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# An Institutional Analysis of Access to GBV/HIV Services in Rural KwaZulu-Natal, South Africa

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## 1. Introduction

The health systems context in rural South Africa presents significant challenges for addressing the intersecting problems of HIV/AIDS and Gender Based Violence (GBV). In KwaZulu-Natal Province, district level government responses to these issues are principally focused in urban, higher population areas. Rural health systems rely more heavily on non-governmental organizations (NGOs), which have serious time limitations and insecure external funding. Weak management skills, and insufficient capacity to design and monitor services, are key problems. There is also a shortage of health personnel in rural areas, and high attrition rates due to poor work conditions, substandard accommodation environments, inadequate pay and benefits, and illness and stress resulting from the high demands posed by the HIV/AIDS epidemic and other primary health care issues. Overall, the rural health structure is very under-developed, under-staffed, under-resourced and under-trained around issues of GBV and HIV/AIDS.

There is a pressing need for rural health services to focus on health promotion and prevention - including violence prevention - and to develop new strategies for coordinating the activities of health professionals with voluntary associations and NGOs. This paper presents an institutional analysis of why access to GBV and HIV/AIDS services is low in rural KwaZulu-Natal, with a focus on understanding existing professional structures and community beliefs that act as barriers to health system development. Such an understanding can also reveal how existing strengths and resources may be harnessed to encourage changes in the cultural attitudes and structures that support the gender violence-HIV/AIDS nexus, and identify salient points of entry at which interventions can be designed.

### 1.1 An institutional perspective on "Access"

#### 1.1.1 The health system as "Institution"

It is well recognized that the health sector faces certain institutional characteristics that distinguish it from other sectors of society [Jan et al., 2008; Mooney, 1994]. Specifically, these characteristics include the role of institutions in providing access to health benefits, or more exactly, preservation from ill health or health losses. In this view, institutions are not organizations per se, but are the 'rules' that govern the conduct of players, whether individuals or organizations, within society [North, 1993]. Thus, institutions include formal rules such as legislation concerning resource allocation to health and the regulation of professionals, and informal rules such as social customs and community norms that shape

health care practices. An institutionalist analysis views interventions as more than a simple balancing of inputs and outputs (or costs and benefits) and thus provides a more complete account of health decision-making. Such an analysis requires a coherent theory of how health services work in a specific context.

The development of health programs in areas of restricted resources often involves 'institution building' and this paper provides an analysis of how this occurs in the context of HIV/AIDS and gender violence in South Africa. Other recent institutional analyses that have focused on this problem expose implicit costs and values from the perspective of health economics [Jan et al., 2008]. Institutional development may also be concerned with issues of health service quality. However, the current analysis is focused on concepts of equity in access to these important health and social services.

### **1.1.2 Institutional access**

Health systems research is increasingly focused on issues of inequity in access to underlying determinants of health, as well as to curative services. Access is understood to be amenable to policy decisions about the supply of health care. Access barriers deter, delay and minimize the search for health care solutions to HIV/AIDS and gender violence. However, it is important to note that access is also limited by demand-side factors that are less than optimal.

Gilson and Schneider [Gilson et al., 2007] have summarized three key dimensions in defining access, or the degree of fit between the health system and those it serves. These domains concern a dynamic process of interaction between health institutions and individuals or households. 'Availability', or physical access, refers to whether the appropriate health services are in the right place at the right time. 'Affordability', or financial access, refers to the relationship between the cost of health care and individuals' ability to pay. Finally, 'acceptability', or cultural access, refers to the social and cultural distance between health care systems and their users [Guilford et al., 2002; Delius et al., 2002]. Studies of how these dimensions interact with each other are particularly needed, as interventions to address single issues of access may be ineffective in reducing inequity. Within an access framework and from an institutional perspective, we examine the interactions of various material and operational, or procedural, barriers to accessing HIV/AIDS and gender based violence services in an under-resourced rural area in KwaZulu-Natal. This multi-dimensional analysis will hopefully provide the basis for multi-level interventions.

### **1.2 Literature review**

The issue of gender violence and its links to HIV/AIDS in rural settings has not been addressed in a substantive way. There are several complex issues in rural health systems that interact to present significant institutional problems to health and safety. Material barriers to health for poor rural women have been noted to include lack of physical access to public health clinics, low levels of resources and staff in existing clinics, and the high costs of treatment [Delius et al., 2002]. Further, considerable operational or procedural problems exist in terms of staff awareness and training around GBV and HIV/AIDS issues, as well as negative attitudes and gendered discrimination against women seeking contraceptives, HIV/AIDS tests, or HIV/AIDS treatment [MacPhail et al., 2001]. These general structural and operational problems are exacerbated in rural locations, which also have problems of inattention by the government, lack of training and resources, and poor staff recruitment

and retention. In rural areas, traditional socio-cultural norms, practices and beliefs at once inhibit women from seeking health care around GBV and HIV/AIDS, and can produce institutional resistance to the restructuring of health services in ways that might facilitate better patient access.

### **1.2.1 Location, mandate, resources and organization of public health clinics**

Women in rural areas of South Africa may have considerable difficulty accessing public health clinics for several reasons. First, significant variability in access and availability of clinical services mean that some women must travel long distances to reach the nearest clinic. This is physically impossible for many women with disabilities, illness, or who are sick with HIV/AIDS, who may otherwise have reached the clinic by walking or other forms of transportation. Women without economic means cannot pay for the costs of transport, creating a key structural barrier to their ability to access free contraceptives, receive HIV/AIDS testing and counseling, or access treatment if they are HIV/AIDS infected. The nature of voluntary testing and counseling in public health clinics requires multiple visits: formerly in KwaZulu-Natal, HIV test results took an average of three weeks to be processed, for example, and many patients never returned to receive their results [Campbell et al. 2002]. Treatment and counseling may also require multiple visits, which means that women without physical and economic access to clinics may not attend initially or make return visits. Finally, some community-based service providers who would have provided home visits to isolated women have reported that they do not do so because of their own limited funding and access to transport [Russel et al., 2000].

Public health clinics are also very uneven in terms of resource and staff availability across the country, with rural areas suffering the most [Delius et al., 2002; Kelly et al., 2001]. In some rural areas of KwaZulu-Natal, voluntary counseling and testing is not available at all [Kelly et al., 2001]. Many primary health care clinics in rural KwaZulu-Natal are organized to render antenatal services to pregnant women on one specific day of the week, and 40-60 pregnant women often require services on that particular day [Ngidi et al., 2002]. These demands create major challenges in terms of offering adequate Voluntary Counseling and Testing (VCT) follow-up services to these same women.

The physical and organizational structure of clinics is also a component in the improvement of VCT services, as well as for increasing the likelihood that people will feel comfortable attending clinics for HIV/AIDS related reasons [Senderowitz, 1999]. Van Dyk's [Van Dyk, 2002] survey of over 1400 men and women found that 33% preferred to go to an unknown clinic (i.e., not in their community) for voluntary counseling and testing. Of these, 50% do "not trust health care workers to keep a secret", 30% prefer "total confidentiality" which they may not receive at their local clinic, and 13% "fear prejudice and rejection" from going to the local clinic. These fears are highly attributable to the public nature of many clinics, in which there is a lack of privacy and individuals' problems or reasons for coming to the clinic can easily be discerned by onlookers [Senderowitz, 1999; Van Dyk, 2002].

Finally, state provision of free and/or low cost accessible services and drugs to HIV/AIDS patients has long been identified as a crucial step in the prevention and treatment effort [Joint Monitoring Committee on the Improvement of the Quality of Life and Status of Women, 2001a]. However, the roll-out of antiretroviral therapy (ART) is still far from even or universal, despite the fact that the government began providing it through the public health system in 2003. Rural areas continue to experience the least access to publicly-

provided ART [Human Rights Watch, 2008]. In areas where clinics do not offer ART, many people cannot afford the cost of accessing treatment privately. Poor rural women with HIV/AIDS are unlikely to access these drugs for a variety of reasons, including lack of transportation to clinics offering ART, fear of stigma, inability to maintain the level of health (nutrition, clean water, adequate rest) required to take the drugs as prescribed, and a lack of other services or support in the community to help them comply with their medication regimen. Although ART was not available in the public health system when this study was conducted, the same issues around uneven provision of ART by clinics, and lack of training, expertise, equipment and attention to guidelines among health professionals, are still very relevant today.

### **1.2.2 Community, legal and public health handling of violence against women**

Vetten & Bhana [Vetten et al., 2001] outline several problematic and gender-blind aspects of traditional VCT models. VCT and mother-to-child-transmission (MTCT) programmes usually promote partner-notification when a woman tests positive for HIV/AIDS. Such disclosure is encouraged to promote safer sex practices and partner testing. The potential for violent partner reactions to women's disclosure is rarely taken into account; similarly, VCT counselors may suggest couple counseling which may also trigger male violence and abuse. VCT/MTCT counselors or nurses may have little knowledge of domestic violence or expertise in determining if certain patients come from abusive relationships which will place them at even greater risk for abuse upon disclosure. Finally, HIV/AIDS testing is often done in public antenatal clinics without the patients' consent. Patients are often informed of their HIV/AIDS status in non-private settings, where the likelihood of others hearing is high.

Vetten & Bhana also argue that rape crisis centres in public hospitals and/or nurses and counselors on staff who deal with rape victims - are similarly lacking in training on the links between rape and HIV/AIDS. Rape victims are not always referred to HIV/AIDS counseling and testing centres, and nurses are often ill-equipped to counsel the women themselves, as they do not have the proper information or knowledge about the risk of HIV/AIDS following rape (i.e., when can the victim be tested, how long does HIV/AIDS take to incubate) [Vetten et al., 2001; Gernholtz, 2002]. At the time of this study, most clinics in rural KwaZulu Natal were not providing post-exposure prophylaxis (PEP) to rape survivors, and most women faced barriers of lack of transportation, stigma, discrimination and negative attitudes by health professionals, among others, when it came to accessing this life-saving drug. In 2002, the South African government committed to providing post-exposure prophylaxis (PEP) to rape survivors through the public health system. Like ART, however, this roll-out has been slower than desired and uneven, with rural areas being slower to offer PEP to rape survivors (Human Rights Watch, 2008). A corresponding protocol was released by the Department of Health [Department of Health, South Africa, 2003], which requires that all rape survivors be provided with counseling around HIV and PEP, and that referral systems be in place so that survivors of rape can access longer-term counseling. However, preliminary findings have shown that there is a lack of coordination among service providers and poor knowledge among health professionals of PEP guidelines [Birdsall et al., 2004]. A recent Bill [Republic of South Africa, 2007] legislated the provision of PEP to sexual assault providers, but added the requirement that a woman press criminal charges in order to access the life-saving drugs. No references to other treatment or counseling for rape survivors were made in the Bill. It has yet to be seen how these gaps and

the requirement that women report to police will influence women's access. The Bill at once requires coordination between police and health services while eliminating the need for collaboration between health services and voluntary organizations or NGOs that provide other supports. Women who fear further violence from perpetrators or who do not want to go "public" about the rape for fear of stigma, will choose not to file charges and so will be denied access to PEP. It will also be less likely that health professionals will be compelled to refer them to support services or counseling. Pre-existing inefficiencies with service coordination, and gender-blind aspects of post-sexual assault care in rural areas, may be perpetuated as a result of the new Bill.

Many researchers argue that a gap clearly exists in public health clinics and VCT programs in terms of staff training, awareness, attitudes, and overall handling of violence against women in the context of HIV/AIDS; conversely, HIV services have not been adequately integrated into public services provided to survivors of sexual violence [Vetten et al., 2001; Joint Monitoring Committee on the Improvement of the Quality of Life and Status of Women, 2001b; France et al., 2000]. This lack of integration works as a barrier to HIV/AIDS prevention and treatment for survivors of rape, and may put HIV/AIDS infected women at increased risk for violence. For example, non-governmental rape crisis centres and women's shelters require more resources and training around the issues of HIV/AIDS. Shelters for abused women are not always accessible to HIV/AIDS infected women: many of these shelters will not allow HIV/AIDS infected women to reside there, which puts women at risk of more violence at the hands of their partners. Women's shelters and clinics that do address issues of HIV/AIDS are often poorly resourced to do so. Non-governmental rape crisis centres often do not have the resources, knowledge or capacity to give HIV tests, administer PEP, or provide counseling around HIV and PEP.

### **1.3 Research question**

Overall, there are significant barriers documented regarding access to the health system response to GBV and HIV/AIDS. How do these material and procedural barriers to availability, affordability and acceptability interact together in rural areas to aggravate the gender violence and HIV/AIDS nexus?

## **2. Methods**

The Health District Sisonke (DC43) in KwaZulu-Natal was the site for this study. Located in the foothills of the southern Drakensberg mountains, about 90 kms from Pietermaritzburg, this area has a demographic profile with a variety of rural communities broadly representative of the country as a whole. It also has a history of public health involvement and innovation dating back to the 1940s [Jeeves, 1998]. The legacy of apartheid has created a highly uneven landscape, with marked inequalities in access to land, resources, employment, income and services. Migration remains a commonly practiced response to extreme poverty and unemployment in large parts of the district under study, continuing a long-established tradition of migrant labour.

The study setting is a traditional tribal area with poor secondary roads and almost complete lack of public/private transport. There are health clinics at Pholela, Bulwer, Underberg and Ixopo, a district mission hospital at Centacow, as well as a larger referral hospital in the

town of Edendale. From these locations, a sample of 46 key informants was drawn that included doctors, nurses, and VCT counselors. Semi-structured interviews were taped and administered by trained medical students, in Zulu, English or Xhosa, as appropriate. Interviews were done with fully informed consent and the right to refuse consistent with Research Ethics Board approval of universities in Canada (Queen's University) and South Africa (University of KwaZulu-Natal). The overall purpose of the interviews was to understand health workers' attitudes towards HIV/AIDS and GBV and how it affected their own work. However, a subset of questions focused on their experiences and roles, responsibilities and capacities in HIV/AIDS-GBV service delivery, which are reported here. In addition, relevant material was utilized from other interviews done for a larger study with local women, men, faith leaders and traditional healers.

Transcripts were analyzed and categorized according to concepts and issues derived from the literature review.

- distance, transport and public health
- service availability, volunteers
- physical space and confidentiality
- costs and poverty
- compatibility in public health practices versus safety practices
- compatibility in social versus clinical responses to violence
- ignorance and bias
- lack of integrated care

### **3. Results**

#### **3.1 Issues of availability**

##### **3.1.1 Variety in optimal settings for public health care**

Respondents identify two principal and linked dynamics in the impact of rurality on HIV/AIDS care. Interestingly, public health care is perceived to be both a 'place' and a 'service'. Public knowledge in rural areas about HIV/AIDS is low, as it is for many health problems in a traditional rural environment. Negative community attitudes and stigma around HIV/AIDS have a profound impact in small, cohesive rural communities such that a more distant 'place' for testing is preferable to many community members. However, such attitudes also result in late recognition of HIV and delayed decisions to be tested. As the disease progresses, the capacity for ill people to travel declines further. At this point, and as HIV status becomes known to neighbours, a 'service' approach to public health is more preferred by community members. However, lack of transport for health care workers in remote areas affects HIV/AIDS awareness building, case identification, and follow-up services. Further, a service approach might alleviate the problem of limited space at hospitals, as noted below.

##### **3.1.2 Limitations in quantity and scope of practice of professional personnel**

The extreme conditions of HIV/AIDS clearly affect the adequacy of rural health care.

Nurses and VCT counselors are very overloaded and underpaid. Adding nursing staff is often considered to be a solution, but there are also practical barriers such as the need to share accommodation. As well, the limitation in types of South African health human resources is a severe problem. Marriage counselors and social workers are particularly

lacking. Doctors are not only in short supply, but many are temporary. South African medical practitioner licensing requires a one year community residency [Republic of South Africa 1997] which has increased the number of young doctors in rural areas, but often leaves gaps in service:

*Doctors here are very nice but very junior. I think for them it's "let's stick some chest drains in, put a CVP line in and do a 'caesar'. It's because we are only here for a year ...let's turn it into an educational experience. I'm going to do all these courses and come up with these skills."*

Distinctions between various medical professions and their scope of practice also creates service lacunae:

*These patients need to have their bloods taken for CD4 counts, as a nurse I have to do that but it's not within my scope.*

Additionally, strict clinical guidelines for administering ART and considerable job stress creates problems in quality of care:

*When I'm giving everybody else their medication usually at 1800h, the HIV patient won't take it because they have to take it at 2000h. Who is going to sit down and wait for 2000h to give them their treatment? So they must remember for themselves because if they don't then they won't be taking their medication properly.*

### **3.1.3 Lack of physical space, resources and confidentiality**

Having sufficient working space is a concern for all hospital and clinic staff:

*Our ward accommodates 26, especially female medical, so we have floor beds and there we nurse some conditions, and now you as a nurse will have to be on your knees, and how can you put up a drip on the floor?*

However, respondents hold differing views regarding the treatment of patients within the physical space of clinics. Some value the use of physical space for purposes of 'integration' of HIV/AIDS patients, while others value it for the purpose of 'separation'. Both views are linked to issues of ethics. Integration of HIV/AIDS patients with the general outpatient population is recommended by some respondents for the purpose of maintaining privacy of HIV status. Integration is also preferred to maintain equity of service for non-AIDS patients. For others, separation of HIV/AIDS outpatients is desirable for confidentiality of information. Most respondents recommend the separation of inpatients to ensure such privacy:

*The sad thing with HIV positive patients is that they are not protected. We don't have an isolation ward for them, the medical patients are mixed with them ... There is no confidentiality for the HIV patients.*

Numerous respondents identify problems related to the lack of essential medical equipment and supplies for HIV/AIDS care. First, there is a basic lack of equipment (e.g., suction machines, blood pressure instruments) for various clinic locations and needs. Further, existing equipment is not well maintained, or may be lost or stolen. Second, protective supplies (e.g., masks, gloves) that are necessary for working in a HIV/AIDS environment are lacking, especially in the communities. Basic supplies such as HIV test kits, oxygen and medications are not always available. Third, preventive immunizations (e.g., for hepatitis) are not routinely provided to health workers without cost. Although PEP is provided adequately to health workers, it is not necessarily provided to members of the public who might be exposed to the virus through caring for an HIV positive person. Finally, there is lack of coordination in using the available resources. A significant example is the lack of transport for delivery of blood samples to regional laboratories.

### 3.2 Issues of affordability

#### 3.2.1 Poverty is an over-riding risk factor in HIV/AIDS and GBV

Rural incomes are low and provide only marginal resources for health care or for maintaining health. However, the bureaucracy required to supplement rural incomes reflects an interaction between affordability and availability issues:

*I think more funds need to be allocated for them so they'll be able to buy enough formula for the babies and immune boosters for the HIV patients. There needs to be enough funds for them, food like porridge, beans...foods that have protein....We have just one social worker, and it's hard for our HIV patients to access disability grants, and the orphans too, you know getting these grants take a long time.*

Volunteers in the community who participate in essential home care activities find that the costs are too high:

*When this thing started home based carers used to love their job but now they do not get paid and they no longer like it, these people used to help the pensioners a lot but now do not because there is no pay.*

### 3.3 Issues of acceptability

#### 3.3.1 Complex health care concepts and rural people

In environments of socially mediated disease, there is often a tension between public health protocols and community knowledge and priorities. In this study area, clinical criteria for HIV/AIDS treatment occasionally conflict with community understandings of the disease and with their readiness to act:

*Why it is necessary for a person to have an ID for a CD4 count, meaning without an ID you cannot check CD4? Since people need to start treatment when their CD4 count is less than 200, you get people that come in very sick but they can't attend the sessions.*

Similarly, ART compliance is more complicated for rural patients living at home:

*Maybe if they were like other pills and were being taken in the morning, midday, and night without specific times, it would make life easier especially those who are not educated. It would be so much better if the government could change the policy on taking ARVs, and not have a specific time.*

Rural persons are among the last to learn about treatment complexities, or contradictions between earlier medical advice and current practice. For example, breastfeeding had been strongly promoted in rural areas in the past. Then it was not recommended for HIV positive mothers. Similarly, modern methods of birth control can lead to increased risks of HIV infection:

*The rate of HIV would go down if the prevention methods used (Depo-provera), were to be reduced, because you find that people don't want to use condoms.*

Communication of complex health care concepts to rural people can be hindered by the mandate for training new professionals, illustrating the link between acceptability and availability of professional care:

*That's partially medicine. It's got a history of using funny abbreviations that nobody understands but it doesn't improve communication with people... But within the hospital, if you can't have clear communication between all the different health professions and patients, how can we expect the patients to disclose to their partners or families?*

At the same time, language differences between Zulu, Xhosa and English-speaking staff and patients limit effectiveness:

*We are all from different cultures, backgrounds and communication is via translators and it can be difficult. You notice a huge shift in thought and a shift in the doctor/patient relationship as a result of that.*

### 3.3.2 Appropriate social care

Counseling is considered to be a lynch pin in HIV/AIDS and GBV social care. It is an evolving practice that originated in the West and is a common response to post-traumatic stress disorder. In rural South Africa, confidential counseling is increasingly intended to minimize the risks of HIV transmission, to prepare people for medical and social consequences of the disease and to increase treatment compliance. However, counseling may not be viewed in the same way by rural people themselves:

*Our people do not understand the idea behind the concept of counseling. Even when you explain it to them they don't see the benefit of going there. People do not see how their problems can be solved by just talking.*

Community based volunteers for public education, support or home care are often an essential adjunct in integrated HIV/AIDS care. It is rare for adult men or younger women to volunteer, however, as they are usually pre-occupied with wage labor and subsistence activities. In the rural area, the HIV/AIDS volunteers are often older women or unemployed youth, that is, groups having lower community status. Such secondary status and varying concepts of privacy can affect the effectiveness of these volunteers and their acceptance by the community, as noted by one volunteer:

*The problem is that we wouldn't be able to tell the community members what to do...they will say we think we are better. People who do counseling are those that you are close to, you come from the same neighbourhood, so it becomes hard to open up to them; especially if the families are not on good speaking terms. You go and share your story and the counselor will share it with everyone she knows, those are the reasons we fear going for counseling. People who do counseling are not well trained.*

### 3.3.3 Acceptability of health care in the context of violence

Rural communities, in turn, may not be supportive of women who experience violence. Fear of stigma and rejection by partners, family and community members inhibit women from disclosing rape to others and seeking out health care. Lack of knowledge of the risk of contracting HIV and other sexually transmitted infections (STIs) through rape means women do not necessarily consider health care an urgent priority following sexual assault:

*She will not go to the police station because she might be afraid that her neighbours will laugh at her.... I think that she wouldn't go. Before a woman can go for medical help she has to tell certain people. If she does not want her rape ordeal to be known in the area, she can just let it slip. It is difficult for women to go to hospital without telling their mothers first. Moreover, if the raped woman lives with her partner and has not told him about the rape, it would be impossible to seek help. Also, not all women know the dangers inherent in rape. Some forget that the long term effects of rape can be catastrophic (i.e., contracting HIV/AIDS).*

Even violence towards young children elicits contradictory responses. On the one hand, there is a feeling that child rape should be hidden to maintain a girl's reputation for future marriage. At the same time, children are considered to be especially vulnerable to the psychological consequences of rape, particularly stranger rape, and are in need of counseling. Women's susceptibility to GBV and HIV/AIDS due to poverty is clear:

*Look, you know, I'm unemployed. I'm the one without a job and my boyfriend is paying for me too, for my drugs and I must' absorb' a lot.*

Even with a broad understanding of GBV-HIV links and their effects on communities, rural community women often have more immediate priorities than HIV testing and care:

*So hunger is first, violence and a fear of violence is second, generalized poverty is third, ("How am I even going to get to the clinic to get care? I don't have bus fare.") and then fourthly HIV. So*

*sometimes people behave in a risky way because they have to deal with the first and second need and the third need. ("HIV will kill me six years from now, but hunger will kill me in a short while from now.")*

Ironically, in the context of a conservative rural health care environment, gender violence may be viewed as a legitimating pre-condition for a woman to get prompt sexual health care. Exposure to HIV as a result of violence is more accepted in a clinical setting than is exposure due to consensual unsafe sex, which is often considered by health care staff to be preventable.

### **3.3.4 Poorly integrated care for HIV/AIDS and GBV**

In this locale, there is a marked inability to integrate social-psychological, medical and legal processes for HIV/AIDS and GBV care. The rural communities are used to their traditional laws and have poor knowledge of the formal systems for addressing GBV:

*The people from the 'bundus' (olden days) ... most of them don't even know that they must report. The ones that are not informed don't know what to do, especially those from rural areas.*

Police have little experience or sensitivity-training when it comes to dealing with interpersonal issues that are considered to be private matters:

*Police officers will show up at a school and say "I have come here to see the rape child" in a big loud voice so that everyone will know, so that is very poor sensitivity. It's just another crime which I think needs to be investigated.*

The medico-legal system in rural South Africa faces enormous capacity and coordination challenges, both in terms of fulfilling women's rights to adequate post-sexual assault care, and bringing perpetrators of rape to justice:

*There is definitely a problem with logistics though and follow up of these rape cases.... With the junior doctor, the counseling is good, but who will take the specimens? It's the junior doctor, who by the way doesn't know how to do it properly. And then two years later the magistrate throws it out because the examining doctor is now in Canada, and that's it.*

Overall, the rural context of HIV/AIDS and GBV amplifies the impact of availability, affordability and acceptability barriers to health system access:

*Post-prophylactics in this society is a tragedy because women are raped routinely in this country and they rape very violently and they rape the people who are at the highest possible risk for HIV and there isn't a way that a woman can rush somewhere to get access to PEP. It doesn't exist. If you had money, and you had understanding, you could rush to a pharmacist. You could get a script there, pay for it and pay for prophylactics and start your treatment. But if you didn't have knowledge and you didn't have money, there absolutely isn't a way for you to get PEP.*

Many respondents suggest that a local rape crisis centre is the solution.

## **4. Discussion**

Adequate access to health services can be conceptualized as the fit between population health needs and health system resources. Health needs are multi-dimensional and multi-causal, and encompass environmental, physical, psychological, economic and political agents. Consequently, to meet these needs, the development of health system resources must go beyond improving financial and human capacities, and also address suitable socio-cultural-political conditions, operational plans and understandings of professional health care from community perspectives. These elements are particularly important for preventive health care in situations of GBV and HIV/AIDS.

While the access framework used in this paper is useful for categorization of different dimensions of access, there is also a need for exposure of underlying mechanisms that contribute to these barriers. Three major mechanisms affecting access to HIV/AIDS and GBV services in the KwaZulu-Natal rural health care system may be posed from this study. First, due to many years of isolation during the apartheid era, the health professions maintained many traditional features. They were less influenced by broader paradigmatic and practice shifts occurring in health systems in other parts of the world. There continues to be considerable role differentiation and a clear medical hierarchy in South Africa. At best, the health professions are just emerging from a model of health that minimizes a social or community perspective on causes or solutions for health problems. Such medical elitism leads to hierarchies of treatment modalities, for example, an overdependence on post-infection testing and pharmaceutical treatments over the prevention and promotion of healthy social environments. Second and third tier health workers (nurses and VCT counselors) expect full health services (e.g., PEP) for themselves, yet there is not an effective system in place to similarly protect or treat community members. Individual social work professionals are viewed as primarily responsible for managing the consequences of gender based violence, but are restricted to working in clinical settings and are rarely exposed to community conditions that underlie such violence. Overall, traditional power differentials continue to separate health professionals from each other and from the communities they serve. Those who work in areas that carry elements of cultural stigma or shame (GBV or HIV), and more generally, in counseling, prevention or palliative roles (as opposed to curative), experience lower status and professional devaluation. These power dynamics, combined with overwork and lack of resources, is leading to ever-increasing burn-out among those providing GBV and HIV/AIDS related care. This situation is not unique to South Africa and has been recognized by the World Health Organization in its Integrated Management of Adult and Adolescent Illness model that promotes task shifting from doctors to nurses and from nurses to community health workers [World Health Organization, 2004].

Second, there is considerable stereotyping of rural and poorly educated populations. Gender based violence victims may be viewed by health staff as being in primitive social relationships that condone male violence as normative. The female victim is often seen as sharing responsibility since she has stayed in an abusive relationship. Alternately, women are viewed as being victims of an accepted rural tradition of rape. There is little understanding of a middle dynamic that is neither collusive nor coercive, but relational. Generally misunderstood is the victim's deeply ingrained role in 'absorbing' her male partner's anger, frustrations, and violent reactions to persistent social and economic deprivation.

Third, rural South African society presents differing perspectives on appropriate hierarchies for action related to HIV/AIDS and gender based violence. The health care worker considers the proper order of priority to be actions within their scope of practice and experience, that is, HIV/AIDS testing, treatment and prevention education. Poverty alleviation and addressing the social causes of violence are given much lower priority by health workers as these are more distal in the causal chain. Community members, however, consider hunger relief and safety from violence as their most immediate priorities, without which, longer term poverty relief and HIV/AIDS treatment implementation become meaningless. From both perspectives, within a limited resource environment, only the

higher priorities are addressed. Consequently, there is a lack of capacity to address population level solutions to causal indicators and determinants of HIV/AIDS and GBV. For example, there is a lack of understanding of concepts such as community viral load and infectiousness, community safety mechanisms and practices, adaptation of community social standards, and the importance of support groups and counseling in a socially-mediated epidemic.

In this study, the relationship between the formal health structures and traditional ones, and between the government legal structures and the customary ones, were porous. This situation compromises access to the full spectrum of care that can be informed by a social understanding of rural communities and their realities, leaving the great possibility that many patients will fall between the cracks. There is a significant absence of collaboration between traditional and modern structures, which creates problems for access into the health care system and access to the police and magistrates. More positively, health care workers themselves identify the need for help in addressing the alleviation of basic risk factors for AIDS such as poverty, unemployment and poor education in rural settings. For them, training about safe water supply and nutrition were sometimes viewed as more important than specific training in HIV/AIDS management.

These findings suggest that an institution building approach to interventions would be useful in addressing HIV/AIDS and GBV issues in rural areas. Jan et al. [2008] suggest that such an institutional perspective would address individual (agency), household (power relations, communication, well-being), community (networks, norms, relationships and responses) and organizational (resources, coordination) levels. These interventions might include formal legislation, specifically for rural and under-serviced areas, concerning resource allocation to health services and the regulation of professionals. These interventions might also include more training regarding social customs and cultural norms that shape rural sexual practices and traditional health care.

Petersen [1999] suggests that a 'reorientation programme' in the new South Africa is necessary to address neglected issues, such as mental health.. Such reorientation initiatives could also be applied to the context of HIV/AIDS and GBV to address the following:

- the role and functions of the primary health care nurse within a district HIV/AIDS system;
- problems with a narrow biomedical approach to identify and manage HIV/AIDS problems at the primary level of care;
- nursing ideology and its sub-ordination to the medical system;
- culturally congruent care;
- a framework for assessing problems from the perspective of comprehensive care; and
- skills for comprehensive care, including the socio-medical relationship with community members.

Perhaps of highest priority is the need to conceptualize the institutional role of the community in HIV/AIDS and GBV services. According to the originator of the institutionalist approach [Tool, 1977], as well as others who have used it in the health sector [Jan, 1998], the social value of any intervention should be judged in terms of how well an action contributes to the 're-creation of community', as opposed to simple incremental health gains for individuals. Thus, interventions should also have ongoing value to the community, in this case by affecting the capacity of the rural community to transform itself to a new context.

Concrete examples of such transformation are already being achieved in urban South Africa with regard to HIV/AIDS services. These include the establishment of anonymous, rapid VCT sites that are crucial for HIV/AIDS prevention and treatment programs [Joint Monitoring Committee on the Improvement of the Quality of Life and Status of Women, 2001a]. Also, Senderowitz [1999] identified several physical and operational characteristics that transform health facilities to being “youth-friendly”. These include the creation of a separate space and special times for adolescent clients; hours that are convenient for school-going youth; the establishment of clinics in locations convenient for youth; adequate space and sufficient privacy in clinics; and comfortable, youth-oriented surroundings (posters, audio-visual material on youth issues, avoid overly “sanitized” décor). Finally, the Community Agency for Social Enquiry [Community Agency for Social Enquiry, 2001] determined through its survey of urban HIV/AIDS service organizations that government could establish or fund HIV/AIDS information/resource drop-in centres to take the burden off clinics, develop programs focusing on AIDS discrimination and stigma, and develop clear policy guidelines that standardize training for health care workers. Similar recommendations could be adapted for the South African rural environment.

Urban South Africa is now making advancements in terms of providing comprehensive GBV services, again drawing on an integrated and collaborative approach to care. Many urban areas of South Africa have medico-legal clinics which have evolved into “one-stop clinics”. Also called Thutheleza Centres (TTCs), these clinics provide medical treatment, police services, HIV and PEP counseling, PEP and STI prophylaxes and emergency contraceptives, and referrals to NGOs and voluntary organizations for longer-term counseling, all under one roof. TTCs are considered to be “best practices” in post-rape care. However, there is a major service gap in rural areas, where TTCs have yet to be rolled out fully. As respondents for this study indicated, such centres would be invaluable in their communities given existing service gaps.

Other major programmatic shifts in the sexual assault arena in recent years include the emergence of Community Forums (some are called “community policing forums” or “medico-legal forums”). In the absence of TTCs, communities have organized regular meetings between governmental and non-governmental service providers (including police stations, health clinics, gender violence and women’s NGOs, children’s services, Department of Welfare units, and other community organizations). These meetings provide a forum for information-sharing, the development of a comprehensive referral system, identification of problems that still need to be addressed to meet the needs of the community, and the development of strategies (task delegation as well as collaborative activities) to deal with the problems identified. Intersectoral collaboration has become a goal in the area of GBV in informal settlement and township communities, pointing to the beginnings of transformation of traditional hierarchies and structures of service delivery in urban areas.

Both TTCs and Community Forums are good examples of actions contributing to the “re-creation of community”. With proper adaptation to the rural context, the replication of similar structures and/or forums in rural areas could improve community capacity to facilitate improved access (in terms of availability, affordability, and acceptability) to GBV and HIV/AIDS services. They would contribute to the breaking down of traditional power hierarchies and the division of labour. They might also encourage health and community

professionals at all levels to see their work as complementary and mutually beneficial, and to view service integration and collaboration as a key strategy for delivering quality and accessible GBV and HIV/AIDS services in a resource-scarce environment.

## 5. Conclusions

The main problems related to availability, affordability and acceptability of HIV/AIDS and GBV services in this rural south African setting included many *material* limitations: variations in optimal settings for public health care; limitations in quantity and scope of practice of professional personnel; lack of physical space, resources and confidentiality; and poverty as an over-riding risk factor in HIV/AIDS and GBV. Similarly, *operational* limitations included the complexity of modern health care concepts for rural people; lack of appropriate models for rural social care; acceptability of health care in the context of violence; and poorly integrated care for HIV/AIDS and GBV. These problems may arise from health professions' maintenance of traditional features, stereotypes of rural and poorly educated populations, and differing perspectives on appropriate action related to HIV/AIDS and gender based violence. Interventions for complex social health issues such as HIV/AIDS and GBV should be judged in terms of how well they contribute to the 're-creation of community' through addressing both material and operational limitations of public health systems, as opposed to simple incremental health gains for individuals.

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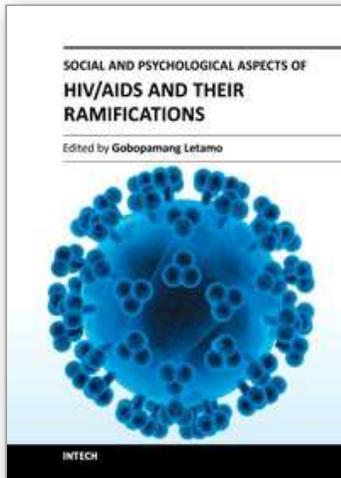
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This book has assembled an array of chapters on the social and psychosocial aspects of HIV/AIDS and their impact on HIV/AIDS and related behaviours. The book addresses key areas of HIV and AIDS, including, but not in any way limited to, care-seeking behaviour, adherence, access, psychosocial needs and support services, discrimination and the impact the epidemic has on various sectors of the economy. The book has seventeen chapters; seven chapters deal with social aspects of HIV/AIDS, four with psychosocial aspects of HIV/AIDS, and the remaining six chapters with the impact of social and psychosocial factors on HIV/AIDS and related behaviours. The book is an essential reading for academics, students and other people interested in the field of HIV and AIDS.

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