

**The effect of a provincial communication strategy to address HIV, AIDS, STIs and  
TB (HAST) in the Limpopo Province**

by

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**SUPERVISOR: PROF S P HUMAN**

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## *Dedication*

*This thesis is dedicated to:*

*Frans Rapakwana my late father, a man of inspiration, who unfortunately could not live to witness this achievement and my mother, Linah Rapakwana, she has been there always and caring mother in my life*

**STUDENT NUMBER**

**746 324 3**

**DECLARATION**

I declare that **THE EFFECT OF PROVINCIAL COMMUNICATION STRATEGY TO ADDRES HIV AND AIDS, STIs AND TB (HAST) IN THE LIMPOPO PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other institutions.

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**SIGNATURE**

**NGWAKO JOHANNAH RAPAKWANA**

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**DATE**

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***“I can do all things through Christ who strengthens me”. Philipians 4:13***

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*“Le ka moso “*

# **THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV AND AIDS, STIs AND TB (HAST) IN THE LIMPOPO PROVINCE.**

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## **ABSTRACT**

The lack of a contextualised, relevant communication strategy focusing specifically on HAST diseases in the Limpopo Province was the impetus for this research. The purpose of this study was, therefore, to explore the knowledge, perceptions and utilisation of health facilities for HAST in order to develop an acceptable and effective communication strategy for the Province to address the high rate of HAST diseases.

The study followed a qualitative approach guided by the major tenets of the Health Belief Model, namely, to determine modifying factors, individual beliefs and cues for action. An in-depth literature review was followed by focus group interviews with the community members and personal interviews with District and Provincial Deputy Directors. Based on these findings, a communication strategy was drafted and piloted for three months in one of the districts in Limpopo. Further refinement of the communication strategy followed after member-checking and further interviews with directors HAST.

The final strategy specifically focused on risk groups with each of the diseases in terms of their beliefs and perceptions. It further resulted in guidelines for health providers in

terms of the content and implementation of effective communication strategies within the context of educational, cultural, social and economic factors relevant to Limpopo.

## **KEY CONCEPTS**

Acquired immune deficiency syndrome (AIDS), Communication, Communication strategy, Human immunodeficiency virus (HIV), Sexually Transmitted Infections (STIs) and Tuberculosis (TB).

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## LIST OF ABBREVIATIONS

ACSM	Advocacy, Communication and Social Mobilisation
AIDS	Acquired immunodeficiency syndrome
ART	Anti-Retroviral Treatment
CCMTP	Comprehensive Care, Management and Treatment Programme
DOH	Department of Health
DOTS	Direct Observed Treatment Short-course strategy
DENOSA	Democratic Nursing Association of South Africa
HAS	HIV and AIDS and STIs
HAST	HIV, AIDS, STIs and TB
HCBC	Home and Community Based care
HCT	HIV Counselling and Testing
HIV	Human immunodeficiency virus
HTA	High Transmission Areas
IDUs	Intravenous Drug Users
MTCT	Mother to Child Transmission
M & E	Monitoring and Evaluation
NDOH	National Department of Health
NGO	Non-Governmental Organisation
NPO	Non- Profit Organisation
NSP	National Strategic Plan on HIV, STIs and TB: 2012-2016
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PSP	Limpopo Provincial Strategic Plan on HIV, STIs and TB: 2012- 2016

OVC	Orphans and Vulnerable Children
STIs	Sexually transmitted infections
SANAC	South African National AIDS Council
TB	Tuberculosis
WHO	World Health Organisation

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## CHAPTER 1

### ORIENTATION TO THE STUDY

#### 1.1 INTRODUCTION

Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) was unknown to the world just 40 years ago. In the last 35 years, however, the pandemic has claimed hundreds of millions of lives across the world, with developing countries, and more specifically sub-Saharan Africa, carrying the burden of its impact (Bailey, 2016). To respond to this pandemic, most of the countries in the world adopted several approaches to curb the scourge of HIV and AIDS. Some of these strategies include the provision of condoms, offering of HIV counselling and testing, the provision of antiretroviral treatment, the promotion of medical male circumcision and health education (WHO, 2012a). Implementing an effective communication strategy is regarded by Department of Health in South Africa (2011:12) as one of the strategies available to prevent HIV and other communicable and lifestyle diseases. According to Tatham (2008:3), a communication strategy is a systematic series of sustained and coherent activities conducted across strategic, operational and tactical levels, which enables target audiences to understand preventative and promotive measures and to encourage particular types of behaviour. Though there are different communication strategies used to address communicable and life style diseases, not all the strategies have the same positive impact.

According to Uniteforsite, (2013:2), a multi-prolonged approach to communication strategies has a greater impact on prompting healthy lifestyles as opposed to an isolated and once-off approach. The importance of an effective communication strategy in the adoption of sustained healthy lifestyles motivated the researcher to explore communication within the context of her working environment.

This chapter presents an outline of the study. In Chapter 1 the background to the problem is explained, resulting in the development of a problem statement. The research design and aims and objectives of the study are also described briefly. The

details of the study during the implementation phases are discussed in following chapters, as described in the lay-out of the study at the end of this chapter.

## **1.2 THE BACKGROUND TO THE RESEARCH PROBLEM**

Human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), sexually transmitted infections (STIs) and tuberculosis (TB) (combined known as HAST) are diseases rife in Africa. The prevalence of HIV in the Southern Africa Development Community (SADC) region is alarmingly high (SADC, 2011:1). The top five countries which are severely affected by the HIV epidemic in the SADC region are Swaziland (25.9%), Botswana (21.9%), South Africa (19.1%), Zimbabwe (15%) and Malawi (10.6%) (UNAIDS, 2015:1). There is, however, disparity in terms of the prevalence of HIV in the nine provinces in South Africa in terms of the population survey of 2012. KwaZulu-Natal has the highest HIV prevalence (16.9%). The Limpopo Province, where the study was conducted, has an HIV prevalence of 9.2%, while the Northern Cape, which has the lowest population, has an HIV prevalence of 5.0% (Shisana et al., 2014). According to a survey undertaken in ante-natal clinics in public health facilities in Limpopo, the HIV prevalence rate in the Limpopo Province was estimated at 21.3% in 2012 and 20.3% in 2013 (Department of Health, 2015:55). The difference in the estimated prevalence of HIV, in terms of the two methods of data collection used, is illustrative of the need for a more reliable database of HIV prevalence. HIV is, however, not declared as a notifiable disease due to the stigma that is still attached to the disease. People are, therefore, reluctant to disclose their status and many deaths due to HIV are reported in terms of HIV-related diseases, which mask the true prevalence of the disease.

Tuberculosis and HIV/AIDS are co-infections and the high number of HIV-positive persons results in an increase in the number of people with active Tuberculosis (TB). Due to the fact that HIV and Aids are mainly transmitted through sexual intercourse, it is also important to address other sexually transmitted infections (STI) in a strategy to

promote healthier lifestyles in the battle against HIV/AIDS. This principle is embedded in the National Strategic Plan in terms of integrating intervention strategies against HIV/AIDS, STI and TB in (SANAC, 2011).

The Limpopo Province has an estimated 5.4 million residents (Census, 2011), of which 409 161 are people living with HIV and 176 000 are people on antiretroviral treatment. Approximately 50% of HIV-positive individuals are also diagnosed with TB (Moloko, 2013:1). This situation poses a huge burden on the Province as most adult members of families die due to HAST-related conditions, leaving a large number of child-headed households in the Province. (Department of Health, 2014: 3).

The high prevalence of HIV; AIDS, sexually transmitted diseases (STDs) and TB (HAST) results in increased unemployment, overcrowding, physical abuse and other social problems, which not only affect adults but also youth and children. The burden of HAST has social, economic and direct and indirect financial implications for Limpopo. In terms of direct health service delivery, this burden includes mass testing campaigns (involving 577 000 people, of which approximately 50 000 tested positive between April and September 2013); distribution of condoms (33 million male condoms and 830 000 female condoms were distributed in the last six months of 2012); male circumcisions (72 000 circumcisions were performed of which 50 000 were performed by health professionals and 22 000 were performed during traditional rituals and cultural practices) (Moloko, 2013:1). In the 2007/2008 fiscal year, the Limpopo Province spent R552 million on HIV/AIDS and TB, which increased by 35.4% to R747.7 million in 2008/09 and increased further to R915 million in 2012/13 (SANAC, 2013:2). Other related expenditure included in-patient costs; treatment and social security funds allocated to orphans, vulnerable children, family support grants and to meeting other social security needs. (SANAC, 2013:2).

In terms of prevention, provision is made in the National Strategic Plan (NSP) for HIV and AIDS, STIs and TB 2012–2016 for the communication of health information to individuals in order to empower them to make informed decisions on behaviour changes and on the prevention of diseases (SANAC, 2011:10). Although communication as a

preventive strategy is clearly emphasised in terms of various policies and guidelines (The National Strategic Plan for HIV and AIDS, STIs and TB 2012-2016, Limpopo Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016, the discussion document on the Development of the South African AIDS Council Communication strategy, National TB Advocacy, Communication and Social Mobilisation (ACSM) strategy 2007 and Provincial Communication Strategy 2009-2014 [Department of Health, 2007; Department of Health, 2011]), the nature, implementation and impact of communication as an intervention strategy has not been determined in the Limpopo Province.

As the Provincial Coordinator for the Advocacy, Communication and Social Mobilisation (ACSM) programme; one of the researcher's key responsibilities is to refine existing policies and guidelines into a feasible, acceptable and effective communication strategy with the aim of impacting positively on HIV, AIDS, STI and TB (HAST) prevalence in the Province.

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

Although guidelines and policies have been developed in an attempt to address the high prevalence of preventable disease in the country (Department of Health, 2011:25), these documents focus mainly on general principles for the prevention of communicable diseases, the processes of identifying risk groups, the importance of providing accessible services and the criteria for and the processes of isolating individuals to prevent the spread of communicable diseases (Department of Health, 2011:25). Despite the use of these existing guiding documents, indications are that the HIV infection rate, one of the HAST diseases in the Limpopo Province, is gradually increasing.

HIV prevalence among antenatal clinic (ANC) attendees in the Limpopo Province declined from 21.5% in 2007 to 20.7% in 2008, but increased to 21.4% in 2009, 21.9% in 2010 and 22.1% in 2011 (National Department of Health, 2011:9). The need is,

therefore, identified to refine existing policies and guidelines into a more focused communication strategy to address HAST diseases in the Limpopo Province.

## **1.4 AIM OF THE STUDY**

### **1.4.1 Research Purpose**

The purpose of the study was to develop and pilot a contextualised relevant communication strategy for HAST in the Limpopo Province.

### **1.4.2 Research Objectives**

The objectives of the study were to:

- explore and describe the level of understanding of HAST in the Province;
- explore and describe the nature of HAST services in the Limpopo Province;
- explore and describe the factors impacting on the high prevalence of HAST in the Limpopo Province;
- develop and pilot a contextualised relevant communication strategy for HIV, AIDS, STI and TB (HAST) for the Province.

## **1.5 SIGNIFICANCE OF THE STUDY**

Existing communication strategies are universal and general in nature. A contextualised developed communication strategy, which considers the context of people in the Limpopo Province, will be an important contribution as a tool that could be utilised by health professionals to address HAST in the Province.

The inclusion of monitoring and evaluation criteria will enhance an evidence-based approach, which will contribute towards a communication strategy from which both community members and health authorities can benefit. The community will be able to receive HAST messages which are relevant to their social, economic and cultural context. The communication strategy will address communication barriers and contribute to lifestyle and behaviour changes.

## 1.6. DEFINITION OF KEY CONCEPTS

The following are key concepts used in this study and their definitions:

**1.6.1 Acquired immune deficiency syndrome (AIDS):** A person is described as having AIDS when their HIV-related immune-deficiency is so severe that various life-threatening, opportunistic infections and/or cancers occur and these conditions only occur because the immune system is weakening (AIDS. Gov., 2015:1).

**1.6.2 Communication:** is a dynamic process in which people share their thoughts with other people through the use of symbols, in a particular setting (Samovar et al., 2013:27). According to Anderson (2011:2), communication is the transfer of information between or among people. In this study communication refers to the exchange of thoughts, messages and information among professionals and community members, specifically on issues related to HAST.

**1.6.3 Communication Strategy:** According to Tatham (2008:3) a communication strategy is a systematic series of sustained and coherent activities, conducted across strategic, operational and tactical levels, that enables understanding by target audiences, identifies effective conduits and develops and promotes ideas and opinions through those conduits to promote and sustain particular types of behaviour.

**1.6.4 Human immunodeficiency virus (HIV):** is a retrovirus that can undergo an unusual biological process in which the genetic material, in the form of single-stranded RNA, can be converted to double-stranded DNA. If left untreated, HIV can lead to AIDS. (AIDS. Gov., 2015:1)

**1.6.5 Sexually transmitted infections (STIs):** A sexually transmitted infection, or STI, is a disease (bacteria, virus, or parasite) that is usually passed from one person to another through sexual activity. This does not necessarily have to include penetration, as some STIs are passed from skin to skin contact (Department of Health, 2016:4).

**1.6.6 Tuberculosis (TB):** is an infectious disease that primarily affects the lung parenchyma. Its causative organism is *Mycobacterium tuberculosis*, of which there are a number of strains. This organism is transferred to a host by infected droplets from respiratory tract, sputum, dust and sometimes infected milk (Mnisi, Peu and Mayer, 2012:1).

## **1.7 THEORETICAL GROUNDING OF THE RESEARCH**

A theoretical grounding is the conceptual underpinnings of a study which is theory-based (Polit and Beck, 2012:728).

### **1.7.1 Theoretical Assumptions**

An assumption is a principle that is accepted as the truth based on logic or reason, without necessarily having scientific proof (Polit and Beck, 2010:547).

In the context of this research, the following assumptions, adapted from Glanz, Rimer and Viswanath (2008), were accepted:

- Implementation of a coordinated communication strategy to address HAST using a multi-sectoral approach is necessary for prompting engagement of people in health-promoting behaviours;
- An effective communication strategy will address some of the drivers of HAST;
- Motivation is necessary to develop people's self-efficacy with regard to addressing HAST by individuals;
- A person's knowledge of HAST is necessary for promoting behaviour change;
- Knowledge, attitudes and behaviour towards HAST are partly determined by socio-cultural context;
- Demographic factors, such as age, sex, language and socioeconomic status, can act as barriers which may prevent engagement in the health-promoting

behaviour, despite knowledge of the risk and challenges related to HAST. If a person believes that a particular action will reduce susceptibility to HAST or decrease its seriousness, that person is likely to engage in that behaviour. People who perceive that they are susceptible to a HAST will engage in behaviours to reduce their risk of developing such conditions.

### **1.7.2 Theoretical Framework**

A theoretical framework is the overall conceptual underpinning of a study based on a theory (Polit and Beck, 2012:128; Polit and Beck, 2010:198). This study is guided by the major tenets of the Health Belief Model described by Glanz, Rimerand and Viswanath (2008:49). The Health Belief Model (HBM) is a health behaviour change model developed to explain and predict health-related behaviours (Glanz and Bishop, 2010).

Although the study has as focus the communication of health information, the ultimate goal of a communication strategy is to change behaviour. Behaviour is mainly influenced by knowledge, beliefs, perceptions and value systems. This theoretical framework was therefore applied to the study to ensure that all the elements to change behaviour and improve the uptake of health services and health have been integrated in the communication strategy). The major tenets of the Health Belief Model include:

- Modifying factors;
- Individual beliefs;
- Action.

## Modifying Factors

## Individual Beliefs

## Action

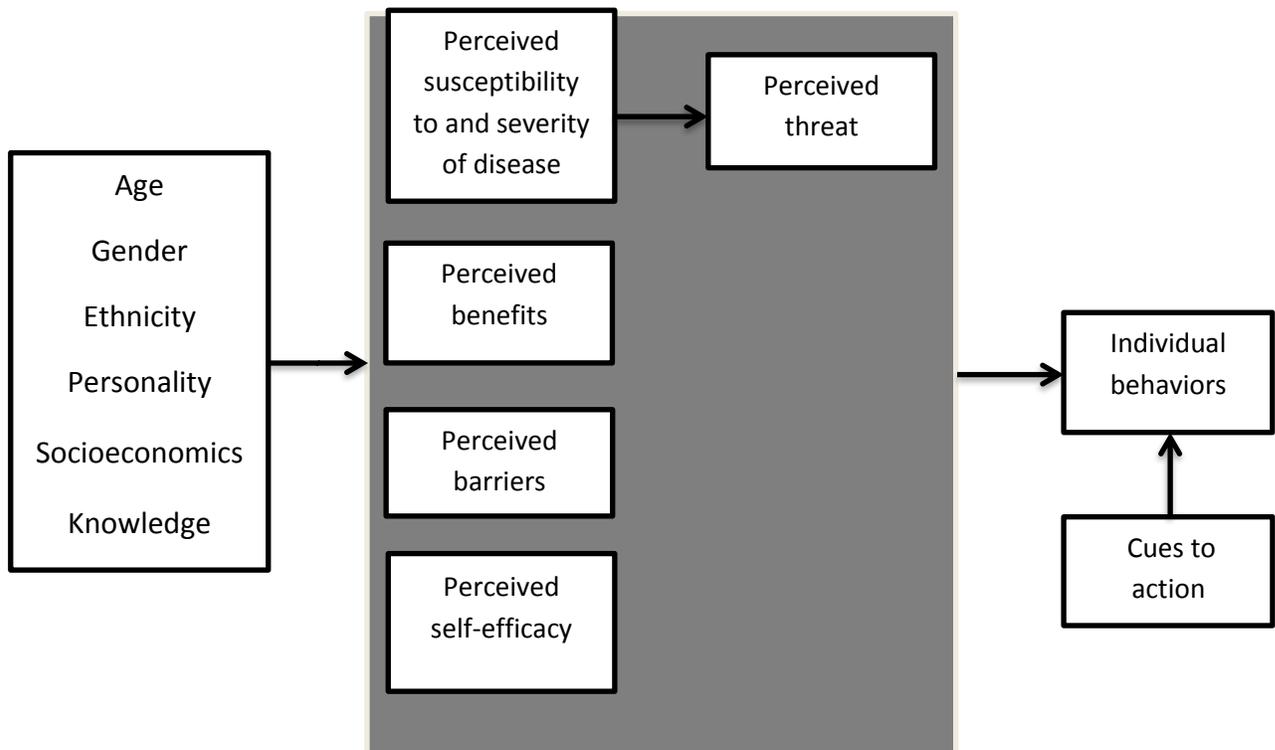


Figure 1.1: Health Belief Model Components and interrelationships (Glanz et al., 2008:49)

### 1.7.2.1 Modifying Factors

Modifying factors play a major role in determining behaviour. These factors are both personal and environmental in nature. Factors that typically influence health behaviour have been researched and reported on extensively and an in-depth understanding of these by the researchers will result from a literature study, while the specific modifying factors specifically relevant to the context of the study will follow from data collected from participants in the study.

According to Polit and Beck (2012:732) a literature review is a critical analysis of available findings of research in the specific field to identify trends, understanding the context and obtaining a sound scientific knowledge base in the field of research.

### **1.7.2.2 Individual Beliefs**

The Health Belief Model contains several primary concepts that can act as predictive indicators of why people will take specific action. These beliefs will drive the actions of individuals to prevent illnesses, to visit health services in time and to comply with treatment regimens to control illnesses and health conditions. The researcher obtained information on perceptions, beliefs and values on HAST diseases and available health services through a focus group interview with community members.

### **1.7.2.3 Cues of Action**

Cues to action include events, people, or elements that serve as drivers to change in behaviour (Hyden, 2014:71). Information on these cues for action was determined through in-depth personal interviews with health care providers and policy makers, namely district and provincial Deputy Directors.

## **1.8 THEORETICAL FOUNDATIONS OF THE STUDY**

The discussion that follows introduces the research paradigm, research approach and research design used in this study.

### **1.8.1 The research paradigm**

A paradigm is a basic and general framework to organise the research. The paradigm contains basic assumptions, key issues and principles relevant to the field of study, models and approaches to scientific research and methods to obtain valid and reliable data (Neuman, 2011:94). Creswell (2014:6) further defines a paradigm as a specific world view which the researcher uses as a point of departure.

For this study the researcher used the constructivist paradigm. This paradigm posits that individuals instinctively seek an understanding of the world in which they live in an attempt to develop subjective meaning of their experiences (Creswell, 2014:8). Using this particular paradigm enabled the researcher to gain an understanding of the

understanding of the people in Limpopo with regard to HAST diseases. An in-depth understanding of this understanding enabled the researcher to develop, refine and test an appropriate communication strategy for the Province.

### **1.8.2 Research approach**

The study followed a qualitative approach in order to develop a communication strategy for the Province. Qualitative research implies the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative material using a flexible research design (Polit and Beck, 2012:739). According to Holloway and Wheeler (2010:3) qualitative research is a form of social inquiry that focuses on the way people make sense of their experience and the world in which they live. As stated before, health-related behaviour is largely determined by perceptions, beliefs and values. These elements cannot be measured quantitatively. To address the research questions a qualitative approach was, therefore, the most appropriate approach.

### **1.8.3 Research design**

Research design is the overall plan for addressing a research question, including strategies for enhancing the study's integrity (Polit and Beck, 2012:741). According to Burns and Grove (2009:218) research design is the blueprint for conducting a study. The researcher used a qualitative exploratory design. An exploratory design is a sequential design in which qualitative data are collected with the aim of collecting rich data to the point of saturation (Polit and Beck, 2012:727). In this study qualitative data was collected through focus groups with community members and personal interviews with district and provincial health Deputy Directors responsible for HAST in the Province.

These Deputy Directors are responsible for the following programmes related to HAST and are central to the implementation of programmes, which include: Advocacy, Communication and Social Mobilisation for HAST; Tuberculosis; HIV Counselling and Testing; Prevention of Mother to Child Transmission of HIV and AIDS; Comprehensive Care Management and Treatment, Care and Support; TB and HIV Integration, Sexually

Transmitted Infections, High Transmitted Areas; Medical Male Circumcision and Condom logistics.

## **1.9 RESEARCH METHODOLOGY**

The study was divided into two phases. In the first phase the researcher explored the current situation in terms of modifying factors related to health-related behaviour, determined the perceptions, beliefs and values that guide the health behaviour of community members in terms of HAST diseases and how managers and policy makers of health services related to HAST diseases responded to cues for action. In the second phase the researcher utilised the data gathered in the first phase to develop, refine and test an appropriate communication strategy for the Province.

### **1.9.1 Phase 1: Situational analysis**

The analysis of the current situation regarding behaviour in terms of HAST diseases involved a study population, sampling, data collection and data analysis for situational analysis was addressed in this phase.

#### **1.9.1.1 Study population and sampling**

A study population is defined as the entire aggregation of cases in which the researcher is interested (Polit and Beck, 2012:273). Burns and Grove (2009:343) define a population as a particular type of individual or elements.

A sample is a subset of the population comprising a selected number of the study population who represent the characteristics of the study population (Polit and Beck, 2012:742).

Holloway and Wheeler (2010:137) describe sampling as the purposeful selection of an element of the whole population to gain knowledge and information. The study population and sampling for this study varied for each of the tenets of the Health Belief Model and is discussed below.

#### *1.9.1.1.1 Sampling to determine modifying factors*

The main source (study population) of information for exploring modifying factors that may influence health-related behaviour was obtained through an in-depth literature study. Current and appropriate scientific literature sources in the relevant field of research were accessed by using scientific databases. Sampling of literature was done in terms of relevance to the topic and currency. The scientific evidence reported on in scientific literature served as the basis for the guiding questions used during interviews and to enrich the findings obtained from the focus groups.

#### *1.9.1.1.2 Sampling related to individual beliefs*

The study population to determine individual beliefs (which also included knowledge, perceptions and values) about the factors identified in the literature study relevant to HAST consisted of community members. In an attempt to represent the study population, participants in focus groups were sampled purposively to represent various levels of community members, such as representatives of the Capricorn District AIDS Council, which includes the House of Traditional Leaders and traditional health practitioners. In addition, gender differences, age differences, disability, faith groups and people living with HIV and AIDS were also accommodated. Participation in the study was voluntary.

#### *1.9.1.1.3 Sampling for cues of action*

The study population drawn on to confirm, assess and determine cues for action consisted of all Deputy Directors for HAST - both at District and Provincial level. No sampling was done and participation was on a voluntary basis. It should be noted that the six Assistant Directors were not included in the study population. The six Assistant Directors were used as the study population during the second phase, namely the implementation of the draft communication strategy and, as such, did not participate in the interviews to determine cues of action. This decision was justified in terms of not introducing bias during the pilot stage.

### **1.9.1.2 Data collection**

According to Polit and Beck (2012:725), data collection is the gathering of information to address a research problem. Burns and Grove (2009:695) describe data collection as precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypotheses of a study. The data collection for each of the tenets of Health Belief Model is briefly discussed below.

#### *1.9.1.2.1 Individual beliefs*

Focus group interviews were used for exploring perceptions, beliefs and values of individuals. Focus groups are interviews with a group of about 5 to 10 participants whose opinion and experiences are solicited within an interactive group, (Polit and Beck, 2012:341; 555). Data was recorded with the permission of the participants and was transcribed, analysed and categorised using a qualitative approach.

#### *1.9.1.2.2 Cues of action*

An interview guide based on literature was utilised for to facilitating and guiding the group interviews.

An interview is a method of data collection in which a researcher explores, through focused and predetermined questions, information about a specific topic from identified key persons who could provide the most valid and reliable data (LoBiondo-Wood and Haber, 2006: 565). A personal interview implies face-to-face and direct interaction between the researcher and the respondents (Polit and Beck, 2012:737). Personal interviews were undertaken with 18 HAST District and Provincial Deputy Directors. An interview guide was developed based on information obtained through the focus group interviews with community members.

For the purpose of piloting the interview guide, the Assistant Directors were requested to complete an evaluation form which was used to refine the interview guide.

### **1.9.1.3 Data analysis**

Data analysis is the systemic organisation and synthesis of the research data (Polit and Beck, 2012:725). Content analysis using a qualitative approach was performed to analyse data. Qualitative content analysis is the analysis of narrative data with the aim of identifying prominent themes and patterns among themes (Polit and Beck, 2012:564). Qualitative content analysis involves breaking down data into small units, coding and naming the units according to the content they represent and grouping coded material based on shared concepts (Polit and Beck, 2012:564). Details of the process will be discussed in Chapter 4. The findings from the data analysis led to the development of a communication strategy, which formed the basis of phase two of this study.

### **1.9.2 Phase 2: Development of HAST communication strategy**

Based on available literature as well as the information obtained through the personal interviews with district and provincial managers and community members' focus group interviews, a communication strategy was drafted.

This draft strategy was piloted in one of the five districts in the Province. During the pilot stage Assistant Directors of Capricorn District responsible for HAST were requested to implement and test the draft strategy in terms of the level of understanding, the acceptability, relevance and accessibility, appropriateness, feasibility and acceptability of both the strategy and the information contained in the draft communication strategy. The feedback resulted in the refining of the strategy. It is acknowledged that a limitation of the study is the fact that assessment of the impact of such a strategy is a long-term goal and that it was not possible to assess this impact during the pilot phase of the study.

## **1.10 TRUSTWORTHINESS**

Trustworthiness is the degree of confidence qualitative researchers have in their data, and is assessed using the criteria of credibility, transferability, dependability, conformability and authenticity (Polit and Beck, 2010:570). According to Polit and Beck (2012:106), qualitative researchers discuss methods for enhancing the trustworthiness of the study data and findings. Trustworthiness is illustrated in terms of credibility, dependability, conformability and transferability (Houser, 2012:224; Polit and Beck 2010:106; Polit and Beck, 2012:584; Rebar et al., 2011:155; Holloway and Wheeler, 2010:302;). All these criteria were employed in the study to ensure trustworthiness in all phases of the study. A detailed description of the application of these criteria is discussed in Chapter 3.

## **1.11 ETHICAL CONSIDERATIONS**

According to Houser (2012:54), there are three fundamental ethical principles that guide researchers, namely, respect for a person, beneficence and justice. These principles are based on those human rights that need to be protected in research.

In this study the researcher adhered to the following principles: respect for a person, beneficence, justice, respect for human dignity, right to privacy, informed consent and benefit from research. A detailed description of the application of the ethical principles follows in Chapter 3.

## **1.12 SCOPE OF THE STUDY**

The study focused only on the inputs made by HAST programme Deputy Directors at provincial level in the Limpopo Province and the focus group interview with community members of Capricorn District AIDS Council.

### **1.13 STRUCTURE OF THE THESIS**

This thesis consists of six chapters. A short description of each of these is provided in this section to guide readers and help them follow and understand the discussions.

Chapter 1: This chapter provides an overview of the study and includes the background to the study; the problem statement; the purpose of the study; the research questions and objectives; definitions of the concepts; the research methodology; ethical considerations; the research setting; the theoretical assumptions; the theoretical framework; data analysis and significance of the study.

Chapter 2: The second chapter of this thesis reports on an in-depth review of literature related to HAST globally and in South Africa, in particular. The Health Belief Model is comprehensively dealt with.

Chapter 3: This chapter reports on the application of the research methodology. This chapter includes discussions on the research populations, sampling, ethical and legal issues pertaining to each phase of the research process, the data collection process and how the data were analysed to obtain valid and reliable information on which evidence based conclusions can be argued.

Chapter 4: In chapter 4 the analysed research results are argued and discussed.

Chapter 5: Based on the findings discussed in chapter 4, a draft communication strategy was developed and is presented in this chapter. The process and outcomes of your pilot phase and assessment of the communication strategy are discussed.

Chapter 6: In the last chapter the final recommendations regarding the implementation and utilisation of the strategy are discussed. This chapter further provides detailed reflective information about whether the objectives of the study have been met and what the limitations of the study were.

## **1.14 CONCLUSION**

This chapter described the background of the study, the research questions and objectives the study aim to achieve, the research design and methodology as well as the considerations for trustworthiness and ethics, the study limitation and significance of the study. The chapter was concluded with a summary of the organisation of the thesis.

Chapter 2 deals with the literature review undertaken for the study.

## **CHAPTER 2**

### **THE CONTEXT OF THE STUDY AND LITERATURE REVIEW RELEVANT TO THE STUDY FIELD**

#### **2.1 INTRODUCTION**

This chapter aims to provide the reader with the context of the study in order for the reader to understand the context and the extent of the literature reviewed. An in-depth analysis of existing national and provincial documents, policies and strategies relevant to the burden of disease was conducted. This was further complemented by literature on the key concepts such as lifestyle change, communication strategies in health as well as the measurement and monitoring of intervention strategies. The purpose of the literature review is to identify trends, identify gaps and understand the relevance and impact of communication, intervention and monitoring around the burden of disease, especially in terms of HIV, AIDS, STIs and TB.

Current and appropriate scientific literature sources in this field of research were sourced through databases such as <http://www.healthlink.org.za> (health information), the Computerized Index to Nursing and Allied Health Literature (CINAHL), the Oasis library catalogue, references to South African materials, references to journal articles, public health facilities, a Magnet search of references for material in South African libraries and the International Nursing Index. A subject librarian also assisted the researcher to access relevant and current peer reviewed journals, books and annual reports.

#### **2.2 INTERNATIONAL AND NATIONAL TRENDS OF PREVALENCE OF HIV AND AIDS, STIS AND TB**

According the 2013 UNAIDS report on the global AIDS epidemic, an estimated 35.3 million people were living with HIV globally in 2012 (Mona, 2014:11). There were

approximately 2.3 (1.9–2.7) million new infections worldwide in 2012 (UNAIDS [Joint United Nations Programme on HIV/AIDS], 2013:4, in Modeste and Majeke, 2014:1).

HIV prevalence in the Southern African Development Community (SADC) region is the highest in the world, with approximately 11.3 million people living with HIV in 2009. Globally, 34% of all people living with HIV (PLHIV) reside in ten countries in Southern Africa (SADC, 2013:9). Most of the world's children living with HIV, constituting 90% of global child HIV infections, reside in the Southern African region (SADC, 2013:9).

South Africa has the highest number of people living with HIV and AIDS in the world (Shisana et al., 2014). It is one of the countries bearing the greatest brunt of the burden of HAST diseases. South Africa has a quadruple burden of diseases as it has (i) a very high prevalence of HIV and AIDS, which has now entered into a synergistic relationship with TB; (ii) high maternal and child morbidity and mortality; (iii) an exploding prevalence of non-communicable diseases, mostly driven by risk factors related to lifestyle; and, (iv) a high incidence of violence, injuries and trauma (Department of Health, 2014:3). In this study the focus of the burden of disease was on HIV, AIDS, STIs and TB due to the fact that HAST diseases are the leaders among the four categories mentioned above. According to the UNDP (2012:1), HIV prevalence levels are high in South Africa when compared to prevalence levels in other countries in Northern, Western and Middle Africa.

The highest provincial HIV prevalence in the country was recorded in KwaZulu-Natal (KZN), which increased from 37.4% in 2012 to 40.1% in 2013. Provinces with increased HIV prevalence estimates when compared with 2012 figures include: Eastern Cape, where the HIV prevalence increased from 29.1% in 2012 to 31.4% in 2013 and Mpumalanga, where the HIV prevalence increased from 35.6% in 2012 to 37.5% in 2013. These small increases fell within the expected sampling variability.

In 2013, the lowest HIV prevalence rates were recorded in the Northern Cape (17.5%), the Western Cape (18.7%) and Limpopo (20.3%). North West, Limpopo, the Western Cape and the Northern Cape recorded prevalence rates of between 20.0% and 30.0%.

The Northern Cape and the Western Cape are the only provinces that have HIV prevalence below 20.0% (Department of Health, 2015:24).

Nationally, the age groups 30-34 years and 35-39 years have the highest HIV prevalence, with rates in both groups at 42.5%. There is a doubling of prevalence between those aged 15-19 years (12.7%) and those aged 20-24 years (24.0%). The age group 15-19 years is the most important indicator to use for providing evidence when monitoring HIV incidence (new infections). HIV prevalence in this age group has been suggested as a proxy measure for the incidence of HIV because of onset of sexual activity and, hence, prevalent mortality (Department of Health, 2014:33).

World Health Organisation (WHO) estimates show that South Africa currently ranks as the third highest in the world in terms of TB burden, behind India and China, with an incidence that has increased by 400% over the past 15 years, reaching 970 new infections per 100,000 people in 2009 (WHO Report, 2012:17). This increase in the incidence of TB is compounded by the presence of multidrug-resistant tuberculosis (MDR-TB), with almost 7,386 confirmed MDR-TB cases in 2010 and 741 confirmed cases of extensively drug-resistant TB (XDR-TB) during the same period (WHO Report, 2012:20). The HIV epidemic is currently driving the TB epidemic, with more than 70% of TB patients also living with HIV (Department of Health, 2012:22).

Approximately 1% of the South African population develops TB every year. Case detection for all forms of TB has steadily increased from 279 260 in 2004 to 401 608 in 2010. The number of new smear-positive cases has remained stable during the same period.

The highest prevalence of latent TB infection, estimated at 88%, occurred among people in age group 30-39 years in the country's townships and informal settlements. This underscores the fact that TB is a disease of the poor.

Township and informal settlement conditions are characterised by overcrowding and low social-economic status, all of which provides fertile ground for TB infection and the onset of the disease (Department of Health, 2011:22).

In 2009 the cure rate for TB was at 78% globally. This rate of treatment success was only reached in three regions, namely, the Eastern Mediterranean at 85%, the Western Pacific at 92% and South-East Asia at 87% (WHO, 2009b:21). In the African and American regions, the treatment success rate was 75% and 76% respectively. South Africa managed to reach a 73% TB treatment success rate, which is far below the global average treatment success rate of 85% (WHO, 2009b:20 in Maswanganyi et al., 2014:1).

The Stop TB strategy implementation rate is not yet at 100% as only 18 countries are implementing this strategy (WHO, 2009b:37). Progress against TB has been made between 1995 and 2005 as a result of the implementation of DOTS and Stop TB. It was reported that among patients notified with TB in 2008, 85% were successfully treated, thus reaching the 85% target for successfully treated new smear-positive cases (WHO, 2009b:37). Globally, DOTS coverage reached 94% in 2007, which does not correlate with the cure rate of less than 70%. All WHO-defined regions have adopted the DOTS strategy, but they differ in coverage as follows: Africa 93%; America 91%; Mediterranean 97%; Europe 75%; South-East Asia 100%; and Western Pacific 100% (WHO, 2009b:34). The percentage of DOTS coverage does not support the low cure rate still experienced in the different countries, especially in Africa (Maswanganyi et al., 2014:2). According to the WHO, the implementation of DOTS in South Africa by 2009 was 100% (WHO, 2009a:35).

In South Africa, it is estimated that 11 million STI cases occur annually. For example, in Hlabisa, a rural area in KwaZulu-Natal, among 321 women attending district antenatal clinics, 52% were found to have at least one STI (gonorrhoea, chlamydial infection, trichomoniasis or syphilis) and 18% had more than one infection (Sonko et al., 2003:1).

### **2.3 LIMPOPO PROVINCE TRENDS OF THE PREVALENCE OF HIV & AIDS, STIs AND TB**

In 2013 the Limpopo HIV prevalence rate among antenatal women was estimated at 20.3%. The overall HIV prevalence in Limpopo moderately decreased by 1.1% from 21.4% in 2009 (Department of Health, 2015:54).

In Limpopo the Districts of Capricorn, Mopani and Waterberg recorded an HIV prevalence rate of less than 30.0% in the past five years and a moderate decrease in HIV prevalence was recorded from 2009 to 2013. A moderate increase in HIV prevalence of 1.5% was recorded in the Sekhukhune District and an increase of 0.7% was recorded in the Vhembe District from 2000 to 2013, respectively (Department of Health, 2015:55).

The trends in the districts with respect to HIV prevalence rates in this Province has shown changes in the HIV prevalence rates in the Vhembe District, which has consistently recorded the lowest HIV prevalence rate, prevalence increased from 14.6% in 2011 to 17.7% in 2012 and 15.0% in 2013. Sekhukhune showed a similar trend, with prevalence rates increasing from 18.9% in 2011 to 23.0% in 2012 and 18.1% in 2013. This could be attributed to small and variable sample sizes. The Waterberg District continues to record the highest HIV prevalence rate in this Province, although a notable decrease of 3% from 30.3% in 2011 to 27.3 % in 2012 and 2013 was recorded (Department of Health, 2014: 55).

Limpopo does not follow the same trends as the national trends with age comparison. There is a decrease in prevalence rate between the ages of 30-34 years (from 34.0% in 2012 to 16.2% in 2013) and 35-39 years (from 30.8% in 2012 to 9.1% in 2013) (Figure 2.9). There is a double increase in prevalence rates in the age group 15-19 years from 7.3% in 2012 to 18.6% in 2013 (Department of Health, 2015:54). HIV prevalence in this age group has been suggested as a proxy measure for the incidence of HIV because of the onset of sexual activity and, hence, prevalent mortality (Department of Health, 2015:33). According to the South African National HIV Survey (2012:130), all females aged 15–24 years, black African females; especially those that are aged 20–34 years,

as well as black African males aged 25 to 49 years require specialised interventions aimed at raising awareness about the impact of HIV, promoting condom use and reducing multiple sexual partnerships.

According to Mothiba and Maputle (2012:1), in their study of factors contributing to teenage pregnancy in the Capricorn District of the Limpopo Province, sixty-two per cent (62%) of the respondents started engaging in sexual activities between the ages of 13 and 15 years; 54% engaged for the first time in sexual intercourse between the ages of 16 and 19 years, while 4% started sexual activity at the age of 10 to 12 years; 48% of the partners of teenagers were 21 years of age and above. Pregnancy prevention strategies were recommended based on these results. The strategies focused on reproductive health services, male involvement and adult-teenager communication programmes.

District prevalence assists the Department to identify areas of focus and distribution of resources. The districts with low prevalence are also encouraged to continue with communication messages and resources are also distributed to these districts to keep the momentum going.

The HIV epidemic, coupled with other institutional challenges, has had negative impacts on the outcome of TB case management, as those co-infected with HIV experience a higher mortality rate (Department of Health, 2011: 22). Among HIV-positive patients who acquire extensively drug resistant TB (XDR-TB), the mortality rate is high. TB screening among people living with HIV is around 40%, with a very low rate (about 38%) of those on isoniazid preventive therapy (IPT). There is late initiation of ART in TB patients, contributing to the mortality rate. Treatment success rate of new infectious TB cases is around 74% as compared to the global target of >85% (Department of Health, 2011: 22). In the Limpopo Province District Health System report, DOTS, coverage in 2007 ranged between 75% and 80% (Maswanganyi et al., 2014:2).

In Limpopo in 2002 the number of cases of male urethral discharge (MUD) per 1 000 males aged >+ 15 years was 47% (Sonko et al., 2003:7). STI incidence per population

aged  $\geq 15$  years is 10.6%, while the national figure was 6.5% in July 2002 (Ramkisson et al., 2014).

## **2.4 FACTORS INFLUENCING THE PREVALENCE OF HAST**

### **2.4.1 Lifestyle**

The risk factors that increase the spread of HIV in individuals and populations are multi-tiered and interconnected (SADAC, 2013:16). Vulnerability and marginalisation of some sub-groups, such as sex workers, prisoners, men who have sex with men (MSM), transgender persons, injecting drug users (IDU) and migrant populations increase their risk of HIV infection (Department of Health, 2011: 26). Transgender persons are at a higher risk of being HIV positive. Due to lack of knowledge and understanding of this community, and because of the stigma attached to being a transgender individual, this population is often at risk of sexual abuse and of being marginalised from accessing prevention, care and treatment services (Department of Health, 2011: 26). According to the Department of Health (2011:6), migrant workers are also at high risk of contracting HIV due to the fact that they move from one area or country to the other without their partners.

Also mentioned in SADAC (2013:9) is the fact that urban populations are at a greater risk of infection than are rural populations due to migration patterns.

According to National Strategic Plan for HIV and AIDS, STIs and TB (2012-2016:26) people who use illegal substances, especially those who inject drugs, are at higher risk of acquiring and transmitting HIV. There is a large and growing problem with drugs such as crack, cocaine and tik, especially among young people and sex workers, highlighting the need to consider scaling-up programmes to reduce substance abuse and harm reduction programmes. Research shows that among injecting drug users, 65% practice unsafe sex (Department of Health, 2011:26).

Alcohol abuse is a major risk factor for HIV acquisition and transmission. Heavy drinking is associated with decreased condom use and an increase in multiple and concurrent sexual partners (Department of Health, 2011: 26). Alcohol and substance abuse is rampant in the Limpopo Province, especially in the farming and mining areas and especially during festive season. There is a marked growth in the establishment of shebeens (local pubs) in both urban informal settlements and rural areas, which are all environments that perpetuate HIV infection as people under the influence of drugs or alcohol are unlikely to use or negotiate protection, such as the use of condoms during sexual activities (Department of Health, 2011:42).

Strategies should be developed to address male gender norms that equate alcohol use with masculinity (Department of Health, 2011: 26). According to Hong, Beaudoin and Johnson (2013:914), adolescents who consume alcohol are also more likely to have unprotected sexual intercourse and have multiple sex partners. Alcohol consumption levels for adolescents are higher among Caucasians than among African Americans and among boys than among girls and this study's findings suggest that interventions that stress descriptive norms will be most effective when targeting these groups (Hong, Beaudoin and Johnson, 2013:928).

#### **2.4.2 Level of knowledge (about HAST related issues)**

Health literacy is an individual's ability to read, understand and apply health-related information (Howard, Jacobson and Kripalani, 2013:991). Of the U.S. adult population, 36% have limited health literacy, which is associated with lower disease-specific knowledge, poor disease control, higher hospitalisation rates and excess mortality (Howard, Jacobson and Kripalani, 2013:991).

It is not surprising that individuals who experience significant health care disparities (e.g., racial and ethnic minorities and those living in poverty) are also the most likely to have poor health literacy (Howard, Jacobson and Kripalani, 2013:991). Patients with limited health literacy tend to rely on the spoken word of their health care provider for health-related information, rather than other information media. However, patients with low health literacy have difficulty in understanding the instructions of physicians.

Effective physician communication is paramount in caring for patients with low health literacy. In addition to the standard communication techniques that should be included in all quality physician–patient encounters (Howard, Jacobson and Kripalani 2013:991). According to Marukutira (2012:22), factors such as lifestyle factors (homelessness, substance abuse), lack of education and mental illness affect adherence to ART.

The initiatives to deal with this problem include prevention through educating communities on the effects of substance abuse; intensified TB and HIV campaigns in the hard to reach areas and working closely with both the Limpopo Liquor Board and the South African Police Services to ensure the implementation of alcohol and substance abuse by-laws (Department of Health, 2011:42). Health literacy experts have recommended specific ways to enhance provider communication with low health literate patients. These include avoiding the use of medical jargon; limiting the amount of information discussed at each visit and having patients repeat back key information in their own words (Howard, Jacobson and Kripalani, 2013:992).

The response to HIV must focus on prevention, treatment, care and support to these vulnerable groups and the affected general population in order to curb the escalating number of new infections (SADAC, 2013:16).

### **2.4.3 Socio-economic environment**

Poverty, low rates of employment, lack of education and homelessness are interwoven, resulting in increased HIV vulnerability (SADC, 2013:30). In contrast, employment may correlate with increased access to information, condoms and a healthy lifestyle. Individuals from poorer socio-economic backgrounds are less exposed to HIV messages and have less access to quality prevention support services (SADC, 2013:30). Poverty also correlates with gender inequality and unequal relationship dynamics that may affect decision making about sexual behaviour (Gillespie et al., 2007 in SADC 2013: 30). The disparity between men and women infected with the virus continues to be of concern; women remain disproportionately affected (SADC, 2013:9).

The socio-economic (poverty, unemployment, etc.) situation in the Limpopo Province provides an environment for multiple, concurrent partners to thrive as well as intergenerational sex (Department of Health, 2011:44). The rate of unemployment plays a key role in depicting the employment status of the labour force in South Africa and, to a fair extent and, the functioning of the economy at large (Department of Health, 2011:15).

#### **2.4.4 Culture, Beliefs and Myths**

Culture is a patterned behavioural response developed over time as a consequence of imprinting the mind through social, religious structures including intellectual and artistic manifestations (Mokgethi, 2011: 54).

Culturally sanctioned bodily mutilation or alteration, such as male or female circumcision, scarification, tattooing, ear and lip piercing, foot binding and some forms of cosmetic surgery (like augmentation mammoplasty) are also associated with the spread of HIV and AIDS (Useh, 2006: 28) due to the fact that instruments used are shared without being sterilised.

According to Useh (2006:28) the moral and ideological attitudes of a society towards AIDS are just as relevant to its control as the search for an effective vaccine. The pattern of multiple concurrent partnerships (MCPs) may be related to the nature of certain cultural norms in the Southern African Development Community (SADC). Widespread cultural acceptance of polygamy and multiple sexual partnerships for men, as well as gender inequality, create power imbalances, which fuel MCPs and undermine the progress of many HIV prevention interventions (SADC, 2013:19).

One of the most pernicious myths currently in the circulation is that sex with an older women or a virgin cures a man with HIV & AIDS (Jones, 2004 in Useh 2006:29; AIDSTAR-One, 2011 in SADC, 2013: 34). This practice, built on perception and beliefs, increases the spread of the HIV to children and young women. Typical victims of this practice also experience serious emotional and psychological effects. The increasing

number of rape victims who are babies and children are associated with this myth (Jones, 2004 in Useh, 2006:29).

Furthermore, denial, stigmatisation and discrimination are deeply entrenched (Department of Health, 2011: 44). Cultural gender norms result in women and girl children being vulnerable, with little power to protect themselves through strategies such as negotiating safer sex practices or advocating for abstinence or delayed sexual intercourse (Department of Health, 2011: 44). During interviews with professional nurses in the study 'Views of professional nurses regarding low tuberculosis cure rate in Greater Giyani Municipality, Limpopo Province' it was revealed that people suffering from TB were influenced by their religious beliefs. They described visits to traditional health practitioners and faith healers as common practice among TB patients (Maswanganyi et al., 2014:6).

## **2.5 NATIONAL AND PROVINCIAL LEGISLATIVE FRAMEWORK**

There are several policies and guidelines utilised in South Africa and in the Limpopo Province for addressing HAST. The following are some of those policies and guidelines:

### **2.5.1 Constitutional mandates**

Section 9 of the Constitution of South Africa states that everyone has the right to equality, including equal access to health care services. This means that individuals should not be unfairly excluded in the provision of health care.

- People have right to access information that is held by another person if it is required for the exercise or protection of a right;
- This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and

- These rights also enable people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitution, respectively (Department of Health, 2015:10).

### **2.5.2 Sustainable Developmental Goals (SDG)**

Sustainable Developmental Goals are to:

- Ensure healthy lives and promote well-being for all at all ages;
- Reduce inequality in access to services and commodities;
- Achieve gender equality and empower all women and girls;
- Promote inclusive societies for sustainable development;
- Strengthen the means of implementation (UNAIDS, 2015:6).

As a set of integrated and indivisible goals, the Sustainable Development Goals (SDGs) give all stakeholders a mandate for integration, the AIDS response being no exception. This strategy sets out what the SDGs mean in concrete terms for the AIDS response and what steps the global community needs to take to achieve targets and drive broader progress (UNAIDS, 2015:16).

### **2.5.3 Batho-Pele Principles**

According to the White Paper on the Transformation of Public Service Delivery (Department of Public Services and Administration, 1997:8), the Batho-Pele approach is based on the following principles: consultation, setting service standards, increase of access, ensuring courtesy, providing information, openness and transparency, redress and value for money.

The principles were developed to serve as an acceptable policy and legislative framework regarding service delivery in the public service. These principles are aligned with the constitutional ideals of:

- Promoting and maintaining high standards of professional ethics;

- Providing service impartially, fairly, equitably and without bias;
- Utilising resources efficiently and effectively;
- Responding to people's needs; the citizens are encouraged to participate in policy-making; and
- Rendering and accountable, transparent, and development-oriented public administration.

#### **2.5.4 Patients' Rights Charter**

The purpose and expected outcomes of the Patients' Rights Charter and the prescribed complaints procedure are to deal effectively with complaints and to rectify service delivery problems. The effective implementation of the Patients' Rights Charter and the prescribed complaints procedure will lead to improvement in the quality of care, raise awareness of rights and responsibilities, raise expectations, change attitude by strengthening the relationship between provider and user and improve the use of services. These are mechanisms for enforcing and measuring the quality of health services (Department of Health, 2001:1).

*According to the Patients' Rights Charter, every patient has the right to:*

- A healthy and safe environment;
- Access to health care;
- Confidentiality and privacy;
- Informed consent;
- Be referred for a second opinion;
- Exercise choice in health;
- Continuity of care;
- Participate in decision-making that could affect his/her health;
- Be treated by healthcare providers that identify themselves;
- Refuse treatment;

- Be fully informed about his/her health insurance/ medical aid scheme policies; and to
- Complain about health services.

The Patients' Rights Charter is published in all the official languages of South Africa and should be prominently displayed at each health facility.

### **2.5.5 National Strategic Plan for HIV and AIDS, STIs and TB 2012-2016**

The National Strategic Plan (NSP) on HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) (2012– 2016) is the strategic guide for the national response to HIV, STIs and TB over the next five years. The plan addresses the drivers of the HIV and TB epidemics, such as substance abuse; mobility and migration; multiple, concurrent and intergenerational sex. It is also designed to address cultural practices, stigmatisation and discrimination; unemployment and inequality in income and wealth and builds on the achievements of the previous NSPs to achieve its goals (Department of Health, 2011:12).

Key strategic enablers that underpin the entire NSP, which will determine the success of its implementation, include: governance and institutional arrangements; effective communication; monitoring and evaluation; and research. Effective communication is critical for the implementation of the NSP to achieve social and behaviour change. A challenge for communication in a hyper-endemic country is to reach specific key populations while still ensuring that the general population is well informed and able to prevent and mitigate the effects of HIV, STIs and TB (Department of Health, 2011:13).

### **2.5.6 Limpopo Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016**

The Limpopo Provincial Strategic Plan for HIV and AIDS, STIs and TB (2012-2016) was developed from the NSP and incorporates research and innovation relevant to provincial needs. A clear plan to ensure research and innovation are prioritised in the Province, but should be further developed in terms of:

- A provincial agenda for HIV and TB research (multi-sectoral);

- Concrete plans to improve capacity for research;
- A dedicated budget for research (Department of Health 2011:52).

Key population for the HIV and TB response are similar to that of the NSP (2012-2016). According to PSP (2012-2016) there are key social drivers of the epidemic in Limpopo, which are:

- Substance abuse;
- Mobility and migration;
- Multiple, concurrent and intergenerational sex;
- Cultural practices, stigmatisation and discrimination;
- Unemployment and inequality in income and wealth (Department of Health, 2011:38).

Communication has to be strengthened between and among stakeholders, including the approach to social mobilisation. An internal and external social mobilisation and communications strategy needs to be developed and implemented. Communication has largely been one of the main challenges in the implementation of the multi-sectoral response; hence the need to strengthen it by ensuring that there is only one point of coordination (Department of Health, 2011:53).

### **2.5.7 Discussion Document on the Development of the South African National AIDS Council (SANAC) communication strategy**

The Discussion Document on the Development of the SANAC was also integrated in the theoretical framework of the study because it provides guidelines and priorities about the importance of prevention and how to target specific risk groups to promote and strengthen healthy behaviour in the context of a healthy development environment (SANAC, 2010: 2).

The communication strategy was accomplished through stimulating, creating and supporting a social movement focusing on increasing the issue awareness and turning it into sustainable actions (SANAC, 2010: 2).

- According to SANAC (2010:11), there is a need to ensure participation of communities in developing a planned and pro-active strategy beyond health issues. To achieve that, the following key principles should be adhered to: *The ability to participate*: In any form of engagement, it is critical that communities are empowered to be directly involved in making the decisions that affect their participation. Participation ensures that communities are able to define their own problems; and to mobilise the masses for collective action towards solutions to local challenges.
- *Effective alignment of interventions to local realities*: This is necessary to ensure that the elements of communication are rooted in the realities of the communities, such as language and resources. This alignment enables a mutual understanding between the agents and drivers of change. This ensures that material and interventions chosen are in line with the local challenges.
- *Enabling access to communication intervention*: Bringing the ever-increasing wealth of information, and the tool to produce local knowledge and express local opinions, closer to those affected communities is vital for the success of information access and learning across communities. Access to, and the ability to locally produce, communication interventions ensures that people are enabled to make informed choices about their lives.
- *Ensuring appropriateness of communication*: Communication channels between the recipients and creators of information need to be constantly open and appropriate to the needs of both parties. Following a bottom-up approach enables policy makers and communities to capture the wisdom and experience that exist and, in so doing, ensure appropriate responses in shaping policy and making decisions about local issues. Locally relevant and produced materials often are able to impact more directly than do large scale blanket communication interventions (SANAC, 2010:11).

### **2.5.8 National TB Advocacy, Communication and Social Mobilisation (ACSM) strategy 2007**

This is the available communication strategy for TB nationally and the Province has no specific strategy for HAST. This communication strategy addresses TB issues only.

Critical to the success of any efforts to control TB is the development and the implementation of a comprehensive Advocacy, Communication and Social Mobilisation Plan to support the National DOTS Strategy. The ACSM strategy aims to ensure that every person knows the basics about TB through the active involvement of all leaders in society (Department of Health, 2007:3).

Communication in TB control seeks to create and improve awareness among the general public about TB (e.g. its symptoms and curability), TB control services (e.g. diagnosis and treatment) and improve interpersonal communication between patients and care providers contributing to behavioural change (Department of Health, 2007:11).

The goals of the Advocacy, Communication and Social Mobilisation Strategy are in line with National TB Strategic Plan. The goals are as follows: to control the spread of tuberculosis, to increase access to services, to improve the quality of care of the infected and affected and to provide management and strategy coordination. These goals will be achieved through:

- Increasing the involvement of leaders, employers and the community in ensuring adherence to TB treatment;
- Creating an understanding that TB is curable if diagnosed and treated early, even if you have HIV;
- Educating communities on the early recognition of symptoms of TB, seeking diagnosis early and the consequences of delayed diagnosis;
- Increasing knowledge about cough, hygiene and prevention of spread of TB infection in communities;
- Improving health-seeking behaviour and TB treatment compliance;
- Minimising the stigma associated with TB in communities;

- Improving knowledge about good nutrition and healthy lifestyles to enhance the quality of life of people living with TB (Department of Health, 2007:9).

The strategy incorporates the communication activities of partners to avoid duplication and to ensure that all work is conducted under one vision (Department of Health, 2007: 11).

### **2.5.9 Communication strategy for the National Health Insurance (NHI) in the Limpopo province**

NHI is a health financing system that is designed to pool funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status (Department of Health 2015:9). Implementation of NHI is based on the need to address structural imbalances in the health system and to reduce the burden of disease including HAST (World Health Assembly, 2012). All South Africans will have access to needed promotive, preventive, curative, rehabilitative and palliative health services that are of sufficient quality and are affordable without exposing them to financial hardships. The right to access quality health services will be on the basis of need and not socioeconomic status (Department of Health 2015:10).

Vhembe District in the Limpopo Province is selected as one of the ten (10) districts nationally to pilot NHI. The selection criteria for the pilot districts included factors such as demographics, socio-economic including income levels and social determinants of health, health profiles, health delivery performance and health service management performance.

The purpose of the strategy is to provide a guideline regarding communications around the NHI and to spread positive messages to ensure that the targeted audiences understand what NHI is all about and the benefits to be derived from its implementation. The objectives for the NHI Communication Strategy include:

- To provide support to other initiatives by the Limpopo department of Health in its request to successfully implement the NHI in a manner that provides

communication that is streamlined to reach the targeted audience timeously, effectively and with no ambiguity of messages.

- To create awareness about the implementation of NHI in particular around the pilot district and beyond.
- To educate the target audience about NHI in particular around the pilot district and beyond.
- To educate the target audience about the NHI and its desired outcomes
- The strategy seeks to boldly communicate the benefits to be derived through the implementation of NHI.
- To mobilize communities, community leaders and key stakeholders to buy in and support the implementation of NHI.

#### **2.5.10 Provincial Communication Strategy 2009-2014: Limpopo Provincial Government.**

This Provincial Communication Strategy sought to set the stage for intensified and coordinated communication between 2009 and 2014. (Limpopo Provincial Government, 2009:2). This was the general communication strategy for Limpopo Province for that specified period, however, it did not include a communication strategy for HAST.

Objectives of Provincial Communication Strategy 2009-2014 were:

- Sustaining public confidence in Government's ability to deliver its promise through popularisation of the new Programme of Action (POA) appreciating the 15 year success of democracy and acknowledging the challenge ahead;
- Make real the vision of a government that cares and is in touch with people through visible and tangible community interaction;
- Market Limpopo to local, national and international stakeholders;
- To improve communication between the Government and its stakeholders;
- To enhance coordination of communication activities between the national, provincial and local government and the parastatals;

- To promote integrated communication and planning between and within all spheres of government;
- To create and maintain positive public perception;
- To establish and maintain interaction between the government and the communities through, *inter alia*, outreach programmes;
- To effectively communicate democratic government achievements and challenges of the first fifteen years of democracy as well as the plans to deal with challenges;
- To create assurance to citizens that government services is their continuous benefit and will in line with constitutional demand be provided to them (Limpopo Provincial Government, 2009:4).

These policies are available nationally and provincially and they all point out that there is a burden of disease in terms of HAST and key population identified, but the gap is a communication strategy to address the burden of disease in terms of HAST in Limpopo.

## **2.6 MONITORING OF HAST PROGRAMMES**

Monitoring and evaluation (M&E) is a textual, graphical and numerical information system used to measure, manage and communicate desired performance levels and programme achievements over time. It involves the collection, synthesis and analysis of information related to the measurement of inputs, outputs, outcomes and impacts, as well as of parameters that affect outputs and outcomes in the programming framework (UNICEF, 2005:43).

*Process evaluation* can be used to track programme activities and how well they are received by the target audience, thereby providing information for midcourse changes, if necessary. An example of a process evaluation activity is conducting in-depth interviews with those affected by the intervention (e.g., exposure to a prevention message about the risk of needle sharing), to assess the effectiveness of the intervention (Krenn and Limaye, 2011:4).

*Summative evaluation* assesses how well the programme achieves its objectives. This usually occurs at the end of the programme and provides information on whether or not the programme has been effective and what needs to be changed to achieve the desired result. An example of a summative evaluation activity is the distribution of a final questionnaire, the results of which are compared with a baseline questionnaire that was used to collect data prior to the start of the programme (Krenn and Limaye, 2011:4).

According to Tatham (2010:13) the monitoring and evaluation stage follows the execution of a campaign and involves assessment of the effectiveness of the campaign as a whole in bringing about the desired change in behaviour within the target audience. Monitoring of the progress of the HAST programmes is done through reports and site visits. Reports are written monthly, quarterly and annually. The National Department of Health visits the Province quarterly to review the programme progress. An analysis of the finances and a site visit are also undertaken. The Limpopo Provincial Strategic Plan for HIV and AIDS, STIs and TB (2012-2016) is monitored through monthly, quarterly and yearly reports as well as a midterm report.

The three forms of evaluation are necessary for an entertainment education activity to be implemented effectively and to measure its degree of effectiveness that is:

- *Formative evaluation* is conducted while an activity is being developed or is on-going, to make adjustments, if necessary, to improve effectiveness;
- *Process evaluation* examines whether the programme procedures were followed;
- *Outcome evaluation* measures the changes produced by the activity (Krenn and Limaye, 2011:4).

The monitoring of HAST in the Limpopo Province is effective and well-coordinated at all levels and reports are available to bear witness to this. The reports and antenatal prevalence surveys are utilised to allocate the resources accordingly.

## **2.7 COMMUNICATION STRATEGIES IN HEALTH**

### **2.7.1 Communication strategies design available**

South Asia has a long tradition of using communication to promote development goals. Communication approaches have been variously used for promoting immunisation, prevention of diarrhoeal dehydration and HIV/AIDS and female literacy, among others. These have been in the form of mass media campaigns, radio programmes, posters, street plays and localised outreach through communities and NGOs (UNICEF, 2005:xi).

It has been a common misconception of public health programmes that health messages and modes of delivery can fit all populations, medical conditions, or circumstances. A growing body of research has shown that presenting general health information without considering individual needs or personal relevance may limit substantially the extent of health behaviour change (Lustria et al., 2013:1040). Internationally, theatre was used because of its traditional popularity and cost effectiveness (Cohen, 2002:3). Campaigns incorporate reinforcing radio spots, print and outdoor media and a wide range of communication tools (e.g., publications, training kits, drama scripts and participation) (Krenn and Limaye, 2011:12). Zambia is guided by its National HIV & AIDS Communication and Advocacy Strategy (2011-2015) using community-based community radio listening clubs, community drama, stories etc. and mass media (television, radio, newspapers, magazines, posters, etc.). In other countries, HIV/AIDS telephone “talk lines” are seen as an excellent way of providing accurate health information and counselling (Krenn and Limaye, 2011:13). Community awareness-raising about TB should be conducted to empower people with the knowledge of TB in order to minimise stigma attached to the disease (Maswanganyi, 2014:7).

Web-based, computer-tailored interventions have multiple advantages over single mode, static interventions. The advantages are: (i) wider access to expert care and feedback; (ii) ability to toggle between modalities and formats to suite different learning styles and literacy levels; (iii) option to communicate synchronously and asynchronously

thus enabling convenient scheduling of interactions and delivery of reminders and messages; and (iv) a wide array of interactive components to enhance user experiences and support skills development, behaviour/goal monitoring, and progress tracking (Lustria, et., al 2013:1041).

HIV and TB communication programmes in South Africa utilise various forms of communication, for example, mass media (broadcast, print and outdoor), small media (posters, booklets, and utility items) and social mobilisation in order to foster dialogue and action at local and community level (Johnson et al., 2013:11). There is a need to achieve different levels of health outcomes from the individuals, families, groups, organisations and communities through a combination of health promotions and health education programmes; hence, according to the study conducted at Burgersfort in Limpopo by Johnson et al., (2013:12), television is the most popular mass media consumed in Burgersfort, with approximately 57% of respondents reporting that they watch television (TV) at least once a week. The SABC1 channel was the most frequently watched TV station (100%), followed by SABC2 (96%) and eTV (94%). DSTV and Top TV were the least accessed channels. This trend is similar to results obtained from the Limpopo Province where the most popular TV station was SABC1 (95%), followed by SABC2 (95%) and eTV (89%). Fourteen percent of respondents reported accessing the internet. Twenty one percent of young respondents (16-24 years) reported accessing the internet compared to 9% of those who were older (25-55 years).

In addition to the above communication media; newspapers, magazines and internet were utilised mostly by males (Johnson et al., 2013: 13). This study found that the reach of Facebook was high (66%). Access to Twitter and Mxit was lower at 1% and 6% respectively. A relatively high percentage of respondents using the social media reported accessing HIV-related information using Twitter (83%) and Facebook (53%) (Johnson et al., 2013: 13). The role of the electronic media is becoming more important. New technologies are being added to the communication mix to reach more people in innovative ways (UNICEF, 2011:5).

Mass media communications are programmes that use various media channels, such as television, radio, electronic technology and print, to draw attention to HIV issues with the objective of changing patterns of behaviour (UNAIDS, 2005 in SADC, 2013:43). A number of media campaigns focus on the need to overcome prejudice and encourage solidarity with people who are infected with, or affected by, the virus. South Africa's Sesame Street, known as Takalani Sesame, demonstrates that it is never too early to challenge HIV-related stigmas (SADC, 2013:45).

Messages can be delivered through mass media—for example, television or radio spots; articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics—or in-person, by health workers, peer educators, counsellors, or other trained personnel. Additional means of delivery include musical or dramatic performances and community events (FHI, 2012:15).

### **2.7.2 Participants in health communication strategy**

Participants in the communication strategy are categorised as primary, secondary and tertiary participants (UNICEF, 2008:22). The primary participant is the person whose behaviour is the main indicator of programme success. Examples of primary participants are parent/caregiver of child being immunised, breastfeeding mothers, parents/caregivers getting the child vaccinated, adolescent girls, people living with HIV (PLHIV), caregivers of children eligible for primary school enrolment or backyard poultry farmers (UNICEF, 2008:22).

Secondary participants are people whose behaviour or actions strongly influence the primary participant's behaviour (UNICEF, 2008:22). They come from the same cultural and social environment as the primary participants. The situation and programme analyses will inform the choice of secondary participants. The communication strategy should work with the programme to include multiple ways in which these people can support the behaviour of primary participants - going beyond information and message dissemination. That is, government health workers - both community- and facility-based, community volunteers and non-governmental organisation workers (UNICEF, 2008:22). The international model of using sex workers as peer outreach workers, advocating on

behalf of other sex workers and empowering women, is a powerful one that resulted in increased use of condoms (Krenn and Limaye, 2011:14). In South Africa, health care professionals, home and community care givers, peer educators (including sex workers) and media are the role players in communicating the HAST message. The secondary participants of the communication strategy in the study were health professionals, lay counsellors, peer educators and home- and community-based carers.

Tertiary participants are those whose actions indirectly help or hinder the behaviours of the other participants (UNICEF, 2008:22). The actions of the tertiary participants reflect the broader social, cultural and policy factors required to create an enabling environment to sustain desired behaviour change. These might include parliamentarians, politicians and high level government officials, who make policy and allocate resources; religious leaders (representing religious organisations at the national and local level); professional associations influencing service delivery policies and members of the AIDS Councils at different levels (national, provincial and municipal) (UNICEF, 2008:23).

According to Mnisi, Peu and Meyer (2012: 5), the use of community members, such as traditional leaders, can contribute to the prevention of multidrug-resistant-tuberculosis and can act as treatment supporters. Because of their respected positions in the community, traditional leaders can also be used in a campaign to prevent MDR-TB. Religious ministers should be encouraged to support people living with HIV in their congregations and be provided with training about the management of symptoms related to HIV and AIDS. This would increase the support base for people who live with HIV in the communities in which they are based, whilst at the same time maintaining consistency in the information being given to those experiencing HIV-related symptoms (Modeste and Majeke, 2014: 8). According to Maswanganyi et al. (2014:1) the involvement of community stakeholders in TB prevention, health promotion and education activities devoted to disease spread and cure is vital so that the stigma attached to TB can be eliminated.

### **2.7.3 Limitations with regards to the communication strategy**

Language and literacy levels impact on access to media information (Johnson et al., 2013:14) due to the fact that most of the information is written in English and not in other languages or in Braille. Only a minority of individuals are able to access these messages as the majority cannot read and write and small media (posters, booklets, and utility items) are mostly written in English, not in local languages (Johnson et al., 2013:12).

According to the HSRC (2014:4), knowledge about HIV transmission and prevention, accompanied by appropriate reduction in behavioural risk practices, is important in combating and reversing the spread of HIV. However, knowledge of HIV remains low in sub-Saharan Africa.

In 2009, the AIDS Foundation of South Africa reported that the shortage of health professionals, resources and infrastructure had a negative impact with respect to the country reaching its Millennium Development Goal objectives, making it difficult to sustain optimal healthcare (Horn and Brysiewicz, 2014:1)

Some of the communication strategies did not consider age, social class, ethnic background, life experiences and language proficiency, which are very important in developing a communication strategy. Women will have stronger attitudes towards their responsibility for maintaining their health than men will, regardless of attribution of responsibility (Boiarsky, Rouner and Long, 2013:884).

The challenge for the Province is to increase access to information, education and communication on HIV and TB, strengthening partnerships with faith based leaders, traditional health practitioners and traditional leaders respectively (Department of Health, 2011:44).

## **2.8 A THEORETICAL FRAMEWORK FOR THE STUDY**

### **2.8.1 History and Background of the Theory**

Health behaviour theories and models can be separated into three different levels of influence: Intrapersonal, interpersonal and community (Hayden, 2014:2). At the intrapersonal or individual level, theories focus on the factors within a person that influence behaviour, such as knowledge, attitudes, beliefs, motivation, self-concept, developmental history, past experience and skills. Interpersonal theories address factors at the interpersonal level and operate on the assumption that other people influence our behaviour, e.g. family, friends, peers and health care providers or care workers. Community level models and theories focus on factors within social systems (communities, organisations, institutions, and public policies) such as rules, regulations, legislation, norms and policies. In health promotion, theories and models are used to explain why people behave in a certain way relative to their health. They help us plan interventions to support the public's adoption of healthier behaviour (Hayden, 2014:3).

The Health Belief Model (HBM) as one of the intrapersonal theories was selected for this study. The HBM was developed by researchers at the U.S. Public Health Services in the late 1950s (Hayden, 2014:64; Glanz, Rimerand and Viswanath, 2008:45). The Health Belief Model has been one of the most widely used conceptual frameworks in health behaviour research, both to explain change and maintenance of health-related behaviours and as a guiding framework for health behaviour interventions. Over the past two decade, the HBM has been expanded, compared to other frameworks, and used to support interventions to change health behaviour (Glanz, Rimerand and Viswanath, 2008:45). The HBM contains several primary concepts which predict why people will take action to prevent, to screen for or to control illnesses. These include susceptibility, seriousness, benefits and barriers to behaviour, cues to action and, most recently, self-efficacy.

### 2.8.1.1 Perceived Susceptibility

Perceived susceptibility refers to beliefs about the likelihood of getting a disease or condition. It is more logical that when a person believes they are at risk for a disease, they will be more likely to do something to prevent it from happening. The use of condoms in an effort to decrease susceptibility to HIV infection or to screen for TB for early detection diagnosis and treatment is recognition of susceptibility.

### 2.8.1.2 Perceived Seriousness (Severity)

Feelings about the seriousness of contracting an illness, or of leaving it untreated, include evaluations for both medical and clinical consequences (for example, death, disability and pain) and possible social consequences (such as the effects of the condition on work, family life and social relations). The combination of susceptibility and severity has been labelled as perceived threat. Risk is defined as the probability that a person may acquire HIV infection. Certain behaviours create, enhance, or perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown; multiple unprotected sexual partnerships; and injecting drugs with contaminated needles and syringes (SADAC, 2013:16).

### 2.8.1.3 Perceived Benefits

This relates to a person's opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease. Even if a person perceives personal susceptibility to a serious health condition (perceived threats), whether these perceptions will lead to behaviour change will be influenced by the person regarding perceived benefits of the various available actions for reducing the threat. If people are using condoms consistently the benefits will be a long, healthy life, free from sexually infectious diseases.

### 2.8.1.4 Perceived Barriers

An individual's own evaluation of the obstacles in adopting a new behaviour (Hayden, 2014:69). Even though there is more information and education about HAST, people

still find it difficult to change their risky sexual behaviour to prevent them from contracting these conditions. There are several factors that reduce the ability of individuals and communities to avoid HIV infection. These may include: lack of knowledge and skills to protect oneself and others; inaccessibility to services due to distance, cost and social and cultural norms; practices and beliefs that stigmatise and disempower certain populations, such as women and girls; men who have sex with men; and laws that act as barriers to the dissemination of essential HIV prevention messages. These factors, alone or in combination, may create or exacerbate individual vulnerability and, as a result, collective vulnerability to HIV (SADAC, 2013:16).

#### 2.8.1.5 Cues to Action

Cues to action are events, people, or things that move people to change their behaviour. Examples include: assertive outreach, marketing or mass media campaigns and training and research; or a family member who has suffered from AIDS related illnesses or TB.

#### 2.8.1.6 Self-Efficacy

The belief in one's own ability to do something as a person generally does not try to do something new unless they think they can do it. If someone believes a new behaviour is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried. For an example, if a woman thinks that introducing condom usage to her male partner is not going to be welcomed and can lead to misunderstanding, she will not introduce it. The focus group discussions or dialogues with other women who have attempted this before can be a verbal reinforcement for reducing her anxiety, thus encouraging her to introduce the condom. Refer to Figure 1.1 for the Health Belief Model.

### **2.8.2 The application of the Health Belief Model**

A review of recent studies in health field revealed that the HBM has been used to analyse patient behaviour patterns and their changes with regard to health care and treatment in HIV and TB. Helman (1985:923) used the theoretical framework of the

HBM to analyse communication between a doctor and a patient. The model was used as a framework catering for the patient's perspective. According to Helman (1985:924), the HBM "has been used to predict, and explain, the incidence of non-compliance" in patients with various medical conditions. This study was conducted over a period of six months with 42 patients, 12 doctors and six nurses (Helman, 1985:924). Data were collected and analysed quantitatively using semi-structured interviews and structured questionnaires. The study concluded that medical professionals must be aware of patients' perceptions of their illnesses in order for communication to be effective and for the goal of effective health care to be attained. Useh (2006) used HBM in her study 'the role of Anglican church in the prevention of the spread of the HIV and AIDS in the Limpopo Province' and indicated that the church, as an agent of change, provides information in the form of education, workshops and counselling to help people make that decision.

The HBM has been used both to explain change in, and maintenance of, health-related behaviours and as a guiding framework for health behaviour interventions. When patients enter the health care system for treatment, they are expected to work towards, and maintain, behaviour change, with the help of various medical professionals whose aim is to assist the individual patient to achieve the ultimate goal of adherence to ART. Consequently, for patients to cope with their new illness and to "live positively", a two-way flow of communication from the various medical professionals is required, informing patients on how to use ARVs correctly. Furthermore, the patients need to be advised and educated about the disease as well as adherence to the medication (Moola, 2010:32)

According to Mokgethi (2011:21), the HBM is perceived barriers which could lead to perceived threats of illegal TOP services; complications and death are portrayed; whereas the benefits outweigh the threats as women's choice to use termination of pregnancy services with proper equipment, trained and willingness of personnel to provide termination of pregnancy and supportive environment.

According to Tlou (2009:12), the Health Belief Model was not chosen for this study and indicated that empirical tests of the model in the context of HIV-preventive behaviour had failed to provide strong support for it. He further argues, referring to other researchers like (Lewis and Kashima, 1993; Montgomery et al., 1989; Warwick, Terry and Gallois, 1993), that the model accounted for a small proportion of variance in HIV/AIDS health behaviour.

In the study the HBM was applied and fitted well as follows:

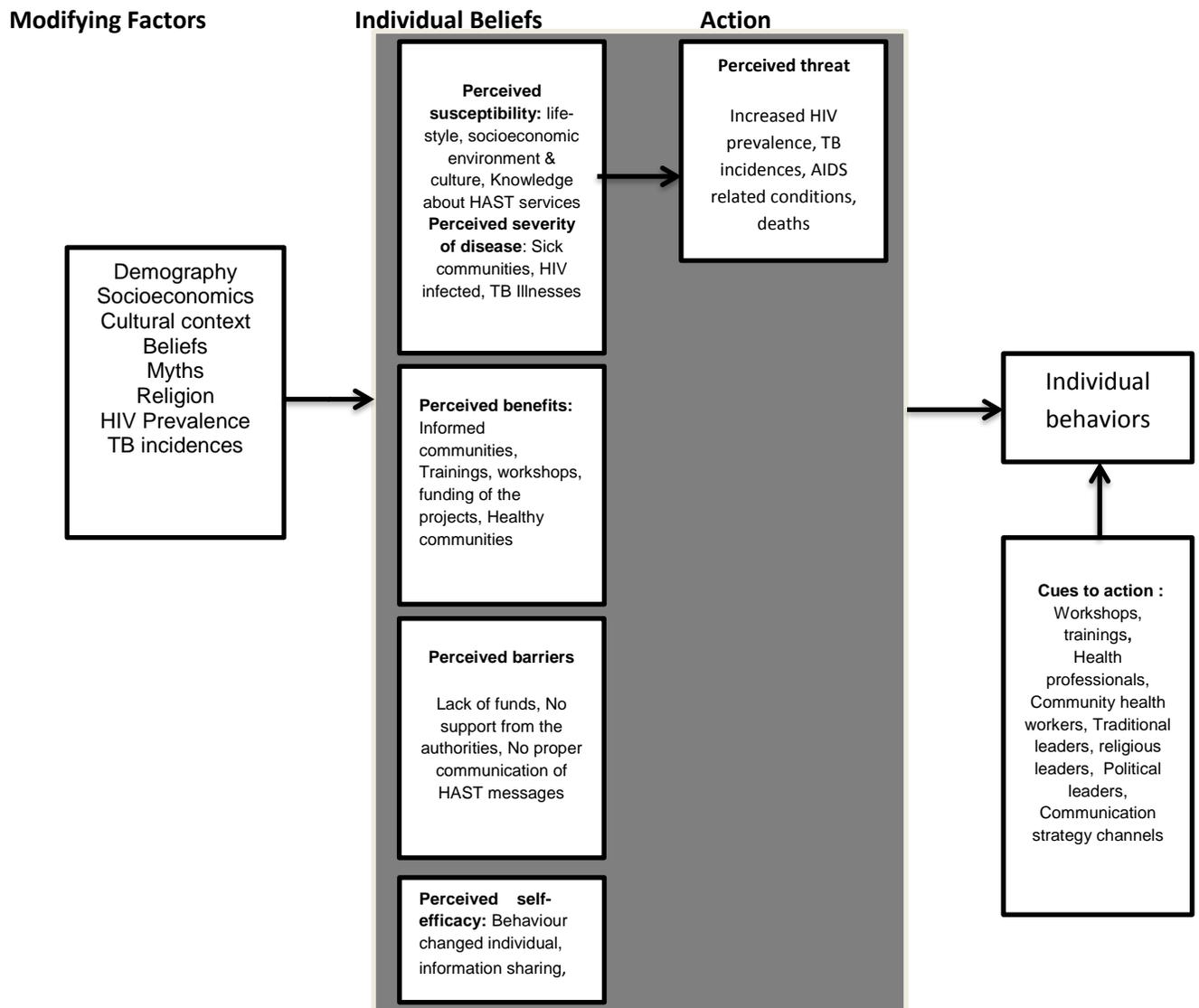


Figure 2.1: Health Belief Model Components and linkages - Applied to Communication strategy (Glanz et al., 2008:49)

## **2.9 CONCLUSION**

This chapter provided a literature review on aspects concerning the research, such as factors related to HAST; international, national and local trends in the prevalence of HAST; the legislative framework; measurements of HAST; communication strategies of HAST, including its limitations, and the theoretical framework informing the study.

The next chapter will explain the research methodology adopted to conduct this study.

## CHAPTER 3

### RESEARCH DESIGN AND METHODS

#### 3.1 INTRODUCTION

The previous chapter focused on the literature reviewed in relation to the research topic. It also provided an overview of the Health Belief Model, which forms the theoretical framework for this study. This chapter describes the research approach, design and methodology that was used to address the lack of a coherent and focused communication strategy, with the aim of designing and implementing guidelines which will lead to a measurable impact on HAST within a provincial context.

In this chapter the discussion focuses on how the study unfolded in two phases and illustrates sampling of the study populations, the collection of data and how both the integrity and the rigor of the study were maintained. The nature of the data obtained and the analysis thereof will be discussed in detail in Chapter 4.

#### 3.2 RESEARCH APPROACH

The study followed a mainly qualitative approach in the development of a communication strategy for the Province. Qualitative research implies the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative material using a flexible research design (Polit and Beck, 2012:739). This approach is relevant to this study because the views of the people need to be explored in order to discover the elements of a relevant, acceptable and appropriate strategy to address HAST.

##### 3.2.1 The Characteristics of Qualitative Research

- *Natural setting:* Qualitative researchers tend to collect data in the field at the site where participants experience the issue or the problem under investigation (Creswell, 2014:186). In this study the researcher moved from one district to the other to collect data and also from office to office where the managers are working, to conduct personal interviews. The focus group interview was

conducted in the Mayor's boardroom where District AIDS Council meetings are held.

- *Researcher as key instrument:* Qualitative researchers collect data themselves through examining documents, observing behaviour or interviewing the participants (Creswell, 2014:186). The researcher conducted the focus group interview and personal interviews by herself, in order to gather data.
- *Multiple sources of data:* Qualitative researchers typically gather multiple forms of data, such as interviews transcriptions, observations, documents and audio-visual material, rather than relying on a single data source (Creswell, 2014:186). In this study, the multiple data sources utilised included interviews, observations and documents.
- *Inductive and deductive data analysis:* Qualitative researchers build patterns, categories and themes from the bottom up by organising the data into increasingly more abstract units of information. This induction process involves working back and forth between the themes and the database until the researcher has established a comprehensive set of themes. Then, deductively, the researcher will look back at the data from the themes to determine if more evidence can support each theme or whether additional information needs to be gathered. Thus, while the process begins inductively, deductive thinking also plays an important role as the analysis moves forward (Creswell, 2014:186).
- *Participants' meaning:* During the entire qualitative research process, the researcher keeps a focus on learning the meaning that participants hold about the problem or issue, not the meaning that the researcher brings to the research or the meaning that the authors express in the literature.
- *Emergent design:* The research process for qualitative researcher is emergent. This means that the initial plan for research cannot be tightly prescribed and some or all phases of the process may change or shift after the researcher enters into the field and begins to collect data (Creswell, 2014:186).
- *Reflexivity:* In qualitative research, the inquirer reflects on how their role in the study and their personal background, culture and experience holds potential for shaping their interpretation of information gathered, such as the themes they

advance and the meaning they ascribe to the data. This aspect of the research method is more than merely advancing biases and values in the study, but how the background of the researcher may actually shape the direction of the study (Creswell, 2014:186).

- *Holistic account*: Qualitative researchers try to develop a complex picture of the problem or issue under study. This involves reporting multiple perspectives, identifying the many factors involved in the situation and generally sketching the larger picture as it emerges. A visual model of many facets of a process or a central phenomenon aids in establishing this holistic picture (Creswell, 2014:186).

### **3.2.2 Application of qualitative approach to the study**

Qualitative research methods *guide the nursing practice*, through the evidence generated by its findings (LoBiondo-Wood and Haber, 2006:151). In this study, the communication strategy developed for mitigating HAST will guide nursing practice as health care personnel become aware of the approaches and the strategies to be utilised in addressing issues of HAST. It will also guide nursing practice by using personal stories to enlighten and enrich understanding of everyday health experience (LoBiondo-Wood and Haber, 2006:151). In this study no personal stories were required, only the work experiences of the Deputy Directors working in HAST were used.

### **3.3 RESEARCH DESIGN**

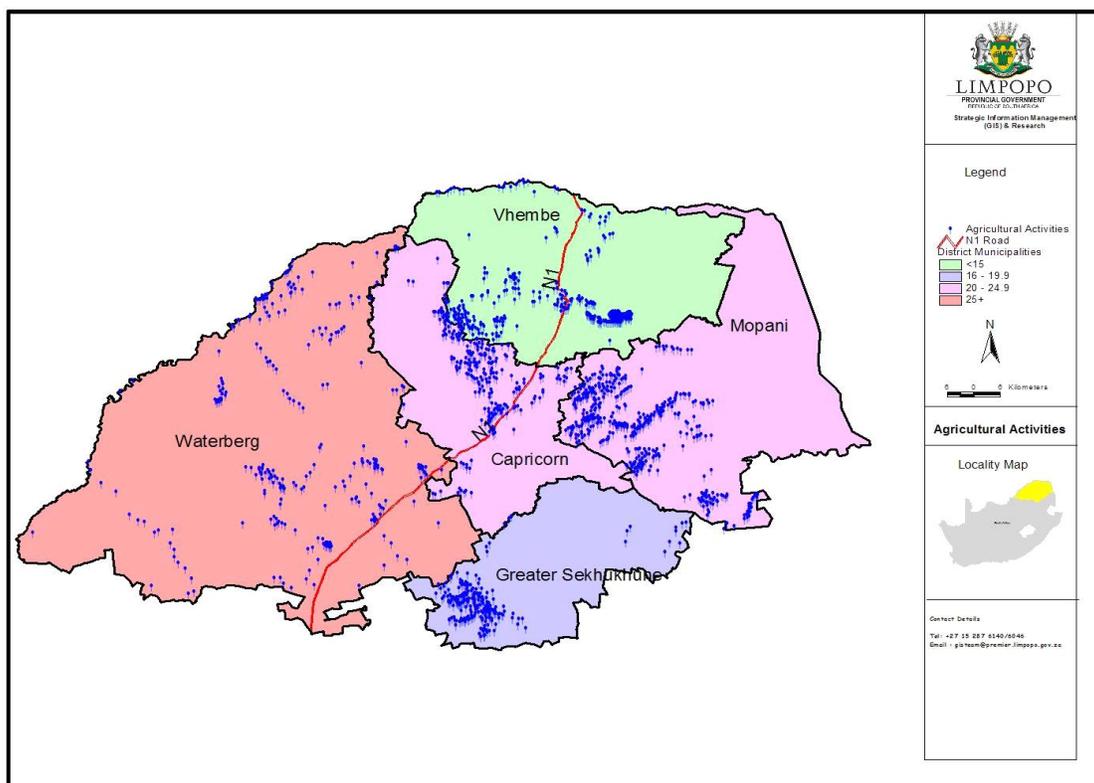
The researcher used an exploratory research design. Exploratory research design is a sequential design in which qualitative data are collected with the aim of collecting rich data to the point of saturation (Polit and Beck, 2012:727). In the study the personal and focus group interviews used explored the views of the Deputy Directors and the community members to the point of saturation.

### **3.4 CONTEXT OF THE STUDY**

The study was conducted in the Limpopo Province, the demography; socio-economic profile and cultural context are discussed as follows:

#### **3.4.1 Demography of the Province**

Limpopo Province is situated in the northern part of South Africa, with an estimated population at 5.56 million people. The Province accounts for 11% of the total population in the Republic of South Africa, which is estimated at 51 million. This makes Limpopo the fourth most populated province in the country, after Gauteng, KwaZulu-Natal and the Eastern Cape, respectively. From a district perspective, the Limpopo Province consists of five districts, namely, Capricorn, Mopani, Sekhukhune, Vhembe and Waterberg. The Province's population is unevenly distributed throughout the five districts (Department of Health, 2011:14). Close to half of the Province's population (47%) is found in the Capricorn and Vhembe Districts, while the Waterberg District accounts for the smallest proportion of the population (13%) in the Province. When it comes to gender structure, districts generally emulate the provincial picture, with females out numbering males (Department of Health, 2011:14). According Statistics SA (2014:15) Limpopo has a total population of 5 630 464, made up of 2 649 113 males and 2 981 351 females. Figure 1 below shows the 5 districts that make up the Province of Limpopo and the concentration of agricultural activities in the Province, which is the main economic activity in the Province, followed by mining (Department of Health, 2011:14)



**Figure 3.1: Map of Limpopo Districts and agricultural activity** (Department of Health, 2011:14)

The population of the Limpopo Province is youthful, with 35% (1.93 million) made up of children under the age of 15 years. Six out of 10 people in the 15 to 64 year age group (3.3 million) are economically active, while elderly people are in the minority, making up 5% of the Province's population. Females constitute the majority, accounting for 54% (3 million) of the Province's population. It is, therefore, critical that the youth and women, including young girls, are prioritised for service delivery, together with key populations (Department of Health, 2011:15).

### 3.4.2 Socio-economic profile of the province

The rural nature of the Province, unemployment, gender inequality and illiteracy are some of the major factors that affect the Limpopo Province (Department of Health, 2011:16). Approximately 80% of the Limpopo Province is rural, with a 19% unemployment rate. Available information shows that one in three people (33.4%) aged 20 and older has had no formal education. The highest proportion of people in this

category (39%) is found in Vhembe District, while Capricorn District has the lowest percentage (9%) (Department of Health, 2011:16).

The rate of unemployment has a direct impact on economic growth in the Province. The unemployment rate in the Limpopo Province is estimated at 22.6%, which compares unfavourably to unemployment in other provinces in the country, such as the Western Cape (21.8%) and KwaZulu-Natal (20.8%) (Department of Health, 2011:16).

### **3.4.3 Cultural Context of Limpopo**

The common languages in the Province are: Afrikaans, English, isiNdebele, Sepedi, Tshivenda and Xitsonga. However, all of South Africa's official languages, plus the South African sign languages, receive proper respect. In terms of effective communication this may imply that all material must be translated into the different languages of clients in the Province (Limpopo Provincial Government, 2009:7).

Kings/chiefs still play an important role in the community and involving them in government communication programmes is highly emphasised. The involvement of other stakeholders, such as the faith groups, business and civic associations should also be emphasised. Cultural practices, such as ritual killings and witchcraft, are still rife in some parts of the Province (Limpopo Provincial Government, 2009:7).

Cultural groups like Ndebele, Tshonga, North Sotho and Vhenda, are mostly Christians but many people also believe that the ancestors or spirits of family members who have died play a powerful role in their lives (Limpopo Provincial Government, 2009:7). When communicating with people in this Province one must be aware of their beliefs and be sensitive to their beliefs and culture. The use of relevant language and tone of voice to show respect is very important. Respect is the key when addressing elders, especially about sex and sexuality-related topics. An adult should address them, not a teenager. There are topics, like medical male circumcision, that only males can address other men on and a tribal gathering (Dikgoro) is the relevant place to have such conversations. A man who has undergone initiation at an initiation school is the only

person who is allowed to address other men at the tribal office. When following these cultural norms and beliefs it becomes easy to reach all communities in the Province.

### **3.5 RESEARCH METHOD**

The research method is discussed in relation to the two phases of the study, i.e. phase one of situational analysis and phase two of communication strategy development.

#### **3.5.1 Phase 1: Situational analysis.**

This section will discuss the research population, sample and sampling procedure, research setting, ethical considerations and limitations. The study methodology was guided by the major tenets of the Health Belief Model as discussed in Chapter 2. These major tenets, which guided the research process, involve modifying factors, individual beliefs and action.

##### ***3.5.1.1 Study setting***

The study was conducted in the Limpopo Province. The social, cultural and geographic context of Limpopo is described in Chapter 3.4. The context of the study assisted the researcher in understanding the modifying factors as it highlighted the aspects of demography, socio-economic profile, cultural context and structure of health system. All these factors have an impact on perceptions towards HAST.

##### ***3.5.1.2 Population***

The study involved multiple populations based on the data collected. For purposes of the literature review, all HAST and communication strategy material was considered. The study population for the focus group interview was made up of civil society members, who were drawn from the database of representatives of the Capricorn District AIDS Council. The following representatives were included in the focus group interview: members of the House of Traditional Leaders, traditional health practitioners, males, participants from the disability sector, faith organisations working within the HIV

and AIDS Partnership, people living with HIV and AIDS and older persons. This sample population was also chosen to further identify the modifying factors, individual beliefs and actions. This population assisted further in clarifying modifying factors and actions. The participants were recruited during a District AIDS Council meeting.

### **3.5.1.3 Sampling**

Non-probability purposive sampling was also done in relation to specific data collection methods, while considering which sources were able to yield relevant information in relation to the modifying factors, individual beliefs and action. For the purposes of the literature review, the inclusion criteria are set out in Chapter 2, section 2.1. Selection of the focus group interview sample population was based on the following criteria: being an active member of the Capricorn District AIDS Council civil society for at least six months and being able to speak Sepedi, which is one of the languages spoken in the Limpopo Province, specifically in the Capricorn District.

All the HAST Deputy Directors at district and provincial level were recruited to participate in the individual interview part of the study during a Provincial meeting. The inclusion criteria included involvement at district or provincial level in HAST projects. These HAST projects included: Advocacy, Communication and Social Mobilisation for HAST; Tuberculosis; HIV Counselling and Testing; Prevention of Mother to Child Transmission of HIV and AIDS; Comprehensive Care Management and Treatment, Care and Support; TB and HIV Integration, Sexually Transmitted Infections, High Transmitted Areas; Medical Male Circumcision and Condom Logistics. After explaining the purpose of the study, all the managers were provided with an interview schedule in order for them to know what the study was all about. Each interview schedule was accompanied by a covering letter (see Annexure D) identifying the person undertaking the research and providing a brief description of the purpose of the study. The name, address and telephone number of the researcher appeared on the covering letter so that respondents could contact the researcher should they wish to do so for whatever reason.

Follow-up individual discussions were also undertaken, followed by a telephonic appointment. All managers agreed to participate. However, only 18 participants were interviewed. The sample size was determined by data saturation.

#### **3.5.1. 4 Data collection**

Three different methods of data collection were used in this study, namely, literature review, focus group discussion and in-depth individual interviews.

##### *3.5.1.4.1 Literature review*

With respect to the literature review, an in-depth literature study was conducted on aspects such as factors related to HAST and international and national trends of the prevalence of HAST. The context of the health systems and formal and informal health resources were discussed within a legislative framework. The communication process, limitations with regard to effective communication and national and international trends regarding communication strategies were explored. Evidence obtained from the literature was integrated into the Health Belief Model (HBM), which forms the theoretical framework of the study. This assisted the researcher to understand the modifying factors, some individual factors and action taken with regard to HAST. A full report on the outcome of the literature review appears as Chapter 2.

##### *3.5.1.4.2 Focus group interview*

In order to get sense of the modifying factors and of individual beliefs, the researcher conducted a focus group interview with the Capricorn District AIDS Council civil society members. A focus group interview refers to interview with group of individuals assembled to answer questions on a given topic (Polit and Beck, 2012:728). An interview involves three way verbal communication between researcher and participants as well as between the participants themselves, it is a group that is designed to obtain the participants' perceptions on a specific (or focused) area, in a setting that is permissive and nonthreatening (Burns and Grove, 2009:701). The purpose of conducting this interview was to determine the level of understanding of HAST, the acceptability, relevance and accessibility of available resources and health systems, as

well as the appropriateness, feasibility and acceptability of strategies. This covered the individual beliefs and the modifying factors. Those who volunteered to participate were provided with information regarding the date and time of the focus group discussion. A total of seven members agreed to participate in the focus group discussion. The researcher used an interview guide to direct the focus group interview and used tentative, probing questions. Questions that were used to facilitate the discussion were as follows:

1. What are your views on general health status in Limpopo Province?
2. Perception about HIV, AIDS & STIs and TB (HAST)
  - How do you feel about the available services HAST diseases?
3. What are the communication strategies that are currently being used in the Province to specifically address the burden of diseases in terms of HAST?
4. Are strategies accommodating all target groups such as disabled, youth and the elderly? Are these strategies cost effective?
5. How do the existing assisting in behaviour change?
6. How do you view your capacity in relation to changing the behaviour?
7. Any capacity to sustain the changed behaviour? Any support for sustainability?
8. What are the attitudes of people towards people infected and affected with HAST? Explain why you respond in this way (see Annexure F).

The Capricorn Municipality boardroom was utilised for the focus group interview. The venue was quiet, private and conducive to the interview. Arrangements for suitable equipment, such as: sufficient chairs arranged in a circle, audiotape equipment, spare batteries, a note book and a pen, drinking bottle water, sweets and tissues were made.

On the day and time scheduled for the focus group interview, the researcher and an assistant welcomed the participants and explained the purpose and course of the study, the voluntary nature of participation as well as the rights of the participants. The participants who agreed to participate were asked to sign an informed consent form (see Annexure D). The role of the assistant was highlighted and confidentiality was adhered to as no names were used. Participants were told that their participation was

voluntary. The use of audiotape recordings was explained to the participants and they all agreed to be recorded.

The focus group interview guide was used only to direct the interview process. The researcher allowed the participants to talk freely. Probing questions were employed to stimulate further discussion and elaboration. In order to create an atmosphere of comfort and acceptance and to stimulate the free flow of communication, the researcher employed interpersonal and communication techniques, such as nodding, maintaining eye contact, listening attentively, paraphrasing, summarising and making minimum verbal responses.

The researcher took field notes during the interviews to record unstructured observations. Field notes refer to the notes taken by researchers to record the unstructured observations made in the field and the interpretation of those observations (Polit and Beck, 2012:728). In this study the researcher, assisted by a research assistant, looked out for shyness or hesitation when participants answered questions. Also observed was tone of voice, body language, comparisons of institutions and resources, emotional expression, attitude and the free flow of language (Sepedi was used as language of communication).

#### *3.5.1.4.3 In-depth individual interview*

For in-depth individual interviews, the researcher visited the Deputy Directors at the place of their work, by appointment, at a time which was convenient to the participants. Personal interviews were done with 18 HAST District and Provincial Deputy Directors between December 2013 and February 2014. As the main purpose of the individual interview was to understand actions which, for this section, included communication approaches used, an in-depth personal interview with District and Provincial Deputy Directors was held so as to understand and identify factors impacting on the prevalence of HAST, as well as determine the availability of the resources and health system within the context of the Limpopo Province. The researcher also used an interview guide for this data collection process. The interview guide comprised of sections that needed an

indication of whether from district or province and years of experience in HAST and the following questions were used to probe the discussion:

1. What are the communication strategies that are currently being used in the Province to specifically address the burden of diseases in terms of HAST?
2. What are the strengths and weaknesses of the above mentioned strategies?
3. Is it important for the province to have a communication strategy to specifically address the burden of diseases in terms of HAST? And why?
4. What are, according to you, the main elements to be included in a specific communication strategy and why?
5. What factors will, according to you, contribute towards the success or the failure of the implementation of a communication strategy? Why? (see Annexure E).

The instrument was designed in such a manner that there was a space in between for the researcher to write. The participants signed a consent form to show that they agreed to participate voluntarily in the study and confidentiality was maintained as no names written on the data collection tool. An in-depth interview was undertaken with each of the Deputy Directors and, using the guide, the researcher was able to write down participants' responses on the each question guide.

### **3.5.1. 5 Data analysis**

Different processes of data analysis were utilised depending on data collection method used.

#### *3.5.1.5.1 Literature review*

For literature review the researcher used the Health Belief Model to analyse the information collected.

### 3.5.1.5.2 Focus group interviews

Data analysis is the systemic organisation and synthesis of the research data (Polit and Beck, 2012:725). Content analysis was performed to analyse data. Qualitative content analysis is the analysis of the content of narrative data to identify prominent themes and patterns among themes (Polit and Beck, 2012:564). Qualitative content analysis involves breaking down data into small units, coding and naming the units according to the content they represent and grouping coded material based on shared concepts (Polit and Beck, 2012:564). Content analysis was performed in all the phases.

The process of analysis goes through certain stages common to many approaches:

- Transcribing interviews and sorting field notes

Transcribing of interviews is one of the initial steps in preparing data for analysis. The fullest and richest data can be gained from transcribing verbatim (Holloway and Wheeler, 2010:282). Verbatim transcriptions of the audio-recorded interview were made by the researcher prior to data analysis (see Annexure E). Transcription is the process of converting audiotaped recordings into text data to ease the process of data analysis (Creswell, 2007:233).

- Organising, ordering and sorting the data

Through organisation and management, the researcher brings structure and order to the unwieldy mass of data. This will help eventual retrieval and final analysis. (Holloway & Wheeler, 2010:284). All transcripts, field notes and other data should have details of time, location and specific comments attached and everything has to be recorded, cross-checked and labelled (Holloway and Wheeler, 2010:285).

- Listening to and reading or viewing the material collected repeatedly

The steps of listening to, viewing and gaining a holistic view of the data as well as dividing them into units or segments of meaning (Holloway and Wheeler, 2010:285).

- Coding and categorising

Coding means marking sections of data and giving them labels or names. It is an early stage in analysis which precedes the development of categories, themes or major constructs. It breaks the data into manageable sections (Holloway and Wheeler, 2010:286).

Furthermore, an independent analyst (co-coder) was asked to analyse the scripts and the results were compared with initial results during analysis to ensure credibility of data, which focuses on improving validity and reliability of data.

#### *3.5.1.5.3 In-depth individual*

The process of analysis of the in-depth individual interview is as follows:

- Organising, ordering and sorting the data

The notes and the information gathered on the questioner guide with similar idea were coloured with different colours.

- Coding and categorising

Coding means marking sections of data and giving them labels or names. It is an early stage in analysis and precedes the development of categories, themes or major constructs. It breaks the data into manageable sections (Holloway and Wheeler, 2010:286). This was done by giving themes and sub-themes from the gathered information.

Furthermore, an independent analyst (co-coder) which was a different person from the focus group one was asked to analyse the scripts and the results were compared with initial results during analysis to ensure credibility of data, which focuses on improving validity and reliability of data.

### **3.5.2 Phase 2: Development of communication strategy**

The researcher followed the following three stages to develop a communication strategy. The stages the researcher went through are as follows: (i) drafting the communication strategy; and (ii) piloting and assessment of the communication strategy.

#### **3.5.2.1 Study setting**

The study was conducted in the Limpopo Province as discussed in 3.5.1.1.

#### **3.5.2.2 Population**

The study involved multiple populations based on the data collection method. The drafting of the communication strategy commenced after the literature review, information obtained from personal interview with the District and Provincial Deputy Directors and the focus group interview with civil society members. The study population for the piloting stage was drawn from the HAST Assistant Directors of the Capricorn District those who are implementers of the HAST programme. The study population for the monitoring, refining and finalisation stage was drawn from HAST senior managers from the Provincial office.

#### **3.5.2.3 Sampling**

Sampling was also done in relation to the specific data collection method, while considering the sources which were able to yield relevant information in relation to modifying factors, individual beliefs and action. For the drafting of the communication strategy, the sampling included the information obtained which assisted the communication strategy draft and included the following topics: acknowledgements; summary; acronyms; introduction; background of the HAST communication strategy; legislative framework; purpose of the HAST communication strategy; guiding principles; target group/audience; communication channel; disease profile/trends; prevention, diagnosis, treatment and support; multi-sectoral approach; resources and budget; policy, capacity building and development; monitoring and evaluation and conclusion. The sample population for the pilot phase was drawn from the HAST Assistant Directors

in the Capricorn District who were recruited during the district review meeting and the inclusion criteria mandated that they had to be HAST programme implementers. All three Directors in HAST were polled for assessment after the pilot stage. The first Director recruited was responsible for the TB Control programme, the second Director recruited was responsible for HIV & AIDS and STIs (HAS) programmes and the third Director recruited was responsible for HAST stakeholder coordination.

#### **3.5.2.4 Data collection**

Three different methods of data collection were used for this study, namely, drafting the communication strategy, piloting the communication strategy and the assessment of the communication strategy.

##### *3.5.2.4.1 Drafting the communication strategy*

The information obtained through the literature review, focus group discussion and in-depth individual interviews was used to draft the communication strategy.

##### *3.5.2.4.2 Piloting the communication strategy*

During the pilot stage Assistant Directors of Capricorn District HAST were given a draft communication strategy document to utilise in their daily work activities for the period of three months (June to August 2015). After three months, member checking with participants was be done to determine the level of understanding of the HAST communication strategy, the acceptability, relevance and accessibility of available resources and health systems as well as the appropriateness, feasibility and acceptability of strategies and information contained in the draft communication strategy.

The draft of the communication strategy document (Annexure Q) was accompanied by a covering letter (see Annexure D) identifying the person undertaking the research and providing a brief description of the purpose of the study. The name, address and telephone number of the researcher appeared on the covering letter so that respondents could contact the researcher should they wish to do so for whatever

reason. The interview guide comprised of a section that required an indication of whether the participant came from district or province and number of years of experience in HAST and the following instructions were given (see Annexure G):

#### WHAT TO DO:

1. Read the draft HAST Communication strategy attached.
2. Implement it in your district were you see it fit with your daily work.
3. Always check if is understood, user friendly, easy to use by community members and health workers.
4. If is acceptable, relevant, feasible and accessible.
5. Availability of resources and Health system.
6. Feasibility and acceptability of strategies and information contained in the draft communication.

The participants signed consent forms to indicate that their agreement to participate voluntarily in the study, and confidentiality was maintained as no names written on the data collection tool.

#### *3.5.2.4.3 Assessment and finalisation stage*

An interview guide, based on the drafted communication strategy, was utilised as data collection instrument for personal interviews with the Directors. Due to the busy schedules of the participants, member checking was done with individual Directors at their place of the appointment. The questions used for the member check to probe discussions were as follows:

1. Did you manage to go through the HAST Communication strategy framework?
2. According to you how do you see the HAST Communication strategy and its implementation, is it acceptable? Feasible? And relevant?
3. How is the relevance of the monitoring process and evaluation criteria embedded in the strategy? (see Annexure H).

### **3.5.2. 5 Data analysis**

Different processes of data analysis were utilised depending on data collection method used.

#### *3.5.2.5.1 Drafting of the communication strategy*

The components that were mentioned in 3.5.2.3 were incorporated and analysed using the information of piloting the communication strategy and monitoring, refining and finalisation stage.

#### *3.5.2.5.2 Piloting the communication strategy*

Data analysis is the systemic organisation and synthesis of the research data (Polit and Beck, 2012:725). The data was analysed through member checking. Data collection was done at a congregational setting during a district review meeting. All six HAST Assistant Directors were present to give their views, after piloting the strategy for three months. The draft communication strategy was flagged through a data projector and all six Assistant Directors gave their inputs, paragraph by paragraph, and member checking with the members was done throughout. Where there was no agreement, discussions were undertaken until the group reach consensus. The detailed communication strategy, with their inputs, is presented in Chapter 5.

#### *3.5.2.5.3 Assessment and finalisation stage*

After a period of two weeks, the HAST Directors were interviewed individually at a time that suited them. An information leaflet, with a consent form, was given to the participants prior to the schedule time of the meeting. Their inputs assisted the researcher to refine the strategy, to determine whether the strategy and its implementation were acceptable, feasible and relevant. A full description of their inputs is reflected in Chapter 5.

### 3.6 TRUSTWORTHINESS

Trustworthiness is the degree of confidence qualitative researchers have in their data; which is assessed using the criteria of credibility, transferability, dependability, conformity and authenticity (Polit and Beck, 2010: 570). Qualitative researchers use somewhat different criteria in evaluating a study's quality (Polit and Beck, 2012:106). According to Polit and Beck (2012:106), qualitative researchers discuss methods of enhancing the trustworthiness of the study data and findings. Trustworthiness is ensured by credibility, dependability, conformability and transferability (Houser, 2012:224; Polit and Beck, 2010:106; Polit and Beck, 2012:584; Rebar et al., 2011:155; Holloway and Wheeler, 2010:302;). The researcher used more than one dimension to ensure trustworthiness in all phases of the study as follows:

*Credibility* refers to a qualitative data measure focused on ensuring that the results represent the underlying meaning of the data (Houser, 2012:224). According to Lo-Biondo, Wood and Haber (2010: 119), credibility is the truth findings as judged by participants and others within the discipline. During interviews the researcher checked with the participants whether they had correctly understood what was said. In the study an audio recorder and a notebook for taking field notes was used to document the findings. Further, findings were transcribed, handwritten and then compiled as a soft copy report.

Credibility was ensured when the HAST Directors provided inputs for refinement of the communication strategy and the interviews also served as verification of the suggested strategy plan in terms of acceptability, feasibility and relevance.

*Dependability* refers to qualitative data measures focused on the stability of the information across individuals or over time, the stability of data over time (Houser, 2012:224). Methods to demonstrate dependability include achieving saturation, member checking and using an audit trail. Data saturation was reached because further information obtained from later participants proved to be repetitive of information from earlier participants. Data saturation occurs when additional sampling yields no new information, only redundancy of data already collected and themes that emerge become

repetitive (Burns and Grove, 2011:317; Lo-Biondo and Haber, 2010:236). Dependability was ensured through the following:

- Research plan, method and implementation, which were checked by the study leader and supported by literature.
- The dense description of research methods and process.

*Transferability* is the extent to which qualitative findings can be transferred to other settings or groups; analogous to generalisability (Polit and Beck, 2012:570). Transferability was ensured through thick description of research methods and processes and also through literature control regarding similar findings in other studies. The study is relevant within the context of the Limpopo Province and will not be transferrable to other provinces.

*Conformability* is those characteristics of findings that reach congruence between two or more independent researchers (Houser, 2012:224). In the study it was ensured as follows:

- A second researcher, experience in qualitative data analysis was employed as co-coder.
- Consensus between researcher and co-coder regarding findings was reached.
- Personal interview scripts, focus group interview audio recorded, transcribed verbatim, field notes, records available for audit were used.
- Findings correlate with/are supported by literature
- Data saturation was reached.
- Personal and interpersonal (researcher and promoter) reflection regarding intentions and decisions occurred.

### **3.7 ETHICAL CONSIDERATIONS**

According to Polit and Beck (2010:167) ethical considerations emphasise that, when people are used as study respondents, care must be exercised in ensuring that the rights of the respondents are protected accordingly. The researcher obtained permission to conduct the study, obtained informed consent from the participants and respected their right to self-determination, privacy, anonymity and confidentiality, and fair treatment (Burns and Grove, 2009: 196).

#### **3.7.1 Ethical approval**

The researcher obtained ethical approval from the Ethics Committee of the University of South Africa (UNISA) with project number HSHDC/256/2013 (Annexure C).

#### **3.7.2 Permission to conduct the study**

Permission to conduct the study was requested in writing from the following authorities:

- Department of Health, Limpopo Province (Annexure A)
- Capricorn District Municipality (see Annexure B)

#### **3.7.3 The ethical principles**

The researcher adhered to the following principles:

- Respect for a person;
- Principle of beneficence;
- Principle of justice;
- Respect for human dignity;
- Principle of right to privacy;
- Informed consent;
- Benefit from research;
- Respect for persons.

Respect for persons means stating that individuals should be treated autonomously, as capable of making their own decisions and persons with limited autonomy or who are not capable of making their own decisions should be protected (Houser, 2012:54). In the study all confidentiality was ensured and participants signed informed consent forms, information leaflets were provided, participation was voluntary and participants were informed that they could withdraw from the study at any time.

- Beneficence

Beneficence means stating that persons should have their decisions respected, be protected from harm, and steps taken to ensure well-being (Houser, 2012:55). The participants were given support during interviews and counselling was offered when needed. During the interviews the participants were given an opportunity to express themselves without intimidation. Approval to conduct the study was obtained from the relevant ethics committees.

- Justice

Justice is a basic principle of ethics that incorporates a participant's right to fair treatment and fairness in distribution of benefit and burden (Houser, 2012:56). The respondents were allowed to withdraw at any time when feeling pressure or tired or for any other reason.

- Respect for Human dignity

Respect for human dignity is a principle that includes the right to self-determination and the right to full disclosure (Polit and Beck, 2012:154). In this study, no real names were used and information leaflets about the research, including consent forms, were given to participants prior the interview to give them time to read and sign if they agreed to participate in the study.

- Right to Privacy

Right to privacy is a situation when the researcher ensures that their research is not more intrusive than it needs to be and the participants' privacy maintained at all times

(Polit and Beck, 2012:156). To ensure right to privacy, the interviews was conducted in a quiet and private place.

- Informed Consent

Informed consent means that the participants have adequate information about the research, comprehend that information and have the ability to consent to, or decline, voluntary participation in the research (Polit and Beck, 2012:157). The information leaflets were given to participants beforehand so that they could read and understand the procedure and then agree, or decline, to participate by signing the consent form.

- Benefit from the research

The participants were informed that there was no financial benefit accruing from participating in the study (Mokgethi, 2011:16). However, the community of Limpopo will benefit from the communication strategy developed through their participation.

### **3.8 LIMITATION OF THE STUDY**

Obtaining information from HAST Deputy Directors, who are colleagues of the researcher, was a challenge due to professional jealousy. The planned focus group interview with District and Provincial Deputy Directors was converted to personal interviews due to geographical distance and busy work schedules of the Deputy Directors, which can be seen as a limitation to the acquisition of more in-depth information.

### **3.9 CONCLUSION**

This chapter discussed the research methodology adopted by the researcher to develop and test a communication strategy to address the burden of HIV, AIDS, STI and TB (HAST) in the Limpopo Province. The study design, population, sampling, research setting, data collection and analysis were described. Ethical considerations that could have impacted on the study, namely, respect for a person, beneficence, privacy and justice, were addressed. Enhancing the trustworthiness of the study data and findings were also described.

Chapter 4 will present an analysis and discussion of data obtained from in-depth personal interviews with District and Provincial HAST managers and the focus group interview with civil society members who were representatives in the Capricorn District AIDS Council.

## **CHAPTER 4**

### **DATA ANALYSIS AND DISCUSSION**

#### **4.1 INTRODUCTION**

In this chapter, the researcher presents the findings of the study regarding modifying factors, individual beliefs and actions within the framework of the Health Belief Model. The findings are based on a literature review, document analysis, data obtained from in-depth personal interviews with District and Provincial Deputy Directors and focus group interviews with members of the Capricorn District AIDS Council, representing the community. An analysis of the data is presented as themes and sub-themes that emerged from the data analysis using a qualitative coding process of transcripts, field notes and observation. The sequencing and the discussion of the findings was influenced by the objectives of the study. Findings were interpreted and tested against the literature findings reported in Chapter 2.

#### **4.2 ANALYSIS OF DATA**

The study, including the analysis of data, was guided by the Health Belief Model (HBM) as the conceptual framework, as illustrated by the research questions that were based on the three major tenets of the HBM, namely:

- Modifying factors
- Individual beliefs
- Action

#### **4.2.1 Modifying factors**

According to the HBM, modifying factors, such as demography, socio-economic factors, cultural context, beliefs and myths, religion, the disease profile, health perceptions influenced the interpretation of health related messages.

##### **4.2.1.1 Demography of the Province**

The Limpopo Province is situated in the northern part of the country with an estimated total population of 5 630 464, with 2 649 113 males and 2 981 351 females (Statistics SA, 2014:15). The Province accounts for 11% of the total population of the Republic of South Africa, which is estimated at 51 million. This makes Limpopo the fourth most populated province in the country, after Gauteng, KwaZulu-Natal, and the Eastern Cape, respectively. From a district perspective, the Limpopo Province consists of five districts, namely, Capricorn, Mopani, Sekhukhune, Vhembe and Waterberg. The Limpopo Province has a concentration of agricultural activities, being the main economic activity, followed by mining (Department of Health, 2011:14).

##### **4.2.1.2 Socio-economic profile of the Province**

The rural nature of the Province, unemployment rate, levels of gender inequality and illiteracy, are some of the major factors that affect the inhabitants of the Limpopo Province. Approximately 80% of the inhabitants of the Limpopo Province reside in the rural areas, with a 19% unemployment rate. Available information shows that one in three people (33.4%) aged 20 years and older has had no formal education. The highest proportion of people in this category (39%) is found in the Vhembe District, while the Capricorn District has the lowest percentage (9%) (Department of Health, 2011:16).

The rate of unemployment has a direct impact on economic growth in the Province. The unemployment rate in the Limpopo Province is estimated at 22.6%, which compares unfavourably with rates in other provinces in the country, such as the Western Cape (21.8%) and KwaZulu-Natal (20.8%) (Department of Health, 2011:16).

Poverty, low rates of employment, lack of education and homelessness are interwoven and contribute towards an increased vulnerability to HIV, TB and other lifestyle-related diseases (SADC, 2013:30). Employment and literacy correlate directly with the level of access to information and the understanding, utilisation of and compliance with health promotion strategies and following a healthy lifestyle. Individuals from poorer socio-economic backgrounds are less exposed to health-related messages and have less access to facilities and structures that can support health (SADC, 2013:30). Poverty and low literacy levels can result in gender inequality, unequal relationship dynamics and limited decision making powers on issues such as sexual behaviour, reproductive health and violence (Gillespie et al., 2007 in SADC, 2013: 30). It should be noted that the nature and contents of a communication strategy should accommodate various literacy levels.

#### **4.2.1.3 Cultural Context of Limpopo**

The cultural traditional systems of kingdoms and chiefdoms are still in place and are recognised as important and influential institutions in the community. Involvement of these traditional leaders in all aspects of health-related issues, including the content and transmission of health-related messages, is highly emphasised. Topics such as medical male circumcision may traditionally only be communicated between males and these discussions should preferably occur during tribal gatherings, where females are excluded (Dikgoro) (Department of Health, 2009:6).

Faith groups, business and civic associations also play an important role in the transmission of health-related messages and subsequent change of behaviour. It is, therefore, important to include these influential role players in the development and implementation of a communication strategy.

Cultural practices, such as ritual killings and witchcraft, are still rife in some parts of the Province (Limpopo Provincial Government, 2009:7) and contribute to the mortality rate in the Province.

Cultural groups, like Ndebele, Tsonga, North Sotho and Venda, are mostly Christians but many people also believe that ancestors or spirits of deceased family members play a powerful role in their lives and that they can be the cause of diseases. This belief can influence the credibility of accepting preventive measures in health practices.

Cultural and religious beliefs contribute to increased vulnerability in terms of HIV. This can be due to practices around the acceptability of polygamy or early sexual debut, wife inheritance, male circumcision and prevalence of barrier contraceptive use (UNESCO, 2002 in SADC, 2013:32), as well as decisions about utilisation of health facilities for ante-natal care, institutional deliveries of babies, the use of contraceptives, breastfeeding and treatment of many diseases.

#### **4.2.1.4 The structure of the Health System at operational level**

The Provincial Directorates of HIV and AIDS, STIs and TB currently still operate as two separate divisions within the Provincial Department of Health. This division of responsibilities means that there are two directors with different budgets. This creates challenges in terms of coordination, standardisation and focus. The fragmentation at both national and provincial levels in terms of policy development and planning, intervention strategies (including health promotion) monitoring the effectiveness of interventions; and separate reporting lines, create specific challenges (Minutes of the HAST Meeting, 2012.06.04).

#### **4.2.1.5 Prevalence of HIV, AIDS, STIs and TB**

In 2013, the Limpopo Provincial HIV prevalence among antenatal women was estimated at 20.3%. The overall provincial HIV prevalence in Limpopo moderately decreased by 1.1% from 21.4% in 2009 (Department of Health, 2015:54).

In Limpopo, the Capricorn, Mopani and Waterberg districts have reported an HIV prevalence of less than 30.0% in the past five years and a moderate decrease in HIV prevalence was recorded between 2009 and 2013 (Department of Health, 2015:54). A

moderate increase in HIV prevalence in Sekhukhune and an increase of 0.7% in Vhembe was recorded between 2000 and 2013, respectively (Department of Health, 2015:55).

According to the 2013 National Antenatal Sentinel HIV Prevalence Survey South Africa, the trends in district HIV prevalence rates in this province has shown an increase in HIV prevalence rates in the Vhembe District, which has consistently recorded the lowest HIV prevalence; from 14.6% in 2011 to 17.7% in 2012 and 15.0% in 2013. Sekhukhune showed a similar trend, 18.9% in 2011 to 23.0% in 2012 and 18.1% in 2013. The Waterberg District continues to record the highest HIV prevalence in this Province, although a notable decrease of 3% from 30.3% in 2011 to 27.3 % in 2012 and 2013 was reported (Department of Health, 2015: 55).

Nationally, the age groups 30-34 years and 35-39 years have the highest HIV prevalence, both at 42.5%. There is a doubling of prevalence between those aged 15-19 years (12.7%) and those aged 20-24 years (24.0%). In Limpopo there is a decrease in prevalence between the ages of 20-24 years (from 36.8% in 2012 to 34.9% in 2013) and 30-34 years (from 42.8% in 2012 to 42.5% in 2013). There is a two-fold increase in prevalence in the age group 15-19 years from 7.3% in 2012 to 18.6% in 2013 (Department of Health, 2015:54). The age group 15-19 years is the most important indicator to use for providing evidence when monitoring HIV incidence (new infections). HIV prevalence in this age group has been suggested as a proxy measure for the incidence of HIV because of onset of sexual activity and, hence, prevalent mortality (Department of Health, 2015:33).

Socio-economic factors are the major contributors to the epidemic. The highest HIV prevalence in the Province is recorded in the Waterberg District and is directly related to an influx of people who seek employment in the mines, the Medupi power station and farming. The focus of information about HAST should, therefore, be directed at the Waterberg District.

The HIV epidemic nationally has had negative impacts on the outcome of TB case management as persons with TB who are co-infected with HIV and experience a higher mortality rate. Among HIV-positive patients who acquire drug resistant TB (XDR-TB), mortality is high. TB screening among people living with HIV is around 40% with a very low rate (about 38%) on isoniazid preventive therapy (IPT). ART should never be delayed in eligible co-infected patients (Loveday & Zweigenthal, 2011: 435). Treatment success rates of new infectious TB cases is around 74% compared to the global target of >85%. These national challenges are also true of Limpopo Province (Department of Health, 2011: 22).

In South Africa, it is estimated that 11 million STI cases occur annually. For example in Hlabisa, a rural area in KwaZulu-Natal, among 321 women attending district antenatal clinics, 52% were found to have at least one STI (gonorrhoea, chlamydial infection, trichomoniasis or syphilis) and 18% had more than one infection (Sonko et al., 2003:1).

In Limpopo in 2002 the number of cases of male urethral discharge (MUD) per 1 000 males age >+ 15 years was 47 (Sonko et al., 2003:7). STI clients per population ≥15 years were 10.6% while the national figure was 6.5% in July 2002 (Ramkisson et al., 2014).

The strategy for disseminating the above information is health talks, information sharing and use of media especially radio to most of the population of Limpopo. The traditional leaders will assist to provide the health talks and information sharing assisted by health care providers. The target groups are the young and adults. Due to the high illiteracy rate pamphlets and posters are not useful to most of the primary target group.

#### **4.2.2 Individual beliefs**

According to the Health Belief Model, the second tenet is individual beliefs. Data on the beliefs and perceptions relevant to HAST diseases was collected in focus group interviews with community members of Capricorn District AIDS Council. As explained previously (1.9.1.1.2) this Council is representative of the community. The data collected was, therefore, a good indication of how various sectors in the community

perceive HAST diseases and what their beliefs were with respect to the causative factors of these diseases, the preventative measures, the treatment regimens and the role of health professionals. The researcher could, therefore, obtain information to ensure that the communication strategy and the content of health-related messages were relevant and the health facilities were accessible, appropriate resources were made available and the communication was acceptable.

According to the major constructs of the HBM, individual beliefs are related to the belief about susceptibility, severity, benefits, barriers and self-efficacy. Probing questions during the focus groups were outlined in Chapter 3 and are as follows:

1. What are your views on general health status in Limpopo Province?
2. Perception about HIV, AIDS & STIs and TB (HAST)
  - How do you feel about the available services HAST diseases?
3. What are the communication strategies that are currently being used in the province to specifically address the burden of diseases in terms of HAST?
4. Are strategies accommodating all target groups such as disabled, youth and the elderly? Are these strategies cost effective?
5. How do they assist in behaviour change?
6. How do you view your capacity in relation to changing the behaviour?
7. Any capacity to sustain the changed behaviour? Any support for sustainability?
8. What are the attitudes of people towards people infected and affected with HAST? Explain why you respond in this way (see Annexure F).

#### **4.2.3 Cues of Action**

For in-depth individual interviews, the researcher visited the Deputy Directors at their area of their work, by appointment, at a time which was convenient to the participants. Personal interviews were done with 18 HAST District and Provincial Deputy Directors between December 2013 and February 2014. As the main purpose of the individual interviews was to understand actions, which, for this section, included communications approaches used, an in-depth personal interview with District and Provincial Deputy

Directors was undertaken so as to understand and identify factors impacting on the prevalence of HAST, as well as the availability of the resources and health system within the context of Limpopo Province. The researcher also used an interview guide for this data collection. The interview guide comprised of the section that required an indication whether the participant was from District or Province and years of experience in HAST. The following questions were used to probe the discussions:

1. What are the communication strategies that are currently being used in the province to specifically address the burden of diseases in terms of HAST?
2. What are the strengths and weaknesses of the above mentioned strategies?
3. Is it important for the province to have a communication strategy to specifically address the burden of diseases in terms of HAST? And why?
4. What are, according to you, the main elements to be included in a specific communication strategy and why?
5. What factors will, according to you, contribute towards the success or the failure of the implementation of a communication strategy? Why? (see Annexure E).

The instrument was designed in such a manner that there was a space in between for the researcher to write comments. The participants signed consent forms to indicate their agreement to participate voluntarily, and confidentiality was maintained as no names written on the data collection tool. The in-depth interview was done with each one of the Deputy Directors and, using the guide, the researcher was able to write down the participants' responses on the each question in the guide.

#### **4.2.4 A discussion on the emerging themes and subthemes in terms of the tenets of the Health Belief Model**

A focus group interview with community members of the Capricorn District AIDS Council was conducted to determine the level of understanding of HAST, the acceptability, relevance and accessibility of available resources and health systems, as well as the appropriateness, feasibility and acceptability of strategies (see 3.5.1.5.2 for more details). Also, in-depth personal interviews with District and Provincial Deputy Directors

were undertaken so as to understand and identify factors impacting on the prevalence of HAST as well as the availability of the resources and health system within the context of the Limpopo Province (see 3.5.1.5.3 for more details).

According to the major constructs of the HBM, individual beliefs include susceptibility, severity, benefits, barriers, and self-efficacy. Questions that were used to probe the discussions were outlined in Chapter 3.

Major constructs	Themes	Sub-themes
1.Perceived susceptibility to and severity of HAST diseases	1.1 Risk of contracting the HAST diseases	1.1.1 Implication of contracting HAST diseases
2.Perceived benefits of addressing the risks around HAST diseases	2.1 Perceptions based on existing knowledge 2.2 Perceived benefits related to health services 2.3 Perceived benefits related to disclosure 2.4 Availability of support structures	2.1.1 Level and nature of knowledge about HAST diseases 2.2.1 Availability of health services for HAST disease 2.2.2 Accessibility of services 2.2.3 Effectiveness of services 2.3.1 Positive experiences on the disclosure of HIV and AIDS status 2.4.1 Support by health care workers 2.4.2 Support by friends, families and community members
3. Perceived Barriers to minimise the risk of	3.1 Lack of accessible and available health promotion	3.1.1 Limitations regarding existing health promotion programmes

Major constructs	Themes	Sub-themes
HAST diseases	<p>programmes</p> <p>3.2 Barriers regarding health workers</p> <p>3.3 Lack of health care facilities and limitations in terms of health care delivery</p> <p>3.4 Stigmatisation and discrimination related to HAST</p>	<p>3.2.1 Lack of necessary skills of healthcare workers</p> <p>3.2.2 Limitations in terms of existing communication strategies</p> <p>3.2.3 Impact of negative and discriminatory attitudes</p> <p>3.3.1 Limited accessibility to specialised healthcare services</p> <p>3.3.2 Limitations in terms of quality of care</p> <p>3.3.3 Gender inequalities</p> <p>3.3.4 Lack of confidentiality</p> <p>3.4.1 Stigmatisation and discrimination</p> <p>3.4.2 Self-discrimination and</p> <p>3.4.3 Impact of stigmatisation and discrimination on adherence to treatment.</p>
4. Cues of Action>Action for change	4.1 Strategies for change of action and behaviour	<p>4.1.1 Media</p> <p>4.1.2 Community involvement</p> <p>4.1.3 Support structures</p> <p>4.1.4 Health workers (skills, attitudes)</p>

Table 4.1 Summary of Individual beliefs and action as components of HBM

The abovementioned themes and sub-themes will now be discussed in depth and interpreted for a meaningful basis to develop an acceptable and relevant communication strategy.

#### **4.2.4.1 Construct 1: Perception susceptibility to and severity of HAST diseases**

##### **Construct 1: Theme1.1: Risk of contracting HAST diseases**

It was evident from the data that many persons infected with HAST diseases are cared for both at home and in the community. Community members are, therefore, typically aware of the risk of contracting these diseases. The fear of stigmatisation is, however, greater than the fear of the disease itself and there is a real fear of transmission of the diseases when taking care of ill persons in the family or the community. One of the participants shared her experienced as follows:

*We are still afraid of the HAST diseases and taking care of those infected even though the diseases are manageable (Older persons in focus group).*

It was further evident that some people have a fear of even knowing their status regarding HAST diseases because of the potential stigmatisation and social isolation.

*As the community members we are afraid of contracting the HAST diseases and therefore it is not easy to agree for testing and screening (Traditional leader in focus group).*

At community level, these fears and the consequences of not addressing these fears can lead to a situation where people affected by these diseases are either “hidden away” from other community members, or are physically and emotionally neglected. The fact that persons do not typically visit screening and testing facilities can lead to infected people not being diagnosed and not being treated, which can result in an increase of transmission. It is, therefore, important that the communication strategy has a strong focus on the importance of prevention and early diagnosis. This implies that

community members and, specifically, the risk groups, such as the youth and spouses of people who have any of the HAST diseases, should have a clear understanding of

how the disease is transmitted and where the available health facilities are where they can be screened and treated.

Health professionals also have a responsibility to allay fears of stigmatisation by providing relevant and correct information and to do so with a caring attitude, without being judgemental and prejudiced. In a study in the SADC (2013: 29) region of Africa, it was found that health professionals have a real concern of contracting these diseases in their interaction with infected people. Health professionals must, therefore, have an in-depth understanding of risky behaviour and how they should protect themselves from transmission of diseases through exposure or potential exposure to infected blood and body fluids. Health professionals should be enabled with the right protective clothing, within a clear policy framework, to apply universal precautions. A large number of patients with whom health professionals interact are unaware of their disease status. This increases the risk of infection of both the health care provider and the patient (Olapade-Olaopa et al., 2006 in SADC, 2013:29).

In study conducted in Cape Town, South Africa, it was found that health care providers face the risk of exposure to blood due to incorrect needle manipulation, the improper disposal of sharps (Mendelson and Meintjes, 2009 in SADC, 2013:29) and inadequate training and management of post-exposure prophylaxis. According Sehube, Zungu and Hoque (2012:12), health care providers are concerned about being infected with HIV during the provision of care to HIV and AIDS patients. As a result of fear of being infected, nurses became reluctant or refused to care for HIV-infected patients. This finding has implications for knowledge transfer, not only to patients and clients, but also to health care workers when designing a communication strategy. This finding may further have implications for the revising or development of policies at government level.

Fear about contracting HAST diseases was also expressed in the focus group, especially a concern about male circumcision being practiced by traditional and cultural leaders that may increase the prevalence of HIV and sexually transmitted diseases due to a lack of knowledge, universal precaution and cultural practices.

*There are adverts on male medical circumcision but still lot of people who undergo the traditional one, are the traditional surgeons taught how to sterilise equipments? Otherwise we are still having problems of contracting HIV (Men sector in focus group).*

*Male medical circumcision needs to be more emphasised on radios unlike traditional male circumcision as lot of boys are dying at the mountains due to diseases (Men sector in focus group).*

Cultural and religious beliefs contributing to an increased vulnerability to HIV and other sexually transmitted diseases include practices around the acceptability of polygamy or early sexual debut, wife inheritance, male circumcision, and prevalence of barrier contraceptive use (UNESCO, 2002 in SADC, 2013:32).

#### **4.2.4.2 Construct 2: Perceived benefits of addressing the risks around HAST diseases**

##### **Construct 2: Theme 2.1: Perceptions based on existing knowledge**

Knowledge about HAST diseases enables and empowers community members to make informed decisions about behavioural changes as well as a foster positive feelings about themselves and other people with HAST diseases.

Participants expressed the need and importance of knowledge:

*As older persons we need more education about the virus so that we can take care of our children (Older persons in focus group).*

*During HAST campaigns we gain more knowledge and they need to be more frequent especially in the rural areas (Men sector in focus group).*

*HIV& TB messages to be more vigorous like before to equip communities with knowledge (Religious sector in focus group).*

The importance of information for people living with HIV and their families, friends and other members of the community on how to manage the disease, is confirmed by

Modeste and Majeke (2014:1). According to the HSRC (2014: 4), knowledge about HIV transmission and prevention is accompanied by appropriate reduction in behavioural risk practices which are important in combating and reversing the spread of HIV. However, knowledge of HIV remains low in sub-Saharan Africa. Sound knowledge of HIV transmission and prevention is a key component of protecting oneself (SADC, 2013:36).

South Africa ranks third in the world in terms of TB burden, according to World Health Organisation (WHO) estimates, with an incidence of 948 new infections per 100,000 people in 2010, which is compounded by high levels of multidrug-resistant tuberculosis (MDR-TB). The estimated number of confirmed MDR-TB cases among new pulmonary TB cases in 2010 was 7,386. The high rates of co-infection (approximately 60% of TB patients are co-infected with HIV) lead to further expansion of the epidemics and complicate treatment and care of patients (PEPFAR, 2012:7). The numbers of MDR-TB and XDR-TB patients have increased due to the concurrent HIV epidemic and due to poorly managed TB patients by health care providers, treatment defaulters and other challenges, ranging from delays in initiation of treatment, inadequate bed capacity to poor infection control (National Department of Health, 2011:4).

HIV/TB Co-infection has been a challenge in the Province but great achievements have been made with regard to case findings and management. The number of patients with “known” HIV status has improved from 22.3% in 2008 to 92.2% in 2013 (Department of Health, 2015:15).

An effective communication strategy should, therefore, address this need and empower people with knowledge about HAST diseases. This implies knowledge about prevention; treatment, care and support. While health education programmes target a certain group of individuals living in a specific geographical area; health promotion as an intervention strategy goes beyond an education programme and also focuses on the need to establish and sustain a more accessible and equitably distributed system for all poor and underserved groups in a particular community (Huff and Kline, 2008:5 in Mthobeni and Peu, 2013:1).

The many forms of conveying knowledge and information were mentioned during the focus group interviews and included workshops formal and informal training sessions, the media and other audio-visual awareness strategies.

*We attend workshops where we are taught about basic HIV & AIDS, STIs and TB (Traditional leader in focus group).*

*I (Traditional Health Practitioner) have also seen that during the meeting at the tribal offices people seem to be understanding HAST (Traditional Health Practitioner in focus group).*

*As older persons we need more education about the virus so that we can take care of our children (Older Persons in focus group).*

Other participants alluded to knowledge gained through promotional material, such as pamphlets and media:

*We also hear messages on radio and during the campaign's we are taught, screened for TB, HIV Counselling and testing done and we collect free condoms and shown how they are used. Pamphlets with information are provided (Traditional Leader in focus group).*

*And also engage the media to always spread the message including the newspaper, radio and for the campaigns to be intensified and be frequent, so that we remind people and stick together to fight this pandemic. Time and again we should be reminded (Religious sector in focus group).*

HIV and TB communication programmes in South Africa utilise various domains of communication, for example, mass media (broadcast, print and outdoor), small media (posters, booklets, and utility items), and social mobilisation aimed at creating dialogue and action at local and community level (Johnson et al., 2013:11).

Mass media communications are programmes that use various media channels, such as television, radio, electronic technology and print to draw attention to HIV issues with the objective of changing patterns of behaviour (UNAIDS, 2005 in SADC, 2013: 43).

## **Construct 2: Theme 2.2 Perceived benefits related to health services**

It appeared that the majority of participants found public health facilities, where they could find information and services, acceptable and accessible.

*There are clinics in our communities in a walking distance where we can consult and hospitals where we are referred for further management. As community members we are satisfied with these services (Traditional Leader in focus group).*

*The clinics are available and the treatment is also available at our facilities. We are happy with health care services in our communities (People Living with HIV in focus group).*

*Rollout of Fixed Dose Combination (FDC) for instant of ARV when looking at Capricorn District is working well and is working with them (People Living with HIV) in the support groups all is well (People Living with HIV in focus group).*

According to National Department of Health (2013:9) provision of good quality health services is a critical component of efforts to improve clinical outcomes and the health status of South Africans. UNAIDS, in its Vision (2015:5), emphasises that all people, regardless of their circumstances, should meaningfully engage with, and have a voice in, the decisions that affect their lives. It is, therefore, imperative for an effective communication strategy, which aims to address the HAST diseases, that people should have access to HIV testing and prevention services tailored to their needs and that they receive appropriate treatment.

The importance of knowledge transfer and health services that are available and accessible will not only contribute towards a decrease in HAST diseases, but will also contribute towards sustainable lifestyle changes and will also empower significant role players to care for people with these diseases.

Health facilities should make this possible. It should be noted that, for the community at large to have access and to benefit from health services, the National Health Insurance Scheme in South Africa has been developed and is currently being piloted. It is

envisaged that this scheme will be implemented in phases. A communication strategy should, therefore, have the flexibility to incorporate new developments and appropriate new information should be incorporated with ease.

Subthemes that have emerged from this theme are, therefore, the availability and accessibility of effective health services.

According to Nteta, Mokgatle-Nthabu and Oguntibeju (2010) the Community Health Care Centres in the Tshwane Region are accessible to most participants who lived within 5 km of such centres and who travel 30 minutes or less to the clinic. Using a taxi or walking were found to be the most common means of transport used to gain access to such a clinic. The findings showed that, generally, participants were satisfied with the services provided. It is known that dissatisfaction with primary care services, especially in the public sector, leads many individuals to health care shops or to visit higher level hospitals for primary care, which consequently, leads to considerable inefficiency and loss of control over efficacy and quality of services (Nteta, Mokgatle-Nthabu and Oguntibeju, 2010).

A study by the Public Service Commission sought to establish the effectiveness of the Department's efforts to implement the Batho-Pele principles in transforming service delivery. The findings show that service users were of the view that the manner in which services were rendered by the Department of Health in the Limpopo Province (Seshego Hospital and Mankweng Hospital), had improved (Public Service Commission, 2012:66). The study found that the Department of Health and Social Development had further rolled-out its service delivery points and health facilities to ensure that previously disadvantaged communities could also access its services. These service delivery points included hospitals, clinics, One-Stop-Centres and Thusong Service Centres (Public Service Commission, 2012: 69).

### **Construct 2: Theme: 2.3 Perceived benefits related to disclosure**

A perceived benefit around HAST diseases seems to be the disclosure of HIV status. Participants noted disclosure as a key for self-acceptance, which has the additional

benefit of being able to openly comply with treatment regimens and self-care. Disclosure further gives access to support groups and results in openly practising preventive measures. This is confirmed by the following statements by participants

*I don't know if there is any strategy we can come up with to close the gap. A strategy that can be used to encourage disclosure so that the people like myself living with the virus to be able to disclose their status and live with it and accept themselves as disclosure is a healing process, it assist with the issue of being afraid to those clinics with special names (ARV clinics) (Focus group – Participants with HIV) .*

*If the person has disclosed her/his HIV status he attends the clinic freely because she/he knows that everybody knows, but if we close this gap of disclosure so that we can encourage people to test and results are positive they need a person to whom they can disclose their status (Focus Group – Participants with HIV).*

*People need to disclose their HIV status like this man (pointing Participant living with HIV) he always encourages us to test and know our statuses (Traditional Health Practitioner in focus group).*

*For me I say these ...people even if it can be myself, if I am like that I will encourage the people to accept their statuses not to be shy of going to the clinic to collect treatment. To accept just like those people with TB, Hypertension and Sugar diabetes, they have accepted themselves and this one (AIDS) can be also be controlled (Older Person in focus group).*

*People need to be told to accept themselves and the home based cares when visiting them at their homes they are also trying to talk with them so that people can accept their statuses (Men sector in focus group).*

HIV disclosure is expected to eventually improve adherence. This was reported in a study conducted in Botswana on adolescents' adherence to ART. Non-disclosure of HIV status was associated with poor adherence to ART (Phalade et al., 2009 in Marukutira,

2012: 18). It is through disclosure that a child or adolescent can understand what it means to be HIV positive and disclosure and the knowledge of HIV would be facilitators of adherence (Marukutira, 2012:53).

The benefits of disclosure should receive attention in an effective communication strategy. To promote disclosure implies that stigmatisation and marginalisation should also be addressed in the strategy.

Subthemes that emerged from this theme, therefore, include both positive and negative experiences related to disclosure, with an emphasis on the positive experiences of disclosure.

### **Construct 2: Theme 2.4: Availability of support structures**

Availability and utilisation of support structures in sustained changes towards a positive and healthy lifestyle have proved to be very effective. The support structures that are available are support groups, Weigh Less, peer groups, faith-based groups and family members. People who are living with HIV or having to cope with TB, have been documented as experiencing a number of related symptoms, such as anxiety and depression as well as other physical symptoms (Modeste and Majeke, 2014:1). Some form of support for sustained compliance with treatment and the management of symptoms related to the diseases are acknowledged as being of great value, and they use different strategies in order to manage these symptoms. Participants acknowledged the value of support by health care workers, family, friends and other members of the community.

*As a person living with the virus we appreciate support from our families, community and health care professionals when rendering services to us (PLHIV in focus group).*

*The availability of support groups at the clinics are means of support and encouragement to take our treatment (PLHIV in focus group).*

*When you disclose your HIV status you will be supported by family members and the communities (Traditional Leader in focus group).*

In a study in Botswana, it was found that support of adolescents who contracted HIV through vertical transmission was essential in terms of their psychological well-being and adherence to a simplified, long-term ART regimen. These support groups further enhanced adherence of the adolescents to attend the health facilities for follow up visits and periodic health checks (Marukutura, 2012:v). Social and moral support to promote sustained adherence to long term treatment is important, especially for people on ART or TB treatment. The DOTS initiative for the treatment of TB by family members and friends is one example of effective support (Mona, 2014:44). A study that was conducted in Tanzania found that respondents who felt that they were not receiving the necessary support from their family members stopped taking their treatment, even in situations where their health was improving (USAID, 2010 in Mona, 2014: 45).

In Uganda, according to Bikaako-Kajura et al., (2006 in Marukutira, 2012:51), children who enjoyed a supporting and trusting relationship with their primary caregivers were found to be inclined to disclose their status as well as to adhere to the treatment.

The importance of support and its relationship to adherence was clear in terms of the following statements by respondents:

*Rollout of Fixed Dose Combination (FDC) for instant of ARV when looking in Capricorn District is working well and we support each other to take treatment during PLHIV support group meetings (PLHIV in focus group).*

*When disclosed your HIV status to the family you are encouraged and supported to take treatment (PLHIV in focus group).*

Support from local leaders, either political or religious, can positively influence the perception of utilising HIV prevention services and to adhere to preventive measures (SADAC, 2013:36).

The importance of, and impact of, support groups in addressing HAST diseases and to promote sustainable compliance with treatment and changed lifestyles was evident from the focus groups. Subthemes that emerged are, therefore, the promotion and establishment of support strategies to people with HAST diseases, as well as to include influential leaders, role players and health professionals as an integral part of a communication strategy.

#### **4.2.4.3 Construct 3: Perceived barriers to minimise the risk of HAST diseases:**

To influence changes and promote healthy lifestyles in terms of the Health Belief Model, policy makers should know and address perceived barriers.

#### **Construct 3: Theme 3.1: Lack of accessible and available of health promotion programmes**

Despite the finding that participants found health services available and accessible (Theme 2), there was a strong emergent theme that health promotion programmes in these health facilities, or elsewhere, were not readily available or accessible.

Most of the participants in the focus group further agreed that health promotion programmes have serious limitations in terms of appropriate and relevant health information.

*You can realize that we have relaxed now, the message of HIV& TB are no longer vigorous like when we were starting because I think that we do have a mind that we are now winning the war against HIV& AIDS but we can see that new infection occur regularly on a daily basis, we have reached a relaxed mode where we don't talk like previously. Yes at churches we are trying to unite people to speak generally on the issue of health including HIV (Tone of voice stronger) but is no more happening like it used to be (Religious sector in focus group)*

Sound knowledge of HIV; other sexually transmitted disease and TB transmission and prevention is a key component of protecting oneself. In theme 2, being knowledgeable about a disease was perceived as a benefit, the lack of knowledge and its implications

emerged as a serious limitation. Although knowledge alone is insufficient to adopt sustained safe and healthy behaviour, the lack of accurate basic knowledge of HIV and STIs and TB can increase the transmission of HAST diseases (SADAC, 2013:36).

According to the HSRC (2014:4) and SADC (2013:36), the lack of knowledge about HIV transmission and its prevention, accompanied by an appropriate reduction in behavioural risk practices, are some of the reasons for the high prevalence of HIV in the sub-Saharan Africa region.

The participants alluded to the gap in health information as follows:

*If you look at health messages...let start with media issues they are not enough I don't know if whether is because they are paid and comparing it with Amstel (Alcohol) advert it will appear ten times more than health advert (Men sector in focus group).*

*We do not receive the health messages in the communities, unless you go to the clinics messages are not easy reach unless you go to clinic you will get a brochure (Men sector in focus group).*

*Where I come from in the communities the campaigns with health messages are not visible only in the townships (Men sector in focus group)*

*TV health messages need to be interpreted by sign language so that one can understand and follow the message if interested (Disability sector in focus group)*

*We need to have the agenda written in brail so that we can be able to read like others (Disability sector in focus group)*

*Information, Education and communication (IEC) materials not available in local language (Personal Interview 1).*

*Communication strategy not reaching all the age groups e.g. elderly not able to walk to events not able to listen to radios and not able to read (Personal Interview 1).*

*Print media not everyone can be able to read, some of people in deep rural areas don't have access to radio and TVs (Personal Interview 1).*

From the evidence above it is clear that in an effective communication strategy on health, health information should be relevant, clear, and available and should accommodate all groups, including persons with disabilities and illiterate people. Health information should further be continuously prioritised in health facilities and other places where communities gather.

### **Construct 3: Theme 3.2 Barriers regarding health workers**

According to Tlou (2009:5), lifestyle changes can be achieved through a combination of efforts to enhance awareness, change behaviour and create environments that support good health practices. These efforts should include health professionals as well as other influential stakeholders.

The lack of skilled and caring healthcare workers seems to have a direct impact on health behaviour and emerged as a strong barrier in minimising the risk of HAST diseases:

*We as disability sector they (health workers) are not good for us. They are not accessible for the deaf and dumb. Counsellors are unable to use sign language of people which for counselling they are unable to talk using sign language, this is a disadvantage (Disabled participant in focus group)*

*The other challenge is the issue of lack of male nurses and mostly is female nurses in our clinics who are assisting them, and men are not free to explain their problems to female nurses (Men sector in focus group)*

Healthcare providers have the responsibility accommodate people living with HAST diseases in a holistic way, guiding them with regard to self-care symptom management strategies, in addition to their treatment (Modeste and Majeke, 2014:8). Radcliffe, Tanney and Rudy (2006:111 in Marukutira, 2012: 66) studied post-traumatic stress and

adherence to medical treatment among youth living with HIV and they showed that maintaining regular follow-up care and treatment with a specific and informative provider, whom they trusted, was associated with increased adherence.

Staff attitudes and shortages of health professionals are some of the barriers alluded to by participants.

*The issue of attitude does not have the remedy necessarily so because personnel come to work already stressed (Religious sector in focus group)*

*If you look at the personnel working in the clinics and hospitals the main challenges is the attitude that you get (Religious sector in focus group)*

*Shortage of personnel in the main problem of the long queues at the health facilities (Men sector in focus group)*

In 2009, the AIDS Foundation of South Africa reported that the shortage of health professionals, resources and infrastructure had a negative impact with regard to reaching the Millennium Development Goal objectives, making it difficult to sustain optimal healthcare (Horn and Brysiewicz, 2014:1)

Limitations, such as those raised by the participants, have a direct influence on the high prevalence of HAST diseases. A coordinated communication strategy should, therefore, address these limitations in an innovative way to accommodate the information needs of varied groups with different and special needs, such as disabled people.

The attitude of health professionals is a real concern, as illustrated in newspapers, complaints to the health ombudsman and the litigation against the health authorities (Suggestion boxes in health Institutions).

The ability of health professionals and health workers to convey the message in a language and in a way that clients and patients can understand the real meaning of the message is a challenge. One way to address this barrier is to explore the use of translations of messages in writing or orally in the public media. These concerns have

been acknowledged to some extent by governmental structures (Limpopo Provincial Government, 2009:7) (Ministry of Health and Social Welfare, 2011: viii).

The shortage of health professionals is both a national and an international phenomenon. An effective communication strategy should, therefore, not only depend on health professionals, but enable other role players with the necessary information to convey appropriate health information effectively. A communication strategy should include support systems for role players other than health professionals and build in checks and balances to monitor the accuracy and relevance of health information.

### **Construct 3: Theme 3.3 Limitations in terms of health care provision**

In theme 2, participants indicated that health facilities are available and accessible. Some participants, however, identified some barriers in terms of health service delivery, specifically in terms of accommodating people with disabilities and patient turnover.

*We as disability sector the health services are not accessible for us. They are not accessible for the deaf and dumb. Counsellors are unable to communicate using sign language with deaf and dumb people during counselling, this is a disadvantage (Disability sector in focus group)*

*I don't see if we can manage health facilities because the queues are very long and patients are waiting for long (Traditional Health Practitioner in focus group).*

Gender inequality and culture influences the prevalence of sexual and physical violence and are reported as limitations to the delivery of effective health services, especially at primary health care level:

*As a department we need to have the strategy to encourage males to join the nursing profession to enhance the health service so that men can be treated by male nurses (Men sector in focus group).*

*To involve men especially in PMTCT for buy-in and support and this will lead to behaviour change (Personal Interview 1).*

*The other challenge is the issue of lack of male nurses and mostly is female nurses in our clinics who are assisting them, and men are not free to explain their problems to female nurses (Men sector in focus group)*

*Men are afraid to know the truth about their HIV status (Men sector in focus group)*

*Women are not afraid of HIV they are only afraid of getting pregnant (Men sector from Focus group)*

*I am against this issue of women terminating pregnancies because that women is capable of killing all men she will have sex with (Traditional health Practitioner in focus group)*

*When I see the health status in our province there is still stigma in the sense that there are different queues for pregnant women and those collecting Anti-retroviral treatment (ARV). While on queue to collect ARV, others already know that they are infected. How about having one common queue? (PLHIV in focus Group).*

Three random clinical trials in South Africa, Uganda, and Kenya showed that circumcision reduced the rates of heterosexual men acquiring HIV by 50% to 60% over a two-year period when compared with uncircumcised men (SADC, 2013:26) It was, however, found that, although evidence showed that medical male circumcision significantly reduced the risk of contracting HIV, discussion of topics, such as medical male circumcision (MMC), is traditionally acceptable only if discussed among men, typically at tribal gatherings (Dikgoro), where women are excluded. According to SANAC (2013) the men's sector aims to support initiatives that address the role of men in combating the spread of HIV and AIDS, as well as mitigating the impact of the disease in our communities, thus, the suggestions by respondents to increase the number of male health professionals.

Overall, it was found that men are less concerned about health and are, therefore, less likely to search for health information. Women typically feel a responsibility for maintaining the health of their families and are, therefore, an important target group for health information dissemination (Boiarsky, Rouner and Long, 2013:884).

Social and cultural norms regarding gender have a strong influence on individual decision-making, especially for females. Young women remain particularly vulnerable to gender inequality and HIV vulnerability because of myths like “curing HIV by having sex with a virgin”, or by having older partners that have increased exposure risk to HIV (AIDSTAR-One, 2011 in SADC, 2013: 34).

*The involvement and empowerment of males in the combating of HAST re important in communication and life style changes (Personal Interview 1).*

### **Construct 3: Theme 3.4: Stigmatisation and discrimination related to HAST**

Stigmatisation and discrimination was frequently mentioned by participants as a barrier to minimise the risk of HAST diseases. It was clear that discriminatory attitudes were inflicted by self, family members and/or members of communities. Respondents stated that infected persons are stigmatised and discriminated against because of their HIV status or other disabilities and/or side effects of the HAST diseases. Stigmatisation is aggravated if clinics are structured in a way that people are separated according to their condition. The findings of this study are in line with the finding by Boiarsky, Rouner and Long (2013:884), who reported that people with stigmatising health conditions may be perceived as less intelligent, less deserving of sympathy and less credible when compared to people with non-stigmatising health conditions.

Some of the participants stated:

*Stigmatisation, labelling and discrimination have serious effects on the effective management of HAST diseases. The management of health facilities should address limitations such as the constant provision of supplies, management of patient flow and provision for confidentiality and competency of staff (Personal Interview 1).*

*Stigma is a real problem and that is the main reason why people are moving from a nearby clinic to go and be assisted in the other clinic faraway were he/she is not known. Also these clinics with special names (referring to special dedicated and named health services, such as “the ARV clinic” stigmatised people. Other*

*people are no longer collecting their treatment because already they are afraid that when people see them in a particular queue or that special clinic then is disclosure (PLHIV in focus Group).*

*When I see the health status in our province there is still stigma in the sense that there are different queues for pregnant women and those collecting Anti-retroviral treatment (ARV). While on queue to collect ARV, others already know that they are infected. How about having one common queue? (Men sector in focus Group).*

*Let me say men are afraid of the truth, they end up saying they don't want to be known by other people and if you don't want to be seen by other people he must go during the night (Men sector in focus Group).*

The presence of stigmatisation and discrimination were also confirmed by most of the participants in the focus interview, which some participants alluded to as follows:

*People are afraid to go for HIV test due to lack of confidentiality..., (Religious sector in focus Group)*

*People are afraid of attending the clinic during the day due to the stigma attached to the HAST Diseases. If clinics operate 24 hours they can attend after hours were there are few people at the health facilities (Traditional Health Practitioners in focus Group).*

*It is due to stigma why most of our people are not free to take their treatment because of the stigma issue we are not going to end it up by now. Is still a lot of work to be done, when we see you coming from that queue we already know that you are sick, let's rather try the issue of increasing the personnel and have one queue (Men sector in focus Group).*

HIV and AIDS-related stigmatisation and discrimination remain major barriers to effective HIV prevention as well as to the provision of treatment, care and support in many countries across the globe, including South Africa (HSRC, 2014:4). As many of the local religions and churches struggle to discuss sensitive topics, such as sex, drug

use and issues related to HIV, people with the disease are further stigmatised and appropriate messages are difficult to disseminate (UNESCO, 2002 in SADC, 2013:32). People with disabilities are at a higher risk of HIV infection because they are vulnerable to violence, sexual abuse, stigmatisation and discrimination, yet they often struggle to obtain meaningful service access (UNAIDS, 2015: 8). Maswanganyi et al. (2014: 7) revealed that TB patients preferred to visit PHC facilities which were far from their homes due to fear of stigmatisation, which also resulted in them defaulting on treatment.

A communication strategy should be designed hand-in hand with policies such as making provision for privacy of patients and clients at health facilities and to address issues such as the Batho-Pele principles of consultation, courtesy, accessibility to services, information, service standards, openness and transparency, redress and value for money (Public Service Commission, 2012:66).

#### **4.2.4.4 Construct 4: Cues for Action/Action for change**

Modifying factors and perceptions and beliefs form the basis of the Health Belief Model and provide cues for action and change. In the development of an effective communication strategy towards the improvement of the health status within the context of the study, the findings discussed above culminated in actions to facilitate change in behaviour. The findings resulted in a better understanding of the characteristics and elements of sustainable behaviour change and guided the researcher in terms of issues related to developing a coordinated communication strategy, which includes monitoring and evaluation to determine the effects and outcomes.

#### **Construct 4: Theme 4.1: Strategies for action**

The research objective to develop an effective communication strategy involves the transfer of health related information through, among other avenues, the media and social networks, community involvement, support and skills, changed attitude and behaviour by health workers and effective and coordinated processes and procedures.

The strategies for action, based on the evidence include:

- Use of mass media and social networks

Most of the participants agreed that media and social networks play a major role in reaching communities as follows:

*When using mass media. The Information can reach people quickly and widely. (Personal Interview 1).*

*We also hear messages on radio and during the campaigns we are taught, screened for TB, HIV Counselling and testing done and we collect free condoms and shown how they are used. Pamphlets with information are provided (Traditional Leader in focus Group).*

*In our district we use mass media such as TV, Radio, electronic or Print- IEC materials, newspaper, Fliers, Posters, Billboards, Banners; Mass campaigns in accordance with national health calendar (Personal Interviews 1).*

*Some of the communication strategy doesn't need funds e.g. imbizo, church gathering and traditional leaders meetings (Personal Interviews 1).*

*Radio stations reach all language groups of the province and beyond (Personal Interviews 1).*

Social media provides a potentially inexpensive and efficient way to monitor real-time gaps and progress in the AIDS response, to equip citizens with data, to enhance their participation in the public sphere and to extend their agency over development-related decision-making (UNAIDS, 2015: 13).

Although many people own mobile phones, this instrument was not mentioned as a means of communication, although it has been observed that many people are in possession of mobile phones and use social media networks such as sms messages, Whatsapp groups, Twitter, etc.

Mass media can be instrumental in breaking the silence around HIV and creating an environment conducive to the discussion of how individuals can protect themselves (SADC, 2013:44). The use of mobile phones and social networks can also be utilised to form support groups and chat groups to support people with HAST diseases, their carers, friends and families. Studies in this regard have been reported by Johnson et al. (2013:11), in particular, a study which was conducted at Burgersfort in Limpopo.

Television and radio were mentioned by most of the participants as the preferred media channel used, which can be utilised for HIV and TB message dissemination so that people can gain more knowledge, leading to behaviour change. Some poor communities do not have access to radio or television, however, the advantage of broadcast media that it reaches large number of people at the same time.

Mass media communications are programmes that use various media channels, such as television, radio, electronic technology and print, to draw attention to HIV issues with the objective of changing patterns of behaviour (UNAIDS, 2005 in SADC, 2013: 43). A number of media campaigns focus on the need to overcome prejudice and encourage solidarity with people who are infected with, or affected by, the virus. South Africa's Sesame Street, known as Takalani Sesame, demonstrates that it is never too early to challenge HIV-related stigmas (SADC, 2013:45).

Some of the communication strategies, however, do not consider age, social class, ethnic background, life experiences and language proficiency, which are very important considerations when developing communication strategy. Women have stronger attitudes regarding the responsibility for maintaining health than do men, regardless of attribution of responsibility (Boiarsky, Rouner and Long, 2013:884).

- Printed material

The use of articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics, or face-to-face discussions by health workers, peer educators, counsellors, or other trained personnel can be considered. The utilisation of these approaches, however, depends on the availability and accessibility of the material and

on the service provider using the material. Availability of funds can be the barrier to access of print material.

The language used needs to be that of the targeted audience group and the material will also have to be made available in Braille. Print material is not accessible by blind people and those who are unable to read and write. HIV and TB communication programmes in South Africa utilise various communication media, for example, mass media (broadcast, print and outdoor), small media (posters, booklets and utility items), and social mobilisation aimed at creating dialogue and action at local and community level (Johnson et al., 2013:11).

- Non-conventional strategies

Additional means of delivery include musicals or dramatic performances and community events (FHI, 2012:15). The strategies should target the youth, in or out of school. The strategy can reach a large number of young people with HAST messages. Non-conventional strategies can be used during the campaign or as stand-alone performances or can introduce a youth dialogue. Internationally, theatre was used because of its traditional popularity and cost effectiveness (Cohen, 2002:3). According to FHI (2012:15), additional means of information delivery include musicals or dramatic performances and community events.

- Community involvement as an essential element of implementation and action.

Community involvement is the key to reaching communities with information, while they themselves become part of such discussions:

*And the other thing that I do...I normally gathers Traditional Health Practitioners (THP) at the tribal offices and tells them about the fact that people to be careful so that they must not spread AIDS pandemic (Traditional Health Practitioner in the focus group).*

*I have also participated during the meeting at the tribal offices people seems to be understanding HIV and TB messages and during the municipality African*

*National Congress (ANC) meetings (Traditional Health Practitioner in the focus group).*

*When we preach we need to include HIV & TB messages so that people can learn and change their behaviour. What we see nowadays pastors are starting to be exposed and no more condemning people who are living with the virus (Religious leader in the focus group).*

*Families need to teach each other. Preach to the children about waiting for the right things in their life to wait to be married first (Traditional Health Practitioner focus group).*

Community engagement and inputs must be an integral part of all aspects of strategy development, implementation and monitoring. This means that a community should be enabled and empowered throughout an effective strategy (UNICEF, 2008:55). Involvement of community members should be integrated into the design process in terms of advocacy, social mobilisation and behaviour change communication (UNICEF, 2008:40).

Support from the political leaders and other key stakeholders is seen as one of the strategies of action in the development of communication strategies. The involvement of community stakeholders in TB prevention, health promotion and education activities devoted to disease spread and cure is vital so that the stigma attached to TB can be eliminated. TB education and awareness programmes should be included in the curriculum of primary schools (Maswanganyi et al., 2014:1). According to SADC (2013: 36), support from local leaders, either political or religious, can positively influence the perception of utilising HIV prevention services and protecting oneself, as alluded to by most of the participants:

*Involvement of all stakeholders to increase buy-in that promotes implementation (Personal Interview 1).*

*There is a need for the political commitment in order to get their buy-in, support and influence the community (Personal Interview 1).*

*All relevant stakeholders to be included from planning to implementation of the communication strategy for their support (Personal Interview 1).*

*Engaging all role players and encouraging ownership (Personal interview 1).*

*The communicators are programme managers, communication section, Head of Departments and Members of the Executive Committee (MECs) (Personal Interview 1)*

- Individual face-to-face communication

Communication with the aim of changing behaviour involves face-to-face dialogue with individuals or groups to inform, motivate, problem-solve or plan, with the objective to promote behaviour change (UNICEF, 2008:55).

*To involve men especially in prevention of mother to child transmission (PMTCT) and to have buy-in for men for support and for behaviour change (Personal Interview 1).*

*Involve all stakeholders that will increase buy-in that promotes all implementers (Personal Interview 1).*

- Up skilling and sensitising of health workers:

Health workers need special skills and the attitudes when dealing with HAST issues as supported by the some of the participants as follows:

*Counsellors to be able to use sign language to avoid interpreters in order to ensure confidentiality of clients issues (Disability sector in focus Group).*

*As a department we need to have the strategy to encourage males to join the nursing profession to enhance the health service to all (Men Sector in focus Group).*

*The work of your Employees Wellness Programme can assist in addressing the challenges of nurses' attitude (Religious sector in focus Group).*

*Debriefing sessions for councillors so that they can offload in order to relieve stress and be more effective during counselling sessions (Religious sector in focus Group).*

Healthcare providers need to be able to manage people living with HIV in a holistic way, guiding them with regard to self-care symptom management strategies other than medication (Modeste and Majeke, 2014:8).

The above mentioned cues for action should be integrated into an effective communication strategy.

### **4.3 CONCLUSION**

The findings were analysed using a qualitative thematic approach and were discussed according to the Health Belief Model. Modifying factors, individual beliefs and action which directed the elements to be included in the communication strategy were identified. Elements that should be included in the development of a coordinated communication strategy include demographic characteristics, socio-economic factors, cultural contexts, health systems and health care delivery and beliefs and perceptions of health care consumers.

## **CHAPTER 5**

### **COMMUNICATION STRATEGY: DRAFTING AND PILOTING**

#### **5.1 INTRODUCTION**

In Chapter 4 the data analysis process and findings were reported on in terms of the constructs of the Health Belief Model. In Chapter 5 these findings will be utilised to develop a draft communication strategy. The legislative framework relevant to all aspects of the HAST diseases, as well as existing current policies and procedures on the prevention, early diagnosis and treatment of these diseases, were included in the draft communication strategy. The findings from this study, however, influenced the content and implementation of the strategy with the aim of effectively enabling the communities to decrease the prevalence and consequences of HAST diseases.

#### **5.2 DRAFT HAST COMMUNICATION STRATEGY**

##### **5.2.1 Legislative framework**

There are several policies and guidelines utilised in South Africa and the Limpopo Province for addressing HAST, such as constitutional mandates; Sustainable Developmental Goals; Batho-Pele Principles; Patients' Rights Charter; National and Provincial Strategic Plans on HAST (2012-2016); South African National (SANAC) Council Strategic Plan; National TB Advocacy, Communication and Social Mobilisation (ACSM) Strategy 2007; Communication Strategy for the National Insurance (NHI) in the Limpopo Province and the Provincial Communication Strategy 2009-2014: Limpopo Provincial Government. These policies and guidelines gave direction in the development of the communication strategy.

##### **5.2.2 Target groups**

UNICEF (2008: 22) identified primary, secondary and tertiary target groups for health information. Primary target groups are those who will have the biggest impact on

reaching the intended outcomes which, in this study, is a decrease in the prevalence of HAST diseases. The primary target groups for the communication strategy are discussed below.

*Primary target groups for HIV and AIDS and other sexually transmitted infections*

- Individuals at high risk or vulnerable (key population), such as sex workers, their clients, different age groups, migrant workers, IDUs, or uniformed services personnel, the disabled, men who have sex with men;
- Various economic work groups, such as miners, farm workers and the youth, and the involvement of men, to buy-in for support and behaviour change;
- People living with HIV (PLHIV);
- Caregivers of children or older persons;
- Local communities and families.

*Primary target groups for TB*

- Various economic work groups, such as miners and farm workers;
- migrant workers, IDUs, or uniformed services personnel;
- Inmates in correctional services;
- Church members;
- Learners;
- Caregivers;
- Local communities and families;
- People living with HIV (PLHIV);
- TB clients.

Secondary target groups include people or groups that can influence and support the sustained behaviour of persons in the primary target group (UNICEF, 2008: 22). These include peer groups; faith based groups, community groups and non-governmental organisations. In terms of this study secondary target groups relevant to HAST diseases are:

*Secondary target groups for HIV and AIDS and other sexually transmitted infections*

- Health professionals, lay counsellors, peer educators and home- and community-based carers;

- People providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers;
- Family members.

*Secondary target groups for TB*

- DOT supporters;
- Family members;
- Health professionals, lay counsellors, peer educators and home- and community-based carers;
- People providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers.

Tertiary target groups are those whose actions indirectly help or hinder the behaviours of other participants (UNICEF, 2008: 22). Tertiary groups include the broader social, cultural and policy making sectors, such as politicians and high level government officials who make policy and allocate resources, religious and community leaders (representing religious organisations at the national and local level), professional associations and regulating bodies. In terms of this study these include members of the Limpopo AIDS Councils, i.e. Provincial, District, Local and Ward Councils.

Tertiary target groups for HIV and AIDS and other sexually transmitted infections include:

- Parliamentarians, politicians and high level government officials who make policy and allocate resources;
- Religious leaders (representing religious organisations at the national level), professional associations influencing service delivery policies and members of the AIDS Councils at different levels (national, provincial and municipal);
- Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; traditional health practitioners (THP);
- Non-governmental organisations and community stakeholders;
- Donors.

### *Tertiary target groups for TB*

- Parliamentarians, politicians and high level government officials who make policy and allocate resources;
- Religious leaders (representing religious organisations at the national level), professional associations influencing service delivery policies and Members of the AIDS Councils at different levels (national, provincial and municipal);
- Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; traditional health practitioners (THP);
- Non-governmental organisations and community stakeholders;
- Donors.

### **5.2.3 Communication strategies**

Communication strategies have to effectively communicate the right message, to the right people in the right way.

Messages can be delivered through mass media – for example, television or radio spots; articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics – or in-person, by health workers, peer educators, counsellors, or other trained personnel. Additional means of delivery include musicals or dramatic performances and community events (FHI, 2012:15).

- Use of mass media and social networks

Most of the participants agreed that media and social networks play a major role in reaching communities. Social media provide a potentially inexpensive and efficient way to monitor real-time gaps and progress in the AIDS response, equip citizens with data, enhance their participation in the public sphere and extend their agency over development-related decision-making (UNAIDS, 2015: 13).

Although many people own mobile phones, this was not mentioned as a means of communication, and it has been observed that many people use social media networks such as sms messages, Whatsapp groups, Twitter, etc.

Mass media can be instrumental in breaking the silence around HIV and in creating an environment conducive to the discussion of how individuals can protect themselves (SADC, 2013:44). The use of mobile phones and social networks can also be utilised to form support groups and chat groups to support people with HAST diseases, their carers, friends and families. Studies in this regard have been reported by Johnson et al. (2013:11), particularly in a study that was conducted at Burgersfort in Limpopo.

- Printed material

The use of articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics – or in-person, by health workers, peer educators, counsellors, or other trained personnel can be considered. The utilisation of these, however, depends on the availability and accessibility of the material and on the service provider to avail themselves of the material for use. Availability of funds can be the barrier to the accessibility of print material.

The language used needs to be that of the target audience group and the material needs to be presented in Braille. Print material is not accessible to blind people and those who are unable to read and write. HIV and TB communication programmes in South Africa utilise various media of communication, for example, mass media (broadcast, print and outdoor), small media (posters, booklets, and utility items), and social mobilisation aimed at creating dialogue and action at local and community level (Johnson et al., 2013:11).

- Non-conventional strategies

Additional means of delivery include musicals or dramatic performances and community events (FHI, 2012:15). These strategies target the youth in and out of school. The strategy can reach large number of young people with HAST messages. The strategy

can be used during campaigns, as stand-alone material or to introduce a youth dialogue. Internationally, theatre was used because of its traditional popularity and cost effectiveness (Cohen, 2002:3). According to FHI (2012:15) additional means of information delivery include musicals or dramatic performances and community events.

- Individual face-to-face communication

Communication with the aim of changing behaviour involves face-to-face dialogue with individuals or groups to inform, motivate, problem-solve or plan, with the objective to promote behaviour change (UNICEF, 2008:55).

- Marketing

Marketing of the communication strategy includes launching, popularisation and to be on the Departmental website so that is known by all and ability to be utilised

According to Limpopo Provincial Government (2009:10) the strategy focuses on the following target market: general public/all citizens of Limpopo, public servants, parastatals, organs of civil society, district and municipalities, traditional authorities, faith groups, community-based organisations (CBOs), the business community and institutions of learning. Popularisation of the communication strategy with this target group is required.

#### **5.2.4 Content**

UNAIDS, in its Vision (2015:5), emphasises that all people, regardless of their circumstances, can meaningfully engage with, and have a voice in, the decisions that affect their lives. It is, therefore, imperative for an effective communication strategy with the aim of addressing the HAST diseases, that people should have access to HIV testing and prevention services tailored to their needs and to receive appropriate treatment.

Community members are, therefore, typically aware of the risk of contracting these diseases. The fear for stigmatisation is, however, feared more than the disease itself

and there is a real fear of transmission of the diseases when taking care of ill persons in the family or the community. The fact that persons do not typically visit screening and testing facilities can lead to infected people not being diagnosed and not being treated, which can result in an increase of transmission.

The community members, and specifically the risk groups, such as the youth and spouses of people who have any of the HAST diseases, should have a clear understanding of how the disease is transmitted and where the available health facilities are where they can be screened and treated.

Health professionals also have the responsibility to allay fears of stigmatisation by providing relevant and correct information, and to do so with a caring attitude without being judgmental and prejudiced. A study in the SADC (2013: 29) region of Africa found that health professionals have a real concern of contracting these diseases in their interaction with infected people. Health professionals must, therefore, have an in-depth understanding of risky behaviour and how they should protect themselves from transmission of diseases through exposure or potential exposure to infected blood and body fluids. Health professionals should be enabled with the right protective clothing, within a clear policy framework, to apply universal precaution. A large number of patients with whom health professionals interact are unaware of their disease status. This increases the risk of infection of both the health care provider and the patient (Olapade-Olaopa et al., 2006 in SADC, 2013:29).

Knowledge about HAST diseases enables and empowers community members to make informed decisions about behavioural changes, as well as develop a positive feeling about themselves and other people with HAST diseases.

According to HSRC (2014:4), knowledge about HIV transmission and prevention is accompanied by an appropriate reduction in behavioural risk practices, which are important in combating and reversing the spread of HIV. However, knowledge of HIV remains low in sub-Saharan Africa. Sound knowledge of HIV transmission and prevention is a key component of protecting oneself (SADC, 2013:36).

The importance of knowledge transfer and health services that are available and accessible will not only contribute towards a decrease in HAST diseases, but will also contribute towards sustainable lifestyle changes and will also empower significant role players to care for people with these diseases.

Participants noted disclosure as a key for self-acceptance, which has the additional benefit of being able to openly comply with treatment regimens and self-care. Disclosure further gives access to support groups and results in openly practicing preventive measures. HIV disclosure is expected to eventually improve adherence. This was reported in a study conducted in Botswana on adherence by adolescents to ART. Non-disclosure of HIV status was associated with poor adherence to ART (Phalade et al., 2009 in Marukutira, 2012:18). The benefits of disclosure should receive attention in an effective communication strategy. To promote disclosure implies that stigmatisation and marginalisation should also be addressed in the strategy.

Availability and utilisation of support structures in sustained changes towards a positive and healthy life style have proved to be very effective. People who are living with HIV have been documented as experiencing a number of related symptoms, such as anxiety and depression, as well as other physical symptoms and they use different strategies in order to manage these symptoms (Modeste and Majeke 2014:1).

It is also critical for adults to be aware and supportive of HIV prevention services available in their communities. Support from local leaders, either political or religious, can positively influence the perception of utilising HIV prevention services and protecting oneself (SADAC, 2013:36).

The importance of, and impact on, support groups in addressing HAST diseases and promote sustainable compliance with treatment and changed lifestyles was evident from the focus groups. The promotion and establishment of support of people with HAST diseases should, therefore, be an integral part of a communication strategy. Accommodation of cultural beliefs and practices should be addressed in a communication strategy.

Stigmatisation and discrimination was frequently mentioned by participants as a barrier to minimise the risk of HAST diseases. It was clear that discriminatory attitudes were inflicted by self, family members and/or members of communities. Respondents stated that infected persons are stigmatised and discriminated against because of their HIV status or other disabilities and/or side effects of the HAST diseases.

HIV and AIDS-related stigmatisation and discrimination remain major barriers to effective HIV prevention as well as to the provision of treatment, care and support in many countries across the globe, including South Africa (HSRC, 2014:4). As many of the local religions and churches struggle to discuss sensitive topics such as sex, drug use, and issues related to HIV, the disease is further stigmatised and appropriate messages are difficult to disseminate (UNESCO, 2002 in SADC, 2013:32). People with disabilities are at higher risk of HIV infection because they are vulnerable to violence, sexual abuse, stigmatisation and discrimination, yet they often struggle to obtain meaningful service access (UNAIDS, 2015:8). Maswanganyi et al. (2014:7) revealed that TB patients preferred to visit PHC facilities which were far from their homes due to fear of stigma, which also resulted in them defaulting on treatment.

### **5.2.5 Implementation of the strategy**

- *Multi-sectoral approach*

It was mentioned by most of the participants that a communication strategy needs a multi-sectoral approach to succeed. Key stakeholders need to be involved early on in every step of the process of developing HIV and TB programmes and their communication strategy components. Stakeholders include policymakers, opinion leaders, community leaders, religious leaders and members of target populations, including PLHIV. Their active participation at appropriate stages of communication strategy development is essential. A stakeholders' meeting should be held at the planning stage to obtain guidance and commitments to the process and to develop coordination mechanisms.

According to SADC (2013:36) support from local leaders, either political or religious, can positively influence the perception of utilising HIV prevention services and protecting oneself. A combination of science, facts, vision, stakeholder buy-in, and audience participation is essential for success (UNICEF, 1999:15).

- *Community participation*

Community engagement and inputs must be an integral part of all aspects of strategy development, implementation and monitoring. This means that community should be enabled and empowered throughout an effective strategy (UNICEF 2008:55). Involvement of community members should be integrated into the design process in terms of advocacy, social mobilisation and behaviour change communication (UNICEF 2008:40).

According to SANAC (2010:11), in developing a planned and pro-active strategy, there is a need to ensure that participation of communities in developmental issues beyond health and the ability to participate is critical that communities are empowered to take direct involvement in the decisions that affect their participation. This brand of participation ensures that communities are able to define their own problems and mobilise for collective action towards solutions to local challenges.

- *Role players in health communication*

It was mentioned that professionals and non-professionals should be the implementers of the communication strategy, which includes the HAST programme managers and politicians.

The international model of using sex workers as peer outreach workers, advocating on behalf of other sex workers and empowering women is a powerful one that resulted in increased use of condoms (Krenn and Limaye, 2011:14). In South Africa, health care professionals, home- and community-based care givers, peer educators (including sex workers) and media are key role players in communicating the HAST messages.

The role players, according FHI (2002:11), include people providing services, such as health workers, private practitioners, pharmacists, counsellors and social service

workers; policymakers, such as politicians; leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; local communities and families.

### **5.2.6 Resources and budget**

Funding is an important issue for the programme communication committee to address before designing a communication strategy (UNICEF, 2008:62). According FHI (2002:19), the behaviour change communication of a project needs good management support to ensure correct sequencing of activities; collaboration and coordination; identification of appropriate resources; and budgeting.

One of the functions of the Limpopo Provincial AIDS Council (LPAC) is to mobilise resources for the implementation of the HIV and TB Provincial Strategic Plan in consultation with the South African AIDS Council (SANAC), strengthening partnerships for a multi-sectoral provincial response among government agencies, NGOs, donors, private sectors and people living with HIV and AIDS (Limpopo Provincial Government, 2011:24).

Seven important areas where resources and budgets are needed which include:

- Communication research;
- Monitoring and evaluation;
- Training/capacity-building;
- Development and production of print materials;
- Development and production of broadcast materials;
- Special events and local planning; and,
- Coordination of meetings.

Planning for ongoing communication capacity-building is essential in implementing a communication strategy, whether in regard to formative communication strategy assessment, design, communication product development, pre-testing, monitoring, or evaluation. Capacity-building is also extremely important for personnel (peer educators, outreach workers, counsellors and community workers) whose primary responsibility is communicating with target populations.

Making sure that peer educators know about the timing, objectives and content of messages through other channels, as well as providing those personnel with adequate communication skills and support materials, will enable them to reinforce key messages and stimulate discussion. These individuals should also be prepared to help people acquire essential new skills and prepare personal plans for action.

Communication training is also necessary for political, religious, social and cultural leaders and authorities. Staff members of implementing agencies who will need to “sell” their programmes to communities and authorities will need new skills as well as support materials. Self-help groups and human rights advocacy groups also need communication skills, particularly if they take on a significant role in building a supportive environment and decreasing stigma. Other parties whose primary responsibility is service delivery will have a communication role and need training in it as well; this includes clinical care providers, HCT staff and social development staff. Materials are meant to be used. Without good communication skills, the best materials are likely to fail and messages are likely to get lost.

Training media professionals should also be part of the plan. The broadest and most cost-effective reach can be accomplished by making use of a well-oriented cadre of media personnel (after all, they will be producing media whether or not they are part of a programme). Conversely, untrained media personnel can perpetuate myths, create stigma and harm the lives of PLHIV and their families, however unintentionally.

Finding adequate capacity-building resources can also be a challenge. It is important to build the capacity of implementing partners and of local, national, regional and international human resources. Strategies for increasing capacity in the area of Communication strategy include:

- Quality strategic planning and design at the beginning of programmes;
- Developing standardised tools, including training modules, guidelines and protocols;
- Setting up national, regional and international training programmes;

- Developing a cadre of local, national, regional and international consultants who can provide quality technical support;
- Working with networks of PLHIV to develop their ability to communicate effectively.

### **5.2.7 Monitoring and Evaluation**

The success of every programme needs to be monitored and evaluated to ensure compliance; to measure if targets are met; specific tools to evaluate the impact; and feedback on the achievements. The utilisation and effectiveness of monitoring and evaluation of the communication strategy was emphasised by some of the participants as follows:

Day-to-day monitoring will provide information for making adjustments in short-term work planning. Periodic programme reviews can be designed to take a more in-depth look at programme progress and larger-scale adjustments or redesign. Involving stakeholders, target audiences and partners as much as possible will provide a better look at what is happening; help make appropriate decisions; and make sure that the people affected by any decisions will be fully aware of them (Family Health International, 202:18).

According to Tatham (2010:13), the monitoring and evaluation stage follows the execution of the campaign and involves assessment of the effectiveness of the campaign as a whole in bringing about the desired change in behaviour on the part of the target audience.

Monitoring of the progress of the HAST programmes is done through reports and site visits. Reports are written monthly, quarterly and annually by programme deputy directors. The National Department of Health visits the Province quarterly to review programme progress and financial status and site visits are also undertaken. The Limpopo Provincial Strategic Plan for HIV and AIDS, STIs and TB (2012-2016) is monitored through monthly, quarterly and yearly reports and a midterm review, which

was conducted in 2015 with the assistance of the National Department of Health and the South African AIDS Council.

A plan for monitoring and evaluation needs to be drawn up during the initial stage of communication strategy design. The information to be gathered for the communication strategy should be linked to the programme's overall monitoring system.

Monitoring is part of the ongoing management of communication activities and it usually focuses on the process of implementation. The following should be closely monitored:

- Reach: Are adequate numbers of the target audience being reached over time?
- Coordination: Are messages adequately coordinated with service and supply delivery and with other communication activities? Are communication activities taking place on schedule, at the planned frequency?
- Scope: Is communication effectively integrated with the necessary range of audiences, issues and services?
- Quality: What is the quality of communication (messages, media and channels)?
- Feedback: Are the changing needs of target populations being captured?

To monitor the course of a communication strategy properly, it is necessary to establish effective information-gathering systems. These include reports, site visits and reviews of materials. Reporting tools and protocols must be standardised to ensure consistency.

Periodic focus-group discussions and in-depth interviews can also help communication strategy programmers assess the perceptions of target populations. Peer educators can collect responses from target populations to help identify changes that may have to be made in the environment or aspects of communication and services that may need to be addressed.

The evaluation of outcomes (actual, measurable changes in behaviour and environment) is generally more complex and may be beyond the resources and abilities of many country-level programmes, and certainly of projects. Good monitoring data enables managers to demonstrate the degree to which programmes have contributed to changes as measured by national surveillance systems, such as the Behavioural

Surveillance Survey (BSS). Questions related to communication intervention can be added to such a survey to assess the reach of the strategy's activities.

### **5.3 PILOTING OF THE DRAFT COMMUNICATION STRATEGY.**

Following the development of the draft communication strategy (Annexure Q), piloting of the draft was implemented. Implementation of the pilot was feasible and specific enough to guide the health workers. Assistant Directors of the Capricorn District HAST were given the draft communication strategy document to utilise in their daily work activities for the period of three months (June to August 2015). After three months, an evaluation was done with the implementers to determine the level of understanding of the HAST communication strategy, the acceptability, relevance and accessibility of available resources and health systems as well as the appropriateness, feasibility and acceptability of strategies and information contained in the draft communication strategy.

The six Assistant Directors for HAST in the Capricorn District were the implementers of Advocacy, Communication and Social Mobilisation for HAST; Tuberculosis; HIV Counselling and Testing; Prevention of Mother to Child Transmission of HIV and AIDS; Comprehensive Care Management and Treatment, Care and Support; TB and HIV Integration, Sexually Transmitted Infections, High Transmitted Areas; Medical Male Circumcision and Condom Logistics programmes.

The Capricorn District facilities where the pilot took place included two tertiary hospitals, namely Pietersburg Provincial Hospital and Mankweng Hospital; 6 District Hospitals, 1 Specialised Hospital, 4 Community Health Centres 96 fixed clinics and non-health settings in the Capricorn District, including non-governmental institutions, TVETs and universities.

The following instruction was attached to the draft of the communication strategy.

1. Read the draft HAST Communication strategy attached;
2. Implement it in your district were you see it fit with your daily work;

3. Always check if it is understood, user friendly, easy to use by community members and health workers;
4. Always check if it is acceptable, relevant, feasible and accessible;
5. Availability of resources and health system;
6. Feasibility and acceptability of strategies and information contained in the draft communication (Annexure F).

At the end of August, member checking was done with the participants after the draft communication strategy was implemented in their working environment for the period of three months. The evaluation was done together in the congregational setting at the Polokwane Royal Hotel, where they were having another meeting. The discussion inputs were undertaken on the draft strategy, page by page, with the participants and all changes were incorporated. Input of the participants in the pilot was mainly in the form of the document and editorial refinement. Aspects which were identified to be included in the strategy included acknowledgements, clarification of acronyms and a summary. Another limitation in the strategy was the guidelines in terms of the legislative framework and other important policy documents, such as constitutional mandates, Batho-Pele Principles, the Patients' Rights Charter and aspects in terms of the envisages National Health Insurance (NHI).

Suggestions were made that statistics in terms of diseases should not be included in detail in strategic documents, but could be provided in a content strategic document. With regard to the target and risk groups, it was suggested that more attention be given to men to buy-in for support and behaviour change; people living with HIV (PLHIV), caregivers of children or older persons and local communities and families.

Feedback was also provided in terms of effective use of social media (such as Facebook, Twitter and blogging) for marketing, communication support and the provision of information, especially in terms of the youth. A Channels and Participant Match was added as this is critical to select the channels which best match the participants.

They highlighted the seven important areas where resources and budgets were needed, which included: communication research, monitoring and evaluation, training/capacity-building, development and production of print materials, development and production of broadcast materials, special events and local planning and coordination meetings. It was mentioned that the communication strategy was relevant to all stakeholders at different settings in HAST and was easy to refer to.

An assessment of the communication strategy was done following the feedback received after the pilot phase. Three Directors, that is the Director responsible for TB control, the Director responsible for HIV, & AIDS and STIs (HAS) and the Director responsible for HAST stakeholder coordination, were given the communication strategy for the period of two weeks and member checking was done with the researcher individually. The following were the questions which were attached to the draft strategy.

Questions that will probe the discussions:

1. Did you manage to go through the HAST Communication strategy framework?
2. According to you how do you see the HAST Communication strategy and its implementation, is it acceptable? Feasible? And relevant?
3. How is the relevance of the monitoring process and evaluation criteria embedded in the strategy (Annexure H).

The following inputs and recommendations were made by the Directors as a result of the meeting. They all agreed that they managed to go through the HAST communication and that the communication strategy would be implemented, is feasible, acceptable and relevant. They all agreed that acknowledgements in the communication strategy should be shifted to the beginning of the study, together with the summary and acronyms, unless the communication strategy is presented as an Annexure.

They further agreed that the communication strategy should commence with the introduction and all other headings and sub-headings agreed to as relevant were Prevention, Diagnosis, and Treatment. Support headings not relevant were taken out. They agreed that the legislative framework that supported the communication strategy should be given in summary only, with details given in Chapter 2. It was agreed that all

legislative frameworks were relevant, except the Millennium Developmental Goals, which should be replaced by Sustainable Developmental Goals, since the MDGs ended in 2015. The objectives were found to be relevant but focus should be on the dual epidemic (HIV & TB), as in the guiding principles. It was agreed that the target audience should include the following: people in peri-mining communities and inmates in Correctional Services.

It was agreed that the communication channels need to be discussed in full, detailing how each strategy would be implemented in the Province. It was agreed that the monitoring and evaluation strategy was relevant. The participants agreed that recent statistics for the disease profile used in the communication should focus only on statistics from.

After all the inputs from the Directors, the document was send back to the senior managers to check and confirm that all the changes were affected. The pilot and assessment were implemented, feedback given was implemented, which resulted in final the HAST communication strategy (Annexure B).

## **5.4 CONCLUSION**

The drafting, piloting and assessment of the communication strategy was highlighted and all inputs incorporated, which then informed the final HAST Communication Strategy Framework (Annexure R).

## CHAPTER 6

### CONCLUSIONS, LIMITATION AND RECOMMENDATIONS

#### 6.1 INTRODUCTION

In this last chapter of the research report, the conclusions, limitations and recommendations based on the research findings are discussed.

The aim of the study was met, namely to develop and pilot a focused communication strategy for HIV, AIDS, sexually transmitted infections and tuberculosis (HAST) in the Limpopo Province.

#### 6.2 RESEARCH OBJECTIVES

The objectives of the study were to:

- explore and describe the level of understanding of HAST in the Province;
- explore and describe the nature of HAST services in the Province;
- explore and describe the factors impacting on the high prevalence of HAST in the Limpopo Province;
- develop and pilot a contextualised relevant communication strategy for HIV, AIDS, STI and TB (HAST) for the Province.

The study was guided by the Health Belief Model (HBM) as a conceptual framework and the research questions were derived from the three major tenets of the HBM described by Glanz, Rimerand and Viswanath (2008:49), namely:

- Modifying factors'
- Individual beliefs;
- Action.

### **6.3 RESEARCH DESIGN AND METHOD**

The study followed a qualitative approach to investigate the phenomena of the HAST diseases in the Limpopo Province (Polit and Beck 2012:739). In the process of collecting, analysing and interpreting the data, findings informed the development of an acceptable contextualised communication strategy with the aim of decreasing the prevalence of HAST diseases through the distribution of relevant health information. The information should enable people at risk, as well as community and family members in general, to make informed decisions about sustainable healthier lifestyles.

An in-depth literature study assisted the researcher to familiarise herself with all the latest trends on the HAST diseases, legislative frameworks, determining factors impacting on life style changes and feasible and acceptable strategies to convey health messages effectively. Data on perceptions, beliefs and other factors that could impact on effective communication and change of lifestyle were obtained through focus group interviews with members of the Capricorn District AIDS Council, i.e. representative of the community.

Data on factors that would impact on the content and implementation of the communication strategy were obtained through interviews with Deputy Directors and Assistant Directors. After piloting the draft strategy for a period of three months, the strategy was refined and is attached as an annexure (Annexure R). Ethical issues were considered throughout the process of the study by ensuring that permission to conduct the study had been received from all relevant authorities before the study commenced, and from the participants.

## **6.4 PHASE 1: SITUATIONAL ANALYSIS**

In the discussion that follows the conclusions and recommendations will be integrated in terms of the tenets of the Health Belief Model.

### **6.4.1 Modifying factors**

Modifying factors such as demography of the Province, culture, socio-economic situation, the health system structure and HIV and TB prevalence have an influence on the HAST epidemic and will therefore also impact on the strategy for effective communication. The mines and farming areas of the Province are areas where there is high HIV prevalence in the Province. The Waterberg District, in particular, saw prevalence rates decrease from 30.3% in 2011 to 27.3% in 2012 and 2013 (Department of Health, 2015: 55), These areas are, therefore, focus areas for health communication. The fact that HIV, sexually transmitted infections and tuberculosis are interlinked in terms of contributing factors, such as unemployment, poverty, malnutrition, overcrowded housing, pollution; and cultural practices, such as preference to visit traditional healers rather than accessing health facilities for screening (SADC, 2013:30), treatment and follow up visits, are evidence that health communication strategies should adopt a comprehensive approach to all these diseases in terms of prevention, transmission, co-existence of diseases, impact on family members and the community as well as information on accessible health facilities. This is in line with Loveday and Zweigenthal who stated that the HIV epidemic nationally has had negative impacts on the outcome of TB case management (Loveday and Zweigenthal, 2011:435).

The Provincial Directorates of HIV and AIDS, STIs and TB currently still operated as two separate divisions, as HAS and TB within the Provincial Department of Health. This division of responsibilities means that there are two Directors with different budgets. This creates challenges in terms of coordination, standardisation and focus. The structures of the AIDS Council at District Level (DAC) are not functional in some of the districts. Districts like the Waterberg, where there are challenges, the structure is not

functional which poses a problem of HAST programme coordination and resource mobilisation.

#### **6.4.2 Individual Beliefs**

Major constructs of HBM, such as perceived susceptibility to and severity of HAST diseases include: risk of contracting the HAST diseases, perceptions based on existing knowledge, perceived benefits related to health services, perceived benefits related to disclosure, availability of support structures, lack of accessible and available health promotion programmes, barriers regarding health workers, lack of health care facilities and limitations in terms of health care delivery, stigmatisation and discrimination related to HAST.

Although there is a high level of stigmatisation and, in many cases, family members care for people infected with HIV at home, many people are still not fully informed about the transmission of these diseases, as indicated by the fear of contracting these diseases through social contact, superficial physical contact and sharing of utensils. It was concerning that even health practitioners have such a level of fear of being infected that they tend to “neglect” infected persons (Sehube, Zungu and Hoque, 2012:12). Lack of health promotion programmes, lack of specialised skills possessed by health care workers, limitations in terms of appropriate health communication and the negative and discriminatory attitude of health care workers, were clearly found to be barriers to behaviour change and decreasing the risk of developing the HAST diseases. HIV and AIDS-related stigmatisation and discrimination remain major barriers to effective HIV prevention as well as to the provision of treatment, care and support (HSRC, 2014:4). TB patients preferred to visit PHC facilities which were far from their homes, due to fear of stigmatisation, which also resulted in them defaulting on treatment.

An effective communication strategy should, therefore, also ensure that health practitioners be fully informed to empower them to convey health messages with accuracy, respect and an attitude that would facilitate people with infections, family members and community members to access health facilities.

Perceived benefits of addressing the risks around HAST diseases were found to be mainly around the benefit of being open about being infected (Marukutira, 2012:53). This leads to access of support systems, openly accessing treatment and in so doing prevent further spread of these diseases.

Knowledge about HAST diseases, the availability of health services for HAST diseases, views on the disclosure of HIV and AIDS status and the nature and structure of support by health care workers were also seen as perceived benefits for behaviour change and decreasing the risk of developing the HAST diseases.

### **6.4.3 Cues of Action**

Cues for action were derived from the perceptions of participants on the risks as well as the benefits related to aspects of HAST diseases. It was found that an effective communication strategy involves the transfer of health-related information through various strategies such as the media, social networks, by community involvement, support structures and through a positive attitude and respectful professional behaviour by health workers.

## **6.5 Phase 2: Development of the HAST communication strategy**

Taking the findings discussed above into consideration, the researcher followed the following two stages to develop communication strategy, namely: drafting the communication strategy, and piloting of the communication strategy.

### **6.5.1 Drafting the communication strategy**

The information obtained from the literature, personal interviews with the District and Provincial Deputy Directors influenced the development of the draft communication strategy draft. The draft strategy focused on elements such as legislative framework, target audiences, communication strategies to convey messages, the content, implementation of the strategy, resources and budget and monitoring and evaluation (see Annexure Q).

In developing a planned and proactive strategy, care was taken to ensure participation of communities in developmental issues beyond health, through empowerment and knowledge transfer. In so doing, communities were able to define their own problems and to mobilise themselves for sustainable collective action towards addressing local challenges as well as to support people infected and affected with HAST diseases.

### **6.5.2 Piloting and assessment of the communication strategy**

The draft communication strategy document was piloted in the Capricorn District by six Assistant Directors for the period of three months (see 3.5.2.4.2). This was done to identify any limitations in the communication strategy in terms of content, guidelines for implementation as well as monitoring and evaluation.

The inputs from the Directors assisted in further with refining the strategy, especially in terms of feasibility and implementation of the strategy. Based on the findings of the pilot and the inputs from the Directors, the following aspects were attended to, in order to refine the strategy further: legislative framework to be brief, the full explanation to be in Chapter 2; target audience to be grouped as primary, secondary and tertiary target groups and to include key populations, such as peri-mining communities. A final communication strategy for health to address the HAST diseases in Limpopo Province appears as Annexure R.

## **6.6 RECOMMENDATIONS**

Based on the findings from the situational analysis and the process of drafting and finalisation of the communication strategy the following recommendations are suggested

- HAST messages (to be sensitive to cultures) to all members of the communities using the channel of communication accessible to them;
- HAS & TB Directorates to be managed by one director for proper management and coordination;
- Strengthen the functionality of District AIDS Councils (DACs), Local AIDS Council (LACs) and Ward AIDS Councils (WADs);
- Availability of health promotion programmes at all levels of care;
- Encourage disclosure for proper care and management and educate people so that stigmatisation and discrimination can be eliminated;
- Community involvement at all level of care.

## **6.7 RECOMMENDATIONS FOR FURTHER RESEARCH**

The following are recommendations for further research:

- The development of a national communication strategy to address HIV & AIDS, STIs and TB in South Africa;
- Assess the impact of HAST messages on behaviour change;
- Development culturally sensitive messages to address HAST;
- The use of technology (sms, Twitter, WhatsApp) to address issue of HAST stigmatisation and discrimination and encourage disclosure;
- The understanding and contribution of political leaders on HAST issues.

## **6.8 MEETING THE RESEARCH OBJECTIVES**

The researcher is of the opinion that the aims of the study and the research objectives have been met. A final and refined health communication strategy was developed based on evidence based research by following the tenets of the Health Belief Model.

## **6.9 CONTRIBUTIONS OF THE STUDY**

The qualitative approach that was followed to develop an acceptable and contextualised health communication strategy will contribute towards the improvement of skills, knowledge and attitude of health practitioners, empower people affected and infected with HAST disease to benefit by facilitating openness of accessing and applying preventive actions, improve on treatment compliance and facilitate community engagement with these diseases. An overall decrease in the prevalence of HAST diseases is anticipated if the strategy is implemented effectively. The researcher is in a position to monitor and evaluate the effects of the strategy over time.

## **6.10 LIMITATIONS OF THE STUDY**

Obtaining information from HAST Deputy Directors who are colleagues was a challenge due to professional jealousy and can also hinder the acquisition of more information. The planned focus group interview with District and Provincial Deputy Directors, which was converted to personal interviews due to geographical distances and busy work schedule of Deputy Directors, can be seen as a limitation to more in-depth information.

## **6.11 CONCLUSION**

The purpose of this study was gain an understanding of the current means of HAST communication in the Limpopo Province in order to develop a contextually relevant communication strategy for the Province. This was achieved through addressing the objectives of the study. The provincial communication strategy to address the HAST in the Limpopo Province was developed and will be utilised by professionals and non-professionals in the Province.

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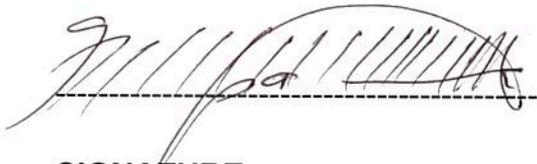
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**STUDENT NUMBER**

**746 324 3**

**DECLARATION**

I declare that **THE EFFECT OF PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV AND AIDS, STIs AND TB (HAST) IN THE LIMPOPO PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other institutions.

A handwritten signature in black ink, consisting of stylized, overlapping loops and lines, positioned above a horizontal dashed line.

**SIGNATURE**

**NGWAKO JOHANNAH RAPAKWANA**

*28.02.2017*

**DATE**

**ANNEXURE A**

**Approval from Department of Health Limpopo Province**



# LIMPOPO

PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

## DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref:4/2/2

Rapakwana NJ

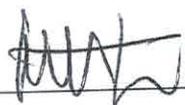
University of South Africa

Greetings,

**Re: The effect of a provincial communication strategy to address burden of diseases in the Limpopo province.**

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
  - Further arrangement should be made with the targeted institutions.
  - In the course of your study there should be no action that disrupts the services.
  - After completion of the study, a copy should be submitted to the Department to serve as a resource.
  - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

  
PP Head of Department

17/2/2013  
Date

**ANNEXURE B**

**Letter requesting and granting consent to conduct the study from  
Capricorn District Municipality**

45 Queen Street  
Ivy Park Ext 20  
Polokwane  
0699

Enquiries: Rapakwana N J  
Work Tel: 015 293 6591  
Cell No: 082 4352 890  
Fax: 086 215 8225

November 11, 2014

To: Chairperson of Capricorn District AIDS Council Technical Committee  
Municipal Manager  
Capricorn District Municipality  
P.O Box 4100  
Polokwane  
0700

Dear Sir/ Madam

**RE: REQUEST TO CONDUCT FOCUS GROUP INTERVIEW WITH  
MEMBERES OF THE DISTRICT AIDS COUNCIL (CIVIL SOCIETY  
MEMBERS)**

I am a student registered for DLITT ET PHIL (Doctoral degree) in Health Studies with the University of South Africa (UNISA). The study topic is to conduct a study in the province on: **THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRES BURDEN OF DISEASES IN THE LIMPOPO PROVINCE.**

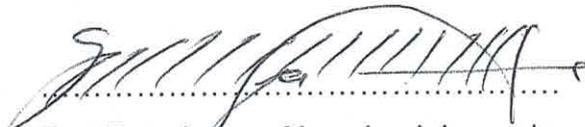
The civil society members (Representatives of: Youth, People living with HIV, Disability, Religious sector, Traditional Leaders, Traditional Health

Practitioners, Men sector) any five of them will participate in the study in the focus group interview. The participation will be on the day of the District AIDS Council (DAC) meeting before or after the actual meeting and the interviews will last for 45 to 60 minutes (one day only). The participants will be requested to assemble at the interview venue on time and the information leaflets will be given to them and consent form will be provided for them to agree to participate and participation is voluntary.

The development of a communication strategy is an important contribution as a tool which could be utilised by health professionals to address the burden of diseases in terms of HIV, AIDS & STIs and TB (HAST) in the Limpopo province.

The researcher undertakes to observe all ethical principles for conducting the research. All information will be kept in confidence. A copy of the research report will be made available to your municipality. The permission letters from Department of Health and also from University of South Africa are attached.

Regards

  
.....  
Rev Rapakwana Ngwako Johannah

2014.11.13  
.....  
Date

**ANNEXURE C**

**Ethical clearance certificate from UNISA**

**UNIVERSITY OF SOUTH AFRICA  
Health Studies Higher Degrees Committee  
College of Human Sciences  
ETHICAL CLEARANCE CERTIFICATE**

**HS HDC/256/2013**

Date: 27 November 2013

Student No: 0746-324-3

Project Title: The effect of a provincial communication strategy to address burden of diseases in the Limpopo Province.

Researcher: Rapakwana Ngwako Johannah

Degree: D Litt et Phil

Code: DPCHS04

Supervisor: Prof SP Human

Qualification: D Cur

Joint Supervisor: -

**DECISION OF COMMITTEE**

Approved



Conditionally Approved



**Prof L Roets**

**CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

  
**Prof MM Moleki**

**ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES



**ANNEXURE D**

**Information Leaflet and informed consent for participants in the  
research project**

## **ANNEXURE D**

### **INFORMATION LEAFLET AND INFORMED CONSENT FOR PARTICIPANTS IN THE RESEARCH PROJECT**

**TITLE OF THE STUDY: THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV and AIDS, STIs & TB (HAST) IN THE LIMPOPO PROVINCE.**

Dear Dr/ Mr / Mrs / Ms

I hereby will like to request you to participate in the research study on the: **THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV and AIDS, STIs & TB (HAST) IN THE LIMPOPO PROVINCE.**

I am the student in the Department of Health Studies at UNISA. The aim of the study is to develop and test a communication strategy to address the burden of disease in terms of HIV, AIDS, STI and TB (HAST) in the Limpopo province. The research Committees at UNISA and the Department of Health in the Limpopo Province has approved the study.

Your participation will include that we meet for the personal interview that will be recorded on a voice recorder to ease the process of data analysis and the scribe. The interview will last for 45 to 60 minutes. The interview will take place at a private place to enhance confidentiality. The appointment will be set with each participant during working hours. No names will be used during the interview. Data will be kept in a safe place by the researcher for confidentiality with the researcher being the only one to access the raw data. You can stop or withdraw your participation at any stage without any consequences to you. Your participation will however be appreciated.

If there are any questions concerning the study and your participation in the study, please feel free to ask me at any time.

You are kindly requested, if you agree to participate to sign the attached consent form to confirm that you are willing to participate in the study.

## AUTHORIZATION TO PARTICIPATE IN THE RESEARCH

### TITLE OF THE STUDY: **THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HAST IN THE LIMPOPO PROVINCE.**

#### **Introduction**

I am Reverend Rapakwana Ngwako Johannah, the researcher responsible for this study and currently registered for Doctoral Degree in Health Sciences at the Department of Health Studies at UNISA. The aim of the study is to develop and test a communication strategy to address the burden of disease in terms of HIV, AIDS, STI and TB (HAST) in Limpopo province.

#### **Procedure**

If you agree to participate in the study you will be taking part in the personal interview which will involve the researcher interviewing you individually to answer questions on a given topic around communication strategies in HAST. Please use your HAST knowledge freely in the discussion and be honest. You will not be judged based on your responses as there are no right or wrong answers. If you have any questions feel free to ask the researcher.

#### **Voluntary nature and right to decline**

Please be advised that your participation is voluntary. If you decide to participate but prefer not to answer certain questions, you are free to do so and for any reasons. You have the right to decline to answer any questions that make you feel uncomfortable, or stop the interview any time. There are no negative consequences if you decline to participate or refuse to answer any question.

#### **Confidentiality and anonymity**

The researcher undertakes to maintain at all times strict confidentiality of you, as participant and the data collected during the research. All collected data will be stored electronically in a secured location, protected with password and only the researcher will have access to it. No personal identities such as names, birth-date, addresses and e-mail or telephone numbers will be attached to your response on the fields notes. Results of the research will be presented and published in the manner that participants will not be identifiable.

#### **Risk and benefits**

No major risk is anticipated to you as participants, however counselling will be readily available to you should you develop emotional trauma as a results of participation in the study. As a participant you will not receive any monetary benefit

for your participation in the study and will not be coerced into participation, however you will contribute to the existing body of knowledge in the field of HAST Communication strategy and may benefit from the outcome of study through your participation.

You will be given a signed copy of the informed consent. If you have any question or concerns about the study, please contact researcher Rev Rapakwana N J on 082 4352 890, [maiterapakwana36@gmail.com](mailto:maiterapakwana36@gmail.com) or the supervisor Prof Human S P at 012 429 6290, [humansp@unisa.ac.za](mailto:humansp@unisa.ac.za).

**CONSENT TO PARTICIPATE IN THE STUDY**

I .....understand that I have been asked to participate in the above mentioned research which aim to develop and test a communication strategy to address the burden of disease in terms of HIV, AIDS, STI and TB (HAST) in Limpopo province.

I confirm that the purpose and the details of the research have been fully explained to me and I declare that I full understand the content of this consent form. I have been given the opportunity to ask questions and I am satisfied with answers. In addition, I have been told that I can decline to participate in the study as is also my right.

I confirm that I have not been forced or put under pressure to participate. Furthermore, I have not been offered any reward in cash or any kind for my participation. I confirm that my participation is voluntary.

I authorize the researcher to use at his discretion the data collected in the course of the study for the purpose of writing the report of this research.

I will be provided with a copy of this consent form and the researcher will keep the original in a safe place.

I have read this information and hereby volunteer to participate in this study.

Signed at:.....(Place) on .....(Date)

.....

Participant’s signature

.....

Witness’s signature

.....

Researcher’s name

.....

Signature

.....

Date

**ANNEXURE E**

**Interview guide for In-depth personal interview with 18 Deputy  
Directors**

**ANNEXURE E****INTERVIEW GUIDE (for HAST Deputy Directors)**

No.	District/Province	Years of experience specifically in the HAST field

Questions that will probe the discussions:

1. What are the communication strategies that are currently being used in the province to specifically address the burden of diseases in terms of HAST?

2. What are the strengths and weaknesses of the above mentioned strategies?

3. Is it important for the province to have a communication strategy to specifically address the burden of diseases in terms of HAST? And why?

4. What are, according to you, the main elements to be included in a specific communication strategy and why?



**ANNEXURE F**

**Interview guide for focus group interview with community members**

## **ANNEXURE F**

### **FOCUS GROUP INTERVIEW GUIDE (for Capricorn District AIDS Council members – Civil society members)**

Questions that will probe the discussions:

1. What are your views on general health status in Limpopo Province?
2. Perception about HIV, AIDS & STIs and TB (HAST)
  - How do you feel about the available services HAST diseases?
3. What are the communication strategies that are currently being used in the province to specifically address the burden of diseases in terms of HAST?
4. Are strategies accommodating all target groups such as disabled, youth and the elderly? Are these strategies cost effective?
5. How do the existing assisting in behaviour change?
6. How do you view your capacity in relation to changing the behaviour?
7. Any capacity to sustain the changed behaviour? Any support for sustainability?
8. What are the attitudes of people towards people infected and affected with HAST? Explain why you respond in this way.

**ANNEXURE G**

**Interview guide for Pilot study**

## ANNEXURE G

# PILOT STUDY GUIDE (FOR CAPRICORN DISTRICT HAST TEAM)

### WHAT TO DO:

1. Read the draft HAST Communication strategy attached.
2. Implement it in your district were you see it fit with your daily work.
3. Always check if is understood, user friendly, easy to use by community members and health workers.
4. If is acceptable, relevant, feasible and accessible.
5. Availability of resources and Health system.
6. Feasibility and acceptability of strategies and information contained in the draft communication.
7. At the end of August I will provide you with the evaluation form or as a team we will fill the evaluation form together.

**ANNEXURE H**

**Interview guide for HAST Directors**

## **ANNEXURE H**

### **PERSONAL INTERVIEW GUIDE (for HAST DIRECTORS)**

Questions that will probe the discussions:

1. Did you manage to go through the HAST Communication strategy framework?
2. According to you how do you see the HAST Communication strategy and its implementation, is it acceptable? Feasible? And relevant?
3. How is the relevance of the monitoring process and evaluation criteria embedded in the strategy?
4. Will you recommend it to be utilised by health professional and non-health professionals in our health facilities?
5. Any inputs?

**ANNEXURE I**

**Master thematic table by co-coder for In-depth personal interviews  
for 18 Deputy Directors**

# ANNEXURE I

## Master Thematic Table

Main Theme	Sub-Theme	Code	Transcript Reference
1) Demographics	i) Location/District	Caprica = 1	T1.1,
		Waterberg = 2	T8.1,
		Unknown = 3	
		Unknown = 4	
		Unknown = 5	
	ii) Work Experience	1 = (0-2 years) - <a href="#">Beginning</a>	
		2 = (3-4 years) - <a href="#">Intermediate</a>	
		3 = (5-10 years) - <a href="#">Management</a>	T1.1, T2.1, T3.1, T6.1, T11.1,
		4 = (11-15 years) - <a href="#">Senior/Upper Management</a>	T4.1, T7.1, T8.1, T9.1, T12.1, T13.1, T14.1, T15.1, T17.1, T18.1
		5 = (>15+ years) - <a href="#">Executive</a>	T5.1, T10.1, T16.1,

### Key Notes:

- Table includes Main Themes, Sub-themes and Transcript Comments or notes to support themes
- Code classification for “work experience – beginning, intermediate, management, senior/upper management, executive etc., can be changed by researcher to suit analysis and explanation
- Transcript Reference reads as follows: T1.1, = transcript 1. Page1; T1.2 = transcript 1.page 2; T1.3 = transcript 1.page 3 etc

Main Theme Code	Sub-Theme Code	Transcript Comment	Transcript Reference
<b>1. Communication Strategy</b>			
Current Strategy	Assertive Outreach	<b>Door-to-door campaign</b> - awareness campaign by professionals and HCBC (TB/HIV); distribution of departmental newsletter,	T1.1,T2.1,T5.1,T6.1,T7.1,T8.1 T11.1,T12.1,T13.1,T14.1, T17.1
		<b>Community campaign</b> - community dialogue/meeting with leaders; information cascade from organization or department-to-community dialogues, church gatherings information sharing	T1.1,T3.1,T4.1,T5.1,T6.1,T8.1 T9.1, T13.1,T14.1,T16.1,
		<b>Focus group discussions</b> - provides in-depth information; church and event gatherings	T8.1,
	Marketing and Mass Media	<b>Mass media channels</b> - TV, Radio, Billboards, Posters, Banners, IEC materials, brochures, flyers, pamphlets, dept newsletter, newspaper,	T1.1, T2.1, T3.1, T4.1, T5.1, T6.1, T7.1, T8.1, T9.1, T10.1, T11.1, T12.1, T13.1, T14.1, T15.1, T16.1, T17.1, T18.1
		<b>Calendar Events</b> - Meetings, Conferences, Indaba's, Imbizo's, Public/World day celebration, Health talks, Road shows	T2.1,T3.1,T4.1, T5.1,T8.1,T9.1, T11.1, T12.1,T13.1, T14.1,T16.1, ,T18.1,
		<b>Promotional Branding Materials</b> -cups, T-shirts, pencils, rulers, caps, bags bottles, Lunch boxes, notepads, key holders, Stickers, Pins, calendars; branding on taxi's and buses etc	T5.1,T8.1,T9.1, T10.1, T11.1, T13.1,T15.1,T17.1, T18.1,
		<b>Entertainment and dramatic art</b> - Communicate through drama's and other acting performance	T2.1,T3.1
	Training and Research	<b>Professional /Technical Health Training</b> - case findings, in-service education to health professionals, health education	T5.1,T6.1,T8.1, T13.1,T14.1
	Stakeholder/Partner/Donor involvement	<b>Civil structure or society</b> - Ngo's involvement, community / traditional leaders and relevant stakeholder involvement.	T1.1,T2.1,T4.1,T8.1
Strategy Strengths	Information Dissemination and Reaction	<b>Marketing/Mass media and Calendar Events</b> - quick diffusion of information, team work, reach large and specific target groups and communities; those who read have enough time to react; fancy approach that gets message or multiple messages to people, long term message on promotional materials, movement of transport to areas where needed with message, the illiterate can be reached through radio, awareness for employees through department newsletters, user-friendly marketing tools,	T2.1, T3.1, T4.1, T5.1, T6.1, T7.1, T8.1, T9.1, T10.1, T11.1, T12.1, T13.1, T14.1, T15.1, T16.1, T17.1, T18.1,

		<b>Door-to-door</b> - ensures direct contact, address people one-on-one, reaching individuals, opportunity to clarify issues or information or on policies, strengthening partner and community relations	T2.1, T5.1, T6.1, T8.1, T13.1, T14.1,
		<b>Language Effect</b> - different language information reaches people in rural or urban areas, different radio stations reaches all language groups,	T6.1, T12.1, T15.1, T18.1,
		<b>Community involvement and empowerment</b> - reaching out to the community on at home basis, strengthens relationships, improves openness and confidence,	T1.1, T14.1, T18.1,
	<b>Treatment and Support / Behavior change</b>	<b>Diagnostic or get to know status</b> - tests for other related conditions e.g. diabetes & hypertension; de-stigmatization, acceptance without discrimination, stimulates change to join support groups, adhere to treatment, reduce infection - morbidity and mortality rates from HIV, TB, and AIDS with healthy behavior	T11.1,
	<b>Capacity building and development</b>	<b>Staff development</b> - enhanced learning or training with much clarity; correlation between theory and practice enhanced, trained healthcare providers,	T2.1, T17.1
	<b>Stakeholder/Partner/ Donor involvement</b>	Availability of NGO' and partners for support; Good strategy brings in high funding support, but some activities or strategies don't need funds; political support,	T1.1, T9.1, T17.1
	<b>Enhanced M&amp;E</b>	Encourages follow-ups	T6.1,
<b>Strategy Weakness</b>	<b>Obstructive communication</b>	<b>Dissemination</b> - Too much causes confusion, costly or not cost effective to disseminate information, or organize events & trainings; shortage of IEC material; info not easily accessible, time consuming to reach target audience; complex information difficult to read or understand; some people just collect brochures and pamphlets because its free but don't read it at all, and some forget to read; multi-tasking affects message assimilation or causes unpaid attention to message; no information material in brail language; some spread out-dated information, deep rural communities fail to access communication strategy on billboards;	T4.1, T5.1, T8.1, T10.1, T11.1, T12.1, T14.1, T15.1, T18.1

		<b>Mass media</b> - expensive and not cost effective, time consuming, as such some posters or billboard too busy with crowded information; door-to-door done less frequently or once after a long time, people forget to read, most people or target audience don't have radio or don't listen to radio; no culture of reading, its challenging and some don't read; information does not reach all target at the same time, with indabas only limited people can be reached,	T3.1, T4.1, T5.1, T6.1, T7.1, T8.1 T11.1, T12.1, T15.1, T18.1,
		<b>Demographic target and gender involvement</b> - not possible to reach everyone; some groups are not reached or get excluded; men rarely participate in awareness campaigns,	T3.1, T5.1, T11.1, T13.1, T16.1,
		<b>Calendar Events</b> - Easily downgraded to traditional event and loses essence; with indaba's only limited number of people can sometimes be reached, poor attendance by community members,	T8.1,
		<b>Language barrier</b> - most information in English and not in local languages hence many people cannot be reached; no language or sign language translator; most posters, brochures, and pamphlets are not available in official and non-official local languages	T3.1, T4.1, T6.1, T8.1, T9.1, T10.1, T15.1, T16.1, T17.1,
	<b>Resource constraint/ shortage/inadequacy</b>	<b>Constraints</b> - fewer staff/team members vs. workload hinders progress; budget constraints/poor funding hinders effective implementation; lack of transportation; expensive to evaluate sometimes; campaigns can be very expensive; insufficient information material to distribute; vandalizing of billboard;	T1.1, T6.1, T7.1, T9.1, T14.1, T17.1
	<b>Policy change</b>	Occurs frequently and affects implementation	T2.1
	<b>Lack of M &amp; E</b>	No follow-ups or continuity	T4.1, T6.1
	<b>Behavior change hindrance</b>	Continued discrimination, marginalization and stigma post knowing status; people don't believe the disease exists, people reluctant to talk about HIV and TB,	T8.1,
	<b>Location / Seasonal constraint</b>	Rural areas - persons living in very rural areas are difficult to reach; rainy season are more difficult to work as well, posters not easily sustained,	T18.1,

<b>Main Theme Code</b>	<b>Sub-Theme Code</b>	<b>Transcript Comment</b>	<b>Transcript Reference</b>
<b>2. Relevance of HAST Communication</b>	<b>Addresses specific HAST and Target needs</b>	Reach people according to their needs, holistic approach to HAST activities, gives direction to program and district and message type to share; everyone will refer to the same document distributed to all facilities, rapidly spread message and reach set goals and target population, communities, individuals, groups etc., focus on HAST programs outlining objectives and specific activities, HAST directorate to address specific challenges for TB/HIV and STI in detail, communicate effectively using relevant strategy and relevant channels, Communities and HCW's are better informed of the burden of HAST disease, provides information on target and demographics; the strategies help to maximize awareness in communities; address age related messages; address specific community needs; addresses challenges	T1.2, T3.2, T5.2, T7.2, T9.2, T10.2, T11.2, T12.2, T13.2, T14.2, T15.2, T16.2, T17.2,
	<b>Sensitization and Treatment</b>	Sensitizes people about infection (HIV & TB) and serious it is; meets target needs; services and preventive measures available; to interact and understand the infection; more information and knowledge results in preventive behavior; classification of information as per burden per area, disease treatment by HAST staff, advice the community to take precautionary measures to keep themselves free from HIV and TB.	T2.2, T8.2, T12.2, T13.2, T16.2
	<b>Research &amp; Capacity Building</b>	New treatment and preventive approaches can be developed; required for health workers, promotes capacity building of health workers /advisors,	T2.2, T13.2
	<b>Stakeholder Involvement</b>	Will be achieved with standard communication strategy, different stakeholders need different communication strategy documented according to their needs,	T4.2,T18.2
	<b>M &amp; E purpose</b>	A roadmap, it gives clear direction and opportunity for evaluation – improvement, you see which strategy is working and which is not and how best to improve it.	T6.2,

Main Theme Code	Sub-Theme Code	Transcript Comment	Transcript Reference
<b>3. Main Elements of Communication</b>	<b>Background to strategy Goals/Objectives/ Type or Approach etc.</b>	<b>Strategy document/outline</b> - Summary, acronyms and definition of terms, table of content, introduction, aims & objectives, background, type of strategy or strategies to use to address targets and challenges, purpose of strategy, guiding principles, term of reference, advantages and disadvantages of strategies; channel/method/media of communication, stakeholder role, summary and conclusion, and references; acknowledgements or partners and contributors. Technical format ensures integrity and credibility, ease of review, follow-up and reference. Must contain elements from the general strategy of the province. For research and policy development purpose; Information on type of strategy or strategies; targets; terms of reference etc. Such collated and outlined information enables program to reach stated and planned goals, & set targets; guides implementation	T1.2, T3.2, T4.2, T5.2, T6.2, T9.2 T11.2, T12.2, T14.2, T15.2, T16.2 T17.2
	<b>Target / Audience</b>	<b>Demographics</b> - Reach set target, and different target groups or specific target groups including communities, different age groups, the disabled, and various economic work groups such as miners, farm workers, the youth etc., involve men to buy-in for support and behavior change;	T2.2, T3.2, T4.2, T10.2, T12.2, T13.2, T14.2, T15.2,
	<b>Strategy and Activities</b>	<b>Disease Profiling</b> - helps integrate HIV/AIDS/TB information with existing healthcare information; activities that define and address challenges and needs with relevance; uses different approaches to create awareness, to reach different target audience; affected group should be knowledgeable as the infected for support,	T1.2, T2.2, T5.2, T7.2, T13.2,
		<b>Prevention, Diagnosis and Treatment Support</b> - enables people to test and know their HIV & TB status; motivate and encourage TB patients to complete treatment and also get partners and family to screen for TB / HIV; adherence to all treatment; provide simple information on signs and symptoms, disease prevention, with open and compulsory treatment to infected and non-infected partners. E.g. pregnant women and unborn babies; helps individuals, groups, communities to take responsibility of their own health; give information on nearest facilities to go to for help	T2.2, T7.2, T8.2, T9.2, T10.2, T12.2, T13.2, T18.2
	<b>Communication Channels</b>	<b>Marketing</b> - mass media information presentation and dissemination approach be suitable for all or specific target audience and age group; use of simple booklet and pamphlet with clarity and understanding; non-infected person be knowledgeable as the infected person for better support	T2.2, T3.2, T5.2, T9.1, T12.2, T14.2,

		<b>Language</b> - information in all official local languages so people can understand, and many people can understand and can be reached, address different communities in their mother tongue,	T4.2, T5.2, T10.2, T14.2, T17.2,
	<b>Management, Stakeholders &amp; Partners role</b>	<b>Ensures who does what</b> - including staff, stakeholders, Partners, donors, TORC, HAST management, etc., management establishes mandates to address and upscale service deliver indicators; use of multi-sectoral approach to include all stakeholders, partners, donors etc., as good strategy brings in funding support;	T11.2, T12.2, T13.2,
	<b>Resources and Budget</b>	internal and external funds for implementing strategy	T13.2
	<b>M &amp; E</b>	ensure activities are in line with set goals and objectives; assess impact and effectiveness with regards to behavior change; identify gaps and apply corrective/remedial action; reflect on previous years, monitor and evaluate progress, impact analysis to see if strategy is changing the behavior of communities towards healthy living	T1.2, T4.2, T5.2, T6.2, T15.2, T17.2, T18.2
	<b>Research, Policy, Capacity Building and Development</b>	New findings a per research results, training can be curriculum focused at technical and university training level for up-to-date nursing or medical staff training; research, policy and human rights related	T2.2, T13.2, T18.2
	<b>Why these elements</b>	To ensure integrity and credibility, easy to follow and implement, easy to review for future reference, will ensure relevance and understanding of messages, to reach many people, a framework that will guide the strategy document as a reference guide, to integrate and collaborate on strategy,	T4.2, T6.2, T14.2, T15.2, T18.2

Main Theme Code	Sub-Theme Code	Transcript Comment	Transcript Reference
4. Factors Influencing and Promoting SUCCESSFUL Communication Strategy	Implementing Strategy and Activities	<b>Strategy Goal</b> - simple, attainable, available strategy; must be made available and accessible to facilities and all people, smart and simple content, addresses all demographic groups and information made available as such	T5.3, T6.3, T7.3, T8.3, T13.3, T14.3, T15.3, T16.3, T18.3
		<b>Event Partnering</b> - partner with various events or piggy-back other events to bring in and disseminate information	T12.3
		<b>Language</b> - use of both written and verbal information in all official languages including Braille which allows information dissemination to reach all target audience; use of appropriate language structure and level so information is easily accessible and understood by all groups; added sign language for the disabled is important	T2.3, T3.3, T5.3, T6.3, T8.3, T9.3 T11.3, T14.3, T15.3
		<b>Marketing, Information message and dissemination</b> - tailor made messages for communities, well designed easy-to-read, smart, simple, and understandable content in accessible convenient form such as a pamphlet, mini brochure or booklet; disseminate correct and appropriate message to create awareness; timing of message, tailor message down for each target and must be relevant, simple, clear, understandable etc., promotes, encourages and enhances resource and information utilization; information made available electronically on website; information must address existing problems and needs	T1.3, T2.3, T3.3, T4.3, T7.3, T9.3 T11.3, T12.3, T13.3, T14.3, T16.3
		<b>Teacher</b> - traditional, academic/professional etc., that disseminates information to the community or target audience is very important – e.g. some tribes and communities still respect traditional leaders to talk to them on any sensitive issues	T2.3
		<b>Family and Community Involvement</b> – knowledge of an addressing community needs; to openly talk about infection and prevention; allows individuals, groups, communities, families to take responsibility on preventive and treatment measures	T1.3, T2.3
	Management	<b>Support and Approval</b> - critical to have management commitment/support or buy-in into developing and implementation of strategy every step of the way; coordination of strategy; standardization of implementation process for uniformity, more resources available with commitment,	T10.3, T12.3, T17.3, T18.3

	<b>Relevant stakeholder / Donor / Partner Involvement</b>	<b>Support</b> – political commitment and buy-in support, participation and involvement of relevant stakeholders, support of strategy and activities; multi-sectoral approach to implementation, political commitment,	T1.3, T4.3, T6.3, T10.3, T12.3, T13.3, T17.3,
	<b>Funding Resources, Capacity Building and Development</b>	<b>Effective and Efficient implementation</b> – availability of resources aids effective planning and implementation of strategies/activities; funds procurement and printing of materials; funds translation of vital documents	T1.3, T5.3, T6.3, T9.3, T10.3, T11.3, T12.3, T15.3, T17.3
	<b>M&amp;E Implementation</b>	<b>Feedback</b> - provides feedback on achievement and impact; information on adherence to planned strategy, activity deadlines or time frames; promotes behavior modification; results in further planning based on needs, challenges/problems and response to strategic plans	T4.3, T6.3, T11.3, T13.3, T18.3

Main Theme Code	Sub-Theme Code	Transcript Comment	Transcript Reference
5. Factors Influencing and Hindering Successful communication Strategy	Poor Implementing Strategy and Activities	<b>Ambiguous goals and objectives</b> - Unrealistic and not so smart goals; isolated and not integrated strategy, complex and complicated results in failed programs; lack of a good strategy in place; planned strategy not available or accessible; complex or complicated and difficult to implement strategy, lack of knowledge of implementers, goals and objectives not met,	T1.3, T3.3, T5.3, T8.3, T12.3, T13.3, T15.3, T16.3, T18.3
		<b>Target and Gender Involvement</b> - strategy NOT address all demographic groups with information made available to all groups: when men are not involved they don't see HIV as their problem or even source of infection; low prevention measures used	T2.3, T3.3,
		<b>Marketing, Poor Communication, Language Barrier</b> - mass media in areas lacking TV, radio, billboards etc., affects communication and dissemination impact; information informants like traditional healers preach a different thing from what they hear in workshops; lack of written and verbal information in all official languages DOES NOT allow information dissemination to reach all target audience (e.g. no information in brail language); the illiterate and disabled does not have access to vital information due lack of appropriate communication barriers; timing is important in transmitting or disseminating information (e.g. working parents get information best in the evening when at home versus when at work). -low accessibility to information results in low use of that information, quality compounded by quantity	T2.3, T3.3, T4.3, T5.3, T6.3, T7.3 T8.3, T9.3, T11.3, T12.3, T14.3, T15.3, T16.3, T18.3
		<b>Values and Trust</b> - when leaders and models don't walk the talk, and people imitate what prominent leaders and models wrongly do or stand for;	T2.3,
	Non-Stakeholder Involvement	<b>Low funding or none</b> - no commitment from left out stakeholders; effective communication to help target groups that need it; partners and donors needed as government cannot work in isolation, no political commitment or buy-in,	T1.3, T4.3, T9.3, T10.3, T15.3

	<b>Poor Management support</b>	No support from senior management and political heads, poor management or supervision of strategies; strategy NOT supported or very politicized and played out; no buy-in, uncoordinated strategy and implementation process; individualized process rather than collective	T10.3, T12.3, T15.3, T17.3, T18.3
	<b>Lack of adequate resources and Funding</b>	poor and ineffective implementation or failure to implement strategy as planned; low or no funding causes inaccessibility to appropriate information; impacts achieving goals/objective and target, no funds to develop strategy document	T1.3, T5.3, T6.3, T7.3, T9.3, T10.3, T11.3, T12.3, T15.3, T17.3
	<b>Absence of M&amp;E</b>	impacts and effects unknown; failure to provide to do M&E and get constant feedback to all supporting stakeholders/donors/partners	T1.3, T4.3, T6.3, T13.3,

**ANNEXURE J**

**General overall data coding by co-coders for In-depth personal interviews for 18 Deputy Directors**

## ANNEXURE J

### General overall data coding by co-coder for In-depth personal interview for 18 Deputy Directors

#### Qualitative Data Coding

##### Main Themes (Overall or General Preliminary Coding)

- 1) Demographics
  - 1 - Location or District
  - 2 - Years of Experience at HAST
- 2) Communication Strategies
  - 1 - Strengths / Promotional Strategies
  - 2 - Weaknesses / Hindering Strategies
- 3) HAST (HIV, AIDS, STI, & TB) Communication Strategy / Strategies and WHY
- 4) Elements of Communication Strategies
  - 1 - Promoting Elements / Factors to Strategy Success
  - 2 - Hindering Elements / Factors to Strategy Failure

#### Notes:

- **Thematic Analysis Framework Approach with Inductive coding** is used to clearly distinguish themes (main theme, sub-themes, reference source etc.) Inductive coding refers to coding generated and done after examining data, its content and use
- **18 transcripts or questionnaire response** were coded
- **Analysis** - quantitative statistical analysis is not applicable but the frequency of responses also called **Quantitative/Quasi-Statistics** which refers to count numbers of events / mentionings mainly used to support themes or categories, can be quantified if need be in simple percentage terms, and these can be tabulated. However, qualitative descriptive analysis are best used to quantify information using words like 'most', 'some', 'few', etc.
- **Responses** - Some respondents did not seem to have understood the questions correctly, as such some answers were much vague, yet coded as best as possible. Not every piece of information was coded as some were overlap and categorized appropriately
- **Demographic (District** - not indicated on some respondent questionnaire, therefore will have to be checked out again or follow-up to get that information. Data cannot be reviewed or analyzed by **District** because of this missing information.

## ANNEXURE J

Main Theme / Q.no	General / Preliminary Coding (Table 1) Sub-Theme	Response Frequency
Location / District	1 -Capricorn	
	2 - Mopani	1
	3 - Sekhukhune	1
	4 - Vhembe	
	5 - Waterberg	1
	6- Province	
Work Experience @ HAST	1 - (0-2 years) Beginning	
	2 - (3-4 years) Intermediate	
	3 - (5-10 years) Management	1+1+1+1+1
	4 - (10-15 years) Upper Management	1+1+1+1+1+1+1+1+1+1
	5 - (15+ years) Executive	1+1+1
Communication Strategies	1 - Door-to-door campaign (awareness campaign by professionals and HCBC; distribution of departmental newsletter, reaching individuals	1+1+1+1+1+1+1+1+1
	2 - Mass media (TV, Radio, Electronic or Print - IEC materials, newspaper, Flyers, Posters, Billboards, Banners ; Mass campaigns in accordance with national health calendar etc)	1+1+1+1+1+1+1+1+1+1+1+1+1+1+1
	3 - Calendar meetings and events (Conferences, workshops, Indabas, Imbizo's etc.)	1+1+1+1+1+1+1+1+1+1+1+1+1+1+1
	4 - Public or World Day celebration (World Aids Day, World TB day used for awareness campaigns)	1
	5 - Entertainment (Communicate through drama's and other acting performance)	1+1+1
	6 - Promotional branding (with HAST messages, T-shirts, rulers, pencils, books, note pads, bags, squeeze water bottles, caps, key holders, cups, lunch boxes, branding on commercial vehicles - taxi's and buses)	1+1+1+1+1+1+1+1+1+1
	7 - Trainings (In-service, Professional and Technical Health trainings)	1+1+1+1+1+1
	8 - Research (Intensified case findings and HTC; )	
	9 - Focus group discussions (provides in-depth information; church and event gatherings;	1+1+1
	10 - Community focused campaign (community dialogue; direct communication cascade from organization to community; from department-to-community dialogues)	1+1+1+1+1+1+1+1
	11 - Stakeholder involvement (Government, NGO's, Philanthropist etc)	1+

Main Theme/Q.no	General / Preliminary Coding (Table 2) Sub-Theme	Response Frequency
Communication Strategy Strengths	1 - Marketing and mass media dissemination (Quick diffusion of information; large target groups, communities, quick professional and technical update and interaction attained; information on specific topics reaches mass target and specific groups; )	1+1+1+1+1+1++ 1+1+1+1+1+1+1 +1+1+1+1
	2 - One-on-one or door-to-door communication (ensures direct contact; effectively addresses problems; encourages follow-ups; opportunity to clarify issues or information; strengthening of partner and community inter-relationships)	1+1+1+1+1+1+1
	3 - Behavior change (de-stigmatization and acceptance without discrimination, stimulates change to join support groups, adhere to treatment, reduce infection – morbidity and mortality rates with from HIV, TB, and AIDS with healthy behavior)	1+1
	4 - Diagnostic status (Get to know status, tests for other related conditions e.g. diabetes & hypertension;	1
	5 - Stakeholder /Donor/ Partner support (good strategy brings in high funding support;	1+1+1
	6 - Language Effect and Reaching Target (multi-language use results in reaching people at all levels, in any area whether rural or urban;	1+1+1+1+1
	7 - Community involvement and empowerment (convey information at home level daily;	1+1
	8 - Staff development (enhanced learning or training with much clarity; correlation between theory and practice enhanced;	1+1
	9 – Enhanced M&E – encourages follow-up	1

Main Theme/Q.no	General / Preliminary Coding (Table 3) Sub-Theme	Response Frequency
Communication Strategy Weaknesses	1 - Information dissemination (Too much causes confusion, costly to disseminate or organize events & trainings; shortage of IEC material; time consuming to reach target audience; complex information difficult to read or understand; some people just collect brochures and pamphlets because its free but don't read it at all, and some forget to read; multi-tasking affects message assimilation or causes unpaid attention to message; no information material in brail language;	1+1+1+1+1+1+1+1+1
	2 - Mass media (expensive and not cost effective; some posters or billboard too busy with crowded information; most people or target audience don't have radio or don't listen to radio; some don't read; information does not reach all target at the same time;	1+1+1+1+1+1+1+1+1+1+1
	3 - Demographic target (some groups are not reached or get excluded;	1+1
	4 - Policy change (occurs frequently and affects implementation	1
	5 - Gender involvement (men rarely participate in awareness campaigns	1
	6 - Behavior Effect (continued discrimination, marginalization and stigma post knowing status; people don't believe the disease exists;	1
	7 - Resource constraints /shortage / inadequacy (fewer staff vs. workload that hinders progress; poor funding hinders effective implementation; lack of transportation to reach target areas; expensive to evaluate sometimes; campaigns can be very expensive; insufficient information material to distribute)	1+1+1+1+1+1+1+1+1+1
	8 - Language barrier (most information not in local languages hence many people cannot be reached; no language or sign language translator; most posters, brochures, and pamphlets are not available in official and non-official local languages	1+1+1+1+1+1+1+1+1
	9 - Lack of M&E (No follow-ups or continuity;	1+1
	10 - Calendar Events (Easily downgraded to traditional event and loose Essence; with indaba's only limited number of people can sometimes be reached)	1+1
	11 – Location and Seasonal constraints (persons living in very rural areas are difficult to reach; rainy season are more difficult to work as well)	1+1

Main Theme/Q.no	General / Preliminary Coding (Table 4) Sub-Theme	Response Frequency
HAST communication Strategy /strategies? Why?	1 - Effective Communication (gives direction to program and district; achieve set goals and reach target population, communities, individuals, groups etc. HCW's are better informed to reach target communities)	1+1+1+1+1+1+1+1+1
	2 - Information dissemination and sensitization (sensitizes people about infection - HIV & TB; meets target needs; services and preventive measures available; to interact and understand the infection;	1+1+1+1+1+1
	3 - Addresses specific HAST and group needs (provides age related messages; address specific community needs; addresses challenges)	1+1+1+1+1+1+1+1
	4 - Infection incidence reduction (more information and knowledge results in preventive behavior; classification of disease burden per area, disease treatment by HAST staff)	1+1+1
	5 - Research purpose (provides information on target and demographics; so new treatment and preventive approaches can be developed;	1
	6 - Capacity building (required for health workers)	1+1
	7 - M & E purpose (A roadmap or direction to improvement;	1

Main Theme/Q.no	General / Preliminary Coding (Table 5) Sub-Theme	Response Frequency
MAIN ELEMENTS to include in communication strategy	1 - Strategy Goals/Objectives / Target and Activities (Summary, acknowledgements or partners and contributors, acronyms and definition of terms, table of content, introduction, aims & objectives, background, type of strategy or strategies, advantages and disadvantages of strategies; stakeholder role, summary and conclusion, and references). Technical format ensures integrity and credibility, ease of review, follow-up and reference. For research and policy development purpose; Information on type of strategy or strategies; targets; terms of reference etc. Such collated and outlined information enables program to reach stated and planned goals, & set targets; guides implementation; activities that define and address challenges and needs with relevance; uses different approaches to reach different target audience; )	1+1+1+1+1+1 +1+1+1+1+1 +1+1+1+1
	2 - Demographics (design information on different target groups or specific target groups including communities, different age groups, the disabled, and various economic work groups etc., involve men for support and behavior change;	1+1+1+1+1+1
	3 - Disease Profiling (helps integrate HIV/AIDS/TB information with existing healthcare information;	1+1+1+1+1+1
	4 - Management (ensures who does what including staff, stakeholders, Partners, donors, TORC, HAST management, etc., management establishes mandates to address and upscale service deliver indicators;	1+1+1+1
	5 - Marketing (Mass media information presentation and dissemination approach be suitable for all or specific target audience and age group; use of simple booklet and pamphlet with clarity and understanding; non-infected; person be knowledgeable as the infected person for better support;	1+1+1+1
	6 - Language (information in all official local languages so people can understand, and many people can be reached	1+1+1+1
	7 - Prevention, Diagnosis and Treatment approach (enables people to test and know their HIV & TB status; motivate and encourage TB patients to complete treatment and also get partners and family to screen for TB / HIV; adherence to all treatment; provide simple information on signs and symptoms, disease prevention, with open and compulsory treatment to infected and non-infected partners. E.g. pregnant women and unborn babies; helps individuals, groups, communities to take responsibility of their own health; give information on nearest facilities to go to for help;	1+1+1+1+1+1 +1
	8 - M&E of strategy (to ensure activities are in line with set goals and objectives; assess impact and effectiveness with regards to behavior change; identify gaps and apply remedial action; reflect on previous years)	1+1+1+1+1+1
	9 - Resource availability (internal and external funds for implementing strategy	1
	10 - Human resource development and capacity building (training can be curriculum focused at technical and university training level for up-to-date nursing or medical staff training;	1+1+1+1
	11 - Stakeholder /Donor/ Partner support (use of multi-sectoral approach to	1

	include all stakeholders, partners, donors etc., as good strategy brings in funding support;	
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Main Theme / Q no.	General / Preliminary Coding (Table 7) Sub-Theme	Response Frequency
Contributing factors to FAILING communication strategy	1 - Non-integrated, ambiguous goals and objectives (results in failed programs; lack of a good strategy in place; poor management or supervision of strategies; unavailability of planned strategy; complex or complicated and difficult to implement strategy;	1+1+1+1+1+1
	2 - Target and Gender Involvement (strategy NOT address all demographic groups with information made available to all groups; when men are not involved they don't see HIV as their problem or even source of infection; low prevention measures used	1+1
	3 - Poor communication, Language and barrier (mass media in areas lacking TV, radio, billboards etc affects communication and dissemination impact; lack of written and verbal information in all official languages DOES NOT allow information dissemination to reach all target audience; the illiterate and disabled does not have access to vital information due lack of appropriate communication barriers; timing is important in transmitting or disseminating information - working parents get information best in the evening when at home versus when at work. Inaccurate information or information distortion - what is heard is not what that is repeated or conveyed to audiences; presentation of irrelevant information causes reluctance to read; complex information not understandable -low accessibility to information results in low use of that information	1+1+1+1+1+1+1 +1+1+1+1+1+1+1 1+1+1+1+1
	4 - Moral Values and broken trust (when leaders and models don't walk the talk, and people imitate what prominent leaders and models wrongly do or stand for;	1+1
	5 - Absence of M&E (impacts and effects unknown; failure to provide constant feedback to all supporting stakeholders/donors/partners;	1+1+1
	6 - Lack of adequate resources and funding (poor and ineffective Implementation or failure to implement strategy as planned; low or no funding causes inaccessibility to appropriate information; impacts achieving goals/objective and target;	1+1+1+1+1+1+1+1 +1+1
	7 - Non-Stakeholder Involvement (low funding or none hence no effective communication to help target groups that need it; partners and donors needed as government cannot work in isolation;	1+1+1+1+1
	8 - Poor Management support (strategy NOT supported or very politicized and played out; uncoordinated strategy and implementation process; individualized process rather than collective;	1+1+1



**ANNEXURE K**

**Data coding by researcher for In-depth personal interview for 18  
Deputy Directors**

## ANNEXURE K

### Data Coding

#### Participants Demographics

Number of Participants	Province or District	Years of Experience	Participated/not participated
1.1	Capricorn District	7yrs	Participated
1.2	Capricorn District	9yrs	Participated
2.1	Mopani District	13yrs	Participated
2.2	Mopani District	-	Not Participated
3.1	Sekhukhune District	7yrs	Participated
3.2	Sekhukhune District	16yrs	Participated
4.1	Vhembe District	9yrs	Participated
4.2	Vhembe District	11yrs	Participated
5.1	Waterberg District	13yrs	Participated
5.2	Waterberg District	14yrs	Participated
6.1	Province	25yrs	Participated
6.2	Province	5yrs	Participated
6.3	Province	13yrs	Participated
6.4	Province	15yrs	Participated
6.5	Province	11yrs	Participated
6.6	Province	11yrs	Participated
6.7	Province	17yrs	Participated
6.8	Province	11yrs	Participated
6.9	Province	14yrs	Participated

Summary: 18 participated out of 19 participants

Years of experience in HAST: 5 Minimum and 25 maximum

Topic	Theme	Sub- themes	Frequency
1. Current Communication Strategy in the province	Various Communication Strategy in the Province	<b>Media:</b> Radio slots, Print media,TV programmes	25
		<b>Campaigns:</b> Door to Door campaigns, Calender and mass HAST campaigns, Road shows	27
		<b>Community involvement</b> Community dialogues, Indaba, Imbizo, Drama, Churches gatherings,	24
		<b>Information ,Education and Communication material</b> Pamphlets, Posters Billboards, Promotional material in the form of T-shirts, rulers, key holders, Banners, Stickers, Branding of buses and Taxi,Flyers, Capacity building, Partners/Stakeholders, health talks, Health education.	64
2. The strength of the strategies	Strength of the communication strategies	<b>Affordability of the communication strategies:</b> Some strategies need no funding e.g	2

		<p>imbizos, church gathering, traditional leaders meetings, other method are cheap</p> <p><b>Reaching out to the community</b> : information spread easily, encourages interaction, contributed to behaviour change, joining support groups, Dramas entertains and inform, encourage treatment adherence, reduce stigma and discrimination, encourages know your status, reduce infection, Mass campaigns reach may at a time, many reached through billboards, radio slots, Door to door address people with specific problems, Different messages</p> <p><b>Language of the communication strategy</b>: local language to be used, simple language used</p> <p><b>Literacy level of the community</b>: IEC material reach those who can read and give messages</p> <p><b>Target audience</b>: Imbizo can reach specific target audience,</p> <p><b>Stakeholder involvement</b>: NGO, Partners, team work, political support</p> <p><b>Policies</b>: Chance to talk to policies</p> <p><b>Capacity building</b>: educating staff, correlating theory and practice</p>	<p>20</p> <p>3</p> <p>1</p> <p>1</p> <p>4</p> <p>1</p> <p>2</p>
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<p>3. The weaknesses of the communication strategy</p>	<p>Weaknesses of the communication strategy</p>	<p><b>Affordability of the communication strategies:</b> Lot of money consumed during mass campaigns, budget constrains, no radios, unavailability of material,</p> <p><b>Reaching out to the community:</b> To much information, calender event traditional people no longer listen to messages, Shortage of IEC material, community attend camapigns for meals, IEC not accessible, most of people do not listen to radio, iteraction not for all during community dialogues, mass campaaigns are time consuming, vandalism of billboards by community members, Deep rural disadvantaged, poor attendance during campaigns, men not participating</p> <p><b>Language of the communication strategy:</b> The deaf and dump marginalised, IEC not in local languages, , most material are written in English, no material in bail, health workers not using sign langauge</p> <p><b>Literacy level of the community:</b> Some people do not believe that infection exist, no culture of reading, those who can not read and write do not get the message, the message does nor reach all the people, lazy to read, posters not for the people who cannot read</p> <p><b>Target audience:</b> Not all target is reached especially youth, not reaching the elderly,</p> <p><b>Partners/ Stakeholders:</b> Labelling of HCB Carers as caring for HIV &amp; TB patients, shortage of staff team members, workload</p> <p><b>Policies:</b> Policies change frequently implementation difficult,</p> <p><b>Monitoring and Evaluation:</b> No followup after mass campaigns</p>	<p>12</p> <p>16</p> <p>10</p> <p>8</p> <p>2</p> <p>3</p> <p>1</p> <p>2</p>
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<p>4. The importance of the province to have communication strategy</p>	<p>Need for communication strategy</p>	<p><b>Prevention and awareness:</b> awareness and disease prevention, reduce new infection  <b>Research purpose:</b> for new developments  <b>Stakeholder involvement:</b> standardization of the strategy,  <b>Reaching people according to needs:</b> reaching people according to their needs, dealing with specific needs  <b>Effective communication using relevant strategies:</b> to communicate effectively, to reach set goals, address challenges  <b>Holistic approach to HAST activities:</b> indicating target and age groups, reach institution of higher learning  <b>It is a roadmap:</b> guidance and direction, for reference  <b>Capacity Building:</b> Health care workers get informed  <b>Monitoring and Evaluation:</b> ability to evaluate the work</p>	<p>6 1 2 7 4 3 4 2 1</p>
<p>5. The main element to be included in a specific communication strategy</p>	<p>The elements of inclusion</p>	<p><b>Table of Content</b>  <b>Foreword</b>  <b>Executive summary of the strategy:</b>  <b>Vision and Mission of the Department of Health:</b> to have common goal and objective  <b>Policies, protocols and mandates:</b> Assist to address needs and upscale service delivery indicators  <b>Acknowledgement</b>  <b>Acronyms and definition of concepts</b>  <b>INTRODUCTION</b>  <b>Background:</b> explaining the burden of HAST disease in the province, ensures relevancy of the message, the logic behind the development of the strategy  <b>Purpose:</b> purpose of the strategy, it ensures understanding of the message by audiences  <b>Guiding principles</b>  <b>Aim, Goal and Objectives:</b> to guide the implementation,  <b>Provincial Demographics:</b> to address age specifics  <b>At Risk population/key population:</b> specific message to address them,  <b>Trends/ disease profile:</b> compare the trends/ challenges of</p>	<p>4 1 1 1 2 2 2 5 1 2 6 1 2 2</p>

		<p>the previous year, to integrate HIV information,</p> <p><b>CONTENT</b></p> <p><b>Different approaches/Method of communication:</b> How to reach disabilities e.g brail for blinds, to reach key population e.g MSM, Miners, farm workers and youth</p> <p><b>Multi- sectoral approach:</b> involve relevant stakeholders</p> <p><b>Age groups, Target audience:</b> to reach different target audience</p> <p><b>Disability</b></p> <p><b>Local Languages:</b> written in local languages, understandable language</p> <p><b>National Calendar events:</b> celebrate the national calendar,</p> <p><b>Prevention of Diseases and Promote HCT and TB screening</b></p> <p><b>Capacity Building:</b> Human resource development, Research related</p> <p><b>Role Players:</b> HAST managers, Communicators, HOD and MEC of Department of Health,</p> <p><b>Treatment, care and support</b></p> <p><b>Human Rights</b></p> <p><b>Resources:</b> Availability of resource for implementation</p> <p><b>Summary</b></p> <p><b>References</b></p> <p><b>MONITORING AND EVALUATION</b></p> <p><b>Monitoring and evaluation and Impact analysis:</b> identify gaps and re-plan, to assess its effectiveness, to be reviewed periodically, to see if strategy is changing the behaviour of our community towards healthy living, monitor its implementation and evaluate progress</p>	<p>4</p> <p>3</p> <p>4</p> <p>1</p> <p>4</p> <p>6</p> <p>4</p> <p>4</p> <p>3</p> <p>2</p> <p>1</p> <p>3</p> <p>1</p> <p>4</p> <p>6</p>
6. Factors contributing to the success of the communication strategy	Feasibility of the communication strategy	<p><b>Information to all:</b> marketing, launching, popularisation, on Departmental website</p> <p><b>Language:</b> local languages, in brail, in different languages, in all official languages</p> <p><b>Leadership ownership:</b> Buy-in top management, Political commitment, traditional leadership</p> <p><b>Stakeholder Involvement:</b> Engaging all stakeholders, encouraging ownership,</p> <p><b>Resources availability:</b> funding availability</p> <p><b>Tailor made message:</b> for</p>	<p>13</p> <p>13</p> <p>6</p> <p>8</p> <p>8</p> <p>5</p>

		<p>community buy-in, uniformity, correct audience, to address the problem, to address all age groups, address the needs of the community</p> <p><b>Accessibility and Availability of the strategy:</b> to all, for referral purposes</p> <p><b>Content to be smart, simple and practical:</b> Coordinated</p> <p><b>Correct message disseminated:</b> People with knowledge to address the community</p> <p><b>Capacity building:</b> Human resource development</p> <p><b>Monitoring and Evaluation:</b> ensure compliance, to measure if targets are met, specific tool to evaluate the impact, feedback on the achievement</p>	<p>9</p> <p>4</p> <p>2</p> <p>1</p> <p>5</p>
7. Factors contributing to the failures of the communication strategy	Non – feasibility of the implementation of the communication strategy	<p><b>No funding/ insufficient fund:</b> it will be unavailable, no budget,</p> <p><b>No leadership by-in:</b> Leaders to be role models, no political commitment,</p> <p><b>Irrelevant messages:</b> By traditional healers irrespective of the workshop attended, not addressing all age groups, lack of knowledge by implementers, wrong timing, complex strategy, uncoordinated</p> <p><b>Poorly Marketed/ poorly communicated:</b> If not launched, not on the websites, poorly communicated</p> <p><b>Language barrier:</b> if only available in English, not in brail, not available in official languages, one language used,</p> <p><b>Unavailability of the communication strategy :</b> not known to the users</p> <p><b>Failure to review and monitor the strategy/Lack of M &amp; E:</b> failure to give feedback, no impact monitoring, failure to review and monitor, weak M&amp;E plan,</p> <p><b>Unrealistic goals:</b> contributing to failure of the strategy,</p> <p><b>Non- involvement of stakeholders:</b> no ownership, implementing strategy in isolation, one man show</p>	<p>9</p> <p>5</p> <p>8</p> <p>7</p> <p>7</p> <p>8</p> <p>10</p> <p>5</p> <p>1</p> <p>8</p>

**ANNEXURE L**

**Fields notes for focus group interview**

## ANNEXURE L

### **TITLE OF THE STUDY: THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV AND AIDS, STIs AND TB (HAST) IN THE LIMPOPO PROVINCE.**

#### **FIELD NOTES FOR FOCUS GROUP**

**27.11.2014**

Participant B (Men's Sector) talked about stigma, demarcated queues for consultation, male nurses shortages as men not free to give history. Training of males to be nurses, Men fear to expose- indirect disclosure- stigma ratio of personnel to clients.

Media- Media is minimal on media especially TV other than e.g. Amstel. No message except at clinic. Campaign at about two months not taking place at peripheral areas more in urban areas. Billboards- wiped off need to be renewed. Engage media especially newspapers and intensify campaigns. The community is not fearing HIV but concern about pregnancy due to information gap.

Messaging irrespective of the diversity of perception, give people time. Surprise visit to health facilities to observe what is happening is needed.

Participant A (Traditional Health Practitioner) – Addressing the issue of stigmatization, 24 hours service rendering by our clinics. Mention the fact that men have fear to be known by others. Adverts to be continuous in the media about HIV and TB.

Participant E (Religious sector) mentioned the first contact affect treatment due to fear of divulging secrets because of the professional attitude. Relationship with the clients is not good. This can be addressed through the EAP programmes to address such services which are not a favours of the clients. Continuous reminders of what is expected of health care professional.

There is some lax with messaging not as vigorous like before we are at the relaxation stage. Capacity for the community to change the behaviour is needed to fight the

epidemic. Training to be focused and well scheduled. We need to stay positive and never give up.

Participant D (Disability)- Access with regards to language, loss of sight as both can lose track of information. Needs interpretation from TV, and radio is better for the blind people.

Participant C (Older Persons) – Older persons not having the knowledge but more at risk because they are cares for the children and grand children. They need to be capacitated.

Participant A (Traditional Health Practitioner) – Family upbringing and family involvement in caring is very important. Families not encourage teenage pregnancies if teenager is pregnant no termination to be done as this as against the customs and our Africa culture.

Participant F (PLHIV) – Rollout of FDC is going well in our facilities. The secluded or isolated ART clinics services with special names shows discrimination and stigmatization through the isolated services which lead to indirect disclosure. Also we need to get ways of improving ways to disclose. Clinics to have updated information on HCT and pamphlets on the notice boards to be current. The HIV positive clients not to be forgotten on the information so that they can prevent infecting others and also be re-infected.

The Civil Society members were well represented by one from each sector as follows: Traditional leader (TL), Traditional Health Practitioner (THP), Men's Sector, Older Persons, People Living with HIV (PLHIV), Disability Sector, and Religious Sector.

CODES	NAME OF SECTOR
A	Traditional Health Practitioner (THP)
B	Men's Sector
C	Older Persons
D	Disability Sector
E	Religious Sector

F	PLHIV
G	Traditional Leader

**ANNEXURE M**

**Transcript for focus group interview**

**ANNEXURE M****TITLE OF THE STUDY: THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV and AIDS, STIs & TB (HAST) IN THE LIMPOPO PROVINCE**

KEY: R: RESEARCHER

RESP: RESPONDENT

TRANSCRIPTION	THEMES
<p>R: As I have just explained all what will be happening in this session and you have agreed to participate by signing the consent forms , let start with the focus group interview. What are your perception on health status...(long pause) ..in the Province in Capricorn District...(pause)..How do you see it? Or how is health status in general?</p> <p>Resp: Thank you. Health status...(pause)...we see it as promoting our communities, they promote our minds and they promote our health in general.</p>	G
<p>R: In other words are they assisting?</p> <p>Resp: Yes, they are assisting</p>	G
<p>R: How they are assisting?</p> <p>Resp: There are clinics in our communities in a walking distance were we can consult and hospitals were we are referred for further management. As community members we are satisfied with these services.</p>	G
<p>R: Others, how do you see it?</p> <p>Resp: We as disability sector they are not good for us. They are not accessible for the deaf and dumb. Counselors are unable to use sign language of people which for counseling they are unable to talk using sign language, this is a disadvantage.</p>	D
<p>R: Ok I get your point, could you kindly describe how they communicate with them?</p> <p>Resp: Those who are blind like us, you are just told that you have this type of disease without you seeing for yourself the results displayed. The disability sector is requesting that health need to promote accessibility.</p>	D

<p>R: What do you mean when you say accessibility can you explain?</p> <p>Resp: When talking about accessibility we mean communication for disabled people, like now you all have the meeting agenda before someone can read the agenda to them they can read for themselves and have an idea of what the meeting is about, but the blind person won't know anything about the meeting and is taking time to catch-up., you already know what is going on in the meeting. The person who is blind is easy to get lost and when addressing item 1 the meeting is already in item 4. when they ask questions is like they are disrupting the meeting, therefore there is a need for the blind people to have a background of what is going to be said in the meeting.</p>	D
<p>R: What do you suggest need to be done?</p> <p>Resp: We need to have the agenda written in brail so that we can be able to read like others.</p> <p>.R: How do you feel now?</p>	D
<p>Resp: We are lost as we will be waiting to hear from you what will be discussed in this meeting?</p> <p>R: Is understandable,</p>	D
<p>Resp: Yes about this health issues someone can say generally the state of health . .hmmm.. in a way has improved but there are still lot of things to be done e.g. if you look at the personnel working in the clinics and hospitals the main challenges is the attitude that you get ..hmmm.. when you talk about the provision of service that you need to be assisted with there is blockage at the reception .hmmm...We had an opportunity at Capricorn District AIDS Council to visit the tribal offices as part of the things that you listen to when you go around. People are afraid to go for HIV test due to lack of confidentiality, there is lot the government need to do to ensure that the state of health improves.</p> <p>Pause...</p>	E
<p>Resp: Hmmm..I am talking on behalf of the older persons, most of them does not understand health issues, for them to understand they need to learn from their children. (clear the throat)..If our children are affected we are the one assisting them. As older persons we need more education about the virus so that we can take care of our children.</p> <p>Pause...</p>	C

<p>Resp: Hmm.. when I see the health status in our province there is still stigma in the sense that there are different queues for pregnant women and those collecting Anti-retroviral treatment (ARV). While on queue to collect ARV, others already know that they are infected. How about having one common queue? The other challenge is the issue of lack of male nurses and mostly is female nurses in our clinics who are assisting them, and men are not free to explain their problems to female nurses.</p>	B
<p>R: Yes</p>	
<p>Resp: As a department we need to have the strategy to encourage males to join the nursing profession to enhance the health service so that men can be treated by male nurses. Sometimes they will say I cannot undress in front of this women is not my wife, actually the person need help but because of female nurse when he consult he change the subject/purpose of his visit and just say I have headache. If we can be able to address those things I think we can ascertain that the health status improves.</p>	B
<p>R: What could be done?</p>	
<p>Resp: To have enough male nurses so that male patients can be able to be seen by them and be able to talk freely.</p>	B
<p>R: Yes you talked about the nurses' attitude what you think needs to be done?</p>	
<p>Resp: Part of it I think ..hmmm.. in every institution there is time for refresher courses where people are taken through to be shown how people can relate to people with communities where they are staying. The issue of attitude does not have the remedy necessarily so because personnel come to work already stressed. Unfortunately when they arrived at work they are forgetting that the environment has changed so that problem do remain at their place/home. The work of your Employees Wellness Programme can assist in addressing their challenges. in helping people so that they can be able to open up to address. In this challenge. They have already mentioned that there is time when you go there you feel as if the nurse or somebody who is helping you is doing you a favor and is not that that you are doing anyone a favor just because I need help at the proper place because this person has been trained and she/he looked for the work so that they can provide the service. The refresher courses can assist personeel from time to time...time to time so that they can be reminded (pause) I think it can assist us to deal these issues.</p>	E

<p>R: Knodding;</p>	
<p>Resp: Exactly it will assist them to change their attitudes and behaviuor.</p> <p>R: We have already talked about the health issues in general, now we are going to HIV,AIDS ,STIs and TB(HAST). Are HAST programmes available? do you know about them in your communities? Do you normally hear about HAST issues</p>	E
<p>Resp: Hmm... rollout of Fixed Dose Combination (FDC) for instant of ARV when looking at Capricorn District is working well and as working with them (People Living with HIV) in the support groups all is well. The thing is that I have seen people been treated wrongly is that the others has talked about long queue, actually the ARV clinics are facilities with special names like: Phela o phedise, Amogelang etc--they are secluded at the back of the clinic buildings. To go there is the disclosure indirect so a person even if the clinic is closer nearby like at Mamabolo village the person would rather move to the furthest one because this one when you visit automatically people would realize your conditio</p>	F
<p>Resp: I think the issue they are talking about is very serious, I was talking to one of the Doctors the day before yesterday showing each other that someone has passed on due to AIDS related illness. When discussing the problem was stigma, that is the main reason why people are moving from nearby clinic to go and be assisted in the other clinic faraway were he/she is not known. Also these clinics with special names stigmatized people. Other people are no longer collecting their treatment because already they are afraid that when people see them in a particular queue or that special clinic then is disclosure.</p>	E
<p>R: What do you think needs to be done?</p>	
<p>Resp: I think when we need to combine all the patients. We must make sure that we focus on issues of personnel because the queue will not be long when the personnel in all the consulting rooms are enough, because we truly want to avoid this issue of indirect disclosure, it has a stigma that is the reason why most of our people are not free to take their treatment because of the stigma issue we are not going to end it up by now. Is still a lot of work to be done, when we see you coming from that queue we already know that you are sick, lets rather try the issue of increasing the personnel and have one queue.</p>	B
<p>R: Hmm..It is understood</p>	

<p>Resp: I don't know if there is any strategy we can come up with to close the gap. A strategy that can be used to encourage disclosure so that the people like my self-living with the virus to be able to disclose their status and live with it and accept themselves as disclosure is a healing process, it assist with the issue of being afraid to those clinics with special names. The person go there freely because she/he knows that everybody knows, but if we close this gap of disclosure so that we can encourage people to test and results are positive they need a person to whom they can disclose their status.</p> <p>R: How others see this?</p>	F
<p>Resp: Hmm...that issue is a problem ...(pause)...because we talk about it and try by all means so that this people need to be told to accept themselves and the home based cares when visiting them at their homes they are also trying to talk with them so that people can accept but still then is a problem. In other words, you don't know how it can be done because if we take this people to the main queues then we will not get it right because the queues will be too long.</p> <p>R: Yes</p>	A
<p>Resp: I don't see if we can manage that because that queue will be long to be managed, I can say that what we can try the clinic to work/operate 24 hours. People who are afraid of attending the clinic during the day when people see them then they can come at night in that way we will be trying something also, because I will know that during the day people see me but if I attend during the night there are no people, when I arrive I will be assisted soon.</p> <p>R: What need to be done?</p>	A
<p>Resp: Let it be that way only the clinics to be available 24hours.</p> <p>R: Ok</p>	A
<p>Resp: I think this can assist because this people are being told during the meetings. During the gathering they are told, let me say men hate the truth.</p> <p>R: Nodding</p>	A
<p>Resp: let me say men are afraid of the truth, they end up saying they don't want to be known by other people and if you don't want to be seen by other people he must go during the night.</p>	A

<p>During the campaigns when we go for test we then know that they are HIV positive? But the time of treatment collection is the issue.</p>	
<p>R: Do we see ourselves continuing with.....</p>	
<p>Resp: For me I say these ...people even if it can be myself, if I am like that I will encourage the people to accept their statuses not to be shy of going to the clinic to collect treatment. To accept just like those people with TB, Hypertension and Sugar diabetes, they have accepted themselves and this one(AIDS) can be cured is not like others (Not knowing that there is no cure for AIDS but the researcher will address it after the session)</p>	C
<p>R: We are really discussing issues here, there are different HAST messages addressing people. Are this messages reaching you and also in which way?</p>	
<p>Pause...</p>	
<p>R: Where do you hear these HAST messages mostly?</p>	
<p>Resp: We attend workshops were we are taught about basic HIV &amp; AIDS,STIs and TB.</p>	G
<p>R: Yes</p>	
<p>Resp: We also hear messages on radio and during the campaign's we are taught, screened for TB, HIV Counseling and testing done and we collect free condoms and shown how they are used. Pamphlets with information are provided.</p>	G
<p>R: How do you benefit from all this?</p>	
<p>Resp: Hmmmm.....Hmmm....Hmmm</p>	B
<p>Pause...</p>	
<p>Resp: I can say if we want to say the truth...</p>	B
<p>R: Nodding</p>	
<p>Resp: If you look at health messages...let start with media issues they are not enough I don't</p>	B

<p>know if whether is because they are paid and comparing it with Amstel(Alcohol) advert it will appear ten times more than health advert.</p>	
<p>R: Yes</p>	
<p>Resp: When watching TV the advert of alcohol will appear 10 times but that time no health advert will appear.</p>	B
<p>R: Hmm,,,</p>	
<p>Resp: TV is the media that we watch most around 20:00(Generation time) everybody is in front of the TV if the health message can appear we will see it. For me I cannot say we receive the message in the communities, unless you go to the clinics messages are not easy reach unless you go to clinic you will get a brochure. The issue of campaigns in the communities is still a gap because we are not yet able to close the gap. Maybe in two months interval we take the campaigns to our communities. Where I come from in the communities the campaigns are not visiblle only in the townships.</p>	B
<p>R: Nodding</p>	
<p>Resp: The campaigns are not there in the rural areas.</p>	D
<p>R: Yes Mr. D what do you think about this?</p>	
<p>Resp: When they were explaining about media on TV is a sketch which we cannot see, unlike on the radio the messages are so clear that everybody can understand and the messages reach us.</p>	D
<p>R: What could be done?</p>	
<p>Resp: In reality health people need to sit down with media and communicate, TV message need to be interpreted by sign language so that one can understand and follow the message if interested.</p>	D
<p>R: It is understood.</p>	
<p>Resp: I am thinking of the challenge that we encounter when you do comparative study of where we come from with HIV messaging.</p>	E

R: Yes	
<p>Resp: You can realize that we have relaxed now, the message of HIV&amp; AIDS are no longer vigorous....hmmm... like when we were starting because I think that we do have a mind that we are now winning the war against HIV&amp; AIDS but we can see that new infection occur regularly on a daily basis, we have reached a relaxed mode where we don't talk like previously. Yes at churches we are trying to unite people to speak generally on the issue of health including HIV (Tone of voice stronger) but is not like is no more happening like it used to be.</p>	E
R: Nodding. They have relaxed with messaging no more stressing them.	E
Resp: Yes	
R: Are u saying this will encourage the new infections? Then what could be done?	B
Resp: Before we can talk what could be done....	B
R: Yes	
<p>Resp: I just want to say I am thinking on this point when you see the billboards that are around they have faded, we have realized that they are no more visible and we are having the mind of winning the battle so it was not important, let us start by renewing the billboards.</p>	B
R: Ok	
<p>Resp: And also engage the media to always spread the message including the newspaper and all to broadcast and for the campaigns to be intensified and be frequent, so that we remind people and stick together to fight this pandemic. Time and again we should be reminded (repeating x 2).</p>	D
R: What are other cost effective methods?	
<p>Resp: (Pause) I think because we are always lacking funds we need a strategy for health to use fundraising so that people can be trained through media and buy 30minutes air time on TV and talk to youth, old persons and communities to be given time to ask questions which will includes blinds people, wheelchair users and deaf and dumb.</p>	E
R: These messages that are communicated now, How does it change people's	

<p>behavior(repeated)?</p> <p>Resp: Yes I agree with it because sometimes when you see something on TV with family you are able to discuss issues you are seeing on TV together. These will be the time to discuss issues with the families like Teenage pregnancy and HIV.</p> <p>R: Yes it is understood; according to you it changes the behavior of people especially when they view it as a family?</p>	E
<p>Resp: There is this thing which is now MMC (Male Medical Circumcision) It is well broadcast on TV and radio.</p> <p>R: Hmmm...</p>	E
<p>Resp: I am not sure but now when I was driving coming here, that advert was highlighted in the radio and I was asking myself when the researchers is saying MMC reduces HIV &amp; AIDS are they no people who are taking advantage of taking advert in a wrong way? Is it not if this knowledge is not reaching people well there is those who can say MMC is part of prevention,</p> <p>R: Hmmm..</p>	E
<p>Resp: Hmmm... others can sleep around without using condoms as long as I am circumcised is good. When you see a response of lot of men undergoing MMC you think maybe is helpful but (strong voice) at the back of my mind i am saying we are not using MMC as part of prevention.</p> <p>R: What do you mean?</p>	E
<p>Resp: Ok they are explaining it very well is not totally prevention.....</p> <p>R: Yes</p>	E
<p>Resp: .... is not 100% prevention is better use it together with a condom</p> <p>R: Hmmm...</p>	A
<p>Resp: And the other thing that I do...I normally gathers Traditional Health Practitioners (THP) at the tribal offices and tells them about the fact that people to be careful so that they must not</p>	A

<p>pread AIDS pandemic. Is there or that when you are circumcised you prevent that --no---no you have just partly preventing.</p>	
<p>R: Hmm...</p>	
<p>Resp: I have also see that during the meeting at the tribal offices people seems to be understanding---during the municipality African National Congress (ANC) &amp; People Living with HIV (PLHIV) most of the gathering I will be with this man (pointing F) who is always telling people that he is now 20yrs living with the virus--he is still alive, they have to understand that if you care for yourself you can live for many years.</p>	A
<p>R: knodding.</p>	
<p>Resp: Yes is like that.</p>	B
<p>R: Actually what capacity is needed for us to change behavior?</p>	
<p>Resp: If i can say nowadays the way sex is advertised on those programmes if they can talk about HIV also it can assist to tell people to be afraid of the diseases and they can even show the young generation, I think it can assist a lot.</p>	F
<p>R: Mr. F?</p>	
<p>Resp: The pastor mentioned the intensifying the issue of HIV &amp; AIDS and I was hurt last week, I was at the other clinic, entering there I found the pamphlets on the wall which is written Voluntary Counseling &amp; Testing (VCT) and I ask myself at this era is there such a clinic which display VCT Pamphlets?</p>	F
<p>R:Hmmm...</p>	
<p>Resp: I talked to sister in charge of that clinic and we did not agree as if I want to teach her the work she knows best. It was just sadly showing another message because according to me is no more voluntary we need to sell it to all the people as HIV Counseling and Testing (HCT)...</p>	F
<p>R: Hmm...</p>	
<p>Resp: Hmm...so that we must change such messages to bring new or updated messages.</p>	B

<p>Resp: Hmm...as men the adverts are talking to us and messages are delivered It is also clear that we need dual protection, we need to be circumcised and still use condoms, but the challenge we encountered across conducting our own studies our people are not afraid of HIV, they are afraid of becoming pregnant.</p> <p>R: Nodding</p>	
<p>Resp: They believe pregnancy prevents you for many opportunities but with HIV you still have those opportunities.</p>	B
<p>R: What is pregnancy preventing them to do?</p>	
<p>Resp: when a person is pregnant nice time is over because she need to take care of the baby 24/7. The time to go for parties is no more but with HIV you still enjoy life. This is due to lack of education.</p>	B
<p>R: Hmm...</p>	
<p>Resp...is still a challenge never mind what we are doing best, but there is still a gap where education and information is still needed to our people.</p>	B
<p>R: Hmmmm...</p>	
<p>Resp: We are all happy because at school our children are all given this information while still young.</p>	B
<p>R:Hmm..</p>	
<p>Resp: But I don't know what still a problem is because people are not afraid of HIV &amp; AIDS and also we must not advertise HIV &amp; AIDS with person who is very ill because people will be afraid to test because they will say we don't want to be like that person. We must not give it stigma that when you are infected you are no longer person who belong to this planet. We need a better way of showing people that there is still a healthy life after their HIV test.</p>	B
<p>R: I will like to go back to that issue of saying as communities do we have capacity to change our</p>	

<p>behavior?</p> <p>Resp: I think that the capacity we do have. I wanted to mention what he just said that the issue of intensifying eeeh rollout of this information, you remember when we started as faith based organization we were called many times to be capacitated to take it to the people for as we are expected to be with people on a daily basis, every weekend we are with people. This things were done the day before yesterday I saw it happening when the financial year is closing you call us so that money need to be spend those type of training are not assisting but the training need to be focused, well budgeted for so that you know what you want to achieve. The more people are capacitated, given knowledge the more it assists them in terms of behavioral change and the more they can talk to everybody.</p>	E
<p>R: Yes</p> <p>Resp: When we preach we need to include HIV &amp; AIDS messages so that people can learn and change their behaviors. What we see nowadays pastors are starting to be exposed and no more condemning people who are living with the virus, people have changed it is possible when we do deliberate focused training we talk to people so that it can be done, but if we do it at the end of the year just for the sake of spending then is just using us not helping us. You are using us just to spend money.</p>	E
<p>R: Hmmm...</p>	
<p>Resp: This can assist and it is possible that people can change their behavior.</p>	E
<p>R: How can we sustain the changed behavior (repeating)?</p>	
<p>Resp: Yes I heard you all what you were saying, everything that we are looking at and every change need to start in the family.</p>	A
<p>R: Hmmm...</p>	
<p>Resp: If in the family there is no discipline there will be no discipline at all for HIV&amp;AIDS, families need to teach each other. Preach to the children about waiting for the right things in their life to wait to be married first. Like when as parents we encourage our children to terminate pregnancy we lose control of our children. If one person terminate pregnancy it means she can kill all men she can have sex with.</p>	A

<p>R: How does she kill them?</p> <p>Resp: Because the blood is boiling (Traditional believe) after termination of pregnancy (repeating) we need to check this in our families not encourage girls to terminate their pregnancies.</p>	A
<p>R: Now as we speak Choice of Termination of Pregnancy (CTOP) is lawful.</p> <p>Resp: No I say is lawful but is the people who created the law and it is people to change that and now we are talking about HIV&amp;AIDS is known by to all due to the documents that are given to us. When Traditional Health Practioners (THP), are looking at it we seeing the same thing THPs diagnose with floor X-ray which differs how medical people diagnose.</p>	A
<p>R: I understand now we are going deeper in traditional issues lets come back (smiling). We talked a lot about people who we stigmatized ,discriminated, is the discriminated the infected or affected? Pause...and stigma and discrimination when comparing it to the past where messages were many is there any different?</p>	
<p>R: G (pointed after raising the hand)</p>	
<p>Resp: We see in our communities.</p>	G
<p>R:Hmmm...</p>	
<p>Resp: The issue of HAST is known but there are those whose beliefs doesn't believe in those issues, there are those who are still refusing when we talk about this it is still regarded as witchcraft is not illness. Also about the stigma the experience is in the families where people are afraid to come forth, they rather go to other services far from home because they are afraid of what people will say about them.</p>	G
<p>R: In other words stigma is still there in our communities?</p>	
<p>Resp: Yes people are not accepted yet, I don't know but those clinics with special names to remain. The main thing is the campaigns to be intensified (emphasized)</p>	G
<p>R: Are there still people who do not utilised our clinics?</p>	

<p>Resp: There are those who still believe that HIV is caused by witchcraft.</p>	G
<p>R: In other words these messages are not reaching them, what could be done?</p>	
<p>R: Do you want to say something (Mr. D)?</p>	
<p>Resp: I say message do reach people, what I am saying is that it is not easy to change the person but when times goes on they will change.</p>	D
<p>R: Ok</p>	
<p>Resp: They will change not as soon as possible, just like now if we can be all blind in this room there are those who can die as soon as possible and others will be happy.</p>	D
<p>R: In which way? I understand those who will die are those who do not accept their status and what about the happy ones? What makes them happy?</p>	
<p>Resp: The happy ones are those who believe in God and to show the works of God if not seeing. In other words whether people understand or not let continue with messages they will end up understanding. English proverb says "If you cannot beat then join them".</p>	D
<p>R: How can we overcome the stigma and discrimination among us?</p>	
<p>Resp: We can talk but we will not going to overcome discrimination and now if we can go to hospital as a blind person it will take time for me to be assisted. The first question that they will ask me with whom did you come?</p>	D
<p>R: You cannot come alone?</p>	
<p>Resp: Yes they say so. If I say alone they will continue asking how? They see me as burden. We are not taking time doing interview but I came for consultation.</p>	D
<p>R: There is still discrimination about people with disability</p>	
<p>Resp: It will never come to an end (facing down and sad). When the message continue to be preached the people will change.</p>	D

<p>R: Yes</p>	
<p>Resp: I understand that it start with the believe as we believe differently we will learn, what brought us here today it affect us all.</p>	A
<p>R: Yes it affect us all.</p>	
<p>Resp: The message is that those who are not believing let us give them time to change I do believe that if you never come across something you will not know the consequences and its pain. But when he/she is affected is now that he/she will say what they were saying all this time is real.</p>	A
<p>R: We do understand but due to time we need to end up our session. Anyone with the last words in short.</p>	
<p>Resp: My last word is that I am asking the Department of Health to target the people who are HIV positive.</p>	F
<p>R: Hmm...</p>	
<p>Resp: Because is us (PLHIV) who spread the virus.</p>	F
<p>R: Nodding</p>	
<p>Resp: And seems we are ignoring them we are now focusing on the negative ones.</p>	F
<p>R: Hmm....</p>	
<p>Resp: Somehow or other to make them turn and show them the right way. Thank you</p>	F
<p>R: Hmmm...</p>	
<p>Resp: Life and death are at the tongue of the person. If we continue to be positive so that.....Yes is difficult were we are now and believe that one day this behavior and the way we think will change. Like the issue of stigma and discrimination let's not through in the towel not give up because the more we talk about it is the more we will move towards the required behavior, let us be positive and I think it is possible.</p>	F

<p>R: Lets close it Men sector?</p> <p>Resp: I also want to say my last words. I request the Department of Health to have surprise visit at our hospitals &amp; Clinics. Don't inform them that you are coming &amp; see what is happening. Last week I took the pregnant women to the hospital and I was told that there was no bed. I left her on the chair when arriving home I received a message that she has delivered I then asked myself where did she deliver because I left her on the chair at the hospital.</p> <p>R: Yes</p> <p>Resp: But if you can have surprise visit you will see lot of things and be able to ensure that community is satisfied.</p> <p>R: In other words services are not reaching people?</p> <p>Resp: Yes service are not reaching all the people.</p> <p><b>Summary</b></p> <p>I like to thank you all, we started with health issues under general then we went deeper in HIV&amp;AIDS issues in different ways of receiving HAST -how do their messages reach and change us and about if we have changed do we remain in that state and concluded that us been here let's not continue stigmatizing others. It is not good to be stigmatized and discriminated, we need not continue with discrimination. Also for us to go for HIV test so that we can be assisted on time.</p> <p>THANK YOU</p>	<p>B</p> <p>B</p> <p>B</p>
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**ANNEXURE N**

**Notes for the co-coder for focus group interview**

## ANNEXURE N

**TITLE OF THE STUDY: THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV and AIDS, STIs and TB IN THE LIMPOPO PROVINCE.**

## FOCUS GROUP INTERVIEW

The focus group interview took place on the 27.11.2014

Venue: Capricorn District Executive Mayor's board room

Time: 12:00 - 13:25 (Actual time for the focus group interview is 00:55:45)

Information leaflet was provided with an attached consent form. The verbal explanation was done in Sepedi so that all could understand. The preferred language of communication was Sepedi. The use of audio-recorder and the presence of the scribe were explained and accepted by the group.

The environment was prepared with following, bottled water and sweets for participants to relax and communicate freely. A board setup was arranged for the purpose. Civil Society members of Capricorn District AIDS Council (One of the five Districts in the Province) participated in the focus group interview. The focus group interview preceded the District AIDS Council meeting on the same day at 14:00. The participants were all vocal and no one dominating the group. The Civil Society members were well represented by one from each sector as follows: Traditional leader (TL), Traditional Health Practitioner (THP), Men's Sector, Older Persons, People Living with HIV (PLHIV), Disability Sector, and Religious Sector.

CODES	NAME OF SECTOR
A	Traditional Health Practitioner (THP)

B	Men's Sector
C	Older Persons
D	Disability Sector
E	Religious Sector
F	PLHIV
G	Traditional Leader

They all knew the topic very well and enjoyed participation. They were giving each other chance to speak and were relevant in their responses.

ATTACHED PLEASE FIND THE FOLLOWING:

- FOCUS GROUP INTERVIEW GUIDE
- INFORMATION LEAFLET WITH CONSENT FORM
- FIELD NOTES
- TRANSCRIPT OF THE FOCUS GROUP INTERVIEW

**ANNEXURE O**

**Transcript Analysis by the researcher for focus group interview**

## ANNEXURE O

**TITLE OF THE STUDY: THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV AND AIDS, STIs AND TB (HAST) IN THE LIMPOPO PROVINCE.**

KEY: R: RESEARCHER

RESP: RESPONDENT

CODES	TRANSCRIPTION	THEME
Accessibility of Health facilities	<p>R: As I have now explained all what is happening, let start with the focus group interview. What are your perception on health status...(long pause) ..in the Province in Capricorn District...(pause)..How do you see it? Or how is health status in general.</p> <p>Resp: Thank you. Health status...(pause)...we see it as promoting our communities, they promote our minds and they promote our health in general.</p> <p>R: In other words are they assisting?</p> <p>Resp: Yes, they are assisting</p> <p>R: Others, how do you see it?</p>	1.3 Community's perception of what health status is.
Not accessible to the disabled	<p>Resp: We as disability sector they are not accessible for us. They are not accessible for the deaf and dumb. Counselors are unable to use sign language of people which for counseling they are unable to talk using sign language, this is a disadvantage.</p>	1.3 Community's perception of what health status is.

<p>Sign language not known</p>	<p>R: Yes</p> <p>Resp: Those who are blind like us, you are just told that you have this type of disease without you seeing for yourself the results displayed. The disability sector is requesting that health need to promote accessibility.</p>	
<p>No brail</p>	<p>R: Accessibility with regard to communications?</p> <p>Resp: When talking about accessibility we mean communication for disabled people, like now you all have the meeting agenda before someone can read the agenda to them they can read for themselves and have an idea of what the meeting is about, but the blind person won't know anything about the meeting and is taking time to catch-up., you already know what is going on in the meeting. The person who is blind is easy to get lost and when addressing item 1 the meeting is already in item 4. when they ask questions is like they are disrupting the meeting, therefore there is a need for the blind people to have a background of what is going to be said in the meeting.</p> <p>R: In other words there is a need to have the agenda written in brail so that you will be able to read like other.</p> <p>Resp: Yes</p>	<p>1.3 Community's perception of what health status is.</p>

<p>Staff attitude</p>	<p>R: You get lost</p> <p>Resp: Yes, to be able to have background of what is going to be discussed.</p> <p>R: Thank you,</p> <p>Resp: Yes about this health issues someone can say generally the state of health . .hmmm.. in a way has improved but there are still lot of things to be done e.g. if you look at the personnel working in the clinics and hospitals the main challenges is the attitude that you get ..hmmm.. when you talk about the provision of service that you need to be assisted with there is blockage at the reception .hmmm...We had an opportunity at Capricorn District AIDS Council to visit the tribal offices as part of the things that you listen to when you go around. People are afraid to go for HIV test due to lack of confidentiality, there is lot the government need to do to ensure that the state of health improves.</p>	<p>1.3 Community's perception of what health status is.</p>
<p>Lack of confidentiality</p> <p>Education to the elders as primary health givers</p>	<p>Pause...</p> <p>Resp: Hmmm..I am talking on behalf of the older persons, most of them does not understand health issues, for them to understand they need to learn from their children. (clear the throat)..If our children are affected we are the one assisting them. As older persons we need more education about the</p>	<p>1.3 Community's perception of what health status is.</p> <p>1.6 Capacity of community members to perform the self-care.</p>

<p>Stigma</p>	<p>virus so that we can take care of our children.</p> <p>Pause...</p> <p>Resp: Hmm.. when I see the health status in our province there is still stigma in the sense that there are different queues for pregnant women and those collecting Anti-retroviral treatment (ARV). While on queue to collect ARV, others already know that they are infected. How about having one common queue? The other challenge is the issue of lack of male nurses and mostly is female nurses in our clinics who are assisting them, and men are not free to explain their problems to female nurses.</p>	<p>1.6 Capacity of community members to perform the self-care.</p>
<p>Lack of male nurses</p>	<p>Resp: Hmmm.. when I see the health status in our province there is still stigma in the sense that there are different queues for pregnant women and those collecting Anti-retroviral treatment (ARV). While on queue to collect ARV, others already know that they are infected. How about having one common queue? The other challenge is the issue of lack of male nurses and mostly is female nurses in our clinics who are assisting them, and men are not free to explain their problems to female nurses.</p>	
<p>Inability to reach male nurses</p>	<p>R: Yes</p> <p>Resp: As a department we need to have the strategy to encourage males to join the nursing profession to enhance the health service so that men can be treated by male nurses. Sometimes they will say I cannot undress in front of this women is not my wife, actually the person need help but because of female nurse when he consult he change the subject/purpose of his visit and just say I have headache. If we can be able to address those things I think we can ascertain that the health status improves.</p> <p>R: In other words presently we are not reaching</p>	<p>1.3 Community's perception of what health status is.</p>

<p>Personnel workshops (Refresher courses)</p> <p>Loss of staff morale- EAP to assist</p>	<p>men, the way I understand it health services does not reach men the way is supposed to.</p> <p>Resp: (Shaking the head) We are not yet reaching them.</p> <p>R: Yes we are not reaching them as they will be changing what they are supposed to be saying in the consulting rooms. Yes you talked about the nurses' attitude. Then how do you see people using health facility as they are supposed to?</p> <p>Resp: Part of it I think ..hmmm.. in every institution there is time for refresher courses where people are taken through to be shown how people can relate to people with communities where they are staying. The issue of attitude does not have the remedy necessarily so because personnel come to work already stressed. Unfortunately when they arrived at work they are forgetting that the environment has changed so that problem do remain at their place/home.</p> <p>The work of your Employees Assistance Programme (EAP) can assist in addressing their challenges. In helping people so that they can be able to open up to address this challenges. They have already mentioned that there is time when you go there you feel as if the nurse or somebody who is helping you is doing you a favor and is not that that you are doing anyone a favor just because I need help at the proper place because</p>	<p>1.3 Community's perception of what health status is.</p>
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<p>Availability of treatment in health facilities is satisfactory</p> <p>Discrimination of HIV &amp; AIDS clinics by names</p>	<p>this person has been trained and she/he looked for the work so that they can provide the service. The refresher courses can assist personeel from time to time...time to time so that they can be reminded (pause) I think it can assist us to deal these issues.</p> <p>R: Yes those who have problem they need to attend Employees Assistance Programme to get help. Thank you.</p> <p>Resp: Exactly; exactly</p> <p>R: We have already talked about the health issues in general, now we are going to HIV,AIDS ,STIs and TB(HAST). Are HAST programmes available? do you know about them in your communities? Do you normally hear about HAST issues</p> <p>Resp: Hmmm... rollout of Fixed Dose Combination (FDC) for instant of ARV when looking at Capricorn District is working well and as working with them (People Living with HIV) in the support groups all is well. The thing is that I have seen people been treated wrongly is that the others has talked about long queue, actually the ARV clinics are facilities with special names like: Phela o phedise, Amogelang etc--they are secluded at the back of the clinic buildings. To go there is the disclosure indirect so a person even if the clinic is closer nearby like at Mamabolo village the person would rather move to the furthest one because this one</p>	<p>1.3 Community's perception of what health status is.</p>
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Lack of disclosure	<p>when you visit automatically people would realize your condition.</p>	
Stigma	<p>Resp: I think the issue they are talking about is very serious, I was talking to one of the Doctors the day before yesterday showing each other that someone has passed on due to AIDS related illness. When discussing the problem was stigma, that is the main reason why people are moving from nearby clinic to go and be assisted in the other clinic faraway were he/she is not known. Also these clinics with special names stigmatized people. Other people are no longer collecting their treatment because already they are afraid that when people see them in a particular queue or that special clinic then is disclosure.</p> <p>R: When I remember when they do this special clinic it was a way of offloading the Out Patient Departments (OPD) queue but the way you are putting it really shows that when you attend that isolated clinic your status is already known. What do you think it can be done? can we bring them back in general OPD to those long queues?</p>	
Increasing Personnel	<p>Resp: I think when we bring them back we must make sure that we focus on issues of personnel because the queue will not be long when the personnel in all the consulting room are many, because we truly want to avoid this issue of indirect disclosure, it has a stigma that is the</p>	2.2 Support for sustainability (staff).

<p>Encourage disclosure of PLHIV</p>	<p>reason why most of our people are not free to take their treatment because of the stigma issue we are not going to end it up by now. Is still a lot of work to be done, when we see you coming from that queue we already know that you are sick, lets rather try the issue of increasing the personnel and have one queue.</p> <p>R: Ehh..It is understood</p> <p>Resp: I don't know if there is any strategy we can come up with to close the gap. A strategy that can be used to encourage disclosure so that the people like my self-living with the virus to be able to disclose their status and live with it and accept themselves as disclosure is a healing process, it assist with the issue of being afraid to those clinics with special names. The person go there freely because she/he knows that everybody knows, but if we close this gap of disclosure so that we can encourage people to test and results are positive they need a person to whom they can disclose their status.</p>	<p>1.6 Capacity of community members to perform the self-care.</p>
<p>Disclosure session during counseling is not enough</p>	<p>R: Mostly disclosure is encouraged during counseling. When you seeing this challenge because during counseling it does not reach home as discussed, where else can we talk about it again so that it can be heard to encourage disclosure?</p>	<p>2.2 Support for sustainability (staff).</p>

<p>24 hours health services will increase accessibility</p>	<p>Resp: Hmm...that issue is a problem ....(pause)...because we talk about it and try by all means so that this people need to be told to accept themselves and the home based cares when visiting them at their homes they are also trying to talk with them so that people can accept but still then is a problem. In other words, you don't know how it can be done because if we take this people to the main queues then we will not get it right because the queues will be too long.</p> <p>R: Yes</p> <p>Resp: I don't see if we can manage that because that queue will be long to be managed, I can say that what we can try the clinic to work/operate 24 hours. People who are afraid of attending the clinic during the day when people see them then they can come at night in that way we will be trying something also, because I will know that during the day people see me but if I attend during the night there are no people, when I arrive I will be assisted soon.</p> <p>R: To continue with those clinics with special names?</p> <p>Resp: Let it be that way only the clinics to be available 24hours.</p> <p>R: Ok</p>	<p>1.3 Community members' perception of what health is.</p>
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<p>Men not utilizing health facilities (fear to be seen and known by others)</p>	<p>Resp: I think this can assist because this people are being told during the meetings. During the gathering they are told, let me say 'men' hate the truth.</p> <p>R: Nodding</p> <p>Resp: let me say men are afraid of the truth, they end up saying they don't want to be known by other people and if you don't want to be seen by other people he must go during his night. During the campaigns when we go for test we then know that they are HIV positive? But the time of treatment collection is the issue.</p>	<p>1.6 Capacity of community members to perform the self-care</p>
<p>Accepting one status</p>	<p>R: Do we see ourselves continuing with.....</p> <p>Resp: For me I say these ...people even if it can be myself, if I am like that I will encourage the people to accept their statuses not to be shy of going to the clinic to collect treatment. To accept just like those people with TB, Hypertension and Sugar diabetes, they have accepted themselves and this one(AIDS) can be cured is not like others (Not knowing that there is no cure for AIDS but the researcher will address it after the session)</p> <p>R: We are really discussing issues here, there are different HAST messages addressing people. Are this messages reaching you and also in which way?</p>	<p>1.6 Capacity of community members to perform the self-care</p>

Workshops	<p>Pause...</p> <p>R: Where do you hear these messages mostly?</p> <p>Resp: we do have workshops.</p> <p>R: Yes</p> <p>Resp: They teach us about HIV &amp; AIDS and TB</p> <p>R: Are this workshops reaches you? Is the language used clear to all of you and is the message heard by all of you?</p> <p>Resp: Hmmmm.....Hmmm....Hmmm</p> <p>Pause...</p>	1.6 Capacity of community members to perform the self-care
Media advert for HAST not enough	<p>Resp: I can say if we want to say the truth...</p> <p>R: Nodding</p> <p>Resp: If you look at health messages...let start with media issues they are not enough I don't know if whether is because they are paid and comparing it with Amstel(Alcohol) advert it will appear ten times more than health advert.</p> <p>R: Yes</p>	1.6 Capacity of community members to perform the self-care

<p>No HAST messages in rural communities</p> <p>No HAST campaigns in the rural communities</p>	<p>Resp: When watching TV the advert of alcohol will appear 10 times but that time no health advert will appear.</p> <p>R: Hmm,,,</p> <p>Resp: TV is the media that we watch most around 20:00(Generation time) everybody is in front of the TV if the health message can appear we will see it. For me I cannot say we receive the messages in the communities, unless you go to the clinics messages are not easy reach unless you go to clinic you will get a brochure. The issue of campaigns in the communities is still a gap because we are not yet able to close the gap. Maybe in two months interval we take the campaigns to our communities. Where I come from in the communities the campaigns are not visible only in the townships.</p> <p>R: Nodding</p> <p>Resp: The campaigns are not there in the rural areas.</p> <p>R: Yes Mr. D is this HAST messages that are said and heard you from disability sector are you able to understand what they are saying and how they are saying?</p> <p>Resp: When they were explaining about media on TV is a sketch which we cannot see, unlike on the</p>	<p>1.6 Capacity of community members to perform the self-care</p> <p>1.6 Capacity of community members to perform the self-care</p>
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<p>TV messages to be interpreted in sign language</p>	<p>radio the messages are so clear that everybody can understand and the messages reach us.</p> <p>R: In other words some of you don't get the message like the blinds who cannot watch TV others who are deaf and dumb cannot listen to the radio.</p> <p>Resp: Yes</p> <p>R: what can be done?</p> <p>Resp: In reality health people need to sit down with media and communicate, TV message need to be interpreted by sign language so that one can understand and follow the message if interested.</p> <p>R: It is understood.</p>	<p>1.6 Capacity of community members to perform the self-care</p>
<p>HAST messages not vigorous as before</p> <p>Mass addressed at</p>	<p>Resp: I am thinking of the challenge that we encounter when you do comparative study of where we come from with HIV messaging.</p> <p>R: Yes</p> <p>Resp: You can realize that we have relaxed now, the message of HIV&amp; AIDS are no longer vigorous....hmmm... like when we were starting because I think that we do have a mind that we are now winning the war against HIV&amp; AIDS but we can see that new infection occur regularly on a</p>	<p>2.2 Support for sustainability</p>

<p>churches on HAST issues</p>	<p>daily basis, we have reached a relaxed mode where we don't talk like previously. Yes at churches we are trying to unite people to speak generally on the issue of health including HIV (Tone of voice stronger) but is not like is no more happening like it used to be.</p> <p>R: Nodding. They have relaxed with messaging no more stressing them.</p> <p>Resp: Yes</p> <p>R: This will encourage the increase in new infections. Then what can be done?</p> <p>Resp: Before we can talk what can be done....</p>	
<p>Billboards messages have faded</p>	<p>R: Yes</p> <p>Resp: I just want to say I am thinking on this point when you see the billboards that are around they have faded, we have realized that they are no more visible and we are having the mind of winning the battle so it was not important, let us start by renewing the billboards.</p>	<p>1.6 Capacity of community members to perform the self-care</p>
<p>Messages during campaigns and in the newspapers</p>	<p>R: Ok</p> <p>Resp: And also engage the media to always spread the message including the newspaper and all to broadcast and for the campaigns to be</p>	<p>1.6 Capacity of community members to perform the self-care</p>

	<p>intensified and be frequent, so that we remind people and stick together to fight this pandemic.</p> <p>Time and again we should be reminded (repeating x 2).</p>	
Lack of funds	<p>R: We talk about billboards, radios how are they cost effective? or can we have other means that are cost effective?</p>	2.2 Support for sustainability
Fundraising	<p>Resp: (Pause) I think because we are always lacking funds we need a strategy for health to use fundraising so that people can be trained through media and buy 30minutes air time on TV and talk to youth, old persons and communities are given time to ask questions which will includes blinds people, wheelchair users and deaf and dumb.</p>	
Behavior change	<p>R: The message that are communicated now, How does it change people's behavior(repeated)?</p> <p>Resp: Yes I agree with it because sometimes when you see something on TV with family you are able to discuss issues you are seeing on TV together. These will be the time to discuss issues with the families like Teenage pregnancy and HIV.</p> <p>R: Yes it is understood; according to you it changes the behavior of people especially when they view it as a family?</p> <p>Resp: There is this thing which is now MMC (Male</p>	1.6 Capacity of community members to perform the self-care

<p>MMC messages not understood</p>	<p>Medical Circumcision) It is well broadcast on TV and radio.</p> <p>R: Hmmm...</p> <p>Resp: I am not sure but now when I was driving coming here, that advert was highlighted in the radio and I was asking myself when the researchers is saying MMC reduces HIV &amp; AIDS are they no people who are taking advantage of taking advert in a wrong way? Is it not if this knowledge is not reaching people well there is those who can say MMC is part of prevention,</p>	<p>1.6 Capacity of community members to perform the self-care</p>
<p>MMC for prevention</p>	<p>R: Hmmm..</p> <p>Resp: Hmmm... others can sleep around without using condoms as long as I am circumcised is good. When you see a response of lot of men undergoing MMC you think maybe is helpful but (strong voice) at the back of my mind i am saying we are not using MMC as part of prevention.</p>	
<p>MMC messages understood by others.</p>	<p>R: What I like about the MMC research is saying 60% prevention. It must be stressed that is only 60%, people need to be educated that 40% need for condom usage otherwise we will be infected. Do you think MMC message are not reaching the people fully?</p> <p>Resp: Ok they are explaining it very well is not</p>	

<p>Information sharing with Traditional Health Practitioners</p>	<p>totally prevention.</p> <p>R: Yes</p> <p>Resp: .... is not 100% prevention is just that is better to have it to also use a condom</p> <p>R: Hmm...</p> <p>Resp: And the other thing that I normally do is to gather Traditional Health Practitioners (THP) at the tribal offices and tell them about the fact that people to be careful so that they also spread AIDS pandemic. Is there or that when you are circumcised you prevent that --no---no you have just partly preventing.</p>	<p>1.6 Capacity of community members to perform the self-care</p> <p>1.6 Capacity of community members to perform the self-care</p>
<p>Encouraging disclosure through information sharing which lead to behavior change.</p>	<p>R: Hmm...</p> <p>Resp: I have also see that during the meeting at the tribal offices people seems to be understanding---during the municipality African National Congress (ANC) &amp; People Living with HIV (PLHIV) most of the gathering I will be with this man (pointing F) who is always telling people that he is now 20yrs living with the virus--he is still alive, they have to understand that if you care for yourself you can live for many years.</p> <p>R: In other words the messages that are given should help people to change the behavior?</p>	<p>1.6 Capacity of community members to perform the self-care</p>

<p>Sex advert to be replaced by HAST messages</p>	<p>Resp: Yes is like that.</p> <p>R: Actually what capacity is needed for us to change behavior?</p> <p>Resp: If I can say nowadays the way sex is advertised on those programmes if they can talk about HIV also it can assist to tell people to be afraid of the diseases and they can even show the young generation, I think it can assist a lot.</p>	
<p>HAST update information</p>	<p>R: Mr. F?</p> <p>Resp: The pastor mentioned the intensifying the issue of HIV &amp; AIDS and I was hurt last week, I was at the other clinic, entering there I found the pamphlets on the wall which is written Voluntary Counseling &amp; Testing (VCT) and I ask myself at this era is there such a clinic which display VCT Pamphlets?</p> <p>R:Hmmm...</p> <p>Resp: I talked to sister in charge of that clinic and we did not agree as if I want to teach her the work she knows best. It was just sadly showing another message because according to me is no more voluntary we need to sell it to all the people as HIV Counseling and Testing (HCT)...</p> <p>R: Hmm...</p>	<p>2.2 Support for sustainability</p>

<p>MMC messages are understood by men</p>	<p>Resp: Hmm...so that we must change such messages to bring new or updated messages.</p>	<p>1.6 Capacity of community members to perform the self-care</p>
<p>Afraid of pregnancy not HIV</p>	<p>Resp: Hmm...as men the adverts are talking to us and messages that are delivered are so clear that we need dual protection, we need to be circumcised and still use condoms, but the challenge we encountered across conducting our own studies our people are not afraid of HIV, they are afraid of becoming pregnant.</p> <p>R: Nodding</p> <p>Resp: They believe pregnancy prevents you for many opportunities but with HIV you still have those opportunities.</p>	<p>1.3 Community members' perception of what their health status is.</p>
<p>Education to the communities is needed</p>	<p>R: What is pregnancy preventing them to do?</p> <p>Resp: when a person is pregnant nice time is over because she need to take care of the baby 24/7. The time to go for parties is no more but with HIV you still enjoy life. This is due to lack of education.</p> <p>R: Hmm...</p>	<p>1.6 Capacity of community members to perform the self-care</p>
<p>Availability of HAST education at</p>	<p>Resp:...is still a challenge never mind what we are doing best, but there is still a gap where education and information is still needed to our people.</p>	<p>2.2 Support for</p>

<p>schools</p> <p>Stigma to AIDS related illnesses</p>	<p>R: Hmmm...</p> <p>Resp: We are all happy because at school our children are all given this information while still young.</p> <p>R:Hmm..</p> <p>Resp: But I don't know what still a problem is because people are not afraid of HIV &amp; AIDS and also we must not advertise HIV &amp; AIDS with person who is very ill because people will be afraid to test because they will say we don't want to be like that person. We must not give it stigma that when you are infected you are no longer person who belong to this planet. We need a better way of showing people that there is still a healthy life after their HIV test.</p>	<p>sustainability</p> <p>1.6 Capacity of community members to perform the self-care</p>
<p>Intensification of Education to the communities</p>	<p>R: I will like to go back to that issue of saying as communities do we have capacity to change our behavior?</p> <p>Resp: I think that the capacity we do have. I wanted to mention what he just said that the issue of intensifying...Ehh.. rollout of this information, you remember when we started as faith based organization we were called many times to be capacitated to take it to the people for as we are expected to be with people on a daily basis, every weekend we are with people. This things were done the day before yesterday I saw it happening</p>	<p>1.6 Capacity of community members to perform the self-care</p>
<p>Focused on training and workshops</p>	<p>of intensifying...Ehh.. rollout of this information, you remember when we started as faith based organization we were called many times to be capacitated to take it to the people for as we are expected to be with people on a daily basis, every weekend we are with people. This things were done the day before yesterday I saw it happening</p>	<p>2.2 Support for sustainability</p>

<p>Religious sectors' involvement is sharing positive messages</p>	<p>when the financial year is closing you call us so that money need to be spend those type of training are not assisting but the training need to be focused, well budgeted for so that you know what you want to achieve. The more people are capacitated, given knowledge the more it assists them in terms of behavioral change and the more they can talk to everybody.</p> <p>R: Yes</p> <p>Resp: When we preach we need to include HIV &amp; AIDS messages so that people can learn and change their behaviors. What we see nowadays pastors are starting to be exposed and no more condemning people who are living with the virus, people have changed it is possible when we do deliberate focused training we talk to people so that it can be done, but if we do it at the end of the year just for the sake of spending then is just using us not helping us. You are using us just to spend money.</p>	<p>1.6 Capacity of community members to perform the self-care</p> <p>2.2 Support for sustainability</p>
<p>Possibility of changing behavior</p>	<p>R: Hmmm...</p> <p>Resp: This can assist and it is possible that people can change their behavior.</p>	<p>1.6 Capacity of community members to perform the self-care</p>
<p>Family involvement lead to family support</p>	<p>R: How can we sustain the changed behavior (repeating).</p>	<p>2.2 Support for sustainability</p>

<p>Discouraging Choice of Termination of Pregnancy (CTOP) due to cultural believes</p>	<p>Resp: Yes I heard you all what you were saying, everything that we are looking at and every change need to start in the family.</p>	<p>2.2 Support for sustainability</p>
<p>Encouraging good behavior.</p>	<p>R: Hmm...</p> <p>Resp: If in the family there is no discipline there will be no discipline at all for HIV&amp;AIDS, families need to teach each other. Preach to the children about waiting for the right things in their life to wait to be married first. Like when as parents we encourage our children to terminate pregnancy we lose control of our children. If one person terminate pregnancy it means she can kill all men she can have sex with.</p>	
<p>Cultural believes</p>	<p>R: How does she kill them?</p> <p>Resp: Because the blood is boiling (Traditional believe) after termination of pregnancy (repeating) we need to check this in our families not encourage girls to terminate their pregnancies.</p>	
<p>Culture vs Modern medicine</p>	<p>R: Now as we speak Choice of Termination of Pregnancy (CTOP) is lawful.</p> <p>Resp: No I say is lawful but is the people who created the law and it is people to change that and now we are talking about HIV&amp;AIDS is known by to all due to the documents that are given to us. When Traditional Health Practioners (THP), are looking at it we seeing the same thing THPs</p>	<p>1.6 Capacity of community members to perform the self-care</p>

	<p>diagnose with floor X-ray which differs how medical people diagnose.</p> <p>R: I understand now we are going deeper in traditional issues lets come back (smiling). We talked a lot about people who we stigmatized ,discriminated, is the discriminated the infected or affected? Pause...and stigma and discrimination when comparing it to the past where messages were many is there any different?</p> <p>R: G (pointed after raising the hand)</p>	
<p>HIV is due to witchcraft</p>	<p>Resp: We see in our communities...</p> <p>R: Hmm...</p>	
<p>Stigma</p>	<p>Resp: The issue of HAST is known but there are those whose beliefs doesn't believe in those issues, there are those who are still refusing when we talk about this it is still regarded as witchcraft is not illness. Also about the stigma the experience is in the families where people are afraid to come forth, they rather go to other services far from home because they are afraid of what people will say about them.</p>	
<p>Intensify campaigns to remove stigma</p>	<p>R: In other words stigma is still there in our communities?</p> <p>Resp: Yes people are not accepted yet, I don't</p>	<p>2.2 Support for sustainability</p>

<p>Behavior will change with time</p>	<p>know but those clinics with special names to remain. The main thing is the campaigns to be intensified (emphasized).</p> <p>R: There are those you mentioned that they still refuse to attend the clinics</p> <p>Resp: There are those who still believe that HIV is caused by witchcraft.</p> <p>R: In other words these messages are not reaching them, what can be done?</p> <p>Resp: Do you want to say something (Mr. D)</p>	<p>2.2 Support for sustainability.</p>
<p>Accepting one's condition</p>	<p>Resp: I say message do reach people, what I am saying is that it is not easy to change the person but when times goes on they will change.</p> <p>R: Ok</p> <p>Resp: They will change not as soon as possible, just like now if we can be all blind in this room there are those who can die as soon as possible and others will be happy.</p> <p>R: In which way? I understand those who will die are those who do not accept their status and what about the happy ones? What makes them happy?</p> <p>Resp: The happy ones are those who believe in God and to show the works of God if not seeing. In</p>	<p>2.2 Support for sustainability</p>

<p>Discrimination will always be there</p>	<p>other words whether people understand or not let continue with messages they will end up understanding. English proverb says "If you cannot beat then join them".</p>	
<p>Discriminating disabled persons</p>	<p>R: How can we overcome the stigma and discrimination among us?</p> <p>Resp: We can talk but we will not going to overcome discrimination and now if we can go to hospital as a blind person it will take time for me to be assisted. The first question that they will ask me with whom did you come?</p>	
<p>Information sharing and Education</p>	<p>R: You cannot come alone?</p> <p>Resp: Yes they say so. If I say alone they will continue asking how? They see me as burden. We are not taking time doing interview but I came for consultation.</p> <p>R: There is still discrimination about people with disability?</p> <p>Resp: It will never come to an end (facing down and sad). When the message continue to be preached the people will change.</p> <p>R: Yes</p> <p>Resp: I understand that it start with the believe as</p>	<p>2.2 Support for sustainability</p>

<p>Focus on HIV reactive people</p>	<p>we believe differently we will learn, what brought us here today it affect us all.</p> <p>R: Yes it affects us all.</p> <p>Resp: The message is that those who are not believing let us give them time to change I do believe that if you never come across something you will not know the consequences and its pain. But when he/she is affected is now that he/she will say what they were saying all this time is real.</p> <p>R: We do understand but due to time we need to end up our session. Anyone with the last words in short?</p> <p>Resp: My last word is that I am asking the Department of Health to target the people who are HIV positive.</p> <p>R: Hmm...</p> <p>Resp: Because is us (PLHIV) who spread the virus.</p> <p>R: Nodding</p> <p>Resp: And seems we are ignoring them we are now focusing on the negative ones.</p> <p>R: Hmm....</p>	
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<p>Behavior change</p>	<p>Resp: Somehow or other to make them turn and show them the right way. Thank you</p> <p>R: Hmm...</p> <p>Resp: Life and death are at the tongue of the person. If we continue to be positive so that.....Yes is difficult were we are now and believe that one day this behavior and the way we think will change. Like the issue of stigma and discrimination let's not through in the towel not give up because the more we talk about it is the more we will move towards the required behavior, let us be positive and I think it is possible.</p>	<p>2.2 Support for sustainability</p> <p>2.2 Support for sustainability</p>
<p>Time will change behavior, stigma and discrimination.</p> <p>Surprise visit to Health facilities</p>	<p>R: Lets close it Men sector (after raising the hand)?</p> <p>Resp: I also want to say my last words. I request the Department of Health to have surprise visit at our hospitals &amp; Clinics. Don't inform them that you are coming &amp; see what is happening. Last week I took the pregnant women to the hospital and I was told that there was no bed. I left her on the chair when arriving home I received a message that she has delivered I then asked myself where did she deliver because I left her on the chair at the hospital.</p> <p>R: Yes</p>	<p>2.2 Support for sustainability</p>

	<p>Resp: But if you can do surprise visit you will see lot of things and be able to ensure that community is satisfied.</p> <p>R: Yes services are not reaching people.</p> <p><b>Summary</b></p> <p>I like to thank you all, we started with health issues under general then we went deeper in HIV&amp;AIDS issues in different ways of receiving HAST -how do their messages reach and change us and about if we have changed do we remain in that state and concluded that us been here let's not continue stigmatizing others. It is not good to be stigmatized and discriminated, we need not continue with discrimination. Also for us to go for HIV test so that we can be assisted on time.</p> <p>THANK YOU</p>	

**ANNEXURE P**

**Co-coder's report for focus group interview**

# CODING REPORT

**FOR:** Rev NJ Rapakwana

**DATE:** 2015-07-11

**STUDY:** The effect of a provincial communication strategy to address burden of diseases in the Limpopo Province

**BY:** Prof TM Mothiba

**Method:** Tesch's inductive, descriptive coding technique (in Creswell, 2009: 185-190) quoted in Botma, Greeff, Mulaudzi and Wright (2010:223) was used by following the steps below:

- The researcher read through all the verbatim transcripts and written field notes of the interviews conducted and got a sense of the whole thereby some ideas as they come to mind were writing down. The researcher had a second round repeat and read the transcripts of all the interview sessions conducted and understood them.
- The researcher efficiently attached codes where there was an existence or frequency of concepts by writing in the side margins of the pages all topics identified which emanated from what the participants have said during the interview sessions conducted. The researcher grouped similar topics, and the once which did not have association were clustered separately.
- The researcher started with analysis of codes and topics identified and went through them by asking self questions such as "what is this codes and topics about?" and "what is the underlying meaning of these?"
- The researcher abbreviated the topics and codes in order to identify meaning of the collected data.
- The researcher developed themes and sub-themes from the coded data and reduced the total list of sub-themes which were related to one another.
- The sub-themes belonging to each theme was clustered together in one column which was followed by the meeting between the researcher and co-coder to reach consensus on themes and sub-themes that each one has come up with independently.

**Table 1 Themes and sub-themes Limpopo Province reflecting the effects of a provincial communication strategy to address ----- in the Limpopo Province**

<p><b>Central storyline:</b> Participants shared analogous knowledge with regard to how they view health promotion aspects in Limpopo Province which was focused mainly on the HIV and AIDS related aspects and the promotion of health by community members themselves and the efforts made by government and media. These views are reflected in were the views related health promotion as experienced by community members. The views were reflected as both negative and sometimes positives. The factors that were identified in promoting or obstructing health promotion included the stigma and discrimination that individuals experienced when they have an HIV positive status which ranged from self-discrimination until discrimination imposed by the healthcare system. Gender related aspects were also identified as factors of concern in relation to HIV positive diagnosis which resulted from knowledge and practices of HIV positive persons. The participants had suggestions of the strategies that could be utilized in order to improve health of the people in communities based on their experiences of what is happening in communities.</p>	
Main themes	Sub-themes
1. Views related to Health Promotion as viewed by community members	<ul style="list-style-type: none"> <li>1.1 Promotion versus lack of health promotion at all levels</li> <li>1.2 <b>Lack of specialised skills by healthcare workers</b></li> <li>1.3 Accessibility to specialised healthcare services problematic</li> <li>1.4 Communication barriers experienced</li> <li>1.5 Improvement in provision of quality care a necessity</li> <li>1.6 Negative attitudes of healthcare workers experienced</li> <li>1.7 Bioethical standard infringement observed</li> <li>1.8 Attitudes towards HIV positive status</li> </ul>
2. Stigma and discrimination related to HIV and AIDS	<ul style="list-style-type: none"> <li>2.1 Existence of stigma and discrimination in healthcare facilities</li> <li>2.2 Self-discrimination and stigmatisation experienced</li> <li>2.3 Stigma and discrimination lead to lack of adherence to ARTs</li> </ul>
3.Views related to Gender issues	<ul style="list-style-type: none"> <li>3.1 A need for gender-sensitive programme</li> <li>3.2 Men's health improvement programmes a necessity</li> <li>3.3 Attitudes and practices of men towards health</li> </ul>
4. Suggestions for context-specific health improvement	<ul style="list-style-type: none"> <li>4.1 Need for context-specific health education programme</li> <li>4.2 Community empowerment health</li> </ul>

	<ul style="list-style-type: none"> <li>programmes</li> <li>4.3 Strategies to reduce stigma and discrimination</li> <li>4.4 Recruitment of specific human resources</li> <li>4.5 Initiation of positive interpersonal relationships</li> <li>4.6 Enhancement of Employee Wellness Programme</li> <li>4.7 Need for 24hour healthcare services</li> <li>4.8 Scrutiny for media coverage</li> </ul>
5. Knowledge and practices related to HIV and AIDS	<ul style="list-style-type: none"> <li>5.1 Existence versus non-existence of HIV and AIDS programmes</li> <li>5.2 Disclosure of HIV positive status viewed as important</li> <li>5.3 Disclosure of HIV positive status problematic</li> <li>5.4 Ignorance versus lack of knowledge related to HIV and related aspects</li> </ul>

**Saturation of data** was achieved related to the major themes and most sub-themes this is confirmed through identification of more verbatim quotes/excerpts from the transcription provided used in that analysis.

**Limitations to interviewing process** – Leading were asked which directed on how the participants have to answer the questions.

**ANNEXURE Q**

**DRAFT HAST Communication strategy framework**

## **ANNEXURE Q**

### **DRAFT HIV AND AIDS, STIs AND TB COMMUNICATION STRATEGY FRAMEWORK**

#### **1. INTRODUCTION**

The document outlines the communication strategy of HIV, AIDS, STI's and TB (HAST). The strategy is part of a comprehensive approach to reach the goals of the Provincial HAST Strategic Plan and the Millennium Development Goals (MDGs 4, 5 and 6). It is an integral component of the Provincial HAST Programme and it recognises the interrelationships of HAST programmes.

The communication strategy for HAST is an inherent process within the Limpopo Province. It develops tailored messages and approaches using various communication channels. This is done in order to promote and maintain individual, community and societal behaviour change through sustaining good health.

#### **2. BACKGROUND OF HIV AND AIDS, STIS AND TB COMMUNICATION STRATEGY**

A country's burden of disease refers to the assessment of mortality, morbidity, injuries, disabilities and other risk factors specific to that country (Econex, 2009:1). South Africa's quadruple burden of disease, namely; a very high prevalence of HIV and AIDS which has now entered into a synergistic relationship with TB; maternal and child morbidity and mortality; exploding prevalence of non-communicable diseases, mostly driven by risk factors related to life-style; and violence, injuries and trauma (Department of Health, 2014:3).

HIV and AIDS were denoted one of the highest causes of death in South Africa, claiming about 314 000 lives in 2009 (Department of Health, 2010:2). The impact of the disease contributed to the growing trend of orphans in South Africa, with an estimated number of 1.95 million AIDS orphans in the country in 2009 (Department of Health, 2010:3). Though there is evidence that the new HIV infection rate has stabilised for the past 3 years, to below 30%, there is still a great need for health education and a health promotion programmes (NSP, 2012–2016:22). The potential impact of appropriate

information to equip people with knowledge and skills to improve their quality of lives is evident.

World Health Organisation (WHO) estimates show that South Africa currently ranks third highest in the world in terms of TB burden, behind India and China, with an incidence that has increased by 400% in the past 15 years, reaching 970 new infections per 100,000 people in 2009 (WHO Report, 2012:17). This increase in incidence is compounded by the appearance of multidrug-resistant tuberculosis (MDR-TB), with almost 7,386 confirmed MDR-TB cases in 2010 and 741 confirmed cases of extensively drug-resistant TB (XDR-TB) during the same period (WHO Report, 2012: 20). The HIV epidemic is currently driving the TB epidemic, with more than 70% of TB patients also living with HIV (Department of Health, 2012:22).

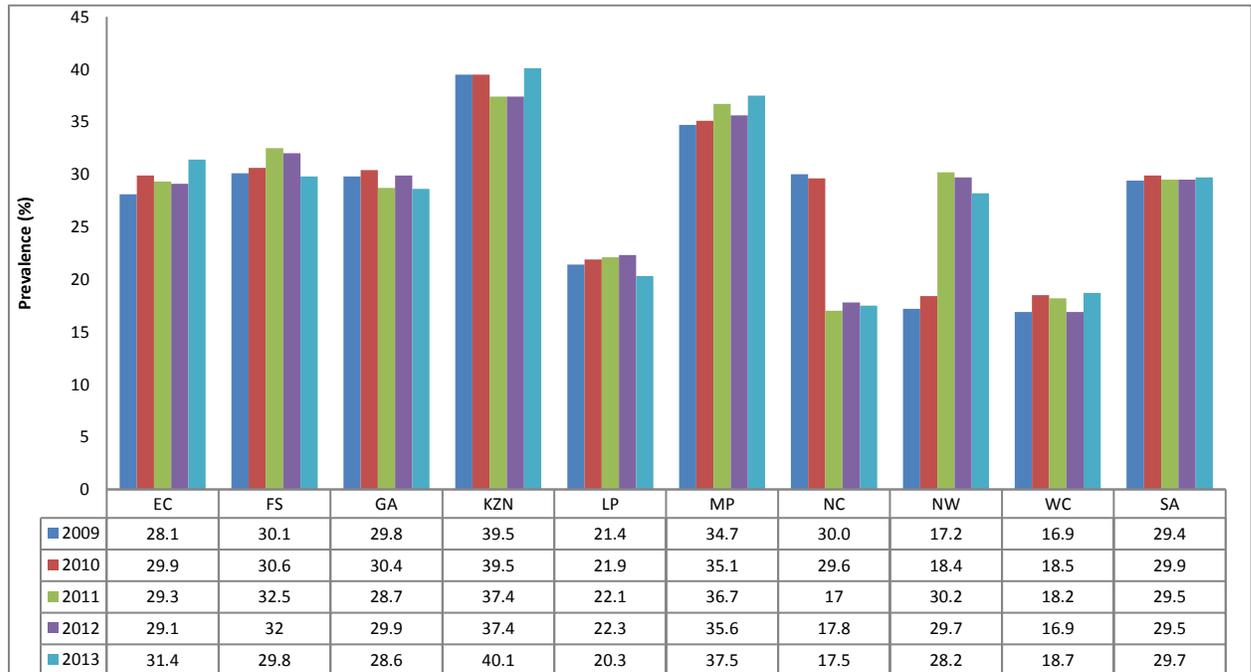
In South Africa, it is estimated that 11 million STI cases occur annually. For example, in Hlabisa, a rural area in KwaZulu-Natal, among 321 women attending district antenatal clinics, 52% were found to have at least one STI (gonorrhoea, chlamydial infection, trichomoniasis or syphilis) and 18% had more than one infection (Sonko et al., 2003:1).

In Limpopo in 2002 the number of cases of male urethral discharge (MUD) per 1 000 males age >+ 15 years was 47 (Sonko et al., 2003:7). In July 2002 the number of STI clients per population older than  $\geq 15$  years was 10.6% while nationally the figure as 6.5% (Ramkisson et al., 2014).

### **3. DISEASE PROFILE/ TRENDS**

The highest provincial HIV prevalence was recorded in KwaZulu-Natal (KZN), where prevalence increased from 37.4% in 2012 to 40.1% in 2013. Provinces with higher HIV prevalence estimates in 2013 when compared to 2012 are: Eastern Cape, where HIV prevalence increased from 29.1% in 2012 to 31.4% in 2013 and Mpumalanga, where HIV prevalence increased from 35.6% in 2012 to 37.5% in 2013. These small increases fell within expected sampling variability. In 2013, the lowest HIV prevalence rates were recorded in the Northern Cape (17.5%), the Western Cape (18.7%) and Limpopo (20.3%). North West, Limpopo, the Western Cape and the Northern Cape recorded

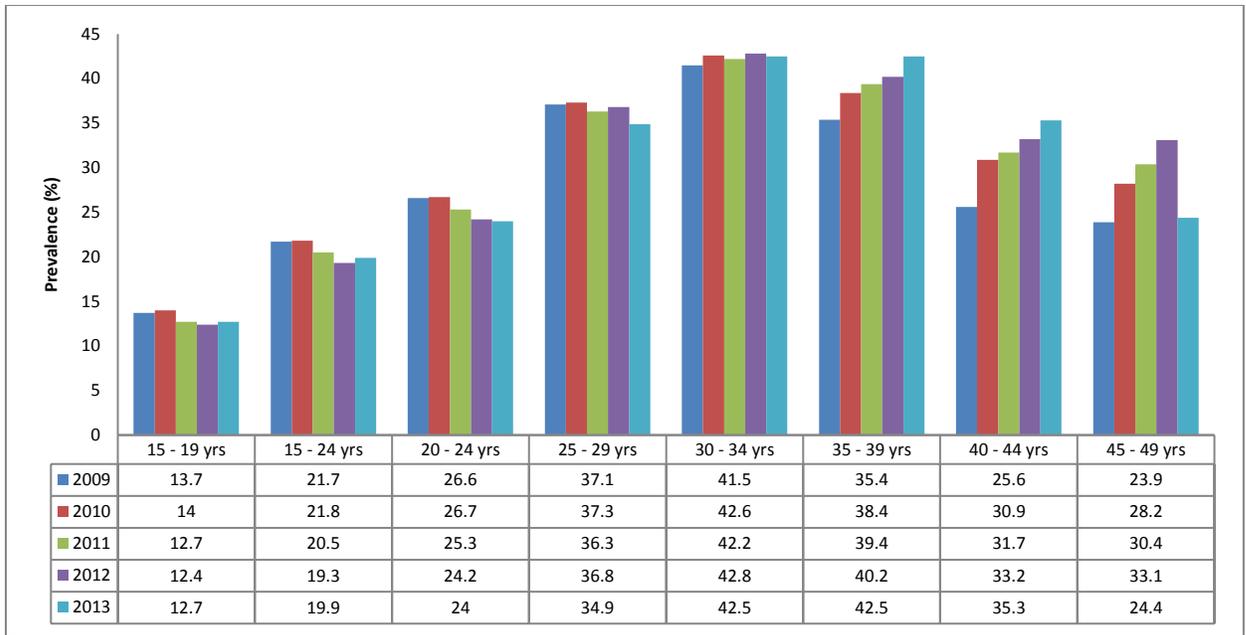
prevalence rates of between 20.0% and 30.0%. The Northern Cape and the Western Cape are the only provinces that have HIV prevalence figures below 20.0% (Department of Health, 2015:24). See figure 5.1 below.



(Department of Health, 2015:26)

**Figure 5.1:** HIV prevalence trends among antenatal women by province, SA, 2009 to 2013

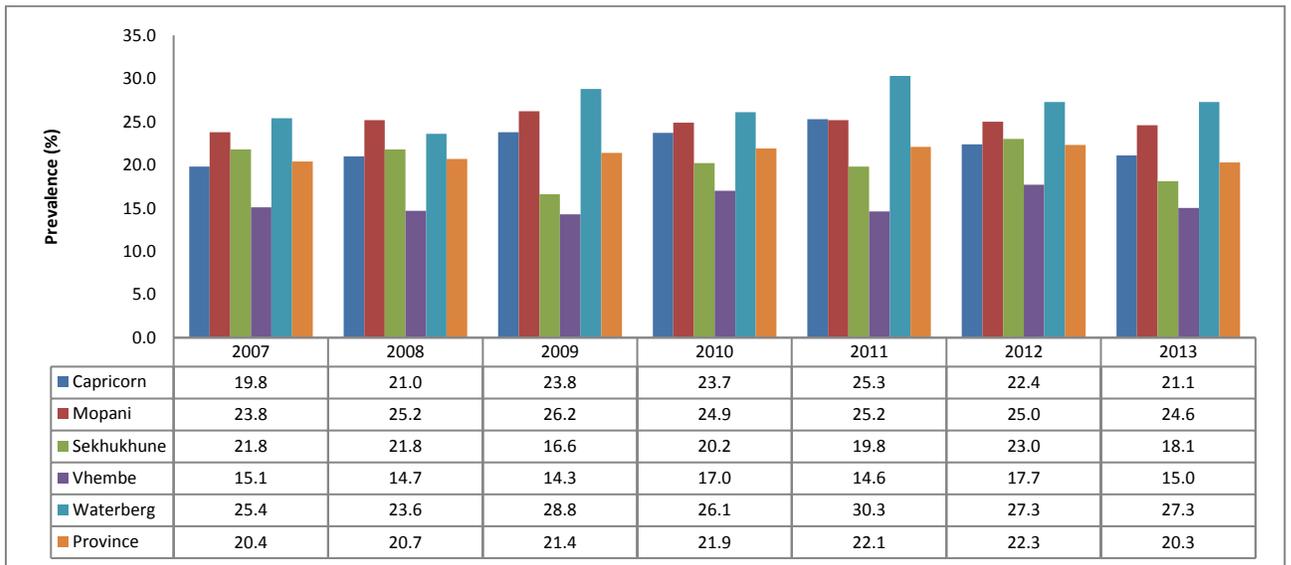
Nationally, the age groups 30-34 years and 35-39 years have the highest HIV prevalence rates, both at 42.5%. There is a doubling of prevalence between those aged 15-19 years (12.7%) and those aged 20-24 years (24.0%). The age group 15-19 years is the most important indicator to use for providing evidence when monitoring HIV incidence (new infections). HIV prevalence in this age group has been suggested as a proxy measure for the incidence because of the onset of sexual activity and, hence, prevalent mortality (Department of Health, 2014:33).



(Department of Health 2015:34)

**Figure 5.2:** HIV prevalence trends among antenatal women by age group, South Africa, 2009 to 2013

The 2013 Limpopo Antenatal Sentinel HIV & Syphilis Prevalence Survey



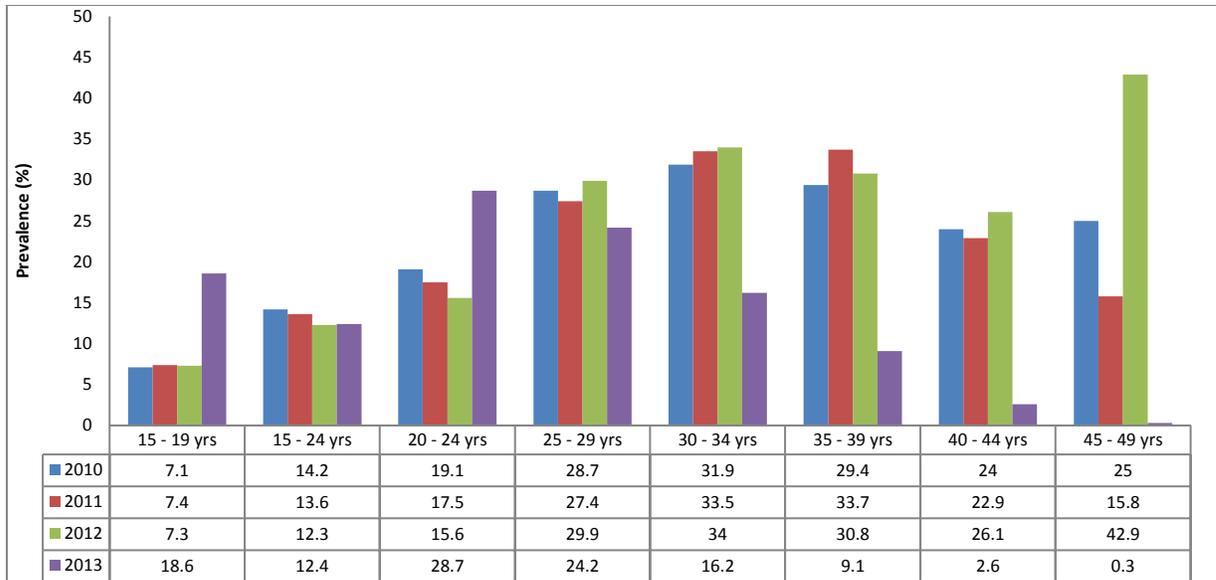
(Department of Health, 2015:55)

**Figure 5.3:** HIV prevalence trends among survey participants by district in Limpopo 2009 to 2013

In 2013, the Limpopo Provincial HIV prevalence rate among antenatal women was estimated at 20.3%. The overall Provincial HIV prevalence figure in Limpopo moderately decreased by 1.1% from 21.4% in 2009 (Department of Health, 2015:54).

In Limpopo, Capricorn, Mopani and Waterberg have recorded HIV prevalence figures of less than 30.0% over the past five years and there was a moderate decrease in HIV prevalence recorded from 2009 to 2013. There was a moderate increase in HIV prevalence in Sekhukhune and a 0.7% increase in Vhembe between 2000 and 2013 respectively (Department of Health, 2015:55).

The trends in district HIV prevalence rates in this Province have shown changes in these rates, with the Vhembe District consistently recording the lowest HIV prevalence rates, from 14.6% in 2011 to 17.7% in 2012 and 15.0% in 2013. Sekhukhune showed a similar trend, 18.9% in 2011 to 23.0% in 2012 and 18.1% in 2013. This could be attributed to small and variable sample sizes. The Waterberg District continues to record the highest HIV prevalence in this Province, although a significant decrease of 3% from 30.3% in 2011 to 27.3 % in 2012 and 2013 was noted (Figure 5.3) (Department of Health, 2014: 55).



(Department of Health, 2015:54)

**Figure 5.4:** Comparison of HIV prevalence trends among antenatal women by age group, Limpopo Province, 2010 - 2013.

Limpopo does not follow the same trend as the national trends per age. There is a decrease in prevalence between the ages of 30-34 years (from 34.0% in 2012 to 16.2% in 2013) and 35-39 years (from 30.8% in 2012 to 9.1% in 2013) (Figure 2.9). There is a doubling of the prevalence rates in the age group 15-19 years from 7.3% in 2012 to 18.6% in 2013 (Department of Health, 2015:54). The age group 15-19 years is the most important indicator to use for providing evidence when monitoring HIV incidence (new infections). HIV prevalence in this age group has been suggested as a proxy measure for the incidence because of the onset of sexual activity and, hence, prevalent mortality (Department of Health, 2015:33). According to the South African National HIV Survey (2012:130) all females aged 15–24 years, black African females, in particular those aged between 20 and 34 years, as well as black African males aged between 25 and 49 years, require specialised interventions aimed at raising awareness about the impact of HIV, promoting condom use and reducing multiple sexual partnerships.

World Health Organisation (WHO) estimates show that South Africa currently ranks third highest in the world in terms of TB burden, behind India and China with an

incidence that has increased by 400% in the past 15 years, reaching 970 new infections per 100,000 people in 2009 (WHO Report, 2012:17). This increase in incidence is compounded by the appearance of multidrug-resistant tuberculosis (MDR-TB), with almost 7,386 confirmed MDR-TB cases in 2010 and 741 confirmed cases of extensively drug-resistant TB (XDR-TB) during the same period (WHO Report, 2012:20). The HIV epidemic is currently driving the TB epidemic, with more than 70% of TB patients also living with HIV (Department of Health, 2012:22).

#### **4. THE BENEFITS OF HAST COMMUNICATION STRATEGY**

- To increase knowledge about HIV and TB in a language or visual medium (or any other medium that communities can understand and relate to).
- To stimulate community dialogue that encourages community and national discussions on the basic the facts relating to HIV and AIDS and the underlying factors that contribute to the epidemic, such as risk behaviours and risk settings, environments and cultural practices related to sex and sexuality, and marginalised practices (such as drug use) that create these conditions. The strategy can also stimulate discussion of healthcare-seeking behaviours for prevention, care and support.
- Promote essential attitude change that leads to appropriate attitudinal changes about, for example, perceived personal risk of HIV infection, belief in the right to and responsibility for safe practices and health supporting services, compassionate and non-judgmental provision of services, greater open-mindedness concerning gender roles and increasing the basic rights of those vulnerable to and affected by HIV and AIDS.
- Create a demand for information and services that can spur (stimulate) individuals and communities to demand information on HIV and TB and appropriate services.
- Improve skills and behaviours, such as condom use and universal precaution, for infection control

- Reduce stigmatisation and discrimination. Communication about HIV prevention and AIDS mitigation should address stigmatisation and discrimination and attempt to influence social responses to them.
- Advocate. The communication strategy can lead policymakers and opinion leaders towards effective approaches to deal with the epidemic.
- Promote services for prevention, care and support. The communication strategy can promote services for STIs, intravenous drug users (IDUs), orphans and vulnerable children (OVCs); HIV counselling and testing (HCT) for mother-to-child transmission (MTCT); support groups for PLHIV; clinical care for opportunistic infections; and social and economic support. The communication strategy is also an integral component of these services.
- Improve skills and sense of self-efficacy. Communication strategy programmes can focus on teaching or reinforcing new skills and behaviours, such as condom use, negotiating safer sex and safe injecting practices. The strategy can contribute to development of a sense of confidence in making and acting on decisions.

## **5. LEGISLATIVE FRAMEWORK**

The following legislation guided and supported the development of the communication strategy:

### **5.1 National Strategic Plan for HIV, STIs and TB 2012-2016**

The National Strategic Plan (NSP) on HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) (2012– 2016) is the strategic guide for the national response to HIV, STIs and TB for the next five years. The plan addresses the drivers of the HIV and TB epidemics, such as substance abuse; mobility and migration; multiple, concurrent and intergenerational sex and managing cultural practices, stigmatisation and discrimination; unemployment and inequality in income and wealth and builds on the achievements of the previous NSPs to achieve its goals (Department of Health, 2011: 12).

## **5.2 Limpopo Provincial Strategic Plan for HIV, STIs and TB 2012-2016**

The Limpopo Provincial Strategic Plan for HIV and AIDS, STIs and TB (2012-2016) was developed from the NSP and incorporates research and innovation relevant to Provincial needs. As outlined in the Provincial Strategic Plan for 2012-2016, the Limpopo Department of Health will continue to strive to achieve the following strategic objectives:

- Addressing social and structural barriers that increase vulnerability to HIV, STI and TB infection;
- Preventing new HIV, TB and STI infections;
- Sustaining health and wellness; and
- Increasing protection of human rights and improving access to justice

The communication strategy will assist the Department to achieve the strategic objectives by the informing the people about the burden of disease in terms of HAST and, thereby, improving their lifestyles.

## **5.3 Millennium Developmental Goals (MDGs)**

The Eight millennium goals are:

- Eradicate extreme hunger and poverty;
- Achieve universal primary education;
- Promote gender equality and empower women;
- Reduce child mortality;
- Improve maternal health;
- Combat HIV/AIDS, malaria and other diseases (including TB);
- Ensure environmental sustainability and
- Develop a global partnership for development (United Nation Developmental Programme (UNDP) in South Africa, 2012:1).

The MDGs can only be achieved through a coordinated and synergistic response through a wide spectrum of inter-sectoral and inter-agency collaboration. MDG 6 is

relevant to the HAST communication strategy and, to be achieved, requires the involvement and relevant stakeholders.

#### **5.4 Discussion Document on the Development of the South African National AIDS Council (SANAC) communication strategy**

The Discussion Document on the Development of the SANAC provides guidelines and priorities about the importance of prevention and how to target specific risk groups to promote and strengthen healthy behaviour in the context of a healthy development environment (SANAC, 2010: 2). According to SANAC (2010:11), in developing a planned and pro-active strategy, there is a need to ensure the participation of communities in developmental issues beyond health.

#### **5.5 National TB Advocacy, Communication and Social Mobilisation (ACSM) strategy 2007**

The ACSM strategy aims to ensure that every person knows the basics about TB through the active involvement of all leaders in the society (Department of Health, 2007:3).

Communication in TB control seeks to create and improve awareness among the general public about TB (e.g. its symptoms and curability), TB control services (e.g. diagnosis and treatment) and improve interpersonal communication between patients and care providers contributing to behavioural change (Department of Health, 2007:11).

#### **5.6 Provincial communication strategy 2009-2014: Limpopo Provincial Government.**

This provincial communication strategy seeks to set the stage for intensified and coordinated communication in the Province.

### **6. PURPOSE OF THE COMMUNICATION STRATEGY**

The purpose of this document is to put forward an integrated strategy to give direction on how to communicate HAST messages to all levels.

## **7. OBJECTIVES OF THE COMMUNICATION STRATEGY**

- To increase perception of risk or change attitudes toward use of condoms;
- To increase demand for services;
- To create demand for information on HIV and TB;
- To create demand for appropriate STI services;
- To Interest policymakers in investing HCT services;
- Promote acceptance among communities of sexuality and the value of reproductive health services.

## **8. GUIDING PRINCIPLES**

- The communication strategy should be integrated with programme goals from the start. It is an essential element of HIV prevention, care and support programmes, providing critical linkages to other programme components, including policy initiatives.
- Formative communication strategy assessments must be conducted to improve understanding of the needs of target populations, as well as of the barriers to, and supports for, behaviour change that their members face (along with other populations, such as stakeholders, service providers and community).
- The target population should participate in all phases of communication strategy development and in much of implementation.
- Stakeholders need to be involved from the design stage.
- Pre-testing is essential for developing effective communication strategy material.
- Planning for monitoring and evaluation should be part of the design of any communication strategy programme.
- Communication strategies should be positive and action-oriented.
- PLHIV should be involved in the planning and implementation of the communication strategy.

## 9. TARGET GROUP / AUDIENCE

UNICEF (2008:22) identified primary, secondary and tertiary target groups for health information.

### *Primary target groups for HIV and AIDS and other sexually transmitted infections*

- Individuals at high risk or vulnerability (key population), such as sex workers, their clients, different age groups, migrant workers, IDUs, or uniformed services personnel, the disabled, men who have sex with men;
- Various economic groups, such as miners, farm workers, the youth and also men should be involved in the buy-in for support and behaviour change;
- People living with HIV (PLHIV);
- Caregivers of children or older persons;
- Local communities and families.

### *Primary target groups for TB*

- Various economic work groups such as miners and farm workers;
- Migrant workers, IDUs, or uniformed services personnel;
- Inmates in correctional services;
- Church members;
- Learners;
- Caregivers;
- Local communities and families;
- People living with HIV (PLHIV);
- TB clients.

Secondary target groups include people or groups that can influence and support the sustained behaviour of persons in the primary target group (UNICEF, 2008:22).

### *Secondary target groups for HIV and AIDS and other sexually transmitted infections*

- Health professionals, lay counsellors, peer educators and Home and community based carers;
- People providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers;
- Family members.

*Secondary target groups for TB*

- DOT supporters;
- Family members;
- Health professionals, lay counsellors, peer educators and home- and community-based carers;
- People providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers.

Tertiary target groups are those whose actions indirectly help or hinder the behaviours of other participants (UNICEF, 2008:22).

*Tertiary target groups for HIV and AIDS and other sexually transmitted infections*

- Parliamentarians, politicians and high level government officials who make policy and allocate resources;
- Religious leaders (representing religious organisations at the national level), professional associations influencing service delivery policies and Members of the AIDS Councils at different levels (national, provincial and municipal);
- Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; traditional health practitioners (THP);
- Non-governmental organisations and community stakeholders;
- Donors.

*Tertiary target groups for TB*

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- Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; traditional health practitioners (THP);
- Non-governmental Organisations and community stakeholders;
- Donors.

### **10. Communication strategies**

Communication strategies have to effectively communicate the right message, to the right people in the right way.

Messages can be delivered through mass media—for example, television or radio slots; articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics—or in-person, by health workers, peer educators, counsellors, or other trained personnel. Additional means of delivery include musical or dramatic performances and community events (FHI, 2012:15). These can be classified as follows:

- Use of mass media and social networks, e.g. television and radio slots, Whatsapp, Twitter, Facebook, Mxit etc.;
- Printed material, e.g. articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics;
- Non-conventional strategies, e.g. musical or dramatic performances and community events;
- Individual face-to-face communication, e.g. Individual or group dialogues;
- Marketing, including launching, popularisation and presence on the Departmental website so that the information is accessible and can be utilised by all.

## 11. CONTENT

It is, therefore, imperative for an effective communication strategy, which aims to address the HAST diseases, that people should have access to HIV testing, prevention services tailored to their needs and to receive appropriate treatment. The content should include prevention, early diagnosis and treatment. The following should form part of the content:

- A health information programme;
- Screening for TB and testing for HIV;
- Knowledge about HAST;
- Infection control;
- The positive and negative effects of disclosure;
- Support structures;
- Stigmatisation and discrimination;
- Availability and accessibility of the effectiveness of health services;
- Influence of the cultural practices.

## 12. IMPLEMENTATION OF THE STRATEGY

- *Multi- sectoral approach*

Key stakeholders need to be involved early in every step of the process of developing HIV and TB programmes and their communication strategy components. Stakeholders include policymakers, opinion leaders, community leaders, religious leaders and members of target populations, including PLHIV. Their active participation at appropriate stages of communication strategy development is essential. A stakeholders meeting should be held at the planning stage to obtain guidance and commitments to the process, and to develop coordination mechanisms.

- *Community participation*

Community engagement and inputs must be an integral part of all aspects of strategy development, implementation and monitoring. This means that community should be enabled and empowered throughout an effective strategy (UNISEF, 2008:55). Involvement of community members should be integrated into the design process in terms of advocacy, social mobilisation and behaviour change communication (UNISEF, 2008:40).

- *Role players in health communication*

It was mentioned that professionals and non-professionals should be the implementers of the communication strategy. This includes HAST programme managers and politicians.

The role players according FHI (2002:11) includes people providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers; policymakers, such as politicians; Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; Local communities and families.

### **13. RESOURCES AND BUDGET**

A communication strategy needs good management support to ensure correct sequencing of activities; collaboration and coordination; identification of appropriate resources; and budgeting.

One of the functions of AIDS Councils is to mobilise resources for the implementation of the HIV & TB Provincial Strategic Plan in consultation with the South African National AIDS Council (SANAC). Another function of these Councils is to strengthen partnerships for a multi-sectoral provincial response among government agencies, NGOs, donors, the private sector and people living with HIV and AIDS.

Planning for ongoing communication capacity-building is essential in implementing a communication strategy, whether in regard to formative communication strategy

assessment, design, communication product development, pre-testing, monitoring, or evaluation. Capacity-building is also extremely important for personnel (peer educators, outreach workers, counsellors and community workers) whose primary responsibility is communicating with the target population.

Ensuring that peer educators know about the timing, objectives and content of messages through other channels, as well as providing those personnel with adequate communication skills and support materials, will enable them to reinforce key messages and stimulate discussion. These individuals should also be prepared to help people acquire essential new skills and prepare personal plans of action.

Communication training is also necessary for political, religious, social and cultural leaders and authorities. Staff members of implementing agencies who will need to “sell” their programmes to communities and authorities will need new skills as well as support material. Self-help groups and human rights advocacy groups also need communication skills, particularly if they take on a significant role in building a supportive environment and decreasing stigma. Other parties whose primary responsibility is service delivery will have a communication role and need training in this as well; this includes clinical care providers, HCT staff and social development staff. Materials are meant to be *used*. Without good communication skills, the best materials are likely to fail and messages are likely to get lost.

Training media professionals should also be part of the plan. Broad and cost-effective reach can be accomplished by making use of a well-oriented cadre of media personnel (after all, they will be producing media whether or not they are part of a programme). Conversely, ill-trained media personnel can perpetuate myths, create stigma and harm the lives of PLHIV and their families, however unintentionally.

Finding adequate capacity-building resources will also be a challenge. It is important to build the capacity of implementing partners and of local, national, regional and

international human resources. Strategies for increasing capacity in the area of a communication strategy include:

- Quality strategic planning and design at the beginning of programmes;
- Developing standardised tools, including training modules, guidelines and protocols;
- Setting up national, regional and international training programmes;
- Developing a cadre of local, national, regional and international consultants who can provide quality technical support;
- Working with networks of PLHIV to develop their ability to communicate effectively.

#### **14. MONITORING AND EVALUATION**

A plan for monitoring and evaluation needs to be drawn up during the initial stage of communication strategy design. The information to be gathered for the communication strategy should be linked to the programme's overall monitoring system.

Monitoring is part of the ongoing management of communication activities and it usually focuses on the process of implementation. The following should be closely monitored:

- Reach: Are adequate numbers of the target audience being reached over time?
- Coordination: Are messages adequately coordinated with service and supply delivery and with other communication activities? Are communication activities taking place on schedule, at the planned frequency?
- Scope: Is communication effectively integrated with the necessary range of audiences, issues and services?
- Quality: What is the quality of communication (messages, media and channels)?
- Feedback: Are the changing needs of target populations being captured?

To monitor the course of a communication strategy properly, it is necessary to establish effective information-gathering systems. These include reports, site visits and reviews of materials. Reporting tools and protocols must be standardised to ensure consistency.

Periodic focus-group discussions and in-depth interviews can also help communication strategy programmers assess the perceptions of target populations. Peer educators can collect responses from target populations to help identify changes that may have to be made in the environment or to aspects of communication and services that may need to be addressed.

The evaluation of outcomes (actual, measurable changes in behaviour and environment) is generally more complex and may be beyond the resources and capabilities of many country-level programmes, and certainly of projects. Good monitoring data enables programmes to demonstrate the degree to which they have contributed to changes as measured by national surveillance systems, such as the Behavioral Surveillance Survey (BSS). Questions related to communication intervention can be added to such a survey to assess the activities' reach.

## **17. CONCLUSION**

The communication strategy should be linked to the overall goals and strategies of HIV and TB prevention, care and support programmes. Individuals who plan and implement HIV and TB programmes should develop strategic approaches that view the communication strategy, not as a collection of different and isolated communication tactics, but as a framework of linked approaches that function as part of an ongoing, interactive process.

**ANNEXURE R**

**Final HAST Communication strategy framework**

## **ANNEXURE R**

### **THE FINAL HAST COMMUNICATION STRATEGY FRAMEWORK**

#### **Acknowledgements**

I like to thank the Almighty God who gave me strength and wisdom to compile this communication strategy; my UNISA supervisor Prof SP Human and co-supervisor Prof AH Mavhunduzi for making my studies more manageable. The HIV and AIDS, STIs and TB Deputy Directors at the District and Provincial levels, Capricorn District AIDS Council civil society members for their contribution in this document. Capricorn District HAS Assistant Directors who piloted the document in a working environment and Directors HAS, TB and Stakeholder Coordination who manage to assess the communication strategy and give their input. All who contributed to the success of this document, may God richly bless you.

#### **Summary**

Strategic design is the hallmark of successful health programmes. Over the past 20 years, health communicators have come to realise that collaboratively designed, implemented and evaluated health communication strategies will help achieve the goal of improving health in a significant and lasting ways by empowering people to change their behaviour and by facilitating social change. Sound communication strategies provide coherence for a health programme's activities and enhance the health programme's power to succeed. Strategic communication is the programme's steering wheel, guiding it towards its goals. Strategic communication is also the glue that holds the programme together or the creative vision that integrates a programme's multifaceted activities.

#### **Acronyms**

AIDS	Acquired Immune Deficiency Syndrome
ACSM	Advocacy, Communication and Social Mobilisation

ART	Anti-Retroviral Treatment
CCMTP	Comprehensive Care, Management and Treatment Programme
DOH	Department of Health
HAS	HIV and AIDS, STI
HAST	HIV and AIDS, STI and TB
HCBC	Home & Community Based Care
HCT	HIV Counselling and Testing
HTA	High Transmission Areas
HIV	Human Immuno Virus
IDUs	Intravenous Drug Users
MTCT	Mother to Child Transmission
M&E	Monitoring and Evaluation
NDOH	National Department of Health
NGO	Non–Governmental Organisations
NPO	Non-Profit organisation
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHIV	People living with HIV
TB	Tuberculosis

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## **1. INTRODUCTION**

The document outlines a communication strategy for HIV, AIDS, STI's and TB (HAST). This strategy is part of a comprehensive approach to reach the goals of the Provincial HAST Strategic Plan and the Sustainable Developmental Goals (SDGs). It is an integral component of the Provincial HAST Programme and it recognises the interrelationship of HAST programmes.

The communication strategy for HAST is an inherent process within the Limpopo Province. It develops tailored messages and approaches using various communication strategies. This is done in order to promote and maintain individual, community and societal behaviour change through sustaining good health.

## **2. BACKGROUND OF HIV AND AIDS, STIS AND TB COMMUNICATION STRATEGY**

A country's burden of disease refers to the assessment of mortality, morbidity, injuries, disabilities and other risk factors specific to that country (Econex, 2009:1). South Africa's quadruple burden of disease, namely; a very high prevalence of HIV and AIDS, which has now entered into a synergistic relationship with TB; maternal and child morbidity and mortality; exploding prevalence of non-communicable diseases mostly driven by risk factors related to life-style; and violence, injuries and trauma (Department of Health, 2014:3).

HIV and AIDS were noted one of the highest causes of death in South Africa, claiming about 314 000 lives in 2009 (Department of Health, 2010:2). The impact of the disease contributed in a growing trend of orphans in South Africa, there are an estimated 1.95 million AIDS orphans in 2009 (Department of Health, 2010:3). Though there is evidence that new HIV infection rate has stabilised over the past 3 years, to below 30%, there is still a great need for a health education and a health promotion programme (NSP, 2012–2016:22). The potential impact of appropriate information to equip people with knowledge and skills to improve the quality of their lives is evident.

World Health Organisation (WHO) estimates show that South Africa currently ranks third highest in the world in terms of TB burden, behind India and China, with an incidence rate that has increased by 400% in the past 15 years, reaching 970 new infections per 100,000 people in 2009 (WHO Report 2012:17). This increase in incidence is compounded by multidrug-resistant tuberculosis (MDR-TB), with almost 7,386 confirmed MDR-TB cases in 2010 and 741 confirmed cases of extensively drug-resistant TB (XDR-TB) during the same period (WHO report 2012: 20). The HIV epidemic is currently driving the TB epidemic, with more than 70% of TB patients also living with HIV (Department of Health, 2012:22).

In South Africa, it is estimated that 11 million STI cases occur annually. For example, in Hlabisa, a rural area in KwaZulu-Natal, among 321 women attending district antenatal clinics, 52% were found to have at least one STI (gonorrhoea, chlamydial infection, trichomoniasis or syphilis) and 18% had more than one infection (Sonko et al., 2003:1).

### **3. DISEASE PROFILE/ TRENDS**

#### **3.1 HIV Prevalence**

Globally, an estimated 34 million people were living with HIV in 2011. Sub-Saharan Africa remains the epicentre of the epidemic and accounts for nearly 70% of the world's HIV and AIDS burden. South Africa is the worst affected country in the world, with an estimated 6.1 million people living with HIV in 2012. This is the largest number of people living with HIV in one country in the world (Department of Health, 2012:4).

In 2012 in Limpopo, the HIV prevalence among antenatal women was estimated at 22.3%. The overall provincial HIV prevalence in Limpopo has increased slightly from 21.9% in 2010 to 22.1% in 2011 and 22.3% in 2012 (Department of Health, 2012:45).

Changes in HIV prevalence rates were seen in the Vhembe District, which has consistently recorded the lowest HIV prevalence in the Province, from 17.0% in 2010 to 14.6% in 2011 and 17.7% in 2012. Sekhukhune showed a similar trend with prevalence

decreasing from 20.2% in 2010 to 18.9% in 2011 and increasing to 23.0% in 2012. This could be attributed to small and variable sample sizes. The Waterberg District continues to record the highest HIV prevalence in this Province, although a decrease of 3% from 30.3% in 2011 to 27.3 % was noted this year (Department of Health, 2012:45).

The HIV prevalence among 15-24 year old pregnant women has been decreasing steadily over the past three years, from 14.2% in 2010 to 13.6% in 2011 and 12.3% in 2012. An HIV prevalence of 34.0% was seen among women in the age groups 30–34 years (Department of Health, 2012:47).

### **3.2 TB Incidences**

Tuberculosis is the most prevalent notifiable medical condition in South Africa. In the Limpopo Province case detection has improved from 21 849 to 20 308 in 2012. The case load showed a steady decline in 2013 to 19 513 and this decline could either be the result of a reversal of the epidemic or due to inadequate screening. We are, however, embarking on intensified case finding (ICF) through TB screening, testing and linking to care. The cure rate has drastically improved from 67.45% in 2008 to 77.35% in 2013, which is approximately a 10% improvement, and treatment success rate of 79.2% in 2013 (Department of Health, 2015:14).

The smear conversion rate has also improved from 59.9% in 2008 to 68.3% in 2012 and the defaulter rate has been reduced from 8.2% in 2008 to 5.0% in 2012. There is a consistent increase in the number of patients with DOT supporter leading to an increase in TB DOT coverage from 72.0% in 2006 to 91.3% IN 2013. This shows a positive contribution to the cure rate in the Province as better adherence to treatment and intensified care in the community is achieved (Department of Health, 2015:15).

HIV/TB co-infection has been a challenge in the Province but great achievements have been made with regard to case findings and management. The number of patients with

“known” HIV status has improved from 22.3% in 2008 to 92.2% in 2013 (Department of Health, 2015:15).

### **3.3 STIs Incidences**

In Limpopo in 2002, the number of cases of male urethral discharge (MUD) per 1 000 males aged >+ 15 years was 47 (Sonko et al., 2003:7). STI clients per population aged ≥15 years is 10.6%, while nationally this figure is 6.5% by July 2002 (Ramkisson et al., 2014).

## **4. THE BENEFITS OF HAST COMMUNICATION STRATEGY**

- To increase knowledge of HIV and TB in a language or visual medium (or any other medium that the target audience can understand and relate to).
- To stimulate community dialogue that encourages community and national discussions on the basic facts of HIV and AIDS and the underlying factors that contribute to the epidemic, such as risk behaviours and risk settings, environment and cultural practices related to sex and sexuality and marginalised practices (such as drug use) that create these conditions. It can also stimulate discussion of healthcare-seeking behaviours for prevention, care and support.
- Promote essential attitude change that leads to appropriate attitudinal changes about, for example, perceived personal risk of HIV infection, belief in the right to and responsibility for safe practices and health supporting services, compassionate and non-judgmental provision of services, greater open-mindedness concerning gender roles and increasing the basic rights of those vulnerable to and affected by HIV and AIDS.
- Create a demand for information and services that spur (stimulate) individuals and communities to demand information on HIV and TB and appropriate services.
- Improve skills and behaviours, such as condom use and universal precautions for infection control

- Reduce stigmatisation and discrimination. The communication about HIV prevention and AIDS mitigation should address stigma and discrimination and attempt to influence social responses to them.
- Advocate. The communication strategy can lead policymakers and opinion leaders towards effective approaches to the epidemic.
- Promote services for prevention, care and support, e.g. services for STIs, intravenous drug users (IDUs), orphans and vulnerable children (OVCs); HIV counselling and testing (HCT); for prevention of mother-to-child transmission (PMTCT); support groups for PLHIV; clinical care for opportunistic infections; and social and economic support. The communication strategy is also an integral component of these services.
- Improve skills and sense of self-efficacy. Communication strategy programmes can focus on teaching or reinforcing new skills and behaviours, such as condom use, negotiating safer sex and safe injecting practices. It can contribute to development of a sense of confidence in making and acting on decisions.

## **5. LEGISLATIVE FRAMEWORK**

The following legislation guided and supported the development of the communication strategy:

- Constitutional mandates;
- Sustainable Developmental Goals (SDG);
- Batho-Pele Principles;
- The Patients' Rights Charter;
- Communication Strategy for the National Health Insurance (NHI) in the Limpopo Province;
- National Strategic Plan for HIV, STIs and TB 2012-2016;
- Limpopo Provincial Strategic Plan for HIV, STIs and TB 2012-2016;
- Discussion Document on the Development of the South African National AIDS Council (SANAC) communication strategy;

- National TB Advocacy, Communication and Social Mobilisation (ACSM) strategy 2007;
- Provincial Communication Strategy 2009-2014: Limpopo Provincial Government.

## **6. PURPOSE OF THE COMMUNICATION STRATEGY**

The purpose of this document is to put forward an integrated strategy to give direction on how to communicate HAST messages to all levels.

## **7. OBJECTIVES OF THE COMMUNICATION STRATEGY**

- To increase perceptions of risk or to change attitudes toward the use of condoms;
- To increase demand for HAST services;
- To create demand for information on HIV and TB;
- To interest policymakers in investing in HIV counselling and testing (HCT) and intensified case finding of TB cases (ICF) services; infection control, treatment adherence and treatment completion;
- Promote acceptance among communities of sexuality and the value of reproductive health services.

## **8. GUIDING PRINCIPLES**

- The communication strategy should be integrated with programme goals from the start. It is an essential element of HIV and TB prevention, care and support programmes, providing critical linkages to other programme components, including policy initiatives.
- Formative communication strategy assessments must be conducted to improve understanding of the needs of target populations, as well as of the barriers to and

support for behaviour change that their members face (along with other populations, such as stakeholders, service providers and community).

- The target population should participate in all phases of communication strategy development and in much of implementation.
- Stakeholders need to be involved from the design stage.
- Pre-testing is essential for developing effective communication strategy materials.
- Planning for monitoring and evaluation should be part of the design of any communication strategy programme.
- Communication strategies should be positive and action-oriented.
- PLHIV and TB ambassadors should be involved in communication strategy planning and implementation.

## **9. TARGET GROUP / AUDIENCE**

UNICEF (2008:22) identified primary, secondary and tertiary target groups for health information.

### *Primary target groups for HIV and AIDS and other sexually transmitted infections*

- Individuals at high risk or vulnerability (key population), such as sex workers, their clients, different age groups, migrant workers, intravenous drug users (IDUs), or uniformed services personnel, the disabled and men who have sex with men;
- Various economic work groups such as miners, farm workers and the youth should be involved, as should men, to buy-in for support and behaviour change;
- People living with HIV (PLHIV);
- Caregivers of children or older persons;
- Local communities and families.

### *Primary target groups for TB*

- Various economic work groups, such as miners, farm workers;
- migrant workers, intravenous drug users (IDUs), or uniformed services personnel;
- Inmates in Correctional Services;
- Church members;
- Learners;
- Caregivers;
- Local communities and families;
- People living with HIV (PLHIV);
- TB clients.

Secondary target groups include people or groups who can influence and support the sustained behaviour of persons in the primary target group (UNICEF, 2008: 22).

### *Secondary target groups for HIV and AIDS and other sexually transmitted infections*

- Health professionals, lay counsellors, peer educators and home- and community-based carers;
- People providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers;
- Family members.

### *Secondary target groups for TB*

- DOT supporters;
- Family members;
- Health professionals, lay counsellors, peer educators and home- and community-based carers;
- People providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers.

Tertiary target groups are those whose actions indirectly help or hinder the behaviours of other participants (UNICEF, 2008:22).

*Tertiary target groups for HIV and AIDS and other sexually transmitted infections*

- Parliamentarians, politicians and high level government officials who make policy and allocate resources;
- Religious leaders (representing religious organisations at a national level), professional associations influencing service delivery policies and Members of the AIDS Councils at different levels (national, provincial and municipal);
- Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; traditional health practitioners (THP);
- Non-governmental organisations and community stakeholders;
- Donors.

*Tertiary target groups for TB*

- Parliamentarians, politicians and high level government officials who make policy and allocate resources;
- Religious leaders (representing religious organisations at the national level), professional associations influencing service delivery policies and Members of the AIDS Councils at different levels (national, provincial and municipal);
- Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; traditional health practitioners (THP);
- Non-governmental organisations and community stakeholders;
- Donors.

## **10. COMMUNICATION STRATEGIES**

Communication strategies have to effectively communicate the right message, to the right people in the right way.

Messages can be delivered through mass media—for example, television or radio slots; articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics—or in-person, by health workers, peer educators, counsellors, or other trained personnel. Additional means of delivery include musical or dramatic performances and community events (FHI, 2012:15). This can be classified as follows:

- Use of mass media and social networks e.g. Television and radio slots, Whatsapp, Twitter, Facebook, Mxit, etc.;
- Printed material, e.g. articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics;
- Non-conventional strategies, e.g. musicals or dramatic performances and community events;
- Individual face-to-face communication, e.g. individual or group dialogue;
- Marketing includes launching, popularisation and placement on the Departmental website so that is seen and utilised by all.

## **11. CONTENT**

It is, therefore, imperative for an effective communication strategy with the aim to address the HAST diseases that people should have access to HIV testing, prevention services tailored to their needs and to receive appropriate treatment. The content must include prevention, early diagnosis and treatment. The following to form part of the content:

- Health information programme;
- Screening for TB and testing for HIV;
- Knowledge about HAST;
- Infection control;
- Positive and negative effect of disclosure;
- Support structures;
- Stigma and discrimination;
- Availability and accessibility of the effectiveness of health services;
- Influence of the cultural practices.

## 12. IMPLEMENTATION OF THE STRATEGY

- *Multi- sectoral approach*

Key stakeholders need to be involved early in every step of the process of developing HIV and TB programmes and their communication strategy components. Stakeholders include policymakers, opinion leaders, community leaders, religious leaders and members of target populations, including PLHIV. Their active participation at appropriate stages of communication strategy development is essential. A stakeholders' meeting should be held at the planning stage to obtain guidance and commitments to the process and to develop coordination mechanisms.

- *Community participation*

Community engagement and inputs must be an integral part of all aspects of strategy development, implementation and monitoring. This means that community should be enabled and empowered throughout an effective strategy (UNISEF, 2008:55). Involvement of community members should be integrated into the design process in terms of advocacy, social mobilisation and behaviour change communication (UNISEF, 2008:40).

- *Role players in health communication*

It was mentioned that professionals and non-professionals should be the implementers of the communication strategy which include the HAST programme managers, and politicians.

The role players according FHI (2002:11), include people providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers; policymakers, such as politicians; Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders; local communities and families.

### **13. RESOURCES AND BUDGET**

The communication strategy needs good management support to ensure correct sequencing of activities; collaboration and coordination; identification of appropriate resources; and budgeting.

Seven important areas where resources and budget is needed which include:

- Communication research;
- Monitoring and evaluation;
- Training/capacity-building,
- Development and production of print materials;
- Development and production of broadcast materials;
- Special events and Local planning; and,
- Coordination of meetings.

### **14. MONITORING AND EVALUATION**

More and more, when development programmes do monitoring and evaluation (M&E), they adopt an approach called, “participatory monitoring and evaluation”, where the people addressed by the programme are also involved in monitoring and evaluating its activities. For communication, this means that the people targeted by communication activities are also involved in tracking progress, and reflecting upon and learning from their own experiences.

Through wider participation in M&E, the focus is very much on learning for everyone involved, not on police-work by programme managers and donors. Ideally then, a broad range of beneficiaries and stakeholders should participate. By taking part in tracking the progress and analysing the results of the activities in which they are involved, the participants' motivation and sense of ownership is substantially improved and the project is more likely to be sustained over time. Essentially, “participatory M&E” is applying the principles of community participation to the M&E process.

A plan for monitoring and evaluation needs to be drawn up during the initial stage of communication strategy design. The information to be gathered for the communication strategy should be linked to the programme's overall monitoring system.

Monitoring is part of the ongoing management of communication activities and it usually focuses on the process of implementation. The following should be closely monitored:

- Reach: Are adequate numbers of the audience being reached over time?
- Coordination: Are messages adequately coordinated with service and supply delivery and with other communication activities? Are communication activities taking place on schedule, at the planned frequency?
- Scope: Is communication effectively integrated with the necessary range of audiences, issues and services?
- Quality: What is the quality of communication (messages, media and channels)?
- Feedback: Are the changing needs of target populations being captured?

To monitor the course of a communication strategy properly, it is necessary to establish effective information-gathering systems. These include reports, site visits and reviews of materials. Reporting tools and protocols must be standardised to ensure consistency.

Periodic focus-group discussions and in-depth interviews can also help communication strategy programmers assess the perceptions of target populations. Peer educators can collect responses from target populations to help identify changes that may have to be made in the environment or aspects of communication and services that may need to be addressed.

The evaluation of outcomes (actual, measurable changes in behaviour and environment) is generally more complex and may be beyond the resources and abilities of many country-level programmes and certainly of projects. Good monitoring data enables programmes to demonstrate the degree to which they have contributed to changes as measured by national surveillance systems, such as the Behavioural Surveillance Survey (BSS). Questions related to communication intervention can be added to such a survey to assess the activities' reach.

## **15. CONCLUSION**

Communication strategy should be linked to the overall goals and strategies of HIV and TB prevention, care and support programmes. Individuals who plan and implement HIV and TB programmes should develop strategic approaches that view communication strategy not as a collection of different and isolated communication tactics but as a framework of linked approaches that function as part of an ongoing, interactive process.

**ANNEXURE S**

**Editing affidavit**



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## To Whom it May Concern

I hereby confirm that I have proof-read the document entitled: "THE EFFECT OF A PROVINCIAL COMMUNICATION STRATEGY TO ADDRESS HIV AND AIDS, STIs AND TB (HAST) IN THE LIMPOPO PROVINCE" authored by NGWAKO JOHANNAH RAPAKWANA.

Each of us has our own unique voice as far as both spoken and written language is concerned. In my role as proof-reader I try not to let my own "written voice" overshadow the voice of the author, while at the same time attempting to ensure a readable document.

Please refer any queries to me.

**Andrew Scholtz**