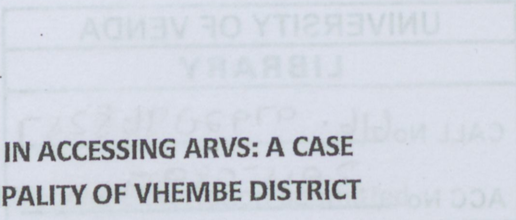

CHALLENGES FACED BY HIV POSITIVE PREGNANT MOTHERS IN ACCESSING ARVS: A CASE STUDY OF TSHIRENZHENI VILLAGES AT THULAMELA MUNICIPALITY OF VHEMBE DISTRICT

by

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A mini-dissertation submitted in partial fulfilment of the requirement for the Degree of

MASTER OF PUBLIC MANAGEMENT

OR TAMBO INSTITUTE FOR GOVERNANCE AND POLICY STUDIES

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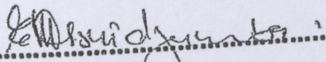
DECLARATION

I, **Tshidzumba Mukondeleli Elisabeth,** hereby declare that this mini-dissertation submitted to the University of Venda for the Degree of Masters in Public Management has never been submitted for any degree in any other university, that is my own work in design and executive and all citations, references and borrowed ideas have been duly acknowledged.



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DEDICATION

On my personal note, I dedicate this project to my parents, Mrs. Muofhe Nedambale and the late Mr. Tshiwela Nedambale. You were the star throughout my study.

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ABSTRACT

The study focuses on the investigation of the challenges faced by HIV positive pregnant mothers in accessing ARVS. Guided by the Department of health policy which provided guidelines in how to deal and assist positive mothers the study was undertaken to check if positive mothers in the area are complying with the strategies and women know their status in advanced.

In the area under investigation the researcher realized that there are challenges that women facing, among them; challenges to reaching the women in need of PMTCT, a risk of the transmission of HIV, assessment of antiviral therapy for expectant mothers and her new baby.

To arrive at the hospital at the advance stage of labour, these challenges included some socio demographic factors, that some women who tested positive drop out of PMTCT programmes for fear of discrimination and rejection by male partners as well as difficulties of some women in the rural areas faces in reaching clinics following onset of labour particularly during the night which leads to their delivery at home or arrive at the hospital at an advance stage.

In some cases it is found that women lacking symptoms did not feel the need to taking ARVs while some develop a stigma and fear of disclosure to partners and family members which act as major barriers to uptake of PMTCT ARV interventions. The national HIV counselling and campaign shows greater impact as more HIV positive know their status at booking however two thirds still do not know their status when booking.

The researcher used both qualitative and quantitative research methodologies. For research design the researcher used field study. A non-probability sampling and its subtype purposive sampling method was used to select the respondents. Two data collected instruments were used to collect data, namely, questionnaire and interview. For data analysis, two data analysis methods were used, which are statistical package for social sciences (SPSS) version 22.0 and the thematic analysis. Various ethical considerations were applied in the study.

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Major findings of the study are:

Majority of the respondent in the study revealed that HIV positive pregnant mothers receive PMTCT. The study focused out that HIV positive pregnant mothers take AR'S to protect their unborn babies. The researcher found that Majority of the respondents revealed that information is given on ARVs to HIV positive pregnant mothers.

The finding shows us that HIV positive pregnant mothers receive support from the families wherein responded that they agree that the families support the HIV positive pregnant mothers. This percentage is high and indicates the family involvement in assisting HIV positive pregnant mothers.

The health facilities are user friendly to HIV positive pregnant mothers indicated by high percentage. Though such facility functions only during the day and they close during the night. The findings show that the community is involved in supporting of HIV positive pregnant mothers with high percentage.

The recommendations of the study are:

The study was conducted in a small village. The study must be conducted which can cover the entire ward 28 of Thulamela Municipality. Further study must be done which can includes more respondents from other municipality. The mobile teams must be trained on PMTC T and NIMART to be able to test initiate client at the community level. The Department of health needs to ensure that all clinics operate for 24 hours with enough staff which can cover day and night shift.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral (drug)
CHC	Community Health Centre
HCT	HIV Counselling and Testing Campaign
HIV	Human Immunodeficiency Virus
MCWH	Maternal Child and Women's Health
MTCT	Mother-to-child transmission (of HIV)
PHC	Primary Health Care
PICT	Provider-initiated counselling and testing
PMTCT	Preventing mother-to-child transmission of HIV
NVP	Nevirapine
AZT	Zidovudine
FDC	Full dose combination

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CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

This study focuses on the challenges faced by Human Immune Virus (HIV) positive pregnant; mothers in accessing Antiretroval treatment (ARVS): a case study of Tshirenzheni village at Thulamela municipality of Vhembe district.In sub- Saharan Africa an estimated 60% Of people living with HIV-1 are women mostly in reproductive age group. Each year approximately 1.4 million positive women become pregnant (World Health Organization 2009).

This chapter presents introduction and background of the study, problem statement, aim of the study, specific objectives of the study, critical research questions, significance of the study, delimitation of the study, limitations of the study, and definitions of operational concepts as well as organisation of chapters.

1.2 BACKGROUND OF THE STUDY

Evian (2003:3) contends that Human Immune Virus (HIV) was discovered by the scientists in September 1983in America. HIV as a virus which causes disease which is known as Acquired Immune Deficiency Syndrome AIDS) was discovered in America in 1981. Acquired Immune Deficiency Syndrome was known as a disease which affects people between 25years to 35years but now is affecting all ages (Evian, 2003:3).Evian (2003:3) further stated that in 1985 the Elisa antibody test for HIV was discovered. The virus appeared to be coming from chimpanzees to the monkey and to the human beings. The migration and the movement of people across large distances, socioeconomic instability, and intravenous drugs and multiple partners' sexual activity enabled the virus to spread rapidly worldwide.

HIV can be transmitted from mother to child during pregnancy, during delivery and during breast feeding. The introduction of a single dose of Nevirapine to pregnant mother during labour after she has been tested and found being positive has reduced the transmission.The program was started in 2000 in South Africa (National guideline, 2008:13).The study is about challenge which leads positive pregnant mothers not accessing antiretroviral treatment in

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rural areas where there is a lack of information. Most of the positive pregnant mothers deliver at home due to the problem of transport.This becomes a problem where positive mothers who deliver at home failing to bring their children for immunization and testing. Stigma aroundHuman Immune Virus(HIV) andAcquired immunodeficiency syndrome(AIDS) is still a challenging issue in the rural areas and thus make it difficult for people to disclose their status resulting in them not going for voluntary counseling and testing. Some of the clinics under the hospital have no good link with antiretroviralclinic. Without treatment, around 15-30% of babies born to HIV positive women will become infected with Human immune virusduring pregnancy and delivery. A further 5-20% will become infected through breastfeeding. This research seeks to provide recommendations which might help to prevent the transmission of Human immune virus from mothers to children during pregnancy and childbirth and medical management of Human immune virus positive pregnant women. It is intended to complement the Department of Health Guide for maternity care National guideline (2004) revised by Gourlay et al., (2013:16:18588).

1.3 PROBLEM STATEMENT

South African National AIDS Council Revised Prevention of Mother to Child Guideline (2013:5) encouraged pregnant mothers to book for giving birth as early as possible preferably before 14 weeks of gestation. The National Guideline provides that no women must be returned back when trying to book. Further the National Guideline stated that all women coming to the clinic for antenatal booking must be seen on the same day. The National Guideline (2013:19) stipulates the baseline which provides the screening of all pregnant mothers and provides information by means of group counseling in all positive pregnant women who do not consider their CD4 350 or more than 350mml.It is stipulated in the Bill of Right (Act No.108 of 1996, Section 24) that every person has a right to an environment that is conducive to his or her health or well-being .This right also applies to HIV positive pregnant mothers and protect them from being exposed to harmful environment at the health facilities. Furthermore, Section 12(1)(c) of the Republic of South Africa Constitution, 1996 provide that all persons have the right to freedom and security of person ,which includes the right to be free in accessing the ARV treatment from public source(RSA 1996: Section 12(1).The right to bodily and psychological integrity, dignity,

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privacy and equality enshrined in the Bill of Right further rprotects the HIV positive pregnant mothers.

Despite the National Guidelines there are still some significant challenges remains to achieve the coverage of counselling and testing for pregnant women and initiation of ARV provision for HIV positive pregnant women. Many women do not attend Antenatal service and those who do not are unlikely to complete the World Health Organisation (WHO) recommendation of visits throughout a pregnancy period.There is a need for expansions of the services to other setting were women can accessservice(e.g. Maternity ward, family planning clinics, immunisation clinics, community health centres and mobile clinics World Health Organization (2009). Many women deliver at home rather than in a health facility thus leading women and their babies failing to take the needed dose for antiretroviral at the time of labour and delivery. Stigma and discrimination play a role in preventing mothers to access ARV and underlying cultural systems that disempower women and then create a situation that makes it challenging to follow through on essential PMTCT programme(Word Health Organization, 2009).The study is conducted in order to come up with the solution on the challenges faced by HIV positive pregnant mothers on accessing ARVS.

1.4 AIM OF THE STUDY

The main aim of the study is to investigate the challenges faced by HIV positive pregnant mothers in accessing ARVS: a case study of Tshirenzheni villages atThulamela Municipality of Vhembe District.

1.5 SPECIFIC OBJECTIVES OF THE STUDY

- To describe the challenges faced by HIV positive pregnant mothers in accessing ARVS.
- To explore the importance of taking ARVs by HIV positive pregnant mothers.
- To assess the accessibility of ARV to the residents of Tshirenzheni Village.
- To determine the strategies that can be used to address the problems faced by HIV positive pregnant mothers in accessing ARVS.

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1.6 CRITICAL RESEARCH QUESTIONS

- What are the challenges faced by HIV positive pregnant mothers in accessing ARVS?
- What is the importance of taking ARVs by HIV positive pregnant mothers?
- How is the accessibility of ARV to the residents of Tshirenzheni Village?
- What are the strategies that can be used to address the problems faced by HIV positive pregnant mothers in accessing ARVS?

1.7 SIGNIFICANCE OF THE STUDY

The study findings will be important because it will increase number of positive pregnant women in accessing ARV in the health facilities and mobile clinics. To empower clinic nurses with information on PMTCT programme. The study findings will increase awareness campaign to community on HIV and AIDS counseling and testing on pregnant mothers at the local chief's kraal, churches, pension pay point traditional health practitioners. To let all pregnant mothers, have information on PMTCT.

1.8 LIMITATION OF THE STUDY

Constrains of the study include shortage of funds for stationery, transport, computer, printer and binding materials. Some respondents may supply wrong information to impress the researcher instead of reporting what is exactly happening; and some respondents may probably not cooperate however; all ethical considerations shall be followed to win the hearts of the respondents to participate freely in the study.There would be transport constrains to visit Tshirenzheni villages and to cover the whole area. The problem with this study is that respondents may withdraw from participating in this research, because the research topic is very sensitive and there is still stigma attached. This study will be conducted in Tshirenzheni village rural community and may not be representative of the larger Vhembe District population.

1.9 DELIMITATIONS OF THE STUDY

The study is based on the challenges faced by HIV positive pregnant mothers in accessing ARVS and the study will be conducted at Tshirenzheni village rural community of Thulamela

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Municipality, Vhembe District. The staff will be consulted to find out if they have enough information to give it to the clients on PMTCT programme.

1.10 OPERATIONALDEFINITION

The definition of concept in guarantee that there will be clarity to the author, as well as the reader, about what is meant by various concepts (Van der Wald2004:4).The researcher wants to ensure that the concepts that are described are defined in the precise sense in which they are to be used in this study. This requires the definitions to be made more operational, that is they should convey observable behavior under given conditions. The main concepts are explained below:

- **Antiretroviral**

The Antiretroviral is the medicines that have specific effect on the virus in which renders it inactive thus improving the immune system. (Clinical guidelines, 2010: ii).

- **Pregnant mother**

The Clinical Guidelines (2010:ii) defines a pregnant mothers are women who have conceived between 25yrs to 45yrs.

- **Prevention of mother to child transmission**

Prevention of mother to child transmission refers to the protection of the unborn baby of HIV infected mother against the HIV virus (Clinical guidelines, 2010:ii).

- **Mother-to-child transmission (MTCT)**

Is an HIV-infected pregnant woman passes the virus to her baby. This can occur during pregnancy, labor, and delivery and during breastfeeding (Clinical guidelines Prevention of mother to child transmission, 2010: ii).

1.11 ORGANIZATION OF THE STUDY

The mini-dissertation presentation is organized into the following headings:

Chapter 1: Introductions and orientation of the study

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This is the introduction chapter, which outlines the purpose and organization of the research. The chapter is composed of an introduction, statement of problem, purpose of the study, objectives of the study, significance of the study delimitation of the study, limitation of the study, reference techniques and research methodology. It also indicates the divisions of chapters in the study as a whole.

Chapter 2: Literature review

The main focus of the literature review in chapter 2 is the review of different literature, which provides the theoretical foundation of the empirical studies and / or documentation on challenges faced by pregnant mothers in Tshirenzheni village with regards to challenges of not accessing antiretroviral treatment

Chapter 3: Research design and methodology

The chapter describes the methodology which would be used when the study is conducted. It consists of the research design, population, sampling, research instrument, data collection, data analysis and definition of concepts.

Chapter 4: Data presentation, analysis and interpretation

The results of the investigation are presented and analyzed. The data will be compared to identify concurring and divergent views.

Chapter 5: Findings, conclusion and recommendations

The chapter focuses on the findings, recommendations and conclusion and it therefore constitutes a brief summary of the whole study.

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CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 reviews the literature in terms of the study. Access to Prevention of Mother to Child Transmission PMTCT programmes provided is critical in order to realize the goal of the National Strategic Plan of HIV and AIDS and STIs 2007-2011 which states that Comprehensive Care Management and Treatment (CCMT) services including provision of ARVs should be made accessible to 80% of people requiring them and to ensure the at least less that 5% of the babies tested for HIV should test positive (SANAC and National Department of Health, 2007).

The type of literature consulted for this review is generally articles from journals and reports produced by government departments and or partners providing aid relief in HIV and AIDS programmes. This chapter includes the literature review on health care workers experiences in when implementing the prevention of mother to child transmission programme. The following aspects are reviewed: Global and national responses to PMTCT of HIV and AIDS, Trends of HIV and AIDS among Antenatal in South Africa, Global Situation of MTCT, Challenges facing PMTCT implementation, barriers on the implementation of PMTCT programme, South Africa PMTCT guidelines interventions and Situation of PMTCT in South Africa including various Conceptual framework that can be used to improve PMTCT.

2.2 LEGISLATIONS ON HIV POSITIVE MOTHERS

The Sub-Saharan Africa Region accounted for: 67% of HIV infections; 68% of new infections among adults and 90% among children and 72% of AIDS-related deaths. About 5.7 million people in South Africa were estimated to be infected with HIV, the highest in Southern Africa and globally (UNAIDS, 2009a). In 2007, there were about 350 000 people believed to have died from AIDS in South Africa (UNAIDS, 2008). This could be attributed to South Africa's high population prevalence of HIV infection and high-risk heterosexual behaviour; the practice of having multiple concurrent sexual partners, unprotected sex and sexual relations with persons whose HIV status is not known; high levels of sexually transmitted infections; population mobility patterns; high HIV viral loads coupled with recent HIV

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infections or advanced HIV disease and high levels of vulnerability due to poor socio-economic conditions (Matjila et al.,2008).

Since its attainment of democracy in 1994, South Africa has formulated several policies and legislative acts such as the constitution of Republic of South Africa 108 of 1996, National Health Act No 61 of 2003, Medical scheme Act No 131 of 1998, Employment Equity Act No 55 of 1998, the Non-Profit Organisations Act No 71 of 1997, Promoting of Equality and Prevention of Unfair Discrimination Act 2000 and Sexual Offenses Act No of 1957 that address the HIV and AIDS epidemic. The policies in the first decade of attaining democracy are well documented and authors are generally critical of the poor response of the Government to the epidemic. Butler (2005), Johnson (2005) and Schneider (2002) discuss some of these policies at length. In contrast, recent policies have indicated shift in policy as government and civil society demonstrate more collaboration than before.

According to Stevens et al., (2007), the HIV & AIDS and STI Strategic Plan for South Africa 2007-2011, represents a broad consensus for an effective national response to the HIV and AIDS as well as other epidemics. The Prevention-of-Mother-to-Child-Transmission (PMTCT) programme, Voluntary Counselling and Testing (VCT) and Antiretroviral therapy (ART) and their implementation challenges constitute the main debate regarding women and HIV and AIDS policy and legislation.

In 2008, the National Department of Health released a document on the Policy and Guidelines for the Implementation of the PMTCT Programme in order to provide an update on the approach to the implementation of the National PMTCT programme. The updated policy outlines four stages of PMTCT, in line with the international standards for a comprehensive PMTCT strategy, namely:

- Primary prevention of HIV especially among women of childbearing age;
- Preventing unintended pregnancies among women living with HIV;
- Preventing HIV transmission from a woman living with HIV to her infant; and
- Providing appropriate treatment, care and support to women living with HIV and their children and families (National Department of Health, 2008:13).

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While these four goals are international basic recommendations, the recent National PMTCT programme prioritises the primary prevention of HIV among women of childbearing age and the providing of appropriate treatment, care and support to women living with their children and families. The policy considers it important to involve civil society in the implementation programme, (National Department of Health, 2008). In July 2008, dual therapy with Nevirapine and AZT was introduced for the PMTCT.

This recent PMTCT policy update is in line with the current HIV and AIDS and STI National Strategic Plan in which PMTCT also features as the third goal to be achieved through two main objectives: firstly, the broadening of existing mother to child transmission services so that they include other related services and target groups and secondly, increasing coverage and improving quality of PMTCT to reduce MTCT to less than 5% by 2011 (South African National AIDS Council, 2007). In 2010, the Department of Health and the South African National AIDS Council issued guidelines on the management of PMTCT entitled Clinical Guidelines: PMTCT (Prevention of Mother-to-Child Transmission). According to the Minister of Health, Dr Aaron Motsoaledi, these guidelines are meant "to serve as a new guide to health practitioners with regard to the comprehensive management of pregnant women who are HIV positive," (Department of Health and South African National AIDS Council, 2010, p.1). This document gives an update of the national PMTCT policy guidelines and intends to provide continual guidance regarding reducing the vertical transmission of HIV, building on work done since the launching of the programme and the 2008 Policy and Guidelines document (Department of Health and South African National AIDS Council, 2010).

The Department of Health's annual antenatal survey for HIV and AIDS showed that on its 2008 sample of 33, 488 women attending 1, 415 antenatal clinics in all the nine provinces, 28% were estimated to be living with HIV. Provinces of KwaZulu-Natal, Mpumalanga and Free State recorded the highest HIV rates, while the Northern Cape and Western Cape recorded the lowest prevalence (National Department of Health, 2009).

The success of the present policy will be measured by its ability to address challenges that have, for long, negatively impacted on the implementation of PMTCT. According to Paradath et al., (2006), there was poor postnatal follow-up, especially in rural areas. A significant

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proportion of women attending PMTCT services were not offered testing due to shortages of counsellors, testing supplies and consent forms (Nkonki et al., 2007). Poor implementation was also due to the fact that the programme was implemented vertically and without any proper integration into the health care system (Beksinska et al., 2006). The majority of South African HIV infected women lacked proper information for decision making regarding pregnancy and childbirth issues since there were some negative factors and obstacles to pregnancy prevention and others were unable to access condoms and contraception consistently (Ramkissoon et al., 2006).

The recent HIV and AIDS policy announced by President Jacob Zuma on the World AIDS Day of 2009 shows how determined the South African Government is to prevent the transmission of HIV from mother-to-child. Within the old policy, HIV positive pregnant women were eligible for treatment if their CD4 count was less than 200, whilst the new policy, which came into effect on 1st April 2010, states that all pregnant HIV positive women with a CD4 count of 350 or who merely show symptoms regardless of CD4 count, can access treatment. The policy also provides that all other HIV positive pregnant women who do not fall under this category can now access treatment at 14 weeks of pregnancy in order to protect the baby, instead of at the last term of pregnancy as per the old policy (Zuma, 2009). With this policy, South Africa shifted from the ART rationing model recommended by WHO (that of CD4 count of 200) to the one recommended by the US Department of Health and Human Services (of CD4 count of 350) which would increase access to ART from 9.5% to 56.3% (Rosen et al., 2005).

The recent guideline for 2013 provide that all women who are newly diagnosed as HIV positive anytime during pregnancy and women who enter ANC with known HIV positive status and not yet on ART and no active psychiatric illness or renal disease to be started on FDC (Full dose combination) (TDF, FTC, EFV). These positive pregnant mothers they are taken baseline blood and requested to come back after 7day to check results. If CD4 is less than 350 they are put on lifelong ART but if is above 350 they continue with FDC as prophylaxis through antenatal labour and delivery, postnatal till one week after complete cessation of breastfeeding. The South African government has promulgated a number of legislations that have bearing on a response against HIV & AIDS and are the constitution of Republic of South Africa 108 of 1996, National Health Act No 61 of 2003, Medical scheme

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Act No 131 of 1998, Employment Equity Act No 55 of 1998, The Non-Profit Organisations Act No 71 of 1997, Promoting of Equality and Prevention of Unfair Discrimination Act 2000, and Sexual Offenses Act No of 1957

2.2.1 The constitution of Republic of South Africa, 1996

The South African Constitution, 1996 in basis of human rights in South Africa.

2.2.2 The National Health Act (Act 61 of 2003)

In general, the National Health Act, 2003 (Act 61 of 2003) provides a framework for a structured uniform system within South Africa according to the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regards to health services, (Republic of South Africa, 2004). Chapter one reaffirms the right of access of pregnant women and children below the age of six to free health services and of all persons to free primary health care services, unless they are covered by a medical aid scheme. However, Government's delay in implementing certain sections of the Act can defeat the original purpose intended; for example, the delay n implementing Certificates of Need provided for in Section 36 (Gray and Jack, 2008). The Certificate of need is meant to increase the coverage of health establishments in the country.

2.2.3 Choice of Termination of Pregnancy Act,(Act 1 of 2008) (as amended)

The Choice of Termination of Pregnancy (Act 96 of 1996) amended in 2008 (Act 1 of 2008), (hereafter referred to as TOP), was passed in order to increase access to reproductive health care services. The Act was amended in view of delegating the monitoring, implementation and functioning of TOP from national to provincial levels.

The Choice of Termination of Pregnancy, 2008 (Act 1 of 2008) recognises the decision to have children as fundamental to a woman's physical, psychological and social health. TOP provides that a woman does not need consent from her husband or partner before she has termination. Section 1 of the Act defines a woman as a female of any age. This means that ages of consent in terms of the Children's Act (as amended) do not apply to girls requesting a termination of pregnancy. Important is that the woman/girl should have the capacity to give the required consent. It also implies that no parental or guardian assistance is needed

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at any stage unless the girl agrees to do so. The Act makes provision for an abortion up to 12 weeks gestational age and after 20 weeks but under specified conditions (Republic of South Africa, 1996).

HIV-positive women who choose to terminate their pregnancies in order to safeguard their health may find this legislation helpful; conversely, it has several implementation challenges. In other cases, women with HIV suffered discrimination from health workers when seeking services related to TOP (Ramkissoonet al, 2006). There are also instances whereby HIV-women seeking TOP services were reported to have been sterilised without their permission (De Bruyn, 2006). Since HIV testing at antenatal services is normally done at about 14 weeks gestation, late termination involving labour cannot, unfortunately, be avoided by women that seek TOP services at this advanced stage (Thom, 2003).

2.2.4 Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007

The Criminal Law Amendment Act, 2007 (Act 32 of 2007) pays attention to sexual offences and HIV (Republic of South Africa, 2007). In most cases, it is women and young girls that are victims. There was an incidence of 143per 100, 000 of the women population sexually assaulted in 1997 and only about half of that were reported to the police (Statistics South Africa, 2000). Of the 4, 000 women interviewed during a survey in 1998, 1 in every 3 was socially assaulted (BBC News, 1999). In 2002, it was estimated that a woman born in South Africa had more chances of being raped than going to school (Dempster, 2002). Police statistics show that 55, 000 rapes were reported between 2005 and 2006. However, a survey by Action Aid revealed that out of 25 men accused of rape in South Africa, 24 walk free (Hunter-Gault, H., 2009). There is also a myth that sexual intercourse with a virgin cures a man of HIV and AIDS (Govender, 1999). This belief leads to a culture that leaves the girl child vulnerable to HIV infection given the high prevalence of HIV in the country.

Chapter 5 of the Criminal Law Amendment Act, 2007 recognises the possibility of a sexual offence victim being exposed to HIV infection. For that reason, it allows for a victim of a sexual offence at risk of exposure to HIV to have access to post exposure prophylaxis but only after reporting the crime to the South African Police Service within 72 hours after the alleged sexual offence. It also gives the victim permission to have the offender tested for HIV within 90 days of the alleged offence. Survivors of unreported cases do not benefit from

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this legislation which is unfortunate since several sexual offences are committed in domestic relationships or subjected to gang sexual assault (Gray and Jack, 2008).

2.3 CHALLENGES FACED BY HIV POSITIVE PREGNANT MOTHERS

The risk of mother-to-child transmission of HIV can be reduced to less than 5 percent through a combination of prevention measures (PMTCT) , including antiretroviral therapy (ART) for the expectant mother and her new-born child, hygienic delivery conditions and safe infant feeding (Kuonza, 2010 &Peltzer, 2011). According to new guidelines issued by the World Health Organization (WHO), a woman with HIV can breastfeed her baby in settings where it is judged to be the safest infant feeding option. She must, however, breastfeed exclusively and she or her newborn need to receive ART at the same time. The challenges to reach pregnant women in need of PMTCT services are immense in the region. Although many countries have made great efforts to establish PMTCT services, many pregnant women in rural areas do not have the means to reach them. Among those who attended antenatal care in 2010, less than a half received an HIV test.

Socio-demographic factors - Maternal education and age were the most frequently investigated factors in quantitative analyses. Seven studies reported an association between lower maternal educational level/literacy and not receiving/ taking ARV prophylaxis (Kuonza, 2010 & Peltzer, 2011).

When tested positive, many women drop out of PMTCT programmes, because they fear discrimination and rejection by their male partners and families. In addition, in countries such as Malawi and Zimbabwe, more than 80 percent of women enrolled in a PMTCT programme still receive single-dose nevirapine rather than another more efficacious ARV regimen (Kuonza, 2010 &Peltzer, 2011).

Obstetric and pregnancy history factors are some difficulties which some women in the rural area faces in reaching the clinic following the onset of labour particularly during the night which leads her to deliver at home or arrive at the hospital at the advance stage of labour (Nkonki, Doherty, Hill, Chopra, Schaay, Kendall, 2007).

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Disease progression three qualitative research studies revealed that HIV positive pregnant women lacking symptoms did not feel the need of taking ARVs (Duff, Kipp, Wild, Rubaale, Okech-Ojony, 2010).

Stigma and disclosure of HIV status and community support. Stigma regarding HIV status and fear of disclosure to partners of family member (particularly grandmother or mother-in-law) are major barriers to uptake of PMTCT ARV interventions in almost all qualitative research (Vargaand Brookes, 2008).

The national ART programme demonstrates increased access through more women being on triple ART at booking, and increasing numbers of pregnant women starting triple ART. This contributes to maintaining the high antenatal prevalence of HIV due to increased survival of women on ART. The national HIV counselling and testing campaign shows greater impact, as more HIV-positive women know their status at booking; however, two-thirds still do not know their status when booking.

Many challenges to South African PMTCT programmes remain. Pregnant women need to book earlier, and facilities should accommodate them without turning them away for later appointments. Women may seroconvert during late pregnancy or breastfeeding, potentially resulting in vertical transmission. Retesting of HIV-negative women through their antenatal phase to the end of breastfeeding is required. This may be done through community outreach by community care workers and can include testing of household members. CD4 cell testing of mothers and early PCR testing in infants need to be increased, which may be facilitated by point of care CD4 and PCR technology. Longer-term outcomes of children are poorly reported in this and other South African studies owing to difficulties in follow-up of mothers and children. This is best addressed through community care workers who understand PMTCT and support mothers through their pregnancy to after weaning, ensuring regular testing of children at local clinics.

2.4 THE IMPORTANCE OF TAKING ARVS HIV BY POSITIVE PREGNANT MOTHERS

HIV and AIDS is now the leading cause of mortality among women of reproductive age and, in several high –burden countries such as South Africa and Zimbabwe, HIV is the leading cause of maternal mortality .The major challenge is to provide more effective ARV

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interventions, including the provision of ART for pregnant women and mothers eligible for treatment (World Health Organization, 2010). It is important to develop monitoring and referral to promote follow-up and complement already existing PMTCT service(WHO, 2010).

Mother-to-child transmission of HIV/AIDS (MTCT) is still a major contributor to the burden of HIV infections among infants and children in Sub-Saharan Africa. The World Health Organization (WHO) recommends either of two drug regimens to prevent MTCT (Option A or Option B) stating that the available scientific and programmatic data does not show that one option is more efficacious than the other (WHO 2010). In Tanzania, the government in collaboration with various partners has chosen to implement WHO Option A(which is giving of AZT as from 14 weeks of pregnancy then one week after delivery)(WHO, 2010).

Among the major challenges of each approach to achieving maximum benefits are low antenatal care (ANC), including first, delays to booking, and later, poor adherence to scheduled visits among pregnant mothers. While attendance to one ANC visit is almost universal, only about half of pregnant women attend the four WHO-recommended visits. Moreover, those that attend often book late in pregnancy. This nationwide challenge can lead to delays or interferences with the appropriate PMTCT medications for mothers —thus substantially diminishing the potential of PMTCT care to reduce mother-to child-transmission of HIV. A low rate of facility-based deliveries is also another challenge to the effectiveness of both new regimens (WHO 2010 option A and B which is the giving of lifelong ART).

2.5 ACCESSIBILITY OF ARVS BY HIV POSITIVE PREGNANT MOTHERS

Failure to utilize PMTCT service cost by the high cost to the low income were many positive women could not afford to pay for the transport. Inadequate human resource also affects the delivery of PMTCT service. There is a number of large scale communication campaigns related to raising awareness of HIV and AIDS as well as broader health-related issues. A principle part of the HIV counselling and testing (HCT) campaign launched in April 2010 is to scale up awareness of HIV. The government aims to bring about general discussion of HIV by using the media. Strategies include publicizing the availability of free testing and counselling in health clinics through door-to-door campaigning and billboard messages to highlight personal experiences and expel the myths and stigma of HIV. The government aims to cover

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50 percept of the population with the campaign message (World l Health Organization Guideline, 2010).

Field implementation of current recommendations, impact of prophylactic regimens on subsequent ART response and possible new indications of ART in pregnant women will be reviewed in this study (World l Health Organization Guideline, 2010).Inadequate human resource capacity was also identified as a constraint to effective delivery of PMTCT services in the study areas. Key informants and health workers who participated in focus group discussions reported that PMTCT units are inadequately staffed and available ones are overworked.

Thus, as one health facility key informant reported: "the problem is not just that of training, but we need more staff to increase our capacity to provide effective services". Other factors that constrain the effectiveness of PMTCT services include inadequate ARV supply, cost of accessing services and low-socioeconomic status of women. Focus group participants and key informants reported that access to PMTCT services is severely restricted for many low income women who live on the outskirts and have to travel long distances to reach health facilities (World l Health Organization Guideline, 2010).

The ability to access PMTCT service will be further influenced by the societal policy and legislative level where the availability or lack of PMTCT services or cost of accessing these resources can impede usage as a result of poverty that places this beyond the realm of those most in need. The social ecology model describes four level s of address in in communication for social and behavioural change: societal, community, social networks and individual. These level are used to categorise the findings of literature according to the following areas: barriers to PMTCT implementation, the key participants to be addressed, key communication themes and messages, and good practices in planning and implementing successful PMTCT communication campaign (UNICEF, 2009).

Disclosure rate reported in one of the studies ranged from 16.7% to 86%, with women attending free-standing voluntary HIV testing and counselling clinics more likely to disclose their HIV status to their sexual partners than women who were tested in the context of their antenatal care. Barriers to disclosure identified by the women included fear of accusations of infidelity, abandonment, discrimination and violence. Between 3.5% and 14.6% of women

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reported experiencing a violent reaction from a partner following disclosure. The low rates of HIV zero status disclosure reported among women in antenatal settings have several implications for prevention of mother-to-child transmission of HIV (PMTCT) programmes as the optimal uptake and adherence to such programmes is difficult for women whose partners are either unaware or not supportive of their participation. This article discusses these implications and offers some strategies for safely increasing the rates of HIV status disclosure among women (World Health Organisation: 2004).

Currently it is recommended that HIV infected pregnant women receive similar HAART regimens to non-pregnant women, other than for considerations of potential adverse effects on the fetus (Suy, Martinez, Coll, 2006). Almost 80% of pregnant women experienced one or more typical adverse effects of antiretroviral drugs (ARV), such as anaemia, nausea/vomiting, aminotransferase elevation, or hyperglycaemia (Lorenzi, Spicher, Laubereau, 2998). Concerns were raised following liver failure with maternal death reported in a randomized study of NVP use in pregnancy with CD4 count > 250 cells/µL, by an AIDS Clinical Trials Group (ACTG) (. Hitti, Frenkel, Stek, 2004). In addition, the data are conflicting, as to whether combination ART during pregnancy is associated with adverse pregnancy outcomes, such as pre-term delivery (Prenatal HIV Guidelines Working Group: 2006). Knowledge of the potential adverse effects of ART, specifically for pregnant women and their foetuses, is very important when considering antiretroviral regimens, especially now a variety of regimens are widely prescribed for pregnant HIV-infected women. This study was conducted to review, retrospectively and prospectively, the adverse effect of antiretroviral therapy among pregnant HIV-infected women and their pregnancy outcomes in a clinical setting.

Knowledge and individual beliefs: Poor knowledge of HIV transmission and the important of taking ARVS lead to the dropping out of HIV positive pregnant mothers from PMTCT program (Mepham, 2011 & Doherty, 2009).

2.6 STRATEGIES THAT CAN BE USED TO ADDRESS THE PROBLEM OF ARVS ACCESS

In 2011, the international community endorsed the elimination of mother-to-child HIV transmission by 2015 as a global goal. AIDS remains the leading cause of death among women of reproductive age (15–44), especially during pregnancy and the post-partum

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period (World Health Organisation: 2009). The impact of the HIV epidemic on maternal mortality has been most serious in sub-Saharan Africa, where an estimated nine per cent of all maternal deaths are directly due to AIDS, particularly in countries where HIV prevalence rates are high (Wilmoth, 2010).

The first PMTCT policy was drafted in 2001. Due to these operational and political factors, the PMTCT programme was implemented at pilot sites in 2001, but only nationally in 2002 and currently the national PMTCT programme is available in 3 000 primary healthcare facilities across the country. It has been estimated that 35 000 babies were born with HIV because a feasible and timely ARV programme was not implemented in South Africa. The Department of Health published new guidelines for PMTCT in 2010 from 2008 PMTCT guideline and the Western Cape was the first to roll out dual therapy regimens (UNICEF, 2009).

The most widely acknowledged shortcoming in South Africa's response to the HIV/AIDS epidemic has been the country's delay in availing treatment for the prevention of mother-to-child transmission (PMTCT) of HIV as well as antiretroviral therapy (ARV) for those with advanced HIV infection (UNICEF 2008). It is estimated that by August 2005, PMTCT services were available to HIV-positive pregnant mothers at 2 525 sites nationwide and only 51.7% of mothers who were identified as HIV positive receive treatment. Further studies indicate that, 90% of districts in South Africa now offer PMTCT, although coverage varies substantially from 48 to100% between districts and provinces (South Africa National Department of Health, 2007). Through the introduction of PMTCT in South Africa, the percentage of HIV positive pregnant women receiving antiretroviral treatment increased from 30% in 2005 to 57% in 2007 (UNAIDS 2008). Improved results were also apparent in Botswana whereby the percentage of women reached by PMTCT services increased from 58% in 2003 to more than 95% in 2007 (UNICEF, 2008).

A study conducted by Medical Research Council (MRC) in 2011, which was presented at the 5th South African AIDS Conference, held June, 2011 in Durban, showcased the recent remarkable achievements of the country's HIV/AIDS response. This include breakthrough on PMTCT intervention findings which shows that HIV prevalence is down to 3.5% at the first immunisation visit at 4 to 8 weeks post-partum. The study reveal that the percentage of

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children who ultimately become infected will be higher, particularly since a significant proportion of the children are not being fed safely with either exclusive breastfeeding or exclusive formula feeding by their caregivers (Smart, 2011).

UNICEF's overall PMTCT strategy is based on a comprehensive four-pronged strategy aimed at integrating key interventions into essential maternal, newborn and child health services. The first prong emphasizes the importance of preventing HIV among women of reproductive age before they get pregnant. The second prong is focused on the prevention of unintended pregnancies among women living with HIV. The third prong focuses on pregnant women who are already infected and demands that HIV testing be integrated into antenatal care, that they receive ARVs to prevent transmission of the virus and for their own health and that they are counselled adequately on the best feeding option for their baby. The fourth prong calls for better integration of HIV care, treatment and support for women found to be positive and their families (UNICEF, 2011).

South Africa is implementing a national action framework for PMTCT that covers the 5 years from 2012 to 2016 (Draft National action framework Department of Health 2011) the framework was tailored to individual districts and provinces and aims to provide a clear understanding of the operational issues that influence the continuous improvement of PMTCT programmes. In addition, there are on-going efforts to increase the ability of local health-care workers to collect high-quality data and use those data to improve the PMTCT programme.

If the national action framework for PMTCT is implemented in tandem with the envisaged strengthening of the health-care system, there is a high probability that, within the next 5 years, South Africa will be on the path to achieving the global goal of eliminating mother-to-child HIV transmission by 2015.

Consequently, reducing vertical transmission became one of the highest priorities in the South African National HIV/AIDS Strategic Plan of 2007 to 2011. The goal has been to reduce HIV transmission to 5% in HIV-exposed infants by 2011. To accomplish this, performance would have to be improved along each step of what has been called the PMTCT cascade meaning the separate interventions involved in the programme including coverage, HIV testing uptake, results delivery, intervention delivery, follow-up and support (Smart, 2011).

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Quantitative monitoring (measuring how much, how many, quantity) tends to document numbers associated with the program, such as how many posters were distributed, how many counseling sessions were held, or how many times a promotional radio spot was aired. It focuses on which program elements are being carried out and how often. Quantitative monitoring tends to involve record-keeping and numerical counts. The activities in the project/program timeline of activities should be closely examined to see what kinds of monitoring activities might be used to assess progress. The method for monitoring and its associated activities should be integrated into the project timeline.

Qualitative monitoring (quality) will ask questions about how well the elements are being carried out. Questions may include: how are people's attitudes changing toward stigma, family planning, care and support; what is the influence of program activities on real or incipient behavior change; how information permeates communities "at-risk;" and so on. To obtain this type of information— which can also work as part of the feedback system—such qualitative methods as in-depth interviews and focus group discussions are often used.

2.7 THE IMPACT OF HIV AND AIDS IN SOUTH AFRICA

The HIV/AIDS pandemic is a major threat to social and economic development. The estimated number of HIV-infected people in South Africa rose from 3.8 million in 1999 to 5.5 million in 2006. This represents an estimated adult prevalence rate of 21.5%, which is substantially higher among the black parts of the population than the white. Of the 500 000-750 000 people who currently need anti-retroviral treatment (ART), only 130 000 have access to it. The pandemic's effects in the medium and long term will be to reduce the total population, the average life expectancy, and the proportion of the population that is economically active, while drastically increasing the number of orphans. The social and economic costs will be staggering. Field implementation of current recommendations, impact of prophylactic regimens on subsequent ART response and possible new indications of ART in pregnant women will be reviewed in this paper (WHO 2009).

Improving national prevention of mother-to-child transmission (PMTCT) services in South Africa has been challenging. PMTCT outcomes were analysed at 58 primary- and secondary-level antenatal facilities across seven high HIV burden sub-districts in three provinces, over an 18-month period during which new South African PMTCT clinical guidelines were

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implemented and a nurse quality mentor programme was expanded.(Family Health international :2004).

Pregnant women visit antenatal clinics at a relatively advanced stage of pregnancy; fewer than 40% of them attend for the first time before 20 weeks' gestation. Some pregnant women even go into labour without having attended an antenatal clinic once. The PMTCT policy introduced in 2010 requires HIV-positive pregnant women to attend an antenatal clinic early, at 14 weeks' gestation, so that interventions can be started as soon as possible. Increasing early attendance will require interventions at both the individual and community levels to raise demand for services. In addition, changes in attitudes towards health-care services and in their organization will be needed to boost supply. This inconveniences pregnant women, who may have to be referred to another facility for treatment initiation, and increases the possibility that they will be lost to follow-up.

2.8 TRENDS OF HIV AND AIDS AMONG ANTENATAL IN AFRICA

Sub-Saharan Africa remains the region most heavily affected by HIV. In 2008, sub-Saharan Africa accounted for 67% of HIV infections worldwide, 68% of new HIV infections among adults and 91% of new HIV infections among children. The region also accounted for 72% of the world's AIDS-related deaths in 2008. An estimated 1.9 million people were newly infected with HIV in Sub-Saharan Africa in 2007, bringing to 22 million the number of people living with HIV. Two thirds (67%) of the global total of 33 million people with HIV live in this region, and three quarters (75%) of all AIDS deaths in 2007 occurred (World Health Organization, 2009).

Adult national HIV prevalence is below 2% in several countries of West and Central Africa, as well as in the horn of Africa, but in 2007 it exceeded 15% in seven southern African countries such as Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, and was above 5% in seven other countries, mostly in Central and East Africa such as Cameroon, the Central African Republic, Gabon, Malawi, Mozambique, Uganda, and the United Republic of Tanzania. Antiretroviral therapy coverage is notably higher in Eastern and Southern Africa (48%) than in West and Central Africa (30%). Treatment coverage for adults (44%) remains higher than for children at 35% (World Health Organization, 2009).

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Sub-Saharan Africa has made remarkable strides in expanding access to services to prevent mother to child HIV transmission. In 2008, 45% of HIV-infected pregnant women received antiretroviral drugs to prevent transmission to their new-borns, compared with 9% in 2004. However, coverage is much higher in eastern and southern Africa with 64% than in west and central Africa with 27% (World Health Organization, United Nations Children's Fund, & UNAIDS, 2009). In 2008, an estimated 390 000 children were infected in sub-Saharan Africa. As services to prevent mother-to-child transmission have been brought to scale, the annual number of new HIV infections among children has declined fivefold in Botswana, from 4600 in 1999 to 890 in 2007. There is also evidence that mother-to-child transmission is contributing a declining proportion of new infections in Lesotho. Although the vast majority of infections in children are the result of mother to child transmission, indications suggest that a small proportion of infections in children under the age of 15 could be the result of rape or other sexual abuse (UNAIDS HIV and AIDS epidemic update, 2009).

Southern Africa continues to bear a disproportionate share of the global burden of HIV as 35% of HIV infections and 38% of AIDS deaths in 2007 occurred in that sub-region. Altogether, sub-Saharan Africa is home to 67% of all people living with HIV. Women account for half of all people living with HIV worldwide, and nearly 60% of HIV infections in sub-Saharan Africa. An estimated 370 000 children younger than 15 years became infected with HIV in 2007. Globally, the number of children younger than 15 years living with HIV increased from 1.6 million in 2001 to 2.0 million in 2007 and almost 90% live in sub-Saharan Africa. In Swaziland, children were estimated to account for nearly one in five (19%) new HIV infections in 2008. Prenatally acquired infection accounted for 15% of new HIV infections in Uganda in 2008. In the United Republic of Tanzania, only 53% of women and 44% of men reported awareness that medications and other services are available to reduce the risk of mother-to-child HIV transmission (UNAIDS HIV and AIDS epidemic update, 2009).

In southern Africa, reductions in HIV prevalence are especially striking in Zimbabwe, where HIV prevalence in pregnant women attending antenatal clinics fell from 26% in 2002 to 18%. In Botswana, a drop in HIV prevalence among pregnant 15 to 19 year olds, from 25% in 2001 to 18% in 2006 suggests that the rate of new infections could be slowing.

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The epidemics in Malawi and Zambia also appear to have stabilized, amid some evidence of favorable behavior changes and signs of declining HIV prevalence among women using antenatal services in some urban areas. In Lesotho and parts of Mozambique, HIV prevalence among pregnant women is increasing. In some of the provinces in the central and southern zones of the country, adult HIV prevalence has reached or exceeded 20%, while infections continue to increase among young people. After dropping dramatically in the 1990s adult national HIV prevalence in Uganda has stabilized at 5.4% (UNAIDS HIV and AIDS epidemic update, 2009).

Prevention of mother to child transmission (PMTCT) interventions such as antiretroviral (ARV) prophylaxis have dramatically reduced the risk of vertical transmission from around 40% to less than 5% in some research and pilot settings in Sub Saharan Africa. Governments have committed themselves to reduce the proportion of infants infected with HIV by 50% by 2010, by ensuring that 80% of women have access to PMTCT interventions. However recent data show that overall coverage of ARVs for HIV positive pregnant women is 33% and there is poor coverage in countries with the greatest number of pregnant women living with HIV such as South Africa with 50% coverage, Nigeria with 3% coverage and Tanzania with 15% coverage (Doherty, Chopra, Nsibande & Mngoma, 2009).

To achieve wide coverage, PMTCT programmes must be integrated into existing public health systems, with services provided by all antenatal and delivery clinics. So far, only a few low and middle-income countries have achieved this goal (UNICEF, 2003).

The epidemic in Zimbabwe is believed to be declining as a result of prevention programmes, in particular behavior change and Prevention of Mother to Child Transmission (PMTCT), as well as impact of mortality. The number of patients on ART increased from 99 408 (9 594 children) at the end of 2007 to 148 144 (13 278 children) in December 2008 and 218 589 (21 521 children) by end of December 2009. The 2009 number represents 56.1% of adults and children needing treatment (Zimbabwe Country UNGASS special session report on HIV AND AIDS, 2010).

The level of knowledge about HIV and AIDS prevention was high with 75.7% women (15-49 years) and 81.3% men (15-54 years) who knew that condoms could be used to reduce the risk of getting HIV. A decline in HIV prevalence among all pregnant women (15-49 years) in

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2004 was first reported by the Ministry of Health and Child Welfare. This trend continued in 2006, with prevalence decreasing from 25.8% in 2002, 21.3% in 2004, 17.7% in 2006 to 16.1% in 2009 among antenatal clinic attendees, 15-49 years. Similar trends were also observed among younger pregnant women (15-24 years) where prevalence declined from 20.8% in 2002, 17.4% in 2004, and 12.5% in 2006 to 11.6% in 2009 (Zimbabwe Country UNGASS special session report on HIV AND AIDS, 2010).

HIV prevalence in the total population of South Africa has stabilized at a level of around 11%. A decline in HIV prevalence at national level has been observed among children aged 2 to 14, from 5.6% in 2002 to 2.5% in 2008. An observation on HIV prevalence of all people aged 2 years plus show stabilization from 2002 to 2008 to 11%. In children aged 2 to 14 years, the prevalence has decreased by a difference of 3.1% from 2002 to 2008 (Shisana et al., 2009).

A study conducted in South Africa by HSRC in 2008 indicate that there has been a steady decline in HIV prevalence among children over the three surveys, with a significant reduction in national HIV prevalence by 3.1 percentage points among children aged 2 to 14 between 2002 and 2008. This reduction in HIV prevalence occurred in all provinces except Mpumalanga which remained at a high level of3.8%. The change in HIV prevalence in children is accompanied by a reduction in HIV incidence and is likely to be attributable to the successful implementation of several HIV prevention interventions related to addressing HIV in early childhood, particularly programmes to prevent mother-to-child transmission in the Western Cape, where the largest decline of 6 percentage points occurred (Shisana et al., 2009).

The overall national HIV prevalence among antenatal women aged 15-49 years is 29.3%. In 2006 and 2007, the HIV prevalence was 29.0% and 29.4% respectively. The findings suggest that HIV prevalence over the last three surveys has stabilized around this level. The Western Cape reported the lowest estimate of 16.1% while KwaZulu-Natal had the highest HIV prevalence in the country at 38.7%. Mpumalanga has shown an increase in HIV infection from 32.1% in 2006 and to 34.6% in 2007 to 35.5% in 2008. The population survey found the HIV prevalence to have stabilized at around 11% in the population over 2 years of age (South Africa UNGASS Country Progress Report on, 2010).

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In South Africa Proportion of HIV positive pregnant women receiving antiretroviral medicines to reduce the risk of mother-to-child transmission was 83% in 2009 and it was 86% in 2008. Prevention of Mother-To-Child Transmission of HIV (PMTCT) is now almost universally available in public primary health facilities, and South Africa achieved the NSP target of >95% coverage in public sector antenatal service sites in 2008. A dual therapy regimen of Nevirapine and AZT was adopted in 2008. The estimate for 2008 is that 86% of HIV positive pregnant women received ART to prevent MTCT of HIV and in 2009 this figure declined to 83%. However in Gauteng province the introduction of dual therapy was not well recorded in the antenatal service and for this reason it is likely that the figures for 2009 were an under-estimate of PMTCT coverage. The overall goal of the PMTCT programme is 100% coverage of all pregnant women who need PMTCT. Given UNAIDS estimates, this can range from 110,000 to 280,000 women (South Africa UNGASS Country Progress Report, 2010).

Out of all ANC patients presenting for services, the rate of those agreeing to an HIV test increased from 88% to 96% in the last two years and around 90% of those testing HIV positive received a Nevirapine dose either in ANC services or during labour. District Health Information System, (2009) PMTCT indicators show 1st antenatal visit was 101% in 2008 and 88% 2009 and among those antenatal client tested for HIV was 88% 2008 and 96% in 2009. Antenatal client tested HIV positive was 22% in 2008 and 23% in 2009. Antenatal client Nevirapine uptake was 110% 2008 and 90% in 2009 (South Africa UNGASS Country Progress Report, 2010).

Thirty eight per cent (38%) of the 52 districts recorded HIV prevalence of between 30% and 40% of which eight were in KwaZulu-Natal, four in Gauteng, three in the Free State, two in North West and Eastern Cape and one in Mpumalanga, 30% of the health districts recorded HIV prevalence of between 20.0% and 30.0%. Five of these districts were located in the Eastern Cape, three in Limpopo, two in Free State, North West and Gauteng and one in Northern Cape, Mpumalanga and Western Cape provinces. Still only 19% (10 out of 52) of the 52 health districts recorded prevalence between 10% and 20%. Five were located in the Western Cape Province, three in Northern Cape and two in Limpopo, the HIV prevalence in Capricorn district significantly decreased from 24.2% in 2006 to 19.8% in 2007. Namakwa district in the Northern Cape recorded the lowest HIV prevalence in the country, although

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the HIV prevalence in this district increased from 5.3% in 2006 to 7.3% in 2007(South Africa Department of Health National Antenatal Sentinel HIV and Syphilis Prevalence Survey report, 2008).

In 2008, the North-West provincial HIV prevalence amongst 15-49 antenatal women was 31.0%. The HIV prevalence in this province appears to be increasing from 29.0% in 2006, 30.6% in 2007 and 31.0% in 2008 (National HIV and Syphilis Prevalence Survey report, 2008). Three out of the four (3 out of 4) districts in the North West province have shown an increase in the past three years, except for Bojanala where the prevalence is beginning to show stabilization. In 2008 the highest HIV prevalence (35.2%) was recorded in the district of Dr. Kenneth Kaunda, while the lowest (28.1%) was seen in the district Dr. Ruth S. Mompati (South Africa Department of Health National Antenatal Sentinel HIV and Syphilis Prevalence Survey report, 2008).

2.9 BENEFITS AND CHALLENGES OF ACCESSING ARVS

The 2010 guidelines have great potential to improve the mother's own health and to reduce mother-to-child HIV transmission risk to 5% or lower in a breastfeeding population, from a background transmission risk of 35% (in the absence of any interventions and with continued breastfeeding).The 2010 guidelines have great potential to improve the mother's own health and to reduce mother-to-child HIV transmission risk to 5% or lower in a breastfeeding population, from a background transmission risk of 35% (in the absence of any interventions and with continued breastfeeding)(World Health Organisation, 2014).

The new guidelines offer the potential for all countries to virtually eliminate paediatric HIV. Combined with improved infant feeding practices, the guidelines can help to reduce both child mortality and new HIV infections. The new guidelines offer the potential for all countries to virtually eliminate paediatric HIV. Combined with improved infant feeding practices, the guidelines can help to reduce both child mortality and new HIV infections. PMTCT can also act as a gateway to improved reproductive, maternal and child health services at primary level and, in turn, bolster progress towards achieving the health-related Millennium Development Goals of reducing under-five mortality rates by two thirds, decreasing maternal mortality rates by three quarters, and halting and reversing the spread of HIV/AIDS by 2015(World Health Organisation, 2014).

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The new guidelines enable more consistent policies and support for infant feeding practices among both HIV-positive and HIV-negative mothers in the general population. Given the importance of breastfeeding as a child survival intervention, the availability of ARV interventions could make a major contribution to reducing child mortality in the entire community (World Health Organisation, 2014).

The major challenges in scaling-up national PMTCT services and implementing the new guidelines are weak health infrastructure, limited human resources, limited management capacity, and limited funding and support for PMTCT. However there are many hopeful signs that PMTCT now have greater priority both at the national and international level. Given the confusion in the past around HIV and infant feeding, comprehensive communications strategies are now needed to give health workers confidence to recommend breastfeeding and ARVs and for HIV-positive mothers to want to breastfeeding (World Health Organisation, 2014).

2.10 EMPIRICAL EVIDENCE OF TSHIRENZHENI ON HIV POSITIVE PREGNANT MOTHERS IN ACCESSING ARVS

Tshirenzheni village is situated 50km from the Siloam Hospital and majority of the people are illiterate but is very difficult for HIV positive pregnant mothers to book early, for them to be counselled and tested. Even though some women who understand the importance of booking early and to be on the programme, it is still difficult for them to book early. Most of the positive pregnant mothers are found during delivery which exposes the child to HIV.

Some villages are on the mountain which is difficult for the mobile team to access them. The road is damaged to such an extent that it is difficult to reach them. Due to lack of knowledge, trust and stigmatisation from the home based care, the community does not like the home based care to give them information about HIV. Most of the people who in Tshirenzheni they leave in harmony, supported by the current research wherein 29(64,4%) of the community support HIV positive mothers.

2.11 CONCLUSION

The literature review confirms that a number of barriers currently prevent the successful implementation of PMTCT programme having critical implications for the design of effective

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PMTCT communication strategies. One important reason for the improving access is that HIV testing among pregnant women is increased and expansion of provider – initiated testing and counselling in antenatal clinics, labour and delivery centres, and other health care settings. It can be concluded that access to ARVs for the HIV positive pregnant mothers in order to protect their children not to be infected by HIV there is a little progress. The HIV positive pregnant mothers must be given information on the programme in order for them to make decision on their reproductive live.

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CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter presents research design and methodology that were used when conducting the research study. Research methodology is a way to systematically solve the research problem. It is the study of various steps that are generally adopted by a researcher in studying his research problem along with the logic behind them. All this means that it is necessary for the researcher to design his methodology for his problem as the same may differ from problem to problem.

3.2 RESEARCH DESIGN

According to Mouton (2009:175) research design is a plan of how the researcher plans to execute the research problem that has been formulated.Kothari (2004:175) defines a research design as the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure.

The researcher will use the field study in order to reach more participants. Field study is because the investigation is carried out of the usual environments where a phenomenon has occurred. Field research or fieldwork is the collection of information outside of a workplace setting. The approaches and methods used in field research vary across disciplines. The researcher will use interview and questionnaire. Although the method generally is characterized as qualitative research, it may (and often does) include quantitative dimensions.

3.3 RESEARCH METHODOLOGY

Silverman 2006:402)defines methodologyas the choices that is made about appropriate models, cases to study methods of data gathering ,forms of data analysis .Polit and Hungler (2004:233) define methodology as the ways of obtaining, organizing and analyzing data. In this study, research methodology involved a selection of appropriate research approaches,

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research methods, sampling procedures, respondents and instruments for collecting and analyzing data .In this study qualitative and quantitative method were used.

Creswell (2003:33) defined qualitative study as an inquiry process of understanding social or human problems based on building complex holistic nature formed by reporting detailed views of information and conducted in a natural setting. Kothari (2004:169) defines qualitative research as more subjective in nature and involves examining and reflecting on the less tangible aspects of a research subject. The qualitative research produces narratives which document the course of the research project itself and it make a researcher to find natural history Sampford .R.,Jupp .V. (2006:244).

Burns & Grove (2003:30) define quantitative research as formal, objective, systemic process in which numerical data are used to obtain information about the world. Kothari (2004:169) defines quantitative research are the way of collecting data from more participants, so it is not possible to have the depth and breadth of knowledge about information. Quantitative is usually highly detailed and structured and results can be easily collated and presented statistically.

3.4 STUDY AREA

The study will be conducted at Tshirenzheni village in Thulamela Municipality in Vhembe District between Siloam village and Tshikombani village along the main road from Thohoyandou to Wyllie sport. The researcher needs to identify the gaps which make the HIV positive pregnant mother not accessing ARVS.

3.5 STUDY POPULATION

Sapsford, JUPP (2006:27) defines population as the total collection of element actually available for sampling, rather than in some more general way.Neuman (2000:54) defined a population as a group of many cases from which a researcher draw as sample.The population in this study comprises of all HIV positive mothers of Tshirenzheni village composed of 500 HIV positive mothers.

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3.6 SAMPLING

DeVos (2001:119) views a sample as considered for actual inclusion in population considered for actual inclusion in the study. Kothari (2004:55) defines a sample design as a definite plan for obtaining a sample from a given population. Sampling group consist of HIV positive pregnant mothers and clinic staff.

3.6.1 Sample methods

In this study the researcher is going to use non-probability sampling and its subtype of purposive sampling method. These enable the researcher to use his/her judgement to choose people that are presented or are available that best meet the researcher's objectives or target groups.

3.6.2 Sample size

The study will be conducted from HIV positive pregnant women at Tshirenzheni village. Only 50 participants of which 40 will be HIV positive pregnant women are selected and 10 clinic staff.

3.7 DATA COLLECTION

Data collection is the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate outcomes. Sapsford&Jupp(2006:56) defines the data collection as the collection of information about the world with the intension of guiding behaviour which can be used by others in a variety of ways. Bulmer & Warwick (2000:146) define data collection as a research which involves a series of strategic decisions of objective requiring attention at every step in the research, from the initial conceptualisation of the question under investigation to the final analyses of the information collected. For this study the researcher used questionnaire and interview.

Sapsford&Jupp (2006:121) define questionnaire as a structured set of questions, containing all necessary instructions for respondents to fill in by themselves. Warwick &Bulmer (2000:149) define questionnaire as wording of questions in more an art then a science, systematic research on the effect of question wording that take the field somewhat beyond

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the realm of art and considerable practical experience suggesting proven means of avoiding bias in many situations. Sapsford & Jupp 2006:159) define open -ended questionnaire as a freedom to answer in his or own way rather than in terms of researcher's predefined answer categories. The researcher used a structured questionnaire to collect data.

Sapsford & Jupp (2006:117) define interview as asking questions structured by an interviewer to research information according to his or her research interest. Bulmer & Warwick (2000:205) define interview as a form of census and surveys; this normally takes place by personal enumeration or face to face interview. Noaks & Wincup (2004: 80) define open–ended interview as active listening in which the interviewer, allows the interviewee the freedom to talk and ascribe meanings while bearing in mind the broader aims of the project. For this study the researcher applied an open-ended interview.

3.8 DATA ANALYSIS

Mogorosi (2003:19) defines data analyses as the actual process of analyzing raw data as received from and agreed a plan on process. In this study the following procedure of data analyze, adapt from Cresswell (2003:190).The Statistical Package for Social Sciences (SPSS Version 22.0) would be used to analyses data collected through questionnaire and the information will be presented in the form of frequencies, percentages and means differences.

Data collected through interview will analyzed by thematic analyses and the information will be presented in a narrative way.The researcher qualitatively analysed the data by using Creswell's steps (1994). The steps are discussed as follows:

- **Planning for recording data**

The researcher should plan for the recording of data in a systematic manner that is appropriate to the setting, participants or both, and that will facilitate analysis before data collection commences. The researcher should demonstrate awareness that techniques for recording observations, interactions and interviews should not be introduced excessively on the on-going flow of daily events. The researcher planned for the recording of data systematically and made sure that it was appropriate to the setting and participants. The

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researcher also made sure that the instrument and other equipment that were used for data recording and collection were available.

- **Data collection and preliminary analysis**

Data analysis in a qualitative inquiry necessitates a two-fold approach. The first aspect involves data analysis at the research site during data collection and the second aspect involves data analysis away from the site, following a period of data collection.

- **Managing or organising the data**

This is the first step in data analysis away from the site. At the early stage in the analysis process, researchers organise their data into files folders, index card, or computer files. Researchers convert their files to appropriate text units, for example a word, a sentence, for analysis either by hand or by computer.

- **Reading or writing memos**

After the organisation and conversion of the data, researchers continue to analyse by getting a feeling for the whole database. Writing memos in the margins of field notes or transcripts or under photographs help in this process of exploring a database. These memos are short phrases, ideas, or key concepts that occurred to the reader. After the conversion and organizing of data, the researcher continued with analysis by reading and writing memos. The researcher read all the data that was gathered from the respondents with the aim of getting the understanding of the data.

- **Generating categories, themes and patterns**

This is the most difficult, complex, ambiguous creative and enjoyable phase. The analytic process demands a heightened awareness of the data, a focused attention to the data and openness to the subtle, tacit under currents of social life.

- **Coding the data**

Coding the data is the formal representation of analytical thinking. The tough intellectual work of analysis is in the generating of categories and themes. The researcher then applies some coding scheme to those categories and themes and diligently and thoroughly marks

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passage in the data using the codes. This is the part where the researcher applied analytic thinking and coded the categories. The researcher also worked the passages in the data by using codes.

- **Testing the emergent understanding**

The researcher begins the process of evaluating the plausibility of his developing understanding and exploring them through the data. Part of this phase is evaluating the data for their usefulness and creativity.

- **Searching for alternative explanation**

As the researcher discovers categories and patterns in the data the researcher should engage in critically challenging the very patterns that seem so apparent. The researcher searched for other meaning of the information that was gathered from the respondents that made it easier to understand since respondents only gave their own experiences but with different explanations.

- **Writing the report**

The researcher presents the data, a package of what was found in text, tabular or figure form, for example, by creating a visual image of the information. The researcher may present a comparison table of a matrix. The researcher wrote a report after the completion of collecting data. The researcher used tabular form which created a visual image of the information.

The researcher will use the following steps when collecting data:

- Planning for recording data,
- Reading and writing memos,
- Coding the data,
- Searching for alternative explanations, and
- Writing the report.

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3.9 ETHICAL CONSIDERATIONS

De Vos (2008) defines ethics as asset of moral principles which individual or group, is subsequently widely accepted and which offers rules and behavior or group. Dienar and Grendal (2004) define ethics as ethical principles and guidelines that helps to prevent abuses to client. In this study the researcher will dealing with sensitive issues. The following issues were taken onto considerations to protect the welfare and the right of participants.

3.9.1 Permission to conduct research

Permission to conduct research will be requested from the University of Venda, District and the Provincial Department of health and Ethics committee. The political office bearers and Headmen of Tshirenzheni village will be consulted. Informed consent will be obtained from all participants.

3.9.2 Voluntary participation

Saunders, Lewis and Thornhill (2003: 131) define voluntary participation as the rights of individuals to withdraw partially or completely from the process. For the purpose of the study the researcher will use a voluntary involvement by respondents. The researcher did not force the respondents to be included in the study and only included those who volunteered to be included in the study.

3.9.3 Anonymity

Saunders, Lewis and Thornhill (2003:131) defines anonymity as the means of ensuring the client's name that will not be published, this principle is very important particularly in the this topic as a contributory factors to young women becoming HIV positive while pregnant.

3.9.4 Confidentiality

Saunders, Lewis and Thornhill (2003:131) defines confidentiality is when only the researcher is aware of the participants' identities and has promised not to reveal those identities to others. Participant will be assured that whatever is being discussed is not going to be shared with anybody or exposed to others and their names will not appear or published anywhere.

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3.10 CONCLUSION

The literature review confirms that a number of barriers currently prevent the successful implementation of PMTCT programme having critical implications for the design of effective PMTCT communication strategies. One important reason for the improving access is that HIV testing among pregnant women is increased and expansion of provider –initiated testing and counseling in antenatal clinics, labour and delivery centers, and other health care settings. It can be concluded that access to ARVS for the positive pregnant mothers in order to protect their children not to be infected by HIV there is a little progress. The positive pregnant mothers must be given information on the programme in order for them to make decision on their reproductive live.

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CHAPTER 4

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The previous chapter presented the research design and the subsequent methodologies that the researcher followed and which indicated the structure and the procedures that were followed to answer the researcher's study questions. It has been revealed that the study was conducted in a mixed methodology where qualitative and quantitative research methodologies were used and this chapter present, analysis and interpretation of the study. The responses to the questionnaires items are presented graphically in tabular form and the responses to the interview items are presented in narrative form and are followed by a brief synthesis of the findings for the item and the detailed findings are discussed in chapter five.

4.2 ANALYSIS OF DATA COLLECTED THROUGH QUESTIONNAIRE

In this section, the researcher presents the data collected through questionnaire.

4.2.1 Section A: Biographical Information of Respondents

This section presents the biographical information of the respondents in this study. The information is presented in graphical and tabular form and followed by a synthesis of the findings.

Table 4.1 Gender of respondents

	Response	Frequencies	Percentage
1	Male	01	2.2%
2	Female	44	97.8%
	TOTAL	45	100%

The above table presents the biographical information of the respondents in terms of gender. A total of 45 respondents took part in this study, of the 45 respondents, 44 (97.8%) were females whereas 01 (2.2%) respondent was male. All targeted 45 respondents managed to return the questionnaires, and all the questionnaires were analysed. From the table below, a conclusion can be drawn that majority of the respondents at 44(97.8%) were females.

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Table 4.2 Age of respondents

	Response	Frequencies	Percentage
1	Less than 20 Years	06	13.3%
2	21 – 30 Years	14	31.1%
3	31 – 40 Years	11	24.4%
4	41 – 50 Years	09	20.0%
5	51 Years and Older	05	11.1%
	TOTAL	45	100%

Most of the respondents at 14 (31.1%) who took part in this study were aged between 21 and 30 years. Eleven (24.4%) of the respondents were aged between 31 and 40, and 09 (20.0%) were between 41 and 50 years. Six (13.3%) respondent were less than 20 years and there were 05 (11.1%) respondents from 51 years and older. It can therefore be concluded that in this study, majority of the respondents who took part in the study were aged between 21 and 30 years.

Table 4.3 Gestational Period of respondents

	Response	Frequencies	Percentage
1	Less than 04 Months	10	22.2%
2	06 Months	07	15.6%
3	09 Months	28	62.2%
	TOTAL	45	100%

With regard to the gestational period of the respondents, majority of the population at 28 (62.2%) were between the period of 09 months whereas 10 were less than 04 months. Few respondents at 07 (15.6%) were having the gestational period of 06 months. From the above information, the researcher conclude that majority of the respondents who took part in the study were having 09 months gestational period.

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Table 4.4 Distance to the Clinic

	Response	Frequencies	Percentage
1	Near	17	37.8%
2	Far	22	48.9%
3	Very Far	06	13.3%
	TOTAL	45	100%

Table 4.4 indicates that majority of respondents in this study at 17 (37.8%) revealed that they are staying near to the clinic while, 22 (48.9%) stated that they are staying far from the clinic. Few respondents at 06 (13.3%) indicated that they are staying very far from the clinic. Majority of respondents who took part in the study are staying far from the clinic.

Table 4.5 Mental Status

	Response	Frequencies	Percentage
1	Very Good	22	48.9%
2	Good	17	37.8%
3	Satisfactory	03	6.7%
4	Poor	03	6.7%
	TOTAL	45	100%

The above table presents the mental status of the respondents. A total of 22 (48.9%) indicated that there metal status is very good, while 17 (37.8%) revealed that there good. Three (6.7%) of the respondents indicated that there mental status is satisfactory while also 03 (6.7%) revealed that there mental status is poor. Majority of respondents who took part in the study showed that there mental status is good.

4.2.2 Section B: HIV Positive Pregnant Mothers

In this sub-section, data is analysed using graphical statistics which is further divided into four themes which arose from the survey questionnaire respondents. The four themes are the challenges faced by HIV positive pregnant mothers; importance of taking ARVs by HIV positive pregnant mothers; accessibility of HIV positive pregnant mothers; and the

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strategies than can be used to address the challenges faced by HIV positive pregnant mothers.

4.2.2.1 Challenges faced by HIV positive pregnant mothers

This sub-section presents data regarding the challenges faced by HIV positive pregnant mothers. The data is presented in the form of tables followed by brief interpretation

Table 4.6 HIV positive pregnant mothers receive PMTCT

	Response	Frequencies	Percentage
1	Strongly agree	19	42.2%
2	Agree	19	42.2%
3	Not sure	02	4.4%
4	Disagree	03	6.7%
5	Strongly disagree	02	4.4%
	TOTAL	45	100%

Table 4.6 indicates that 19 (42.2%) of the respondents strongly agreed that HIV positive pregnant mothers receive PMTCT, while also 19 (42.2%) agreed with the statement. Three (6.7%) of the respondents disagreed that HIV positive pregnant mothers receive PMTCT, whereas 02 (4.4%) strongly disagree. Two (4.4%) of the respondents were not sure whether HIV positive pregnant mothers receive PMTCT or not. From the above statistics, a conclusion can be drawn that majority of the respondents agreed that HIV positive pregnant mothers receive PMTCT.

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Table 4.7 Community support HIV Positive mothers

	Response	Frequencies	Percentage
1	Strongly agree	05	11.1%
2	Agree	29	64.4%
3	Not Sure	06	13.3%
4	Disagree	03	6.7%
5	Strongly disagree	02	4.4%
	TOTAL	45	100%

The majority of the respondent at 29 (64.4%) agreed that community support HIV Positive mothers, while 05 (11.1%) strongly agreed with the idea. Three (6.7%) of the respondents disagreed that community support HIV Positive mother, whereas only 02 (4.4%) strongly disagreed with the statement. Six (13.3%) of the respondents revealed that there are not sure whether community support HIV Positive mother or not. The above information revealed that majority of the respondents agreed with the idea that community support HIV Positive mother.

Table 4.8 HIV positive pregnant mothers receive support from families

	Response	Frequencies	Percentage
1	Strongly agree	06	13.3%
2	Agree	26	57.8%
3	Not Sure	10	22.2%
4	Disagree	03	6.7%
5	Strongly disagree	0	0.0%
	TOTAL	45	100%

The above table presents whether HIV positive pregnant mothers receive support from families, and majority of the respondents at 26 (57.8%) agreed with the statement, while only 03 (6.7%) of the respondents disagreed. Six (13.3%) of the respondents they strongly agreed with the idea that HIV positive pregnant mothers receive support from families,

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whereas there was no respondent who strongly disagreed with the idea. Ten (22.2%) of the respondents indicated that there are not sure whether HIV positive pregnant mothers receive support from families or not.

Table 4.9 Religious believe allows HIV positive mothers to access ARVs

	Response	Frequencies	Percentage
1	Strongly agree	03	6.7%
2	Agree	07	15.6%
3	Not Sure	10	22.2%
4	Disagree	19	42.2%
5	Strongly disagree	06	13.3%
	TOTAL	45	100%

The above table present 19 (42.2%) disagree that religious believe allows HIV positive mothers to access ARVs the majority, 10 (22.2%) of the respondent are not sure that religious believe allows HIV positive mothers to access ARVs. Seven (15.6%) agrees that religious believe allows HIV positive mothers to access ARVs. Three (6.7%) of the respondent strongly agrees religious believe allows HIV positive mothers to access ARVs. Six (13.3%) strongly disagree that religious believe allows HIV positive mothers to access ARVs.

Table 4.10 Staff has good attitude to HIV positive pregnant mothers

	Response	Frequencies	Percentage
1	Strongly agree	15	33.3%
2	Agree	16	35.6%
3	Not Sure	07	15.6%
4	Disagree	05	11.1%
5	Strongly disagree	02	4.4%
	TOTAL	45	100%

Table 4.10 indicate that sixteen respondents which make (35.6%) agree staff has good attitude to HIV positive pregnant mothers. Fifteen (33.3%) strongly agree staff has good

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attitude to HIV positive pregnant mothers. Seven (15.6%) are not sure of staff has good attitude to HIV positive pregnant mothers the statement or not. Five (11.1%) disagree staff has good attitude to HIV positive pregnant mothers. Two (4.4%) strongly disagree staff has good attitude to HIV positive pregnant mothers.

4.2.2.2 Importance of taking ARVs by HIV positive pregnant mothers

This portion presents the importance of taking ARVs by HIV positive pregnant mothers. The information in this section are presented in graphical and tabular forms and followed by a discussion of the findings.

Table 4.11 HIV positive pregnant mothers take ARVs to protect their unborn babies

	Response	Frequencies	Percentage
1	Strongly agree	15	33.3%
2	Agree	18	40.0%
3	Not Sure	06	13.3%
4	Disagree	05	11.1%
5	Strongly disagree	01	2.2%
	TOTAL	45	100%

Table: 4.11 indicate that Fifteen (33.3%) strongly agree that HIV positive pregnant mothers take ARVs to protect their unborn babies. Eighteen (40.0%) agree that HIV positive pregnant mothers take ARVs to protect their unborn babies. Six (13.3%) were not sure that HIV positive pregnant mothers take ARVs to protect their unborn babies. Five (11.1 %) disagree HIV positive pregnant mothers take ARVs to protect their unborn babies, whereas one (2.2%) strongly disagree that HIV positive pregnant mothers take ARVs to protect their unborn babies.

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Table 4.12 ARVs prolong the life span of HIV positive pregnant mothers

	Response	Frequencies	Percentage
1	Strongly agree	13	28.9%
2	Agree	12	26.7%
3	Not Sure	17	37.8%
4	Disagree	01	2.2%
5	Strongly disagree	02	4.4%
	TOTAL	45	100%

Table 4.12 shows that Thirteen (28.9%) strongly disagree that ARVs prolong the life span of HIV positive pregnant mothers. Twelve (26.7%) agree ARVs prolong the life span of HIV positive pregnant mothers. Seventeen (37.8%) disagree ARVs prolong the life span of HIV positive pregnant mothers. One (2.2%) disagree ARVs prolong the life span of HIV positive pregnant mothers, whereas two (4.4%) strongly disagree ARVs prolong the life span of HIV positive pregnant mothers.

Table 4.13 The Department of Health proves ARVs to breastfeeding HIV positive pregnant mothers to protect the transmission of virus to the baby

	Response	Frequencies	Percentage
1	Strongly agree	12	26.7%
2	Agree	20	44.4%
3	Not Sure	07	15.6%
4	Disagree	04	8.9%
5	Strongly disagree	02	4.4%
	TOTAL	45	100%

Most respondent Twelve (26.7%) strongly agree that the Department of Health proves ARVs to breastfeeding HIV positive pregnant mothers to protect the transmission of virus to the baby. Twenty (44.4%) agree the Department of Health proves ARVs to breastfeeding HIV positive pregnant mothers to protect the transmission of virus to the baby. Seven (15.6%) were not sure the Department of Health proves ARVs to breastfeeding HIV positive

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pregnant mothers to protect the transmission of virus to the baby. Four (8.9%) disagree the Department of Health proves ARVs to breastfeeding HIV positive pregnant mothers to protect the transmission of virus to the baby. Two (4.4%) strongly disagree the Department of Health proves ARVs to breastfeeding HIV positive pregnant mothers to protect the transmission of virus to the baby.

Table 4.14 ARVs reduces the mortality rate to HIV positive mothers

	Response	Frequencies	Percentage
1	Strongly agree	16	35.6%
2	Agree	11	24.4%
3	Not Sure	13	28.9%
4	Disagree	05	11.1%
5	Strongly disagree	0	0.0%
	TOTAL	45	100%

Table 4.14 indicated that Sixteen (35.6%) strongly agree ARVs reduces the mortality rate to HIV positive mothers. Eleven (24.4%) agree ARVs reduces the mortality rate to HIV positive mothers. Thirteen (28.9%) were not sure ARVs reduces the mortality rate to HIV positive mothers. Five (11.1%) disagree ARVs reduces the mortality rate to HIV positive mothers whereas no one strongly agree that ARVs reduces the mortality rate to HIV positive mothers.

Table 4.15 Morbidity rate is reduced to HIV positive mothers who are taking ARVs

	Response	Frequencies	Percentage
1	Strongly agree	07	15.6%
2	Agree	18	40.0%
3	Not Sure	17	37.8%
4	Disagree	02	4.4%
5	Strongly disagree	01	2.2%
	TOTAL	45	100%

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Table: 4.15 indicate that seven (15.6%) strongly agree that morbidity rate is reduced to HIV positive mothers who are taking ARVs. Eighteen (40.0%) agree that morbidity rate is reduced to HIV positive mothers who are taking ARVs. Seventeen (37.8%) were not sure morbidity rate is reduced to HIV positive mothers who are taking ARVs. Two (4.4%) disagree that morbidity rate is reduced to HIV positive mothers who are taking ARVs; whereas one (2.2%) strongly disagree morbidity rate is reduced to HIV positive mothers who are taking ARVs.

4.2.2.3 Accessibility of HIV positive pregnant mothers

This section provides a description of the accessibility of HIV positive pregnant mothers, and the information in this section are presented in graphical and tabular forms and followed by discussions.

Table 4.16 HIV positive pregnant mothers travel a short distance to health facilities

	Response	Frequencies	Percentage
1	Strongly agree	03	6.7%
2	Agree	21	46.7%
3	Not Sure	07	15.6%
4	Disagree	14	31.1%
5	Strongly disagree	0	0.0%
	TOTAL	45	100%

Table 4.16 indicates that three (6.7%) strongly agree that HIV positive pregnant mothers travel a short distance to health facilities. Twenty one (46.7%) agrees HIV positive pregnant mothers travel a short distance to health facilities. Seven (15.6%) were not sure HIV positive pregnant mothers travel a short distance to health facilities. Fourteen (31.1%) disagree HIV positive pregnant mothers travel a short distance to health facilities.

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Table 4.17 Information is given on ARVs to HIV positive pregnant mothers

	Response	Frequencies	Percentage
1	Strongly agree	15	33.3%
2	Agree	18	40.%
3	Not Sure	09	20.0%
4	Disagree	02	4.4%
5	Strongly disagree	01	2.2%
	TOTAL	45	100%

Table 4.17 indicates that eighteen (40%) agree that information is given on ARVs to HIV positive pregnant mothers. Fifteen (33.3%) strongly agree information is given on ARVs to HIV positive pregnant mothers. Nine (20.0%) are not sure that information is given on ARVs to HIV positive pregnant mothers. Two (4.4%) disagree that information is given on ARVs to HIV positive pregnant mothers. One (2.2%) strongly disagrees with the statement that information is given on ARVs to HIV positive pregnant mothers.

Table 4.18 The Department of Health has got trained staff to initiate HIV positive Pregnant mothers

	Response	Frequencies	Percentage
1	Strongly agree	03	6.7%
2	Agree	20	44.4%
3	Not Sure	16	35.6%
4	Disagree	05	11.1%
5	Strongly disagree	01	2.2%
	TOTAL	45	100%

Table 4.18 indicates that twenty agree that the Department of Health has got trained staff to initiate HIV positive pregnant mothers. Sixteen (35.6%) they are not sure the Department of Health has got trained staff to initiate HIV positive pregnant mothers. Five (11.1%) disagree that the Department of Health has got trained staff to initiate HIV positive

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pregnant mothers. Three (6.7%) strongly agree that the Department of Health has got trained staff to initiate HIV positive pregnant mothers. One (2.2%) strongly disagree that the Department of Health has got trained staff to initiate HIV positive pregnant mothers.

Table 4.19 There is enough ARVs to give HIV positive pregnant mothers

	Response	Frequencies	Percentage
1	Strongly agree	12	26.7%
2	Agree	19	42.2%
3	Not Sure	08	17.8%
4	Disagree	05	11.1%
5	Strongly disagree	01	2.2%
	TOTAL	45	100%

Table: 4.19indicates that nineteen (42.2%) agree that there is enough ARVs to give HIV positive pregnant mothers. Twelve (26.7%) strongly agree that there is enough ARVs to give HIV positive pregnant mothers. Eight (17.8%) are not sure that there is enough ARVs to give HIV positive pregnant mothers. Five (11.1%) disagree that there is enough ARVs to give HIV positive pregnant mothers. One (2.2%) strongly disagree that there is enough ARVs to give HIV positive pregnant mothers.

Table 4.20 Health facilities operate from Sunday to Saturday for 24 hours

	Response	Frequencies	Percentage
1	Strongly agree	03	6.7%
2	Agree	20	44.4%
3	Not Sure	02	4.4%
4	Disagree	09	20.0%
5	Strongly disagree	11	24.4%
	TOTAL	45	100%

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Table: 4.20 indicates that twenty (44.4%) agree that health facilities operate from Sunday to Saturday for 24 hours. Eleven (24.4%) strongly disagree that facilities operate from Sunday to Saturday for 24 hours. Nine (20.0%) disagree that facilities operate from Sunday to Saturday for 24 hours. Three (6.7%) strongly agree that facilities operate from Sunday to Saturday for 24 hours. Two (4.4%) are not sure that facilities operate from Sunday to Saturday for 24 hours.

4.2.2.4 The strategies than can be used to address the challenges faced by HIV positive pregnant mothers

The following paragraph focuses on the strategies than can be used to address the challenges faced by HIV positive pregnant mothers. The responses to a questionnaire items are presented graphically and in a table form and are followed by a discussion of the findings for the item.

Table 4.21 The health facilities are free for HIV positive pregnant mothers

	Response	Frequencies	Percentage
1	Strongly agree	13	28.9%
2	Agree	28	62.2%
3	Not Sure	04	8.9%
4	Disagree	0	0.0%
5	Strongly disagree	0	0.0%
	TOTAL	45	100%

Table: 4.21indicates that twenty eight (62.2%) agree that the health facilities are free for HIV positive pregnant mothers. Thirteen (28.8%) agree that the health facilities are free for HIV positive pregnant mothers. Four (8.9%) are not sure that the health facilities are free for HIV positive pregnant mothers. Zero (0%) disagree the health facilities are free for HIV positive pregnant mothers. Zero (0%) strongly disagree the health facilities are free for HIV positive pregnant mothers.

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Table 4.22 The revised guidelines and policies are available for HIV positive mothers

	Response	Frequencies	Percentage
1	Strongly agree	10	22.2%
2	Agree	14	31.1%
3	Not Sure	18	40.0%
4	Disagree	03	6.7%
5	Strongly disagree	0	0.0%
	TOTAL	45	100%

Table: 4.22 indicates that eighteen (40.0%) not sure that the revised guidelines and policies are available for HIV positive mothers. Fourteen (31.1%) agree that the revised guidelines and policies are available for HIV positive mothers. Teen (22.2%) strongly agree that the revised guidelines and policies are available for HIV positive mothers. Three (6.7%) disagree the revised guidelines and policies are available for HIV positive mothers. Zero (0%) strongly disagree that the revised guidelines and policies are available for HIV positive mothers.

Table 4.23 All HIV positive mothers receive VCT during the first booking

	Response	Frequencies	Percentage
1	Strongly agree	15	33.3%
2	Agree	19	42.2%
3	Not Sure	08	17.8%
4	Disagree	03	6.7%
5	Strongly disagree	0	0.0%
	TOTAL	45	100%

Table: 4.23indicates that nineteen (42.2%) agree that all HIV positive mothers receive VCT during the first booking. Fifteen (33.3%) strongly agree that that all HIV positive mothers receive VCT during the first booking. Eight (17.8%) are not sure that that all HIV positive mothers receive VCT during the first booking. Three (6.7%) disagree that that all HIV positive

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mothers receive VCT during the first booking. Zero (0%) strongly disagree that all HIV positive mothers receive VCT during the first booking.

Table 4.24 Retesting of pregnant mothers is done on the 32 weeks of pregnancy

	Response	Frequencies	Percentage
1	Strongly agree	10	22.2%
2	Agree	17	37.8%
3	Not Sure	14	31.1%
4	Disagree	04	8.9%
5	Strongly disagree	0	0.0%
	TOTAL	45	100%

Table: 4.24 indicates that seventeen (37.8%) agree that retesting of pregnant mothers is done on the 32 weeks of pregnancy. Fourteen (31.1%) they are not sure that retesting of pregnant mothers is done on the 32 weeks of pregnancy. Ten (22.2%) strongly agree that retesting of pregnant mothers is done on the 32 weeks of pregnancy. Four (8.9%) disagree that retesting of pregnant mothers is done on the 32 weeks of pregnancy.

Table 4.25 ARVs are given to all HIV positive mothers

	Response	Frequencies	Percentage
1	Strongly agree	12	26.7%
2	Agree	17	37.8%
3	Not Sure	08	17.8%
4	Disagree	08	17.8%
5	Strongly disagree	0	0.0%
	TOTAL	45	100%

Table: 4.25 indicate that seventeen (37.8%) agree that ARVs are given to all HIV positive mothers. Twelve (26.7%) strongly agree that ARVs are given to all HIV positive mothers. Eight (17.8%) disagree that that ARVs are given to all HIV positive mothers. Eight (17.8%) are

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not sure that ARVs are given to all HIV positive mothers. Zero (0%) strongly disagree that ARVs are given to all HIV positive mothers.

4.3 ANALYSIS OF DATA COLLECTED THROUGH INTERVIEW

In this section, the researcher present the responses to the interview items are presented in narrative form.

Question 1: What are the challenges faced by HIV positive pregnant mothers in Accessing ARVs?

Participant A:

With regard to this question, participant A replied that there is poor co-ordination of programs and there is issue of supermarket approach which prevent pregnant mothers to be given information as they come one by one on one professional nurse, there is no time to give health talk as they will be busy wanting to finish the people on the quire.

Participant B:

With regard to this question, participant B replied that HIV positive pregnant mothers receive support from the staff and families and the staff has good attitude towards them.

Participant C:

With regard to this question, the participant C replied that they do not receive information about PMTCT as they face rejection from the family members and the community, and for that reason they are afraid of isolation and losing of their partners.

Participant D:

With regard to this question, the participant D replied that clinics are not accessible during the night which means that the staffs work only during the day. The nursing staffs at the clinic do not have enough knowledge on PMTCT program. Staff does not have good attitude toward HIV positive pregnant mothers. The cultural believes of HIV positive mothers also is a challenge toward the program.

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Participant E:

With regard to this question, the participant E replied that the staff member does not have information on PMTCT program. The clinics are not accessible during the night. Staff members has bad attitude towards HIV positive client that contribute to the client not coming back again for follow-up. The cultural believe of the client which makes them not to book in time which means at 14week.

Question 2: What is the importance of taking ARVs by HIV positive pregnant mothers?

Participant A:

With regard to this question, the participant A replied that ARVS prevent the transmission of the virus to the unborn baby. It builds resistant to people leaving with HIV toward other infection. It reduces the death of the women leaving with the HIV.

Participant B:

With regard to this question, the participant B replied that the ARVS prolong our lives and reduced mortality and morbidity for mother and children.

Participant C:

With regard to this question, the participant C replied that ARVS are taken to prevent the unborn baby from being infected by the virus. It also prolongs the life of the mother. The ARVS also protect the child from being infected during breast feeding.

Participant D:

With regard to this question, the participant D replied that the ARVS prevent our baby of becoming infected by HIV virus. The ARVS prolong our life span.

Participant E:

With regard to this question, the participant E replied that the ARVS are taken to prevent the unborn baby of becoming infected by the HIV virus. The ARVS are given to HIV positive mothers to prolong their life.

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Question3: How is the accessibility of ARV to the residents of Tshirenzheni Village?

Participant A:

With regard to this question, the participant B replied that there is poor road infrastructure which makes it difficult for the mobile team to reach the area. Mobile team nurse are not all trained on NIMART (Nurse Initiative ART) which make them not to initiate positive pregnant mothers on site.

Participant B:

With regard to this question, the participant B replied thatthere is no tar road wherein mobile clinic can reach our place.

Participant C:

With regard to this question, the participant C replied that it is a distance; we have to walk in order to access the health service. The area is not well developed they need to travel to go to the main road to bought a taxi.

Participant D:

With regard to this question, the participant D replied that the roads infrastructures are bad. The mobile team staff must be well trained on PMTCT and NIMART.

Participant E:

With regard to this question, the participant E replied that clinics open during the day and during the night is closed. Mobile team staffs to be trained on PMTC and NIMART (Nurse Initiative ART). There is poor road infrastructure.

Question 4: What are the strategies than can be used to address the challenges faced by HIV positive pregnant mothers?

Participant A:

With regard to this question, the participant A replied that training of mobile nurses on NIMART. Distribution of new guideline to all service point and conducting of in-service

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training to the staff. Awareness campaign must be conducted to the community on the availability of the program.

Participant B:

With regard to this question, the participant B replied that mothers get health services free and ARVS are given to all HIV positive pregnant mothers for free.

Participant C:

With regard to this question, the participant C replied that the clinic should open for 24 hours so that we can access for the service anytime we have the need. They should increase trained staff so that they can work shift some during the day some during the night.

Participant D:

With regard to this question, the participant D replied that the mobile team staffs to be trained on NIMART and PMTCT programme in order to help the people on the site.

Participant E:

With regard to this question, the participant E replied that awareness campaign to be conducted to the community on the availability of the program. The new guidelines to be distributed to the staff when there are some changes. Health talk to be given to each and every pregnant mother during the first booking, and early booking should be enforced. The staff should be trained on the program.

4.4 CONCLUSION

The chapter has discussed the responses of challenges faced by HIV positive pregnant mothers in accessing ARVS: a case study of Tshirenzheni villages at Thulamela municipality of Vhembe district. The respondents' uses questionnaires and interviews. Data collected from this mixed method are presented in the following theme that were identified in the interview: the challenges faced by HIV positive pregnant mothers in accessing ARVS, the importance of taking ARVs by HIV positive pregnant mothers, the accessibility of ARV to the resident of Tshirenzheni Village and the strategies that can be used to address the problems

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faced by HIV positive pregnant mothers in accessing ARVS. The data obtained from the interview are only concerned with the HIV positive mothers and the staff.

The data from questionnaire s were presented according to the theme and contributed both to analysis of both questionnaires and interviews. The following them were established the challenges faced by HIV positive pregnant mothers in accessing ARVS, the importance of taking ARVs by HIV positive pregnant mothers, the accessibility of ARV to the resident of Tshirenzheni Village and the strategies that can be used to address the problems faced by HIV positive pregnant mothers in accessing ARVS. Document that were consulted were the Bill of Rights in the South African Constitution and the PMTCT (Prevention of Mother to Child Transmission) Guidelines. The following Chapter will discuss the conclusion and recommendation based on the data collected.

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CHAPTER 5

FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

The Chapter concludes the study by drawing conclusion about the possibility of the successful of intervention of HIV positive pregnant mothers in accessing ARVS and the reduction of mortality and morbidity of the pregnant mothers unborn babies and those who are being breastfed.

5.2 MAJOR FINDINGS OF THE STUDY

The researcher in this section will present the major findings of the study base on the research objectives. The four specific objectives of the study were; to describe the challenges faced by HIV positive pregnant mothers in accessing ARVS, to explore the importance of taking ARVs by HIV positive pregnant mothers, to assess the accessibility of ARV to the residents of Tshirenzheni Village, and to determine the strategies that can be used to address the problems faced by HIV positive pregnant mothers in accessing ARVs.

5.2.1 Major findings on the challenges faced by HIV positive pregnant mothers in accessing ARVS

The first objective of the study sought to describe the challenges faced by HIV positive pregnant mothers in accessing ARVS, the researcher found out that 38 (84.4%) of the respondents agreed that HIV positive pregnant mothers receive PMTCT. The researcher found out that 29 (64.4%) agreed that community support HIV positive mothers. The researcher found that 26 (57.8%) agree that HIV positive mothers receive support from families. The researcher found out that 19 (42.2%) agree that religious believe allows HIV positive mothers to access ARVs. The researcher also found out that 16 (35.6%) agree that staff have good attitude towards HIV positive mothers.

5.2.2 Major findings on the importance of taking ARVs by HIV positive pregnant mothers

The second objective of the study sought describe the importance of taking ARVs by positive pregnant mothers, the researcher found out that 18 (40.0%) agree that HIV positive pregnant mothers take ARVs to protect their unborn babies. The researcher found out that

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17 (37.8%) were not sure that ARVs prolong the lifespan of HIV positive mothers. The researcher found out that 20 (44.4%) agree that the Department of Health proves ARVs to breastfeeding HIV positive pregnant mothers to protect the transmission of virus to the baby. The researcher found out that 16 (35.6%) strongly agree that ARVs reduces the mortality rate of HIV positive mothers. The researcher also found out that 18 (40.0%) agree that the morbidity rate is reduced to HIV positive mothers who are taking ARVs.

5.2.3 Major findings on the accessibility of ARV to the residents of Tshirenzheni Village

The third objective of the study sought to describe accessibility of HIV pregnant mothers. The researcher found out that 21(46m7%) agree that HIV positive mothers travel a short distance to health facilities. The researcher found out that 18 (40%) agree that information on ARVs was given to HIV pregnant mothers. The researcher found out that 20 (44.4%) agree that the Department of Health has trained staff to initiate HIV positive pregnant mothers. The researcher found out that 19 (42.2%) agree that there is enough ARVs to give to HIV pregnant mothers. The researcher also found out that 20 (44.4%) agree that Health facilities operate from Sunday to Saturday 24 hours.

5.2.4 Major findings on the strategies that can be used to address the problems faced by HIV positive pregnant mothers in accessing ARVs

The fourth objective is to describe the strategies that can be used to address the challenges faced by HIV positive pregnant mothers. The researcher found out that 28(62.2%) agree that the health facilities are free for HIV positive pregnant mothers. The researcher found out that 19(42.2%) agree that all HIV positive mothers receive VCT during the first booking. The researcher found out that 17(37.8%) retesting for pregnant mothers is done on the 32 weeks of pregnancy. The researcher also found out that 17(37.8%) agree that ARVs are given to all positive mothers.

5.3 RECOMMENDATIONS OF THE STUDY

The researcher recommends that HIV positive pregnant mothers must have access to ARVS. The researcher recommends that the Department of Health must develop strategies that can be applied to address the challenges faces by HIV positive pregnant mothers. The researcher recommends that it is important for HIV positive mothers to take ARVs.

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It is recommended that the community in general needs more information on HIV testing, before a person can start thinking of taking ARVs. Availability of ARVs potentially acts as a motivating factor for people to seek testing services. This means that as ARV literacy must be promoted to ensure equitable provisioning of HIV testing in the facilities. Furthermore the population needs to be sensitized and provided with information on the availability of HIV testing and counselling services. Regarding the disparities in access to information about ARVs, it can be noted that awareness raising and sensitization on ARVs ought to widen to include all sections of the society; the rich and the poor, users of ARVs and nonusers, PLHAs and those that are HIV negative i.e., reaching everyone. This strategy seeks to arouse social support for PLHAs to use ARVs, but also goes hand in hand with strategies for eliminating stigma and discrimination, which also undermine the use of ARVs and adherence. Methods which reinforce highly interpersonal, customised, individualised means of delivery of information need to be promoted.

5.4 RECOMMENDATIONS FOR FUTURE STUDY

Further study must be done which can includes more respondents from other municipality. The mobile teams must be trained on PMTCT and NIMART to be able to test initiate client at the community level. The Department of health needs to ensure that all clinics operate for 24 hours with enough staff which can cover day and night shift.

5.5 CONCLUSION

It is important that everybody must know their HIV status, whether they are pregnant or not because HIV/AIDS is real and it infect everyone it doesn't respect anyone, no one is immune to HIV it affect both the rich and the poor. HIV and AIDS is now the leading cause of mortality among women of reproductive age and, in several high –burden countries such as South Africa and Zimbabwe, HIV is the leading cause of maternal mortality .Knowing your status prolong your life, because of ARVS.The data collected provide evidence that HIV positive pregnant mothers receive support from the families and that the community is involved in supporting of HIV positive pregnant mothers as indicated by the current study wherein 29(64.4%) agree that community support HIV pregnant positive mothers. So it makes it easy for the mothers to adhere to their ARVs. The study concluded that 16 (35.6%) strongly agree that ARVs reduces the mortality rate of HIV positive mothers and morbidity

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rate is also reduced to HIV positive mothers who are taking ARVs 18(40.0%). The sampling method used was no probability sampling and purposive sampling. Data collection used for this research was questionnaire and interview with open ended questionnaire.

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APPENDIX A

Letter to the respondents

PO .BOX 126

NZHELELE

0993

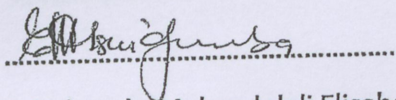
Dear Respondent

I TshidzumbaMukondeleliElisabeth, a student at the University of Venda, registered for Masters of Public Management. I am conducting a study on:CHALLENGES FACED BY HIV POSITIVE PREGNANT MOTHERS IN ACCESSING ARVS: A CASE STUDY OF TSHIRENZHENI VILLAGES AT THULAMELA MUNICIPALITY OF VHEMBE DISTRICT.

I would like you to be the participant of the study.

Hope you will find this in order.

Yours faithfully



TshidzumbaMukondeleli Elisabeth

Student no: 9423753

Cell: 0825972562

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RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms ME Tshidzumba

Student No: 9423753

PROJECT TITLE: Challenges faced by HIV positive pregnant mothers in accessing ARVS: A case study of Tshirenzheni Villages at Thulamela Municipality of Vhembe District

PROJECT NO: SMS/14/PDN/03/2803

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof MP Khwashaba	University of Venda	Supervisor
Mr E Mahole	University of Venda	Co-supervisor
Ms ME Tshidzumba	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2014
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: ....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

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LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

Tshidzumba ME

University of Venda

Private Bag X5050

Thohoyando

0950

Greetings,

Re: Challenges faced by HIV positive pregnant mothers accessing ARVs: A case study of Tshirenzheni Villages at Thulamela Municipality of Vhembe District.

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

Head of Department

13/06/2014

Date

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APPENDIX B

INSTRUMENT

QUESTIONNAIRE

CHALLENGES FACED BY HIV POSITIVE PREGNANT MOTHERS IN ACCESSING ARVS: A CASE STUDY OF TSHIRENZHENI VILLAGES AT THULAMELA MUNICIPALITY OF VHEMBE DISTRICT

This is the study onchallenges faced by HIV positive pregnant mothers in accessing ARVs: a case study of Tshirenzheni villages at Thulamela Municipality of Vhembe District. I would like you to be part of the study. Please put a cross (x) in an appropriate answer. There is no wrong or write answer.

SECTION A: BIOGRAPHYCAL INFORMATION OF THE RESPONDENT

1. Gender

Female	
Male	

2. Age of respondent

Less than 20years	
21 to 30years	
31to 40years	
40 to 50years	
51 and above	

3. Gestational period

Less than 4month	
6moth	
9 month	

4. Distance.

Near	
Far	
Very far	

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5. Mental status

Very good	
Good	
Satisfactory	
Poor	

SECTION B: HIV POSITIVE PREGNANT MOTHERS

	Challenges faced by HIV positive pregnant mothers.	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
6	HIV positive mothers receive PMTCT					
7	Community support HIV positive mothers					
8	Positive mothers receive support from families					
9	Religious believe makes positive mothers to access ARVS					
10	Staff has good attitude to positive pregnant mothers.					

	Importance of taking ARVS by HIV positive pregnant mothers	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
11	HIV Positive pregnant mothers take ARV to protect their unborn babies.					
12	ARVS prolong the life span of HIV positive pregnant mothers					
13	The department of health provide ARVS to breastfeeding positive mothers to protect the transmission of virus to the baby					
14	ARVS reduces the mortality rate to HIV positive mothers					
15	Morbidity rate is reduced to positive mothers who are taking ARVS					

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	Accessibility of HIV positive pregnant mothers to ARVS.	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
16	HIV positive pregnant mothers travel a short distance to health facility					
17	Information is given on ARVS to positive pregnant mothers					
18	The department of Health has got more trained staff to initiate positive pregnant mothers					
19	The health facilities has got enough ARVS to give HIV positive mothers					
20	The health facilities open from Sunday to Saturdays for 24hrs					

	The strategies that can be used to address the challenges.	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
21	The health facilities are free for HIV positive pregnant mothers.					
22	The revised guideline and policies are available for the HIV positive mothers					
23	All HIV positive mothers are done VCT during the first booking					
24	Retesting of pregnant mothers is being done on the 32weeks of pregnancy					
25	ARVS are given to all pregnant positive mother					

"THANK YOU FOR YOUR PARTICIPATION"

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