

CHAPTER ONE

1. INTRODUCTION

1.1 Background of the Study

Inequities in access to health care and adequacy of treatment among people living with HIV/AIDS have been well documented (Whetten, Leserman, Whetten, Ostermann, Thielman, Swartz & Stangl, 2006). Several studies have shown that access to and utilisation of health care services is not equal among all HIV-infected individuals. In particular, marginalised populations such as racial/ethnic minorities, substance users (Sohler, Wong, Cunningham, Cabral, Drainoni & Cunningham, 2007; Andersen, Tinsley, Milfort, Wilcox, Smereck, Pfoutz et al., 2005), the unstably housed, and the mentally ill (Mijch, Burgess, Judd, Grech, Komiti, Hoy et al., 2006) have poor access to and utilisation of health care services.

Treatment with antiretroviral therapy (ART) has been shown to improve survival and slow progression of HIV disease (Louwagie, Bachmann, Meyer, Booyesen, Fairall & Heunis, 2007). To utilise ART effectively, individuals must be able to access HIV primary care services. Without utilising HIV primary care services on a regular basis, it is nearly impossible to reap the benefits that are now available for the treatment of the disease (Cunningham, Sohler, Wong, Relf, Cunningham, Drainoni et al., 2006). Many people living with HIV/AIDS (PLWHA) are not in contact with the formal health system until they reach very advanced stages of the illness. Evidence suggests much use informal treatments (Brown, Lawrence, Kritz, Goldsmith, Bini, Robinson et al., 2007) that are prescribed and administered by family members (especially parents) and lay providers (Vanlandingham, Im-Em & Yokota, 2006).

Poor access to care stems from many factors, including lack of providers in low-income areas, transportation problems in getting to providers as well as discrimination by providers (Cooper, Dickson, Blanchard, Cullingworth, Mavimbela, Mollendorf, Van Bogaert & Winikoff, 2005).

With no coverage (medical aid), the poor are forced to delay care until absolutely necessary, often seeking assistance only when their illness has progressed to a serious state. In South Africa, despite recent improvements in access to health facilities, large inequities in coverage of health services and health status persist (Tanser, Gijsbertsen & Herbst, 2006).

In addition to the many societal, socio-demographic and behavioural factors affecting utilization of PHC services, it has been widely shown that geographical accessibility of the health services has a direct bearing on utilisation of these services (Paula, 2000). Geographical location of health care facilities unequally affects the ease of access of different groups of consumers and influences utilisation patterns (Paula, 2000). Proximity to care is associated with increasing frequency of use of health care facilities (Tanser et al., 2006; Hutchinson & Mahlalela 2006).

Counselling and testing is an entry point for increasing access to HIV/AIDS care and treatment. In other regions of Africa, VCCT is deficient in many respects: medical services are often unavailable, support is absent, availability is restricted and there are few trained counsellors (Coovadia, 2000). In South Africa, the majority of health care facilities experience problems such as staff shortage, poor delivery of medication, lack of proper consultation and counselling rooms in several health institutions throughout the country (Peltzer, Skinner, Mfecane, Shisana, Nqeketo & Mosala, 2005).

1.2 Problem Statement

HIV/AIDS has become one of the 'chronic illnesses' that pose a challenge to the health care system and a threat to human existence both in South Africa and other countries. Out of a population of nearly 48 million South Africans, about 5.4 million people were HIV positive by middle 2006 and about 11% of the HIV infected was already sick with AIDS. Progression to AIDS is more rapid in children than in adults and it is likely that a large proportion of HIV infected children are urgently in need of access to ART.

The infant and under five mortality rates were 48 and 73 per 1000 live births respectively, about 38 000 babies were infected with HIV at birth, around 26 000 through breastfeeding and about 300 000 children became orphans in 2006 due to AIDS (Dorrington, Johnson, Bradshaw & Daniel, 2006). In 2007, the estimated infant mortality rate was at 45, 2 per 1000 (Statistics South Africa, Mid-year population estimates, 2007). This release assumes a mother-to-child transmission rate of 32% if no HIV treatment program is followed (Mid-year population estimates, South Africa, 2007). With the life expectancy that is already 13 years below what is expected, the life expectancy in 2006 was estimated at approximately 49 years for males and 53 years for females. It is estimated that over half of the 15 year olds now are not expected to survive to the age of 60. (Mid-year population estimates, South Africa, 2007). HIV prevalence and incidence rates remain very high, with a peak incidence in the late twenties. Research findings indicate that HIV-infected individuals are nearly nine times more likely to die than uninfected individuals. New infections are being driven by high incidence in the 15-24 year age groups (Nyirenda, Hosegood, Bärnighausen & Newell, 2007).

The projections show that the prevalence in the country is reaching a plateau, with Kwazulu Natal being the highest (39.1 %), and the Western Cape the lowest with 15.2 %. In Limpopo Province, prevalence projections nationally is estimated at 20.7%. Estimates by districts among antenatal clinic attendees in 2006 and 2007 were: Waterberg 25.4 %, Mopani 23.8 %, Sekhukhune 21.4 %, Capricorn 19.8 % and Vhembe 15.2 % (The National HIV and Syphilis Prevalence Survey South Africa, 2007).

Of the 5.4 million infected in 2006, 711 000 were in need of HIV health care, and about 540 000 were already sick with AIDS and did not have access to ART. Without proper health care, an expected 505 000 deaths a year will occur by 2010 due to AIDS. With treatment, it can be reduced to 388 000 a year (a difference of 1000 deaths a year).

It is projected that AIDS deaths could be even as low as 291 000 a year if 90% of people progressing to AIDS were to receive treatment (Dorrington et al., 2006). For mid 2007, the median time lapse from becoming HIV-positive until death due to AIDS was estimated to be 10 years for both males and females, and a female-to-male HIV prevalence ratio of 1:2 was assumed (Mid-year population estimates, South Africa, 2007).

The hardship for those infected with HIV/AIDS and their families begins long before they die, with the stigma related to suspected infection, the fear and despair that often follow diagnosis, the loss of income and support when a breadwinner or caregiver becomes ill, the diversion of household resources to provide care, the terrible burden upon family members particularly children caring for terminally ill parents, and the trauma of bereavement and orphanhood (AIDS Foundation South Africa, 2005).

South African labour unions, through the Congress of South African Trade Unions (COSATU) have long supported the demand for adequate care and treatment for PLWHA. Workers are affected by HIV/AIDS as breadwinners who risk losing their income if they become sick, as partners of people with HIV/AIDS, as caregivers to sick people, as guardians to orphaned children. Mineworkers were among the first group of workers recognised to be vulnerable to HIV infection. This is due to high levels of mobility, the tendency to have more than one sexual partner, often including sex workers. However, recently, the infection rates among other workers, such as educators and health professionals have risen alarmingly. Since HIV/AIDS is striking the economically active age group, companies started seeing reduced productivity, absenteeism, sickness, and resultantly deaths among the workforce (AIDS Foundation South Africa, 2005).

Access to and utilisation of health care services is therefore crucial. There are however few studies other than the study by (Tanser et al., 2006), investigating on health care accessibility and utilisation patterns in South Africa.

1.3 Aim of the study

This study aims to investigate if PLWHA have access to health care. It further aims to determine utilisation patterns as well as to investigate how gender differences, socioeconomic, geographic location, and cultural beliefs influence access to and the utilisation of health care among PLWHA.

1.4 Objectives of the Study

- To determine as to whether PLWHA have access to health care services.
- To determine if PLWHA utilise health care services if available.
- To determine how gender differences, socioeconomic factors, geographic location, and cultural beliefs influence access to and utilisation of health care.

1.5 Research Questions

- Do PLWHA have access to health care?
- Do PLWHA utilise health care services if available?
- How do gender differences, cultural beliefs, socioeconomic factors and geographic location influence utilisation of health care services?

1.6 Rationale of the Study

The purpose of this study is to explore patterns of access to and utilisation of health care services among PLWHA.

1.7 Significance of the Study

It is essential to understand both those people who are as well as those who are not accessing and utilizing health care services in order to improve access to and utilisation of HIV primary care services. With more knowledge about the latter group, programs can be created or modified to target such individuals, and to inform the development and modification of programs in order to facilitate appropriate utilisation of care.

It is essential to understand accessibility patterns of health care from the perspective of take-up of new interventions.

It is also crucial that factors influencing the utilisation of health services be studied. This is particularly important in the context of South Africa where health resources as well as health care providers are unevenly distributed between rural and urban areas. Certain health institutions in rural areas still lack basic resources for provision of good health care. Understanding these factors is helpful in identifying reasons for differences in utilisation, consumer satisfaction, outcomes. It also helps in and for formulating policies and programs that encourage appropriate utilisation, discourages inappropriate utilisation, and promotes cost-effective care.

Timely and adequate use of health care services is related to improved quality of life among HIV infected. It is likely to result in cost-saving to society by lowering the number of visits to expensive emergency departments and in preventing unnecessary hospitalisations (Mkanta & Uphold, 2006).

1.8 Operational Definition of Terms

Health care access: It is defined as accessibility of health care services.

Utilisation: It is defined as the use of health care facilities

CHAPTER TWO

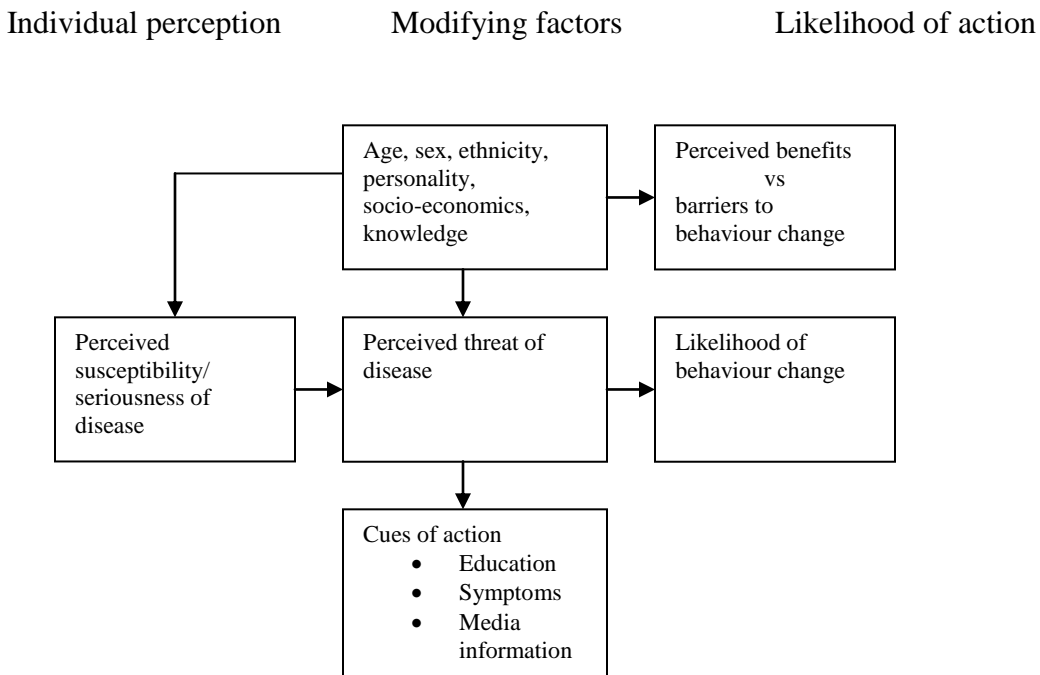
2. THEORETICAL AND CONCEPTUAL FRAMEWORK

Two theoretical frameworks were used. The Health Belief Model (HBM) and the Behavioural Model of Utilisation (BMU).

2.1 The Health Belief Model (HBM)

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists working in the U.S. Public Health Services in response to the failure of a free tuberculosis health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviours.

Figure 1: HBM Conceptual Model



2.1.1 Scope and Core Assumptions

The Health Belief Model has been applied to a broad range of health behaviours and subject populations. Three broad areas can be identified preventive health behaviours, which include 1) health-promoting (e.g., diet, exercise) and health-risk behaviours (e.g. smoking) as well as vaccination and contraceptive practices. 2) Sick role behaviours, which refer to compliance with recommended medical regimens, usually following professional diagnosis of illness. 3) Clinic use, which includes physician visits for a variety of reasons (Mkanta & Uphold, 2006).

The HBM is based on the understanding that a person will take a health-related action (e.g., health care utilisation) if that person: feels that a negative health condition (i.e., progression from HIV to AIDS) can be avoided; has a positive expectation that by taking a recommended action (e.g., medication compliance), he/she will avoid a negative health condition (i.e., progression of the disease/ reduction in CD4 count); believes that he/she can successfully take a recommended health action (e.g., healthy life style, can use condoms comfortably and with confidence to avoid re-infection).

The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. An added concept, cues to action, would activate that readiness and stimulate overt behaviour. A recent addition to the HBM is the concept of self-efficacy, or one's confidence in the ability to successfully perform an action. This concept was added to help the HBM better fit the challenges of changing habitual unhealthy behaviours, such as unprotected sex, being sedentary and smoking (Mkanta & Uphold, 2006).

The Health Belief Model (HBM) provides the most basic approach to health care utilisation. It relates utilisation to individuals' perceptions of their susceptibility to illness, the seriousness of a given illness, the benefits of action weighed against the risks of action, and cues for action such as symptoms. However, it ignores relevant external factors, such as an individuals' ability to pay for health care services and their general access to these services. Therefore, the Behavioural Model of Utilisation (BMU) will be used to address such issues.

2.2 Behavioural Model of Utilisation (BMU)

The BMU was initially developed in the late 60's to assist the understanding of why families use health services. It also helps to define and measure equitable access to health care, and assist in developing policies to promote equitable access (Phillips, Morrison, Andersen & Aday, 1998).

2.2.1 Scope and Core Assumptions

The BMU is one of the most frequently used frameworks for analysing patient utilisation of health care services. The model integrates a range of individual, environmental, and provider-related variables associated with decisions to seek care. Its focus is on the environmental and provider-related factors that influence utilisation, which are referred to as contextual variables as they measure the context in which utilisation occurs (Phillips, et al., 1998).

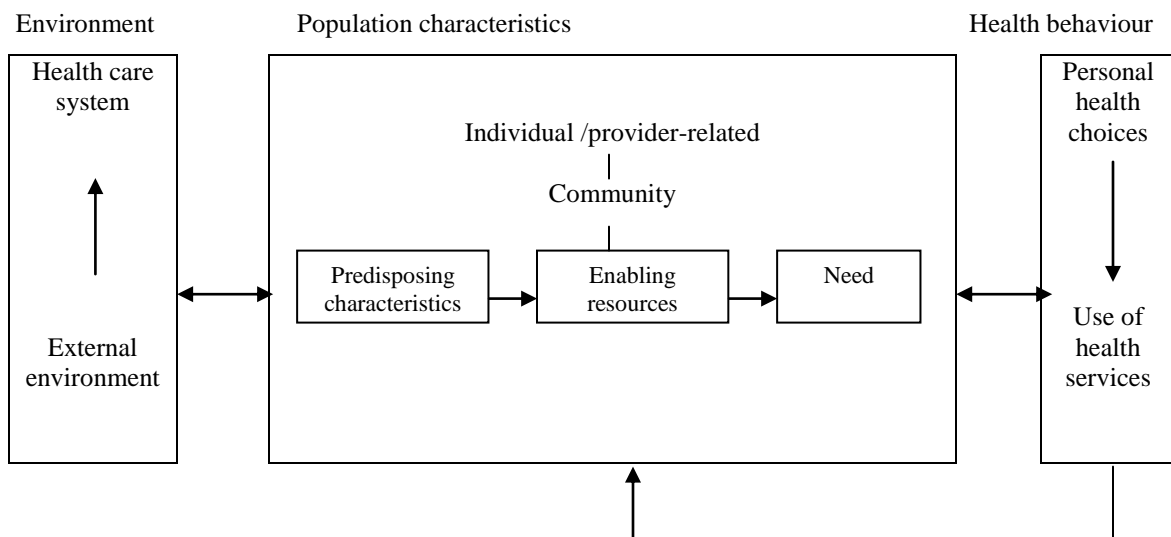
According to the model, an individual's use of health care services is considered to be a function of three characteristics: predisposing, enabling, and need factors (Andersen, 1995).

Predisposing factors are characteristics of an individual that exist prior to the illness and include the following three dimensions: demographic characteristics such as age, gender, marital status; social structure characteristics such as education, race/ethnicity and occupation; and health beliefs such as personal attitudes regarding medical care, medical professions, and illness. Enabling factors are community and personal resources that facilitate the individual's use of health services such as regular source of care, income, and health insurance (medical aid). Need factors represent either a subjective acknowledgement of need (e.g., patient's symptoms) or an objective professional recognition of need for services (e.g., disease severity) (Phillips, et al., 1998).

In the earliest versions of the model, contextual factors (i.e., environmental, and provider related variables) were included as determinants of service utilisation. Environmental variables are defined as health care delivery system characteristics, external environmental factors, and community-level enabling variables. The health care delivery system characteristics are health policies, resources, financial arrangements influencing the accessibility, and the availability of providers. The external environmental factors reflect the economic climate, relative wealth, politics, level of stress and violence, as well as prevailing norms of the society. Community-level enabling variables include attributes of the community were the individual lives that enable the individual to obtain service (e.g. availability of physicians in the community). Provider-related variables are patient factors that may be influenced by providers and which enable patients to obtain service (e.g. whether individuals have a regular source of care, the convenience of obtaining care, previous use of services and the out-of-pocket price of service), as well as provider characteristics that interact with patient characteristics to influence utilisation (e.g., specialty or gender of physician) (Phillips, et al., 1998).

Although the model posits that utilisation is determined by societal, contextual, and individual factors, individual factors have continued to be the focus of many empirical studies on service utilisation. Also, from the initial emphasis on identifying the significant predictors of service use, there has been a trend to also study how health care utilisation predicts outcomes such as patients' perceptions of their health status and general patient satisfaction. Furthermore, in the latest modification, a feedback loop was included. In addition, health outcomes are expected to result in changes in both health behaviour and personal characteristics (Phillips, et al., 1998).

Figure 2: Utilisation Model



Adapted from Andersen (1995)

CHAPTER THREE

3. LITERATURE REVIEW

3.1 Factors That Influence Access To And Utilization of Health Care Services

Different factors influence utilisation of health care services in PLWHA (Mendias & Paar, 2007). Research has shown differences in health status and health care utilisation factors related to culture, economic status, and health care development (Chamberlain, Watt, Muggah, Trim & Bantebya, 2007).

3.1.1 Stigma

HIV/AIDS is perhaps the most stigmatised medical condition in the world. Research conducted across continents has consistently demonstrated that adversarial views of PLWHA are common (Simbayi, Kalichman, Strelbel, Cloete, Henda, & Mqeketo, 2007). Like elsewhere in the world, AIDS stigmas create a barrier to HIV prevention (Malta, Bastos, Strathdee, Cunningham, Pilotto & Kerrigan, 2007) including HIV testing and counseling in South Africa (Petros, Airhihenbuwa, Simbayi, Ramlagan, & Brown, 2006).

Stigmatisation of people living with HIV/AIDS is a key obstacle to HIV/AIDS care. It serves as a strong deterrent to people seeking HIV/AIDS-related care. Ignorance has been found to often play a role in perpetuating stigma. It is acknowledged that efforts to reduce stigma should be an integrated part of all HIV/AIDS management (Campbell, Foulis, Maimane & Sibiya, 2005).

Among HIV-positive women in sub-Saharan Africa, a primary reason for not disclosing their HIV/AIDS status and failure to seek care are fears of AIDS stigma (Shisana, Rehle, Simbayi, Parker, Bhana & Zuma 2005). Stigma may either be directly experienced by an individual or may be perceived, which is an individual's fear or concern that negative attitudes or discrimination would occur if the HIV status is known (Whetten, Reif, Whetten & Murphy-McMillan, 2008).

The theoretical literature emphasises that stigma results not only from fear of physical contagion but also from fear of symbolic contagion. This poses a threat to both the health and well-being of individuals and to the well-being and legitimacy of the status quo. It has been found that family members sometimes hide away sick relatives, depriving them of health care and support. Families themselves prevent anyone from helping them and that families sometimes disown dead relatives and refuse to collect their bodies from the mortuary (Campbell et al., 2005).

HIV/AIDS stigmatising beliefs are the product of multiple social influences including attributions of responsibility for HIV infection and beliefs that individuals with HIV/AIDS are contaminated and tainted. AIDS stigmas also reproduce inequalities of class, race, and gender. People with HIV infection are often ascribed responsibility for their condition because HIV is contracted from behaviours that are considered avoidable, namely unsafe sex and drug use practices. AIDS stigmas are also inextricably enmeshed with other stigmas associated with risk behaviours, such as sexual promiscuity, homosexuality, and sexual exchange. Adverse reactions are greatest toward people with AIDS who contracted HIV through sexual and drug use behaviours, relative to those who contracted HIV via blood transfusion. Similarly, individuals who contract HIV via injection drug practices or multiple sex partners are blamed more for their HIV infection than people described as contracting HIV by having sex with only one partner (Simbayi et al., 2007).

Socially constructed views of AIDS can be assimilated and internalised by infected persons. Internalised AIDS stigmas have the potential for adverse behavioural and emotional ramifications including not seeking treatment and or care services (Shisana et al., 2005).

Prevention of mother-to-child-transmission (PMTCT) is a politically and scientifically accepted approach to reduce the impact of HIV, especially on children. Fear of stigma and discrimination was found to be the most important barrier to the utilisation of PMTCT services among HIV positive pregnant women (Nguyen, Oosterhoff, Ngoc, Wright & Hardon, 2008).

Findings from a study conducted by Nguyen et al., (2008) reveal that HIV positive women were found to experience stigma and discrimination at all points of seeking services: counselling, ante natal clinic (ANC) visits, abortion, delivery, and post-delivery care. Many women revealed that they received poor care and did not want to revisit the hospital where they had delivered. Several women complained that they were not allowed to sit down during the counselling sessions, or that they had to cover the chair with newspaper before being allowed sitting down (Nguyen et al., 2008).

3.1.1.1 Symbolic Contexts of Stigma

The following were found to be the contexts that sustain the types of rejection and isolation of PLWHA: the symbolic context (i.e. mapping out the wider field of social representations within which stigma is located); the economic, political, and local community contexts within which these representations are constructed; and the organisational context of efforts to address HIV/AIDS (Campbell et al., 2005). Stigmatisation of PLWHA is supported by an associative network of symbolic links (sometimes logical and sometimes arbitrary) between such individuals and other negatively valued groups or attributes.

Another factor that supported stigmatisation of HIV/AIDS is the link made between sex, sin, and immorality. The church was the main contributor of symbolic ammunition sustaining this link (Campbell et al., 2005). In their study Campbell et al. (2005) found that nearly every informant reported that stigma originated in the association between HIV/AIDS and sex.

In a study that was conducted in Cape Town, South Africa it has been found that AIDS stigmatising beliefs were frequently endorsed (Shisana et al., 2005). Although still prevalent, AIDS stigmas appear to be declining somewhat in South Africa. The national HIV/AIDS household survey in South Africa in 2005 showed that endorsements of AIDS stigmatising beliefs had declined from the previous household survey reported in 2003. Nevertheless, they found that 29% of South Africans stated that they would not buy food from a vendor who has HIV and 20% stated that HIV-positive children should be kept separate from other children to prevent infection (Shisana et al., 2005).

3.1.2 The socioeconomic determinants

More than 50% of South Africa's residents live in poverty. Unemployment rates across the country range from 25% to 42%. Although the rate of HIV infection is similar across all income groups, the impact of the disease is more severe in poorer households, where health care and funeral costs comprise a larger percentage of the overall income (Ojikutu, Jack, & Ramjee, 2007). The relationship between poverty and health is complex. Many factors play into this link. This includes poor environmental conditions, low educational levels, (Barnighausen, Hosegood, Timaeus & Newell, 2007) awareness of needed medical care, financial barriers in accessing health services, and a lack of resources necessary to maintain good health status. People in poverty live on very stretched incomes and have difficulty meeting day-to-day costs of living. This leaves little room in their limited budget for anything beyond the essentials of food and shelter. They have limited budgets for food and may only be able to afford inexpensive food, which tends to be processed and lacks important nutrients (Cummings, Mengistu, Negash, Bekele & Ghile, 2006).

Lack of health insurance has been repeatedly identified as one of the most significant barriers to obtaining health care for PLWHA (Anthony, Gardner, Marks, Anderson-Mahoney, Metsch, Valverde, Del Rio & Loughlin, 2007). Research findings indicate that the unstably housed receive less adequate health care than the stably housed (Mizuno, Wilkinson, Santibanez, Dawson, Knowlton, Handley & Gourevitch, 2006), and hence may be more likely to experience adverse clinical outcomes (Smith, Rapkin, Winkel, Springer, Chhabra & Feldman, 2000).

3.1.3 Geographical Location

In addition to the many societal, socio-demographic, and behavioural factors affecting utilisation of PHC services, it has been widely shown that geographical accessibility of the health services has a direct bearing on utilisation of these services. Proximity to care has been shown to be an important factor affecting a large spectrum of health outcomes. Variations in the use of health services are more strongly associated with road distance and estimated travel time (Tanser, Gijsbertsen & Herbst, 2006).

In a study conducted by Tanser et al. (2006), in Hlabisa, Kwazulu Natal, on modelling and understanding primary health care accessibility and utilisation, it has been found that usage of the clinics by urban homesteads were approximately 20 to 30 times higher than in the case of their rural counterparts. It has also been found that those who live in rural areas have limited access to support, experience poorer health status and poorer outcomes (Stewart, Cianfrini & Walker, 2005).

3.1.4 Gender

Gender has been found to influence access to and utilisation of care services (Penniman, Taylor, Bird, Beckman & Collins, 2007). A study conducted by Peltzer et al. (2005) in the Eastern Cape, South Africa, shows that medical recommendations made in PMTCT programmes are often difficult for women to implement as they are overshadowed by community norms, values, and beliefs.

Women's decisions to participate fully in a PMTCT programme are influenced by the opinions of their partners, as well as other family and community members. Also, this decision is influenced by women's perceptions and fear of possible negative reactions by others. Partners, parents, in-laws, and other relatives have varying degrees of influence and significant authority about testing, disclosure, and drug treatment. When women are able to decide on their own to adhere to all of the recommended practices, they are going against social norms (Peltzer et al., 2005). Lack of education and inability to freely discuss sexuality denies women access to health information, potentially exposing women to adverse consequences such as HIV infection and health seeking behaviours (Cummings et al., 2006).

3.1.5 Traditional Medicine Use: Cultural Norms versus Western Standards

The use of traditional practitioners as a choice of health care for HIV/AIDS among African cultures is common, it being an alternative to an inefficient western health care system. Although herbal and traditional medicines are generally not well researched and are poorly regulated, patients continue to access them since they report that they are important to local cultures, values, and beliefs (Mills, Cooper & Kanfer, 2005), privacy and absence of time limitations per consultation (Summerton, 2006) as well as paying special respect to social and spiritual matters (Peltzer, Mngqundaniso & Petros, 2006). The use of complementary and alternative medicine is prevalent among HIV-positive individuals despite the success of antiretroviral treatments, and limited evidence of their safety and efficacy (Littlewood & Vanable, 2008). The use of complementary and alternative medicine is also associated with greater HIV-symptom severity and longer disease duration. HIV-positive complementary and alternative medicine users commonly report that they use complementary and alternative medicine to prevent or alleviate HIV-related symptoms. These include dermatological disorders, nausea, depression, insomnia, and weakness, reduces treatment side-effects and improve quality of life (Littlewood & Vanable, 2008).

Substances touted to be ‘immune boosters’ are commonly sold throughout South Africa. There is no evidence to suggest that these ‘boosters’ have any impact on the immune system, can treat HIV infection, or cure any HIV-related opportunistic infection. However, there is evidence to suggest that HIV-infected South Africans are choosing these and other alternative therapies over the western standard, ART (Mills, et al., 2005).

Many South African patients consult traditional healers as a first effort to remedy ailments including HIV/AIDS (Peltzer, 2000; Peltzer, 2001). In a community survey, Peltzer (2003) found that among rural adult South Africans, of those who reported to have had sexually transmitted diseases in the past 12 months, 36% have consulted traditional healers for treatment. In areas of high HIV prevalence traditional healers have been found to often play a role in sexually transmitted diseases and HIV care and treatment.

The perceived weaknesses of the traditional healing system by the non users include harmful treatment regimens, prolonging the seeking of appropriate health care when traditional remedies fail to produce the desired effect, destroying interpersonal relationships of PLWHA through witchcraft accusations, psychological torment caused by the belief that HIV/AIDS can be cured by traditional remedies; and increasing the workload of western practitioners by patients after undergoing various traditional treatment regimens that failed to cure the disease (Summerton, 2006).

Services provided by traditional healers are invaluable. There are however concerns related to some of their practices. Research has revealed significant HIV risk practices among traditional healers. Traditional healers have been implicated in the spread of infectious diseases including HIV by re-use of treatment instruments and lack of hygienic habits such as hand washing. Also, prescription of toxic plants for HIV treatment have resulted in severe adverse events, including death (Kaboru, Muchimba, Falkenberg, Höjer, Faxelid & The Bridging Gaps Research Team, 2008).

It has been found that the use of herbal medicines with antiretroviral agents may put patients at risk of treatment failure, viral resistance or drug toxicity as it has effects on antiretroviral metabolism (Mills, Brian; Rolf van, Elizabeth, Kumanan, Blair, Kazuhiro & Isadore, 2005).

For many Africans, a traditional healer may be the only 'health care provider' that they have ever known. According to the World Health Organization, 80% of Africa's population uses traditional medicine for primary health care. In South Africa, 75% of HIV-infected people use remedies (muti) dispensed by these traditional healers (sangomas). There is a concern that traditional medicine is a barrier to ART rollout in South Africa. Several studies have demonstrated the toxicity of standard traditional therapies. High rates of dehydration, vomiting, diarrhea, altered mental status, and renal failure were found among patients at Chris Hani Baragwanath Hospital in Gauteng who reported use of traditional remedies. When therapies that cause these adverse effects are used with ART, unpleasant toxicities may occur, and the efficacy of the antiretroviral regimen may be compromised (Ojikutu et al., 2007).

The use of traditional remedies before ART is also a concern because HIV-related complications, such as wasting and renal failure, may be exacerbated. Regardless of the potential adverse effects, HIV-infected patients continue to seek advice and treatment from community-based traditional healers. Low cost, proximity to the community, and respect for traditional leadership continue to drive the demand for services provided by healers. In Cape Town's Tygerberg Hospital, traditional healers are being trained to recognise the signs and symptoms of the HIV infection and to refer patients to local testing facilities. Although incorporating traditional healers into the HIV/AIDS treatment team is appropriate, promotion of traditional or alternative therapies as viable alternatives to ART raises a serious concern among treatment advocates (Ojikutu et al., 2007).

3.1.6 The Government as a Barrier to ART

South Africa's approach to AIDS has been shaped by persistent opposition and direct resistance to implementing programmes using antiretroviral therapy on the part of the former president, President Mbeki and his health minister, Dr Manto Tshabalala-Msimang. This initially originated from President Mbeki's questioning of the science of AIDS and his support for AIDS dissidents who believe that HIV is a harmless passenger virus and that AIDS symptoms are caused by malnutrition. Having lost that battle, the health minister continued a war of attrition by portraying ARVs as 'poison' and by supporting and protecting purveyors of scientifically untested alternatives to ARVs. The promotion of a mixture of garlic oil, lemon juice, and beetroot by the health minister as a treatment for HIV infection sparked a firestorm of controversy and led to both national and international uproar. Moreover, the promulgation of these alternative therapies for HIV has led many to doubt the commitment of the national government to deliver on its promise to provide comprehensive care and treatment, including ART, to HIV-infected patients in the public sector (Natrass, 2006).

The health minister has fought a rear-guard action by resisting the introduction of ARVs for mother-to-child transmission prevention (MTCTP) until she was forced to do this by a constitutional court ruling, and by resisting the introduction of highly active antiretroviral therapy for AIDS-sick patients until a cabinet revolted in late 2003 forced her to back down on this too. Undaunted, she continued to undermine the 'rollout' of antiretroviral treatment in the public sector, *inter alia* supporting unproven substances, and by couching this within a dissident discourse that highlights the side-effects of ARVs (Natrass, 2006).

In the process, the president and the minister have undermined the authority of established science and have eroded the independence and effectiveness of the institutions governing medical research and the scientific regulation of medicines. Elections to be held around April 2004, external pressure to comply with the international effort spear-headed by UNAIDS and the World Health Organisation to improve access to antiretroviral treatment probably also played a role as it made the South African government's resistance to ART look ever more out of step with global opinion and action in other developing countries (Nattrass, 2006).

The health minister procrastinated. The result was a slow start and poor performance in relation to the planned targets. Rather than actively supporting the rollout, the health minister constantly points to the side effects of ARVs whilst highlighting the benefits of nutrition (notably garlic, lemon, and olive oil), saying that patients must exercise 'choice' in their treatment strategies. Promotion of alternative treatments for HIV/AIDS has also led to an enormous amount of confusion among PLWHA. This has resulted in HIV/AIDS patients being reluctant to take ARVs because they feared they are 'poisonous'. Not only does this pose serious problems for effective and safe governance within the health sector, but it threatens the health and lives of the many HIV/AIDS patients who are ill-equipped to judge the relative efficacy of antiretroviral and alternative therapies (Nattrass, 2006).

3.1.7 Distrust

Distrust of health care providers as well as beliefs about the government's role in the spread of HIV by PLWHA have been found to be a barrier to service use, health care seeking behaviours and therefore to optimal health outcomes (Ostertag, Wright, Broadhead & Altice, 2006; Whetten et al., 2006; Whetten et al., 2008).

The belief in conspiracy theories about the HIV disease that AIDS was created by the government to kill minorities is relatively common and has been found to be more prevalent among African-Americans especially those with less education, and lower income. In their study, Whetten et al. (2008) found that respondents believed that a significant amount of information about HIV/AIDS was being held back from the public.

3.2 The Constitutional Right to Access to Health Care Services

While a recent study indicates that over two thirds of all constitutions have provisions regarding health and health care, the dearth of global health-rights jurisprudence suggests that these rights have not enjoyed widespread judicial enforcement. This picture is slowly changing, and there is a small but growing jurisprudence on health-related rights, led in particular by the South African Constitutional Court's enforcement of the domestic constitutional right to access health care services. The South African Constitutional Court's adjudication of health rights goes some way towards subverting the notion that enforcing social rights exceeds judicial capacity and violates the appropriate democratic separation of powers between the branches of government. However the South African experience also underscores the importance of the individual and institutional choices made by judges in enforcing health rights. Although the constitutional entrenchment of health rights has ensured some degree of justiciability, the court retains discretion regarding its standard of judicial review of socioeconomic policies, the extent of its deference to policy deficiencies and resource allocations as well as the scope and content of the entitlement and duties these rights confer, and the nature of the relief it would order for litigants (Forman, 2005).

Despite a government rhetorically committed to transformation (the meta-slogan of post-apartheid governance) and to increasing access to health care, progress has been fairly limited and in cases such as HIV/AIDS treatment policies. The right to health contained in the Constitution has proved a critical tool for remedying grossly unreasonable government policies on HIV/AIDS (Forman, 2005).

3.2.1 Health Rights in the Constitution

In addition to rights to adequate housing, food, water, and social security, the constitution entrenches a range of health-related rights. These include children's rights to basic health care services, prisoners' rights to adequate medical treatment, and the right to an environment that is not harmful to health or well-being. The primary health right is contained in section 27, which is formulated as follows:

- Everyone has the right to have access to health care services, including reproductive health care.
- The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- No one may be refused emergency medical treatment.

The constitutional rights effectively exclude the government's broader public health responsibilities, given the relatively limited contribution that health care makes to improving population health. Indeed, social conditions such as poverty and inequality are far greater determinants of health, given the direct correlation between disease prevalence and socio-economic status. However, the Constitution makes no explicit provision for these broader public health responsibilities and this has important implications for the ambit of the right with regard to public health more generally. The scope of this narrower right to access health care services is not explicit from the wording of section 27, which provides little indication of what is encompassed within the entitlement to health care services, nor the extent to which resource limitations and progressive realisation could permissibly limit the state's duty to ensure access (Forman, 2005).

3.3 Provision of Antiretroviral Therapy in South Africa

The public sector roll-out programme for the PMTCT transmission with nevirapine started at 18 pilot sites in 2002. An ARV treatment plan was published in 2003 and roll-out of treatment started at 32 accredited sites in April 2004. Although stigma, discrimination and cultural beliefs still affect voluntary testing and recognition of HIV/AIDS, in 2004 many more patients were initiated on ARV therapy. Twenty ARV products are currently available in South Africa. Current first line treatment is a twice-daily triple ARV regimen including two nucleoside reverse transcriptase inhibitors and either nevirapine or efavirenz. At least 95% adherence is required for this regimen to be fully effective and not induce resistance. Achieving this high level of adherence remains a concern (Abah, Addo, Adjei, Arhin, Barami, Byarugaba, Chibuta et al., 2005).

3.3.1 ARV Roll-out

The Limpopo Province (population 6.5 million) is the most rural and the second poorest province in South Africa. In 2001 almost half of Limpopo's population was unemployed and one third had little or no education. More than 80.0% of the population relies on the public health system. Of the six districts in Limpopo, the Mopani district (16,500 km², population of 1.2 million) had the highest antenatal HIV prevalence (29.8%, compared to National: 30.1%) (Vintges, Marincowitz, Struthers, 2006).

In June 2006 in the Mopani district six public health hospitals (one regional and five district hospitals) were providing ARV treatment to about 1800 patients. The seventh hospital was accredited in September 2006. In addition, one private (not for profit) initiative is providing ARV treatment to about 150 patients (Vintges et al., 2006).

In line with the national government's operational plan, Limpopo's provincial task team planned to have ARV service points integrated into existing health care systems at the primary care level in phase 2 and 3 of the roll-out. In June 2006 three health centres were nominated to prepare for accreditation for ARV roll-out (Vintges et al., 2006).

It is expected that the provincial and national teams will accredit more sites for ARV roll-out in the Mopani district in the near future. The aim is to have seven hospital sites and seven health centre sites operational in phase 2. In phase 3 all clinics would be involved in the roll-out (Vintges et al., 2006).

3.3.2 Challenges of Provision of Antiretroviral Therapy In South Africa

3.3.2.1 Poverty

Poverty is certainly not unique to South Africa, even when treatment itself is free, poorer populations suffer from disparities in access to care. Seventy-two percent (72 %) of poor individuals in South Africa live in rural areas where district hospitals (ART roll-out sites) are long distances from the homes of community members. Therefore, transportation costs may be the most significant barrier to accessing therapy for unemployed patients. For patients who are employed and have a source of income, the opportunity of losing a day of work to travel for health care may still be too high to afford. Peculiar to South Africa, however, is the conundrum created by the social welfare program instituted in the early 1990s. Welfare grants are available to needy citizens; these include child care, old age pension, and disability grants. The disability grant (approximately monthly stipend US \$100) is available to anyone 18-65 years of age who is deemed unable to work for medical reasons. Recipients may become the primary breadwinner for an extended family. An HIV-infected person can qualify for a disability grant if they have a CD4 cell count of 200 cells/mm³ or less or an AIDS defining illness (Ojikutu, Jack & Ramjee, 2007).

Once ART is initiated and the immune system is reconstituted, the patient no longer qualifies for the grant. This system would serve as a reasonable safety net if the now 'well' individual had a reasonable chance for gainful employment. Therefore, it is likely that the patient and the family will lose their sole means of support. Anecdotal reports suggest that some patients may be choosing to not start ART or even to discontinue therapy because of fear of losing the disability grant once immune reconstitution occurs (Nattrass, 2006).

3.3.2.2 Lack of Resources

Though important achievements have been made, challenges still lie ahead in the execution of the roll-out plan. The lack of resources and human capacity as well as limited expertise is hampering the programme. Several vacancies in the existing ARV sites remain unfilled. The work is done by professionals who have other responsibilities in the hospitals (Vintges et al., 2006). Because of infrastructural deficits and bureaucratic roadblocks, the availability of treatment has unfortunately not yet reached most rural community clinics, (Nattrass, 2006).

3.3.2.3 Adherence

The importance of medication adherence in HIV care has been well documented. Individuals with poor adherence were found to have lower rates of virological suppression and higher rates of adverse events and death. Low literacy is one of the factors associated with poor adherence in HIV. In general, patients with low literacy have less knowledge of the management and treatment of their own chronic diseases and have poorer disease outcomes. In addition, low literacy has been linked with incorrect perceptions about the goals of HIV medications and about HIV transmission risks. Erroneous beliefs regarding the use of HIV medications and their side effects may explain observational findings of studies on low adherence rates in individuals with low literacy level. Mistaken beliefs of how the medications should be taken could result in individuals making clinically significant errors in pill taking (Graham, Bennett, Holmes, & Gross, 2007).

Adherence barriers commonly reported in Africa include forgetfulness, suspicion of treatment, complex regimen, heavy pill burden, access to medication, and concomitant substance abuse. These factors were common in both developed and developing countries. However, financial constraints among paying patients are among the leading factors associated with poor adherence in Africa. Adequate treatment preparation, comprehensive HIV education and a supportive patient-provider relationship were found to positively impact adherence significantly (Aspeling & Van Wyk 2008).

3.3.3 Paediatric HIV Care and Treatment in South Africa

The number of children receiving ART is increasing steadily. However, significant inequalities in access to ART exist between and within provinces. This contributes to high morbidity and mortality in infants. Challenges for paediatric ART include a lack of sufficiently trained health care personnel and inadequate facilities as well as the complexity of drug regimens and formulations. The compartmentalisation of the ART rollout program hinders PMTCT and makes it difficult for children to be identified and referred into appropriate services. In addition, provision of ART to HIV infected children is more complex than provision to adults, because of the following reasons (Meyers, Moultrie, Naidoo, Cotton, Eley & Sherman, 2007).

- CD4 cell percentage, rather than the absolute CD4 cell count, is used in children, and the cut-off for initiating therapy differs according to the age of the child.
- Drug doses need to be regularly reviewed to keep up with growth.
- No guidance is provided in the South African guidelines for infants younger than 6 months of age, because few formulations have been studied in this age group and because mortality is so high, these young infants deserve special attention.
- Even for older children, fewer formulations exist than for adults, and palatability is generally poor.

3.3.4 Integration of ARV with Primary Health Care

The current design of the ARV programme relies heavily on doctors in accredited ARV clinics to provide the medication. Experience in the roll-out has shown that this approach is not sustainable for the number of patients who require ARVs, and increasingly services 'down-refer' patients to primary health care (PHC). Essentially PHC is the level of care where most patients end up. The doctor-centric model with a vertical ARV programme needs to be revised. Some of the most successful rural projects have achieved a high level of horizontal integration of the ARV programme into existing PHC services from the start.

Patients are assessed, do the adherence training and are initiated on ARVs at the peripheral clinics by doctors and nurses. This has minimised the requirement of many additional resources that have been difficult to attract to rural areas. As many of the rural sites have shown, such an approach can lead to significant improvement of support to the clinics as laboratory services transport and doctors' visits to the clinics improve. Even though a large degree of variation was noted between the different approaches, the integration of ARV services into the PHC level of care is key in the success appropriate ARVs rollout (Gaede, 2006; Bradford, Coleman & Cunningham, 2007).

CHAPTER FOUR

4. METHODOLOGY

4.1 Characteristics of the Study Population

The study population comprised of 200 participants with a \bar{X} age of 30 years (SD=8.1), of which 45% were males and 55% were females. Sixty-three percent (63%) were single, 22% were married, 10% divorced, and 4% widowed. Thirty four percent (34%) have been diagnosed with HIV/AIDS for 3-5 years, 24% for 6-10 years, 17% for 1-2 years, 12% for more than ten years, 9% for less than 1 year and 3% were not sure of the duration of their illness. The participants were predominantly Sepedi speaking (94%) and predominantly from rural areas (91%), only 8% were from urban areas. Seventy-six percent (76%) had a secondary, 14% primary, and 8% tertiary educational level. With regard to their employment status 71% were unemployed and the populations' \bar{X} income was R845.00 (SD=R1458.6), with 28% of the income mainly coming from the disability grant due to the illness as well as from the child support grants. Of the study population, only 10% had medical insurance (medical aid).

Table 1. Sociodemographic and Health Characteristics (N=200)

Sociodemographic and Health Characteristics	N (%)
Gender:	
Males	90 (45)
Females	110 (55)
\bar{X} Age = 30.2 yrs (SD = 8.1)	
Residential area:	
Rural	183(91)
Urban	17 (8)
Marital status:	
Married	45 (22)
Single	126 (63)
Divorced	20 (10)
Widowed	8 (4)
Educational level:	
Primary	29 (14)
Secondary	152 (76)
Tertiary	16 (8)
Employment/income status:	
Unemployed	142 (71)
Employed	58 (29)
Mean income amount = R845.0 (SD =R1458.6)	
Main source of household income	
No income	86 (43)
Formal salary	58 (29)
Government grant (Disability & child grants)	56 (28)
Duration of illness:	
< 1 year	18 (9)
1-2 yrs	34 (17)
3-5 yrs	68 (34)
6-10 yrs	48 (24)
More than 10 yrs	25 (12)
Not sure	7 (3)
Medical aid (Insurance):	
Yes	20 (10)
No	180 (90)

4.2 Study Design

This was a quantitative study based on a cross-sectional design.

4.3 Sampling Method

Multistage stratification was used to randomly select samples. Firstly, rural and urban areas were stratified into zones, and then every second street and every second household was stratified for sampling until the required sample was met. There was however some challenges with this sampling method, particularly in urban areas where there was nobody in many of the households due to work/employment reasons that resulted in a fewer number of urban dwellers.

4.4 Procedure

The study was approved by the University ethics committee. The purpose and significance of the study was explained to the participants, and formal informed consent was sought from participants willing to take part in the study. Eligibility criteria of the study was being diagnosed with HIV (self report), and be at least 18 years of age or older to be able to give informed consent. The questionnaire was translated into Sepedi and back-translated into English for validation (back-to-back translation) and was interview administered.

4.5 Data collection tools

Health care access: Questions adapted from the study by Cunningham et al. (2005), were used to assess access to health care.

Health care utilisation: Utilisation of health care services was assessed within the previous 6 months measured by number of:

- Primary care visits (hospital/clinic).
- Emergency department visits.
- Hospitalisations.

Poor health care utilisation was defined as fewer than two outpatient visits over the past six months (also adapted from a study by Cunningham et al., 2005).

Cultural beliefs: Self-constructed questions were used to assess cultural beliefs.

4.6 Data Analysis

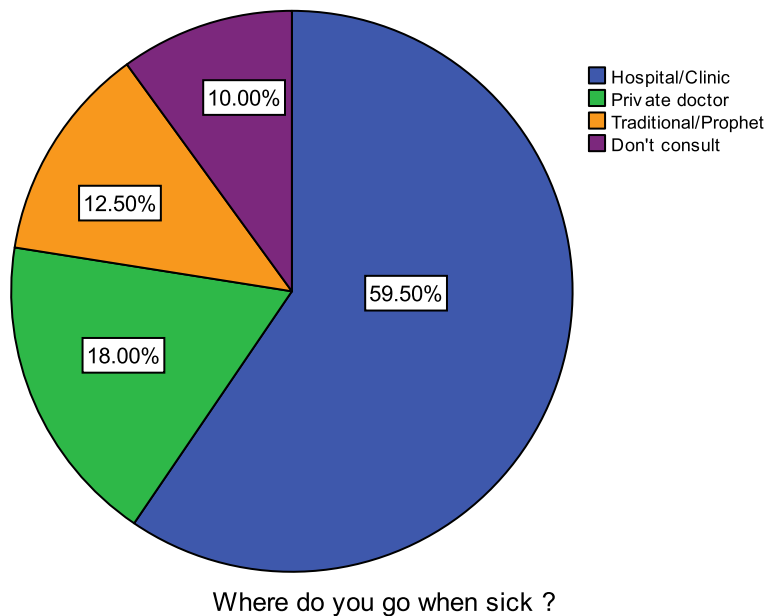
Descriptive statistics, frequencies, were used to calculate the sociodemographic characteristics, access to and utilisation of health care. ANOVA (Analysis of Variance) was used to determine the relationship between variables (dependent variables - health care and health utilisation; and independent variables - gender differences, cultural beliefs, socioeconomic factors and geographical location and).

CHAPTER FIVE

5. PRESENTATION OF RESULTS

Research Question 1: Do PLWHA have access to health care services?

Graph 1 - Consultation for HIV/AIDS



Fifty nine percent (59%) of the participants were found to have access to primary health care services (hospital/clinic), 18% to private doctors' services. Twelve percent (12%) reported to consult with traditional healers/prophets, and 10% reported not consult at all for their disease.

Table 1- Frequencies of health care access

Health Care Access	N = 200	
	N (%)	N (%)
	Yes	No
Have Regular Doctor for HIV/AIDS?	124 (62)	76 (38)
Access to ARVs?	119 (60)	81 (40)
Have difficulty going to Hospital/Clinic when want to?	10 (5)	190 (95)
Have difficulty going to Private Doctor when want to?	21 (11)	179 (89)

Sixty-two percent (62%) of the participants reported to be having a regular doctor for HIV/AIDS, whereas 38% reported not to be having one. Sixty percent (60%) were found to have access to ARVs, and 40% not. Ninety five percent (95%) of the participants reported not have difficulty going to the hospital/clinic when they wanted to consult, and only 5% reported having difficulties.

Research Question 2: Do PLWHA utilise health care services?

Table 2 - Frequencies, descriptives of health care utilisation

Health Care Utilisation	N = 200	
	N (%)	\bar{X} (SD)
Hospital/clinic visits last 6 months	180 (90)	2.8 (1.9)
Private doctor visits last 6 months	117 (58)	1.7 (1.1)
Over night hospital stay last 6 months	53 (26)	.4 (.7)
Emergency room visits last 6 months	20 (10)	.1 (.5)

Ninety percent (90%) of the participants were found to utilise primary health care services, with 2.8 as \bar{X} number of visits (SD=1.9). Fifty-eight percent (58%), were found to utilise private doctors' services (\bar{X} number of visits of 1.7, SD=1.10).

Twenty-six percent (26%) reported to have stayed over night at hospital (\bar{X} number of visits of .41, SD=.74), and 10% have visited an emergency room (\bar{X} number of visits of .14, SD=.48).

Research Question 3: Are there gender differences in primary health care service utilisation?

Research Question 4: Does educational level influence utilisation of primary health care service?

Table 3: Descriptives of hospital/clinic utilisation by gender and educational level

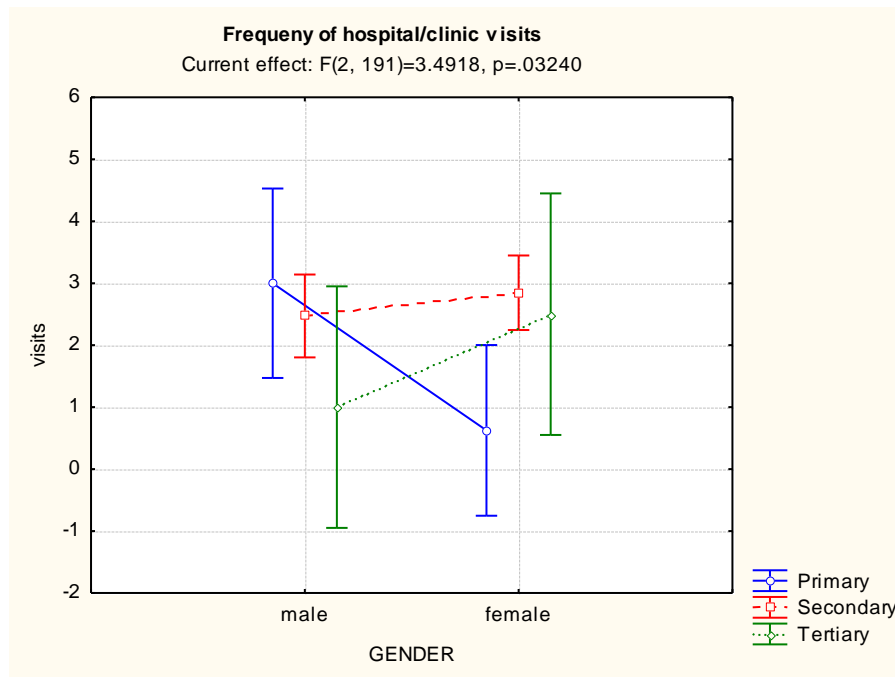
Gender	Educational Level	\bar{X} (SD)
Males	Primary	3.0 (2.2)
Males	Secondary	2.5 (2.9)
Males	Tertiary	1.0 (2.1)
Females	Primary	0.6 (1.5)
Females	Secondary	2.8 (2.9)
Females	Tertiary	2.5 (3.6)

Table 3.1: ANOVA-relationship between gender, educational level and hospital/clinic utilisation

Gender	DF	F	P
Gender	1, 19	0.087	NS
Education level	2, 19	1.66	NS
Gender x Education level	2, 19	3.49	.03*

*P< 0.05

Graph 2: Relationship between gender, educational level and hospital/clinic utilisation



There was no significant difference found between males and females in terms of hospital/clinic (primary health care) services utilisation, there was further no significant difference found between educational level and hospital/clinic utilisation. There was however a significant difference in gender and educational level interaction. Males with primary education were found to visit hospital/clinic more than females. Females with tertiary education were found to visit hospital/clinic more than males.

Research Question 5: Do PLWHA with lower educational level utilise private doctors' services?

Table 4: ANOVA - Level of education and private doctors' service utilisation

Level of Education	\bar{X}	SD	DF	F	P
Primary	0.97	0.97	1, 191	0.077	NS
Secondary	1.73	2.06	2, 191	1.663	NS
Tertiary	2.69	1.89	2, 191	3.491	.032*

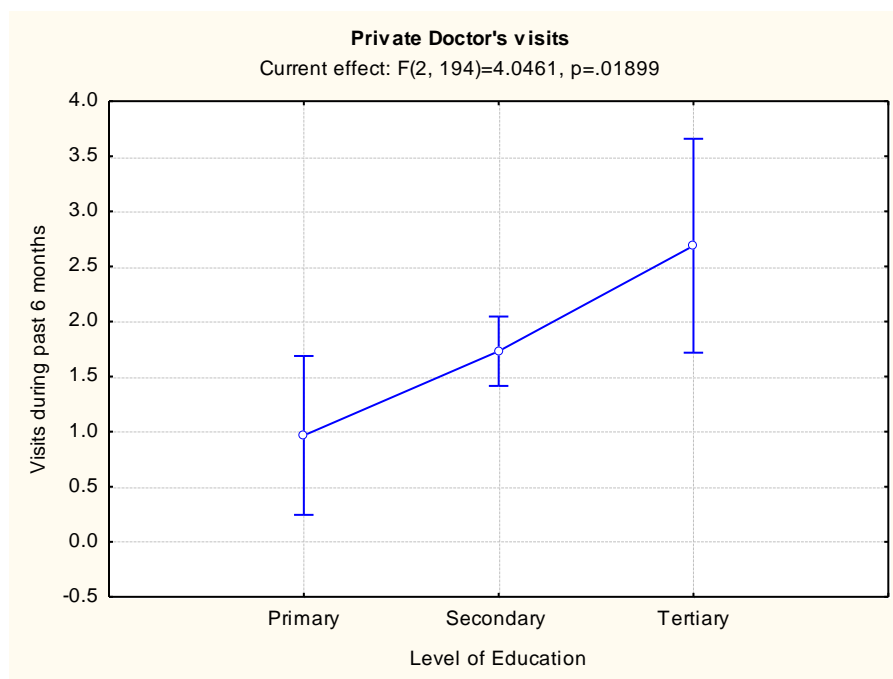
*P< 0.05

Table 4.1: *Post-hoc* analysis (Bonferroni)

Level of Education	Primary	Secondary	Tertiary
Primary	-	0.170	0.016*
Secondary		-	0.198
Tertiary			-

*P<0.05

Graph 3: Level of education and private doctors' service utilisation



Results indicate that PLWHA with lower educational level were significantly found not to utilise private doctors' services as compared with those with higher education level. Post-hoc analysis indicates the significant difference to be between those with primary and tertiary education.

Research Question 6: Do PLWHA who live in rural areas utilise private doctors' services?

Table 6: ANOVA - Residential area and private doctor utilization

Residential Area	\bar{X}	SD	DF	F	P
Rural	1.562	1.868	1.198	8.425	.004*
Urban	3.000	2.739			

*P < 0.05

Graph 4: Residential area and private doctor utilisation



Findings show that PLWHA residing in urban areas were significantly found to utilise private doctors' services more than those who reside in rural areas.

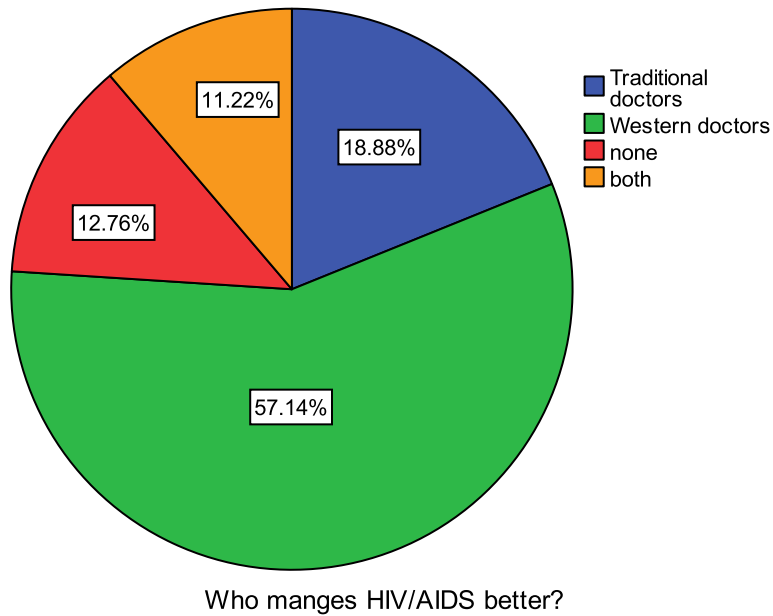
Research Question 7: Do cultural beliefs have an influence on access to and utilisation of health care services?

Table 7: Traditional medication and HIV/AIDS

Traditional medicine for HIV/AIDS	N = 200	
	N (%)	N (%)
	Yes	No
Safe use of traditional medicine for HIV/AIDS	57 (28)	117 (58)

Fifty-eight percent (58%) of the participants reported that it is not safe to use traditional medication for HIV/AIDS. Twenty-eight (28 %) reported it to be safe.

Graph 2 - HIV/AIDS management



Fifty-seven percent (57%) of the participants believed western doctors could manage HIV/AIDS better, whereas 19% believed in traditional doctors. Thirteen percent (13%) indicated that no one could manage the disease and 11% reported that both (western and traditional doctors) can manage the disease equally well.

CHAPTER SIX

6. DISSCUSSION OF RESULTS

6.1 Access to health care services

PLWHA in this study were found to have access to health care services. Access to health care was determined by identifying a health care facility they consult at, having a regular doctor for their illness, and having access to ARVs (Adopted from the study by Cunningham et al., 2005). Most of the participants (59%) were found to access primary health care services (hospital/clinic), and they were also found to have a regular doctor they consult with for their illness. These findings suggest access to HIV-related primary health care in this population. The high proportion of participants receiving care in hospital/clinic is encouraging given evidence that the experience of primary care providers in managing patients with AIDS is associated with patient survival (Palacio, Shiboski, Yelin, Hessol, Greenblatt, 1999). Amongst others, the mostly reported reasons for hospital/clinic utilisation were that the hospital provides better care/service and better medication (30%); and that at the clinic it is free of charge (24%).

When assessing accessibility or barriers to health care services, a high proportion of the participants (95%) did not have difficulties in accessing health care services. However, a few reported difficulties or barriers to health care access. These ranged from financial reasons (being too sick to walk and have no transport money), poor service delivery at health care facilities (long queues, ill-treatment by the nursing staff), social support (did not have someone to take them to hospital/clinic), psychological reasons (too depressed to go) (Uphold & Mkanta, 2005), household responsibilities (no one to baby sit for them), as well as work related reasons.

Although not prevalent, there were also participants who were found not to access health care services because of consulting with traditional healers and or prophets (mainly from the Zion Christian Church - ZCC). Others reported not to consult at all for their illness.

Those who reported not to consult were mainly those participants who according to HBM, their perceived benefits of seeking care was less. They believed consulting would not make any difference as it would not take the virus away. Some indicated that they just want to die. These could be due to inadequate knowledge about the disease and its management modalities. In Addition, the high level of stigma and discrimination against PLWHA can lead them to have death wishes and therefore neglect treatment, or even at times predispose them to or perpetuate suicidal tendencies.

Findings in this study indicate PLWHA (60%) to be having access to and to utilise ARVs. Only a few reported non use. The commonly reported reason for accessing and utilising such a treatment were that the illness has a good prognosis with ARVs utilisation. Amongst the barriers found to ARVs' access and utilisation was: the use of traditional and ZCC medication, the believe that it is not HIV/AIDS but Makgoma and or Sekgalaka, negative attitudes towards ARVs ('ARVs make the condition worse', 'I don't take rubbish', 'this is a money making business, they don't help in any way', 'western doctors just want to kill us with these ARVs').

Despite wide media coverage on ARVs, alarmingly (although not prevalently reported) some participants (4%) reported that they did not know about ARVs, they had no knowledge as where to get them, and also didn't know that it is free at the primary care facilities. This could be ascribed to low health literacy as a result of ignorance. The public statement of the minister of health, Dr Manto Tshabala Msimang that ARVs are toxic and poisonous seem to have also had an influence on people accessing and utilising ARVs. Her statement has robbed the country of many lives that could have survived using ARVs who are ill-equipped to judge the relative efficacy of ARVs.

6.2 Utilisation of health care services

Participants in this study were found to utilise health care services. Two or more outpatient visits in the past 6 months and non-use of emergency departments as the usual place for care were determinants of good utilisation. (Adopted from the study by Cunningham et al., 2005). Hospitalisation and use of emergency services imply poor management of the illness and that care is sought with disease severity.

6.2.1 Gender and utilisation

In the general population, it is thought that men are more likely than women to ignore or self-treat themselves and avoid medical care. In this study, there were no gender differences found in access to and utilisation of health care services. Similarly, in their study, Cunningham et al., (2007) found that men and women with HIV were equally likely to seek outpatient care.

Contradictory, other studies have found women to utilise health care service less than males. Women were found to be more likely to be hospitalised and to utilise emergency department services. They were found to have more care giving responsibilities than men competing for health care (Penniman et al., 2007).

Although no gender difference was evident with regard to utilisation of health care services, there was however a significant association found between the interaction of gender and educational level. Women with higher educational level utilised health care services more than their male counterparts. The explanation of this pattern of utilisation is not yet clear, it might perhaps have to do with male ego issues. It however needs further exploration.

6.2.2 Cultural beliefs, access to and utilisation health care services

Cultural beliefs were found not to influence access to and utilisation of health care services in this population. Most participants (58%) believed that it is not safe and unhealthy to use traditional medication for HIV/AIDS. They believed that traditional healers are not well trained, not knowledgeable, inexperienced and their medication is ineffective in dealing with HIV/AIDS, and that they have unhygienic practices. Unhygienic practices of traditional healers were also reported in other studies (Summerton, 2006; Kaboru et al., 2008).

Like in previous studies (Peltzer, 2003; Mills et al., 2005; Peltzer et al., 2006; Summerton, 2006; Littlewood & Vanable, 2008), the use of traditional medication for HIV/AIDS has been found in this study (28%). Despite the fact that studies (Peltzer, 2001) have demonstrated significant HIV/AIDS risk practices by traditional healers, there were some participants who did not access and utilise health care services due to their beliefs in traditional healers. The following are some of the reasons for utilisation of such medications: the believe that traditional medicine is safer than ARVs as it does not have side effects (12%), the believe that traditional healers are able to cure diseases western doctors can't, and that they are empathetic, one is free to tell them anything (2%). There was also some stereotypical believes (2%) reported that hampered access to and utilisation of health care services, as one participant reported 'From long time ago, African people were using traditional healers before the western treatment regimen was introduced, why a change now?'

The use of both western and traditional medication was evident (although less prevalent - 11%), and need further exploration. These participants believed both western and traditional doctors could manage HIV/AIDS equally well. This pattern was found to complicate HIV/AIDS treatment resulting in adverse effects which put patients at risk of treatment failure, viral resistance, and or drug toxicity (Mills et al., 2005).

Worryingly, some participants believed that what they are suffering from is not HIV/AIDS (despite having tested positive at the hospital) but a condition called 'Makgoma' and or 'Sekgalaka', which is believed to be only treatable by a traditional healer or a prophet. Although not prevalent, it is a dangerous cultural believe that need immediate attention, that could have serious implications on the efforts to combat the spread of HIV/AIDS in the country, as people with such believes will continue spreading the disease.

6.2.2.1 'Makgoma' and 'Sekgalaka' as Barriers to HIV Care

From the study, 'Makgoma' is said to be an African name for a condition/syndrome that affects a man or a woman who have sex with a man or a woman whose partner has passed away and is not cleansed or not properly cleansed (in an African traditional manner). The person may eventually die. 'Sekgalaka' is also said to be an African name for a skin condition that ranges from rash, oral thrush to severe skin lesions. As a result, the symptom manifestations of HIV/AIDS are intentionally (as a form of denial of the disease) or mistakenly attributed to 'Makgoma' and or 'Sekgalaka'. The chain of infections and deaths of those who are believed to be suffering from 'Makgoma', is not attributed to HIV/AIDS, but to the extinction of competent and experienced traditional healers (who were able to treat the disease) by those who hold the 'Makgoma' believe.

6.2.3 Socioeconomic factors and health care utilisation

As primary health care services in most of the South African health care facilities are free or less costly, socioeconomic factors (i.e. education, income, residential area) were found not to have an influence on the actual access to and or utilisation, but rather to the type of health care services utilised. Private health care services are mostly more expensive than primary health care. Participants with higher educational level significantly utilised private services more than primary health care for their illness due to their enabling socioeconomic factor.

Participants with higher educational level were mostly employed with high income (Cunningham et al., 2007), and mostly had medical aids (insurance) that enabled them to consult with such services. Anthony et al. (2007) in their study found that participants with medical insurance were four times as likely as those without any medical insurance to have seen a care provider.

Other studies have also demonstrated the association between higher educational level, increased health care utilisation and decreased use of emergency services as usual place for care (Mizuno, Wilkinson, Santibanez, Dawson Rose, Knowlton, Handley, Gourevitch & Inspire Team, 2006).

Reasons reported for utilisation of such services were that, private doctors provide quality care, offer speedy service (there are no long queues), and that private doctors don't insult and humiliate patients like nurses do at the clinics and hospitals. These are issues that need to be addressed to make primary health care more accessible for those who are financially disadvantaged to consult with private health care services.

6.2.4 Geographical location and health care utilisation

Proximity to health care facilities or geographical location could have contributed to access to and utilisation of health services in this population. Most participants were residing at close proximity to the clinic and hospital, and most reported to walk to either the hospital or clinic with 54% of them traveling for less than 30 minutes. Therefore, accessing the health care facilities was reported not to be a hassle. The association between proximity to care and increased use of care have also been indicated in previous studies (Palacio et al., 1999; Paula 2000; Tanser et al., 2006; Hutchinson & Mahlalela 2006).

The type of residential area (urban/rural) was found not have a direct influence on utilisation, but determined the type of health care service utilised. Participants who are residing in urban areas, significantly utilised private more than primary health care

services as opposed to their rural counterparts. This pattern of utilisation is explained by the socioeconomic factors of urban area dwellers that enable them to afford such service. Almost all participants residing in urban areas were employed, had a tertiary education level, which implied a high income.

6.3 Conclusion

The following conclusion is made from the study:

- Participants in this study were found to have access and to utilise health care services, particularly primary health care. However, the barriers (i.e. poor service, humiliation by nursing staff) outlined by the non-users of primary health care services need immediate attention to improve the quality of HIV primary care and to maximise access to and utilisation of such services.

6.4 Recommendations

- Educational and awareness programmes need to be tailored and or strengthened on the health risks of the use of both western (ARV treatment) and traditional medicines for HIV/AIDS, especially in rural areas.

6.5 Limitations of the study

- Because data were from self-report, there is the likelihood that the recall of participants did not accurately represent utilization of health care services.
- The nature of the questionnaire, the outnumbered urban area dwellers by the rural counterparts somehow limited the power of the statistical analysis.
- The sample of PLWHA included was representative of selected geographic areas in Limpopo province, generalization of the results can be misleading.

6.6 Implications for future research

- The cultural beliefs of ‘Makgoma’ and or ‘Sekgalaka’ vs HIV/AIDS need to be explored further, as it has serious implications on HIV prevention and management efforts.
- Reasons for gender differences in primary health care utilisation among the highly educated class need to be investigated.
- Since Limpopo Province is predominantly rural and poor, and a high proportion of participants in the study were unemployed, the influence of the disability grant on health seeking behaviours for HIV/AIDS need to be investigated.

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