Investigating the impact and challenges of implementing the National Counselling and Testing Campaign in the Ga-Motupa Community in Limpopo

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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

The National Department of Health and The South African National AIDS Council (SANAC) jointly agreed to launch a massive campaign for HIV Counselling and Testing. The campaign was launched as an effort to step up and supplement and modify the programmes that are already running in the country, to fight HIV and AIDS. The campaign is known as the National HIV Counselling and Testing Campaign and it is based on the National HIV Counselling and Testing Campaign Strategy of SANAC (2010).

The study aimed to investigate the impact of the campaign in terms of awareness levels of the benefiting groups as well as the challenges experienced by the relevant role players in implementing the campaign at the Ga-Motupa community in Limpopo. The investigation tools used in the research were interview schedules. Three focus groups were sampled from the target groups, namely care givers, learners and ABET educators. Individual participants were a health worker, a project leader and one educator from a primary and a secondary school. The research process entailed interviews and discussions with individuals and focus groups. Schedules were prepared beforehand to guide and direct the discussions and to guide the collection of data.

The researcher planned to use the qualitative method of research because of the nature if the topic. The use of focus groups discussions and interviews were therefore relevant for this kind of study as the intention was to find out the experiences of the participants in the campaign, both the implementers and the beneficiaries. The respondents were chosen, based on their role in the HCT campaign.

The main findings were that the HCT campaign was not yet fully understood by the beneficiaries. The main implementers of the campaign, mainly health workers and care givers, were the only ones with a high level of awareness of the activities and critical information of the campaign.

Secondly, the beneficiaries such as the learners and educators had little or no information concerning the newly launched HCT campaign. The information received was general and was about the Voluntary Counselling and Testing launched back in 1996-2004.

Thirdly, the campaign had left out some of the main role players such as the local traditional leaders, traditional healers and the religious community which are listed in the strategic document as key role players.

Opsomming

Die Nasionale Department van Gesondheid en die SA Nasionale VIGS Raad (SANAC) het gesamentlik ooreengestem om die groot veldtog vir MIV Berading en Toetsing aan die gang te sit. Die veldtog was begin as 'n poging om die program wat reeds aan die gang was aan te vul en te wysig. Die veldtog staan as die Nasionale MIV Berading en Toetsing bekend en is op die Nationale MIV Berading en Toetsing Veldtog Strategie van SANAC (2010) gebaseer.

Hierdie studie het die impak van die veldtog ondersoek in terme van bewustheidsvlakke van die groepe wat voordeel trek sowel as die uitdagings deur die relevante rolspelers ondervind in implementering van die veldtog by die Ga-Motupa gemeenskap in Limpopo.

Navorsingsgereedskap wat gebruik is was onderhoudskedules. Drie fokus groupe is getrek van die teikengroepe: sorggewers, leerders en ABET opvoeders. Individuele deelneemers het 'n gesondheidswerker, 'n projekleier en een opvoeder van 'n laer en sekondêre skool ingesluit. Die navorsingsproses het onderhoude en besprekings met individue ingesluit, asook fokusgroepe. Skedules is voorberei om die besprekings en data insameling te lei.

Die navorser het die kwalitatiwe metode gebruik weens die aard van die onderwerp. Die gebruik van fokusgroepe en onderhoude was dus relevant vir hierdie tipe studie omdat die plan was om die ondervinding van deelnemers in die veldtog te bepaal, beide die uitvoerders en die voordeeltrekkers. Die deelnemers is gekies weens hul rol in die veldtog.

Die hoof bevindinge was dat die veldtog nog nie ten volle deur voordeeltrekkers verstaan is nie. Die hoof uitvoerders, meestal gesondheidswerkers en sorggewers, was alleenlik die met 'n hoë vlak van bewustheid van aktiwitiete en kritiese inligting oor die veldtog.

Tweedens, die voordeeltrekkers, soos leerders en opvoeders, het min of geen inligting oor die nuwe veldtog gehad nie. Die inligting ontvang was algemeen en oor die Vrywillige Berading en Toetsing van 1996-2004.

Derdens, die veldtog het van die hoof rolspelers uitgelaat soos die plaaslike tradisionele leiers, tradisionele genesers en die godsdienstige gemeenskap wie in die strategiese dokument as sleutel rolspelers genoem is.

Table of Contents **Page**

Chapter 1: Introduction

1.1. Introduction

The research focused on the National HIV Counselling and Testing Campaign (HCT). The objective was to investigate the impact of the campaign as well as look into the challenges experienced by the role players as they implemented the campaign.

1.2. Aim of the research

The research therefore investigated the level of awareness of the HCT campaign among the implementers as well as the targeted benefactors, the impact of the social mobilisation in terms of the participation of the community in the campaign, the challenges experienced by the implementers as well as the readiness and availability of the resources in the health system.

1.3. Structure of the Study/Overview

Chapter 1 gives the problem statement, background and rationale for the choice of the study. It gives a motivation regarding the relevance of the study as well as indicating the method of the study. Finally in this chapter, I outline the objectives of the study and the methods used.

Chapter 2 deals with the literature review, the relevant content that informs the study topic. These are the policy documents on HIV and AIDS which are most seminal to the topic; the strategic plans at National and Provincial level. I also refer to other related studies done regarding HIV and AIDS campaigns.

Chapter 3 outlines the research strategy and clarifies the reason for the choice of the strategy. It also outlines how and why the specific participants were chosen and how the data collection process was carried out, using interviews schedules and focus groups discussions.

Chapter 4 deals with the research findings as posed in the problem statement; it covered the analysis and interpretation of the information provided by the participants, based on responses they provided to the moderator or interviewer.

Chapter 5 gives concluding remarks, followed by the bibliography and the appendices of relevant documents used.

1.4. Problem Statement

For the purpose of understanding this investigation, it is important that I discuss the background sufficiently to ground my argument for doing the research. I will hereunder, give a brief motivation as to why I chose the HCT campaign as the focus of this study. I will also give an overview of the basic tenets or key components of the HCT campaign. I will then explain the relevance of this research on the HCT campaign in the identified community.

The launching and roll out of a particular campaign does not always guarantee that it will address or solve all the problems for which it was launched in the first place. The HCT campaign was endorsed in 2009 by the cabinet of the South African Government. The endorsement of the campaign meant that all efforts to fight HIV and all diseases related to it would to be scaled up. The build-up to the launch of the National HCT was also marked by the announcement of the launch date by the Minister of Health, which was set for 1 April 2010 (National HCT Campaign Strategy document, 2010).

The campaign would advocate for a change or revision of the counselling and testing protocol, for example the new protocol stipulates that HIV Counselling and Testing (HCT) should be offered by health providers on the occasion of any patient's visit to any health facility for any ailment (SANAC, 2010).

Due to the fact that almost six million South Africans are HIV+ there was no other opportune time to address the epidemic at such a higher and more resolute level than this one.

The document points out that "The imperative of expanding the number of clients counselled and tested for HIV comes as a result of the magnitude of South Africa's epidemic. Over 1200 people become infected with HIV every day in South Africa." The drive or motive of the National campaign is stated as: "Expanding access to HIV counselling and testing: a gateway into prevention, treatment and care".

The campaign has four objectives, namely: Mobilize for people to know their status**,** support people with key messages, increase the incidence of health seeking behaviour and increase access to treatment. The campaign has targeted all provinces but aims to use certain districts as monitoring sites.

The campaign has four key components, namely: the launch, social mobilisation, communication / advocacy and health systems.

On world AIDS day 2009, the campaign was launched, opening the way for the provinces and districts to launch their campaigns. In June 2010, the campaign for the Mopani District was launched at the Ga-Motupa Community at Relela showground. The launch was a massive exercise, characterised by health workers and more than twenty testing stations. The launch was a success as an event but the real impact can only be tested on the basis of whether the momentum is sustained or not.

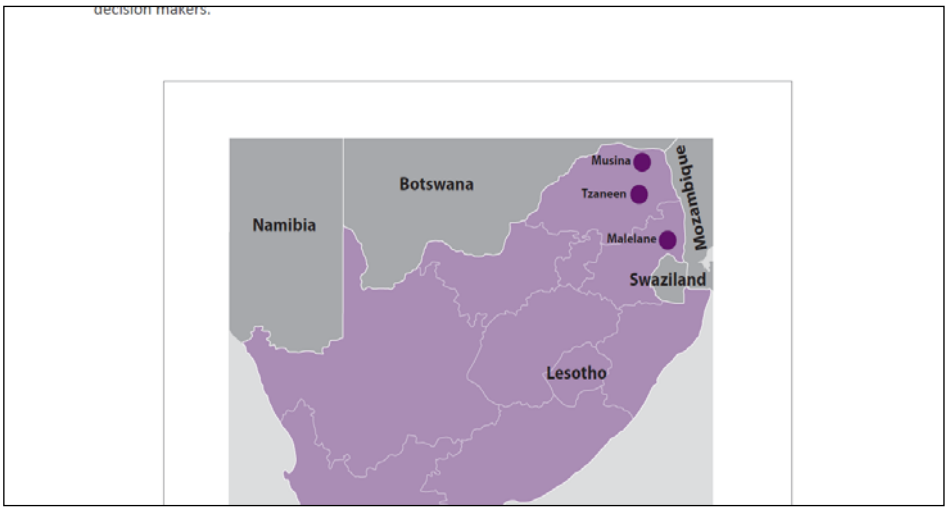
This investigation aimed to look at the aftermath of the campaign launch, namely the implementation of The National HIV Counselling and Testing Campaign (HCT) within the community in question. It also aimed to look into the experiences of the care givers and health workers as the main implementers of the campaign, as well the beneficiaries such as learners and educators. The health system in its role to facilitate implementation was also part of the study.

1.4.1. Background and Rationale

The Ga-Motupa Community

The village of Ga-Motupa is found in the Limpopo Province, almost 120 kilometres East of Polokwane, and situated 17 km North of Tzaneen in the Mopani district. It is under the ruler ship of the Modjadji dynasty. The majority of working adults are employed by farmers in and around Tzaneen. The majority of these adults live below the breadline as they are paid low wages. The context of community is described by ART Care as follows: “Subsistence farming and seasonal working in the agricultural sector is the norm”. Poverty is the major problem and unemployment estimated at 67%. Mopani has an estimated population of 1,2 million and the HIV antenatal prevalence rate is 25%. Ga-Motupa is part of Mopani and situated near Tzaneen (see map).

Location of Ga -Motupa near Tzaneen in Limpopo:



Map: Courtesy of IOM Report, (2010)

Ga-Motupa village as part of Tzaneen and HIV prevalence

In 2010 the International Organisation for Migration did a study on the farm workers in this region, including Tzaneen farms. The report has this to say about prevalence: "out of 27 798 participants on whom test results were available, 1106 (39,5%) were HIV positive. More than half of farm workers between 30 and 39 years of age are infected (52.2%)" (IOM report, 2010). The 2009 Department of Health surveillance reporting the Mopani district identified Ga-Motupa as an area of high prevalence in HIV positive people.

The recent ILO report on HIV prevalence among farm workers in Limpopo has indicated Tzaneen to have the highest prevalence in comparison to Musina. The 2008-2009 report of the department of health has indicated that the Ga-Motupa community is the hardest hit by HIV in terms of the number of people infected daily and those living with HIV. The local clinic is responsible for collecting anonymous statistics from antenatal weekly surveillance tests results.

1.4.2. Health workers and Care givers as the main implementers of the HCT campaign

Health workers and care givers are at the forefront of the HCT campaign and many other health programmes. They face both personal challenges and workplace challenges. They face a lot of stress and are exposed to health hazards. Issues such as exposure to the risk of

infection TB or HIV, the trauma of having to see a person whom they had hoped would survive dying and burn out are some of the main challenges of care givers.

HIV counsellors face situations where they have to break the news to a person that they have tested HIV positive. In most cases the volunteers in the healthcare system have to wait for more than five months to receive the R500.00 stipend promised them by the NGO or department of health.

Interventions to support and assist the health workers and care givers have been proposed, such as a health package of HIV treatment for health workers, improving the quality of training for health workers, making the workplace safer; improving stress management skills and making HIV services for health workers accessible (Sharp, 2009).

Health workers face challenges in their work environment such as occupational stress, bereavement overload, over identity with their patients, stigma whether internal or external and burnout. The risk faced by health workers is evident in the argument that "the number of nurses with AIDS in South Africa could outstrip the number of nurses being produced in the next couple of years" (Smart, 2009). It can be argued that care givers although not qualified like the nursing personnel, have to do work similar to that of professional nurses, such as administering Directly Observed Treatment (DOT) for TB and Antiretroviral Treatment to HIV positive people in the communities, with very poor compensation. The risk faced by care givers is not different from that faced by nurses at the clinic or hospital.

1.4.3. Educators and learners as beneficiaries of the HCT campaign

South Africa's current five year HIV and AIDS and STI Strategic Plan for South Africa (NSP), 2007-2011, aims to increase political leadership and public commitment to fighting the epidemic, and strengthen inter-departmental and inter-sectoral responses, and to increase resources and to build capacity at provincial and district levels for the planning and implementation of HIV and AIDS programmes. It also seeks to protect human rights and reduce stigmatisation.

The national plan is led by the National Department of Health, mandated by the South African National AIDS Council (SANAC). It is multi-sectoral in nature and therefore achievements or failures are owned by various stakeholders, including ministries at national,

provincial, district and local levels who incorporate its principles in programmes and implement it.

The impact of HIV and AIDS on the classroom environment is described as follows:
Teachers and students are under severe psychological and physical stress. Due to the stigma attached to HIV and AIDS discriminatory practices in the teaching learning processes are prevalent. Teachers are ill-prepared to cope with rapidly changing conditions of learning, due to the new curriculum and pressure of work resulting from absent colleagues. Currently, there is no support system to help teachers cope with the challenge of HIV and AIDS within the school environment.

Impact on the School Environment

There is disruption in management of teaching personnel and the overall organization of schools due to death and absenteeism of teachers, discrimination and stigmatization. School managers (principals) are ill-prepared to face new challenges, as well as pressure from communities regarding perceived insecure working conditions.

Impact on teachers and learners

Teacher absenteeism is very high due to attending memorial services and funerals, teacher illness and death. Learning is adversely affected when a teacher dies.

Impact on the community

A climate of suspicion hangs over the school when a teacher dies, and this has a strain on relationships between schools and communities. The integration of teachers into communities is compromised as they are feeling alienated. School management committees, when they exist, are busy settling conflicts. Parents and community leaders are ill-informed about and unprepared to cope with, HIV AND AIDS (Boukary, 2006).

Limpopo has around 400 000 HIV positive people. Around 7% of the population and 14% adults between the ages of 20 and 64 were HIV positive in 2008 (Metropolitan report, 2003).

The epidemic in Limpopo has not reached a mature phase yet and is still growing with new infections almost double the number of AIDS related deaths. An estimated 70 000 people were in need of antiretroviral treatment in 2008 with around 49% having taken up treatment.

The above summary is an extract from ASSA2003, available from**:** www.actuarialsociety.org.za.Metropolitan

1.4.4. Performance Monitoring and Evaluation and Support

Performance is described as the degree to which a development intervention operates according to specific criteria/standards/guidelines or achieves the results in accordance with stated plans (UNFPA, 2004). Monitoring is described as a continuous management function that aims primarily at providing programme managers and key stakeholders with regular feedback, and indications of progress or lack thereof in the achievement of intended results (UNFPA, 2004).

In implementing programmes such as the HCT campaign, it is of great value that the stakeholders should engage in monitoring and evaluating the process, in order to ensure that the objectives are reached as planned. The health systems and the day to day challenges experienced by health workers and care givers can be the object of monitoring and evaluation. This can be done in many forms that ensure the campaign is on track.

Participatory evaluation is described as an active involvement in the evaluation process of those with a stake in the programme, such as partners, customers (beneficiaries) and other interested parties (USAID, 1996).

Participatory evaluation has the advantage of involving key players in designing evaluation instruments. It helps the participants to learn more about the programme and enhances their understanding. It builds teamwork and improves the participants' evaluation skills.

Methods such as informant interviews, focus group interviews, community group interviews, direct observation, mini surveys, case studies and village imaging could be used in tracking the progress of the campaign.

The study intended to find out how the implementers are able to follow the progress of the campaign in terms of evaluating the impact of their work in the community. It appears that the current monthly and weekly feedback meetings at the clinic in Ga-Motupa try to serve this purpose.

It is this background that motivated me to do an investigation into the HCT campaign and its implementation in the area. The aim was to provide some insight into the process of implementing the campaign so that the HIV pandemic could be reduced in the area.

The study could validate the effectiveness of the HCT strategy and confirm its success and provide a basis for further research aimed at quantifying the gains of the campaign.

This study was however a small qualitative investigation, that aimed to look at the challenges and problems, observe the ways in which solutions are sought to ensure the successful implementation of the campaign.

The degree of the success of the campaign from a technical point of view can be the subject of another study wherein surveillance statistics can be compared prior and after the campaign was implemented.

1.5. Research objectives and methods

I focused on the following aspects for the investigation: The awareness of the HCT campaign and its related aspects by the role players, the impact of social mobilisation in the community and the challenges experienced by the role players as well as the health systems as a resource. The National Strategic Plan, The National HIV Counselling and Testing Campaign Strategy therefore, formed the basis of this research.

I conducted four interviews, one with the project leader of the care givers, one interview with the local clinic's health professional, and the last two with one educator each, from a primary school and a secondary school.

Secondly I used focus groups, two separate groups of learners aged between 12 and 18 years of age and a third focus group where care givers, a pastor and a traditional healer were to be represented. The last focus group consisted of practitioners of Adult Basic Education (ABET). I made use of these broad and diverse focus groups to get as many views as possible about HCT with regard to impact, awareness and challenges.

Permission letters were distributed to the anticipated participants beforehand to assist with arrangements. The learners at primary school had to receive consent from their parents or guardians and the school headmaster in order to participate. The participants were informed

about the purpose of the study and were given the opportunity to participate of their own free will or withdraw at any time during the activity.

Questions for the individual interviews and focus groups were prepared beforehand in order to make it easier to manage and guide the focus group discussions and interviews.

I decided to use the qualitative approach on this research as I wanted to find out about the day to day experiences of the implementers as well as the benefactors of the campaign.

The qualitative research method allowed me the scope to gather information that is not necessarily technical but information relevant to my research question that could be supplied from a range of viewpoints and perspectives of the diverse respondents.

1.6. Conclusion

The research investigated the implementation of the HIV Counselling and Testing campaign (HCT) in the Ga-Motupa community, and intended to find out the kind of impact the campaign had had since its official launch in 2010 as well as to find out about the challenges experienced by the implementers of this campaign.

Chapter 2: Literature review

2.1. Introduction

In my literature review, I will first focus on the policy and strategic official documents that informed the HCT campaign. Secondly I will discuss literature that outlines the planning and implementation of campaigns. I will also discuss other research reports, dealing with the implementation of HIV and AIDS campaigns.

2.2. Official documents that inform the HIV & AIDS Strategy

The research was informed by the following policy and strategic documents: The National Strategic Plan (2008-2011), The National HCT campaign strategy (2010) and the Limpopo Department of Education HIV and AIDS strategy 2008-2012. The documents outline plans and strategies to fight HIV and AIDS at national, provincial and district levels in the country. They set out targets that aim to reduce the number of new HIV infections by 50% by 2011. They further aim to reduce the impact of HIV & AIDS on individuals, families, communities and society by expanding access to an appropriate package of treatment care and support to 80% of all people diagnosed with HIV.

The National Strategic Plan also particularizes young people aged 15-24 with regard to addressing behaviour change. The priority areas regarding the youth focus on prevention, treatment, care and support, monitoring research and surveillance as well as human rights and access to justice (NSP, 2009).

According to SANAC (South African National Aids Council) a partner with the Department of Health in the fight against HIV and AIDS, the National Strategic Plan (2009) is a document that represents the country's multi-sectoral response to the challenge of HIV and AIDS. It also seeks to provide continued guidance to all sectors in responding to the epidemic. The plan is informed by medical and scientific knowledge.

The national HIV Counselling and Testing Campaign Strategy is a document prepared by the strategic partner of the Department of Health, SANAC and the National Ministry of Health.

The document outlines the plan to scale up the response to the HIV epidemic nationally. It is informed by the NSP on AIDS and STIs (2007-2011). The NSP is has been developed by all key stakeholders in the government, civil society and the private sector (SANAC). It is the

National Strategic Plan (NSP) that informs the National HIV Counselling and Testing Campaign (HCT).

The HCT campaign according to the National HCT Campaign strategy (2010) has the following new guidelines:

New protocols and a shift for HIV counselling and testing, were being introduced that would differ slightly from the known Voluntary Counselling and Testing Programme. In the new protocol, all health facilities should provide HCT to patients who visit the health facility on any ailment. The healthcare worker has an obligation to explain to the patients, the importance of knowing one's HIV status.

Patients with both TB & HIV infections should start receiving treatment at 300 CD4 count instead of less than 200. Pregnant HIV positive women are to start treatment at CD4 count 350 regardless of symptoms at 14 weeks of the pregnancy to prevent mother to child transmission of HIV.

All health institutions in the country should be able to provide counselling, testing and treatment. The rationale given by the department of health, among other arguments was the high level of HIV prevalence in the country. It points further that 1 200 people become infected with HIV everyday in South Africa. The document argues that currently 5.2 million South Africans, which are ten percent of the total population, are living with HIV (SANAC, 2010).

2.2.1. Implementation of strategies

The rationale for the National Ministry of Health, SANAC and all key role players in launching the campaign is to scale up the fight against HIV and AIDS, to prevent HIV through behaviour change and to allow early access for treatment by those who test HIV positive.

The SANAC report (2010) points to the targets of those already tested in terms of percentages of statistics by province. Limpopo is estimated to have approximately 5 357 949 people while the target population for HCT is 2 275 491. The report indicates that 1 350 641 of the total population are reported to have already been tested, and 59% of the target number is reported to have been tested already. The figures were recorded from 2004-2009 in each province.

The document points to the achievement of regional HCT campaigns in countries like Kenya, Uganda and Tanzania.

Kenya and Uganda conducted door to door testing campaigns and 85% HIV testing was conducted among pregnant women as “provider-initiated-training”. This means that the training was initiated by the nurses or health service provider whenever a person visited a health facility for antenatal check-up.

Malawi conducted a one-week testing campaign in 2008, where 186 217 people were tested using static, mobile and outreach sites. Tanzania tested 3,25 million people during a six month HCT campaign.

These examples have led to South African National Ministry of Health and its key stakeholders SANAC to agree to apply similar strategies, to launch the HCT Campaign.

The campaign will target 15 million people in all the districts by the end of June 2011 in all the provinces. The campaign was launched at the national level in April 2010, while the district launch for Mopani was on 10 June 2010, launched at Ga-Motupa village. The village had attracted the provincial department by the high numbers of people that tested HIV positive at the local clinic.

My interest in the study was to find out how the campaign was being implemented in the community, looking at the impact of the campaign, awareness and challenges, from the perspective of the implementers and the benefactors of the campaign. These are the health workers, professionals, caregivers and faith based organisations such as churches and religious organisations. I also had an interest in looking into the availability, capability and efficiency of the local health facilities in coping with the requirements of implementing the HCT campaign.

The Limpopo Department of Education commissioned a study by the HSRC with funding from the Irish Aid, to develop a strategy for the department. (Strategy for HIV & AIDS, Limpopo Department of Education; HSRC, 2008). The strategy was designed to cover the period: 2008-2012. Its development took into account the National Strategic Plan and its main objectives. It contains an outline of the impact of HIV/AIDS on the education sector in the Limpopo Province.

The report lists the following figures of educator mortality in the Limpopo Province: in 2007 alone, of the 127 educators who died in Limpopo province, a total of 15 educators (12.5%) were in the Mopani Region. The loss of one educator is one loss too much, due to the investment the government has already made to develop the individual.

These figures highlight the need for implementing campaigns and programmes effectively, not only for prevention but for care and support of those living with HIV and AIDS. The probability is that teacher deaths due to unspecified sickness have increased.

The report reiterates on the NSP 2000-2005 and 2007-2011 recommendations. The report also referred to the role the teacher unions play as stakeholders in the fight against HIV and AIDS. The strategy reinforces the pillars of the HCT campaign; Prevention, Treatment, Care and support, Human Rights and access to justice and Impact mitigation.

2.2.2. Related Literature on HIV and AIDS campaigns

A similar but not directly related investigation was carried out by Ntseane and Preece on Why HIV /AIDS prevention strategies fail (Ntseane & Preece, 2005). Their study focused on women in Botswana. Their findings revealed that the "Abstain, Be faithful and Condomise" (ABC) approach in providing preventive messages was not effective. They argued that the use of biomedical and health education strategy was ignoring cultural and societal dynamics which were partly responsible for the spread of HIV/AIDS.

The study went about to investigate power relations among ethnic women with their men with regard to sexual issues. Their findings were that sex had multiple functions in the society which were not addressed by the prevention strategies, and sex was also found to be culturally regulated and that health education on HIV and AIDS had ignored these aspects (Ntseane & Preece, 2005).

Similar challenges in campaign implementation are documented in the investigative work done by other researchers among the mining communities in South Africa. The programmes that the mining management had set up were of a good standard based on the biomedical model and health education. The programmes however did not take into account the belief system and cultural background of the beneficiaries of the programmes, namely the mine workers.

The investigation revealed that issues such as belief in traditional medicine, religious "prophets" and cultural practices and scepticism in using condoms had to be addressed and packaged into the HIV/AIDS programmes. The study also revealed that the living conditions of mine workers and lack of recreational facilities had a negative impact on behaviour change educational messages (Campbell, 2003).

A study released by UNESCO outlines that strategies for fighting HIV and AIDS should be guided by principles, namely that they should be comprehensive in approach.

These approaches should be well coordinated among all related structures and role players. The second principle should be that of long-term perspective and sustainability.

Since HIV and AIDS develop in phases, short term plans that are not sustainable will not be successful. The third principle should be that of acknowledging unity and diversity. This will enable programmes to be as inclusive as possible so that no group or individual will be left out on the basis of their economic, ethnic, gender or social status both as recipients of services as well as being participants in decision making and service provision. Finally the strategies should mobilize people and society and should be culturally rational (UNESCO, 2001).

The other significant discussion was presented by Burger (2008) in her thesis: A possible future of HIV and AIDS management in the school education sector in South Africa.

The study presents a grim and painful scenario of the situation in the education sector. She cited Shisana et al (2005) in a study entitled “The health of our educators”, which indicates that HIV prevalence among educators is at 12.7%, in the country, figure slightly higher than the prevalence among the general population which is at 11% (Shisana et al (2005) in Burger, 2008).

HIV and AIDS are not short term problems and will still affect Africa by 2025, despite what is done today. She points out five driving forces that are viewed as being crucial and which may tip the scales for the triumph over HIV/AIDS or defeat by HIV/AIDS. These issues are:

The argument is whether all the primary role players will work together in unity or petty differences will erode the unity and give HIV /AIDS the upper hand. She further indicates that prevention will be more difficult where there is inequality due to ethnic and religious tensions. Standing together to tackle the pandemic may contribute to unity that might help to defeat HIV and AIDS.

She further points out that beliefs, values and meanings about transmission and prevention may evolve and finally determine the view of HIV/AIDS in the context of being punishment or stigma or an opportunity. In many communities in South Africa, HIV/AIDS is still viewed as a punishment from God or the ancestors. Some still hide behind witchcraft as being the

cause of HIV and AIDS. HIV and AIDS could also be viewed as an opportunity for growth and evolution of the human species.

She raises a salient factor on how resource capabilities are viewed; that it should be viewed as more than being a short term issue but rather as being a leadership human capacity institutions and systems issue. Investment should be made by countries to provide adequate sustainable human, financial and systems resources directed at combating HIV and AIDS. The resources that are made available should be able to match the challenge of HIV and AIDS.

Another factor linked to the above is the application of knowledge in a fresh way, looking at content, better understanding of sexual behaviour, and effects of people living with the virus and viewing care givers as important. This could imply looking at behaviour change from other perspectives, avoiding stigma and proving adequate support systems and resources to make the task of care givers easier to perform.

She also points to the importance of power distribution and authority in terms of gender and age. This refers to stopping the abuse of women, children, and of employees by employers, managers and supervisors (Burger, 2008).

Peer education is one other strategy that has been researched and discussed by various authors. The use of peer education is seen as being effective in the fight against HIV as people are able to speak and communicate on issues on an equal footing. This could be effectively used to educate colleagues, learners at high school and students at tertiary institutions and youth in general (Horizons, 1999).

The UNAIDS epidemic update 2009, is another seminal document that has an impact on my study. The 2009 AIDS epidemic update outlines the nine priority areas for 2009-2011. It makes the following affirmations that we can:

Reduce sexual transmission of HIV, prevent mothers from dying and babies from becoming infected with HIV, ensure that people living with HIV receive treatment, protect drug users from becoming infected with HIV, remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS, stop violence against women and girls, empower young people to protect themselves from HIV, and enhance social protection for people affected by HIV and AIDS (UNAIDS & WHO, 2009 : HIV & AIDS Epidemic update).

These priorities can be viewed as similar to those of the HCT campaign. The difference is that the HCT campaign has specific targets e.g. Reach 15 million South Africans with HCT messages by 2010, and halving or reducing HIV incidence in terms of new infections by June 2011.

The HCT campaign launched in April 2010 is seen as the major instrument in achieving these goals.

It is of great significance to note that in countries North of South Africa, countries like Tanzania, a six month campaign of HCT was held. The sustenance of the momentum of a campaign for such a long period, says something about the commitment and determination of the stakeholders, to achieve their set goals.

The 2009 UNAIDS update 2009 points south Africa as being the home of the world's largest population of people living with HIV (5.7 Million). The stabilisation of HIV is said to have stabilized at high levels. The question is, given the NSP, such strategies that include policy development, Wellness Programmes (DOE: Limpopo, 2008) and the HCT campaigns, shouldn't the awareness levels translate into the lowering of the prevalence? What are the challenges experienced by the role players which prevent these objectives from being achieved? International Organisation for Migration Report

Research was done among farm workers in Limpopo and Mpumalanga Provinces. A total of 2798 farm workers were tested for HIV. Among these, a total of 1106 were found to be HIV positive while 1692 were found to be HIV negative. The figures show that the prevalence of HIV is very high among farm workers with almost 4 people out of every 10 being HIV positive. This is said to be the highest prevalence ever published in Southern Africa among a working population (IOM, 2010).

2.3. Conclusion

The study of these documents above highlights the need to investigate the way HIV and AIDS campaigns are conducted in terms of their impact and the challenges experienced by those who implement them as well as the experience the implementers go through in their work. It also highlights the situation of HIV prevalence in the Limpopo Province and, Ga-Motupa community in particular, especially with regard to the IOM report (2010).The monitoring of performance should also include a supporting function for the health workers and care givers.

Chapter 3: Methodology

3.1. Introduction

This is the exposition of the research methodology as a science. It incorporates the method I have identified as a vehicle to do the research. In this exposition, I will explain the methodology and then the rationale for choosing the methodology. I will also give information on sampling, data collection and an exposition of the actual data collection process.

3.2. Research design

Definitions: A research design is an outline, a plan or a strategy used to investigate the research problem.

The one purpose of the research design is to control unwanted variation by incorporating one or more techniques. This makes for a more reliable conclusion than if only one technique is used. It is described as a strategic framework for actions that serve as bridge between research questions and the execution or implementation of the research.

Research is viewed as a process, consisting of four stages, namely defining the research questions, designing the research, implementing the research i.e. collecting and analysing data and lastly writing a research report. A research design should provide a plan that specifies how the research is going to be executed in such a way that it answers the research questions. The aim of a research design is to plan and structure a given research project in such a manner that the eventual validity of the research findings are maximised (Durrheim & Terre Blanche, 1999).

Phases of the planned research

In my research the following steps were planned based on the field of interest:

Phase one had to do with identifying the research problem. I then decided on the method of investigating the particular problem. The research problem guided me in the choice of the key participants. Having identified the key participants, it was then easier to make contacts by phone and in person, so that I could make arrangements to meet the leaders and discuss my

plans as well as issues of consent to participate. Once permissions were obtained, I then developed interview schedules that I would use to guide the discussions.

The interview schedules were divided into two sets, namely those for individuals and those for focus groups. The interview schedules were further designed as to differentiate those used for health workers focus groups from those used for learners. Arrangements were finalised about the time and places. The process took at least two weeks to complete in terms of preparations.

Phase two consisted of the actual data collection through the use of individual interviews and focus group discussion of the key participants that were sampled based on their role in the campaign (implementers or beneficiaries) as well as being in the community as residents or workers. The collection of information was done through writing and voice recording using the cell phone.

Phase three is the stage when I had to study, reflect and, write down the findings from all groups and individuals consulted. I then had to analyse and interpret the information I received or the experiences I encountered in my interaction with the participants. This is the stage where the components of qualitative research are evident in interpretative, multi method triangulation and being in the surroundings of the target people being researched.

The fourth and the final phase involves recommendations and conclusions. The researcher will make recommendations, based on what he/she has found in the study. The recommendations revolve around solving the problem that was being investigated.

3.3. Qualitative research

3.3.1. Definition

The qualitative research method is a method of research where researchers collect data in the form of written or spoken language or in the form of observations that are recorded in a language, and analyse the data by identifying and categorising themes. (Durrheim & Terre Blanche, 1999).

They further explain that qualitative methods allow the researcher to study selected issues in depth and give provision for openness and detail as they identify and attempt to understand the categories of information that emerges from the non numerical data emerging from interviews and discussions.

It consists of three components namely interpretative, multi method and thirdly it is conducted in the person's natural surroundings such as school, playground, at a therapy session or the office. The interpretative aspect allows the researcher to look into everything concerning the research object such as words, appearance, pictures, documents and other non-numerical data. The multi method aspect allows the researcher to use a variety of methods to collect data. It is taken that using several methods allows a better understanding of the matter or phenomenon that is being investigated. The use of several methods to reach a better conclusion or understanding is called triangulation (Christensen, 2004).

3.3.2 The rationale for using qualitative research in this particular investigation

I chose the qualitative research method based on the above definitions. The objective of my research topic was not to collect technical or numerical data but to delve into issues and experiences of the implementers of the HCT campaign in the rural village of Ga-Motupa.

Qualitative research is described as naturalistic, holistic and inductive rather than being deductive. It studies real world situations as they unfold naturally. It is non-manipulative, unobtrusive and non-controlling. It is open to whatever emerges during the study and avoids predetermined constraints on outcomes (Durrheim & Terre Blanche, 1999).

Secondly it is holistic. It looks at the broader picture or whole phenomena (phenomenology) rather than the sum of its parts. It focuses on interdependences and does not reduce issues to a few discreet variables and linear cause and effect relationships.

Finally it involves immersion in the details and specifics of the data in order to discover important categories, dimensions and interrelationships. It begins at exploring genuinely open quarters instead of testing theoretically derived hypotheses, (Durrheim, 1999).

The choice of this method was meant to give a near direct experience of the issues around HCT and to provide an opportunity to make a follow- up through future studies on other aspects that may emerge during the current research.

3.4. Data Collection tools and techniques used

3.4.1 Interviewing: An interview is a more natural form of interacting with people than making them fill out a questionnaire, do a test or perform some task. It gives us an opportunity to know people intimately, so that we understand how they feel (Durrheim, 1999).

An interview can be structured through formal questions, like a prepared questionnaire. It can also be semi-structured, to enable the researcher to focus on what he /she wants. In its kind of an interview, an interview schedule can be developed where lists of key topics and sub-topics are outlined in advance (Durrheim, 1999).

I have in my plan used the semi-structured interview, for the educator, the care giver, project leader and health professional. Each of the participants responded to the set of questions I prepared beforehand, allowing myself to probe where I needed more clarity.

3.4.2. Participant observer method

This approach involves interacting with people in a naturalistic way and it makes it possible to understand their world inside out (Durrheim & Terre Blanche, 1999). I decided not to use this method outright as it would requires a long time and needed me to be imbedded in the target milieu, where I would not even be recognized a researcher.

3.4.3. Focus Groups

My approach was more inclined to using focus groups and interviews as the main methods of data collection. Focus groups are defined as a group of selected individuals and assembled by the researcher to discuss and comment from personal experience, on the topic that is the subject of research (Powell et al, 1996).

Focus groups are a form of group interviewing. Group interviewing involves interviewing a number of people at the same time, the emphasis being a question and response between the

researcher and the participant. Focus groups “rely on the interaction within the group itself, based on the topics that are supplied by the researcher” (Morgan,1997).

3.4.3.1 Main purpose of focus groups

The main purpose of focus groups is to draw upon the participant’s attitudes, feelings, beliefs, experiences and reactions in a way in which it is not feasible using other methods e.g. observation one to one interviews or questionnaire surveys. They elicit individual attitudes, beliefs and feelings. They elicit a multiplicity of views and emotional feelings within a group context (Gibbs, 1997).

They are useful when there are power differences in the group e.g. decision-makers professionals and participants (Morgan & Kruger, 1993 in Gibbs, 1997). Focus groups can also help to explore or generate hypotheses. Develop questions and concepts for questionnaires and interview guides.

3.4.3.2 The role of moderator in focus groups

The moderator is the person in charge of the research focus group. They have to explain to the group the purpose of the discussion. He /she have to make the participants feel at ease and promote or facilitate the discussions. This could involve challenging some people who are quiet to participate, probe and challenge the group to debate some aspects. They keep order and have to create opportunities for everyone to participate.

3.4.3.3 Ethical Considerations

Moderators are to ensure that information about the discussions and purpose are clearly understood by everyone. The participants have to agree to keep the information discussed as confidential. The moderator should be honest and keep participants informed about what is expected from the participants.

3.4.4. Qualitative validity

William M.K Trochim (2006) presents a compelling argument as measuring the validity of a qualitative study, without using the qualitative criteria. He outlines alternative criteria for judging qualitative research, namely:

Credibility: It involves establishing that the results of qualitative research are credible from the perspective of the participants as in the research. The purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes; the participants are the only ones who can legitimately judge the credibility of the results.

Transferability: refers to the degree to which results of qualitative research can be generalized or transferred to other settings. The researcher can enhance transferability by doing a thorough job of describing research context and assumptions that were central to the research.

Dependability: in qualitative research, refers to the need for the researcher to account for ever-changing context within which research occurs.

Conformability: the degree to which the results could be confirmed or corroborated by others. To address conformability the researcher can document the procedures for checking and rechecking the data through the study.

The table below shows the different approaches in judging validity between qualitative and quantitative research. The comparison illustrates the divergent views regarding the two methods.

Traditional criteria for judging quantitative research	**Alternative criteria for judging qualitative research**
Internal validity	Credibility
External validity	Transferability
Reliability	Dependability
Objectivity	Conformability

www.social research methods.net/kb/qua/val.php.

Other ways of establishing validity/dependability and credibility in qualitative research related to the above are amongst others outlined as follows: Member check, where another researcher double checks the findings. Interviewer corroboration is similar to member check but here interviewers who worked side by side compare their findings.

Peer debriefing involves sharing of findings by colleague researcher. Other methods are prolonged engagement, negative case analysis, auditability, conformability and bracketing balance (Lincoln & Guba, 1985).

3.5. Research Population

The purpose of my investigation was to find out from the beneficiaries, the impact of the HCT campaign at Ga-Motupa village. The second objective was to find out the extent to which the intended beneficiaries are aware that a particular campaign is running in the community. Thirdly the aim was to find out if there were any challenges of implementing the campaign in the area. The research population therefore is guided by these objectives. The research design as described in the preceding discussion, informs the decision on sampling.

3.5.1. Sampling: The local health workers, caregivers, learners of a primary and secondary school, educators, pastors, traditional healers were identified as the population from which to draw my sample.

The sampling put the population into two categories, the implementers and the beneficiaries. Some of the participants such as the Care givers could be classified as both implementers and benefactors of the HCT campaign. The participants had to come from the target community and it should be possible to access them in a short time.

3.5.1.1.Purposive sampling is said to be the most common where participants are chosen according a particular criteria. The size depends on availability of resources. In the case of this study, I decided to keep the sample size of the learners for the focus groups at six. The size of the focus group of care givers requested was six as well.

3.5.1.2. Quota sampling

The type of sampling, is decided while designing the study as to how many people, with which characteristics can be included as participants. Characteristics may include age, place of residence, gender, class, profession, marital status, HIV status etcetera.

Differences between quota sampling and purposive samples

Both identify participants based on certain criteria. Quota sampling is mere specific with respect to sizes and proportions of subsamples. E.g. looking for people who are HIV positive-quota sample would go for an equal number of men and women. (FHI,2009)

3.5.1.3.Snowball sampling

This method is also known as chain referral sampling. “Participants, with whom contact has already been made, use their social networks to refer the researcher to other people. It is used to find and recruit hidden populations” (FHI, 2009).

3.5.2. Ethical guidelines

Qualitative research methods: A data collectors guide Module I- Family Health International points out that a qualitative researcher must undergo formal training in ethics, where he can be trained in mentoring, intellectual property, fabrication of data and plagiarism.

Another important aspect in the ethical guidelines regarding qualitative research is that, research participants are top priority to the research itself. If the participants will be harmed by the research, it’s the research that must be sacrificed.

The discussion document further points to the Belment Report on Ethical principles and guidelines for the Protective of Human subjects of Research (National Institute of Health, 1979). The report outlines three core principles that are universally accepted:

Respect for persons: People will not be used simply as a means to achieve the research objectives.

Beneficence: Participants should be made to understand the risks and benefits of participation.

Justice: The beneficiaries of the research results should be the ones to participate in the research.

Respect for communities: Researchers should have respect for the values that are fundamental in the communities where they conduct the research that might be affected by the outcomes of the research process. The researcher should protect the community from harm.

3.5.3. Informed consent

Participants should be informed about the research before they participate. Depending on the size and nature of the research, all relevant stakeholders need to be informed about the research and what it entails. Formal permission should be obtained where necessary.

In conducting in depth interviews and focus groups, the participants should be informed about the purpose of the research, what is expected of a research participant and the time required. They should be informed about the expected risks and benefits both social and psychological. The fact that participation is voluntary they should be informed that they can withdraw at any time. They should also be informed that what they share in the research will be kept confidential. The researchers should also provide contact numbers in case someone wants to call. The contact numbers of the senior researcher should also be provided in case participants want to consult him/due to problems arising from the research process.

3.6. The data collection process

3.6.1. Interview schedule development

In developing the interview schedule the researcher should clarify the reason for the study, determine the information he/she will require from the participants, prepare and list the questions that will be asked, and also identify any additional information that may be required (Durrheim & Terre Blanche, 1999).

An interview schedule is a group of written questions used to gather information from respondents, and it is regarded as one of the tools for gathering data in social sciences.

The study required the researcher to find out from the respondents, a specific type of information based on the HCT implementation. The questions designed would help the researcher to find out about the awareness, impact and challenges of implementing HCT campaign.

The qualitative research open-ended questions “allow the respondents to communicate their own experiences or opinions about a specific issue in their own words without restriction” (Durrheim & Terre Blanche, 1999).

I developed the questions with the aim and purpose of allowing my respondents to express themselves freely. The only instance where the question was close-ended was on some items where I needed direct answers, for example HCT as compared to VCT.

3.6.2. The information collection process

Each category had a set of questions to respond to, prepared beforehand. The categories were classified as follows: **Focus groups** (a) care givers, pastors, traditional healers, traditional

leaders; (b) ABET practitioners drawn from the life skills HIV & AIDS; (c) education programme trainees; (d) primary and secondary school learners. **Interviews**: (a) Educators, one from the primary school and the other from a secondary school; (b) Health professional, and NGO project leader.

The questions were prepared beforehand and they assisted me in focusing on the issues that I wanted to investigate. I also discovered in the process that the focus group in the primary school was less interactive compared to the one at secondary school. The focus group discussion shifted in its approach to a form of semi-structured interview.

The secondary school learners on the other hand were able to debate and discuss issues put to them by the researcher, in a more rigorous way, with depth and insight.

The responses and feedback to questions were recorded on the writing pad, to be able to refer to them during analysis. The researcher also used a cell phone for voice-recording the responses to support the notes. The salient issues that came up from the discussions were noted down for further reflection, analysis and interpretation.

The focus group discussions conducted with the care givers, was informative, vibrant and diverse concerning issues of HCT, such as the new protocol on CD 4, testing for all patients visiting any government health facility and condoms. They also raised the issue that they saw as challenges. The size of the group made up of twenty five care givers was posing a participation problem as I had to create space for all participants to share their view and experience.

The focus group discussions enabled the researcher to understand the dynamics that are at play in the day to day work of the care givers. Issues of scarce resources, support staff for counselling and financial problems in respect to stipends were raised.

Focus group discussions – Care givers

Care givers involved with the HCT campaign in Ga-Motupa are recruits of a USAID funded NGO, called Humana-People to People. The project started in 2008 with +- 5 volunteers and has now grown to 25 volunteers and one project leader. The NGO has an office in Ga-Motupa where they meet daily or weekly or monthly for debriefing meetings and reports. The volunteers receive a monthly stipend of R500.00. The age group of the care givers ranged

from 21-45. The majority of the care givers were women. The educational levels differed but the majority do not have matriculation but are literate.

They come from poor families with little or no income. The caregivers are receiving a monthly stipend of R500.00. Sometimes they work for more than three months without receiving the stipend.

Focus Group: Adult Basic Education (ABET) Practitioners

During the data collection campaign, I decided to conduct insert a group which was not originally part of the sample. I arranged a focus group session with ABET practitioners, who were part of a workshop on sexuality education which was organised by the department of education.

I sampled six practitioners, all women aged between 35 and 45 years. The practitioners came from three different circuits of the department of education, namely Modjadji, Sekgosese East and Giyani. The circuits are separated by between 50 and 100 kilometres from one another and from Ga-Ga-Motupa village.

The Rationale of including the sample: The ABET practitioners are part-time contract workers of the department of education. Most of them are not having another job and are therefore staying at home and attend to tutoring in the afternoons, from 13:00-16:30.

In the case of an effective and successfully carried out information campaign, they would be know it and pass the information to their learners. Secondly, the fact that the focus group is not made up of people from the same community could add value to or expand on the information received from people who live at Ga-Motupa community.

Focus group: Learners primary school and secondary school

The first school is Ga-Motupakgomo situated 600 metres from the local clinic. It has approximately 900 learners and has grade R-7, the school has a vegetable garden and school nutrition programme. It has about 25 educators. The school has an HIV/AIDS committee, an HIV policy and OVC programme. My focus group consisted of 6 learners. The age of the learners and the presence of the deputy principal could have stifled their free participation.

Educators Interview

The educators are from Ga-Motupa-Kgomo primary school and Mohlatlego-Machaba secondary school. The schools are within a distance of four kilometres from each other. The educators were interviewed separately as were the focus group discussions. I had prepared ten interview questions to use in the interview.

3.7.Conclusion

The data collection process was planned in a way that it could address the objectives of my research question. The interview schedules were helpful in ensuring that the data collection process was focused.

Chapter 4: Research findings

4.1. Introduction

In this section, I will outline the findings of my investigation, based on each question posed. I will interpret and comment on what I understood the responses to mean, in relation to the research objectives. I will then make recommendations based on the findings.

4.2. Focus groups findings

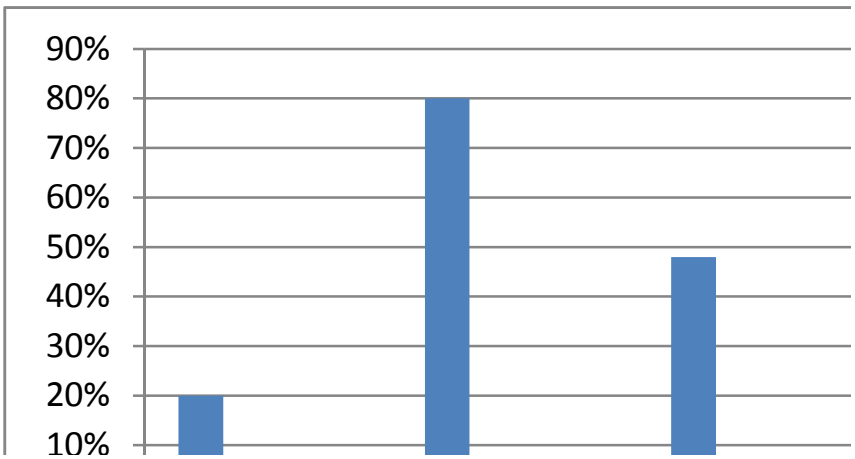
The following graphic estimates were created to illustrate a graphic representation of levels of awareness of the HCT campaign among participants.

Is the HCT campaign well understood by all involved?

The health professionals and the caregivers were the only primary participants in the research who knew the HCT campaign. The finer details were still hazy for some caregivers.

The beneficiaries of the campaign, being learners, caregivers as members of the community, educators, ABET practitioners (as members of the community as well) indicated that they had heard little if not nothing about the HCT despite its national, provincial and district launches in 2010.

Chart 1: Focus groups estimated levels of awareness on the HCT campaign.



Note : The Care givers had a higher level of awareness of the newly launched HCT campaign than the other focus groups. The learners at the primary school (learners 1) seemed to be

better aware of the HCT campaign activities than their counterparts, the secondary school learners (learners 2).

4.2.1. Care givers: findings

Care givers involved with the HCT campaign in Ga-Motupa are recruits of a USAID funded NGO, called Humana-People to People. The project started in 2008 with +- 5 volunteers and has now grown to 25 volunteers and one project leader. The NGO has an office in Ga-Motupa where they meet daily or weekly or monthly for debriefing meetings and reports. The volunteers receive a monthly stipend of R500.00. The age group of the Care givers ranges from 21-45. The majority of the care givers are women. The educational levels differ but the majority do not have matriculation but are literate. They come from poor families with little or no income. The caregivers are receiving a monthly stipend of R500.00. Sometimes they work for more than three months without receiving the stipend.

The first question expected the group to respond to the statement that the prevalence of HIV is reported to be very high in the community. One care giver responded that it was possible that the prevalence of HIV could be high in Ga-Motupa. “There are many taverns here, people go and drink beer, and when they are drunk, they have sex without using condoms.”

There were only six young men aged between 24-35 years in the group. One young man indicated: “the condoms that are being issued are for big people. Small children aged between 8 and 15 try to use them after going to taverns but they can’t put them on because they are small, something should be done to make condoms that fit them because they are having sex”.

One young lady in the group added : “There are young girls in the village who go to Tzaneen in the evening to sell their bodies as sex workers, maybe they also have sex without condoms or they cannot use them even when they want to because they want money.”

The participants seemed to confirm that there could be behaviour patterns that were promoting the spread of HIV and AIDS in the community.

Another input from one of the young women was that people don’t want to go for testing until it is too late to help them, while blaming the opportunistic sicknesses to witchcraft.

One other statement given in support to the high prevalence report was that “foremen demand to sleep with you before you can get a job at the farms.” The level of poverty was said to

drive young people seek pregnancy and risk HIV/AIDS infection in order to access the government social grant and food parcels in case they become pregnant.

The responses given by the participants indicated the need to address the HIV problem from social, cultural, religious and economic perspectives. The issue of power relations between men and women, employer and employee or job seeker was bigger than what it is perceived to be.

On responding to item three, which required the group to elaborate VCT and HCT, the care givers responded knowledgeably and explained the new rules and protocol with ease. On further trying to find out about the launch of the campaigning at Ga-Motupa, the group was not certain whether a launch took place or not. Among a group of 25, only three indicated having participated in the launch of the HCT campaign at the local Relela showground on 10 June 2010.

Items 5-7

How do you see your role in the HCT campaign at Ga-Motupa village?

The question looked for their awareness of the pivotal role they play as agents of change in the fight against HIV in their community. The response was indicative to their understanding of being a link between the Department of Health and treatment they receive. They indicated their role as being information givers, encouragers for taking medication and referring agents.

They saw their role as being critical and central in fighting HIV/AIDS and TB. HIV through mobilising people to go tests and TB by providing directly observed treatment (DOT). Some challenges were noted that I will outline at the end of this report.

4.2.2. ABET practitioners findings

I selected two items: from appendix 1: Items 9 and 11.

The response for item 9 was: The HCT campaign as it is currently being implemented is not known among the ABET practitioners on but one of them collided with the request to be tested for HIV when she visited the local clinic at Muyexe (a village in the presidential nodal areas 250km North East of Polokwane).

Item 11 wanted to find out about the involvement of the ABET centres in the HCT campaign. The discussions led to the realisation that there was no effort from the implementers of the

campaign so far, to involve the ABET sector in fighting HIV pandemic. The sentiment echoes the report on the HIV and AIDS Strategy 2008-2012, (pp 21-23) of the Limpopo Education Department, which pointed out on the neglect of Further Education and Training (FET) colleges regarding HIV and AIDS preventative programmes within all campuses in Limpopo.

The focus group discussion also highlighted the role that ABET centre can play due to their annual intake of most learners who are unable to pass matric and are no longer eligible to continue as fulltime learners.

The inclusion of this focus group also broadened the scope of the sample that was available for exploring the research data and could provide corroborative evidence of the impact of the HCT campaigns in most remote villages in Limpopo province and Mopani district in particular.

4.2.3. Learners; Primary and Secondary school findings

The presence of the deputy principal was meant to provide reassurance for the learners but it seems to have had the opposite effect. The result was that the focus group approach shifted to that of a structured interview.

Items 1-3.consisted of close-ended questions. The purpose was to find out about their knowledge of the campaign. The questions drew a zero response despite probing.

Item 4. the group reported that there were no activities for prevention messages except those that come through Life Orientation and Life skills lessons in class.

Item 5. The school is being visited by the local clinic for health support messages. The school had been visited once in 2010 by the Municipality, the local NGO Humana and the local clinic health workers.

Items 6-10. Responses to these questions indicated that activities on HIV and AIDS were taking place at school but the HCT campaign as newly launched was unknown to learners in the focus group.

4.3. Individual Interviews findings

4.3.1. Professional Health Worker and NGO Project leader

The local clinic provided me with a health worker to interact with. She is 28 years old and responsible for HCT. She is a volunteer and paid by NGO. The project leader of the local NGO was prepared to be interviewed. The interview was semi-structured and focused on the HCT campaign.

Items 1-2 were responded to well, indicated thorough knowledge of the HCT campaign and the changes in the protocol.

Item 3. The response indicated a relationship between the provincial, district office and the regional office management. These officials visit monthly and weekly respectively to monitor the work and implementation of programmes including HCT.

The nursing professional responsible for the HCT campaign meets with the care givers on a weekly and monthly basis to discuss problems, challenges and cases that are special. The meetings are used to provide new information and guidelines.

Item 4. The health worker I interacted with indicated the shortage of or lack of enough human resources as she was the only person at the clinic responsible for HCT on a daily basis. While I was busy interviewing her, someone who needed counselling knocked at the door for assistance. It was then that she indicated “I am the only one who is responsible for counselling patients and testing them for HIV”. “We volunteers, myself and the care givers, we are not paid by the department of health, and we have not been paid any stipend since November 2010” She said this, looking at the table top, trying to be strong and holding her breath as she spoke. She looked disturbed by the fact that the work was heavy and yet there was no compensation.

Item 5. The roles that the health worker fulfils in the HCT campaign are of counselling of people who come for testing, ensuring that the testing kits are available by communicating with the clinic manager, keep the records of all tested individuals, control the weekly statistics and meet with the care givers on a weekly and monthly basis for debriefing. The discussion of the case load and experiences is chaired by the local clinic nursing manager. It seemed that most of the work was done by the volunteer counsellor who is usually drawn from PLWHA’s from the NGO.

The health worker indicated that the campaign had led to bigger workload as everyone coming to the clinic had to be encouraged to test for HIV. She pointed out that on some days "you have more people that test HIV positive than those that test HIV negative" and that was scary to see and very discouraging.

Items 6-8 responses: She indicated that churches, traditional healers and traditional leaders needed to come on board as there were no messages coming from these quarters about them being involved in the campaign.

Item 9. She lamented that she was the only volunteer at the clinic and she was not coping with the work as she had to do counselling for everyone who must test. She expressed the wish that it would help if the department of health could employ counsellors and have them on their payroll. Indunas should be involved in organising HCT information campaigns in villages to ensure that everyone is informed.

The relationship between the clinic and care givers is good. This good relationship can assist the campaign implementers to achieve more if they take advantage of it.

Other challenges raised by the Health worker were that:

There was only one doctor who visited the clinic to attend patients. She felt that there was a need to have a doctor who would come specifically to attend to HIV positive patients who are on ARVs. The other challenge was that there was only one mobile unit for servicing the village and it was not able to access all the people who needed help.

The apathy of churches and local pastors still created a challenge for the HCT campaign to spread to all the corners of the community. Traditional healers were not part of the campaign and this created problems as many people consulted them when they are sick and they give them false promises that make them not to come for tests or take ARVs.

4.3.2. Educator Interview findings

Item 1& 2: None of the two educators were aware of a campaign called HCT in their schools. Neither were they able to outline the similarities of differences between VCT and HCT even when the abbreviations are explained. The researcher then had to clarify the concepts and

then posed a question about the knowledge of the HCT campaign and the response was negative.

Item 3. The teacher at the secondary school indicated that there were no planned activities for HIV prevention messages within the school. The Life Orientation subject was the only vehicle and any other programmes were seen as distractions to the academic programme.

The primary school educator indicated that the school had a committee that was responsible for organising events for the school to participate in the annual HIV and AIDS calendar.

Items 4 & 5. On the question about the school policy on HIV and AIDS, the secondary school educator indicated that people have been trained on policy development at the school. Unfortunately, no policy had been developed yet and there was no committee responsible for HIV and AIDS matters at the school.

The educator from the primary school confirmed the existence of a committee for HIV called the Health Advisory Committee. She also confirmed that a policy on HIV and AIDS had been developed for the school.

Item 6. Both educators indicated that they had never heard about the newly launched HCT campaign. The schools indicated that a one day campaign at school where a mobile clinic would be made available to provide testing on site would assist the HCT campaign.

Item 7. The teachers would appreciate to be given training/workshops by the care givers and the clinic on the HCT campaign.

Item 8. The teachers, both the primary and secondary indicated to be having a database used to guide and support orphans and vulnerable children (OVCs).

Item 9. The teacher has not seen or heard anything about the strategy for HCT in Limpopo Education Department.

Item 10. Partners: The schools would appreciate to have health workers and care givers as partners. The secondary school had never had any visit from the clinic or the NGO. Chart 2. findings of individual interviews:

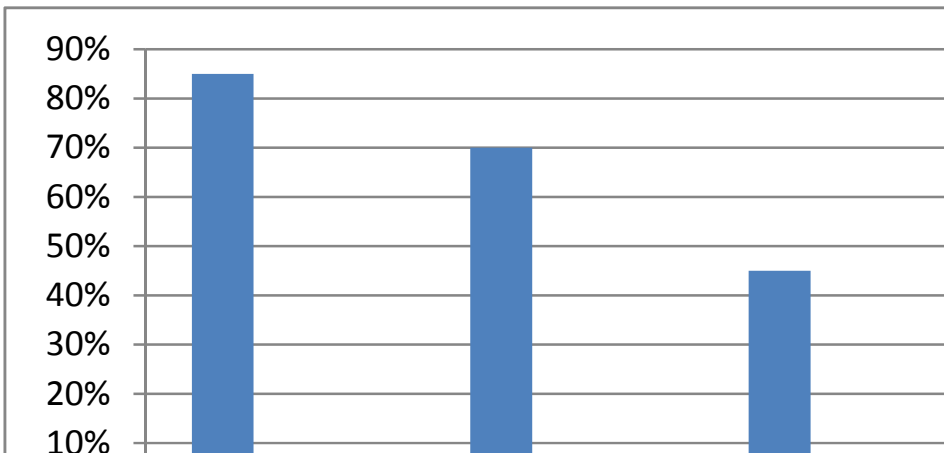


Chart 2. Estimation of HCT campaign levels of awareness among individual participants interviewed.

Note: The Health worker and the NGO project leader had a higher level of awareness in comparison to the two educators. The educator at the primary school (educator 1) was more aware of activities going on in the community about HIV than the educator at the secondary school (Educator 2).

Deductions: Based on these findings, it shows that the levels of awareness on the HIV Counselling and Testing campaigns are still very low among the target groups. The awareness levels may as well be depicting the general awareness levels among school going youth and the other categories not linked to the health department of NGO sector.

The implementers of the campaign are well prepared in terms of the information that must be communicated to the masses in the community. The challenge is for the department and its stakeholders, to refine the strategies of the campaign so that the targets may be reached and the main objectives of the campaign may be achieved.

4.4. Analysis of the findings in relation to the research topic

4.4.1 Care givers

The majority of the care givers have sufficient knowledge and information regarding the HCT campaign. They displayed awareness of the new protocols for counselling, testing and treatment. They knew the policy for testing everyone who came to the clinic for any ailment. Chart 1 above which illustrates levels of awareness, points the care givers as the most knowledgeable group concerning the campaign, followed by the learners at the primary

school. The learners at the secondary school are not aware of the HCT campaign. The ABET practitioners are the least knowledgeable.

4.4.1.1. Impacting the community with knowledge and information. The above analysis indicates that the campaign has not yet successfully covered the community as it should have done. The schools are key centres of information distribution in most communities. The ABET practitioners also represent the majority of poor rural communities that was supposed to be targeted by the campaign. The HCT campaign will not be able to benefit the community if it remains as the property of the implementers. The knowledge and information gap between the implementer and the beneficiary should be narrowed to have the campaign declared effective.

4.4.1.2. Representivity

The responses of the various groups that were involved in the research, based on their level of awareness, could be a reflection of the reality in terms of the knowledge and awareness about what is going on with regard to the new campaign on HCT in the country especially in the most rural and most affected communities. The seeming response in the form of numbers of people coming to the clinic for counselling and testing can be attributed to the work done by care givers as they move from house to house attending to the TB patients more than to the success of the campaign itself.

4.4.1.3. Coordination among the implementers of the campaign

The local clinic and care givers have good coordination through their weekly, monthly and quarterly meetings. The NGO that works with the local clinic seems to relate well with the local clinic management, looking at the way the meeting for planning the research programme was coordinated. The use of cell phones and word of mouth is effective in communicating important messages across.

4.5. Challenges among Care givers and Health workers

The investigation has highlighted the challenge of lack of resources such as more mobile clinics, shortage of doctors, the overburdening of health workers and care givers with work load, trauma and stigmatization. Care givers run the risk of contracting TB as they do (DOT)

and are stigmatized as they are perceived as being HIV positive. They work for months without the promised stipend, which further demoralises them.

The dysfunctional health system

The respondent health worker indicated that only one mobile clinic for HCT was available in the village. The mobile clinic was supplied by an NGO. Poor staffing has led to only one counsellor being outsourced from the local NGO to do counselling and testing for the patients at the clinic.

Shortage of testing kits sometimes occurs and people have to be turned away without being tested. This is indicative of a health system that is not ready to implement HCT.

The question is: Is the 50% target set by SANAC and the NDOH going to be reached given such gaps in the health system?

4.6. Educators and learners as benefactors of the HCT campaign

Educators in Limpopo die almost every week, given the notices of memorial services issued by the union for educators, SADTU in the area. Despite the fact that the cause of death is not known, it is indicative of a pattern that has shown a high teacher mortality rate in the community. The findings show that some schools have policies that address issues of HIV and AIDS while some don't have. An example is the secondary school whose educator was interviewed. On the issues of school policy nothing was available at the school.

The HCT campaign was not known by the educator who was interviewed. There was no understanding of the difference between VCT and HCT .

The indication is that teachers as benefactors of the HCT campaign have not received any information on HCT. The care givers had pointed out earlier that schools are not their target group. The result is that at the time the research was done, the HCT campaign had not reached the school. The teacher indicated that for the year 2010, no health worker had visited the school.

The learners pointed out in their feedback and discussions that "our friends want money too much, so they fall in love with older persons to get money if their parents cannot afford to give them more money". One learner pointed out that their peers were operating as sex

workers in Tzaneen. These learners were actively debating that the HCT campaign has not reached them even through clear radio messages. One learner said “I am listening to Capricorn FM and I have never heard anything about the HCT campaign.”

Educators and learners are supposed to be in a better position to receive the HCT messages because they are young, active and interact with many of their peers. If the message is not reaching them, very few will know their status and some may continue to infect others unaware of their own status. The young people aged between 15-25 are the most vulnerable. Learners and educators have so far not benefited from the HCT campaign, either in terms of receiving information on HIV/AIDS or TB other the old messages they have received before the launch of the campaign in June 2010.

4.7. Performance Monitoring Evaluation and Support

The care givers are monitored weekly, monthly and quarterly by their supervisors. Reports are written and problem areas are addressed. All experiences are shared for the others to learn. This provides a good support system. The HCT campaign is currently not being monitored as a campaign in its own right, to ensure the flow of information to all relevant beneficiaries as listed in the strategic document, for the youth in big churches such as the Shembe, Zion Christian Church or International Pentecostal Holiness Church.

The implementers of the campaign focus more on taking daily numerical data and the monitoring and support for the foot soldiers is hardly done.

4.8. Conclusion

The findings outlined above, point to a need by all the stakeholders to develop systems that will enable the momentum of the HCT campaign to be sustained not only at national level and the designated provincial monitoring sites only, but at every community.

In the next chapter I will discuss the recommendations, based on the findings with specific reference to the target area studied.

Chapter 5: Conclusions and recommendations

5.1. Concluding remarks

This is a small study but it highlights in its own way the challenge of launching campaigns and sustaining their momentum until the set goals are accomplished.

Having looked at the responses and analysed the feedback and the target set by the department, for example halving HIV infection by 50% by June 2011, the goal seems bigger than the effort being exerted, especially in a remote village like Ga-Motupa where the HIV prevalence have been reported to be very high.

5.2. Recommendations

To achieve the goals of the HCT campaign at Ga-Motupa I would recommend that the department of health should put into place systems that will ensure that the HCT campaign is managed effectively so that it can reach all the target groups. Secondly, the momentum of the HCT campaigns should be sustained at a very high level until everyone even in the remote area has heard and knows about it. All relevant stakeholders at all the right levels and coordinating their interaction to achieve the set goals for example pastors or leaders of churches especially the large and influential churches in the community, local chiefs and Indunas, local municipal counsellors must be involved.

The Department of Health should provide adequate resources in a way that matches the resoluteness with which this campaign has been launched. The monitoring should not stop at collecting monthly data but provide support for the workers in the HCT programme.

Government and NGOs should create strong and effective compensation systems to provide the already exhausted and frustrated care givers with enough financial support. The FET colleges and ABET centres should be targeted with programmes for HCT. On-site testing at schools, churches, FET colleges and taverns, using mobile clinics should be done to ensure that the target is reached.

The government should target the cell phone service providers, and transmit HCT messages for a protracted period of time. The use of local community radio stations should be solicited

and messages should be broadcast that will ensure that every young person whom is sexually active should consider taking an HIV test.

Schools should plan advocacy campaigns into their annual programmes and ensure that correct messages are passed to the learners. The HCT campaign should target taverns and night- clubs.

Care givers and health workers should be given support in terms of counselling. They should be given immediate medical attention in cases of sickness because they are highly exposed to many infectious diseases. Volunteers should be given their stipend on a regular basis as a motivation instead of leaving them hungry for several months.

5.3 Limitations of the research

Time spent with focus groups: I would have loved to have more time to interact with the focus groups. I believe more could have been understood especially with regard to the challenges they come across as they carry out their day to day duties and their door to door campaign.

I would have loved to have done a wider study of campaigns and of the things that make them fail or succeed and looked into the unique nature of a campaign such as the HCT campaign.

The campaign is hardly a year old since its launch, maybe doing a study like this after one year could yield more realistic information. Therefore there is a possibility that the study could have been conducted prematurely. Another study may be done between in June 2011 and June 2012, looking at the monitoring instruments and how effective they might have been in improving the HCT momentum.

I have however looked at issues that I feel may be considered in monitoring and evaluating the campaign as it matures into a full year of being in operation.

The other limitation was in the unobtainable official statistics at the local clinic, this has to a certain extent deprived the critical part of clear numerical data I could have used to.

5.4. Areas of further research

The investigation has created questions that might still need to be researched, such as:

(1) Effective ways to institutionalizing HIV & AIDS education as prevention for the spread of HIV among learners.

(2) How pastors and traditional healers can assist to fight HIV & AIDS within their settings.

(3) HIV and AIDS Campaigns that succeed and their distinguishing features.

(4) Challenge of resources and skills for the care giver.

(5) How taverns and shebeens can be transformed from being vulnerable spaces of spreading HIV into safer environments for 0% HIV spreading.

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7. APPENDICES

Appendix 7.1 Focus group questions Care givers

Topic: The impact and challenges of implementing the national HIV Counselling and Testing campaign in Ga-motupa village

Focus group discussion questions

Target Group: Care givers, Project Leaders, Pastor, Traditional Healer

Scope of questions: The questions will focus on the following aspects as guided by the research questions:-

The prevalence of HIV and AIDS in the area and its implications

The HCT campaign, launch and implementation

The role of the role players and their relationship with one another in relation to the HIV campaign

- The impact the campaign has had regarding HIV and AIDS in the community
- The challenges experienced in implementing the goals of the campaign
- Challenges in benefiting from the HCT campaign

Discussion guide

1. The community of Ga-Motupa is reported to be among the highest in HIV prevalence in the Mopani district. Can you comment about the report?

2. Are there any reasons that lead to such a situation?

3. Can you outline the difference of similarity between Voluntary Counselling and Testing? and The National HIV Counselling and Testing Campaign?

4. If indeed there are differences, can you explain why the campaign was launched? was there any event that marked the launch at the village/community? Explain your experience and Your understanding of this event.

5. How do you classify /see yourself /see your role to be in this campaign?

6. As a role player of one sort or another, how is your relationship with the other participants In this campaign?

7. Explain the activities you are engaged in the HCT campaign in the community.

8. Outline the problems and challenges you experience as you play your role in the HCT Campaign in your community.

9. How do you see people responding to the HCT campaign in the community?

10. Comment on the involvement of the churches in the HCT campaign.

11. Comment on the involvement of the schools in the HCT campaign.

12. Are there any gains or achievements or any difference the campaign has made in the lives Of the people in the community regarding HIV and AIDS, Testing and Counselling?

13. The HCT campaign has to do with people getting information, receiving counselling getting tested, receiving Anti-retroviral treatment.

QUESTION 5-7

How do you see your role in the HCT campaign at Ga-Motupa village?

The question looked for their awareness of the pivotal role they play as agents of change in the fight against HIV in their community. The response was indicative to their understanding of being a link between the Department of Health and treatment they receive. They indicated their role as being information givers, encouragers for taking medication and referring agents.

They saw their role as being critical and central in fighting HIV/AIDS and TB. HIV through mobilising people to go tests and TB by providing directly observed treatment (DOT). Some challenges were noted that I will outline at the end of this report.

9. On the response of the people, they indicated that the response to their call for people to test is positive, confirmed by the high volumes of people turning up to the clinic for testing.

10. On the involvement of the churches as community institutions, the respond was pointed as poor participation and involvement.

11. On the involvement of the schools, to the HCT Campaign, the response indicated a very poor or low involvement.

12. On the gains of the campaign- they pointed out to the high volumes of people who go to the clinic on a daily basis for testing.

13. The understanding of the guidelines of the HCT campaign, given by Care givers was according to the SANAC strategic document provided by the Department of Health.

14. On improving the HCT campaign, the focus group participants indicated that schools were not part of their target group. In terms of their brief, they were responsible for home visits to do DOT for TB patients. They pointed out the need to increase their human resource so that teams may go to schools to communicate the HCT campaign messages. Churches were pointed out as being ideal for the spreading of the HCT messages but there seemed to be apathy, resistance or a lack of interest by local church leaders. One of the crucial stakeholders in the strategic document is the broader church movement. SANAC 2010.

15. Concerning how they felt about the HCT campaign they indicated that it brought hope to

HIV + people. They indicated a frustration on the basis that it was difficult for them to walk to other parts of the village which were mountainous and sometimes inaccessible during rainy seasons. They expressed a need for NGO or department of health t provide transport.

8 & 16. Allowed the group to deliberate on the challenges of implementing the HCT campaign, namely:

Non participation of churches in a more active and direct way

- Lack of resources such as transport as they walk long distances in the villages to reach homes with TB patients as they conduct door to door campaign
- Lack of financial support
- Lack of female condoms at the clinic
- The need to be trained to be able to administer HIV tests at the homes of the people as most don't prefer to go to the clinic due to stigma

- The issue of condoms being too big for young people who start sexual activity while still too young was heavily debated

The focus group discussion raised issues that highlighted the following salient factors:

- The HCT campaign is well known to Care givers
- Those people that are reached by Care givers come to know about HCT
- There are more reasons to step up the momentum and pace of the HCT campaign
- Schools, churches, traditional authorities have not been successfully reached by the HCT campaign
- Much more work needs to be done to sustain the momentum of the HCT campaign since its launch in the village in 2010

apy, receiving PMTCT and treating

Of opportunistic infections, STI's and TB.Discuss the statement.

14. If you were to improve on the HCT campaign in the community, how would you do it?

Make suggestions

15. What is your personal feeling about the HCT campaign in general, and with specific?

16. If there is any other comment or input you want to make, please be free to comment

Appendix 7.2 Focus Group discussion questions-Learners

Focus group : Learners (primary school and secondary)

S**cope of the questions**: The questions will focus on the following aspects as guided by the

Research questions:

- The prevalence of HIV and AIDS in the area and its implications
- The HCT campaign, launch and implementation
- Role of the role players and their relationship with one another in relation to the HIV campaign
- The impact the campaign has had regarding HIV and AIDS in the community
- The challenges experienced in implementing the goals of the campaign
- Challenges in benefiting from the HCT campaign

Questions/ Items

1. Please explain the concept VCT and HCT to me.
2. Outline the difference between the words.
3. How is the level of HIV among people of your age in the community?
4. How has your school mobilized for the prevention of the spread of HIV?
5. Can you list/mention people, groups or individuals who visited your school and spoke about HCT?
6. There are several radio stations and programmes of radio stations that you listen to, can you mention those that talk about HCT and explain the content or information given?
7. How do you as a learner get involved in the HCT campaign within your school?
9. How have you benefited /gained from the HCT campaign in the school or community
10. How would you see it if the HCT campaign was successful?
11. Can you suggest ways that the HCT campaign can be implemented to help learners at school?

Appendix 7. 3 Interview questions, professionals

Interview Questions/Items

Participant : professional health worker/ ngo project leader

1. Can you explain to me the basic difference between the current strategy of fighting HIV /AIDS and the one used previously?

2. What are the main issues addressed by the HCT campaign?

3. How do you collaborate with the other role players and who are these?

4. What challenges do you experience and how do you address them?

5. In managing the HCT campaign as per the strategic plan at your level, what are the most?

Important things do you have to look at?

6. Outline the gains of the campaign in the community since its launch in 2010.

7. How do you see people responding to the campaign?

8. Give a general view of the HCT campaign with regard to anything that has to do with

Implementing the campaign with reference to fighting HIV and AIDS in the community.

9. If you were to improve on the success of the campaign, what aspects would you suggest?

10. Any other comment

Appendix 7.4 Participant: educator

Interview questions

1. What do you know about the HCT campaign?

2. How has the campaign reached the school?

3. How would you say is the participation level of the learners and the educators?

4. Can you explain how HIV/AIDS is managed at the school?

5. Does the school have an HIV policy that is based on the National/Provincial policy?

6. How is the general willingness of the school at large for participating in Counselling and Testing?

7. In engaging the school in a more active participation in the HCT campaign, what would You the school can do?

8. Based on the requirement of the government to care for OVC's, what is the school's role?

9. The department of education in Limpopo has a strategy to address the issue of HIV among Staff members through the Wellness directorate. Can you explain the impact of this Programme at the school?

10. In keeping with the HCT campaign requirements/objectives, which partners do you think Would enhance the participation of your school, and in turn help the school benefit from The exercise and how would you engage them?

Appendix 7.5 : Permission for child to participate in focus group discussions

Consent to participate in research

Investigator : Sipho Simeon Mushwana Contact : 0768470054/082624661

The purpose of the research is to investigate the impact and challenges of implementing the HCT campaign among learners .The research among other participants, requires that learners attending school in Ga-Ga-Motupa village should participate.

All information given will be treated as confidential. No harm either physically, emotionally or psychologically will befall any learner who participates in the exercise.

Kindly complete the consent form below as confirmation that your child is allowed to participate in the focus group to be conducted at school.

I.....being the parent of .....have read the consent request and understood the purpose of the research. I have had the opportunity to ask questions and understand that my child can change their mind or I can choose to withdraw my child at any time during the focus group. I have not been coerced to allow my child to participate in the focus group discussion.

Signature of parent: Date.....

Signature of researcher: Date.....

Appendix 7.6 Authorization for Participation

I understand that as a participant in this research study:

- My participation is voluntary. I is not required to participate; I can choose to quit at any time.
- The confidential research interview will be recorded using an audio recording device.
- My identity will not be revealed in any publication or document resulting from this study or to anyone other than the research interviewer and the supervisor.

I have read or had the agreement read and explained to me and have decided to participate in the research interview.

Research Participant's name (Print):

Research Participant's Signature:

Date:

Witness: