978) which investigated family planning needs, knowledge of HIV transmission and HIV disclosure in a cohort sample that had undergone PMTCT in a resource-poor setting, found that from 116 HIV-positive women (76.3%) and from 642 HIV-negative women (85.2%) received counselling on safe sex during pregnancy. Only 65.8% and 62.3%, respectively, practised safe sex during pregnancy and this did not differ by HIV status. During postnatal visit, almost all women (92.2% HIV-positive and 92.7% HIV-negative) received counselling on family planning. The study also found that the most frequent method of contraception among both HIV-positive and HIV-negative women was condoms, followed by hormonal injections and pills (Peltzer, 2008).

Part of counselling, as stipulated in SA PMTCT policy and guidelines, states that all women should be counselled on family planning methods (Department of Health, 2008). Another study conducted by Strachan, Kwateng-Addo, Hardee, Subramaniam, Judice and Agarwal (2004:7) looked at the analysis of family planning content in HIV and AIDS, VCT and PMTCT policies in 16 countries and found that family planning has to be included in efforts to prevent MTCT. The authors mention that women participating in PMTCT interventions should have access to family planning, counseling services and information about the benefits of birth spacing as this can help HIV-positive and HIV-negative women plan for future pregnancies. Further, referral to family planning services should be available to clients who desire a family planning method and in countries with high HIV prevalence, there may be

instances where family planning clinic can offer HIV counselling and either provide VCT or refer clients for testing (Strachan et al., 2004:8-12).

A study conducted by Dalal, Andrews and Dawad (2011) in Bangladesh to examine the association between contraception use and intimate partner violence (IPV) among women of reproductive age found that of the 10,996 respondents 79% women had used some method of contraception. Forty-three per cent of all women were using modern methods, 8% were using traditional methods, 29% were non-users, but intended to use and 20% of women were non-users and never intended to use any contraceptive methods (Dalal et al., 2011:92).

2.3.6 INFANT FEEDING METHODS

The South African national PMTCT programme adopts an approach to infant feeding that seeks to maximise child survival. According to the South African PMTCT policy and guidelines, infant feeding counselling should take cognisance of the specific circumstances of the pregnant woman or mother, including her individual ability to meet the Acceptability, Feasibility, Affordability, Safety and Sustainability (AFASS) criteria to ensure appropriate infant feeding choices are made (Department of Health, 2008). A randomised controlled trial which was conducted in an urban PMTCT setting in Kenya found that infants in the formula-feeding group whose mothers had access to clean water, free formula and frequent support by health workers, had a 40% lower risk of HIV transmission (Doherty, Chopra, Jackson, Goga, Colvin & Persson, 2007). Doherty et al. (2007:1792) note that within this randomised controlled study conducted in Kenya, in only three cases was the mother asked about access to clean water, fuel and fridges before deciding upon a feeding option.The recommendation by the World Health Organisation (WHO) and UNICEF for HIV-positive women is avoidance of all breastfeeding only if replacement feeding is acceptable, feasible, affordable, sustainable and safe (Doherty et al., 2007:1792).

The AFASS criteria, as stated in the SA PMTCT policy and guidelines, require that the mother should perceive no barrier in choosing and executing the option for cultural or social reasons, or for fear of stigma and discrimination (Department of Health, 2008). The criteria requires the mother (or family) to have adequate time, knowledge, skills and other resources to prepare and feed the infant, and the support to cope with family, community and social

pressures (Department of Health, 2008). The mother and her family should be able to afford payments for the purchase, preparation and use of the feeding option, including all ingredients such as fuel and clean water and any other equipment, without compromising the health and nutrition spending of the family (Department of Health, 2008). If the woman decided to give the infant formula milk, she should ensure formula milk is correctly and hygienically prepared by clean hands, using clean, safe water and clean utensils (Department of Health, 2008).

A study by Oladokun, Brown and Osinusi (2010) that evaluated the infant-feeding choice practices and possible determinants among HIV-positive women enrolled in a prevention of mother-to-child transmission programme in Ibadan (Nigeria) found that the choice of infant feeding was the formula milk in 92.5% of the women and only 6.2% of women chose to exclusively breastfeed their infants. Only three women opted to mix feed their infants (give both formula milk and breastfeed) and this included two women who had twin babies (Oladokun, 2010:1110-1114). The study also found that the key reason which influenced the choice of infant feeding was the need to reduce the risk of transmission which was recorded among 84.6% of the women (Oladokun, 2010:110-1114).

The policy and guidelines (2008) further state the importance of individualised feeding counselling as it is critical in enabling women to make the feeding choice that will maximise HIV free survival.The South African Infant and Young Child feeding policy and implementation guidelines and the Baby Friendly Hospital Initiative (BFHI) - including the ten steps to safe infant feeding, as outlined in the BFHI – provide a framework to facilitate feeding support for HIV-positive and HIV-negative women (Department of Health, 2008).

According to the PMTCT protocols and guidelines by the Department of Health (2008) all health care personnel, lay counsellors and community caregivers should receive standardised training in infant feeding counselling and HIV. Secondly, trained health care personnel should provide high quality and unbiased information about risks of HIV transmission through breastfeeding and risks of replacement feeding. Thirdly, counselling on infant feeding must commence after the first post-test counselling session and infant feeding should be discussed with women during every antenatal visit. Fourthly, mixed feeding should be strongly discouraged as it predisposes to childhood infections and increases the risk of HIV transmission in HIV-positive women (Department of Health, 2008). The PMTCT clinical

guidelines (2010) by the Department of Health state that free commercial infant formula should be provided to infants for at least six months and mothers should receive practical support including demonstrations on how to safely prepare formula and feed the infant. It further states that at six months infants with or at risk of poor growth should be referred for continued nutritional monitoring and dietary assistance, appropriate formula milk product for the infant's age and circumstances should be chosen and lastly infants weighing less than 2 kg should receive a special low birth weight formula until they weigh at least 2 kg after which formula should be given for a term and a soy protein-based formula should not be given to an infant less than 2kg (Department of Health, 2010).

All health care workers caring for mothers, infants and young children should fully adhere to all the provisions of the International Code of Marketing of Breast Milk Substitutes and its subsequent resolutions, which will be superseded by the South African Regulations relating to Foodstuffs for Infants, Young Children and Children once they are promulgated. These regulations have been adapted to allow for infant feeding in the context of HIV. In cases where the commercial formula is provided free of charge at the health facilities,managers, supervisors, and health care personnel should ensure an uninterrupted supply at the clinic level. A reliable procurement and distribution system should be put in place (Department of Health, 2010).

2.3.7 INFANT VACCINATION

The PMTCT guidelines state that all children are required to receive immunisation at six, ten and fourteen weeks and at nine months and eighteen months. It is strongly recommended that an HIV PCR test be perfomed on infants between five and six months and whose mothers meet the AFASS criteria to inform the decision to stop exclusive breast feeding (EBF) at six months. If the infant is confirmed HIV-positive, breastfeeding should continue and if HIV-negative, breastfeeding can be stopped and the infant should be re-tested six weeks after breastfeeding has stopped, using PCR if less than18 months or HIV ELISA, if more than18 months (Department of Health, 2008).

A study by Wilkison et al. (1997) at Hlabisa Health District found that 4% of mothers reported that their children had never been vaccinated, whilst 0,6% did not know whether

their children had received vaccination or not. Seventy-six percent of mothers believed they had completed the schedule of vaccination whilst 20% believed they had not and 8% did not know. Of the 459 mothers who reported any vaccination, 93% reported that they had attended the same site each time (Wilkison, 1997:668-670).

Infants vaccinated at the private sector were 1.7%. However, when asked only 40% of mothers indicated that they would take their children for vaccination if they had fever, cough or diarrhoea; 57% indicated they would not take their children for vaccination. Only 3% of the 480 children surveyed had never received a Road to Health Card (RTHC); 73% had RTHC available for inspection during the survey; 61% reported that the RTHC card was locked away at home and unavailable for inspection (Wilkison et al., 1997:668-670).

The study by Wilkison et al. (1997) was conducted when the PMTCT programme was not yet implemented, but PMTCT policy and guidelines were already in place which had to be followed by health care professionals. Health care professionals had to ensure that all infants discharged from the hospitals and clinics were issued with the road to health cards, as outlined in the protocol.

2.4 Opportunities and barriers to participation in the PMTCT programme

2.4.1 Lack of Transport

According to a study by Skinner, Mfecane, Gumede, Hendaand Davis (2005), there are numerous factors hindering women from participating in PMTCT programmes in South Africa. The study assessed barriers to PMTCT service in rural areas of the Eastern Cape, specifically Flagstaff, and found that one of the barriers in accessing the PMTCT programme was lack of transport. Flagstaff district was found to be the poorest and least developed area in South Africa with limited public transport due to poor quality of the roads. Only one bus travelled in the early hours of the morning and very late in the afternoon, which becomes a challenge when a pregnant woman goes into labour and requires visiting the clinic to access PMTCT services (Skinner et al., 2005:117-122). In Flagstaff, it was also found that very few villagers own vans, the only vehicles able to survive poor quality of the roads in the area. The distance from the clinic to the village is far making it difficult and expensive for villagers to hire vans from neighbours in order to arrive at the clinic in time. In many cases, people die

before they get to the clinic since they have to wait for long hours to get an ambulance (Skinner et al, 2005:117-122).

2.4.2 STIGMA, DISCRIMINATION AND DENIAL AGAINST HIV-POSITIVE PEOPLE

Stigma is a complicated process and usually affected by dynamics such as race, gender and socio-economic status. Goffman (2009:4-5) defines stigma as a 'significant discrediting' attribute possessed by a person with an 'undesired difference'. It is a powerful means of social control applied by marginalising, excluding and exercising power over individuals who display certain traits. The author further states that a stigmatised individual is a person with a 'spoiled identity' who is 'rendered unworthy' by others (Goffman, 2009:4-5).

A study conducted by Kalichman and Simbayi on AIDS stigma in 2003 found that the AIDS stigma items reflected negative beliefs about people living with AIDS, for example, dirty, cursed, untrustworthy and shamefulness of the behaviour of people with AIDS. The results showed that individuals who had not been tested for HIV held significantly greater AIDS-related stigmas than individuals who had been tested. People who had not been tested were more likely to agree that people with AIDS are dirty and should feel ashamed and guilty. Individuals who were not tested were also more likely to believe that people with AIDS must have done something wrong to have AIDS and were more likely to endorse that they would rather not be friends with someone who has AIDS. The Kalichman and Simbayi study added that those who had not been tested were more likely to agree that people with AIDS should not be allowed to work with children. For people who had been tested, there were no significant differences between those who knew their results and those who did not know their test results on AIDS stigmatising (Kalichman & Simbayi, 2003:443-444).

Tackling stigma – which is itself an expression of denial – was, and remains, a great challenge. In this respect, simple devices such as the 'HIV-positive' T-shirt has proved to have remarkable power in confronting people's attitudes about HIV at the same time as emerging as a badge of the activist community and signifying both solidarity between the living and tribute to those who have died. The first HIV-positive T-shirt carried the picture of murdered NAPWA activist, Gugu Dlamini, and the slogan 'Never Again'. Since then, there

have been numerous further 'editions' (Treatment Action Campaign, 2000). There have been a number of incidents reported in South Africa on AIDS stigma, including the murder of Gugu Dlamini in December 1998 for publicly disclosing her HIV-positive status (Treatment Action Campaign, 2000). Tallis (2002) study on stigmatisation and HIV revealed that only one third of participants who had revealed their HIV status were positively accepted in their communities. One out of 10 indicated that they had been met with hostility and rejection.

Reports of stigma are pervasive, extending even to the health professions. The AIDS Law Project reported that the Health Professions Council of South Africa failed to act against 28 doctors who breached patient confidentiality. Many of the patients who were mostly domestic workers, whose employers had been told of their diagnosis, were dismissed (Skinner et al., 2005).

A study done by Oanh, Ashburn, Pulerwitz, Ogden, Nyblade (2008) at a Vietnamese hospital to address HIV-related stigma and discrimination and improve the quality of care in the health care setting found that the levels of fear of casual contact with HIV-positive individuals that would lead to HIV infection was very high. Almost half of hospital workers (48%) feared sharing utensils with HIV-positive individuals, and 37% feared touching the skin of a person who was infected with HIV. Hospital workers with high exposure to bodily fluids in their daily work reported the highest level of fear-based stigma (Oanh et al., 2008:2).

Stigmatising attitudes reflecting negative value judgments were also common. At least 40 percent of all hospital workers in each of the hospitals reported that HIV was a punishment for bad behaviour, and nearly 40%reported that HIV-positive individuals should be ashamed of themselves. More than a third of hospital workers in each hospital also felt that they would feel ashamed if they were also infected with HIV(Oanh et al., 2008:2). The authors add that discriminatory practices were very common such as signs on the bed or outside patient files indicating a patient's HIV status or the clothes of HIV-positive patients being burned when no longer being used by the patient. Furthermore, approximately half of the hospital workers reported fear of HIV transmission and related stigmatising attitudes led them to treat HIV-positive patients differently, for example, avoiding to touch them or avoiding them altogether. Almost half of hospital workers reported using gloves, or a mask at all times when attending to a patient with HIV, even during casual contact with patients. In each of the four hospitals, workers who reported high levels of fear-based stigma were more likely to report

overusing barrier protections (p<.001). In qualitative interviews, hospital workers often described situations in which patients with HIV were treated in a discriminatory way in an effort to "protect" themselves or other patients from becoming infected with HIV. The interviews also revealed that many hospital workers felt bad about their discriminatory practices (Oanh et al., 2008:2).

2.4.3 DISCLOSURE

As part of pre-test counselling, as outlined by Department of Health in guidelines for the implementation of the PMTCT protocol, it should be explored if the person who came for testing has somebody he/she is willing to disclose his/her HIV status to should it be found that this person is HIV-positive. Through the PMTCT programme, men are encouraged to disclose their HIV-positive status to their partners should they be found to be infected and encourage their partners to test for HIV (Department of Health, 2008).

Brou, Djohan, Becquet, Allou, Ekouevi, Viho, Leroy and Desgrees-du-Lou (2007) conducted a study in Abidjan to investigate if women tested for HIV within PMTCT programme were able to disclose their HIV-positive status to their partners and encourage them test for HIV. The study found that disclosure happened just before delivery, sometimes during early weaning at four months to prevent HIV postnatal transmission and upon resumption of sexual activity. The partners of HIV-positive women who were informed of their partners' status were more likely to undertake HIV testing than those who were not informed (Brou et al., 2007:1914).

2.4.4 MALE INVOLVEMENT AND SUPPORT

According to a study by Byamugisha, Tumwine, Semiyaga and Tylleskar (2010), men who had eight years or more of education were two times likely to get involved in PMTCT programme. Men who were aware of their HIV-positive status were four times more likely to get involved in PMTCT programme. Those who had heard about the PMTCT programme were two times likely to get involved and those who feared to disclose their HIV-positive status to their spouses were less likely to involve themselves in PMTCT programmes

(Byamugisha et al., 2010:4). The study also found a number of factors that hinder men from participating in the PMTCT programme. Men in the focus group mentioned that rudeness and rough handling of HIV-positive and pregnant women by health care workers discouraged them from participating in PMTCT programme. Further, the fact that they were not allowed to attend antenatal clinics with their pregnant partners negatively affected attendance. Additionally, lack of space to accommodate both pregnant women and their partners in most public health clinics'waiting rooms, which are too congested to accommodate women let alone their partners, also had a negative impact. Finally, women who were not accompanied by their partners were uncomfortable sitting in a waiting area with strangers. Cultural factors were also discussed as some men believe that it is unmanly to accompany a wife to an antenatal clinic as it is women's business.

Men were asked, through focus group discussions, what their thoughts were for improving the situation regarding the HIV scenarios. Their responses were that men should be sensitive about ANC and PMTCT and their benefits; a refresher course needed to be conducted for midwives and nurses; men should be invited by health care workers to ANC using their wives' cards for them to be acquainted with the clinic; government should bring services closer to the people; welfare of staff should be improved and more staff should be recruited into the health service (Byamugisha et al., 2010:5-6). A meeting of experts held in Geneva in 2008 on "Equal sharing of responsibilities between women and men including care-giving in the context of HIV and AIDS"recommended the following: positive contributions already shown by some men of shifting social norms should be recognised and other men to be promoted to do the same; men and boys to be trained to provide care and support; building on existing civil society models and innovative initiatives aimed at engaging men; integrating a focus on engaging men and boys into existing AIDS plans and policies, including especially national AIDS plans; improving the health system's capacity to reach men with HIV prevention and treatment services so as to reduce the burden of care; and taking gender transformation work with men to scale by integrating a focus on men and gender equality into national programmes and policies that can reach large numbers of men and boys (Byamugisha et al., 2010:6-8).

Another study conducted by Theuring, Mbezi, Luvanda, Jordan-Harder, Kunz and Harms (2009:95) in Mbeya region in Tanzania to assess male attitudes regarding partner involvement in ANC or PMTCT services found that of the 124 interviewed respondents 68%

stated they knew what PMTCT was; 26% declared that they did not know anything about PMTCT and 6% stated they partly knew what it was. Most respondents (123 out of 124 persons, 99%) stated they approved of PMTCT interventions and 82% stated they would also approve of infant feeding alternatives to breastfeeding in order to save a baby from infection. Sixteen respondents (13%) did not agree to all this and (5%) were undecided. From 22 respondents who did not provide a positive answer on infant feeding support, more than three quarters were married and had children (Theuring et al., 2009). It is, thus,vital that HIV-positive and pregnant women get support from their partners, family members and friends, people who will assist them in looking after their children as they regularly go for antenatal visits at the clinic.

2.4.5 MONITORING AND EVALUATION

Dunn (1994:335) states that monitoring is the policy-analytic procedure used to produce information about the causes and consequences of public policies. Monitoring permits analysts to describe relationships between policy-programme operations and their outcomes as the primary source of knowledge about policy implementation (Dunn, 1994:335). In one sense, monitoring is simply another name for efforts to describe and explain public policies. As such, monitoring represents "a way to make designative claims about past and present policy actions". Monitoring and evaluation is crucial within the Department of Health, to ensure that the policies and protocols which have been developed are being implemented (Department of Health, 2008).

In his State of the Nation address in 2009 President Jacob Zuma called for the establishment of Performance, Monitoring and Evaluation unit to ensure that public servants' performance is up to standard for service delivery to be improved. In January 2010, the Department of Performance Monitoring and Evaluation was established by government to ensure that public officials' performance has a meaningful impact on citizens' lives. The department, in close cooperation with the National Planning Commission, now plays an important role in setting expectations of improved outcomes across the three spheres of government (The presidency of the Republic of South Africa, 2011).

According to Dunn (1994:19), monitoring provides policy-relevant knowledge about the consequences of previously adopted policies, thereby assisting policymakers in the policy implementation phase. In addition, Dunn states that many agencies regularly monitor the outcomes and impacts of policies by means of various policy indicators in the areas of health, education, housing, welfare, crime and science and technology.

The policy and guidelines for implementation of the PMTCT programme by the Department of Health (2008) state that monitoring and evaluation of the PMTCT programme is essential and should be guided byinformation flow from both directions as this is important in measuring quality and ensuring that there is improvement in surviving delivery. This includes regular assessment meetings at all levels as well as the provision of individual attention to sites that report problems and unsatisfactory statistics.In addition, the minimum national set of indicators for the PMTCT programme should be collected at the following stages of the intervention: antenatal care including routine offer of voluntary HIVcounselling,testing and retesting; administration of PMTCT prophylaxis to mother during delivery; administration of PMTCT prophylaxis to infant and feeding choice; follow-up for mother and child, and infant testing and feeding (Department of Health, 2008).

2.4.6 MISSED APPOINTMENTS

A study which evaluated missed opportunities for participation in PMTCT programme in South Africa conducted by Nkonki et al. (2007) found that some women participants missed their NVP tablets because of lack of monitoring and evaluation by the Department of Health. Six out of fifteen women participants reported not to have been tested during antenatal care because there were no HCT counsellors during that period; others reported they were informed that the testing kits were not available at the facility.

Of the respondents who tested for HIV, some reported not to have received their HIV test results in time; some received their HIV test results after delivery, thus failing to receive and use NVP tablet as prescribed by the PMTCT guidelines and others reported to have been tested a day before their delivery (Nkonki et al., 2007:3). There were also respondents who tested for HIV and received their HIV test results, but did not take their NVP tablets with them. Some respondents reported a lack of treatment supply from the facility, incorrect

instructions from health care workers about when to take the tablet and stigma and ignorance (Nkonki et al., 2007:3).

According to Nkonki et al (2007:4), there were series of missed opportunities that led to women not receiving NVP according to the national PMTCT protocol. For instance HIV testing serves as an entry point to PMTCT and yet the majority of respondents were not tested for HIV due to health system failures.

2.5 CONCLUSION

The literature reviewed highlights how public health clinics were run before 1994, where people had to pay for clinical services. It further highlights new policies and programmes introduced after 1994 by the ANC government in order to address health problems. In addition, the chapter outlined statistics on HIV and AIDS before the PMTCT programme was implemented nationally in 2002 as well as recent figures which indicate a decline in baby mortality rates caused by mother to child transmission of HIV. Studies on PMTCT programme which were conducted in different countries after the programme was implemented have been referred to.

The chapter also discussed the importance of HIV testing by pregnant women in order to protect the unborn child. If a pregnant woman is found to be HIV-positive she is encouraged to do a test (CD4 count test) which will determine the number of infected cells in her body. According to the PMTCT policy and guidelines by the Department of Health (2013), if the number of infected cells in a persons' body are less than 350 (CD4<350), the infected person should commence medication immediately. Women found to be HIV-negative are encouraged to stay negative and counselled to use condoms all the time and eat healthy food. Literature shows that women are educated on infant feeding choices. Those who decide to exclusively breastfeed are encouraged to do so for the next six months. It is also important for HIV-positive women to disclose their status to family members and friends in order to be supported should they need to pay regular visits to the clinic or hospital.The next chapter focuses on the research methodology.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methods and processes used in the study as well as the reasons for choosing the method.The researcher chose qualitative research method, which explored the meanings, variations and perceptual experiences of phenomena (Crabtree & Miller, 1992:6)). This method is chosen in order to enable participants freely narrate their stories. Various research instruments were used during the data collection process, which are detailed in this chapter.

The study assessed the administration and implementation of the PMTCT protocol and guidelines and chose a system which allowed participants to narrate, to a large extent, what they felt comfortable discussing with the researcher.

3.2 RESEARCH DESIGN

A research design is the way the researcher attempts to formulate his/her research questions. It consists of a plan and a roadmap that allows him/her to test the validity of his/her hypothesis or answers to his/her questions, taking into account the factors that he/she believes might affect the relationship between the dependent and independent variables (Webb & Auriacombe, 2006:589).

According to Neuman (1997:19-21), research dimensions can be broken down into three categories: namely, exploratory, descriptive and explanatory research. Exploratory research deals with new issues or topics that have not been researched before in order to learn more about these issues or topics. Descriptive research, describes an already developed social phenomenon and explanatory research concerns itself with the “Why”, and asks questions such as why things are happening the way they are happening.

It should be noted that research methodology is different from a research design in that research methodology refers to "methods, techniques, and procedures that are employed in the process of implementing the research design or research plan" (Babbie & Mouton 2005:104). Some research designs are specific, detailed and have specifically formulated decision steps, while others tend to be more flexible, semi-structured and open ended (Babbie & Mouton, 2005:104).

The research design chosen for this study was the case study design. Research participants were health care professionals based in public health facilities under study, PMTCT managers or coordinators and patients attending antenatal and postnatal services in three public health clinics in uMgungundlovu district municipality. The three public health clinics where the study took place were a sub-set of the public health clinics nationally. According to Yin (1989:18), a case study is an inquiry that investigates contemporary phenomena with a real life-context where the boundaries between phenomenon and context are not evident, and in which multiple sources of evidence are used.

MacNabb (2002:286) indicates that there are several definitions of case studies. Bonama (in MacNabb 2002:286) states that a case is a description of management situation based on interview archives, naturalistic observation and other data, constructed to be sensitive to the context in which management behaviour takes place and to its temporal restraints. It consists of detailed investigation often with data collected over a period of time, of phenomena with their context (Cassel & Symon, 2004:324) and the aim is to provide an analysis of the context and processes which illuminate the theoretical issues being studied.

3.3. QUALITATIVE RESEARCH METHOD

A case study approach to qualitative data collection was used by drawing on open-ended interview questions and participant observation using an interview guide. This method also allowed the researcher to probe for more clarity and to rephrase questions where and when necessary.

Qualitative research methods explore issues and try to understand phenomena. According to Babbie and Mouton (2001:270), qualitative research attempts to study human action from the perspective of the social actors themselves. Webb and Auriacombe (2006:61-66), citing

Bryman (1999), state that qualitative research is committed to viewing events, norms and values from the perspective of the people who are being studied. These researchers provide detailed descriptions of the social settings they investigate, which enables them to understand the subject's interpretation of what is going on. In addition, qualitative scholars attempts to understand events and behaviour in the context in which they occur following a holistic approach. Finally, qualitative researchers' view life as streams of interconnecting events, an interlocking series of events and as a process of constant change (Webb & Auriacombe, 1995:61-66). In sum, therefore, the qualitative research methodology was chosen because of its flexibility in exploring issues and answering questions such as why people behave in certain ways. The qualitative research methodology was chosen because of its advantages, outlined in the next section.

3.3.1 ADVANTAGES OF USING QUALITATIVE RESEARCH

One of the advantages of using qualitative research methods, as noted by Cresswell (2009), is that it tends to be more flexible as it allows for more adaptation from respondents when responding to questions. For instance, open-ended questions have the ability to evoke responses that are meaningful and culturally salient to the participant,unanticipated by the researcher, rich and explanatory in nature.

Cresswell (2009:62) states that qualitative methods are typically more flexible as they allow greater spontaneity and adaptation of the interaction between the researcher and the study participant. For example, qualitative methods ask mostly open-ended questions that are not necessarily worded in exactly the same way with each participant. The relationship between the researcher and the participant is often less formal than in quantitative research. Participants have the opportunity to respond more elaborately and in greater detail than is typically the case with quantitative methods. Further, qualitative research method captures the socio-emotional nuances that are often overlooked by the quantitative approach (Cresswell, 2009:62). In applying the qualitative research methods during this study, the researcher was able to obtain sufficient information and was aware of the disadvantages and limitations, some of which are explained in the next section.

3.3.2 DISADVANTAGES OF USING QUALITATIVE RESEARCH

One major disadvantages of using qualitative research methods, as stated by Malterud (2001:483), is that the use of open-ended interview questions allows too much flexibility from participants and large amounts of data are collected which becomes challenging during analyses. Another disadvantage is that they are too formal and too narrative and shy participants may not be able to express themselves in front of the interviewer, resulting in not much information being obtained. Lastly, the researcher's background and position will affect what he/she chooses to investigate, the angle of investigation and the methods judged most adequate (Malterud, 2001:483). Validation by consensus or repeatability is seldom adequate in qualitative research. The investigator always enters a field of research with certain opinions about what it is all about (Malterud, 2001:484).

The disadvantages of using open-ended interview questions during this study were that participants gave responses which were not direct and had to be probed several times for detailed information. For instance when one HIV- positive participant was asked "Did the health care professional explain what it means to be HIV- positive to you and the baby" her response was " I don't remember but I know that HIV is the same like other diseases, you should have a positive mind, take care of yourself and follow instructions". Another disadvantage was that most participants between the ages of 19 and 25 years were younger than the interviewers, which made it difficult for them to express themselves freely when discussing sexual matters. In order to address this disadvantage, the study participants were assured of confidentiality and anonymity. They were encouraged to talk as freely as they can with the interviewers as all information collected was for research purposes only and they were not going to be judged by the responses they shared with the interviewers.

3.4 TARGET POPULATION OF THE STUDY

According to O'Sullivan and Rassel (1989), 'population' refers to the total set of units in which the investigator is interested, the largest set from which the sample is drawn. The authors' further state that a population may be composed of people, but it may also consist of units such as government organisations, households, businesses, records or pieces of

equipment (O'Sullivan &Rassel, 1989:121). The population of this study refers to women attending antenatal and postnatal services in three public health clinics.

Neuman (2000:216) states that a target population refers to the specific pool of cases that a researcher wants to study. Units in a population must all conform to a set of specification (O'Sullivan & Rassel, 1989:121).The study took place in three public health clinics (PHC) within uMgungundlovu health district (Mbalenhle, Caluza and KwaPata). One research assistant (RA) was recruited to assist with data collection after appropriate training was provided to the RA on the study aims. The study sought responses to experiences from the participants who were attending antenatal or postnatal services in public health facilities.

The target population consisted of participants who voluntarily agreed to participate in the study. These included the following: four health care professionals working at KwaPata clinic within antenatal, maternity or with PMTCT programme consisting two HCT counsellors, sister-in-charge and a nurse who were fully responsible for PMTCT. Three other nurses were neither involved nor trained on PMTCT matters.

The study also included three health care professionals working at Caluza clinic within antenatal or maternity departments with PMTCT programme. The interviewees were two nurses and the sister-in-charge, both of whom were involved in PMTCT programme. There was also a non-governmental organisation (NGO), which was based at the clinic named Mothers to Mothers (M2M) and traditional healers who were fully engaged in PMTCT matters. The respondents at Mbalenhle clinic within ANC/maternity department or with PMTCT programme involved three health care professionals involved in PMTCT. These included two nurses out of four who were also involved in PMTCT and one counsellor out of three involved in PMTCT. In total, ten health care professionals were interviewed in all three clinics under study.

Four pregnant women attending KwaPata clinic were selected to participate in the study. On 11 July 2011, 13 pregnant women had visited the clinic for ANC, which is run twice a week. Every third woman was recruited and enrolled into the study, if she was pregnant and had come for antenatal services on the day and voluntarily agreed to participate within the study. This was done in order not to interrupt the clinic flow and was implemented after observing how long it took the health care professional to complete clinical observation on one patient. It was also implemented in order to avoid patients fighting over their places in line, and

curiosity on who is selected and why. The permission to assess the clinic records had been sorted from the sisters in charge in all three clinics prior to commensing with the study. It was explained to them that these were to be used for statistical purposes only within the study, and will not be discussed outside of clinic level. According to the clinic records, on average a month (as per clinic register) 58 women visit the clinic for ANC.

Three pregnant women were selected from Caluza clinic. Fifteen women had visited the clinic on 14 July 2011 and every third woman was recruited and enrolled in the study, if she was eligible, for instance, pregnant and came for antenatal service on the day and willing to participate within the study. On average per month 72 (as per clinic register) pregnant women attended ANC services as it was run four days a week. Three pregnant women were selected from Mbalenhle clinic: 18 had attended ANC services on 13 July 2011 and on average per month 270 (as per clinic register) women attended ANC services, which were run daily.

Three women who had given birth to babies not older than 12 months were selected and interviewed for the study at KwaPata clinic. There were six women who had visited the clinic for postnatal services on 13 July 2011. On average per month, 23 women (as per clinic registers) visited the clinic for postnatal services. Out of eight who had come for postnatal services, registers revealed that on average a month 28 (as per clinic register) women visited the clinic for postnatal services. Onewoman who had given birth to a baby not older than 12 months was also interviewed at Mbalenhle clinic.This was because most women did not come back for postnatal services. On average 40 women (as per clinic registers) returned for postnatal services. Lastly, three PMTCT coordinators were interviewed; they were not based at the clinics, but managers of the three clinics under study.

The women who participated in the study attended antenatal and postnatal services were aged between 18 and 49 and identified by the health care professionals after their consultation. They were advised to go to the research assistant who began the conversation with them in line with the research instruments. The health care professionals were recruited from antenatal and postnatal sections. The PMTCT coordinators were recruited from the district office, where they were based.

3.5 SAMPLE SIZE

According to O'Sullivan and Rassel (1989:121), a sample is a subset of units selected from a large set of the same units. The subset provides data for use in estimating the characteristics of the large set.

In total, 30 participants were interviewed: 10 health care professionals, 10 pregnant women, 7 women who had given birth to babies not older than twelve monthsand 3 PMTCT coordinators or managers. The study participants were all above the age of 18 years.

Table 3.1 shows the breakdown of participants interviewed from each PHC under study.

Table 3.1: Participants recruited for the study

	Kwapata clinic	Caluza clinic	Mbalenhle clinic	Total number
Healthcare professionals	4	3	3	10
Pregnant women	4	3	3	10
Women who have given birth	3	3	1	7
PMTCT coordinators/ managers	1	1	1	3
Total	12	10	8	30

The study attempted to answer questions directed at four sets of participants: health care professionals, HIV-positive patients, mothers of babies less than 12 months old and PMTCT coordinators at clinics.

The first set of questions put to health care professionals related to:

- awareness of the PMTCT policy and guidelines to be practised in their health facilities, consultation process when the policy and guidelines were developed and training on policy and guidelines;
- availability of PMTCT policy and guidelines at public health clinics and whether the health professionals knew how these had to implemented, to whom, when and how; and
- Whether the policies were being implemented accordingly, challenges encountered in implementing these guidelines and possible solutions to the challenges.

The next set of four questions was directed to HIV-positive patients visiting public health facilities. This was done with a view to establish if, as citizens of the country, they were receiving the services (care and information) they ought to be receiving in public health facilities. They were asked questions relating to:

- provision of HIV and AIDS information during their recent visit to the clinic and whether information dissemination was done in groups or individually;
- whether they had been offered a chance to test for HIV and if it was explained why this was important;
- whether they had been given a chance to do CD4 blood count (for HIV-positive participants) and if they had been provided with drugs or medication to prevent mother to child transmission of HIV; and
- whether the health care professionals explained to them what it meant to be HIV-positive for both the mother and the baby and if they knew HIV-positive pregnant women can infect their babies with HIV whilst pregnant, when they go into labour or during breastfeeding.

The third set of four questions was directed to women who had delivered babies not more than twelve months earlier. They were asked the questions about:

- receiving information on HIV and AIDS and also if they had been offered a chance to test for HIV when they were pregnant;

- whether they had been given a chance to do CD4 blood count and an explanation of its importance;
- receiving information on important medication to be administered to pregnant, HIV-positive women; and
- receiving information on infant immunisation and PCR testing for infants.

The last set of six questions was directed to PMTCT coordinators who were also responsible for the functioning of the three public health clinics under study. The questions related to:

- availability of both the PMTCT programme in their respective facilities and the policy and guidelines;
- consultation of PMTCT coordinators and health care professionals when the PMTCT protocols and guidelines were drafted at national level;
- training, how this was conducted in their facilities;
- provision of HIV and AIDS information to health care professionals as information changes from time to time;
- their views on whether patients visiting the facility who ought to be enrolled into the programme were enrolled; and
- challenges faced by the health care professionals and possible solutions.

3.6 TYPES OF SAMPLING METHODS IN QUALITATIVE RESEARCH

There are different types of sampling methods in qualitative research. The three types of sampling methods: convenience sampling, purposive sampling and snowball sampling are discussed below.

3.6.1 CONVENIENCE SAMPLING

Convenience sampling is also known as accidental or haphazard sampling and involves sampling on the basis of the availability of units (O'Sullivan & Rassel, 1989:121). Convenience sampling is when the researcher, for example, chooses a certain group of individuals available to him/her by virtue of their accessibility. The PMTCT coordinators who participated in the study were recruited and selected using the convenience sampling method since they were easily accessible and knowledgeable in the running of the three public health clinics under study.The disadvantage of convenience sampling is that one cannot estimate population parameters from sample statistics (O'Sullivan & Rassel, 1989: 121).

3.6.2 PURPOSIVE SAMPLING

Purposive sampling is also known as judgment or expert choice sampling. The main criteria for selection of any units from the population using this sampling procedure are the investigator's judgment that the unit somehow represents the population (O'Sullivan & Rassel, 1989:122).

The type of sampling used in the study was purposive sampling. The researcher used her judgement in assuming the population was represented by the group of pregnant women at the clinics. Participants were recruited specifically because they were women, 18 years and over, either pregnant or had just given birth to babies not more than twelve months. These participants were recruited within the maternity sections of the clinics and were relevant to the research topic. Every third woman who was in the queue for antenatal or postnatal services was invited, selected and interviewed if she was willing to participate in the study. Open-ended interviews with the help of an interview guide were carried out with women after the informed consent process.

Women who were recruited within the antenatal section and found to be HIV-negative were given different questions from those found to be HIV-positive. The women, who were found to be HIV-negative as per HIV testing conducted at the clinic, were encouraged to stay healthy by practicing safe sex all the time. They were also encouraged to retest after the window period of three to six month and educated on healthy living habits, for instance

eating habits. Women who were found to be HIV-positive as per HIV testing conducted at the clinic during their pregnancy and were willing to participate in the study were taken through the informed consent process. They had to indicate their willingness to participate in the study by signing the informed consent form after it was explained to them and they had agreed to its understanding.

3.6.3 SNOWBALL SAMPLING

In this type of sampling, the researcher makes initial contact with a small group of people who are relevant to the research topic and then uses people to establish contact with others. The disadvantage of snowball sampling is that it is less likely that the sample will be representative of the population (Bryman, 2012:203).

Three groups of study participants were selected from antenatal and postnatal sections through the snowball approach. Participants were introduced to the researcher by the health care professional. Participants included pregnant women attending postnatal services at the clinic over the age of 18 years, women who had delivered babies who were not older than twelve months and health care professionals working within the maternity or PMTCT section at the clinics. In all the three clinics there were two sections within maternity section or department, one for women who had come for antenatal services and another for those who had come for postnatal services, for instance babies' immunisation and medical check-up.

3.7 DATA COLLECTION

The interviewer considered multiple sources of data collection instruments for this study and used open-ended interview questions as well as participant observation.Unstructured interviewing can access rich data to improve the research design or to elaborate on the statistical findings in a final report (O'Sullivan & Rassel, 1989:190).The method of data collection which was used in this study was open-ended interview questions. These unstructured interviews enabled participants to talk freely and reveal more useful information to the researcher. The informed consent was administered to all women who were approached regarding the study and voluntarily agreed to participate signed the form. After the

completion of the informed consent process an interview guide was used to get as much information as possible from participants on their experiences regarding the PMTCT programme. Participants were encouraged to talk freely with the research assistant and give as much information as they could give; in addition notes were taken down which were later translated and recordings transcribed.

3.7.1 ADVANTAGES OF OPEN-ENDED INTERVIEW QUESTIONS

According to O'Sullivan and Rassel (1989:191), the advantages of unstructured interviews include helping develop hypotheses, identifying appropriate measures in programme evaluation and appropriate measures, especially in programme evaluation. Additionally, open-ended interview questions enable participants to share their experiences and perceptions in a much freer and informal manner without being confined to "Yes or "No" answers. This interview format allows participants to narrate what they feel comfortable narrating and also shape the direction and pace of the interview. Open-ended interview questions used during this study enabled participants to share their experiences and the challenges they went through after they had discovered their HIV-positive status. Most respondents were able to talk about their shocks, disappointments, anger and blame as well as many more challenges they experienced after they had discovered they were HIV-positive. In so doing, the interviewer was able to collect as much useful information as possible, this was done through taking of detailed notes as well as recordings which were later transcribed and translated.

3.7.2 DISADVANTAGES OF OPEN-ENDED INTERVIEW QUESTIONS

Some of the disadvantages of open-ended interview questions are that they are too informal and narrative and participants' responses become too broad. Secondly, too much data is collected which are expensive to analyse and sometimes the interviews go out of line. As much as it was important to collect detailed information during the interview process, it became impossible during this study to record all responses from the participants because of the nature of interview style. The interviews were at times too informal and narrative in respect of participants' responses being broad and irrelevant most of the time. For this reason probing skills were employed to get most of the information from participants.

3.8 OBSERVATION

Marshall and Rossman (2011:139) state that observations entail the systematically noting the recording of events, behaviours and objections in social research. Observation is central to qualitative research. The term 'observation' captures a variety of activities that range from informal presencein the setting, getting to know peopleand learning the routine to using strict time sampling to record action and interaction and using a checklist to tick off pre-established actions (Marshall &Rossman, 2011:139).

The health care professionals were observed as they carried out their daily routine activities at the clinics. The HCT counsellors were observed as they conducted their morning group educational classes and the nurses as they conducted group education classes in the mornings and also registered patients took weight, heights, urine and high blood pressure (BP) check-ups. The babies were observed as they received immunisations and were subjected to height and weight measurements.

3.8.1 PARTICIPANT OBSERVATION

Participant observation is both an overall approach to inquiry and a data-gathering method; it demands first-hand involvement in the social world chosen for study (Marshall & Rossman, 2011:140). It is crucial for the researcher to document everything that takes place in the field. In fact, field notes should be taken as soon as the researcher arrives in the field, and when the team steps out of the car for the first time in the field (Crabtree & Miller, 1992:58-59). The researcher and research assistant documented their observations from the first day they arrived at the field sites as well as their assumptions and expected outcomes. They were able to collect data successfully in all three public health facilities because of the good rapport they had built with the participants and other health care professionals at each facility.

3.8.2 ADVANTAGES OF PARTICIPANT OBSERVATION

According to Crabtree and Miller (1999:57-59) as time passes in the field, participants are less likely to adjust their behaviour owing to the researcher's presence, the research is much more accommodated rather than reacted to and the chances of witnessing the phenomenon as

it actually occurs are greatly enhanced. Secondly, the differences between real and verbal behaviour are made apparent and the information obtained from interviewees and questionnaires may not reflect actual behaviour. Thirdly, the questions may be framed in the language of the participant so that the richness and complexity of the human condition can be more fully appreciated than understood.

3.8.3 DISADVANTAGES OF PARTICIPANT OBSERVATION

Participant observation is of good choice if the focus of interest is how the activities and interactions of a setting give meaning to certain behaviours or beliefs (Crabtree & Miller, 1992:47). On the first day and during the first few hours of the study, it was observed that the health care professionals were not comfortable as they performed their daily duties since they were being observed by the research team. It is a natural thing for people to be uncomfortable when a stranger is around and observing.The following day, the researcher reiterated that the research was being conducted for the purposes of university research study only. The attitude of the health care professionals improved when they realised that they were not being monitored as they had thought. When their anxieties were dissipated theywere more willing to share their working space with the researchers.

3.9 DATA ANALYSIS

The data which was collected was analysed using thematic design.Thematic analysis is a categorizing strategy for qualitative data (Boyatzis, 1998). According to Joffe (2011), the end result of thematic analysis should highlight the most salient constellations of meanings present in the data set.Researchers review their data, make notes and begin to sort it into categories. When styled as a data analytic strategy it assist researchers to move their analysis from a broad reading of the data towards discovering patters and developing themes (Boyatzi, 1998).

Boyatzi (1998) further states the flexibility of thematic analysis, what the researchers do with the themes once they uncover them differs based on their intentions of the research and the process of analysis.

3.10 ETHICAL CONSIDERATIONS

Lutabingwa and Nethonzhe (2006:695) argue that one of the dilemmas faced by researchers is whether to give full information to the participants about their research study or withhold certain information. Additionally, when researchers are studying people's behaviours or asking questions, they have responsibilities to those people. Participants have the right to be educated about the study's aims and objectives, potential benefits for their participation in the study as well as risks to be expected.

3.11 PERMISSION TO CONDUCT RESEARCH

According to Crabtree and Miller (1992:52-53), permission to conduct research in the area should be requested once a site has been selected which the researcher believes will provide access to the data of interest. The authors further point out the importance of rehearsing how to answer various questions which may be asked by different personnel regarding the proposed study when seeking permission and taking full advantage of anyone who can assist in gaining entry.

It was imperative for measures to be taken to safeguard the scholarly rigour of the research, as well as the rights and dignity of participants in the study. One of the steps that were taken was to seek permission from the Department of Health district manager to conduct the research (see Annexure A). Consent was also sought from and granted by the Department of Health (See Annexure B). In addition, a research proposal and research questionnaire were submitted to the ethics committee of the UKZN for prior approval. Letters of informed consent were distributed to the respondents prior to the interviews being conducted (see Annexure C) and letters of consent received from the respondents to indicate their willingness to participate (See Annexure D).

There were delays before permission was granted. This was simply because the district manager was on leave. Having taken full advantage of everyone communicated with made it possible to receive positive feedback within one week since the district manager returned from leave.

3.12 CLINIC MANAGEMENT AND STAFF

Usually, when seeking permission to conduct a study, full details are provided on the study's main aims and objectives, duration and study participants. All these were detailed in a letter written to the district manager. Nevertheless, it is imperative for the researcher to explain again, in detail, on her/his arrival at the clinic, the purpose of the study, main aims and objectives and other details to the clinic management at each site.

The clinic management team at each of the three clinics where the study was conducted played a vital role regarding logistical arrangements. The research team was warmly welcomed by management and introduced to the entire clinic staff at each and every clinic. Working space was allocated although this was challenging.

In one clinic a counsellor's room was allocated to the researchers and this arrangement made it possible to interview the participants and maintain confidentiality without causing any disruptions to the clinic flow. In two other clinics, there was a huge challenge with regard to space and the researchers took turns in sharing the room with the HCT counsellors. Overall, in all three facilities visited members of staff were very supportive and accommodating.

3.12.1 INFORMED CONSENT AND VOLUNTARY PARTICIPATION

The major principle of social research ethics is that informants' participation in research study must be entirely voluntary (Babbie & Mouton, 2005:546). Participants have the right to informed consent. This means that their participation should be based on an adequate understanding of the study's aims and objectives (Lutabingwa & Nethonzhe, 2006:697). Dunn and Pharm (1999:21) define informed consent as a process or information exchange that takes place between the prospective subject and the investigator before, during and, sometimes, after the study. Informed consent is the cornerstone of ethical research practice and the subject must be informed of the purpose of the research and risks that may be incurred if and when participating (O'Sullivan & Rassel, 1989:208).

The National Institute of Health (1979) defines informed consent as a mechanism for ensuring that people understand what it means to participate in a particular research study. O'Sullivan and Rassel (1989:209) state that informed consent does not only mean that a

person consents to participate as a research subject, but also that a person must have sufficient information about the study such aswhat the study entails, its benefits, possible risks and people/investigators to be contacted in case there are questions or concerns. In this study, a number of issues were discussed verbally as well as through written documentation with the participants before they were interviewed. These included the nature and purpose of the study, voluntary participation, confidentiality and anonymity, withdrawal from the study at any stage; identification of the researcher and information on where to reach her/him as well as the potential value of the study.

3.12.2 CONFIDENTIALITY

Confidentiality is a significant ethical issue in studies dealing with HIV and AIDS. It refers to the protection of information so that researchers cannot or will not disclose records with individual identifiers. Anonymity refers to collecting information so that researchers cannot link any piece of data to a specific individual (O'Sullivan & Rassel, 1989:249-250).During the informed consent process, study participants need to be assured by the interviewers or the researchers that the discussions between them will always remain confidential. This refers to the fact that whatever information is being discussed by both parties will not be discussed elsewhere, unless consent has been granted to do so. Study participants also need to be informed of shared confidentiality whereby participants' information may be shared amongst other research staff for research purposes only.

3.13 CONCLUSION

This chapter looked at the research methods used in the study and reasons for using these methods. It has further explained the processes used to collect data as well as the relevant protocols observed. The chapter has explained the processes used in the selection of participants. In addition, it has discussed the rationale for using open-ended interviewing system with the use of interview guides as well as participant observation.

Ethical considerations have been discussed including the processes followed in gaining entry from the district management office to conduct the study in the three PHCs within

uMgungundlovu District Municipality. This included the informed consent process and voluntary participation of participants in the study.

The advantages and disadvantages of using the qualitative research methods have been highlighted. Chapter 4 presents the data and discussion.

CHAPTER 4

PRESENTATION AND DISCUSSIONS

4.1 INTRODUCTION

This study set out to assess the administration and implementation of the PMTCT programme in three public health clinics within UMgungundlovu health district, KwaZulu-Natal. The intention was to gain an insight on the challenges experienced by health care professionals in implementing the PMTCT programme in public health clinics and make recommendations on how to better administer the programme.

This chapter covers two phases: the first phase presents the data obtained from the population studied, whilst the second phase interprets the results with reference to the research questions in section 1.9 of Chapter 1.

The respondents were assured of anonymity in order to encourage honest and free participation. The interviews were conducted with respondents after the study was fully explained and they had voluntarily agreed to participate. The data presented in this chapter were obtained from an interview schedule, questionnaires and observation.

4.2 PRESENTATION OF RESULTS

The results are arranged according to the themes of research issues raised in section 1.9 in Chapter 1.

4.2.1 Assessment of prevention of mother-to-child transmission programme in UMgungundlovu health district in KwaZulu-Natal

The data presented relate to PMTCT policy and guidelines, consultation of health care professionals when policy and guidelines were developed, training on the guidelines, availability of the guidelines in PHCs and implementation, information on HIV and AIDS received at PHCs, HIV testing offered to HIV-positive and pregnant women, CD4 count

blood drawn, HIV-positive mother and infant, information on HIV and AIDS received and HIV testing, encouraging CD4 count blood test, information on medication, infant immunisation and PCR testing, running of the PMTCT programme in PHCs, consultation process, training on PMTCT, information on HIV and AIDS by HCP, patients' enrolment into PMTCT programme, challenges faced by HCP. The following codes are used: health care professionals (HCP); HIV-positive and pregnant women (PHIV+); HIV-positive women who have delivered (DHIV+); PMTCT coordinators (C-PMTCT).

4.3 Prevention of mother-to-child transmission policy and guidelines – HCP

The health care professionals from the three public health clinics under study (Mbalenhle, KwaPata and Caluza clinics) were asked if they had the PMTCT protocols and guidelines within their facilities. This question was asked to establish the extent to which they were familiar with the protocols and guidelines. This was also necessary for the research because in order for the PMTCT protocols and guidelines to be implemented properly, they should be available in a public health care facility. The respondents from all three PHCs under study indicated that the PMTCT policy and guidelines were available in their facilities. Some health care professional from one of the clinics reported that in addition to the PMTCT policy and guidelines they also had antenatal and postnatal guidelines; PMTCT child transmission; as well as information charts, which were pasted in all consultation rooms.

4.3.1 Consultation on development of prevention of mother-to-child transmission policies HCP

The health care professionals were asked if they were consulted when the policies, protocols and guidelines were drafted before being implemented nationally in 2002. This was necessary because people own decisions which they are part of, and also for the fact that people live in a democratic South Africa where consultation is of vital importance. Through its policies and protocols, the Department of Health aims at ensuring that the duties performed by the health care professionals are standardised nationally. For instance, the duties or procedures performed by health care professionals in Mpumalanga Health District within PMTCT

programme should be similar to those performed by health care professionals in KwaZulu-Natal Department of Health.Six out of ten respondents indicated that there was lack of consultation when the national PMTCT policy and guidelines were drafted at national level. In addition, the respondents pointed out that the Department of Health failed to acknowledge that provinces are unique and, therefore the PMTCT policy and guidelines cannot be standardised.

4.3.2 Implementation of the mother-to-child transmission policy in public health clinics

The health care professionals were asked if they knew how the PMTCT policy and guidelines had to be implemented in their facilities. The response indicated that not all health care professionals knew how these policies had to be implemented because not all of them had attended training sessions. This is a service delivery concern for public managers which impacts negatively on citizens' lives. It was necessary for the research to ask this question because the PMTCT programme cannot succeed if the health care professionals do not know how to administer or implement the PMTCT policies.

4.3.3. Training of health care professionals on prevention of mother-to-child transmission policy and guidelines

When asked if they attended training sessions on PMTCT policy and guidelines, the health care professionals mentioned that each health facility had a trainer who was responsible for all departments of health training sessions. It is important to note, however, that the trainers were not solely responsible for the training sessions. They also carried other tasks within the facilities as they were employed as nursing sisters. Staff members within the department were updated on policy amendments through memoranda, fascimile and emails, which were circulated from the district office. The findings revealed that the PMTCT coordinator also provided training whenever it was necessary.

4.4 Information on HIV and AIDS received at public health clinics – PHIV+

The response from the HIV-positive patients revealed that HIV and AIDS information was offered to patients visiting the PHC under study. The information was covered during the morning group sessions and it covered the following: education on HIV transmission, HIV prevention, importance of using the condoms, healthy living lifestyle, disclosure, feeding options and important medication to be administered like ARVs.

HIV-positive and pregnant women were asked if they were offered a chance to test for HIV during their pregnancy. The respondents indicated that HIV testing was offered to them at the PHCs. In addition, HIV-positive women were encouraged to test for HIV and were educated on how their babies will be protected from being infected with the virus.

4.4.1 CD4 count blood draw offered – PHIV+

The respondents, HIV-positive women indicated that they were educated on the importance of having a CD4 count blood drawn as soon as they tested HIV-positive. This will determine whether they need to commence on ARV treatment or not. On 12 August 2011, the deputy president, Mr Kgalema Motlante, announced that HIV-positive people with CD4 cell count 350 and less were eligible for ART (Parliamentary circular, 2011).HIV-positive and pregnant women were asked if they received information on important medication to be administered during their antenatal visits to the PHC. The respondents mentioned that they received education on different types of ARVs and other medication for pregnant women. They were also educated about the Nevirapine tablet which is given to HIV-positive and pregnant women at seven months. This tablet has to be swallowed by an HIV-positive woman when she experience labour pains. In addition, they were educated on ARVs for infants as well as the importance of infant immunisation. This information is crucial to HIV-positive women.

4.4.2 Mother and infant both HIV-positive what it meant – PHIV+

The respondents reported that they received education from the health care professionals on what it meant to be HIV-positive. They reported being educated on the fact that being HIV-positive did not mean they were going to die. This information was in the form of group

sessions held at the clinic and in pamphlets distributed. In addition, they were educated on the importance of healthy eating, exercising and drinking a lot of water.

4.5. HIV information received and offered HIV testing – DHIV+

In response, the respondents mentioned that they received information on HIV and AIDS which included topics on how to prevent HIV infections. They also mentioned receiving education on how they can protect their unborn babies from HIV infections. They were encouraged not to engage in unprotected sex, especially whilst they were pregnant. In addition, they were given information on exclusive breastfeeding and exclusive formula feeding. They also mentioned that during their antenatal visits to the clinics they were educated on the importance of ensuring that the CD4 cell count was done. The CD4 cell count test is administered to HIV-positive women who tested HIV-positive on the ELISA test. It determines the number of cells in the body as well as the viral load.

4.5.1 Infant immunisation and PCR testing for infants – DHIV+

The respondents, women who had delivered their babies and who visited the clinic for postnatal care mentioned that they were educated during antenatal visits about the importance of immunising their babies. Babies born by HIV-positive women are at higher risk of acquiring diseases hence the importance of their immunisation. The respondents further mentioned that they were encouraged to take their babies to the clinic for PCR testing. This test is administered to infants to determine their HIV status.

4.6 Prevention of mother-to-child transmission programme ran in public health clinics – C-PMTCT

The PMTCT coordinators responsible for each health care facility under study were asked if the PMTCT programme was administered in their facilities and if the PMTCT protocols and guidelines were available in their respective facilities. This question was necessary because

they are responsible for monitoring their respective clinics. One PMTCT coordinator managing each of the three clinics where the study took place was interviewed.

The response was that not all health care professionals were trained on the PMTCT protocols and guidelines. The PMTCT coordinator responsible for the clinic where not all HCP attended training sessions mentioned that she was aware of the situation and had plans to rectify the situation. The respondents from the three PHCs under study mentioned that their facilities had the PMTCT policy and guidelines. In addition, they mentioned that it was their responsibility to ensure that their facilities had copies of the guidelines and that the health care professionals were trained on how to implement the guidelines.

The PMTCT coordinators were asked if the PMTCT programme was run in their facilities and how they made sure that the policy and guidelines were sufficiently available in their facilities. The findings revealed that the PMTCT coordinator visited their facilities frequently to meet with clinic staff and monitored how the clinics were being run. They further mentioned that during their visits to respective clinics they supplied the material that was needed, things like protocols, pamphlets, condoms and stationery. In addition, the health care professional received the PMTCT protocols and guidelines from the nursing college where they were trained. Those health care professionals who were not trained before 2000 and did not attend PMTCT training sessions nor receive the guidelines as part of their curriculum at the college had to attend training sessions conducted by the facility trainers.

4.6.1 Health care professionals consulted when prevention of mother-to-child transmission programme developed – C-PMTCT

The PMTCT coordinators were asked if the health care professionals were consulted or attended training sessions on PMTCT policies and guidelines policy and guidelines. The response was that the policy and guidelines were drafted at national level and the district office was consulted when these were drafted. In addition, not all HCP could attend the training sessions owing to budgetary constrain. The PMTCT coordinators and clinic management attended the workshops where briefings on the policy and guidelines took place and were expected to update other HCP who could not attend the workshops.

4.6.2 Training sessions on prevention of mother-to-child transmission in public health clinics – C-PMTCT

The respondents revealed that not all health care professionals were trained on the PMTCT protocols and guidelines. This had negative implications both on public health managers as well as the community and as it did not show justice was done. The principles are very important in public administration and management and this is further emphasised by new freedoms placed upon citizenry by democracy (Wessels & Pauw, 1999:135). Public officials have no option but to deliver on promises made to the citizens. Health is amongst the crucial aspects that need to be delivered by government to the citizens. It is, therefore, vital that the health department is properly planned and organised in such a manner that officials know how to perform their tasks and when. Officials of the Department of Health needs to be clear of the tasks they are expected to perform, to whom, when how and also of the consequences for poor performance.

4.6.3 Information on HIV and AIDS by health care professional – C-PMTCT

The respondents revealed that the PMTCT coordinator visited their facilities frequently to meet with clinic staff and monitored how the clinics were being run. During their visits to their respective clinics they supplied the material that was needed, such as protocols, pamphlets, condoms and stationery. They further mentioned that the health care professional received the PMTCT policy and guidelines from the nursing college where they were trained but there are those health care professionals who were trained before year 2000 who did not receive PMTCT training and, therefore, did not have the PMTCT protocols and guidelines let alone the knowledge of how these had to be implemented at the college. As stated in 4.2.4.3, public health managers need to ensure that the health department is properly planned so that the officials are able to deliver on their services.

4.6.4 Patients visiting public health clinics enrolled into prevention of mother-to-child transmission programme – C-PMTCT

The respondents said that not all patients were enrolled into the programme soon enough. Some of the reasons patients were not being enrolled immediately into the programme were that not all health care officials received training sessions. This was a challenge when those who knew how the programme had to be implemented were not available at work.

4.6.5 Challenges faced by health care professionals in implementing the prevention of mother-to-child transmission programme – C-PMTCT

The coordinators in two facilities indicated that it was not always possible for the health care professionals to implement the PMTCT policy and guidelines to all patients owing to insufficient staff at the clinics. They also reported that there were not enough consultation rooms, the facilities were crowded; buildings old and needed to be renovated. In one facility the coordinatorr reported that patients relocated to new areas and collected their ARVs in different clinics. This made it difficult to track and monitor patients. As a result, most patients failed to honour their scheduled appointments.

4.7. INTERPRETATION OF FINDINGS

In the analysis of results, the main tendencies and patterns are discussed with reference to the research questions as the purpose of the study was administration of the PMTCT prevention programme in uMgungundlovu health district of KwaZulu-Natal. The following codes have been used for interviewed participants: health care professional (HCP); pregnant and HIV-positive women (PHIV+); HIV+ women who have delivered babies (DHIV+); PMTCT Coordinators (C-PMTCT).

4.7.1 Healhcare practitioners' awareness of prevention of mother-to-child transmission policy and guidelines

The Department of Health, like any other government department, is guided by national policy and guidelines. The PMTCT policy and guidelines issued by the Department of Health in 2002, state that all public health facilities should be implementing the PMTCT programme in PHCs (Department of Health, 2008). It should be noted that the PMTCT policy and guidelines are not stagnant; they are revised and restructured yearly at national level. The other policies used in conjunction with the PMTCT policy and guidelines are antenatal and postnatal guidelines; PMTCT child transmission; and information charts. The information charts are pasted on the walls in consultation rooms and used as reminders since they outline the procedures to be followed when enrolling patients into PMTCT programme. The PMTCT policy and guidelines is the cornerstone for the successful implementation of the PMTCT programme. It is the responsibility of public officials to ensure that the citizens are treated with respect, have access to the basic services as stated in the constitution and that the Batho Pele principles are adhered to at all times.

4.7.2 Consultation with health-care practitioners when policies are developed and training

It is essential to find out if health care professionals are involved when policy and guidelines are developed. This is because people own decisions which they were part of. In addition, South Africa is a democratic country where consultation is of vital importance. It should be noted that not all health care professionals attend workshops when policy and guidelines are discussed. Instead, they are represented by a group of individuals who are not hands-on when it comes to PMTCT matters. Some respondents reported that the Department of Health has failed to acknowledge that provinces are unique and experience different challenges and expect PMTCT policy and guidelinesto be one-size-fits-all, which is sometimes not possible. There are various issues the department needs to take into serious consideration in order to ensure that the PMTCT programme is implemented correctly. The core issues include dealing with staff shortages, training of all staff, space and challenges.

Healthcare professionals cannot be expected to perform their duties to maximum standards if they have not been trained on how to implement policies. The Department of Health facilities under study had trainers based within health facilities and health managers need to ensure that people employed to perform certain tasks do perform their tasks as expected because if they do not this impacts negatively on the work of public administrators.

4.7.3 Availability of the prevention of mother-to-child transmission policy and guidelines to health care practitioners in all public health clinics

According to the PMTCT policy and guidelines (2008), the PMTCT programme should be rolled out in all PHCs (Department of Health, 2008). The PMTCT policy and guidelines should be made available in all health care facilities by the clinic managers through workshops, trainers or the district office. Four out of ten (10) health care professionals interviewed actually took out their copies of the PMTCT policy and guidelines to show the interviewer. It is necessary that PMTCT policy and guidelines should always be used as reference in PHCs as they are not static and being revised and amended on yearly basis. It should be noted that it is the responsibility of the clinic managers to ensure that public health facilities have the necessary resources in order to be able to carry out their tasks effectively for the benefit of citizens.

4.7.4 Prevention of mother-to-child transmission protocols implementation by health care professionals public health clinics

Although the PMTCT policy and guidelines were available in all three PHCs under study, not all health care professionals knew how these had to be applied. This is because they had not been trained and the training task had been assigned to somebody. This is a poor performance issue impacting negatively on service delivery and affecting the country as a whole. The Constitution of the Republic of South Africaspecifies that public administration should adhere to a number of principles, which include:

- promoting and maintaining high standard of professional ethics;
- impartial and equitable provision of services;
- efficient and economicalutilisation of resources;
- responsiveness to people's needs; and
- encouragement of the public to participate in policy-making (van de Waldt, 2004:8).

Patients, who are citizens, are supposed to receive all the services which are offered in public health facilitiesas a constitutional and democratic right.

4.7.5 Challenges encountered health care professionals in implementing the prevention of mother-to-child transmission policy and guidelines

Healthcare professionals have challenges with patients who relocate to different areas and do not honour their scheduled appointments in health facilities. These participants miss out on important educational classes which are run on daily basis at the clinics as well as medication issued. For instance, pregnant women who are found to be HIV-positive are given the NVP tablet at seven months, which helps in reducing HIV infection from mother to child during birth. The other challenge is that most HIV pregnant women still rely on their partners to use condoms and the chance of getting sexually transmitted infections are increased. Some religious affiliations discourage the use of medications, especially ARVs, and people who can be saved by taking medication die unnecessarily. These undermine the efforts of improving health care system in the country.

The PMTCT policy and guidelines require all pregnant women to be tested for HIV perform CD4 count; receive education on ARV and on-going education on healthy living. These activities cannot be performed in one day, hence the importance for women to honour their scheduled appointments. Stigma was also identified as a challenge faced by pregnant women who fear to disclose their HIV-positive status to their partners, family members and friends because they will be discriminated against or abused.

4.7.6 HIV and AIDS information received and HIV testing offered – PHIV+

In some of the health care facilities, there are other organisations or partners working hand-in-hand with the health care professionals. These include Mothers–to-Mothers (M2M) and Amakhosi or sangoma, who also provide group education to patients. The involvement of Amakhosi in health care facilities has proved to be effective since they are able to encourage people to test for HIV. There are still those people in communities who, when they are sick, believe they have been victims of witchcraft when, in fact, they have HIV or full-blown AIDS. Amakhosi or sangoma are based in communities and are known for using traditional medicines. They are able to counsel people to test for HIV and use western medicine, if they have to.

Sexually active people should be made aware of the importance of HIV counselling and testing as part of a good, comprehensive medical care (Buckley & Gluckman, 2002:257). The information on HIV and AIDS is available in pamphlets, which are distributed in health care facilities and through educational sessions run in clinics. The HIV test that is commonly used is the ELISA antibody test which testsfor antibodies that are found in the serum which have been separated from red blood cells (Whiteside & Sunter, 2000:16).

In the country, women below the age of 49 years have the highest HIV prevalence rates and mother-to-child transmission now accounts for 10% of new infections (NACA, 2012:11).

Table 4.1: Epidemiology of HIV in Nigeria

	2008	2012
National Median HIV Prevalence	4.6%	4.1%
Estimated number of people living with HIV	2.980,000	3.359.363
Annual AIDS Death	192,000	217,148
Number requiring Antiretroviral Therapy	857,455	1,449,166
New HIV Infections	336,379	388,846
Total number of AIDS Orphans	2.175,760	2.193,745

Source: National Agency for the control of AIDS (NACA, 2012:11)

4.7.7 Information received on important medication – PHIV+

People who have tested HIV-positive are encouraged to do CD4 cell count blood test on the same day they tested HIV-positive. Pregnant women receive education on important medication during their scheduled visits at the clinics. Those women found to be HIV-positive are informed about treatment adherence classes, which are run for two weeks before ARV medication can be issued. The fact that most women do not honour their scheduled appointments in health facilities is a concern because there are a number of educational classes that are run in public health facilities with the aim of benefiting patients. Medication is one of the main topics that are covered during educational classes held in health facilities.

4.7.8 HIV meaning for both mother and baby – PHIV+

As part of the group education sessions in clinics, women were educated on positive living, which included eating healthy food, exercising and drinking a lot of water. In addition, HIV-positive and pregnant women were educated on how to take good care of themselves. This included condom usage when involved in sexual intercourse. It is the responsibility of public health officials to provide information on HIV and AIDS to citizens.

4.7.9 Information on HIV and AIDS received when pregnant – DHIV+

It must be noted that infant feeding is one of the important pieces of information given to pregnant women. HIV-positive women are encouraged to exclusively breastfeed their babies for six months. The PMTCT policy and guidelines state that mothers should exclusively breastfeed their babies for at six months (Department of Health, 2008). There are numerous advantages for both the mother and the infant in breastfeeding, as breastfeeding protects against respiratory infections and diarrhoeal disease (Pratt, 2003:219). This topic together with other topics like healthy eating, exercising, and condom usage are discussed during the morning group education sessions held in PHC's.

4.7.10 CD4 count conducted when pregnant – DHIV+

The HIV-positive women who had delivered their babies mentioned that they received information on the importance of conducting CD4 count blood cells during their pregnancy. They further mentioned that they were encouraged to do CD4 count blood test as soon as they were tested HIV- positive as this would determine the number of CD4 cells in their body. If the CD4 count blood cell was less than 250 they had to commence with the ARV.

4.7.11 Infant immunisation and PCR testing for infants – DHIV+

The findings revealed that most women do not return to the clinics for postnatal care, as advised by the health care professionals. It is highly recommended that children infected with HIV are fully immunised as a matter of importance since they are at a higher risk of being infected with infectious diseases (Pratt, 2003: 236).

4.7.12 Prevention of mother-to-child transmission programme run in health care facilities and availability of policy guidelines

The findings revealed that the PMTCT programme is run in PHCs. However, not all health care professionals are trained on the policy and guidelines. The fact that not all HCP are trained on the policies is a drawback to the citizens of the country.

4.7.13 Consultation of prevention of mother-to-child transmission coordinators and health care professionals when policies are developed– C-PMTCT

The PMTCT coordinators indicated that they were consulted and invited when workshops were held to discuss PMTCT matters. The workshops involved amendments made to the PMTCT policy and guidelines, which were done yearly. It should be noted that the HCP felt it was important that they too were invited when such matters were discussed as they are responsible for their implementation.

4.7.14 How training was conducted in health care facilities – C-PMTCT

The PMTCT coordinators reported that each health facility under study had a trainer who was based within the facility. It should be noted, however, that the trainers were not just responsible for training sessions; they had other tasks to perform at the clinics.

4.7.15 How patients were enrolled into the programme – C-PMTCT

The PMTCT coordinators acknowledged the fact that not all patients were enrolled into the PMTCT programme early enough due to a number of challenges. At the first facility, the coordinator mentioned that only one nursing sister had been trained on the how to administer the PMTCT programme and patients were turned away when she was not available. In addition to that, there was not enough working space at the clinic. At the second facility, the challenge of not having sufficient staff was mentioned, whilst at the third relocation was cited as the main challenge. The coordinators mentioned that as public managers their objective is to ensure that the principles of Batho Pele are adhered to at all times. Improving the delivery of public service is a significant matter in South Africa.

4.7.16 Challenges faced by the health care professionals – C-PMTCT

There are numerous challenges experienced by HCP when implementing the PMTCT programme in PHC. These include:

- Insufficient staffing

- Space challenges
- Insufficient training sessions
- Relocation of patients

Insufficient staffing compromises the work flow at the clinics and results in some patients leaving the clinics unattended. This is a service delivery issue, which impacts on the rights of citizens. Some PHCs are overcrowded and there is no space in the waiting room to conduct group education classes, which has negative effects on the community. Information needs to be made available to patients so that they are able to make significant decisions about their lives. The HCP are supposed to be well trained on the PMTCT policy and guidelines to enable them carry out their functions competently.

A lot still remains to be done and while programmes like the PMTCT are in place, it would appear that their implementation is not as effective as they should be. The reason is not that there is a lack of a plan or policy to prevent the transmission, but rather that the public administration processes discussed in section 1.5 are perhaps not being followed as they should.

4.8 CONCLUSION

This chapter dealt with both the presentation and interpretation of the findings. The study shows that much has been done since the implementation of the PMTCT programme in 2002. A discussion held with patients attending antenatal and postnatal services as well as with the health care professionals and coordinators indicated lot of effort has been put into the fight against HIV and AIDS.

Although there are lot of improvement to be accomplished by Department of Health, it must be noted that the majority of the health care professionals are aware of the PMTCT policy and guidelines, which need to be implemented in their facilities. There is a great need for management in public health facilities to revisit Gurlick's POSDCORB: planning, organising and staffing to ensure that the programme is run effectively and is as such a benefit to the citizens of the country at large (Hughes, 2003:30-31).

Chapter 5 outlines the summary of the findings, draws conclusions and makes recommendations based on findings of the study and provides suggestions for further research.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This research study was carried out with the aim of assessing if the PMTCT programme was being administered in public health facilities of KwaZulu-Natal. The study evaluated the possibility for effective and efficient delivery of PMTCT policy and guidelines, which were developed at national level. It became important to assess if the PMTCT policies, protocols and guidelines could be taken as one-size-fits-all as Frederick Taylor, the father of scientific management believed there is "one best way" of accomplishing any given task. Taylor believed work needed to be standardised; and processes and procedures clear to enable people to perform their tasks competently (Hughes, 2003:27).

It was also important to ascertain if the PMTCT programme was accessible to all citizens who attended public health facilities as this is their constitutional and democratic right. The South African government, under the leadership of President Jacob Zuma, has shown its commitment to the fight against HIV and AIDS. To date, community awareness programmes are carried out in various communities, including HIV counselling and testing and medical male circumcision (MMC) through which male involvement in HIV and AIDS matters is encouraged.

5.2 REVIEW OF THE STUDY

One of the main objectives of the study was to analyse the current situation regarding the administration of the PMTCT programme in three public health clinics in KwaZulu-Natal specifically uMgungundlovu health district. The second was to establish if the health care professionals were aware and trained on the PMTCT policy and guidelines and if these guidelines were administered properly. It became crucial to assess the challenges encountered by HCP in implementing the guidelines and also if patients visiting health care facilities received all necessary information.

These objectives were guided by the research questions set out in section 1.9 of Chapter 1.

The dissertation is structured into five chapters.Chapter 1 introduced the study, provided national and international statistics on HIV and AIDS and PMTCT, rationale of the study as well as the problem statement.

Chapter 2 reviewed previous studies on PMTCT programme, its implementation and administration, discussed existing literature on PMTCT in South Africa and globally.

Chapter 3 described the research strategy and data collection method.

Chapter 4 presented the results of the study as well as the analysis and interpretation of the results; it explored the challenges encountered by health care professionals in public health facilities when administering the PMTCT programme.

Chapter 5 the final chapter concludes the study, summarized the key issues and made recommendations on how government policies can be formulated to assist in the effective administration of the PMTCT programme.

5.3. SUMMARY OF THE FINDINGS

This section presents the summary of the findings of the study in relation to the objectives of the study and the research questions that guided the study.

5.3.1 Administration of prevention of mother-to-child transmission policy and guidelines

The study established that the three PHCs under study administered the PMTCT programme. In two out of the three clinics under study, HIV counselling and testing was offered on daily basis as well as CD4 count blood tests, except for one clinic where the programme was administered only two times a week. The fact that the PMTCT programme was not administered on daily basis in one of the three clinics impacted negatively on the community of uMgungundlovu district and surrounding areas. In addition, it had bad implications for public health managers as this was a service delivery issue. One of the characteristics of good governance is effectiveness and efficiency where institutions are expected to produce results that meet the needs of society (van der Waldt, 2004:12).

The study also established that the majority of patients did not honour their scheduled appointments at clinics, especially those who were scheduled for postnatal services. The HCP were asked what they thought were the reasons for patients not returning for postnatal care at the clinics and they stated that patients had reported having challenges of family support (family member to look after children whilst the woman has gone to the clinic). Most patients had not disclosed their HIV status to other family members for fear of being discriminated against hence they could not explain their frequent visits to the clinic. Stigmatisation and discrimination against HIV-positive people are common amongst different race groups in communities and people are reluctant to disclose their HIV-positive status. The results of a study which was conducted by Tarisai (2002) on stigmatisation and HIV revealed that only one third of participants who had revealed their HIV-positive status were positively accepted in their communities and one out of ten indicated that they had been rejected.

There was proper planning in two of the clinics under study. In these clinics group education sessions were conducted in the morning, while the women waited for their antenatal or postnatal services. The group education was conducted after morning prayers as well as registration of patients, issuing of cards, urine, weight and height administration. As stated by Hughes (2003:44), managers are responsible for proper planning and organisation of work within their departments; they are also responsible for ensuring that employees know what tasks need to be completed, how, when, and by whom (Hughes, 2003:44-45). The processes were organised in an appropriate manner and essential functions were carried out by the right staff and nursing managers directed and coordinated several tasks at theseclinics. The HCT counsellors, M2M mentors, PMTCT sisters and sangomas conducted group education sessions with women in turns in one of the clinics. In one facility however, group education sessions were not conducted because of space constraints and the fact that there was one small waiting area for all patients (those who had come for minor ailments, HIV care and support as well as postnatal and antenatal services). One-on-one counselling was conducted with the HCT counsellors or nurses in one of the facilities since group education could not be conducted owing to space challenges. The challenge of space had negative implications for the public health managers who were viewed as having failed the citizens in ensuringthat they had access to the PMTCT programme.

5.3.2. Training sessions on prevention of mother-to-child transmission policy and guidelines

The research study established that the PMTCT policies, protocols and guidelines were available in all three public health facilities. In addition, the health care professionals had attended training sessions (at Mbalenhle and Caluza clinics) on the PMTCT policies, protocols and guidelines with the exception of KwaPata clinic. At KwaPata clinic, however few a HCP had attended training sessions on the PMTCT protocols and guidelines and knew how patients had to be enrolled into the PMTCT programme.

The fact that some of the HCP had not attended training sessions on the PMTCT policy and guidelines, and were unsuccessful in implementing the programme raises serious concerns for public health managers. Managers are responsible for the delegation of tasks to employees; employees need to be clear on what tasks to perform, to whom, when and how. It should be noted that the three public health clinics under study had trainers who were responsible for the training sessions in their respective clinics. It is the responsibility of the public health managers to ensure that the trainers employed by the Department of Health do perform their tasks efficiently.

The patients who attended KwaPata clinic for antenatal and postnatal services were deprived of their constitutional and democratic right since the PMTCT programme could not administered competently.

Frederick Taylor, the father of scientific management, believed in “one best way” of performing any given task.Work needs to be standardised and procedures clear so that people are able to follow instructions accordingly (Hughes, 2003:27). Likewise, public health managers need toproperly plan what tasks need to be performed by whom, when and how, for instance, ensuring that the trainers provide training sessions to the HCP. Adequate training should be provided to all HCP to enable them to carry out their tasks anywhere they are deployed within the country.

5.3.3. Implementation of the prevention of mother-to-child transmission programme to the community/citizens

According to the PMTCT policy and guidelines (2013), all women visiting public health clinics for antenatal and postnatal services should receive necessary information on PMTCT programme, which is administered in PHCs. Some of the critical points to be covered in educational sessions include: HIV counselling and testing, CD4 count blood draw, HIV prevention, use of condoms, ARVs and other medications, disclosure and healthy living. The study established that the PMTCT protocols and guidelines were being implemented to a satisfactory level in two facilities under study. Most women who visited the clinic for antenatal and postnatal services received crucial information through morning group sessions, which was conducted on daily basis.

All patients received morning group sessions as they were still seated at the waiting area and these educational sessions were administered in combination with other partners based at the clinic. In one facility for instance M2M counsellors and sangomas both conducted the morning sessions jointly with HCP. The fact that the PMTCT programme was implemented appropriately in two facilities had positive results for citizens.

5.3.4 Health care professionals and prevention of mother-to-child transmission coordinators consultation

Participation by citizens is a key cornerstone of good governance (van der Waldt, 2004:10). It was essential to find out if the HCP or PMTCT coordinators were involved when policy and guidelines were developed. It was established that the HCP were not always involved when the PMTCT policy and guidelines were developed or amended. Some of the HCP pointed out that they felt they should have been involved in all discussions which took place as they were directly involved in implementing the programme. The PMTCT coordinators have always been part of the discussions when PMTCT policy and guidelines are revised. It should be noted that participation can either be direct or through genuine intermediate institution or representatives (van der Waldt, 2004:10-11). Owing to budgetary constraints by government

departments, the Department of Health does not have enough funding to send all HCP for training.For this reason they are mostly represented by the PMTCT coordinators.

5.3.5. Anti-retroviral drugs and other medications for HIV-positive and pregnant women

Anti-retroviral drugs decrease the viral load and inhibit viral production in the infant, thus decreasing the risk of MTCT (Whiteside & Sunter, 2000:147). ARVs help to reduce the viral load in the woman's body and infants' risks of contracting the virus through the umbilical cord and exposure to the mother's bodily fluids during childbirth and breast feeding. Information on different types of ARVs is given in public health facilities including ARVs for both infants and adults. Women are also educated on Nevirapine tablet, which is given to HIV-positive and pregnant women at seven months. This tablet has to be swallowed by an HIV-positive woman when she experiences labour pains. It reduces the chances of HIV infection from the mother to her baby as a large amount of blood is lost during labour. In addition to ARVs, women are educated on other important medication to be administered to pregnant women.

There have been a number of committees, groups and bodies formed since 1994 with the intention of reviewing HIV and AIDS policies.This indicates commitment from government in the fight against the reduction of HIV in the country. There has been a reduction in HIV prevalence in children since the roll out of the PMTCT programme in 2002. The PMTCT programme is reported to have saved up to 70 000 children every year at Chris Hani Baragwaneth hospital (News 24 May 2012). In this facility, as in most public health facilities where the programme is run, when a woman tests HIV-positive, intensive counselling is conducted over and above the group counselling which takes place every morning. Treatment and medication (ARVs) is offered to HIV-positive women whilst pregnant and after they have delivered.

5.4 CONCLUSION

Having examined the extent to which the PMTCT programme is run in public health clinics, the study achieved its purpose of assessing the administration of the prevention of mother to child transmission programme in uMgungundlovu health district. Like all public programmes formulated at the national level but implemented in a decentralised system, PMTCT programme achieved some of its intended objectives. This was mainly due to the clear guidelines and protocols that were provided to all clinics and which many clinics strictly followed. However, and as happens when guidelines are followed without concerns for the local context, there were a number of implementation challenges. In the main, these were due to a lack of resources such as insufficient consultation rooms, congested waiting areas as well as staff shortages. Although the PMTCT coordinators were invited when the PMTCT policy and guidelines were developed at national level, the HCP were not included, but they felt they ought to be involved as well since they were directly responsible for the programme. There was lack of planning and organising in one of the health care clinics which impacted negatively on health care managers and disadvantaged the community from accessing the PMTCT programme. Although all the health care clinics under study had facility-based trainers, not all HCP attended training sessions and this resulted in poor implementation of the programme in one health facility. It also deprived the community members (especially those women who visited the clinic for antenatal and postnatal care) from accessing the PMTCT programme as it was their constitutional and democratic right to receive necessary and relevant information when visiting public health facilities for clinical care.Another critical point discussed when enrolling women into the PMTCT programme is medication which should be administered to pregnant women, especially those who are found to be HIV-positive by ELISA test.Information on different types of ARVs as well as other important medication to be administered is provided to all pregnant women visiting public health facilities.

5.5. RECOMMENDATIONS

It is hoped that the recommendations made will assist and guide the Department of Health in addressing the challenges experienced when enrolling patients into PMTCT programme.

5.5.1 Administration of prevention of mother-to-child transmission policy and guidelines

The research established that the three public health clinics under study administered the PMTCT programme. In one facility,however,the programme was administered two days a week compared to two other facilities where it programme was run five days a week. Research also established that the majority of patients who were scheduled for postnatal services did not honour their scheduled appointments. When the HCP were asked what they thought were the reasons for non-attendance, they stated that most patients reported having challenges of family support since they had not disclosed their HIV-positive status to families. It is recommended that the Department of Health ensures the PMTCT programme is administered five days a week in all PHCs. The Department of Health also needs to focus on making the following improvements in all public health clinics:

- Renovations as some facilities have old and small buildings.
- Addressing staff shortages since this impact negatively on PMTCT programme.
- Specimen storage at facilities which will accommodate patients arriving at the clinics in the afternoon for CD4 blood.
- Increased community awareness programmes – these will assist in the fight against stigma attached to HIV and AIDS.

5.5.2 Training sessions on prevention of mother-to-child transmission policy and guidelines

The three public health clinics under study had facility based trainers. However, not all HCP attended training sessions on administration of the PMTCT programme. It is, thus, recommended that the Department of Health management ensures that the trainers who are employed withinhealth facilities are performing their tasks and HCPare trained on the programme implementation so that it is administeredproperly.The Department of Health also needs to ensure that the refresher training sessions are held as they are essential in ensuring that staff members are up-to-date with latest developments.

5.5.3 Implementation of the prevention of mother-to-child transmission programme to communities/citizens

Most community members particularly pregnant womenwere not enrolled into the PMTCT programme in one facility and this was due to a lack of training by HCP as well as space challenges. It is thus recommended that public managers within health facility ensures that the members of the community who visit the PHCs for antenatal and postnatal services and ought to be enrolled into PMTCT programme are enrolled as this is their democratic right. There should be proper planning in all health care facilities; all HCP should be trained on the PMTCT programme so that they are able to implement the programme thoroughly.

5.5.4 Consultation with health care practitioners and prevention of mother-to-child transmission coordinators

The PMTCT coordinators were invited when the PMTCT policies, protocols and guidelines were developed at national level. It also established that although the coordinators were invited, the HCP were not included and they felt they had to be included since they were directly involved with programme implementation. It is recommended that the department of health ensures that both the PMTCT coordinators and at least one HCP from one facility

attend the workshops when input is made to PMTCT policies, protocols and guidelines as well as the PMTCT programme at large.

5.5.5 Anti-retroviral drugs and other medications for HIV-positive and pregnant women

HIV-positive and pregnant women as well as those women who had delivered their babies and were visiting public health clinics received education on important medication to be administered.It is recommended that the department of health management ensuresthat patients from all communities have access to medical information like ARVs, diabetic treatment and other important medication administered to pregnant women as well as women who have delivered their babies.

It is important to note that the PMTCT policy and guidelines cannot be implemented as one size fits all since different clinics have different challenges. At KwaPata clinic for instance the PMTCT programme was run two days a week because ofa lack of resources whereas the two other clinics under study ran the programme five days a week. The fact that the programme was ran two days a week in one facility and five days in the other raises serious concerns for public health managers. If everything is standardised in PHCs if there is equivalent numbers of consultation rooms, equal number of HCP employed, and reasonable waiting areas the implementation of the PMTCT policies, protocols and guidelines can be standardised. Unlike Taylor who believed in “one best way” of performing any given task, there cannot be one best way of implementing the PMTCT programme in public health clinics since they are unique.

It is recommended that the administration of PMTCT programme be improved radically in order to curb the death of babies infected with HIV during birth.

5.6. Suggestions for further research

Further research could examine the reasons for insufficient staffing and space shortages within the Department of Health PHCs as they impact negatively on service delivery. The

other challenges which the study did not elaborate on are lack of equipment in PHCs and how to address stigma attached to HIV and AIDS in communities.

WERE THERE ANY LIMITATIONS?

REFERENCES

Babbie, E. & Mouton, J. 2001. *The practice of social research.* Cape Town: Oxford University Press.

Babbie, E. & Mouton, J. 2005. *The practice of social research.* Cape Town: Oxford University Press.

Baek, C., Mathambo, V., Mkhize, S., Friedman, I., Apicella, L. & Rutenberg, N. 2007. *Key findings from an evaluation of the mothers2mothers program in KwaZulu-Natal*. South Africa: Horizons Systems Trust.

Boyatzis, R.E.1998. Transforming qualitative information: Thematic analysis and code development.Thousand Oaks, London, & New Delhi: SAGE Publications.

Boyne, G.A. 2002. Public and Private Management: What's the difference? Journal of management studies, 39: 98-120

Brou, A.H., Djohan G., Becquet R., Allou, G., Ekouevi, D.K., Viho, I., Leroy, V. & Desgrees-du-Lou, A. 2007. *When do HIV infected women disclose their HIV status to their male partner and why? A study in a PMTCT programme. PLos Medicine*, 4(12):1912-1920.

Bryman, A. 2012. *Social research methods*. New York, NY: Oxford University Press.

Byamugish R., Tumwine, J.K., Semiyaga, N. & Tylleskar, T. 2010. *Determinants of male involvement in the prevention of mother to child transmission of HIV programme in Eastern Uganda: a cross sectional survey*. *Reproductive Health Journal,* 5(7):3-9.

Cassel, C. & Symon, G. 2004. *Essential guide to qualitative methods in organisational research*. London: Sage.

Crabtree, B.F. & Miller, W.L. 1992. *Doing qualitative research: research methods for primary care*. London: Sage.

Cresswell, J.W. 2009. *Research design: qualitative, quantitative and mixed methods approach*. Chicago, IL: Sage.

Chopra, M., Doherty, T., Jackson, D., & Ashworth, A. 2005. *Preventing HIV transmission to children: quality of counselling of mothers in South Africa*. *Acta Paediatrica*, 94:357-363.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D. & Mclntyre, D. 2009. *The health and health system of South Africa: historical roots of current public health challenges*. *Health in South Africa*, 374(9692):817-834.

Cloete, J.J.N.1998. *South African Public Administration and Management*. Pretoria: JL van Schaik.

Dalal, K., Andrews, J. & Dawad, S. 2012. *Contraception use and associations with intimate partner violence among women in Bangladesh*. *Journal of Biosocial Science*, 44(1):83-94.

Delva W., Mutunga L., Quaghebeur A. & Temmerman, M. 2006. *Quality and quantity of antenatal HIV counselling in a PMTCT programme in Mombasa, Kenya. AIDS Care,* 18(3): 189-193. August.

Department of Health. 2008. Policy and guidelines for the implementation of the PMTCT programme. Pretoria: Government Printer.

Department of Health. 2010. Policy and guidelines for the implementation of the PMTCT programme. Pretoria: Government Printer.

Doherty, T., Chopra, M., Jackson, D., Goga, A., Colvin, M., & Persson, L. 2007. *Effectiveness of the WHO/UNICEF guidelines on infant feeding for HIV-positive women: Results from a prospective cohort study in South Africa*. *AIDS*, 21(3):1791-1797. May.

Dunn, W.N. 1994. *Public policy analysis: an introduction*. New Jersey, NJ: Prentice Hall.

Du Toit DFP & van der Waldt.1999 *Public administration and management: the* grassroots. Kenwyn: Juta & Co.

Dunn, C.M. & Pharm, G.C. 1999. *Protecting study volunteers in research: a manual for investigative sites*. Boston, MA: Centre Watch Publisher.

Escr-net/Minister of Health v Treatment Action Campaign (TAC). http://www.escr-net.org/docs/i/403050. [8 February2014]

Fourie, P. 2006. *The political management of HIV and AIDS in South Africa: one burden too many?* New York, NY: Palgrave Macmillan.

Goffman, E. 2009. *Stigma: notes on the management of spoiled identity*. New York, NY: Simon & Schuster.

Gulick, Luther and Urwick, Lyndall (eds) (1937) Papers on the Science of Administration (New York: Institute of Public Administration)

Hughes, O.E. 2003. *Public management and administration: an introduction*. 3rd ed. Hampshire: Palgrave Macmillan.

HSRC, MRC, Cadre & NICD.2009. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: a turning tide among teenagers? Cape Town: HSRC Press.

Kapczynski, A. & Berger J. 2009. The story of the TAC case: The potential and limits of socio-economic rights litigation in South Africa, Cape Town, Social Science Electronic Publishing

Kalichman, S.C. & Simbayi, L.C.2003.*HIV testing attitudes, AIDS stigma and voluntary HIV counselling and testing in black townships in Cape Town*, South Africa. Sexually Transmitted Infections, 79 (6):442-447.

Kroon, J. 1990. *General management*. Cape Town: Kagiso Tertiary.

Kroon, J. 1995. General Management: Four basic functions of management. Pretoria: Kagiso tertiary

Lau, C. & Adamson, S.M. 2004. HIV and AIDS in Sub-Saharan Africa. *Croatian Medical Journal*, 45(4):402-414. Lutabingwa, J. & Nethonzhe, T. 2006. Ethical issues in social research. *Journal of Public Administration*, 41(3):694-702.

Malterud, K. 2001. *Qualitative research: standards, challenges, and guidelines*. *The Lancet*, 358(9280):483-488.

Manzi, M., Zachariah, R.T., Buhendwa, L., Kazima, J., Bakali, E., Firmenich, P. & Humblet, P. 2005: High acceptability of voluntary counselling and HIV testing but unacceptable loss to follow up in a prevention of mother-to-child HIV transmission programme in rural Malawi: scaling up requires a different way of acting. *Tropical Medicine and International Health*, 10(12):1242-1250.

Marshall, C. & Rossman, G.B. 2011. *Designing qualitative research. California*: Sage.

Moynihan, D.P. 2006. Managing for results in State Government: Evaluating a Decade of Reform. Public Administration Review, 77-89

National Agency for the Control of AIDS (NACA) (2012) Global AIDS Response: Country Progress Report, Abuja, Nigeria, Federal Republic of Nigeria.

Neuman, W.L. 2000. *Social research methods*. London: Allyn & Bacon.

News 24. May 2012. News on Prevention of Mother to Child Transmission programme.

Nkonki, L.L., Doherty, T.M., Hill, Z., Chopra, M., Schaay, N. & Kendaal, C. 2007. Missed opportunities for participation in prevention of mother to child transmission programme: simplicity of Nevirapine does not necessarily lead to optimal uptake, a qualitative study. *AIDS Research and Therapy*, 4(27):1742-6405.

Oanh, K.T.H., Ashburn, K., Pulerwitz, J., Ogden, J. & Nyblade, L. 2008. Improving hospital based quality of care in Vietnam by reducing HIV related stigma and discrimination. Horizon: 1-136.

Oladokun, R.E., Brown, B.J. & Osinusi, K. 2010. Infant feeding pattern of HIV-positive women in a prevention of mother-to-child transmission (PMTCT programme). *AIDS Care*, 22(9):1108-1114.

O'Sullivan, E. & Rassel, G.R. 1989. *Research methods for public administrators*. 3rded. New York, NY: Addison Wesley.

Pratt, R.J. 2003. *HIV and AIDS: A foundation for nursing and healthcare practice*. 5th ed. London: Taylor & Francis.

Peltzer, K., Weichao L. & Pelisa, D. 2008. Government employees: family planning amongst HIV-positive and HIV-negative PMTCT clients in a resource poor setting in South Africa. *AIDS and Behaviour*, 13(5):973-975.

Republic of South Africa. 1996. *The Constitution of the Republic of South Africa of 1996*. Pretoria: Government Printer.

Republic of South Africa. 1998. *The White Paper on Local Government of 1998.* Pretoria: Government Printer.

Republic of South Africa. 2000. *The Promotion of Access to Information Act, Act 2 of 2000*. Pretoria: Government Printer.

Rotheram-Borus, M., Richter, L., van Rooyen, H., Tomlison, M., Stein, A., Rochat, T., de kadt, J., Mtungwa, N., Mkhize, L., Ndlovu, L., Ntombela, L., Comulada, W.S., Desmond, K.A. & Greco, E. 2011. Project Masihambisane: a cluster randomisedcontrolled trial with peer mentors to improveoutcomes for pregnant mothers living with HIV. *Trials Journal*, 12(2):1-10.

Strachan, M., Kwateng-Addo, A., Hardee, K., Subramaniam, S., Judice, N. & Agarwal, K. 2004. An analysis of family planning content in HIV and AIDS, VCT & PMTCT policies in 16 countries. Policy Working Paper Series no 9: 1-32, January.

Sherman, G.G., Jones, S.A., Coovadia, A.H., Urban, M.F. & Bolton, K.D. 2004. *PMTCT from research to reality results from a routine service*. *South African Medical Journal*, 94:289-292.

Scott, V. E., Chopra, M., Conrad, L. & Ntuli, A. 2005. *How equitable is the scaling up of HIV services provision in South Africa. South African Medical Journal*, 95(2):109-113.

Skinner, D., Mfecane, S., Gumede, T., Henda, N. & Davids, A. 2005. Barriers to accessing PMTCT services in rural area of South Africa. *African Journal of AIDS Research*, 4(2):115-123.

Stillman, Richard, J. 1987. The American Bureaucracy (Chicago: Nelson – Hall)

Tallis, V. 2002. Gender and HIV and AIDS: overview report.university of Sussex, institute of development studies, bridge project.

Tarisai, V. 2002.Tarisai's story, SAFAIDS "Positive Voices" series, victoria: The communication. Initiative available at: http://www. Comminit.com/commentary/sld -4989 html.accessed June 2012

Theuring, S., Mbezi, P., Luvanda, H., Jordan-Harder, B., Kunz, A. & Harms, G. 2009. *Male involvement in PMTCT Services in Mbeya region*. *AIDS and Behaviour*, 13(1):92-102.

The presidency of the Republic of South Africa, 2011. Circula: Statement on meeting of the South African National AIDS Council (SANAC). Cape Town

UNAIDS, J. 2010. Global report: UNAIDS report on the global AIDS epidemic. UNAIDS: Geneva.

UNAIDS (2011) 'UNAIDS World AIDS Day Report', available at: http://www.unaids.org/en/media/contentassets/documents/unaidspublication/2011/JC2216 WorldAIDSday report 2011 en.pdf, site accessed 21 May 2014

Van der Waldt, G. 2004. *Managing performance in the public sector: concepts, considerations, and challenges*. Lansdowne: Juta&Company.

Webb, W. & Auriacombe, C.J. 2006. Research design in public administration: critical consideration. *Journal of Public Administration*, 41(3):588-602.

Wessels, J.S. & Pauw, J.C.(eds) (1999). Reflective public administration: views from the south. Oxford University Press.

Whiteside, A., & Sunter, C. (2000) AIDS: the challenge for South Africa. Human & Rosseau

Weber, M. 2009. *From Max Weber: Essay in sociology. United States of America*: Routledge.

Wilkison, D., Cutts, F., Ntuli, N. & Karim, A.S.S. 1997. Maternal and child health indicators in a rural SA health district. *South African Medical Journal, 8*7(4):456-459.April.

Wilkison, D., Gouws, E., Sach, M., & Abdool Karim, S.S. 2001. Effect of removing user fees on attendance for curative and preventive primary health care services in rural South Africa. *Bulletin of the World Health Organisation*, 79(7):665-671. July.

World Health Organisation. 2010. Global strategy for health by the year 2000. Geneva: World Health Organisation.

Yin, R.K. 1989. Research design issues in using the case study method to study management information systems. The information systems research challenge: Qualitative and Quantitative approaches ME Sharpe.

Zuma, J.Z. 2009. *State of the nation address.* Pretoria.

Appendix 1

UNIVERSITY OF
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28 June 2011

Ms LN Mtungwa (8831018)
School of Public Administration
Faculty of Management Studies
Westville Campus

Dear Ms Mtungwa

PROTOCOL REFERENCE NUMBER: HSS/0396/011M
PROJECT TITLE: Administration of the Prevention of Mother to Child Transmission Programme in Umgungundlovu district – KwaZulu-Natal

In response to your application dated 23 June 2011, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.
PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Supervisor: Dr BC Mubangizi
cc. Mrs C Haddon

HEALTH
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Enquiries: Mrs. N. M. Zuma-Mkhonza
Ref No: 16/17
03 June 2011

TO: MS L. N MTUNGWA
HSRC –FACULTY OF HUMAN DEVELOPMENT AND SOCILA SCIENCE
UNIVERSITY OF KWA-ZULU NATAL

RE: PROVISIONAL APPROVAL OF A RESEARCH PROPOSAL

I have pleasure in informing you that provisional permission has been granted to you by the District Office to conduct research In ***In Prevention Of Mother To child Transmission (PMTCT) Programme In Kwa-Zulu Natal With Specific Reference To UMgungundlovu Health District .***

PLEASE NOTE THE FOLLOWING

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department and your Ethical Approval.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thank you

MRS N. M ZUMA-MKHONZA
THE DISTRICT MANAGER
UMGUNGUNDLOVU HEALTH DISTRICT

Appendix 3

University of KwaZulu-Natal School of Public Administration

MPA Research Project

Researcher: Mtungwa Lillian Nonhle

Contact number: 083 547 6833

Supervisor: Dr B C Mubangizi

Contact number: 031- 260 8730

Research Office: Ms P Ximba 031 260 3587

Dear respondent

My name is Lillian Nonhle Mtungwa, MPA student within the School of Public Administration and Management at University of KwaZulu-Natal (UKZN–Westville campus). I would like to invite you to participate in a research project on "Assessment of Prevention of Mother to Child Transmission (PMTCT) programme in KwaZulu - Natal with specific reference to UMgungundlovu district".

The study is aimed at assessing the implementation as well as delivery of PMTCT programme in public health facilities in KZN. I am hoping to get an understanding on how the programme is delivered within public health facilities in KZN especially UMgungundlovu district.

Please understand that you are not being forced to take part in this project, the choice to participate or not is yours alone. However, I would really appreciate it if you do share your thoughts with me. If you agree to participate, you may stop me and tell me that you don't want to go on with the interview at any time without any consequences to you. There will be no monetary gain from participating in this research project.

Confidentiality and anonymity of records identifying you as a participant will be maintained by the School of Public Administration, UKZN.

If you have any questions or concerns about participating in this study, please contact me or my supervisor at the numbers listed above.

The interviews may not last more than 25 minutes to be completed. I hope you will take the time to complete the questionnaire.

Thank you for your time.

Yours sincerely

Investigator's signature: _____

Date: _____

This page is to be retained by participant

Appendix 4

University Of KwaZulu-Natal – School of Public Administration

School of Public Administration

Researcher: Mtungwa Lillian Nonhle

Contact number: 083 547 6833

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CONSENT

I_____ (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

_____ _____

Signature of participant Date

This page is to be retained by researcher

Appendix 5

University of KwaZulu-Natal – School of Public Administration

MPA Research Project

Interview Cover Sheet

Interviewer's name:

Date of interview:

Name of health facility (Tick)

Mbalenhle clinic	
Caluza clinic	
KwaPata clinic	

Start time of interview

End time of interview

1. In your opinion are there any PMTCT protocols and guidelines to be practised within public health facilities? Please explain.
2. As a manager/PMTCT Coordinator were you involved when these protocols and guidelines were developed? Please explain
3. How do health care professional receive training on the protocols and guidelines?

4. How do you ensure that all the public health facilities have got the sufficient protocols and guidelines in their facilities

5. In your opinion do you think these protocols and guidelines are delivered and implemented as they should? Please explain.

6. Can you briefly mention the challenges encountered by the health care professionals when implementing the PMTCT programme?

7. What do you think might be the solutions to the challenges mentioned?

8. Do you have any final comments?

Appendix 6

University of KwaZulu-Natal – School of Public Administration

MPA Research Project

Interview Cover Sheet

Interviewer's name:

Date of interview:

Name of health facility (Tick)

Mbalenhle clinic	
Caluza clinic	
KwaPata clinic	

Start time of interview

End time of interview

1) During your recent visit to the health facility did you receive information on HIV and AIDS

and how was this received? Individually or in a group?

2) Were you offered a chance to test for HIV, and was it explained why it was important for you to test?

3) Were you given a chance to do CD4 blood count? (HIV-positive participants)

4) Were you provided with the drugs or medication to prevent mother to child transmission

of HIV? (for HIV-positive participants)

5) Did the health care professional explain what it meant to be HIV-positive for you and the baby?

6) Did you receive information about where you can go to receive more support about questions and concerns you may have about your HIV infection?

7) Can an HIV-positive mother infect her baby during pregnancy, delivery and breast-feeding?

Appendix 6

University of KwaZulu-Natal – School of Public Administration

MPA Research Project

Interview Cover Sheet

Interviewer's name:

Date of interview:

Name of health facility (Tick)

Mbalenhle clinic	
Caluza clinic	
KwaPata clinic	

Start time of interview

End time of interview

1) Were you offered a chance to test for HIV and AIDS when you were pregnant?

2) Did you receive education on HIV and AIDS?

3) Were you offered a chance to do CD4 count and were it explained why this was important.

4) Did you receive education on important medication to be administered when pregnant?

5) Did you receive information on infant immunisation?

6) Did you receive information on PCR testing for infants?

7) Were you educated on feeding options? Please explain.

8) Did you receive information on how to take care of your baby and attend all scheduled visits?

Appendix 7

University of KwaZulu-Natal – School of Public Administration

MPA Research Project

Interview Cover Sheet

Interviewer's name:

Date of interview:

Name of health facility (Tick)

Mbalenhle clinic	
Caluza clinic	
KwaPata clinic	

Start time of interview

End time of interview

1) Is the PMTCT Programme run in your facility? Please explain.

2) Are the protocols and guidelines available within your facility and how do you get hold of them? Please explain.

3) Were you as a Coordinator consulted when the PMTCT guidelines and protocols were drafted?

4) Were the health care professionals consulted when the protocols and guidelines were drafted? Please explain.

5) How is the training on PMTCT protocols and guideline provided in your facility? Please explain.

6) How is information on HIV and AIDS received by health care professionals?

7) Do you think patients visiting this facility who ought to be enrolled into the programme are enrolled?

8) What do you think are the challenges faced by the health care professional regarding PMTCT protocols and guidelines?