

**THE IMPLEMENTATION OF THE NATIONAL HIV/AIDS POLICY IN THE
VHEMBE DISTRICT**

by

EMMANUEL B.K. LUYIRIKA

**Thesis presented in partial fulfilment of the requirements for the
degree of Master of Public Administration at the University of
Stellenbosch**

Supervisor: Professor Fanie Cloete

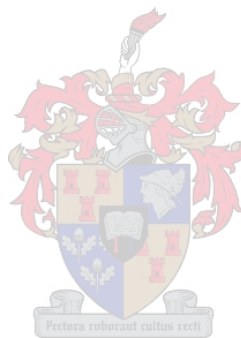
December 2003



DECLARATION

I, the undersigned hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Emmanuel B.K. Luyirika



SUMMARY

The implementation of national policies is a key function of government through its various departments. This is very crucial in the health sector where lives of individuals are involved. The implementation of the national HIV/AIDS policy is very important in dealing with the epidemic.

This study combined both quantitative and qualitative methods to analyse the implementation of the South African government's national HIV/AIDS policy in the Vhembe District of the Limpopo Province. The quantitative phase involved the stratified sampling process, resulting in identifying 2 health workers from each of the 25 health units in the district comprising of 22 community clinics, the infection control unit, the counselling unit at the hospital and 2 from among the doctors. A total of fifty respondents were selected from a workforce of about 500.

The staff profile indicates that 76 % of the health workers interviewed were below 40 years of age and 28% of them were chief professional nurses. Of the health workers, 78 % had been in the current position for between 1 and 5 years, 6 % for 6 to 10 years, 6 % for 16 or more years and 10 % for less than one year. All of them had a diploma as a minimum qualification, 8 % had 2 diplomas, 2 % had 3 or more diplomas, 2% had degrees and 2 % had a degree plus diplomas.

In terms of HIV/AIDS policy implementation, 100% of all the facilities provided HIV prevention information to clients, 60% of these facilities worked with other organisations in HIV prevention, but only 4% had voluntary counselling and testing (VCT) services. In these health units only 28% had had staff trained regarding HIV/AIDS issues. In addition 96 % of the health units had the male condom stocked at any one time and only 12 % stocked the female condom.

In terms of sexually transmitted diseases (STD) control, all clinics were using the syndromic approach in management of STDs and also claimed to have youth-friendly services. On the other hand only 80 % of the facilities had had staff trained in STD management using the syndromic approach.

In the area of prevention of mother-to-child transmission of HIV,

(PMTCT) none of the clinics had VCT services for pregnant women and only 8% of them had PMTCT counsellors. Because of the lack of VCT services only 4% of the clinics had known HIV positive mothers attending the antenatal care services.

On the issue of post-exposure prophylaxis (P.E.P.) all clinics had protocols for this and 88% of them had antiretroviral drugs (ARVs) stocked for post-exposure treatment for health workers. However, only 8% of these clinics had a betadine douche as the only post-exposure intervention for raped women.

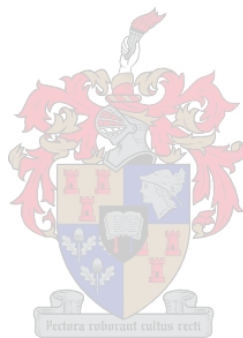
In the area of treatment care and support for patients none of these clinics offered ARVs, 24 % had protocols for prevention and management of opportunistic infections, 4% were involved in any form of home-based care, 4% had HIV/AIDS dedicated services and 24% collaborated with community non-governmental organisations (NGOs) in HIV/AIDS care.

The qualitative phase of the study highlighted what health workers perceived as prominent features of the national HIV/AIDS policy and these included prevention of HIV by use of condoms, faithfulness and pre-test counselling. The respondents also interpreted the social response by government to include provision of home-based care, care of orphans, food provision and safe guarding rights of victims. Other issues that were perceived to be part of the national HIV/AIDS policy were STD management, health education, provision of training to health workers in HIV/AIDS issues, provision of home-based care and occupational health and safety for health workers.

The government was also perceived to have a negative attitude towards AIDS NGOs, not providing adequate numbers of the female condom and denying patients antiretroviral drugs (ARVs).

The recommendations made on the basis of the study therefore include strengthening the training of health workers in HIV/AIDS care and management, improved provision of VCT services, wider distribution of the female condom, provision of prevention of mother-to-child transmission of HIV (PMTCT) services and the linking of research and care to provide

evidence-based practice. Other recommendations are that there should be support programmes for health workers with HIV, addressing gender issues in implementation and provision of ARVs especially where it is already known that they help.



OPSOMMING

Die implementering van nasionale beleid is 'n sleutelfunksie van die regering, verrig deur sy onderskeie departemente. Dit is veral deurslaggewend in die gesondheidssektor waar die lewens van individue op die spel is en die implementering van die nasionale MIV/VIGS- beleid is baie belangrik in die hantering van die epidemie.

In hierdie studie is beide kwalitatiewe en kwantitatiewe metodes gekombineer om implementering van die Suid-Afrikaanse regering se nasionale MIV/VIGS -beleid in die Vhembe-distrik van die Limpopo-provinsie te analiseer. Die kwantitatiewe fase het 'n gestratifiseerde steekproefproses behels, wat gelei het tot die identifisering van 2 gesondheidswerkers uit elk van die 25 gesondheidseenhede in die distrik, bestaande uit 22 gemeenskapsklinieke, die infeksie-beheereenheid, die beradingseenheid by die hospitaal en die geledere van die dokters. So is 'n totaal van 50 respondente geselekteer uit 'n arbeidmag van ongeveer 500.

Die personeelprofiel dui aan dat 76% van die gesondheidswerkers wat ondervra is jonger as 40 jaar was en dat 28% van hulle hoof professionele verpleegsters was. Van die gesondheidswerkers was 78% vir 1 tot 5 jaar in hul bestaande posisie, 6% vir 6 tot 10 jaar, 6% vir 16 of meer jare en 10% vir minder as 1 jaar. Almal van hulle het 'n diploma as 'n minimum kwalifikasie gehad, 8% het 2 diplomas, 2% het 3 of meer diplomas, 2% het grade en 2% het 'n graad plus diplomas gehad.

In terme van die MIV/VIGS beleidsimplementering het 100% van die fasiliteite MIV- voorkomingsinligting aan kliënte verskaf, 60% van hierdie fasiliteite in samewerking met ander organisasies, terwyl slegs 4% vrywillige berading en toetsdienste verskaf het. Slegs 28% van die gesondheidseenhede het oor personeel beskik met opleiding in MIV/VIGS-

kwessies. Verder het 96% van die gesondheidseenhede die manlike kondoom in voorraad gehad teenoor slegs 12% eenhede die vroulike kondoom.

In terme van die seksueel-oordraagbare siektebeheer, het al die klinieke die sindroom-benadering in die bestuur van seksueel- oordraagbare siektes toegepas en het beweer dat hulle dienste jeugvriendelik is. Daarteenoor het slegs 80% van die fasiliteite beskik oor personeel wat opgelei was in seksueel- oordraagbare siektebestuur met toepassing van die sindroom-benadering.

Op die terrein van voorkoming van moeder- na- kind- oordraging van HIV het geen van die klinieke oor vrywillige berading en toetsdienste vir swanger vroue beskik nie en slegs 8% van hulle het wel moeder-na-kind-oordragingsberaders gehad. As gevolg van die gebrek aan vrywillige berading en toetsdienste het slegs 4% van die klinieke kennis gedra van HIV- positiewe moeders wat voorgeboortelike sorgdienste bygewoon het.

Wat na-blootstellingsvoorbehoeding aanbetref, het alle klinieke protokolle gehad en 88% het antiretrovirale medisyne in voorraad gehad vir na-blootstellingsbehandeling van gesondheidswerkers. Slegs 8% van hierdie klinieke het egter 'n betadine-spoeling("douche") as die enigste na-blootstelling intervensie vir verkrachte vroue gehad.

Op die gebied van die behandeling van en ondersteuning aan pasiënte het geen van hierdie klinieke die antiretrovirale medisyne aangebied nie, 24% het protokolle vir die voorkoming en bestuur van geleentheidsinfeksies gehad, 4% was betrokke in enige vorm van tuisgebaseerde sorg, 4% het oor MIV/VIGS -gerigte dienste beskik en 24% het met gemeenskapsvrywilligerorganisasies saamgewerk in die voorsiening van MIV/VIGS-sorg.

Die kwalitatiewe fase van die studie fokus op wat gezondheidswerkers beskou as prominente kenmerke van die nasionale MIV/VIGS- beleid en wat insluit die voorkoming van HIV deur die gebruik van kondome, getrouheid en voor-toets- berading. Die respondente vertolk die regering se sosiale reaksie as insluitend die verskaffing van tuisgebaseerde sorg, die versorging van weeskinders, voedselvoorsiening en die beveiliging van slagoffers se regte. Ander kwessies wat ook gesien word as deel van die nasionale MIV/VIGS beleid is seksueel- oordraagbare siektebeheer, gezondheidopvoeding, die verskaffing van opleiding aan gezondheidswerkers in MIV/VIGS-probleme, die voorsiening van tuisgebaseerde sorg en beroepsgesondheid en veiligheid vir gezondheidswerkers.

Die regering se houding teenoor VIGS vrywilligerorganisasies is ook as negatief vertolk deur onvoldoende hoeveelheid van die vroulike kondoom te verskaf en antiretrovirale medisyne te weerhou van pasiënte.

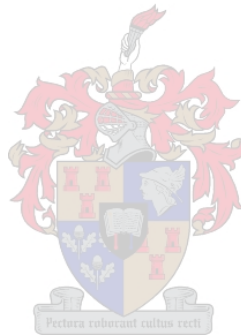
Die aanbevelings wat op grond van die studie gemaak is, sluit in die verbeterde opleiding van gezondheidswerkers in MIV/VIGS-sorg en -bestuur, verbeterde verskaffing van vrywillige berading en toetsdienste, wyer verspreiding van die vroulike kondoom, verskaffing van MIV-dienste vir die voorkoming van moeder-na-kind-oordraging en die konnektering van navorsing en sorg om 'n inligtingsbaseerde praktyk te skep. Ander aanbevelings is dat daar ondersteuningsprogramme vir gezondheidswerkers met MIV behoort te wees wat geslagskwessies aanspreek in die implementering en verskaffing van antiretrovirale medisyne waar dit reeds bekend is dat dit wel help.

TABLE OF CONTENTS	page
Declaration.....	ii
Summary.....	iii
Opsomming.....	vi
Table of contents.....	ix
List of figures.....	xi
List of tables.....	xii
Acronyms.....	xiii
1. Chapter one: Introduction and problem statement	1
1.0 Introduction.....	1
1.1 Health Services in Vhembe District.....	1
1.2 Problem statement.....	2
1.3 Aim of the study.....	3
1.4 Objectives of the study.....	3
1.5 Motivation for the study.....	4
2. Chapter two: Review of related literature	6
2.0 The importance of effective policy implementation in policy success	6
2.1 Literature search	7
2.2 The content of the literature review	8
2.3 HIV/AIDS policy implementation in Uganda	8
2.4 HIV/AIDS policy implementation in Senegal	11
2.5 HIV/AIDS policy implementation in Brazil	11
2.6 HIV/AIDS policy implementation in South Africa	13
2.7 Summary of HIV/AIDS policy implementation in selected countries	16
3. Chapter three: The empirical methodology	18
3.1 Introduction	18
3.2 The quantitative phase of the study	18
3.2.1 The study population	18
3.2.2 The sampling process	19
3.2.3 Conducting a pilot study	21

3.2.4 Method of data collection	21
3.2.5 Analysis of the quantitative results	23
3.3 The qualitative phase of the study	23
3.3.1 Sampling for the qualitative phase	23
3.3.2 The pilot study for the qualitative phase	23
3.3.3 The method of qualitative data collection	24
3.3.4 Analysis of the qualitative data	24
3.4 Limitations of the study	24
4. Chapter four: The results of the study	25
4.1 Introduction	25
4.2 Results of the quantitative phase of the study	25
4.3 Results of the qualitative phase	38
5. Chapter five: Discussion of study results	50
5.0 Introduction	50
5.1 Discussion of results of the quantitative phase	50
5.2 Discussion of qualitative results	57
5.3 Conclusions	59
5.4 Recommendations	60
7. Bibliography	64
8. Appendices	
8.1 Questionnaires	69
8.2 Letter to the Limpopo Province Department of Health	78
8.3 Consent Form	79
8.4 Letter from Stellenbosch University	80
8.5 Letter from The Northern Province Department of Health	81
8.6 Letter From Donald Fraser Hospital	82
8.7 Map of Limpopo Province	83

LIST OF FIGURES

Figure 1 The age of health workers involved in the study	28
Figure 2 The qualifications of health workers in the study	29
Figure 3 The position held by health workers	30
Figure 4 Years spent in current position by health workers	31
Figure 5 Implementation of prevention measures	32
Figure 6 The level of implementation of the STD control plans	33
Figure 7 The implementation of prevention mother-to-child transmission of HIV	34
Figure 8 Implementation of post exposure services	35
Figure 9 Implementation of treatment, care and support	36
Figure 10 On-going research and health worker support in clinics	37



LIST OF TABLES

Table 1.1 The sampling detail	20
Table 4.1 The profile of respondents in the quantitative phase	26



ACRONYMS

AIC	- AIDS Information Centre
AIDS	- Acquired Immunodeficiency Syndrome
ANC	- Antenatal Clinic
ARVs	- Antiretroviral agents that drugs used to treat the HIV
ATM	- Auto Teller Machine
AZT	- Zidovudine, an agent used to treat HIV
Bactrim	- A drug known as Cotrimoxazole used to prevent opportunistic infections in HIV infected persons
Betadine	
douche	- An Iodine containing compound used to kill germs.
CPN	- Chief Professional Nurse
Condom	- A latex sheath worn on the genitalia as protection before sex
Dictaphone	- An audio tape recorder
GDP	- Gross Domestic Product
HIV	- Human Immunodeficiency Virus
Indinavir	- A drug agent used to treat HIV
MO	- Medical Officer
Nevirapine	- A drug agent used to treat HIV
NGOs	- Non-Governmental Organisations
Opportunistic	
Infections	- Infections that take advantage of a body weakened by HIV
PAHO	- Pan American Health Organisation
PEP	- Post-exposure prophylaxis
PMTCT	- Prevention of Mother-To-Child Transmission of HIV
PN	- Professional Nurse
Pre-test	
counselling	- Counselling given before an HIV test is performed
Prophylaxis	- Prevention of acquiring infection by use of drug agents
Rand	- The South African currency
SPN	- Senior Professional Nurse
STD	- Sexually Transmitted Diseases

Syndromic

management - Using drug combinations to treat most common STDs at once

TASO The AIDS Support Organisation

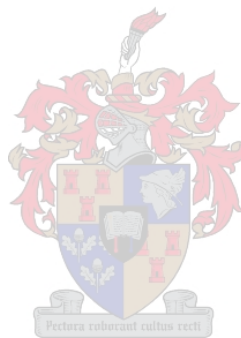
TAC - Treatment Action Campaign, an AIDS treatment pressure group in South Africa

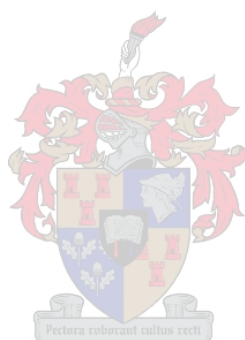
TB - Tuberculosis

3TC - Lamivudine, a drug agent used to treat HIV

VCT - Voluntary Counselling and Testing

WHO - World Health Organisation





CHAPTER ONE: INTRODUCTION AND PROBLEM STATEMENT

1.0 INTRODUCTION

The implementation of the national HIV/AIDS policy in the management of health care services is crucial in the fight against the epidemic. It is therefore important that one understands the views of role players in the process who in this case happen to be health workers. Background information about the area under study and the problem statement will therefore be properly highlighted in this chapter as well as the aim, objectives and motivation for the study.

1.1 HEALTH SERVICES IN VHEMBE DISTRICT

Vhembe is the most northerly district of the Limpopo Province, formerly Northern Province. It comprises the Mutale, Thohoyandou-Malamulele, Louis Trichardt, Makhado and Messina municipal areas. The Mutale area is one of the remotest areas in the Limpopo Province and in South Africa in general. It has many poor unemployed people with many diseases characteristic of a rural poor population such as tuberculosis, malnutrition, malaria, and this is in addition to HIV and AIDS. The remoteness of the area is exemplified in the fact that there is no established recognisable modern supermarket, no ATM machine, and many residents do not have access to running water or electricity.

The Mutale area has a population of about 250,000 people (Situational Analysis of the Donald Fraser Hospital Health Ward, 2001) that is served by 21 community primary health care clinics, one health centre and the 438-bed Donald Fraser Hospital that is outside the boundaries of the area. There is a community mobile team, which provides basic primary health care services at 115 visiting points usually at the headmen's kraals, schools or small shopping points in areas that are distant from the clinics. The entire Mutale area is served by only two private general practices owned by two private medical doctors. Nurses who run the clinics and the health centre provide the rest of the health care services where a government-paid doctor visits once a week

when the hospital in the district is not short-staffed. The professional nurses run the primary health care clinics in the community where they treat all ailments including AIDS and then refer to medical officers those patients they find difficult to manage at the clinic level.

The entire staff complement for the hospital, health centre and the clinics that serve the area is about 500. Of these there are only 9 medical doctors, about 300 professional nurses and the rest are enrolled nurses and support staff. There is not a single hospice for the terminally ill, neither is there an old age home. The professional nurses and medical doctors are at the forefront of managing HIV/AIDS patients and implementing HIV/AIDS policy at hospital and community clinic levels. The hospital that serves the area is located outside its borders. There is no major town in the entire area and Mutale Town is a small trading centre (Situational Analysis of Donald Fraser Hospital Health Ward, 2001; Map of the Limpopo Province Health and Welfare Districts, 1997 Appendix 8.7 page 83).



1.2 PROBLEM STATEMENT

HIV/AIDS is a major disease epidemic that is impacting significantly and negatively on the health status of the population in South Africa and all over the world, especially in poorer countries. The compromised immunity that results from this infection has led to the proliferation of previously controllable diseases like tuberculosis and diarrhoeal diseases, the resurgence of previously rare cancers and the increase in numbers of people who are chronically ill in the population. This state of affairs has made an impact on all spheres of society and therefore demands a coherent national policy to address the health, social and economic needs of the population affected by this disease.

The impact of the implementation of the national HIV/AIDS policy in the various sectors of government, and especially the health services, is so far not known. Very little information exists to indicate what the impact of the various actions taken by government in an effort to address HIV and AIDS

related issues in society is. The very nature of current policy initiatives concerning HIV and AIDS is that they must meet the needs of the affected and infected as well as the political objectives of the government. This has however been affected by the debate about whether HIV causes AIDS. The lack of in-built strategies for planning, evaluating and assessing the impact of the policy means that there is a gap between what is intended by the national HIV/AIDS policy, what is actually being done, and the impact of those actions on the ground.

In the case of South Africa, like in that of many other countries where HIV and AIDS pose a national threat, problems relating to policy implementation should be clearly understood, and especially so by the people who are at the forefront of policy implementation. Health workers in South Africa are faced daily with the repercussions of HIV/AIDS and are therefore the appropriate starting point when assessing the process of implementation of the national HIV/AIDS policy.

1.3 THE AIM OF THE STUDY

The aim of the study was to obtain baseline information about the implementation of aspects of the national HIV/AIDS policy in the health care facilities in the Mutale area of the Vhembe district of the Northern Province.

1.4 OBJECTIVES OF THE STUDY

1. To establish the profiles of the health workers at the forefront of HIV/AIDS policy implementation;
2. To establish if the HIV/AIDS policy has been translated into action at the health care delivery points in terms of HIV prevention, treatment, care and support of HIV/AIDS patients and implementation of research efforts;
3. To discover positive and negative spin-offs from the policy as well as generating new recommendations; and
4. To assess the perceptions of health workers regarding the national HIV/AIDS policy in general.

1.5 MOTIVATION FOR THE STUDY

First of all the motivation for the study arose from the researcher's observation that a lot of debate goes on around the HIV/AIDS issue with many claims made by policy makers and complaints raised by those affected and/ or infected by HIV more especially in the press. Such a debate was likely to obscure the achievements as well as block the clear highlighting of what else needs to be done. The impression of the researcher was that the politicians were wasting a lot of time trying to convince the population that the issues around HIV/AIDS are not necessarily treatment but dealing with poverty and nutrition. In addition, the researcher felt that very confusing messages were being sent to the people and there were unnecessary delays in implementing treatment options for people living with AIDS.

Many of the issues that are delaying provision of treatment for AIDS patients, such as toxicity of these drugs and the linkage between HIV and AIDS, have already been sorted out in many other countries. The researcher is therefore of the view that political opinions should not delay the scientific fraternity and medical experts in implementing measures that are life-saving and have already been proven by research elsewhere to be helpful. The study was therefore a deliberate effort to assess what has been achieved and what more needs to be done to improve the implementation process.

Secondly, the use of health care workers in doing the study can act as a catalyst to provide insight into what more needs to be done to improve the policy.

Thirdly, participation in such a study provides awareness about the national HIV/AIDS policy in terms of how it is translated into action and brings out policy issues that are neglected in the delivery process.

Fourthly, the understanding of positive effects of the policy helps to base decisions on fact rather than emotion in such critical and potentially emotional issues as HIV/AIDS. Given the fact that most press reports in South Africa concentrate on already proven side issues, it was important to undertake a study to unearth the achievements that are overshadowed by the debate about the disease and the opinions of politicians.

Finally, because community needs change at every stage of the epidemic, bringing health workers together creates a forum in which new ideas can be generated to improve the management of services in the context of the national HIV/AIDS policy, besides giving feedback to policy makers.



CHAPTER TWO: REVIEW OF RELATED LITERATURE

This chapter comprises of a literature study on the implementation of HIV/AIDS policies in Uganda, Senegal, Brazil and South Africa.

2.0 The importance of effective policy implementation for policy success

In general terms policy implementation is the stage when government orders its officials to execute the concerned policy in the relevant government departments, local authorities or other public institutions. The researcher's interest in this study is the implementation of policy relating to the management of the HIV/AIDS scourge. Effective policy implementation is crucial in the successful response of governments to societal needs. The policy implementation process is fraught with constraints, which may include selection of a wrong strategy, poor initial planning, limited resources and poor response to problems, among others. According to Morah (1995:79), the obstacles to optimal policy implementation include lack of administrative control, the nature of the policy itself, pressure politics, goals consensus, goals clarity and communication and the difficulties of joint action. For effective policy implementation to take place all these and other contextual obstacles need to be overcome.

According to Cloete (1999a), the public policy process involves two distinct phases; the design phase and the implementation phase. The implementation phase is the stage when the design, blueprint or framework is translated from unwritten ideas or concepts into visible consequences in society. Both these phases need to be deliberately meticulous, exhaustive and inclusive if policies that impact positively on the society once implemented, are to exist.

According to Cloete (1999b) while quoting the Presidential Review Commission of 1998, a systematic effort to monitor and evaluate the impacts of government policies and services and to be responsive to the results of such exercises by systematic policy reviews, is a prerequisite of good governance.

Furthermore, the process of policy implementation needs to put into consideration the needs and interests of interest groups and individuals who were not consulted or involved in policy formulation. According to Smith (1985:136) policies can be modified to suit group or individual needs and which is a burden borne by the implementers. In the end, however, this may subvert the general purposes of the policy in question. An all-inclusive policy formation process therefore should precede the implementation process.

The best and most significant practices in policy implementation strategies which will promote good, people-centred governance are visionary leadership, policy auditing and prioritisation, strategic institution building, integrated human and other resource management, "revocracy" (a synthesis of revolutionary and democratic strategies of policy management), network-based operational management, affordable financial management priorities and practices, ethical public management practices, morality-based partnerships, flexibility and pragmatism instead of ideological determinism (Cloete, 2000:323 in 1999 Winelands Conference) . Any government trying to implement a policy as sensitive and as relevant as an HIV/AIDS policy needs to consider these best practices.



2.1 The literature search

The literature search for this chapter was based on books, newspapers, journals and the Internet. This was necessary for a number of reasons. First of all HIV/AIDS issues are contemporary and have been widely covered by a number of updated websites, newspapers, journals and books. Although this method is in agreement with the idea raised by Mouton (2001:91), Mouton tends to put more emphasis on scientific journals and books rather than the Internet per se. The researcher argues that most journals and literature sources covering HIV/AIDS policy implementation are now comprehensively covered by a number of active websites, including those of the World Health Organisation and United Nations AIDS Programme, which are periodically updated. These websites carry very recent and regularly updated information that is more relevant than books. This is because HIV/AIDS is a relatively new

disease with new issues about it coming up at a rate faster than books can be written and published.

2.2 The content of the literature review

The content of the literature review has been built around the implementation of national HIV/AIDS policies for the various countries selected. This is in agreement with what Mouton (2001:91) recommends namely that literature review content should be built around the problem statement.

The implementation of policies as a form of national response to HIV/AIDS is more difficult than the formulation of such policies. Many countries have had to formulate and implement policies integrated with existing health care services in order to meet the challenge. The following case studies of three countries in Africa and Brazil explain the point.

2.3 HIV/AIDS policy implementation in Uganda

Uganda has had a significant HIV/AIDS epidemic since the early 1980s. It is a relatively small country with a population of about 25 million and limited resources, with almost half the national budget funded by donor countries and international agencies. In the 1980s and 1990s some towns had as much as 30 percent of the adult population infected with HIV. This triggered a response from the president and the government through formulation of policies to enhance prevention of HIV and treatment and care for the infected. This response spread to all sectors of society and involved the creation of awareness through school curricula, FM radio stations, television and billboards. In addition, a project has been implemented to treat opportunistic infections and tuberculosis. Drugs for these infections have been delivered even to non-governmental healthcare facilities. All this has been stated by the Ministry of Health of the Republic of Uganda in the documents on the official website. (Republic of Uganda, Ministry of Health Online-Policies and Programmes, www.health.go.ug June 1 2002).

Formulation and implementation of appropriate policies backed by political commitment is key to a successful fight against HIV and AIDS. In Uganda the presence of a conducive policy environment supported by a legal regime and willingness on the part of the government to support the programme has been very helpful in policy implementation (Nsubuga et al, 1998).

The implementation of HIV/AIDS in the management of health care services was started in the 1980s. This involved treatment efforts, research, prevention and care for the terminally ill as well as their families. Some of the roles of the conventional public health care system were also delegated to other non-governmental organisations and religious groups. Procedures like pre- and post-test counselling were widely availed through existing health care services and by collaboration with non-governmental volunteer organisations like The Aids Support Organisation (TASO), the Aids Information Centre (AIC), churches and mosques. Volunteers were allowed into hospitals to cover areas that the limited resources of the public hospital system could not cover (Piot, P. Sowetan Tuesday July 2, 2002).

The HIV tests for patients and those who wanted it voluntarily were availed throughout the public and non-government health sector at almost no cost to the consumer. Hospitals and clinics worked together with local churches, mosques and civic groups to provide accessible premarital tests and counselling. Health workers were not the only custodians of HIV-related care but other non-medical volunteers were co-opted to assist.

The national government viewed the non-governmental sector as partners rather than competitors. The NGO sector was allowed to operate within hospitals to provide counselling, follow-up of patients and provision of home-based care.

Because of the lack of resources to purchase condoms for all who needed them, the emphasis was put on abstinence; voluntary tests and the responsibility of buying condoms lay with the individual. This was contrary to many trends where people thought that provision of free condoms was a solution. Free condoms were only given to people who were known to be

positive, soldiers and university and college students.

The health care providers were trained in the treatment of AIDS-related diseases in the hospital whereas lay people were trained to manage these in a home setting. This reduced the burden on the health care system and created a force of helpers within the community who acted as agents of change and reduced the burden on the health care services.

There was never suspicion or negative interference between the health care workers and the political leadership as far as the scientific issues of HIV causation and management are concerned. The Ugandan president, Yoweri Museveni, is dedicated to promoting dissemination of information and advising the various arms of government in dealing with AIDS. He created an active national AIDS commission situated in the president's office. This created an atmosphere with no ambiguity and encouraged the combining of various efforts to deal with the issue as stated in the article "HIV in Africa: the epidemic continues" (Nsubuga et al 1998).

Research issues gathered momentum and many Ugandan hospitals and medical institutions collaborated with western counterparts to research various aspects of the disease. During the early part of the epidemic when the HIV tests were still expensive, the Ugandan government encouraged health care workers to use the World Health Organisation's classification in reporting AIDS cases. These were then compiled in a quarterly report, which was periodically released to the public, indicating reported cases by health care facility and district. The data was used to establish trends over a period of time and to create awareness.

The Uganda national HIV/AIDS policy was not too prescriptive and allowed the health workers to improvise without being out of line. The government, in collaboration with other international agencies like the Centres for Disease Control and Prevention (Atlanta, USA), Mildmay International, Makerere University and other NGOs, has provided facilities for research, care and training in the field of HIV/AIDS management. Evidence of the national HIV/AIDS policy in Uganda in any given hospital includes a dedicated regular program to treat AIDS patients through AIDS clinics, free voluntary HIV/AIDS

counselling and testing and involvement of non-governmental organisations in patient support.

All the national HIV/AIDS policies in Uganda are limited by the fact that the government spends about 5 US dollars per person per year on health compared to 96 US dollars per capita in Brazil. Uganda has a Gross Domestic Product (GDP) per capita of less than 350 US dollars compared to 2200 US dollars per capita in South Africa. The successes recorded in bringing down the rate of infection have happened against these odds.

According to Mr Mike Mukula, the Ugandan Minister of Health (2002), as quoted on the official ministry website, the implementation of these policies has resulted in reduction of HIV prevalence rates from 14 % in the early 1990s to less than 6% at the moment; the increase in the age at which teenagers have their sexual debut from 14 years in 1989 to over 16; condom use with non-regular partners from 57.6% in 1995 to 76% in 1998 and a reduction in numbers of men who have sex with non-regular partners (www.health.go.ug; www.newvision.co.ug July 14 2002).

2.4 HIV/AIDS policy implementation in Senegal

Senegal is an example of an African country that addressed the HIV/AIDS epidemic at an earlier stage by implementing deliberate unambiguous policies. It is a predominantly Islamic state that opted to educate people and provide preventive services to all who were at risk. This included the treatment of sexually transmitted diseases, the education and provision of condoms to sexual workers and use of existing social structures to create awareness about the disease. This has meant that Senegal has kept HIV at a level less than 2% percent of the population while in other countries the level of infection has kept on rising. Senegal is the only African country that has managed to keep the prevalence of HIV at a level below 2% over a prolonged period and at less than 12 % among prostitutes, as established in the findings of the national surveillance system (Lamptey et al 1998).

2.5 HIV/AIDS policy implementation in Brazil

Brazil has significant numbers of people with HIV/AIDS. It has a population of about 170 million and a Gross National Product per capita of about 6840 US dollars. The Brazilian policy on HIV/AIDS and health care in general has been more organised than those of most other developing countries and this was a result of deliberate and comprehensive action by the government. The federal constitution of 1988 deals with health as a right to all and a responsibility of the state. By 1997 Brazil had more than 103,262 cases of AIDS reported and more than 500,000 with HIV. By 2001 the reported AIDS cases were 200,000. Most inpatient hospital services are provided under a system of public reimbursement for services by private entities and 80 % of all hospitals are private. The public sector on the other hand provides for 75% of all outpatient care services. This public-private arrangement has ensured that a large percentage of the population has easy access to health care with both public and private sectors playing distinct but complementary roles (Brazil, Country Health Profile (PAHO/WHO), 2001)

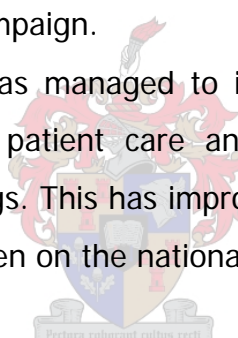
Brazil has implemented HIV/AIDS policies based on the premise that prevention and care are inseparable. The government has implemented a process, which provides HIV positive individuals access to HIV/AIDS treatment in the public hospital system (Piot. Sowetan Tuesday July 2, 2002). The antiretroviral drugs, preventive efforts and health promotion have been provided by the government. The government has started a manufacturing process for generic drugs used in the management of HIV and AIDS-related diseases. These drugs have been availed in the health care system creating easy access for the patients.

The government introduced a law that permitted Brazilian companies to manufacture cheap equivalents of drugs used in HIV and AIDS management if the patent owners failed to set up factories within Brazil in a three-year period. This enabled hospitals to stock relatively cheap generic drugs to manage the patients. In addition the government facilitated NGOs like Medicins Sans Frontiers (MSF) to access these drugs and these in turn provided them free of charge to patients. By June 2001 MSF had managed to

provide free AIDS drugs on an ongoing basis to more than 90,000 patients. The Brazilian President Fernando Henrique Cardoso defended the policy of ignoring patents as far as AIDS drugs are concerned. In April 2001 Brazil introduced a resolution at the United Nations Human Rights Commission, which called for universal medical treatment for people with HIV and AIDS. This resolution was overwhelmingly supported by all members of the Commission (Soares, 2002). The government has through treating and caring for AIDS patients almost wiped out morbidity due to AIDS as patients are now living a normal life despite their infection.

According to Darlington (2001), Brazil has managed to bring down the cost of AIDS drugs by providing them free. Brazil was manufacturing eight of the twelve available antiretroviral drugs by 2001. This has been possible due to a deliberate government policy to treat the victims and a vigorous preventive and awareness campaign.

In conclusion, Brazil has managed to implement nation-wide policies effecting prevention efforts, patient care and support and the deliberate provision of antiretroviral drugs. This has improved the quality of life for AIDS patients by reducing the burden on the national health care system.



2.6 HIV/AIDS policy implementation in South Africa

Section 27 of the South African Constitution (1996) includes the right to access health care services in the Bill of Rights. The same Constitution in Section 27 (2) puts the onus on government to achieve the full realisation of this right. This implies that implementation of good policies to deal with HIV/AIDS is not an option for the government but a constitutional requirement and a legitimate expectation of the government by the people.

The national HIV/AIDS policy in South Africa has not been coherent and consistent. There has been a problem with the nature of the national HIV/AIDS policy that has been different on paper from what is uttered by the President and his Minister of Health. This has become an obstacle despite the fact that there is a relatively good and well-established public service. The

current policy comes as a five-year strategic plan for the period 2000-2005, which is not very specific in most areas. However, it is the only guideline that can be used as the national standard to measure what has been achieved and what is yet to be.

The policy requirements regarding HIV/AIDS and issues in the implementation of a good national policy include prevention of HIV and sexually transmitted diseases, provision of treatment care and support for those infected and affected, the conducting of relevant research in the area of HIV/AIDS in relation to policy development, medical care and the accommodation of human and legal rights. All these should be carried out in the context of collaboration and interaction between government, the private sector, civil society and non-governmental organisations. In addition, the lead agencies in each area of implementation need to have fully equipped manpower in terms of knowledge, skills, financial resources and the facilities to carry out the tasks.

The negative publicity regarding the controversial stance by the South African President disputing the fact that HIV causes AIDS has done damage to the South African government in the area of HIV/AIDS. It has been stated that President Mbeki does not believe that HIV causes AIDS (Swan, 2001). In this regard there has been a problem with the nature of the national HIV/AIDS policy that has been different on paper from what is uttered by the President and his Minister of Health. This has resulted in caution when dealing with AIDS patients as health workers fear to be caught outside Government's rules. Where a medical superintendent has gone ahead and allowed a community Non-governmental Organisation to provide services and antiretroviral drugs to rape victims, the provincial authorities have responded by suspending the concerned official charging him with misconduct and eventually firing him (Smith, 2002; Altenroxel; 2002).

There cannot be good implementation of the HIV/AIDS policy in South Africa while the President's utterances disregard and oppose conventional wisdom and no attention is paid to the recommendations of experts in the concerned field. The views held by the President act like barriers to achieving

good policy implementation and are dangerous as they can lead to more AIDS cases which would have been avoided (Deane, 2003).

In the mid 1990s, the South African HIV/AIDS policy was dealt a blow by the discovery that over 14 million rand was spent on the development of a play which never took off. This badly dented the relationship between AIDS activists, the media and the government and led to negative publicity. Most of the people in the fight against AIDS viewed this as a waste of resources, and, moreover proper tendering procedures were not followed. Instead of solving the AIDS problem corruption was allowed to take root (PIMS, 2000. www.dogonvillage.com; Baleta, 2000).

Furthermore, the decision by the government to appeal against a court ruling which ordered the provision of Nevirapine to HIV positive pregnant mothers showed the determination of the government to stick to its unpopular decision of not using antiretroviral drugs. This has resulted in another ruling by the Constitutional Court ordering Government to provide the said drugs to pregnant women.

There is also an apparent lack of consultation and cooperation between the government and the people who live with AIDS as well as AIDS activists. This is because the government view has come to be perceived as being against conventional science. The controversy means that the national HIV/AIDS policy is less than clear.

The South African epidemic has been exacerbated by social and family disruption as a consequence of apartheid and migrant labour, high mobility due to good transport systems, high poverty, an overburdened health system and high levels of sexually transmitted diseases. This is further worsened by low status of women, shifting social norms permitting a large number of sexual partners and often lack of clear non-judgemental information and services for the youth (PIMS, 2000).

The implementation of HIV/AIDS policies in South Africa has therefore to be understood against the background of the above controversies and historical perspectives.

2.7 Summary of HIV/AIDS policy implementation in the countries considered

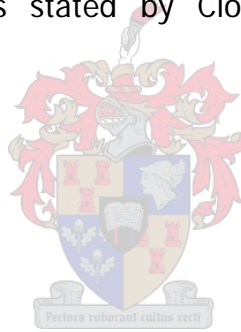
It is clear from the review that selected countries opted for different policy strategies to deal with the HIV/AIDS epidemic. Uganda used political as well as the community establishments in creating awareness. The national policy in Uganda and the openness and interest of the President in the issue facilitated other role players like non-governmental organisations and health workers to do their best with limited resources. The result has been increased awareness and availability of voluntary counselling and testing and a decline in new infections. This approach is in agreement with the most significant best practices as state by Cloete (2000). There was a visionary President who encouraged flexibility and pragmatism in a context of limited financial resources.

Senegal, on the other hand, emphasized early education and awareness about the disease besides addressing the issue of sex workers, despite the fact that it is predominantly Islamic. The result has been an increase in the number of people who are aware about the disease and the infection rate has not gone beyond 3% of the population for the last decade. The Senegalese context displays a high degree of prompt action, flexibility of handling sex workers in a predominantly Islamic state and clear goals and communication of messages to relevant population groups.

Brazil, which has more GDP per capita than Uganda and Senegal, emphasized the use of existing health services, both public and private, to provide free treatment to all AIDS patients. This, coupled with increased public awareness through vigorous prevention efforts has resulted in management of the epidemic to controllable proportions. Brazil used affordable financial management priorities and practices by integrating the management of HIV/AIDS within the existing health care service delivery system. This is in agreement with best practices in policy implementation as stated by Cloete (2000:323).

In South Africa the policy implemented in HIV/AIDS management has been shrouded in controversy owing to the President's denial that HIV causes

AIDS, a view that is contrary to conventional medicine. This dent into anti-HIV/AIDS effort is in addition to other scandals like the Sarafina II debacle where more than 14 million rand was used to promote a play, which hardly covered a tenth of the country. The efforts of the South African government to implement policies addressing the HIV/AIDS epidemic are fraught with scandals, rigidity and lack of pragmatism on the part of President Mbeki and the Minister Of Health. There is also the impression that the South African government cannot network and establish partnerships with other role players as some of the President's views are divergent from conventional medical science and are not in agreement with those held by the majority of the health experts in the field of HIV/AIDS care. The stance by the President and the repeated failures by government to give in to the demands of AIDS activists and health workers create an environment where the policy implementation strategies as stated by Cloete (2000) cannot be easily followed.



CHAPTER THREE: THE EMPIRICAL METHODOLOGY

3.1 Introduction

The empirical part of this study combined both quantitative and qualitative techniques. It has been stated by Creswell (1994:177) that the combining of the two approaches helps the researcher to better understand the concept being tested or explored. In this chapter the researcher describes both quantitative and qualitative techniques and the advantages for using them in this particular study. The chapter further describes the particular design of the study, the study population, sampling techniques, method of data collection, analysis, validation, reliability, issues of bias and peer review as well as ethical considerations. The study was officially supported and approved by the University of Stellenbosch, the Donald Fraser Hospital, the Vhembe District Health Department and the Limpopo Province Department of Health (see Appendices 8.4, 8.5 & 8.6: pages 80-82).

3.2 The quantitative phase of the study

The quantitative phase involved the developing of a questionnaire (see Appendix 8.1) to use as a tool to collect the data on the profile of the health workers as well as what they consider to be national HIV/AIDS policy and how much of such policy has been implemented in their respective practices.

3.2.1 The study population

The study population that offered the sampling frame was the complement of health workers in the Mutale area of Vhembe District in the Northern Province. The health workers referred to are the professional primary health care nurses who work in the 22 community clinics, the chief professional nurses who are heads of these clinics and the medical practitioners who work in the Donald Fraser Hospital, the district hospital that serves this area. The community clinics from where the health workers were drawn are Masisi, Tshipise, Manenzhe, Matavhela, Thengwe, Mulala, Rambuda, Tshikundamalema, Guyuni, Tshixwadza, Shakadza, Folovhodwe,

Tshiungani, Madimbo, Makuya, Vhuri Vhuri, Sambandou, Tshifudi, Tshaulu, Duvhuledza, Lambani and Mutale.

3.2.2 The sampling process

The sampling used in the quantitative process was random-stratified in nature. This involved the selecting of people in predetermined groups. There were two groups consisting of: a) professional nurses and chief professional nurses involved in patient care in the district and b) medical practitioners who work at the Donald Fraser district hospital. The complement of 44 professional nurses was drawn from the 22 clinics by randomly picking two from each clinic. This was done by gathering 22 groups of professional nurses from each clinic and then randomly choosing two from each of the groups. The second group of 4 nurses was randomly drawn from the infection control unit that deals with HIV/AIDS care and counselling at the hospital. Two medical practitioners were randomly drawn from the 9 medical practitioners at the hospital. This number gives a total of 50 health workers who constitute 10 % of the total establishment of all health workers in the district. The sample from the hospital was drawn from the Infection Control Unit that deals with HIV/AIDS counselling, treatment and follow-up of HIV positive patients in the hospital. The following table (Table I.1) describes how the various groups of health workers were sampled. The names from each of the groups were collected and by simple random sampling the respondents were chosen as is recommended by Lawrence and Schofield (1993:184-185). This was done for each of the 24 groups to get the samples.

TABLE 1.1: THE SAMPLING DETAIL

	NAME OF CLINIC/UNIT	PROFESSIONAL NURSES IN UNIT	RANDOM SAMPLE
1	MUTALE HEALTH CENTRE	16	2
2	TSHIPISE CLINIC	7	2
3	TSHAULU CLINIC	7	2
4	MANENZHE CLINIC	4	2
5	MATAVHELA CLINIC	4	2
6	RAMBUDA CLINIC	4	2
7	THENGWE CLINIC	4	2
8	TSHIKUNDAMALEMA	4	2
9	GUYUNI CLINIC	4	2
10	TSHIXWADZA CLINIC	4	2
11	SHAKADZA CLINIC	4	2
12	FOLOVHODWE CLINIC	4	2
13	TSHIUNGANI CLINIC	4	2
14	MADIMBO CLINIC	4	2
15	MASISI CLINIC	4	2
16	MULALA CLINIC	4	2
17	MAKUYA CLINIC	4	2
18	VHURI VHURI CLINIC	4	2
19	SAMBANDOU CLINIC	4	2
20	TSHIFUDI CLINIC	4	2
21	LAMBANI CLINIC	4	2
22	DUVHULEDZA CLINIC	4	2
23	INFECTION CONTROL	6	2
24	COUNSELLING	8	2
25	MEDICAL PRACTITIONERS	9	2
	TOTAL	129	50

The above table gives a summary of the numbers of units within the district from which samples were drawn by stratified random sampling.

3.2.3 Conducting a pilot study

Before the official process of data collection began a pilot study was conducted. This was done to test the questionnaire and ensure reliability as an instrument of conducting the study. This approach to testing the questionnaire is recommended by Neuman (1997:140) as well as Lawrence and Schofield (1993:184). Five health workers (10% of the sample population) who were not to be part of the study were asked to complete the questionnaire. As a result of this exercise, the questionnaire was revised to ensure that it was understandable and elicited what it was constructed for.

3.2.4 Method of data collection

Data for the quantitative phase of the study was collected by use of a questionnaire (see appendix 8.1) as is recommended by Brynard & Hanekom (1997:38). It had 5 major sections based on the National Strategic Plan for HIV/AIDS for the period 2000-2005 as put forward by the Minister of Health (RSA, Department of Health, 2000). This questionnaire looked at the implementation of the five aspects taken from the national HIV/AIDS policy in the various units and clinics in the district. The five sections were:-

- A) Profile of the respondent,
- B) Prevention of HIV,
- C) Treatment, care and support,
- D) Research,
- E) Guidelines for HIV positive health workers.

In the national policy the issue of prevention of HIV is comprehensively covered. It is the first priority area with six goals, which are: -

1) Promoting safe and healthy sexual behaviour by promoting health-seeking behaviour and safe sex practices, broadening responsibility for HIV prevention to all sectors of government and civil society, dealing with HIV among migrants, implementing counselling and care programmes for all national departments and improving access to male and female condoms especially among those aged between 15 and 25 years. The lead agencies in this effort are supposed to be the Departments of Health, Education and Labour, the Youth Sector and the NGOs.

2) Improving the management and control of STDs by ensuring syndromic management of STDs in the private and public sectors, collaborating with traditional healers to improve health-seeking behaviour for STD treatment and increasing access to youth-friendly reproductive health services.

3) Reducing mother-to-child transmission of HIV by improving access to HIV testing and counselling and family planning services as well as implementing treatment protocols to reduce HIV to babies.

4) Providing post-exposure services and medical management of women who have been sexually assaulted.

5) Providing treatment, care and support for those with HIV/AIDS

6) The conducting of research and providing a support programme for HIV-infected health workers.

The various respondents whose names were chosen through the sampling process were offered to take part in the study and those who were willing were gathered at a central point at the hospital and given enough time to fill in the questionnaires. These were then collected on the same day and taken for analysis. This was done by appointment with the various clinics in a manner that all clinics were covered on the same day to get the willing health

workers. There were no lost questionnaires as a result of the proactive method of collection.

3.2.5 Analysis of the quantitative results

The responses in the five sections of the questionnaire were analysed and the results were tabulated into various categories of tables and figures and assessed.

3.3 The qualitative phase of the research

The qualitative phase of study involved the use of 3 focus groups whose members discussed issues using already set guidelines covering various aspect of HIV/AIDS policy in South Africa. According to Britten et al (1995:104-112), the qualitative method especially using focus groups contributes to generation and development of themes as well as investigating beliefs and attitudes on the topic.

3.3.1 Sampling for the qualitative phase

The sampling was purposively done, drawing three groups of people from the three categories of workers, namely nurse managers in charge of community clinics, doctors and members of the overall management team based at the hospital. This resulted in the first group of 8 nurse managers, a second group of 7 doctors and a third group of 6 members of the overall management team which is in charge of the hospital and community clinics. According to Neuman (1997:206), purposive sampling is a non-probability method that is used to select people with a specific purpose in mind. The people selected should be knowledgeable and willing to talk about their experiences in the context of the group (Wood, 1992:29-39)

3.3.2 The pilot study for the qualitative phase

The questionnaire for the qualitative phase was piloted on a group of health workers who were not to be part of the study. All unclear issues were corrected and the method of data collection was also practiced. The process

of analysis was also tried on the pilot results.

3.3.3 The method of qualitative data collection

This involved the use of dictaphones in the focus groups to record the proceedings as a moderator took the gathered members through the qualitative questionnaire as set out in Appendix 8.1, page 73. In addition to the recording of proceedings, field notes were recorded by the moderator. The recorded information was then transcribed into an orderly transcript with all the proceedings as verbally expressed by members of each group. This is in agreement with the recommendations of Rubin and Rubin (1995:124)

3.3.4 Analysis of the qualitative data

The transcribed information was then colour-coded manually to group common ideas together and develop themes. The themes were then recorded in an orderly fashion with some quotations from the actual interview.

3.4 Limitations of the study

The sample of the health workers included only nurses and medical officers and excluded others such as physiotherapists and clinical social workers. This could mean that certain issues pertinent to the work of those cadres left out of the study were not analysed.

Secondly, the study area is one of the remotest parts of the country, which means that this alone could bias the results as the implementation process is expected to move slowly, given the remoteness.

Lastly, the whole of the studied district lies in the previously disadvantaged homeland of Venda, which means that the study was done in an area which is still catching up with the rest of the country in terms of capacity building, whence the delay in implementing the national HIV/AIDS policy.

CHAPTER FOUR: THE RESULTS OF THE STUDY

4.1 Introduction

This chapter has two sets of data, which include the results of the quantitative study and the results of the qualitative study. The quantitative results show the profile of the respondents and then the actual data about the study. The qualitative results on the other hand show the themes as generated from the focus groups.

4.2 Results of the quantitative phase of the study

4.2.1 The profile of respondents

The profile of the various health workers who participated in the study is summarised in Table 4.1 on page 25. The aspects looked at include the age, qualifications, position held at the time of the study, the period spent in that position and the community clinic or section in the hospital where that respondent is a health worker/ manager.



Table 4.1: THE PROFILE OF RESPONDENTS IN THE QUANTITATIVE PHASE

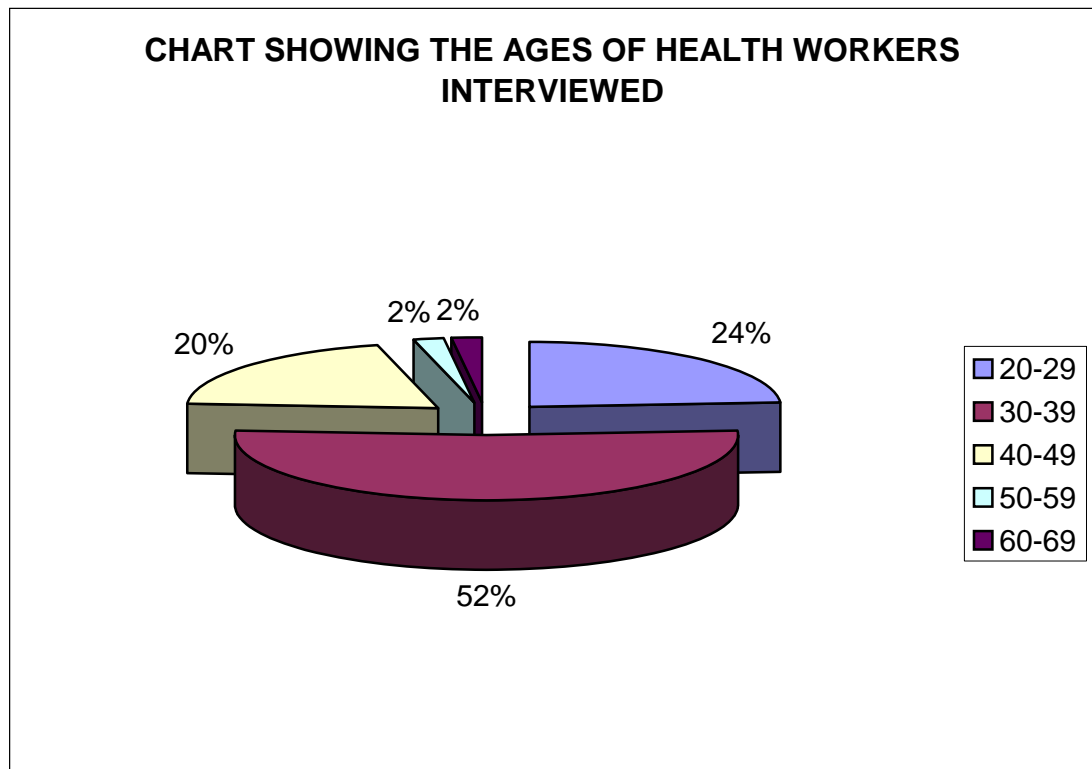
NUMBER	AGE	QUALIFICATIONS	POSITION HELD	PERIOD IN POSITION	CLINIC OR SECTION
1	48	2 DIPLOMAS	CPN	25	INFECTION CONTROL
2	43	4 DIPLOMA 1 HONOURS DEGREE	CPN	22	INFECTION CONTROL
3	26	DIPLOMA	PN	1	MULALA CLINIC
4	37	DIPLOMA	PN	3	MULALA CLINIC
5	26	DIPLOMA	PN	3	DUVHULEDZA CLINIC
6	34	DIPLOMA	PN	0.25	DUVHULEDZA CLINIC
7	38	DIPLOMA	PN	4	TSHIPISE CLINIC
8	37	DIPLOMA	PN	2	TSHIPISE CLINIC
9	32	DIPLOMA	PN	2	VHURI VHURI CLINIC
10	27	DIPLOMA	PN	3	VHURI VHURI CLINIC
11	34	DIPLOMA	PN	0.25	SHAKADZA CLINIC
12	39	DIPLOMA	CPN	5	SHAKADZA CLINIC
13	32	DIPLOMA	SPN	5	TSHIXWADZA CLINIC
14	43	DIPLOMA	PN	3	TSHIXWADZA CLINIC
15	29	DIPLOMA	SPN	1	MATAVHELA CLINIC
16	37	2 DIPLOMAS	CPN	4	MATAVHELA CLINIC
17	36	DIPLOMA	PN	1	MASISI CLINIC
18	29	DIPLOMA	PN	1	MASISI CLINIC
19	30	DIPLOMA	PN	1	MANENZHE CLINIC
20	24	DIPLOMA	PN	1	MANENZHE CLINIC
21	43	DIPLOMA	PN	2	LAMBANI CLINIC
22	36	DIPLOMA	PN	3	LAMBANI CLINIC
23	46	DIPLOMA	CPN	2	MAKUYA CLINIC
24	43	DIPLOMA	PN	3	MAKUYA CLINIC
25	32	DIPLOMA	PN	0.25	TSHIUNGANI CLINIC
26	35	DIPLOMA	PN	3	TSHIUNGANI CLINIC
27	64	3 DIPLOMAS	CPN	17	MUTALE H.CENTRE
28	50	DIPLOMA	CPN	10	MUTALE H. CENTRE
29	33	DIPLOMA	CPN	0.5	THENGWE CLINIC
30	31	DIPLOMA	PN	8	THENGWE CLINIC
31	43	DIPLOMA	CPN	1	TSHIFUDI CLINIC

NUMBER	AGE	QUALIFICATION	POSITION	YEARS IN POSITION	CLINIC
32	49	DIPLOMA	CPN	2	TSHIFUDI CLINIC
33	27	DIPLOMA	PN	2	RAMBUDA CLINIC
34	29	DIPLOMA	PN	3	RAMBUDA CLINIC
35	28	DIPLOMA	PN	1	MADIMBO CLINIC
36	33	DIPLOMA	PN	1	MADIMBO CLINIC
37	33	DIPLOMA	CPN	2.5	TSHIKUNDAMALEMA
38	30	DIPLOMA	PN	3	TSHIKUNDAMALEMA
39	43	DIPLOMA	PN	3	TSHAULU CLINIC
40	33	2 DIPLOMAS	SPN	3	TSHAULU CLINIC
41	28	DIPLOMA	PN	2	SAMBANDOU CLINIC
42	26	DIPLOMA	PN	4	SAMBANDOU CLINIC
43	32	DIPLOMA	PN	0.25	GUYUNI CLINIC
44	34	DIPLOMA	PN	3	GUYUNI CLINIC
45	32	DIPLOMA	PN	4	FOLOVHODWE CLINIC
46	36	DIPLOMA	CPN	2	FOLOVHODWE CLINIC
47	35	MBCHB/DIPLOMA	MO	8	D. FRASER HOSPITAL
48	28	MBCHB	MO	1	D.FRASER HOSPITAL
49	43	2 DIPLOMAS	CPN	5	COUNSELLING/ONCOLOGY
50	33	DIPLOMA	CPN	3	COUNSELLING/ONCOLOGY



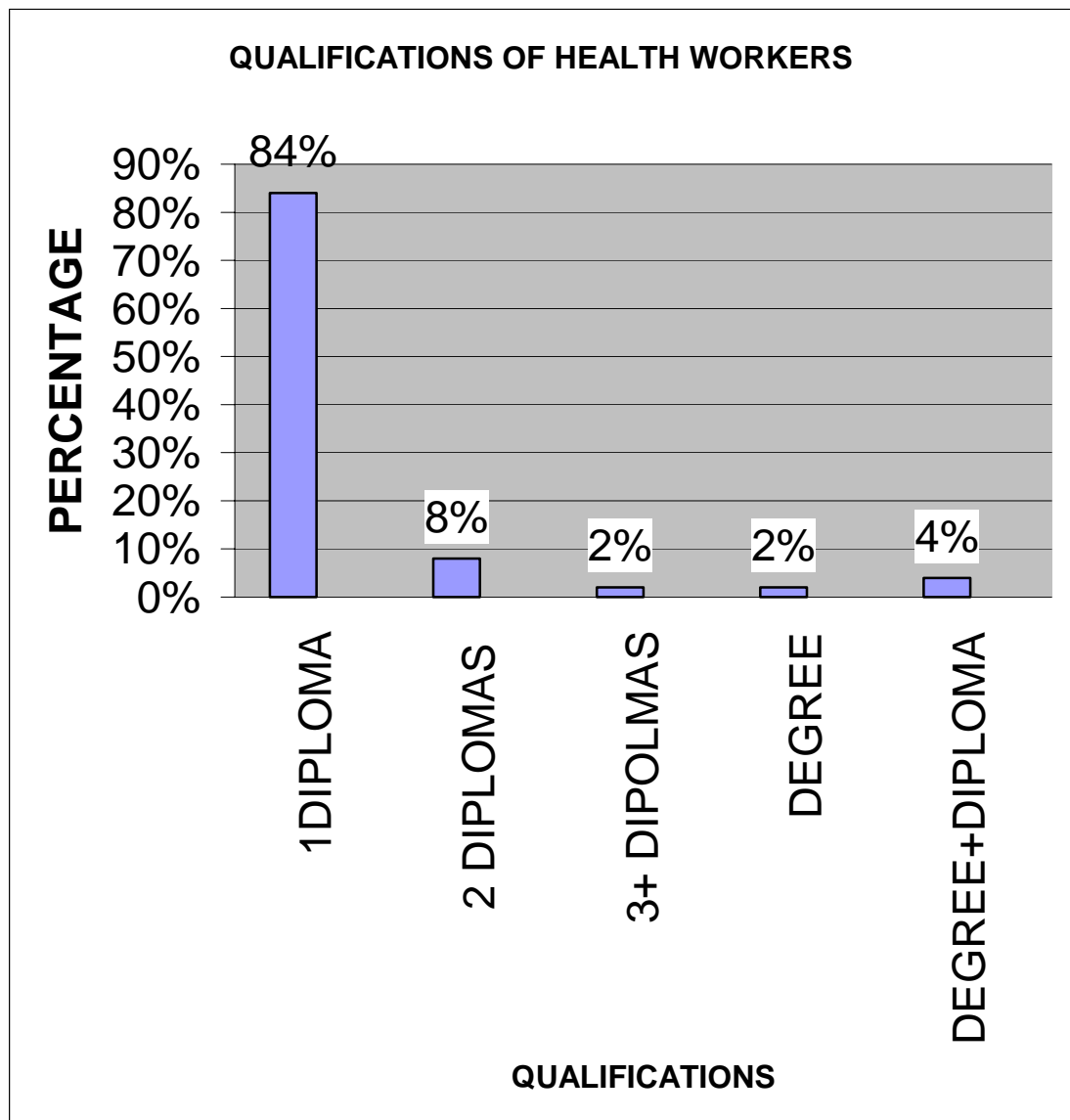
The table above clearly indicates that all the health workers (100%) interviewed held a diploma as the minimum qualification.

Figure 1: THE AGE OF THE HEALTH WORKERS INVOLVED IN THE STUDY



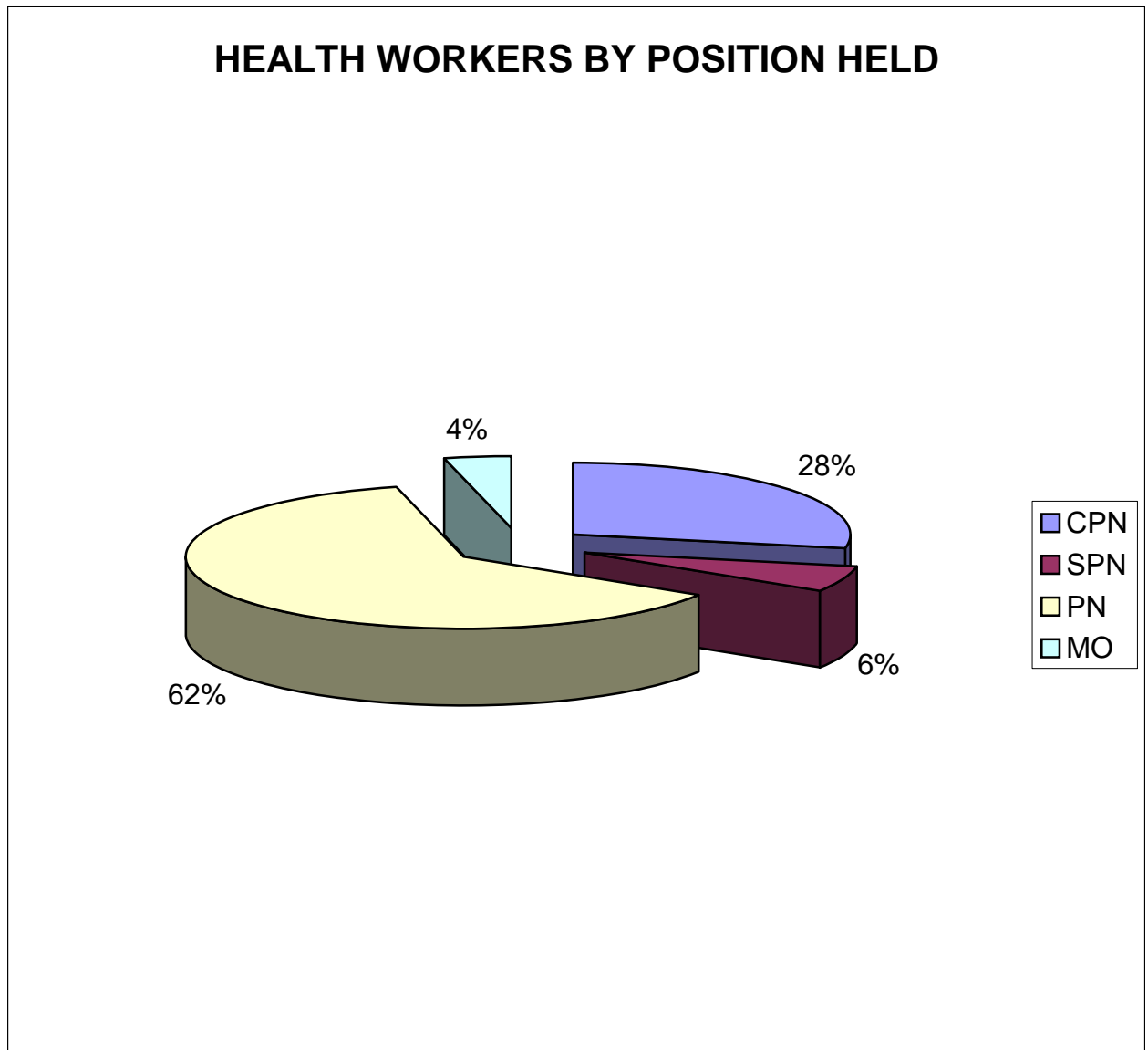
Fifty-two percent of the health workers involved in the study were aged between 30 to 39 years, 24 % were in the age range of 20 to 29 years, 20 % were in the 40 to 49 years range, 2% were 50 to 59 years and 2 % were 60 to 69 years old.

Figure 2: THE QUALIFICATIONS OF HEALTH WORKERS IN THE STUDY



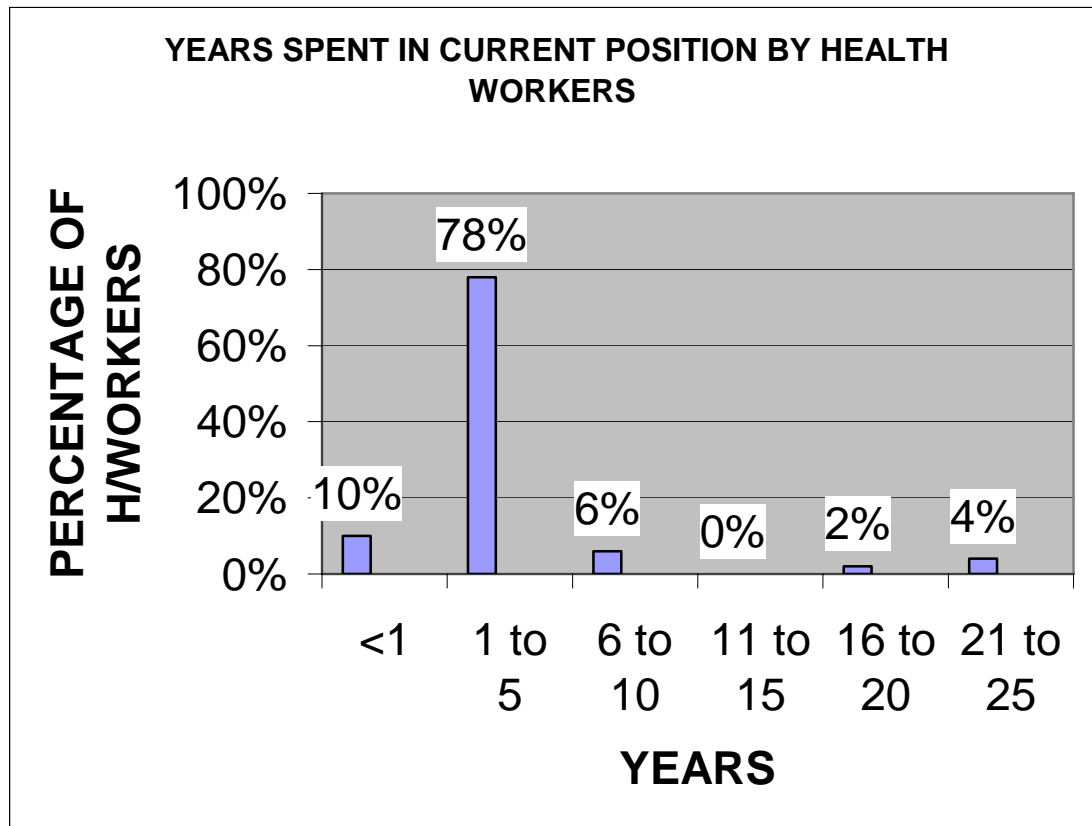
Of all the health workers involved in the study, 84% had a diploma, 8 % had 2 diplomas, 2 % had three or more diplomas, 2 % had a degree and 2% had a degree and diploma.

Figure 3: THE POSITION HELD BY HEALTH WORKERS



Of the health workers interviewed, 62 % were professional nurses (PN), 28% were chief professional nurses (CPN), 6% were senior professional nurses (SPN) and 4% were medical officers (MO).

Figure 4: YEARS SPENT IN CURRENT POSITION BY HEALTH WORKERS

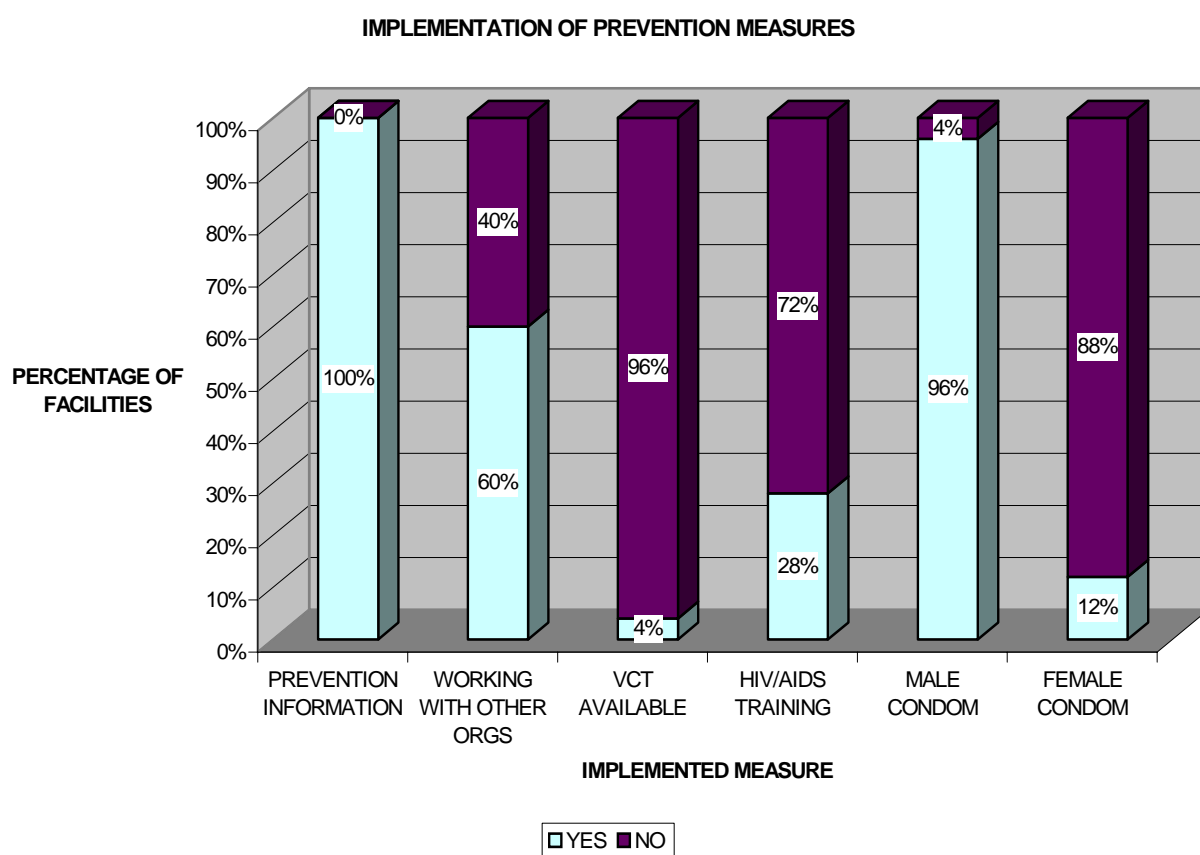


Of the health workers interviewed 78% had been in the current position for 1 to 5 years, 10% for less than 1 year, 6% for 6 to 10 years, 4% for 21 to 25 years and 2 % for 16 to 20 years.

RESULTS UNDER AREA 1, PREVENTION OF HIV

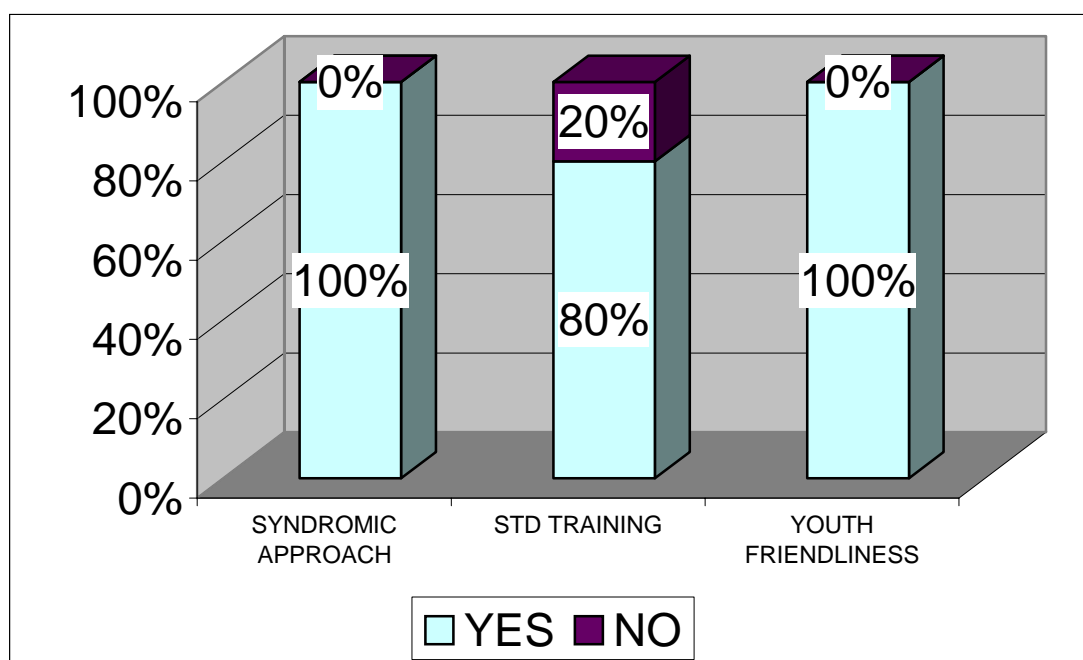
In the area of prevention of HIV, six areas were looked at. The respondents from the various clinics and sections indicated which aspects of prevention have been implemented. The results are summarised as follows;

FIGURE 5: IMPLEMENTATION OF PREVENTION MEASURES



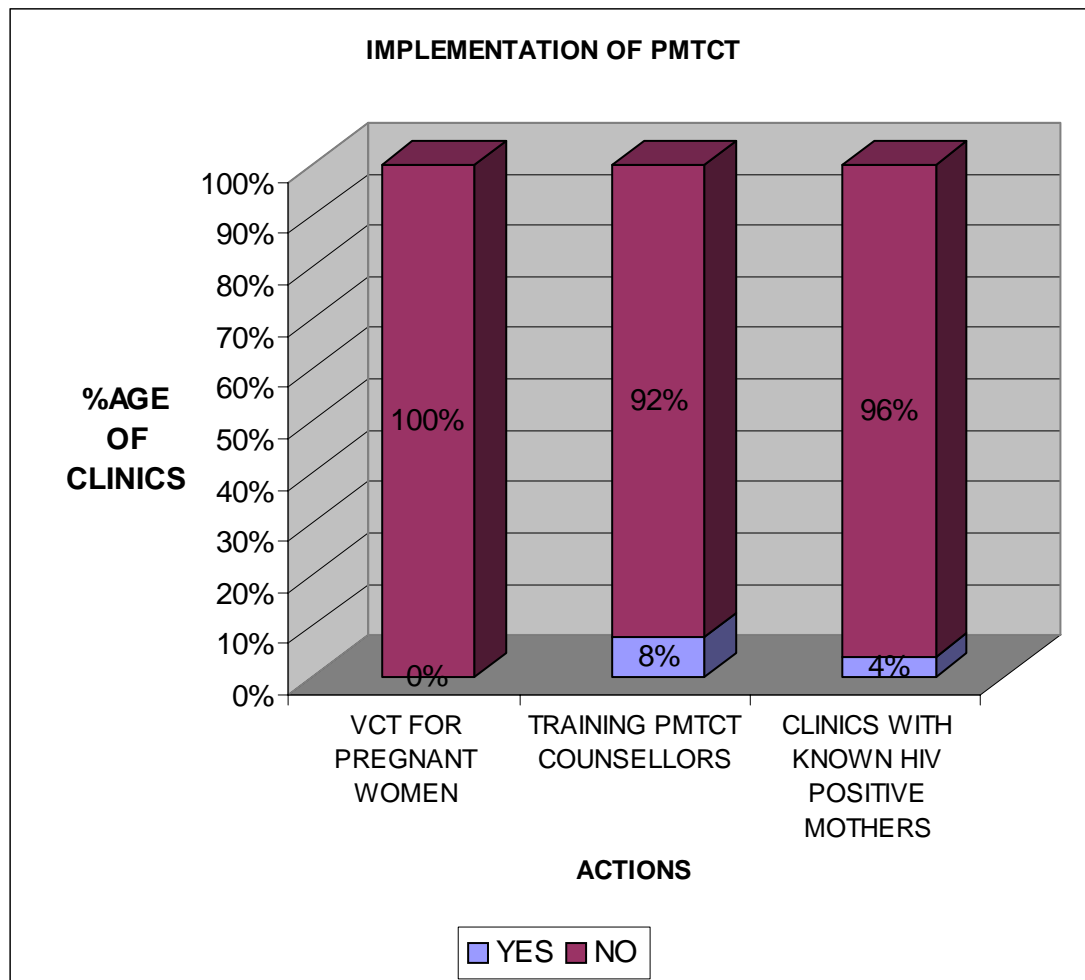
In all the clinics/facilities HIV prevention information is availed to patients, 60% of clinics work with other organisations in HIV prevention efforts, 4% provide voluntary counselling and testing (VCT), 28% have had staff trained in HIV/AIDS counselling and care, 96% have a constant supply of the male condom and only 12 % stock the female condom.

Figure 6: THE LEVEL OF IMPLEMENTATION OF THE STD CONTROL PLANS IN CLINICS



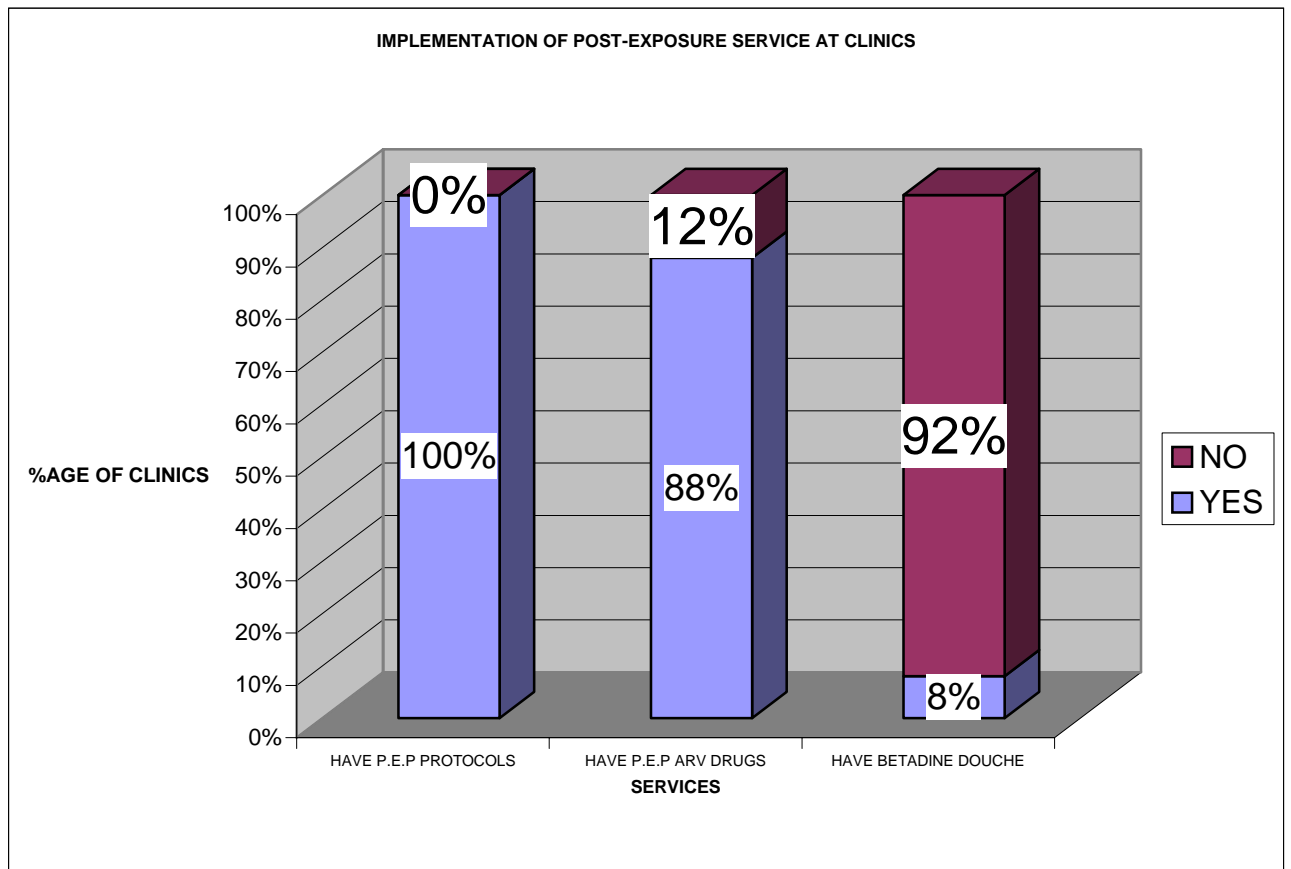
All clinics (100%) use the syndromic approach in managing sexually-transmitted diseases (STDs), 80% had staff who had undergone STD training and 100 % claimed to have youth-friendly STD care.

Figure 7: IMPLEMENTATION OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV



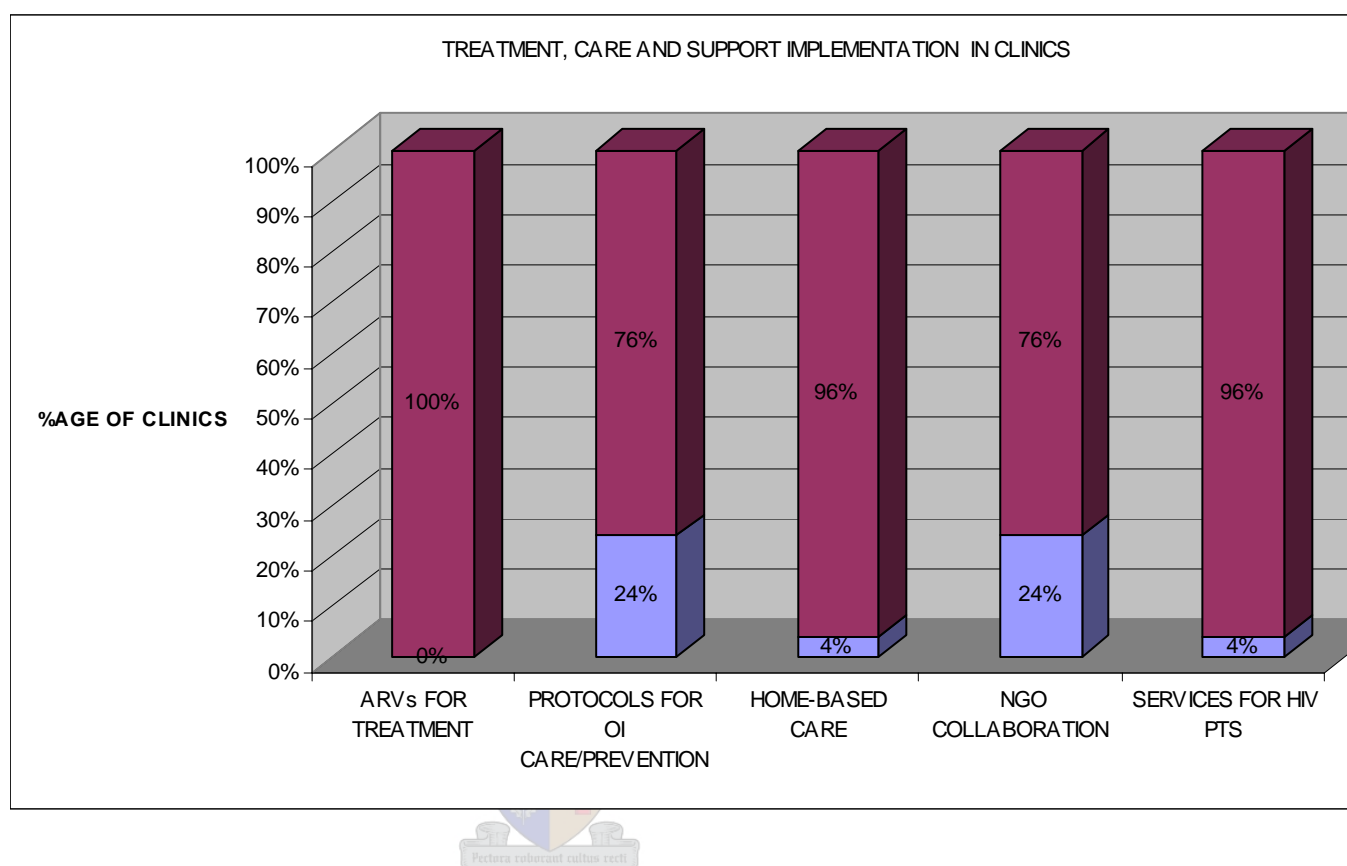
In this study none of the clinics had voluntary counselling and testing (VCT) dedicated to pregnant women, 8% of them had trained PMTCT counsellors and only 4% of these clinics had known HIV women attending antenatal care services.

Figure 8: IMPLEMENTATION OF POST-EXPOSURE SERVICES



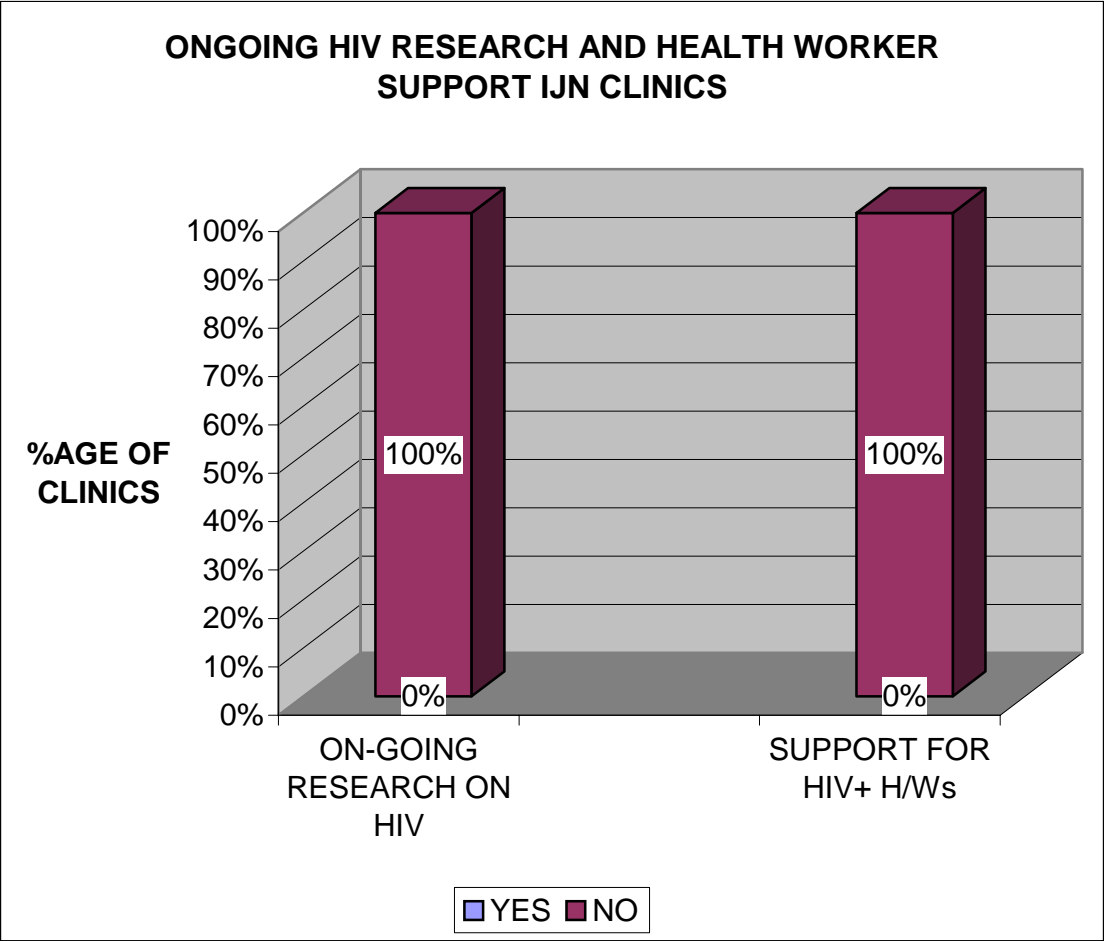
All the clinics had protocols for post-exposure prophylaxis (P.E.P.) for health workers, 88% of them had non-expired antiretroviral drugs for P.E.P. and only 8% had the Betadine douche used to treat women who have been sexually assaulted.

Figure 9: IMPLEMENTATION OF TREATMENT, CARE AND SUPPORT



All the clinics did not have antiretroviral drugs (ARVs) for patients, 24% had protocols for prevention and treatment of opportunistic infections, 4% were involved in some kind of home-based care, 24% were collaborating with non-governmental organisations (NGOs), and only 4% had some kind of services dedicated to HIV positive patients.

Figure 10: ONGOING RESEARCH AND HEALTH WORKER SUPPORT IN CLINICS



In the areas of ongoing research and implementation of a support programme for HIV positive health workers, none of the clinics involved in the study had any work going on in these two areas.

4.3 RESULTS OF THE QUALITATIVE PHASE

PART A: THE MAIN COMPONENTS OF THE NATIONAL HIV/AIDS POLICY

The main components of the national HIV/AIDS policy as perceived by the health workers who took part in the focus groups were developed into themes. These are summarised as follows:

4.3.1 PREVENTION

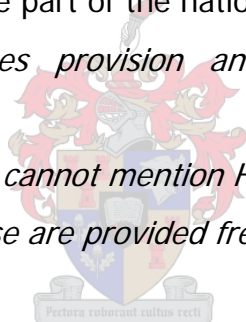
This was perceived to feature prominently in the national HIV/AIDS policy. A number of measures are believed by health workers to be part of the national policy. This is evidenced by measures mentioned which include:

4.3.1.1 CONDOM USE

Condoms were believed to be part of the national strategy to prevent HIV.

"The government encourages provision and use of condoms" (Nurse manager)

"It is becoming clear that you cannot mention HIV prevention without mentioning condoms and these are provided free of charge by Government." (Nurse manager)



4.3.1.2 FAITHFULNESS

Faithfulness in relationships is believed to be encouraged by the national HIV/AIDS policy.

"The national policy encourages faithfulness of an individual to one partner" (Nurse manager)

"Faithfulness is difficult to enforce, however government has made it clear that people should be faithful when in relationships to reduce the spread of the disease." (Doctor)

4.3.1.3 PRETEST COUNSELLING

Pre-test counselling was believed to be one of the emphasized points in the national HIV/AIDS policy.

"The national policy encourages pretest counselling for HIV tests and the observance of confidentiality so that individuals learn not to spread the disease without everybody around knowing that they are positive" (Hospital manager)

"Counselling before HIV tests has been encouraged by government and this is reflected by a number of facilities where we cannot test patients without proper understanding and written consent." (Nurse manager)

4.3.2 SOCIAL RESPONSE

The respondents perceived the national HIV/AIDS policy to emphasize the social response to those affected by HIV/AIDS. This was mentioned in various groups and these were some of the quotations:-

4.3.2.1 HOME-BASED CARE

The provision of home-based care for AIDS patients was believed to be part of national policy.

"The national HIV/AIDS policy encourages the provision of home-based care to the ill HIV positive persons." (Nurse manager)

"The issue of home-based care for AIDS patients has been mentioned by Government but a lot more needs to be done to help." (Nurse manager)

4.3.2.2 CARE OF ORPHANS

The care of orphans was believed to be part of the national policy.

"The government through its policies is encouraging the care and the provision of care to orphans". (Hospital manager)

"Orphans are a big issue when there is HIV and Government is encouraging their care though much more needs to be done." (Hospital manager)

4.3.2.3 PROVISION OF FOOD AND FOOD SUPPLEMENTS

The government policy on HIV/AIDS was also believed to include the provision of food to HIV affected people.

"The government through social workers is providing food to some of the HIV/AIDS patients". (Hospital manager)

4.3.2.4 SAFE GUARDING RIGHTS OF PEOPLE WITH HIV

The rights of individuals with HIV are perceived by the respondents to be safeguarded. The respondents made the following remarks:

"The government has emphasized the issue of non-discrimination and non-stigmatisation of HIV positive individuals." (Doctor)

"Confidentiality is emphasised and the privacy of HIV results is guaranteed by the national policy." (Doctor)

"The government has made sure that patients have to consent before being tested." (Nurse manager)

"The employees cannot be fired on the basis of their HIV status." (Hospital manager)

4.4 MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

The national policy has put emphasis on treatment and prevention of sexually transmitted diseases.

"The government has set in its policy the prevention and treatment of STDS as priority." (Nurse manager)

"The STD charts and drugs are available in our clinics since many of the patients we treat have STD problems." (Nurse manager)

"It has been made possible by government to treat all treatable STDs by provision of the drugs at the clinics where treatment is free." (Hospital manager)

4.5 CURTAILING THE NGOS

The national policy is perceived to discourage the NGOs from taking a centre stage in HIV/AIDS issues. A single example where government was in disagreement with an NGO seems to overshadow any good intentions that government may have towards NGOs.

"The government seems to discourage NGOs from participating in the process of care and this is evidenced by the attitude towards the Treatment Action Campaign and the NGO in Mpumalanga which was stopped from providing AIDS drugs to rape victims." (Nurse manager)

PARTS B & C: POLICY RESULTS: THE ACTIVITIES IN THE HEALTH FACILITIES RESULTING FROM THE NATIONAL POLICY ON HIV/AIDS

4.6 PREVENTION OF HIV

A number of measures have been implemented in the various health units as stated by the participants in focus groups.

4.6.1 HEALTH EDUCATION

Health workers in their various health units have implemented the issue of health education about HIV/AIDS.

"We always talk to our patients about HIV/AIDS in the clinics" (Nurse manager)

"We have been able to teach people how to use condoms." (Nurse manager)

4.6.2 CONDOMS

The various participants in the focus groups stated how the condoms have been provided.

"We have a continuous supply of condoms which are provided free of charge." (Nurse manager)

"We are giving our clients condoms." (Nurse manager)

"We have many people coming pick condoms." (Doctor)

"Even women are asking for female condoms." (Nurse manager)

"Free condoms are now available." (Hospital manager)

4.6.3 COUNSELLING

The issue of counselling came up as very important in implementation.

"We offer counselling to patients about HIV." (Nurse manager)

"Privacy of counselling has been reinforced." (Doctor)

4.7 CARE FOR PATIENTS

There seems to have been deliberate efforts to improve on care given to HIV/AIDS patients.

4.7.1 TRAINING HEALTH WORKERS

Some of the health workers have been trained to be able to manage HIV/AIDS patients.

"Some of us have been trained in provision of voluntary counselling and testing." (Nurse manager)

"We have had workshops to educate us on prevention and treatment HIV and AIDS and improving general care." (Nurse manager)

4.7.2 TRAINING VOLUNTEERS

There is a perception that health workers alone cannot provide adequate care to all the patients and therefore the need to get support in the community. And various steps have been taken in this direction.

"We have been able to train volunteers, care groups and patient supporters as well as community health workers and local NGOs in care issues." (Hospital manager)

4.7.3 PATIENT SUPPORT

There has been an observation that patient care and support have improved as a result of some of the aspects of the HIV/AIDS policy.

"The provision of food and disability grants to AIDS patients is a good policy which is helping our patients." (Hospital manager)

"The confidentiality of results has been emphasized and equality of all emphasized, despite status." (Hospital manager)

"We have been taught the rights of positive people." (Hospital manager)

4.7.4 HOME-BASED CARE

There has been a deliberate effort, according to the participants, to generate awareness about home-based care.

"Awareness about home-based care for AIDS patients has been created but there is need for more to be done." (Nurse manager)

4.7.5 IMPROVED PATIENT CARE

The participants observed the improvement in patient care as a result of some deliberate efforts to tackle certain problems in AIDS.

"In our district we have been able to start medications to prevent and treat opportunistic infections." (Doctor)

"Availability of Bactrim as prophylaxis against opportunistic infections for AIDS patients has been made possible and this means that AIDS patients can to an extent be protected against some of these devastating infections." (Doctor)

"Free Bactrim has been availed to patients." (Nurse manager)

4.8 OCCUPATIONAL HEALTH AND SAFETY

Most participants indicated how steps have been taken in their various health units to improve on occupational health and safety.

"We have had needle stick injury awareness and provision of antiretroviral agents (ARVs) but basically for health workers who could get exposed to HIV while on duty." (Hospital manager)

"We have packages in our clinics which contain the drugs Lamivudine, AZT and Indinavir in case a health worker gets needle stick injury." (Nurse manager)

"Employee safety has been put as a priority by emphasizing universal safety precautions for all health workers." (Hospital manager)

"Educational programmes in the area of employee safety have been implemented." (Hospital manager)

"Stocking of ARVs namely 3TC, AZT and Indinavir in our clinics for health workers who sustain needle pricks from infected patients has meant that better care is now available for health workers." (Nurse manager)

*"The national AIDS policy emphasized and ensured a safe work environment."
(Hospital manager)*

4.9 PART D:

GAPS IN THE NATIONAL HIV/AIDS POLICY WHICH IMPACT NEGATIVELY ON HEALTH CARE DELIVERY

The health workers participating in the study observed several gaps and negative spin-offs of the national HIV/AIDS policy which impact negatively general health care provision at the various health care facilities where they work.

There were issues that the health workers stated as confusing to them and to the general public. These issues stem from inconsistent statements made by the politicians in power and some officials in the Department of Health. There are other issues as well that are considered inadequate at the moment. All these issues are stated below:

4.9.1 DENIAL OF THE AIDS STATISTICS

There has been a constant denial about the extent of HIV in our society in South Africa.

"We often hear statements attributed to the president that HIV/AIDS is not responsible for the currently increased natural deaths among the young adults." (Nurse manager)

"We have heard that some politicians have said that HIV does not cause AIDS." (Nurse manager)

4.9.2 ANTIRETROVIRAL DRUGS

There were perceptions among the health workers that these drugs have been withheld from patients on the pretext that that they are dangerous.

"The national policy is quiet about the provision of ARVs to patients." (Doctor)

"The government has not put in its policy provision of antiretroviral drugs. People are being denied of working drug regimens." (Nurse manager)

"The government has not addressed the issue of provision of ARVs to rape

victims.” (Doctor)

“The government has refused to provide Nevirapine to pregnant women to protect their babies on the pretext that it is dangerous to them.” (Doctor)

“The government is slow to implement prevention of mother-to-child transmission of HIV.”(Nurse manager)

4.9.3 FEMALE CONDOM PROVISION

There was a perception that not enough has been done to supply the female condom adequately.

“There is a serious lack of consistency in the supply of the female condom.” (Nurse manager)

4.9.4 AIDS ORPHANS

There was a perception that not enough was being done on the ground to assist AIDS orphans.

“I think a lot has been said about AIDS orphans but not enough is done to assist them.” (Nurse manager)

“Proper care for AIDS orphans is still lacking and there is a lot still which needs to be done.”(Nurse manager)

4.9.5 CONFIDENTIALITY

There were aspects of confidentiality in HIV/AIDS which the health workers felt are not yet adequately addressed to enhance better provision of care to AIDS patients.

“We see in our area that confidentiality is over-emphasized that it is compromising support for patients. This is because those NGOs and other people who want to help do not have the information about who is affected. This acts as a hindrance to provision of support.”(Nurse manager)

“Even social workers fail to get access to these patients because of over-emphasis on confidentiality.”(Nurse manager)

4.10 PART E: OTHER NATIONAL POLICIES THAT ARE COMPLEMENTING THE NATIONAL HIV/AIDS POLICY

It was observed that some national policies are complementing the national HIV/AIDS policy and therefore helping those affected by the disease.

4.10.1 PROVISION OF DISABILITY GRANTS

The provision of disability grants to HIV/AIDS patients is seen as a way of helping these patients access basic needs of life without struggle.

"Provision of disability grants is helping these otherwise helpless people to get some money." (Hospital manager)

4.10.2 THE NATIONAL TB PROGRAMME

The National Tuberculosis (TB) Programme is seen as helpful to AIDS patients because it addresses one of the commonest problems in HIV/AIDS.

"The provision of good TB treatment regimens is helping AIDS patients deal with one of the most common infections among them." (Doctor)

4.11 PART F: OTHER NATIONAL POLICIES THAT ARE COMPROMISING THE EFFORTS IN THE NATIONAL HIV/AIDS POLICY

There are some national policies that are perceived to be negatively impacting on the national HIV/AIDS effort. In the following sections these policies are discussed.

4.11.1 THE ABORTION ACT

The allowing of women and girls as young as 13 years to abort without question and without the strong emphasis on counselling to address the risk of HIV was seen by the groups as undoing whatever prevention gains have been made.

"Girls as young as 13 are allowed to abort without question and this means that we are losing the moral control of irresponsible sex. HIV spreads through sex and of that we are already aware." (Hospital manager)

"It now appears that we are saying that pregnancy is more dangerous than

HIV by enacting this abortion thing. We are likely to have a society that is careless about sex and the result will be the spread of HIV.”(Doctor)

4.11.2 POOR POLICING AND LEGAL MEANS TO CURB CHILD ABUSE AND RAPE

The participants of the focus groups perceive the national policing and judicial services as inadequate to curb the spread of the disease through rape and child abuse.

“The police and the judicial systems are incapable of curbing the ongoing rapes and abuses of children. We already know that a lot of women and girls have got HIV this way.”(Doctor)

“The inadequate implementation of laws relating to rape and child abuse means that the disease will continue to spread irrespective of the current HIV/AIDS policies.”(Nurse manager)

4.12 PART G: OTHER ISSUES THAT HEALTH WORKERS SAID NEED TO BE ADDRESSED IN THE NATIONAL EFFORT AGAINST HIV/AIDS



There are issues that the health workers mentioned as needing attention and inclusion in the current national HIV/AIDS effort.

4.12.1 PROPER FACILITATION OF NGOS

The national government was perceived to be hostile to AIDS NGOs and sees them as competitors and threats rather than partners.

“The government should facilitate NGOs involved in HIV/AIDS care rather than competing with them in response to public needs. They should be trained to avoid poor performance and help coordinate their efforts to avoid duplication of services.”(Doctor)

“Some of the services, such as home-based care, should be allocated to local NGOs which have a better understanding of the local issues.”(Nurse manager)

4.12.2 COORDINATION OF NATIONAL DEPARTMENTS

The health workers mentioned the need to have the various departments in government coordinated to ensure a multi-sectoral response and therefore better impact on AIDS issues.

"The various sectors of government and society should be coordinated to help curb the disease."(Hospital manager)

"We should co-opt the various national departments and social sectors to fight against HIV/AIDS."(Nurse manager)

"There should be a multi-sector policy involving church people, the police, justice and other departments like education to address HIV/AIDS issues."(Nurse manager)

4.12.3 ADDRESSING POVERTY

The health workers expressed the need to address the levels of poverty that have a bearing on the spread of HIV.

"There is need for deliberate efforts to address the rampant poverty which helps HIV spread especially among the disadvantaged communities."

4.12.4 INCORPORATING HIV/AIDS IN HEALTH CARE TRAINING

There was a belief that more needed to be done regarding training health workers.

"All health workers should be trained in HIV/AIDS counselling and AIDS care."(Nurse manager)

"Emphasis should be put on the total care of AIDS patients when training health workers including social workers and dieticians."(Nurse manager)

4.12.5 PROVISION OF ARVs

The issue of ARVs came out in all discussions as something that needs to be addressed.

"All HIV positive patients who need to have Antiretroviral drugs should be given that opportunity."(Doctor)

"All public hospitals should stock ARVs for those who need them." (Doctor)

4.13 PART H: THE MAIN IMPACT OF THE NATIONAL HIV/AIDS POLICY ON HEALTH WORKERS

The health workers who took part in the focus groups observed a number of effects that result from the current policy at their places of work.

4.13.1 SAFETY AT WORK

The health workers reported a big impact of the national HIV/AIDS policy on safety at the work place in terms of protection from acquiring infections.

"There has been a big push towards protecting health workers by providing them with protocols on universal precautions when dealing with patient and body fluids and handling medical equipment used on patients." (Nurse manager)

"The national policy has meant that we have protocols to follow if one is injured and the ARVs have been stocked in all our clinics." (Nurse manager)

4.13.2 CONDOM PROVISION

The condoms have been observed as one tool government has availed to all without reservation.

"Condoms have been provided in almost all of our clinics on a continuous basis." (Nurse manager)

"The condoms are now always available and free of charge to all who require them." (Doctor)

CHAPTER 5: DISCUSSION OF RESULTS

5.0 INTRODUCTION

This study has been done in two phases both of which looked at the implementation of the national HIV/AIDS policy. The quantitative phase of the study gave factual information about what is on the ground in terms of the implementation process. This is in relation to what has been stated in the national HIV/AIDS policy as stipulated in the HIV/AIDS and STD strategic plan for South Africa, 2000-2005.

The qualitative phase of the study, on the other hand, brings out the perceptions and views of the health workers in a focus group context without limiting them through a rigid questionnaire, as was the case with the quantitative phase.

This chapter discusses the results of the study as generated from both phases.

5.1 DISCUSSION OF RESULTS OF THE QUANTITATIVE PHASE

The findings of the quantitative phase brought out a number of issues which are both important and indicative of how far implementation of the national HIV/AIDS policy in South Africa has progressed in the case study. The results show how the national policy has been implemented in terms of staffing, implementation of prevention efforts such as proper management of STDs, prevention of mother-to-child transmission of HIV and post-exposure prophylaxis for health workers. Other issues examined in the study are treatment, care and support for HIV/AIDS patients and relevant research. The findings of this study come against a background of denial on the part of Mr Mbeki, the President of South Africa, that HIV causes AIDS. This reluctance by the President to admit that HIV causes AIDS may have an impact on the way implementation of HIV/AIDS policies takes shape. In countries such as Uganda and Brazil, where Presidents and the political leadership have played very constructive roles, the implementation of HIV/AIDS policies has been positively enhanced and the result has been a notable reduction in the suffering of HIV/AIDS patients.

5.1.1 Staff profile

All the health workers interviewed from each of the 25 healthcare facilities were fully qualified professionals with a minimum of at least a diploma for registered nurses while some had a bachelors degree. This is in agreement with national standards that at least each of these primary care facilities should have qualified personnel for each relevant category of cadres. This means that the people responsible for implementing the policies in prevention, treatment and care are qualified enough. Appropriate and sufficient human resources with the appropriate know-how to implement policies in these health care facilities are available. As reflected in the results, 100% of those who are nurses have diplomas and 10 % of these have at least 2 diplomas.

Secondly, 96 % of the staff interviewed are 50 years or younger, which means that they will see through the national strategic policy of 2000 to 2005 to its completion. This augurs well for the policy implementation in the case study because the health workers will have at least 15 years or more in the service before reaching retirement age. They are all still trainable in areas relevant to the national HIV/AIDS policy implementation.

On the side of experience, 88% of the staff have served as health workers in their present ranks for 5 years or less. These staff are still trainable and many of them are already conversant with the HIV/AIDS issues. It is much easier to change those who have not overstayed in the service, as they will be willing to take on new skills as opposed to those who are just waiting for retirement.

In terms of specific training for HIV/AIDS counselling and care, only 28 % (7 out of 25 clinics) of the facilities had had at least a staff member trained. This means a lot more needs to be done in this area to make sure that there are staff trained specifically to handle HIV/AIDS issues.

Of all the health workers interviewed only 28 % have had any form of training in HIV/AIDS care and 88 % of these have been in the current position for 5 years or less. This means that the current training of these health workers while in training colleges or during the in-service training does not address HIV/AIDS issues, and yet this is the biggest health problem the country faces.

5.1.2 Implementation of HIV prevention measures

For HIV/AIDS policy to be beneficial, there is need to have a very significant component addressing prevention of the disease, given the fact that up to now there is no cure. This has been reflected to an extent in the national HIV/AIDS policy in South Africa and has been to an extent implemented in the various health care facilities from where the interviewees in this study were drawn.

All the facilities in this case (100 % or 25 facilities) had implemented the provision of HIV prevention information to clients who attend there and 60 % of them were involved with other organisations in HIV/AIDS awareness. The involvement of public facilities or institutions with other agencies or organisations in the community is within the context of the national HIV/AIDS policy as mentioned in goal 1 of priority area 1 (Republic of South Africa, Department of Health. HIV/AIDS & STD Strategic Plan for South Africa, 2000-2005:14).

The thesis revealed that despite the national policy putting emphasis on increasing the number of VCT sites and increasing the number of persons seeking VCT as stated in Goal 6 of Priority area 1 (HIV/AIDS & STD Strategic Plan for South Africa 2000-2005: 16), 96 % of the facilities where interviewees were drawn are not involved in provision of VCT services. This should be understood against the backdrop of some of these primary health care facilities being about 100 kilometres from the hospital where VCT services are available.

Very few people can afford to travel this distance just for VCT services. According to Sangiwa et al (1998) proper VCT can act as an intervention to reduce HIV transmission. This implies therefore that the failure to implement proper VCT near to the people in the clinics is a disservice to the people and to prevention efforts. According to Avelino F.L. et al (1998), linking STD-AIDS services with primary health care is important in dealing with the epidemic. It has been reported that this approach leads to better acceptance of these services by the populace. The data collected shows that the implementation

of the national HIV/AIDS policy needs to be extended to the level of the health facility nearest to the people as far as VCT provision is concerned. On the other hand condoms are part of the national HIV/AIDS policy as stated in the HIV/AIDS and STD Strategic Plan for South Africa 2000-2005 (2000: 14) under priority area one and the government commits itself to providing these in all public health services and government buildings. It is a positive indication that in 96 % (24 of 25) of the facilities from where the interviewees were drawn, male condoms were always available. The implementation of condom provision has been slow on making female condoms available as this study reveals that only 12 % of the facilities had the female condom available. The unavailability of the female condom in most of the clinics indicates the gaps in the women's HIV prevention services. It has been mentioned by Edwards (1999) that these gaps and unmet needs for women are a reality. This sexist implementation as far as condoms are concerned indicates that in order to avoid contradiction with the national policy which advocates for improved access to and use of both the female and the male condom, more gender balance is still very necessary.

5.1.3 Management of sexually transmitted diseases

It is known that proper management and control of STDs to a certain extent reduces the risk of transmitting HIV (Ballard et al 2000:52). The national policy puts emphasis on building the capacity of health professionals to provide comprehensive HIV/AIDS and STD treatment, care and support (HIV/AIDS and STD Strategic Plan for South Africa 2000-2005 (2000:14-16). In this study it was found that 100 % of the clinics or facilities studied had implemented the syndromic management of STDs as recommended nationally and 80 % of these had implemented the training of staff in the same. In addition 100 % of the clinics had implemented youth-friendly STD programmes. This is a positive sign of how the implementation process is being executed, given the fact that STDs have an impact on HIV transmission. Proper management of STDs as part of the HIV/AIDS policy leads to provision of more appropriate health care once implementation takes place. In addition,

the risk of transmitting HIV in the community is reduced. The impact of the policy when properly implemented on HIV transmission and STD prevention will be enormous. The fact that condoms have an impact on both HIV and other STDs means that implementing condom use correctly and extensively can reduce the two problems. According to Ballard et al (2000:2) condoms should be made available in all facilities providing STD management services because they reduce the risk of infection considerably even though they are not an absolute protection.

5.1.4 Prevention of mother-to-child transmission of HIV

It is saddening to note that at the time of this study all the facilities (100 % of the 25 clinics) had no programmes to prevent mother-to-child transmission of HIV and there was nothing being done to reduce this already existing risk. It has been observed that the risk of the mother transmitting the virus to the baby during and after pregnancy can go above 25 % among HIV infected women (Anderson, 2001:232). Interventions for this kind of transmission are already known (Anderson, 2001: 244), and the national HIV/AIDS policy emphasizes the implementation of clinical guidelines to reduce mother-to-child transmission of HIV (HIV/AIDS & STD Strategic Plan for South Africa 2000-2005:15). It is further revealed that of the 25 facilities involved in the study only 2 out of 25 (4 %) had counsellors trained in prevention of mother-to-child transmission of HIV. Furthermore the lack of VCT services in peripheral clinics means that very few women know their HIV status while pregnant since most of them in the case study deliver at the primary health care clinics where VCT services are not available. It is therefore not surprising that only 2 out of 25 facilities (4 %) had known pregnant women with HIV attending the antenatal care services. Most of such women come from the cities where this has already been implemented, or they have taken the personal initiative to know their HIV status. Some of the interventions known to prevent mother-to-child transmission are cheap and can be easily integrated into the already existing health services. For example, the provision of single-dose Nevirapine to a pregnant woman during labour and

provision of a single dose of the same drug to the baby in the first 72 hours of life reduces the risk of transmission tremendously. This is very easy to integrate in existing health care services in South Africa because it is cheap and the majority of the women in the country deliver within the health care facilities.

5.1.5 Post-exposure prophylaxis

In the national HIV/AIDS policy the issue of protecting workers from acquiring the HIV infection from their patients is addressed both in the private and public sectors and it is stipulated therein that services for needle stick injuries and occupational exposure should be made available (HIV/AIDS & STD Strategic Plan for South Africa 2000-2005:16). The risk of health workers acquiring HIV from their patients exists and as of October 1998 there were 187 known such cases in the United States of America (CDC, 1998) and 264 cases worldwide (Ippolito, 1999). This finding makes the implementation of the post-exposure services very relevant.

In this study 100 % (all 25 facilities) had implemented the protocols for post-exposure prophylaxis and 88 % (23 of 25 facilities) had stocked non-expired antiretroviral drugs for the prevention of HIV infection in health workers who get exposed to infected material. This is a step in the right direction and is in agreement with the national policy.

It was, however, clear from the study that only 8 % (2 out of 25) of the facilities had interventions to prevent acquiring HIV after rape. The intervention in these 2 facilities is basically the use of a Betadine douche immediately after a woman has been raped. There is more that could be done to reduce the risk of acquiring HIV for raped women. This could include use of antiretroviral drugs.

5.1.6 Treatment, care and support of HIV patients

The most striking thing about the national HIV/AIDS policy is that it mentions the use of ARVs when dealing with post-exposure prophylaxis but is quiet about the use of these drugs in prevention of mother-to-child transmission

and treatment of HIV patients. Indeed none of the facilities have any of these drugs for the two mentioned areas of care.

On the issue of having services dedicated to HIV positive people, only 4 % (1 out of 25) had that arrangement. Secondly, only 24 % (6 out of 25) of the facilities had available protocols for the prevention of opportunistic infections. This means that HIV positive patients are still left to acquire otherwise cheaply preventable opportunistic infections.

At the time of the study, none of the facilities had got involved in any kind of home-based care within the community and yet this would reduce the number of patients seeking care for every little medical problem. Only 24 % (6 out of 25) of the facilities had shown interest in a home-based care arrangement by collaborating with NGOs within the community. The national policy on the other hand emphasizes the need to establish strong links between health facilities and community-based support programmes (Republic of South Africa, Department of Health, HIV/AIDS & STD Strategic Plan for South Africa 2000-2005:17). This shows that a lot more needs to be done to facilitate and implement home-based care programmes in the community to be able to meet the needs of many patients without necessarily putting the burden on the available services and beds in the public health sector.

It is already apparent that HIV/AIDS is becoming a major cause of death in South Africa especially among the reproductive age groups, as evidenced by the data from cemeteries and the death register (Dorrington et al, 2001:18).

5.1.7 Research, monitoring and surveillance

The national HIV/AIDS policy (Republic of South Africa, Department of Health, HIV/AIDS & STD Strategic Plan for South Africa 2000-2005: 19) encourages the use of research in vaccine development, on the use of ARVs in prevention of mother-to-child transmission, conducting of clinical trials, collaboration with traditional healers and the review of international research. A lot of work has already been done in this area in many countries from which the South African government can learn (McIntyre & Gray, 2002:218-220). The study

revealed that none of these facilities had any ongoing research in the area of HIV/AIDS in the any of the areas mentioned above. This calls for the encouragement of research in the respective areas within this particular district, given the fact that it is a very rural area in one of the remotest parts of South Africa.

5.2 DISCUSSION OF RESULTS OF THE QUALITATIVE PHASE OF THE STUDY

The health care workers who participated in the focus groups emphasized the issue of prevention as important in dealing with HIV and they perceived it to be prominent in the national HIV/AIDS policy. Prevention as an emphasis is important and it is very crucial for the nation when health care workers are aware of the most important steps to be taken to curb the disease. The main sub-themes developed under prevention during the focus groups are condom use, faithfulness and provision of pre-test counselling. These were considered essential by the health care workers, who call for the implementation process to acknowledge these as well.

The second theme generated in the focus groups was the social response. The health care workers perceived the national HIV/AIDS policy to be strong on the social response to HIV/AIDS and this contained provision of home-based care, care for the orphans, provision of food and food supplements and the safeguarding of the rights of people with HIV/AIDS. There was a distinction in the discussion between what they believed was government policy and what was implemented. There was a perception that not enough had been done in the area of social response as far as implementation was concerned. This is a sign that the policy implementation process in South Africa is still stagnant and is not meeting the needs of the people at the greatest point of need. The people were therefore let down in a manner that is almost identical to the way the Apartheid Government ignored HIV/AIDS before the 1990s (PIMS:2000)

The health care workers believed that the management of STDs is part of the national HIV/AIDS policy. A number of steps have accordingly been taken in

this direction. Due to the fact that all these clinics offer free health care services, availability of facilities and drugs to manage STDs means that patients can access these services freely. This is in agreement with the national HIV/AIDS policy (HIV/AIDS & STD Strategic Plan For South Africa 2000-2005:15).

The implementation of measures to curb other sexually transmitted diseases in addition to HIV is believed to be been done by provision of treatment protocols and drugs to manage these diseases.

The focus group discussions perceived the government policy on NGOs to be hostile. The health workers believed that Government dislikes AIDS NGOs and in certain instances has curtailed the services of these NGOs. This perception is not in line with what is stated in the national policy, which says that NGOs are lead agencies in several priority areas like prevention, treatment, care and support (Republic of South Africa, Department of Health, HIV/AIDS & STD Strategic Plan for South Africa 2000-2005:14-16). This means that Government still has to act in a manner that changes this negative perception about it in relation to AIDS NGOs. It has been found in countries like Uganda and others that much pioneering work in care and support for HIV patients has been done by the NGO sector either by mobilising international resources or by harnessing local aid budgets. This is because these NGOs can act rapidly and flexibly in response to new issues (Gilks et al, 1998:96). The South African government therefore needs to address these perceptions as national HIV/AIDS policies are implemented. This can only work in the general interest of the population. The perceived utterances by the South African president that HIV is not the cause of AIDS and the persecution of health workers, who go ahead and provide antiretroviral drugs with the understanding that HIV causes AIDS, can only be interpreted to mean that the political leadership is hindering effective policy implementation. As is already mentioned in the literature study, it is common knowledge that these HIV drugs improve the lives of patients as has happened in Brazil and Uganda (Guay et al, 1999:795-802).

Despite that negative perception about government policy towards AIDS

NGOs, there was some notable achievement by government that came up in the focus groups. This was the provision of disability grants to AIDS patients, health education at clinics, creating awareness about home-based care and the provision of occupational health and safety services for health care workers.

There were other perceived gaps in the national HIV/AIDS policy, which the health care workers described. This included the exclusion of ARVs in the care services, denial of AIDS statistics in relation to the death of young adults in South Africa and the delay in distribution of the female condom.

5.3 CONCLUSION

The prevention and management of HIV/AIDS is a national challenge and the implementation of the contents of the national HIV/AIDS policy in the management of health care services is very important.

This study has revealed that a number of aspects of the national HIV/AIDS policy have been implemented to the benefit of the population making use of the health services in the case study. This includes the provision of the male condom, the provision of drugs for control of STDs, the management of health care workers exposed to the virus and many others. However, a lot of aspects too in the national HIV/AIDS policy have not been implemented, such as the use of ARVs in the context of HIV care, on the pretext that research is needed. Such non-implemented aspects are delaying the meeting of needs of several people. The facilitation of and co-operation with NGOs fighting HIV/AIDS still remains an issue and the study reveals gaps in this regard.

The fact that health care workers take the prevention of HIV and the care of infected people as a serious issue and still find difficulty to meet some of the patients' needs means that the implementation process is not keeping the same pace as the evolving need in the health care facilities.

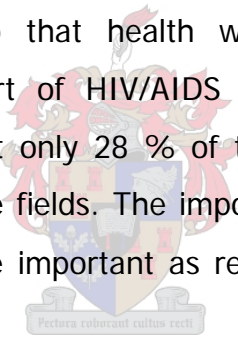
A number of policy issues relating to the health of women such as the provision of the female condom, prophylaxis after rape and PMTCT services are still lacking. This is reflective of a gender bias in the implementation of the national HIV/AIDS policy and calls for urgent action.

In order for the government to help both the population and health care workers overcome this challenge the national HIV/AIDS policy needs to be implemented quickly and effectively.

5.4 RECOMMENDATIONS

The national HIV/AIDS policy is aimed at dealing with the medical, social, economical and political issues raised by HIV/AIDS in the country. It is therefore important that out of this study recommendations as mentioned below, are made to improve the delivery of services in the area of HIV/AIDS prevention, care and support. These recommendations are stated in the following paragraphs.

There is need for government to implement a strong training programme in the health care services so that health workers can acquire skills in counselling, care and support of HIV/AIDS patients. This is urgent and important, given the fact that only 28 % of the facilities in this study had people trained in any of these fields. The importance of training in this area has already been found to be important as reported by del Rio (2003) and Weber (2001).



The government needs to implement the provision of voluntary counselling and testing (VCT) at the health facilities nearest to the people other than just at hospitals. This is because going to hospital in the case study may involve travelling more than 100 kilometres just to access the services. An example in the case study is that the nearest health facility to the hospital where VCT is done is about 30 kilometres and therefore the need to act quickly. This also calls for integrating VCT services in TB initiatives and the use of mobile units to reach the distant areas on a regular basis and the putting of more focus on the clinics in the community as points of service delivery for HIV/AIDS care (Naidoo, 2003; Fahlen, 2003).

The study reveals that the female condom is not yet widely available in the study area and many patients ask for it. This calls for urgent measures to popularise and distribute the female condom so that women can take charge of their own sexual health. This should be combined with the implementation of measures to enhance cultural changes to stop risky behaviour and cause changes in social and sexual lifestyles.

The management and control of STDs as part of the national HIV/AIDS policy is crucial in HIV/AIDS control. This therefore calls for the training of health care workers in syndromic management of STDs, especially those at the primary health care level where patients do not have to pay any money.

The fact that during the study no programmes to prevent mother-to-child transmission (PMTCT) of HIV were running at any of the facilities means that a lot more needs to be done in this area. It is already clear in many countries that effective options already exist to prevent the transmission of HIV from mothers to their babies, as has been indicated by McIntyre and Gray (2002). PMTCT needs to be widely implemented to act as a preventive effort for HIV/AIDS among children and also to serve as a way of educating women and the community about HIV/AIDS (McIntyre & Gray, 2000; McIntyre, 1996).

The linking of research and care in the management of HIV/AIDS is crucial if evidence-based practice is to be achieved. It is important to popularise this approach to care, especially in the primary health care settings. This will help keep health care workers abreast with evidence-based practice and improve the quality of care delivered through the health care system (Sanne et al, 2000).

The study found that within the health care system there was no programme to provide support for HIV positive workers. This means that steps have to be taken to address this need before many workers are lost. It is already

apparent that health care workers are at risk of acquiring HIV from their patients, in addition to the other modes of transmission prevalent in the general population.

The perception that Government dislikes AIDS NGOs is a real one, as brought out in the focus group discussions. This therefore calls for government to review its approaches when dealing with these NGOs, so that they can work together as partners, as stated in the national policy, and not as competitors.

The use of ARVs in HIV/AIDS care needs to be re-emphasized and not merely talked of in the area of research and post-exposure prophylaxis. The government through its policy needs to recommend these as useful drugs, as found in some of the current non-governmental ARV programmes such as the one of Medicins Sans Frontiers in Kyelitsha (Parder, 2003). This programme in Kyelitsha has already provided ARVs to more than three hundred AIDS patients, with very good outcomes. The only limitation should be cost and not Government's unwillingness to recommend their use. These drugs should be freely recommended and availed especially to those who urgently need them as Government devises means to avail them to the rest of the population (Dorrington et al, 2001:38; Chetty, A, 2002)

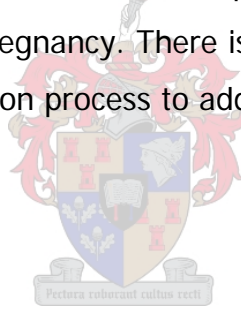
Defensive statements by Government, for example the denial of the HIV/AIDS statistics, do not enhance the drive to fight the disease. This issue is apparent in the results of the focus group discussions and calls for corrective action to avoid making statements, which disorganise the implementation process and confuse the population (Dorrington et al, 2001:38).

The care for orphans and the provision of home-based care are mentioned in the national HIV/AIDS policy, but according to findings of this study, health workers feel not much has been implemented in this direction. This calls for more elaborate measures to address these issues. There is already proof that if communities are helped with good policies and support, then the effort as

mentioned by Mukwaya (2003) can be successful.

Health workers mentioned the Abortion Act of South Africa as compromising the anti-HIV campaign because it gives young girls leeway to conceive and abort without necessarily consulting their parents. This Act should be revised to be in agreement with other laws in terms of consent, taking account also the age when one is still a child. This will help to include abortion services in the overall national HIV/AIDS prevention efforts.

The study reveals a degree of gender bias in the implementation process, putting women and children at a disadvantage. This is mainly evidenced by the issues around the female condom, lack of sufficient after-rape services and the reluctance of government to provide antiretroviral drugs to pregnant women; and yet this is the most effective option for women who find out their HIV serostatus during pregnancy. There is therefore need to add gender sensitivity to the implementation process to address the above issues.



BIBLIOGRAPHY

AIDS Foundation Of South Africa, AIDS in South Africa, 2002.
<http://www.aids.org.za/aids>. 30/06/2002, Musgrave, South Africa.

Altenroxel, A. 2002. Doctors' ethical dilemma around AIDS drugs. The Star Newspaper. <http://www.iol.co.za>. 12/12/2002.

Anderson, J.R. (ed) 2001. A guide to the clinical care of women with HIV. Rockville, Maryland: US Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau.

Avelino, F.L.; Borromeo, M.E.; Sanguisin, M; Wi, T; Mora, R; Capuno, M; Lanan, B; 1998. Integration of STDs-AIDS services to primary health care; a community-based approach. International Conf. AIDS, 1998. Geneva.

Ballard, R., Htun, Y., Fehler, G., Neilsen; 2000. The diagnosis and management of sexually transmitted infections in Southern Africa. Johannesburg: South African Institute of Medical Research.

Brazil, Country Health Profile, Pan American Health Organisation/World Health Organisation, 2001; <http://paho.org/English/SHAprflbra> 30/06/2002.

Baleta, A. 2000. Msimang dismisses AIDS council criticism. Cape Argus, <http://www.iol.co.za> 23/06/2003

Britten, N., Jones, R., Murphy, E., Stacy, R. 1995. Qualitative research methods in general practice and primary care. Family Practice. 12 (1):104-112.

Brynard, P.A., Hanekom, S.X. 1997. Introduction to research in Public Administration and related disciplines. Pretoria: J.L.van Schaik.

CDC/National Centre for HIV, STDs and TB Prevention. Fact Sheet: Preventing Occupational HIV transmission to health care workers. October, 1998. Atlanta.

Chetty, A. 2002. Medical Association backs antiretroviral use. <http://www.iol.co.za/index.php> 12/05/2003

Cloete, F. 1999 (a). Conceptualising capacity for sustainable governance. *Africanus* 29 (2) 1999: 8-19

Cloete, F. 1999 (b). Achieving the capacity for sustainable governance. *Africanus* 29 (2): 86-103

Cloete, F. 2000. The Bottom Line. In: Theron, F, Van Rooyen, A, Van Baalen, J (eds) *Good governance for people: Policy and management*. School of Public Management and Planning, University of Stellenbosch, Bellville.

Creswell, J.W. 1994. *Research design, qualitative and quantitative approaches*. Thousand Oakes: Sage Publications.

Darlington, S. 2001. Brazil pushes AIDS fight beyond its borders. Reuters NewMedia, <http://www.aegis.com> 26/04/2001.

Deane, N. 2003. The pall of politics. Mail & Guardian online. <http://www.mg.co.za>. 08/08/2003.

del Rio, C. 2003. New challenges in HIV care: Prevention among HIV-infected patients. *Topics in HIV Medicine, IAS-USA, San Francisco*, 11 (40): 140

Dorrington, R., Bourne, D., Bradshaw, D., Laubscher, R., Timaeus, I.M; 2001. The impact of HIV on adult mortality in South Africa; Technical report, Burden of disease unit, Medical Research Council, Tygerberg, South Africa.

Edwards, C.S; Nesbitt, C; 1999. When will we be heard? Needs and gaps in the women's prevention services. National HIV Prevention Conference, Aug 29-Sept 1.

Fahlen, M. 2003. HIV/AIDS a double humanitarian challenge. Southern Africa AIDS Information Dissemination Service, SAFAIDS News, 11: 2-4.

Gills, C; Floyd, K; Haran, D; Kemp, J; Squire, D; Wilkinson, D; 1998: *Sexual health and health care: Care and support for people living with HIV and AIDS in resource poor settings*; Department for International Development, UK.

Guay, L.A; Musoke, P; Fleming, T; Bagenda, D; Allen, M; Nakabiito, C, et al. Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial. *Lancet* 354:795-802.

Ippolito, G.; Puo, V; Heptonstall, J; Jugger, J; De Carli, G; Petrosillo, N; 1999. Occupational HIV infection in health care workers; Worldwide cases through September 1997. *Journal of Clinical Infectious Diseases*, 28: 365-83.

Lamptey, P; Delaporte, E; Mboup, S; Meda, M; Fransen, L; Carael, M; Ndoeye, I. 1998: HIV/AIDS control programme in Africa: A successful study in Senegal. International AIDS Conference, Montpellier, France.

Lawrence, M; Schofield, T. 1993. Medical Audit in Primary Health Care. Oxford: Oxford University Press.

McIntyre, J.A. 1996. Management of HIV positive pregnant women, *CME*, 4 (6): 781-98.

McIntyre, J.A; Gray, G. 2000. Preventing mother-to-child transmission of HIV. *Southern African Journal of HIV Medicine*, 5:30-31.

McIntyre, J.A; Gray, G. 2002. What can we do to reduce mother-to-child transmission of HIV? *BMJ*, 324:218-221

Morah, E.U. 1995. Obstacles to optimal policy implementation in developing countries. *TWPR*: 18 (1): 79-106

Mouton, J. 2001. How to succeed in your Master's and Doctoral studies. Pretoria: Van Schaik Publishers.

Mukwaya, S. 2003. Helping communities help themselves; Chimanimani Community-based Orphan Care Programme, Southern African AIDS Information Dissemination Service, SAFAIDS News, 11:7-8

Naidoo, P. 2003. Integrating Tuberculosis and HIV services in Cape Town – Challenges, Opportunities, and Scaling-up. Presentation at the International AIDS Society Conference on HIV Pathogenesis and treatment. Paris, France

July 14.

Neuman, W.L., 1997. Social Research Methods: Qualitative and quantitative Approaches. Boston: Allyn & Bacon, Viacom Company.

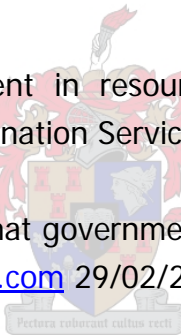
Nivasan, V.S; Palanivel, K. 1998. Impact of training in sexually transmitted diseases quality care to private medical practitioners in Tamil Nadu, South India, International AIDS conference 1998. Geneva.

Nsubuga, Y; Rwomushana, J; Odongokara, F; Kanyunyuzi J.F; Nakaweesi, A; Bakyaaita, N; Madraa, E. 1998. The role of appropriate policies in the fight against HIV/AIDS; Uganda's experiences and the way forward. International AIDS conference 1998, Switzerland.

Parker, R.G; Galvao, J; 1998. HIV/AIDS policy in Brazil. International AIDS conference on AIDS. Geneva.

Parder, M. 2003. HIV treatment in resource-poor communities. Southern Africa AIDS Information Dissemination Service, SAFAIDS News, 11 (1):17-18.

PIMS. 2000. Policy briefing: What government has done about AIDS in South Africa. <http://www.dogonvillage.com> 29/02/2003.



Piot, P. AIDS in Africa. Sowetan 2 July 2002

Republic of South Africa, Department of Health, 2000: HIV/AIDS &STD Strategic Plan For South Africa, 2000-2005. Pretoria.

Republic of South Africa, 1996: The Constitution of the Republic of South Africa, 1996.

Republic of Uganda, Ministry of Health online, Policies and Programmes. <http://www.health.go.ug>. 01/06/2002

Republic of Uganda, Ministry of Health online. AIDS in Uganda. <http://www.health.go.ug>. 14/07/2002

Rubin, H.J; Rubin, I.S. 1995. Qualitative interviewing; The art of hearing data.

Thousand Oaks: Sage Publications,

Sanne, I; Firnhaber, C; Sentsch, V; Ive, P. 2000. Ethics and HIV research. Southern African Journal of HIV Medicine, Launch Edition: 42-45.

Sangiwa, G., Coates, T., Balmer, D., Furlonge, C. Kamega, C., Grinstead, O. 1998. VCT reduces risk behaviour in developing countries: Results for the VCT study: VCT study group. International Conference on AIDS. Geneva

Situational Analysis of Donald Fraser Hospital Health Ward, 2001;
Community Health Services Department, Donald Fraser Hospital, Vhufuli.

Smith, D. 2002. Hospital stands firm on sacked Von Mollendorf. Saturday Star Newspaper, <http://www.iol.co.za> 12/06/2002

Smith B.T. 1985. Evaluating development policies and programmes in Third World countries. San Francisco: John Wiley & Sons LTD

Soares C. A; 2002. US drops Brazil AIDS drugs case; BBC News, http://news.bbc.co.uk/1/hi/english/business/newsid_1810000/1810000.stm, 05/07/2002.

Swan, N. 2001. AIDS in South Africa; Health Minutes, <http://www.abc.net.au/health/minutes/stories>, 30/06/2002.

The Editor, The New Vision, 2002. <http://www.newvision.co.ug> 14/07/2002

Weber, L.M; Richards, P.A; Gray, S.V. 2001. HIV education and health care students: Where are we going? Southern African Journal of HIV Medicine, 5: 40-42.

Wood, L.M. 1992. Focus group interview, In: Family Practice Research. Canadian Family Physician 38(12):2821-2827

8. APPENDICES

APPENDIX 8.1A

THE QUESTIONNAIRE FOR THE QUANTITATIVE PHASE OF THE STUDY

A. Profile of respondent (Fill in the spaces)

AGE.....QUALIFICATIONS.....
POSITION HELD.....YEARS IN POSITION.....
SECTION IN HOSPITAL.....OR
COMMUNITY CLINIC.....

B. PRIORITY AREA I: PREVENTION OF HIV

SECTION B1 PROMOTION OF SAFE AND HEALTHY SEXUAL BEHAVIOUR

Tick yes or no or any other option and only explain when asked

1.Does your clinic or section give out HIV prevention information to the community?

Yes.....If yes how.....

No.....

2. Is your institution involved with other outside organisations or departments in HIV/AIDS awareness?

Yes.....If yes which ones.....

No.....

3. Is there a voluntary counselling and testing programme at your institution?

Yes.....No.....

4. Have the health workers in your clinic or section been trained in HIV/AIDS counselling and care? (Tick where appropriate)

Yes.....No.....

5. Do you have free male condoms at your clinic/ section to the clients?

No.....

Sometimes.....

All the time.....

6. Do you have free female condoms at your clinic/ section?

No.....

Sometimes.....

All the time.....

7. Does the community ask for the condoms?

Yes.....

No.....

SECTION B2: MANAGEMENT AND CONTROL OF STDS

8. Do you use the syndromic approach in managing STDs?

Yes.....No.....

9. Have you been trained in syndromic management of STDs?

Yes.....No.....

10. Do you collaborate with traditional healers in HIV prevention programmes?

Yes.....No.....

11. Do you consider your clinic/ facility friendly to youth who want to access condoms, STD management and reproductive health services?

Yes.....No.....

SECTION B3: REDUCTION OF MOTHER-TO-CHILD TRANSMISSION

12. Do you have a voluntary HIV counselling and testing facility for pregnant women at your clinic/ section?

Yes.....No.....

13. Do you have trained HIV counsellors in your team to deal with mother-to-child transmission?

Yes.....If yes state number.....

No.....

14. Do you have known HIV positive women receiving antenatal care services in your clinic/section?

Yes.....No.....

SECTION B4: POST-EXPOSURE SERVICE

15. Do you have a protocol on how to prevent HIV infection among health workers after needle stick or other exposure at work?

Yes.....No.....

16. Do you have a non-expired supply of antiretroviral drugs at your facility for post-exposure use for occupational injuries?

Yes.....No.....

17. Do you have any interventions to reduce the post-exposure transmission of HIV for sexually abused women?

Yes.....If yes what type.....

No.....

SECTION C: PRIORITY AREA II: TREATMENT, CARE AND SUPPORT

18. Do you have dedicated treatment services for HIV positive patients?

Yes.....No.....

19. Do you have protocols for treatment and prevention of opportunistic infections?

Yes.....No.....

20. Is your facility involved in home-based care provision?

Yes.....No.....

21. Do you collaborate with any community organisations in offering home-based care to HIV/AIDS patients?

Yes.....No.....

If Yes which organisation.....

SECTION D: PRIORITY AREA III: RESEARCH

22. Is there any research, ongoing or completed, in your facility dealing with HIV/AIDS issues?

Yes.....No.....

SECTION E: PRIORITY AREA IV

23. Do you have a programme in place or guidelines for supporting fellow workers who may have HIV?

Yes

No.....

I do not know.....

Thank you for your cooperation

APPENDIX 8.1B

THE PROPOSED FRAMEWORK GUIDELINES FOR THE RUNNING OF THE FOCUS GROUPS DURING THE QUALITATIVE PHASE OF THE RESEARCH

PART A

What, according to your understanding, are the main components of the National HIV/AIDS policy?



The coat of arms of the University of Wrocław is a heraldic shield divided into four quarters. The top-left quarter is red with a white cross. The top-right quarter is blue with a white eagle. The bottom-left quarter is blue with a white cross. The bottom-right quarter is red with a white cross. The shield is surrounded by a red and white wreath. Above the shield is a crown. Below the shield is a banner with the Latin motto: "Pectus coluntur cultus recti".

PART B

What activities in your institution are resulting from that policy?

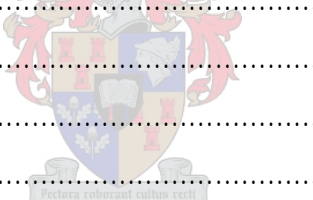
.....

.....

.....

.....


PART C



VELUT ARBOR ÆVO CUNCTIS FRUITUR


PART D

What aspects of the national HIV/AIDS policy have affected the process of health care delivery negatively and state how they have done that?

The image shows the crest of the University of Cambridge. It features a shield divided into four quadrants: top-left is red with a white lion, top-right is blue with a white cross, bottom-left is blue with a white lion, and bottom-right is red with a white cross. A white book is open in the center of the shield. Above the shield is a red ribbon or scroll. Below the shield is a motto scroll with the Latin text "Pectora roburant cultus recti". The entire crest is centered on a white background with horizontal dotted lines.

PART E

What other national policies are helping to enhance the national HIV/AIDS policy? State how such policies are enhancing the HIV/AIDS policy.



PART F

What other national policies are impacting negatively on HIV/AIDS prevention programmes at your institution and state how they do this?

.....

PART H

What in your opinion still needs to be included in the national HIV/AIDS policy to meet some of the current HIV/AIDS-related public needs?

.....

.....

.....

.....

.....

PART I

What in your opinion has been the main impact of the current national HIV/AIDS policy at your place of work?

.....

.....

.....

.....

.....

.....



APPENDIX 8.2

LETTER TO THE DEPARTMENT OF HEALTH

Dr Luyirika Emmanuel
Donald Fraser Hospital
Private Bag x 1172 Vhufuli
0971
Date.....

TO THE HEAD,
DEPARTMENT OF HEALTH,
NORTHERN PROVINCE

RE: PERMISSION TO CONDUCT RESEARCH FOR THE MPA OF
STELLENBOSCH UNIVERSITY

I am a final year student doing masters in Public Administration at the above-mentioned university. I am humbly requesting that your department grants me permission to conduct research on the topic " The implementation of the national HIV/AIDS policy in the management of health care services in the Vhembe District (Mutale Area) of the Northern Province". It will involve the administration of a questionnaire and the running of three focus groups. Your timely consideration of this request will be highly appreciated.

Yours truly,

Dr Emmanuel Luyirika MB,ChB (Makerere) BPA (Hons) (Stellenbosch)
M Fam Med (Medunsa)
Family Physician

APPENDIX 8.3

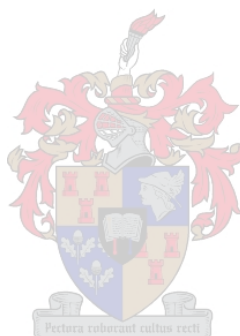
CONSENT FORM

I.....hereby voluntarily consent to take part in answering a questionnaire, which is part of research to assess the implementation of the current national HIV/AIDS policy in the management of health services at my place of work. I understand that this research will be beneficial in establishing facts, which will be helpful for future management of services and resources.

I therefore participate in this research without being forced.

.....
Signature

.....
Date





UNIVERSITEIT VAN STELLENBOSCH
UNIVERSITY OF STELLENBOSCH

27 February 2002

TO WHOM IT MAY CONCERN

It is hereby certified that **Dr EBK Luyirika** (student number 13478842) is a registered student for the Masters Degree in Public Administration at the University of Stellenbosch for 2002.

He is currently busy with his research for his thesis on "The implimentation of the national HIV/AIDS policy in the management of Health Care Services in the Vhembe District (Mutale Area) of the Northern Province". It would be appreciated if any information that he might need in his research could be made available to him.

If you have any further enquiries, please phone Helene Herselman at (021) 918 4193.

Yours sincerely

H HERSELMAN

p. DEPUTY REGISTRAR (BELLVILLE PARK CAMPUS)



NORTHERN PROVINCE
DEPARTMENT OF HEALTH AND WELFARE

TEL.: (015) 290 9000
(015) 290 9001
FAX.: (015) 291 5961
(015) 291 5146

PRIVATE BAG X9302
PIETERSBURG
0700

Enquiries: Sinah Mahlangu

Reference: Research & Quality Improvement

18 April 2002

Donald Fraser Hospital

Private Bag X1172


VHUFULI 0950

Dr Luyirika, EBK.

THE IMPLEMENTATION OF THE NATIONAL HIV/AIDS POLICY IN THE
MANAGEMENT OF HEALTH CARE SERVICES IN THE VHEMBE DISTRICT
(MUTALE AREA) OF THE NORTHERN PROVINCE.

1. Permission is hereby granted to Dr Luyirika to conduct a study on "The implementation of the National HIV/AIDS policy in the management of health care services in the Vhembe district (Mutale area) of the Northern Province"
2. The Department of Health & Welfare needs a copy of the research findings for its own resource centre.
3. The researcher should be prepared to assist in interpretation and implementation of the recommendations where possible.
4. Implications: Permission should be requested from hospital management to do research.

Sincerely,


ACTING HEAD OF DEPARTMENT
DEPARTMENT OF HEALTH & WELFARE
LIMPOPO PROVINCE

DR JAN MOOLMAN BUILDING
34 HANS VAN RENSBURG STREET
PIETERSBURG 0700



Northern Province

DONALD FRASER HOSPITAL
HEALTH AND WELFARE

Private Bag X1172
VHUFULI
0971

Tel. 015-963 1778/9
015-963 1783/4
015-963 1791/2
Fax. 015-963 1796

Ref. No. 15/1

Enq. : Dr Ddungu P.E.M.

Date : 09.05.2002.

TO ALL SECTIONS.

RE : APPROVAL OF RESEARCH PROPOSAL - DR E.B.K. LUYIRIKA.

1. Permission is hereby granted to Dr Luyirika E.B.K. to conduct a study on "The Implementation of the National HIV/AIDS Policy in the Management of Health Care Services in the Vhembe District, Mutale Area of the Northern Province."
2. A copy of the requisite approval from the Provincial Research and Quality Improvement Committee is attached.
3. The relevant sections in the hospital are requested to cooperate with him as he conducts the above study.

Yours Sincerely,

MEDICAL SUPERINTENDENT.

/aan-09.05.2002/

c.c. Dr Luyirika E.B.K. ✓



PEOPLE FIRST, VANHU EMAHLWENI, VHATHU PHANDA, MENSE EERSTE

Nein - Adolphus distinct

Nein - Adolphus distinct



