EXPLORING THE ACCESSIBILITY OF ANTIRETROVIRAL TREATMENT AMONGST PEOPLE LIVING WITH HIV AND AIDS AT PUBLIC HEALTH CARE FACILITIES IN GERT-SIBANDE REGION IN MPUMALANGA

by

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Declaration of independent work

DECLARATION

I declare that **EXPLORING THE ACCESSIBILITY OF ANTIRETROVIRAL TREATMENT AMONGST PEOPLE LIVING WITH HIV AND AIDS AT PUBLIC HEALTH CARE FACILITIES IN GERT-SIBANDE REGION IN MPUMALANGA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledge by means of complete references.

Mohale M.O.

Signature:……..

Date:……

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Abstract

The aim of the study was to explore the accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care Facilities in Gert-Sibande Region in Mpumalanga. The study was conducted at a selected Public Health Care facility in Gert Sibande Region at Msukaligwa Municipality in Mpumalanga. The study focused primarily on people attending wellness programmes that are living with HIV and AIDS, receiving antiretroviral treatment in Public Health Care facilities.

Research design of the study was exploratory which fundamentally used to explore a new topic or to learn more about issues where little is known. The research approach was purely qualitative methodology which allowed the researcher to explore deeply the perceptions of people living with HIV and AIDS and the capabilities in the provision of antiretroviral treatment at public health care facilities in Msukaligwa municipality of Gert-Sibande Region in Mpumalanga. Qualitative interview is the method that has been used to gather data from 23 participants who took part in the study. Questions of the interview were semi-structured in-depth one-on-one interviews and were used to explore understanding in relation to the accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care Facilities in Gert- Sibande Region in Mpumalanga.

The findings of the study revealed that, there is good accessibility of antiretroviral treatment at public health care facilities in Msukaligwa Municipality of Gert-Sibande Region in Mpumalanga. There is also an existence of negative staff attitude towards patients and a probable poor service delivery at the referral local clinics.

It can be concluded that there is a need to re-look into the current Hospital's reception filing system and the turnaround time at certain areas of the Hospital and the capacitation of staff at the wellness centre. There is also a need to intensify the established programmes and the encouragement of people on treatment to take their antiretroviral treatment consistently.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARVs	Antiretroviral medication
CCMDD	Central Chronic Medicine Distribution and Dispensing program
HIV	Human Immunodeficiency Virus
KZN	Kwazulu Natal Province
MP	Mpumalanga Province
NHI	National Health Insurance
NDoH	National Department of Health
NRF	National Revenue Fund
PrEP	Pre-Exposure Prophylaxis
PEP	Post Exposure Prophylaxis
SANAC	South African National AIDS Council
SAPS	South African Police Service
START	Strategic Timing Antiretroviral Treatment
TB	Tuberculosis
UNAIDS	United Nations Program on AIDS
USA	United States of America
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

This chapter entails the background of the study and it also discusses the rationale of the study, statement of the problem, the aim of the study, the objective of the study, research questions and significance of the study and definition of terms. The study explores the accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care facilities in Gert-Sibande Region in Mpumalanga. Treatment against Human Immunodeficiency Virus (HIV) and acquired Immunodeficiency Syndrome (AIDS) epidemic on a global level continues to be a challenge. HIV and AIDS are a serious and still an incurable disease that has become a threat to human kind. Therefore treatment of the HIV and AIDS is an integral part of addressing the challenges of living with it (UNAIDS 2014:1).

There are various factors that contribute toward poor or good access to antiretroviral treatment. Those factors are; limited capacity of health systems, low and declining number of health professionals, high drug prices, long-term financial sustainability, inadequate laboratory and patient care infrastructure, poor patient follow-up and poor sustainability of drug supply (Poku 2005:124).

A fundamental notable problem is the roll-out program of antiretroviral treatment which, according to the researcher seems somehow less effective. This study assist in giving a clear explorative indication of what is the state of access to antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care facilities in Gert-Sibande Region in Mpumalanga.

This section discusses the background of the study. In this section the researcher defines what the study is all about and gives an outline about global perspectives regarding the accessibility of antiretroviral treatment. This section also discusses the

rationale for the study; outlines the statement of the problem. The aim, objective, significance and research questions of the study are also discussed.

Terms pertaining to the study are also defined and there is also a review of the related literature regarding the similar studies. Research methodology of the study is also discussed together with the research method, research design and area of study, target population, sampling and sample size, research instruments for data collection and the process are outlined in this study.

Methods to ensure credibility and trustworthiness of the research findings are also discussed The study‘s piloting strategy and how a pilot study will be conducted, are also explained. Data analysis and the issue of ethical considerations are detailed. The management of HIV and AIDS is critical and the use of antiretroviral treatment is of fundamental importance (Gast 2010:11).

1.2 Background of the Study

According to statistics people living with HIV globally in 2014 were estimated at 36.9 million and out of 36.9 million people, 25.8 million are found in the Sub-Saharan Africa. This shows that around 70 percent of people living with HIV reside in the Sub-Saharan Africa. South Africa has the biggest and most high profile HIV epidemic in the world. In 2016 an estimated 7 million people were living with HIV, with 180,000 South Africans dying from AIDS-related illnesses. It is estimated that in South Africa a new infection rate is at 380 000. Kwazulu Natal (KZN) still led the South African provinces by 40% followed by Mpumalanga Province (MP) with 37.7%. South Africa has the largest antiretroviral treatment roll-out program in the world. Life expectancy has also increased by five years since the height of the epidemic. Moreover, the efforts pertaining to curbing the spread of the epidemic have been largely financed from South Africa‘s domestic resources (Avert 2014:13).

The history of HIV and AIDS in South Africa is perhaps the most controversial one in the Sub-Saharan Africa. It is littered with examples of government in action and harmful interference, pseudoscience, and conflict between politicians, HIV and AIDS organizations and scientists. This is influenced largely by treatment activism; resources

have multiplied to address the pandemic while treatment costs have plummeted. However, these gains are currently threatened by intellectual property challenges to the availability of affordable medication; increasing criticism of HIV and AIDS funding; and a general pull back by donors. Recent scientific breakthroughs suggesting that treatment is also a highly effective form of prevention and a global activist movement in support of new global financing mechanisms means governments in a resource constrains environment should bear the brunt (Smith 2013:4).

The effect of this slow and interrupted response is still being felt in a country that is currently having the world's largest HIV and AIDS epidemic. Though certain groups are more at risk of HIV transmission than others, South Africa has a serious generalized epidemic affecting people from all sectors of society. In most regions, including the World Health Organization African Region, men eligible for antiretroviral treatment appear to be less likely to be receiving treatment than women. This implies that a man seems to be ignorant in issues involving HIV and AIDS. South Africa with a high burden of HIV infection is potentially on the track to achieve universal access. However, South Africa still needs urgent major support to boost scaling up of treatment from both private and public sector. It is therefore crucial that social and structural barriers to HIV and AIDS treatment are reduced to ensure better roll-out programmes in heavily burdened countries (WHO 2012:07).

This escalating prevalence figures simply imply that there is a huge demand of antiretroviral treatment (ART) in Africa and Sub-Saharan African countries, where South Africa and Mpumalanga Province are located. Whatever challenges faced by Sub-Saharan African countries are similar in Gert-Sibande Region. The Gert-Sibande Region is no exception to other Sub-Saharan African countries' Provincial Sub-Regions in terms of huge demands of ARVs.

The study focuses primarily on the one variable which is; accessibility of antiretroviral (ARV) treatment amongst people living with HIV and AIDS at Public Health Care Facilities in Msukaligwa municipality of Gert-Sibande Region in Mpumalanga. The study investigates the state of access to antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care facilities in Msukaligwa municipality of Gert-

Sibande Region in Mpumalanga. According to Ermelo regional hospital board meeting (2014:14) the availability of Tuberculosis (TB) and antiretroviral treatment has been as follows:

First quarter 85 percent, second quarter 93 percent, third quarter 94 percent, fourth quarter is 93 percent with annual availability of 91 percent. This indicator shows clearly that there is 9 percent shortage per annum of TB and antiretroviral treatment in Ermelo hospital and the surrounding clinics in 2013. So it is of vital importance to establish the impact that the 9 percent had on people living with HIV who are inclined to access treatment (Ermelo Hospital Strategic Plan 2014:14).

The study assist in giving clarity regarding the state of access to treatment amongst people living with HIV and AIDS in Public Health Care facilities in Msukaligwa municipality of Gert-Sibande Region Mpumalanga. The Ermelo Regional Hospital Board (2014:6) further suggests that the leading causes of death are HIV and AIDS related death followed by TB, hypertension and diabetes mellitus following third and fourth respectively (Ermelo Hospital Strategic Plan 2014:06).

HIV and AIDS pose a serious threat to socio-economic conditions of South Africa and the response against the impact caused as a result, should be highly intensified. The researcher holds a view that there is still an alarming inadequate supply of antiretroviral treatment in Public Health Care facilities around South Africa and Mpumalanga Province.

The important factor in selecting a problem to be studied is its significance to health and contributing to the body of knowledge, findings of this study are valid not only for the South African context, but by addressing issues that are entailed in the South Africa‘s National Strategic Plan on HIV and AIDS. The results can be generalized to other countries with similar challenges. The results of this study provide baseline knowledge and understanding of the underlying conditions of access to antiretroviral treatment in Public Health Care facilities. The researcher believes that the recommendations of the study made to the Chief Executive Officer and Hospital Board and the District Manager will contribute to a solid foundation that will assist in improving challenges pertaining to

antiretroviral accessibility in Public Health Care facilities in Msukaligwa Municipality of Gert-Sibande Region of the Mpumalanga Province (Brink 2002:78).

1.3 Rationale for the Study

The researcher was employed by the South African Police Service (SAPS) as a forensic analyst and a safety representative who is a Non-Executive Board Member at Ermelo Regional Hospital. What motivated the researcher to conduct this study were the opinions expressed by some colleagues at the work place regarding accessibility of antiretroviral treatment in Public Health Care facilities in Gert-Sibande Region. Their opinion ranges from their direct involvement in accessing antiretroviral treatment in Public Health Care facilities and general challenges that they experience when accessing the antiretroviral treatment.

Other colleagues' opinions are drawn from the experiences of their close family members who rely on Public Health Care facilities for the provision of antiretroviral treatment. This motivated the researcher to have an interest in exploring the experiences regarding accessibility of antiretroviral treatment in Health Care facilities in Msukaligwa Municipality of Gert-Sibande Region. Information released by Department of Health Ermelo Regional Hospital Board (2014:6) indicate that there is still a significant increase in deaths of people living with HIV and the researcher saw it fit to conduct the study to establish whether antiretroviral treatment is easily accessible in the Health Care Facilities in Msukaligwa Municipality of Gert-Sibande Region. The empirical findings of this study will be used, to influence the Board members in meetings regarding the identified challenges that need attention. The researcher realised that it is in the best interest of the public to receive flawless provision of antiretroviral treatment as they are aware of the consequences of not adhering to the antiretroviral treatment (NSP 2012-2016:17).

The researcher developed a keen interest in undertaking this research whereby government programs, especially the structural functioning of those programmes (roll-out programmes) are examined to ensure that they produce the desired results. The researcher's previous occupation, his role at Ermelo Hospital as well as the fact that

HIV and AIDS is still the most formidable public health problem facing South Africa motivated the researcher to conduct the study. The epidemic poses a serious challenge to every person and is a problem that requires communities, non-governmental organizations, government departments and academic institutions to work in collaboration with each other if the disease is to be brought under control. The researcher is of the view that, a true partnership is important to face the challenges posed by HIV and AIDS (Poku 2005:16).

1.4 Statement of the Problem

There has been a notable poor accessibility of antiretroviral treatment in Public Health Care facilities in South Africa. Economic divisions also affect the manner in which people living with HIV and AIDS survive. The researcher holds a view that living with HIV in difficult economic situation has proven to be strenuous. In South Africa, HIV is not a disease of poor people and the economic challenges faced with financing the costs of living with HIV and AIDS are high. Therefore, any unemployed person who is infected has to rely on social grant that is paid by government and which fails to cover all the costs related to living with HIV and AIDS (Squire 2007:16).

The problem identified for this study relates to the treatment programme in South Africa's Health Care facilities in relation to the roll-out programme of antiretroviral treatment in Mpumalanga province. The study assist in determining whether there is flawless accessibility of antiretroviral treatment or not. Avert (2014) indicates that the choice of antiretroviral treatment depend on a number of factors, including the availability and price of the drugs, the number of pills, the side effects of the drugs, the laboratory monitoring requirements and whether there are co-blister packs or fixed dose combinations available and moreover, the accessibility of those drugs in public domain.

It has been indicated that Mpumalanga has just less than half a million HIV positive people. Around 13% of the population and one in every five adults were estimated to be HIV positive in 2013. The Mpumalanga epidemic is reaching maturity with new infections and AIDS related deaths approaching 40 000 per annum.

An estimated 87 000 people were in need of Antiretroviral treatment in 2013 with around 44% having taken up treatment (Nicolay 2013:5).

The focus is on people living with HIV and AIDS who are on wellness programmes in different Health Care facilities in Gert-Sibande Region. If poor access to antiretroviral treatment continues chances is that, people living with HIV and AIDS might develop resistance due to their inconsistencies in receiving antiretroviral treatment.

According to Poku (2005:124), the issue of how best to move forward with comprehensive policies and programmes that aim to mitigate the social and economic impact of the HIV and AIDS pandemic has become a central concern for African policy makers. It is now increasingly clear that to achieve this objective it is essential to address the issue of care and support for those affected, and to increase the access of people living with HIV and AIDS to effective treatment. African countries or governments had been identified to be experiencing challenges in scaling up programmes for treating and caring for people living with HIV and AIDS (Ige and Quinlan 2012:2).

The problem of inconsistent accessibility of antiretroviral treatment must be solved as it can have a direct impact on the lives of people living with HIV and the mission of scaling up treatment.

1.5 Aim of the Study

The aim of the study is to explore understanding in relation to accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care facilities in Gert-Sibande Region in Mpumalanga.

1.6 Objectives of the study

To realize the aforementioned aim of the study, the following research objectives will be addressed**:**

- To explore where do the patients get access to antiretroviral treatment.
- To explore and describe how accessible are these antiretroviral treatment in public health care facilities.
- To explore and describe what can be done to improve accessibility of antiretroviral treatment amongst people living with HIV and AIDS in Gert-Sibande Region of Mpumalanga.
- To assess the capacity of Public Health Care facility in Gert-Sibande Region and to develop an improved program that will strengthen accessibility of antiretroviral treatment in Mpumalanga Province.

1.7 Research Questions

The study will answer the following questions:

- Where do people with HIV and AIDS access antiretroviral treatment?
- What measures can be taken to improve accessibility of antiretroviral treatment amongst people living with HIV and AIDS in Gert-Sibande Region of Mpumalanga Province?
- What can be done to explore and improve the accessibility of antiretroviral treatment in a Public Health Care facility in Mpumalanga?
- What are the capabilities of a Public Health Care facility at Gert-Sibande Region in the development of an improved programme that will strengthen accessibility of antiretroviral treatment in Mpumalanga Province?

1.8 Significance of the Study

The study aimed at benefitting people who are attending wellness programmes in public health care facilities, in reference to those who are living with HIV. It adds to a new body of knowledge. Those benefits would take place through the outcome of the study results which will be given to management of the Ermelo Provincial Hospital in order to improve

their services. The management of Ermelo Provincial Hospital can use the study results to make recommendations to the provincial management of the department of health regarding strengthening of HIV and AIDS roll-out programmes and ensuring regular monitoring and evaluation of such programmes. When such an initiative has been applied, therefore patients will receive the best quality service as far as antiretroviral treatment is concerned. The study might open up new pathways for further researches in the field of HIV and AIDS. People living with HIV's opinions or perceptions regarding the accessibility of antiretroviral treatment will be pivotal as it would be a true reflection of how local programmes are performing (Ermelo Hospital Strategic Plan 2014:06).

Overall the study's contribution is viewed as a cornerstone for future programmes to be strengthened and intensified, regular monitoring and evaluation. Academic institutions are set to benefit from this study and other scholars who are in the field of HIV and AIDS are also going to gain a useful insight. Further research can also emanate from the findings of this study.

The National Department of Health (NDoH) and the management of Ermelo Regional Hospital Board and other stakeholders will also benefit from the research findings. Both parties would benefit enormously from the research results by intensifying the areas that needs attention as far as provisioning of antiretroviral is concerned. The Department of Health and the Hospital management can strengthen the areas that are lacking in terms of overall objectives of the mission and strategic plan of the department and that of the Republic of South Africa.

1.9 Brief Description of the Research Process

Exploratory study was used as the research design and the qualitative research methodology approach was also opted. The qualitative research approach was used which provide insight with regard to accessibility of antiretroviral treatment amongst people living with HIV and AIDS at public health care facilities in Gert-Sibande Region in Mpumalanga.

Twenty three (23) participants were interviewed in the office situated next to the wellness Centre and each interview lasted between 10 to 36 minutes. The main research questions as well as probing questions in the interview guide were used to facilitate the interview process.

More details are unpacked in Chapter 3.

1.10 Assumptions of the Research

The study had the following assumptions or knowledge claim:

(a) That there is poor accessibility of antiretroviral treatment amongst people living with HIV and AIDS at public health care facilities in Gert-Sibande Region in Mpumalanga.

(b)That the participants will feel comfortable to talk about their experiences about access to antiretroviral treatment during the interviews.

1.11 Operational Definition of Key Terms

The following operational definitions were used for the key concepts in this study:

(a) **HIV -** Human Immunodeficiency virus is a virus that enters the body from outside and cause a deficiency to the immunity of the body‘s natural ability to defend itself against infection and disease (Van Dyk 2008:4).

In this study it will be appropriate that participants’ level of knowledge and understanding of HIV be determined, as it will help to explain their attitudes towards antiretroviral treatment.

(b) **AIDS -** Acquired Immune Deficiency Syndrome is a disease, caused by the Virus transmitted in bodily fluids, in which there is a severe loss of cellular immunity (Concise Oxford Dictionary 2012:22).

In this study it will be appropriate that participants' level of knowledge and understanding of AIDS be determined, as it would help explain their attitudes towards antiretroviral treatment.

(c) **Antiretroviral Treatment -** refers to the medication used to suppress viral load in the blood system of people living with HIV, as intensely as possible for as long as possible by using tolerable and sustainable treatment for an indefinite period of time (Van Dyk 2008:4).

In this study it will be relevant that participants' level of knowledge and understanding of antiretroviral treatment be determined, as it would help explain their attitudes towards adherence and access to treatment.

(d) **People Living with HIV** - refers to people living with Human Immunodeficiency Virus.

In this study people living with HIV referred to participants in the study, where knowledge and understanding of accessing treatment will be explored.

(e) **Gert-Sibande Region** - refers to one of the three (3) districts of Mpumalanga province and it is having its seat in Ermelo, predominantly IsiZulu and SiSwati speaking people.

(f) **Access** - refers to the right or opportunity to use something.

In this study it will be appropriate that participants' right and opportunity of accessing treatment will be explored.

(g) **Exploration** - refers to inquiring into or discuss in details (Concise Oxford Dictionary 2012:411).

(h) **Mpumalanga Province** - is formerly known as the Eastern Transvaal, is the province of South Africa and boarding Swaziland and Mozambique and accounting 6.5 % of South African land.

In this study exploration refers to inquiring into details about people living with HIV about access to treatment in Gert-Sibande Public Health Care facilities.

1.12 Summary

This Chapter has presented the background to the study in terms of what the study entail. This Chapter also presented the rationale for the study and the statement of the problem. The aim of the study and also the objective of the study. Research questions, significance of the study, and definition of terms. The next chapter (Chapter 2) deals with the reviewing of the related literature regarding, the accessibility of antiretroviral treatment globally and within the Republic of South Africa. Chapter 2 also deals with the theoretical framework of the study and also what has already been researched about the related studies.

1.13 Outline of the Dissertation

This study will be presented in five chapters:

Chapter 2 will contain a literature review relating to accessibility of antiretroviral treatment. The Chapter will also discuss other researches about the topic and the importance of accessing antiretroviral treatment in public health care facilities. The study will also focus on the state of antiretroviral treatment in South Africa and challenges of rolling out antiretroviral treatment within the Republic. The public health care facilities in South Africa will also be examined and their capacity in providing treatment to those who are eligible for it.

Chapter 3 deals with the research methodology and provides details of the research approaches used, the nature of the in-depth personal interviews, description of participants as well as the method of data collection.

Chapter 4 presents the findings and analyses of the findings from the interviews conducted at Ermelo Provincial Hospital according to the purpose and objectives of the study.

Chapter 5 presents the conclusion and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section reviews different literature regarding the accessibility of antiretroviral treatment and the significance of accessing such treatment to people living with HIV. A literature review provided an opportunity for the researcher to conduct a systematic review of the existing body of knowledge and research to gain an understanding of the research topic and its context. Like the rest of other researches, most original researches are seen as an extension of what has previously been learned about a particular topic. A review of the literature is the way we learn what's already known and not known (Babbie, 2010:506).

2.2 Other Research on the Topic

2.2.1 Historical overview

The first recognized cases of AIDS occurred in the United States of America (USA) in 1981 when a very rare form of pneumonia suddenly appeared simultaneously in several patients. These patients had a number of characteristics in common: they were all young homosexual men with compromised (damaged) immune system and caused diarrhea and weight loss, was identified in central Africa in heterosexual people. Initially, scientists and doctors were baffled because the causes and the modes of transmission of this new disease could not be immediately identified. Only in 1983 was it discovered that the disease was caused by a virus, known at that stage as lymphadenopathy-associated virus. In May 1986 the virus causing this condition was renamed HIV (Human Immunodeficiency Virus). Two viruses associated with AIDS: HIV-1 and HIV-2 (Van Dyk 2008:4).

HIV and AIDS is still one of the world's most serious health and development challenges. There are approximately 36.9 million people currently living with HIV and

tens of millions of people have died of AIDS-related causes since the beginning of the epidemic. While new cases have been reported in all regions of the world, 70% are in sub-Saharan Africa. Most people living with HIV do not have access to prevention, care, and treatment, and there is still no cure (The Henry Kaiser Family 2015:1).

Sub-Saharan Africa, the hardest hit region, is home to 70% of people living with HIV but only about 13% of the world's population. Most children with HIV live in this region (88%).Almost all of the region's nations have generalised HIV epidemics-that is; their national HIV prevalence rate is greater than 1%. In 9 countries, 10% or more of adults are estimated to be HIV-positive. South Africa has the highest number of people living with HIV in the world (7 million) (The Henry Kaiser Family 2015:2).

There are still challenges of scaling up HIV and AIDS treatment programs in Africa (Poku 2005:124). The researcher argue that, despite the work of dedicated staff and the resources put in the health care systems, South Africa is one of those countries treatment is often discussed as if, it stood alone from other health and related issues. The strict provision of post-exposure prophylaxis to people at risk requires a special consideration as far as review is concerned. The researcher hold a view that, access to antiretroviral treatment is still a serious challenge that needs a special attention. The public health care system of the Republic of South Africa still provide antiretroviral treatment as a therapy to prevent Mother-to-Child transmission of HIV, to manage occupational exposure and to manage rape and sexual assault patients(Van Dyk 2008:109).

HIV and AIDS related service delivery in South Africa is inextricably linked to socio-economic rights and development. Responses to HIV and AIDS have been guided by the constitutionally entrenched right to health as well as by the developmental mandate of local governments. These criteria have been challenged, however, by changing policies regarding HIV and AIDS, the role of the state in service provision, the way service users are viewed and ambiguities regarding the decentralization of health services. The civil society service provision has culminated in innovative methods of maximizing antiretroviral therapy, which have yet to engaged with and consolidated by various spheres of health provision(Ige and Quinlan 2012:84).

The South African government's HIV and AIDS strategy initially rejected provision of treatment in favor of prevention of the spread of HIV. The government saw civil society being 'partners' in service delivery. Civil society organizations actually went further, advocating for government provision of antiretroviral treatment and even initiating treatment programs in different localities. Various policy documents affirmed the role of a civil society even after the government changed its strategy and began to create a public antiretroviral programme (Ige and Quinlan 2012:89).

Ermelo is located within the Msukaligwa Sub-district Municipality in the Gert-Sibande Region the Mpumalanga Province of South Africa. It has been suggested that Gert-Sibande Region like the rest of the country faces a quadruple burden of disease consisting of HIV and AIDS and tuberculosis, high maternal and child mortality. It is further indicated in the hospital strategic plan that, like any other part of the South Africa, the Gert-Sibande Region health care system has been characterized by a fragmented and inequitable system due to the huge disparities that exist between the public and private health care sectors with regard to the availability of financial and human resources, accessibility and delivery of health services, this implies that there are negative effect in terms of antiretroviral treatment accessibility (Ermelo Provincial Hospital Strategic Plan 2014:17).

According to Ermelo Hospital Strategic Plan (2014:20) the district health information system however indicates that in the Msukaligwa Sub-district, the leading cause of death in 2013/2014 are HIV and AIDS followed by TB, hypertension and diabetes mellitus. So this report suggests clearly that, HIV and AIDS still contribute greatly in the cause of death within Msukaligwa Sub-district.

The study also explores the structural functionalism of the Mpumalanga Provincial antiretroviral roll-out programme in public health care facilities. Decoteau (2013:19) indicates that people in informal settlements often cannot or will not assume the biomedical technologies of the self-required to take antiretroviral either because of structural obstacles associated with squatter conditions or because the regimen includes a rejection of indigenous healing. Most patients in Ermelo are very conservative and they still rely on indigenous healing.

Decoteau (2013:19) further state that HIV and AIDS have radically shaken-up the epistemological anchors both biomedical and indigenous healing paradigms. The fact that the disease is incurable but treatable seriously challenges the ontological foundations of South Africa indigenous healing. And yet, biomedicine's answer, antiretroviral, comes with its own complications. Because of serious under resourcing, public clinics, and hospitals have been equipped to properly manage this epidemic, and so indigenous healers have taken a burden of providing the psychological and social support HIV and AIDS sufferers require, in addition to treating symptoms and opportunistic infections (Ige & Quinlan 2012:166).

2.2.2 The theoretical framework

According to Chirambo & Ceasar (2003:12) the health belief model is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. The health belief model has been developed and adapted to explore a variety of long and short-term health behaviour including sexual risk behaviours and the transmission of HIV. It has been argued by Tayler (2004:4) that individuals' perceived ability to successfully carry out a health strategy, such as using a condom consistently, greatly influences his/her decision and ability to enact and sustain a changed behaviour.

Health belief model does not take other factors that may influence health behaviors, the model does not include the influence of social norms and peer influence on people's decisions regarding their health behaviour. The model emphasises the behavioural modification as a very important aspect in risk reduction in the fight against the scourge of HIV and AIDS (Manique 2004:88).

When one tries to draw a comparison between this theory and the proposed research, one can confirm that people should first be aware of their susceptibility of contracting diseases. It is upon the overall perception of individuals towards their susceptibility of contracting diseases that will influence their behaviour towards such risk. Behaviour change requires psychological awareness of a particular danger that pose a threat to that individual.

Adherence to antiretroviral treatment for example is seen as a safer behaviour in delaying progression of the HIV into a fully blown AIDS in human body. If a person is aware that adhering to medication will bring positive changes in his state of health then that person is likely to adhere to antiretroviral treatment. But if a person is not well aware of the implication of adhering to antiretroviral treatment and the direct consequences of such behaviour, such person is likely to ignore the commitment of taking such treatment and therefore that might lead to defaulting (Van Dyk 2008:122).

Defaulting is described as a failure to fulfil an obligation (Louw and Reynolds 2010:307).The researcher perceived adherence to antiretroviral treatment as an obligation. It has been further argued in this theory that, key variables in this theory are perceived threat. It has been further indicated that perceived threat has two parts which is, perceived susceptibility and perceived severity of a health condition. Perceived susceptibility is defined as one's subjective perception of the risk of contracting a health condition. According to Manique (2004:87) perceived severity is referred to as feelings concerning the seriousness of contracting an illness or of leaving it untreated including evaluations of both medical and clinical consequences and social consequences.

This indicates that people should be aware of what is going to happen when one contract a specific virus such as HIV and the consequences that follows the contraction of such a disease. In other words it is very much important for people to learn more about a threat, in this case HIV and the consequences of living it untreated through the use of antiretroviral treatment. People need to also be made aware of the social consequences that are brought by HIV and AIDS. For example, after losing a breadwinner in the family due to HIV and AIDS related death, the family particularly children ended up leaving school and forced to seek jobs. That can be referred to as a social consequence brought by an illness or HIV and AIDS.

Perceived benefits according to Chirambo & Ceasar (2003:45) believed effectiveness of strategies designed to reduce the threat of illness perceived barriers is referred to as the potential negative consequence that may result from taking particular health actions,

including physical, psychological and financial demands. It is very important for individuals to have a clear understanding of the overall consequences that may result from a particular health action which can impact on the physical, psychological and financial demands. Perceived benefits had been referred to as effectiveness of strategies designed to reduce the threat of illness.

Perceived barriers and cues to action referred to either bodily or environmental such as media publicity that motivates people to take action. It has also been mentioned that other variables are diverse demographic, socio-psychological and structural variables that affect an individual's perceptions and thus directly influence health related behaviour. Self-efficacy is referred to as the belief in being able to execute successfully the behaviour required to produce the desired outcome. For example using condoms every time an individual have sexual intercourse can protect one from contracting HIV (Van Dyk 2008:123).

It has been further indicated that the health belief model has been used to explore a variety of health behaviour in diverse populations.

2.2.3 The importance of access to antiretroviral treatment

The researcher holds a view that, HIV remains untreatable and the only aid available is the suppression of the HIV. The suppression of the virus is made possible by the antiretroviral treatment.

According to Van Dyk (2008:95) the HI Virus uses enzymes to replicate itself inside CD4 cells. Two of the most enzymes used by the virus are reverse transcriptase enzyme and protease enzyme. Antiretroviral treatment act by blocking the action of these enzymes. Antiretroviral treatment interfere with the reverse transcriptase enzyme prevents the virus from changing its RNA into proviral DNA. Other antiretroviral drugs inhibit the formation of new viruses by paralyzing the protease enzyme and so preventing the assembly and release of newly replicated HI Viruses from the infected cells.

The increasing affordability of antiretroviral drugs to suppress HIV and the technical monitoring of the drugs actions in people's bodies offers hope for preventing hundreds of thousands of deaths each year (Poku 2005:128).

So it is essential to always have these drugs available in health care facilities to ensure that those who are in need have access to treatment. The benefits of antiretroviral treatment cannot be overemphasised. They range from a reduction in opportunistic infections, including the most common in South Africa such as TB to a substantial reduction in HIV transmission as a result of universal treatment. Antiretroviral treatment reduce viral load, reduce mortalities, and increase the quality of life of HIV patients. The direct benefits of antiretroviral treatment consist of increased productivity of those living with HIV, a reduction of the socioeconomic impact of HIV and AIDS, and a reduced exposure to stigma for antiretroviral patients whose better health status makes them less identifiable. With early treatment, these benefits are increased. However, while early treatment in South Africa is expected to be beneficial, it has possible implications for funding shortfalls, a deterioration in the health care system, and uncertainty regarding its effect on risk behavior and new HIV transmission (Smith 2013:255).

Development in medical technologies had multiple effects. In the affluent countries of the developed world, they have changed the apocalyptic character of public discourse regarding HIV and AIDS. Today in the developed world, HIV is often characterized as a chronic and manageable disease. Improved treatment technologies have also changed the shape of the developed-world HIV advocacy and activism.

The advent of effective HIV treatment has sharpened focus on disparities in treatment access and delivery between different parts of the globe. However similar disparities exist within countries, where refugees cannot secure fully-fledged citizenship and the related rights to health care, where radicalized, sexualized, gendered and economically disempowered social groups experience HIV service exclusion, and where HIV service provision may differ radically between geopolitical areas and across urban and rural communities. The various histories and epidemiologies of HIV epidemics, different levels of prevalence, varieties of political ownership and response, and widely divergent

resource availability also strongly differentiate prevention and treatment technologies (Lovett-Scott and Bartlett 2014:13).

Across all these situations, antiretroviral treatment has nevertheless defined ‘new’ post-treatment or treatment possibility generations, emerging in the mid-1990s in the developed world and post-2003 in most developing countries. These generations differ widely in the medical and other resources available to them, but have some potentially shared assumptions about living with HIV and the risks of HIV transmission. HIV positive people taking antiretroviral treatment in the developing world are also now having experiences similar to those in developed-world countries living long term with HIV medication. However, in the developing world, this group continues to live alongside large numbers of people who need but cannot access antiretroviral treatment, as well as large numbers of people newly infected each year. Moreover, effective treatment, or its possibility, arrived at very particular times within each epidemic. For instance, ART became available only after many HIV positive people in developed countries and some African countries, such as Uganda and Tanzania, had died. Within other low-resourced countries such as South Africa, where the epidemic developed later, this second, post-treatment or treatment-possibility generation involves people doing well on ART, living alongside many who are dying (Davis and Squire 2010:4).

2.2.4 Antiretroviral treatment in South Africa

The provision of antiretroviral treatment has been a serious challenge in South Africa and this dated back in 2004.The roll-out programme of antiretroviral treatment in 2004 was slow due to the fact, that the state avoided financing the public provision of antiretroviral treatment. The presence of antiretroviral treatment in public health care system might be determined by the structural functionalism of the roll-out programme, and the capacity to facilitate the roll-out of antiretroviral drugs and ideological opposition to antiretroviral treatment in the health care facilities. The study uncovers those underlying factors that determine the existence of poor or good accessibility of antiretroviral treatment in public health care facilities in Ermelo. For a full functional roll-out program to be successful there is a major need for human capacity. Human capacity comes at the expense of capital and in a country that is still developing and faced with

many social challenges; the capacity strengthening might be a pipe dream (Squire 2007:42).

The researcher‘s view is supported by the slow reaction by the public health sector to introduce pre-exposure prophylaxis to people at risk. PrEP as it is familiar known is currently conceived or imagined as similar to the contraceptive pill or to an anti-malaria pill.

It has been stated that PrEP consists of ‘one pill a day’ made up of the HIV antiretroviral drug Tenofovir which, in some instances, is combined with Emtricitabine and called Truvada. Both Tenofovir and Emtricitabine are used as part of HIV antiretroviral combination treatment (ART).The researcher believe that, the slow introduction or the reluctance to introduce the PrEP in public health care facilities is perpetuated by the notion which, forms the concluded perception of the decision makers in government that, the provision of PrEP might discourage the use of condoms. This view is totally unfounded as it is not supported by empirical findings. Infection rate still continue to rise despite the availability of free condoms in every part of this country. Mortality rate still rise despite the provision of communication education and programs to combat HIV and AIDS. Access to antiretroviral treatment to everyone who wants to use them either as a PrEP or Post-exposure prophylaxis must be made possible in public health care facilities across the country (Davis and Squire 2010:168).

HIV treatment includes the use of combination antiretroviral therapy to attack the virus itself, medications to prevent and treat the opportunistic infections that occur when the immune system is compromised by HIV.

The issue of access to treatment is not simply a matter of antiretroviral medication since there is a need to ensure that, relatively inexpensive drugs are available for opportunistic infections such as TB and diarrhea (The Henry Kaiser Family 2015:2).

It has been indicated that in many countries access to drugs and other material inputs needed for effective care of those with HIV-related illnesses are generally not available for reasons often of resource constrains. In South Africa, the response of government in general has been to argue that there are budgetary constraints limiting access to

antiretroviral treatment, and that these constraints will continue for the foreseeable future (Poku 2005:131).

The researcher assert that, certain conditions can be identified as important in determining improved access to treatment for those living with HIV and AIDS. These conditions can be broadly grouped into two categories: challenges related to demand and challenges related to supply. The supply challenges are associated with the logistical problems of taking this massive demand in the context of the existing deficits in political will, health system including leadership, human resources, technical expertise, physical infrastructure, equipment and supplies.

According to UNAIDS (2005:17) there are seven challenges that have been identified as contribution factors that preclude effective, long-term, or widespread development in Africa. The contributing factors are the legacy of Africa's history (post-colonialism has been unable to overcome deep divisions). The cycle of poverty, inequality, and disease (rising populations put pressure on inadequate social sector infrastructure, and AIDS further depletes capacity. The divisions rupturing society (scarcity promotes division, HIV and AIDS stigma feed off divisions).

The quest for swift dividends African leaders and their donor partners want to show quick results, so are unable to invest in long-term change).The challenges of globalization: integration and marginalization (trade rounds and reducing foreign investment fail to benefit Africa, worse formal economy is left to rely on a narrow primary export base). Aid dependency and the quest for global security (aid donors fail to live up to the rhetoric of harmonization and the so-called global war on terrorism spills over into Africa, determining donor funding patterns). The other factor is the response to HIV and AIDS epidemic: shortcuts and magic bullets (the scramble to roll out antiretroviral therapy, leaves few lasting benefits, and prevents the much needed scale-up of HIV prevention) (UNAIDS 2005:18).

2.2.5 Challenges of rolling out ARVs

For the roll out program and the improved accessibility of antiretroviral treatment to be improved there must be a full commitment from the range of key stakeholders. It must

also be noted that in the African context, limited human, physical and financial resources present major barriers to scaling up treatment provision. It must be noted that most African countries had severe capacity constraints and were not meeting the health needs of their populations long before HIV and AIDS even existed (Poku 2005:142).

UNAIDS (2005:17) further suggest that, traps and legacies describes how HIV and AIDS does catalyze people and institutions into a response, but they cannot make sufficient headway with depleted capacities and infrastructure. The additional burden of responding to the HIV and AIDS epidemic detracts from other development effort-continuing underdevelopment in turn undermines the ability of many countries to get ahead of the epidemic. The spate of xenophobic attacks in South Africa had an effect in the patterns of resource distribution in Africa. International relation and trade relations might have also been affected by the xenophobic attacks.

It has been pointed out that there is problems of fatigue and complacency represent important challenges in nations at the vanguard of coping with the disease. This complacency and fatigue are not merely individual attitudes, but also critical social issues. The researcher realized that there is an important role to be played by activists, both from within and from outside of government in bringing these issues to the attention of the public health leaders, who fund, formulate and implement HIV prevention programme (Pandamsee and Klein in Smith 2013:271).

Various perceptions are expressed by different patients in health care domain. Their perceptions are based on their experiences while receiving medical assistance in the form of antiretroviral treatment. In Ermelo Regional Hospital there are wellness programme designed to specifically provide antiretroviral treatment to HIV and AIDS patients. The determination of whether there is poor accessibility or good accessibility is answered by the empirical findings of this study which will be interpreted at the later stage.

According to Whiteside and Barnett (2002:05) for the last 20 years a few academics and policy makers have debated whether or not HIV and AIDS has social and economic impacts and what they might be. Most have preferred to ignore and deny the problem.

The authors have spent much of this period researching these issues. We have looked at what HIV and AIDS does to the lives of individual, communities, companies and societies. It is surprising how few senior policy makers and even fewer politicians have been prepared to consider the potential consequences of the epidemic and what should be done about them. In part this has been the result of the glacial pace at which governments and international organizations are able to move and change. Politicians, policy makers, community leaders and academics have all denied what was patently obvious-that the epidemic of HIV and AIDS would affect not only the health of individuals but also the welfare and well-being of households, communities and, in the end, entire societies. The effects of diseases are rarely considered beyond the clinical impact on individuals.

UNAIDS (2005:18) indicated that efforts in Africa to roll-out antiretroviral treatment continues, but are impeded by a combination of underdeveloped and overwhelmed systems and overall costs.

Accessibility of the antiretroviral treatment is determined by the effectiveness of any national intervention program. South Africa health system also has its own intervention programs. Those programs are aimed at dealing with the scourge of HIV and AIDS in public health care system. The researcher wonders whether the available local intervention plan yields the desired results. Results of the impact are determined by the sustainability of the intervention.

Smith (2013:31) defines sustainability as a process within a local system whose aim is to maintain improved health status. This local system is composed of local stake-holders (individuals, communities, and local organizations) that operate within a larger environment. A sustainable process enables these local stakeholders to express their potential through balanced improvements in several key components - service delivery, organizational capacity, and community capacity. The actors within the local system improve their functioning and develop mutual relationships of support and accountability. The researcher believes that sustainability of any program will be tested by monitoring and evaluation of such program.

It has been argued that, there are critical and uncertain forces driving HIV and AIDS in Africa. Five powerful driving forces were identified in the project as being crucial to the future of HIV and AIDS in Africa. These drivers each have their own dynamic and operate at many different levels, from the house hold and community, to the regional and international arenas. In addition, these drivers interact, creating further complex dynamics. One of those five powerful driving forces is the leveraging of resources and capabilities. The struggle against HIV and AIDS is sometimes presented as simply a question of funding. It has been demonstrated that considerably more resources are needed; the issue is also about leveraging what is available to achieve more-especially when resources are limited. Resources include money, leadership, human capacity, institutions and systems. It is clear that resources may become exhausted under the pressures of the epidemic and the underdevelopment. Funds could be dissipated in short-term, conflicting initiatives, with little long-term benefit (UNAIDS 2005:13).

According to Ige and Quinlan (2012:100), the civil society response in South Africa to AIDS prevention and treatment services has been constituted largely under the auspices of the South African National AIDS Council (SANAC). The SANAC was established as an independent body in 2000 but restructured in 2006 to make it more effective and accountable in overcoming the HIV and AIDS epidemic. This followed a criticism that SANAC was not genuinely representative of civil society and that its process were erratic. SANAC is a multi-sectorial partnership body comprised of top-level government representative and elected civil society representatives from a wide range of sectors. SANAC has been viewed as playing a management and advocacy role in strengthening mobilization, monitoring and providing national oversight in response to HIV and AIDS. It is specifically tasked with advising government on HIV and AIDS related policy, creating and strengthening partnerships for an expanded national response and mobilizing resources for SANAC partnership activities. Establishment of SANAC somehow contributed positively in the accelerated process in the provision of ARVs.

Life expectancy of South Africans for both males and females has significantly improved to 62 years, which is an increase of eight and a half years since 2005. The HIV policy

turnaround in 2015 led to a massive roll-out of HIV testing and treatment for 8.2 million people living with the virus. This has contributed immensely to healthier and longer lives for those infected (Vuk'uzenzele 2016:09).

Deputy President Cyril Ramaphosa has launched the national campaign for girls and young women called Phila. It was launched after it has been estimated that 2 000 girls and young women between the ages of 15 and 24 get infected by HIV in South Africa each week (ENCA News 2016).

Government, through the Ministry of Health, aims to revive prevention campaigns, especially amongst the youth. The state-owned pharmaceutical company, *Ketlaphela*, has been established to supply antiretroviral drugs to the National Department of Health from the 2016/17 financial year. The white paper on National Health Insurance (NHI) was released in December 2015 for public comments. NHI is aimed at achieving universal access to health care for all people in South Africa (Vuk'uzenzele 2016:09).

The establishment of the state-owned pharmaceutical company clearly indicates that, there is an existing challenge in scaling up of antiretroviral treatment in the Public Health Care facilities across the Republic of South Africa. The company has been established to participate in the supply of anti-retroviral treatment to the National Department of Health from 2016/2017 financial year. The president of the Republic of South Africa Jacob Zuma indicated that the country's HIV policy turnaround in 2009 has led to a massive rollout of HIV testing and treatment for 3.2 million people living with the virus (Vuk'uzenzele 2016:11).

Evidence across the globe attests that, the challenges for largest number of people with HIV and AIDS, however, is obtaining the drugs/treatment in the first place. Combination therapies are expensive; for example, the new combination ART drug, Atripla, costs approximately $25,000 per year. In addition, there are costs for other drugs to manage symptomps and opportunistic infections. Those who have health insurance are protected from some of these large costs. For most, however, including those without insurance, without personal resources, and on medical aid, the cost is high, often prohibitively so. In the USA, we know that the HIV and AIDS epidemic has moved into

socioeconomically disadvantaged populations that do not and will not have access, either directly or through public or private social services, to the funds for combination therapies. In developing countries, where the epidemic is spreading most rapidly and where money for care is limited, few resources are available for combination therapies (Fan et.al 2014:188).

The benefits of access to treatment cannot be overemphasized. They range from a reduction in opportunistic infections, including the most common in South Africa such as tuberculosis, to a substantial reduction in HIV transmission as a result of universal HIV testing and immediate treatment. ARV treatment suppresses viral loads, reduce mortality, and increase the quality of life of HIV patients (Smith 2013:255).

2.2.6. The effect on funding

An immediate effect of early treatment is the need for more funding to treat additional patients. Given the fact that affordability of HIV and AIDS treatment in South Africa always has been an issue, the question that arises is whether the country is likely to be able to afford early treatment in the future. While an immediate answer to this question remains elusive, it can be understood through an analysis of past HIV and AIDS treatment funding trends and future funding prospects (Smith 2013:255-256).

The South African government under President Jacob Zuma showed a clear commitment ensuring that treatment is accessed by all South Africans, but the main issue is sustainable funding that is currently received.

It has been noted that South African government generally fund its policies in two ways: equitable share grants (or unconditional grants) and conditional grants. Equitable share grants are received by provincial and local governments directly from the National Revenue Fund (NRF) thought of as “a bank of revenue for the government”. The term “equitable share” signifies the fairness with which these funds are distributed. Provincial and local governments receive the money based on a formula that takes their needs (in terms of health status, education, population, poverty level, and administration) into account, although they do not need to abide by the formula in spending the money, which makes the grant unconditional. Conditional grant funding consists of money

received by provincial and local governments indirectly from NRF via the national government, which has to spend according to national government priorities (Free State Department of Health, 2010).

The national government's HIV and AIDS funding trends can be understood by examining its conditional grants to provincial and local governments' HIV and AIDS programs. These conditional grants are channeled through three social sector departments: the National Department of Health, which is mainly responsible for HIV and AIDS treatment; the department of social development, which is responsible for social HIV and AIDS programmes; and the department of Education, which is responsible for HIV and AIDS life skills programmes. The increase in funding for HIV and AIDS treatment since 2004 does not, however, provide a clear picture of the extent to which the country has met the funding requirements of its treatment policy. Funding shortfall can have a direct consequence in the number of people on treatment (Smith 2013:256).

The researcher holds a view that increasing funding in order to provide early treatment to eligible patients would require a significant increase in revenue. Increasing revenue will require an increase in tax rates and/or an increase in taxable income.

Donors have thus far played a significant role in HIV and AIDS funding in South Africa, but this source of funding is bound to shrink in the short term. In particular, European countries have been contributing to South Africa HIV and AIDS treatment via their donations to global fund to fight HIV and AIDS, Tuberculosis and Malaria (Smith 2013:260).

Karim and Karim (2010:503) argued that, suitable infrastructure is needed to manage HIV-infected individuals at primary care level, but funding is not readily available and qualified health care personnel are in short supply. Private health care attracts most health care funding, but is accessed by less than 20% of South Africans. The effective use of antiretroviral therapy requires meticulous adherence. Poverty, alternative disease constructs, stigma, gender and unpredictable drug supply are important factors influencing adherence. South Africa is undergoing a period of profound socioeconomic

development, and the HIV and AIDS epidemic presents the medical system with extraordinary health care challenges. Many factors that affect regimen selections include costs.

The medicine management cycle is an essential component when considering implementation of antiretroviral treatment in South Africa. This is traditionally portrayed as a cycle in which choosing medicines must be followed by procurement, distribution and use. The disintegration between the public and private sector in South Africa continues to complicate all parts of this cycle. Examining all aspects of the medicine management cycle is essential when considering the most effective way to implement antiretroviral treatment in South Africa (Karim and Karim 2010:551).

Exploring accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care facilities also assist in understanding the medicine management cycle in that particular facilities. A choice of a medicine or a group of medicine must be followed by processes to ensure its efficient purchase (procurement), and then by actions that ensure accessibility at the point of care (distribution), followed by steps to ensure the necessary conditions for effective prescription, supply and ultimate consumption by the patient (use). The final step is to make sure that future selection decisions are informed by these steps, so continuing the cycle. The cycle is supported by various management functions (including the organizational design features and operations of the health system, its financing mechanisms, information technology resources and human resources), as well as by the policy and legal framework within which the system operates (Karim and Karim 2010:552).

Funding is perhaps one of the most difficult factors to address as access reliance is placed on a nation's ability to fund health care (Prather and Lovett-Scott 2014:35).

2.2.6.1 HIV Policy change in South Africa

Exploring accessibility of antiretroviral treatment amongst people living with HIV and AIDS at public health care facilities in Gert-Sibande Region of Mpumalanga province in South Africa cannot be done distinctively so, without examining National policies on HIV and AIDS.

After some years of controversy regarding its attitudes toward HIV and AIDS policies, the South African government has shown serious commitment to HIV and AIDS policy making since 2007. Previously ARV treatment in South Africa was initiated for patients with 200 CD4 counts or below. One of the previous policies in this regard concerns the raising of the treatment threshold from 200 CD4 counts to 350 CD4 counts referred to as early treatment (Smith 2013:253).

Government updates HIV policy to allow ARV treatment for all South Africans (Child 2016:1). All HIV positive South Africans will qualify for anti-retroviral treatment from September 2016 regardless of their CD4 count (measure of immune system strength). Currently, patients have to have a CD4 count of 500 to qualify for anti-retroviral. But the World Health Organization (WHO) recommends that as soon as a person tests HIV positive they should start treatment. This is even they feel healthy. Long term research showed people who start ARV treatment earlier get less sick and are likely to live longer. People on treatment correctly stop the virus replicating are therefore not infectious so the more people on treatment, the lower the new infections rate will be (Child 2016:1).

The minister announced this policy change during his budget vote speech in parliament. Professor Salim Karim, Director of AIDS Research Centre Caprisa, said “the Minister’s announcement is undoubtedly a step in the right direction”. He continued “This policy change has been expected and follows hard on the heels of the December World Organization guidelines on antiretroviral treatment. The impetus for this policy change emanates from compelling new evidence from the Strategic Timing Anti-Retroviral Treatment (START) trial presented at the Vancouver AIDS conference last year”.

A 2011 trial conducted in 35 countries called the Strategic Timing Anti-Retroviral Treatment (START) study had 4,685 HIV positive participants, half who started HIV treatment as soon as they were diagnosed. The other group waited until their CD4 count dropped below 350. The group that started treatment later had double the incidence of TB, Non Hodgkins Lymphoma, Karposi Sarcoma (skin cancer) and a non-HIV related diseases such as heart attacks and certain cancers-86 versus 41 in the group who had treatment immediately. The evidence that starting treatment early was

so compelling that the trials was stopped early as it became unethical to delay treatment to those not receiving it (Child 2016:2).

It has been clearly demonstrated scientifically that, early therapy conveys a double benefit, not only improving the health of individuals but at the same time, by lowering their viral load, reducing the risk of transmitting HIV to other persons. These findings have global implications for the treatment of HIV and AIDS. It has been also stated that Sex workers who are negative have qualified for free Truvada to prevent them becoming positive since December 2015 (Child 2016:2).

2.2.6.2 Challenges on the policy

If everyone eligible under an early treatment policy were treated and new HIV transmission decreased to a significant extent, then the early treatment policy would be sustainable. However, the issues in earlier sections about resources constraints to put on treatment everyone who needs it, the possibility of high HIV transmissions as a result of an increase in risk behavior and the effect of other factors that influence HIV transmission (Smith 2013:264).

It was noted that despite the country's effort to increase funding since 2007, all eligible patients did not receive treatment at least until 2012. It was further found that the economic prospects of the country and other international sources of funds did not indicate a promising future with respect to fundraising. A plausible strategy for these issues would be to ensure that everyone eligible for treatment under the policy is treated while at the same time strategies to reduce significantly new HIV transmission are adopted. Designing interventions that follow up patients on treatment and their potential partners requires considerable resources. It has been noted with great concern that there is also a significant amount of people who defaulted treatment and feel scared to go back for treatment. Early treatment policy is likely to aggravate the state of the current health care system, which is characterized by inequity and inefficiency inherited from the apartheid system (Smith 2013:266).

2.2.7 Public Health Care facilities in South Africa

HIV and AIDS have become an added burden on already strained health care systems. The full extent is not yet apparent because of the latent period between infection and illness and death. Data on the effect of HIV and AIDS on health care systems are scarce, most studies being small and cross-sectional (Karim & Karim 2010:359).

The main impact on adult health services appears to be increased hospital admissions, leading to ward overcrowding and possible exclusion of HIV negative patients as a result. It is unlikely that the public health sector is going to be able to sustain the increasing costs of treating HIV positive patients, which means that some form of rationing is inevitable and is probably already happening (Karim & Karim 2010:359).

The researcher is of the view that, the evidence clearly suggests that HIV and AIDS are now the leading cause of morbidity and death in Sub-Saharan Africa, including South Africa and the epidemic has therefore become an added burden on already strained health care systems.

2.2.8 Conclusion

This Chapter provided literature review from multiple sources regarding accessibility of antiretroviral treatment and the significant of accessing such treatment. The Chapter also examined the historical overview of the pandemic, the theoretical frame work and the description of the health belief model. The antiretroviral treatment in South Africa was also reviewed and challenges of rolling out antiretroviral treatment. The state of public health care facilities in South Africa was also examined.

The following Chapter presents the research design and the research methodology used in the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Chapter 3 outlines the research design and research methods used in this study. Each of the methods is discussed in line with the purpose and objectives of this study.

Based on the evidence reviewed from the literature in Chapter 2 the researcher opted for qualitative research design to explore the perceptions of participants' accessibility of antiretroviral treatment in health care facilities in the Gert-Sibande Region.

Bless *et.al* (2006:43) defines research methodology as an approach employed to conduct research where a distinction is drawn between qualitative and quantitative research, applied and basic research, and between exploratory, descriptive, correlational and explanatory research.

Qualitative research was adopted for this study based on the fact that, it allowed the researcher not only to explore the experiences and perceptions of participants on wellness programs receiving antiretroviral therapy in Gert-Sibande Region health care facilities. It also give the researcher an opportunity to gain knowledge and more understanding about accessibility of antiretroviral treatment in health care facilities in Gert-Sibande Region (Babbie 2010:296).

In this Chapter, research design, research methods, sampling, data analysis, validity of the study and ethical considerations are discussed in more details.

3.2 The Research Design

Babbie (2010:92) state that social research is conducted to explore a topic, that is, to start to familiarise a researcher with that topic. This approach typically occurs when a researcher examines a new interest or when the subject of study itself is relatively new. Exploratory research is fundamentally used to explore a new topic or to learn more

about issues where little is known. The qualitative nature of the research allowed the researcher to explore more deeply the perceptions of people living with HIV and AIDS and the capabilities of the provision of antiretroviral treatment at health care facilities in Gert-Sibande Region of the Msukaligwa Municipality in Mpumalanga.

3.3 Research Method

Interviews have been employed for this study. It has been indicated that interviews are discussions, usually one-on-one between an interviewer and an individual, meant to gather information on a specific set of topics (RAND Corporation 2009:06).

Kumar (2011:144) define interviews as a commonly used method of collecting information from people. Any person-to-person interaction, either face to face or otherwise, between two or more individuals with a specific purpose in mind is called an interview. Face to face interviews are used for this study based on the fact that a researcher had a freedom to decide the format and content of the questions to be asked to the participants. This had been done with the opportunity in choosing wording of the questions the way in which they would be asked and the order in which they are asked.

3.3.1 Semi-Structured Interviews

Cohen and Crabtree (2006) indicated that semi-structured interviewing is characterised by the interviewer and the participants engaging in a formal interview. The interviewer develops and uses an interview guide. The interview guide comprises of the list of questions and topics that need to be covered during the conversation, usually in a particular order. The interviewer follows the guide, but is able to follow topical trajectories in the conversation that may stray from the guide.

Kumar (2011:149) notes the significance of semi-structured interviews as a strategy for obtaining information from participants as it is more appropriate for complex and sensitive areas. The researcher opted for this tool of collecting data based on the fact that it was difficult to obtain more than one chance to interview participants. Semi-structured interviews afforded the interviewer with an opportunity to prepare participants before asking sensitive questions and to explain complex ones to participants in person.

In-depth information was uncovered during the interviews and observations were also made from non-verbal reactions.

In this study, the researcher was offered and office located next to the wellness center. Participants were recruited at a very close proximity. The location of the office gave participant comfort in terms of expressing their personal experiences about accessing antiretroviral treatment in the health care facility in a detailed and in private space. The interviews which lasted between 10 to 36 minutes each was also done there with little interruption and other disturbances.

The structure of the interviews included and introduction to the research, and explanation of the research ethics, explaining to participants the purpose of audio recording, obtaining permission to record each conversation from each participant, starting with broad research questions, based on the purpose and objectives of the study and were open-ended, and moving to the sub-questions and finally closing the session by asking for any additional comments or remarks. Probing questions were also used to allow participants to answer in more detail about the subject matter. The researcher continually reminded the participants to stop him if they no longer feel comfortable about the questions or the study itself. The participants were males and females 18 years and above speaking predominantly in *isiZulu* and *siSwati*.

3.4 Sampling

Sample was drawn from persons who are 18 years and above and attending wellness program at Gert-Sibande Regional Public Health Care facility in Mpumalanga Province. Neuman (1997:201) defines sampling as a process of systematically selecting cases for inclusion in a research project. Babbie (2010:192) asserts that there are two general types of sampling procedures which are probability sampling and non-probability sampling. Babbie (2010:192) further indicated that there are four types of non-probability sampling which are: reliance on available subjects, purposive (judgmental) sampling, snow ball sampling and quota sampling. If a non-probability sampling procedure is used, the researcher can only hope that those selected for study bear some likeness to the larger group. Participants come from a heterogeneous

background. The likeliness of participants in this study is their intake of antiretroviral medication and attending a wellness programme at the Public Health Care facility.

Non-probability sampling procedure includes accidental quota sampling, purposive sampling and systematic matching sampling. While useful for many studies, non-probability sampling procedures provide only a weak basis for generalization (Neuman 1997:208).

So the researcher chose purposive sampling for this study. Participants were purposively or judgementally sampled. In this study, participants were selected on the basis of their characteristics, elements, and the purpose of the research. Participants were selected on the basis of their HIV status and their attendance of the wellness program in public health care facilities in Gert-Sibande region of Mpumalanga Province. Participants receive antiretroviral treatment and come from diverse backgrounds.

According to Babbie (2010:193) purposive or judgmental sampling is a type of nonprobability sampling in which the participants to be interviewed are selected on the basis of the researcher's judgment about which ones are the most useful or representative to the whole population. Those who were attending wellness program and not yet receiving antiretroviral treatment were excluded in the study. Those persons under the age of 18 years but already on antiretroviral treatment were also purposively excluded.

3.4.1 Sample Size

According to Neuman (1997:221) sample size is determined by the kind of data analysis the researcher plans to employ and how accurate the sample has to be for the researcher's purposes, and on population characteristics. Bouma and Ling (2004:125) argue that in general, large samples are not necessarily better than smaller ones.

Sample size in this study comprised of twenty three (23) participants selected purposively. These participants were drawn from a heterogeneous population. Bless et al (2006:108) assert that a researcher's decision about the best sample size depends on three things: The degree of accuracy required, the degree of variability and diversity

in the population. The researcher targeted people who are living with HIV who is already on antiretroviral treatment and attending wellness programme in the health care facilities.

3.5 Data Analysis

The study employed qualitative data analysis. Babbie (2010:393) define qualitative data analysis as the non-numerical assessment of the observation, content analysis, in-depth interviews, and other qualitative research techniques. During data analysis the researcher formed new concepts and refined those concepts that are grounded in the data. Neuman (1997:421) assert that concept formation is an integral part of the data analysis and begins during data collection.

Researcher developed new concepts, formulated conceptual definitions and examines the relationships amongst concepts. The researcher also created thematic categorization and transcribe the data which was collected to ensure that empirical findings are uncovered for this study.

By analyzing data the researcher managed to organize data and applied ideas simultaneously to create or specify a case. This method of creating a case called casing, brings the data and theory together (Neuman1997:421).

So due to the fact that, data was collected using recording device, the researcher had an opportunity to transcribe the data and follow the above mentioned processes to ensure that findings are more comprehensive and detailed.

The analyzed data managed to bring order, structure and meaning to the mass of data collected. This was central to the aim of the data gathered from semi-structured interviews, based on the evidence emanated from the themes and sub-themes which again based on the purpose and objective of the study (Adendorff 2015:37).

The qualitative data of this study was transcribed and then analysed in a step-by-step process (Babbie 2010:297).The aim of the research was to organise the information into codes/categories or themes. A specific coding was done to similar themes and clustered them into research questions. All these codes were then reverse-integrated

into themes and sub-themes. Patterns and themes were identified, outlined and summarized in Chapter 4.

3.6 Validity of the Study

According to Babbie (2010:327) validity concerns whether measurements actually measure what they are supposed to rather than something else. Kumar (2011:184) indicated that validity of the study refers to the ability of a research instrument to demonstrate that it is finding out what you designed it to.

3.6.1 Trustworthiness

According to Kumar (2011:185) trustworthiness is determined by four indicators which are credibility, transferability, dependability and confirmability.

3.6.1.1 Credibility

Credibility involves establishing that the results of qualitative research are credible or believed from the perspective of the participants in the research. Qualitative research explores perceptions and experiences about accessibility of antiretroviral treatment in public health care facilities in Gert-Sibande Region in Mpumalanga. It is believed that the participants in this study are the best judge to determine whether or not the research findings have been able to reflect their opinions and feelings accurately. That opinion determination was done during the debriefing session with the participants.

3.6.1.2 Transferability

The results of this study yield a high level of generalizability and transferability to other contexts or settings. The researcher opted to keep records of the processes he undergone during the conduction of this study to allow other researchers to follow and replicate the results.

3.6.1.3 Dependability

The researcher holds a strong view that the results of this study are very dependable

3.6.1.4 Confirmability

The research results in this study could be confirmed or corroborated by others. If the similar research is taken within the specified period, chances of obtaining similar results are very huge, however one need to bear in mind that circumstances and conditions constantly changes (Kumar 2011:186).

3.7 Ethical Considerations

The researcher asserts that, the ethical considerations concerning participants and good data management were maintained throughout the study (see informed consent form as Appendixes and Institutional Ethical Clearance Certificate).During the conduct of this research ethical clearance were obtained from the University of South Africa and Mpumalanga Department of Health. Berg *et.al* has said (quoted in Adendorff 2015:39), it is generally accepted that since researchers in the behavioral sciences typically conduct research that involves human subjects, ethical considerations are the responsibility of the researcher.

The following ethical considerations were maintained during the study:

3.7.1 Informed Consent

Babbie (2010) indicated that the ethical norms of voluntary participation and no harm to participants have become formalised in the concept of informed consent. In this study participants indicated their willingness to participate in the study voluntarily and consent forms were signed by the participants before the commencement of the study. The participants also willing fully divulge their identities to the researcher and gave consent to take part in the study. Anyone who meets the inclusion criteria and volunteer to take part in the study had to sign the consent form individually because of the sensitivity of the research topic. Those who could not write their names on the space provided due to inability to write were encouraged to cross “x” next to the space allocated for the signature in the informed consent form. Before the study can take place, each participant was given a chance to ask questions about the study and they were

reminded of their rights regarding participation and their freedom to terminate the interview at any given stage.

3.7.2 Voluntary Participation

Participation was voluntary and participants were informed that they could at any given stage withdraw or terminate their participation in the study and they will not forfeit any privilege bestowed to them as patients and services they are entitled to within the Public Health Care Facility.

3.7.3 Confidentiality

Babbie (2010:67) asserts that research project guarantees confidentiality when the researcher can identify a given response with a given participant. The researcher assured participants that, the information obtained throughout this study is treated with a high degree of confidentiality and the use of an office situated next to wellness center assisted in camouflaging every participant. All responses from the participants were protected from anyone within the facility and were not made public. Access to the interview guides was limited to the researcher throughout the duration of the study.

3.7.4 Debriefing

Babbie (2010:70) debriefing entails interviews to discover any problems generated by the research experience so that those problems can be corrected.

In this study a Psychologist working within the public health care facility was always on stand-by to deal with any emotional situation that might emanate from the participants. In this study participants were debriefed after each interview and were asked about their views and experiences of the interviews and whether they wanted to add any additional comments or suggestions related to the study. Ethical considerations were adhered to and from all the twenty three (23) participants none of them asked for a Psychological counseling. Participants largely indicated that they have accepted their HIV statuses and received counseling after they have tested positive in their respective health care

facilities. Participants indicated that they have adapted and accepted their new HIV statuses and had made a significant progress since tested positive.

3.8 Conclusion

This Chapter focuses on the research methodological steps involved in conducting this study. In this chapter, the qualitative, explorative research design of this study was explained. Data collection and analysis were properly made and issues pertaining to ethical considerations were also discussed.

In Chapter 4, the researcher reports on the qualitative research findings of this study.

CHAPTER FOUR

THE FINDINGS OF THE STUDY

4.1 Introduction

To reflect: the purpose of the study was to explore the accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care Facilities in Gert-Sibande region in Mpumalanga. This was done by exploring the experiences in relation to accessibility of antiretroviral treatment amongst people living with HIV and AIDS in Health Care Facilities in Gert-Sibande region in Mpumalanga and establishing the current state in relation to accessibility of antiretroviral treatment in those facilities.

4.2 Profile of Participants

The interviews were conducted with twenty-three (23) participants living with HIV and receiving antiretroviral treatment in the Public Health Care Facility in Gert-Sibande region. Ermelo regional hospital was chosen as a research site and participants were recruited from their wellness program. In order to maintain confidentiality of the participants the researcher opted to use numbers to refer to participants. Different numbers from 1-23 were allocated to each participant and allocation of numbers was done in a sequential order of interviews. Numbers were allocated sequentially meaning that the first participant was allocated with number 1.The second participant was allocated with number 2 and that form of allocation continued up until the 23rd participant. The use of Pseudonyms was not preferred by the researcher instead age, gender and language were used to categories participants. The following table indicates the profile of participants.

Table 1.1 Research Participants

Participant	**Age**	**Gender**	**Language**
Participant 1	61 years	Female	Si Swati
Participant 2	50 years	Female	Si Swati

Participant 3	67 years	Female	Isi Zulu
Participant 4	45 years	Male	Isi Zulu
Participant 5	45 years	Male	Si Swati
Participant 6	27 years	Female	Isi Zulu
Participant 7	28 years	Female	Isi Zulu
Participant 8	58 years	Female	Si Swati
Participant 9	40 years	Male	Isi Zulu
Participant 10	29 years	Female	Isi Zulu
Participant 11	25 years	Male	Isi Zulu
Participant 12	46 years	Male	Isi Zulu
Participant 13	49 years	Female	Si Swati
Participant 14	59 years	Male	Si Swati
Participant 15	26 years	Male	Isi Zulu
Participant 16	40 years	Female	Si Swati
Participant 17	64 years	Female	Isi Zulu
Participant 18	49 years	Male	Shona
Participant 19	53 years	Male	Tsonga
Participant 20	18 years	Female	Isi Zulu
Participant 21	19 years	Male	Si Swati
Participant 22	21 years	Male	Isi Zulu
Participant 23	23 years	Male	Isi Zulu

As indicated in the table 1.1, the participant's age ranged from eighteen (18) years to sixty seven (67) years, and thirteen (13) participants spoke Isi Zulu, eight (8) participants spoke SiSwati, one (1) participant spoke Tsonga and one (1) spoke Shona. The sample's composition is influenced mainly by the demographics in the district. It has been mentioned in the literature that Mpumalanga is pre-dominantly SiSwati and IsiZulu ethnic groups. Eleven (11) participants were females and twelve (12) participants were males. Three (3) participants were infected through mother-to-child

transmission, meaning that they were born with it and twenty (20) participants were infected heterosexually.

4.4 Key Findings

The following themes were generated after the process of data analysis:

4.4.1 Theme 1: The capabilities of Gert-Sibande public health care facilities in providing antiretroviral treatment.

All twenty-three (23) participants indicated that they don't have any problem in accessing antiretroviral treatment. All the participants indicated that they had never encountered any shortage of antiretroviral treatment at the public health care facility or the research site.

The participants' answers clearly refute earlier suggestions from the literature review where it has been stated that various factors, play a bigger part in accessing antiretroviral treatment. One of the notable factors was the roll-out program which was viewed as less effective (UNAIDS 2014:3).

Access to antiretroviral treatment for example, is seen as a safer behaviour in delaying progression of the HIV into a fully blown AIDS in human body. If a person is aware that adhering to medication will bring positive changes in his state of health then that person is likely to adhere to antiretroviral treatment (Van Dyk 2008:122).The theory also suggest that participants were fully aware of the importance of accessing treatment and the important part played by the antiretroviral treatment.
It has been clearly demonstrated by twenty-three (23) participants that access to antiretroviral treatment is a significant step towards improvement of health conditions.

The participants' views regarding the capabilities of Gert-Sibande public health care facilities were as follows:

Participant 1

“Uyazi mina la esibhedlela njengoba bengigula, bangikhipha konke bangiphatha kahle.”

Here at the hospital they removed everything (operated) and took great care of me.

“Ayikho into esike siyithole emitholampilo ngoba izinto ziyashoda ,abantu bese beya esibhedlela ukuze bathole amakhambi asincedayo.”

I never experience any shortage of medication at the Hospital; people go to the hospital in order to get treatment.

Participant 2

“Amaphilisi esiwatholayo awasebenzi kahle emzimbeni bese sigcina siphindela khona basinike amanye.”

The pills that we are receiving, sometimes they were not effective in our bodies; therefore we went back to the Hospital to get other pills.

Participant 3

“Esibhedlela mangiyolanda amaphilisi ngosuku olunqunyiwe ngiyawathola, angikaze ngibuyele emuva ngoba kuthiwa aphelile.”

When I went to the hospital to fetch my antiretroviral treatment at the specified date, I never went home without treatment.

Participant 4

“*Amaphilisi angiphethe kahle, ngaqala ngo 1992 ukuwathatha kulesibhedlela.”*

Antiretroviral treatment is good for me, since I started taking treatment in 1992 at this Hospital.

Participant 5

“Konke kuhamba kahle amaphilisi ngiyawathola. Ngithola amathathu engiwaphuza ekuseni na ntambama”.

Everything goes well with regard to antiretroviral treatment and is always accessible. I get three kinds of tablets, and I take them in the morning and in the afternoon.

Participant 6

“Anginayo inkinga yokungawatholi amaphilisi selokhu ngaqala ukuwathatha ngo 2013, futhi angikaze ngihlangabezane nenkinga yokungawatholi amaphilisi emtholampilo.”

I didn’t have any problem in accessing antiretroviral treatment since 2013.I have never experience any problem regarding the shortage of antiretroviral treatment at the health care facility.

Participant 7

“Selokhu ngaqala ukuwathatha ngo Mashi 2016 ngiyawathola”.

Since I started treatment in March 2016 I always access it.

Participant 8

“Angikaze ngifike la ngingawatholi amaphilisi, ngiwathola ngazozonke izinsuku”.

During all my visits to the Hospital, I always access treatment without any problems.

Participant 9

“Uma ngiwalandile ngiyawathola amaphilisi”.

When I come to collect antiretroviral treatment, I always access it.

Participant 10

“Ngaqala ngo Juni 2014 e Piet Retief ukuthatha amaphilisi. Angikaze ngithole inkinga yokuthi ngingawatholi amaphilisi khona. Manje sengizoqala ukuwathatha e Ermelo.”

I started taking treatment around June 2014 at Piet Retief, and I have never experience any shortage of antiretroviral treatment.

Participant 11

“Ngihlala ngiwathola amaphilisi”.

I always get antiretroviral treatment

Participant 12

“Uma sifika esibhedlela sihlale siwathola amaphilisi”.

When coming for treatment, we always access antiretrovirals treatment.

Participant 13

*“Ngihlale ngiwathola amaphilisi angibi nayo inkinga”***.**

I always get antiretroviral treatment, and I have never had any problem.

Participant 14

“Ukutholakala kwemithi nako akunankinga”.

Accessibility of antiretroviral treatment is very good.

Participant 15

“Angikaze ngifike ngingawatholi”.

I never come for treatment and not receive it.

Participant 16

“Uma ufike ngosuku obekelwe lona uyawathola amaphilisi”.

Whenever you arrive at a specified date you always receive them.

Participant 17

“Ama ARV’s ayatholakala. Noma angangiphathi kahle bayangishintshela banginike amanye”.

Antiretroviral treatment is accessible. They change treatment if they notice signs of complications and side effects.

Participant 18

“Amaphilisi engiwatholayo angiphethe kahle futhi angenza ngiphile”.

The type of antiretroviral treatment that I am currently receiving is fine, and is giving me life.

Participant 19

“Okwamanje konke kuhamba kahle ngiyawathola amaphilisi”.

Currently everything is fine and I am able to access treatment.

Participant 20

“Sengizoqala ukuwathatha la esibhedlela amaphilisi, phambilini bengiwathatha eTholampilo, ngaqala ukuwathatha ngo 2013.”

This is the first time that I am receiving treatment at this Hospital. Previously I was receiving treatment at Tholampilo Hospital since 2013.

Participant 21

“Ngazalwa nalo igciwane lengculazi, futhi amaphilisi ngiyawathola.”

I was born with HIV and I always access antiretroviral treatment.

Participant 22

“Ngaqala ukuthatha amaphilisi kulesibhedlela ngo 2009, angikaze ngingawatholi amaphilisi.”

I have never experience any problem since I started receiving antiretroviral treatment in 2009.

Participant 23

“*I never had any problems, the only problem I have is when I have to come in the morning, and there will be a lot of people at the reception”.*

It is evident from the responses above, that a total of twenty three (23) participants had no problem in accessing antiretroviral treatment from the Ermelo Regional Hospital which falls under the Gert-Sibande region. All (23) participants clearly indicated that the general accessibility of antiretroviral treatment is very good at the Ermelo Regional Hospital.

The following **sub-theme** was created from **Theme 1**

4.4.1.1 Structural problems in accessing antiretroviral treatment

Six (6) participants indicated that they don’t have problems with the accessibility of antiretroviral treatment but they have a problem with *how* they access the antiretroviral treatment. They cited that too much time is wasted at the reception area where files are stored and sometimes not found. In that process, the participants indicated that they sometimes spend one (1) to two (2) hours waiting to be assisted. This fact was corroborated by participants (6), (8) and (23) that in some instances a skeleton (temporary) file will be opened upon the realization that their original files are not located. This inconveniences participants based on the fact that time was wasted and they normally ask permission from their employers to come and get their antiretroviral treatment. It has been corroborated by participants (9) and (18).The reception area was perceived as a serious challenge and creates unnecessary delays in the process flow of accessing antiretroviral treatment.

Participant 6

“Ngezinye izinkathi uyafika uhlale isikathi eside, uthole ukuthi ufike uhlale one or two hours ulindile o nurse basetiyeni”.

In some instances one could wait for about one to two hours while the nurses are still on tea time.

Participant 8

“Indawo le selindakuyo kule ngaphambili uthole ukuthi ifayela abaliboni,bagcine bangakhele i skeleton file ukuthi ngithole amaphilisi”.

The only place where we wait for a longer period is at the reception area. At some point I realized that my file has been misplaced, and a skeleton (temporary) file would be opened so that I can access antiretroviral treatment.

Participant 9

“Nako e reetla for the first time ne re sena information, ba kgona go rethusa ra etsa

faele. The only thing ke administration in terms of the information and some negative attitude from the staff members”.

By the time we come for the first time, we didn’t have information and we were helped and they opened files for us. The only thing is administration in terms of the information and some negative attitude from the staff members.

Participant 18

“I only encounter problems at the reception area because it is always full of people and that delays me. The administration at the reception area needs to be sorted out”.

Participant 23

“Abasheshi bakunike i help. Phambili bathatha isikathi ukukhipha ifayela”.

They don’t help us timeously. At the front (reception area) they take too much time to locate a file.

It appears from the above responses by participants that there are serious issues of structural efficacy. It is evident that the above quoted participants actually experienced structural problems at the reception area when accessing antiretroviral treatment. The fact that participants wait longer periods of time at the reception area before they can access files clearly has a negative impact on the participants as too much time is spent at the reception area before they could be referred to the wellness section.

For a full functional roll-out programme to be successful there is a need for development of human resource capacity. Human resource capacity comes at the expense of capital resources, and in a country that is still developing and faced with many social challenges, capacity building challenges might be a pipe dream (Squire 2007:42).

Although the other eighteen (18) participants never mentioned any delays at the reception area, that might have been caused solemnly by the fact that a question was never formulated to explore the state of the reception area. The fact that five (5) participants individually mentioned that there is a lot of delays at the reception area clearly affirm the existence of structural challenges with reference to the roll-out programme.

4.4.2 Theme 2: Things that have to be done in order to improve the accessibility of antiretroviral treatment in the Gert-Sibande public health care facilities.

Participant 4

“Konke ku right angikaze ngihlangabezane ne zinkinga”.

Everything is right because I have never experienced any challenges.

Participant 5

“Isimo sihle”. Sihle asiphoqhi”.

The situation is fine, and it has never disappointed me.

Participant 6

“Sometimes silinda isikathi eside uthole ukuthi kuyabanda, ugcine uhlala boma one or two hours ba ngaku sizi. Isikhathi sokulinda siningi”.

Sometimes we wait longer periods of time in very cold conditions approximately one or two hours without being helped. The waiting period is too long.

Participant 7

“Mina ngibona ku right ngalendlela abasebenza ngayo”.

In my view the current system of providing antiretroviral treatment seems to be good.

It appears from the statements indicated above that generally participant feel happy about the current system of providing antiretroviral treatment and no suggestions were made regarding the improvement in the current system. The issue of the delays caused by the reception area is also mentioned by participant six (6).

However, other participants mentioned below viewed the current situation differently and they had their own suggestions:

Participant 2

“Inkinga yilendaba yokuthi silale ema benchene la kubanda khona. Ngicela ukuthi e Ermelo bathole o Doctor. Abekho o Doctor abaneleko.”

The major problem is the issue of sleeping on the benches where it is very cold. I request more Doctors to be hired at this facility because there are not enough Doctors.

Participant 10

“Lokulinda uthole ukuthi udokotela akekho”. Udokotela bathi uphumile ngemoto yakhe ngasolo ngimlindile”.

The issue of waiting for the doctor for a longer period. The doctor drove out of the facility with his own car even though I am still waiting for him.

Participant 12

“Ngicabanga ukuthi mabenga beka amadate okuthatha amaphilisi kahle, ngicabanga ukuthi kungaba ncono”.Ngihlala ngisala namaphilisi amaningi mangiyo thatha amanye futhi.”

I suggest that if they could coordinate their dates properly, I could first finish the previous antiretroviral treatment before being given the next batch, in that way the situation could be very much better.

Participant 14

“Mina ngicabanga ukuthi baqhashe bo nurse abaningi.”Ama lunch abo bawalungise ukuthi noma omunye ase lansthini omunye asale asebenza”.

I suggest that the Department of Health should hire more nurses. The lunch times of those nurses is supposed to be well coordinated by nurse in charge. When one nurse goes on lunch the other nurse would remain behind working.

Participant 16

“Mina ngicabanga ukuthi sifanele sikhulume. Labo abahleli emakhaya kufanele batshelwe ukuthi beze ukuzo thatha amaphilisi”.

I think we have to give health education to those who are sitting at home and encourage them to come for treatment.

It is evident that regardless of the accessibility of antiretroviral treatment being good, there is still a need to improve the process flow. There is also the issue of human resource challenges that need to be addressed by the Department of Health. It appears from the above statements that there is a serious challenge with regard to the shortage of nurses, doctors, pharmacists, social workers, psychologists and general workers. The challenges encountered by the above mentioned participants, clearly indicate that there is still much to be done on the structural functioning of the whole process of accessing antiretroviral treatment. It is also confirmed by the literature below that:

Gert-Sibande health care system has been characterized by a fragmented and inequitable system due to the huge disparities that exist between the public and private health care sectors with regard to the availability of financial and human resources, accessibility and delivery of health services. This implies that there are negative effect in terms of antiretroviral treatment accessibility (Ermelo Provincial Hospital Strategic Plan 2014:17).

Karim and Karim (2010:503) argued that, suitable infrastructure is needed to manage HIV-infected individuals at primary care level, but funding is not readily available and qualified health care personnel are in short supply. Private health care attracts most health care funding, but is accessed by less than 20% of South Africans. This is evidenced by the number of people on antiretroviral treatment at the public health care facilities.

It can be concluded that the efficiency of the wellness programme in this health care facility need to be evaluated. There seems to be challenges that range from human capacity, adequate resources and tailor made campaigns aimed at encouraging people who were previously on the wellness programme. People living with HIV and who are defaulting from antiretroviral treatment needs special encouragement in the form of HIV and AIDS awareness.

4.4.3 Theme 3: The situation for the past three months in relation to the accessibility of antiretroviral treatment.

Participant 1

"Treatment isahamba kahle"

Antiretroviral treatment is still going well.

Participant 2

"Ku sese right for mina"

It is still right for me

Participant 3

"Mina ngisese right angina nkinga"

I am still fine and I don't have any challenges.

Participant 4

"Angikaze ngibe nenkinga"……beku right bengana nkinga "

I have never experienced any challenges and the situation was fine.

Participant 5

"Mina ngibona isimo sihle azange ngihlangabezane nenkinga"

I felt that the situation was good and I have never experienced any challenges.

Participant 6

"Bengi wathola angikaze ngibe nenkinga".

I was accessing antiretroviral treatment and I have never had any challenges.

Participant 7

“No angikaze ngibe nenkinga”.

No I have never experienced any challenges.

Participant 8

“Qha! angikaze ngidilindiswe kodwa inkinga isemzimbeni wami, basho igciwane liyakhuphuka”.

I have never been delayed but the challenge is, I was told that my viral load was increasing in my body.

Participant 9

“They were accessible, except the delays at the reception area”.

Participant 10

“Isimo sona si right”.

The situation was good.

Participant 11

“Ngiyacala ukuthatha I treatment la ePiet Retief isimo besikahle bekungana nkinga”.

This is for the first time receiving antiretroviral treatment at this facility.The situation in Piet Retief where I was receiving antiretroviral treatment, the situation was fine and there were no challenges.

Participant 12

“Simo si right”

The situation was good.

Participant3

“Simo besikahle”

The situation was good.

Participant 14

“Ayikho inkinga”.

There is no challenge.

Participant 15

“Kimi beyi right”.

For me it was good.

Participant 18

“I never had any problems except delays”. “But now I have changed strategies, I no longer come in the morning because of the delays”.

Participant 19

“Mina bengihlala ngiwathola”.

I always used to get antiretroviral treatment.

Participant 20

“Ya! wona bewatholakala amaphilisi”.

Yes antiretroviral treatment was always accessible.

Participant 21

“Ngiyawathola amaphilisi kodwa inkinga iyi one, bangishintshele amaphilisi amanye se banginiga leli eli one”.

I didn't have any challenge in accessing antiretroviral treatment. The only challenge that I have experienced is the change of the prescription from the multi-pills to a single dose.

Participant 22

"Mina ngiyacala ukuthatha amaphilisi lana".

For me, this is for the first time receiving the antiretroviral treatment at this facility.

Twenty (20) participants indicated that accessibility for the past three months has been good and they never encounter any problems. It is very clear that the Department of Health is doing well in procuring and availing antiretroviral treatment to the multitudes of people on treatment in this facility. The twenty (20) participants also indicated that the accessibility of antiretroviral treatment has been good and it can be concluded that generally there is no problem interms of access to antiretroviral treatment at the health care facility. This refutes the statement in the literature (see Chapter 2) to the effect that in many countries access to drugs and other material inputs needed for effective care of those living with AIDS-related illnesses are generally not available for reasons often of resource constrains. In South Africa, the response of government in general has been to argue that there are budgetary constraints limiting access to antiretroviral treatment, and that these constraints seem to continue for the foreseeable future (Poku 2005:131).

Responses from the twenty (20) participants clearly refute such claim and contrary to that, participants clearly indicated their gratitude as far as access to antiretroviral treatment is concerned. The participants' responses also confirm or attest to responses made from Theme 1 with regard to the capabilities of Gert-Sibande public health care facilities in providing antiretroviral treatment.

This clearly confirms that participants acknowledge the significance of accessing antiretroviral treatment in the public health care facilities and the pivotal role that is played by antiretroviral treatment.

Adherence to antiretroviral treatment, for example, is seen as a safer behaviour in delaying the progression of the HIV into a fully-blown AIDS in human body. If a person

is aware that adhering to medication will bring positive changes in his/her state of health then that person is likely to adhere to antiretroviral treatment. But if a person is not well aware of the implications of adhering to antiretroviral treatment and the direct consequences of such behaviour, such a person is likely to ignore the commitment of taking such treatment and therefore that might lead to defaulting (Van Dyk 2008:122).

The above statements clearly show that participants have been committing themselves in coming for antiretroviral treatment on a consistent basis.

The other three (3) participants had different opinions. Participant 16 indicated that she stopped taking treatment in 2014 and she has just come back to re-start the antiretroviral treatment, whereas participant 17 and 23 indicated that they have been accessing antiretroviral treatment but completely unhappy about the negative attitude of the staff members.

Participant 16

"Mina ngike ngasitopa ukuthatha amaphilisi ngo 2014 September manje sengibona e weight yami idropper kakhulu".

I stopped taking antiretroviral treatment in September 2014 and I realized that I was losing a lot of weight.

Participant 17

"Be si right, kodwa banoku sebenza mabathanda".

The situation was good, but they (nurses) work whenever they like.

Participant 23

"Baya bheda". Ba lazy abasebenzi bala. Aba treat umuntu kahle".

They are pathetic. Workers here are lazy and they don't treat people well.

The three participants hold different sentiments but in the context of their comments they don't indicate inaccessibility of the antiretroviral treatment at the health care facility. They only indicate the negative experience they received from the nurses. The same applies to participant 16 who also had an argument with one of the nurses at the clinic where she was receiving antiretroviral treatment, and that argument resulted in her stopping from coming to the clinic as from 2014 until the date of the interview.

It can also be concluded that all participants were fully aware of the significance of receiving antiretroviral treatment, and the consequences of not taking antiretroviral treatment. It can be concluded, therefore, that there were no challenges in accessing treatment at the public health care facility. Antiretroviral treatment has always been available to people living with HIV at the public health care facilities.

4.4.4 **Theme 4**: Experiences in relation to antiretroviral treatment

Twenty (20) participants emphasized the fact that the accessibility of antiretroviral treatment played a significant role in ensuring a better health for them. The situation at the facility is good except the delays and the negative attitudes of some staff members. There seems to be consistent perception in terms of access to antiretroviral treatment at the health care facilities and structural challenges were highlighted in this regard.

Participant 1

"Mina since ngizala esibedhlela angikaze ngibe nenkinga".

Since I have been coming at this hospital I never encountered any challenge.

Participant 2

"I government mina ngiyayibonga ngoba ngabe angisaphila".

I am grateful for the government for helping me, otherwise I could have been dead by now.

Participant 3

“Sengine sikhathi ngoba sengi right mara ngizophinda ngiwalande amaphilisi”.

It has been a while now since I have been coming for antiretroviral treatment; however I will keep on returning to collect more pills.

Participant 4

“Amaphilisi ayaphuzeka awana nkinga”.

The pills are easy to swallow and they don’t give me any challenges.

Participant 5

“Kubalulekile ngoba ngesinye isikhathi ngabuyela phansi ngagula futhi”.

It is very important because at some point my health deteriorated and I fell sick again.

Participant 6

“Inkinga ukulinda one hour or two hours mara ekugcineni ayatholakala amaphilisi”.

The problem is waiting to be assisted for about one hour or two hours eventually the antiretroviral treatment is available.

Participant 7

“Last year ngike ngachekha bangitshela ukhuthi ngizo thatha amaphilisi ngathi bayangihlolela ngabese ngacala ngagula,ngabese ngiyeza ngizothatha amaphilisi”.

Last year I got tested and I was advised to come for antiretroviral treatment. I was in denial until the point where I started getting sick that is when I decided to come for treatment.

Participant 8

“Ngifundile ukuthi isibedlela siyanakekela kakhulu ngoba mabengiya kodokotela bengizo badala ngani. Abasebenzi bala ba sweet”.

I have learned that the hospital is taking good care of me. I was not going to afford the fees for the private doctor. Generally workers here are so sweet.

Participant 9

“There are no issues about experiences because the improvement is great”. “The only thing nne ele reaction ya maoto nne a ruruga”.Mara improvement yona is good”.

There are no issues about experiences because the improvement is great. The only thing was the swelling of the legs and the reaction. Legs were swelling but now there is a huge improvement.

Participant 10

“Nedi ikhona lento engingayi thandi, lento yokuthi bayasimuvisa, hambe uye clinic uhambe uye kuphi kuphi,uthole ukuthi mina angifuni ukuya e clinic, ene masebathi hamba vele ufanele uhambe”. “Mina i Clinic angiyifuni”.

There is only one thing bothering me. The thing of referring us to the clinics, I don’t like it.

Participant 11

“Futhi ngifunde kuthi mangithole isikhathi ngizi vocavoce, ngidle healthy kuze kuzo assistana nala maphilisi”.

I have learned that whenever I have time I must take care of myself by exercising and eat healthy food so that my treatment can become effective.

Participant 12

“Ngifunde ukuthi wona abalulekile ukuthi ngasonke isikhathi uwalande unga yeqhisi”.
I have learned that it is very much important to get antiretroviral treatment without defaulting.

Participant 13

“Bafanele basimukele bangathathi ukuthi mawuphuza amaphilisi kusho ukuthi ikhanda lakho alisebenzi”.

They must accept us the way we are, it does not mean that if we are on antiretroviral treatment, that does not mean that we are mentally retarded.

Participant 14

“Uma ungena la ngaphakhathi i patient kufanele ibe one kungabe nomunye umuntu”. Ngesinye isikhathi uthola aba ngani babo sister sebangaphakathi bese bayaxoxa”. “ Abanye bonoku hambisa I information yakho ngaphandle”.

When a patient is in the consultation room, there must not be any unauthorized person. There were challenges that nurses’ friends were often allowed to come in the consultation room and some of them took the information to the local community.

Participant 15

“I sase right kwa manje angazi ekuhambeni kwesikhathi”.

It is still good for now, and I don’t know what will happen when time goes on or in the future.

Participant 16

“Umehluko ukhona ngoba i weight yami yehlile kusuka ku 83 kilograms kufika ku 77 kilograms amaphilisi wona ayanceda”.

There is a huge difference because my weight initially dropped from 83 kilograms to 77 kilograms; therefore, antiretroviral treatment really helps.

Participant 17

“Mina angijabule ngalendlela le abasiphathaku ngakhona”

I am happy the way we are treated.

Participant 18

“The accessibility is not a problem I always get my medication and I don’t have any problem. They offer counseling before starting treatment”.

Participant 19

“La maphilisi lawo ayangilulamisa angiphatha kahle”.Amaphilisi angi ncende ka khulu”.

The treatment improved my health condition and has assisted me a lot.

Participant 20

“Ngezinye izikhathi basinika I ncwadi ukuthi sithole amaphilisi kuma clinic ene kuyafana nala esibhedlela”

In some instances they give us a letter to collect our antiretroviral treatment at the nearest clinic. The situation is similar to the one here at the hospital.

Participants 1 to 20 indicated that their experiences in relation to antiretroviral treatment are good based on the fact that the treatment improved their health condition significantly. They acknowledge in full the significance of accessing antiretroviral treatment. The twenty (20) participants clearly indicated their awareness of adhering to antiretroviral treatment.

Similar perceptions were also expressed by the other three participants 21, 22 and 23 emphasized much on how they are treated when coming for treatment and not on the significance of taking antiretroviral treatment. Participant 20 indicated that she is not happy about being referred to the clinic due to the fact that at the clinics the service is very much poor. She indicated that she preferred the hospital than at the clinic due to the poor service rendered by the clinics. Participant 21 indicated lack of social support as a very serious problem. The participant is only 19 years old and lost all his parents due to AIDS related diseases and who got infected through mother-to-child

transmission. Participant 22 indicated that it is normal to get queues at any public health care facility and he is fine with the manner in which treatment is provided to him.

It is evident from the views of all participants that their experiences regarding antiretroviral treatment are generally good. The areas that need to be improved are the process flow and implementation of the code of conduct from the health personnel. The participants perceived the turn-around time as a major challenge that needs to be given a serious attention. Their perceptions regarding antiretroviral treatment vary due to the fact that some participants takes a single dose while the other participants take multi-dose. Participants had different views regarding new antiretroviral treatment and their views vary from one participant to the other. Generally, a single dose pill is seen as a relief to those participants who feel very uncomfortable in taking multiple pills.

4.4.5 Theme 5: Overall experiences about the accessibility of the antiretroviral treatment.

Participant 1

“Mina bayangiletha abelungu bami la esibhedlela”. “Mina sengihola i pension.Bangitshelile ukuthi imithi singayithola nasemakhemisi”.

My employers transport me to the hospital. I am currently receiving social grant. I was informed by the health personnel that antiretroviral treatment can be obtained at the pharmacies.

Participant 2

“Basisizile ngalendaba yokuthi siphuze leli eiliyi one ngoba asisakhohlwi ukuphuza.Ma wazi ukuthi ngiphuza ngo seveni,ngiyazi ukuthi ngaleso sikhathi ngiya liphuza,noma ngihamba ngiyali thatha ngilifake kwenyei container ukuthi anganaki loyo muntu”.

They really helped us a lot by introducing a single dose because it is only taken once at seven. I know that on the prescribed time I am taking my pill or taking it along with me

whenever I am visiting and put it in different container so that the person I am visiting should not notice the type of the pill I am taking.

This implies that client-patient confidentiality/privacy could be maintained (Pera and Van Tonder 2011).

Participant 4

"Kimi ku right angikaze ngibe ne nkinga"

I have never experienced any challenge.

Participant 5

"Akubi nenkinga yonke into i right".

There is no challenge, everything is good.

Participant 6

"Mina ngiya wathola amaphilisi angikaze ngifike la ngingawatholi".

I have never experienced any shortage of antiretroviral treatment.

Participant 7

"Partner yami ayifuni ukuza la esibhedlela, ayifuni kuza ukuzo thatha amaphilisi".He does not want to take treatment and we are having sex without a condom".

My partner does not want to come to the hospital for treatment. He does not want to take treatment and we are having sex without a condom.

This implies that there is a need for intensification of health education in relation to sexually transmitted diseases that include HIV.

Participant 8

“Mina ngiya jabula ukutholakala kwamaphilisi kulesibhedlela”.

I am happy about the availability of pills (antiretroviral treatment) at this hospital.

Participant 9

“Overall experience is good”.

Participant 10

“Khona ku right indaba mina angifuni i clinic”. Angifuni ukuthatha amaphilisi e clinic”.

The situation is good but I don’t like to receive antiretroviral treatment at the clinic.

The participant is of the opinion that receiving antiretroviral treatment at the clinic might compromise the integrity of the nurse-patient confidentiality. The clinics are seemed to be under resourced in terms of equipment and human resource capacity that might hinder professional accessibility of antiretroviral treatment.

Participant 11

“*Yonke into ePiet Retief beyihamba kahle”.Beyingekho inkinka”*

Everything was going well at Piet Retief and there were no challenges.

Participant 12

“Mina ngifunde ukhuthi wona abalulekile ukuthi ngaleso sikhathi uwalande”. Ngoba abaluleke kakhulu”.

I have learnt that the antiretroviral treatment is important and I should go and collect them at the prescribed date.

This has showed that participants have a clear understanding about the importance of antiretroviral treatment and the follow-up date.

Participant 13

“Kunalento le yokuthi uma uthatha amaphilisi ngathi uyasangana”. Mina ngifuna ukuthatha amaphilisi khona la esibhedlela”.

There is this perception that whenever a person is on antiretroviral treatment is mentally retarded. I just want to get my antiretroviral treatment at this hospital.

There seems to be a negative perception from the community that, people who are on antiretroviral treatment are mentally retarded. There is a need to educate the community to accept people living with HIV and who are on antiretroviral treatment. (A further research on the impact of antiretroviral treatment with regard to mental retardation should be conducted).

Participant 14

“Mina ngicela ba increaze bo dokotela ku wellness ngoba ku sebenza u dokotela oyi one”.

I just request an increase in the number of doctors at the wellness section because only one doctor is working there.

Participant 15

“I experience yami yokuthatha amaphilisi i sase right okwamanje ne staff si right”

My experience of getting antiretroviral treatment is still good for now and the staff is also good.

Participant 16

“Amaphilisi aletha umehluko, bengidla kahle before ngi defaulter.Mina ngifuna abo nurse basiphathe kahle”.

Antiretroviral treatment brings so much improvement, I was in good health before I defaulted, and I just pledge that nurses must treat us well.

This implies that participants on wellness program must be encouraged not to stop antiretroviral treatment by health care personnel. Nurses must always portray positive attitudes towards their clients/patients.

Participant 17

“Angifuni ukuya e clinic.E clinic lento eyenza ukuthi ngingafuni iloko ukuma ngaphandle uphinde uyoma ngaphakhathi, uthethiswe yonke lento”.

I don’t want to go to the clinic because you will be told to queue outside and when you get inside they shout at you.

There seems to be a challenge of service delivery at the clinic, therefore, the researcher is kindly requesting the intervention from Mpumalanga Department of Health. The intervention might be in the form of staff training on the Batho Pele Principles, ethical conduct and client orientation and customer focus.

Participant 18

“The service needs to be improved especially at the reception area. But in terms of access to antiretroviral treatment everything is good”.

The participants seem not to be satisfied about the service at the reception area. There is a need to address those challenges in order to improve comprehensive health service delivery.

Participant 19

“Avikela umzimba wami”.Bengigula mina before ngicala ukuthatha amaphilisi”.

Antiretroviral treatment protects my body and I was very sick before I commenced treatment.

Participant 20

“Bo nurse bala bafanele bathathe i lunch ngoku shiyana bangayithathi ngesikhathi esiyi one”.

Nurses should not take lunch at the same time; they must rotate their lunch times.

The nurses ‘attitude need to be re-oriented from a negative to a positive attitude. The Nursing Service Manager of the hospital should make sure that their subordinates are handling members of the community in dignified manner.

Participant 21

“Mina ngike nga defaulter isikhathi eside, amaphilisi lawo bangiphawo wona manje awana power”.

I defaulted for a long period of time and I have noticed that the antiretroviral treatment that I am receiving now does not have power.

There seems to be a need for further research on the effect of antiretroviral treatment on people living with HIV and got infected through Mother-to-Child transmission.

Participant 22

“Mina ngasho ngathi ikahle angikhomplaini, ngaphandle nje ukuthi kuba slower nyana”.

All I can say is that I don’t have any complain except from the fact that they are bit slower sometimes.

Participant 23

“Ku right ngingasho ngithi i place yabo e right”.
The place is generally good.

It is clear that participants are generally happy about getting treatment at the hospital and they also indicated some discomfort in taking their antiretroviral treatment at the nearby clinics. Participants are happy about receiving their treatment on regular basis and also indicated that they never encountered any problems in relation to the non-availability of the antiretroviral treatment. Participants are generally happy about the introduction of a single dose antiretroviral pill which is viewed as easy to take and is taken once a day. It is viewed by participant 2 as very encouraging and easy to take.

A researcher has noted that other participants hold different views regarding their overall experience in coming for treatment. Some participants indicated that there are areas that need to be improved and those areas are not limited to structural functioning of the program, but also to staff or personnel way of rendering service. That view can be confirmed by expression from participant 20, that nurses need to rotate their lunch times. Participant 20 suggested that the wellness programme must operate throughout the day and nurses lunch times need to be well coordinated so that when one nurse goes on lunch the other one can remain rendering service at the wellness center.

All participants are generally aware of the significant of taking antiretroviral treatment. The latter statement can be confirmed by the views expressed by participant 19.

The overall experience about the accessibility of the antiretroviral treatment in public health care facility is good. The waiting period at the reception and the negative attitudes of the nurses need to be addressed.

4.4.6 Theme 6: Effect by the availability and non-availability of the antiretroviral treatment.

Participants' views regarding their feelings when accessing treatment with special focus on the availability of antiretroviral treatment and the non-availability of the antiretroviral treatment in public health care facility. The participants' perception towards antiretroviral treatment and its significance were explored in this section.

Participant 1

"Kungiphatha kahle Ukutholakala kwamaphilisi"

The accessibility of antiretroviral treatment is very good.

Participant 2

"Ngaphatheka kabi".

I will feel bad

Participant 3

“Mina ngaphatheka kahle ngobangizokwenza njani”.

I will feel fine because there is nothing I can do.

Participant 4

“Kungangiphatha kabi ngoba mangifikile ngingawatholi angeke phela kulunge njalo”.

I will feel very bad because there is nothing that will be better under those conditions.

Participant 5

“Bafanele bangichazele ukuthi uma aphelile aphele njani”.

They have to explain when the antiretroviral treatment is not available.

Participant 6

“Yoo! angeke ngibe right ngoba ngifanele ngiphuze everyday,yaa….. ngeke ngibe right.

I won’t feel good because I have to take the pills (antiretroviral treatment) every day.

Participant 7

“Ku ngiphatha kahle”.

The situation is good.

Participant 8

“Kungangi limaza loku ngoba nje ngala maphilisi lawo ngiwadlako abaluleke kakhulu kabi empilweni yami”.

It can hurt me because the pills (antiretroviral treatment) that I am taking are playing a important role in my life.

Participant 9

“That will be a disaster, a very bad thing to happen”. I don’t wish that to happen”.

Participant 10

“Phela ngingaphatheka kabi, ngizokwenze njani if angiwatholi”.

I will really feel bad if I don’t get the antiretroviral treatment at the hospital.

Participant 11

“Kungangiphatha kabi ngempela ukuthi inkinga kuzabe kuse i viral load se iba phezulu a masosha ami awasakhoni ukuthi alwenayo ngalendlela e lamele”.

I will feel very bad if I find the medication not available because the viral load will rise and my immune system will be unable to deal with the virus.

Participant 12

“Ngeke ngiphatheke kahle”.Ngizo phatheka kabuhlungu”.

I won’t feel good if I don’t get treatment. I will be hurt by the non-availability of the antiretroviral treatment.

Participant 13

“Ngaphatheka kabuhlungu ngoba i mpilo yami angkeke ngiphile ngaphandle kwawo”.

I will really feel bad because it is my life, and i won't survive without the antiretroviral treatment.

Participant 14

"Kungaba kabi mara mangithole I message ukuthi aphelile ngizo mukela".

I will feel bad but if I get a message that the antiretroviral treatment is finished I will just accept.

Participant 15

"Abaluleke kakhulu".

The antiretroviral treatment is very much important.

Participant 16

"Amaphilisi uma atholakala ngiphatheka kahle". Kuno bungozi phakhathi uma ongawathathi njengoba i weight yami be yehla".

When pills (antiretroviral treatment) are accessible and available I feel good. There is a danger when one does not take them because my weight dropped a lot.

Participant 17

"Mina ngizo kwenza njani umabathi aphelile ngoba ngophila ngawo".

I don't know what I can do if I am told that the pills (antiretroviral treatment) are finished because I survive because of them.

Participant 18

“It will be a problem because I am supposed to take medication on daily basis. So I am always impressed by the service rendered here”.

Participant 19

“Nda phatheka kabuhlungu”. “Mabangitshela ukhuthi aphelile”.

I will feel bad if I am informed that the antiretroviral treatment is finished.

Participant 20

“Kungaba buhlungu masingathola ukuthi awekho”.

I will feel pain if I am told that the antiretroviral treatment is finished.

Participant 21

“Mina angisana ndaba ukhuthi ngiyawathola or angiwatholi,mina nje ngilinde ukufa”.

I don’t care whether I access them or not the only thing that I am waiting for is to die.

Participant 22

“Ngeke ngiphatheke kahle if angiwatholi ngoba abalulekile kakhulu emzimbeni wami”.

I won’t feel good because antiretroviral treatment plays a big role in my body.

Participant 23

“If angiwatholi nginga phatheka kabuhlungu”.

If I don’t get antiretroviral treatment I will feel very bad.

Most participants indicated that the continuous availability of antiretroviral treatment in the public health care facility plays an integral part in the improvement of their health condition. Participants also pointed out that if ever the situation can change and start experiencing shortages in the availability of antiretroviral treatment, they will surely feel very disappointed as they have realized over time that taking antiretroviral treatment actually improved their health conditions.

That can be confirmed by the health belief model that; the perceived benefits of an action where the proposed action is effective in reducing the health risk will likely encourage consistency in that particular action. The course of getting antiretroviral treatment has the health benefits such as improvement of health condition and the reduction of opportunistic diseases (Chirambo & Ceasar 2003).

It is evident from the above views expressed by participants that they are fully aware of the health benefits that are brought by taking antiretroviral treatment. Only participant 21 indicated that he does not care whether he access treatment or not .Participant 21 indicated that he is actually waiting to die and that is also confirmed by his admission that he has been defaulting numerous times.

The researcher’s recommendations will be discussed in Chapter 5 where key findings of the study will also be outlined.

4.5 Conclusion

This chapter presented the key findings of the research based on the research purpose and objectives and provided evidence for each of the research questions, as well as a basis on which to apply selected theory: Health Belief Theory.

Participants' views where expressed regarding the following: the capabilities of Gert-Sibande public health care facilities in providing antiretroviral treatment. The measures to improve the accessibility of antiretroviral treatment in Gert-Sibande public health care facilities. The situation with regard to accessibility of antiretroviral treatment for the past three months. The participants experience in relation to antiretroviral medication when receiving treatment. The participants' experiences in relation to accessibility of antiretroviral treatment. The effect on participants of the availability or the non-availability of antiretroviral treatment in the public health care facility.

The next chapter draws an overall conclusion of the study so as to make recommendations.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The aim of this study explored the accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care Facilities in the Gert-Sibande region in Mpumalanga and how people taking antiretroviral treatment in the public health care facility experience when coming for treatment. The study aimed at exploring understanding in relation to accessibility of antiretroviral treatment amongst people living with HIV at Gert-Sibande Public Health Care facilities in Mpumalanga Province.

To achieve this purpose, a qualitative research methodology was chosen based on the literature and the applicable theory to motivate an explorative research design.

5.2 Summary of Findings

The following were found on the exploration of accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care facilities in Gert-Sibande region in Mpumalanga.

5.2.1 The capabilities of Gert-Sibande public health care facilities in providing antiretroviral treatment.

5.2.1.1 Structural problems in accessing antiretroviral treatment

All twenty-three (23) participants found that they access antiretroviral treatment flawlessly and are happy about the availability of antiretroviral treatment at the public health care facilities and none of the participant ever mentioned any experience relating to shortage of antiretroviral treatment.

All the participants indicated that they are happy about the un-interrupted supply of antiretroviral treatment and confirmed their wishes of getting treatment whenever they need it. It is evident from the participants' responses that antiretroviral treatment is

easily accessible at Ermelo Regional Hospital where research took place and through the response from certain participants, who were taking treatment from Piet Retief Hospital, expressed the similar experiences by mentioning that also at Piet Retief Hospital there were no problems in accessing antiretroviral treatment.

The views expressed by participants support the theoretical empiricism of the Health Belief Model which emphasises behavioural modification as a very important aspect in risk reduction in the fight against the scourge of HIV and AIDS (Manique 2004:88).

The efforts by participants to come for treatment showed that psychologically they are aware of the danger for not coming for the treatment, and the threat posed by failure to take antiretroviral treatment. Although some participants indicated that they have defaulted at some point while taking treatment, the fact that they are now back on treatment really indicate that they are fully aware of their susceptibility to opportunistic diseases whenever they are not taking treatment. Participants are aware of the perceived susceptibility and perceived severity of health conditions (Manique 2004:87).

Participants who were defaulting are back on treatment and this is evident that antiretroviral treatment is playing a significant part in improving the health conditions. All participants shared similar views in relation to access to treatment. The participant only mentioned the delays caused by administration of files, as a delaying factor in accessing treatment and suggested that, if administration of files can be done at the wellness center that can assist in speeding up the process of accessing treatment. The other challenge pointed out by most participants is the issue of referral to the local clinics. Most participants didn't like the fact that when their conditions are getting better, they are often referred to the nearby clinics to get their antiretroviral treatment.

Participants pointed out that there are so many delays at the clinic than at the hospital and the fact that queues are very long at the clinics is a nightmare for them. The participants often pointed out that the nurses' negative attitudes at the clinics is very bad and discourages them from going to the clinics. According to Squire (2007:42) for a full-functional roll-out programme to be successful there should be human capacity. Human capacity development takes precedence over capital allocation.

This view is supported by participants who mentioning that there is only one doctor working at the wellness centre. It is also reported by participants that nurses sometimes take lunch at the same time and thus causes unnecessary delays in receiving treatment.

Administration of files and the capacitation of the existing personnel are critical areas for improvement.

5.2.2 Things to be done to improve the accessibility of antiretroviral treatment in Gert-Sibande public health care facilities.

There were different opinions regarding things that can be done to improve the accessibility of antiretroviral treatment in Gert-Sibande public health care facilities. Despite the fact that participants most of them were aware of the hospital's Central Chronic Medicine Distribution and Dispensing Programme (CCMDD), it became clear that participants feel comfortable to receive their antiretroviral treatment at the hospital rather than at the designated private pharmacies.

The Central Chronic Medicine Distribution and Dispensing Programme (CCMDD) is an alternative chronic medication access programme for the public sector patients at the nearest pick up points to their homes or place of work. The approach seeks to relieve health facilities of the increased number of patient visits. The programme aimed to improve supply of medication to stable chronic patients outside the facilities at points easily accessible to them. The Department of Health realized that the public health care facilities handle unnecessary repeat visits of stable patients, the administrative duties are often neglected leading to overcrowding, high head counts, long waiting times, negative staff attitudes due to work overload, occasional shortage of medicines and complaints from clients about non-availability of medicine (Department of Health 2016:2).

Participants were aware of the existence of the (CCMDD) but indicated that they don't feel comfortable receiving their medication at the private pharmacies despite the fact

that they are health condition is stable. It has been indicated that patients who are stable are also often referred to the nearest clinics to get their medication there, but participants indicated that they don't like going to the clinics due to either long queues or staff's negative attitudes at the nearest clinics.

Eight participants indicated that they are happy about the current system of providing antiretroviral treatment, when asked about what can be done to improve the current system of accessing antiretroviral treatment. These participants also mentioned that they have never experienced shortage of antiretroviral treatment in the facility.

Six participants indicated that the reception area / administration system of the files need to be improved. They emphasized that they spend long waiting time at the reception area either, the file cannot be located and a skeleton (temporary) is instead opened. This is a prevalent norm at the reception area of the hospital according to the six participants. It has also been suggested by one participant that there should be someone appointed to receive first time patients in terms of informing them about the process flow at the reception area just like at the banks where people are directed according to their required services. Another participant suggested that the filing system of people living with HIV should be integrated with the wellness programme, meaning that those living with HIV should not queue at the reception area. It is suggested that they must just come directly at the wellness centre and receive their medication there.

Three participants suggested that there must be more additional staff members at the wellness centre. Additional doctors were also suggested by one participant to assist the rising volumes of people on antiretroviral treatment. One participant further suggested that the nurses at the wellness centre should coordinate their lunch time so that the service delivery is not affected. The participants also noted that during lunch time all nurses who work at the wellness centre go on lunch and the wellness centre is closed for that duration and that causes unnecessary delays.

Another three participants indicated that they had defaulted and that ranges from varying reasons such as; lack of social support from the government in terms of the provision of social grants and food parcels to supplement their required diet of a patient

on antiretroviral treatment. Another participant's reason for defaulting was based on the much improved health condition. He indicated that since he started taking treatment there was a huge improvement in his health condition to a point where he thought it is no longer necessary to take antiretroviral treatment therefore he decided to default. Now he realized that his health condition has deteriorated due to the fact that he stopped taking treatment and decided to come back for treatment again. The third participant's reason for defaulting was based primarily on the nurses' negative attitude at the clinic where she was taking treatment. She decided to come to the hospital to access her antiretroviral treatment. She indicated that since she stopped taking her treatment her weight dropped dramatically. The participant indicated that she was weighing around 83 kilograms before defaulting and now she weighs 77 kilograms. The latter statement is also supported by Smith (2013:262) that, HIV treatment suppresses viral load and infectiousness and improves health status, and the counseling and other medical care that comes with treatment which normally accompanied by a decrease in sexual risk behaviour.

It is therefore suggested by the researcher that programmes aimed at encouraging people living with HIV who have defaulted to come for treatment again. It is evident from the participants' views that there are still a lot of people who were on treatment and for various reasons decided to stop taking treatment. Social mobilization programme should be initiated to encourage those who have defaulted to come forward and be re-registered in the antiretroviral treatment programme.

Two participants suggested differently on the subject matter. One participant indicated that dates should be coordinated due to the fact that he is having a lot of antiretroviral treatment in access. He pointed to the fact that dates are very close to each other therefore when he goes for treatment he finds that he still has a lot of pills in his possession. Another participant highlighted the introduction of the CCMDD as something that will definitely improve the patient service and the extension of operating hours is highly recommended.

One participant pointed out that, it was for the first time for him coming for treatment, therefore, he cannot suggest nor have an opinion about improvement of service in relation to accessibility of antiretroviral treatment.

Concluding the views of participants ‘s suggestions on the improvement of the accessibility of antiretroviral treatment in Gert-Sibande public health care facilities, the health belief theory validates participants’ views that perceptions of reality, rather than objective reality, influence behavior. The importance of the consequences of behavior in predicting actions, while cognitive theory modified this by stressing the relevance of the person’s subjective valuations, and their judgment of the likelihood that an action would have desired consequences. In this theory, health behaviors are influenced by a person’s desire to avoid illness or to get well, and by their confidence that the recommended action will achieve this (Janz *et.al* 2002).

5.2.3 The situation for the past three months in relation to the accessibility of antiretroviral treatment.

Twenty one (21) participants indicated that there has been a consistent accessibility of antiretroviral treatment for the past three months. Two participants had different views. One participant (1) indicated that he does not know about the situation for the past three months as he has just commenced treatment on the day of the interview. Another participant indicated that the situation at the hospital has been very bad. He further elaborated by indicating that the staff is lazy, he is not treated very well. But other than what he already mentioned, it becomes clear that he gets his treatment consistently. It can also be highlighted that the consistent accessibility of antiretroviral treatment is not only limited to Ermelo Provincial Hospital, but also to Piet Retief hospital as one participant indicated in his comment that he was taking medication in Piet Retief and he never encountered any problems in relation to availability of antiretroviral treatment.

The above views of participant clearly refute the initial claims from the literature review (Chapter 2) that, there are still challenges of scaling up HIV treatment programs in Africa (2005:124).It is evident from the views expressed by participants that the

provision of antiretroviral treatment in public health care facilities in Gert-Sibande is good.

5.2.4 Experiences in relation to antiretroviral treatment.

Various perceptions were expressed by all twenty three participants in relation to their experiences of antiretroviral treatment.

Fifteen (15) participants acknowledged the role that is played by antiretroviral treatment in improving their health conditions. Their experience ranges from recovering from weight loss, to the improvement in their health conditions. Some participant acknowledge the complications that come with taking antiretroviral treatment but however indicated that once one get used to taking treatment the situation improves each day. The significance of antiretroviral treatment cannot be over emphasized; their main functions have been explained in detail in (see Chapter 2).

Smith (2013: x) indicated that recent scientific breakthroughs suggesting that treatment is also a highly effective form of prevention. It is very clear that participants understood the significance of accessing treatment and those who had relapses have come forward to seek assistance at the public health care facilities.

Eight (8) participants expressed different views and their responses vary according to what they have experienced. Some participants named the fact that they are often referred to the clinics and they don't feel comfortable in taking their treatment at the nearby clinics. Despite the CCMDD's clear objectives, participants do not like the idea of being referred to the local clinics even when their health conditions have been normalized or stabilized. Other participants complained about the waiting period before being assisted by the staff. The issue of lack of privacy was also highlighted by one participant. Participant indicated that sometimes some staff members such as cleaners or other members who are not working at the wellness are sometimes present in the consultation room and therefore patient 's confidentiality is often compromised.

It is validated by Van Dyk (2008:430-438) that, people living with HIV have the right to confidentiality and privacy about their health and HIV status. It is further argued that South African courts have recognized that confidentiality and privacy regarding HIV status extends to health care colleagues.

The issue of staff's negative attitudes towards patients was also mentioned and their work ethics, commitment and passion have been under a lot of criticism from several participants. The nurses' treatment towards people living with HIV is not good according to some participants. The participants' further indicated that taking antiretroviral treatment is associated with mental retardation by the nurses. This assumption might be perpetuated by a scientific evidence that suggest that one of the opportunistic diseases associated with HIV is the neurological disorder normally caused by fungal infection in the central nervous system or *Toxoplasma encephalitis* better known as protozoal infection of the brain that causes damage to the brain itself (Van Dyk 2008:58).

One participant indicated that there is lack of social support from the side of government. The participant complained that he often takes antiretroviral treatment on an empty stomach. Socio-economic situation of the participant was described as very poor and the participant got infected through Mother-to-Child transmission and he left school due to his poor health and now there is no social grant from the government since he turned 18 years of age. The participant indicated that it will be better if he receive food parcels from the government.

Another participant complained about the staff's negative attitudes at the clinic. Some participants indicated that they don't want to be referred to the nearest clinics due to long queues, poor service and nurses' negative attitudes towards them. One participant who had defaulted for a year mentioned that there was a reason for stopping treatment. The reason for the participant to stop taking treatment is the manner in which she was mistreated by the male at a local clinic. She mentioned that the negative attitude of that particular nurse contributed negatively towards her defaulting treatment. She further elaborated that she started losing weight dramatically and got sick and she decided to come back for treatment but this time not at the local clinic where she had an encounter

with the nurse, this time she decided to come to the hospital hoping for a better treatment.

5.2.5 The overall experience about the accessibility of antiretroviral treatment

Fourteen (14) participants stated that overall experience about the accessibility of the antiretroviral treatment is good. This clearly validated the fact that accessibility of antiretroviral treatment in Gert-Sibande public health care facility is good and it must also be noted that this cannot be said about the surrounding clinics and other hospitals. But the gist of the matter is participants who took part in this study clearly pointed out that there is poor service at the surrounding clinics and they don't want to be referred to the clinics even if their health condition has stabilized as per CCMDD objectives. Participants clearly shared the same feeling about the uneven health care delivery system between the hospital and the surrounding clinics. Participants also mentioned a very fragmented health care delivery system at the clinics which might be influenced by various reasons that need to be systematically studied.

Eight (8) participants expressed different views regarding their overall experience about the accessibility of antiretroviral treatment. Some participants mentioned that the introduction of a single dose pill is seen as a relief especially to people who are not confortable in taking pills. Participants acknowledged the fact that they are fully aware of the CCMDD programme and they feel very comfortable to take their treatment at the hospital rather than at the private pharmacies. One participant indicated that the private pharmacies will bring a lot of relief to the public health care facilities which are always overcrowded. Another participant mentioned that it will be a wise move if the hospital management can integrate or centralise wellness centre by having its own administration, nurses, doctors and its own pharmacy.

Other participants mentioned that barriers created by the nurses' negative attitudes should be removed in order to ensure an ameliorated situation for patients without being emotionally abused. Some participants mentioned the unequal socio-economic situation as a barrier towards effective antiretroviral treatment. Social and economic support was

seen as an integral part in ensuring that people on treatment afford adequate food and proper shelter. This view is also supported by Karim and Karim (2010:418) asserted that economics itself influences the epidemic, as one of the drivers and determinants of the scope and the scale of the epidemic. All economic decisions are driven by choice, scarcity and uncertainty.

One (1) participant indicated that it will be proper to answer this question after initiating antiretroviral treatment.

5.2.6 The effect of the availability and non-availability of the antiretroviral treatment

Twenty two (22) participants indicated that if ever they were to visit the hospital and be told that the antiretroviral treatment is out of stock they would definitely feel very bad. They further elaborated by pointing out that their lives would be at stake should they cease to take their antiretroviral treatment on a regular basis. Participants shared the same feeling regarding the availability and accessibility of antiretroviral treatment in Gert-Sibande health care facility.

The above statements clearly affirmed their high level of self-efficacy as it has been demonstrated in the health belief theory. The participants' belief in their self-efficacy influenced the choices they made, their aspirations, how much effort they mobilized in a given activity, how long they persevered in the face of difficulties and setbacks, whether their thought patterns were self-hindering or self-aiding to them (Van Dyk 2008:125).

It is evident that participants are fully aware of the importance of accessing antiretroviral treatment and to persevere against structural obstacles that are existing in the public health care facility, this clearly demonstrate their highly developed self-efficacy which is always rewarded by the availability of antiretroviral treatment.

5.3 Limitations of the study

The study had the following limitations:

5.3.1 The role of the researcher

During the interviews the researcher has noted that most participants continued to address him as " Doctor" despite the fact that he introduced himself clearly as a student from the University of South Africa. The participants might have been biased in answering certain questions that would have negatively impacted the credibility of the health care facility. The researcher was tempted to interview the same participants in a different setting, preferably a neutral venue or at their homes where they would have felt more comfortable and relaxed. The researcher is of the opinion that the formal bureaucratic setting of the hospital might have influenced the rationality of some participants who were mostly above forty (40) years of age and/or more. Qualitative research implies that data collection should take place within the natural setting, however the question that still lingers in the researcher's mind is how natural is the natural setting?

During the pilot study three participants were requested to take part in the pilot study to test the questions in advance, however, the researcher has noted some differences between participants in the pilot study and the ones who took part in the actual study.

During the pilot study three participants were talking in high pitch voices and seemed to be more relaxed than participants in the actual study. These are the reasons why the researcher was willing to interview the twenty three (23) participants in a different setting or location, preferably at their homes where it is more relaxed than at the hospital.

It has been observed that most of the participants were talking in low pitch voices. It seems as if the participants didn't want to be overheard by other people such as nurses and other personnel within the facility. Despite the fact that the researcher introduced himself as a Master's student, it became obvious from the reaction of participants that they continued perceiving the researcher as part of the hospital personnel.

5.3.2 Research site and participants

The study was conducted at the Ermelo Regional Hospital which falls under Gert-Sibande region; however the conclusions and recommendations could not be made with regard to other public health care facilities in Gert-Sibande but solemnly in regard to Ermelo Regional Hospital. The conclusions and recommendations cannot be made in regard to the local clinics, but only a further research is recommended at the local clinics to establish the state of accessibility of antiretroviral treatment in those facilities. Despite a high number of participants indicating that they don't want to be referred to the clinics due to poor service, one cannot use that information as foregone conclusion to suggest that there is a poor service delivery at local clinics. Empirical study need to be conducted to establish or refute such claims.

It was difficult to interview patients who are defaulting and who are no longer coming for treatment. It could have been much better if their views and opinions regarding accessibility of antiretroviral treatment were documented. The information collected only relates to the participants and cannot be generalized to the general people living with HIV and AIDS who are on treatment.

The researcher went into the interview with no preconceived ideas and was motivated to explore the accessibility of antiretroviral treatment in Gert-Sibande public health care facilities.

Time of the study was very limited on the part of the researcher and the bureaucratic barriers disabled the study to overlap to the three local clinics.

5.4 Recommendations

The researcher would like to make the following recommendations based on the research findings:

- The Provincial Department of Health in Mpumalanga has a need to re-look into the current Hospital management and administration system especially patients' files.

- Turnaround time at the reception area needs to be taken into consideration for the betterment of an efficient and a speedy service delivery.
- The management needs to explore the possibility of capacitating the hospital wellness centre with more staff.
- Confidentiality and privacy of patients should be maintained at all times by health care professionals. Nurses should be advised not to allow their friend and colleagues access into the consultation room while they are busy with the patients and or clients.
- All stable patients should be encouraged to continue taking treatment at the Hospital until introduced gradually to clinics and private pharmacies. But the service delivery challenges at the clinics have to be addressed by the Department of Health Mpumalanga Province.
- The CCMDD programme needs to be properly marketed and effectively communicated to all people on chronic treatment to enable them to fully understand about its significance.
- The programmes that are aimed at identifying and encouraging clients, who have defaulted or relapsed from taking antiretroviral treatment, should be developed and implemented.
- The management of Ermelo Regional Hospital needs to assess the conditions at the three local clinics emphasising more on accessibility of antiretroviral treatment. They must also take into cognizance the structural and human resource challenges that are faced by the clinics health care personnel. The nurses at the clinics need a behavioural change with regard to their reported negative attitudes towards people living with HIV.
- The Department of Social Development needs to be reminded about their constitutional obligations and clear mandates bestowed on them in relation to socio-economic conditions of some patients on antiretroviral treatment, who does not access social grant and who are eligible to receive it. Policies on social grant needs to be revisited in terms of people living with HIV. The concern was revealed by participants living with HIV, who were receiving social grant before

the age of eighteen 18 years but the grant got terminated according to government policy on social grant, leaving them with a socio-economic burden

- The political statement that was issued by the National Minister of the Department of Health in relation to accessibility of antiretroviral treatment of all HIV positive patients regardless of their CD4 count needs to be critically scrutinised. The success of this bold stand or statement by the Minister can only be a reality provided that all vacant posts within the Department of Health institutions are filled with the adequate skilled health care professionals. This will include the unfreezing of all the frozen posts including structural review and adjustments of the clinics and the hospitals (Durban AIDS Conference 2016).

5.5 Suggestions for Further Research

This was a qualitative explorative research and based on what the researcher uncovered during the study, it is suggested that more research should be conducted including but not limited to the following:

- Systematic investigation of the effectiveness of the current HIV and AIDS programmes in Public Health Care Facilities.
- Study aimed at establishing the number of patients who have defaulted and who are no longer taking antiretroviral treatment in public health care facilities.
- Research exploring the socio-economic impact of HIV and AIDS on fragmented family structures.
- Research aimed at exploring the impact of HIV on patients who got infected through Mother-to-Child transmission.
- Similar study is suggested at a larger scale that includes all health care facilities of the Gert-Sibande Region.

5.6 Recommendations for Policy and Practice

The researcher has the following recommendations for policy and practice:

- The current updates of the HIV policy which allows ARV treatment for all South Africans who tested positive regardless of their CD4 count should be implemented and maintained.
- The provisioning of Pre-exposure prophylaxis (PrEP) should be implemented to enable those who are negative to remain negative.

5.7 Conclusion

This Chapter outlined major conclusions and the recommendations based on the empirical findings of the study. The objectivity of the researcher is reflected throughout this study.

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Vuk'uzenzele,March 2016.

APPENDICES

APPENDIX A

PARTICIPANT INFORMATION LEAFLET

TITLE OF THE STUDY: Exploring accessibility of antiretroviral treatment amongst people living with HIV and AIDS at Public Health Care facilities in Gert –Sibande Region in Mpumalanga.

Researcher: M.O Mohale

Student Number: 31498728

Supervisor: DR.T.R Netangaheni: 076 841 0983 /076 189 5087

Good day

1**.** You are invited to take part in a research study. The researcher (M.O Mohale) will avail himself for any enquiries regarding the study.

2**.** The purpose of the study is to explore the accessibility of antiretroviral treatment amongst people living with HIV and AIDS in Gert-Sibande Public Health Care facilities in Mpumalanga.

3**.** The researcher will ask you some questions and with your permission record and write down the answers. There will also be follow-up questions during the interviews.

4. The University of South Africa had granted the research ethical approval, which means the study will comply with the code of ethics of scientific research on human participants.

5. Participants have the right to full decision making, right to full disclosure, informed consent, right to privacy, referrals and the participants have a right to discontinue with the study at any given time without penalty. You will not be prejudiced or forced in carrying on with the study.

6. The study will not pose any physical harm and or discomfort to the participants and anything that may pose threat or risk shall be eliminated .The nature of this study is such that no physical harm is anticipated whatsoever.

7. There is no direct reward in participating in the study; the reward is indirect as the results of the study might be used to improve the situation in public health care facilities in Gert-Sibande region.

8. The information collected from the study will be treated with strict confidentiality. No participant‘s information shall be disclosed to any one and such information shall be treated with great confidentiality.

Researcher: M.O Mohale **:** Mobile Number: 0790763307 / 0735086706

Supervisor: Dr T.R Netangaheni**:** Mobile Number: 076 841 0983

Chairperson of the Health Sciences Ethics Committee:

Prof L. Roets email**:** Roetshjl@unisa.ac.za

APPENDIX B

INFORMED CONSENT

I hereby confirm that I have been informed by the researcher, Mr. M.O Mohale about the nature, conduct benefits and the risks of the study. I have received, read and understood the participant information leaflet regarding the study.

I am aware that the results of the study including my personal details will be anonymously processed in the study report.

I may, at any stage without prejudice, withdraw my consent and participation in this study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in this study.

Participant's name……Date……

Participant's signature…… Date……..……

Researcher's signature……Date……..……..

Witness's signature……... .Date……

Clearance Certificate

Accessibility of antiretroviral treatment has been a major problem and it has been ignored for quite some time now. Mr. M.O Mohale, student number 31498728 is a masters student at the University of South Africa whose title: Exploring the accessibility of antiretroviral treatment amongst people living with HIV in Gert-Sibande Public Health Care facilities In Mpumalanga has been approved by the research Ethics Committee in the Sociology Department. Please allow him an opportunity to undertake research at your institution or organization. Your assistance in responding to the questions asked will be appreciated. Be assured that this investigation will be conducted ethically until the study is concluded. Anonymity, privacy and confidentiality, among other ethical considerations will be fulfilled. Please remember that you may withdraw whenever you feel uncomfortable during the course of the investigation.

.....

I……..undertake to participate in this research project and assure the researcher of my cooperation. This is also meant to confirm that I have been informed of all my rights as a research respondent. I am willing to participate in this investigation.

Subject's signature ……

Name……

Date……

Time……

APPENDIX C

INTERVIEW GUIDE OF PARTICIPANTS IN WELLNESS PROGRAM IN GERT-SIBANDE REGION

SECTION A

BACKGROUND INFORMATION

This section of the interview guide refers to the background or biographical information will allow us to compare groups of participants.

Once again, you are assured that your response will remain anonymous. Your cooperation is appreciated. The researcher will spend plus / minus 35 minutes with the participant during the interview.

1. Gender……

2. Age……..

3. Ethnicity……

4. What are the capabilities of Gert-Sibande public health care facilities in providing antiretroviral treatment?

Answer……..
……
……..

5. What can be done to improve the accessibility of antiretroviral treatment in Gert-Sibande public health care facilities?

Answer……..
..……
……..

SECTION B

This section explores your preferences with regard to access to antiretroviral treatment.

1. What was the situation for the past three months in relation to the accessibility of antiretroviral treatment?

Answer……..
……
……..

2. What are your experiences in relation to antiretroviral medication when coming for treatment?

Answer……..
……
……..

3. What is your overall experience about the accessibility of the antiretroviral treatment?

Answer……..

…..……

…….

4. How do you get affected by the availability and the non-availability of the antiretroviral treatment?

……

……

……..

This is the end of the interview.

Thank you for participating in the study your time is highly appreciated.

APPENDIX D

UNISA university of south africa

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

REC-012714-039

HSHDC/512/2016

Date: 3 February 2016 Student No: 3149-872-8

Project Title: Exploring accessibility of antiretroviral treatment amongst people living with HIV and AIDS at public health care facilities in Gert-Sibande Region in Mpumalanga.

Researcher: Mr Matome Oliver Mohale

Degree: Advanced Behaviour in HIV/AIDS Code: SB8001X

Supervisor: Dr TR Netangaheni
Qualification: D Litt et Phil
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
FOR **CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**
Prof L M. Mokoka

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

APPENDIX E

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

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Tel I: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Enquiries: Themba Mulungo (013) 766 3511

19 May 2016

P.O BOX 1389
Ermelo
Mpumalanga, 2350

Dear Matome Oliver Mohale

APPLICATION FOR RESEARCH & ETHICS APPROVAL: EXPLORING ACCESSIBILITY OF ANTIRETROVIRAL TREATMENT AMONGST PEOPLE LIVING WITH HIV AND AIDS AT PUBLIC HEALTH CARE FACILITIES IN GERT-SIBANDE REGION IN MPUMALANGA

The Provincial Health Research and Ethics Committee has approved your research proposal in the latest format that you sent.

PHREC REF: MP_2016RP21_439

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

MR. JERRY SIGUDLA
MPUMALANGA PHRC

MPUMALANGA PROVINCE
DEPARTMENT OF HEALTH
PLANNING & INFORMATION
2016 -05- 19
DATE/STAMP
PRIVATE BAG X 11285
NELSPRUIT 1200

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX F

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ERMELO HOSPITAL

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

TO : **PHARMACY AND WELLNESS DEPARTMENT**
: **ERMELO HOSPITAL**

FROM : **Ms. M.C MBUYANE**
: **CHIEF EXECUTIVE OFFICER**
: **ERMELO HOSPITAL**

DATE : **20 JUNE 2016**

SUBJECT : **REQUEST TO ACCOMMODATE MR. MATOME OLIVER MOHALE**

1. The above matter refers :
2. Kindly assist Mr. Matome Oliver Mohale with the information he may request in your ward regarding his research.
3. He had an approval from provincial office.
4. Thanking you in advance.

Ms. C.M. Mbuyane
Chief Executive Officer
Ermelo hospital

20/06/2016
Date