HOME-BASED HIV COUNSELLING AND TESTING: PERCEPTIONS AND ACCEPTANCE IN A RURAL FARMING COMMUNITY OF SOUTH AFRICA

by

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DECLARATION

I declare that **HOME-BASED HIV COUNSELLING AND TESTING: PERCEPTIONS AND ACCEPTANCE IN A RURAL FARMING COMMUNITY OF SOUTH AFRICA** 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.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

22 October 2018

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SIGNATURE **DATE**

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ABSTRACT

South Africa is facing an ongoing public health crisis with increasing and alarming human immunodeficiency virus (HIV) statistics. Farmworkers in South Africa are highly vulnerable and susceptible to HIV. This study involved the farmworker community on a farm in the North West province of South Africa. The purpose of this study was to explore the perceptions and acceptance of home-based HIV counselling and testing (HBHCT) in a rural farming community, using an interactive World Café method to stimulate creative discussions around questions that matter. Thirty-one farmworkers participated in the World Café. This study had an explorative approach and qualitative design.

The study did not investigate the number of HIV infections or sexual practices on the farm, and did not offer an HIV test or any other medical treatment to any participant.

Data were collaboratively analysed by the researchers and the participants. Content analysis of data was conducted. The findings indicated that majority of the farmworkers had a positive perception of HBHCT, and that there was a serious need for HIV prevention and intervention in this community. Some concerns were raised among the participants regarding the confidentiality of HBHCT, attention should therefore be paid to these concerns.

More research is needed to establish linkage to care after HBHCT. It remains unclear whether the migrant farmworker population would be effectively linked to HIV care and treatment without legal identification documentation. The acceptance of HBHCT in the farming community by farmers, should be explored.

The study found that there would be a high level of acceptability if HBHCT were to be offered to farmworkers in this region. This study created insight into the HIV care and prevention needs of the local farmworker community, as well as highlighted the barriers the farmworkers face in attending primary healthcare (PHCs) clinics for HIV testing.

Key concepts

AIDS; acceptance; farm, farmworker; HIV; home-based HIV counselling and testing; perception; rural farming community; the World Café.

OPSOMMING

Suid-Afrika staar ’n voortdurende openbare gesondheidskrisis in die gesig met toenemende en onrusbarende menslike immuungebrekkige virus (MIV)-statistieke. Plaaswerkers in Suid-Afrika is uiters kwesbaar en vatbaar vir MIV. Hierdie studie het die plaaswerkergemeenskap van ’n plaas in die Noordwes-provinsie van Suid-Afrika geteiken. Die doel van hierdie studie was om die sieninge en aanvaardingsvlakke van tuis-gebaseerde MIV-berading en -toetsing (TSMBT) te ondersoek, deur gebruik te maak van die “World Café”-metode om kreatiewe bespreking rondom belangrike vrae te stimuleer. Een-en-dertig plaaswerkers het deelgeneem aan die “World Café”.

Hierdie studie het nie die aantal MIV-infeksies of seksuele praktyke op die plaas ondersoek nie, en ook nie ’n MIV toets of enige ander mediese behandeling vir enige deelnemer aangebied nie.

Die studie het gevind dat die meerderheid van die plaaswerkers ’n positiewe persepsie van TSMBT gehad het, en dat daar ’n dringende behoefte aan MIV-voorkoming en -ingryping in hierdie gemeenskap is. Bekommernis is uitgespreek deur die deelnemers rakende die konfidensialiteit van TSMBT, dus moet aandag hieraan geskenk word.

Die studie het gevind dat daar ’n hoë vlak van aanvaarding van TSMBT sal wees as dit aan die plaaswerkers in hierdie streek gebied word. Hierdie studie skep insig in die MIV-sorg- en -voorkomingsbehoeftes van die plaaslike plaaswerkergemeenskap, en beklemtoon die hindernisse vir plaaswerkers om die primêre gesondheidsorgkliniek te besoek vir MIV-toetsing.

Sleutelwoorde

Aanvaarding; die “World Café”; MIV; plaas; plaaswerker; plattelandse plaasgemeenskap persepsie; tuis-gebaseerde MIV-berading en -toetsing; VIGS.

ABSTRACT

INingizimu-Afrika ibhekene nokuqhubeka kokukhula kwenkinga yezempilo, kanye nokudlondlobala okushaqisayo kwezibalo zegciwane lesandulela ngculazi (HIV). Abasebenzi basemapulazini eNingizimu-Afrika ibona abasengozini enkulu yokutheleleka ngegciwane lesandulela ngculazi. Lolucwaningo lwenziwe emphakathini wabasebenzi basemapulazini esifundazweni sase-North West eNingizimu-Afrika. Inhloso yalolucwaningo bekuwukubona imibono kanye nezinga lokwamukela ukululekwa nokuhlolela igciwane lesandulela ngculazi emakhaya(i-HBHCT) emphakathini wasemapulazini kusetshenziswa Isizinda sokucobelelana ngolwazi (i-World Cafe) ukukhuthaza izingxoxo ezakhayo nokubuza imibuzo esemqoka. Bangama-31 abasebenzi basepulazini ababambe iqhaza esizindeni sokucobelelana ulwazi (i-World Cafe).

Lolucwaningo aluzange luphenye izibalo zabantu abatheleleke ngegciwane lesandulela ngculazi kanye nezinga labo lokuzibandakanya ocansini, futhi aluzange lunike abebebambe iqhaza ithuba lokuhlolela igciwane lesandulela ngculazi(HIV) kanye nokulashwa kwanoma iluphi uhlobo.

Imiphumela iveze ukuthi iningi labasebenzi basemapulazini babe nemibono emihle mayelana nosizo lokululekwa nokuhlolela igciwane lesandulela nngculazi (HIV) emakhaya (HBHTC), futhi kunesidingo esikhulu sokuthi kungenelelwe kulomphakathi ukuze kuvikelwe igciwane lesandulela ngculazi (HIV). Kube nokukhathazeka kwababebambe iqhaza mayelana nezimfihlo zokulekelelwa ngokwelulekwa kanye nokuhlolela igciwane lesandulela ngculazi emakhaya(HBHCT),ngalokhoke kufanele kubhekelelwe lokho kukhathazeka.

Ucwaningo luveza ukuthi kuzokwamukelwa ukuqala usizo lokwalulekwa nokuhlolela igciwane lesandulela ngculazi (HBHCT) kubasebenzi basemapulazini kulesisifundazwe. Lolucwaningo luveze ngokujulile izidingo zokunakekela kanye nokuvikela igciwane lesandulela ngculazi (HIV) emphakathini wabasebenzi basemapulazini kulendawo, laphinde lwaveza nezithiyo (Barriers) abasebenzi basemapulazini abahlangana nazo mabevakasha emitholampilo (PHCs) ukuyohlola igciwane lesandulela ngculazi.

Okusemqoka

Igciwane lengculazi; Ukwamukela; Ipulazi; Umsebenzi Wasepulazini; Ukwalulekwa kanye nokuhlolelwa igciwane lesandulela ngculazi ekhaya; Umphakathi wasemakhaya; Isizinda sokucobelelana ngolwazi (World Café).

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CHBC	Community home-based care
CHW	Community health worker
DoH	Department of Health
HBHCT	Home-based HIV counselling and testing
HCT	HIV counseling and testing
HIV	Human immunodeficiency virus
IMB	Information-motivation-behavioural
IOM	International Organization for Migration
NGO	Non-governmental organisation
PHC	Primary healthcare
SSA	Sub-Saharan Africa
Stats SA	Statistics South Africa
STI	Sexually transmitted infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children’s Emergency Fund
VCT	Voluntary counselling and testing
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In this chapter, the reader is orientated to the study and its components. The background, research problem and purpose, objectives, and key concepts are discussed. This dissertation comprises five chapters, namely:

- Chapter 1: Orientation to the study
- Chapter 2: Literature review
- Chapter 3: Research methodology
- Chapter 4: Analysis, presentation and description of the research findings
- Chapter 5: Conclusions and recommendations

1.2 BACKGROUND TO THE RESEARCH PROBLEM

South Africa is facing an ongoing public health crisis with increasing and alarming human immunodeficiency virus (HIV) statistics. In places where the HI virus is mature and prevalent, renewed calls for integration arise. International and governmental commitment towards HIV prevention and care ensures antiretroviral therapy (ART) to all those who qualify, but few people know their HIV status and therefore benefit from the treatment. Effective and feasible projects are needed to reach rural communities with a high prevalence of HIV (United Nations International Children's Emergency Fund [UNICEF] 2013:3).

Primary healthcare (PHC) clinics in rural areas bear a heavy burden with large influxes of individuals seeking diagnostic and medical care. Such an inundation of patients may result in long waiting times and, in turn, undersupplied PHC clinics.

According to McLaren, Ardington and Leibbrandt (2013:2), those who generate the lowest income tend to live the farthest from healthcare facilities. McLaren et al (2013:2) further explain that although healthcare is free in these areas, the travel time and

distance remain an impediment to seeking PHC – of which HIV testing and treatment form an invaluable part.

Knowledge of and testing for HIV are an important part of HIV prevention and care for HIV-negative and -positive clients (Sabapathy, Van den Bergh, Fidler, Hayes & Ford 2012:2). Pioneering new means to increase HIV testing has been set out as a global priority.

Current research suggests that fresh and experimental strategies like home-based HIV counselling and testing (HBHCT) are needed for an increase in the coverage of HIV testing in rural areas, as evidenced by the following: "South Africa seems well suited for home-based HIV counselling and testing, given its diverse geography, limited access to healthcare facilities in some high-risk settings, varied levels of infrastructure, and epidemiological HIV profile" (Doherty, Tabana, Jackson, Naik, Zembe, Lombard, Swanevelder, Zembe & Chopra 2013:346).

It is apparent that research is needed to establish the common perception and acceptance of HBHCT and healthcare education among the residents of agricultural communities. Further study would also be beneficial to determine why selected communities are not utilising their allocated PHC facilities to their full capacity by testing for HIV and returning for the required follow-up examinations.

Doherty et al (2013:346) explain that HIV counselling and testing (HCT) is the main intervention needed for accessing available treatment programmes but the testing rates remain low. It is believed that HBHCT may increase overall HIV testing rates.

According to Lugada, Levin, Abang, Mermin, Mugalanzi, Namara, Gupta, Grosskurth, Jaffar, Coutinho and Bunnel (2010:245), voluntary counselling and testing (VCT) is the primary access point for HIV avoidance, management, and care. HIV testing statistics and HIV awareness remain low in sub-Saharan Africa (SSA) and especially in South Africa, despite tremendous efforts from the government, non-governmental organisations (NGOs), and international health organisations.

According to the official online forum of the World Health Organization (WHO 2016), SSA has the most HIV-infected individuals in the world and holds up to 70% of the

global HIV-infected individuals. The WHO (2016) also states that in 2015, newly infected individuals (15 years and above) in South Africa were between 1 700 000 and 2 200 000.

At this point in time, there is no known cure for HIV (WHO 2017:1). Therefore, the key to alleviating this public health burden is prevention. Although major-scale clinical research is currently ongoing on preventative medications and vaccinations against HIV, major breakthroughs have not been made. While there might be a preventative breakthrough in the next few years, HIV-infected people must still be identified and treated.

The same applies to uninfected individuals who may not know the routes of transmission and risky behaviour that may lead to an HIV infection or may know the former but do not understand the impact of HIV on an individual and their dependants.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The research problem arises from the alarming rate at which South African people transmit HIV despite all the efforts made to reduce these numbers. The fact is that there is still a sizeable number of Southern Africans who remain untested and are unsure of their HIV status (Vandormael, De Oliveira, Tanser, Bärnighausen & Herbeck 2018:5).

Education about HIV testing is extremely important but is insufficient by itself; rural inhabitants must be tested for HIV to successfully prevent transmission. There is an immense need for HIV education and testing in rural communities. The HIV stigma also lurks in these communities and therefore intervention is needed (Naik, Tabana, Doherty, Zembe & Jackson 2012:2).

Rural farmworker communities in South Africa need HIV and acquired immunodeficiency syndrome (AIDS) support. HBHCT could be a viable and affordable option to reach these communities but would this method of HIV testing and care be accepted by the farm workers and the greater farming community? HBHCT can only be sucsessful if it is utilized and accepted by its clients. (Doherty, Tabana, Jackson, Naik, Zembe, Lombard, Swanevelder, Zembe & Chopra 2013:346).

A data gap has been identified and perceptions and acceptance of HBHCT has not been explored among the farm workers in this community.

1.4 RESEARCH AIM/PURPOSE

The purpose of this study will be to explore the perceptions and acceptance of HBHCT in a rural farming community, working primarily with farm labourers. If this study shows a high level of acceptance for HBHCT, this method may increase the uptake of HIV testing and health education in the rural communities.

This study will bring some insight into the HIV care and prevention needs of the local farmworker community, as well as to highlight the barriers they face in attending the PHC clinic for VCT and follow-up visits.

1.5 RESEARCH OBJECTIVES

According to Hofstee (2015:86), research objectives are what a researcher aims to achieve with a study. Objectives are measurable and concise variables that focus on the areas where the researcher's ambitions are directed. The research objectives of this study are as follows:

- To explore the perceptions of the farmworkers regarding HBHCT.
- To determine acceptance of HBHCT in a rural farming community.
- To explore the main barriers that prevent participants from testing for HIV and following up at their closest clinic.
- To enquire about the existing knowledge of HIV/AIDS among farmworkers and the necessity of testing for HIV.

1.6 RESEARCH QUESTIONS/HYPOTHESES

1.6.1 Primary research question

The primary research question that this study seeks to address is: What are the common perceptions and acceptance levels of HBHCT and healthcare education in the selected rural farming community?

1.6.2 Secondary research question

The secondary research question that this study seeks to address is: What are the main barriers for farmworkers to seeking HIV testing, counselling, and treatment at their closest PHC facility?

1.7 DELINEATION AND LIMITATIONS

1.7.1 Delineation

This study did not investigate the number of HIV infections among farmworkers and did not ask for the number of participants who have been tested before. The researcher did not offer an HIV test to any participant or instruct any participant to go for an HIV test at a designated testing centre.

The researcher did not attempt to enquire into the personal relationships of the participants or ask about their sexual orientation or preferences. There was no enquiry into sexual behaviour or practices of the participants as these topics do not pertain to the research question.

The fieldworkers and researcher did not offer medical treatment of any kind to the participants, but would not have ignored an emergency situation.

1.7.2 Limitations

This study was conducted in the North West province only and was not repeated in another province with different farmworkers and can therefore not be generalised to farmworkers in other provinces. Financial and time constraints prevented the researcher from repeating the study in a different province.

At the time of sampling, the researcher did not have direct access to the population and therefore did not know that all but one of the population were external migrant workers, although the researcher did expect some of them to be migrant workers.

1.8 DEFINITIONS OF KEY CONCEPTS

Acceptance levels

Acceptance levels refer to the degree to which a person agrees with a practice or service and will make use of that practice or service in their daily life (*Oxford English Mini Dictionary* 2012:3).

AIDS

According to Mayo Clinic (2015:1), AIDS is "a chronic, potentially life-threatening condition caused by the human immunodeficiency virus (HIV). By damaging your immune system, HIV interferes with your body's ability to fight the organisms that cause disease".

HIV

According to the WHO (2016:1), HIV "infects cells of the immune system, destroying or impairing their function. Infection with the virus results in progressive deterioration of the immune system, leading to 'immune deficiency'. The immune system is considered deficient when it can no longer fulfil its role of fighting infection and disease.

Infections associated with severe immunodeficiency are known as 'opportunistic infections', because they take advantage of a weakened immune system".

Home-based HIV counselling and testing (HBHCT)

Taking Taegtmeyer (2012:6) as an authoritative source in this regard, the study defines HBHCT as VCT conducted by an HIV-testing professional in a participant's area of residence, outside of the setting of a healthcare clinic.

Perception

Perception refers to a subjective judgment by a participant, which has concrete effects on his/her behaviour regarding HBHCT. This may include beliefs and attitudes, as well as social mores (*Oxford English Mini Dictionary* 2012:437).

1.9 OPERATIONAL DEFINITIONS

Acceptance levels

For the purposes of this study, participants may display one of three levels of acceptance for home-based VCT:

(1) Disagreement: the participant does not agree with a practice or refuses to make use of a service.
(2) Ambivalence: the participant neither agrees nor disagrees with a practice but will likely only make use of a service when prompted by others.
(3) Active acceptance: the participant agrees with a practice and makes regular use of a service.

AIDS

AIDS occurs when HIV has progressed and damaged the immune system to such an extent that the body no longer has the ability to fight organisms that make the body sick and cause infections (Mayo Clinic 2015:1).

HIV

According to the WHO (2016), HIV “infects cells of the immune system, destroying or impairing their function. Infection with the virus results in progressive deterioration of the immune system, leading to ‘immune deficiency’. The immune system is considered deficient when it can no longer fulfil its role of fighting infection and disease. Infections associated with severe immunodeficiency are known as ‘opportunistic infections’, because they take advantage of a weakened immune system”.

Home-based HIV counselling and testing (HBHCT)

Taking Taegtmeyer (2012:6) as an authoritative source in this regard, the study defines HBHCT as VTC conducted by an HIV-testing professional in a participant's area of residence, outside of the setting of a healthcare clinic. HBHCT in the study refers to the action of testing the members of the rural farming community on the farms for HIV in their area of residence by means of a mobile clinic.

Perception

The perception analysed in this study refers to a subjective judgment by a participant that has concrete effects on his/her behaviour regarding HBHCT. This may include beliefs and attitudes, as well as social mores (*Oxford Mini Dictionary* 2012:437).

Rural farming community

For this study, a rural community is defined as one that does not have easy access to the infrastructure provided by urban areas, and that has a relatively low population density. Such communities are typified by agricultural labour communities found throughout rural South Africa. The participants of the study will comprise of people living as a rural community, in a South African farm.

1.10 CONCLUSION

This chapter orientated the reader to the study and its components. The background, research problem and purpose, objectives, and key concepts were discussed in this chapter. The literature review that follows discusses HIV in South Africa and globally, HBHCT in South Africa, health and social barriers to the farming communities in South Africa, and the use of the World Café in qualitative studies.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The concept of HBHCT has received much attention from public health researchers. In this discussion, the researcher will present some of the relevant data found in various peer-reviewed journals, online articles, and books regarding HBHCT, HIV in the global community, HIV in South Africa, and HIV testing in South Africa. The researcher will also elaborate on the South African farmworker community, its barriers to HIV testing, overall health issues, and social concerns. A total of 58 peer-reviewed articles were obtained that were deemed overall relevant, of which 21 articles pertained to the research question and were used in this discussion.

2.2 HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN THE GLOBAL COMMUNITY

When one considers HIV on a global scale, the South African statistics are shocking. The 90-90-90 vision and targets as set out in Melbourne in 2014 were ambitious but it is possible to achieve the 90-90-90 goals by December 2020 and virtually end the global HIV epidemic. The 90-90-90 global targets are set out in Figure 2.1.

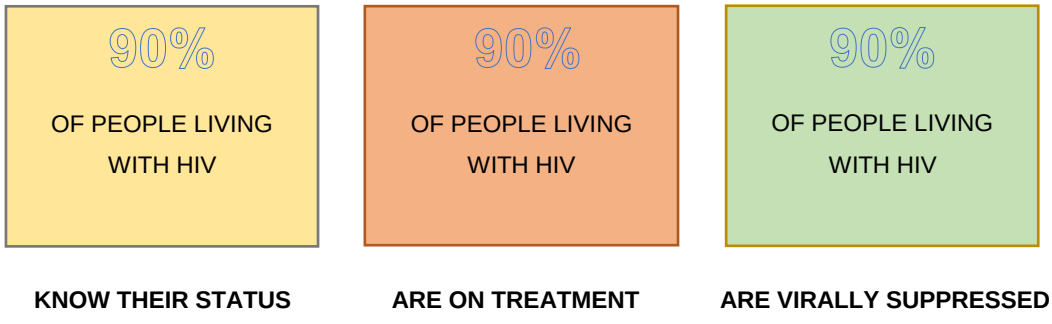

Figure 2.1 90-90-90 global targets

(Source: Adapted from the Joint United Nations Programme on HIV/AIDS [UNAIDS] 2017:8)

UNAIDS (2017:8) explains that East and Southern Africa's progress since 2014 has been remarkable and the progress can be compared to that of Latin America. The UNAIDS (2017) report states that if the progress continues, Southern Africa might reach the 90-90-90 goals by the target date with other regions like North America and Europe. The Caribbean, Asian, and the Pacific regions are close but delay on either the first 90 goal or second 90 goal. It is said that other regions are in danger of missing this important global public health goal. It is important to note here that without the first 90 goal, the other two cannot follow.

According to Dalal, Feikin, Amolloh, Ransom, Burke, Lugalia, Ouma, Laserson, Mermin, Breiman and Bunnell (2013:47), who conducted a door-to-door HBHCT study in rural and urban Kenya, most HIV-infected individuals in SSA are unaware of their status. Far fewer individuals know their sexual partner's HIV status. Dalal et al (2013:47) explain that the attainment of HIV-reducing goals depend on the sum of individuals diagnosed, who are living with HIV, and who undergo treatment and care. Bringing HIV testing and counselling to most rural areas may reduce obstacles to HIV testing, and may increase HIV testing among rural inhabitants.

SSA needs an effective and feasible project to reach the rural communities with a high prevalence of HIV (Pillay 2009:213). Naik et al (2012:8) emphasise that "the success of national HIV/AIDS programs will thus necessitate the expansion of HIV-testing coverage through the implementation of innovative facility- and community-based models such as home-based HIV counseling and testing (HBHCT)".

2.3 HIV IN SOUTH AFRICA

According to UNAIDS (2017:101), 76% of South Africans living with HIV currently know their status but that there is a gap of 2.7 million people who are unaware of their HIV status. Although these results may be considered an achievement, it may also be justified to argue otherwise. Considering the massive efforts on the forefront of HIV research in Southern Africa, as well as the substantial governmental and international budgets allocated annually, the above figures essentially demonstrate unsatisfactory progress in increasing the number of people who are aware of their HIV status over the timeframe.

In most recent published statistics (Statistics South Africa [Stats SA] 2017:7), of all deaths reported in South Africa in 2017, 25.1% were AIDS-related deaths. It is estimated that the overall number of people living with HIV has increased with 2.12 million since 2002.

In contrast to the increasing overall population living with HIV in the past 16 years, the rate of infection seems to have declined since 2002 from 1.9% to 0.9% (Stats SA 2017:7). It can be argued that the number of infected individuals recorded increased because of a higher uptake of HIV testing and the number of more infected individuals becoming known.

HIV counselling and testing (HCT) is a crucial action in achieving a reduced number of new infections and re-infections, and will link HIV-infected individuals to vital medication and antiretroviral (ARV) medication for a longer life expectancy, essential health education, and support. However, national testing rates continue to be below standard, according to a survey conducted in 2008. The national adult HIV prevalence was 17.8%, yet only 24.7% of this group were tested for HIV and were aware of their status (Naik et al 2012:5).

According to the Department of Health (DoH 2005:5), local and international developments and suggestions emphasise core elements like the 5 Cs – Confidentiality, Counselling, Consent, Correct results, and linkage to Care combined with HCT programmes such as HBHCT – which may reduce the percentage of missed HCT opportunities.

2.4 HOME-BASED HIV COUNSELLING AND TESTING (HBHCT) IN SOUTH AFRICA

2.4.1 Uptake/acceptance

HBHCT refers to the services rendered by trained HIV counsellors/workers who offer an HIV test to an individual in their home or place of safety. It is the act of bringing the HIV test to the client to overcome certain barriers to HIV testing and brings an HIV test to a client who would not have made a journey for an HIV test in other circumstances. This

method of HIV testing has been implemented successfully in metropolitan and rural areas in SSA where there was low HIV testing exposure (Taegtmeyer 2012:6).

HBHCT can be conducted effectively, with positive outcomes, when conducted by lay counsellors within the community. This was demonstrated by the study conducted by Doherty et al (2013:346) on the effects of HBHCT.

Home-based testing showed a greater uptake in proportion to HIV testing in community clinics. Contributions included an increased number of couples testing and receiving counselling together in a highly stigmatised rural setting, which in turn decreased risky sexual practices.

HBHCT could be acceptable in rural communities. This was demonstrated by the findings of the large-scale study conducted by Naik et al (2012:2). This study focused on the acceptability and characteristics of the client when performing HBHCT. The researchers captured client characteristics, testing history, HBHCT uptake, as well as reasons for refusing HBHCT. They visited 3 328 homes and 75% of the residents were tested. The researchers concluded that HBHCT is viable and exceedingly adequate in the rural sub-district of KwaZulu-Natal where the study was conducted.

Clients who tested positive in the HBHCT do visit PHC centres for follow-up care. This was demonstrated in the study by Naik, Doherty, Jackson, Cabana, Swanevelder, Thea, Feeley and Fox (2015:1), where 62% of the clients who tested HIV positive during the HBHCT were successfully linked to clinics for follow-up care within three months.

2.4.2 Reasons for clients refusing HBHCT

Current research points to the great significance of the refusal to undergo testing and the need to understand it, and ultimately to address this problem.

Barriers to linkage to care after HBHCT include:

- not believing the test results
- not finding time to seek healthcare
- believing that ART makes you sick

- using alcohol
- being in a younger age group (15-24 years) (Naik et al 2015:9)

Concerns of counselling, support, and referral arise when HBHCT is proposed. As Mayor (2014:1) states, “How can we ensure appropriate follow-up for those who are reactive (indicating a potential positive result), and those who are negative but potentially in the window period?”

Major (2014:2) further explains that any project to increase the knowledge of the HIV status of at-risk individuals should be considered a net benefit. Appropriate follow-up, counselling, and referral must be of upmost importance in such instances (Major 2014:2).

HBHCT acceptance among community members is extremely important as HIV testing should be voluntary. This method of HIV testing is believed to have a generally high uptake compared to HIV tests offered at local clinics, as evidenced by Sabapathy et al (2012:9-11), who conducted a systematic review and meta-analysis on 19 papers published between 2000 and 2012 that centred on HBHCT done in SSA. They discovered that among these studies, the level of acceptance was exceptionally high for clients to receive an HIV test at home.

Sabapathy et al’s (2012:9-11) study explains that the average percentage of clients that accepted home-based testing was at around 83% and of those tested, 99% received their test results. More than three-quarters of those offered an HIV test accepted and the statistics of undiagnosed HIV prevalence were high. Of the 83% tested, between 40% and 70% had a former undiagnosed positive result, highlighting the significance of HBHCT (Sabapathy et al 2012:9-11).

The abovementioned meta-analysis also reports on a study conducted in Uganda, where the number of people in the community ever tested for HIV increased from 19% to 62% with an HBHCT programme. The hypothesis here is that this will be the case in most rural areas in SSA (Sabapathy et al 2012:9).

One of the many benefits of HBHCT is explained by Sabapathy et al (2012:11). Delayed presentation of HIV treatment for sero-reactive clients contributes to morbidity and

mortality related to HIV/AIDS. Clients tend to go to their local clinic to test for HIV only when symptoms are present, whereas with HBHCT, early detection and a better prognosis are very possible. Some of the other benefits include increased HIV knowledge and understanding, and it can be used in conjunction with other methods like public and workplace testing.

Similar benefits of HBHCT are stated by Taegtmeyer (2012:6) in a recent HBHCT guide handbook published by the WHO, namely that HBHCT contributes to a family-centred attitude and may lead to reduced HIV stigma in the community. Taegtmeyer (2012:6) concurs with Sabapathy et al (2012:9) that HBHCT facilitates early diagnosis among HIV-positive clients and has a larger group/couple extent than other methods.

The former literature (Taegtmeyer 2012:6; Sabapathy et al 2012:9) serves as evidence that acceptability of HBHCT is elevated in the areas that were included in these populations and that there are many benefits related to HBHCT. In such a stigmatised HIV culture among the rural communities of SSA, it is important to raise awareness, increase the level of HIV understanding, and increase HIV testing uptake in the population in question, i.e. the rural farming communities.

2.5 THE SOCIAL AND HEALTH BARRIERS/CHALLENGES FOR FARMING AND AGRICULTURAL WORKERS

Farming and agricultural workers were described as a “sickly workforce” in a recent *Business Day* article by Govender (2017:1). The article explains that lifestyle diseases are burdening the farmworkers and it is theorised that these are due to low wages, substance abuse, physical and emotional stress, and chronic illnesses that are worsened by being far from healthcare facilities. HIV/AIDS remains an immense challenge in the rural agricultural community.

A report written by Visser and Ferrer (2015:79), based on their statistical analysis of the living and working conditions of the farmworkers in South Africa, shed light on the challenges that South African farmworkers are continuously facing and the impact thereof.

According to reports, the number of individuals living on farms in 2011 was approximately two million. Of the employed farm occupants, 65.1% were earning less than R1 600 monthly. Approximately 500 000 people in this group live on farms and work in the agricultural, fishing, and forestry industry and can be classified as farmworkers or labourers (Visser & Ferrer 2015:1).

Among the farmworkers in Visser and Ferrer's (2015:2) study, only 35% were entitled to paid sick leave in 2014 and a mere 1.5% received medical aid contributions from their employers, and the majority of this group had working hours of 41 to 45 hours a week. With statistics like these, it is no surprise that South African farmworkers are burdened with uncontrolled chronic disease, of which HIV and sexually transmitted infections (STIs) are not excluded.

A doctor's note or medical certificate from the clinic to get health assessments, chronic medication, or an HIV test just do not suffice, taking into account that they just cannot afford a day of unpaid leave; not to mention the transport cost or the time it would take to commute to the nearest clinic.

Above and beyond unpaid sick leave, employers insist on a medical certificate from the first day of illness to prevent sick leave abuse. This results in sick and poor farmworkers traveling long distances and waiting in queues at a clinic when they should actually be resting (Visser & Ferrer 2015:6).

An article by Pieczkowski and Jönsson (2004:1) on the HIV/AIDS vulnerability of migrant farmworkers was published after a three-month-long study on the South African-Mozambican border to gain knowledge on the availability and accessibility of healthcare and HIV vulnerability in this population. The researchers mainly focused on the migrant aspect of the farming community.

Migrant farmworkers beyond the borders of South Africa and broader SSA are in the same category of vulnerability to HIV/AIDS, as supported by Tiruneh, Wasie and Gonzalez (2015:6), who state that migrant farmworkers' poor socio-economic environment places them at the epicentre of HIV vulnerability.

Farmworkers in Southern Africa are significantly vulnerable to HIV/AIDS as many farmworkers fall into a high-risk migrant population (Pieczkowski & Jönsson 2004:3). The researchers explored the farmworkers' understanding of and mindsets toward HIV/AIDS and investigated healthcare services available to the farmworkers in this area. Some of their key findings included the following:

- High-risk sexual behaviour is common in the migrant farmworker population because the farmworkers often travel or migrate to where work is available, without their stable partners. They describe condom use in this population as "extremely poor" as condoms are not readily available. The farmworkers also have certain concerns and misconceptions about condoms; for example, that they are ineffective or that they transmit HIV. Many workers stated that they had multiple sexual partners on the farm, especially during harvesting season.
- Lack of HIV knowledge and misunderstanding of HIV/AIDS are largely due to a lack of presence of and interventions by public health organisations or NGOs, as well as government involvement. Pieczkowski and Jönsson (2004) argue that the former has created and evolved widespread misconceptions about HIV/AIDS and found that some farmworkers even believe that there is a cure for HIV/AIDS or that this virus is not lethal if left untreated.
- Although PHC clinics in the region are available, nurses at these clinics reported low numbers of HIV testing among farmworkers, with a high occurrence of STIs.

The impact of migration and split households should not be underestimated in terms of farmworkers and HIV. Migrating farmworkers, both men and women, appear to cultivate new sexual relationships in the farming compounds that are often hazardous.

Cross-border migrant farmworkers are especially at risk of HIV as they rarely have access to the sporadic mobile clinics and informational drives targeting farmworkers. Pieczkowski and Jönsson (2004:2) explain that this is the case because above and beyond the fact that cross-border migrants avoid South African public health services out of fear of being extradited, they are also lonely and far away from their families for long periods of time. This encourages risky sexual behaviour because of their fundamental need for acceptance and leisure.

To counteract the problems identified, Pieczkowski and Johnson (2004:2) recommend the implementation of the following: increased VCT access to farmworkers, HIV knowledge among farmworkers, HIV awareness campaigns, support strategies for HIV-positive farmworkers, more efforts to improve living and recreational conditions in farming communities, and further research into the effect of HIV on migrant and South African farmworkers, as well as how to alleviate the HIV burden in South African farming communities.

2.6 BARRIERS TO HEALTHCARE IN THE COMMUNITY AND WORKPLACE

Community health workers (CHWs) are commonly seen as the first point of contact for rural inhabitants and vulnerable communities. There are major constraints involved for CHWs in achieving optimum community health in vulnerable communities that should be constantly emphasised as CHWs have the capacity to build trusting relationships and reach these communities. Some of the constraints include limited training opportunities for CHWs, poor supervision, and lack of governmental and non-governmental collaboration.

Three case studies were conducted in the Eastern Cape and Gauteng with three CHWs, focusing on adherence of HIV and tuberculosis (TB) treatment and the impacts of broader social issues. Two of the CHWs in Gauteng, relying only on government support, reported not being able to relieve the underlying issues effectively. The third CHW, having support from an NGO, had the necessary resources to alleviate the underlying social barriers for increased adherence to treatment, for example not having food to take with medication (Nxumalo, Goudge & Manderson 2016:2).

Nxumalo et al (2016:62) emphasise the impact of institutional support for CHWs. The goal should be to build trusting relationships within the community and ultimately reaching community health goals. Attending to the social barriers that influence health and treatment adherence might result in better uptake of ARVs and building trust in the community health system.

The South African farming community was reported as belonging to the poorest community groups of the population. They are also one of South Africa’s most

vulnerable groups when considering health, access to healthcare, income, social and cultural practices, and infrastructure (Lemke 2005:846).

Lemke (2005:847) emphasises that South African farmworkers are immensely underserved regarding health and social development. The poverty-stricken individuals and families in these communities suffer from alcohol abuse, poor nutrition, occupational hazards, and social practices. An alarming number of farmworkers migrate to seasonal harvesting farms where they have new sexual partners and practise hazardous social activities out of loneliness or lack of proper recreation.

HBHCT on the farms where farmworkers both live and work will fall under workplace HIV testing as well as HBHCT. Weihs and Meyer-Weitz (2016:495) described barriers to HIV testing in the workplace after conducting an extensive literature review and meta-analysis. The researchers' aim was to include mostly client-reported barriers rather than barriers reported by health institutions. The most common barriers to HIV testing in the workplace were found to be:

- fear of stigmatisation by colleagues and healthcare workers
- distrust in how confidential the results of the HIV test are
- thinking that the workplace has ulterior motives for HIV testing at work
- job security after testing
- not having enough time for the test
- fear of others knowing their results, as evidenced by emotional response by the employee to the results and denial of risk/lack of HIV knowledge

Some of the recommendations made for future workplace HIV testing include emphasis on the confidentiality of HIV testing and encouraging follow-up HIV testing. It is proposed that HIV-testing campaigns in the workplace must be amended to the workplace culture and not be generalised or standardised. Weihs and Meyer-Weitz (2016:497) suggest that more research is needed to gain a better understanding of barriers to effective HIV testing in the workplace.

Nxumalo et al (2016:61) explored the experiences and barriers to care according to the CHWs and their recipients in South Africa. They explain continuous health

disproportions as a strong driver for change in third-world countries and placed PHC at the epicentre of the success or failure of health outcomes.

2.7 COMMUNITY HOME-BASED CARE (CHBC) AND LAY COUNSELLORS

The South African farmworker and agricultural community is widely known as a resource-limited and vulnerable group. In a collaborative framework developed CHBC in resource-limited communities, it is explained that its aim is to achieve the best quality of life (Hirschfeld & Lindsey 2002:3).

Hirschfeld and Lindsey's (2002:3) study outlines strategies and a development process to be followed to roll out a successful CHBC project, and emphasises that attention should be paid to the needs assessment and community assessment phase.

The literature elaborates on different levels of a needs assessment to consider when planning and implementing a CHBC project, of which education and training of CHWs form a great part. CHWs and their approach are imperative to such projects as they are the first point of CHBC. Hirschfeld and Lindsey (2002:54) recommend the following to be included in the CHW syllabus:

- Basic nutrition guidelines
- HIV transmission and prevention education
- STI prevention information
- CHW motivation
- Managing referrals to treatment and care
- Terminal care
- Traditional treatment practices

Above and beyond CHW needs, the client or community needs assessment should be a priority. Resources such as essential medication, prevention materials, and educational materials in the community should be established. Outreaches should be utilised at every opportunity to reduce stigma in the community and educate its people. Different levels of literacy and language should be recognised to rule out miscommunication and implement the project at the appropriate educational level. Hirschfeld and Lindsey

(2002:54) advise that there should be a central base location where the CHBC team can keep accurate records, have meetings, and keep materials and stock.

Lay counsellors in South Africa carry a heavy burden as a result of staff shortages, high volumes of patients, and lack of resources and support, as reported by Mwisongo, Mehlomakhulu, Mohlabane, Peltzer, Mthembu and Van Rooyen (2015:2). An evaluation of the lay counsellor profession was conducted in 2015 involving 32 lay counsellors from different HCT sites. Of the 32 participants, almost 50% reported that they did not have adequate counselling rooms in which to provide private HCT. Other common reports included lack of advanced counselling skills when a difficult case presents itself; for example in the case of discordant couples.

Most counsellors reported that they received adequate training but from different HCT institutions. The researchers recommend streamlining the training of lay counsellors to boost their confidence when confronted with a difficult situation. Greater counsellor supervision and support may further reduce stress. Better infrastructure and counselling rooms may improve work conditions and job satisfaction (Mwisongo et al 2015:5).

Most HCT activities in South Africa are carried out by lay counsellors rather than other healthcare professionals due to lack of access to medical institutions and staff in resource-limited settings. The DoH supports approximately 8 000 lay counsellors in South Africa, and the demand keeps increasing due to the escalation of availability in ART (Mwisongo et al 2015:5).

HBHCT in rural areas such as farming communities can utilise lay counsellors for a project to be more resource effective. It is therefore important to explore ways to optimise lay counselling services, and whether this type of resource utilisation should be an option at all. From conducting a systematic review, Petersen, Fairall, Egbe and Bhana (2014:201-210) put the optimisation of lay counsellors in South Africa into perspective.

The aim of using lay counsellors should be to ultimately link prospective sick clients to care. Seeing that lay healthcare providers do not belong to any governing body or have a formal medical degree, Petersen et al (2014:201) explored other ways of optimising

this practice in South Africa by influencing behavioural change in their clients, to take more responsibility for own health, and to promote self-management and prevention.

The study found that lay counsellors who used the information-motivation-behavioural (IMB) skills model in a coordinated and overseen environment with sufficient training succeeded in changing high-risk HIV behaviours. High-risk behaviours, such as unprotected sex, alcohol abuse and sex, and having multiple sexual partners can be reduced with trained lay counsellors.

Petersen et al (2014:208) recommend that lay counsellors' responsibilities should be outlined and structured as they found that multiple studies point to lay counsellors being confused and unsure of what exactly is expected of them. They also report that lay counsellors feel unappreciated and excluded from the healthcare workforce as they do not belong to or fall under a professional healthcare body.

Lay counsellors play an important role in SSA HIV and other communicable disease programmes, therefore proper training and structuring of this profession should be explored and implemented.

2.8 CONCLUSION

To conclude this discussion, the following aspects are clear. Although previous studies indicate that there are mostly high uptake and acceptabillity rates of HBHCT, more research is needed concerning HBHCT and its acceptance levels among farmworkers in South Africa. It is also clear that the South African farmworker workforce is mostly secluded, and HIV campaigns and upscaled efforts are needed to reach this vulnerable population. There are immense barriers to access to healthcare for the farmworker population, as well as social and funding barriers to infiltrate these communities propperly.

Lay counsellors may be extremely useful when implementing HBHCT in the farming community but they may need strong guidance, leadership, strategies, and procedures to follow.

The following chapter will report and elaborate on the research methodology. Data-collection methods and procedures are discussed in detail, and an extensive report follows on the World Café methods and its phases of implementation.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 2 reviewed the literature relevant to the study. Chapter 3 expands on the methodology that was followed to conduct the study. The methodology of a dissertation is vital to the success of a comprehensive and useable outcome as the results can only be tested, compared, or comprehended if the methodology is understood (Hofstee 2015:107).

To be able to answer the research question and explore the perceptions and acceptance levels of HBHCT in a rural farming community, working primarily with farm labourers, and considering all possible directions, and strengths and weaknesses, the researcher decided to implement an interactive World Café as the study's primary data-collection method.

This chapter explains in detail the study approach, the research design, the setting and population, sampling size and method, strengths and weaknesses, data collection and analysis, and ethical considerations.

3.2 APPROACH

The researcher chose an explorative approach to the research as obtaining the perceptions and acceptance of a concept from study participants requires an explorative approach to be able to extract common themes and patterns to report (Brink, Van der Walt & Van Rensburg 2012:114).

As this study is primarily explorative in nature, it relied on qualitative research. This approach was used to gain a better understanding of the situation on the farm regarding the perceptions and acceptance of HBHCT. The findings from this qualitative research will be used to develop insights and a hypothesis aimed at responding to the research questions.

Dudovskiy (2016:1) explains that explorative research intends to reach a better understanding of a problem and that the researcher conducting the study must be willing to change direction because of new insights and data that might arise.

3.3 RESEARCH DESIGN

This had a qualitative, explorative, descriptive, and contextual design that recorded the perceptions and acceptance levels of HBHCT in a rural farming community context in the North West province. Descriptive contextual designs aim to comprehend the intricacy and personal understanding of a complete event through in-depth appreciation of the participating subjects and features (Fox 2015:1).

Qualitative research refers to a design used by researchers who study a phenomenon or data that are exceptionally difficult to quantify. Qualitative research explores and promotes understanding of human experiences, feelings, and tendencies (Brink et al 2012:113).

The study was conceived as an explorative design and its purpose was to explore and describe the perceptions and acceptance of the rural farm community regarding HBHCT and furthermore to explore and describe the barriers and factors that prevent the rural farm community to test for HIV and going for follow-up visits at their closest PHC clinic. The findings were used to develop recommendations for HBHCT in rural farm communities.

3.4 SETTING AND POPULATION OF THE STUDY

3.4.1 Setting

The setting of a research study refers to the environment in which the data will be collected. The setting of a study should be carefully considered (Hofstee 2015:120). The selected setting for the study was a farm situated in the North West province about 32 km from the closest PHC clinic.

The World Café was conducted close to the participants' living areas, where they could feel comfortable and familiar with the surroundings.

3.4.2 Population

The population of a study refers to the entirety of individuals that meet the eligibility criteria of the researcher to participate in a research study (Brink et al 2012:113). The population for this study consisted entirely of farmworkers, both male and female, over the age of 18 and who currently reside on the farm. Forty farmworkers currently reside on the farm.

Population and community context should be carefully considered, as Doherty et al (2013:346-348) recommend that HBHCT should be studied in an area where it may reach a younger population with higher-risk sexual behaviour like a rural farming community.

Naik et al (2012:1-8) made a similar suggestion as that of Doherty et al (2013:346-348) that future projects should be planned and developed to reach a wider scope of clients. They also stress that more intervention is required to meet the specific and unique needs of the different sub-groups.

3.5 SAMPLE AND SAMPLING METHODS

A sample is the fraction of the population chosen by a researcher to participate in a research study (Brink et al 2012:113).

3.5.1 Sample size

The researcher was unsure of the number of farmworkers who left the farm during the weekend of the World Café for social reasons. The target sample size was adjusted to accommodate for some farmworkers who left the farm for the weekend and was set at 35 adults. A total of 31 adults attended, signed consent forms, and participated. A World Café event invitation was given to the population of potential participants (see Annexure F).

3.5.2 Sample method

This study used non-probability sampling with purposive sampling. The researcher chose this method because access to the participants was limited at the sampling stage and it was impossible for the researcher to determine whether each participant had an equal chance of being included in the research study (Brink et al 2012:139).

Purposive sampling selects participants who are typical or representative of the study phenomenon, or who are especially knowledgeable about the questions asked, as determined by the researcher (Brink et al 2012:141).

The researcher decided to allow the participants to self-select, keeping the population and sample size in mind.

3.6 TRUSTWORTHINESS IN QUALITATIVE RESEARCH

Demonstrating rigour in qualitative studies is extremely important to show that the findings have integrity and are able to make an impact on existing literature. Trustworthiness in qualitative research can be ensured by implementing strategies proposed by Brink et al (2012:118) and Hadi and Closs (2015:643). Some of these strategies include triangulation, reflection, peer debriefing, member checking, prolonged engagement, and referral adequacy.

3.6.1 Credibility

Credibility in this study is evident by using the techniques proposed by Brink et al (2012:118). These techniques are discussed in the following sections.

3.6.1.1 Triangulation

Triangulation is a method commonly used in qualitative studies to ensure credibility. Two or more sources of data, different researchers, or methods are implemented to reduce bias that is usually connected to only one data method, researcher, or source (Hadi & Closs 2015:643).

Different questions were asked to each group of participants, every time by a different table host. In effect, each question was answered five times by five different groups. Data were collected using three different sources, namely paper table covers, table host fieldnotes, and researcher fieldnotes. Conclusions were recorded on video and audio.

3.6.1.2 Prolonged engagement

According to Brink et al (2012:171), prolonged engagement is reached by staying in the field until data saturation has been achieved. The fieldworkers and the researcher remained in the field until all rounds were concluded and data saturation had been reached. There was an isolated incident where one of the table hosts needed more time and was granted to her until she had reached data saturation.

3.6.1.3 Accounting for disconfirming evidence

A negative case analysis was conducted by asking open-ended questions to identify the negative thoughts, opinions, and feelings toward HBHCT on the farm.

3.6.1.4 Referral adequacy

All findings were recorded on video and audio for the purpose of referring back for secondary analysis. All table covers, photos of the day, fieldnote books, and consent forms serve as proof of the data collection and will be kept in a locked cabinet for five years.

3.6.1.5 Research participant review

All but four participants were present for the conclusion and primary data-analysis phases. These were done according to the World Café principles for the purpose of validation of data.

3.7 DATA-COLLECTION METHODS AND PROCEDURES

An interactive World Café was employed as the primary data-collection method. World Cafés generate focused and creative conversations between participants and discussion guides in a comfortable roundtable setting (Fouché & Light 2010:28-48). The researcher hosted a World Café event for the participants, in which the setting was familiar to the participants.

According to Kaplan and Mountain (2015:1), the World Café is a methodology used to accentuate the influence of conversation. They explain that the main design of the World Café addresses matters of organising and decision-making, and produces qualitative information. The participants moved between topic tables, and thoughts and opinions cross-pollinate (see table statements/topics discussed at the World Café in Annexure G).

This method can be incorporated with a theory discussed by Schein (2013:7-8), which explains the art of asking the right questions, listening rather than telling, and paying special attention to how the questions are asked to increase effective communication.

The World Café is a relatively new approach to data collection. This technique was co-founded by David Isaacs and Juanita Brown (Schieffer, Gyllenpalm & Isaacs 2004:1). As Schieffer et al (2004:1) state, the "World Café is a technique for harnessing group intelligence, for channelling the brilliance of a roomful of independent thinkers into a coherent message comprehensible by anyone".

The World Café is not exclusively utilised for academic research but can be implemented in any social or organisational structure, with the aim to ask and answer questions that matter to a group of independent participants working collaboratively to provide valuable input.

The art of the World Café is the creative conversation that evolves because of asking the right questions in an intimate and comfortable setting. It illustrates the power of thinking and communicating together in a creative manner that is partially structured but not limited. As the participants move around and cross-pollinate ideas, new connections are built and new ideas form.

The World Café has been implemented for an array of research but can also be used for problem-solving and interest-based interventions. For this research, the review focused on previous published research conducted with the World Café method on diverse and vulnerable groups.

The literature on the use of the World Café in rural and vulnerable communities is limited. The World Café has received wide attention from businesses for corporate use. In the small amount of literature available, there has been an increased understanding of what these communities need to improve their health and social behaviours and conditions, as well as developing new mechanisms to deal with related issues. Community-orientated World Cafés have had positive outcomes with new programmes being rolled out and stakeholders being identified (Yankeelov, Faul, D'Ambrosio, Gordon & McGeeney 2018:2).

The community engagement method of the World Café illuminates the ideas and culture of local existence. By using creative conversation, collective thinking, and knowledge sharing, ideas and strategies come to light. The World Café can bring a diverse group of people together to voice their opinions and ideas about a community matter to ultimately lead to strategic intervention (Yankeelov et al 2018:7).

A study by Carter, Swedeen, Cooney, Walter and Moss (2012:16) that used the World Café as their primary methodology involving a group of vulnerable children reported successful data collection. Research by Khong, Bulsara, Kill and Hill (2017:1180-1193), involving the elderly, was excecuted using the World Café method. The elderly population also fall under the vulnerable population umbrella. The researchers used a modified World Café approach in a vulnerable community. They asked five questions pertaining to their research to create general themes of conversation under the group of participants. The World Café provided fresh insights into this topic by voices directly from the affected community (Khong et al 2017:1180-1193).

In the literature presented above, it is clear that the World Café can be used in vulnerable and rural communities with a desirable outcome. It is important to apply the seven principles of the World Café on the target population's socio-economic and

cultural circumstances and beliefs. It also seemed plausible for the researcher to let the participants self-select to be in the study.

Figure 3.1 The World Café guidelines

(Source: Orloff 2015:1)

3.7.1 The World Café process

The World Café process was divided into four phases, namely the planning phase, the opening phase, the implementation phase, and the closing phase.

3.7.1.1 Planning phase

The planning phase's duration stretched over a period of one year, from June 2017 to June 2018. First, a farm needed to be secured. The researcher reached out to four farmers to determine who of them would be interested in receiving the research team on the farm.

Out of the four, only three farmers responded that they would be interested. The chosen farm was closer to the residing town of the research team and about the same distance from the closest local PHC clinic as the other two farms. Permission to conduct the study on the farm was sought after receiving ethical clearance to conduct the study (see ethical clearance certificate in Annexure A and permission from the farmer in Annexure C).

The recruitment of potential participants was next on the planning list as the World Café cannot happen without the appropriate population and sample size. Parkhurst, Preskill and Gopal (2017:2) explain that a sample size of 15 to 20 individuals should be the minimum to carry out a successful World Café and can be implemented with up to 1 000 people.

The researcher established a working relationship with one of the female farmworkers. She agreed to act as the gatekeeper for the purposes of this study. The gatekeeper interacted with the participants where needed in the planning phase.

Gatekeepers in a research setting are used to control access to vulnerable participants and are more often used in studies with sensitive research topics (McFadyen & Rankin 2016:82).

The gatekeeper was trained to explain that participation was voluntary, as well as the purpose of the World Café to her co-workers. The researcher travelled to the farm three months in advance to train the gate keeper in person on how The World Café will work and what type of question will be asked. A numbered attendance and demographics list accompanied the World Café invitations, as well as coupons for lunch on the day was given to the gatekeeper to distribute accordingly (see Annexure F). The researcher decided to use the gatekeeper as a recruiter to have someone from the community invite participants rather than using someone they might not feel comfortable with, or run the risk of participants feeling coerced into participating.

The invitation used for the World Café was designed to give a fun and colourful feeling, using yellow, blue, and purple colours, rather than the widely used red associated with

HIV/AIDS (see Annexure F). The reason for this design was to prevent stigmatisation and fear of being tested for HIV at the event.

The next important aspect that needed to be secured was the table hosts. Table hosts serve as the conversation facilitators at each table (Schieffer et al 2004:1). The researcher selected the table hosts with great caution and consideration. The World Café needed table hosts who could communicate freely and with confidence, without making the participants feel vulnerable or exposed. In conjunction with the former, the table hosts needed to be knowledgeable in the field or with research in general.

The following five table hosts were chosen:

(1) A female radiographer with an honours degree.
(2) A male financial broker with a winning personality and with an honours degree.
(3) A female Geographics lecturer at the University of Pretoria with a master's degree.
(4) A female Emergency Unit trained and registered nurse who is currently working in Urology Research Nursing, and who has a bachelor's degree.
(5) A female retired social worker currently working as a tour guide, who has a bachelor's degree.

All the table hosts received a document two weeks prior to the data-collection day that included the purpose, aims, and objectives for the day, some conversation guidelines, and guidelines on when to steer the conversation back to the topic at hand (see Annexure D). The training also included some field note-taking tips. Each table host had a field notebook with their name on and the table question with the conversation guidelines for the day (see Annexure D for the training document).

The researcher planned according to the attendance list and table host list, the numbers for the table and chair hire, catering, entertainment for the participants' children, and the World Café T-shirts (see Annexure I). The World Café food, equipment, and stationery were financed through the bursary awarded to the student from the university, while the children's entertainment was financed by the researcher. The stationery included paper table covers, pencils, fibre-tipped colour pens, name tags, poster paint and brushes, colour-coding stickers, and the printing of informed consent forms and confidentiality

binding forms. Provisions were made for taking care of the participants' children during the World Café. The researcher provided a childminder to supervise the children at play while the World Café was in progress.

3.7.1.2 Opening phase

The participants live close to the roofed area where the facilities were set up for the day. The World Café was held under a tractor and corn storage facility with an open, roofed space. Next to the storage facility is a lawn where lunch and tea were served. A jumping castle was set up on the lawn for the participants' children to play under supervision of a childminder.

They seemed curious, constantly peeking around the corner and were shy, while washing their laundry as if not on their way to the World Café. Even though they were invited and indicated that they wanted to be part of the World Café, it took some reassurance to get them to move to the roofed area to start. Some cheerful café music played over the speakers and as soon as the first few participants entered, the rest followed with happy and relaxed dance movements. The café background music created a relaxed atmosphere and mood for the participants (The World Café 2017:2).

The World Café hosts handed out participant information leaflets and informed consent forms to all the participants. The participants were given an explanation of the rationale for the study, as well as the content of the participant information leaflet. The participants were given an opportunity to ask questions.

No questions were asked in the group informed consent discussion but the researcher made her way from table to table to ask if the participants had any questions.

Four participants asked if they would be tested for HIV on the day, and the researcher reassured them that there would be no testing for HIV on the day. Two of the four participants wanted an HIV test, and the other two seemed scared that we would test them. Participants 18 years of age and older then signed the informed consent form (see Annexure E) before the World Café commenced. Two interpreters were present. They communicated well in both Afrikaans and English as well as Tswana and Zulu.

An A2 poster was set up prior to the commencement of The World Café with general rules for the day (Yankeelov et al 2018:5). The rules for the day included the following (see Annexure H):

(1) Sign informed consent form
(2) Respect all people attending the World Café
(3) Listen to one another
(4) Ask questions
(5) Enjoy the World Café

Each conversation table had one host that remained stationary. The hosts for the day were either healthcare professionals or individuals with experience in research activities.

3.7.1.3 Implementation phase

During the World Café, each table had five to six guests seated at a time. The session started with an invitation to discuss the issue at hand and information regarding the proposed HBHCT. Each conversation table had a question or statement to discuss and to interpret in a creative way. Tables delivered a report of the beliefs, feelings, and attitudes discussed in the form of a poster table cover.

The hosts made field notes of each group that sat at their table regarding the main discussion points and general feelings about the statement until data saturation was reached. After 20 minutes, the participants moved to a new table, leaving their table cloth behind for the table host of the next group to draw and write on. Each table represented a question. As each group moved on to the next table, a new question or topic of discussion was introduced. After all the rotations, the group came together where ideas and recommendations were “harvested”.

When all the rotations had concluded, the table hosts hung their table cloth on a “washing line” and presented the participants’ collective feelings and ideas about the statements made at their table. This stage was video and audio recorded.

The following seven design principles were incorporated into the World Café session (The World Café 2017:1):

(1) Set the context

The context was set by carefully developing questions that matter most to be able to answer the research question by the community affected. Free condoms were available on all the tables to reiterate the HIV/AIDS context without using the commonly used red colour for HIV-themed events.

(2) Create a hospitable space

The World Café was held in a roofed barn with tables and chairs placed in an informal manner, approximately 200 m from the participants' living quarters. Tea and scones were served to warm up the participants and table hosts as it was a cold day.

The groups were colour coded with a coloured sticker on the shirts for them to be able to constantly identify their group members.

The participants and table hosts all wore their World Café T-shirts to create a feeling of unity. The participants' children were accommodated at the World Café with a jumping castle and some colouring books, to make the parents feel comfortable about the safety of their children.

(3) Explore questions that matter

The following five open-ended questions were explored to enable answering the research question:

Question 1 / Table 1:
What is HIV/AIDS? What is your view on HIV testing?

Question 2 / Table 2:
What are the problems that prevent you from going to the PHC clinic for HIV testing?

Question 3 / Table 3:
What would you like about a mobile clinic or nurse that comes to the farm to do HIV testing and health education (teach you about HIV/AIDS and other chronic diseases)?

Question 4 / Table 4:
What would you not like about a mobile clinic or nurse that comes to the farm for HIV testing and health education (teach you about HIV/AIDS)?

Question 5 / Table 5:
What do you think the other people in your community will say about HIV testing at home or on the farm?

(4) Encourage everyone's contribution

The participants were encouraged to participate, to communicate if they wished to do so, and to have fun with the information session before the start of Round 1. They were reassured that there was no wrong or right answer and that each opinion was important.

The table hosts were given a glittered talking stick to encourage participation. A talking stick is generally used to pass around as an ice breaker. The person holding the stick can speak and if they do not wish to speak, they pass it to the next person. Only two table hosts used the stick in the first round when the participants introduced themselves. The remaining three hosts did not use the stick as they did not deem it necessary. The table hosts explained that their participants spoke freely. The researcher left the use of the talking stick up to the table hosts' discretion.

The researcher moved through the tables once per round to ensure that everyone understood and answered all questions asked. The researcher also motivated the participants to express their feelings and ideas by drawing and painting on the table covers if they did not want to express it verbally.

(5) Connect diverse perspectives

The table hosts explained the previous groups' pictures and artworks on the paper table cover to their new groups and asked the participants how they felt about those ideas and insights.

As the researcher moved through the tables, new ideas, insights, and questions came to light and they were carried over to the next table to hear what they had to say about these discussion points.

(6) Listen together for patterns and insights

Training for the table hosts included listening together for common conversation patterns in each round of rotations. The table hosts and researcher made in-depth fieldnotes on all conversation topics and insights.

(7) Share collective discoveries

Once the five rounds concluded, all the participants and table hosts came together and the table cover presentation started. Each table host presented their table cover and question to the rest of the World Café party.

All but four female participants listened and participated in the conclusion. These four participants asked the researcher to excuse them as they would have liked to stay but needed to use the rest of the afternoon to do their laundry as they do not have time during the week to do their chores.

There were a few questions from the researcher directed at the table hosts for clarification of statements, but none from the participants.

Table 3.1 Itinerary for the World Café

ITINERARY FOR THE WORLD CAFÉ	
TIME	**EVENT**
08:00 – 09:00	Welcome, tea, and signing of informed consent forms
09:00 – 09:30	Table seating, final explanation of the proceedings, and questions
09:30 – 09:50	Round 1
09:50 – 09:55	Rotation
09:55 – 10:15	Round 2
10:15 – 10:20	Rotation
10:20 – 10:40	Round 3
10:40 – 11:00	TEA TIME
11:00 – 11:20	Round 4
11:20 – 11:40	Round 5
11:40 - 12:10	Conclusion, presentations, and data analysis
12:10 – 13:00	LUNCH
END	

The World Café ran on schedule and ended at 13:00.

3.7.1.4 Closing phase

The researcher thanked the table hosts and participants for sharing their opinions and feelings and spending the day at the World Café. The researcher gave the table hosts a few minutes to collect their thoughts and make their last notes. Table cover presentations then started as explained above.

When the table cover presentation concluded, all were invited for lunch. During both tea and lunch time, the male participants waited for all the female participants (including those who went to do their laundry) and the children to eat first and then they went to dish up without any direction or instruction on lunch formalities from the researcher.

3.8 STRENGTHS AND WEAKNESSES

The weaknesses the researcher experienced using this data-collection method included the following:

Some language barriers arose in the rural farming community of the North-West province during data collection. This is a weakness as the World Café relies on free and

creative communication. Most participants were migrant workers and a range of languages was spoken, with English being the main language. All the participants who signed consent could read and communicate in English. Two lay interpreters were present, who helped some participants convey complex messages in English.

The participants started the first round being very shy and unfamiliar with this method. It was the first time that they had participated in such an activity and heard about this method of research (some of the participants were unfamiliar with the concept of research in general). After a few minutes of introducing themselves and getting to know the table hosts, they became more relaxed and at ease.

One of the table hosts required more than 20 minutes for her discussion per round as she had a different fieldnote-taking method than the others. The researcher gave her a minute or two extra for each round while attempting to keep the schedule and conversation flowing.When the conclusion and table-cover presentation commenced, the participants were once again shy to give their input and speak in front of the group. Core themes and insights of the day were mainly identified by the table hosts and researcher while the participants listened and nodded in agreement, with only some engaging in the final conversation.

Finally, the World Café needs a large amount of careful planning and materials to make this data-collection method a success. It is a time-consuming process to make everything work, from selecting the participants to the catering and everything in between.

The strengths the researcher experienced using this data-collection method included the following:

One of the main strengths of the World Café is the move-along system that makes it easy to collect data on multiple questions and statements around one theme. This is an extremely enjoyable activity for the participants as they get to express themselves in a creative way while having a meaningful conversation on a topic that they are well accustomed with.

The time limitation on each round is long enough to discuss the question or topic in detail but not long enough to open the door for boredom. It ensures that the participants remain interested in the current topic and to get excited for the next topic when the end bell rings.The tea and lunch breaks, as well as the moving around between rounds, keep the participants happy and interested and curb some of the fatigue that might occur when participants sit in an enclosed space for long periods of time.

Including the participants in the primary phase of data analysis ensures increased credibility and dependability. The researcher does not only rely on his or her opinion of the data collected but primarily analyses the data with the participants who were the source of the collected data.

The World Café comes across as an event rather than a task for the participants. In the affected population, it is not often that an event is held specifically for them. The participants all mentioned that they enjoyed the music in the background and the social feeling of the day.The participants were relaxed and content with their children being looked after by a childminder within their view, moving between the tables and playing on the jumping castle. The participants were not worried about who would look after their children if they spent the whole morning at the World Café.

Keeping the population in mind, most of the participants mentioned that it was the first time in their lives that their opinion was asked about a certain topic or issue. This method empowered the participants to a certain extent.If planned carefully, the World Café commences without much interference from the researcher. It flows from one round to the next with ease and it feels as if the data collects itself to an extent.

3.9 DATA MANAGEMENT AND ANALYSIS

Data were collaboratively analysed by the researchers and the participants. Content analysis of data was conducted. Content analysis is a form of qualitative data analysis that is used to analyse illustrations, narratives, or any other type of media to identify themes and how the themes are expressed (Ungvarsky 2016:9).

In this study, the data collected from the participants were in the form of pictures and narratives drawn and written on table covers during the World Café. Content data

analysis has two types of techniques: conceptual and relational analysis. Relational analysis was used for the purpose of this study. Relational analysis examines the similarities and differences in themes identified in the data. Relational analysis also examines how themes are connected (Ungvarsky 2016:10).

The following guidelines suggested by Brown and Isaacs (2005:140) were followed:

Firstly, after the completion of the presentation rounds where fieldnotes were taken, the group engaged in a conversation to share the collective insights gained from the presentation round. The World Café hosts displayed the summarised fieldnotes with statements, ideas, discoveries, and insights that were shared during the presentation round to guide the collective conversation.

Secondly, the groups were asked to identify the underlying themes and discoveries that presented themselves during the whole process. Statements and results that share the same underlying idea or meaning were grouped together under every question, and key themes were identified according to the participants' input.

The researcher and the study supervisor reviewed the written material from the participants and revisited the fieldnotes and audio recordings to confirm the themes. The conclusions on the themes utilised the information from the preliminary analysis and from the group analysis during the World Café.

The data were presented in the following manner:

(1) Themes were identified and paired with sub-themes under each theme.
(2) Interpretation of findings for each theme was presented.

The written material from the World Café, audio-visual recordings, and fieldnotes will be kept locked in a drawer at the researcher's home for a minimum period of five years.

3.10 LIMITATIONS

Due to time and financial constraints, the researcher could only carry out the World Café once, on one farm with one population. Optimally, the data collection would have been repeated on another farm, in another region with a smaller or larger sample size.

The researcher could not make use of professional translators for the data collection due to financial constraints. Farmworker communities mostly comprise migrant workers and speak a range of different languages.

The distance to most farming communities is extensive and the researcher did not have the resources to travel to the farm more than twice: once to deliver the invitations and participant interest list, and the second time for the data collection. The researcher would have preferred to conduct an informed consent discussion and explanation of the World Café to the participants beforehand to reduce feelings of uncertainty on the day of data collection.

The day the data were collected was an extremely cold day. Although the space had a roof, it had no protection from cold wind. The large cemented floor surface also contributed to the cold conditions. The researcher had no way to protect the participants and research team from the cold conditions as the farmer only approved the designated area for data collection.

3.11 ETHICAL CONSIDERATIONS

Ethical principles guide researchers to conduct research in an ethical way. There are three principles to be adhered to when conducting a research study, namely beneficence, respect for persons, and justice (Brink et al 2012:31).

3.11.1 Beneficence

This principle protects research participants from harm and discomfort. Subjects' wellbeing must be the first priority, and no harm should be caused on a physical, emotional, or social level (Brink et al 2012:32).

Beneficence was applied in this study by not harming the participants on any level and placing the wellbeing of the participants first.

3.11.2 Respect for persons

This entails complete autonomy for all participants, and having the right to discontinue participation at any time. Participants should be able to decide if they want to enter participation completely voluntarily and have the option to withdraw at any time if they wish to do so (Brink et al 2012:32).

Respect for persons was ensured in this study by informing all participants that their participation was voluntary and that they were allowed to withdraw without penalty at any time.

3.11.3 Justice

Two main principles should be adhered to in order to achieve justice in a research study:

(1) **Conducting a fair study with regard to selection and treatment:** Participants had the opportunity to self-select. The entire workforce on the farm was invited to participate and to be part of the research population.

(2) **Right to privacy:** Anonymity and confidentiality were insured by not recording any of the participants' names. The participants participated in the study knowing what information would be shared and what information would be withheld. The privacy of the participants was regarded as high priority.

Informed consent (see Annexure E) was obtained by verbally giving information and an informed consent form, using layman's terms in the participants' language of choice. The sample group was highly likely to be illiterate or semi-literate. An interpreter was present during the informed consent session, as well as during the data-collection session.

Participation was autonomous and voluntary. The confidentiality of all information gathered was ensured. All the participants were treated equally and fairly, and had the

right to discontinue their participation, or to raise a concern whenever they felt that they were not comfortable (see consent form in Annexure E).

3.12 POSSIBLE RISKS FOR THE PARTICIPANTS

There were no expected risks for the participants. The World Café took place during the weekend (on a Sunday) when participants were off duty. There was no interference from their employer as the employer and his family were not part of the World Café to avoid participants' fears of discrimination or intimidation. Free and voluntary participation was ensured. The employer was notified of their right of non-participation when permission to conduct the study was sought.

3.13 ETHICAL CONSIDERATIONS FOR FIELDWORKERS

Fieldworkers included the table hosts, the moderator, and the translator. All fieldworkers were orientated about the responsibilities required of them during the World Café session and possible questions they might receive from the participants. They were asked to sign a confidentiality binding form, agreeing to keep all information confidential (see Annexure B).

3.14 SITE APPROVAL

Preliminary consent was obtained on 18 May 2017 from the farmer to host the World Café on the farm, on the employees' off day near their place of residence. An information document was sent to the employer via email with the specifics of the study as well as a consent form to conduct research on his farm. The name of the farm will not be mentioned in the study. Official permission from the farmer was obtained on 1 July 2018 (see site approval letter in Annexure C).

3.15 REIMBURSEMENTS, GIFTS, AND SERVICES FOR THE PARTICIPANTS

These refer to compensation for time spent, reimbursements for transport, or any reasonable direct cost to participants paid back to participants to neutralise participation. No reimbursements were made to participants as they incurred no costs to participate in the research (Grady 2005:1681).

All the participants and their children received food on the day, as part of the World Café principles. The researcher prepared a light meal for the World Café.

The participants received World Café T-shirts, sponsored by the researcher, as well as government-provided condoms. The materials were given to all available, irrespective of participation.

3.16 CONCLUSION

The World Café used as an academic method to collect research data proved to be a valuable method for qualitative data collection and primary analysis. This method was enjoyed by the participants and fieldworkers alike. It delivered high-quality concentrated data on the research questions. When planned cautiously, the World Café can be implemented easily with almost any population. This chapter described in detail the methodology, approach, design, data collection, reliability and validity, and ethical considerations of the method. Chapter 4 explains the analysis, presentation, and description of the research findings.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION TO THE RESEARCH FINDINGS

The World Café was attended by 31 participants out of the possible 40 farmworkers included in the population, of which 14 were female and 17 were male participants who all worked and resided on the farm located in the North West province of South Africa. All the participants signed informed consent and none were illiterate. Content analysis of the data was conducted. The analysis yielded five themes and respective subthemes (see Table 4.1 for detailed information regarding the themes and sub-themes).

The data are presented in the following manner:

(1) Themes were identified and paired with sub-themes under each theme.
(2) Interpretation of findings for each theme.

Table 4.1 Themes and sub-themes

Themes	Sub-Themes
Theme 1: Knowledge of HIV/AIDS and the necessity of testing	**Sub-theme 1:** Knowledge about HIV/AIDS **Sub-theme 2:** Testing for HIV is a good idea **Sub-theme 3:** Prevention of HIV transmission
Theme 2: Barriers hindering participants from going to the PHC clinic to test for HIV	**Sub-theme 1:** No PHC facility within walking distance **Sub-theme 2:** Traveling to the PHC facility is expensive **Sub-theme 3**: Lack of transport **Sub-theme 4:** Lack of identification documents – "Malala pipe" **Sub-theme 5:** Unpaid sick leave – 'No work, no pay' **Sub-theme 6:** Waiting period at the clinic is too long **Sub-theme 7:** 'Fear of the unknown' – HIV test outcome **Sub-theme 8:** Clinic hours incongruent to participants' working hours **Sub-theme 9:** Lack of safety for women and children when travelling to the clinic
Theme 3: Perceptions of farmworkers regarding a mobile clinic coming to the farm for HBHCT	**Sub-theme 1:** Positive aspects regarding a mobile clinic coming to the farm for HBHCT **Sub-theme 2:** Negative aspects regarding a mobile clinic coming to the farm for HBHCT
Theme 4: Possible perceptions of other community members regarding HBHCT on the farm	**Sub-theme 4:** Possible perceptions of other community members regarding HBHCT on the farm

The researcher observed that most participants were migrant farmworkers and not South Africans. The researcher did not instruct participants on where and how to place themselves at the tables and let them informally select their own groups by only instructing them to have five or six individuals at a table. The researcher chose this method to let the participants sit with others they feel comfortable with. The outcome was two tables with all females, and three tables with mostly males. The two female tables chose to sit next to each other (the red and green group). The researcher chose not to intervene with their table and seating selection.

The chapter concludes with an overview of the findings and sub-conclusions.

Figure 4.1 The World Café in progress

4.2 THEME 1: KNOWLEDGE OF HIV/AIDS AND THE NECESSITY OF TESTING

In Theme 1, participants knew the basics of HIV/AIDS but mostly indicated that they needed more health education. All participants indicated that they thought it was a good idea to test for HIV. The participants stated that they were in need of basic preventative

measures like condoms. Theme 1 had three sub-themes: knowledge about HIV/AIDS, testing for HIV is a good idea, and prevention of HIV transmission.

4.2.1 Sub-theme 1: Knowledge about HIV/AIDS

Group 1: The participants in Group 1 were identified by the table host as the red group according to the group's colour-coded stickers, were described as an extremely shy group, and were all female. The group first engaged in the painting and drawing activities and then slowly started conversing about the question. None of the group members knew what HIV was but knew that it can make an individual ill and that they have to test for HIV often (they did not specify how often). All the participants conversed about how they did not know what the signs and symptoms of HIV/AIDS were. Some of the participants mentioned the name of the clinic that they can go to for HIV testing and medication. Some (about half the group) of the participants also mentioned voluntarily that they have tested there once before.

Group 2: The participants in Group 2 were identified by the table host as the blue group according to the group's colour-coded stickers. The table host described this group as another all-female group, but less shy and reserved than the first. They engaged in a creative conversation about the question and the following data were obtained:

Some of the Group 2 members mentioned that HIV is a virus that transmits through sexual activity. One participant mentioned that the HI virus "destroys soldiers in the body". Group 2 participants knew and conversed about HIV that can be prevented through condom use. Most participants said that they were scared because they were unsure of other ways that HIV can transmit from one person to the next. Some mentioned that they thought HIV can also spread via kissing and hugging one another.

The Group 2 participants concluded that if you are HIV positive, you should only be eating white meats like chicken and fish and not red meats like beef. This practice was apparently learned at the clinic. This practice could have either started because the health worker explained that an HIV-positive individual should follow a healthy diet and the message got distorted, or the health worker was uneducated on the diet an HIV-positive individual should follow, or because of a cultural practice. It is unclear how widely this practice is followed.

Group 3: The participants in Group 3 were identified by the table host as the purple group according to the group's colour-coded stickers. This all-male group was described by the table host as expressive and talkative. The purple group all knew what HIV/AIDS was and one participant chose to inform the table host that he was an educated man, and explained to the rest of the group that the acronym "AIDS" stands for "acquired immunodeficiency syndrome". He also elaborated on the acronym and explained that it meant that a person does not have soldiers anymore to fight diseases. Some Group 3 participants stated that HIV transmits through sexual contact and a wound infection or cut. The participants used the word "ARVs" when they referred to HIV treatment but did not know what the abbreviation stood for. The purple group's artworks were profound and they expressed their conversation creatively by drawing accident scenes, a virus, and a mobile clinic.

Figure 4.2 Drawing of a virus

Group 4: The blue group consisted of all males. This group started the discussion around how HIV is incurable but that they were unsure what it does to the human body. The participants stated that HIV is transmitted via unprotected sex, infected wounds, and sharp objects. The participants talked about how it was their duty to protect their partners and themselves by using condoms when having sex.

Group 5: The yellow group was represented by mostly male participants. The participants started the conversation by debating the abbreviations of HIV/AIDS.

They explained HIV as a disease that kills the soldiers in the body and then any virus can enter the body.

4.2.2 Sub-theme 2: Testing for HIV is a good idea

Group 1: All group members said that they thought it was a good idea to test for HIV as it is better to know if you are sick so that you can receive treatment and live a longer life. The group painted mostly heart-shaped pictures in colourful colours and did not write any words on the table cover, but mentioned that the hearts resembled health.

Group 2: This group decided that it was a good idea to test for HIV. They further elaborated on the importance of knowing their status so that they could receive treatment and not look and feel ill anymore. Even though they thought it was good to know their HIV status, they were scared of telling other people their result. They stated that their family and friends might laugh at them and they might not get a boyfriend or girlfriend. This group was more inclined to draw stick-figured pregnant women with two figures holding flowers. One participant drew her house next to a tree with a sheep eating grass. They also painted some single flowers and heart-shaped illustrations.

Group 3: This group stated that it was a good idea to test for HIV. They agreed among one another that it was better to know if they were sick, so that they could do something about it.

Group 4: This group stated that it was a very good idea to get tested for HIV often to be happy and healthy. They noted that HIV medication was strong and could help you if you tested positive for HIV.

Group 5: This group also agreed that it was a good idea to test for HIV.

4.2.3 Sub-theme 3: Prevention of HIV transmission

Group 3: This group made artworks resembling HIV transmission through unprotected sex, condoms with symbols highlighting that it was important to use them, as well as scissors and wounds indicating ways of transmission. One participant added that they should all prevent HIV transmission by “loving one partner” and keeping them forever.

Group 5: This group stated that HIV was incurable but preventable by not having unprotected sex, abstaining from sex, and being faithful to their partners. They all agreed that an HIV-positive individual’s life was not over but that education was important because the disease spreads easily. They spoke about following a healthy diet and lifestyle and receiving treatment if diagnosed with HIV. One participant told the group that “life is a journey and not a destination; your body, your responsibility”. All the Group 5 participants agreed that there was a major lack of access to condoms and that they needed to travel far to obtain condoms at the local clinic. One of the participants made a sketch of a condom and another wrote down: “Health is the state of well-being and physical fitness.”

4.2.4 Interpretation of Theme 1 results

In terms of the presented data, it is clear that HIV and health education in general is desired in the farming community. The participants mostly knew that HIV is transmitted through unprotected sexual contact with an infected individual. Some of the participants described HIV as a virus that destroys soldiers in the body and that the body can then not protect itself against other opportunistic diseases. The participants referred to HIV treatment as ARVs.

No participants mentioned that they did not think it was a good idea to test for HIV. Most of the participants stated that it was better to know when you are sick and get treated, than to not know, deteriorate, and infect others. Tiruneh et al (2015:6) also found that migrant farmworkers know the essence of HIV/AIDS but not the specifics, and reported that they mostly know that HIV is a dangerous virus to contract.

Most of the participants stated that they feared HIV to an extent as there is no cure for HIV and they know that it kills. The male participants volunteered to say that if condoms were freely available they would always use them to protect themselves and their partners. The female participants did not mention anything about their willingness to use condoms. The participants took all the condoms that were made available to them at the World Café and one of the participants stated that they were not sure when they would be able to get condoms again. Musariri and Odimegwu (2016:13) concur with these findings in saying that lack of access to condoms among farmworkers remains a barrier to HIV prevention.

The responses to Theme 1 can be summarised as follows:

(1) The participants knew the basics of HIV/AIDS but mostly indicated that they needed more health education.
(2) All the participants indicated that they thought it was a good idea to test for HIV.
(3) The participants are in need of basic preventative measures like condoms.

4.3 THEME 2: BARRIERS HINDERING PARTICIPANTS FROM VISITING THE PRIMARY HEALTHCARE (PHC) CLINIC TO TEST FOR HIV

In Theme 2, the participants described the barriers that hinder testing for HIV. Barriers included lack of clinics, lack of transport, lack of identification documents, unpaid sick leave, and the trip to the clinic being expensive.

Figure 4.3 Participants in the World Café discussing Question 2

4.3.1 Sub-theme 1: No PHC facility within walking distance

Group 1: The participants started their conversation with the fact that they did not have a clinic close to them to go to. If they wanted to go to a clinic, they had to travel to the closest town about 40 km away.

Group 2: This group painted two mobile clinics and labelled them with “We need help” and “Please send us mobile clinic”.

4.3.2 Sub-theme 2: Traveling to the PHC facility is expensive

Group 1: The participants explained that one trip to the nearest clinic would cost them about R60 to the clinic and R60 back. To put this into context, the farmworkers earn a minimum daily wage that is currently R16.25/hour, according to Wageindicator (2018:1). This would mean that if they work eight hours a day, their daily earnings would be about R130. That adds up to almost a whole day's earnings just to get to the clinic and back.

Group 2: The participants discussed the distance they must travel to the closest clinic and mentioned that transport was a big problem for them. Some of the participants said that they have never visited the clinic because they do not have the money to travel there.

4.3.3 Sub-theme 3: Lack of transport

Group 1: The participants mentioned that travelling to the clinic was not always possible as there was minimal public transport in those areas and that they mostly hiked to the town and back. Upon probing, the participants mentioned that to hike means that they must walk for periods and wait until someone stops to pick them up or give them a lift. The group stated that the travelling time to the clinic was three hours. They reported that in cases of emergency, they call an ambulance but the emergency vehicles mostly take hours to reach them or never come.

Group 3: The participants stated that the clinic was too far and transport was not easily accessible for them to be able to travel to the clinic.

Group 4: The participants opted to tell the table host that many of the farmworkers on the farm were relatives. The participants started straight away with the transport topic. They named the two closest clinics to the farm, which were both about 40 km in opposite directions, but there were no taxis traveling to one of the clinics so they all had to go to the other clinic, with extremely limited transport opportunities. Artworks on the table cover for this group included an ambulance, a participant's girlfriend, and someone's house with a toilet in the bushes.

4.3.4 Sub-theme 4: Lack of identification documents – “Malala pipe”

Group 1: Another major barrier raised that prevented the participants from visiting the local clinic for HIV testing and follow-up visits was the appropriate identification documentation. The group agreed that this was an enormous problem for them. They knew that they were supposed to pay for public health services but they cannot get healthcare if they do not have documentation. They were scared that the healthcare workers would phone the police if they went to the clinic. The participants expressed that the local people experienced negative feelings toward them at the clinic.

This group creatively expressed their feelings through pregnant stick figures, describing them as ill because they were thin. They also painted some hearts and flowers. One of the participants painted her boyfriend who has TB, and made a bright-red dot on his lung.

Group 2: The participants raised the issue of them not having passports or other forms of identification to present at the clinic and stated that they mostly did not get seen by healthcare workers at the clinic without it. “Malala pipe” is they name are they sometimes called at the clinic if they do not have documentation, which, directly translated, means homeless person.

Group 3: The session started with the participants stating that some of them had problems to access the clinic because the clinic usually asked for proof of residence or identification, or both. They stated that it is not impossible but very difficult to obtain healthcare from the clinic.

Group 4: The participants also mentioned the barrier of migrant worker documentation. Most of these participants stated that they had a major problem with the appropriate documentation to seek healthcare. One of the participants stated that they were also charged as much as R400 to be seen by healthcare workers at the clinic if they did not have identification documents. He noted that he did not mind paying for healthcare but the amount was just too much for him and most other farmworkers.

Group 5: Once again, the participants discussed the issue of them not having proper documentation to attend the PHC clinic. The group said that the clinic was free for them;

this was not elaborated on but the researcher assumed it was because their babies were born in South Africa.

Figure 4.4 Drawing of hearts and flowers

4.3.5 Sub-theme 5: Unpaid sick leave – "No work, no pay"

Group 3: One of the participants used the term "no work, no pay", but when asked to elaborate on sick leave, he seemed scared to an extent and declined the invitation to elaborate.

4.3.6 Sub-theme 6: Too long waiting period at the clinic

Group 1: The participants raised the concern that the waiting time at the clinic, according to them, was about four hours, and travel time another three hours.

Group 3: The next conversation topic revolved around them not being helped straight away when they arrived at the clinic, but rather being told to "come back next week to see the doctor". They stated that this seemed like an impossible task for them to go to the clinic twice for one problem.

4.3.7 Sub-theme 7: "Fear of the unknown" – HIV test outcome

Group 2: Some participants had gone for HIV testing, but stated that they were scared to tell other people their result. They stated that their family and friends might laugh at them and they might not get a boyfriend or girlfriend if they tested positive.

Group 3: The participants said that they thought others were afraid of the outcome of an HIV test but they were not. The participants concluded that they thought people needed more health education about HIV for them to know the importance of testing regularly for HIV. Their artworks ranged from sick farm animals to sick people on the street. One of the participants painted a fish; he lived close to the ocean when he grew up in Mozambique.

Group 5: The participants mentioned that although they were sometimes afraid of the results, they did indeed want to visit the clinic for HIV testing. They did not care what other people might think if they went for a test, but it was extremely difficult for them to get there. They stated that they were scared to test for HIV because it kills, but rather wanted to know their HIV status than to live a sickly life. These participants did not have the knowledge to differentiate between HIV and AIDS.

4.3.8 Sub-theme 8: Clinic hours incongruent to participants' working hours

Group 4: The participants had a conversation that revolved around their working hours and the clinic's working hours. They did not want to take a day off work to go to the clinic for HIV testing because it would be too costly for them if it was not an emergency. The farmworkers work Monday to Saturday and the clinics are not open on a Sunday. The participants added that they thought everyone needed more health education and it was just not possible for them to go to the clinic for that.

4.3.9 Sub-theme 9: Lack of safety for women and children when travelling to the clinic

Group 5: This group explored some of the barriers to visiting the clinic for HIV testing through creative conversation. The most prominent problem here was the danger of women and babies traveling to the clinic by means of hitchhiking. The group told the

table host stories of scary encounters on the road while traveling to the clinic with their babies. This group wrote statements on the paper table cover reading: “We need mobile clinic to come, please come and help us” and “We feel good today”. They also painted some pregnant moms and babies.

4.3.10 Interpretation of Theme 2 results

The most common problem that emerged as a barrier for the farmworkers in the region to go for HIV testing at the PHC clinic was transport, and the distance they had to travel to reach the clinic. It was widely discussed that public transport like taxis and buses were scarce and they needed to hitchhike in other cases. The travel time was long and unpredictable and it was extremely difficult to plan a trip to the clinic in advance. The table cover painted a picture of unpredictability concerning everything from transport to cost, getting to and from the clinic. Healthcare in general seemed unpredictable for this population.

Heideman (2010:12) studied the HIV/AIDS vulnerability of farmworkers in the Free State and found that a major barrier for these workers to visit the closest PHC clinic was transport, and stated that the farmworkers did not have any transport from the farm except for the farmer’s wife who would drive them.

Most of the participants were migrant workers, and this is greatly significant as it poses the next major problem for participants to visit the PHC clinic. Most of the participants reported that they were either not helped at the clinic as they did not have an identification document, or they were shown away at the clinic due to their migrant status irrespective of having a document or not. The participants mentioned that they were afraid of being apprehended by the police if they visited the clinic without identification documents.

The DoH has made it clear on numerous occasions that migrants in South Africa have the basic right to healthcare, which includes ART, but accessing such treatment and care still remains a major problem for cross-border migrants in South Africa (Vearey & Nunez 2010:7). The participants also mentioned that they experienced negative feelings and comments from other patients and healthcare staff at the clinic because they were not South Africans, and were told to go back to their own countries.

The participants reported that they were expected to pay for health services as they were not citizens, on top of the cost to them getting there in the first place. Keeping the former costs in mind, there is a “no work, no pay” situation on the farm, which would mean that the farmworkers also lost the day’s earnings to visit the clinic. This means that visiting the PHC clinic has major cost implications for them.

Another problem reported during data collection was the amount of time it takes to finally get helped at the clinic. Long traveling times and waiting times at the clinic could take the whole day. Local clinics are not open over the weekends when farmworkers might have some time off work to visit the clinic.

The responses to Theme 2 can be summarised as follows:

(1) Transport to and from the community is a major barrier.
(2) Travel costs in non-emergency situations are not viable to pay.
(3) No sick leave; workers lose the day’s wages to visit a clinic.
(4) Migrant farmworkers are concerned about discrimination at the clinics.

4.4 THEME 3: PERCEPTIONS OF FARMWORKERS REGARDING A MOBILE CLINIC VISITING THE FARM FOR HIV COUNSELLING AND TESTING (HCT)

4.4.1 Sub-theme 1: Positive aspects regarding a mobile clinic visiting the farm for HCT

Group 1: The group started the conversation with their most significant barrier, which was transport. They once again explored the reasons why transport was such a big problem for farmworkers in the region and discussed the fact that a mobile clinic would eliminate the barrier. They would like a mobile clinic because it would be easy to go for HIV testing every three months. Group 1 also spoke about being able to test for HIV if it was free and accessible. They all mentioned that they would test every time the mobile clinic visited the farm.

The conversation progressed to participant’s health education needs. The participants stated that they would like to learn about HIV, diabetes, hypertension, and TB. One of

the participants asked if a mobile clinic on the farm would be able to teach them about the warning signs of communicable diseases and chronic illnesses. This group, being mostly men, said that they would want a clinic that catered for male health as there was a mobile clinic at a gas station about 10 km from the farm every six months that mostly wanted to help mothers and babies.

The group made artworks of mobile clinics with captions like “I love it” and “Wow for the idea of a mobile clinic”.

Group 2: The discussion had a slow start, with one participant stating that she did not want a mobile clinic and the others debating with her about the reasons for her statement. The table host could not follow the conversation completely as this happened in Xitsonga, a language the table host was not familiar with. The table host did not elaborate further on the participant’s reasons.

The rest of the group, being mostly women, discussed that they would like a mobile clinic to visit the farm because they would like more accessible immunisations and treatment for their babies. The group conversed about the possibility of the mobile clinic identifying high-risk pregnancies, seeing that the women on the farm mostly delivered one another’s babies. The group also discussed the fact that it would not be such a big financial burden to test for HIV if the mobile clinic could come to them.

This group painted a mobile clinic with a sick female individual inside. There was also a painting with a heart and a caption reading “Care”.

Group 2 participants concluded that they did not know what to do when they felt sick and that the mobile clinic might help them with that. Group 2 made artworks of sick people with speech bubbles and two colourful mobile clinics next to their houses and animals on the farm.

Group 3: The participants explained that they desperately needed health education and believed that a mobile clinic would be able to teach them what they needed to know. Some of the participants said that they needed to know more about HIV and all the ways it could be transmitted, prevented, and treated. The participants around the table

spoke about the accessibility of a mobile clinic and how it would no longer be required to travel long distances for an HIV test and pay a lot of money just to know their status.

The Group 3 participants said that they would also like to know more about TB, cholera, and malaria if a mobile clinic would visit the farm. The participants wanted to know more about what they could do to treat themselves and when they should go to the clinic or call an ambulance for help.

This group expressed their feelings in writing in terms of what they would like about a mobile clinic and wrote statements like “Signs and symptoms of HIV/AIDS”, “We need testing for HIV and malaria”, and “We would appreciate information for HIV”.

Group 4: The purple group discussed education first and stated that they needed health education on prevention of chronic illnesses and HIV, and stated that if a mobile clinic could provide this, they would accept it as a major positive component. The participants stated that they wanted to know more about the risk factors and behaviours that could lead to one contracting HIV.

They would like a mobile clinic because it would hopefully be scheduled and they would then be able to plan ahead. Most of the Group 4 participants wanted to get an HIV test done every three months. They stated that if a mobile clinic travelled from farm to farm, they would be able to use it during the week and would not have to take leave for an HIV test or check-up.

The participants spoke about how they would be able to receive basic medical attention without having to travel far. They would like a mobile clinic because it would eliminate the travel barrier for them.

One of the Group 4 participants raised the issue of proper documentation. They talked about how the previous mobile clinic that attended to the farmworkers did not require legal identification and they were able to use the services they could not get at the PHC clinic in town. They said that if the proposed mobile clinic allowed migrant workers to be treated, they would be extremely grateful.

The Group 4 participants painted different modes of transport, including an ambulance, as shown in Figure 4.5.

Figure 4.5 Illustration of an ambulance

Group 5: The Group 5 participants discussed the advantages of a mobile clinic and how they would be able to access HCT without having to travel to the PHC clinic by hitchhiking or paying for a taxi that did not come around that often. The group talked about how nice it would be just to be able to talk to an individual with a medical background and ask questions if they were unsure of symptoms. The participants talked about the possibility of a referral letter to the clinic if someone needed to be seen by a doctor.

They spoke about other illnesses that were a burden for them and how the idea of a mobile clinic that visited them on the farm could alleviate some of that burden. They mentioned hypertension, high cholesterol, diabetes, and malaria.

The Group 5 participants wrote statements like “We say a big yes for HIV tests” and “Stop AIDS, we can do it”. One participant painted big blue X-shaped objects and indicated that they were diseases.

4.4.2 Sub-theme 2: Negative aspects regarding a mobile clinic visiting the farm for HCT

Group 1: The Group 1 participants around the table were somewhat sceptical about the degree of confidentiality that a mobile clinic on the farm would have regarding their employer and other farmworkers on the farm, as well as on neighbouring farms. Most of the workers were also undocumented and the participants raised their concerns about healthcare workers alerting the authorities or just telling other people of the number of undocumented farmworkers on the farm.

They also raised concern about the number of farmworkers in the region who would want to attend the proposed mobile clinic for HIV testing and health education. The participants said that there might sometimes be many people attending the clinic and other times none. The participants were scared that if no one attended, the mobile clinic would stop visiting the farms.

The Group 1 participants also had a conversation about the mobile clinic that used to attend to them and how they could not get off work to visit the clinic during weekdays. The participants talked about the possibility of the clinic visiting the farms over weekends.

They expressed their feelings creatively by writing and drawing on the table cover. One of the Group 1 participants wrote: “Mobile clinic don’t come anymore.” One participant painted a condom with the caption “To prevent AIDS use this”.

Group 2: The participants stated that they were not scared that the mobile clinic would not manage them in a confidential manner. They conversed about how they trusted the healthcare workers and that they knew their results would be kept confidential. Others around the table had mixed feelings about the confidentiality of a mobile clinic.

The major issue that this group raised in a conversation about a mobile clinic on the farm to offer HIV testing and health education was that it might only do that and not offer other health services. The participants spoke about how desperate they were for chronic healthcare. The participants highlighted how good it would be if the mobile clinic could refer them to the PHC clinic if needed.

Figure 4.6 Illustration of a mobile clinic next to a house

Group 3: The participants' discussion revolved around how they would not have any problem with a mobile clinic visiting the farm for HIV testing. The participants said that they trusted the healthcare workers and the confidentiality requirement they adhered to. When prompted by the table host to share some negative stories or experiences they previously had with the mobile clinic, they all denied that there were any.

The researcher hypothesises that the participants may have felt scared to share anything negative about what they would not like about a mobile clinic visiting the farm in anticipation that it might influence someone's decision to send a mobile clinic to the farm. Some of the participants raised the concern of undocumented farmworkers and how they might not be helped if a mobile clinic visited them on the farms. One of the Group 3 participants painted a big cross with the caption "NO ID, NO HELP", and another wrote "No negative for mobile clinic, only positive".

Group 4: Similar to the former group, Group 4 participants did not have much to share about what they would not like about a mobile clinic visiting the farm. They mentioned that they trusted the healthcare workers of South Africa and that confidentiality was not an issue for them.

The participants painted their artworks on the table cover for most of the session and painted their houses, flowers, and their babies, and wrote “We accept mobile clinic to come here”.

Group 5: This group conversed firstly about how they would not be able to get off from work if the mobile clinic should come during the week or during their working hours, especially if they were not sick but only going for an HIV test. The participants talked about the possibilities of the proposed mobile clinic coming over the weekend.

Next, they discussed the widely mentioned barrier concerning undocumented farmworkers. The participants discussed the possibilities of them being able to attend the mobile clinic if they did not have the proper documentation.

The Group 5 participants stated that they were not afraid of judgement from co-workers and even if there might be some judgement, it would not stop them from testing for HIV at the mobile clinic.

The participants painted a mobile clinic and wrote the following statements on the table cover: “Not scared to use a mobile clinic, it is our own health”, “Must be regularly done”, and “Mobile clinic should come during weekend”.

4.4.3 Interpretation of Theme 3 results

Most participants liked the idea of HBHCT with a mobile clinic going from farm to farm to do HIV testing, and mentioned that it would be majorly beneficial to them. The participants felt that if they were not expected to travel so far for an HIV test, it would be much easier to get tested and receive treatment if necessary.

Mutale, Michelo, Jürgensen and Fylkesnes (2010:3) found that HBHCT was more acceptable in rural than urban areas in SSA and believe that this method diminishes the inequalities of access to HCT services. Mutale et al (2010:3) state that of the individuals HBHCT was offered to, only 20.6% had been tested for HIV before. In another study conducted in rural Tanzania, Njaua, Watt, Ostermann, Manongi and Sikkema (2012:3) made similar findings regarding the high acceptably of HBHCT.

The participants noted that they did not get a day off work to visit the clinic, but if a mobile clinic visited the farm for HIV testing, they would not have to take unpaid leave and would only be gone from work for an hour at most. Visser and Ferrer (2015:10) note that paid sick leave is uncommon among farmworkers working without a contract in South Africa and even more so for the undocumented migrant farmworkers in South Africa.

The participants established that the farmworkers would like to receive health education from a person with medical knowledge and stated that they needed to be educated about chronic and communicable diseases other than HIV. The participants mentioned that they needed more information about HIV, malaria, diabetes, hypertension, STIs, TB, maternal health, and male health. The participants indicated that they would like to be educated about the signs and symptoms of different illnesses.

The participants noted that if there were to be medical professionals visiting the farm, they would also be able to help with the treatment referral of HIV and other illnesses. The participants indicated that they had a general problem with healthcare and that even the presence of a medical professional would be beneficial to them.

The participants would like a mobile clinic to visit the farming region as it would be regulated and scheduled and it might be easier for them to plan their tests.

Overall, the participants did not exactly have issues with the proposed mobile clinic, but had a few concerns about the operational logistics. Some participants mentioned that it might be a problem if the mobile clinic visited during the week for HIV testing, while others said that it would be fine, as they would not have to take off work the whole day and could visit the mobile clinic during their lunch breaks.

Another concern raised by the participants was the documentation issue and whether they would be able to visit a mobile clinic without the proper documentation. The participants mentioned that they could visit the previous mobile clinic without proper documentation.

Some participants had mixed feelings about the confidentiality of their HIV results and were unsure if they could trust the healthcare workers to not inform their employer of their results. The participants also mentioned that this would not stop them from testing for HIV. Some of the participants stated that they were scared that if there was a day that no one used the mobile clinic, it would stop coming. Njaua et al (2012:3) found similar issues regarding confidentiality and state that the clients would not feel that HBHCT is entirely private if the counsellors were from the same area as the clients. The researcher hypothesises that some of the participants might have been cautious to state negative feelings toward the idea of a mobile clinic for HIV testing in an attempt to not influence the outcome of the study in a negative way.

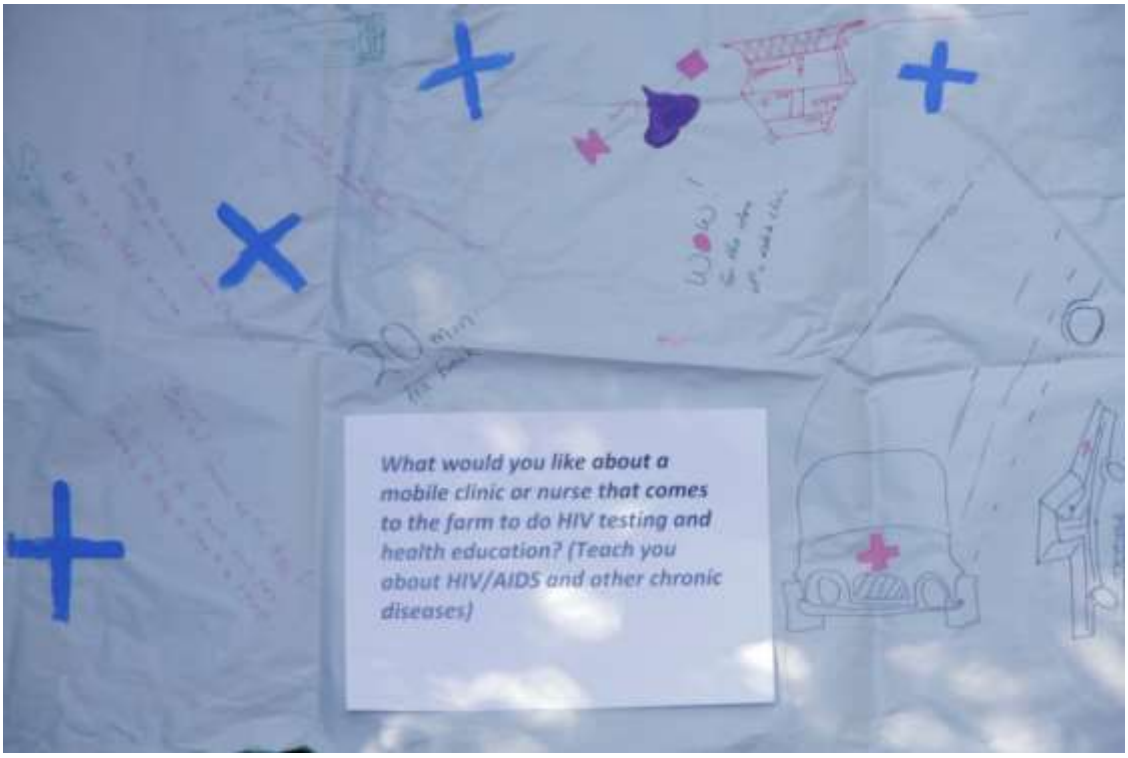

Figure 4.7 Table four cover

The responses to Theme 3 can be summarised as follows:

Sub-theme 1

(1) HIV testing will be easily accessible from a mobile clinic.
(2) Farmworkers would not have to take a day's leave to get tested for HIV.
(3) The farmworkers would like to have a knowledgeable individual teach them about HIV/AIDS and other chronic diseases.
(4) HBHCT in the form of a mobile clinic would be scheduled and they would be able to plan their tests and visits to the mobile clinic.

Sub-theme 2

(1) The participants had concerns about the confidentiality of their results if HBHCT were done on the farm where they both worked and lived.
(2) Most participants would not be able to attend the mobile clinic for HIV testing if the clinic only attended to South African citizens and not migrant workers (both legal and illegal workers).
(3) The participants worked during the weekdays and would sometimes not be able to utilise the HBHCT service if it was not offered over weekends.

4.5 THEME 4: POSSIBLE PERCEPTIONS OF OTHER COMMUNITY MEMBERS REGARDING HBHCT ON THE FARM

The researcher brought this topic to the participants to elicit information that might have been held back when the participants were directly asked about issues. The participants talked freely because they were speaking "on behalf" of other community members.

Group 1: Group 1 started their conversation concerning HBHCT and what the larger community would think about it. They stated that they thought the community would appreciate such an opportunity and think it would be "good".

The closest clinics were far and they thought that the rest of the community had the same barriers with transport to the clinic. The participants stated that if a mobile testing station was close to the farms, most of the farming community would use it. The participants mentioned that they believed most people thought it was a good idea to test for HIV so that they would be able to manage the disease and live longer lives.

They talked about how no one would judge them if they visited a mobile clinic or testing station, and the larger community would most likely follow. The participants also talked about how they thought that their employer would accept a mobile clinic on the farm as it would create healthier workers on the farm.

The Group 1 participants expressed themselves in a creative manner by painting pictures of the HI virus and painting faces on the virus particles. There were also some pictures of animals like cats and dogs with speech bubbles saying “I feel good” and “Stop HIV”.

Group 2: The participants had a conversation about how the community would know that testing was confidential and would not be shared with their co-workers or employer. This group of participants were also sceptical about how their employer would feel about a testing station on the farm.

The participants elaborated a bit on the schedule such a mobile clinic would follow and the intervals of the visits. The participants mentioned that the community would be able to utilise such a service if they could plan when they would be able to visit the mobile clinic accordingly and know when the clinic would be visiting the respective farms so that they could tell the others in their community.

The Group 2 participants once again mentioned that most of the farmworkers in the community were undocumented, and they too would only be able to use the service if it was rolled out for the community members rather than only for South African citizens or documented migrants.

One of the Group 2 participants stated that other farmworkers and their families would benefit greatly from HBHCT. Another participant said that the proposed mobile clinic should not only pass by, but stop and call them so that they would know that the clinic was there.

Another conversation branched into the dangers of stigma if the mobile clinic had HIV branding and offered only HIV testing and referrals. One of the Group 2 participants added that the clinic should offer a range of diagnostic tests so that the community

would not label a patient of the clinic as HIV positive. Another participant disagreed with the former statement, saying the community would not judge as they know that it is important to know your status.

The participants painted a mobile clinic and a sick family, indicating illness with small marks on the bodies. The participants also wrote about how they had fun.

Group 3: The participants stated that the broader community would appreciate such a service on the farms. They thought their employer would also appreciate such a service as it would not require them to leave work for an HIV test. One of the participants mentioned that he thought the farmworkers on the neighbouring farms would like the idea of HBHCT.

The Group 3 participants agreed that the farmworkers on the other farms were also desperate for any healthcare and would also like to know more about chronic illnesses and male and female health. Some of the participants mentioned that the previous mobile clinic only attended to antenatal, postnatal, and female health. The participants, being an all-male group, once again noted that they needed male healthcare.

They spoke more about how they hoped that the proposed mobile clinic would help them without the appropriate documents as documentation was not required by the previous mobile clinic that visited them.

The Group 3 participants asked if the research team would come back and offer them HIV tests in the future. One participant mentioned that they enjoyed the day and that they needed help. One of the participants painted himself and his house on the farm.

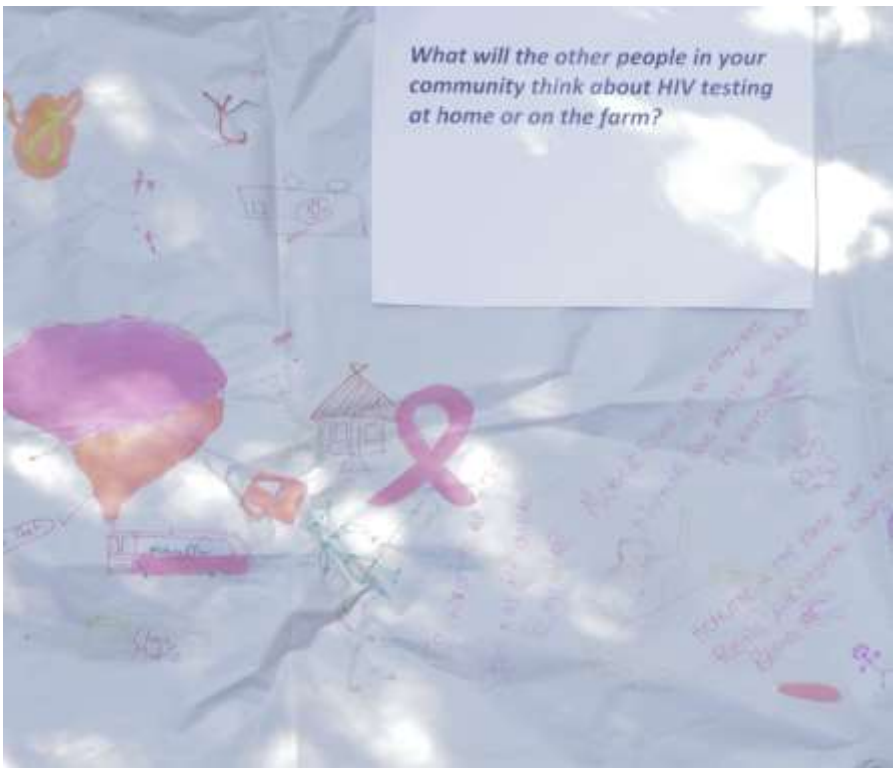

Figure 4.8 Table five cover

Group 4: The conversation developed around the fact that the community would be happy if HBHCT was made available to them, seeing that transport to the nearest clinic was so expensive. The participants also mentioned that they thought their employer would be happy as the employees would not have to miss work to go for an HIV test, and a mobile clinic would help the employees to be in a better state of health.

The Group 4 participants also engaged in the documentation issue and said that they would prefer a mobile clinic as a mobile clinic usually did not require documentation from migrant workers. The participants mentioned that the community was distraught that the mobile clinic did not come for follow-up visits anymore and that they thought the community would like it very much if a mobile clinic could come to the community again.

The participants painted flowers and heart-shaped figures and created colourful artworks on the table cover.

Group 5: The Group 5 participants explored the question but did not have much to say except that they thought the broader community would appreciate HIV testing at the farms. They also mentioned that they thought the farmers or employers would not mind

such a service on the farms and that they would in fact appreciate HBHCT for their employees.

Some of the Group 5 participants stated that they thought not many of the community members were patients of the closest PHC clinic as the clinic was situated much too far from the farming community and that they thought everyone was experiencing the same problems as them.

The participants engaged mostly in the creative activity and painted pregnant women and some children on the table cover. A long road was also painted on the table cover with an ambulance on the road.

4.5.1 Interpretation of Theme 4 results

The question generated an overall positive response, with the participants stating that they thought the neighbouring farms would appreciate and utilise such a service. The participants noted that the farmworkers on the neighbouring farms were in the same position as they were and they thought that everyone in the region was quite desperate for healthcare. No one had easy access to an HIV test and such a service might ensure that more people would want to get tested if they were more educated about HIV.

Some of the participants mentioned that they were unsure of the degree of confidentiality such an HBHCT service would offer and what the farmworkers in the community would think of the degree of confidentiality if they were to get tested for HIV on the farms.

Most of the participants agreed that they thought the employers in the region would also appreciate such a service as it would create healthier workers and that the employees would then not stay away from work for an entire day for an HIV test.

The participants stated that many of the farmworkers in the region were migrant workers and would therefore have the same documentation problem as they did. If such a service would be rolled out in the region, it would have to cater for migrant workers as well as South African citizens for them to utilise such a service.

The responses to Theme 4 can be summarised as follows:

(1) The participants agreed that the greater farming community would accept and appreciate HBHCT on the surrounding farms.
(2) Most participants agreed that the employers in the community would also accept and appreciate HBHCT on the surrounding farms as it would create healthier workers and community members.
(3) The participants were mostly unsure of how the larger community would feel regarding confidentiality and HBHCT.

4.6 CONCLUSION

This chapter discussed the research findings, the analysis of the research findings, and the sub-conclusions of the research findings after each theme. It is overall clear that the population is in dire need of HIV/AIDS care and prevention intervention, but the farmworkers are mostly not South African citizens and it would therefore be a more complicated matter to attend to. The participants welcomed the research team even though they were somewhat scared at first, indicating to the researcher that they were willing to take what they can get in terms of healthcare. All the participants thought that it was a good idea to get tested for HIV and liked the idea of HBHCT, but the barriers to being tested and treated added up to a complex list of issues.

The next chapter includes discussions about these barriers and their significance, as well as the level of acceptability of HBHCT. The researcher discusses how the research questions were addressed in this study, makes recommendations, and concludes the dissertation.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This study comprised a qualitative research design using the World Café as the primary data-collection method. The researcher hypothesised that the rural farmworker communities in South Africa are in need of HIV/AIDS support and that they would be inclined to accept HBHCT on the farms if given the opportunity.

Following the research findings, some major barriers for the population concerning both HIV testing and care at the local clinic came to light, as well as the proposed HBHCT on the farm. Valuable thoughts and feelings toward the idea of HBHCT and the degree of acceptability in the population are now known. Discussions will follow under the following headings:

- Summary of findings
- Discussion of problems
- Conclusions
- Summary of contributions
- Suggestions for future research
- Conclusion

5.1.1 Summary of findings

After five rounds of questions/statements, the researcher made the following observations:

- The participants knew the basics about HIV/AIDS and that it is mainly transmitted via unprotected sexual contact with an infected individual.
- Almost all the participants stated that they needed more education on HIV/AIDS and other illnesses.

- The participants all agreed that they did not have easy access to preventative measures such as condoms.
- All the participants agreed that is a good idea to test for HIV.
- Participants communicated a high level of acceptability of HBHCT.

The population of farmworkers had a few major barriers that prevent them from testing for HIV at the PHC clinic closest to the farm. Transport to and from the clinic, as well as the associated travel cost, is first and foremost the biggest barrier for them, given that the closest PHC clinic is about 40 km away and there are not many public transport options available for them to utilise. The participants admitted to mostly walking and trying to get people to stop along the way for them to get a ride into town. The female participants stated that they were scared to do so.

Another major barrier that emerged was that the participants were migrant workers and some were not legally permitted to work in South Africa. The health repercussions of the former means that these farmworkers were also not legally allowed to follow up at the PHC clinic and get an HIV test there. Legal migrant workers are permitted at the clinic but pay a fee for healthcare. This means that the total daily travel costs and fee required at the clinic add up to an unaffordable amount for an HIV test for these workers. The participants mentioned that they did not receive paid sick leave from their employer. A clinic visit that may take the whole working day would also cost them their daily wage.

The participants were extremely in favour of HBHCT as it would make HIV testing easily accessible and would mean that they would not have to take sick leave or struggle with transport. The participants were excited about the idea of an individual knowledgeable about HIV educating them about the virus. They were mostly sure that the greater farming community and other farmworkers in the region would greatly appreciate such a service for the same reasons as they would. The participants mentioned that they would then be able to test for HIV every three months.

One of the concerns that emerged from the creative conversation held on the farm was uncertainty about the confidentiality of their HIV results if it was done in the proximity of their co-workers, family, and employer.

The participants stated that they would not be able to attend the mobile HIV testing station or clinic if it only catered for South African citizens, and added that most of the farmworkers in the region would also not be able to utilise such a service as they were mostly in the same illegal position as the participants.

5.2 DISCUSSION OF PROBLEMS

5.2.1 Migrant farmworkers

At the time of sampling, the researcher did not have direct access to the population and therefore did not know that all but one of the participants were external migrant workers, although the researcher did expect some of them to be migrant workers. It has become known to the researcher that most farmworkers in this farming community were in fact also migrant workers but it remains unclear whether this is a common phenomenon beyond the borders of this community.

Research suggests that there is a large non-citizen community that resides in the farm regions of South Africa. Visser and Ferrer (2015:9) state that there were as many as 132 863 confirmed non-citizens living in the farming communities of South Africa in 2013, as cited by Census 2011 (Stats SA 2013b). A further 107 000 individuals were listed as either not applicable or not specified. It is unknown precisely how many of these individuals are farmworkers.

The research finding that pointed to external migrant farmworkers not being allowed to work in South Africa without a permit and who would not be able to utilise an HBHCT service if this service catered only for South African citizens and the financial implication thereof can therefore not be applied to all farmworkers.

Regardless of the former, the remainder of the findings are applicable to farmworkers with the same demographics as the participants, irrespective of citizenship.

5.3 CONCLUSION

Farmworkers are categorised as a vulnerable population in South Africa and HIV is highly prevalent in these communities. (International Organization for Migration [IOM]

2004:iiii). To reduce new HIV infections in vulnerable communities, such as the rural farming communities of South Africa, we need to know what is needed and what will be accepted.

The environment in which farmworkers live and work exposes them to dangerous health pitfalls, and HIV is no exception. Living off and feeding a family on minimum wage is a difficult task on its own, but adding the long distance to healthcare facilities, migrant worker status, boredom, poor sanitation, and long working hours, HIV/AIDS just adds to the list of issues that cannot easily be circumvented (IOM 2004:2).

HBHCT is an innovative and cost-effective way to reach these communities by offering HIV testing to those who cannot easily access healthcare facilities. It also provides these farmworkers with the much-needed education and prevention measures to reduce the number of new HIV infections, and links those in need of it to the appropriate HIV/AIDS care (Fylkesnes, Sandoy, Jurgensen, Chipimo, Mwangala & Michelo 2013:9).

The predominantly migrant farmworkers on the farm in question relate to an entirety to the former. The research objectives were to establish the acceptance levels of home-based HIV care in a rural farm community, to determine the needs level for home-based HIV care in a rural farming community, and to explore the main barriers that prevent participants from testing for HIV and following up at their closest clinic.

Following the summary of research findings, the researcher drew conclusions according to the primary and secondary research question, as well as the problem statement. They are presented in the following sections.

5.3.1 Primary research question

What are the common perceptions and acceptance levels of HBHCT and healthcare education in the selected rural agricultural community?

Overall, the participants in the selected rural farming community, referred to as farmworkers, showed a substantially high acceptance level of the idea of HBHCT on the farm. All the participants thought that it was a good idea to test for HIV as often as possible and all but one of the participants would welcome a mobile HIV clinic on the

farm. The participant who did not welcome a mobile HIV clinic on the farm did not elaborate on her reasons. All the participants admitted to an immense need on the farm and surrounding community for HIV health education.

As evidenced by the research findings, the rural farming community in question is extremely underserviced in terms of healthcare and the farmworkers in the community yearn for HIV testing, health education, and preventative measures such as access to free condoms (IOM 2004:1). Musariri and Odimegwu (2016:13) describe the migrant community of South Africa as highly susceptible to HIV with a relatively low rate of condom use. They state that condom use in the migrant farmworker communities is more prevalent in the areas where condoms are freely accessible, and even more so, in communities that are financially stable.

The farmworkers expressed a sense of fondness toward a previous mobile clinic that had served them and were extremely unhappy when this mobile clinic no longer came to do its three-monthly rounds like it always had. They stated that most members in their community used this service and they would be extremely relieved if they had a chance to obtain HBHCT, free access to condoms, and linkages to healthcare.

The researcher thus hypothesises that HBHCT would be an extremely viable programme to roll out in the farming communities of the North-West province and would be received with a high level of acceptance by the farmworkers, the greater farming community, and the employers.

5.3.2 Secondary research question

What are the main barriers for farmworkers seeking HIV testing, counselling and treatment at their closest PHC facility?

The barriers set out by the farmworkers that prevented them, or made it difficult for them, to get an HIV test at their closest PHC facility were in fact not minor barriers. The transport barrier to the people living on farms in this region and many others inhibited them first and foremost to plan a visit to the clinic as there was no reliable transport to and from the towns where the PHC clinics are located. Farmworkers in the region are left to chance for a passing vehicle or taxi willing to give them a ride to the clinic. The

safety of the farmworkers is therefore also left to chance in the dangerous crime climate of South Africa. With the luck of a taxi passing by, farmworkers in this region pay a costly amount to reach the desired destination, which almost adds up to their entire day's wage. This is just not a viable price to pay for an HIV test, seeing that there are no guarantees of paid sick leave for the day.

The second major barrier for migrant farmworkers was that they did not have the necessary documentation to present at the clinic to be seen as a patient. The participants reported that they had to visit the clinic in fear of being deported or spotted by the police in cases of emergency. This is a risk farmworkers are not willing to take for an HIV test. The health of migrants living in South Africa is not a priority and they are shown away at clinics at alarming rates. As Human Rights Watch (2009:2) states, "[s]ystemic government failures to protect migrants from arrest and deportation, has created a massive health crisis for migrants".

5.3.3 Research objectives

The following research objectives were met:

- To explore the perceptions of the farmworkers regarding HBHCT.
- To determine acceptance of HBHCT in a rural farming community.
- To explore the main barriers that prevent participants from testing for HIV and following up at their closest clinic.
- To enquire about the existing knowledge of HIV/AIDS among farmworkers and the necessity of testing for HIV.

5.4 SUMMARY OF CONTRIBUTIONS

Rolling out a viable public health programme in any area needs sound knowledge on the level of acceptance thereof, as the people participating in the programme need to voluntarily and willingly take part for it to be successful. Frieden (2014:2) explains that advances in public health need extensive evaluations in other areas to build on existing knowledge for a practice or programme to be scaled up effectively.

5.4.1 New knowledge to the field

HBHCT has been researched in different settings and communities but the perceptions and level of acceptance of HBHCT in a farming community with farmworkers is an area that is still lacking. This is an underserviced and vulnerable population about healthcare in South Africa, and intervention is clearly needed to alleviate some of the health burdens in these types of communities.

HBHCT is a viable option to reach farmworkers on South African farms who do not have the resources to get HIV testing done at a PHC clinic due to the barriers mentioned in Section 5.3.2. Before this study, it was unknown what farmworkers would think of it and whether they would utilise such a service if offered to them.

5.4.2 Theoretical implications

The research findings of this study support the theory of Doherty et al (2013:346-348), who explain that home-based testing may increase overall HIV testing rates in South African communities who are located far from PHC clinics. Farmworkers in the region belong to this group and the researcher came to a supported conclusion that HBHCT would increase HCT uptake in this community.

This study also supports Naik et al's (2012:1-8) theory, who recommend that the specific and unique needs of different sub-groups should be carefully considered when developing and implementing future projects – in this case HBHCT – to be able to understand the community context and the scope of clients. This study highlighted the complex issues of migrant farmworkers and their perceptions on HBHCT, as well as farmworkers as a sub-group and their HIV care and prevention needs.

5.5 SUGGESTIONS FOR FUTURE RESEARCH AND RECOMMENDATIONS FOR IMPLEMENTATION

5.5.1 Suggestions for future research

The researcher suggests that more information is needed on whether employers or farm owners would accept an HBHCT team or individual on their farm and workplace. It is

assumed that some farmers would experience a sense of anxiety if such a service is offered to farmworkers on their farm and if such practitioners would have access to their farms. Privacy and confidentiality issues might arise regarding whether the health worker(s) would report migrant workers on the farm. Irrespective of the participants mentioning that they thought their employer would appreciate such a service, there is no available data on the level of acceptance the employers would display. The significance of the former should be seen in perspective as it would have a great impact on the actual rollout of such a programme.

Another suggestion made by the researcher is to study farmworkers' acceptability of HBHCT by offering HBHCT to the migrant and South African farmworkers, monitoring linkage to care, and comparing the two groups afterwards. It remains unclear whether the migrant farmworker population would be effectively linked to HIV care and treatment without legal identification documentation.

5.5.2 Recommendations for implementation

The following recommendations for implementation are made:

- Such a programme should be scheduled and communicated to farmworkers and their employers so that it will be easier to plan when they can attend the HBHCT service.
- Such a service should be provided free of charge considering the financial situation of farmworkers.
- Confidentiality should be reiterated always to reassure people when they utilise HBHCT.
- The most important recommendation made by the researcher is that HBHCT should be offered to all farmworkers, irrespective of their nationality and migrant status, considering the numerous barriers they must overcome to get tested for HIV.

5.6 CONCLUSION

This dissertation explored the perceptions and acceptance of HBHCT in a rural farming community in the North West province of South Africa. The research reached its goals

by determining the barriers this community faces to get tested for HIV at the closest PHC clinic. The study also highlighted the HIV care and prevention needs of this sub-group. The researcher discovered that the population had an immense need for HIV education, prevention, and care, and concluded that HBHCT would likely receive a high uptake if offered on farms in the region. Most of the participants indicated that they would appreciate a service that would cater for migrant farmworkers as the farmworkers in the region were predominantly from neighbouring countries, working in South Africa unofficially.

Let us not neglect the health of our vulnerable communities that farm the food for our tables. They live in isolated areas and can be easily overlooked, but absolutely should not be.

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ANNEXURES

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

1 November 2017

Dear Miss Olivia Kasselman

Decision: Ethics Approval

HSHDC/727/2017
Miss Olivia Kasselman
Student: 61290971

Supervisor: Dr MG Makua
Qualification: D Litt et Phil
Joint Supervisor: -

Name: Miss Olivia Kasselman

Proposal Home based HIV testing perceptions and acceptance in a rural farming community of South Africa

Qualification: **MPCH94**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 1 November 2017 to 1 November 2019.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 1 November 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

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Open Rubric

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof J E Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekimm@unisa.ac.za

Prof A Philips
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ANNEXURE B: CONFIDENTIALITY BINDING FORM

CONFIDENTIALITY AGREEMENT

Title of Research Project: Home-based HIV testing: perceptions and acceptance in a rural farming community.

Local Principal Investigator: Mej. O Kasselman (RN)

As a member of this research team I understand that I may have access to confidential information about study sites and participants. By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study sites and participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study sites or participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information, unless specifically authorized to do so by approved protocol or by the local principal investigator acting in response to applicable law or court order, or public health or clinical need.
- I understand that I am not to read information about study sites or participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I agree to notify the local principal investigator immediately should I become aware of an actual breach of confidentiality or a situation which could potentially result in a breach, whether this be on my part or on the part of another person.

Contact Information of the research team:

Miss O Kasselman
0845068233
olivemila@hotmail.com

Dr M Makua
012 4296524
makuamg@unisa.ac.za

_____	_____	_____
Signature	Date	Printed name
_____	_____	_____
Signature of local principal investigator	Date	Printed name

ANNEXURE C: SITE APPROVAL LETTER

SITE APPROVAL LETTER

University of South Africa

Master's in Public Health

Pretoria

Subject: Site Approval Letter

To whom it may concern:

This letter acknowledges that I have received and reviewed a request by *Miss O Kasselman* to conduct a research project titled: "Home-based HIV testing: perceptions and acceptance in a rural farming community."

at and I approve of this research to be conducted at our facility.

I also acknowledge that I understand The World Café process and that I have received the whole process in writing.

When the researcher receives approval for his/her research project from the University of South Africa, I agree to provide access for the approved research project. If we have any concerns or need additional information, we will contact the Principal Researcher: Miss O Kasselman

Sincerely,

[*name of senior administrator*]: Nolene van der Walt

[*position/title*]: Mrs

[*phone/email*]: 082 467 6868 | nolsie1@hotmail.com

Contact Information of the research team:

Miss O Kasselman

0845068233

olivemila@hotmail.com

Dr M Makua

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makuamg@unisa.ac.za

ANNEXURE D: TABLE HOST GUIDELINES

Dear…
Table Host, Child minder, Caterer, Moderator, Sound and Video, Recruiter and set up.

Let me start off by sincerely thanking you for offering your valuable Sunday morning for the sake of my data collection day. **The World Cafe.** Without you, this day will not be possible.

The World Café is a relatively new method for data collection and has not been as commonly used as other methods for data collection. The purpose of this method is to create creative conversations that matter by people influenced directly.

The purpose of the day will be to establish whether the farm workers will likely accept Home-Based HIV testing, counseling and other general health education on the farm instead of a health care facility/primary health clinic.

We will aim for a fun creative day on the farm while collecting data through conversations that matter.

Estimated Itinerary for The World Cafe: Sunday 1 July 2018

08:00 – 09:00 Welcome, tea and singing of Informed Consent Forms.

09:00 – 09:30 Table seating, final explanation of the proceedings and questions

09:30 – 09:45 Round 1

09:45 – 09:50 Rotation

09:50 – 10:05 Round 2

10:05 – 10:20 TEA TIME

10:20 – 10:35 Round 3

10:35 – 10:40 Rotation

10:40 – 10:55 Round 4

10:55 – 11:00 Rotation

11:00 – 11:15 Round 5

11:15 – 12:00 Conclusion, presentations and data analysing

12:00 – 13:00 Lunch

END

Depending on external factors, Itinerary might change slightly

How the world Café works..

During The World Café, each table will have four to five guests seated at a time. The session will start with an invitation to discuss the issue at hand and information regarding the proposed HIV home-based testing.

Each table will deliver a report of the beliefs, feelings and attitudes discussed in the form of a poster table cover. Each conversation table will get a statement to discuss, and interpret in a creative way.

The host will make field notes of each group that sits at their table regarding the main talking points and general feelings about the statement until data saturation is reached.
After 20 minutes the participants move to a new table leaving their tablecloth behind with the table host for the next group to draw and write on. Each table cloth will represent a question. The next table host will introduce a new question or topic of discussion. After all the rotations, the group comes together where ideas and recommendations are ''harvested''.

When all the rotations have concluded, the group unites in to one big group and the table hosts hang their table cloth on a ''washing line'' and presents their collective feelings and ideas about the statements made at their table. This stage will be recorded either by video and voice recordings.

Conclusions/Presentations by the Table Hosts:

At the end of The World Café, each table host will present their findings and table cloth to the rest of the group. You can leave your table cloth on the ''washing line'' when you are done. You can present each main theme that you identified with your question, and what the general thoughts were about them. Also present single thoughts, that differed from the rest. You can present for up to 5 minutes , but less or more is also okay. The key here is to speak loudly and clearly. This will be the main source of data collection.

The following seven Design principles will be incorporated into The World café session:
(The World Café, 2017:1)

1) Set the context

2) Create a Hospitable space

3) Explore Questions that matter

4) Encourage Everyone's Contribution

5) Connect diverse perspectives

6) Listen together for patterns and insights

7) Share Collective Discoveries

- All table hosts, please see attached list of the 5 questions that will be asked, and some conversation points that might be helpful. We want to aim for a flowing conversation between the participants. All points raised by them are important.
- Conversations can sometimes take a different turn and it is then that I would like you to subtly steer it back to your question at hand. I have written in blue, the things that are important to your question that I would like to harvest.
- Each table host will get a talking stick, but the decision remains with the table host if it will be used or not. It can either be used if you have a shy group at the table and no one wants to raise an opinion OR if you have a very talkative group and struggle to make field notes as they are all speaking together.
- I will create a whatsapp group for all those involved to share the location of the farm as well as updates, if any.
- Please do not hesitate to contact me if you have any questions.

ANNEXURE E: INFORMED CONSENT FORM

Farming community members invited to participate in HIV/AIDS research for the project titled: Home-based HIV testing: perceptions and acceptance in a rural farming community.

Principle Researcher: O Kasselman
University of South Africa
Home-based HIV testing: perceptions and acceptance in a rural farming community.

This Informed Consent Form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

You are invited to participate in a research study about HIV/AIDS, a sexually transmitted disease which is very common in South Africa, and in this area. The researcher will give you information and invite you to be part of this research. You may talk to anyone you feel comfortable with about the research and you may take time to decide if you want to be part of the research or not. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take some time to explain. You may also ask questions later to me or any of the field workers.

Purpose of the research

HIV is making a lot of people sick in South Africa. We are looking for ways to stop this from happening. We believe that you can help us by telling us what you know about HIV and if you will accept HIV testing on the farm rather than to go to a clinic that is far away from the farm. We will not test you for HIV in this research project but will only talk about HIV, how you feel about it and how you will feel about having an HIV test on the farm. We know that it is difficult to get to the clinic because of working hours and distance to the clinic and want to explore other ways of helping the farm workers to get more information about HIV/AIDS, to know their HIV status and help the farm workers to get HIV care and medication.

Type of Research Intervention

If you decide to be part of the research we will all get together and sit around tables and talk to each other and do some activities like drawing. The name for this intervention is The World Café and it is all about talking and conversation about HIV. The researcher or n member of the research team will ask a few easy questions and we will talk in the group about the questions. This activity is a whole day activity with a tea and lunch break in between.

Participant Selection

You are being invited to be part of this research because you live and work on a farm and may live far away from the clinic.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate, nothing will change and this research has nothing to do with your job or this farm

You may change your mind later and stop participating even if you agreed earlier.

Procedures

If you accept, you will be asked to take part in a discussion with 4-5 other people at a time. The discussion will be guided by a group discussion leader.

During The World Café session, each table will have four to five guests seated at a time. The session will start with an invitation to discuss the issue at hand and information regarding the proposed HIV home-based testing. Each table then starts conversation, writing down and making drawings of significant opinions, feelings and ideas on the paper table cover by means of words and drawings.

Each conversation table will get a statement to discuss for example: What prevents you to go to the clinic for HIV testing? The host will make field notes of each group that sits at their table regarding the main talking points and general feelings about the statement until we have enough information.

After 20 minutes the participants move to a new table taking their tablecloth with them. There the new table host will introduce a new question or topic of discussion.

When all the rotations are done, the group unites in to one big group and the table hosts presents their collective feelings and ideas about the statements. This stage will be recorded either by video or voice recordings.

Duration

The Research will happen on one scheduled day, with no follow up visits.

Risks

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the discussion if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

Benefits

Participants may benefit from taking part in the research study by learning more about HIV/AIDS. Benefits to the community and society include a chance of uptake of home-based HIV testing in the area by answering the research question.

Reimbursements

We will not give an incentive for taking part in the research, however All participants and their children will receive food and other refreshments on the day, as part of the world café Principles. The researcher will prepare a light meal e.g. finger foods for the world café.

Confidentiality

The research being done in the community may draw attention and if you participate you may be asked questions by other people in the community. We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up in a secure location. It will not be shared with or given to anyone except with to research team.

We will ask you and others in the group not to talk to people outside the group about what was said in the group. We will, in other words, ask each of you to keep what was said in the group confidential. You should know, however, that we cannot stop or prevent participants who were in the group from sharing things that should be confidential.

Sharing the Results

The World Café research findings will be used to write an article and shared more broadly, for example, through publications and conferences.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in The World Café at any time that you wish.

Who to Contact

If you have any questions, you may ask them now or later. If you wish to ask questions at a later stage you can contact:

Miss O Kasselman
0845068233
olivemila@hotmail.com

Dr M Makua
012 4296524
makuamg@unisa.ac.za

You can ask me any additional questions about any part of the research study, if you wish to. Do you have any questions?

Part II: Certificate of Consent

I have been invited to participate in research about HIV and Home-based HIV testing.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant _____

Date _____

Day/month/year

If illiterate [1]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____

Signature of witness _____

Date _____

Day/month/year

Thumb print of participant

Statement by the researcher/person taking consent:

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. Participate in a World Café discussion session which will be recorded.

2. Participation is completely voluntary

3. Data collected is confidential

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my

[1] **A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.**

ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

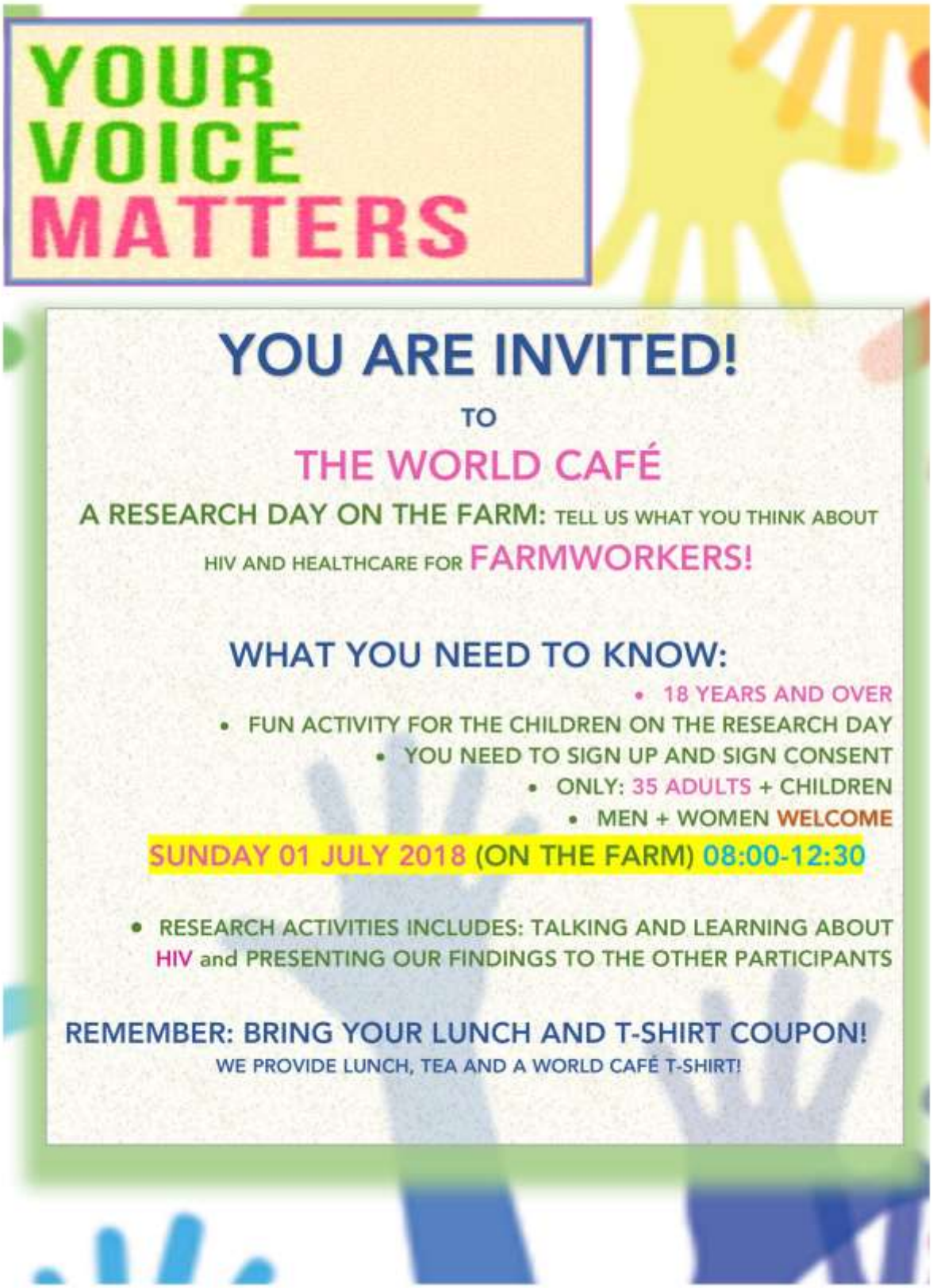
Print Name of Researcher/person taking the consent_____

Signature of Researcher/person taking the consent_____

Date _____

Day/month/year

ANNEXURE F: WORLD CAFÉ EVENT INVITATION



YOU ARE INVITED!

TO

THE WORLD CAFÉ

A RESEARCH DAY ON THE FARM:
TELL US WHAT YOU THINK ABOUT HIV AND HEALTHCARE FOR FARMWORKERS!

WHAT YOU NEED TO KNOW:

- 18 YEARS AND OVER
- FUN ACTIVITY FOR THE CHILDREN ON THE RESEARCH DAY
- YOU NEED TO SIGN UP AND SIGN CONSENT
- ONLY: 35 ADULTS + CHILDREN
- MEN + WOMEN WELCOME

  SUNDAY 01 JULY 2018 (ON THE FARM) 08:00-12:30

- RESEARCH ACTIVITIES INCLUDES: TALKING AND LEARNING ABOUT HIV and PRESENTING OUR FINDINGS TO THE OTHER PARTICIPANTS

REMEMBER: BRING YOUR LUNCH AND T-SHIRT COUPON!
WE PROVIDE LUNCH, TEA AND A WORLD CAFÉ T-SHIRT!

If you have any questions contact: Olivia: 0845068233

NAME&SURNAME	CONTACT NUMBER	ATTENDING THE WORLD CAFÉ: YES/NO	T-SHIRT SIZE: S/M/L	NUMBER OF CHILDREN COMING	AFRIKAANS OR ENGLISH
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2)					
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1 X The World Café T-Shirt 1 1 X lunch + Juice Keep this coupon safe and bring it along to The World café to receive your lunch and T-shirt.	1 X The World Café T-Shirt 2 1 X lunch + Juice Keep this coupon safe and bring it along to The World café to receive your lunch and T-shirt.	1 X The World Café T-Shirt 3 1 X lunch + Juice Keep this coupon safe and bring it along to The World café to receive your lunch and T-shirt.
1 X The World Café T-Shirt 4 1 X lunch + Juice Keep this coupon safe and bring it along to The World café to receive your lunch and T-shirt.	1 X The World Café T-Shirt 5 1 X lunch + Juice Keep this coupon safe and bring it along to The World café to receive your lunch and T-shirt.	1 X The World Café T-Shirt 6 1 X lunch + Juice Keep this coupon safe and bring it along to The World café to receive your lunch and T-shirt.

ANNEXURE G: TABLE STATEMENTS/TOPICS

The World Café tool:

Statements and questions to be discussed at each conversation table at The World Café session:

1) What is HIV/AIDS? Do you think it is a good idea to test for HIV?

How does HIV spread, what symptoms do they think HIV will present with, if the consensus is yes, it is a good idea to test for HIV, why do they say so. Is HIV a virus? How can we prevent HIV? Who can get infected with HIV? Is there a cure for HIV? What happens if you get infected with HIV. How often should you test for HIV, is once enough? The conversation may evolve into anything concerning feelings and thoughts toward HIV. Please write down field notes as much as possible. Motivate the participants to draw, paint and write anything they talk about on the paper table cloth.

2) What are the problems that prevent you from going to the primary clinic for HIV testing?

General themes like not wanting to miss work, sick leave, stigmatization, money to travel to and from the clinic, transport, scared of the results, no motivation to test, Long waiting times at the clinic. basically, anything that might seem like a problem to them. Please write down field notes as much as possible. Motivate the participants to draw, paint and write anything they talk about on the paper table cloth.

3) What would you like about a mobile clinic or nurse that comes to the farm to do HIV testing and health education? (Teach you about HIV/AIDS and other chronic diseases)

Any positive themes about home-based HIV testing will be valuable.. There is a mobile clinic that visits [redacted] garage +- 8 km from the farm. If they use the mobile clinic, motivate them to discuss things they like about the mobile clinic. Please write down field notes as much as possible. Motivate the participants to draw, paint and write anything they talk about on the paper table cloth.

4) What would you not like about a mobile clinic or nurse that comes to the farm for HIV testing and health education? (Teach you about HIV/AIDS)

Any negative themes about home-based HIV testing will be valuable. Fear of stigmatization from co-workers. Fear of stigmatization from employer. Not trusting the privacy and confidentiality of Home-based Health Care. Here you can also stimulate the conversation by asking them to share stories or bad experiences of previous health encounters. There is a mobile clinic that visits [redacted] garage +- 8 km from the farm. If they use the mobile clinic, motivate them to raise concerns about the mobile clinic. Please write down field notes as much as possible. Motivate the participants to draw, paint and write anything they talk about on the paper table cloth.

5) What will the other people in your community think about HIV testing at home or on the farm?

It is important with this question to explore and stimulate creative conversation. We want to know what they think the people at the church, shop or other family members will think about home-based Health care and HIV testing. Do they think the other farm workers on the neighboring farms will accept this method of HIV testing? Do they think the employer will prefer this method of health care? Please write down field notes as much as possible. Motivate the participants to draw, paint and write anything they talk about on the paper table cloth.

Contact Information of the Research team:

Miss O Kasselman	**Dr M Makua**
0845068233	012 4296524
olivemila@hotmail.com	makuamg@unisa.ac.za

ANNEXURE H: RULES OF THE WORLD CAFÉ

ANNEXURE I: WORLD CAFÉ T-SHIRT DESIGN

ANNEXURE J: LANGUAGE EDITING CERTIFICATE

GRAMMAR GUARDIANS

30 October 2018

To whom it may concern

Re: Proofreading and academic editing of thesis: Ms O. Kasselman

I, J.L. van Aswegen of Grammar Guardians, hereby confirm proofreading and academic editing of the thesis "Home-based HIV Counselling and Testing: Perceptions and Acceptance in a Rural Farming Community of South Africa" by Ms Olivia Kasselman in October 2018.

Please contact me on 082 811 6857 or at jeanne@grammarguardians.co.za regarding any queries that may arise.

Kind regards,

J.L. van Aswegen

Grammar Guardians

ANNEXURE K: TURNITIN ORIGINALITY REPORT

Turnitin Page 1 of 35

Document Viewer

Turnitin Originality Report

HOME-BASED HIV COUNSELLING AND TESTING: PERCE... By Kasselman Olivia

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