ABSTRACT

This research was conducted with the aim to evaluate the policy interventions on HIV and AIDS in pregnant women in the Lukhanji sub district of Chris Hani District Municipality. The study would also propose policy improvement strategies towards curbing the spread of HIV and AIDS in pregnant women. In realizing these goals, the entire research process was guided by the research objectives and questions which sought to evaluate policies and strategies relevant to HIV prevalence in pregnant women. The secondary research objectives were accomplished through the review and analysis of the relevant literature and theories. Qualitative research approach was used in determining the findings and conclusions from the study.

Data was collected using qualitative research methods and in this case a structured questionnaire was developed and distributed to the study participants. The Questionnaires were handed and discussed with each participant. Demographics, socioeconomic and cultural factors were considered in designing the data collection tool. These factors are known to have an impact on the prevalence of HIV. It has been shown through the study that demographic variables have an effect on HIV prevalence. Hence when considering policy interventions these should be taken into account.

All the respondents were given enough time and they provided clear and comprehensive responses to the questionnaire and follow up discussions. The evaluation of the responses showed that various HIV prevention related policies are being implemented within the Lukhanji sub-district. Numerous programmes relating to HIV and AIDS, also specifically covering pregnant women are being rolled out across the sub-district. HIV prevalence in the study population is rated as average to low when comparing with the district, provincial and national statistics. Current data obtained from the study indicates that HIV prevalence stands at 17%. This finding demonstrates the heterogeneity of HIV prevalence when comparing this result with current provincial and national statistics. Evaluation of the different HIV and AIDS programmes that are aligned to provincial and national policy somehow explain the positive outcomes observed in the Lukhanji sub-district

The study recommends that more work be done in reaching out to the communities using various communication channels and strategies. This could address the challenges associated with the lack of cooperation with local traditional leaders, because this has been found to have a negative impact on implementation of some programmes such as circumcision. One of the positive findings from the study is the accessibility of health care facilities to the local rural communities. Further research on the subject should be undertaken to ensure continuous evaluation as this topic is viewed as a continuous global issue.

Acknowledgements

This research is the product of interaction between the research respondents and the researcher and a number of people whom I remain grateful for. I would therefore like to acknowledge the following people for support and contribution, namely:

- My mother, Nombulelo Winnifred Sinyanya for her continuous support and encouragement and the unwavering belief she has in me.
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- My late dad, Mbuyiseli Liberty Sinyanya for inspiring the love for education since my early years. This has kept me focused and principled in order to achieve my academic goals. Aah Zizi!

Dedication

This study is dedicated to my dearest parents, my father Mbuyiseli Liberty Sinyanya (aah Zizi!) and Nombulelo Winnifred Sinyanya (aah Mam'Zangwa) for honouring their responsibility in ensuring that I had a better education right from my formative years. Moreover, their unconditional love in shaping and instilling certain values and principles which have determined the person I have become.

Declaration

I hereby declare that this research is my original work and has not previously been submitted in any university for any qualifications, except where the references is cited in the text or in the bibliography accordingly.

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Y. SINYANYA **NOVEMBER 2015**

List of Annexures

Annexure A	Letter of approval by the sub-district Manager
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List of Figures and Tables

List of Acronyms

Acronym	
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
NDoH	National Department of Health
RSA	Republic of South Africa
SANAC	South African National AIDS Council
ECAC	Eastern Cape AIDS Council
AUC	African Union Commission
PAP	Pan African Parliament
WHO	World Health Organisation
ART	Anti-Retroviral Treatment
NEPAD	New Partnership for Africa's Development
UNAIDS	United Nations Programme on HIV and AIDS
DoH	Department of Health
UNGASS	United Nations General Assembly Special Session
CHDM	Chris Hani District Municipality
IDP	Integrated Development Plan
MDG	Millennium Development Goals
ANC	Antenatal Care
PMTCT	Prevention of Mother-to-child transmission
HSRC	Human Sciences Research Council
NAG	National Advisory Group
PEPFAR	President’s Emergency Plan for AIDS Relief
VCT	Voluntary Counselling and Testing
ABC	Abstain, Be Faithful, Condomise
NACOSA	National Advisory Council of South Africa
NSP	National Strategic Plans

PSP	Provincial Strategic Plans
NASA	National AIDS Spending Assessment
CD4	Cluster of Differentiation 4
HAART	Highly Active Antiretroviral Therapy
NDP	National Development Plan
TB	Tuberculosis bacillus
HST	Health Systems Trust

CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

The essence of evaluating policy interventions on HIV and AIDS in pregnant women remains a critical matter that cannot be deferred anymore. The notion of public health intervention for pregnant women has been subjected to different debates and interpretations by academics, medical research institutions, and government sectors across the globe, organisational practitioners and managers (WHO and UNAIDS 2003:6). This study provides a contribution to such ongoing debates and interpretations by evaluating the impact of HIV and AIDS policy interventions in pregnant women in the Lukhanji sub-district within the Chris Hani District Municipality.

Whilst evaluating these policy interventions, the study aims to determine whether some improvement strategies can be suggested towards reducing the spread of HIV and AIDS in pregnant women.

So far, the report on the National Antenatal Sentinel HIV and Syphilis Prevalence Survey, conducted in the nine provinces by the South African National Department of Health, estimates that 29.5% of pregnant women between the ages 15-49 were living with HIV in 2011 (2013:4). Johnson (2012: 23) argues that the number of pregnant women infected with HIV was likely to remain high for at least the next twenty years, due to the increasing number of people and pregnant women who were receiving life-long antiretroviral treatment (ART).

Other studies on the prevalence of HIV infections in pregnant women reported rapid increase in prevalence over the years, and this was found to be slowing down around 2010 (DoH 2013:19). Barron et al (2012:70) predicts that this situation will plateau around 2016. These authors reveal that these outcomes will only be achieved if health care policies, strategies, preventative and curative interventions are implemented effectively.

In the midst of government interventions to curb the spread of HIV especially in pregnant women, the report on HIV Epidemic Response and Policy Synthesis (2011:6) indicates that the unexpected rapid increase in HIV infection in the RSA has resulted in the epidemic settling at very high levels in the country, compared to other parts of the world. It is against this backdrop that this study is being conducted so that measures and strategies aimed at improving the health care challenges and reducing the impact of HIV infections, particularly in pregnant women can be recommended to the relevant authorities.

This chapter examines the research context, background information and also reflect on the problem statement, objectives, research questions, and significance of the study. It also covers literature and theories on HIV prevalence, the research design and methodology.

1.2 Research Context and Background

A report by the Joint United Nations Programme on HIV and AIDS (2013: 68) indicates that whilst progress was being made in preventing new HIV infections and reducing the number of deaths due to AIDS, the number of people living with HIV was still growing. The same report (2013: 4) estimates that approximately 35.3 million people were infected with HIV worldwide. The report further showed that South Africa was the country with the highest number of HIV infected people in the world. A Human Sciences Research Council (HSRC) study indicated that 469 000 new HIV infections occurred during 2012 in South Africa (2012:xxix).

A report on the meeting of the AUC hosted in collaboration with the NEPAD Agency, members of parliament from the continent representing national, regional and the Pan African Parliament (PAP) recognized the comparative advantage that is possessed by members of parliament, especially the need for follow through on the implementation of policies and legislative frameworks (2014: 2). At this meeting the parliamentarians committed on the following:

- To advocate for and engage with national stakeholders to ensure that ending AIDS, TB and Malaria epidemics remains a key priority in the national, continental and global agenda beyond 2015.

- To gather data on access to health services by vulnerable and key populations as well as to review laws and policies that affect access to services.

- To support the initiative to achieve universal access to HIV treatment on the continent, including HIV treatment for children, as an important catalyst for saving lives, preventing new HIV infections and moving towards ending the AIDS, TB and Malaria epidemics.

A report by WHO (2013:17) further indicates that the expansion of effective treatment together with preventive interventions would enable countries to reach a “tipping point” beyond which the number of people starting HIV treatment would exceed the number of people who are acquiring infection by the virus. According to this report, RSA is amongst several countries in the world that appear to have passed that “tipping point”. The same report indicates that countries with high HIV prevalence also tend to have high testing rates for HIV infection. Amongst the priority countries in the WHO Global Plan on HIV, South Africa is one of four countries that had recorded more than 95% HIV testing rate.

According to Barron et al (2012:70) the prevalence of HIV infections in pregnant women in RSA have also shown a rapid increase in the prevalence of HIV infection over the years, and this was found to be slowing down around 2010. Predictions by the same experts in the field are that this situation will plateau around 2016. It is also advised that this outcome will only be achieved if health care policies and strategies, and other preventive and curative interventions were implemented effectively.

According to the results of the survey conducted by the NDoH on Antenatal Sentinel HIV and Syphilis Prevalence Survey (2013: 19), five out of the nine RSA provinces (Free State, Gauteng, KwaZulu-Natal, Mpumalanga and North West) have recorded HIV prevalence estimates above the national average of 29.5% - see table X. Only Northern Cape and Western Cape have HIV prevalence rates of less than 20%.

	District Municipality	% HIV Prevalence Estimate (NDoH 2012: 23)
1	Cacadu	25.8
2	Nelson Mandela Metro	28.3%
3	OR Tambo	28.4%
4	AmaThole	28.4%
5	Alfred Nzo	28.9%
6	Chris Hani	29.5%
7	Joe Gqabi	29.9%
8	Buffalo City	34.1%

Table 1.1: *HIV prevalence estimates among antenatal women by district for the Eastern Cape Province (2013:23)*

A report published by the SANAC, indicates that the unexpectedly rapid increase in HIV infection in the RSA has resulted in the epidemic settling at very high levels in the country, compared to other parts of the world (2011: 6). The same report indicates that due to the high HIV prevalence levels from high numbers of infected people and continuing new infections, bringing about change will require a long-term and sustainable large scale response. The report also points out that the HIV epidemic was spreading heterogeneously across and within provinces, requiring different levels of effort in different locations (DoH 2013: 21).

1.2.1. Statistical Context

The South African government's commitment towards addressing challenges posed by HIV infections including pregnant women are reflected in the National Strategic Plan on HIV, STIs and TB 2012-2016 (NSP 2012-2016). The NSP 2012–2016 has the following four strategic objectives**:**

- Address social and structural barriers to HIV, STI and TB prevention, care and impact;

- Prevent new HIV, STI and TB infections;
- Sustain health and wellness; and
- Increase protection of human rights and improve access to justice.

The NSP is geared towards providing strategic direction to assist national, provincial, district and lower levels, such as sub-districts and community level stakeholders, in developing Implementation Plans to deal with the burden of HIV and AIDS, STIs and TB. It also aligns South Africa's response to the epidemics with international and regional obligations, targets and commitments aimed at dealing with HIV, STIs and TB infections.

In the context of the NSP strategic objectives, this study focuses on evaluating policy interventions on HIV and AIDS in pregnant women in the Lukhanji Sub-district Municipality. For the purposes of this study, the data available from the Lukhanji Sub-district of the CHDM was analysed together with various relevant health policies and strategies, in addressing the objectives of this study. The relevant information and data from various sources was evaluated in order to determine progress and identify challenges with regards to the objectives and implementation of the NSP 2012-2016, and South Africa's targets within several international agreements, such as the UNGASS Declaration of Commitments on HIV and AIDS (2013). Key to the evaluation was the impact made with regards to reducing or eliminating HIV infections, particularly in pregnant women who are the population group for this research.

According to Statistics South Africa (2013: 4), the following are some of the national estimates regarding HIV and AIDS:

- The total number of people living with HIV was estimated at approximately 5.26 million in 2013.
- For adults aged 15–49 years, an estimated 15.9% of the population is HIV positive.
- Approximately seventeen percent (17%) of South African women in their reproductive ages are HIV positive
- The estimated overall HIV prevalence rate is approximately 10%.

The report by HSRC (2012: 35) stated that the South African HIV prevalence estimate was 12.2%, which translates to about 6.4 million people. This was regarded as a statistically worrying development when compared to national estimates of 10.6% in

2008. These estimates differed substantially from province to province with the Eastern Cape recording the fourth lowest estimate at 11.6%. The current estimates of HIV prevalence according to StatsSA is about 10%.

This illustrates why it is important that, whilst making general observations about the HIV situation in the country, similar monitoring and evaluation of data should take place at the level of the provinces, districts and sub-districts so that interventions and plans that are introduced and implemented are relevant to the actual challenges at these levels. The HIV prevalence results show a reduction of 2.5% between 2010 and 2012, and a reduction of 3.8% from the 2001 baseline of 23.1%. Based on this trend, it is clear that more efforts are needed if South Africa is to achieve the 2015 target of 5.3% in this age group.

The recent HSRC survey (2012: 5) noted that, although the HIV and AIDS epidemic in South Africa is generalised, specific groups had an HIV prevalence above the national average and these were regarded as key populations with higher risk of HIV exposure. Special interventions were proposed for these people. Amongst the identified groups were the following - Black African females aged 20–34 years (HIV prevalence of 31.6%), people co-habiting (30.9%) and Black African males aged 25–49 years (25.7%). Thus, the proposed research identifies the importance and need to continuously monitor and evaluate policy interventions on HIV prevalence in pregnant women at the different localities, including the districts.

1.2.2 Study Population

Lukhanji is one of eight Local Municipalities in the CHDM, in the Eastern Cape Province of South Africa. It includes the following towns Queenstown, Whittlesea, Sada, iLinge, Lesseyton and several other surrounding rural areas (Machibini, Gwatyu farms, Hewu, Zingquthu). The population of Lukhanji is estimated at about 190 723 (2015: www.statssa.gov.za), people living within an estimated 51 054 households (CHDM IDP Review 2014-2015). The population gender distribution consists of 48% males and 52% females. Health is one of the five key priorities in the alignment of the budget to the Integrated Development Plan (IDP) as shown in the Budget Strategy and Expenditure Framework for 2014/15-2016/17, which was adopted in March 2014.

Figure 1.1 –Map of Chris Hani District showing location of Lukhanji Sub-District

1.2.3 The Concept of "HIV Prevalence"

HIV prevalence is an estimate of the proportion of a defined population (e.g. pregnant women, youth, adults, employees, etc) who are infected with HIV during a specified period. This estimate is used to model estimates of HIV prevalence in other population groups. Pregnant women who attend public health antenatal clinics provide the basis for national-level HIV-prevalence estimates in South Africa. This survey is limited because it does not include HIV prevalence rate for men, children, elderly and women attending private antenatal clinics. Allen (2000: 11) acknowledges that the National HIV prevalence survey of women attending antenatal clinics does provide useful data, but the need is expressed to supplement these data with additional information that can assist in characterising the HIV and AIDS epidemics more accurately and monitor and evaluate health interventions.

Recent surveys have been conducted that use population-based data that includes HIV data, a range of demographic data, information on knowledge, attitudes, sexual behaviour and other HIV and AIDS-related practices. The population-based surveys have allowed for an expanded understanding of HIV prevalence, which also covers

the differences in infection levels amongst males and females, as well as differences related to geographic location, geo-type of residence and behavioural factors.

According to the report on HIV Epidemic, Response and Policy Synthesis, in South Africa, as in other parts of the world, HIV has been shown to be spreading heterogeneously across and within provinces (2011:7). This observation was based on both HIV incidence and prevalence data.

1.3 Research Problem Statement

In spite of progress made in as far as addressing the global challenge of HIV and AIDS along the lines of policy interventions, the Millennium Development Goals (MDG) report acknowledges uneven achievements and shortfalls (2015:4) especially MDG 6 which is linked to the research topic.

The HIV prevalence amongst antenatal women in South Africa, as indicated in recent reports, stands at about 29.1%. The survey conducted by the NDoH indicates that the Eastern Cape Province has the third highest number of new HIV infections (47 464) when compared to the other provinces (2013: 10). The Eastern Cape Provincial Strategic Plan for HIV-AIDS, STIs and TB 2012-2016 further confirms that the province has an estimated annual HIV infection incidence rate of 1.5%, which is slightly higher than the current national incidence rate of 1, 2%.

On the other hand, the report by the NDoH showed there was a slight decrease of the HIV prevalence in the Eastern Cape (2013: 29), but this is still regarded as an alarming situation that requires more attention and urgent intervention in addressing the burden of HIV infection especially in pregnant women. CHDM, where Lukhanji Sub-district is located, is amongst the three district municipalities that have HIV prevalence estimates equal to or higher than provincial and national estimates, as indicated in the latest HIV survey (2012:30).

Having stated the problem with regards to HIV prevalence in pregnant women within the Lukhanji sub-district policies had to be developed and implemented in order to manage the situation. As a mitigating measure various programmes such as PMCTC,

ART, ANC, were introduced. It therefore becomes crucial to evaluate the impact of these policy interventions.

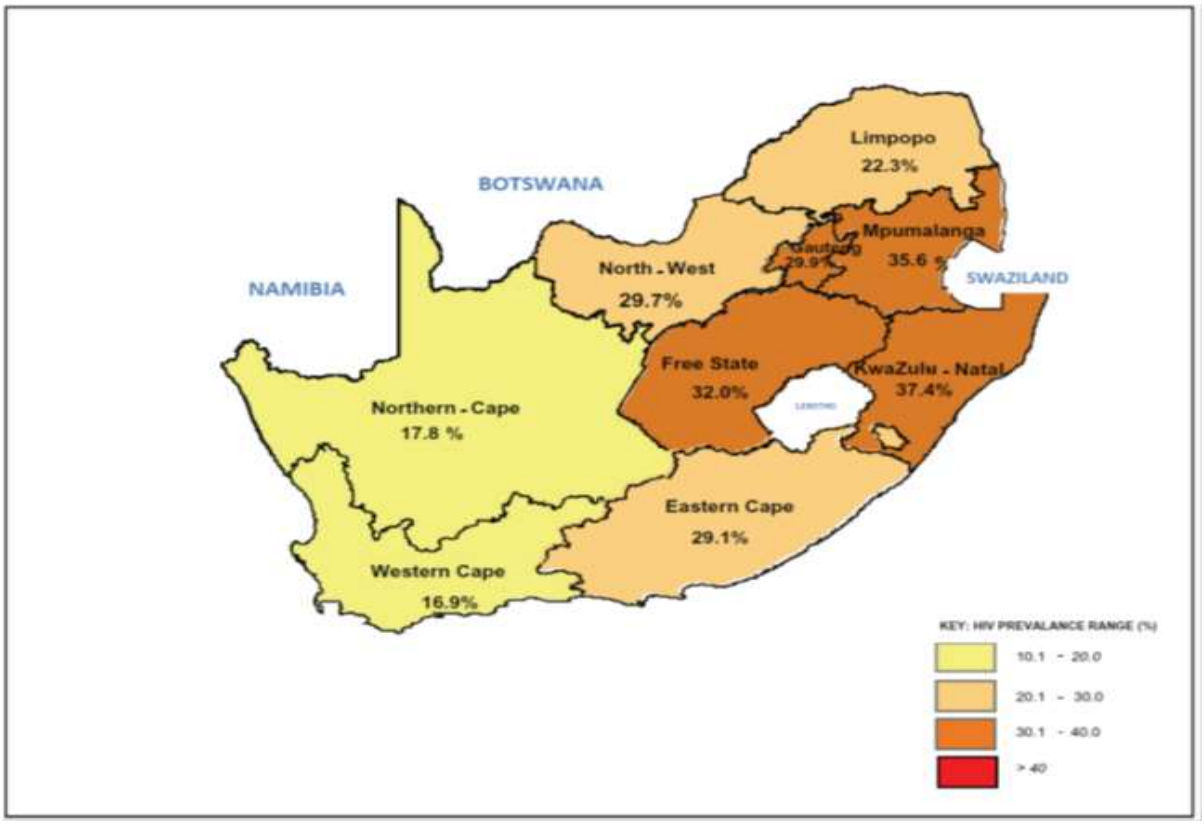


Figure 1.2 – *HIV prevalence distribution by Province (NDoH 2013: 21)*

1.4 Aims and Objectives

The primary and secondary research objectives of this study are outlined in the following sub-sections:

1.4.1 Primary Research Objective

The primary research objective of this study is to evaluate the policy interventions on the prevalence of HIV in pregnant women in the Lukhanji sub-district Municipality so that some improvement strategies to curb the spread of HIV can be suggested.

1.4.2 Secondary Research Objectives

- Evaluate available data on HIV prevalence in the Lukhanji Sub-district Municipality with the view to determine the implementation and impact of health care intervention measures that have been introduced or proposed to deal with the challenge in this population group.
- Determine progress in relation to the implementation of health care interventions in order to identify the contributing factors to the observed situation.
- Suggest appropriate strategies that can be adopted to improve curbing of HIV prevalence in pregnant women

1.5 Research Questions

In order to achieve the above outlined primary and secondary research objectives of the study, the entire research process will be guided by the following research questions:

- What is the prevalence of HIV infections in pregnant women in the Lukhanji Sub-district Municipality of the Eastern Cape Province?
- Which factors contribute to the HIV prevalence situation in the study population of the Lukhanji Sub-district?
- Which strategies can be adopted to curb the HIV prevalence in pregnant women?

1.6 Significance of the Study

This study is important because it will bring about much needed awareness on progress made through HIV and AIDS policy interventions for pregnant women and its related aspects such as: knowledge and attitudes on sexual behaviour, PMTCT, ART, ANC programmes and family planning, including condom usage, to the entire community of Lukhanji. Such a study will enable the relevant department to examine the effectiveness of the current strategies and thus deploy new intervention measures.

The adoption of such strategies is expected to result in a knowledgeable community whose lives will be changed for the better. In addition, this study is also important on

the basis that it will contribute to the extensive research that has been conducted over the years and that has produced a wealth of data on HIV prevalence, HIV incidents and biological, behavioural and societal co-factors of the epidemic. In addition, this study will provide additional theories on HIV prevalence in pregnant women. The next section will look into literature and theories which are relevant to this study.

1.7 Limitations of the Study

The study focuses on the evaluation of policy interventions on HIV and AIDS in pregnant women, a case study of Lukhanji sub-district municipality in the Eastern Cape Province. Lukhanji is one of the eight local municipalities in the CHDM. It includes the following towns Queenstown, Whittlesea, Sada, iLinge, Lesseyton and several other surrounding rural areas (Machibini, Gwatyu farms, Hewu, Zingquthu). The reason the research chose the Lukhanji sub-district is to have a focused scope in order to complete the study. The limitation of this study is lack of input from pregnant women who are the target group and beneficiaries of the services and programmes offered by primary health care and hospitals.

1.8 Study Overview and Chapter Organization

The study was accomplished and is presented according to the following five chapters.

Chapter 1: Introduction and Motivation of the Study

This chapter examines the overview of the study. It outlines the problem leading to the study, research objectives, questions, significance of the study and overview and chapter organization.

Chapter 2: Literature review

Relevant literatures and theories are examined in this chapter according to the research objectives and questions. The discussions centre around evaluating policy

interventions on the prevalence of HIV in pregnant women, looking at the existing data and strategies for improving HIV prevalence.

Chapter 3: Research design and methodology

The research design, methods and techniques that were used in this study are described in this chapter. This chapter examines research design, target population and sampling, data collection method, data analysis, validity and reliability and ethical considerations.

Chapter 4: Findings, interpretations and discussions

This chapter presents the interpretations and discussions of the interview findings. The process is structured around sections derived from research objectives and questions, and sections that are replicated from the research instrument.

Chapter 5: Conclusion and recommendations

This chapter examines the recommendations of the study. The process is accomplished with the aim of responding to the last research objective which deals with the strategies that can be adopted to curb the HIV prevalence in pregnant women.

Chapter 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter provides the evaluation of relevant literature and theories. The evaluation of literature and theories is accomplished according to sections that are aligned to the research questions and objectives. In the first instance, the chapter evaluates policy interventions on HIV and AIDS in pregnant women in the Lukhanji sub-district, nationally and globally.

In South Africa pregnant women who attend public health antenatal clinics provide the basis for the national population HIV prevalence level estimates. This estimate is used to model and is also taken to represent the estimates of HIV prevalence in other population groups. In 1990 there was an estimated 75000 - 120000 South Africans living with HIV. In 1988 government set up the AIDS Unit and the National Advisory Group (NAG) to focus on the emerging epidemic, within the NDoH. These were the initial coordinated interventions aimed at developing HIV and AIDS policies and programmes in the country.

The first National Antenatal Sentinel HIV Prevalence Survey in South Africa was conducted in 1990. Data collected from the study indicated that at that stage about 0.8% of pregnant women were infected with HIV (www.sahistory.org.za 2015:1). The study conducted by the NDoH, in 2011 which covered all the nine provinces in the country shows that an estimated 29.5% of pregnant women (aged 15-49) were living with HIV (2013: 4). Five out of the nine provinces (Free State, Gauteng, KwaZulu-Natal, Mpumalanga and North West) have HIV prevalence estimates that are higher than the national average.

South Africa recorded its first case of the AIDS in 1982. This was a homosexual man who had contracted the disease whilst visiting the United States of America (www.sahistory.org.za 2015:1). The first recorded death from AIDS in the country occurred in 1985. In 1987 the government issued regulations in which AIDS was added to the official list of communicable diseases. This chapter responds to the

research objectives and questions in an attempt to recommend improvement strategies, by referring to various relevant literature sources.

2.1.1 Knowledge, Attitudes, Practices and Beliefs Relating to HIV and AIDS

The AIDS risk reduction model is concerned with people's efforts to change sexual risk behaviours related to HIV infection. There are three stages in the model, the first being recognition and labelling of certain sexual behaviours as high risk for contracting HIV. In the knowledge phase, people use information to reduce their risky sexual behaviours.

The second stage involves making a commitment to female participants to reduce high-risk activities, for example condom usage. Noar (2007:63) classifies the third phase as the development of coping skills to sustain empowerment by engaging with development interventions. This stage is broken down into three main strategies, namely continuously obtaining correct information, developing social coping mechanisms and acting on solutions to difficult situations like negotiating safer sex.

2.1.2 International and National Trends to Address the Effect of HIV and AIDS

International funding from the United States of America assisted in 2004 with the launch of the PEPFAR, which enabled the start of the antiretroviral therapy programme in South Africa. The report by Health Systems Trust (2013: 21) states that PEPFAR announced that the funding would be halved over 5 years to 2017, which would cause the majority of staff paid by President's Emergency for AIDS Relief (PEPFAR) to return to the government sector.

The National Treasury (2013) report indicates increases in government spending between 2009 and 2012 owing to the new early treatment threshold of a CD4 count of 350 cells to qualify for antiretroviral therapy. It is important to realise that the majority of funding is channelled into the antiretroviral drug programme, which includes prevention of mother-to-child transmission and therefore has very little effect on prevention programmes in the communities and workplace

Over the years, many companies have been slow to recognise the threats to profits posed by HIV and AIDS. It is, however, the company's responsibility to adopt a healthy well-defined commitment to protect and support their employees and the workplace is an ideal place in which to disseminate prevention messages (SABCOHA, 2012:1). Multi-sectoral responses are mandatory to effectively address the impact of HIV and AIDS. Currently, most HIV workplace programmes refer to a range of company-based interventions including an HIV policy, HIV counselling and testing (HCT).

2.2 HIV Prevalence

The NDoH (2012:11) developed and adopted the Antenatal Sentinel HIV Prevalence Survey tool for monitoring trends for strategic intervention and to develop responses to assist policy development and planning The objective for conducting the annual antenatal sentinel surveys is to determine the distribution of HIV infection among pregnant women attending public health antenatal clinics at national, provincial and district levels of the Health Care System. The data from these surveys is used to inform the projections and estimation of the epidemic in the general population within the country.

The HIV prevalence in South Africa has grown significantly over the years to 29.5%, as shown by the recent national survey (2013: 21). Experts regard this as relatively high, and therefore requiring further interventions, despite observations and statistics trends indicating that there is stabilization of the epidemic in the country. Although from recent statistics, HIV prevalence in South Africa appears to be stabilizing, and currently the national estimate stands at 29.5%, the data further shows that there is a significant increase in the number of districts that have prevalence levels which are higher than this national estimate (2013:21).

The same national survey shows that four of the eight districts in the Eastern Cape Province had levels that were higher than the national average and these are Joe Gqabi, Buffalo City Metro, Amathole, and OR Tambo.

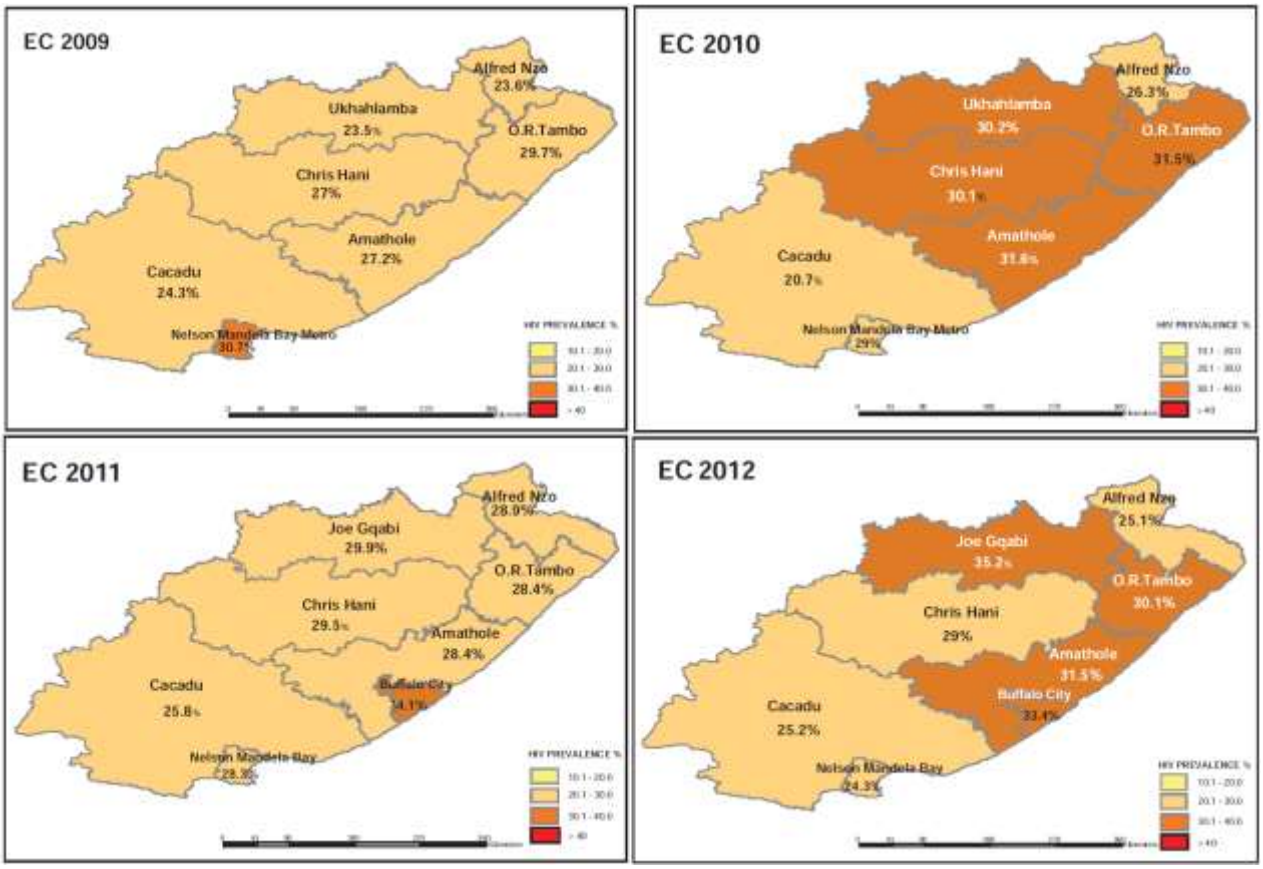


Figure 2.1 *HIV Prevalence Distribution among antenatal women Eastern Cape 2009-2012*

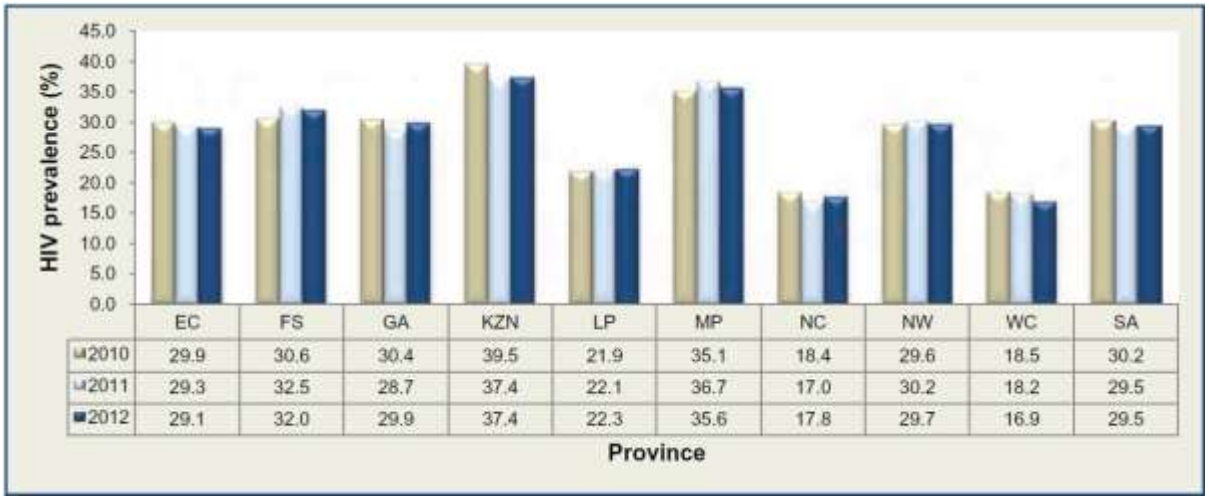
The 2012 situation in Joe Gqabi, OR Tambo and Amathole showed deterioration in the control of HIV prevalence when compared to the 2011 estimates in these districts. The report notes that due to smaller sample sizes and changes in municipality boundaries during the assessment period, there could be larger percentage sampling errors compared to the provincial results. Buffalo City Metro, although showing some slight improvement still remains among the worst affected areas. The fact that this metro was relatively new, and had the highest HIV prevalence estimate in 2011, has been viewed as a factor that could have affected the collection and analysis of data which may have affected the estimate. The HIV prevalence level in Chris Hani district, where Lukhanji Municipality is located, has remained relatively stable at 29% between 2011 and 2012. This is almost equivalent to the prevalence level of the Eastern Cape Province, which is 29.1% for the 2012 survey.

In 1996 it was estimated that about 20.5 million people, worldwide, were infected by HIV and that about 7500 infections were occurring daily. This led to the WHO to project

that by the year 2000 about 30-40 million people worldwide would be infected by the virus. The report by UNAIDS (2012: pg) reveals that Sub-Sahara Africa has become the epicenter of the HIV and AIDS epidemic, accounting for an estimated 70% of the global disease burden, which amounts to an estimated 34 million people living with the virus. South Africa has become the most affected country with about 6.1 million people living with HIV and this is the largest number of people from a single country estimated to be infected by the virus.

Recent estimates by Statistics South Africa StatsSA (2014: 7) put the number of people in the country, who are living with HIV, at about 5.26 million. Results from a survey conducted by the NDoH indicate that the Eastern Cape Province has an HIV prevalence rate of 29.1%, which is just lower than the national figure (2013: 21).

When analysing HIV prevalence estimates at the District Municipality level, the NDoH survey results indicate that the situation is significantly heterogeneous (2013: 23). Furthermore, when comparing the results between 2010 and 2012, there is an increase from 23 to 27, the number of districts with HIV prevalence estimates above the national average of 29.5%, and an increase from 19 to 23, the number of districts with HIV prevalence estimates between 30% and 40%. In the Eastern Cape the HIV prevalence estimates from the 2012 survey for the eight districts range between 25.8% which is the lowest for the Cacadu District Municipality, and 34.1% which is the highest for the Buffalo City District Municipality.



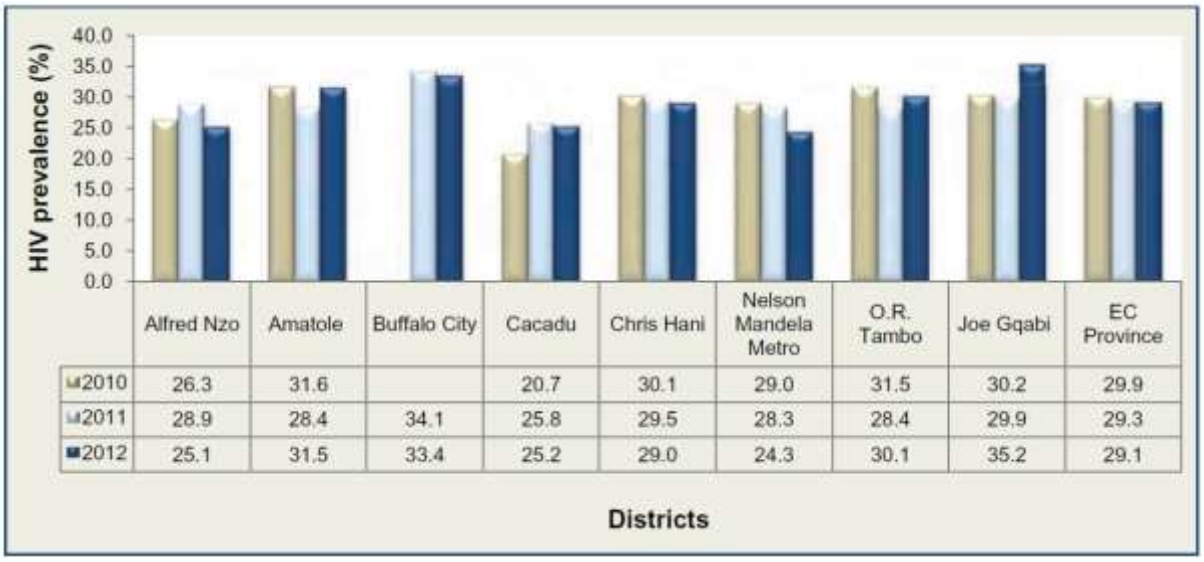
	EC	FS	GA	KZN	LP	MP	NC	NW	WC	SA
2010	29.9	30.6	30.4	39.5	21.9	35.1	18.4	29.6	18.5	30.2
2011	29.3	32.5	28.7	37.4	22.1	36.7	17.0	30.2	18.2	29.5
2012	29.1	32.0	29.9	37.4	22.3	35.6	17.8	29.7	16.9	29.5

Figure 2.2 : *HIV prevalence trends among antenatal women for the nine RSA provinces – (NDoH 2013: 20)*

In 2014, South African HIV surveillance experts met in Pretoria and they indicated that overall, the HIV prevalence in the country had increased despite some significant gains in responding to the AIDS epidemic by government. This reflected the country's success ART coverage which has contributed to people who are infected by the virus living much longer. The RSA has the largest ART programme in the world.

The need to gather information at district level was identified as important in understanding the disease and coming up with correct interventions at this level due to the known differences in population distribution, poverty levels, access to services and other factors, that can contribute to the prevalence of diseases. Recent studies have also confirmed differences in HIV prevalence levels between the different districts within the provinces. A case in point here are the levels in four provinces in the Eastern Cape that are higher than the national average.

Shisana et al (2014: 109) commissioned by the HSRC reported that, South Africa still has a generalised and heterogeneous HIV and AIDS epidemic that is complex and differs by province, districts, locality types, and among different age groups, sex and race groups. In addition, the study noted that whilst HIV prevalence by province remained relatively the same between 2005 and 2012, some provinces such as the Eastern Cape and Gauteng had shown sharp increases in prevalence.



	Alfred Nzo	Amatole	Buffalo City	Cacadu	Chris Hani	Nelson Mandela Metro	O.R. Tambo	Joe Gqabi	EC Province
2010	26.3	31.6		20.7	30.1	29.0	31.5	30.2	29.9
2011	28.9	28.4	34.1	25.8	29.5	28.3	28.4	29.9	29.3
2012	25.1	31.5	33.4	25.2	29.0	24.3	30.1	35.2	29.1

Figure 2.3: *HIV Prevalence Trends among Antenatal Women, Eastern Cape Municipal Districts 1990-2012 (DoH 2013: 30)*

The NDoH (2013: 29) conducted a nation Antenatal Sentinel HIV and Herpes Simplex type-2 Prevalence Survey survey between 2010 and 2012 and found that the Eastern Cape Province HIV prevalence declined by 0.8%, from 29.9% in 2010 to 29.1% in 2012. During this period the Chris Hani District Municipality, consisting of Lukhanji and other sub-districts, recorded a decline from 30.1% in 2010 to 29.0% in 2012.

A review of the literature on women empowerment and debates around female condoms highlights the challenges women experience in negotiating condom use. The latter sections of this chapter address issues relating to the introduction of the female condom as a method designed to empower women in negotiating safer sex, the barriers and challenges to its uptake and use and the future of female condoms.

2.2.1 HIV and AIDS Communication

Health communication can cover a range of health, diseases and prevention issues. For the purpose of this study, the discussion on health communication will focus on HIV and AIDS with regards to women. A number of health communication campaigns in South Africa have addressed various issues relating to HIV and AIDS, including prevention, treatment, care and support and VCT. Snyder (2007) reviews that a health communication campaign that is carried out using at least one form of media is referred to as a mediated health communication campaign. According to Mckee et al (2004) mass communication channels like radio, television and the internet have been very effective in reaching large mass audiences; a combination of mass media and interpersonal channels can yield effective health communication results.

Wheelock et al (2012) states that the strength of the UNAIDS definition for this study is that it considers young adults who comprise the population of this study and are most vulnerable to HIV infection. It also presents consistent condom (either male or female condoms) use as a preventive method. However some scholars have argued that the UNAIDS definition is still limited in terms of its benefits, particularly for pregnant women and girls, as many cannot negotiate safe sex with partners or choose to abstain from sex.

2.3 Policy Development and Government Strategies to Fight HIV and AIDS

South Africa has joined various global efforts to fight the HIV and AIDS epidemic, including those that are coordinated by the WHO. The initial global campaign under this international organisation was the WHO Global Programme on AIDS which was started in 1987 and was discontinued in 1995. The report by WHO (1996: 4) explains the formation of the Joint United Nations Programme on HIV and AIDS (UNAIDS) in 1996. This programme was aimed at coordinating the fight against HIV and AIDS at a global level.

In trying to improve awareness and ensure better outcomes in fighting HIV and AIDS, the Networking HIV/AIDS Community of South Africa (NACOSA – www.nacosa.org.za) was established in 1991 to develop comprehensive government policy to deal with the emerging HIV and AIDS crisis in the country. At this stage the number of heterosexual individuals who had contracted the virus was equal to that of homosexual individuals, and therefore the disease could no longer be viewed as affecting only homosexuals, as was previously the case. In August 1994, President Nelson Mandela accepted the *National AIDS Plan* produced by NACOSA, which focused on the following aspects:

- Prevention of HIV infections through public education campaigns
- Reducing transmission of HIV through appropriate care, treatment and support for the infected
- Mobilizing local, provincial, national and international resources to combat HIV and AIDS

Amongst the interventions to promote awareness about HIV and AIDS was the promotion of the stage play SARAFINA, produced by Mbongeni Ngema. But, this was later reviewed and regarded as a failure. A review of the NACOSA Plan in 1997 revealed the lack of political leadership in the fight against HIV and AIDS. This resulted in the adoption of a revised plan, the National AIDS Control Programme (www.sahistory.org.za), which then laid emphasis on the following objectives:

- Behavioral change
- Human rights protection of infected persons

- Mass media education and
- Community support

Some of the notable developments at that stage were the debates around the introduction of ART. Government asserted that the HIV and AIDS policy should focus on prevention rather than treatment and there was disagreement between government, AIDS activists and drug researchers. By 2000, the South African National AIDS Council (SANAC) was established with the view to consolidate political leadership and improve civil society involvement in the fight against HIV and AIDS. This led to the launch of two major government programmes that year; these are:

- National Integrated Plan (NIP) for children infected and affected by HIV and AIDS
- HIV/AIDS/STD National Strategic Plan for South Africa 2000-2005

These Programmes were aimed at promoting the following RSA government goals:

- Reducing new infections, particularly among the youth
- Reducing the impact of HIV and AIDS in individuals, families and communities

Subsequent evaluations and scientific research revealed that despite all these interventions and changes in policy there was very little progress made and success achieved in combating the ever increasing global epidemic from HIV and AIDS. Changes were introduced in the HIV and AIDS policy in 2005 which incorporated government commitment to improve public access to ARVs. At this stage the country had recorded more than five million cases of people living with HIV and AIDS www.sahistory.org.za).

In 2006 a new government five year NSP for HIV, STDs and TB 2006-2010, was developed and finally launched in 2007. The NSP focused on four key priorities:

- Prevention
- Treatment, care and support
- Human and legal rights
- Monitoring, research and surveillance

The NSP has been revised and the South African government's commitment towards addressing challenges posed by HIV and AIDS are reflected in the NSP on HIV, STIs and TB 2012-2016. There are four key strategic objectives in the existing strategy, which are the following:

- Address social and structural barriers to HIV, STI and TB prevention, care and impact;
- Prevent new HIV, STI and TB infections;
- Sustain health and wellness; and
- Increase protection of human rights and improve access to justice.

In line with the national strategies, the ECAC developed and adopted Provincial Strategic Plan on HIV and AIDS, STIs and TB (PSP). The most recent are the PSPs 2007-2011 and the current one, PSP 2012-2016. The Eastern Cape PSPs are aimed at pursuing the following mission: "*develop and strengthen a multi-sectorial, well-coordinated and highly effective response to the HIV and TB epidemics*". The province is guided by the strategic vision - To achieve a *province "free of new HIV and TB infection; full coverage of services for the population; high quality of care and support for all people affected by HIV, TB and STIs; a society free of stigma and discrimination and access to services; and justice for all*".

Johnson et al (2010: 4) published a study which indicated that, a large number of people living with HIV and AIDS in the Eastern Cape Province had reached the stage of illness and needed to access treatment programmes. In addition, the message from the findings of the study was that although HIV prevention programmes are the cornerstone of the HIV response in the province, treatment, care and support interventions were also critical. The authors proposed that social and behavioural communication, which contributes to HIV prevention, should also support and promote biomedical prevention interventions.

The study by Johnson et al, (2010: 4) looked at various factors and drivers of the HIV epidemic, with the view to assist policymakers and planners in designing HIV strategies and programmes for the Eastern Cape Province. Key amongst these were the following:

- Media access and reach to HIV Care Programmes (HCPs)
- Structural drivers
- Behavioural drivers
- Biomedical drivers
- Treatment, care and support
- Social capital, looking at personal experience of HIV, community participation and leadership, and stigma

The study identified some gaps in these areas which would inform future planning and strengthening of interventions strategies and programmes. The importance of the study in assessing progress is that it identified specific audiences and therefore recognized that specific messages need to be communicated accordingly.

According to SANAC (2013: 1) the report on the AIDS spending assessment of Eastern Cape Province from 2007-2010 reflected the following important observations:

- The province had an HIV prevalence of 29.3% among the general population, which was the fifth highest in the country in 2011. This had dropped from 29.9% in 2010. Using a model this gave an estimated 715 736 people living with HIV in the province.
- The provincial estimates based on modelling indicated that about 201 501 people were on ARVs in 2011. This was a steady increase of people estimated to be taking ARTs in the province indicating 297 000, 379 000 and 461 000, in 2012/13, 2013/14 and 2014/15
- Government is the overwhelming funding agent for HIV/AIDS and TB expenditure in the province. The funding has been predominantly spent on treatment and care. It is explained that treatment and care encompasses not only ARTs (about 45%), but also TB treatment, Home-based Care (HBC), palliative care, nutritional support, psychological support, step---down care, etc. In the Eastern Cape, Chris Hani District had the highest *per capita* HIV and AIDS Expenditure during this period. (See graph below)

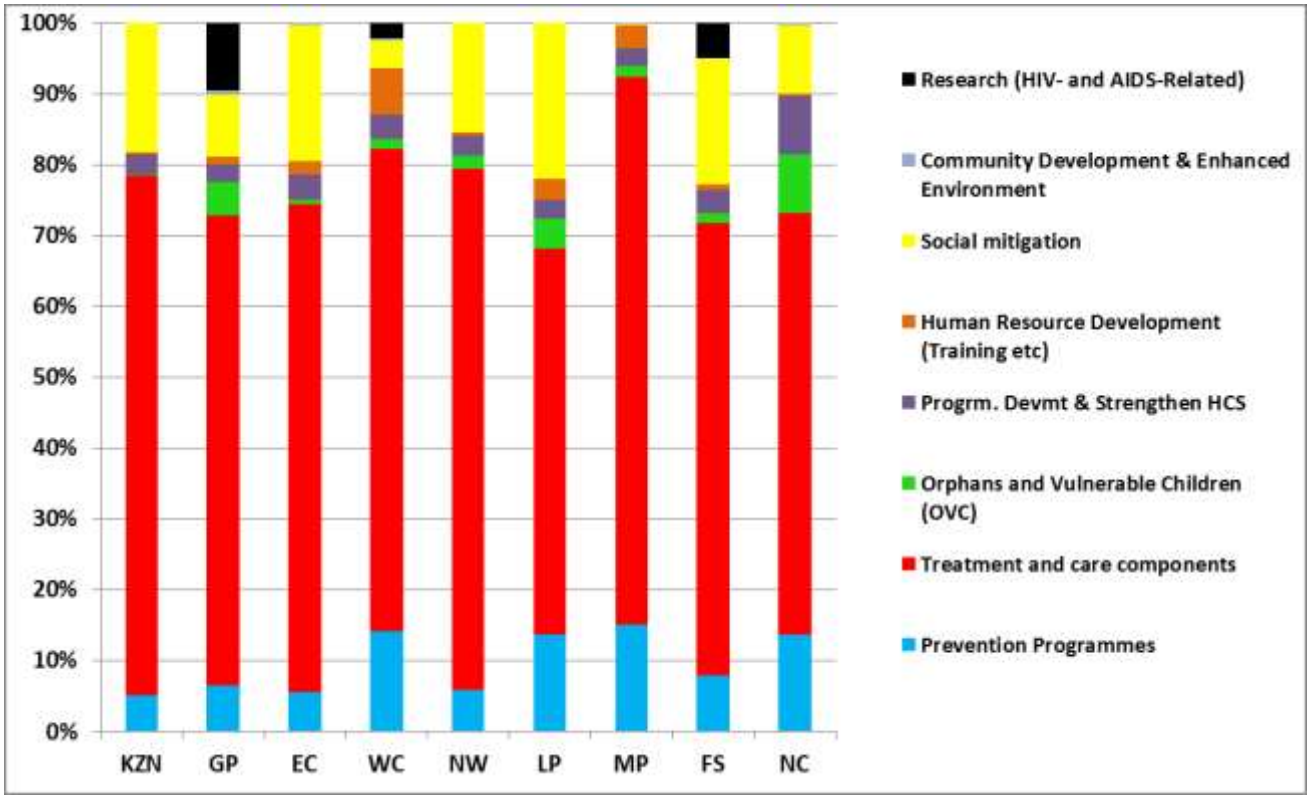


***Figure 2.4**: Proportional Provincial HIV/AIDS Spending Activities in South Africa (Source: SA NASA [2011: 7], UNAIDS, SANAC, CEGAA).*

The same study showed that at that stage there was an overall underspending of over half a billion rands, particularly on the prevention interventions. Hence it was proposed that there must be an increase in prevention spending in order to reduce the number of new HIV infections.

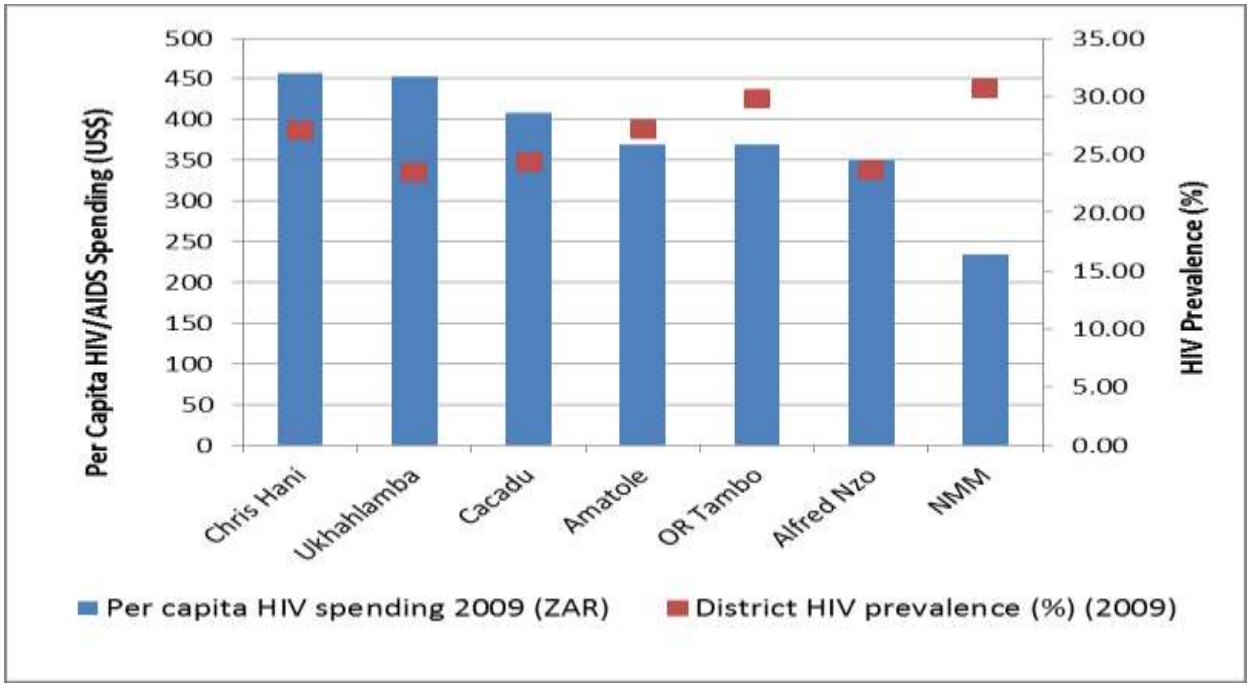


***Figure 2.5**: Per Capita 2009/10 HIV/AIDS Expenditure by District*

Based on the findings from this study the following recommendations were made at that stage to the provincial government:

- Expand the HIV/AIDS and TB response beyond health sector
- Improve intergovernmental budget planning
- Measure the impact of Department of Education interventions
- Increase priority given to prevention
- Prioritise TB prophylaxis
- Avoid crowding out by ARV spending
- Increase support to NGOs and CBOs
- Improve the frequency and accuracy of data collection on expenditure
- Centralise and institutionalize HIV/AIDS expenditure data
- Increase transparency of funding from external sources
- Advocate for greater contribution from business sector.

It is important to note that the current, PSP 2012-2016 is responding to the observations and proposals from the study conducted by Johnson et al (2010: 2), and

the review of the PSP 2007-2011, and the report from the NASA study conducted by SANAS, and other relevant studies. The concerns and shortcomings that were identified have been highlighted in the interventions in PSP 2012-2016. The review of PSP 2007-2011 revealed that, the Eastern Cape Province, had addressed the HIV and TB treatment situations well, with evidence of greater access to ARTs, but the prevention of, and treatment management of TB and HIV had remained inadequate, and the co-ordination and mobilisation of impact mitigation activities remained very inadequate.

The development of PSP 2012-2016, noted several elements that will assist the province in achieving the objectives of the strategy, these include amongst others the following:

- A need for a strong monitoring and evaluation system was identified to ensure correct capturing of what the province intends to achieve from the current PSP 2012-2016.
- The review process identified the need for the shift from biomedical and behavioural interventions to structural, economic and social drivers of the HIV and TB epidemics.
- On top of the strategic priorities it was acknowledged that the interventions must be enabled by the presence of strong functional structures at district and local levels

It is therefore necessary to determine if these critical elements are in place, and therefore there is also progress on the envisaged changes from the implementation of PSP 2012-2016, with only a year to go to-date. This study, which focuses at district and sub-district level on evaluation of policy intervention on HIV and AIDS in pregnant women will be able to assist in answering some of these questions and also determine whether these programmes are effective.

2.4 Prevention of Mother-To-Child Transmission of HIV (PMTCT)

The report by UNAIDS (1999: 5) recognized that mother-to-child transmission (MTCT) was the largest infection source to children under the age of 15 years. At that time,

UNAIDS also reported that the lives of about 3 million children had been lost to the epidemic and about 1 million were living with the virus. About 90% of these HIV infected babies were born in Africa. This was a serious health concern as it was realised that AIDS was threatening to reverse progress made over the years in improving child survival and in worst affected countries the epidemic was already doubling infant mortality.

UNAIDS (1999: 6) found the risk of transmission of the virus from mother to child to be estimated at 15-25% in industrialised countries and 25-35% in developing countries. The virus can be transmitted during pregnancy, child birth or breastfeeding. The trial conducted in Thailand showed that treatment of pregnant mothers with the ART drug Zidovudine was able to reduce the risk of transmission of the virus by 10%, when breastfeeding was also strictly avoided. This and other trials conducted at the time led to the introduction of ART drugs as part of the strategy for PMTCT of HIV. In 2000 at the thirteenth International AIDS Conference, held in Durban, it was reported that ART drugs were effective in the PMTCT of HIV.

The government introduced the PMTCT Programme in 2002 following a court ruling and several attempts challenging the court order on the roll out of a complete programme.

WHO (2006: 1) released a consensus statement from an HIV and Infant Feeding Technical Consultation Meeting that was held in Geneva Switzerland which was based on the review of new evidence and experience regarding HIV and infant feeding. The aim of the consultation was to clarify and refine UN guidelines. Based on the new evidence and experience consensus was reached on a number of issues and their implications, and among those were the following issues which are summarised below:

- Studies conducted in South Africa, Zimbabwe and Cote d'Ivoire showed that excluding breastfeeding for up to six months was associated with 3-4 fold decrease in risk of HIV transmission.
- Low maternal CD4+ count, high viral load in breast milk and plasma, maternal sero-conversion during breastfeeding and breastfeeding duration were confirmed as important risk factors for postnatal HIV transmission and child mortality.

- There were indications that maternal HAART for treatment-eligible women may reduce postnatal HIV transmission,
- Early breastfeeding cessation at 4 months was associated with reduced HIV transmission but also with increased child mortality from 4 to 24 months
- Breastfeeding of HIV-infected infants beyond 6 months was associated with improved survival compared to stopping breastfeeding
- Improved adherence and longer duration of exclusive breastfeeding up to 6 months were achieved in HIV-infected and HIV-uninfected mothers when they were provided with consistent messages and frequent, high quality counselling in South Africa, Zambia and Zimbabwe.
- Weak and poorly organized health services affect the quality of infant feeding counselling and support.
- Scaling-up quality infant feeding counselling and support and related interventions needs sustained and strong commitment and support from international agencies and donors working in concert with Ministries of Health.
- Increasing access to early infant diagnosis in the first months of life and to paediatric ARV treatment provides new opportunities for postnatal infant feeding assessment, counselling, and follow-up nutritional support.

Based on the discussions and shared experience the consultation made several recommendations for policy-makers and managers of HIV-AIDS programmes, and amongst those were the following:

• "The most appropriate infant feeding option for an HIV-infected mother should continue to depend on her individual circumstances, including her health status and the local situation, but should take greater consideration of the health services available and the counselling and support she is likely to receive.

• Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.

• When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended.

• At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breastfeeding with additional complementary foods is recommended, while the mother and baby continue to be regularly assessed. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.

• Whatever the feeding decision, health services should follow-up all HIV-exposed infants, and continue to offer infant feeding counselling and support, particularly at key points when feeding decisions may be reconsidered, such as the time of early infant diagnosis and at six months of age.

• Breastfeeding mothers of infants and young children who are known to be HIV-infected should be strongly encouraged to continue breastfeeding.

• Governments and other stakeholders should re-vitalize breastfeeding protection, promotion and support in the general population. They should also actively support HIV-infected mothers who choose to exclusively breastfeed, and take measures to make replacement feeding safer for HIV-infected women who choose that option.

• National programmes should provide all HIV-exposed infants and their mothers with a full package of child survival and reproductive health interventions10 with effective linkages to HIV prevention, treatment and care services. In addition, health services should make special efforts to support primary prevention for women who test negative in antenatal and delivery settings, with particular attention to the breastfeeding period.

• Governments should ensure that the package of interventions referenced above, as well as the conditions described in current guidance11, are available before any distribution of free commercial infant formula is considered.

• Governments and donors should greatly increase their commitment and resources for implementation of the Global Strategy for Infant and Young Child Feeding and the UN HIV and Infant Feeding Framework for Priority Action in order to effectively prevent postnatal HIV infections, improve HIV-free survival and achieve relevant UNGASS goals."

The WHO released the revised principles and recommendations for HIV and Infant Feeding in November 2009 (Doherty et al, 2009:2). The revised principles recommend that national and sub-national authorities do estimation on which feeding strategies are likely to provide the greatest chance of HIV-free survival for infants.

According to a report by NDoH (2007) it is stated that about 38 000 South African children had acquired HIV from their mothers around the time of birth and an additional 26 000 were infected during the breastfeeding period recognized PMTCT as a mainstay of the response against HIV and AIDS in children. The PMTCT is regarded as critical for reducing maternal and child mortality and morbidity that is caused by the epidemic. It is for this reason that South African government has seen the need again in 2011 to implement an improved PMTCT Programme.

The study published by Shisana et al (2014: 112) reported and cautioned that "while South Africa's efforts to further expand antiretroviral treatment programmes were to be commended, the high rates of new infections and the trends of increased HIV risk behaviour in the country was suggestive of an evolving complacency among people at risk for HIV infection.The study proposed that urgent interventions be implemented to counter potential behavioural risk compensation (i.e. an increase in risky behaviour) in the era of a successful ART roll-out programme.

2.5 Progress in Relation to the Implementation of Existing Policies and Strategies

The DoH (2013: 5) Mid-Term Review report indicated that South Africa was making good progress in achieving some of the ten targets of the UNGASS Declarations. The results of the 2013 review show that South Africa has achieved MDG 9 and is on track to reach MDGs 1, 2, 3, 4, 6, and 10. The country is lagging behind towards meeting MGDs 5, 7 and 8, and these are:

- To reduce tuberculosis (TB) deaths in people living with HIV by 50%;
- To eliminate gender inequalities, abuse of women and children and to increase the capacity of women and girls to protect themselves from HIV infection;
- To eliminate any stigma and discrimination against HIV positive people

This therefore means that, despite progress in certain areas, more work still has to be done in comprehensively dealing with the disease burden caused by HIV and AIDS in the country. This is also particularly so because, despite the generalised achievements on some of the targets, the progress made is not uniform across the country. There are differences of success in different localities, that is, provinces, districts and sub-districts.

According to the NDoH (2013: 5) National Antenatal Sentinel HIV and Herpes Simplex type-2 Prevalence Survey, between 2010 and 2012 the Eastern Cape Province HIV prevalence declined by 0.8%, from 29.9% in 2010 to 29.1% in 2012. In terms of the MDG 6 age group 15-24 years, the province has shown a reduction from 21.8% in 2010 to 19.4% in 2012. This is still far from achieving the two thirds reduction target of MDG 6. During this period the Chris Hani District Municipality, consisting of Lukhanji and other sub-districts, recorded a decline from 30.1% in 2010 to 29.0% in 2012.

This trend shows that even at the district level more work needs to be done to achieve the MDG 6 targets by 2015, which is just two years from the last survey on which the current data is based. The study of the sub-district will help determine how the picture varies at this lower level.

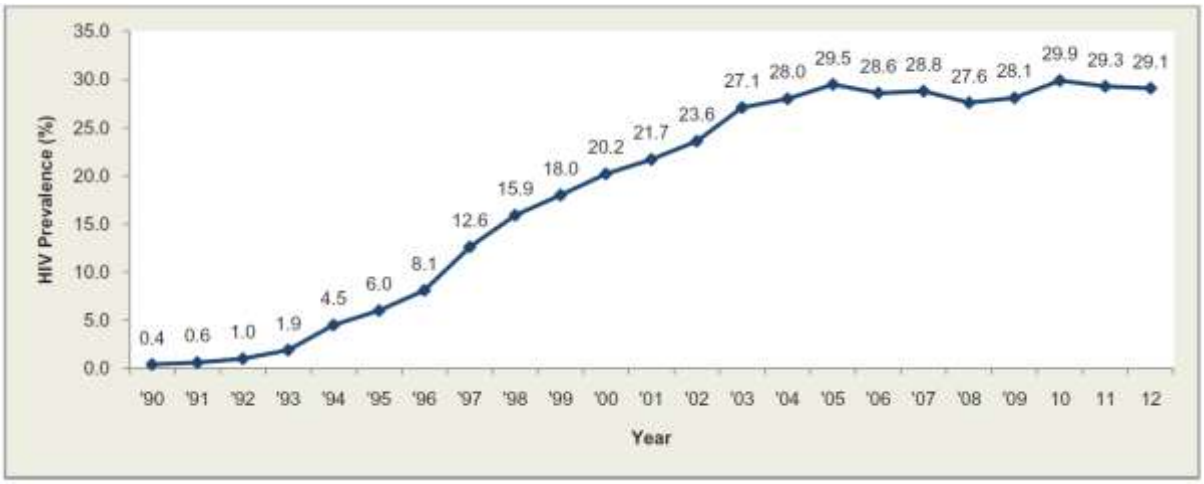


Figure 2.6: *HIV Epidemic Curve among antenatal Women, Eastern Cape 1990-2012 (DoH 2013:29).*

2.5.1 Adopted Strategies for Improving HIV Prevalence

In 2001, world leaders met under the UN and adopted the UNGASS Declaration of Commitments on HIV and AIDS in response to the growing global health crisis caused by the spread of HIV infections and the burden of AIDS. This is a global consensus framework aimed at achieving the UN MDG. This framework was revised again in 2011 at the UN General Assembly where a new Declaration on HIV and AIDS was adopted under the theme: “Intensifying Our Efforts to Eliminate HIV and AIDS.”

According to UNAIDS (2010) South Africa’s constant focus on HIV and AIDS has yielded positive results, since the country is making progress in dealing with some of the challenges posed by this epidemic. Extensive research done over the years has yielded much data on HIV prevalence, its incidence and various co-factors of the epidemic. But despite these developments, the country still has the highest number of people living with HIV.

South Africa has been and always plays an active role in addressing world health, security and other related challenges which also affect the country directly or indirectly, as indicated in this case by its commitment in supporting this global initiative. As a country and a member state that has committed to the 2001 and subsequent UNGASS Declarations on HIV and AIDS and TB, the country therefore is obliged to fulfill the MDGs. South Africa has prioritized the ten targets set out in the UNGASS Declaration and its actions are guided by the NSP on HIV, STIs and TB, 2012-2016.

In formulating the NSP 2012-2016, the South African government has taken note of the fact that there is a multitude of HIV epidemic drivers which in turn require a multitude of HIV interventions. This knowledge is important when making a selection of the appropriate combination of interventions that will address the challenges in given provinces, districts or sub-districts based on the actual HIV epidemic drivers. A study of this nature therefore becomes very relevant in this regard.

According to the NDoH (2013: 19) National Antenatal Sentinel HIV and Herpes Simplex type-2 Prevalence Survey, South Africa’s recent reviews show that HIV prevalence in pregnant women is stabilizing, it remains a worrying factor that such stability is still very high and far from achieving the targets of the MDGs. According to

the MDGs, South Africa is expected to move from its baseline HIV prevalence level of 23.1% recorded in 2001 to achieve a target of reducing HIV prevalence in the 15-24 year group of pregnant women in the country by two thirds that is to 5.3% in 2015. HIV prevalence in this age group (15-24) has decreased as follows from 2010 to 2012.

- 2010 = 21.8%
- 2011 = 20.1%
- 2012 = 19.3%

The NDP (2011: 43) recognizes that women make up a large percentage of the poor, particularly in rural areas. In its recommendations on women especially pregnant women, it is proposed that coverage of ART to all HIV-positive people requiring such drugs should be expanded, alongside treatment of high-risk HIV-negative persons. The NDoH (2012: 26) National Antenatal Sentinel HIV and Herpes Simplex type-2 Prevalence Survey states that this therefore requires placing more attention on the 30-49 year age group that has shown an increase in HIV prevalence between 2010 and 2012.

2.6. Conclusions

In this chapter a detailed review of the literature has been conducted. To this extent, a comparative study on the subject was undertaken with the view of substantiating the research topic and determining the relevance of the study and its findings. Substantiial work has been conducted both locally and internationally reflecting on challenges and progress made in dealing with the HIV and AIDS epidemic.

South Africa has been identified as one of the countries bearing the burden of this epidemic. Despite this situation, significant progress has been made. Whilst previous studies reflect some successes with regards to declining prevalence, more work still remains to be done, consistently to avoid reversal of the gains that have been achieved. Empirical evidence clearly demonstrate the seriousness of government, at different levels to deal with the disease burden. Various policies have been adopted and are effectively being implemented. Of note is the adjustment of these policies over the years to ensure that appropriate interventions are developed, such as the shift in

focus from treatment based focus, to preventive interventions, as reflected in the national strategies and programmes.

The adoption of programmes that specifically focus on local conditions are important in dealing with this challenge as various studies have identified the heterogeneous nature of the epidemic. The next chapter will detail the research design and methodology employed in the sourcing of the data as well as the evaluation.

Chapter 3:

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This study was based on qualitative research aimed at undertaking an in-depth evaluation of the policy interventions by government to address the prevalence of HIV in pregnant women in the Lukhanji Sub-district Municipality. The research design, methods and techniques that were used in the study are described in this chapter. The research methodology covers target population and sampling, data collection method, data analysis, and ethical considerations.

The study approach and research methodology was informed by previously used and accepted methods so as to ensure the credibility and validity of the findings. This was used in choosing the target population, data collection and analysis. In order to ensure protection of the rights of any individuals whose detailed information would be used, ethical considerations were addressed with the relevant authorities.

3.2 Qualitative Research Design

Saunders et al (2003:62) posit that a research design refers to the outline or sketch of processes prescribing techniques, methods and tools which are used in the primary data collection, analysis, presentation and interpretation in the light of the research objectives and questions. According to Saunders et al (2003: 62), the main objective of a research design is usually to determine the extent to which the chosen method can lead to the eliciting of information which is relevant to the issue raised in the research objectives and questions. On the other hand, Statistics Canada (2003: 14) reveals that there are two main types of research designs; qualitative and quantitative.

They stated that qualitative research refers to the methodology which requires respondents to provide detailed explanations of the nature of the problems being researched. In order to achieve this, qualitative research uses various methods such as case study, observation, structured and unstructured interviews, as well as focus

groups. Babbie and Mouton (2008: 273) argue that it is no surprise that qualitative study is inductive in its approach as it begins with immersion in the natural setting, describing the events accurately as they occur or have occurred and ultimately coming up with a theory that will make sense of the observation.

Unlike quantitative research, Statistics Canada (2003: 14) stated that quantitative research, on the other hand, requires respondents to provide summarized numerical responses, and usually uses experimental and non-experimental research designs. Neuman, (2011: 199) explains the goal of quantitative measurement as the capture of details of the empirical social world and expression of the findings in numbers. However, this study used the qualitative research approach because this would enable in-depth evaluation of the policy interventions on the prevalence of HIV in pregnant women in the Lukhanji sub-district Municipality.

Data on HIV prevalence in the Lukhanji Sub-district municipality was collected through the structured questionnaire that was provided to senior government officials responsible for different HIV and AIDS programmes. Stakeholder engagement involved distribution of the questionnaire and follow up discussions which were based on the research objectives and questions. The written and recorded responses were sampled and consolidated according to the different agencies and structures that participated in the study. Because the data was required for qualitative evaluation of the HIV prevalence, technical data was not provided. The evaluation focused on determining existing policies and the extent of their implementation in the sub-district. The respondents were also invited to reflect on the successes and challenges faced in ensuring effective policy implementation. This approach was aimed at ensuring that in-depth evaluation of the policy interventions could be conducted, giving a fair and reliable reflection on progress.

3.3 Target Population and Sampling Techniques

Bryman and Bell (2007: 153) interpret the target population as the total collection of all units of analysis which the researcher wants to draw specific conclusions regarding issues raised in the research objective, questions and hypothesis. They (2007:153) further state that it is not usually feasible to include all the units during a study, due to

costs and time constraints. In order to manage these challenges, they suggest that an appropriate sample for the study must be determined using the appropriate strategies. Hussey and Hussey (1997: 66) also agrees that the target population refers to the subjects who are the focus of the study.

For the purposes of this study, maximum variation sampling was undertaken. The target population for this study is the Lukhanji sub-district community, with particular focus on pregnant women. The following government structures and departments were targeted in terms of participation, that is, health officials, sub-district and district municipality officials, and the provincial HIV council who are the custodians of the PSP. A non-governmental organisation involved in HIV and AIDS work, Africare, also participated in the study.

The population sample per stakeholder was as follows:

Structure (Stakeholder)	**Participants** **(Programme Managers)**
Department of Health (Lukhanji Health Sub-District)	One (1) official
Department of Health (Chris Hani Health District)	Three (3) officials
Chris Hani District Municipality	Two (2) officials
Eastern Cape AIDS Council (ECAC)	One (1) official
Africare (NGO - partner to the DoH for primary healthcare)	One (1) official

Table 3.1: *Population sample*

3.4 Data Collection Process (Structured Interview Questionnaires)

Thompson (2000) posits that data collection is likely to be more structured in an evaluative or investigative study which looks at the operation of a service or a policy. Fielding (1995) suggests there are two main types of qualitative interviews: unstructured, non-standardized or in-depth interviews which involve a broad agenda that maps the issues to be explored across the sample. In this study, structured

interviews using pre-designed questionnaires were the principal primary data collection method that was explored.

The method entailed questionnaires with structured open-ended questions and was presented to the participants from whom responses were expected. This process was conducted in line with the research questions and objectives as outlined earlier on in the study. Careful consideration was undertaken in order to ensure that statements or questions were structured and worded so that they would be easily understood by the participants. Pre-testing of the questionnaires was done prior to undertaking the actual study, in order to determine the credibility of its contents.

Kopper (2008:33) states the following advantages and disadvantages of using questionnaires in a research, these are namely:

3.5 Data Evaluation

This research followed a thematic form of data analysis. Daly et al (1997: 82) defines thematic analysis as a search for themes that will emerge as important to the description of the phenomenon. Rice and Ezzy (1999: 258) further argue that it is a process that involves the identification of themes through careful reading and re-reading of data. It is a form of pattern recognition within the data, where emerging themes become the categories for analysis. Upon the completion of the data analysis, an assessment and evaluation of the contents of the collected responses was undertaken in order to determine common themes.

According to Riege (1997), qualitative research can be judged/analysed by means of four criteria, namely Transferability, Dependability, Credibility and Confirmability.

Transferability: Transferability refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings. From a qualitative perspective, transferability is primarily the responsibility of the one doing the generalising. Herein the researcher has enhanced transferability by describing the research context and the assumptions that were central to the research.

Dependability: This is concerned with whether the same results would be obtained if one could observe the same thing twice. The idea of dependability emphasises the

need for the researcher to account for the ever-changing context within which research occurs. The research is responsible for describing the changes that occur in the setting and how these changes affected the way the researcher approached the study.

Credibility: The credibility criteria involves establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research. Since from this perspective the purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes, the participants are the only ones who can legitimately judge the credibility of the results.

Confirmability: Confirmability refers to the degree to which the results could be confirmed or corroborated by others. There are a number of strategies of enhancing confirmability.

The gathered information was consolidated according to the participating structures or stakeholders. The determined categories were created and the responses for each group were placed together in order to determine the group findings. This process was undertaken in line with the outlined research objectives and questions as indicated above. The findings are presented in tables in the form of responses to specific questions and additional comments based on the experiences and observations by participants. Also discussion assessments have been taken into account in determining whether the objectives for the study have been fulfilled.

In conducting this study, ethical issues have been taken into account throughout the research process in order to protect the identity of any individuals whose specific data is mentioned in any of the studies. Informed consent on the use of data was obtained from all relevant stakeholders and contributors to this research.

3.6 Ethical Considerations

Riege (2003) states that ethics refers to the system of moral values which are concerned with the degree to which research procedures adhere to the professional, legal and social obligations of the participants. Wayne & Stuart (2007:45) say that, in order to do this, one must avoid doing harm to people and guard against both physical and psychological damage. People have a right to privacy and the researcher must

keep data collected confidential. Emphasis is put on the importance of confidentiality of the collected data. There will be some kind of contract/agreement between the researcher and the respondents, not necessarily a written document, but at least a series of implicit or explicit agreements by which the researcher is bound, e.g. researcher should give assurance to respondents about anonymity at all times.

Apart from instrumentation and procedural concerns when doing research, collecting data from people raises ethical issues that must be addressed before the study begins. These include avoiding harm to people, protecting privacy, respecting people as individuals and not subjecting them to unnecessary research.

Firstly, permission was requested from the institution to conduct the type of research as indicated by the topic and research proposal. The study participants were invited to participate on a voluntary basis and everything concerning the study was explained to them. They were informed of their rights to participate voluntarily and that anonymity was guaranteed. They were afforded the respect they deserve and it was explained that they had the right to self-determination and freedom to participate. They therefore could discontinue with the study at any time without coercions or fear of being penalized.

3.7 Limitations to the Study

Important limitations are inherent in a case study of this kind. Firstly, because the survey instrument used was a self-reporting measure, the information presented by participants is based upon their subjective perceptions, experiences and independent observations. Although participants were assured of confidentiality, it is therefore possible that they could either over- or under-report when providing information.

Secondly, even with the high level of participation in this study, there is a possibility that responses of individuals who did not participate may have differed in some manner from those who participated. The findings of the study may not be generalized to the overall prevalence of the pandemic in the Lukhanji sub-district, but can be utilized as a measure of the situation on the ground.

3.8 Conclusions

This chapter discussed the research methodology employed in this study, in gathering data from the relevant participants who are active participants and stakeholders in HIV and AIDS programmes. The choice of participants was partly informed by the fact that the different officials are in charge of policy implementation. The professional conduct displayed ensured that information is shared freely, but taking into account ethical issues, and ensuring protection of those whose details and specific data was acquired.

Consideration was taken to ensure reliability and relevance of the data. Further engagements took place through personal discussions ensuring that clarity is provided where gaps were identified in the information. Additional comments proved useful in explaining how some of the HIV and AIDS programmes work, and this would help in understanding the findings. The data received was adequate in ensuring that the evaluation, or qualitative research analysis was done effectively.

The next chapter explains the information received and the evaluation thereof. The data is packaged according to the stakeholder categories and analyzed in terms of the inputs received from each structure. The findings are presented, interpreted and analyzed accordingly, and in line with the research objectives.

Chapter 4

FINDINGS, INTERPRETATIONS AND DISCUSSIONS

4.1 Introduction

This chapter presents the responses, data interpretations and evaluation, and discussions of the results obtained from the study. The data is structured around sections derived from the research objectives and questions. The questions were aimed at ensuring that participants would reflect what is observed or experienced by the various organisations when assessing their HIV and AIDS programmes, with particular focus on policy issues and the implementations thereof. The assessment therefore provides an indication of the programme impact on HIV prevalence in the study population and the geographical location chosen for the study. This is in line with the approach and the methodology that was chosen, that is, to conduct a qualitative study with the aim of evaluating the impact of policy intervention on HIV and AIDS prevalence for pregnant women in the Lukhanji Sub-district Municipality.

Responses from the same organization are grouped together so that the views or experiences shared by officials from the same organization and the data that is provided represent an organizational assessment of the situation with regards to HIV and AIDS. The different responses to the same questionnaire, from eight different officials, representing five different organisations, were received and these were processed, consolidated and evaluated. The different individuals that responded are senior officials who are in charge of specific and different aspects of the HIV and AIDS intervention programmes in a given organisation. The tables that following below represent the results of the study and responses to the specific questions that were raised in the questionnaire.

4.2 Sample Profiling

The figures below illustrate the distribution in terms of gender, educational level, and age distribution in years of the respondents who completed and returned the questionnaires.

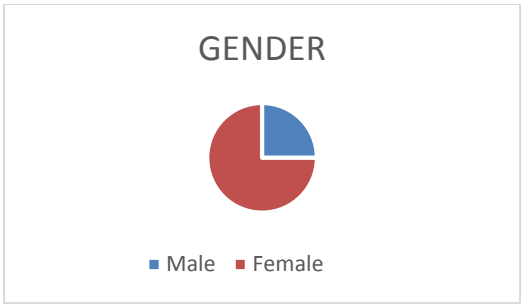


Figure 4.1: *Gender Distribution*

The study population and respondents to the questionnaire consisted of 70% females (n=6) and 30% males (n=2). This gender distribution is represented by the pie chart as illustrated above.

Educational Level

All the respondents are senior officials in their respective organisation, and they all have tertiary qualifications. In their respective organisations their programme managers.

Age Distribution of the Respondents

The respondents belonged to the following age groups; 30-39 (n=2), 40-49 (n=2); 50-59 (n=3), and 60+ (n=1). These different age groups are represented in the following pie chart:

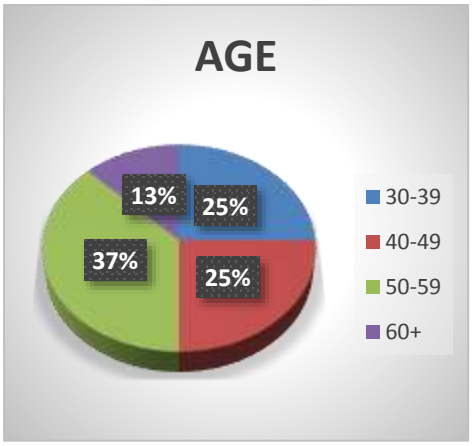


Figure 4.2: *Age Distribution*

4.3 Results

The results from the research are presented in tabular form, since this would make it easier to reflect on observations relating to a particular questions. Five tables have been created that represent the responses that were provided by each of the five participating organisations – i.e.

- Chris Hani Health District
- Chris Hani District Municipality
- Lukhanji Health Sub-district
- Eastern Cape AIDS Council (ECAC)
- AFRICARE

Table 4.1 *– Responses from Chris Hani Health District to the Research Questionnaire*

ORGANISATION: - *Chris Hani Health District*	
QUESTIONS	***RESPONSES***
How do you rate the HIV and AIDS prevalence	➢ Low
What do you think are the contributing factors to the current situation in this area?	• Community mobilization • Intersectoral collaboration • Implementation of Government policies • Availability of prophylactic ARV Drugs • Decentralization of the ART service to PHC level for accessibility • Client empowerment • Supportive supervision • Mentoring • Health care providers are well capacitated • The health care workers (CHWs) education session are instrumental in imparting informed decision on pregnant women • The robust education and awareness conducted by the District AIDS Council and its various stakeholders yield to this result
What programmes in your area of responsibility are being implemented to address HIV and AIDS	• Contraceptive services • Termination of pregnancy [CTOP] • Sexually transmitted Infections [STI] • Post Exposure prophylaxis • Condom and High Transmission Areas • TB & HIV/ AIDS

	• HCT • PMTCT/ EMTCT • ART Services • Home Community Based Care • Nutrition • Health promotion • High Transmission Area [HTA] (High risk group) • Peer Education • Man Partners
How would you rate the progress in terms of implementation of the respective HIV and AIDS programmes	**<u>Challenges</u> –** • Dept of Education policies not allowing contraceptive services within school premises. Removal of New contraceptive [Implanon] by young girls who complain of side effects like bleeding. • Not all our facilities are having trained health workers • Engaging key populations still a challenge [MSM, SW etc] condom storage in some sub districts still a challenge • Linkage between facilities and CBOs still a challenge; Referral issues • Transport is a challenge in reaching far away facilities • Tracking participants, stigmatisation and funding are problems with the HTA programme • Poor coordination is challenging in the Men as partners programme *Most of the programmes are regarded as success in terms of community participation and these include – dealing with STIs, Pregnancy termination, collaboration on fighting HIV and AIDS, HCT, PMTCT, ART services, and Home/Community based care*
In your area of responsibility, do you regard the health-care facilities as accessible	• Most facilities are accessible [39 facilities] • The facilities do cope with community demand as reflected in the DHIS - PHC utilization rate norm is 3.0, Nurse patient workload norm is 35 to 40 yet most facilities perform below this norm • Shortage of personnel is experienced in some of the facilities.
Is the Prevention of Mother-to-Child Transmission of HIV (PMTCT) part of your HIV and AIDS programmes	PMTCT is implemented as part of a comprehensive programme. • The following programmes are also implemented for women – STI prevention, INH Prophylactic Treatment

	[IPT], Prevention of TB, Cervical cancer screening, HCT, ART Services
Eastern Cape Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016	• Unemployment , poverty is working against the Department of Health efforts in implementing the strategy, resulting in high maternal mortality , neonatal maternal rate • HIV positivity among pregnant women is still high at 17.3% during the 1st Quarter of 2015, compared to 11.0% during 1st Quarter of 2014 • Condom distribution rate is improving at 30.0% during 1st Quarter of 2015, compared to 24.0% during same period in 2014, but the national norm is 50.0%. So this is still low. • The wellness programme is functioning very well with eligible clients put on ART and retained in care[Total clients remaining on ART in 2014 1st Quarter were 6,771 and went up to 8,116 in 2015 same period • Decentralization of facilities and accessibility to ART services, and availability of drugs contribute to protection of the right to health • Stigma at community level has shown tremendous decrease. Women freely and openly participate in discussions on HIV and AIDS. • HIV, STI and TB Prevention - The utilisation rate of the health facilities by women in particular in relation to this pillar has increased • Sustaining health and wellness - The provision of ARVs in all facilities, the insertion of an implant as a birth control measure are evidence toward the achievement of this pillar
What challenges have you identified and improvements do you think should be introduced to address ineffective impact from current policies on HIV and AIDS?	Community leaders need to take charge and refrain from heavily relying on government officials to advance or advocate policy mandates relating to HIV and AIDS

Table 4.2 *– Responses from Chris Hani District Municipality to the Research Questionnaire*

ORGANISATION: - *Chris Hani District Municipality*	
QUESTIONS	***RESPONSES***
How do you rate the HIV and AIDS prevalence	➢ Average
What do you think are the contributing factors to the current situation in this area?	• Poverty • Unemployment • Alcohol abuse *This is due to the social challenges that tend to drive the increase in HIV prevalence within the communities. These range from alcohol and drug abuse, gender based violence, multiple concurrent partnerships, and intergenerational sex.* *Queenstown also is a High Transmission Area (HTA) due to existence of a the truck stop where the commercial sex workers target the truck drivers, making the community vulnerable to HIV infection.*
What programmes in your area of responsibility are being implemented to address HIV and AIDS	• HIV and AIDS prevention programmes • Treatment Care and Support Programmes • Door to door campaigns • Dialogue programmes *Community field workers such as ground diggers, community care givers, Community based organization members, Local AIDS Council members, Ward based structures such as war room members – Take part in capacity building programmes.*

	Conduct HIV Counselling and testing campaigns in partnership with the Department of Health during the campaigns in community programmes *Coordinate Circumcision programmes in partnership with the Department of Health and the House of traditional leaders* *Technical support to Local AIDS Councils for functionality and Facilitation of Sectors participating in HIV and AIDS programmes such as sectors of People living with HIV, NGOs, Men's sector, etc.* Coordination of the **District AIDS Council** involves ensuring that all stakeholders work in an integrated manner to address the challenges brought by HIV to the communities coupled with promotion of prevention programmes to curb the increase in HIV infection.
How would you rate the progress in terms of implementation of the respective HIV and AIDS programmes	<u>HIV and AIDS related Programmes</u> **–** 1.PMTCT 2.Integrated Nutrition Program 3.Health promotion These three programmes are regarded as successful and making an impact within the Lukhanji sub-district *HIV prevalence among pregnant women at Lukhanji is currently at 17%. It is below national average (30%) and Provincial HIV prevalence (29%)* *National target for antenatal care bookings before 20 weeks as per PMTCT legislation is 70%. Provincial target is 60%. Currently Lukhanji is sitting at 70%, which reflects success at implementation of this policy. However there are still challenges of 30% of women who do not access*

	this service. These are teenage girls at school, also unwanted pregnancy and delayed bookings. • *Full participation by all stakeholders pose a challenge* • *Availability of accredited HIV and AIDS training interventions is a challenge* • *There is still some reluctance by some of the community members to test and know their status* • *Coordination of Circumcision programmes – challenges related to abuse of initiates when they are in the bush and poor participation from traditional leaders*
In your area of responsibility, do you regard the health-care facilities as accessible	Lukhanji area has got health facilities that can be regarded as accessible as they are situated within the communities within a walking distance from the residences. Areas that do not have health facilities are provided with mobile health services

Health Care Facility	**Accessible/Not Accessible** *(Specify)*	**Coping with Community Demand – Yes/No** *(Specify)*
1.Philani Clinic	Accessible, within every 5 km there is a clinic servicing the population in that area. There is also access to ARVs for pregnant women.	• *The challenge remains ability of centres to cope with the demand. There are more people who access the health care centres versus the number of staff that can offer the services. The health care facilities also struggle to cope with the high demand for Anti-retroviral treatment*
2. Gardens Clinic	Accessible, within every 5 km there is a clinic servicing the population in that area. There is also access to ARVs for pregnant women.	• *The challenge remains ability of centres to cope with the demand. There are more people who access the health care centres versus the number of staff that can offer the services. The health care facilities also struggle to cope with the high demand for Anti-retroviral treatment*
3.Nomzamo Clinic	Accessible, within every 5 km there is a clinic servicing the population in that area. There is also access to ARVs for pregnant women.	• *The challenge remains ability of centres to cope with the demand. There are more people who access the health care centres versus the number of staff that can offer the services. The health care facilities also struggle to cope with the high demand for Anti-retroviral treatment*
4.Ezibeleni Clinic	Accessible, within every 5 km there is a clinic servicing the population in that area. There is	• *The challenge remains ability of centres to cope with the demand. There are more people who access the health care centres versus the*

	also access to ARVs for pregnant women.	*number of staff that can offer the services. The health care facilities also struggle to cope with the high demand for Anti-retroviral treatment*
5.New rest Clinic	Accessible, within every 5 km there is a clinic servicing the population in that area. There is also access to ARVs for pregnant women.	• *The challenge remains ability of centres to cope with the demand. There are more people who access the health care centres versus the number of staff that can offer the services. The health care facilities also struggle to cope with the high demand for Anti-retroviral treatment*

Is the Prevention of Mother-to-Child Transmission of HIV (PMTCT) part of your HIV and AIDS programmes	PMTCT is one of the key HIV and AIDS programmes.
Eastern Cape Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016	• Social and structural barriers have been addressed to a large extent through increasing health care facilities mostly in urban areas that provide treatment care and support to pregnant women. However there are still challenges and gaps in rural areas where there are no health care facilities. Women have to travel far to urban areas to access health care services. • Although there has been a slight decrease in new HIV, STIs and T.B infections, this decrease is not significant. The implementation of strategy has not yet had major impact on the prevalence of HIV, STIs and T.B • Programme implemented such as health promotion, nutrition and PMTCT have an impact in sustaining health and wellness. However poverty still poses a challenge. • Legislation provides protection of human rights. Communities are aware of their rights through education and awareness campaign and media. There are also provisions made to ensure access to justice even for people who are not able to afford justice e.g. Legal Aid. • The latest Provincial report shows that there is 10% over achievement on HCT provincially showing good sign in achieving this sub objective. • Over achievement of condom distribution has also been indicated in the April to June 2015 reports of ECAC. • 91% uptake of the IPT of newly diagnosed shows a fair performance of the objective. • MMC has also shown improvement from the previous quarter.

	• It is difficult to indicate the programmes targeting pregnant women only as their programmes are implemented during their antenatal clinic (ANC) visits to the facilities. Pregnant women are however members of the communities in which these programmes are implemented however it does not show whether there were pregnant women or not.
What challenges have you identified and improvements do you think should be introduced to address ineffective impact from current policies on HIV and AIDS?	High rate of teenage pregnancy remains a challenge – Prevention programmes have been introduced targeting teenagers at school and youth out of school

Table 4.3 *– Responses from Lukhanji Health Sub-District to the Research Questionnaire*

ORGANISATION: - Lukhanji Health Sub-district	
QUESTIONS	***RESPONSES***
How do you rate the HIV and AIDS prevalence	➢ Average
What do you think are the contributing factors to the current situation in this area?	• Alcohol abuse, Poverty related social ills , myths that sleeping with virgins clear one of HIV • Failure/ refusal of clients to test –HCT • Non-disclosure by partners to one another • Not using condoms
What programmes in your area of responsibility are being implemented to address HIV and AIDS	• HCT • PMTCT • TB/HIV • CCMT • Outreach/WBOT door-to-door at community level • Circumcision /Mens Health
How would you rate the progress in terms of implementation of the respective HIV and AIDS programmes	**Challenges –** The programmes in the sub-district are regarded as successful in terms of HIV and AIDS prevention, but the following were highlighted: • Some areas are hard to reach • Still areas with PCR positives from mostly outside the catchment area but tested in the clinics- Less than 1% • Integration not taking place well in some clinics – but hand-holding is done • Some challenge with transport to reach all areas, in particular bush areas • Parents not involved at times in the care of initiates and or not disclosing status, and also not all initiates come early for health care services
In your area of responsibility, do you regard the health-care facilities as accessible	The health care services are regarded as relatively accessible except for the areas specified such as bush areas

Is the Prevention of Mother-to-Child Transmission of HIV (PMTCT) part of your HIV and AIDS programmes	PMTCT is implemented as part of a comprehensive programme. The following programmes are also implemented for women – TB/HIV, Child Health, Breastfeeding options
Eastern Cape Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016	In relation to the strategy the following have been initiated and applied within the Sub-district: • Health talks and offering choices on health care • Massive TB screening has started and the 90 90 90 strategy is being implemented • WBOT initiative • Confidentiality of all information pertaining to clients
What challenges have you identified and improvements do you think should be introduced to address ineffective impact from current policies on HIV and AIDS?	• Increase the WBOT health care workers door-to-door initiatives • Local (Sub-district) Aids Councils to be revived and strengthened • All partners to be held accountable to focus areas they have agreed to do

Table 4.4 *– Responses from Eastern Cape AIDS Council (ECAC) to the Research Questionnaire*

ORGANISATION: - Eastern Cape AIDS Council (ECAC)	
QUESTIONS	***RESPONSES***
How do you rate the HIV and AIDS prevalence	➢ Average
What do you think are the contributing factors to the current situation in this area?	• The low levels of education and lack of job opportunities (unemployment)
What programmes in your area of responsibility are being implemented to address HIV and AIDS	• PMTCT • Teenage Pregnancies • Male Circumcision • Prevention of HIV
How would you rate the progress in terms of implementation of the respective HIV and AIDS programmes	**<u>Challenges</u> –** • *Teen pregnancies is regarded as a major challenge in which there is lack of success in addressing* • *Social Drivers still pose challenges in dealing with preventive measures for HIV and AIDS* • *Still boys are dying during traditional circumcision, the impact of HIV and AIDS is yet to be determined in contributing to this challenge*
In your area of responsibility, do you regard the health-care facilities as accessible	No comment
Is the Prevention of Mother-to-Child Transmission of HIV (PMTCT) part of your HIV and AIDS programmes	PMTCT is implemented as part of a comprehensive programme. The following programmes are also implemented for women: • Young Girls in school Programme • Youth Programme targeting out of school youth

Eastern Cape Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016	In relation to the strategy the following were reported: • All district municipalities and government departments have a strategy for HIV and TB • The incident rate has declined • Wellness programmes exist in all public entities and the private sector is leading in the provision of employee wellness • Protection of human rights and improvement of access to justice - *Not much effort has been given to this. It is the current focus for the remainder of the PSP duration*
What challenges have you identified and improvements do you think should be introduced to address ineffective impact from current policies on HIV and AIDS?	• The HIV policy for learners • The Post-exposure Prophylaxis

Table 4.5 *– Responses from AFRICARE to the Research Questionnaire*

ORGANISATION: - AFRICARE	
QUESTIONS	***RESPONSES***
How do you rate the HIV and AIDS prevalence	➢ Average
What do you think are the contributing factors to the current situation in this area?	1. Migration of people in and out of the sub-district to other provinces and back 2. Poverty that affect prevention and health seeking behaviours and weak sexual negotiation power 3. Sexually transmitted infections 4. Multiple partners by women or their partners without using protection from HIV and pregnancy
What programmes in your area of responsibility are being implemented to address HIV and AIDS	• HIV Counselling and testing • PMTCT (prevention of mother-to- child transmission) • MomConnect • ART treatment (NIMART) • Pharmacy Africare identified the following as important aspects with regards to HIV and AIDS in the sub-district: • HBC – target home based care at households • OVC – target orphans and vulnerable children • Health system strengthening – Governance, leadership, procurement, finance management, human resources management, pharmaceutical services and service deliveries at health facilities and program level.
How would you rate the progress in terms of implementation of the respective HIV and AIDS programmes	The following were noted: • *OVC – Given lowest priority, left to community based organisations* • *HBC – given lowest priority, left to community care givers, not professional staff*
Programme / **Successful**	**Some Challenges** *(Mention)*
HIV Counselling and testing / Yes	• The sub-district is behind quarterly and annual target

PMTCT (prevention of mother-to- child transmission)	Yes	• Intra-partum HIV infection is high 4.6% • Changing guideline very often
MomConnect	Yes	• Slow registration of pregnant women attending antenatal care
ART treatment (NIMART)	Yes	• The losses in following up on defaulters are increasing
Pharmacy	Yes	• Depot occasionally lacks enough ARV stock
In your area of responsibility, do you regard the health-care facilities as accessible		• The Health care facilities are regarded as accessible to communities as indicated below. • The referral systems between health facilities have improved tremendously but need to continue in order not to lose patients already in the system. This is especially so for deliveries at the referral hospitals (Frontier) and the district hospital that need to be followed at their PHC facilities.

Health Care Facility	**Accessible/Not Accessible** *(Specify)*	**Coping with Community Demand – Yes/No** *(Specify)*
1.PHC facilities	Accessible	Yes
2. District Hospitals	Accessible	Yes
3. Referral Hospital	Accessible	Yes

Is the Prevention of Mother-to-Child Transmission of HIV (PMTCT) part of your HIV and AIDS programmes	PMTCT is implemented, with the following other related health programmes	
	Programme	**Comments**
1.	***HCT***	• *Now routine for all patients attending health facilities, irrespective of reasons for seeking care. It has always been voluntary*
2.	***PICT (Provider Initiate Counselling & Testing)***	• *Offered by health care provider attending to patients, irrespective of reason for seeking care*

3.	***Condoms***	• *Prevention infection using physical barrier*
4.	***Family planning***	• *Prevent unintended pregnancy and birth spacing*
5.	***Abstinence and being faithful***	• *Traditional method for all people at risk*
6	***ART***	• *Those on treatment has lower risk to transmit to partner and to the unborn child*
Eastern Cape Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016		The following observations were highlighted with respect to the HIV and AIDS strategy
	Strategic Objectives	**Comments**
1.	***Address social and structural barriers to HIV, STI and TB prevention, care and impact***	• Yes – the policies, capacity building by training and the medicines are available to the first level health facilities. There is leadership and political commitment from highest to the lowest • The services are not charged
2.	***Prevent new HIV, STI and TB infections;***	• Yes –services available at every health facility and offered free
3.	***Sustain health and wellness***	No Comment
4.	***Increase protection of human rights and improve access to justice*.**	• The rights are enshrined in constitution and the health care Act and actively implemented • Also in the national strategic document, discrimination and stigma is addressed

What challenges have you identified and improvements do you think should be introduced to address ineffective impact from current policies on HIV and AIDS?	• Need well trained service providers placed at service points • Address adequate stocking of ARV drugs which sometimes run out • Improve Governance at local levels and ownership of services by the community • Educate the community and support them to advocate for services and resources

4.4 Discussions

The general participation in the study, was good as indicated by the number of responses and the quality of the comments and observations that were shared by the participants who represent different key organisations and structures involved with HIV and AIDS programmes. A limitation to this study and on the overall assessment, based on inputs from the participants, was the lack of input from communities that are beneficiaries from the different services provided by the organisations and public institutions that deal with these issues and responsibilities. Given the focus and objective of the study, this limitation does not affect the envisaged outcome as the target population was part of the deliberate design of the study. But, this had to be taken into account when making the assessment and generalisations from the study, and also in planning future studies on this topic.

According to Massyn et al (2015: 304) the overall assessment of the Lukhanji sub-district is that HIV prevalence is at an average and low levels when comparing with the provincial and national statistics. In this study the current evaluation from the sub-district statistics show very low levels of HIV prevalence, at 17% as indicated in the report from the Chris Hani District Municipality (CHDM) and also the assessment by the Chris Hani Health District.

HIV testing coverage including ANC and TB and HIV co-infection on ART rates, the CHDM was amongst the top ten in the country. But, when considering the trends on leading causes of deaths by age in the district, HIV and AIDS was identified as one of the leading causes in almost all the different age groups that were analysed, that is; under 5 years, 5-14 years, 15-24 years, and 25-64 years. It is only the 65 and older years group that HIV and AIDS was not a leading cause of death**.** This is an important fact to note despite the observed low levels of HIV prevalence at the sub-district level.

The need to gather information at district and sub-district levels is important in understanding the disease and coming up with relevant correct interventions due to the known differences in population distribution, poverty levels, access to services and other factors that can contribute to the prevalence of diseases.

The significance of the findings of this work is based on the fact that the data provided talks to the interaction that is at the community level, where policy interventions are

expected to make an impact. It must be borne in mind that the results are not necessarily representative of the provincial or national picture, since the work focused on the Lukhanji Sub-district population. The picture therefore at the district, provincial and national levels, and in other sub-districts may differ from what is observed at Lukhanji sub-district Municipality. But, lessons can be drawn from the experience at this low level on how some of the policy interventions that are being implemented are impacting on HIV and AIDS, and this should influence more work to be done at this level.

When comparing the current health performance observations to previous assessments, that is 2008-2010 and 2011-2013, there was improvement in terms of HIV and AIDS as leading causes of death, as indicated in the work done by the Massyn et al (2015: 303). This outcome could be attributed to several improvements in health care achievements such as indicated in the figure that follows below (*Figure*). The table in the figure also shows certain areas where improvements are expected.

Category	**Indicator [2014-2015]**	**District Average**	**Provincial Average**	**National Average**	**(2014-2015) Provincial Target [National Target]**
PMTCT	Antenatal 1st visit before 20 weeks rate [Percentage]	59.6%	48.8%	53.9%	42.0%% [65.0%]
	Antenatal client initiated on ART rate [Percentage]	92.6%	91.7%	91.2	(No target) [93%]
	Infant 1st PCR test around 6 weeks uptake rate [Percentage]	101.8%	95.2%	100.6%	No target

	Infant 1st PCR test positive around 6 weeks rate [Percentage]	1.9%	1.7%	1.5%	(1.7%) [1.8%]
HIV	HIV testing coverage (including ANC)	42.5%	36.0%	32.1%	No targets
	Male condom distribution coverage	34.7%	33.6%	38.4%	No targets
	Percentage of TB cases with known HIV status (ETR.Net) [Percentage]	94.9%	92.3%	92.8%	No targets
	TB/HIV co-infected client on ART rate (ETR.Net) [Percentage]	90.7%	89.1%	78.9%	No targets

Table 4.6 *– Indicator Performance, focusing on HIV statistics: Chris Hani District Municipality [DC13] (Health Systems Trust 2014-2015; District Health Barometer, p303-304)*

The general assessment of the district is that it has shown improvement in the performance of several indicators. The general average of the assessment during the 2014-2015 period indicates better performance when comparing with the provincial and national averages. The district has recorded high numbers in terms of TB and HIV co-infection statistics. This could be associated with the high poverty levels in this area. These observations at the district level could also contribute to the situation at the sub-district level even though this was not observed from the evaluation of HIV prevalence in Lukhanji sub-district. Better performance observations from Lukhanji could be attributed to the extensive HIV and AIDS programmes that are rolled out, as indicated in the findings from this study. This is important to note since it has been reported previously that at different levels HIV prevalence is heterogeneous.

The CHDM did not perform very well when it comes to TB outcomes during the 2013 reporting period, and no records were obtained for 2014. The TB treatment success rate was significantly low and yet the death rate was also very high during this period. For the district, one of the important interventions that need urgent intervention is TB. This will have an impact on the success rate in dealing with HIV infection and AIDS in

the district. This must also be taken note of when considering health policy interventions at the sub-district level, as in this case TB incident variable was also not part of the study.

With regards to the implementation and achievement of objectives of the PSP for HIV and AIDS, STIs and TB 2012-2016, within the Lukhanji Sub-district the different HIV and AIDS programmes that were assessed in this study reported progress in this regard, in terms of implementation. This illustrated that within the Chris Hani Health District, the strategy implementation was making an impact even at the level of the sub-district. It would be important to determine the level of implementation and progress made later as 2016 is the final year for the review of the strategy. It is also important to note that the sub-district is implementing various programmes that are addressing various aspects of HIV and AIDS, and reporting positive progress.

The observations within the Lukhanji sub-district Municipality support other studies that have indicated that HIV infections and disease prevalence would begin to plateau around 2016 (Barron et al 2012: 70). Amongst factors that could lead to this outcome would be the consistent implementation of health care interventions. This appears to be the case in the Lukhanji sub-district as indicated by the various interventions that have been mentioned in the responses to this study.

When assessing progress made to-date with regards to the PSPs for HIV and AIDS, STIs and TB 2012-2016, it can be indicated that more work still needs to be done despite the improvement at the district and sub-district levels. The rollout and coordination at the district level shows progress in this regard. But, with high levels of TB co-infection there is more that needs to be done. The review of PSP 2007-2011 revealed that, the Eastern Cape Province, had addressed the HIV and TB treatment situations well, with evidence of greater access to ART, but the prevention of, and treatment management of TB and HIV had remained inadequate, and the co-ordination and mobilisation of impact mitigation activities remained very much inadequate.

The development of PSP 2012-2016, noted several elements that were to assist the province in achieving the objectives of the strategy, these include amongst others the following (PSP 2012-2016: 18):

- A need for a strong monitoring and evaluation system was identified to ensure correct capturing of what the province intends to achieve from the current PSP 2012-2016.
- The review process identified the need for the shift from biomedical and behavioural interventions to structural, economic and social drivers of the HIV and TB epidemics.
- On top of the strategic priorities it was acknowledged that the interventions must be enabled by the presence of strong functional structures at district and local levels

Given the observations and current trends made from this sub-district study. The above interventions are highly supported and recommended.

It must be indicated that there are important developments on the programmes identified in the study, such as the awareness and outreach programmes that engage the communities fostering preventive measures. Secondly, the study reveals progress in terms of the accessibility of health care facilities to the communities and the testing coverage for HIV infections. Another important observation is the inter-sectoral target groups for the different programmes, which cover both the youth and adults, and reach out across genders. Whilst government is driving the programmes, the involvement of the private sector, as mentioned in some of the reports is also very significant, especially considering the impact that HIV and AIDS have on the work force. Overall the programmes present a very balanced approach in implementing preventive measures against the spread of HIV infections and AIDS.

The 2013 report on the AIDS spending assessment of Eastern Cape Province from 2007-2010 (SANAC, 2013:4) reflected the following, among other important observations:

- Government was the overwhelming funding agent for HIV and AIDS and TB expenditure in the province (SANAC 2013:4). The funding was predominantly spent on treatment and care. In the Eastern Cape, Chris Hani District had the highest per capita HIV and AIDS Expenditure during this period.
- The provincial estimates based on modelling indicated that about 201 501 people were on ARTs in 2011. There was a steady increase of people estimated to be

taking ARTs in the province indicating 297000, 379000 and 461000, in 2012/13, 2013/14 and 2014/15, respectively (SANAC 2013:1).

- The province had an HIV prevalence of 29.3% among the general population, which was the fifth highest in the country in 2011. This had dropped from 29.9% in 2010.

4.5 Conclusions

Looking at the previous reported observations on HIV and AIDS in the province it can therefore be seen that the situation had started changing. There is focus on preventive measures and also the mention of involvement of the private sector in addressing the challenges posed by the HIV infections and AIDS pandemic. The work done in this study shows progress in terms of implementation of policies on HIV and AIDS at lower levels such as the sub-district. It can be concluded that it is this kind of approach and consistent focus within the sub-district and the CHDM that has contributed to the reported low levels of HIV prevalence in this area.

Certain critical elements that could adversely affect maintaining this state of affairs are the reported lack of ART supplies from depots and the lack of success in addressing teenage pregnancies. These are areas that would require urgent and focused intervention. It is envisaged that these should be addressed, particularly the observations under the provincial strategy which indicate that social drivers are still posing challenges in dealing with preventive measures for HIV and AIDS. This aspect forms the focus of the HIV and AIDS strategy in the province. The next chapter will examine the conclusions and recommendations.

The findings and observations from this study support previous projections from earlier studies which predicted that the high levels of HIV prevalence would be plateauing around 2016. As previously suggested this outcome would be achieved if health care interventions are implemented consistently. Noting the progress made and extensive roll out of HIV and AIDS programmes in the Lukhanji sub-district, this predicted outcome appears obtainable. The HIV prevalence level in CHDM, where Lukhanji Municipality is located remained relatively stable at 29% between 2011 and 2012 (NDoH 2013: 21). This was similar to the prevalence level of the Eastern Cape

Province, which was 29.1% for the 2012 DoH survey (2013:21). In this study Lukhanji sub-district has managed to obtain HIV prevalence levels of 17% which could be attributed to focused and consistent implementation of the relevant HIV and AIDS preventive interventions.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter examines the general conclusions and recommendations from the study. The process is accomplished with the aim of responding to the last research objective which deals with the strategies that can be adopted to curb the HIV prevalence in pregnant women. Whilst various programmes are being implemented in the Lukhanji sub-district, in relation to the HIV and AIDS strategy of the province, there are areas that have been identified where certain improvements are needed.

5.2 General Conclusions

Current assessments by different stakeholders show a picture that indicates success of various programmes, and in general the strategy that is being implemented by government. The fact that the sub-district and regional health entities report a HIV prevalence of 17% is a good indication of this success. The successes could also be ascribed to the good collaboration between the different entities and stakeholders, and the positive response that they get from the communities. The close collaboration and good interaction has enabled the various stakeholders to identify specific areas of weakness which hopefully will be addressed in improving the situation further. It is worth noting that certain challenges have been identified despite the successes that are observed from the interventions that are currently being implemented. Amongst these are the following:

- Failure to improve the threatening developments on teenage pregnancies
- The shortage of ART drugs at depots
- The lack of cooperation and involvement of traditional leaders, especially on programmes such as circumcision
- Difficulties in reaching out to tough terrains such as bush areas, despite the general assessment indicating accessibility of health care facilities to the communities

- The need for capacity in some facilities, despite the general mention that the facilities are coping with the community demand
- The expressed need from the provincial HIV and AIDS programme to improve focus and attention to learners
- The need to improve coordination and communication amongst the stakeholders

Generally it can be concluded that the programmes that are implemented in the Lukhanji Sub-district are on track in addressing the HIV prevalence challenges. Many of these are based on the policy imperatives as outlined in the various strategies and government programmes that support health care policies that are relevant to this issue.

5.3 Recommendations

The following recommendations are made in response to the observed challenges as mentioned in the study findings. These are also informed by the fact that they were been highlighted by the actual practitioners that are interacting with the communities in implementing government policies on HIV and AIDS, and health care in general.

- Encourage government to ensure adequate supply of ARTs at all the depots and health care facilities. This is very important especially noting scientific evidence that has shown that breaks and inconsistency in taking ART medication/drugs could lead to the development of drug resistance.
- Recommend improvement of education programmes, especially those targeting the youth and learners. This is an urgent requirement that could address the observed high rate of teenage pregnancies in the sub-district. The fact that Queenstown, has been regarded as a High Transmission Area, and the observation of high levels of poverty and unemployment really necessitate that interventions be taken urgently to educate vulnerable groupings within the community, such as young women.
- Encourage the involvement of traditional leaders in the fight against HIV and AIDS, especially noting the deaths and illnesses that affect initiates during the circumcision exercise.

- Capacity building at health care facilities, and improvement of the interaction with community based and home based care givers. This will provide an important force multiplication factor that should enlighten the burden or load on health care facilities.
- In general it is recommended that the different recommendations indicated in the different reports by the various stakeholders, which have been summarised in this report, should be attended to as these are based on the observations and needs of the communities in this area. Some of these should be taken note of and addressed in policy reviews so as to ensure that the interventions are sustainable, and whatever gains have been achieved these are not reversed.

6. BIBLIOGRAPHY

Allen, D M, Simelela N P and Makhubalo L (2000). **Epidemiology of HIV/AIDS in South Africa**. *South AfrIica J HIV Med, July 2000.*

Babbie, E. and Mouton, J., (2008). ***The Practice of Social Research***. 8th ed. Cape Town: Oxford

Barron, P.; Pillay, Y.; Doherty, T.; Sherman, D.; Jackson, D.; Bhardwaj, S.; Robinson, P. and Goga, A. (2012) **Eliminating Mother-to-Child HIV Transmission in South Africa;** *Bulletin of the World Health Organization,* 91:70-74.

Bryman, A. and Bell, E. (2007). ***Business Research Methods*****.** 2nd ed. London: Oxford.

Chris Hani District Municipality (2012). ***Chris Hani District Municipality-5 Year Integrated Development Plan 2012-2017.*** South Africa: Queenstown

Daly, J., Kellehear, A and Gliksman, M. (1997) ***The Public Health Researcher:*** *A Methodological Approach.* Melbourne: Oxford.

Eastern Cape AIDS Council (2012) ***Provincial Strategic Plan for HIV-AIDS, STIs and TB 2012-2016.*** Port Elizabeth: The Council.

Fielding, N.G. (1995). **'Qualitative Interviewing' in N. Gilbert** (ed) *Researching Social Life*, London: Sage.

Human Sciences Research Council (2012) ***South African National HIV Prevalence****, Incidence and Behaviour Survey,* Cape Town: HSRC.

Human Sciences Research Council Survey (2008). ***South African National HIV Prevalence,*** *Incidence, Behaviour and Communication Survey*. *A Turning Tide Among Teenagers*. Cape Town: HSRC.

Hussey, J. and Hussey, R. (1997) ***Business Research;*** *A Practical Guide For Undergraduate and Postgraduate Students*. London: MacMillan

Johnson LF (2012). **Access to Antiretroviral Treatment in South Africa 2004–2011.** *South Afr J HIV Med,* 13: 22-27.

Johnson, S. Kincaid, D.L. Laurence, S. Chikwava, F. Delate, R. Mahlasela, L.(2010) ***Second National HIV Communication Survey 2009: Findings from Eastern Cape.*** Pretoria: JHHESA

Massyn, N., Peer, N., Padarath, A. Barron, P. Day, C. (2015). ***District Health Barometer 2014/2015.*** Durban: Systems Trust

McKee, N. Bertrand, J.T. and Becker-Benton, A. (2004). ***Strategic Communication in the HIV/AIDS Epidemic.*** Sage Publications: New Dehli

National Coordinating Committee – **Millennium Development Goals South Africa (2013)**. MDGs Country Report 2013: *The South Africa I Know the Home I Understand*. Cape Town: National Planning Commission, the Presidency.

National Department of Health (2011). ***South Africa HIV Epidemic, Response and Policy Synthesis Pretoria.*** The Department

National Department of Health (2011): *Technical Report* - ***HIV Epidemic, Response and Policy Synthesis***. *Getting to Success Improving HIV prevention in South Africa.* Pretoria: The Department.

National Department of Health (2012). ***The 2010 National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa***, Pretoria. The Department.

National Department of Health (2013). ***Mid-term Review of Progress in achieving the 2011 UN General Assembly Political Declaration on HIV/AIDS targets and Elimination*** *Commitments in South Africa. Republic of South Africa Global AIDS Response Progress Report.* Pretoria: The Department.

National Department of Health (2013). ***The 2012 National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa***, Pretoria. The Department

National Department of Health, South Africa (2008). ***The National HIV and Syphilis Prevalence Survey*** - *South Africa. Technical Report.* Pretoria: The Department.

National Department of Health, South Africa (2009). ***The National HIV and Syphilis Prevalence Survey*** - *South Africa.* Pretoria: The Department.

National Department of Health, South Africa (2011). ***SANAC - National Strategic Plan for HIV,*** *STIs and TB 2012–2016.* Pretoria: The Department.

National Planning Commission (2011). ***National Development Plan*** - *South Africa, Vision: 2030 – Our Future Make it Work.* Cape Town: The Presidency, Republic of South Africa.

Neuman, W. L., 2011. ***Social Research Methods. Qualitative and Quantitative*** *Approaches.* 7th ed. Whitewater: University of Wisconsin.

Pan African Parliament (2014). Online media release 27 March 2014. Midrand: South Africa

Rice, P. and Ezzy, D. (1999) ***Qualitative Research Methods****: A health focus.* Melbourne: Oxford University Press.

Riege, M. (2003). ***Validity and reliability tests in case study research: a literature review with hands on applications for each research phase: Qualitative Market Research, An International Journal.*** Volume 6, Issue 2. Page 75-86

SABCOHA (2012). ***Eastern Cape Business Sector Provincial Strategic Plan 2012-2016.*** Eastern Cape

SANAC. (2013) ***Eastern Cape Provincial AIDS Spending Assessment Brief (2007/08-2009/10).*** Eastern Cape

Saunders, M. Lewis, P. and Thornhill, A. (2003). ***Research Methods for Business Students*****. London:** Pitman Publishing.

Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) ***South African National HIV Prevalence, Incidence and Behaviour Survey,*** *2012*. Cape Town, HSRC Press.

Snyder L. B(2007), Health Communication Campaigns and their Impact on Behaviour, Journal of nutrition Education and Behaviour, Volume 39 (2), pages 32 -40

Statistics Canada (2003). ***Survey Methods and Practices***. Ottawa, Ontario: The Department.

Statistics South Africa (2013). ***Mid-year Population Estimates 2013.*** *Statistical Release P0302.* Pretoria: StatsSA.

The National Treasury Report (2013). ***Annual Report.*** South Africa

Thompson, P. (2000). ***The Voice of the Past: Oral History*****,** 2nd edition. Oxford: Oxford University Press.

UN General Assembly Special Session (UNGASS) (2001) ***Declaration of Commitments on HIV/AIDS****.* New York: United Nations.

UNAIDS (1999), ***Prevention of HIV Transmission from Mother to Child:*** *Strategic Options, Geneva*,

UNAIDS (2009). ***Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV Operational plan for the UNAIDS action framework****: addressing women, girls, gender equality and HIV*. New York: UNAIDS.

UNAIDS (2010). ***The Global AIDS Epidemic. Global Report Fact Sheet***. New York: UNAIDS. (2012).

Wayne, G. and Melville, S. (2007). ***Research Methodology: An Introduction.*** 2nd Edition. Juta: Cape Town

WHO (2006), ***HIV and Infant Feeding Technical Consultation***, Geneva 25-27 October 2006

WHO (2013). ***Guide to conducting programme reviews for health sector response to HIV***. WHO Library Cataloguing

WHO and UNAIDS (2003)

WHO. (2007). ***Prevention of Mother To Child Transmission (PMTCT): Briefing note.*** WHO Library Cataloguing

WHO; 1996 HIV/AIDS and Sexually Transmitted Diseases – ***WHO Policy and Strategic Orientations*****).**

www.nacosa.org.za

www.statssa.gov.za

www.sahistory.org.za

"ANNEXURE A"

THE SUB-DISTRICT MANAGER
DEPARTMENT OF HEALTH
LUKHANJI SUB-REGIONAL OFFICE
QUEESNTOWN
South Africa

Dear Sir

PERMISSION TO CONDUCT RESEARCH WITH STAFF MEMBERS AND SERVICE RECEIPIENTS.

I am a registered student at the University of Fort Hare doing the Masters in Public Administration. As a requirement of the degree, I am expected to conduct a research on a proposed subject. My proposed research topic is as follows" **Evaluation of Policy Interventions on HIV and AIDS in Pregnant Women: A Case Study of Lukhanji Sub-district Municipality in the Eastern Cape Province in South Africa"**

Participants will be contacted by the researcher and invited to complete the self-administered questionnaire. Ethical issues will be strictly adhered to, thus the strict focus on topic, matters concerning confidentiality, secrecy and respondents will not be mentioned by names on the research report. Data will be collected through questionnaires and are strictly based on the research topic.

Your kind assistance in granting me permission will be highly appreciated.

_____

Y. SINYANYA
RESEARCHER

“ANNEXURE B”

CONSENT FORM

AGREEMENT BETWEEN RESEARCHER AND RESEARCH PARTICIPANT

I (participant’s name) _____agree to participate in the research of **Ms Yoliswa Sinyanya.**

I understand that:

The researcher is a registered student at the University of Fort Hare conducting the research as part of the requirements for a Masters of Public Administration degree.

The researcher is interested in my understanding and experience of the role of leadership.

My participation will involve writing a narrative with regard to the research being done. I may also be interviewed if clarification is needed on my written narrative.

The transcriptions and written narratives will be retained and kept safely during the course of this study.

Anonymity is guaranteed. The report on the project may contain information about experiences and personal attitudes, but the report will be written in such a way that respondents will not be able to be identified by the general reader.

Researcher: _____ Date: _____

Participant: _____ Date: _____

Annexure C

RESEARCH QUESTIONNAIRE

EVALUATION OF POLICY INTERVENTIONS ON HIV AND AIDS FOR PREGNANT WOMEN: *- A CASE STUDY OF LUKHANJI SUB-DISTRICT MUNICIPALITY IN THE EASTERN CAPE PROVINCE IN SOUTH AFRICA*

SECTION A: PERSONAL DETAILS AND SAMPLE DEMOGRAPHICS

Please indicate the applicable answer with an "X"

1. **Gender:**

Female	
Male	

2. **Age Group:**

20-29	**30-39**	**40-49**	**50-59**	**60 +**

3. **Language Proficiency:**

	English	**Afrikaans**	**Xhosa**	**Other** (specify)	**Sign language** (Used/Nor used)
Speak					
Read					
Write					

4. **Education Qualifications:**

	Secondary (*Matric*)	**Tertiary** (*Diploma, Degree*)	**Other** (*Certificates in Short Courses*)
Mark Level Reached with X			
Specific Qualification – Certificate, Diploma or Degree name			

5. **Position in the Municipality/Organisation/Department:**

	Management	**Other Position**
Specify Management level (Top/Middle/Lower)		

SECTION B: HIV AND AIDS PREVALENCE

1. ***How do you rate the HIV and AIDS prevalence rate among pregnant women in your area of responsibility within the Lukhanji Sub-district?*** (**Very Low – Very High**; *Compare to Provincial/National averages*)

Very Low	Low	Average	High	Very High

2. ***What do you think are the contributing factors to the current situation in this area?***

3. ***What programmes in your area of responsibility are being implemented to address HIV and AIDS in the Lukhanji area? What are the population target groups of the specific programmes?***

	Programme	Target Group(s)
1.		
2.		
3.		
4.		
5.		

Additional Comments:

4. ***How would you rate the progress in terms of implementation of the respective HIV and AIDS programmes as per your evaluation?***

Programme	**Successful**	**Some Challenges** *(Mention)*	**Unsuccessful** *(Reasons)*
1.			
2.			
3.			
4.			
5.			

Additional Comments:

5. ***In your area of responsibility, do you regard the health-care facilities as accessible to pregnant women of Lukhanji area, and are these facilities coping with the demand for health-care provision?***

Health Care Facility	**Accessible/Not Accessible** *(Specify)*	**Coping with Community Demand – Yes/No** *(Specify)*
1.		
2.		
3.		

4.		
5.		

Additional Comments:

6. ***Is the Prevention of Mother-to-Child Treatment (PMTCT) part of your HIV and AIDS programmes in your area of responsibility? Are there any other programmes that are implemented as part of HIV and AIDS prevention specifically targeting pregnant women?***

   Please indicate the applicable answer with an "X"

   PMTCT Implementation

Yes	
No	

Other Programmes Targeting Women

	Programme	**Comments**
1.		

2.		
3.		
4.		
5.		

7. The government of the Eastern Cape Province, in line with National Government Strategy, adopted the Eastern Cape Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016. Do you think that the implementation of the strategy has made an impact in terms of achievement of the strategic objectives, specifically for HIV and AIDS prevention in pregnant women?

	Strategic Objectives	**Comments**
1.	• *Address social and structural barriers to HIV, STI and TB prevention, care and impact*	
2.	• *Prevent new HIV, STI and TB infections;*	

3.	• *Sustain health and wellness; and*	
4.	• *Increase protection of human rights and improve access to justice*.	

8. What challenges have you identified and improvements do you think should be introduced to address ineffective impact from current policies on HIV and AIDS?

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