

HIV POSITIVE PREGNANT WOMEN'S EXPERIENCES OF THE ANTENATAL  
CARE AT A REGIONAL REFERRAL HOSPITAL IN SWAZILAND

By

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## DECLARATION

I declare that **HIV POSITIVE WOMEN'S EXPERIENCES OF THE ANTENATAL CARE SERVICES AT A REGIONAL REFERRAL HOSPITAL IN SWAZILAND** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

**SIGNATURE: .....**

**DATE: 22 January 2015**

**(WENDY PATIENCE GULE)**

## **DEDICATION**

This work is dedicated to my loving husband, my mom and dad.

## **ACKNOWLEDGEMENT**

First and foremost, I thank the Almighty God for making it possible for me to embark on this journey and complete the study.

My sincere thanks go to:

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# **HIV-POSITIVE WOMEN'S EXPERIENCES OF THE ANTENATAL CARE SERVICES AT A REGIONAL REFERRAL HOSPITAL IN SWAZILAND**

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## **ABSTRACT**

In its efforts to reduce maternal mortality and prevent Mother-to-Child Transmission of HIV, the government of Swaziland developed and implemented several programmes including a special antenatal care package for HIV-positive pregnant women in line with the WHO (2009) guidelines. Since the implementation of this latest special ANC package for HIV-positive women, little is known about how these services are experienced by the intended recipients. The purpose of this study was to explore and describe the actual experiences of HIV-positive women with the antenatal care services provided at a regional referral hospital in Swaziland, with the view of providing more insight into the quality of ANC services from the users' perspectives.

A qualitative descriptive, exploratory design was used to address the above purpose. The researcher used purposive sampling to select the participants who met the inclusion criteria for the study. Semi-structured individual interviews were used and saturation was reached after 18 individual face-to-face interviews. Thematic content analysis was used to analyse the collected data.

Fourteen themes related to the participants experiences with the ANC services and seven related to measures for improvement emerged from data. In general HIV

positive pregnant women expressed positive views towards ANC services they received at the target institution. The results give an indication on the quality of the focussed ANC package provided at the hospital and specific recommendations for improvement are outlined.

**KEY WORDS:** Antenatal care, HIV positive women, experiences of the antenatal care, maternal death, quality of care.

## **LIST OF ABBREVIATIONS**

ANC	Antenatal care
CDC	Centres for Disease Control
CSO	Central Statistics Office
HIV	Human Immunodeficiency Virus
MDG	Millennium Development Goal
MOH	Ministry of Health
NERCHA	National Emergency Response Council of HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
SMI	Safe Motherhood Initiative
WHO	World Health Organisation

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# **CHAPTER 1**

## **ORIENTATION TO THE STUDY**

### **1.1 INTRODUCTION**

The first chapter provides an orientation to the study. It includes the background and rationale, the statement of the research problem, the aim and objectives of the study, the significance of the study, the theoretical framework of the study, the definition of key concepts, and an overview of the research method. The structure of the dissertation is provided at the end of the report.

### **1.2 BACKGROUND AND RATIONALE OF THE STUDY**

Maternal mortality and Human Immunodeficiency Virus (HIV) continue to be major challenges for the Kingdom of Swaziland like in many other developing countries. According to the World Health Organization (WHO 2010) the risk of a woman dying from pregnancy related causes in developing countries is 36 times higher than a woman in developed countries.

In Swaziland, it is estimated that 1 in 69 pregnant women has the probability of dying or being at risk of dying during the course of the pregnancy. Maternal mortality in the country increased from 229 per 100, 000 live births in 1997 to 589 per 100,000 live births in 2007 (Swaziland' Central Statistics Office (CSO) 2008). According to the Swaziland' Ministry of Health (MOH 2011a) 41.1% of pregnant women attending antenatal care (ANC) in Swaziland were HIV positive. The rate of mother-to-child transmission (MTCT) of HIV among HIV-positive women during pregnancy is between 5-10% (MOH 2011a), of note is

that about 25% of maternal deaths in Swaziland are as a result to advance HIV infection.

The Government of Swaziland is committed to the Millennium Development Goals (MDG), especially MDG5 which aims at reducing maternal deaths by 75% in 2015 (MOH 2011b). This means the country has to reduce maternal mortality from 589 per 100 000 to 92 per 100 000 by 2015. One of the strategies to attain this goal is by increasing the proportion of child-births attended by skilled health personnel from 70% in 2000 to 100% by 2015 (MOH 2011b).

Swaziland' Ministry of Health rolled out significant HIV and AIDS prevention and treatment programmes which include Prevention of Mother-To-Child Transmission (PMTCT) of HIV. Within this programme, focussed antenatal care package in line with WHO (2009) guidelines were developed and implemented throughout the country (MOH 2010a). According to the package, the first antenatal care visit should take place as soon as the woman realises that she is pregnant, preferably before 14 weeks of gestation. During this visit, health professionals are expected to distinguish pregnant women who require basic care from those requiring specialised care. They are also expected to provide the same initial care to all women who present late in pregnancy and have missed some of the scheduled visits (WHO 2010).

The importance of antenatal care for the pregnancy outcome and the well-being of the mother are widely acknowledged. ANC allows health professionals to monitor the progress of pregnancy thereby optimizing maternal and foetal health. The main objective of ANC is to identify and treat

problems during pregnancy and advice on a range of issues that may affect the pregnant woman. It involves a critical evaluation of the physical, psychological and social effects of the pregnancy on the woman, and may also involve the participation of family (Fraser & Cooper 2009).

The provision of quality antenatal care can play a greater role in reducing MTCT of HIV and HIV related maternal deaths (WHO 2009). Reports from the Swaziland' Ministry of Health suggests that the majority of women living in Swaziland could access ANC services if needed. The 2011 Report of the Ministry of Health showed that the proportion of pregnant women assisted by a health professional increased from 70% in 2000 to 74.1% in 2006. During the same period, the percentage of women delivering in health facilities increased from 56% to 74.1%, while the national ANC coverage was estimated at 96% (MOH 2011a).

It is within the above context that this study looked at the HIV-positive Women's Experiences with the Antenatal Care they received at one of the facilities that uses the focussed ANC package. Using the experience of care as a guiding framework, the researcher assumed that the anticipated improvement will be best exemplified by the users' actual experiences with the ANC services. Therefore the study attempted to answer the following question: "How do HIV-positive women experience ANC services after the implementation of the special ANC package?"

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

In its efforts to reduce maternal mortality and prevent Mother-to-Child Transmission of HIV, the government of Swaziland developed and implemented several programmes including a focused antenatal care package for HIV-positive pregnant women in line with the WHO (2009) guidelines. Since the implementation of this focused ANC package for HIV-positive women, little is known about how these services are experienced by the intended recipients. It is therefore important to understand how HIV-positive women experience those services.

The literature on the quality of care suggests that a key indicator of the quality of care provided by healthcare institution is the actual experience of care as expressed by users. In addition, anecdotal reports from some government officials suggest that the implementation of the focused ANC packages have not translated into significant improvement in the maternal mortality rate amongst HIV-positive women. These reports attributed this slow improvement to the quality of the ANC provided to this group of women. It is therefore important to understand HIV-positive women's experiences of the ANC services they receive. It is well known that the client actual experience of care is a critical indicator of the quality of care. The researcher believes that the results would provide an indication of the quality of the ANC services provided to HIV-positive pregnant women.

### **1.4 PURPOSE AND OBJECTIVES OF THE STUDY**

The purpose of this study was to explore and describe the actual experiences of HIV-positive women with the antenatal care services provided at a regional

referral hospital in Swaziland with the view of providing more insight into the quality of ANC services from the users' perspectives.

The objectives of the study were twofold:

- To describe and explore HIV-positive women' experiences with the antenatal care they received at a Regional Referral Hospital in Swaziland.
- To describe and explore HIV-positive women' perspectives on measures required to improve the antenatal care services provided to HIV-positive women in Swaziland.

### **1.5 SIGNIFICANCE OF THE STUDY**

It is known that consumers' cumulative experience of care is one of the key components of the quality of care. The results of this study can be used by health services managers and policy-makers to improve the special ANC package for HIV-positive women. Nurse and midwifery educators can also use the results as baseline information for the development of in-service training programmes. The results can also be used as baseline data in country wide survey on the quality of the focused ANC package for HIV-positive women in Swaziland. Finally, the results of the study will enhance our understanding about the ANC services received by HIV-positive women in Swaziland.

### **1.6 DEFINITIONS OF KEY TERMS**

**Antenatal care** is the care given to a pregnant woman from the time conception is confirmed until the beginning of labour (Fraser & Cooper 2009).

In the context of this study, it referred to the care received by HIV-positive pregnant women during their antenatal visits at the selected research setting.

**HIV-positive women** are woman who has been tested at a medical facility for the Human Immunodeficiency Virus (HIV), and has been found positive for antibodies to HIV (MOH 2010b). In this study, HIV-positive women included women with known HIV-positive status who attended antenatal care services at the selected research setting.

**Experiences of the Antenatal Care** referred to the HIV-positive women' description of their personal views and feelings about the antenatal care services they received at the selected research setting.

**Maternal death** is defined as “a death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to- or aggravated by- the pregnancy or its management, but not from accidental or incidental causes” (WHO 2009:134).

**Quality of care** is defined as the way individuals and clients are treated by the system providing care (Mitchell (2008). It is the extent to which the offered care is in conformity with the real care termed as good care (Hulton, Matthews and Stones 2000). In this study, quality of care referred to the provision of ANC services to HIV positive pregnant woman, and the manner in which the services are offered by midwives in light of the (MOH 2010a) guidelines' recommendations.

## **1.7 THEORETICAL FRAMEWORK**

The researcher used the experience of care as a theoretical framework in structuring the study and the interpretation of the findings. The experience of



care is a component of the quality of care model, which explains why consumers either access services at all, access them late or suffer an avoidable adverse outcome, despite timely presentation. The model brings together a number of distinct yet integrated components related to institutional standard of care; psychosocial and cultural factors; hospital logistics and management; and the overarching health system. It divides quality within the institutional delivery services into two, namely the provision of care and experiences of care (Hulton *et al* 2000).

The experience of care component of the model is based on the understanding that client's actual experience of care is a significant indicator of quality care. If user's cumulative experience at a facility is such that it deters some from returning for a subsequent delivery or leads to rumours, which have the same effect in the wider community, we cannot talk of actual quality of the provision of care to these users (Hulton *et al* 2000). These elements are addressed in details in Chapter 2.

## **1.8 OVERVIEW OF THE RESEARCH METHOD**

The study was carried out within the qualitative research approach, using a qualitative descriptive, exploratory design. Purposive sampling was used to select the participants. Semi-structured individual interviews were used to collect data. The researcher observed all the ethical principles outlined in the University of South Africa Research Policy as well as the universal ethics principles. Ethical approval was obtained from the Ethics Committees of the University of South Africa and the Ministry of Health of the Kingdom of

Swaziland. Individual consent was obtained from each participant. More details on ethical considerations are included in Chapter Three.

## **1.9 STRUCTURE OF THE DISSERTATION**

The report of this study is structured into five chapters. A list of references and relevant supporting documents are included as appendixes at the end of the report.

**Chapter One:** The first chapter provided an overview of the study and articulates the context of the research problem and theoretical framework that underpinned the study.

**Chapter Two:** The second chapter presented the different studies and documents related to antenatal care and the experiences of women with regard to the antenatal care.

**Chapter Three:** The third chapter discussed the methodology used in the research.

**Chapter Four:** The fourth chapter focused on data analysis; presenting and describing the research findings.

**Chapter Five:** The fifth chapter concluded with a summary of results, limitations of the study and recommendations based on the research findings.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

The literature review is one of the basic elements of a research work as it searches what you have established about your research problem from scanning literature; what other scholars have written about this topic and also identifies the theories that address the topic. It enables the researcher to show how his findings add to the already existing body of knowledge (Babbie & Mouton 2011). In this study, the researcher looked at different studies and reports relevant to women's experiences with the antenatal care received from health facilities with particular attention on HIV positive pregnant women. This chapter describes the health care delivery system of Swaziland, the importance of ANC services on the pregnancy outcomes, the focussed ANC package for HIV positive pregnant women in Swaziland, and the impacts of users' experiences of health care.

#### **2.2 HEALTH CARE DELIVERY SYSTEM OF SWAZILAND**

Swaziland is the smallest landlocked country in Southern Africa with approximately 17,000 square kilometres and a population estimated at 1.02 million. Administratively, the country is divided into four regions: Hhohho, Lubombo, Manzini and Shiselweni (CSO 2008; MOH 2011b). It is classified as a lower middle income country, with an economy that is largely agriculture driven (MOH 2011d). The country's healthcare delivery system is based on the primary health care philosophy. It comprises a national referral hospital,

regional referral hospitals (one for each administrative region), health centres and local clinics. Local clinics provide basic maternal and new-born health care services and refer clients when needed to health centres. From the health centres, clients may be referred to the regional referral hospitals and subsequently to the national referral hospital (MOH 2011a).

The Government of Swaziland attaches great importance to the health of women and children, as revealed by MOH (2014), therefore has put in place policies and strategies to encourage all pregnant women to attend ANC preferably as early as before 14 weeks of pregnancy, and also that they may attend at least 4 visits throughout the duration of the pregnancy (MOH 2014). With the assistance of the ministry of health, the government of Swaziland is also committed, as per the MDG 5, to reducing maternal deaths from 370 per 100 000 women in 1990 down to 92 per 100 000 by 2015 and to increase the proportion of child-births attended by skilled health personnel from 70 percent in 2000 to 100 percent by 2015.

In Swaziland the public sector remains the main source of ANC services, serving about two thirds (68 percent) of women (CSO 2008). However, women from the rural area (72 percent) sought health care from the public providers while only 57 percent of women from the urban area did so. MOH (2010a) states that HIV positive pregnant women deserve the whole package of care as all other women. Their medical history, obstetric, family and psychosocial history should be taken. Physical examination must be performed, together with basic laboratory investigations, nutritional assessment and counselling. They should be given relevant immunisations, screened for tuberculosis and be educated and counselled on the danger

signs in pregnancy, sexually transmitted infection's signs and symptoms, and be educated on the importance of delivering under the assistance of a skilled health worker.

### **2.3 IMPORTANCE OF ANC SERVICES ON PREGNANCY OUTCOMES**

The importance of antenatal care in improving the pregnancy outcome and the well-being of the mother are widely acknowledged. It is also known that pregnancy complications and problems are a primary source of maternal and child morbidity and mortality, therefore the major objective of ANC is to identify and treat problems during pregnancy such as anaemia and infections, and screening for complications and advice on a range of issues that may affect the pregnant woman.

Antenatal care is crucial for the surviving and the well-being of the mother and her child (CSO 2008). Majority of maternal deaths could be avoided if women could have access to quality medical care during pregnancy, during childbirth and during the postpartum period. They further state that good ANC attendance helps in establishing contacts with the pregnant woman at a peripheral level so as to detect, treat and prevent infections that might be the cause of some of the great numbers of maternal deaths (Nikiema, Kameli, Capon, Sondo and Martin-Prevel 2010). Authors (Mrisho, Obrist, Schellenberg, Haws, Mushi, Mshinda, Tanner and Schellenberg 2009) suggest that improving maternal and newborn health requires strengthening of existing evidence-based interventions in antenatal care.

ANC is one of the recommended and highly effective interventions in helping to reduce the alarming maternal and new born mortalities (Kyei, Chansa &

Gabrysch 2012). ANC visits at health care facilities are meant to ensure safe outcomes for both the mother and the baby (Kamil & Khorshid 2013). The key element of antenatal care is to optimise the health of both the mother and her unborn child throughout the pregnancy. It involves a critical evaluation of the physical, psychological and social effects of the pregnancy on the woman, and may also involve the participation of family (WHO 2009). It monitors the progress of the pregnancy, provides an important opportunity for pregnant women to access a wide range of interventions including education, counselling, screening, treatment, monitoring and promoting the well-being of the mother and foetus (Nyamtema, Jong, Urassa and Roosmalen 2012).

Fraser and Cooper (2009) highlight the fact that midwives carry a huge responsibility in helping women through the hard work of pregnancy and pain of labour. A woman's first introduction to midwifery care is crucial in forming her initial impressions of the maternity service. The midwife has to develop a trusting partnership with the pregnant woman, providing a holistic approach to the woman's care and promoting an awareness of the public health issues for the woman and her family. It is during the antenatal visit that the midwife can recognise some complications of pregnancy and therefore referring her to appropriate obstetric team or relevant health professionals (Fraser & Cooper 2009).

Furthermore, Fraser and Cooper (2009) argue that many women attending antenatal clinics have fears with their ability to cope with pregnancy throughout delivery, and midwives are responsible for addressing those fears and instilling confidence to them. They also emphasize the importance of

rendering services that are sensitive and appropriate to all women, during pregnancy, labour and delivery. During the antenatal care visits, the midwife evaluates the physical, psychological and social effects of the pregnancy on the woman. She may also screens for the socioeconomic conditions which are likely to increase the possibility of certain adverse outcomes of the pregnancy (Tetui, Ekirapa, Bua, Mutebi, Tweheyo and Waiswa 2012)

The Swaziland Ministry of Health implemented significant HIV and AIDS prevention and treatment programmes which include PMTCT. Within this programme, focussed antenatal package in line with World Health Organisation guidelines were developed and implemented throughout the country (MOH 2010a). According to MOH (2010a) the first antenatal care visit should take place as soon as the woman realises that she is pregnant, preferably before 14 weeks of gestation.

Nearly all women in Swaziland receive ANC from a skilled provider such as a doctor, midwife, nurse or nursing assistant but it is worth noting that midwives and nurses are the most common ANC providers (CSO 2008). 97 percent of pregnant women regardless of their background do attend the ANC services in the country. However, this attendance seems to be associated with the education level and the economic status. Women with higher education levels and higher wealth quintiles are more likely to use ANC services than women with lower education level and lower wealth quintiles (CSO 2008).

The ANC attendance is a success story globally, with about 71 percent of women worldwide receiving ANC. In Africa, the ANC service has reached over two thirds of pregnant women, with a great increase in the coverage of

the first trimester ANC visit (Boswell & Baggaley 2002). In Tanzania, 94% of women make at least one antenatal visit during the course of their pregnancy (Mrisho *et al* 2009). In a report published by the Ministry of Health of Swaziland in 2011 (MOH 2011a:5), it was shown that the percentage of pregnant women assisted by a health professional increased from 70 percent in 2000 to 74.1 percent in 2006; and the percentage of women delivering in health facilities increased from 56 percent in 2000 to 74.1 percent in 2006. In 2008, the national ANC coverage was estimated at 96 percent. This means that the majority of women living in Swaziland could access ANC services (CSO 2008).

However, the high coverage of ANC services, the increased number of pregnant women being attended by skilled personnel and the introduction of the special ANC package for HIV-positive pregnant women did not translate into significant improvement in the maternal mortality rate. The quality of antenatal care was one of the factors attributed to this slow improvement (CSO 2008). It is therefore of utmost importance that the basic information on the quality of care to be offered to HIV infected women during the antenatal period and throughout pregnancy.

## **2.5 FOCUSED ANC PACKAGE FOR HIV POSITIVE PREGNANT WOMEN**

As discussed in the background of this study, the Ministry of Health of the Kingdom of Swaziland developed and implemented focussed ANC package for HIV positive pregnant women. It was anticipated that the implementation of this focussed antenatal package will lead to improved quality of ANC for this



group of women. This package includes nine main components that are described in this section of the literature.

### ***2.5.1 History taking***

The objective of the first visit to antenatal care is to assess health by taking a detailed medical history, obstetric, family and psychosocial history. It is in this stage that the midwife enquires about the HIV status of the woman and her partner, history of medications (including antiretroviral drugs) that the pregnant woman is taking. The midwife will also check records (if available) for more information about the client (Fraser & Cooper, 2009).

For HIV positive pregnant women, their history should involve determining pre-ART care and any antiretroviral treatment taken. Also enquire about partner and family support, and about other treatment that she may be taking, including traditional medicines or herbal products. The next step would be to draw blood for conducting CD4 cell count as well as for liver function tests and renal function test. The earlier the CD4 cell count is taken the earlier the woman may be initiated on antiretroviral treatment if need be (MOH 2010a).

### ***2.5.2 Physical examination and vital signs***

A general clinical assessment, obstetric assessment and risk assessment should be conducted. Assess also for current signs of illness, such as common symptoms of tuberculosis and sexually transmitted infections. It is important to check the pregnant woman's blood pressure and other vital signs such as temperature, pulse rate and weight (Fraser & Cooper 2009). The

health care provider should also perform staging of clinical disease to determine the need for antiretroviral treatment.

According to MOH (2010b) pregnant women with advanced HIV disease have a higher chance of transmitting HIV infection to the child. Therefore, it is important that clinical staging be performed since the emergence of HIV related signs and symptoms are indications of advanced HIV infection. WHO (2009) states that initiation of antiretroviral treatment among pregnant women benefits both the health of the mother and prevents HIV transmission to her child during pregnancy, thereby catering for wellbeing of child.

### ***2.5.3 Basic laboratory investigations***

The woman should be helped by the midwife in making an informed choice about the tests that are available (Fraser & Cooper 2009). All pregnant women should undergo screening and testing; rapid plasma reagent (RPR) for syphilis, haemoglobin level to assess anaemia, blood group and Rhesus factor to prepare for blood transfusion if it becomes necessary and to prevent haemolytic disease of the new-born (Fraser & Cooper 2009).

Test for HIV if status is unknown; do baselines, such as CD4 cell count, liver function tests, and full blood count, if known. Urinalysis should be performed to rule out proteinuria, and for early detection of urinary tract infections and glucose in urine (MOH 2010a; Fraser & Cooper 2009).

### ***2.5.4 HIV testing and counselling***

HIV testing and counselling should be offered to all women whose HIV status is unknown, and ensure that clients get their results (MOH 2010a). HIV testing

and counselling should be offered in pregnancy since treatment in pregnancy is beneficial in reducing mother to child transmission of HIV (Fraser& Cooper 2009). MOH (2010a) stated that for all women who have tested negative previously, it is of utmost importance that during the third trimester they are retested to ensure that new infections are captured and treated according to acceptable standards.

### ***2.5.5 Establish eligibility for antiretroviral treatment***

All pregnant women diagnosed with HIV should be promptly assessed for antiretroviral treatment eligibility and initiated immediately if eligibly (MOH 2010a). WHO (2009) emphasizes that earlier antiretroviral therapy for a larger group of HIV positive pregnant women benefits the health of the mother and also help prevent mother to child transmission of HIV during pregnancy. Therefore, all HIV positive pregnant women with low CD4 count (less than 350cells/mm<sup>3</sup>) and those who are in clinical stage 3 and 4 must be initiated on antiretroviral treatment as soon as possible.

Furthermore, WHO (2009) states that initiating antiretroviral treatment to HIV positive pregnant women improves their health and reduces HIV related mortality and morbidity. It also reduces mother to child transmission of HIV during pregnancy. MOH (2010a) reveals that it is estimated that initiating antiretroviral treatment at a CD4 threshold of 350cells/mm<sup>3</sup> would prevent up to 80 percent of maternal deaths and postnatal infant infections.

On the other hand, some of the HIV positive pregnant women may not be eligible for antiretroviral therapy. These, according to WHO (2009), are having a higher CD4 cell count (above 350 cells/mm<sup>3</sup>) and are on clinical stage 1

and 2. They should be given antiretroviral prophylaxis, which will reduce the risk of HIV transmission from mother to child. They (the women) don't need antiretroviral treatment for themselves since they have a relatively strong immune system; it is basically for the protection of their infants.

### **2.5.6 Nutritional assessment and counselling**

Assess woman's nutritional status, and enrol on food by prescription if need be. The woman should be given nutritional supplements, which are iron tablets, folic acid and multivitamin, and be counselled on proper diet based on locally available foods (MOH 2010a). Maternal nutrition is an important factor to be considered during the antenatal period; however, there is no evidence demonstrating its benefit in preventing mother to child transmission of HIV (Teate *et al* 2011:140; MOH 2010b), yet it is crucial for the developing fetus.

According to MOH (2010b) a pregnant woman's weight gain should be monitored at every ANC visit, and nutritional assessment accompanied by nutritional counseling should be done. Feasible advices should be given to them in as far as eating balanced diet and eating foods high in energy is concerned.

### **2.5.7 Immunization**

All pregnant women should be given tetanus toxoid and be given all necessary education about the importance of this immunization (MOH 2010a). According to a report from the CDC (2013) pregnant women with an unknown tetanus vaccination history should be given tetanus toxoid vaccines to maximise protection against maternal and neonatal tetanus.

### ***2.5.8 Screening for tuberculosis***

All pregnant women should be screened for tuberculosis and be treated as per need (MOH 2010b). A screening algorithm was designed for TB diagnosis among adults living with HIV, in which results are based on sputum tests. Refer or provide diagnostic and follow up services as necessary.

### ***2.5.9 Provide education on pregnancy and delivery***

Counsel the pregnant woman on some danger signs in pregnancy which include bleeding, high body temperature (which might be a symptom of possible infection), and swelling of hands and feet, which if it reaches the knees, affects the face or is increasing in the fingers, may be indicative of hypertension of pregnancy. Also, if the woman notices severe pallor, headache, that will be a sign of danger and the woman has to quickly seek health care. Other danger signs are abdominal pains, which may be indicative of some disorder (CSO 2008).

Moreover, the Republic of South Africa (RSA) department of health (2012) emphasizes that the midwife should counsel the woman on the signs and symptoms of sexually transmitted infections. These may include vaginal discharges and vaginal sores, and the woman should seek health care immediately she notices these. The women should be educated on the importance of not taking alcohol and drugs during pregnancy, since they have detrimental effects on the unborn baby more especially in the first trimester, which include restricted growth, facial abnormalities, central nervous system problems, and behavioural and learning difficulties. The pregnant woman

should also be advised on self-care, nutrition and on the importance of rest (Teate *et al* 2011).

## **2.6 IMPACTS OF USERS' EXPERIENCE OF HEALTH CARE**

Manary, Boulding, Staelin and Glickman (2013) confirm the link between patients' experience of care and the health outcome. They argue that the better the patient's experiences, the better the health outcomes. Users' positive experiences with the care they received are correlated to adherence to clinical guidelines. In general, clients who are in bad state of health are more likely to be dissatisfied with the health care services they received, yet the opposite is true for those in good health (Bleich *et al* 2009).

Users' actual experiences of care influence their future utilisation of health services. User's cumulative negative experience at a facility deters some from returning for subsequent visits (Hulton *et al* 2000). According to Hulton *et al* (2000), a woman's experience of care can be divided into four broad groups:

- (i) experience with human and physical resources,
- (ii) cognition,
- (iii) respect, dignity and equity;
- (iv) the emotional support she gets during labour and beyond.

### **2.6.1. Experience with human and physical resources**

According to Hulton *et al* (2000) a woman's experience of care is not attached only to the quality and appropriateness of the maternity care she receives, but also to her impression of the condition of the physical resources

(infrastructure), as well as the time she spent with the qualified staff in the institution; which is looking directly at human resource.

In addition to proper medical attention, the infrastructure and its hygienic conditions play an important part in the users' view of the quality of health care. The overall environment of the maternity department has to be acceptable to almost all the women receiving care in the institution. Furnishing of all health facilities and providing adequate and appropriate supplies and equipment, such as scales for weighing pregnant women has been voiced out as a concern by pregnant women whose history of ANC attendance is not good (Mrisho *et al* 2000).

Rao, Kumar, Rao, Chatterjee and Sundararaman (2011) reports that in India there is a severe shortage of human resources for health, which is shortage of qualified health workers mostly in the rural, remote and underserved areas. This leads to having many of those staying in these remote areas receiving care from unqualified providers. On the other hand, Mrisho *et al* (2009) records that staff shortages, lack of equipment and supplies in clinics are the complaints that dominate conversations in some interviews that were carried out on pregnant women in Tanzania. Some women have reached a decision saying going for ANC under such conditions was wastage of time.

In Swaziland, the report on the Service Availability Mapping (SAM) (2010) showed that the distribution of human resource for health has improved over the past two years with the upgrading of hospitals and health centres. Midwives and nursing assistants form a majority of the country's nursing

category and are mostly practicing in public health facilities. Non-Governmental Organisations (NGOs) and industry oriented organizations accounted for the least number of nurses practicing in their facilities.

The need for competent and qualified human resource for health service delivery in Swaziland cannot be looked down upon if the country is to meet the MDGs in 2015. The public sector has the highest proportion of health care workers trained on HIV areas followed by Mission and non-governmental sectors. Private and Industry owned facilities has the least staff exposed to HIV trainings (SAM 2010).

### **2.6.2 Cognition**

Cognition in the model relates to two aspects of experiences of care, that is, the extent to which the woman feels she comprehends what is going on and she is satisfied in all answers she gets for her questions, and whether she actually receives enough information, and that the information is well understood (Hulton *et al* 2000). This however may depend on the effectiveness of information exchange between the care provider and the client. The care provider should ensure that he/she gives the client time to ask questions concerning the service she is being given.

The client/woman's subsequent behaviour will be affected by whether she understood what was being done and why. The criteria that may be used to measure cognition include knowing that necessary information is conveyed in a language that the client understands, women understands their options and are prepared for treatment (Hulton *et al* 2000).



The importance of good communication is well recognised, since deficiencies in communication might result in anxiety and dissatisfaction of care by the ANC mothers. In a study looking at antenatal care experiences of women at a London hospital, poor communication was identified as a major challenge in the interaction between health providers and the women. There was absolute lack of information provision, especially about the overall arrangement and purpose of ANC to the pregnant woman. Most pregnant woman were reported to have information deficiencies regarding possible problems during pregnancy, many of those women became assertive to address their needs while others became reluctant in engaging with the health providers (Raine, Cartwright, Richens, Mohammed and Smith 2010).

### ***2.6.3 Respect, dignity and equity***

There are many instances in which care givers cannot adhere to treating clients with the respect and dignity they expect like during labour and delivery. They may display elements of poor quality care such as insensitive treatment, tactlessness and moral judgements (Hulton *et al* 2000). Some care givers may be perceived as rude, proud, negligent and vulgar. However, the women do not have to undergo any unnecessary humiliating procedures, and they should all be treated with the same standard of care regardless of education, class and age. WHO (2013) clarifies that health rights and equity should be accessed by all people receiving health care from health institutions. This involves obtaining informed consent, and ensuring confidentiality for every patient.

McCliman, Dunn and Slowther (2011) view respect, dignity and equity as the ingredients of client centred care. They argue that respecting patients involves listening their side of the care they are receiving, and working out their reasoning in order to help patients reach an informed decision making. Barry *et al* (2012) on the other hand, admits that quality of care for a pregnant woman is influenced by the relationship that exists between herself and the provider, since this relationship will affect the decisions that she makes concerning her ANC.

#### **2.6.4 Emotional support**

Emotional support within the model refers to the support given by the staff members to each client as per need. It can also mean the woman's access to social and emotional support (Hulton *et al* 2000:44). Assistance during the course of pregnancy is crucial to the pregnant woman. It involves being taken care of by a skilled provider who will provide both medical and emotional support as per need. This means that health practitioners should be equipped not only with medical tasks but also with supportive tasks, which they should perform sensitively and competently (CSO 2008).

### **2.7 CONCLUSION**

The second chapter discussed the literature relevant to the research topic. The next chapter will look at the methodology used in this study.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

In this chapter, the research methodology is described in terms of the design, the setting, the sample and sampling techniques, data collection procedures, data management and analysis, the ethical considerations, and scientific rigour. Authors (Babbie & Mouton 2011) describe the research methodology as a plan or layout of how the study will be conducted. This plan should include the design, the technique and procedure employed in implementing the research.

#### **3.2 RESEARCH DESIGN**

This study used a qualitative descriptive, exploratory design to explore and describe HIV-positive women' personal experiences with the ANC provided at a Regional Referral Hospital and the measures for improving their experiences. The researcher believed that understanding HIV-positive pregnant women' experiences with ANC they received can be best depicted through qualitative inquiry. The literature suggests that experiences are often expressed with subjective views and emotional feelings which are best captured through qualitative enquiry (Johnson & Christensen 2012; Maree 2011).

A qualitative descriptive, exploratory design is an interpretative methodological approach that depicts more subjective knowledge (Babbie & Mouton 2011). Authors (Burns & Grove 2011; Polit& Beck 2012) agree that

the purpose of a qualitative descriptive, exploratory design is to “explore and describe a phenomenon in a real life situation”. The researcher used the above design to describe and explore HIV-positive women’ personal experiences with the ANC provided at the Regional Referral Hospital.

### **3.3 RESEARCH SETTING AND POPULATION**

Swaziland is the smallest landlocked country in Southern Africa with approximately 17,000 square kilometres and a population estimated at 1.02 million. Administratively, the country is divided into four regions- Hhohho, Lubombo, Manzini, and Shiselweni (CSO 2008). The country’s healthcare delivery system is based on the primary health care philosophy. It comprises one national referral hospital, four regional referral hospitals (one for each administrative region), and health centres and local clinics. Local clinics provide basic maternal and new-born health care services and refer clients when needed to health centres. From the health centres, clients may be referred to the regional referral hospitals and subsequently to the national referral hospital (MOH 2011a).

This study took place at the Regional Referral Hospital serving the population of the Manzini administrative region. It is the only referral hospital for Manzini region and the second main referral hospital in the country. It has an approved bed capacity of 350 and serves a population estimated at 350,000. The researcher targeted HIV-positive mothers who have attended antenatal care clinics at the above hospital. According to Burns & Grove (2011), a target population is a subset of elements (people, behaviours, events) that the research focuses on.

### **3.4 SAMPLE AND SAMPLING TECHNIQUES**

Purposive sampling techniques were used to recruit participants. The researcher selected HIV positive women, who were attending antenatal care at the targeted research setting. Purposive sampling is a non-probability sampling in which the units to be studied are selected based on the researcher's judgements (Babbie 2010). In purposive sampling, the researcher uses a set of criteria to select participants who have experienced the phenomenon of interest and are able to describe those experiences (Joubert & Ehrlich 2010).

In this study, the researcher interviewed only HIV-positive women who:

- were at least 18 years old
- attended at least one ANC visit during the previous six months of the data collection period, and
- were willing to be interviewed.

The researcher assumed that the six months window period between the last antenatal visit and the interview will allow the informants to recall their actual experiences easily and to describe them objectively.

The final sample consisted of 18 participants. This number was determined by data saturation. The researcher used the antenatal care and the delivery registers of the hospital to identify the participants who met the above criteria. It is argued that the sample size in qualitative study is determined by data saturation. The researcher stopped data collection when there was no more new information coming up from the participants, which means that data had reached saturation point (Kumar 2011).

### **3.5 DATA COLLECTION METHOD AND PROCEDURES**

The researcher made use of semi-structured individual interviews to collect data from the HIV-positive women who had consented to participate in the study. Semi-structured interviews according to Taylor (2014) are flexible interviews in which the interviewer does not follow a formalised list of questions but rather follows an interview guide. They allow for open response in participants' own words rather than a 'yes or no' type answer (Clifford, French and Valentine 2010).

The advantages of semi-structured interviews include the following; guaranteed depth of information, researcher can probe to understand perspectives and experiences of studied phenomenon, and flow and sharing of views becomes more natural as the order of questions is not fixed. Researchers prepare in advance a guide of written topics, which is a list of areas or questions to be covered with each participant. This technique ensures that researchers will obtain all the information required. It gives people the freedom to respond in their own words to provide as much detail as they wish, and to offer illustrations and explanations (Polit& Beck 2008).

However, using semi-structured interviews also has its own disadvantages. These include the fact that interviewing is time consuming and expensive, the quality of data may vary when many interviewers are used, and also the researcher might introduce his/her bias, either in the framing of questions or in the interpretation of responses (Kumar 2011). Analysis of findings is also difficult and time consuming.

The researcher found the semi-structured interviews to be more relevant to the objectives of the study. It allowed the researcher to structure the questions according to the components of the experiences of care while allowing the participants to express their personal experiences within these structures.

The initial contact with the identified participants was done through telephone and physical contact by the researcher. The aim of this initial contact was to ask them if they were willing to participate in a study looking at their experiences with antenatal care. An appointment for individual interview was set on the date, time and place convenient to the participants. The formal consent form was signed on the day of the interview. Interviews were conducted in various locations to suit the needs of individual participants. However, most of the participants opted to be interviewed in the hospital environment, and the most common reason was that they meant to come to hospital on a certain day and would appreciate if the interview would take place on that very same day.

The researcher began each interview on a friendly note by greeting and asking general questions in order to allow the informants to settle down. This was followed by the three main questions of the study, which was done intermittently with probing questions to allow the informants to answer the main questions. Probes are prompts to obtain response clarity (Johnson & Christensen 2012), helping the participants to elaborate on their responses of the main question. The probing questions were not the same for each interviewee, and did not follow any order and was used where appropriate to facilitate the flow of information.

Field notes were also used to document all relevant non-verbal expressions and reactions that were observed from the participants during the interviews. According to Polit and Beck (2008), field notes ensured that reflective ideas that evolve during the interviews and analysis of data are documented as a continuous process. Questions were sometimes explained further where the researcher thought that the informant required further explanation, and where the informant requested for further clarification of a question. Each interview lasted about 20 minutes.

The interview schedule included three main open-ended questions, which were related to the:

- actual ANC received by the participants during the different ANC visits in the hospitals and at home,
- experiences of the participants with the above care, and
- Measures they think should be taken to improve ANC services provided to HIV-positive women in the hospital.

An interview schedule has the advantages of: saving interview time, increasing the efficiency and comprehensiveness of the interview; and keeping the interactions focused. It contributed to the researcher's ability to certify that the same general area of information is gathered from each interviewee (McNamara 2009). It is also agreed that an interview schedule provides more focus than the conversational approach, but still permits some degree of freedom and flexibility in order to obtain the required data from informants (Taiylor 2014).



In order to familiarize herself with the interview schedule and the interviewing techniques, the researcher conducted three pilot interviews with HIV-positive women who met the inclusion criteria for this study. These interviews were tape-recorded and transcribed verbatim by the researcher. The transcripts were discussed with the research supervisor. Appropriate corrections were done on the satisfaction of the research supervisor.

### **3.6 DATA MANAGEMENT AND ANALYSIS**

Data management and analysis began during the data collection process. Data management as the first step of data analysis involves transcribing, organizing, developing categories and coding data (Holloway & Wheeler 2002). Transcription of data was done within 24 hours of each interview. After each interview, the researcher transcribed the audio-recorded data verbatim into written text. Transcription of data assisted the researcher to immerse herself into the data and to organize the data. Field notes of non-verbal communication codes, such as nodding, silence, body language were later added to the transcripts.

The researcher transferred the recorded audio data onto a laptop computer, while an ear piece was used to listen to each respondent's data again in order to compare it to the written documents. The researcher made all the necessary corrections and kept the same codes that were used on the original manuscripts. The capturing and typing of data was done according to the order of questions on the interview schedule and related probing questions.

After capturing data into MSWord, the researcher created folders corresponding to the components of the experience of care that was used as

a framework for the study. Information in each folder was further organized and captured into a table format, which contained five columns. The informants' answers with the corresponding code were captured in the first column. The informants' answers were copied from their transcribed manuscripts and pasted into this column with the probing questions. Thereafter, the researcher reviewed the documents and proceeded with cleaning the data.

Data analysis started after the cleaning process. The researcher used the Thematic Content Approach as a framework to guide the data analysis process. Following the cleaning of data, the researcher studied the data in order to identify concepts that emerged from data by using an inductive approach. Similar concepts were highlighted with the same colour. The quotes from which the concept emerged were also given the same colour. At the end of this exercise, the identified concepts were copied and pasted into the second column of the table. Similar concepts were grouped together in the third column. The fourth column contains the number of times that a concept emerged from the data. These groups of concepts were examined to derive possible subthemes, which were captured in the fifth column. Each sub-theme was captured with the emerged concepts. In the last column the researcher captured possible theme with the related interpretation after consulting the literature.

### **3.7 SCIENTIFIC RIGOUR**

Rigor refers to the steps taken to ensure trustworthiness of the research results (Davies & Logan 2008). It is the striving for excellence in research

through the use of discipline, adherence to detail and strict accuracy. In this study, scientific rigour or trustworthiness was achieved through confirmability, dependability, credibility, and transferability.

### **3.7.1 Confirmability**

Confirmability refers to the degree of the objectivity of the results, recommendations, and conclusion as well as the neutrality of the researcher in the research process (Kumar 2011). Confirmability in this study was achieved through the ethical clearance process of the Higher Degree Committee of the University of South Africa and the researcher adherence to the approved research protocol.

### **3.7.2 Dependability**

Dependability is concerned with whether similar results would be obtained with similar participants in a similar context (Kumar (2011). According to Shento (2004), the meeting of the dependability criterion in a qualitative work is difficult. However, in this study, the researcher observed the principle of dependability by providing detailed description of the data management and analysis procedures in the report.

### **3.7.3 Credibility**

Credibility refers to confidence in the truth of the data and data interpretation (Kumar 2011). This means that the researcher attempts to demonstrate that a true picture of phenomenon under scrutiny is being presented (Shento 2004). In this study, credibility was ensured through multiple reviews of the field notes and audiotapes; the neutrality of the researcher during the

interviews, member checking, careful handling of emotional expressions, and the examination of findings by the supervisor.

### **3.7.4 Transferability**

Transferability is defined as the extent to which the results of a qualitative study can be generalized or transferred to other settings (Kumar 2011). It looks at how applicable or how useful the results are to a similar group or setting (Davies & Logan 2008). Transferability in this study was ensured by providing detailed descriptions of the informants' characteristics, the informants' description of the phenomenon, as well as the researcher's observations in reporting the findings.

## **3.8 ETHICAL CONSIDERATIONS**

This study was conducted according to the ethical principles outlined in the University of South Africa Research Policy as well as universal ethics principles. Ethical approval was obtained from the Ethics Committees of the University and the Ministry of Health of the Kingdom of Swaziland granted permission to access the research setting. Permission to access ANC register was sought from the Hospital administrator. The universal ethical principles that guide social and health research (autonomy, rights to privacy and confidentiality, justice, and protection from risk and harm) were adhered to in this study.

### **3.8.1 Autonomy**

This principle stressed the voluntary nature of the participation to the research project. It is argued that research participation must be completely voluntary

and the participants should be well informed and understand what is involved in the study (Babbie 2010).

The autonomy of the participants was ensured through informed consent. The information about the study was given to the participants in verbal and written forms. Verbal information was given to the participants during the initial contact while written information was contained in the participant information sheet attached to the consent form. The researcher reviewed the information sheet with the participants before the interviews. Each participant was offered the opportunity to ask questions of clarification. The participants were also informed about their rights to withdraw from the study at any time. They were ensured that refusing to participate or withdrawing from the study will have no adverse effects on them as the researcher was working in the same setting. Thereafter, they were requested to sign the written consent form.

### ***3.8.2 Rights to confidentiality, privacy, and Justice***

Confidentiality refers to an agreement with the research investigators about what can be done with the information obtained about a participant, meaning that the participant's identity is not revealed to anyone other than the researcher and his or her staff. Privacy is the controlling of other peoples' access to information about a person. Respecting the privacy of research participants is at the heart of the conduct of ethical research (Johnson & Christensen 2012). Anonymity on the other hand is the best way to protect privacy of research participants. This means keeping the identity of the participants from everyone including the researcher.

The researcher conducted the interviews in place and time that were convenient to the participants, while data management, analysis and reporting were handled in a way that no other person would be able to link the descriptions to individual participants. The researcher did not collect any other data outside of the scope of this study, and all the informants were treated equally during the interview process. Informants' names were substituted with codes in the interview transcripts, and the audio records were strictly handled by the researcher.

### ***3.8.3 Protection from harm and risk***

According to Kumar (2011), harm includes not only hazardous medical experiments but also any social research that might involve such things as discomfort, anxiety, harassment, invasion of privacy or demeaning or dehumanising procedures. This study did not have any potential to cause physical or psychological harm to the participants. The study did not have any potential risks. However, the researcher ensured that interview questions were carefully phrased and that participants were offered an opportunity to ask questions at the end of the interviews.

In addition, the researcher was cognisant of the risk of HIV-related stigma. In order to avoid the potential for HIV-stigmatization, the researcher exercised confidentiality with regard to the HIV status of the participants. Participants' consent form did not include the HIV status of the participants.

### **3.9 CONCLUSSON**

This chapter outlined the methodology that guided this study. It explained why these particular design and techniques of data collection were used. It also examined how data were processed in the study and how the ethical principles were observed.

## **CHAPTER 4**

### **PRESENTATION AND DISCUSSION OF THE MAIN RESULTS**

#### **4.1 INTRODUCTION**

The objectives of this study were twofold. To describe and explore the HIV-positive women' experiences with the antenatal care they received at a Regional Referral Hospital, and their perspectives on measures required to improve the antenatal care services provided to HIV-positive women at a selected Regional Referral Hospital in Swaziland. These experiences were explored in terms of the HIV-positive women' description of their personal views and feelings about the actual antenatal care they received. As described in Chapter Three, the researcher used a quality descriptive design with semi-structured individual interview to address the objectives of the study. Data saturation was obtained after 18 interviews.

In this chapter the researcher presents and discusses the main results of the findings. The results of the findings are presented according to the two objectives of the study. The first sub-section describes the characteristics of the participants. The second and third sub sections present the main findings related to the two objectives of the study. The researcher used the extracts from the participants' descriptions to support the results. The researcher maintained the exact language and phrases that were used by the participants but some grammatical amendments were made in order to maintain the logical flow and clarity of lexes.



## 4.2 CHARACTERISTICS OF THE PARTICIPANTS

The participants were described according to the following six variables: age, marital status, highest level of education, employment status, number of parity, and number of ANC visits in the past six months. Table 4.1 gives a summary of the characteristics of the participants.

**Table 4.1: Characteristics of the participants (N=18)**

Variables	Frequency	Percentage (%)
<b>Age (in years)</b>		
• 19 – 24	5	28.0
• 25 – 30	7	39.0
• 31 –36	6	33.0
<b>Marital status</b>		
• Married	9	50.0
• Single	9	50.0
<b>Highest level of education</b>		
• Primary level	4	22.0
• Secondary level	6	33.0
• High School level	5	28.0
• Tertiary education	3	17.0
<b>Employment status</b>		
• Employed	11	61.0
• Unemployed	7	39.0
<b>Number of parity</b>		
• 1	3	16.7
• 2	6	33.3
• 3	6	33.3
• 4	5	27.8
<b>Number of ANC visits in the past 6 months (from the date of the interview):</b>		
• 2	2	11.0
• 3	3	16.7
• 4	7	39.0
• 5	5	27.8
• 6	1	5.5

As indicated in Table 4.1, 50.0% were married and 50.0% were single; 100% were educated; and 61.0% were employed or self-employed. The women's parity ranged from 1 to 4, while their age varied from 19 years to 36 years with a mean age of 27.6 years. The number of ANC visits in the past six months ranged from 2 to 6 times. In addition, it emerged from the descriptions provided by the 18 participants that they received the focused ANC package prescribed by the Ministry of Health for HIV positive pregnant women (MOH 2010a).

### **4.3 HIV-POSITIVE WOMEN' EXPERIENCES WITH THE ANC SERVICES**

Participants were asked to describe their personal experiences with the ANC services they received at the research setting. Fourteen themes derived from the thematic content analysis of the descriptions provided by the participants. These themes were classified into six sub-categories and two main categories. Table 4.2 provides a summary of these categories with the related sub-categories and themes. Discussions are included at the end of each category.

**Table 4.2: HIV positive women' experiences with the ANC care services**

Categories	Sub-categories	Themes
<b>1. Experiences with physical and human resources</b>	1.1 Structure of the ANC clinic	<b>1 Multiple duty stations</b>
		<b>2 Lack of privacy</b>
	1.2 State of the equipment	<b>3 Poor equipment</b>
		<b>4 Long waiting hours</b>
	1.3 Organisational management	<b>5 Slow delivery of services</b>
		<b>6 Non-adherence to working hours</b>
<b>2. Experiences with the provider-user interaction</b>	2.1 Cognition	<b>7 Communication</b>
		<b>8 Comprehensive information</b>
	2.2 Respect, dignity, and equity	<b>9 Appropriate respect</b>
		<b>10 Friendliness</b>
		<b>11 Equal treatment</b>
	2.3 Emotional support	<b>12 Promptness of nurses</b>
		<b>13 Adequate attention</b>
<b>14 Empathy</b>		

### **Category 1: Experiences with physical and human resources**

This category reflects the participants' views and feelings regarding the structure and the state of the physical and human resources. As described earlier, the physical resources elements of the clients' experiences of care refer to their views and feelings regarding the state of the infrastructure and the equipment. While the human resources elements of the clients' experiences of care refer to their views and feelings regarding the actual contact time with qualified staff that is different from his/her impression of how she/he was treated by staff during an interaction (Hulton, Matthews & Stones

2000). Six themes derived from the participants descriptions. These themes were sub-divided into three sub-categories as indicated in Table 4.2.

### **Sub-category 1.1: Structure of the ANC clinic**

As indicated in Table 4.2, multiple duty stations and lack of privacy were the two themes classified under this sub-category. These themes reflect the participants' views and feelings regarding the structure of physical infrastructure where the ANC services are provided in the hospital.

#### ***Theme 1: Multiple duty stations***

This theme was mentioned by all 18 participants. They were unhappy about the number of duty station they have to go through during the ANC visits.

These views were exemplified by the extracts below:

*It is not good, I wish it could do everything in one single room and go straight home. But you have to move to many different rooms before you are done.*

*After collecting your file, you must go to room where they check your weight, blood pressure and temperature and asked you few questions. From there you are given a container to go bring urine, then go to the laboratory, from there go to another room for full physical examination and sometimes you are sent to another room and by the time you get to the pharmacy you feel so exhausted.*

*It is not comfortable; I wish that they could do everything in one room with all the nurses there. This going in and out from all these rooms is*

*just too much for us. ...some of us are very weak because of our status.*

### **Theme 2: Lack of privacy**

All the 18 participants felt that their right to confidentiality was violated by the way the ANC is structured. Each pregnant woman attending the ANC clinic is given card which she has to produce every time she comes for the ANC. This card contains the HIV status of the woman. According the participants, their HIV positive status was no longer a secret because they have to produce this at all the duty stations. This view was well captured by the extracts below:

*This endless move from one room to another exposes you to a lot of nurses. At each room they check your card and see your status, which means that at the end of the day your status is known by everybody in the hospital because of this process.*

*May there be confidentiality in their treatment process as currently there is none, yet we (referring to HIV positive pregnant women) are also humans and have equal rights with those that are HIV negative.*

### **Sub-category 1.2: State of the equipment**

This sub-category reflects the participants' views and feelings regarding the state of the equipment used during the ANC services at the hospital. As indicated in Table 4.2, one theme derived from the thematic content analysis of the participants' descriptions of their experiences with ANC.

### ***Theme 3: Poor equipment***

Some participants were concerned about the status of the equipment, namely the CD4 count machine. They felt that this equipment is not always functional as illustrated by the extract below:

*The only part I don't like is the CD4 machine which is always reported out of order; this makes us not to know how healthy and strong we are.*

### **Sub-category 1.3: Organizational management**

This sub-category reflects the participants' views and feelings regarding the time spend at ANC before being attended by a healthcare professional and the process of the ANC delivery. As indicated in Table 4.2, two themes: *long waiting hours and non-adherence to the working hours* emerged from the thematic content analysis of the participants' descriptions of their experiences with ANC under this sub-category.

### ***Theme 4: Long waiting hours***

Waiting hour refers to the time the client spends in the facility before they receive the care they sought. The participants felt that the time they spent in the facility is not acceptable. They wait a long time before being attended by healthcare professionals. This view was shared by all the 18 participants.

*The time I spent waiting to be attended by a nurse is too long. Considering that sometimes you have to go back to work, this delay affects you psychologically as you have to think of what to tell your boss and colleagues when you get back at work.*

Some participants attributed the long waiting hours to the shortage of nurses as captured in the following extract from one of the participants:

*I think that the long waiting hours is due to the number of nurses on duty. Because you have to wait for a long time before being called in to see by a nurse.*

#### **Theme 5: Non-adherence to working hours**

Participants felt that the healthcare workers at the ANC do not adhere to the official working. This non-adherence leads to the delay in access the required care as well as to the waiting hours.

*The clinic has enough nurses but the major problem is the time they arrived at the clinic. The clinic is scheduled to start at 8h00 AM but you will find that some clinic staff start working at around 10h00 AM. Thus late coming causes the delay in the delivery of ANC.*

#### **Theme 6: Slow delivery of service**

This theme refers to the time a healthcare professional spend completing a procedure. Participants were of the view that healthcare professionals are slow in carried out a procedure. They wondered if this slow delivery was due to the protocol or to the competence of nurses as exemplified in the extract below:

*I cannot say that the hospital is short staffed but what I noticed is the way they perform their duties (pause)...they are slow. I do not know if they (nurses) are responsible for this slow process or it is due to the protocol that they have to follow.*

Others were more concerned about this slow pace of delivery than the long waiting hours.

*I am not so much concerned about the waiting time because there are many people who use this hospital...my main problem is the slow pace in delivering the care.*

The results of this study as presented in this section suggest that HIV positive pregnant women had a mix of negative and positive experiences towards physical and human resources. The negative experiences were expressed in terms of long waiting hours, non-adherence to working hours, and slow delivery of services. There seems to be a relationship between those experiences. Multiple duty stations may lead to long waiting hours, while slow delivery of services may be attributed to the poor status of equipment. The non-adherence to the working hours may cause long waiting hours as well. The lack of privacy expressed by the participants in this study was mainly linked to the multiple duty stations. Some HIV-positive women felt that entering more than one room exposed them to different individuals and in the process, their right to privacy was violated.

The fragmentation of services, which is captured as multiple stations was negatively viewed by the participants and created the feeling of the violation of their privacy. Would the above situation be attributed to the omission of the physical infrastructure in components of the focussed ANC package developed by the Ministry of Health (MOH 2010a)? Or could it be attributed to



the common status of the health infrastructure described in many developing countries (Mrisho et al. 2009).

Although these negative experiences may be explained by the non-inclusion of the managerial component into the focused ANC package (MOH 2010a and b), the same trend is also documented in the literature. In a study conducted by Novick's (2009) women experienced long waiting hours at the ANC services and they attributed those experiences to staff shortages, delay of health providers in resuming work, and also to meetings which took place in the department. Previous study (Kabakian-Khasholien *et al.* 2000) showed the link between the level of privacy and the number of staff. Women were satisfied with the level of privacy they were given at the hospital for as long as the number of staff did not exceed three in the room, and were all females.

## **Category 2: Experiences with provider-user interaction**

This category reflects the participants' views and feelings about the way they were treated by healthcare providers during their actual interaction. Provider-user interaction is an important component of the experience of care framework that guided this study. The latent dimensions of provider-client interactions, which are relatively hidden but nonetheless powerful components of the interactions shape client-provider exchanges. Such components reflect the fundamental differences in the status, power and culture of participants in the encounter. This entails having all healthcare users being treated with appropriate respect, the same standard of care regardless of their education background, age, and class; and not being subjected to unnecessary

humiliation (Hulton, Matthews & Stones 2000). As illustrated in Table 4.2, this category includes three sub-categories and eight themes.

### **Sub-category 2.1: Cognition**

Cognition as an element the experience care framework refers to the extent to which a client feels she understands what is going on and feels that her questions have been answered adequately; and whether she actually receives sufficient information in a form that she and her family can understand and that she has the right to know. It is often measured by assessing if - the information is communicated in a manner that could be easily understood by the clients; the clients are fully prepared and understand their options; the reasons for a specific intervention are clearly explained; and the information about follow-up care is effectively communicated (Hulton, Matthews & Stones 2000). Two themes: *effective communication and comprehensive information* are the two themes that emerged from the thematic content analysis of the participants' descriptions of their experiences related to the cognition sub-category (see Table 4.2).

### **Theme 7: Communication**

Communication refers to the quantity and the quality of information given to the HIV positive pregnant women at the ANC clinics. Some participants were satisfied with the quantity and the quality of the information given to them by health professionals, while others felt that the information given to them was not enough. These views are reflected in the extracts below:

*They gave me enough information, told me to take ARVs in time so as to protect my baby from coming out with the virus. I was told on how to*

*take care of myself during pregnancy. They told me that I should eat well balanced meals with all three food groups and not to drink alcohol or smoke.*

*Before everything begins they explained almost everything to me, and allowed me to ask if I had any. They gave me information regarding my HIV status and what precautions should I take. I can say that now I am knowledgeable about HIV and the pregnancy.*

The extracts below depict the views of participants who were unsatisfied about the quality of the information she receives from the ANC.

*I can't remember being offered any health education. I am just using my experience. I followed the basic precautions.*

*Nurses did give me some information, but it was not detailed. I did not receive enough information about HIV.*

### ***Theme 8: Comprehensive information***

This theme refers to the information regarding follow-up and adherence to treatment. Participants felt that health professionals gave them important information regarding the follow-up and adherence to treatment.

*They told me that I should take my RVA treatment regularly and respect the doses. I was also encouraged to use a condom at all times during sexual intercourse.*

*I was given advice that since I tested positive, my partner should also come for testing.*

## **Sub-category 2.1: Respect, dignity and equity**

The relationship between the client and provider should be characterized by privacy, confidentiality, informed choice, concern, empathy, honesty, tact and sensitivity (Hulton *et al* 2000: 43). As illustrated in Table 4.2, three themes: *appropriate respect, friendliness, and equal treatment* emerged from the thematic content analysis of the participants' descriptions of their experiences related to this sub-category.

### ***Theme 9: Appropriate respect***

Participants felt that coming to the hospital was not a waste of time as they would be treated in a manner that they kept on looking forward to come again. This view was articulated by all the 18 participants. It was well captured by the extract below:

*I always look forward to my next appointment because of the treatment I receive from the staff. They talk to you with respect; they don't shout at you or ill-treat you.*

### ***Theme 10: Friendliness***

This theme refers to the easiness to interact with the providers. All the 18 participants find the healthcare providers to be very friendly and easy to interact with.

*I am happy with the attitude of the staff at the ANC clinic. They are very sociable and easy to interact with and always smiling.*

### ***Theme 11: Equal treatment***

Participants felt that healthcare providers treated them without any discrimination. They were treated the same way other pregnant women were treated.

*Nurses and all health professionals treated me well. No one discriminated against me because of my HIV status even though written on ANC card. They interacted with me in the same way they did with other women who were attending the same services.*

### **Sub-category 2.3: Emotional support**

This sub-category reflects the participants' views and feelings regarding the quality of care received at the clinic. Emotional support as per the conceptual framework used in this study refers to the support given by the staff members to each client as per need. It can also mean the woman's access to social and emotional support (Hulton *et al* 2000).

As illustrated in Table 4.2, three themes: *promptness of nurses, enough attention and empathy* emerged from the thematic content analysis of the participants' descriptions of their experiences related to the provision of care sub-category.

### ***Theme 12: Promptness of nurses***

Despite the long waiting time before being seen by a nurse, some participants said that nurses are readily available and prompt to attend to them. These views were well articulated in the extracts below:

*Nurses are very helpful and quick to attend to you. Once you get your file...you will be immediately seen by a nurse. It happens in all the duty stations.*

*Despite their number, you always find a nurse ready and quick to attend to you.*

### **Theme 13: Enough attention**

All the 18 participants felt that they received enough attention from healthcare professionals during the visits. This view was mainly attributed to the multiple duty stations. They were of the views that the multiple duty stations exposed them to professionals with different expertise.

*You are given enough attention by staff at the clinic...in each and every duty station they do different things. It really makes me believes that no one is neglected.*

*I like the attention given to us in the clinic. For each visit you have to go through many duty stations and be seen by different people at each duty station. Unlike being seen by one person who will take care of everything. It makes me feel confident and not to miss my appointments.*

### **Theme 14: Empathy**

Participants were of the views that nurses showed great feelings of understanding and appeared to share their problems.

*They would say, now that you are taking your treatment you have taken a great decision, and tell you that they will support you all the time you see'.*

*I was encouraged to join a support group for HIV positive women which I did. It helped me a lot, specifically in the understanding of the HIV and pregnancy, and on how to live positively with my status. I also learnt a lot about mother to child transmission.*

The results of this study show that HIV positive pregnant women had positive experiences about their interaction with the healthcare providers. As illustrated with the results, the interaction between the HIV positive pregnant women and the health professionals during ANC services was characterized by appropriate respect, friendliness, equal treatment, effective communication, comprehensive information, promptness, attention, and empathy. These experiences are indicators of good quality of care (Hulton *et al* 2000).

These results are supported by previous studies (Raine *et al* 2009:590; Shabila, Ahmed and Yasin 2014). These studies suggest that positive interaction between pregnant women and the providers is an indicator of client-centred approach to maternal care and an enabler for future utilisation of maternal services. Effective communication is a key element for the provision of health education to HIV positive pregnant women, which is of the strategy of the focused ANC package (COS 2008). Communicating empathy is an important attribute that a midwife should possess. Fraser and Cooper

(2009:265) highlight the fact that midwives have huge responsibilities in helping women through the pregnancy stages and labour. The midwife has to develop a trusting partnership with the pregnant woman and demonstrate empathy toward the woman and her family.

Promptness of nurses and satisfaction with the care received might suggest a certain level of adherence to the focused ANC package and an indicator of quality ANC services. According to the Ministry of Health (MOH 2010a), the focused ANC package for HIV positive women was implemented with the intent of improving the quality of ANC care provided to this group of women. These positive experiences can also be attributed to the increasing number of qualified human resources for health as noted in the Service Availability Mapping report (SAM 2010).

Finally, may these positive experiences explain the high rate of antenatal care in the country? As stated earlier, 97 percent of pregnant women regardless of their background do attend the ANC services in Swaziland (CSO 2008).

#### **4.4 MEASURES REQUIRED TO IMPROVE THE ANC SERVICES**

Participants were asked the following main question: ‘what measures should be taken to improve the antenatal care services provided to HIV-positive women at the Regional Referral Hospital?’ Seven themes derived from the thematic content analysis of the descriptions provided by the participants to the above question. These themes were classified into three main categories as illustrated in Table 4.3. Participants felt that these measures should be put in place to improve their experiences with the ANC services. All these measures are related to the descriptions of their experiences with the ANC



services they received at the regional referral hospital as presented under point 4.3.

**Table 4.3: Measures required improving HIV positive women's experiences with the ANC care services**

Categories	Themes
1 Organizational and policy related measures	<b>1 Reduce the number of duty stations</b>
	<b>2 Reinforce working hours</b>
	<b>3 Increase the number of nurses</b>
	<b>4 Organise home visits</b>
2 Direct provision of care related measures	<b>5 Enhance health education</b>
	<b>6 Increase emotional support</b>
3 Users' related measures	<b>7 Partner involvement</b>

### **Category 1: Organizational and policy related measures**

As indicated in Table 4.3 three themes: *reduce the number of duty stations, reinforcement of working hours, and increase the number of nurses* were identified and categorized as organizational and policy related measures.

### **Theme 1: Reduce of the number of duty stations**

Participants felt that measures need to be taken to reduce the number of duty stations at the ANC services. This view was express by all the participants as illustrated in some of the extracts below:

*The stages that you undergo expose you to a lot nurses because you have to go from room to room, and in every room they check your card*

*and see your status. We request that this system be changed, may we have one nurse giving you all the services you have come for.*

*If there can be a change in process of entering so many rooms, it will make real difference, specifically in term of time. You always finish late because of these different rooms.*

*We must at least have a single door where everything will be taken care of, not going from one door to the next, it is time consuming.*

*They must help us on the issue of going for different rooms; they must just use one room. The up and down is really not fine. ,*

## **Theme 2: Reinforce working hours**

Participants stated that there are measures that are required to reinforce adherence to working by nurses.

*Somebody must ensure that nurses come at work on time so that we can also be attended on time and not spend most of our time here and getting tired of waiting.*

## **Theme 3: Increase the number of nurses**

Some participants felt that the number of nurses providing the ANC services must be increased in order to improve their experiences with the ANC services.

*I think that the number of nurses needs to be increased in order to improve the service. You come here early in the morning and then go back home very late.*

*Each client must be attended by a single nurse and get the whole service from that one nurse, and take the time you need. That goes to say more nurses are needed in this department and our plea is that may this be taken into consideration.*

*If there can be four nurses in a single room to service four patients at a go then we cannot be complaining of queues every day.*

#### **Theme 4: organize home visits**

It was felt that the hospital should organise home visits or mobile clinics as measures required for improving their experiences with the ANC care services.

*May there be an arrangement that we have nurses visiting our homes, communities to render the same ANC services, educating us together with our families. Maybe the light may dawn to everyone on the importance of knowing your HIV status.*

The organizational and policy related measures proposed by the HIV positive pregnant women fall into the scope of managers and policy-makers. These measures are known for their positive influence on the quality of care and on the utilisation of health care services. Mrisho *et al* (2009) stipulated that in order to increase the quality and the effectiveness of ANC services, staff shortages in terms of quantity and quality, lack of equipment and supplies in health facilities must be addressed.

Reducing the number of duty stations and the reinforcement of working hours as proposed by the participants are aimed at reducing the waiting time and

enhancing their rights to privacy. These measures are line with the government policy on increasing ANC coverage (MOH 2010a) and previous studies on access and utilisation of antenatal care services (Novick 2009; Ganga-Limando, Moleki & Modiba 2014). The implementation of home visits proposed by the participants should be viewed within the role of midwives in the implementation of maternal death review as a measure to improve maternal death (Dartey and Ganga-Limando 2014; WHO 2010)

## **Category 2: Direct provision of care related measures**

This category refers to measures that are directly linked to the care received and can be implemented by the practitioner without additional resources. As indicated in Table 4.3, two themes: *enhance health education and increase emotional support* emerged from the descriptions of all the participants.

### **Theme 5: Enhance health education**

Participants expressed the need to see an increase in health education on issues related to HIV transmission and on how to live positively with their status.

*HIV positive pregnant women should be given more information about being positive, which should involve diet, how to prevent mother to child transmission of HIV, prevention of HIV from being passed to someone else whom you are helping, and even if you are being taken care of by someone who doesn't know your status.*

*May they emphasize on the importance of prevention of HIV transmission to the unborn babies and may they also have ways of*

*teaching Positive women on the importance of protecting their HIV negative partners and families.*

Some participants suggested that this health education should be continuous and integrated into the all healthcare services.

*Nurses should continue giving us more information even if it means repeating one and the same thing each time I come to the hospital.*

### **Theme 6: Increase emotional support**

The participants felt that they needed more support from the health providers. They stated that the more the nurses show love to them, the more okay they feel. One participant said;

*HIV positive pregnant women need more love from their care givers and the emphasis that they are not alone in this journey. This helps them to follow all that has been taught in hospitals/clinics, and also encourages them to attend ANC classes just because of the support they will get which comes as a comfort to those whose families are not supportive.*

Enhancing health education and emotional support as proposed by the participants are congruent with the strategy outlined in the focused ANC package for HIV positive pregnant women. This package stressed the importance of the assistance to HIV positive women during the course of pregnancy. This assistance involves being taken care of by a skilled provider who will provide both medical and emotional support as per need. This means that health practitioners should be equipped not only with medical tasks but

also with supportive tasks, which they should perform sensitively and competently (CSO 2008).

### **Category 3: Users related measures**

This category refers to the measures that HIV positive women have to undertake in order to improve their ANC experiences. One theme emerged under this category as illustrated in Table 4.3.

#### **Theme 7: Partner involvement**

Participants strongly believed that one of the measures required for improving their experiences with ANC services would be for them (HIV positive pregnant women) to get their partners involved in the ANC services.

*If women may try and come to hospital with their men, because some women lack support from their husbands, and this can enhance support as they (the man) would be involved and will also get the necessary health education.*

Partner involvement in reproductive and maternal health issues has been recognized as an effective measure in preventive the transmission of sexually transmitted diseases and HIV among others (MOH 2010a). The focused ANC package for HIV positive pregnant women includes strategies on HIV testing and counselling, on health education but none of these strategies refer to the inclusion of male partner (MOH 2010a).

## **4.5 CONCLUSION**

This chapter presented and discussed the results of the main findings of the study according to the main objectives. These results were discussed according to exiting literature and the context of which the study took place. The next chapter will provide a general conclusion and the recommendations based on the results.

## CHAPTER 5

### CONCLUSION, RECOMMENDATIONS, AND LIMITATIONS

#### 5.1 CONCLUSION

The purpose of this study as stated in the first Chapter was to explore and describe the actual experiences of HIV-positive women with the antenatal care services provided at a regional referral hospital in Swaziland with the view of providing more insight into the quality of ANC services from the users' perspectives. The study was based on the understanding that HIV-positive women's experiences of the ANC services they receive are critical indicators of the quality of care. The researcher used the experience of care as a theoretical framework to conceptualize these experiences and to interpret the findings. The purpose of the study was addressed through two main objectives as described in the first Chapter. The researcher used these two objectives to structure the presentation and discussion of the results.

The researcher conducted qualitative semi-structured individual face-to-face interviews with HIV positive pregnant women who attended at least one ANC clinic at the selected Regional Referral Hospital. Data saturation was reached after eighteen interviews. The generated data was analyzed through thematic content analysis. The summary of the characteristics of the eighteen HIV positive pregnant women interviewed is presented in Table 1 in Chapter four. It was noted that the eighteen received the focused ANC package prescribed by the Ministry of Health for HIV positive pregnant women.



Twenty one themes derived from the thematic content analysis of the descriptions provided by the participants regarding their personal experiences with the ANC services and measures to improve ANC services. Fourteen of these themes were related to the personal experiences of the HIV positive pregnant women regarding the ANC services received; and seven to the proposed measures for improving ANC services. These results were summarized in Tables 4.2 and 4.3 respectively. The results of the main findings summarized in Table 4.2 as presented and discussed in Chapter Four showed that HIV positive pregnant women have negative and positive experiences toward the ANC services they received at the Regional Referral Hospital under the study. As indicated in Table 4.2, the negative experiences were expressed through six themes related to the physical and human resources. While the positive experiences were expressed through eight themes related to the provision of care. The results of the main findings summarized in Table 4.3 showed that seven measures for improving ANC services were proposed by HIV positive women. These measures were grouped according to their nature into three categories as shown in Table 4.3.

The results of the main findings of this study confirm the main assumption of this study which argues that the implementation of the implementation of focused ANC package for HIV positive pregnant women has not translated into significant improvement of the quality of the ANC services provided to this category of pregnant women. The results of this study also confirm the literature on the quality of care which suggests that a key indicator of the quality of care provided by healthcare institution is the actual experience of care as expressed by users. Finally, the results of this study provide an insight

into the type and nature of measures required to improve the quality of ANC services provided to HIV positive pregnant women.

## **5.2 RECOMMENDATIONS**

As stated in the first Chapter of this study, consumers' cumulative experience of care is a significant component of the quality of care. If a HIV positive pregnant woman's cumulative experience at ANC services is such that it deters her from returning for subsequent visits or hospital delivery, we cannot talk of actual quality of the provision of ANC services. In view of the above understanding and of the main findings of this study, the following recommendations are made:

1. Hospital management and relevant policy-makers are urged to implement the following organisational and policy measures:
  - 1.1. reorganise the structure of ANC services delivery with specific attention on the number of duty stations
  - 1.2. provide leadership and management in-service training to unit managers;
  - 1.3. increase the number of professional nurses allocated to the ANC services; and
  - 1.4. include focused ANC services package into the mobile clinics or outreach programmes;
2. Health services managers include unit managers should
  - 2.1. closely monitor the implementation of the focused ANC services package;

- 2.2. provide comprehensive guidelines on the content of the health education to be given to the HIV positive pregnant women;
- 2.3. Organize in service training on interpersonal and psychosocial skills to nurses.
3. The Ministry of Health should commissioned a national study looking at effective way of encouraging male participation in sexual and reproductive health issues in the socio-cultural context of Swaziland.
4. Similar study should be extended to other health facilities in the country.

### **5.3 LIMITATIONS**

This study was undertaken within the qualitative research approach and, therefore, the results of the findings cannot be generalized.

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## APPENDIX 1: INTERVIEW SCHEDULE

**Wendy Patience Gule**  
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Telephone: (+268) 76457276  
E-mail: [48057584@mylife.unisa.ac.za](mailto:48057584@mylife.unisa.ac.za)

### INTERVIEW SCHEDULE

**Title of the study:** HIV-positive Women' Experiences of the Antenatal Care at a Regional Referral Hospital in Swaziland

**Date of Interview:**.....

**Place of the interview:**.....

**Code:**.....

#### Biographical data

Name:.....

Address:.....

Age:.....

Occupation:.....

Highest Level of Education:.....

Number of antenatal visits during the past six months:.....

Date of the last visit: .....

#### Interview questions:

1. Can you tell me in your own words, your experiences with the antenatal care you received at Manzini Regional Referral Hospital?

*Examples of Probing questions:*

- What did you think about the attitudes of nurses/midwives towards you?
- How did it make you feel?
- What did you think about the attitudes of doctors towards you?
- How did it make feel?
- Do you think that nurses/midwives gave you enough information regarding HIV ( risk and prevention of mother to child transmission; importance of ARV Treatment, complications and side effects; diet; ect)

2. In general, how have you been treated by nurses/midwives and doctors during your ANC visits at Manzini Regional Referral Hospital?

3. What would you say about the overall quality of ANC you received at Manzini Regional Referral Hospital?

*Examples of Probing questions:*



- Would you say it was poor or good?
  - *What makes you say so?*
  - *Who do you think provided you with the best ANC in that hospital?*
  - *Looking at your own experiences, would you recommend any HIV-positive pregnant women to attend ANC services at Manzini Regional Referral Hospitals?*
  - *What are the main reasons for the above decision?*
4. How do you think, HIV-positive pregnant women should be treated at ANC services at Manzini Referral Hospital?
5. What do you think should be done to improve the antenatal care services provided to HIV-positive women at Manzini Regional Referral Hospital?
- Examples of Probing questions:*
- What changes do you want to see?
  - Who should lead the above changes?
  - How should the above changes be implemented?
  - Who should be monitoring the above changes?

## APPENDIX 2: PARTICIPANT INFORMATION FORM

### PARTICIPANT INFORMATION FORM

**Project Title:** HIV-positive Women Experiences of the Antenatal Care at a Regional Referral Hospital in Swaziland

#### **What is the research about?**

This is a research being conducted by **Wendy Patience Gule**, a Master student at the University of South Africa. You are invited to participate in this research because you attended the antenatal care services at Manzini Regional Referral hospital in the last six months. The purpose of this study is to propose guidelines for improving the antenatal care experiences of *HIV-positive women* at Manzini Regional Referral Hospital in Swaziland.

#### **What will I be asked to do if I agree to participate?**

You will be asked to answer questions which will be asked by the researcher. The researcher will schedule an individual interview with you, on time and place convenient to you. During this one on one interview, you will be given the opportunity to share your personal experiences with the care you received at the antenatal visit at Manzini Regional Referral Hospital, and your views on what you think should be done to improve the antenatal care experiences of HIV-positive women at Manzini Regional Referral Hospital. The interview will not take more than one hour. The interview will be conducted by the researcher. The interview will be audio-taped and notes will also be taken in order to allow the researcher to analyze and write the final report for the study.

#### **Would my participation in this study be kept confidential?**

The information you will share with the researcher will be kept confidential as much as possible. Your name or address is not required. The tape will be locked away by the researcher for a period of three. No individual names or identity will be used in the report. Should an article be written about this research project, your identity will be protected to the maximum extent possible.

#### **What are the risks of this research?**

There are no known risks associated with your participation in this research. However, the researcher understands that during the course of the interview, you may recall experiences that may be stressful to you. Should this happen, the research will refer you to the appropriate service for counseling. In case you prefer the interview to be held outside of your house, the researcher will cover your transport cost.

#### **What are the benefits of this research?**

This research will not have any monetary benefit to you as a participant. However, your experiences will assist the researcher to make recommendation for improvement of antenatal care. Your experiences will contribute to the learning process of the researcher.

#### **Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part in the research. You may choose to withdraw your participation at any time should you decide to participate in the research and you will not be penalized or lose any benefits which you otherwise qualify for.

#### **What if I have questions?**

If you have any questions about the study itself, please contact me (**Wendy Patience Gule**) on Telephone: 076457276 or on Email: [48057584@mylife.unisa.ac.za](mailto:48057584@mylife.unisa.ac.za)

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact: The Research Supervisor at +27-(12)-4294131; E-mail: [gangam@unisa.ac.za](mailto:gangam@unisa.ac.za)

This research has been approved by the Higher Degree Research Committee and Ethics Committee of the Department of Health Studies, University of South Africa.

### APPENDIX 3: CONSENT FORM

**Wendy Patience Gule**

P.O.Box 7946, Mbabane, Swaziland

Telephone: (+268) 76457276

E-mail: [48057584@mylife.unisa.ac.za](mailto:48057584@mylife.unisa.ac.za)

#### PARTICIPANT CONSENT FORM

**Title of the study:** HIV-positive Women Experiences of the Antenatal Care at a Regional Referral Hospital in Swaziland

**Dear Participant,**

I am a Master Student at the University of South Africa (UNISA). I am conducting a research project as part of the requirement of the degree. The study is looking at HIV-positive Women Experiences of the Antenatal Care at a Regional Referral Hospital in Swaziland. You are kindly requested to participate in the individual interview at the time which is more convenient to you. The interview will be tape recorded and no one else will have access to the tapes except the researcher. The tapes will be stored in a safe by the researcher and will be destroyed after five years. The information is confidential and your name will not appear on the report. The participation is voluntary and there will be no consequences should you refuse to participate. Even if you agree to participate, you may withdraw from the interview at any time.

If you have any questions regarding the study you may contact the Research Supervisor directly at this number +27-(12)-**4294131**.

I ..... voluntarily consent to participate in the above mentioned research project.

The background, purpose, risks and benefits of the study have been explained to me. I have received an information sheet and understand the contents thereof. I also understand that I may withdraw from the study at any time without prejudice. I understand that my participation in the study will be acknowledged, although my identity and the identity of health facility will be withheld.

I agree to be audiotaped during my participation in this study.

I understand that my participation in the study is voluntary.

.....  
Participants' signature

.....  
Date

.....  
Witness

.....  
Date

## Appendix 4: SWAZILAND MINISTRY OF HEALTH ETHICAL CLEARANCE

Telegrams:  
Telex:  
Telephone: (+268 404 2431)  
Fax: (+268 404 2092)



MINISTRY OF HEALTH  
P.O. BOX 5  
MBABANE  
SWAZILAND

### THE KINGDOM OF SWAZILAND

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**FROM:** The Chairman  
Scientific and Ethics Committee  
Ministry of Health  
P. O. Box 5  
Mbabane

**TO:** Ms. Wendy Gule  
Principal Investigator

**DATE:** 13<sup>th</sup> February 2014

**REF:** MH/599C/ FWA 000 15267/IRB 0000 9688

HIV-positive Women's Experiences of the Antenatal Care Services at a Regional Referral  
Hospital in Swaziland

The committee thanks you for your submission to the Swaziland Scientific and Ethics Committee, an Expedited review was conducted.

In view of the importance of the study and the fact that the study is in accordance with ethical and scientific standards, the committee therefore grants you authority to conduct the study. You are requested to adhere to the specific topic and inform the committee through the chairperson of any changes that might occur in the duration of the study which are not in this present arrangement.

The committee requests that you ensure that you submit the findings of this study (Electronic and hard copy) to the Secretariat of the SEC committee.

*The committee further requests that you add the SEC Secretariat as a point of contact if there are any questions about the study on 24047712/24045469.*

The committee wishes you the best and is eagerly awaiting findings of the study to inform proper planning and programming to use for analysis.

Sincerely,

**Dr. S.M. Zwane**  
DIRECTOR OF HEALTH SERVICES  
(THE CHAIRMAN)  
cc: SEC members



**Appendix 5: UNIVERSITY OF SOUTH AFRICA ETHICAL CLEARANCE**



**UNIVERSITY OF SOUTH AFRICA  
Health Studies Higher Degrees Committee  
College of Human Sciences  
ETHICAL CLEARANCE CERTIFICATE**

HS HDC/204/2013

Date: 18 September 2013                                  Student No: 4805-758-4  
Project Title: HIV positive women's experiences of the antenatal care services at  
a Regional Referral Hospital in Swaziland,  
Researcher: Wendy Patience Gule  
Degree: MA in Nursing    Code: MPCHS94  
Supervisor: Dr M Ganga-Limando  
Qualification: PhD  
Joint Supervisor: -

**DECISION OF COMMITTEE**

Approved

Conditionally Approved

Prof L Roats  
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE



Prof MM Moleki  
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRIES