

The role of a formal treatment support partnership between community based organisations (CBO) and a company in levels of adherence of employees on anti-retroviral treatment

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DECLARATION

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ABSTRACT

The advent of antiretroviral therapy (ART), especially highly active antiretroviral therapy (HAART), has brought about more than just a gleamer of hope, but a reasonable degree of hope and objective reality that antiretroviral therapy can prevent (for a reasonable period of time in some situations) progression of HIV to AIDS. This positive development, has not just come without its own fair share of challenges. One of the major challenges of ART, is that once a person starts using them, there is no choice of either, one may decide to use them for the short term and just fill better and stop using them, or use them for a reasonably longer period of time and then take some breaks between certain intervals. ART is meant to be taken for an individual's life time, which may at certain circumstances and mostly be measured in terms of decades, and this in its own is a major problem, both financially and healthwise.

Taking into consideration the foregoing scenario, the researcher undertook to conduct a descriptive quantitative study. It was assumed that companies have HIV/AIDS workplace policies, which allows and encourage them to take care for their employees health care need, and in so doing, they may enter into partnerships, with relevant stakeholders like Community Based Organisations (CBOs) and Primary Health Care Institutions (PHCIs) in particular. The envisaged partnership between these key stakeholders, was then seen as an important factor in increasing or maintaining higher levels of adherence in employees on Antiretroviral (ART) treatment. Therefore, the stated research hypothesis was: **A formal treatment support partnership between community based organisation (CBO) and a company increase levels of adherence in employees on anti-retroviral treatment.**

The study found that, employees on treatment understand the reason why they were offered treatment uptake support, which may mean that, they understand the importance of having treatment support and having access to such in order to maintain higher levels of adherence.

The study further found that the majority of participants never missed their treatment doses, whilst having a treatment uptake supporter. In a way this tells that, patients with treatment uptake support, is highly likely to maintain higher levels of adherence than the patient who does not have such support.

The study also found that, a majority of participants showed knowledge, that their HIV/AIDS workplace policies have a clause which allow and encourage multi-sectoral partnerships for HIV/AIDS management. This study also found that, a critical number of participants strongly agreed that, indeed, it will be beneficial to have an established partnership between the Company, the Primary Health Care Institution (PHCI) and a CBO. An overwhelming number of participants, strongly supported or agreed to the notion that, efforts should be made to establish formal partnerships amongst relevant stakeholders.

The major implication for this study is that, there is a need for future in-depth research to be conducted on this subject in order to reach necessary conclusions on the need as well as viable means of implementing a multi-sectoral approach (partnership) to HIV/AIDS management in the world of work and beyond.

OPSOMMING

Die doel van hierdie studie was om te bepaal of 'n formele behandelingsprogram, ondersteun deur die organisasie) bydra daartoe dat pasiënte op antiretrovirale medikasie hulle medikasie volgens die voorskrifte en voorgeskrewe intervalle gebruik.

Vraelyste is ontwikkel en pasiënte op bestaande programme is vir die studie gebruik.

Daar is bevind dat pasiënte op antiretrovirale programme die belangrikheid verstaan dat hulle getrou hulle medikasie moet neem en dat hulle geneig is om dit wel te doen, veral as die medikasie deur hulle onderskeie organisasies verskaf word. Dit word trouens bevind dat die meerderheid van die proefpersone byna nooit vergeet het om hulle medikasie te neem nie.

Die hoofbevinding van die studie is dat dit baie belangrik is dat daar 'n formele ondersteuningstruktuur tussen die gemeenskapstruktuur (wat medikasie voorsien) en die onderneming wat die behandeling borg, moet bestaan ten einde optimale effektiwiteit te verseker.

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CHAPTER 1 INTRODUCTION

Antiretroviral therapy (ART) has transformed HIV infection into a treatable, chronic condition. However the need to continue treatment for decades rather than years, calls for long-term perspective of ART. Adherence to the regimen is essential for successful treatment and sustained viral control (Nischal, Khopkar & Saple, 2005, pp. 316).

1.1. Research Objectives

- To assess knowledge of existence of HIV/AIDS workplace policy among employees from local factories.
- Assess the role played by people living with HIV/AIDS in implementing policy provisions.
- To see if there is a clause that encourage establishment of partnerships in workplace HIV/AIDS management.
- To assess the level of helpfulness by a CBO in treatment support and adherence.
- To assess the levels of support for HIV/AIDS management partnerships among employees.

As a matter of background to the question at hand, this study will at first present findings from the relevant literature which will form part of literature review, the second part after the introduction. This (literature review) section takes a look into a shared decision-making in a partnership setting, as proposed by the National Prescribing Centre in the United Kingdom. This is done by looking into a particular approach called competency framework for decision-making for achieving concordance in terms of medicines prescription by healthcare professionals and taking by patients in order to achieve adherence. This section forms the basis for argument for partnerships.

The third part seeks to operationally define the research problem, and forward the hypothesis. It also looks into issues of research design, sample design, ethical considerations for the study, measuring instrument, as well as the

proposed statistical analysis. The fourth part will be a thorough analysis of the study results. And the fifth part will be the conclusion and recommendations.

CHAPTER 2 LITERATURE REVIEW

2.1 A competency framework for shared decision-making

Having discussed the concept of partnership, it should be now then linked to our main object of study here, that of forging and sustaining partnerships for the main intent of achieving adherence in medicines taking patients. A document published by National Prescribing Centre (NPC) in partnership with Keele University, in the United Kingdom (UK), entitled A Competency Framework for Shared Decision-making (2007), will be used as a basis for our discussion here.

At first, this document will start by taking a quick look into three main concepts that underpin our discussion here, and these are compliance, adherence and concordance. The term non-compliance and non-adherence are used by researchers and clinicians to describe the many ways in which patients for one reason or another, depart from the regimen of medicine taking that their doctors recommend (NPC, 2007). It may be safely conclude that, within this, context a direct opposite from this medicine behavior by patients results in compliance and thus adherence.

2.2. Compliance

NPC (2007) further assert that, compliance measures patient behaviour: the extent to which patients take medicines according to the prescribed instructions. However, concordance measures a two-way consultation process: shared decision making about medicines between a healthcare professional and a patient, based on partnership, where the patient's expertise and beliefs are fully valued (NPC, 2007).

2.3. Concordance

On the otherhand, (NPC, 2007) define concordance or shared decision-making as a way for health care practitioners and patients to agree about medicines

together. They note that this approach looks for an alliance to be struck by prescribers and patients, an agreement on how medicines will be used to solve the problem under discussion, after both of them have had their say. In some cases that may mean a patient chooses to place all responsibility for treatment choices with their healthcare professional (NPC, 2007).

2.4. Adherence

The World Health Organisation (2003) defines adherence as the extent to which a person's behaviour – taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider. Osterberg and Balschke (2005) note that the term adherence has become preferred to the term compliance because compliance implies the patient is passively following orders, adherence can imply a treatment plan agreed by both patient and physician (WHO, 2003; Osterberg & Balschke, 2005, as quoted in

<http://mednet3.who.int/EMI/expcom/CHILDREN/items/ADHERENCE.pdf>).

2.5. A Challenge of Non-Adherence

Johnson and Witt (2007), interestingly note that patients in developed and developing countries face common barriers to adherence like fear of disclosure, forgetfulness, difficult regimens, high pill burden, suspicions about treatment, concomitant substance abuse, work and family responsibilities, falling asleep, and access to medication, however, in resource-poor countries, access to medication is further challenged through patient's socio-economic conditions and the availability of medication (Johnson & Witt, 2007: 3).

2.5.1. Remedial Actions for Adherence

Johnson and Witt (2007), also highlight a number of interventions used in high-income and resource-constrained settings. They note that there is a number of interventions being carried out successfully primarily in high-income settings, they include interventions which may be summarily classified in the following categories:

- Directly observed therapy also known as DOT (including Modified DOT and directly Administered Antiretroviral Therapy [DAART])
- Social support
- Knowledge and counselling
- Financial incentives
- Technological devices
- Additional effective interventions combined elements of each of the categories outlined above, and all these interventions could be replicated in resource-constrained settings.

Directly observed therapy with antiretrovirals (DOT-ART/DAART) appear to show promise as an intervention to improve adherence to therapy in HIV. However, one of the major difficulties is that, unlike tuberculosis where DOTS is standard practice in many settings, antiretroviral therapy is lifelong, rather than time limited as occurs with tuberculosis (TB),

(<http://mednet3.who.int/EMI/expcom/CHILDREN/items/ADHERENCE.pdf>)

. This article also note that there is evidence that both family and community DOT supporters can achieve good treatment outcomes, highlighting the fact that not all care needs to be provided at a health care facility; families and communities have an important role to play. Allowing patients to choose their own treatment supporter can also facilitate supervision that is most appropriate to their daily lives, making therapies easy to include in routine activities has also been identified as an important mechanism to improve adherence

(<http://mednet3.who.int/EMI/expcom/CHILDREN/items/ADHERENCE.pdf>)

. Quite a number of authors on treatment adherence emphasise the fact that there is no single cure for all intervention that is guaranteed to everlastingly improve adherence, however, a single or combination of interventions, can be used depending on a particular setting. It is also noted that funding streams, including donor programs, need to consider integration of adherence support programs into their work to ensure that the large amounts of money spent on medicines is used most effectively to improve health outcome

(<http://mednet3.who.int/EMI/expcom/CHILDREN/items/ADHERENCE.pdf>).

2.6. Lack of Partnerships

In South Africa, it is common knowledge that the private sector even though they may have a well documented HIV/AIDS Workplace Policy, which emphasise closer working relationship between the company and the community within its vicinity, where most of its employees come from, they still find it difficult to work with these communities, especially organised structures operating within the sector of health and welfare, or providing services of Home Community Based Care within these communities.

Even though companies may provide antiretroviral treatment as part of their Workplace HIV/AIDS policy, employees are individuals living within the community. Moreover, people have a tendency to wait till their sero-positive HIV/AIDS status has reach a symptomatic stage of AIDS before they seek help, mostly by then, they have lost strength and can no longer go to work easily and its people within the family and the community who then take responsibility.

2.7. A Case for Shared Decision Making in Medicine Taking

NPC (2007) note that, prescribed medicine is the most common form of medical intervention, accounting for almost 15% of all health. The National Health Services (NHS) in the UK spent £8 billion on medicines in 2005. The NPC publication (2007) further assert that medicine use is also rising: the average person in England received 13.1 prescription items in 2003, a 40% increase over the previous decade (DH, 2004, as quoted in NPC, 2007). It is argued that, it is common knowledge that non-compliance with prescribed medicine prevents many people from getting the most out of medicines. A recent review of the evidence in a study conducted by Carter and Taylor in 2003, concluded that compliance overall is approximately 50% but varies across different medication regimens, different illnesses and different treatment settings (Carter and Taylor, 2003, as quoted in NPC, 2007).

2.7.1. The Patient As A Primary Decision Maker

NPC (2007) further highlight the fact that, the concordance approach recognises that the decision whether to take a medicine or not ultimately lies with the patient. A successful prescribing process will be an agreement that builds on the experiences, beliefs and wishes of the patients to decide whether, when, how and why to take medicines. This agreement may not always be easy to reach, but without exploring and addressing these issues patients may not be able to get full benefit from the diagnosis and treatment of the illness (NPC:2007).

It is also highlighted that, it is important to note that concordance is not a new politically correct way of referring to compliance. Compliance measures patient behaviour: the extent to which patients take medicines according to the prescribed instructions. However, concordance measures a two-way consultation process: shared decision-making about medicines between a healthcare professional and a patient, based on partnership, where the patient's expertise and beliefs are fully valued (NPC:2007).

For the above-noted scenario to successfully take place, it has to happen within a particular predetermined setting, thus, it is recommended that we certain competencies should be taken into consideration, and therefore a particular competency framework is suggested as a way to go. A competency framework or competency is defined as a quality or characteristic of a person which is related to effective or superior performance. Competencies can be described as a combination of knowledge, skills, and attitudes. Competencies help individuals (and their managers) look at how they do their jobs (NPC:2007).

2.7.2. A Competency Decision Making in Practice

A competency framework is a collection of those competencies thought to be central to effective performance. Development of competencies should help individuals to continually improve their performance and to work more effectively (NPC:2007).

This document by NPC (2007) suggest that competency frameworks are extremely flexible tools which can be used to support a wide range of activities. And the these may include: helping to ensure that individual healthcare professional possess all the relevant expertise, helping individuals and their employers / managers, identify gaps in knowledge and skills and therefore identifying ongoing training and development needs, informing the commissioning, development and provision of appropriate education and training programmes, and supporting individual continuing education and professional development (NPC:2007).

NPC (2007) highlights some of the most key features of the competency framework, as they argue that, this framework can be used by all healthcare professionals involved in engaging patients in shared decision-making about their medicines regardless of professional background or employing organisation, some of the statements supporting the competencies required by healthcare professionals, initially, using this framework effectively will take time. How each of the statements supporting the competencies applies to an individual, or a team, must be considered, when considering these statments, beware that some are more complex than others, therefore the reader is expected to spend more time on the more complex statements (NPC:2007).

This particular framework is also expected to take some structural form, which is here highlighted as containing eight competencies, which include among other things, the eight competencies, which are listening, communicating, context, knowledge, understanding, exploring, deciding, monitoring (NPC:2007). It is also noted that each of these competencies has: an overarching statement which gives a general indication of what the competency is about, a number of statements which are a guide to how individuals who have that competency will be behaving in practice (NPC:2007). The suggested framework can be graphically illustrated in the following table.

Table: 2.1: Competency framework for shared decision-making with patients: summary (adapted from NPC, 2007)

BUILDING A PARTNERSHIP			
<p>① LISTENING</p> <p>Listens actively to patient</p>	<p>② COMMUNICATION</p> <p>Helps the patient to interpret information in a way that is meaningful to them</p>		
MANAGING A SHARED CONSULTATION			
<p>③ CONTEXT</p> <p>With the patient defines and agrees the purpose of consultation</p>	<p>④ KNOWLEDGE</p> <p>Has up-to-date knowledge of area of practice and wider health services</p>		
SHARING A DECISION			
<p>⑤ UNDERSTANDING</p> <p>Recognises that the patient is an individual</p>	<p>⑥ EXPLORING</p> <p>Discuss illness and treatment options, including no treatment</p>	<p>⑦ DECIDING</p> <p>Decides with the patient the best management strategy</p>	<p>⑧ MONITORING</p> <p>Agrees with the patient what happens next</p>

2.8. The Concept of Partnerships and Collaborations

Rosenau (2000) as quoted in Marra (2004) define partnership, as the formation of cooperative relationships between government, profit-making firms, and non-profit private organizations to fulfill a policy function. Working together Rosenau highlight the fact that they seek to meet the

objectives of each while, hopefully, performing better than either one acting alone (Marra, 2004: 152).

McDonald (1999) define partnership as a relationship, which goes beyond the mind and the intellect, and enters the heart and the emotions, it requires a sharing of visions, dreams and hopes, fears, aspirations and frustrations, among members of the project constituencies (Marsden & Oakley, 1990, as quoted in McDonald, 1999:166).

Jolley, Lawless and Hurley (2008), argues that, The Alma Ata Declaration states that, primary health care involves in addition to the health sector, all related sectors and demands the co-ordinated, efforts of all those sectors. Collaborative partnerships therefore form a key component of primary health care and health promotion practice and should be included in evaluation (Jolley et al., 2008, p 154).

Jolly et al. (2008) asserts that, while a widely agreed definition of what makes a partnership is hard to find the following seems appropriate to the primary, health care context: A group of organisations and individuals who share some interests and are working toward one or more common goals beyond the reach of any one organisation or individual. Furthermore, a partnership, has been described as: a joint working arrangement where partners are otherwise independent bodies co-operating to achieve a common goal; this may involve the creation of new organisational structures or processes to plan and implement a joint program as well as sharing relevant information, risks and rewards (Jolley et al., 2008, p 154).

2.8.1. Reasons for Collaboration

Collaboration is done for a number of reasons including: application of innovative solutions to often difficult or complex problems, and opportunities for the problem to be viewed by people from various perspectives and innovative solutions offered beyond what an individual person or organisation could achieve (Jolley et al., 2008, p 154).

These authors, further assert, that other benefits include increasing knowledge of partners' activities and, in some cases, providing economic efficiencies and avoiding the duplication of effort. Partners can contribute their own resources, in-kind and financial, to allow a program greater depth or reach than might be provided through collaboration along with a greater potential for impact both at the community, level and in promotion of the program to a wider audience (Jolly et al., 2008, p 154).

Rein & Scott (2009) highlight the fact that during the last decade, a partnership boom has occurred. Partnership has been described as: the development approach of our time, the mantra for the new millennium, and a new and innovative type of environmental governance (Zadek et al., 2001, p. 23, Kjaer, 2003 p. 13, Tennyson, 1998, p 3, Witte et al., 2003, p 2, as quoted in Rein & Scott, 2009, p 79). These two authors, further note that, from its endorsement as an approach towards achieving environmental and developmental change at the 1992 Rio Earth Summit, (Tennyson, 1998, p 4, 2004, p 3), partnership has been promoted by large number of corporations, governments, international agencies, and non-governmental organisations as the most effective way of working towards the achievement of sustainable development. The authors further assert, that according to Zadek (2003, p 9), it is a movement which came of age 19 years after Rio, at the 2002 World Summit for Sustainable Development in Johannesburg, where Kofi Annan declared that:

The Summit represents a major leap forward in the development of partnerships with the UN, governments, business and civil society coming together to increase the pool of resources to tackle global problems on a global scale (Rein & Stott, 2009, p 79).

2.9. The Context for Partnerships and Collaborations

Rein & Stott (2009) interestingly note that there has been a tendency within the literature on partnerships to portray these forms of collaboration as a kind of magic bullet capable of providing solutions to diverse development

problems across a variety of settings through win-win situations where all stakeholders benefit.

Jolley et al. (2008) argues that according to the World Health Organisation, primary health care will: promote maximum community and individual self-reliance and participation on the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develop through appropriate education the abilities of communities to participate. Community participation in the planning, implementation and evaluation of services is a key component, of the primary health care approach (Jolley et al. 2008, p 153).

As noted above, these authors, also argue that both, the literature and health services use a variety of terms to describe communities and community participation. They note, that the term community participation is used in their piece of writing to denote the fact that, and include participation of patients, clients, consumers, community representatives, community members and citizens. Other terms for community participation include community engagement, community partnerships and community involvement (Jolley et al. 2008, p 153).

Community participation has been defined as, the involvement of consumers in the development of health services. This can include involvement in policy development, strategic planning, service planning, service delivery and evaluation and monitoring (Jolley et al., 2008, p 153).

Contextually, participation can occur at any or all stages of health service decision making and should go beyond the standard satisfaction survey. The term of ladder of participation is used and describes the levels of community participation. It is argued that, these levels are not mutually exclusive and participation may occur at several levels simultaneously (Jolley et al., 2008, p 153). It is also argued that more recently, participation has been suggested as a complimentary continuum rather than a ladder, with organisation and community capacity as key factors in facilitating community participation. It is also, conclusively noted that, the ladder, however, does provide an

opportunity for services to think about their approach to participation, their goals and what is achievable. The desired level of participation will depend on the particular program or service (Jolley, et al., 2008, p 153).

2.10. The Need for Partnerships

Billet, Ovens, Clemens, and Seddon (2007), note that despite a lack of applied research, social partnerships are increasingly being adopted by both government and non-government agencies to meet localised needs, especially in education and other fields (health care in our case). They argue that earlier work identified partnerships arising from community concerns, governmental enactment and negotiation between government agencies.

However, across these distinct kinds of social partnerships, the partnership work that was central to their operation was particularly relevant (Billet et al., 2007: 637). In the study, they report on in their paper cited here, these authors argue that , researchers engage with ten long standing social partnerships to elicit, synthesise and verify the principles and practices underpinning their work. They note that, the principles and practices that are proposed as most likely to assist the effective formation, development and transformation of social partnerships overtime comprise building and maintaining: (i) shared goals; (ii) relations with partners; (iii) capacity for partnership work; (iv) governance and leadership; and (v) trust and trustworthiness (Billet et al. 2007: 637). On these basis, they conclude that these principles stand as ideals and goals to guide the development and continuity of social partnerships that can support important (health)educational initiatives, and provide bases for evaluating partnership work (Billet et al. 2007: 637).

Sanginga, Chitsike, Njuki, Kaaria and Kanzikwera (2007) in their research paper on research conducted on partnerships in the agricultural sector, notes that stakeholder participation and multi-stakeholder partnerships form key cornerstones of and strategic approaches to the new paradigms of integrated Agricultural Research for Development (IAR4D) and Agricultural Innovation Systems (AIS) that aim to improve the relevance, efficiency, equity,

ownership, sustainability and impacts of agricultural and natural resources management technologies and innovations (Johnson et al., 2003; Michelsen, 2003; Sayer and Campbell, 2001, as quoted in Sanginga et al., 2007). Even though these practises are observed from the agricultural sector, they may be relevantly drawn and benchmarked for implementation in the health care sector.

As is analogous with the health care sector, Sanginga et al., (2007), further argue that, the new paradigms call for change in the way agricultural research is being conducted (Hall et al., 2001; Sayer and Campbell, 2001, as quoted in Sanginga et al, 2007). The innovation system theory sees agricultural research as a complex process produced by a network of actors and stakeholders that co-evolve with the technologies and processes they generate (Sanginga et al., 2007). They further argue that a key feature of the innovation system theory is that innovations are often complex systems whereby networks of research, entrepreneurial, and other actors interact to produce and use new knowledge (Douthwaite et al., 2004; Hall et al., 2001, as quoted in Snginga et al., 2007).

Central to this theory (Innovation Systems Theory) is the concept of partnerships, as farmers and rural communities are increasingly faced with complex problems which cross traditional boundaries and mandates of agricultural research and development, (Hall et al., 2004, as quoted in Sanginga, et al., 2007). It can be safely argued that this scenario also prevails within the health care sector, especially in the era of HIV/AIDS, whereby multi-sectoral partnerships are forged, between governments, non-governmental agencies/ organisations (NGOs), pharmaceutical companies, research institutions and local communities among others.

Marra (2004) asserts that, over the past decades, international development and donor agencies, including the World Bank, have given prominence to the roles of government agencies, NGOs, education institutions, and private sector organisations in partnering for poverty alleviation, social welfare, education, research and development, organisational capacity building, and the development of civil society. Non governmental organisations are seen as an integral component of civil society and an essential counterweight to state

power, opening up channels of communication and participation, providing training ground for activists (Hulme, 1996, as quoted in Marra, 2004), and ensuring national competitiveness through research and innovation (Hellstrom & Jacob, 1999, as quoted in Marra, 2004). What has been argued here about the role of NGOs' as champions for development and holding together developmental partnerships, can be said to be true with Community Based Organisations (CBOs).

Marra (2004), further argue that, as the state's monopoly over development projects has declined, so bilateral and multilateral organisations have begun to interact with other agents of social change at the local level (Hirschman, 1984, as quoted in Marra, 2004). This author further state that specific funding, such as the so-called social funds, technical assistance, training, and other types of services in kind have become the typical instruments used by these organisations for grassroots development (Marra, 2004:152). It is further argued that, in parallel, because of the very transformation of the role of the state in development, NGOs, grassroots organisations CBOs, and universities have begun to proactively seek out partners among the international community of donors to enhance their activities (Marra, 2004:152).

Kinnaman and Bleich (2004), startlingly note that, when Albert Eistein declared that – the problems that exist in the world today cannot be solved by the level of thinking that created them, she further critically expantiate, by noting that solving the critical and imminent problems we confront demands a different level of thinking and behaving (Kinnaman et al., 2004:310). These authors, further conclude by saying that, if collaboration is key, then a critical first step is to develop a clear understanding of it as a strategy , that is to say, what it is, what it costs, what conditions are necessary for it to exist, when is it necessary, and what valued outcome it realistically can generate (Kinnaman et al., 2004: 310).

Table 2.2. Origins and characteristics of partnerships (adapted from, Billett et al, 2007)

Types	Genesis	Goals	Processes
Communit partnership	Concerns problems, issues identified within the community	to secure resources to address issues, problems and concerns, often from agencies Outside the community	Consolidating and making a case and then working with external agencies to secure adequate responses
Enacted partnership	From outside the partnership which is to be the target of the engagement, yet with goals or resources tha the community is interested in engaging with	To secure outcomes aligned to external funding body	Responding to requirements and accountabilities of external partner/sponsor through engaging thecommunity in activies associated with those goals
Negotiated partnership	Need to secure a provision of service or support that necessitate working with partners	To develop effective working relations outside of the organisation that comprises the social partnership	Working with and finding reciprocal goals withpartners

2.11. The Local Context

The document entitled HIV/AIDS Guide for the Mining Sector (2004) highlights the fact that, throughout Southern Africa, the mining sector has been at the forefront of efforts to respond to the HIV/AIDS epidemic. Nowhere is

this more true, than in respect of providing antiretroviral treatment to infected employees (CIDA:2004).

Quoted in this document is a report entitled Mining, Minerals and Sustainable Development (MMSD), which highlights three important points among others, as recommendations for the mining industry to consider when addressing issues of HIV/AIDS namely: to build capacity to deliver community-based interventions by channelling resources into CBOs and NGOs; to allow communities a greater say in the course of interventions; and to provide long term funding. To monitor and analyse HIV/AIDS intervention programme outcomes to develop and improve quantitative understandings of cost benefit relationships. For company stakeholders to continue to take the initiative, but in partnership so as to play a greater role in capacity building and developing best practice (CIDA,2004: 29).

2.12. Evaluating Partnerships

Before one may engage in an effort to try and take a look at the concept of analysing partnerships, it is viewed as of prime importance to start by taking a quick glance at what makes partnerships effective. Jolley et al (2004) argue that conditions that effective partnerships among others include trust and effective communication between partners, mutual benefits derived from the collaboration, clearly defined roles and responsibilities and mutually agreed goals. These authors, further note that a review of partnership measurement tools by the Communities Scotland Group, identified the following factors as critical to the effectiveness of partnerships: presence of a key person/driving force; no one individual or agency is dominant, the process is genuinely collaborative; common vision and clear sense of purpose shared by all; partnership operates in an environment where work is valued, is part of the ethos and no inter-agency rivalry; trust is valued and has been given sufficient time to develop; and working in partnership is seen as productive and enjoyable (Jolley et al., 2004: 154).

Rein and Stott (2009) in their study entitled Working Together, they argue that, few, if any, of the partnerships had regularised evaluation procedures built into their management systems and projects. They further argue that this

reality made it difficult for the partnerships to obtain a sufficiently balanced and integrated set of perspectives on the effectiveness of the partnerships and their projects (Rein and Stott, 2009: 85). They conclude that, in fact, neither the strength nor the weaknesses of the partnerships appeared to have been fully appreciated by partners or intended beneficiaries (Rein and Stott, 2009:85). This scenario also sound true with most of organisational operations for organisations carrying out their activities within the context of partnerships at the community level in South Africa as a developing country.

In the more or less the same voice, Jolley et al., (2008) note that in the wide range of literature on evaluating partnerships, some authors have identified that its complex and context-dependent nature make it very difficult to devise a tool that will fit every partnership in every circumstance. The unpredictable and changing nature of partnerships overtime complicates the task of evaluation as a fixed tool may not detect changes in direction and shifts in relationships (Jolley et al., 2008:154).

Joley et al., (2008) substantiate the foregoing point by citing findings from a review of a study of a partnership assessment tools, which was conducted using the Health Action Zones program in the UK. This review is reported to have highlited the fact that, partnership assessment tools should have three functions, which are reflection on partnership effectiveness; benchmark and/or describe current status; and target strengths and weaknesses for development/ interventions (Jolley et al., 2008:154). Stated here are some of the most basic points to consider, also in evaluating community based partnerships, as in our case in the intentions of this study.

Having put forth the forgoing assertions on the lack of a one size fits all partnerships evaluation tools, McDonald (1999) gives us a sigh of relief as, and as she notes that, there is no shortage of suggestions regarding ways to improve the evaluation of development assistance projects. She substantiates this point by noting that, pleasingly there is a fair degree of consensus about the way in which this should be achieved. She notes that many writers elaborate on the importance of making changes in certain areas, but in a collection of articles based on the proceedings of an international conference

conducted by aid agencies in 1989, Marsden and Oackley provide the most comprehensive coverage of key factors that can assist effective evaluation in this field (McDonald, 1999:166). These authors state these as comprising among other things the need to:

- Ensure participation of stakeholder groups through-out evaluation;
- Address the issues of relevance to stakeholders;
- Look beyond purely assessing the achievement of objectives to include unexpected outcomes;
- Orient the evaluation towards enhancing learning for the entire project community;
- Develop appropriate methodologies that provide relevant, timely and accurate information;
- Build evaluation activities into on-going project activities;
- Use strategies to enhance the capabilities of the project for community to undertake future evaluations;
- Assess the impact of the project within the broader social, political and cultural context;
- Ensure appropriate feedback to all stakeholders throughout the evaluation process

McDonald (1999) further argues that, in order to integrate the above outlined principles into an evaluation, it is necessary for aid and development agencies to cultivate quite different attitudes such as, a fundamental re-alignment of the relationship between donor agency and beneficiary; longer term contact with the project community, redefining the role of the evaluator as a facilitator, mediator and catalyst (Marsden and Oackely, 1990, as quoted in MacDonald, 1999:166). Marsden and Oakely (1990) in MacDonald (1999) suggest several project level indicators that could be reviewed in order to assess whether or not an evaluation has enhanced local capacity and equality in partnership, including: evidence of shared decision making (and) leadership, signs of solidarity and cohesion, commitment to the project , its goals and activities;

improve(d) technical and managerial competence; and capacity for self reflection, critical analysis and action (Marsden and Oakely, 1990, as quoted in Macdonald, 1999:166).

Rein and Stott (2008) conducted a study in Zambia and South Africa, on six cross-sector partnerships. They found that, the *Zambian Business Coalition on HIV/AIDS*, which linked business and NGOs in order to combat the HIV/AIDS pandemic, was the only partnership to have a self-monitoring and evaluation process incorporated into its projects.

However, it was noted that, as coalition staff acknowledged, this process was not widely undertaken and did not involve all members (Rein and Stott, 2008: 85). It is also argued that, although defining an evaluation strategy was part of the Coalition's plans for the future, the evaluation parameters had not yet been devised in-depth at the time the study was conducted (Rein and Stott, 2008:85).

The foregoing assertions, point to the fact that, even though monitoring and evaluation of partnerships, has been and is highlighted as an integral part of any programme's operational sustainability and functionality, it is not yet been taken seriously and given its room as an important part of project planning and implementation, although the literature on the subject strongly suggest.

Having systematically assessed the foregoing situation, on monitoring and evaluation of partnerships, Jolley et al., (2008) have reached a conclusion that, context is all important to the workings of any partnership and must therefore be taken account of in evaluation. These authors, further state that, it is tempting to take a goal-based approach and simply measure whether a partnership has achieved what it set out to do but this does not allow the partnership to analyse where it has come from, what strengths are and how weaknesses can be addressed (Jolley et al., 2008: 154). To back-up this assertion, they argue that, partnerships that have not achieved their goals or are struggling will require a more introspective and reflective process built into their evaluation (Jolley et al., 2008: 155). This assertion, strongly affirms what

Rein and Stott (2008) has found out among partnership organisations they studied in South Africa and Zambia, in particular.

One other important point that Jolley et al., (2008) make with regard to this issue at hand, they argue that, conversely, many existing measurement tools focus solely on processes at the expense of outcomes. They assert that partnerships should not be viewed as an end but rather rigorously examined to determine the benefits of working in partnerships outweigh the cost (Jolley et al., 2008:155). These authors also suggest that, the measure of a partnership's success should be beneficial changes at the level of service provision to users and carers or to the wider interface of health and social care (Jolley et al., 2008: 155).

Complimentary to the foregoing point, these authors suggest the following criteria for evaluating the outcome-related success of a partnerships: **improvement in accessibility of service users; more equitable distribution of services; improved efficiency, effectiveness and quality of service along with reduced overlap and duplication; improved service experiences for users and carers; and improved health status, quality of life and well being at a population level (Jolley et al., 2008:155).**

Jolley et al. (2008) conclude on the following point, thus, there is a widespread support for the idea that partnership evaluation should be multi-faceted rather than relaint on a single quantitative tool. They point out that, other methods may include field notes, observation by an outsider, records of meetings and interviews with participants, these authors further note that, it is also suggested that evaluation should acknowledge the costs and barriers to effective partnerships in order to address these if possible (Jolley et al., (2008:155).

CHAPTER 3 RESEARCH PROBLEM

3.1. Research Problem

As having said earlier on, the research problem is based on the premise that community organisations have a significant role to play in increasing levels of adherence. Therefore, the research problem to be discussed and analyzed is:

Does a formal treatment support partnership between community based organisation (CBO) and a company increase levels of adherence in employees on antiretroviral treatment?

3.1.1. Operationalisation

The term formal partnership, in this research proposal, can be understood in the context of a well defined partnership which involves adequate and mutual understanding of the task at hand, coupled with mutual and adequate understanding of what needs to be done, by whom, how, with what, and when? In order to ensure that a formal partnership between a CBO and a company increase levels of adherence, a particular emphasis will be on operationalising the partnership in terms of being seen and understood to be addressing the following areas:

- Existence of a Workplace HIV/AIDS policy
- Existence of a clause encouraging participation of PLWHAs (possibly drawn from the local community) as the workplace HIV/AIDS policy champions
- Existence of a support group for both employees infected and affected by HIV/AIDS and attached to a community organisation (CBO).
- Existences of clearly defined systems for skills, knowledge, and financial resource sharing.
- A referral system to the CBO services
- Proper communication channels

3.1.2. Hypothesis

In line and with regard to the research problem and its operationalisation given above, the following statement can be given as a formulated hypothesis:

A formal treatment support partnership (the independent variable) between CBO and a company increase levels of adherence (the dependent variable) in employees on antiretroviral treatment.

3.2. Research Design

The descriptive research focuses on describing some phenomenon, event, or situation (Christensen, 2007: 39). In essence, a descriptive research approach, effectively tries to give a graphic explanatory account of how a particular variable is related to another, thus giving a picture of how a particular situation takes place. The researcher does not know for sure, as to who actively participate in the activities of HIV/AIDS management within the workplace as provided within the HIV/AIDS workplace policy, and also the researcher may not know who has benefited either directly or indirectly from the services of a workplace support group that is attached to a community based organisation, or directly from the community based organisation. Taking into consideration the foregoing reasons, it becomes clear that the situations calls for an Ex Post Facto study to be conducted.

Neither the existence of a formal treatment support partnership (the independent variable), nor the increased levels of adherence (the dependent variable) in employees on antiretroviral treatment are or can be subjected under the researchers control. Since these are not under the direct control or manipulation of the experimenter, but chosen after the fact, it is justifiable for the experimenter to use Ex Post Facto research design. The experimenter has no control over who has used the services of a community based organisation, or who did not. Instead employees decide on their own volition either to use services of the community based organisation as encouraged within the context of their Workplace HIV/AIDS Policy, or as a result they have automatically assigned themselves into these two categories:

- Those who saw the need to seek care and (treatment) support from the CBO
- Those who did not see the need to seek care and support from the CBO

When engaging in data collection exercise, the study we employed a field study in which an interview technique is used to gather data on a given state of affairs in a representative sample of the population; this technique is called the survey (Christensen, 2007:54).

At the opening of the interview, participants will be ensured of their anonymity and the confidentiality of the proceedings before they can commit themselves and continue. In case the participant likes to proceed with the conversation, they will first be asked as to whether they know about the company's Workplace HIV/AIDS Policy, do they make use of the treatment support services rendered by the community based organisation within the framework of the policy or not. Depending on their answers, they will then be into two groups. Answers based on the operationalised formal treatment support partnership (independent variable) as stated will be asked.

There could be some other variables that may correlate with the formal treatment support partnership in increasing the levels of adherence in employees on antiretroviral treatment. Among such correlating variables may be the employees wanting to use the services of a community based organisation, some not wanting to use such services, employees just wanting to be seen as active in addressing issues that affect others, employees not wanting to be seen as desperate and using services not so glamorous, issues of confidentiality, participation in Workplace HIV/AIDS Policy as enhancing their chances of get career advances, stigma attached to partaking in such structures, perspective of the company and other stakeholders to such matters.

If the study determines that a formal treatment support partnership indeed increased the levels of adherence in employees on antiretroviral treatment. The study will further ascertain whether there is any correlational influence between the formal partnerships in increase of adherence.

3.3. Sample Design

To subject our stated hypothesis to a test, a sample of patients who are on treatment and under the supervision of the Patient Advocate (PA), working in local factories, nearby where the CBO is based, was selected into a sample. Seventy participants were selected. Participants were selected as they came for monthly medical check-ups and to take their medical treatment supplies, were selected and requested to partake in an interview survey in order to make a profound and valid inference to determine if formal partnership between a community based organisation and a company increases adherence in employees on antiretroviral treatment or not. A random sampling was used. Random sampling, mean a sampling procedure where population group is just selected into the sample indiscriminately, for example in our case just taking three patients that are assigned to a Patient (Treatment) Advocate (PA) without following any predetermined criteria, out of the five patient case load that is assigned to a PA, and those not enlisting PA services.

3.2.1. Ethical Considerations

As the study was initiated, issues of confidentiality, personal and organisational integrity were taken into cognisance. Management at the local community based organisation (CBO), individual PAs, and participants that were to take part in the study were ensured of their confidentiality and preservation of their dignity. These issues were discussed and acceded to by all parties. Participant's informed consent was obtained prior to participation in the study.

3.4. Measuring Instrument

As participants or subjects were interviewed, a questionnaire was administered to them, to determine whether they have ever used the services of a community based organisation or not. Therefore a face to face interview survey was used. Following a particular participant's answer, specific set of questions was asked to which the subject was expected to answer questions on a likert scale, therefore, with answers in a range of strongly agree, agree somewhat, neutral, disagree somewhat and strongly disagree . The set of

questions asked were structured and formulated in such way that they allowed the experimenter to test the operationalised problem question, as well as the other variables that may be confounding the independent variable as noted above. Therefore, a set of twenty questions was administered to participants.

3.5. Statistical Analysis

The Likert scale questionnaire responses for the 70 participants were recorded and captured into Microsoft excel spreadsheet, which was then, transferred into the Statistical Package for Social Sciences (SPSS). The independent t-test was performed to determine if the means (averages) differ between the two groups. The data was analysed on SPSS in such a way that it showed the null hypothesis can be reject and the alternative hypothesis can be upheld, thus prove that the group means are not equal. The significance level was computed in order to enable us to either reject or accept the null hypothesis.

The use of t-test for independence, allow the analysis to determine the degree of association that existed between the two variables (formal treatment support partnership and adherence). And most importantly that such relationship is not based on chance, but on empirical scientific evidence.

CHAPTER 4 RESULTS OF THE STUDY

It is assumed that a critical number of employees questioned who have used the services of a community based organisation in taking their treatment, would report a high degree of satisfaction with treatment support received and progressive care. These employees will be much concerned about how the company value or how much supportive it is to such a relationship, as it requires all stakeholders to effectively partake for it to be effective and sustainable.

It was also assumed that those employees, who haven't enlisted the help of a community based organisation's treatment support facility, would not have much to say about the quality of service and its usefulness. These employees

will, on the other hand be in a position to envision the usefulness of such an arrangement, especially those who have HIV/AIDS infected, sick, and most likely (HIV/AIDS and Treatment) illiterate next of kins back home. Even though they may see this formal arrangement, as might be helpful to them, but they may be much more bothered about the issues of confidentiality and stigma. Their responses were expected to be scattered around neutral, disagree somewhat, and strongly agree in most questions.

4.1. Statistical analysis

Table: 4.1. Respondent's gender (N=70)

		Gender			
		Frequency	Percent	Valid Percentage	Cumulative %
Valid	1	23	30.7	32.9	32.9
	2	47	62.7	67.1	100.0
	Total	70	93.3	100.0	
Missing	Missing System	5	6.7		
Total		75	100.0		

Table 4.1., is a tabular representation of the survey result based on their gender. The study had a total of seventy participants (N=70). The frequency column indicates that, out of 70 participants, 23 (N = 23) were males and 47 (N = 47) were females. Missing responses were (n=5), which we could not ascertain here whether were from males or females. We therefore, had 33% of male participants and 67% of females which makes up a 100%.

4.2. Participant's Gender Frequency

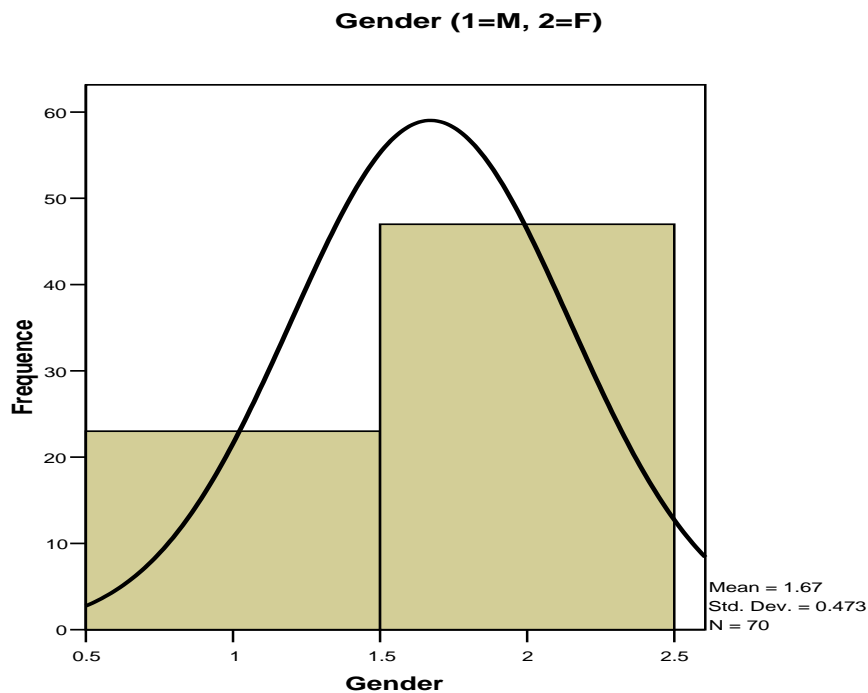


Figure: 4.1. Participant Gender frequency graph

The foregoing Graph shows a Mean of 1.67, which means that, more than half of the participants were women.

4.3. Subject Code

Table: 4.3. Subject code

		Subject Code			
		Frequency	Percent	Valid Percentage	Cumulative %
Valid	0	33	44.0	47.1	47.1
	1	37	49.3	52.9	100.0
	Total	70	93.3	100.0	
Missing	Missing System	5	6.7		
	Total	75	100.0		

As had been stated in the design section, that the respondent groups will be into two groups, those who have enlisted the services of a PA and a CBO, and those who have not opted for a service, the above table's first column represents the

subject codes whereby 0 (zero) represents those who did not take up the treatment support by the PA and 1 (one) represent those who have taken up treatment support with the PA.

Thirty three (N=33) participants did not take up treatment support services with the CBO, by the PA. Thirty seven (N=37) participants took up treatment up take support service with the CBO, by the PA. Therefore, we had N=70 participants in total.

4.4. Enlisting PA Support

Table: 4.4. Cross Tabulation

Cross Tabulation: Subject Code * Enlist support of PA

Effective		Enlist support of PA					Total
		1	2	3	4	5	
Subject	0	9	6	10	4	4	33
Code	1	1	0	0	2	34	37
Total		10	6	10	6	38	70

Responses to the questionnaire are to in a form of a Likert scale, ranging from Strongly Agree (5), Agree somewhat (4), Neutral (3), Disagree Somewhat (2) and Strongly Disagree (1). Table 4.4. is primarily a representation of such. However, it also presents responses of all participants from the two groups (N=70) on a Likert Scale.

Reading from Table 4.4., it is stated that a total of n= 38 strongly agreed to importance of enlisting the support of a PA in treatment uptake. Interestingly, out of the n=38, only n=4 were from the zero group. Taking responses (n) from 2 to 3 on the Likert scale, and add them together, gives n= 16, if adding n = 16 to n= 38, gives =54. The study is particularly interested in n= 16 here because they fall in neutral and disagree somewhat categories. This may mean that perhaps if they can be well informed of the benefits of the treatment support arrangement that could be more so since their responses are not conclusive and therefore based on doubt. With regard to the n= 6 on 4 of the likert scale, their responses can be relied on somehow, because their doubtful answer may,

perhaps be based on issues of trust, confidentiality, or just the fact that they can rely on other sources of support for treatment support and adherence.

Finally however, a deduction can be made, from the foregoing table that, the majority of the respondents saw the need and importance of enlisting the support of the PA.

4.5. Reasons for Treatment Support

Table: 4.5. Reasons for Treatment Support

		Reasons for Rx support			
		Frequency	Percent	Valid Percentage	Cumulative %
Valid	1	4	5.3	5.7	5.7
	2	4	5.3	5.7	11.4
	3	13	17.3	18.6	30.0
	4	6	8.0	8.6	38.6
	5	43	57.3	61.4	100.0
	Total	70	93.3	100.0	
Missing	Missing System	5	6.7		
Total		75	100.0		

The question on Table 4.5., was probing as to whether the participants understand the reason why they were offered treatment up take support. Table 4.5., is a summary of responses to the question on a Likert scale. From the Table it is clear that, more than half of the participants understood the reasons why they were offered treatment support. N=43 said they strongly agree to the question and that accounted for n=61%. More interestingly though, is the fact that, n=19% of the responses fell on the neutral point of the likert scale, which may mean that there is still work to be done to further improve on the above positive score.

4.6. Missed Doses

Table: 4.6. Missed Treatment Doses

		Missed Rx doses			
		Frequency	Percent	Valid Percentage	Cumulative %
Valid	1	40	53.3	57.1	57.1
	2	2	2.7	2.9	60.0
	3	21	28.0	30.0	90.0
	4	2	2.7	2.9	92.9
	5	5	6.7	7.1	100.0
	Total	70	93.3	100.0	
Missing	Missing System	5	6.7		
	Total	75	100.0		

Here, the study wanted to see if the participants, with a PA as their treatment uptake supporter, have ever missed any of their treatment doses. The above table depicts a likert scale summary of responses, whereby N= 40 or N= 57% of the participants disagreed that they ever missed their treatment doses whilst having a PA as a treatment uptake supporter. Also to note, is the fact that N= 21 or N= 30% of the participants were on the neutral spot, which may mean that, perhaps they have either forgotten ever missing doses or they have missed on few occasions, a situation that may be turned around and improve on our positive results. Therefore, if we can add N= 57% and N= 30%, we can get N= 87%. However, generally the findings here indicate that, the majority of participants agree that having a PA as a treatment supporter improves adherence levels.

4.7. Multi-sectoral Partnership

Table: 4.7. HIV/AIDS Policy Allow Multi-sectoral Partnership

HIV/AIDS Policy allow multi-sectoral partnership

		Frequency	Percent	Valid Percentage	Cumulative %
Valid	1	18	24.0	25.7	25.7
	2	5	6.7	7.1	32.9
	3	12	16.0	17.1	50.0
	4	6	8.0	8.6	58.6
	5	29	38.7	41.4	100.0
	Total	70	93.3	100.0	
Missing	Missing System	5	6.7		
Total		75	100.0		

The survey question to the above Table, was probing, as to whether, to the participants understanding, their company's HIV/AIDS policy allow for multi-sectoral in HIV/AIDS management. The above Table is a summary of responses to that question. The number of participants who responded to the question was N=70. The majority of responses at n= 41%, strongly agreed to the question and the number of respondents is N=29. n=26% of the respondents strongly disagreed to the question, the total number of respondents in this category at N=18 strongly disagreed to the question. N= 12 of the respondents were neutral on the question at n= 17%, whilst N=5 disagreed somewhat to the question with n= 7. N= 6 of the respondents, agreed somewhat to the question, with n= 9%.

The foregoing tells us that, the majority of the respondent's, responses suggest that, their workplaces have HIV/AIDS policies and such policies allows for multi-sectoral partnerships.

4.8. Company Supportive to Health Care Efforts of HIV/AIDS Positive Person

Table: 4.8. Company Supportive to Care Efforts of HIV/AIDS Positive Person

Company supportive to health care efforts of HIV/AIDS positive person

		Frequency	Percent	Valid Percentage	Cumulative %
Valid	1	20	26.7	28.6	28.6
	2	2	2.7	2.9	31.4
	3	31	41.3	44.3	75.7
	4	7	9.3	10.0	85.7
	5	10	13.3	14.3	100.0
Total		70	93.3	100.0	
Missing	Missing System	5	6.7		
Total		75	100.0		

The majority of the respondents at N=31 fell on the Neutral category on the Likert scale, with n= 44% of responses. N= 20 are on the Strongly Disagree. N=20 of the participants were on the Strongly Disagree category in the likert scale with n= 29% responses. N=10 of the participants were on the Strongly Agree category on the Likert scale with n=14%. N= 7 of the participants, fell on the Disagree Somewhat category of the Likert scale with n= 10%. N= 2 of the participants were in the Disagree Somewhat category in the Likert scale n= 3%.

4.9. Beneficial Formal Partnership Between the Company, PHI and a CBO

Table: 4.9. Beneficial Formal Partnership between Company, Primary Health Care Institution and a CBO

Beneficial formal partnership between the company, PHI and a CBO

		Frequency	Percent	Valid Percentage	Cumulative %
Valid	1	8	10.7	11.4	11.4
	2	1	1.3	1.4	12.9
	3	5	6.7	7.1	20.0
	4	2	2.7	2.9	22.9
	5	54	72.0	77.1	100.0
	Total	70	93.3	100.0	
Missing	System Missing	5	6.7		
	Total	75	100.0		

The statement on the survey's questionnaire was – you think it will be more beneficial if there is a formal partnership for HIV/AIDS management between your Company, Public Health Institution, and a CBO. 1 on the Likert scale, on the Table 4.9., represents the Strongly Disagree category. Thereon, N= 8 participants responded to the question with n=11%. 2 was the Disagree Somewhat category on the Likert scale, with N= 1 respondent, at n=1% of a response. 3 on the likert scale was Neutral, the number of participants in this category is N= 5 with n=7% of responses. 4 on the Likert scale, as presented on the table above, depicts the N= 2 responding to the question as Disagreeing Somewhat, with n= 3% of a response score. 5 on the Likert scale summary above, depicts N= 54 number of participants, as Strongly Agreeing with the notion as stated above, at n=77%.

4.10. Future Effort to Establish Formal Partnerships

Table: 4.10. Future Efforts to Establish Formal Partnerships

Future Effort to establish form partnerships

		Frequency	Percent	Valid Percentage	Cumulative %
Valid	1	3	4.0	4.3	4.3
	5	67	89.3	95.7	100.0
	Total	70	93.3	100.0	
Missing	System Missing	5	6.7		
Total		75	100.0		

One on the Likert scale as depicted on the table above, N= 3 the represents the respondents, a category of respondents who Strongly Disagreed to the notion that, do you think in future, efforts should be made to establish such formal partnerships, and the number of responses stood at n= 4%. On the other hand, 5 on the Likert scale, represents a category of patients who Strongly Agreed to the question, with their scores standing at n=96%.

4.11. Independent Sample t-Test

Table: 4.11. Independent Sample Test

	The Levene variances test on the equality of variances		t-Test for the mean equalities.						
	F	Sig	t	df	Sig. (2-tailed)	Mean Difference	Difference Std-dev	95% interval confidence of difference	
								Inferior	Superior
Enlist Support of PA									
Equal variances Hypothesis	4.356	.041	1.805	68	.076	.686	.380	-.073	1.445
Unequal variances Hypothesis			1.938		.058	.686	.354	-.024	1.397

Table 4.11., depicts the results of an independent sample results for the two groups experiment. $t(68) = 1.805$ $p = .076$. The p value computed for this study is above or greater than the critical value of t required for significance at the 0.05 level regardless of whether a one – or two tailed level of significance were used (Christensen, p 418: 2007). This provides the information needed to make a decision regarding a null hypothesis. Because the obtained value of t is greater than the critical value of t , the likelihood that the difference in the mean scores of the two groups of participants occurred by chance is less than 5 in 100 (Christensen, 418: 2007). Given the foregoing scenario, one can safely say that a critical number of participants in this study agreed to the notion that, it is important to enlist support of a PA in treatment uptake, to increase levels of adherence to antiretroviral treatment.

CHAPTER 5 CONCLUSION

In conclusion, antiretroviral treatment has come at a time when it is most needed by companies who have already suffered a hard blow in their profit margins, due to increased levels of employee morbidity, attrition and mortality, which then results to decline in productivity levels and loss in profits. Antiretrovirals give companies and their employees an advantage over the scourge of HIV/AIDS, with its life enhancing and prolonging effect.

The level of morbidity in particular, needs to be significantly reduced with introduction of antiretrovirals by certain companies to their employees and their significant others or spouses. However, for that to happen, higher levels of adherence need to be achieved.

In order make the foregoing scenario a reality, one need to take into consideration, the findings of the study which we conclude on here. The study shows that not all companies are taking care of their employees. It further gives an indication that even though companies may have Workplace HIV/AIDS Policies, these are not properly implemented.

Though, this was a small scale study, confined in a relatively small setting, but the findings hereof, may imply that there is a need for a further in-depth research study in this area of HIV/AIDS management (multi-sectoral partnerships for HIV/AIDS management) with CBO as an important partner.

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ADDENDUM A: INTERVIEW QUESTIONNAIRE

Interviewer Code:.....

Interviewee Code:.....

Questions or a checklist of antiretroviral patients who are/were employees at different companies, who are now part of the Patient Treatment Support Programme and receiving care and support from Patient Advocates (PAs) attached to a CBO.

Purpose of the Study

This study aims at validating the hypothesis that formal treatment support partnership between CBO, Health Care Facility and a Company increase levels of adherence in employees on antiretroviral treatment.

Instructions: Please place a tick on an appropriate box next to the answer of your choice.

Question Number	Question	Strongly Agree (5)	Agree Somewhat (4)	Neutral (3)	Agree Somewhat (2)	Strongly Disagree (1)
1	It is important to enlist support of a PA in treatment uptake.					
2	You view a PA as a treatment partner/buddy.					
3	You understand the reason why were you offered treatment uptake support.					
4	You did attend treatment literacy training before being					

	introduced to this arrangement.					
5	You think you are aware of the potential hazards of not taking treatment as per agreed schedule.					
6	You voluntarily chose to be assigned the current treatment assistant.					
7	At the point of PA assignment, you discussed issues of confidentiality.					
8	There are formal mechanisms to enforce compliance to the above obligations.					
9	With a PA as your uptake supporter, you have missed any of your doses.					
10	You regularly communicate with your PA.					
11	To your understanding, there					

	are mechanisms in place to facilitate effective communication.					
12	In your knowledge, your company or place of work has a workplace HIV/AIDS policy.					
13	If your place of work has a workplace HIV/AIDS policy, it has been formally presented to employees.					
14	To your understanding, your company's HIV/AIDS policy allow for multi-sectoral partnership in HIV/AIDS management.					
15	Your company allows active participation of people living with HIV/AIDS in implementing policy provisions.					
16	Your company provide workplace					

	based antiretroviral treatment.					
17	It was your personal decision to seek help on antiretroviral therapy from a public health care institution.					
18	Your company is supportive to your health care efforts as an HIV/AIDS positive person.					
19	You think it will be more beneficial if there is a formal partnership for HIV/AIDS management between your company, public health institution, and a CBO.					
20	Do you think in future, efforts should be made to establish such formal partnerships?					

