

Views of professional nurses regarding the prevention of mother-to-child transmission of HIV and AIDS programme in the clinics of the Polokwane municipality, Limpopo province, South Africa

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Abstract

The introduction of prevention of mother-to-child transmission (PMTCT) of HIV and AIDS programme has created an additional workload for the already overworked staff in a weak health system. A qualitative research approach applying the descriptive and exploratory design was conducted in the 15 clinics of the Polokwane municipality. The aim of the study was to explore and describe the views of professional nurses who are in-charge of clinics regarding PMTCT of HIV and AIDS programme for pregnant women. Purposive sampling method was used to select one professional nurse in-charge per clinic. Face to face interviews using a semi-structured tool were conducted. A voice recorder was used to capture the interviews and field notes were written to document participants' non-verbal reactions. The following categories emerged: Success story regarding an increase in the number of testees, need for more counsellors and inherent problems which are poor baby compliance, faulty coding system and poor service delivery. It is recommended that the National Department of Health and NGOs allocate more resources regarding handling of stigma and non-disclosure of HIV-positive status.

Keywords: Professional nurses, Mother-to-child Transmission of HIV and AIDS, prevention.

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Introduction

According to UNAIDS/WHO (2001) and Human Sciences Research Council (HSRC) (2009) Sub-Saharan Africa accounted for 67% of all HIV (Human Immune Virus) and AIDS (Acquired Immune-Deficiency Syndrome) infections and 71% of all new infections globally in 2008. South Africa is experiencing a maturing generalised HIV epidemic (HSRC, 2009). Heterosexual sex is the predominant mode of HIV transmission followed by mother-to-child transmission (MTCT). Young adults, particularly females, are at the greatest risk of infection (HSRC, 2009).

Although one-third of the people living with HIV and AIDS have been identified to be in the 15-24 years age group (UNAIDS/WHO, 2001) and the prevalence

amongst the 20-24 and 25-29 years age group is twice as high as that of males, it is encouraging that the HIV prevalence has decreased from 10.3% in 2005 to 8.6% in 2008 (HSRC, 2009). As this group of people are in the prime of their child-bearing period they are, therefore, most likely to infect their offspring.

In South Africa it was estimated that between 3 and 4 million children were infected with HIV through MTCT annually. Mother-to-child transmission of HIV is reportedly one of the major means of HIV infection in children (UNAIDS/WHO, 2001). The prevalence of HIV in children born from infected mothers were 14% in infants younger than 6 weeks and remained 22-23% in children older than 15 months (Rollins et al., 2002). Piot and Coll-Seek (1999) cited in Rosenfield and Figdor (2001) reported that, in 1999, 50% of all the deaths among children 5 years and younger in developing countries such as South Africa and Zimbabwe, were due to HIV and AIDS.

To reduce the rate of MTCT of HIV in South Africa, the National Department of Health embarked on the prevention of mother-to-child transmission (PMTCT) of HIV and AIDS intervention programme for pregnant women in all the nine provinces of South Africa in 2002(Chopra et al., 2009). In the past, pregnant women, who seek antenatal health at the clinic or public hospital, were offered voluntary counselling and testing (VCT) for HIV. Those who tested HIV-positive were given nevirapine (NVD) 200 mg at 28 weeks of pregnancy to self-administer it at home at the onset of labour or rupture of membranes. That has since changed.

A pregnant woman who has tested HIV-positive and CD4 count is 350 cells/mm³ and more and is on WHO clinical stage 1 or 2 of AIDS should be put on antiretroviral prophylaxis with AZT to reduce mother-to-child transmission of HIV. Whereas a pregnant woman who has tested HIV-positive and whose CD4 count is 350cells/mm³ or less and is on WHO clinical stage 3 or 4 and should receive lifelong antiretroviral treatment to reduce the likelihood of MTCT of HIV (Department of Health, South African National AIDS Council, 2010).

All the infants, whose mothers are HIV-positive, should be given antiretroviral prophylaxis neverapine (NVD) soon after birth for 6 weeks. Polymyrase Chain Reaction (PCR) HIV test should be conducted on such infants at 6 weeks. Those who test HIV-positive should have a confirmatory viral load and be referred for urgent initiation of ART at the HIV clinic in the hospital. Whereas for those who have tested HIV-negative NVP should be stopped if formula fed and the mother is on lifelong ART (Department of Health, South African National AIDS Council, 2010).

The introduction of PMTC programme has created additional workload for already overworked staff in a weak health system (Horwood et al., 2010). The

follow-up of HIV-exposed children remains poor, with fewer than half of the babies having PCR test and starting on co-trimoxazole at the first immunisation visit poor (Horwood et al., 2010). Hospitals are still witnessing large numbers of HIV-infected children (Meyers et al., 2006).

There is, therefore, a need to explore the views of professional nurses regarding the VCT programme for the PMTCT of HIV and AIDS in order to assess how the VCT sites are functioning and also the success rate of the programme as well as problems that emanate from the administration of this programme.

Methodology

Research design

The study adopted the qualitative, descriptive and exploratory approach (Burns & Grove, 1993). The qualitative design focused on exploring the phenomenon under study that is the views of the professional nurses with regard to the counseling programme for the PMTCT of HIV and AIDS in the Limpopo Province. The qualitative approach was chosen based on the need to obtain in-depth and detailed information concerning the nurses' views regarding VCT for PMTCT of HIV and AIDS.

Population and sampling

The population included all the rural clinics of the Limpopo Province, in the Capricorn District, Polokwane Municipality offering VCT for PMTCT of HIV and AIDS and all registered nurses allocated to the clinics. Fifteen clinics were randomly selected from the total number of 30 clinics. Purposive sampling was used to select fifteen professional nurses in-charge of the fifteen clinics selected in order to explore and describe their views regarding VCT for PMTCT programme.

Data Collection

Data were collected from the 15 professional nurses in-charge of the selected clinics using an interview guide. One central question "What are your views regarding the VCT programme for PMTCT of HIV" was asked in the same way to each participant. Probing for further information gathering was done. A voice recorder was used to record the interviews and field notes were written to document non-verbal communication which could not be captured through the audio recorder.

Data analysis

The researchers commenced the analysis of qualitative data by reading and re-reading verbatim transcripts. A pattern of concepts was identified and grouped into categories and sub-categories. The categories and the sub-categories were used as a framework for content analysis.

Trustworthiness

To maintain trustworthiness of the qualitative data, Lincoln and Guba's model as cited in De Vos (1998), concentrating on the following strategies was applied: credibility, transferability, dependability and confirmability. Credibility and dependability were ensured by giving a detailed description of the research methodology used and the researcher spent more time collecting comprehensive data. Purposive sampling method was used to select the participants and also ensured transferability. Verbatim transcripts, field notes and protocol were sent to an experienced independent coder for analysis to ensure confirmability.

Ethical Aspects

Permission to conduct the study was granted by the Research Ethics Committee of the University of Limpopo, the Limpopo Provincial Department of Health and Social Development and the supervisors of the clinics. The respondents were informed that participation in the project was voluntary and they could terminate the interview at any stage. Only respondents who gave informed consent were included in the study.

Results and Discussion

Profile of the clinics

All 15 clinics opened daily. About 60% of the clinics opened from 07h00 to 16h00 and were not accessible after 16h00, whereas 40% operated on a 24-hour basis. All the clinics that offered primary health care services are expected to be accessible always.

Only (7%) of the clinics used the appointment system, while (80%) provided the service to clients without any appointment at anytime and day of the week that the clients presented themselves at the clinic, while 13% used both systems as requested by clients. The problem with giving a client an appointment is that she may decide not to come back and thus not become aware of her HIV status. The clinics were regarded as the first contact between the client and the health service, hence it was expected that they should provide service at all times that clients presented themselves.

In 60% of the clinics, VCT was conducted in a private room, while the consulting room was used in 33% of the clinics. Cubicles were used to a negligibly low extent (7%). Due to the stigma attached to HIV and AIDS, it is ideal that VCT should be conducted in a private room to ensure that privacy and confidentiality are maintained. According to Hamilton and Dinat (2006), counselling should take place in a private room where there are no interruptions or where the client and the counsellor will not be overheard in order to maintain privacy and confidentiality of what is discussed.

Two-thirds (67%) of the clinics had a written policy on confidentiality with regards to VCT for HIV and AIDS, whereas a third (33%) indicated that the clinic did not have any written policy on confidentiality. It is not clear how confidentiality was upheld at clinics that lacked a written policy on confidentiality. Confidentiality is a basic principle entrenched in all caring and/or helping professions. Shown in Table 1 are the categories and sub-categories which emerged.

Table 1: Categories and sub-categories

Categories	Sub-categories
1. VCT for PMTC success story	1.1 Number of voluntary testees increasing 1.2 Need for more counsellors 1.3 Promotion of VCT for PMTC
2. Inherent problems in VCT for PMTCT	2.1 Shortage of relevantly trained registered nurses 2.2 Poor baby compliance 2.3 Faulty coding system 2.4 Stigma associated with being HIV-positive 2.5 Poor service delivery
3. Referral problems	3.1 Poor collaboration between health professionals 3.2 Client emotional state 3.3 Proximity of referral

Category 1: VCT for PMTCT success story

The respondents cited the successes which they had observed with regard to VCT for PMTCT of HIV and AIDS programme in the past year. From the responses, 3 sub-categories emerged:

Sub-category 1.1: Number of Voluntary Testees Increasing

According to the respondents' views, more clients have accepted to be tested. Their views were supported by the following statements:

“The rate of accepting the test has increased; there is statistical evidence to this effect.”

The fact that the number of people who agree to be tested has increased concurs with the statement credited to the deputy president of South Africa, Kgalema Montlanthe who on the occasion to mark the World AIDS Day (1st December, 2010) reported that HIV testing has increased by 500% compared to 2009 (Department of Health, South Africa, South African National AIDS Council, 2010). The present study was conducted in 2008.

Sub-category 1.2: Need for more counsellors

More counsellors are needed because of the increased number of clients who require counselling and testing, establishment of support groups and counselling of family members after the death of loved ones. Some of the professional nurses stated:

“We have motivated for an extra counsellor.”

“We need more counsellors because even clients who initially refused to be tested do volunteer to be tested at a later stage.”

Sub-category 1.3: Promotion of VCT for PMTCT

People should be made aware of any programme that needs to be supported. From the responses received, staff members in the public clinics were promoting VCT in many ways:

“We give health education talks on HIV and AIDS, STIs, VCT for PMTCT daily at this clinic.”

“VCT billboards are put at all strategic points at entrances to the clinics.”

Category 2: Inherent problems in VCT for PMTCT Programme

Although the successes of VCT for PMTCT were highlighted above, there were also problems observed with this programme. Some of these problems were inherent in the design and implementation of the programme itself, whereas, others have occurred due to human error. Some of these problems could also be attributed to insufficient training of lay counsellors and registered nurses and lack of resources. Seven sub-categories emerged when respondents were asked to elaborate and describe the problems that they had observed with regard to VCT for PMTCT of HIV and AIDS:

Sub-category 2.1: Shortage of relevantly trained registered nurses

All registered nurses who offer VCT for PMTCT of HIV and AIDS should undergo an initial 10-day and an additional 5-day training course.

“Registered nurses who are trained in VCT for PMTCT of HIV and AIDS are not enough.”

“One registered nurse has to deal with large numbers of HIV and AIDS infected patients alone.”

Sub-category 2.2: Poor baby compliance

Pregnant women who are HIV-positive should bring their babies to the clinic for testing after 6 weeks. According to the respondents, fewer babies were brought for testing after 6 weeks, as expressed in these statements:

“Positive mothers do not bring their babies for testing after 6 weeks.”

“In my clinic there are no babies who have been tested for HIV after 6 weeks despite the fact that there were women who tested HIV-positive.”

Sub-category 2.3: Faulty coding system

The respondents discovered the flaws in the coding system as expressed by the following statements:

“Only the pregnant women’s antenatal records are coded thus it was not easy to detect if the baby has to be tested at the immunization clinic.”

“It is difficult to trace babies who need to be tested for HIV because their immunization cards are not coded at the hospital.”

In PMTCT training healthcare providers are trained on when babies should be brought for testing and how to code an immunization card for babies born by HIV-positive or HIV-negative mothers (Centre for Disease Control and Prevention, 2001).

Sub-category: 2.4 Stigma associated with being HIV-positive

Although it was pointed out earlier that counselling has reduced stigma, the following statements reflect that being HIV-positive was still problematic. In trying to conceal their HIV-positive status some clients have resorted to dangerous practices indicated below:

“Because of the stigma attached to HIV and AIDS some mothers do not disclose their status to their husbands or partners.”

“Some women who have tested positive tear up the coded area of the antenatal record and change to other clinics where they refuse to take the test.”

“Some women who have tested HIV-positive deliver at home and do not take the NVD tablet.”

Charbonneau, Maheux and Belad (2006) and Visser (2007) reported that non-disclosure of positive HIV/AIDS status because of stigma prevents people from accessing preventive, curative and appropriate dental care.

Sub-category 2.5: Poor service delivery

Proper records have to be kept of nevirapine (NVD) stocks and the numbers which have been issued. When NVD tablets are delivered to the clinics these tablets are counted against the number issued. It was disturbing to note that because proper NVD records were not kept, the delivery of NVD had been stopped.

“It is now 9 months that we are unable to get NVD from the pharmacy.”

“We refer positive clients to other clinics because we do not have NVD.”

Category 3: Referral problems

Despite the fact that there were successes achieved with the referral system, problems were also encountered. The following 3 sub-categories emerged with regard to the referral problems namely: poor collaboration of health professionals, client emotional state, proximity of referral and quest for alternative interventions.

Sub-category 3.1: Poor collaboration between health professionals

Problems cited by professional nurses with regard to the referral system, include attitude of health professionals towards nurses, lack of feedback and unavailability of some professionals. These referral problems were confirmed by the statements expressed by the respondents:

“Some of them don't even give us feedback about the clients referred to them.”

“Some professionals develop a negative attitude towards nurses when clients are referred to them.”

Mahlo and Muller (2000) outlined the problems experienced by role players which are related to communication difficulties, staff competence, cost saving versus quality care, procedural complexity among others. This was seen as having a negative impact on the working relationship which affects the quality of care provided to patients.

Sub-category 3.2: Client emotional state

Respondents in this study confirmed that clients who had tested HIV-positive experienced emotional problems, which impacted negatively on their intention to access help as confirmed by these statements:

“Some clients are lost after referral, they move on to other facilities thinking that their positive HIV test results will be negative (seeking negative HIV test results).”

“Some clients delay to go for ARV treatment even when referred in time as they go from one healer to another seeking cure.”

Moving from one healer to another concurs with the findings by Pitman (2001) about clients who flocked to Nigeria to be cured of AIDS by a spiritual healer called Pastor Joshua.

Sub-category 3.3: Proximity of Referral

When a client was referred to receive health care outside the clinic, she was not provided with transport and had to organise her own transport. An ambulance was summoned only for clients who were critically ill. It has been observed that the farther the referral institution, the more difficult it became for clients to reach their destination. Mashia and Van Wyk (2004), stated that although health care service may be free of charge, making use of the service may be costly as geographical accessibility may be too difficult for patients to reach health service. For example, one nurse stated that:

“Some clients cited lack of money as a reason for not having gone to the social worker.”

Conclusion and Recommendations

For the PMTCT of HIV and AIDS programme to be successful all the stakeholders must be involved and more resources should be allocated towards research and clinic infrastructure. All the recommendations based on the findings of this study are intended for use by the different stakeholders to improve the VCT for PMTCT of HIV and AIDS programme:

- A confidentiality policy should be made available to all the sites that offer VCT to protect the clients and guide the health professionals.
- All health care professionals working in the public clinics and hospitals maternity units, that is, registered nurses, enrolled nurses and enrolled nursing assistants should be trained in VCT to improve efficiency and coverage.

- The National Department of Health and NGOs should allocate more resources towards reducing stigma and non-disclosure of HIV-positive status.
- Pharmacists should provide the clinics with NVD whenever it is requested.
- More resources should be allocated towards implementing intervention programmes and research projects to deal with stigma associated with the non-disclosure of HIV status.

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