A SUSTAINABLE COMMUNITY COALITION CONCEPTUAL FRAMEWORK FOR ORGANISATIONAL STAKEHOLDERS TO MANAGE ALCOHOL MISUSE AS A RISK FACTOR OF HIV INFECTION

by

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DECLARATION

I declare that **A SUSTAINABLE COMMUNITY COALITION CONCEPTUAL FRAMEWORK FOR ORGANISATIONAL STAKEHOLDERS TO MANAGE ALCOHOL MISUSE AS A RISK FACTOR OF HIV INFECTION** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree or any other institution.

Signature
Jacobs Kgalabi Ngako

Date
31 January 2020

DEDICATION

This thesis is dedicated to my wife Refilwe Ngako. She instilled courage in me to achieve whatever I strive for.

All gratitude goes to my lovely family: my sons, Kgothatso and Kagiso, my daughters, Boikanyo and Reatlegile. Thank you very much for the support, motivation and encouragement provided throughout the duration of my studies.

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ABSTRACT

The overall aim of this study was to construct and describe a conceptual framework that can serve as a frame of reference for organisational stakeholders to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa. A Participatory Action Research (PAR) design that was qualitative and theory generative in nature was followed in this study. A phased approach with specific objectives aligned to the PAR cycle, namely observe (Phase One), reflect (Phase Two), plan (Phase Three) and act (Phase Four), was followed. These phases were actualised through an exploratory, descriptive and contextual research design, guided and theoretically influenced by critical theory.

Data in Phase One were collected through 10 key informant interviews. Data were collected in Phases Two to Four through 10 dialogue meetings. Data collected in the four phases were used to construct and describe the conceptual framework that was evaluated by five experts in the field of mental health and substance misuse for refinement (Phase Five). Thematic data analyses was done to identify emerging themes. Key issues identified were that the community is characterised by fragile community coalitions that hamper the management of alcohol misuse as a risk factor of HIV infection. Factors to be considered to sustain the coalition were identified as sharing a common vision, promoting a trusting relationship, formalising the coalition, transformational leadership, strengthening organisational unity, and access to financial resources.

This research adds knowledge in the field of mental health and substance misuse by providing a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. The conceptual framework could be used to inform policy, further research, education and improve practice in the field of mental health and substance misuse. Although the study was limited to a specific geographical area of a community in the North West Province, South Africa, the findings can be adapted to fit a specific setting.

KEY CONCEPTS:

Sustainability; community coalition; alcohol misuse; HIV infection; Participatory Action Research; conceptual framework.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBOs	Community-Based Organisations
CSAP	Centre for Substance Abuse Prevention
CBOs	Community-Based Organisations
CSO	Civil Society Organisations
CTC	Communities that Care
EBPI	Evidence-Based Prevention Interventions
FAS	Foetal Alcohol Syndrome
FBOs	Faith Based Organisations
HIV	Human Immunodeficiency Virus
NGOs	Nongovernmental Organisations
NHI	National Health Insurance
NPOs	Not for Profit Organisations
PAR	Participatory Action Research
PHC	Primary Health Care
PROSPER	Promoting School-community-university Partnerships to Enhance Resilience
SADAG	South African Depression and Anxiety Group
SAMHSA	Substance Abuse and Mental Health Services Administration
STIs	Sexually Transmitted Infections
TB	Tuberculosis
REC	Research Ethics Committee
SEL	Social and Emotional Learning
SPF	Strategic Prevention Framework
SIG	State Incentive Grant
WHO	World Health Organisation

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Worldwide, alcohol use is estimated to be 6.4 litres of pure alcohol per person aged 15 years and older per year (WHO 2018:45). According to the South African Wines Industry Statistics (2017:27), alcohol consumption in South Africa is projected at 7.27 litres of pure alcohol per person aged 15 years and older per year, which is higher than the global norm. Alcohol misuse contributes to non-communicable diseases such as hepatitis and cardiovascular diseases, intentional and unintentional injuries, Foetal Alcohol Syndrome (FAS), and communicable diseases that include Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), Tuberculosis (TB) and Sexually Transmitted Infections (STIs) (WHO 2018:62).

Given the association between alcohol misuse and HIV, Rehm, Probst, Shield and Shuper (2017:4) argue that HIV/AIDS management and interventions on alcohol misuse should be integrated. The management of alcohol misuse requires intervention by all relevant stakeholders that include government departments, the private sector, Non-Governmental Organisations (NGOs), academic institutions and civil society (WHO 2018:135).

The global strategy on alcohol misuse and its related health and social consequences is the most detailed policy document providing guidance on the management of alcohol misuse. This is done through global action that includes public health advocacy and partnership, and target areas of policy options are recommended, including community action (WHO 2018:25). In South Africa, legislation and policies are in place to combat harmful uses of alcohol and HIV. One such legislation in South Africa is the Prevention of and Treatment for Substance Abuse Act, 2008 (South Africa 2008:s9). As prescribed in the Act, prevention programmes must ensure that communities are empowered to be knowledgeable and proactive in dealing with alcohol misuse and its related public health and social consequences, such as HIV/AIDS. The other policy documents (plans) of relevance

to combat alcohol use and HIV are the National Drug Master Plan (NDMP) 2019-2024, South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022, and the Health Sector Drug Master Plan 2019-2025. These policy documents advocate for evidence-based multisectoral approaches to combat substance abuse and HIV infection.

As described by Watson-Thomson, May, Jefferson, Young, Young and Schultz (2018:4), community coalitions have been used as a multisector approach for community change on a variety of health issues, including the management of substance misuse. Watson-Thomson et al (2018:4) further state that community coalitions are effective in the management of social determinants of health and well being through the engagement of a variety of stakeholders. The aim of this study was to construct and describe a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

In this section, I describe the study's background, the setting, the problem statement, as well as the rationale for choosing a PAR approach.

1.2.1 Background to the study

The disease burden of substance abuse, including alcohol misuse, constitutes a global problem. The most recent figures on alcohol misuse in South Africa (collected from specialist substance abuse treatment centres) show the most frequently used substances among patients admitted for specialist care is alcohol. Between 14% of patients in Gauteng and 38% in the Central region who received treatment in treatment centres reported their primary drug of choice to be alcohol (Dada, Burnhams, Erasmus, Lucas, Parry, Bhana et al 2019:2). Studies on alcohol consumption and HIV have also demonstrated a link between alcohol misuse and risky sexual activities that contribute to HIV infection. These studies describe possible pathways in which alcohol contributes to HIV infection (Bello, Moultrie, Somji, Chersich, Watts & Delany-Moretlwe 2017:66; Carrasco, Esser, Sparks &

Kaufman 2015:485; Lan, Scott-Sheldon, Carey, Johnson & Carey 2016:181; Rehm, et al. 2017:2; Letsela, Weiner, Gafos, & Fritz 2018:175).

Bello et al (2017:66) argue that alcohol misuse has an impact on decision making, consequently contributing to risky sexual behaviour such as sex without protection, having many sexual partners, commercial sex, and rape. Letsela et al (2018:186) also concur that alcohol misuse contributes to sexual assault such as rape, which is a risk factor of the spread of HIV infection. In addition, a study by Carrasco et al (2015:485) found that people who consumed alcohol before engaging in sexual activity reported inconsistent condom use and having more sexual partners, which are risk factors for spreading HIV infection. In another systematic review, Lan et al (2016:181) similarly found a high tendency for having sex without using a condom, and having many sexual partners among people who misuse alcohol.

According to Rehm et al (2017:2), alcohol misuse negatively impairs decision making resulting in riskier sexual behaviours. They describe the biological effects on HIV transmission through a suppressed immune system. Additionally, alcohol misuse has been linked to poor intake of antiretroviral medication (Rehm et al 2017:4). Given the link between alcohol misuse and HIV, it is thus important to customise HIV prevention, care, treatment and rehabilitation for key populations such as people who use alcohol. Through these interventions, the management of alcohol misuse should be incorporated with the treatment of HIV/AIDS through the involvement of multiple stakeholders, including the public sector, pirate sector, NGOs, and civil society as alluded to in the introduction.

The establishment of community coalition is heralded as a multisectoral approach to facilitate community change on health issues including, among others, substance misuse problems (Watson-Thomson et al 2018:4; Brown, Wells, Jones & Chilenski 2017:600; Dean 2017:4; Fagan & Hawkins 2015:343). However, the sustainability of this approach to manage alcohol and other substance abuse problems in communities remains challenging given that the coalition relies on cooperation and collective decision making from a variety of organisational stakeholders with different backgrounds (Fagan & Hawkins 2015:343).

In order to promote inclusive collaboration and participation among different stakeholders, while at the same time empowering organisational stakeholders to implement evidence-based practice, Mash (2014:2) suggests the use of PAR. As described by MacDonald (2012:35), PAR is scientific data collection and analysis for the aim of taking action and creating change. PAR can be understood from the work of Kurt Lewin, generally considered one of the founding fathers of action research (MacDonald 2012:37). According to MacDonald (2012:37), Lewin believed that collaboration with people in workplace decisions increases their motivation in their work; he used the term 'Action Research' as a strategy to learning and understanding a social system while simultaneously imparting changes.

PAR can also be traced to the work of Paulo Freire, who believed that the development of critical consciousness among oppressed communities are vital to assisting them in transforming their reality (Mash 2014:2). Freire emphasised the importance of critical consciousness for social change that requires individuals to be informed about socio-economic and political contradictions. He also stressed that action should be taken to change the oppressive elements of reality, thus emancipating the oppressed people (Glassman & Erdem 2014:207).

1.2.2 Study setting

The PAR was undertaken in a specific community in the North West Province, South Africa. The community consists of a number of organisations that include, among others, Faith-Based Organisations (FBOs), Nongovernmental Organisations (NGOs), Not For Profit Organisations (NPOs), government departments that include Health, Education, and the local government. It is a semi-urban area in which most of the people are unemployed. There are a number of taverns and shebeens in which people, mostly the youth, consume alcohol.

Findings from the South African census, last conducted in 2011, reflect that the community consists of a population of 38 671 with 10 475 households, the gender ratio is 49.5% male and 50.5% female, 99.21% of the people are Black African, and 41.2% use Setswana as their first language. Twenty percent of the 10 475 households have no income. The unemployment rate in the community under study

is 30.4% (South Africa 2012). To protect the privacy of the specific community under study, and to ensure that participants remain anonymous, I refer to the community under study as the community in the North West Province, South Africa, throughout the thesis.

1.2.3 Statement of the research problem

I am a mental health nurse practitioner working with substance abuse policy. My interest in the study developed during my engagement as a project manager for research conducted on alcohol abuse and HIV infection in the aforementioned community during 2011. I worked with organisational stakeholders in the community while conducting research on a programme to manage alcohol misuse and HIV in alcohol outlets. During my engagement with organisational stakeholders in the community, I observed that as a risk factor of HIV infection, alcohol misuse was problematic in the community. I also noted that the current intervention was not successful as not all relevant stakeholders were working in collaboration. A lack of participation during community meetings by some of the relevant stakeholders, such as alcohol outlet owners and the youth, were observed. Furthermore, I did not know the nature of the involvement of organisational stakeholders in managing alcohol misuse as a risk factor of HIV infection, and how the intervention could be sustained over time.

Findings from research studies have identified the sustainability of community coalitions in the management of substance abuse, including alcohol misuse, as a challenge (Giesbrecht, Bosma, Juras & Quadri 2014:222; Flewelling & Hanley 2016:837; Johnson, Collins, Shamblen, Kenworthy & Wandersman 2017:619). Failure to sustain community coalitions result in a lost opportunity for positive gains that may be derived from effective participation by organisational stakeholders. As suggested by Abrams (2017:13), prevention efforts can only deliver benefits if they are sustained over time. Similarly, Greenberg, Mark, Feinberg, Johnson, Perkins, Welsh and Spoth (2015:10) argue that sustained community coalitions are more likely to impact on public health.

Most programmes to combat substance abuse and/or to prevent HIV/AIDS do not survive beyond the initial phases (Gibbs, Campbell, Akintola & Colvin 2014:8; Carrasco et al 2015:485; Griesbrecht et al 2014:209). Gibbs et al (2014:8) demonstrate challenges in sustaining programmes through three case studies to manage HIV. A review of literature by Carrasco et al (2015:485) on alcohol and HIV risk-reduction interventions shows a reduction of alcohol and HIV risk activities in the short term, but less success in the longer term. Similarly, a study by Griesbrecht et al (2014:209) on the sustainability of implementing alcohol policies shows that post-intervention, alcohol misuse tends to go back to pre-intervention rates if the intervention is not sustained.

Local efforts to sustain policy interventions include long-term community engagement, capacity building, monitoring implementation, as well as access to sufficient financial resources (Giesbrecht et al 2014:222). Flewelling and Hanley (2016:837) confirmed that there is only an increase in the capacity of a community-based coalition during the timeframe in which they are funded.

Community coalition capacity, as described by Flewelling and Hanley (2016:831), refers to the characteristics of the organisation(s) responsible for coordinating the implementation of specific intervention programmes within the community. Flewelling and Hanley (2016:839) attribute the success of coalition capacity to well organised and well managed internal structures, strong community cohesion, and outreach, as well as access to multiple funding. Johnson et al (2017:619) argue that the sustainability of prevention interventions are enhanced when a community coalition is supported by capacity building, technical support and training, improvements in funding resources and coalition formalisation.

Despite the challenges in sustaining substance use and HIV-related community coalitions, limited theory exist on how these coalitions can survive beyond the initial implementation phases. Bradley (2017:1) confirmed a shortage of theory-based research regarding coalition-building processes and outcomes and long-term sustainability. Literature on sustainability is also highly fragmented across many research areas, and lacks common definitions and conceptual frameworks (Shelton, Cooper & Stirman 2018:57), and most conceptual frameworks that exit do not

adequately address sustainability in the context of long-term change. Consequently, this study aimed to close the gap by constructing and describing a conceptual framework that can serve as a frame of reference to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa.

Against the background of literature supporting alcohol misuse as a risk factor of HIV infection (Rolland, Paille, Mann & Aubin 2016:1; Carrasco et al 2015:485; Lan et al 2016:181; Rehm et al 2017:1) and despite positive accounts of the short-term benefits of community coalition (Flewelling & Hanley 2016:831), the sustainability of this approach remains questionable. The sustainability of community coalition to manage alcohol misuse as a risk factor of HIV infection in the community under study was observed to be a challenge, as seen by the lack of sustained collaboration by all relevant affected organisational stakeholders. Given the problem statement, I aimed to address the following research question:

- How can PAR facilitate the construction and description of a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa?

To answer the research question, I crafted sub-questions aligned to the PAR cycle to answer particular questions relating to each phase, namely observe, reflect, plan and act (Zuber-Skerritt 2015:18). A fifth phase was added to construct and describe the conceptual framework.

- Who are the organisational stakeholders that could be involved in the construction and description of a sustainable community coalition framework to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa (Phase 1: Situational analysis to observe, Chapter 4)

- What is the nature of the organisational stakeholders' current engagement in the management of alcohol misuse and/or HIV infection? (Phase 1: Situational analysis to observe, Chapter 4)
- What are organisational stakeholders' perspectives on the construction and description of a sustainable community coalition to manage alcohol misuse as a risk factor of HIV infection? (Phase 2: Reflect, Chapter 5)
- How can organisational stakeholders participate in sustaining a community coalition to manage alcohol misuse as a risk factor of HIV infection? (Phases 3 & 4: Plan & Act, Chapter 6)
- What should a sustainable community coalition conceptual framework to manage alcohol misuse as a risk factor of HIV infection in this community consist of? (Phase 5: Construction and description of the conceptual framework, Chapter 7)

1.3 AIM AND OBJECTIVES OF THE STUDY

The aim of this study was to construct and describe a conceptual framework that can serve as a frame of reference for organisational stakeholders to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa. In addition, it is envisaged that the framework will also provide mental health practitioners working in this or similar settings with a frame of reference to manage alcohol misuse as a risk factor of HIV infection underpinned by critical theory.

To achieve the overall aim, the research was conducted in a phased approach with specific empirical objectives aligned to the PAR cycle, namely observe, reflect, plan and act, as stated in Section 1.2. and reflected in Figure 1.2 (Zuber-Skerritt 2015:18). In Phase Five, I used data collected through Phases One to Four to construct and describe the framework.

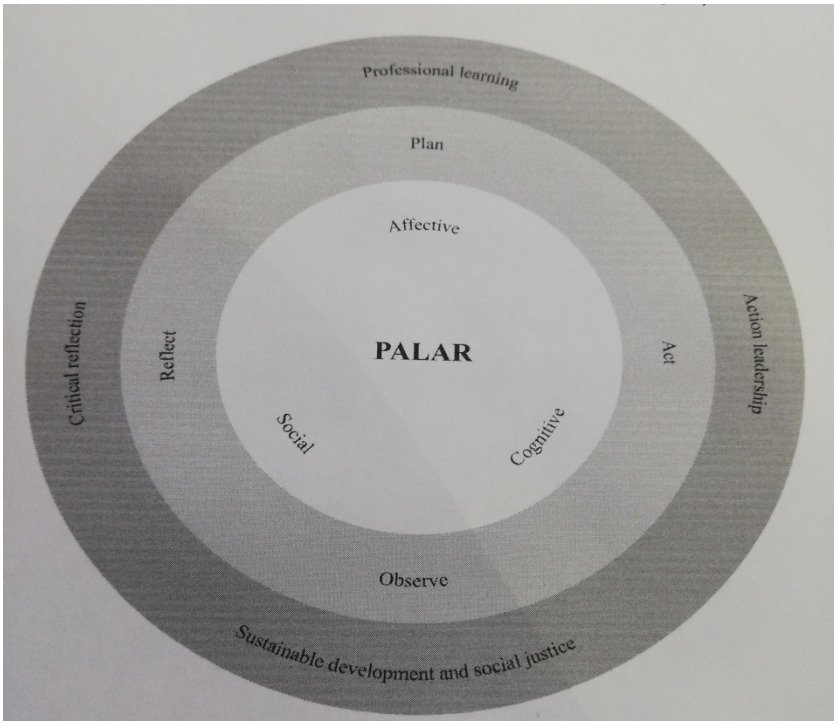
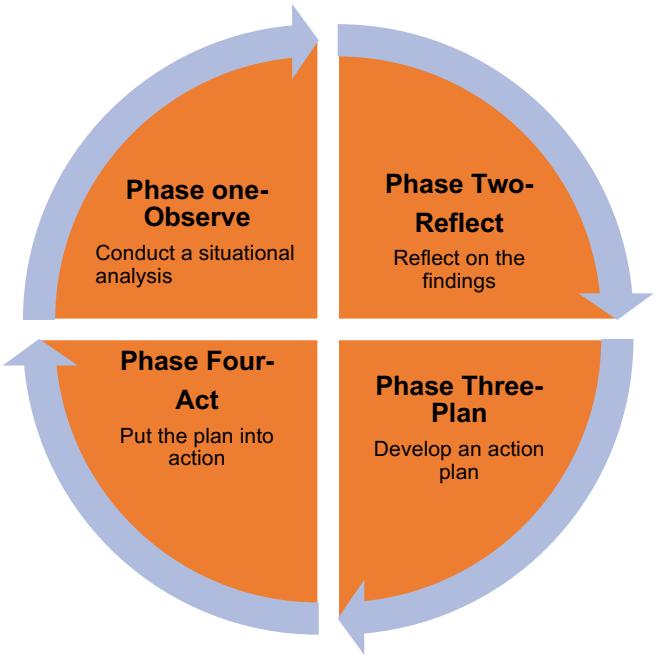


Figure 1.1: Participatory Action Learning and Action Research (Zuber-Skerritt 2015)

The original figure by Zuber-Skerritt (2015:18), shown in Figure 1.1, describes Participatory Action Learning and Action Research (PALAR). PALAR is a holistic, integrative concept that incorporates related concepts and values, such as participation, collaboration, communication, community of practice, and networking. It is a holistic approach to learning, research, and development that focuses on the mind, feelings, and human relationships. This holistic approach, as described by Zuber-Skerritt (2015:18), is necessary for the success of the PALAR process through cycles of planning, acting, observing, and reflecting in order to achieve the maximum benefit for professional learning and development, action leadership, social justice, and critical thinking, which are vital for sustainable community engagement. The adapted participatory action research cycle in this study is reflected in Figure 1.2.



Phase Five
Construction and description of the conceptual framework

Figure 1.2: Adapted participatory action research cycle (Zuber-Skerritt 2015)

Phase One: Situational analysis to *'Observe',* thus gaining a better understanding of the context and research phenomenon (Chapter 4).

- To identify, explore and describe the type, nature and involvement of organisational stakeholders, and their perspectives regarding the development of a sustainable community coalition to manage alcohol misuse as a risk factor of HIV infection in a community in the North West Province, South Africa.

Phase Two: *'Reflect'* by sharing findings from Phase One with organisational stakeholders (Chapter 5).

- To draw conclusions about the type and nature of organisational stakeholders in the community, as well as their involvement and perspectives to manage alcohol misuse as a risk factor of HIV infection.

Phases Three and Four: *'Plan'* and *'Act'*

Planning involves setting and determining the activities for achieving objectives (Fadlallh 2015:247). This phase involved two intertwined processes, 'plan' and 'act'. Planning entailed exploring how the organisational stakeholders could be involved in sustaining a community coalition to manage alcohol misuse as a risk factor of HIV infection in this setting. Conversely, 'acting' focused on the implementation and evaluation of the chosen activities by the organisational stakeholders over a particular period (refer to Chapter 3, Section 3.2) to create action for change. These two intertwined processes and the outcomes of each phase are discussed in Chapter 6.

Phase Five: '*Construction and description of the conceptual framework to manage alcohol misuse as a risk factor of HIV infection'* (Chapter 7).

- To construct and describe a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection.

1.4 FOUNDATIONS OF THE STUDY

My experience of working with this community in 2011 led me to believe that it is critical to empower key organisational stakeholders within the community through engagement and participation to succeed in managing alcohol misuse as a risk factor of HIV infection. I envisaged that organisational stakeholders' – as people affected by alcohol misuse as a risk factor of HIV infection – participation in the research process would empower them to sustain the coalition.

1.4.1 Meta-theoretical assumptions

Critical theory was selected both on a meta- and theoretical level. I accepted Loewenson, Luarelll, Hogstedt, D'ABruoso and Shroff's (2014:21) description of the following ontological, epistemological and methodological assumptions as meta-theoretical assumptions.

1.4.1.1 Ontological

Ontology is about the nature of reality (Loewenson et al 2014:21). From a critical theory perspective, reality is shaped by socio-political and economic contexts and clarified over time. From a participatory perspective, reality is subjective, co-created, and can be understood through subjective experience and action (Loewenson et al 2014:21). Therefore, I departed from the assumption in this study that reality, and consequently the findings and final outcome of the study, will be shaped by the socio-political environment of the community, as well as by the interactions between individuals, families, organisational stakeholders, and myself as a researcher.

1.4.1.2 Epistemology

Epistemology refers to what is known and what can be known by reality (Loewenson et al 2014:21). From a critical theory perspective, knowledge is subjective and context-specific, while from a participatory perspective, shared experience and participatory action are used to build socially constructed knowledge susceptible to transformation (Loewenson et al 2014:21). Hence, the study was informed by the assumption that organisational stakeholders can learn and apply basic research to improve the health status of the community through actions for change. Organisational stakeholders in this study learned basic research skills such as identifying their own problems and possible ways of addressing it in the community to institute change. They were able to use the evidence generated through their participation in the PAR to engage in the construction of a sustainable community coalition framework to manage alcohol misuse as a risk factor of HIV infection shaped by the context in which they live.

1.4.1.3 Methodological

Methodology refers to how knowledge about reality can be produced and grounded in collaborative action (Loewenson et al 2014:21). In this study, I subscribed to the assumption that knowledge is produced through the inclusion of subjective meanings grounded in shared experiences between the researcher and organisational stakeholders (Loewenson et al 2014:21). I used PAR in this study to facilitate action

for change and to generate knowledge as a collective process, engaging and working with, rather than working on, organisational stakeholders, who were previously the subjects of research (Mash 2014:2).

1.4.2 Theoretical perspective

I have been guided and theoretically influenced by PAR theory, Critical theory, practice oriented model, practice oriented model by Dickoff et al 1968), Bronfenbrenner's ecological framework as well as Theory Generation criteria, by Chinn and Kramer (2011).

1.4.2.1 PAR theory

PAR originated in the 1940s by Kurt Lewin (Polit & Beck 2017:482; Glassman et al 2017:207). PAR recognises that the production of knowledge can be political and can be used to extert power. In PAR, researchers and participants collaborate in defining the problem, selecting research methods, analysing the data and producing the findings. Polit and Beck (2017:482) argue that PAR produces information that is directly used by study participants to create change.

1.4.2.2 Critical Theory

I have been guided and theoretically influenced by critical theory (Polit & Beck 2017:480; Loewenson et al 2014:20). Polit and Beck (2017:725) refer to critical theory as "interpreting the world that involves a critique of society, with the goal of envisioning new possibilities and effecting social change". Critical theory holds that reality is dynamic, and access to reality occurs through shared meaning (Loewenson et al 2014:21).

Critical theory originated from Marxism-oriented German scholars (Polit & Beck 2017:480) and emerged as a critique of current forms of research, on the basis that knowledge is built out of collective subjective experiences by people commonly exposed to reality (Loewenson et al 2014:20). In this study, I was concerned with

questions about the current situation in the community on how to sustain activities to manage alcohol misuse as a risk factor of HIV infection.

The overall aim of critical theory is to integrate theory and practice for people to become aware of contradictions and disparities in their beliefs and social practices, and become inspired to change them. Critical researchers are oriented towards a transformation process and call for inquiries that foster self-knowledge and socio-political change (Polit & Beck 2017:480). The design of critical research often begins with a comprehensive situational analysis and interpretation of the problem. Polit and Beck (2017:480) emphasise multiple perspectives through triangulation of multiple methodologies. I used multiple data collection methods such as key informant interviews (Polit & Beck 2017:733), dialogue meetings (McNiff 2017:26) and field notes (Creswell & Creswell 2018:186).

In critical theory, knowledge is viewed as transactional, subjective, value-mediated and value-dependent. My role was that of transformative agent and advocate (Polit & Beck 2017:481).

1.4.2.3 Practice-oriented model

A practice-oriented model is based on six aspects of survey list activity described by Dickoff, James and Wiedenbach (1968:423), namely; agent, recipient, dynamic, procedure, context and outcome. The six aspects of survey list activity correspond to the following questions: Who or what performs the activity (the agent), who or what is the recipient of the activity (recipient), what is the energy source of the activity (dynamic), what is the guiding procedure of the activity (procedure), in what context is the activity performed (context), and what is the end point of the activity (outcome) (Dickoff et al 1968:423). The application of a practice-oriented model is described in Section 7.2.3.

1.4.2.4 Bronfenbrenner's ecological framework

Bronfenbrenner's ecological framework for human development was first introduced in the 1970s (Vélez-Agosto, Soto-Crespo, Mónica, Vizcarrondo-Oppenheimer, Vega-Molina & Coll 2017:901). The Bronfenbrenner ecological framework examines human development by studying how human beings create specific environments in which they live. As described by Vélez-Agosto et al (2017:902), the environment is composed of systems at four different levels; the microsystem, the mesosystem, the exosystem, and the macrosystem. The Bronfenbrenner ecological framework has been used extensively in mental health and substance abuse research (Van Zyl 2013:582). The application of the framework is described in Section 7.2.3.6.

1.4.2.5 Theory generation criteria

Chinn and Kramer (2011:197-205) describe criteria of theory generation as clarity, simplicity, generality, accessibility, and importance. Clarity is the extent to which the definition of the concepts is clear and well defined (Hagran & Fakharany (2015:14). Generality refers to the width of scope of the framework and its application to a broad group of situations (Chinn & Kramer 2011:202-203). Simplicity reflects the number of concepts and their interrelationships, and that these should be kept to a minimum (Chinn & Kramer 2011:201-202). Accessibility refers to the degree to which empiric indicators of the concepts can be identified by others in the field (Chinn & Kramer 2011:203-204). The importance of the conceptual framework is the significance of the conceptual framework (Chinn & Kramer 2011:204). Criteria of theory generation and the application are discussed in Section 7.3.

1.5 DEFINITION OF KEY CONCEPTS

1.5.1 Sustainability

Mendes, Plaza and Wallerstein (2016:62) define 'sustainability' as the ability of health promotional activities to be institutionalised within community infrastructures. The phrase 'sustainable community coalition' in this study is defined as the capacity of a formal alliance of diverse organisations and stakeholders in a specific

community of the North West Province, South Africa, to support and maintain its activities for managing alcohol misuse as a risk factor of HIV infection through action for change over time.

1.5.2 Community coalition

Community coalition is defined as groups of individuals or organisations that work in collaboration to achieve a common vision (Cardazone, Sy, Chik & Corlew 2014:347). Orellano-Colón, González-Laboy and Rosario (2017:2) define a 'coalition' as a union of people and organisations whose representatives commit to an agreed-upon aim and shared decision making to contribute to the outcomes of a specific problem. A community coalition in this study refers to the formal alliance of diverse organisations, represented by key organisational stakeholders (see Section 1.5.3) in a specific community in the North West Province, South Africa, to support and maintain activities in managing alcohol misuse as a risk factor of HIV infection.

1.5.3 Organisational stakeholder

According to Freeman (cited in Beringer, Jonas & Kock 2013:2), an 'organisational stakeholder' refers to individuals or organisational representatives who can be influenced by the achievement of an organisation's objectives. Organisational stakeholders in this study refer to individuals from a variety of organisations like tavern owners from tavern owners' associations, police officers from local police services, and councillors from local government, who participate in an alliance to manage alcohol misuse as a risk factor of HIV infection in a specific community. The roles of organisational stakeholders in this study were to collaboratively participate in the development of a sustainable coalition through PAR to improve the management of alcohol misuse as a risk factor of HIV infection in the community.

1.5.4 HIV infection

HIV is a virus that leads to AIDS (Ngoma, Roos & Siziya 2015:561). In this study, HIV infection will include the transmission of HIV from person to person related to sexually risky behaviour associated with alcohol misuse.

1.5.5 Drug

A drug is a psychoactive or dependence-producing substance such as alcohol, cannabis, cocaine or heroin (South Africa 2013:18). A drug, in this study, refers to alcohol, which can influence a person to engage in risky sexual activities that may lead to HIV infection due to its intoxicating effect

1.5.6 Alcohol misuse

Rolland et al (2016:1) define 'alcohol misuse' as alcohol consumption pattern at levels more than the low-risk drinking level. Rehm et al (2015:23) describe alcohol misuse in terms of the quantity of alcohol consumed; that is, drinking more than 20g of pure alcohol per day. Alcohol misuse in this study refers to the use of alcohol by community members, which may influence an individual to engage in risky sexual activities that may lead to HIV infection.

1.5.7 Management of alcohol misuse

The management of alcohol misuse refers to strategies and interventions for the prevention and treatment of alcohol abuse (WHO 2018:25). Management of alcohol misuse in this study refers to the activities I undertook in collaboration with organisational stakeholders to manage alcohol misuse and its related public health consequences over time. Management is a process consisting of planning, organising, leading and control (Fadlallh 2015:246).

1.5.8 Mental health practitioners

'A mental health practitioner', as defined in the Prevention of and Treatment for Substance Abuse Act, 2008 (South Africa 2008:s 1), is a registered health professional who has been trained to provide mental health care, treatment and rehabilitation services. Mental health practitioners promote the mental health of individuals, families, groups and communities, and are involved in the management of alcohol misuse. In this study, mental health practitioners refer to health

professionals providing comprehensive mental health services to individuals, families, and communities experiencing alcohol use problems.

1.5.9 Empowerment

Cattaneo and Goodman (2015:84) define ‘empowerment’ as a shift in the experience of power attained through interaction in the social world. Empowerment in this study refers to an experience of empowerment by individuals and organisational stakeholders in the community attained through participation in PAR to manage alcohol misuse as a risk factor of HIV infection.

1.6 RESEARCH DESIGN AND METHODS

An overview of the research design and methods that I used to achieve the aim and objectives of the research follows. The methods are described in relation to the chosen PAR cycle of observing, reflecting, planning and acting (Zuber-Skerritt 2015:6), complemented by a fifth phase that focuses on the construction and description of the conceptual framework.

1.6.1 Research design

A PAR design that was qualitative and theory generative in nature was followed in this study. PAR recognises full participation of organisational stakeholders in studying and transforming those organisations (Morales 2016:159). PAR was relevant for this study as the aim was to construct and describe a sustainable community coalition conceptual framework through participation, action and research in collaboration with organisational stakeholders in their natural setting. The research design is described in more depth in Chapter 3 (see Section 3.3).

1.6.2 Research methods

As described by Polit and Beck (2017:743), a ‘research method’ is a systematic technique used to structure a research study. In this section, I provide an overview of

the methods that I used during the operationalisation of each of the five research phases. These methods are described in more depth in Chapter 3 (see Section 3.4).

Phase One: Situational analysis to *'Observe'* (Chapter 4)

This phase entailed a situational analysis through the use of key informant interviews (Peersman 2014:3) and field notes (Gray, Grove & Sutherland 2017:257) to identify, explore and describe the type, nature and involvement of organisational stakeholders, as well as their perspectives of a sustainable community coalition to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa. Purposive and snowball sampling (Gray et al 2017:345) were used as sampling strategies to select information-rich participants (key informants) and achieve data saturation (Gray et al 2017:352). For a detailed description of the sampling and data collection strategies, refer to Chapter 3 (Section 3.4).

Phase Two: 'Reflect' (Chapter 5)

In Phase Two, I shared the data collected in Phase One with the organisational stakeholders in the community, including some of the key informants who participated in Phase One by means of 10 dialogue meetings (McNiff 2017:26). These meetings were held in order to draw conclusions about the type and nature of organisational stakeholders in the community, as well as their perspectives about alcohol misuse as a risk factor of HIV infection. This was also a critical part of consensus-building. Data were collected through minutes of the dialogue meetings. Refer to Chapter 3 for a comprehensive description of the methods applied during this phase (Section 3.4).

Phases Three and Four: 'Plan' and 'Act' (Chapter 6)

During this phase, I collected data from the organisational stakeholders through the minutes of follow-up dialogue meetings. I also kept field notes. The data obtained assisted me in constructing an action plan for implementation in collaboration with organisational stakeholders. Refer to Chapter 3 (Section 3.4) for a comprehensive description of the methods applied during this phase.

Phase Five: 'Construction and description of the conceptual framework to manage alcohol misuse as a risk factor of HIV infection' (Chapter 7)

Data collected through the previous phases were used to construct and describe a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. The conceptual framework was developed by consolidating data collected from Phases One to Four using theory development in accordance with Dickoff, James and Wiedenbach's (1968:423) thinking map, with reference to the agent, recipient, dynamic, procedure, context and outcome. Evaluation reports from purposively selected experts in the field of substance abuse were used to refine and finalise the conceptual framework. The methods employed during this phase are described in more detail in Chapter 3 (Section 3.4).

1.6.3 Data analysis

In line with the PAR approach, the analysis was informed by a process of building consensus with research participants throughout the research cycle (Mash 2014:4). All qualitative data that were generated during Phases One to Four were analysed by following the steps described by Creswell and Creswell (2018:193-198). Data analysis for Phase Five was done by identifying key issues raised and recommendations suggested by experts in the field of substance misuse and HIV, to refine and finalise the conceptual framework. The data analysis process is discussed in more detail in Chapter 3.

1.7 TRUSTWORTHINESS

It is important to conduct high-quality research. There have been debates on scientific terms to be used to describe research quality due to differences in paradigms and philosophical views. Whereas the standards of reliability and validity have been widely used in quantitative research, Polit and Beck (2017:558) recommend the standards of trustworthiness for qualitative research. The framework as described by Lincoln and Guba (cited in Polit & Beck 2017:559), which has been widely accepted in qualitative research, was applied in this study. The criteria for developing trustworthiness in qualitative research include credibility, dependability,

confirmability, transferability and authenticity. In addition, reflexivity (Gray et al 2017:65) will also be discussed. These strategies to ensure trustworthiness are described in more detail in Chapter 3.

1.8 ETHICAL CONSIDERATIONS

For PAR to achieve its aims and objectives, there is a need to consider ethical principles related to research, in general, and specific attention related to unique features of PAR processess, in particular (Loewenson et al 2014:74). I describe the ethical principles that guided this study from inception and the application of the conditions relevant to each principle in more depth in Chapter 3 (Section 3.5).

1.9 SIGNIFICANCE OF THE STUDY

The PAR approach aimed to empower organisational stakeholders to participate in generating evidence-based knowledge through identifying their own problems, planning, organising, leading and controlling the implementation of activities to manage alcohol misuse as a risk factor of HIV infection, subsequently contributing to improving the quality of life of community members. As described by Mash (2014:2), PAR helps to emancipate and empower communities in solving their own health problems. It is supported by Chesnay (2015:10) that PAR is best used where the hope of empowerment is the greatest, and participants are considered to be the holders of local knowledge.

Although a number of research studies link the sustainability of community coalition to key aspects such as community capacity building and adequate resource allocation (Bradley 2017:9; Giesbrecht et al 2014:222; Flewelling & Hanley 2016:839), these studies did not sufficiently develop theory in the form of models or conceptual frameworks to address the problem of sustaining community coalition in the particular field under study.

Shelton et al (2018:60) argue that frameworks that emphasise community-based PAR are important in planning for sustainability by addressing the needs of organisational stakeholders. This framework can be used to assess key issues that

affect sustainability. Abrams (2017:126) suggest that a framework can be used to identify facilitating and inhibiting issues that affect sustainability. Additionally, this framework can be used as a model for collaboration and change by community-based coalitions, particularly coalitions on substance abuse prevention (Bradley 2017:1). It is envisaged that the framework will also provide mental health practitioners working in this or similar settings with a frame of reference to manage alcohol misuse as a risk factor of HIV infection underpinned by critical theory.

1.10 STRUCTURE OF THE THESIS

This thesis comprises of the following chapters:

Chapter 1- Orientation to the study
Chapter 2- Literature review
Chapter 3- Research design and methods
Chapter 4- Phase One: Description of the findings and literature control
Chapter 5- Phase Two: Reflection on the findings
Chapter 6- Phases Three & Four: Planning and action
Chapter 7- Phase Five: Construction and description of the conceptual framework
Chapter 8- Conclusions, limitations and recommendations

1.11 SUMMARY

This chapter provides the background and rationale of the study. Alcohol misuse and HIV infection were introduced. The research problem and problem statement were discussed, as well as the aims and objectives of the study. The significance of the study, its foundation, scientific rigour, ethical considerations, scope and limitations were also discussed. In the next chapter, I review literature by critically assessing and synthesising the conceptual and empirical research on issues to consider in sustainable community coalitions.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, I turned to the body of scholarly literature in the field of community coalitions and substance misuse by reviewing the literature regarding coalitions and sustainability. The chapter describes the aim, literature search methods, findings, limitations and conclusion.

2.2 AIM

As described by Chesnay (2015:28), a literature review shares what is known about the research area. The aim of this review of literature was to identify and synthesise scientific evidence relevant to community coalition sustainability along with substance and alcohol misuse, to understand what is already known about sustainable community coalitions in the field of substance use, to provide a baseline of new research, to determine how best to contribute to existing knowledge, to facilitate an interpretation of findings after the data are analysed, and to use the findings to construct and describe the conceptual framework (McNiff 2017:105). Coughlan, Ryan and Cronin (2013:4) argue that a literature review provides comprehensive background knowledge relevant to a specific topic, and facilitate the development of conceptual frameworks through exploration and evaluation of existing knowledge. The following research questions guided the literature review process: What is known regarding sustainable community coalitions? What are the potential opportunities and challenges that can be harnessed for this study?

2.3 LITERATURE SEARCH METHODS

I conducted a traditional literature review by performing a search of scientific papers using Medline, Pubmed, EMBASE, CINAHL, Web of Science, PsychINFO and Google scholar databases. I searched these databases using the following keywords: Coalition, partnership, alliance or union, substance use/abuse, alcohol

abuse and sustain. The following inclusion criteria were applied: articles had to be written in English; published in a peer-reviewed journal; had a publication date not more than five years old; and described research focusing on community coalitions, sustainability, and alcohol or substance misuse. The review took place in 2019.

2.4 FINDINGS

Thirteen research papers relevant to the current study were located and are presented in Table 2.1, followed by a discussion on key issues.

Table 2.1: Summary of key findings from research papers reviewed

Author	Research focus	Study design	Study aim	Relevant key issues
1.Flewelling & Hanley (2016:830-840)	Community coalition capacity and underage drinking prevention	Process evaluation of community-based coalitions	To assess: • If funded coalition capacity increased over time • Whether, and to what extent coalition capacity contributes to reductions in underage alcohol consumption	• The capacity of coalitions increased during the timeframe in which they received funding (Page 837) • Community coalition capacity was linked with reductions in underage alcohol consumption reduction (Page 839) • Success of community coalition is linked to, organisational stakeholder cohesion and access to multiple sources of funding (Page 839)
2. Johnson et al (2017:610-621)	Sustainability of community-based coalitions	Telephone interview and web-based survey	To examine: • survival of coalitions beyond state funding • factors that predict sustainability	• Most of the coalitions studied survived beyond initial state funding (Page 616) • Predictors of sustainability included; access to financial resources, improved coalition

Author	Research focus	Study design	Study aim	Relevant key issues
				capacity, level of coalition formalisation, and Intervention trialability (Page 618)
3.Brown et al (2017:600-609)	Sectoral diversity in community coalition	A survey of community coalition organisational representatives	To examine sectoral diversity in community coalition	• A high level of sectoral diversity is linked to lower perceptions of coalition processes (Page 605) • Skilled leaders and participatory decision making strengthen coalition intersectoral communications (Page 607) • High level of intersectoral communication is linked to positive coalition outcomes (Page 607)
4.Fagan & Hawkins (2015:1-32)	The role of coalitions in school-based learning	Randomised controlled trial	To discuss how community coalitions can increase learning in schools	• Coalitions from diverse community sectors who shares a common vision are more likely to achieve targeted outcomes (Page 17) • All communities fully implemented the Communities That Care (CTC) model and received training and technical assistance (Page 7)
5.Pérez-Gómez, Mejia-Trujillo, Brown and Eisemberg (2016:538-546)	Adaptation and Implementation of evidence-based prevention system	Communities that care youth survey	To pilot the process of implementation of Communities that Care	Salient risk factors: • Drugs availability in the community • Rules and norms are in favour of drugs in the community • Low commitment to schools

Author	Research focus	Study design	Study aim	Relevant key issues
				• Low perception of risks of drug use (Page 542) Challenges • limited knowledge of drug misuse prevention • limited access to officials from local authorities and governmental (Page 542) Achievements • All pilot communities continued with the coalition after pilot funding ended (Page 543)
6.Powell and Peterson (2014:470-486)	Empowering organisational characteristics of community-based substance abuse coalitions	Evaluation of community coalitions through self-administered online surveys	To test a model of organisational characteristics as predictors of empowerment and coalition success	• Leadership has a positive effect on coalition effectiveness • Empowerment is positively associated with social support on effectiveness (Page 478)
7. Cooper, Bumbarger and Moore (2013:1-13)	Sustainability of evidence-based prevention programmes	Online survey research	To: • Examine sustainability in a non-research context beyond initial funding • Identify key issues that differentiate programmes that were sustained programmes against those that were not sustained	• Most programmes sustained at the same level of functioning two years after initial funding ended (Page 6) • Most programmes were operating at a reduced functioning level compared to the grant-funded periods (Page 6) • Better coalition functioning and community outreach significantly correlate to programme sustainability (Page 6)

Author	Research focus	Study design	Study aim	Relevant key issues
				• More frequent interaction with the program developer, knowledge of the logic model, planning and financial alignment were linked to program sustainability (Page 7) • Participant recruitment was a barrier to sustainability (Page 7)
8. Snyder (2014:1-128)	Evidence-based practice and coalition functioning	A case study, survey and key informant interviews	To: • Describe substance abuse coalitions functioning • Identify key issues related to the implementation of evidence-based interventions and coalition functioning	• All coalitions had a defined vision, mission and goals of reducing substance misuse (Page 91) • All coalitions have established organisational structure (Page 83) • All coalitions were able to identify challenges regarding the coalition (Page 63) • An empowering leadership style was evident in all the coalitions (Page 52)
9. Giesbrecht et al (2014:203)	Implementing and sustaining effective alcohol-related policies	Literature review of alcohol intervention and policies	To identify alcohol interventions and policies and challenges facing action on alcohol To determine how action on alcohol can be sustained	• Challenges were related to, sustaining local efforts to implement alcohol policy, providing adequate training and resources, and addressing the diversity of community stakeholders (Page 219) • Action on alcohol can be sustained through capacity building and

Author	Research focus	Study design	Study aim	Relevant key issues
				diversifying funding resources (Page 222)
10. Bradley (2017:1-163)	A learning model of community collaboration	Case study to examine substance abuse community coalitions	To examine community coalitions' success with substance abuse prevention program To test the grounded theory model of community collaboration	• Assessing community readiness, identifying needs, and acquiring resources can strengthen community capacity (Page 7) • Using interventionns appropriate for community needs, and evidence-based strategies would contribute to long-term changes (Page 51) • Grants serve as the primary resource to fund salaries, meetings, and training, and to implement strategies; shared funding among participating organisations reduce the financial burden and develop partnerships (Page 131) • Practitioners may need to expand the scope of collaborative engagement to encourage member training and leadership (Page 144)
11.Greenberg et al (2015:158-167)	Financial sustainability of community coalitions	Longitudinal study	To evaluate the level and factors that impact sustainability funding	• Effective team functioning during early phases of a coalition is a predictor of sustainability (Page 160)

Author	Research focus	Study design	Study aim	Relevant key issues
				• Coalition member expertise and sustainability planning is a predictor of fundraising success (Page 166) • Sustained community coalition partnerships are likely to have a sustained public health effect (Page 166)
12. Goldstein, Sapere and Daviau (2017:123-130)	Role expectations between paid and unpaid coalition members	Online survey research	To examine the degree of agreement between paid and unpaid members of a coalition	• Unpaid coalition members had a perception that paid staff had more responsibility for most of the activities • Paid staff perceived that the activities should be shared between paid and unpaid staff members (Page 127)
13. Bermea, Lardier, Forenza, Garcia-Reid and Reid (2018:1-14)	Motivation for participation in community coalition	Semi-structured interviews with community-based substance abuse coalition members	To explore how people are motivated to participate in a coalition	• Holding a community membership facilitated an understanding of challenges faced by the community (Page 6) • A feeling of emotional connection to others (Page 6) • Participation in a coalition is a means of fulfilling community needs through action for change (Page 10) • Community stakeholders held a belief that participating in a coalition will foster capabilities to

Author	Research focus	Study design	Study aim	Relevant key issues
				implement change the community (Page 7)

The key issues to be considered to sustain community coalitions identified from the reviewed papers include sharing a common vision, leadership, capacity building for coalition members and the community, access to financial resources, formalising the coalition, and membership diversity. Each of the key issues is discussed next.

2.4.1 Sharing a common vision

Sharing a common vision has been identified as one of the key issues that contribute to community coalition sustainability (Knight 2016:3; Cooper et al 2013:9; Snyder 2014:48; Fagan & Hawkins 2015:15). Knight (2016:3) argues that the coalition needs a shared vision to guide organisational stakeholders through its work and decision making. A coalition characterised by a collective vision, mission and mutually agreed priorities is more sustainable and contributes to organisational stakeholders achieving the collective good (Cooper et al 2013:9). In another study by Snyder (2014:48) on the examination of coalition functioning, sharing a common vision contributed to strengthening coalition activities, ultimately reducing substance use among the youth. Similarly, Fagan and Hawkins (2015:15) state that coalitions from diverse community sectors who shares a common vision are more likely to achieve targeted outcomes.

2.4.2 Leadership

Numerous studies have identified leadership as one of the key issues to consider in sustaining community coalitions (Anderson-Carpenter, Watson-Thomson, Jones & Chaney 2017:11; Flewelling & Hanley 2016:831; Powell & Peterson 20145:478; Brown et al 2017: 607; Snyder 2014:59). Anderson-Carpenter et al (2017:11) argue that strengthening leadership promotes buy-in from community stakeholders and facilitates changes. A study by Flewelling and Hanley (2016:838) also found that

collaborative leadership was positively associated with interventions targeted at a reduction in underage drinking.

Similarly, Powel and Peterson's (2014:478) study found that leadership have a positive effect on substance abuse prevention in community-based coalitions' effectiveness. Leadership predicts effectiveness through its relationship in terms of its role, social support and collective belief systems (Powel & Peterson 2014:478). Brown et al (2017:607) add that coalition leaders, due to their knowledge, encourage members from different sectors to work together. They also claim that skilled team leaders may help coalitions promote intersectoral communication, consequently actualising sustained public health impact. In a study conducted by Snyder (2014:59), coalition members' perceived leadership style and competence had a high level of influence on coalition decision making. Snyder (2014:111) concludes that leadership skill contributes to greater coalition capacity to implement evidence-based prevention activities.

2.4.3 Capacity building

Capacity building for coalition members is positively associated with the sustainability of public health interventions (Anderson-Carpenter et al 2017:1; Johnson et al 2017:618; Giesbrecht et al 2014:222). Strengthening coalition capacity through mentoring and technical assistance is linked to community readiness for change. Johnson et al (2017:618) agree that when community coalition is supported by training and technical assistance, an evidence-based prevention intervention is enhanced. Giesbrecht et al (2014:222) concur that capacity building enhances collaboration among a variety of stakeholders to develop and implement interventions to manage alcohol misuse and related problems. Findings by Flewelling and Hanley (2016:839) moreover confirm that community coalition capacity is associated with a reduction in underage drinking.

2.4.4 Access to financial resources

Access to financial resources helps finance the implementation of coalition activities (Giesbrecht et al 2014:219; Flewelling & Hanley 2016:839; Johnson et al 2017:617;

Snyder 2014:65). Giesbrecht et al (2014:219) suggest that diversifying sources of funding to avoid dependence on a single source will contribute to programme sustainability. Similarly, findings from the study by Flewelling and Hanley (2016:839) reflect that diversity of funding sources is positively associated with a reduction in the prevalence of underage alcohol consumption. However, it is not known if the coalitions were sustained beyond the funding period (Flewelling & Hanley 2016:837).

Johnson et al (2017:619) discovered that most of the coalitions were still in operation five-and-half years after the initial funding ended. In another study by Bradley (2017:52), it was found that the community coalition continued to exist after the initial financial assistance ended because they were able to diversify funding sources. Similarly, Greenberg et al (2015:162) claim that community teams were sustained for the first five years due to funding drawn from numerous sources.

2.4.5 Formalising the coalition

A coalition is more likely to be sustained when there is a formalised organisational structure (Goldstein et al 2017:124). Johnson et al (2017:619) agree that the level of coalition formalisation predicts the number of years that interventions are sustained. The level of coalition formalisation is positively related to coalition functioning (Snyder 2014:15). Flewelling and Hanley (2016:831) further state that one characteristic of effective community coalitions includes having a formalised procedure. Berger (2013:20) argues that formalising, goals, objectives and expectations are associated with the overall success of coalitions. Additionally, formalising a coalition may include defining formal positions within the coalition and the development of bylaws to help clarify individual roles and what members can expect from the coalition (Berger 2013:20).

As described by Bradley (2017:55) during the Startegic Prevention Framework State Incentive Grant (SPF SIG), the coalition formalised its structure as seen by the formal makeup of the human resource structure. The individuals serving on the committee were sector representatives from different groups or organisations, such as faith-based, business, law enforcement, media, education, and health services. Each committee member had defined roles and responsibilities and signed a

coalition agreement, which was renewed annually (Bradley 2017:64). In another study by Snyder (2017:79), all coalitions established a formal structure, had specific rules and regulations guiding the coalition, formalised meeting procedures, and identified leaders to facilitate meetings and voting procedures.

2.4.6 Membership diversity

Membership diversity has been found to be the driver for coalition sustainability (Bradley 2017:114, Christens & Inzeo 2015:425). In a study by Bradley (2017:114), diversity was identified as a strength for the coalition members. During the initial years of the SPF SIG grant for state-wide substance abuse prevention, the coalition members were primarily adult, white, female, and from the social work field. Coalition leaders made an effort to recruit members for increased diversity, resulting in more diverse groups that included different ethnicities. Bradley (2017:68) argues that membership diversity helped in establishing a wide perspective and strengthening the ability to reach an increased number of people on the substance abuse prevention programme. Similarly, the study by Bermea et al (2018:4) demonstrates that diversity helps prevent discrimination in service delivery. Similarly, Christens and Inzeo (2015:425) concur that membership diversity in terms of personal characteristics such as race and economic status, organisational situation such as public agencies and NPOs, are drivers of success in coalitions.

Conversely, Brown et al (2017:607) argue that sectoral diversity may have a negative influence on coalition sustainability. The authors (Brown et al 2017:601) suggest that despite its potential, sectoral diversity can complicate decision-making consensus due to differences in knowledge, terminology, beliefs and organisational priorities. They propose that collaboration could be achieved by strengthening intersectoral communication.

2.5 GAPS IDENTIFIED

Although the literature review identified issues to be considered to sustain community coalition in managing substance misuse, the review did not reflect how such a framework should look. However, the issues identified will guide the

development of a sustainable community coalition conceptual framework to manage alcohol misuse as a risk factor of HIV infection.

2.6 LIMITATIONS

The current literature review is limited because of its reliance on literature published in English as it was not practically possible to review papers in other languages. Secondly, I did not include grey literature in this review as it was not practical to search all unpublished research. Accessing grey literature may provide valuable information; however, as argued by Coughlan et al (2013:55), this practice requires a lot of time. Lastly, I did not rigorously evaluate the studies included. However, the selected studies provided valuable information on issues to be considered in sustaining community coalitions.

2.7 CONCLUSION

Key issues to consider for the sustainability of community coalitions from the reviewed papers were identified as sharing a common vision, leadership, capacity building for coalition members and the community, access to financial resources, formalising the coalition, and membership diversity. Sharing a common vision contributes to strengthening organisational stakeholders' decision making and establishing mutually established priorities, and organising activities (Snyder 2014:48) for achieving the collective good (Knight 2016:3; Cooper et al 2013:9). Leadership strengthens organisational mobilisation of resources to work towards achieving a common vision, ultimately achieving community-level change (Anderson-Carpenter et al 2017:11).

In addition, capacity building (through training and technical support) for organisational stakeholders and individuals in the community assist in developing collective skills, capabilities and competency to facilitate change. Furthermore, access to diverse funding sources is strongly associated with the sustainability of coalitions (Giesbrecht et al 2014:219). The level of coalition formalisation may include defining formal positions within the coalition, and the development of bylaws to help clarify individual roles and what members can expect from the coalition

(Berger 2013:20). Formalising coalitions contributes to improved coalition functioning and positive outcomes (Snyder 2014:15). Although membership diversity has been identified as a driver of success in community coalition sustainability (Bradley 2017:68; Christens & Inzeo 2015:425), it can complicate decision-making consensus due to differences in organisational priorities.

Understanding the aspects that influence community coalitions will be considered along with the findings of this study to construct and describe a sustainable community coalition conceptual framework which could be used by mental health practitioners to empower organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. In the next chapter, I discuss and describe the research design and methods in order to orientate the reader on how the study was conducted.

CHAPTER 3
RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

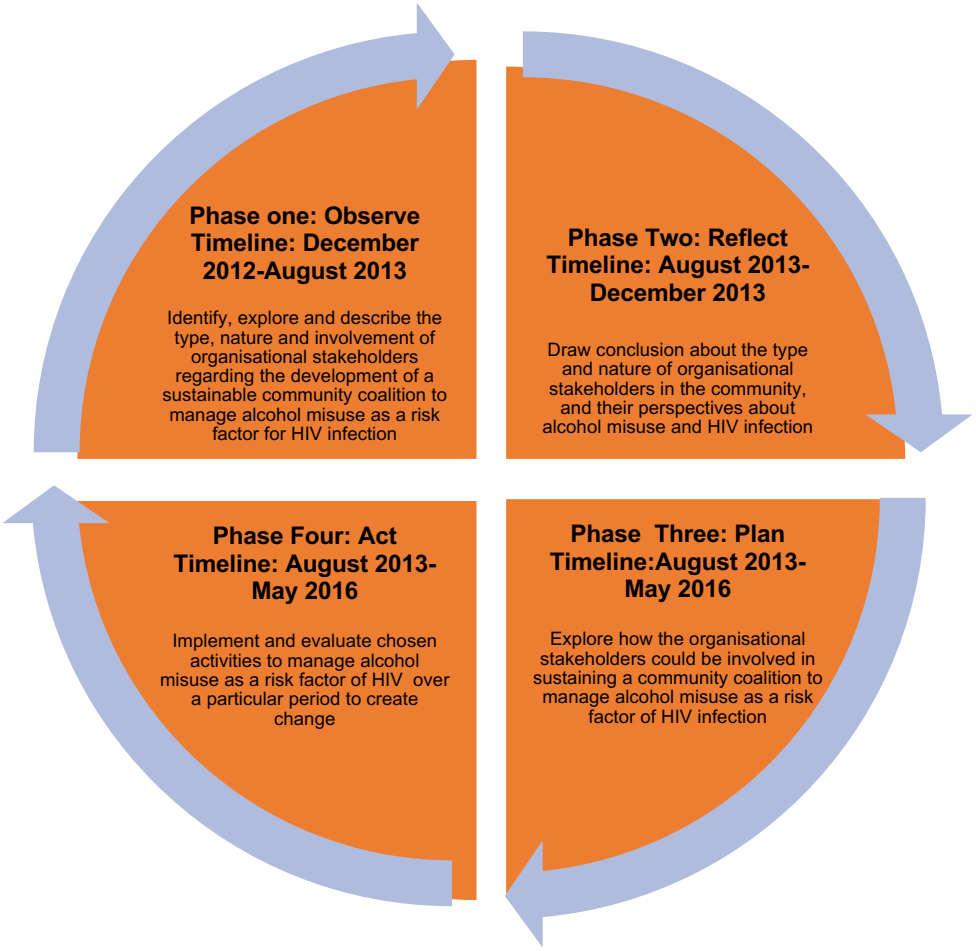
In Chapter 1, the orientation to the study, focusing on a description of the setting, problem, and the paradigmatic underpinning and rationale for selecting PAR as the methodology to achieve the overall aim of the study was discussed. As described in Chapter 1, the overall aim of this study was to construct and describe a conceptual framework that can serve as a frame of reference for organisational stakeholders to sustain community coalition to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa.

In the previous chapter, I provided a literature review on community coalitions' sustainability relevant to substance misuse by synthesising data from peer-reviewed articles that focused on the sustainability of coalitions and substance misuse. In this chapter, I describe the PAR research methodology in depth, in particular relating to the actualisation of the research design and methods through the five interrelated research phases identified in Chapter 1. Polit and Beck (2017:743) define a 'research design' as the overall plan for addressing research questions, including how a study's integrity is enhanced. It explains why I pay attention to the research design and methods, including the application of the methods to ensure trustworthiness and ethical research practices.

3.2 AIM AND OBJECTIVES

The aim of this study was to construct and describe a conceptual framework that can serve as a frame of reference for organisational stakeholders to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa. The PAR was actualised through the application of the four phases of the PAR cycle, namely observe, reflect, plan and act, as described by Zuber-Skerritt (2015:18). In Phase Five, I constructed and described the conceptual framework for mental health practitioners to manage

alcohol misuse as a risk factor of HIV infection as it signifies the significant contribution of the study. The objectives of each of the five phases, including the timeline in which each phase was undertaken, are summarised in Figure 3.1. The activities undertaken in each of the phases was cyclical, involving a non-linear pattern of observing, reflecting, planning and acting.



Phase Five

Construct and describe the sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection

Timeline: May 2016 – November 2019

Figure 3.1: Adapted Participatory Action Research Phases of a sustainable community coalition conceptual framework (Zuber-Skerritt 2015:18)

3.3 RESEARCH DESIGN

As described, a PAR design that was qualitative and theory generative in nature guided this study. PAR is a collaborative process in which there is mutual participation of the researcher and study participants throughout the research on key issues that affect them (Polit & Beck 2017:482; Creswell & Creswell 2018:231; MacDonald 2012:38). The intent of PAR is to collaborate with organisational stakeholders in shaping the research to build evidence (Creswell & Creswell 2018:231), and use the evidence to take action for change.

A cyclical process of PAR, as described by Zuber-Skerritt (2015:18), was applied according to the previously identified phases. A conceptual framework was constructed and described based on data collected from all phases of the PAR cyclical process, as described in Section 3.2.

The qualitative research design was exploratory, descriptive and contextual. According to Polit and Beck (2017:15), explorative qualitative research starts with a phenomenon of interest and seeks to understand the nature of the phenomenon and how it is manifested. The phenomenon of interest refers to the study's focus or the concept of interest (Gray et al 2017:105). The phenomenon of interest in this study refers to 'sustainable community coalition' in the context of managing alcohol misuse as a risk factor of HIV infection. The explorative design was multi-method in nature (Reiter 2017:139) as indicated in Section 3.4. It aimed to allow for an in-depth understanding of the context and the research phenomenon from the perspectives of selected organisational stakeholders. Step One was to explore which organisational stakeholders could potentially be recruited to participate in the PAR based on their availability, and engagement in the community at the time of the study and their characteristics (nature). Once identified, Step Two was to explore these stakeholders' perspectives regarding the construction and description of a sustainable community coalition to manage alcohol misuse as a risk factor of HIV infection and to invite them to take part in the PAR.

Descriptive qualitative research observes, describes, and documents aspects of a situation in a natural setting (Polit & Beck 2017:206). Gray et al (2017:200) concur

that descriptive research is undertaken in a natural setting and offers researchers an opportunity to collect, identify and analyse data to understand and describe new meanings of the data. In this study, I present my interaction with the organisational stakeholders in substantial detail by describing the findings. I focused on portraying the deeper meaning of their experiences of the research phenomenon in the natural setting by using their own words in order to create change. In addition, I aimed to describe the different concepts and relationships relating to the sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection.

The contextual nature of this qualitative study was firmly entrenched in the social, political and economic context in which a sustainable coalition should operate. Bradley (2017:40), with reference to sustainable coalitions, argues that there are various contextual factors in the natural context that affects its operation, *inter alia,* political climate, geography, history of collaboration and funding. Loewenson et al (2014:40) support this view and argue that PAR is best suited to understand and transform people directly affected by the conditions.

The community in this study, as described in Chapter 1 (see Section 1.2.2), is characterised by a high incidence of alcohol misuse and HIV infection. A high rate of unemployment, especially among the youth, is linked to alcohol misuse and the spread of HIV in the community under study. Virtanen, Lintonen, Westerlund, Nummi, Urban, Janlet and Hammarström (2016:5) also found a link between alcohol misuse and unemployment, and Harhay, Bor, Basu, McKee, Mindell, Shelton and Stuckler (2013:410) suggest that people attempt to relieve the painful experiences of unemployment through alcohol consumption. Alcohol misuse in the community under study may therefore be linked to a high rate of unemployment.

The theory-generative design refers to drawing together accumulated facts and making sense of them (Polit & Beck 2017:121). According to Loewenson et al (2014:40), theory in PAR is developed by reflecting on the collective lived experiences of those affected. In this study, I worked in collaboration with organisational stakeholders throughout the study. I listened to their voices in shaping the research and built evidence to develop theory in the form of a sustainable

community coalition conceptual framework to manage alcohol misuse as a risk factor of HIV infection.

3.4 RESEARCH METHODS

Polit and Beck (2017:743) describe 'research methods' as the techniques to structure a study by systematically collecting and analysing relevant data. In the section that follows, I describe the methods that were used in the cyclic PAR process with reference to the population and sampling, inclusion and exclusion criteria, recruitment of participants, the role of the researcher, data collection methods, data analysis, and the construction and description of the conceptual framework.

3.4.1 Population and sampling

The population is described as the entire set of individuals or objects having some common characteristics (Polit & Beck 2017:739). Accessible population is the aggregate of cases that conform to designated criteria and that are accessible for a study. The target population is the aggregate of cases about which the researcher would like to generalise (Polit & Beck 2017:249). According to Statistics South African's Census 2011, the population in the community under study was 11 694 individuals aged 18 years and older (South Africa 2012). The population in this study is all individuals and organisational stakeholders affected by alcohol misuse as a risk factor of HIV infection in the community under study.

Purposeful and snowball sampling was used to select participants from the population. Purposive sampling uses the researcher's knowledge about the population to make participants' selection. Snowball sampling is a variant of convenience in which early sampling members are asked to refer other people who meet the eligibility criteria (Polit & Beck 2017:252-254). I used purposive and snowball sampling (Gray et al 2017:345) as non-probability sampling methods whereby the participants were selected with the aim of identifying relevant data, categories of data, patterns and data relationships, ultimately aiming to achieve data saturation (Polit & Beck 2017:741). Polit and Beck (2017:492) support the use of snowballing as a method of sampling by requesting early participants to refer other

potential participants. In qualitative studies, the sample size is reliant on information needs, to the point at which data saturation is reached (Gray et al 2017:352; Polit & Beck 2017:497).

3.4.1.1 Phase One - Sample 1: Key informants

The sample for Phase One was composed of 10 key informants aged between 24 and 65 years in the community, who satisfied the inclusion criteria set out in Section 3.4.1.2. These were a tavern owner, local business owner, a member of a FBO, a member of local government, a sports centre manager, a member of a local NGO, a project manager of a drug abuse NGO, a general manager of a drug abuse NGO, a supervisor of dance club organisation, and a social worker. Six of the participants were females and four were males. The sample for phase one is summarised in Table 3.1.The demographic profile of participants during this phase is presented under the findings in Chapter 4 (Section 4.2).

Table 3.1: Phase One: Sample of individuals in the community (key informants)

Key informants	N
Tavern owner	1
Local business owner	1
A member of a FBO	1
A member of local government	1
A sports centre manager	1
A member of local NGO	1
A project manager of a drug abuse NGO	1
A general manager of a drug abuse NGO	1
A supervisor of a dance club organisation	1
A social worker	1
Total (N)	**10**

3.4.1.2 Phases Two to Four- Sample 2: Organisational stakeholders

The population in Phases Two to Four was all organisational stakeholders in the community affected by alcohol misuse as a risk factor of HIV infection. A total of 21 organisations, such as NGOs, NPOs and relevant government departments that included the Department of Social Development, Health, South African Police Services and Local government, were identified in the community under study. The final sample for Phases Two to Four were organisational stakeholders in the community that satisfied the inclusion criteria as described in Section 3.4.1.2. The sample of organisational stakeholders is summarised in Table 3.2. The demographic profile of participants of these phases is presented under the findings in Chapter 5 (Section 5.2).

Table 3.2: Phases Two to Four: Sample of organizational stakeholders in the community

Organizations	N
NGOs	7
NPOs	6
FBOs	4
Government Departments	4
Total (N)	**21**

3.4.1.3 Phase Five - Sample 3: Experts

In this phase, a sample of five experts in the field of substance misuse that met the inclusion criteria described in Section 3.4.2 participated in the study to evaluate the conceptual framework, described in more detail in Section 3.4.7.

3.4.2 Sampling criteria

The sampling criteria were considered in terms of being mindful of social justice, ethical principles and the integrity of the research. Filmalter (2016:26) argues that action research occurs in a specific context and social justice implications make it

important to include the people or organisations that are involved in decision-making and implementation processes that may have a direct or indirect effect on people's lives. Zuber-Skerritt (2015:7) concurs that PAR is aimed at social justice and the equality of participants.

3.4.2.1 Phase One - Sample 1: Key informants

Inclusion criteria

During Phase One of the study, the following inclusion criteria were applied in selecting key informants: To participate in the key informant interview, participants had to have knowledge and understanding of alcohol misuse, its potential link to HIV, and what can be done to manage the problem on a local level. Therefore, they had to be able to answer relevant questions that would ultimately inform the management of alcohol misuse as a risk factor of HIV. Their understanding was determined with the assistance of those who referred me to these participants. In addition, they had to be 18 years and older in order to consent to participate, available to participate in the study, and residing in the specific area under study to provide relevant data.

Exclusion Criteria

Participants younger than 18 years were excluded from participating in the key informant interviews as they were considered to be minors and legally could not provide informed consent to participate. Furthermore, people who were not residents of the community under study were excluded on the basis that they would not provide sufficient information about the research phenomenon relevant to the specific community under study.

3.4.2.2 Phases Two to Four - Sample 2: Organisational stakeholders

Inclusion criteria

During Phases Two to Four of the study, the following inclusion criteria were applied in selecting organisational stakeholders: participants had to have knowledge of the area and the research phenomenon, be over the age of 18 years, available to participate in the study, and the organisations to which they were affiliated operated in the specific community under study.

Exclusion criteria

Organisational stakeholders affiliated with an organisation that does not operate in the specific area under study were excluded from participating in the study.

3.4.2.3 Phase Five - Sample 3: Experts (for evaluation purposes)

Inclusion criteria

During Phase Five of the study, the following inclusion criteria were applied in selecting experts: Study participants had to have a minimum master's degree in health and/or social sciences or related fields, had conducted research in the field of health, had knowledge and experience in theory or conceptual framework development, had knowledge and experience in substance misuse and/or HIV research.

Exclusion criteria

Experts who had not worked on substance misuse and/or HIV research were excluded from phase five of the study.

The sampling criteria considered during different phases of this study are summarised in Table 3.3

Table 3.3: Sampling criteria considered during Phases One to Five of the study

Phases	Inclusion Criteria	Exclusion criteria	Number of participants	Participants characteristics
Phase 1 Sample: Key informants	Knowledge of alcohol misuse and its potential link with HIV infection Have knowledge of possible intervention to manage alcohol misuse as a risk factor of HIV infection Be 18 years and older Available to participate in the study Residing in the specific area under study	Below 18 years People not residing in the community under study	10 Key informants	• Tavern owner (age 36 years, female) • Local business owner (age 32 years, male) • FBO member (age 65 years, female) • Local government (age 36 years, male) • Sports centre manager (age 31 years, female) • Local NGO (age 35 years, female) • Project manager of a drug abuse NGO (39 years, male) • General Manager of Drug abuse NGO (age 55 years,

Phases	Inclusion Criteria	Exclusion criteria	Number of participants	Participants characteristics
				female) • Supervisor of Dance club organisation (age 27 years, male) • Social Worker (24 years, female)
Phase 2-4 Sample: Key Informants	Presumed to have knowledge of the area and the research phenomenon, over the age of 18 years, Available to participate in the study, the organisations they affiliated to were operating in the specific community under the research study.	Organisational stakeholders belonging to organisation that does not operate in the specific area under study	Minimum of 8 and maximum of 52 organisational stakeholders	• Aged between 20-65 years drawn from organisations that included: NPOs, NGOs, FBOs, local government, local drug treatment centre, local sub-district Department of Health, SAMRC, youth representatives and community policing forum
Phase 5 Sample: Experts	A minimum of master's level degree in health and/or social sciences Having had conducted research in the field of health, knowledge and experience in theory or conceptual framework development, Have knowledge and experience in substance abuse and/or HIV research.	Experts who have not worked on substance abuse and/or HIV research were excluded	5 experts in the field of substance misuse	• Central Drug Authority and University of the North West Researcher • Two researchers from the SAMRC with master's degree and working on substance misuse and HIV research project • A researcher from the University of Pretoria with PhD qualification, focus area on alcohol misuse • Gauteng Department of Health mental health nurse managers, with a focus area on substance misuse

3.4.3 Recruitment of participants

Participants for Phases One to Four were recruited through snowballing, in which early informants were asked to refer other study participants until data saturation was reached. Polit and Beck (2017:492) argue that snowball sampling has the advantage that it is more cost efficient and practical, and that it strengthens trusting relationships with new participants. The recruitment of participant is described in more detail in Sections 3.4.3.1 to 3.4.3.3.

3.4.3.1 Phase One: Sample 1 - Key informants

During Phase One, the ward counsellor recommended the first key informant. Subsequent participants who met the inclusion criteria (Section 3.4.1.2) were

selected based on the recommendations of current participants until data saturation was reached.

3.4.3.2 Phases Two to Four: Sample 2 - Organisational stakeholders

Organisational stakeholders helped in the recruitment of participants through the identification of key informants. The recruitment of organisational stakeholders through Phases Two to Four was done by writing letters to organisational stakeholders identified with the help of key informants inviting them to participate in this study (Annexure A). These organisational stakeholders were invited to attend stakeholder dialogue meetings to share information about the research study and to negotiate their prospective future participation in the study. Furthermore, invitation pamphlets were placed in strategic areas such as shops, churches, taverns, and the police station in the community, to ensure exposure of the invitation to all relevant organisational stakeholders in the community. Individuals from a variety of organisational stakeholders that included NGOs, FBOs, and government departments were identified to participate in the study.

Dialogue meetings were scheduled with organisational stakeholder to identify organisational stakeholders who were affiliated with these organisations in order to invite them to participate in the reflective engagement process needed for planning, as well as to obtain their buy-in to ultimately participate in taking action in the proposed sustainable community coalition to manage alcohol misuse as a risk factor of HIV infection.

3.4.3.3 Phase Five: Sample 3 - Experts

In this phase, five experts in the field of substance misuse were contacted telephonically and asked if they were available and willing to participate in the current study. Upon agreeing, they were sent the framework as well as an evaluation tool for evaluation and feedback (described in more detail in Section 3.4.5).

3.4.4 Role of the researcher

My role is described in line with the role of a researcher according to Wittmayer and Schäpke (2014:2), which includes me being a change agent, knowledge broker, reflective scientist, and facilitator. My role as a change agent was that of motivating organisational stakeholders to participate in the PAR by creating a space to freely voice their own views about alcohol misuse as a risk factor of HIV infection. During Phase One of this study, I initiated a discussion on alcohol and HIV-related challenges through key informant interviews. Participating as key informants served as a space for this group of organisational stakeholders to share their experiences of alcohol misuse as a risk factor of HIV infection at the local level.

Through the sharing of experiences, participants were motivated and empowered to identify and address local challenges faced by the community (Wittmayer & Schäpke 2014:2). During Phases Two to Four (dialogue meetings), I created an opportunity for organisational stakeholders to network with people outside the local environment such as researchers from the South African Medical Research Council (SAMRC). The researchers from the SAMRC have extensive experience with research relevant to the management of alcohol misuse as a risk factor of HIV infection and therefore contributed in sharing their experiences on the research phenomena. Furthermore, during dialogue meeting four, I linked organisational stakeholders to district governmental officials in order to strengthen support structures in the government sphere.

My role as knowledge broker was that of creating an opportunity for organisational stakeholders to establish a common understanding of challenges faced by the community, as well as promoting a shared vision between organisational stakeholders in the community (Wittmayer & Schäpke 2014:9). McCall, Mollison, Parker and Pauly (2017:37) describe a knowledge broker as acting as a link between academics and knowledge users, and include activities such as being a linking agent, capacity building and knowledge sharing. In this study, I promoted an opportunity for knowledge exchange among organisational stakeholders, facilitated the development of positive attitudes towards research, and engaged organisational stakeholders as knowledge users to create a shared understanding of knowledge

(McCall et al 2017:43). This was done by creating a space to share experiences and ideas on the management of alcohol misuse as a risk factor of HIV infection through dialogue meetings.

During the study, I systematically collected data, analysed the data, and interpreted and shared the data with organisational stakeholders throughout the PAR cycle in line with my role as a reflective scientist (Wittmayer & Schäpke 2014:7). As a facilitator, I initiated the PAR process through the selection of participants, I introduced participants to the PAR process, and introduced the research area to organisational stakeholders through dialogue meetings. My role was that of facilitating organisational stakeholders to engage in dialogue sessions to share ideas and experiences of how alcohol misuse as a risk factor of HIV infection can be managed at a local level and how to take action for change. Furthermore, I organised and facilitated dialogue meetings and created an opportunity for organisational stakeholders to take action regarding the management of alcohol misuse as a risk factor of HIV infection in this setting.

3.4.5 Role of organisational stakeholders

Organisational stakeholders, as participants, played a role as change agents, generating and using evidence to implement change. They assisted with compiling a list of other organisations in the community who could participate in the coalition. They played a role in the recruitment of youth and alcohol outlet owners. A study by Bradley (2017:142) confirms the role of coalition representatives in recruiting participants as increasing coalition membership and diversity. Organisational stakeholders participated in identifying and planning activities to manage alcohol misuse as a risk factor of HIV infection. Furthermore, organisational stakeholders performed actual activities of identifying and implementing activities to manage alcohol misuse as a risk factor of HIV infection, such as distributing condoms at venues serving alcohol.

3.4.6 Data collection methods

Data collection methods refer to a technique of gathering information to answer a research question (Polit & Beck 2017:725). In this study, I used multiple data collection methods that include key informant interviews, field notes and the minutes of dialogue meetings.

3.4.6.1 Phase One – Key informants interviews and field notes

During Phase One, data were collected through key informant interviews using interview guide (Annexure B) and field notes. A key informant is a person who has relevant information and is willing to share information on the phenomenon under study with the researcher (Polit & Beck 2017:733). Interviews were conducted in Phase One with key informants who were presumed to be well informed about alcohol misuse as a risk factor of HIV infection in the specific community of the North West Province, South Africa. These individuals were willing to share their experiences without bias as recommended by Peersman (2014:i). Interviews were audio-recorded and subsequently transcribed verbatim (refer to Annexure C for an example of transcribed data). This was to ensure that interview data are participants' actual responses (Polit & Beck 2017:508).

The first key informant was recruited through the recommendation by the ward counsellor of the community, as previously mentioned. My research supervisor and co-supervisor accompanied me to the first key informant interview session as part of peer debriefing and peer examination. Subsequent participants who met the inclusion criteria were selected based on the recommendations of participants until data saturation was reached. The questions that guided the key informant interview were:

- Tell me about the type of organisations affected by alcohol misuse as a risk factor of HIV infection in this community.
- Tell me about the nature of organisations affected by alcohol misuse as a risk factor of HIV infection in this community.

- What are your views about alcohol misuse as a risk factor of HIV infection in this community?
- What is it like to be a member of this community with a high incidence of alcohol misuse and HIV infection (referring to the role of a key informant)?
- Tell me about activities undertaken by individuals from organisations in this community to manage alcohol misuse as a risk factor of HIV infection.
- How can individuals from organisations participate to establish and sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection?

To ensure that key informants understand concepts such as community coalition, these concepts were briefly explained to participants in a language they understand. When answering the questions, participants had the opportunity to express the concepts in their own words and probing was used to explore the concepts further. I used bracketing to mitigate any potential personal views that may affect the study. Polit and Beck (2017:721) describe bracketing as the process of identifying and witholding any preconceived beliefs and opinions about the phenomenon under study.

The 10 key informant interviews were conducted in either Setswana or English as preferred by the key informant. Interviews were audio recorded. Data collected in Setswana were firstly transcribed verbatim (Annexure C), followed by translation into English (Annexures D). As Setswana is my first language, I did the translation myself and kept records of both the Setswana and English version. Interviews were conducted at different places as preferred by the key informants, such as participants' homes or workplaces. Venue for data collection is described in Table 4.1 in the findings section. For the purpose of triangulation, I wrote field notes to record the unstructured observations made (Annexure E). These included observational, theoretical, methodologic, and personal notes (Polit & Beck 2017:521-522).

a) Observational notes

Polit and Beck (2017:736) refer to observational notes as the researcher's in-depth description of events and interactions in a natural setting. During this study, I documented what I observed in the field to assist in understanding the context of the study. During key informant interviews with participants, I documented nonverbal communication cues such as body language and facial expressions to attach meaning to what was said and what I observed.

b) Methodologic notes

Methodologic notes are reflections on what is observed, and can serve as a reminder to the researcher on how subsequent observation will be made through early identification of strategies that have been identified as effective or ineffective (Polit & Beck 2017:523). During Phase One, I documented the importance of asking open-ended questions and using probing techniques that were effective in generating a deeper understanding of concepts generated during the interview. This helped me to safeguard against the possibility of asking leading questions.

c) Theoretical notes

Theoretical notes serve as an initial point for data analysis. In this study, I documented my own thoughts to assist me in making sense of what was going on during the key informant interviews by attaching meaning to what I observed (Polit & Beck 2017:522).

d) Personal notes

Personal notes are records about the researcher's experience in the field (Polit & Beck 2017:522). Reflecting on such experiences assists the researcher to guard against actions that can have an influence on what is being observed in the participant's role. During this phase, I acknowledged and documented my inner feelings, such as my motivation to work with the community in identifying and

developing a practical solution in solving challenges experienced by stakeholders in the community.

3.4.6.2 Phases Two to Four – Attendance register and minutes of meetings

Ten dialogue meetings were conducted during Phases Two to Four of the research study. McNiff (2017:26) states that dialogues occur when we communicate with others and involves actively listening to others to achieve mutual understanding. Kim (2016:41) argues that in PAR, the dialogue meetings are used to critically analyse social issues from participants' lived experiences to understand critical consciousness. The aim of dialogue meetings in this study was to create an opportunity for organisational stakeholders to discuss and share experiences of alcohol and HIV issues affecting them in order to create change (Refer to Section 3.4.1.2). During dialogue meeting four, I was accompanied by my research supervisor and co-supervisor as part of peer debriefing and examination.

Attendance was recorded in attendance registers and minutes of meetings were kept during all four phases (refer to Annexure F for a sample of minutes of meetings). Organisational stakeholder dialogue meetings were held using resources in the community that included a school hall, local government offices and a local church hall. I facilitated dialogue meetings. Each meeting lasted for about four hours and was operationalised in three distinct phases, namely welcome and introduction associated with the aim of the dialogue session, information sharing, and finally the wrap-up and closing of the dialogue session.

During the introduction, each participant introduced himself/herself by name, the type and role of organisation they come from, as well as expectations from the dialogue meeting. I introduced myself and provided organisational stakeholders the background and aim of the study. During the first meeting, I explained that the aim of the study was to construct and describe a sustainable community coalition framework to manage alcohol misuse as a risk factor of HIV infection. Organisational stakeholders were informed that key informant interviews were conducted during Phase One of the study to gather information on alcohol misuse as a risk factor of

HIV infection. Preliminary findings from Phase One were shared with organisational stakeholders for their reflection.

Organisational stakeholders were given an opportunity to reflect on the preliminary findings and to suggest activities to be undertaken to manage alcohol misuse as a risk factor of HIV infection. This was followed by wrap-up and consensual agreement on the next step as well as proposed dates of the next meetings. In addition, during subsequent meetings two to ten, organisational stakeholders reviewed minutes of the previous meetings, adopted the minutes and discussed matters arising from the previous meeting in order to provide feedback on activities undertaken since the previous meeting. Data were collected in the form of minutes of dialogue meetings.

Dialogue meetings were held in a venue in the community, which is within a 5 km radius from where the organisational stakeholders reside. Therefore ,there was no need for transport fare to attend dialogue meetings. As the dialogue meeting lasted for about four hours, refreshments in the form of snacks, bread and soft drink were provided for free.

3.4.6.3 Phase Five – Framework evaluation tool

Five independent experts in the field of substance misuse were requested to evaluate the conceptual framework. An evaluation template was used based on the criteria of theory generation as described by Chinn and Kramer (2011:197-205). These included clarity, simplicity, generality, accessibility, and importance to evaluate the framework. The four-point Likert scale was used according to the following calibrations: strongly disagree, disagree to some extent, agree to some extent, and strongly agree.

3.4.7 Bias

Polit and Beck (2017:161) define bias as any influence that distorts the findings of the study and undermines trustworthiness or error. Bias can result from the researcher (subjective), participant, and study methods. To guard against my own bias I might bring to the study, I used reflexivity and bracketing by actively engaging

in critical self-reflexion (Cypress 2017:259). Furthermore, during data analysis, I used an independent coder to code the data independently. To guard against participants' bias, I used purposeful sampling and snowball sampling to obtain rich information from a variety of key informants and organisational stakeholders, as reflected in Table 4.1 and Table 5.1, respectively. I also used triangulation, which is multiple data collection methods, such as key informants interviews, filed notes and minutes of dialogue meetings to minimise bias. As described by Fusch, Fusch and Ness (2018:2), one approach to mitigate bias is through triangulation.

3.4.8 Data analysis

Data analysis refers to systematic organising and synthesis of data (Polit & Beck 2017:725). The data analysis process is about making sense of data through exploring an in-depth understanding of the data, presenting the data, and interpreting the meaning of the data (Creswell & Creswell 2018:190-198). I transcribed the data that were generated from interviews verbatim, read minutes that were captured during the dialogue meetings and field notes. Thematic analysis of data collected during the four phases was done following the steps described by Creswell and Creswell (2018:193-195).

3.4.8.1 Phase One

To enhance credibility, during Phase One I analysed the data independently and involved an independent coder to also code the data independently. The coder and I then met to compare, merge and agree on the independently analysed data. The independent coder was requested to sign a confidentiality agreement (Annexure G). Polit and Beck (2017:533) argue that it is prudent to have data independently analysed by two or more people to enhance reliability. The following steps, as discussed by Creswell and Creswell (2018:193-195), were followed in analysing the data:

Step One: Organising and preparing data for analysis

This involves sorting and organising data. All data collected through the audio-recorder, minutes of dialogue meetings and field notes were systematically organised for analysis. Data collected through the audio-recorder were transcribed verbatim, and translated into English when necessary.

Step Two: Reading through all the data

All typed data were read to get a general sense and to reflect on the overall meaning. The key descriptive wording for topics were identified and classified into categories. Data materials belonging to the same category were assembled together to perform a tentative analysis.

Step Three: Start the coding process

Coding involves categorising data and labelling similar categories with a term, assembling the data material belonging to the same category in one place and performing an initial analysis (Creswell & Creswell 2018:193-195).

Step Four: Use the coding process

The coding process was used to produce a description of the setting, data about people, places or events as well as categories and used themes for analysis.

Step Five: Advance on how the description and themes will be represented

Themes were described in a narrative passage to present the findings of the analysis. In addition, tables were used to summarise themes and findings.

3.4.8.2 Phases Two to Four

Minutes of meetings that were captured during the dialogue meetings and field notes were analysed following the steps as described by Creswell and Creswell (2018:193-

195), discussed in Section 3.4.3. Organisational stakeholder representatives participated in data analysis through the sharing of findings from Phase One of the study.

3.4.8.3 Phase Five

During Phase Five, data analysis was done by identifying key themes on comments made by experts.

3.4.9 Construction and description of the conceptual framework

The objective of Phase Five was to construct and describe a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. The conceptual framework in this study refers to a number of abstract and related concepts that describe a sustainable community coalition for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. The framework reflects Dickoff et al's (1968:423) thinking map, with reference to the agent, recipient, dynamic, procedure, context and outcome.

The conceptual framework was developed by identifying and bringing together key concepts generated through the PAR research process and existing literature to give a broader understanding of possible relationships between these concepts (Imenda 2014:189). I presented the conceptual framework to experts in the field of substance misuse who met the inclusion criteria for evaluation and refinement.

The experts evaluated the conceptual framework by using and evaluation template based on criteria of theory generation as described by Chinn and Kramer (2011:197-205). These included clarity, simplicity, generality, accessibility, and importance to evaluate the framework. The four-point Likert scale was used according to the following calibrations: strongly disagree, disagree to some extent, agree to some extent, and strongly agree. Furthermore, participants were asked to provide comments (Please refer to Annexure H). Feedback from the evaluation is discussed in Chapter 7, Section 7.3.

3.5 TRUSTWORTHINESS

It is important to conduct high-quality research. There have been debates on scientific terms to be used to describe research quality due to differences in paradigms and philosophical views. Given that the standard of reliability and validity has been used in quantitative research, Polit and Beck (2017:322) recommend the use of the concept 'trustworthiness' as described by Lincoln and Guba (cited in Polit & Beck 2017:559) which has been widely accepted and applied in qualitative research. The concepts described are credibility, dependability, confirmability, transferability, authenticity (Polit & Beck 2017:559) and reflexivity (Gray et al 2017:65).

3.5.1 Credibility

Credibility is confidence in the truth and interpretation of the data (Polit & Beck 2017:559). Polit and Beck (2017:559) argue that qualitative researchers should consider establishing confidence in the truth of the research findings by enhancing the believability of the findings to research consumers. To demonstrate the credibility of the research, I implemented the following strategies; prolonged engagement, triangulation, member checking, peer debriefing, reflexivity, authority of researcher and supervisor, peer examination, structural coherence and creating a chain of evidence, and referral adequacy.

3.5.1.1 Prolonged engagement

Prolonged engagement refers to the presence of the researcher at the research site for a sufficient duration (Creswell & Creswell 2018:201). Creswell and Creswell (2018:200) argue that prolonged engagement with study participants strengthens the credibility of the research data and findings. I was with participants in monthly meetings for a minimum of two years. Furthermore, I attended two community meetings in which social and structural factors that affect the community were discussed. The two community meetings were organised independently from my own research.

3.5.1.2 Triangulation

Triangulation is the use of multiple data collection techniques to enhance believability on what constitutes the truth (Polit & Beck 2017:161). Multiple data collection methods strengthen the credibility of data, deepen understanding and produce a stronger account of the phenomenon under study by combining multiple views or perspectives of the study. Multiple data collection techniques, through key informants interviews, field notes, and minutes of dialogue meetings, were used to draw conclusions about what constitutes the truth within the context of the study.

3.5.1.3 Member checking

Member checking is a technique of validating the credibility of research findings by creating a space for participants to confirm the accuracy of data (Polit & Beck 2017:565). I presented preliminary findings of the study to organisational stakeholder representatives during Phase Two of this research study to give them an opportunity to reflect on their thoughts about the findings. Moreover, during Phases Three and Four organisational stakeholders were asked to reflect and agree on what was discussed in the previous meeting.

3.5.1.4 Peer debriefing

Peer debriefing involves discussion with other researchers to review their perspectives, reactions, and analysis as they go through the research (Polit & Beck 2017:568). I engaged with my research supervisors, organisational stakeholders and other researchers who are experts in the field of alcohol misuse on an ongoing basis throughout the research process.

3.5.1.5 Reflexivity

Reflexivity refers to the researcher's reflection on how his or her own potential biases and presence in the research setting may influence how data were collected, synthesised and interpreted (Gray et al 2017:65). The reflexivity process requires a conscious awareness of self during the research process and keeping records on

issues that might influence data collection and the interpretation thereof. I was reflective in the decisions made during the research process by critically thinking and documenting the dynamic interaction between myself and participants as reflected in the personal notes.

3.5.1.6 Authority of the researcher and research supervisors

I have obtained a master's degree in mental health, passed an advanced research skills course and completed a research project at master's level. I have also passed a research proposal module for the completion of a doctoral degree. I am currently working on mental health and substance abuse policy in a government department. I am the author of two peer-reviewed papers, one as the first author. The principal supervisor has a doctoral degree and experience in supervising postgraduate students. She has experience in research methodology and is currently working in a research and academic environment. She has experience in facilitating research methodology and research ethics workshops, regularly presents at academic conferences, has co-authored nine papers in peer-reviewed journals, two book chapters and is a co-editor of a book on social science research ethics in Africa. The co-supervisor has experience in research, has a doctoral degree, experience in presenting at workshops and conferences, and is an NRF rated researcher with more than 34 papers published in peer-reviewed journals.

3.5.1.7 Peer examination

Peer examination involved reflective conversations between the researcher, other researchers, research supervisors and participants regarding project planning, implementation and evaluation. As described by Anney (2014:279), peer examination assists in strengthening the credibility of the research process. I involved research supervisors for evaluation and feedback throughout the research process. Furthermore, I presented the research methodology and findings to research colleagues for appraisal.

3.5.2 Confirmability

Confirmability is the potential for congruence between two or more people (Polit & Beck 2017:559-560). I involved an independent coder to assist with data analysis and ensure the accuracy of the data. I also involved a research supervisor and a co-supervisor who have extensive experience in research methodology. Furthermore, I involved research participants in validating the findings. A literature control was included throughout the study.

3.5.3 Transferability

Transferability is the extent to which qualitative findings can be applied to other settings (Polit & Beck 2017:560). As described by Polit and Beck (2017:560), the aim of qualitative researchers is not to generalise but to generate knowledge that might be applied in other situations. In this study, I kept sufficient records on all aspects of the research process to enable other research users to evaluate the applicability of the findings to other settings. I documented the type and number of people taking part in the study, inclusion and exclusion criteria, data collection methods, the number of data collection sessions, as well as the timeframe in which data were collected. A rich, vigorous presentation of data, data analysis and findings were documented.

3.5.4 Dependability

Dependability refers to the consistency of data over time (Polit & Beck 2017:559). To strengthen dependability, I involved organisational stakeholders during Phase Two (reflection on the findings) through reflexive engagement on the findings. A dense description of research methods and findings is provided. Triangulation of data through different data sources such as key informant interview, and minutes of dialogue meetings, was used to add to the dependability of the study. I kept records of field notes. During data analysis, I involved an independent coder to reach consensus on identified themes. I applied a stepwise replication whereby an independent qualitative researcher and I analysed data separately and compared the findings (Anney 2014:278).

3.5.5 Authenticity

Authenticity is the extent to which researchers fairly and faithfully demonstrate different realities throughout their research (Polit & Beck 2017:560). The principle of fairness was demonstrated through honouring all voices, views and perspective of the research participants. Multiple perspectives were used in verbatim quotes and observations. I strove to exercise balance in representing the experiences, thoughts, perception and feelings of study participants.

Shannon and Hambacher (2014:2) refer to ontological authenticity as the extent to which participants understand the complexity of the social environment. In this study, I empowered organisational stakeholders to gain insight into the phenomenon being studied. I worked in collaboration with organisational stakeholders to improve their understanding of community coalition, action research and the management of alcohol misuse as a risk factor of HIV infection. I appreciated the viewpoints of participants and encouraged participants to appreciate the viewpoints of others.

Catalytic authenticity is examining the extent to which the research process leads to actions for change (Shannon & Hambacher 2014:2). In this study, I reflected my thoughts on how organisational stakeholders took actions for change in the management of alcohol misuse as a risk factor of HIV infection. Tactical authenticity is the extent of empowerment of participants to act on the improved understanding that emerged from the study (Shannon & Hambacher 2014:2). I continuously reflected on improvement in organisational stakeholder representatives' skills, and encouraged them to reflect on changes in skill during the research process.

3.6 ETHICAL PRINCIPLES

Ethics approval was granted by the Departmental Higher Degrees Committee of the School of Health Sciences Research Ethics Committee (REC), University of South Africa, Department of Health Studies (Annexure I), the North West Department of Health Policy Planning, Research Monitoring and Evaluation (Annexure J), Sub-district Department of Health (Annexure K) and the local government councillor (Annexure L) before conducting the study. The informed consent was written in

English (Annexure M) and Setswana (Annexure N), and explained in the language preferred by each participant. Furthermore, I adhered to the Belmont Report's ethical principles (Polit & Beck 2017:138) that are also promoted in the Unisa Policy on Research Ethics (UNISA 2016:1-33), namely beneficence, non-maleficence, human dignity and justice.

3.6.1 Beneficence

Polit and Beck (2017:139) state that human research should produce benefits for study participants and society as a whole. In line with the PAR philosophy, the research focused on the needs of individuals, families and organisations in the community in order to address their public health needs (Loewenson et al 2014:90). I worked in collaboration with organisational stakeholders to ensure mutual benefit for both myself and the community by tapping into the local knowledge of these stakeholders relating to the research phenomenon. To ensure that these mutual benefits were attained, the findings of the research were shared with organisational stakeholders during the different phases of the research.

I worked with organisational stakeholders to assess and identify problems associated with alcohol misuse as a risk factor of HIV infection, responded to organisational stakeholder needs while respecting their attitudes and valuing their opinions, ensured full participation and community involvement by creating social and structural factors that enhanced community participation. They further assisted in defining the potential benefits derived from taking action towards addressing the problem and ensuring that the research study provided the best possible intervention to manage alcohol misuse as a risk factor of HIV infection. Organisational stakeholders were given an opportunity to play a role in determining what they thought was the best intervention to manage alcohol misuse as a risk factor of HIV infection.

In addition, I promoted beneficence in this research by being sensitive to the credibility of science. I used credible data sources such as referencing from peer-reviewed literature and published statistics to reflect the reality of the research phenomenon as evidenced by scholarly literature and demographic information

about sustainable community coalition, and alcohol misuse as a risk factor of HIV infection. Qualified and experienced researchers, such as my research supervisors, were involved in providing peer review during the research process. Furthermore, the outcome of the study, namely a sustainable community coalition framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection, could be applied to address the problems in this community.

3.6.2 Non-maleficence

Non-maleficence is about ensuring that research participants do not experience any harm due to participating in the study (Loewenson et al 2014:74). Harm may be physical, social, emotional, spiritual, economic or psychological (Loewenson et al 2014:75). Both the REC and I identified this as a low-risk study, since the participants' involvement was not anticipated to increase the risk of harm or discomfort above everyday threshold (Unisa 2016:13). The participants were adults, and even though the discussions focused on alcohol misuse as a risk factor of HIV, the intention was to create a sense of empowerment for those involved. I aimed to minimise the possibility of risk of harm as far as possible by being sensitive regarding the psychological and social well being of participants through the entire research process. Careful consideration was given to framing questions to minimise social and emotional harm. Participants were provided with information and contact details of organisations that offer free counselling services, such as the South African Depression and Anxiety Group (SADAG).

3.6.3 Respect for human dignity

Respect for human dignity refers to the right to self-determination and the rights to full disclosure (Polit & Beck 2017:140). Prospective participants had a choice to voluntarily decide to participate in the study, without risking any prejudicial treatment, and I informed participants of possible risks and benefits for participating in the study (Polit & Beck 2017:140).

I explained the research process to prospective participants and that they had a choice to decide to participate or withdraw from the study without having to give a

reason. During Phase One of the study, key informants were informed about the study, and were given an opportunity to ask questions before they signed an informed consent form. During Phases Two to Four of the research process organisational stakeholders were also informed of the research study and introduced to ethical principles relevant to PAR. During each of the dialogue meetings, organisational stakeholder representatives were reminded of ethical principles. To strengthen the understanding of ethical principles, a dialogue meeting (dialogue meeting 4) that specifically focused on ethics in PAR was conducted. My research supervisor and co-supervisor participated in the workshop as part of debriefing and peer examination.

Self-determination is the right for participants to make a decision to voluntarily participate in the study (Gray et al 2017:162). All potential participants received full information about the nature, aim, possible risks and benefits for participating in the study, that participating in the study was voluntary, and that they could withdraw from participating in the study without having to give any reason. They were informed that they would not suffer any consequences as a result of withdrawing from participating in the study.

Potential participants had sufficient time to go through the participant information leaflet and to ask questions in the language that they understood. Participants were informed that they would not receive any remuneration or incentives for participation in the form of gifts or money. After the participants had read and understood the participant information leaflet, they signed the consent form. The participation information leaflet, informed consent and interview guide were written in English and Setswana, and explained in the language preferred by a participant. Participants were informed that the findings of the study would be published in scientific journals by using pseudonyms to protect their identity.

Due to the unique nature of the PAR process in conduction the research in the community, to protect the participants and the community from the potential risk of stigmatisation relating to the focus of the study on alcohol misuse and HIV, I anonymised the name of the specific sub-district in which the study was conducted

throughout the thesis. Where relevant for citation purposes, I refer to the sub-district as a specific community in the North West Province.

3.6.4 Justice

Justice refers to treating participants equitably and fairly (Loewenson et al 2014:14). I ensured that all organisational stakeholders received fair and equal treatment without any discrimination and prejudice. The selection of participants was associated with the nature of the research design and not biased in terms of which organisations and organisational stakeholders should participate in the study. Care was taken that participants who did not agree to participate in the study did not suffer any ill effects because of their refusal to participate in the study (Polit & Beck 2017:144).

3.7 SUMMARY

In this chapter, I described the research design and methods. I discussed the PAR approach with reference to the population and sample, as well as data collection and analysis techniques. In order to ensure the trustworthiness of the findings, I discussed how credibility, confirmability, transferability, dependability and authenticity were considered. Finally, I described how ethical issues were taken into account in terms of autonomy, justice, beneficence and non-maleficence. In Chapter 4, I will discuss the findings.

CHAPTER 4
PHASE ONE: DESCRIPTION OF FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

In Chapter 3, I provided a description of the research design and the research methods. In this chapter, I present a narrative account and discussion of the findings of the data collected through 10 key informant interviews with organisational stakeholders, as described in Chapter 3 Section 3.4.1. The aim of this chapter is to identify and describe the type, nature and involvement of organisational stakeholders, and their perspectives regarding the construction and description of a sustainable community coalition conceptual framework to manage alcohol misuse as a risk factor of HIV infection in the community under study. The findings are related to Phase One of the PAR, namely to conduct a situational analysis to 'observe', thus gaining a better understanding of the context and research phenomenon. The findings of this study are re-contextualised within the existing literature. The chapter begins with the demographic profile of participants, followed by a description of the findings and a conclusion.

4.2 PARTICIPANTS' DEMOGRAPHIC PROFILE

During this phase of the study (Phase One), data were collected through interviews with 10 key informants consisting of four males and six females aged between 24 and 65 years. The demographic profile of the key informants is summarised in Table 4.1.

Table 4.1: Demographic profile of key informant participants

Key informant	Gender	Age	Language	Role in the community	Place of interview
1	Female	36 Years	Setswana	Tavern owner	Participant's Home
2	Male	32 Years	English	Business owner	Participant's Business
3	Female	65 Years	Setswana	Local NGO representative	Participant's Home
4	Male	36 Years	English	Local government representative	Participant's Workplace
5	Female	31 Years	English	Sports centre manager	Participant's workplace
6	Female	35 Years	Setswana	Member of NGO	Participants' workplace
7	Male	39 Years	English	Local religious Leader	Participants' workplace
8	Female	55 Years	Setswana	Manager of NGO	Participants' workplace
9	Male	27 Years	Setswana	Supervisor of Dance club	Participants' workplace
10	Female	24 Years	English	Social worker	University Campus

Table 4.2 summarises the number and percentage of the key informants in terms of gender, age, and language. A total of 10 key informants who participated in the study consisted of 40% males and 50% females. Sixty percent of the key informants were in the age range 31- 40 years, 20% in the age range 24-30 years, a10% in the age range 51-60 years, and another 10% in the age range 61-65 years. Half of the key informants were interviewed in English while the other 50% were interviewed in Setswana.

Table 4.2: Key informant participants demographic profile (Sample 1)

Key informant	n	%
GENDER		
Male	4	40
Female	6	60
TOTAL (N)	10	100
AGE in years		
24-30	2	20
31-40	6	60
41-50	0	0
51-60	1	10
61-65	1	10
TOTAL(N)	10	100
LANGUAGE		
English	5	50
Setswana	5	50
TOTAL(N)	10	100

4.3 DESCRIPTION OF FINDINGS AND LITERATURE CONTROL

As described in Chapter 3 (Section 3.4.4), data analysis was done following the steps as described by Creswell and Creswell (2018:193-198), and these were complemented by a control of literature to re-contextualise and support the research findings (Polit & Beck 2014:116). The findings are reflected with reference to the central storyline, four themes, related categories and codes. The categories are not mutually exclusive, and some overlapping occurs.

4.3.1 Central storyline

Findings from this phase of the study revealed that the community is characterised by a fragile community coalition at present that hampers the management of alcohol misuse as a risk factor of HIV infection. Organisational stakeholders in the community face grave alcohol and HIV-related challenges. A number of

organisations such as taverns, shebeens and social clubs increase community members' access to alcohol, ultimately contributing to alcohol misuse in the community. Organisations such as schools and FBOs are negatively affected by alcohol misuse. However, some organisations aim to manage alcohol misuse and HIV infection. Facilitating action and barriers to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection are identified. Findings are reflected in figure 4.1 (green quadrant), followed by a detailed discussion of each theme.

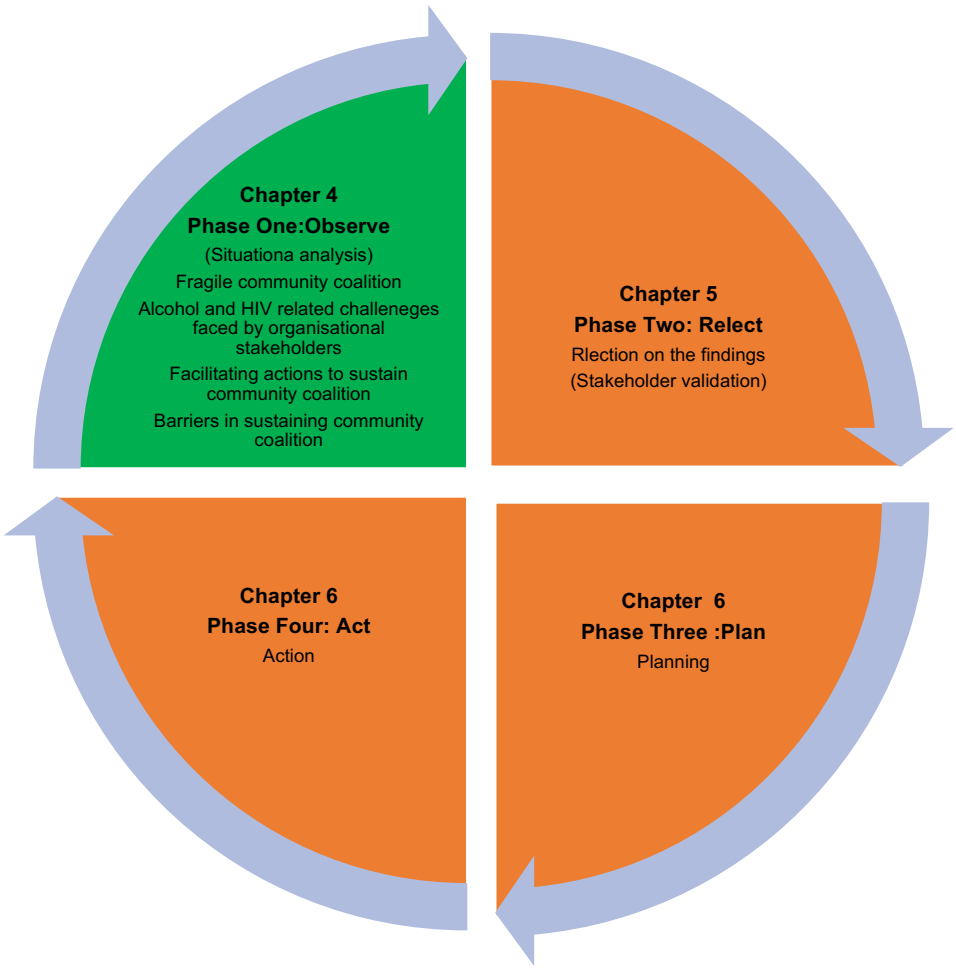


Figure 4.1: Situational analysis

The main themes and categories that emerged from the analysis of the data generated during this phase of the study are summarised in table 4.3.

Table 4.3: Main themes and categories that emerged from data analysis

Theme	Categories	Code
THEME 1 4.3.2 A fragile community coalition that hampers the management of alcohol misuse as a risk factor of HIV infection	4.3.2.1 Organisations that contribute to alcohol misuse as a risk factor of HIV infection	a) High alcohol outlet density (taverns and shebeens) b) High number of social clubs (stokvels)
	4.3.2.2 Organisations that are negatively affected by alcohol misuse as risk factor of HIV infection	a) Schools exposed to alcohol b) Faith-Based Organisations exposed to alcohol
	4.3.2.3 Organisations that manage alcohol misuse as a risk factor of HIV infection	a) The Primary Health Care clinic provides health promotional activities and support strategies b) NGOs provide health promotional activities c) Police manage alcohol misuse through law enforcement d) Faith-Based Organisations through spiritual counselling, prayer meeting and taking care of HIV victims
THEME 2 4.3.3 Alcohol and HIV-related challenges faced by organisational stakeholders	4.3.3.1 Heavy episodic drinking	a) Drinking daily b) Drinking without the limit
	4.3.3.2 Alcohol misuse as a risk factor of HIV infection	a) Sex without condom use b) Rape
	4.3.3.3 Attitudes of people towards alcohol misuse as a risk factor of HIV infection	a) Disrespect b) Denial c) Hopelessness
	4.3.3.4 Lack of parental guidance	a) Children send to buy alcohol b) Children given alcohol c) Parents drinking alcohol in front of children
	4.3.3.5 High rate of unemployment	a) Lack of employment opportunities
THEME 3 4.3.4 Facilitating actions to sustain community coalition	4.3.4.1 Organisational stakeholder unification	a) Organisational Unification
	4.3.4.2 Sharing a common vision	a) Sharing a common vision
	4.3.4.3 Perceived participation benefits	a) Perceived participant benefits

Theme	Categories	Code
THEME 4 4.3.5 Barriers in sustaining a community coalition	4.3.5.1 Ineffective communication 4.3.5.2 Lack of financial resources 4.3.5.3 Lack of Collaboration	a) Communication among stakeholders a) Insufficient funding a) Fragile collaboration

4.3.2 THEME 1: A FRAGILE COMMUNITY COALITION THAT HAMPERS THE MANAGEMENT OF ALCOHOL MISUSE AS A RISK FACTOR OF HIV INFECTION

Community coalition in this research, as defined in Chapter 1, refers to the formal alliance of diverse organisations in a specific community to support and maintain its activities for managing alcohol misuse as a risk factor of HIV infection. Participants describe the community as characterised by a fragile community coalition that hampers the management of alcohol misuse as a risk factor of HIV infection. Three categories of organisations affected by alcohol misuse include organisations that contribute to alcohol misuse as a risk factor of HIV infection, organisations that are negatively affected by alcohol misuse as a risk factor of HIV infection, and organisations that manage alcohol misuse and HIV infection. Each of the categories is described next.

4.3.2.1 Category 1: Organisations that contribute to alcohol misuse as a risk factor of HIV infection

The participants identified organisations that act as a driving force for alcohol misuse, thus increasing the risk for the spread of HIV infection relevant to the patrons of these organisations: firstly, alcohol outlets such as taverns and shebeens, and secondly, social clubs (often called stokvels). Alcohol outlets are distinguished from social clubs in that alcohol outlets are organisations that serve alcohol while social clubs are a group of individuals who meet regularly for mutual and financial wellbeing in accordance with the rule of a particular social club (Lukhele 2018:2).

a) Code (a): High alcohol outlet density (Taverns and Shebeens)

Alcohol outlet density is the number of alcohol outlets within a specific geographical area. The more alcohol outlets in the same geographical area, the higher the alcohol outlet density (Nakkash, Ghandour, Anouti, Nicolas, CHalak, Yassin & Afifi 2018:2). This high alcohol outlet density increases accessibility and availability of alcohol to individuals and families in the community. Participants described two categories of alcohol outlets, namely taverns and shebeens. A tavern refers to a licensed alcohol outlet while a shebeen refers to an unlicensed alcohol outlet (Setlalentoa, Ryke & Strydom 2015:90).

Participants reflected on the high alcohol outlet density of taverns and shebeens as follows:

> *"We have a lot of Taverns, and Shebeens also. But then, so like I can say we differentiate a tavern from a Shebeen by saying usually the taverns is where our youth are going, and the Shebeens are you know, those houses maybe it will be owned by Mmamodise or something." (Participant 10)*

> *"They are everywhere. Yes, everywhere, every section you find a Tavern. Many young people, and there are many young people. You will find many young people there participate, buy alcohol. You know a person does not behave responsible when they are drunk. So they end up contracting those diseases." (Participant 9)*

> *"Most of this effect of alcohol is at the taverns, it is where most of the people get the HIV because some people they drink and then from drinking alcohol they become drunk, and it is where they meet with ladies." (Participant 5)*

Participants described the community as being characterised by a high alcohol outlet density. Phrases such as *"lot of taverns"* and *"taverns everywhere*" were used to describe the high alcohol outlet density. This high alcohol outlet density increases accessibility and availability of alcohol, consequently increasing the risk of alcohol misuse. Alcohol outlets are further described as places where young people meet

sexual partners. When consuming alcohol, they are at an increased risk of engaging in risky sexual activities, ultimately contributing to a greater risk for HIV transmission.

Letsela et al (2018:186) affirm that high alcohol outlet density increases the availability of and access to alcohol and the likelihood of alcohol misuse. Studies on the link between alcohol misuse and alcohol outlet density provide similar findings that there is increased drinking and drunkenness in areas where there are many alcohol outlets (Letsela et al 2018:186), Nakkash et al 2018:2). Jernigan, Sparks, Yang and Schwartz (2013:2) also agree that greater alcohol outlet density contributes to alcohol misuse. The high alcohol outlet density is further evident in the environment characterised by a high number of social clubs.

b) Code (b): High number of social clubs (Stokvels)

Social clubs are a formal group of individuals who meet regularly with the aim of saving money and helping each other cope financially (Landman 2013:54). There are numerous terms used to describe social clubs such as stokvels and Mohodisana (Landman 2013:54). In the context of this study, the terms ‘stokvels’ and ‘social clubs’ will be used interchangeably.
A participant shared:

> “*Eh, the only organisation is this organisations that are attended like Socials, Socials because they drink the whole night. They drink the whole night and misuse drugs and at the end of the day they end up having unprotected sex.” (Participant 9)*
>
> *“Weekends, youth members, school children, they are always there (at stokvels). They forget about books. The very thing, same thing that I told you about, that happens at socials, happens every weekend.” (Participant 9)*

Another participant agreed with Participant 9 about the role of stokvels in driving alcohol misuse as a risk factor of HIV infection:

"You end up saying there are Stokvels, you became a member. They drink. As others are drinking, you are not drinking. You end up thinking that you are left behind. They are having a style. You go to a second Stokvel, you drink two, the following Stokvel, not two anymore but six. Tomorrow you end up getting a person from Stokvel. You end up having unsafe sex. That is the results of alcohol." (Participant 6)

The attendees of these social club meetings are at an increased risk of misusing alcohol in terms of the time they spend at these meetings ("*drinking the whole night*") and frequency ("*drinking every weekend*"). When under the influence of alcohol the attendees are more likely to engage in risky sexual activities such as sex without condom use and sex with casual partners, which are drivers of the spread of HIV (Letsela et al 2018:175).

Despite the stokvel's potential for having a positive contribution in the economic activity of individuals and communities, the availability of alcohol during regular stokvel meetings may contribute to alcohol misuse as a risk factor of HIV infection. Similarly, Setshedi and de la Monte (2016:92) found that alcohol consumption and high-risk sexual behaviour is prevalent at stokvels. Nkomo (2015:194) agrees that skokvels are frequently accompanied by the sale of alcohol and the development of sexual connections. A fragile community coalition that hampers the management of alcohol misuse is further evident in the way that alcohol use affects other organisations such as schools and FBOs.

4.3.2.2 Category 2: Organisations that are negatively affected by alcohol misuse as a risk factor of HIV infection

The high alcohol outlet density exists alongside a number of organisations such as schools and FBOs in the community. Because these organisations share the same geographical area of many alcohol outlets, schools and FBOs are exposed to alcohol misuse.

a) Code (a): Schools exposed to alcohol

A high alcohol outlet density and social clubs expose school attendees to alcohol misuse. Participant 9 stated the following about alcohol and school learners:

> *"Like alcohol abuse is not a good thing. You find a child she is supposed to go to school tomorrow, she is supposed to read. They drop out of school because of these things."*

> *"Weekends, youth members, school children, they are always there* (social clubs)*. They forget about books. The very thing, same thing that I told you about, that happens at socials, happens every weekend."*

Similarly, Participant 7 reflected:

> *"Alcohol affects our community negatively. So look, I mean I do not want to be that person who has lost the job. You don't want to be the person who has dropped out of school because of alcohol use."*

Alcohol misuse emerged from the data as contributing to increased school dropout. A study by Milam, Furr-Holden, Cooley-Strickland, Bradshaw and Leaf (2014:12) found that alcohol outlets built near schools put children at risk of being offered alcohol. Ensuring that alcohol outlets are not built in close proximity to schools may be a possible intervention to minimise school children's exposure to alcohol.

b) Code (b): Faith-Based Organisations (FBOs) exposed to alcohol

FBOs in this study are seemingly affected on two levels. Firstly, as organisations negatively affected by alcohol misuse and HIV, and secondly as organisations that manage alcohol misuse and HIV infection. FBOs, as organisations negatively affected by alcohol use and HIV infection, are discussed in this section, while the role of FBOs in the management of alcohol misuse as a risk factor of HIV infection is discussed later (Refer to Section 4.3.2.3).

Participants stated the following about the effect of alcohol misuse on FBOs:

> *"Yes you find that men and women they drink, and thereafter we enter the church. Then you find people singing, some even crying, what makes them cry, alcohol. That is why I say the church organisations are also affected." (Participant 8)*

> *"I think first of all as a Pastor, in the church, I think churches are also affected by alcohol use or abuse. Yes because we have got youth in our churches that are also engaging in such acts you know. So we are having this problem even in our churches. I mean we have lack of youth attendance to our churches you know, because of alcohol abuse you know. That is how it affects the church." (Participant 7)*

> *"And then in this community when there is a tavern or whatever, I do not know what they do about that because you will find that there is a church that side, a tavern that side, when the church is on there they are making noise it is a tavern, you see how it looks like." (Participant 5)*

High alcohol outlet density affects FBOs in two ways. Firstly, members of the church are exposed to alcohol and end up drinking alcohol before church services. Secondly, due to the close proximity of some alcohol outlets to church buildings, the noise in alcohol outlets competes with church services. In order to minimise exposure of alcohol to the church, as a registration and licensing requirement, the National Liquor Policy prescribes that alcohol outlets must be at least 500 metres away from religious organisations (South Africa 2016:24).

The findings indicated that some organisations fuel alcohol misuse, some are negatively affected by alcohol misuse, and others play a role in managing this problem in the community.

4.3.2.3 Category 3: Organisations that manage alcohol misuse as a risk factor of HIV infection

Organisations identified as managing alcohol misuse and HIV infection include the Primary Healthcare Clinic (PHC), NGOs, Police services, and FBOs.

a) Code (a): The Primary Health Care Clinic provides health promotional activities and support strategies

A PHC is an organisation that, among others, provides health services for people with minor ailments, chronic ailments, family planning, mental health and substance abuse services, prevention and treatment of HIV. In South Africa, the PHC is the first entry to district health services and provides health services free of charge. There is one PHC in the community under study.

Participants stated the following about the role of the PHC in the community:

> *"And HIV infection, ok clinics obviously play the biggest role here because they are the ones who had, actually have to tell the community about the impact of HIV/AIDS, what is HIV/AIDS, what is alcohol misuse, how can it lead to one actually being infected with HIV/AIDS because we know there are many factors that are being, that play a role in one being infected. So the clinic plays that role because they are the main health centre in the community." (Participant 10)*

> *"I can say mostly it plays a role in relation to HIV. Yes the Clinic has campaigns. They help, mostly they distribute condoms. Like the site where I stay they distribute condoms in shops. When I want condoms I have access." (Participant 6)*

> *"If I can tell you the role of the clinic because that is them who will understand. But they do have HIV programmes that have started for ARVs." (Participant 2)*

"And even the organisation like XXX (name of the organisation) is actually from the clinic itself. They have got care workers who go outside and give people medication. I think also health education on issues that affect the community and such. So like this is actually their main role when it comes to that one." (Participant)

The PHC plays a role in the management of alcohol misuse as a risk factor of HIV through primary prevention strategies such as screening and sharing health promotion messages on the dangers of alcohol misuse and HIV infection, secondary prevention strategies such as the provision of ARVs, and tertiary health promotional strategies by supporting NGOs in looking after victims of alcohol misuse and HIV infection as contained in the ideal clinic manual (South Africa 2016:1-251). A study by Crowley and Stellenberg (2014:5) found that PHC clinics provided HIV care and treatment services, and support from NGOs strengthen the services. Mottiar and Lodge (2018:60) also concur that the PHC clinic supports NGOs in HIV treatment roll-out.

b) Code (b): NGOs provide health promotional activities

An NGO is an organisation that is neither a part of government nor a profit-making business. NGOs get support from the PHC to provide health services to the community, as expressed by Participant 8:

"Yes they work with this committee of NGO; they monitor people who are on HIV treatment, ARVs. They help with the counselling in the clinic, and make a follow up for HIV and AIDS people."

Other participants agreed:

"They are the ones that distribute TB and HIV medication to patients in the community, they are health workers." (Participant 3)

"You know and we also come together and address those things and some of them we have got names all that are with us. Most of them they are trying to address challenges that youth are facing today" (Participant 7).

Findings from this study are that NGOs contribute in the management of HIV infection through HIV counselling, delivering medication at patients' homes and monitoring people who are taking HIV/AIDS medication. NGOs contribute to HIV prevention by reaching youth, sharing information, and encouraging people to undergo HIV testing (Mottiar & Lodge 2018:60).

c) Code (c): Police manage alcohol misuse through law enforcement

In an endeavour to create a safe environment, one of the police service activities includes curbing the substance abuse epidemic through enforcement of the liquor legislation. The liquor legislation controls the sale and consumption of alcohol, such as restricting alcohol outlets' operating times, enforcing legal alcohol age limits and prohibiting public drinking (South Africa 2016:s1.6). Participants mentioned the following about the police service:

"The police what I know is that they have eh tried to organise the Taverns. But mainly I think their aim was not to, for them to regulate or to have a campaign on alcohol abuse but it was to have Taverns adhere to their license terms, this turns to two things. If they have to close at two O'clock they have to close at two O' clock in the morning, and they have to open at ten O' clock, it has to be." (Participant 2)

"In relation to alcohol, police officers, what I see happening is like when they find people consuming alcohol in the streets they do not allow that. They will not let them drink alcohol in the street." (Participant 5)

"And then when coming to alcohol I heard that in (Name of place) site they do not allow a child to been seen having a beer. They destroy it and follow the child to identify who have sent him to buy a beer. It is not allowed to send an underage child to buy a beer nor to enter into a tavern." (Participant 6)

Participants described the role of police service in the management of alcohol misuse and HIV infection on two levels. Firstly, the focus is on alcohol outlet managers and servers by ensuring that they stick to operating times, secondly, on patrons through restriction of public and underage drinking.

Restricting operating times is one of the strategies to reduce alcohol-related problems (WHO 2018:100). Increased enforcement on the legal purchase or drinking age may reduce access to alcohol by young people. However, police intervention alone will not suffice to reduce access to alcohol. Therefore, a multisectoral approach involving all stakeholders in the community is needed.

d) Code (d): Faith-Based Organisations through spiritual counselling, prayer meeting and taking care of HIV victims

Unlike in the previous section in which FBOs were affected by alcohol misuse and HIV infection, this section focuses on the role of FBOs in the management of alcohol misuse and HIV infection. Participants stated the following about FBOs:

> *"Yes all the churches. The thing is they have these women of prayer. They meet every Thursday so they organise themselves. Every Thursday they go to a particular church and pray there." (Participant 2)*

> *"And then churches as other organisations they teach that the human body is the Temple of Holy Spirit. Alcohol does not have space in the human body, it is a place for a holy spirit. And then another thing is that the church encourages a person to abstain that is Kingdomise. So when we say Kingdomise we mean that you should abstain, but at the same time because we understand that people live in this world whereby young people rash to do thing. So we encourage that if you do not Kingdomise, then condomise. Yes we encourage in that way." (Participant 8)*

> *"They teach them about the dangers of alcohol. They teach them about the dangers of alcohol, how it will not benefit you, how it cannot benefit you. And*

you, biblically it is wrong like to drink alcohol. They convince them with scriptures. So it helps, I have seen some of the guys been helped. Even those who were drunkard when they come to church somehow they stop drinking. They are convinced with the Bible." (Participant 9)

Findings from the current research study reflect that FBOs manage alcohol misuse and HIV through moral and spiritual teaching (Clarkson 2014:38). FBOs influence the management of alcohol misuse and HIV infection through teaching morality and beliefs about the spiritual basis of disease, rules of family life as well as sexual behaviour. Mash and Mash (2013:6) agree that FBOs play a role in the management of alcohol misuse and HIV prevention through spiritual teaching and morality. FBOs contribute to the management of HIV through the provision of voluntary counselling and testing, and conducting awareness and educational campaigns (Clarkson 2014:26). With regards to alcohol consumption, findings from the study by Hutton, Whitehead and Ullah (2017:430) state that support and encouragement from FBOs contribute to people's moderate drinking.

4.3.3 THEME 2: ALCOHOL AND HIV-RELATED CHALLENGES FACED BY ORGANISATIONAL STAKEHOLDERS

Alcohol and HIV-related challenges in the community include heavy episodic drinking, alcohol misuse as a risk factor of HIV infection, attitude of people towards risk factors of alcohol misuse and HIV infection, lack of parental guidance, and a high rate of unemployment.

4.3.3.1 Category 1: Heavy episodic drinking

Heavy episodic drinking is the consumption of 60 grams of alcohol or more on a single occasion at least once per month (WHO 2018:47). Findings from this study suggest that a drinking pattern is characterised by heavy episodic drinking as observed by frequency and duration of drinking. These are the words of Participant 8 about drinking patterns in the community.

"People in (Name of place) they drink. Some drink from Monday to Monday, every day. There are some who have already developed alcoholism because, maybe I will say alcohol abuse because they drink every day. There are those who only drink during weekends, and those who drink during special occasions, during parties, festive seasons, that is like that."

Participant 1, a tavern owner who serves alcohol, stated the following:

"In Taverns mostly. Yes people drink alcohol without a limit, and they end up just going."

This is what Participant 10 had to say about alcohol consumption:

"It is a tradition in the community, the 1st of September we welcoming spring, people pour water over each other but they have to drink as much as possible. You have a 21st party, it is a ritual. You must have lots of alcohol there. And also the 31st of December, ya most of public holidays. But specifically this three like, there has to be a lot of alcohol that has to be drunk and it is just the way things go there."

Heavy episodic drinking refers to drinking five or more drinks in a row in the span of two weeks (Abrams 2017:36). Heavy episodic drinking in this study is described in terms of frequency (drinking daily) and the quantity of alcohol consumed (drinking without the limit). This pattern of alcohol consumption contributes to the spread of HIV infection (WHO 2018:102). Abrams (2017:4) argue that heavy episodic drinking contributes to sexual abuse and unsafe sex which are risk factors of the spread for HIV infection. Glenshaw, Deluca, Adams, Parry, Fritz, Du Preez, et al (2016:2) concur that heavy episodic drinking is associated with the spread of HIV infection.

4.3.3.2 Category 2: Alcohol misuse as a risk factor of HIV infection

Participants described alcohol misuse as contributing to a change in behaviour that may increase the risk of HIV infection. A change in behaviour in this study refers to an alteration in activities that contribute to risky sex. Such behavioural inhibition may

contribute to rape incidences and sex without condom use that are risk factors of the spread of HIV infection. Participants expressed:

> *"That a person ends up getting HIV infection is because people drink until they lose control." (Participant 5)*

> *"A person just do it, he does not think of tomorrow. He does not think that tomorrow will come. He says no, as long as I get it. When he is having a nice girlfriend he think he will not get infected, let me just go without using protection. Things like that." (Participant 2)*

> *"That is having sex without condom. He will say he did not notice it (condom), yes or he will say it burst, he is the one who have caused this. Some it is because of alcohol. A person will deliberately drink alcohol so that he can do this thing and blame alcohol*." *(Participant 1)*

> *"Alcohol can lead to it HIV infection. If you abuse alcohol, it can lead to HIV infection because when they return from taverns during the night, they commit rape." (Participant 3)*

> *"So there is a problem of gang raped which has become common now, it is no longer called gang rape, is part of sex now. Especially around where we stay here, where guys will go for one girl, and they will sleep with that girl at a go, and it is fun for them, I think they watch a lot of porn movies. So it is too risky especially for young girls to go there alone because it is alcohol, and then without them seeing anything the guys will put in." (Participant 2)*

> *"Yes they can rape you, they can undress you, and they can kill you, without you seeing who took you and then what will happen. The next thing like arriving home save, how do you arrive home safe. How did you travel home?" (Participant 5)*

Alcohol misuse as a risk factor of HIV infection is reflected in my field notes following an interview with Participant 1 as follows:

"I learned from the participant that some people who consume alcohol are at risk of contracting HIV because of a tendency of having multiple sexual partners and not using condoms during sex".

Findings from this study show that alcohol misuse contributes to behavioural changes in the form of inhibition and these contribute to sex without condom use and rape incidence, thus increasing the spread of HIV infection. Studies on alcohol misuse and sexual behaviour have consistently demonstrated a positive link between alcohol misuse and risky sexual activities that could increase the risk of HIV infection (WHO 2018:67; Carrasco et al 2015:485; Lan et al 2016:181; Rehm et al 2017:1).

4.3.3.3 Category 3: Attitudes of people towards alcohol misuse and HIV infection

Findings from this study are that the attitudes of members in the community towards alcohol misuse increase the risk for HIV/AIDS due to a lack of knowledge and denial, among others.

"You see there are some people who say look, I am alive as a result of sex and I will die because of sex. Then I say no, we should not talk like that, tomorrow you will regret." (Participant 1)

"You know some people when they are HIV positive they do not want to disclose. He/she will say she does not want to die alone, or I will not be infected alone. He will tell himself that if he can go to the tavern and get a lady who I can sleep with and I will not use protection and he end up infecting her." (Participant 5)

"Mostly it is the way I was describing saying alcohol and HIV go hand on hand, they relate because of ignorance. People do things knowing that at the end what they will get." (Participant 1)

Some people in the community under study have shown a lack of knowledge and denial about HIV infection and alcohol misuse. Knowledge of HIV transmission, prevention and appropriate alcohol risk reduction are essential in the prevention of the spread of HIV (Sishana, Rehle, Simbayi, Zuma, Jooste, Zungu et al 2014:4). With regard to alcohol misuse, people experiencing substance use problems may delay seeking treatment due to denial or lack of knowledge about alcohol misuse as a risk factor of HIV infection (Probst, Manthey, Martinez & Rehm 2015:2; Hesse 2016:147).

4.3.3.4 Category 4: Lack of parental guidance

Lack of parental guidance regarding alcohol consumption was found to be another challenge faced by the community. Findings from this study reflect that children are exposed to alcohol in two ways; firstly, parents have a tendency to send their children to buy alcohol and this action may influence children to perceive alcohol consumption as a norm in the society. Secondly, some parents offer their children alcohol to drink. Furthermore, some parents who drink alcohol seem to be unable to fulfil their parental role, as key informant number three stated: *"they (minors) tend into orphans meanwhile their fathers are alive."*

Other participants put it this way:

> *"And you know in the past when we were growing up it was like if they send you to buy a cold drink, the last drop of cold drink you will just swallow or whatever just to finish it up before you go to the shop. Then I am surprised if you send young people alcohol in that bottle what do you think, you know young people experiment." (Participant 2)*

> *"I saw a young woman giving a kid less than two years alcohol, she said no I want her to sleep because she is gonna disturb me. I mean that is the beginning of tasting your first alcohol when you are still young, so for me personally I really have doubts that there will be change." (Participant 2)*

"Because we blacks we still have that thing that he is my child, I have the right to send him to buy a beer for me. He is my child I must ask him to go where I want. Without realising that if you ask a child to buy a beer for you, you are teaching a child to drink, what do you expect?" (Participant 6)

"They turn into orphans meanwhile their fathers are still alive. And when looking into their families some are working. But children are suffering. So that is the way alcohol makes the future community to suffer." (Participant 3)

Parents may influence their children to take alcohol at an early stage of development (Moagi 2018:138). During the early years of life, children listen to parents' opinions and observe their behaviour, including their alcohol use. Findings from this study concur with literature that parents who are heavy drinkers may lack parental guidance, consequently influencing children's risk of alcohol misuse (Sirera & Mwenje 2014:15). Furthermore, valuable time that could be spent on family development issues, such as child care, is taken up by drinking activities (Sirera & Mwenje 2014:15). Parental supply of alcohol is associated with increased risky drinking in mid-or late adolescence (Sharmin, Kypri, Khanam, Wadolowski, Bruno & Mattick 2017:7). A systematic review by Rossow, Keating, Felix and McCambridge (2016:214) also confirmed that parental drinking can influence drinking behaviour in their children.

4.3.3.5 Category 5: High rate of unemployment

South Africa is experiencing a high unemployment rate, recorded at 29.1% in the third Quarter of 2019 (South Africa 2019:1) and 30.4% in the province under study (South Africa 2019:7). Participants stated that one reason for alcohol misuse in this community is the high unemployment rate. Participants shared:

"These are the problems here I can say about 85% of youth in (name of place) are unemployed." (Participant 6)

"Yes about use of alcohol I cannot exactly tell because I do not drink. But I see people who visit bars in the morning and they are not safe because others are women. And then unemployment also contributes to people going to bars in the morning." (Participant 3)

"They go hand in hand. High unemployment rate. And high unemployment rate in terms of, we have people who are unemployed but who are not qualified. There is also a difference. You know education can teach you a lot of things. You are unemployed and not qualified. So you are not even dreaming about having a future. I mean if you have dropped out at grade nine, or even grade six at this age that I am, you do not think of any prospect of going to do correspondence or anything… so there are a lot of unemployed young people who are unemployed because they are unemployable." (Participant 2)

Participants stated that there is high unemployment due to a lack of education and skill, especially among the youth. Studies on alcohol use and unemployment have consistently shown a link between unemployment and alcohol misuse (Virtanen et al 2016:5; Harhay et al 2013:414). Findings from this study are consistent with the view that some people may use alcohol to suppress the negative experience of unemployment (Harhay et al 2013:410).

4.3.4 THEME 3: Facilitating actions to sustain community coalition

Key informants described facilitative actions as well as barriers to sustaining community coalition. Facilitating actions included organisational stakeholder unification, sharing a common vision, as well as perceived participants' benefits. Conversely, ineffective communication, insufficient funding, as well as fragile collaboration were identified as barriers to sustaining coalition.

4.3.4.1 Category 1: Organisational stakeholder unification

Unification is about togetherness, sharing information and commitment among community stakeholders to work towards a common aim or goal. Participants expressed:

> *"It is to unite the people and educate them. That is the only way they can realise the benefit. That is the benefit is not only about money. It is the issue of getting that education on how they can protect themselves against HIV/AIDS and alcohol abuse." (Participant 4)*

> *"Unification is to be united, being together, and then we talk, always talking about our own community, talk about diseases, alcohol, nyaope, it is just to unite." (Participant 3)*

> *"What I want to stress is concerning the fact that I wish organisations can unite like I said. I know the three organisations that are well known and already registered, and with us we just got registered, we got our certificate in December." (Participant 3)*

> *"That is why I said if we can be one big family, we become united. We agree by sitting down and then talk about, able to help. I like to help. And I am able to help when there is a need." (Participant 1)*

> *"So I think it will be sustainable if we unite them, obviously if they take these things and see the importance there is no way that they can leave on the way. It will go on and on." (Participant 4)*

> *"I think that when organisations are united and then they agree about what they want to achieve. They will talk and say ok let us do this, or maybe this activity, so that those people who spent most of their time in alcohol serving environment, they can spent their time in activities done in the community. I think that will contribute in reduction in alcohol consumption." (Participant 5)*

The importance of unity is reflected in my field notes after the interview with the first participant as follows:

> *"She spoke positively about helping HIV victims and, realised the importance of working together with other organisations to achieve a common goal".*

I also reflected in my field notes on the proverb used by Participant 3:

> *"The participant used the proverb 'Sedikwa ke ntswapedi ga se thata' which when translated into English means 'unity is strength' to express the importance of unity in a coalition."*

For a favourable sustainable community coalition to exist, there is a need for stakeholders from different organisations to unite and work together for a common goal (Wolfe & Price 2017:10). Brown, Feinberg, Shapiro and Greenberg (2015:3) argue that unity in a coalition makes participation more enjoyable and improves communication among organisational stakeholders. It is through this unification that organisational stakeholders share information, ideas and activities to manage alcohol misuse as a risk factor of HIV infection. Enriquez (2014:161) concurs that a strong unification will exist if coalition members from different backgrounds view the problem as common to them and are willing to share the burden.

4.3.4.2 Category 2: Sharing a common vision

Sharing a common vision was identified as a facilitating action of sustainable community coalition for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection:

> *"So if we can get to know one another, know our mission and vision because we must just have that one umbrella mission to help, just to help the community. Then you can have your own site mission without competing with one another." (Participant 10)*

"We as different organisations if we are in agreement and share the goal that we want to fight against alcohol abuse because it ends up leading to HIV and AIDS infection, as long as we share the goal, I believe that a coalition of people from different organisations can be able to fight against this problem." (Participant 8)

"If as a community we share, let me say the thing we share together. Let me say you are going to speak about how to prevent alcohol misuse. That if you share that problem, another person will come with this idea whiles other people will come with another idea." (Participant 5)

Findings from this study indicate that sustainability in the management of alcohol misuse as a risk factor of HIV infection is facilitated when people from different organisations share a common vision and goals. Organisational stakeholders will share a common vision if they accept that they have a common problem, know and understand each other's management strategies, and believe that working together by combining different ideas to manage alcohol misuse as a risk factor of HIV infection will produce maximum benefits. Findings are in agreement with existing literature that organisational stakeholders' coalition could be sustained if they experience the same shared vision for creating a community of change (Fagan & Hawkins 2015:15; Ishimaru 2014:193; Knight 2016:3). Fagan and Hawkins (2015:15) are of the opinion that when organisational stakeholders are involved in a discussion regarding their vision, they are more likely to share collective responsibility for achieving their goals. Ishimaru (2014:193) concurs that sharing a common vision for change is an important element of coalition sustainability. Further, Knight (2016:3) adds that sharing a common vision guides organisational stakeholders in decision making.

4.3.4.3 Category 3: Perceived participation benefits

Participation benefits are the extent to which organisational stakeholders are rewarded for their coalition involvement. The following quotes support a positive relationship between participation benefits and sustainable community coalition.

"We should not just do things saying as long as we are helping people. It should also help us so that we benefit because we are from different families where we have difficulties." (Participant 6)

"For it to be sustainable I think these NGOs they are here to assist community you see. And the plan is not just to run a one year program and stop. It is to run until they reach their goals. So I think it will be sustainable if we unite them, obviously if they take these things and see the importance there is no way that they can leave on the way. It will go on and on." (Participant 4)

"Benefits like you can at least maybe cook for them, those are one of the things like cook for them, and you can make promises. Promises will make them want to come. Even if those promises are not delivered but it is for a good course. But at the end of the day I think that they will understand what was this all about." (Participant 9)

"Give them something that can sustain them that can make them want to come for more. I do not know what exactly is it but something that can make them come for more. Make them interested, make them curious." (Participant 9)

The benefits derived from participating in a coalition have been identified as a facilitator of community coalition sustainability. The sustained benefits of participation in a coalition will increase the level of involvement in coalitions. The benefits include rewards such as a feeling of fulfilment in helping people, as well as organisational stakeholders' perception of the importance of participating in a coalition. These benefits facilitate the development of interest in participating in a community coalition. Organisational stakeholders that participate in community coalitions often sacrifice of their time. It is therefore important that substantial benefits exist for organisational stakeholders to perceive participation as being worthwhile (Brown, Feinberg & Greenberg 2012:4).

Findings from this study are in line with findings by Bermea et al (2018:6) which identified participation benefits as a predictor of sustained coalition involvement.

Coalition sustainability may be facilitated by financial rewards in terms of salary or stipends, and non-financial rewards such as acquiring skills and developing valuable relationships (Brown et al 2012:7).

4.3.5 THEME 4: BARRIERS IN SUSTAINING A COMMUNITY COALITION

Barriers to community coalition sustainability are those factors that hinder or make sustainability difficult. These barriers were found to be ineffective communication, lack of funding, and lack of community partnership.

4.3.5.1 Category 1: Ineffective communication

Communication is an interaction between different people or different organisations in sharing and exchanging information. Communication in this context is the sharing of ideas and experiences on the management of alcohol misuse as a risk factor of HIV infection among organisational stakeholders. Participants repeatedly quoted a lack of communication as a challenge.

> *"You know eh, if there is a communication breakdown you know within stakeholders you know then sustainability will drop, you know will drop because of course no matter what, we need each other." (Participant 7)*

> *"We need each other, to work together, you know to address this issues you know. So lack of communication will be barrier and also lack of, lack of information." (Participant 7)*

> *"Yes I think communication is like the greatest factor like you know. Organisations have to always communicate with one another. If there are issues, if there is a budget." (Participant 10).*

> *"Some people are ignorant, some people are afraid but. We have got to try, the only reason, the only thing I can think about is communication." (Participant 9*)

In my field notes after an interview with Participant 10, I reflected:

> *"The participant was passionate about communication between stakeholders and repeatedly stressed that an open and transparent communication plays a role in promoting organisational stakeholder unity and sustainability which was also expressed by previous participants."*

Findings from this study are that a lack of communication among organisational stakeholders compromises information sharing, consequently hindering sustained organisational stakeholder participation. Wallerstein, Muhammad, Sanchez-Youngman, Espinosa, Avila, Baker et al (2019:29S) argue that creating a communicative environment for dialogue on social inequities strengthens coalitions. Long (2018:9) agrees that open communication is the fundamental element of human social interaction and plays an important role in creating a positive, sustained change. Open communication among organisational stakeholders is further supported by Seaton, Holm, Bottorff, Jones-Bricker, Errey, Caperchione et al (2018:1106) as being an important factor in promoting a climate of trust and facilitating collaboration.

4.3.5.2 Category 2: Lack of financial resources

Funding is making financial resources available to enable organisational stakeholders to finance goods, services, and attain human resources.

Participants stated:

> *"I wish the Government could fund us so that we can continue with this health education, even people who do not have money will inform us that today my children did not have breakfast, then he does not come to the meeting for nothing, five Rands, fifty Rands, so that he can buy some mealie meal, just two kilograms." (Participant 3)*

> *"We have not yet received any funding. At times it is difficult if you do not have money, these are some of the challenges we face." (Participant 6)*

"Because sometimes all organisations, some which I come from they like to say if you are working after 3 months you will be given money. And then I will work for three months with more energy. After three months there is no money. Then I start writing placats, we need the money, we need the money, we are published in Daily Sun. Then the name of Organisation is spoiled. Then the organisation falls apart." (Participant 6)

"I want to have access to funds, we should raise funds, and have some funds." (Participant 1)

"The particular two organisations I helped them in particular, with their business plan and how to form an organisation. They were not active. Immediately when they got funding they became active." (Participant 2)

Insufficient financial resources to fund health promotional activities may hinder the sustainability of community coalitions. Managing alcohol misuse as a risk factor of HIV infection requires human resources to oversee the implementation of health promotion activities as well as consumables such as condoms, medication and health promotion materials. Insufficient funding may compromise the availability of human resources and health promotion materials. Giesbrecht et al (2014:2016) argue that for a coalition to be sustained there is a need for continuous financial support. Welsh, Chilenski, Johnson, Greenberg and Spoth (2016:14) similarly concur that that sustainability of community coalition organisations is dependent on national-level funding.

4.3.5.3 Category 3: Lack of collaboration

Data from the study revealed that organisational stakeholders did not work in collaboration to manage alcohol misuse as a risk factor of HIV infection, as shown in the following quotes:

"So other than that, they are on, they cannot really meet and work, because the other one is focusing on this and the other one at that, and they are looking at self-enrichment." (Participant 2)

"*And then as long as we are still apart, other organisations are there while others are there, we will be unable to fight against alcohol abuse in the community, we will not defeat AIDS." (Participant 3)*

"The challenges that we can face during formation of coalition is when organisations do not pass messages to other organisations, like if our organisation knows, and we do not inform other organisations like the police service, or the clinic. You find that the clinic does not know anything. People are sitting there waiting for people from the clinic or police officers, or the other organisations somewhere." *(Participant 5)*

"We need to come and work together. You know we need to come and share information you know because we need them, they need what we have, you know, we need each other you know. So it's like that. So if this interaction you know this interaction is often visited you know, and then I think, I think sustainability is going to, to be experienced. You know yes, but if we don't have such activities you know that will be a barrier to sustainability." (Participant 7)

Findings suggest that there is a lack of collaboration among organisational stakeholders in the management of alcohol misuse as a risk factor of HIV infection characterised by lack of interaction and not sharing information, which hinders sustainability. Collaboration among stakeholders has a positive influence on coalition sustainability (Brown et al 2017:602). Preiser Struthers, Mohamed, Cameron and Lawrence (2014:7) agree that intersectoral collaboration empowers stakeholders to play a role in sustaining health promotion activities. Collaboration is also necessary for policy implementation (Carrasco et al 2015:501).

4.4 CONCLUSION

In this chapter, I presented a narrative account and discussion of the findings of the situational analysis (Phase One) of the 10 key informant interviews with organisational stakeholders and literature control. The objective of the situational analysis was to identify, explore and describe the type, nature and involvement of organisational stakeholders, as well as their perspectives of a sustainable community coalition to manage alcohol misuse and HIV infection in a specific community of the North West Province.

During the situational analysis, I learned that the community is characterised by a fragile community coalition that hampers the management of alcohol misuse as a risk factor of HIV infection. Three types of organisations affected by alcohol misuse and HIV infection were identified. These included organisations that contribute to alcohol misuse and HIV infection, organisations that are negatively affected by alcohol misuse and HIV infection, and organisations that manage alcohol misuse and HIV infection. I learned that managing alcohol misuse and HIV infection by these organisations may be hindered by ineffective communication, insufficient funding, as well as fragile collaboration among these organisations. However, issues such as organisational unification, sharing a common vision, as well as the perceived benefit of participating in a coalition could facilitate sustainability.

In Chapter 5 I will reflect (Phase Two) on the findings from the situational analysis (Phase One) in order to draw conclusions about the type and nature of organisational stakeholders in the community as well as their perspectives about alcohol misuse as a risk factor of HIV infection.

CHAPTER 5
PHASE TWO: REFLECTION ON THE FINDINGS

5.1 INTRODUCTION

In Chapter 4, I presented quotes and discussion of the findings of the data collected through the 10 key informant interviews and field notes with the first group of organisational stakeholders (Phase One). The findings were re-contextualised with existing literature by means of literature control to support the findings. In this chapter, I present Phase Two of the study (reflection on the findings), described in line with the PAR design. This chapter presents the reflection of organisational stakeholders on the findings of the situational analysis that was deemed critical for consensus-building, as described in Chapter 3, Section 3.4. The research question "What are organisational stakeholders' perspectives on the construction and description of a sustainable community coalition to manage alcohol misuse as a risk factor of HIV infection" guided this chapter.

I anticipated that the reflective engagement process with the organisational stakeholders would strengthen the findings from Phase One of the study and form a basis for the next phase of the project, namely planning and taking action. In line with critical theory and described by Mash (2014:3), participants in the PAR process are neither subjects to be measured nor to be understood, but rather partners in both action and research, and new knowledge is generated as a consensus of participants' learning.

5.2 DESCRIPTION OF ORGANISATIONAL STAKEHOLDER PARTICIPATION

Negotiating organisational stakeholder participation commenced by identifying and compiling a list of organisations that existed in the community under study with the help of the key informants who participated in Phase One of the study. The organisational stakeholders from the compiled list were invited to participate in organisational stakeholder dialogue meetings. Four of the key informants who participated in Phase One of the study continued to participate in dialogue meetings;

refer to Chapter 3 Section 3.4.3.2 for a detailed description of organisational stakeholder recruitment.

Dialogue meetings were held over a three-year period from 2013 to 2016. The respective dialogue meetings were attended by between 10 and 52 organisational stakeholders from a variety of organisations that included; NPOs, NGOs, FBOs, local government, local drug treatment centre, local sub-district Department of Health, youth organisation representatives and the community policing forum. The demographics of organisational stakeholders who participated in the stakeholder meetings are summarised in Table 5.1, followed by a description of each of the organisations.

Table 5.1: Profile of dialogue meetings and stakeholder participants

Dialogue meeting	Date	Organisations	Number of participants
1	17/08/2013	NGOs NPOs Local drug treatment centre Community health worker Local government	17
2	26/10/2013	NGOs NPOs FBOs Local drug treatment centre	8
3	05/11/2013	NGOs NPOs FBOs Local treatment centre	12
4	05/12/2013	NGOs NPOs FBOs Local drug treatment centre Community policing forum Representatives of local government Representatives of local sub-district Department of Health, Representatives from the SAMRC Research Supervisors from the University of South Africa	52

Dialogue meeting	Date	Organisations	Number of participants
5	25/01/2014	NPOs NGOs FBOs Community policing forum Local government Youth organisation Local drug treatment centre	10
6	18/02/2014	NPOs NGOs FBOs Local government	11
7	15/03/14	NPOs NGOs FBOs Local drug treatment centre	14
8	28/06/2014	NPOs NGOs FBOs Local drug treatment centre	11
9	08/09/2014	NPOs NGOs FBOs Local drug treatment centre	13
10	17/05/2016	NPOs NGOs FBOs Local drug treatment centre Youth organisation	22

The organisations included an NGO that was working in collaboration with the local clinic to support an HIV and TB programme through home visits (community health worker programme); an NGO consisting mainly of female adults from local FBOs, which played a role in organising prayer meetings and distributing food parcels and clothes to disadvantaged members of the community such as orphans and victims of HIV infection; an NGO that focused on helping young victims of substance misuse with counselling, treatment and referral to treatment; a community policing forum that supports the local police service to strengthen law enforcement; one youth organisation registered as an NGO to provide sporting activities in the community; one youth organisation working through the local clinic to strengthen youth user-

friendly service in the clinic; local government officials from the office of the counsellor and officials from the sub-district health office.

In addition, during dialogue meeting four, I was accompanied by my research supervisors from the University of South Africa as well as researchers from the SAMRC. The research supervisors are experts in the field of mental health research. Researchers from the SAMRC are experts in the field of substance use and HIV research, and have previously conducted relevant research in the specific community of the North West Province. The presence of SAMRC researchers in the dialogue meeting was that of peer review and support.

5.3 DESCRIPTION OF FINDINGS AND LITERATURE CONTROL

The key findings from organisational dialogue meetings are summarised in Table 5.2, followed by a full discussion on each of the themes. The salient issues from organisational stakeholders' reflective engagement were mostly consistent with findings from Phase One of the study; however, a few new insights were added to the findings. Organisational stakeholders reached a consensus that the community is indeed characterised by a fragile community coalition that hampers the management of alcohol misuse as a risk factor of HIV infection. Furthermore, organisational stakeholders reflected that they shared alcohol and HIV-related challenges, and described facilitating actions to sustain community coalitions in managing alcohol misuse as a risk factor of HIV infection.

Table 5.2: Summary of key findings from the reflective engagement with organisational stakeholders

Theme	Categories	Code
THEME 1		
5.3.1 A fragile community coalition that hampers the management of alcohol misuse as a risk factor of HIV	5.3.1.1 Lack of participation by key organisations-alcohol outlet owners	(a) Fear of loss of business by alcohol outlet owners
	5.3.1.2 Lack of participation by key organisations-youth	(b) Limited interest by the youth

THEME 2 5.3.2 Sharing common challenges relating to alcohol misuse as a risk factor of HIV infection	5.3.2.1 Negative bio-socio and economic impact of alcohol misuse 5.3.2.2 Lack of parental guidance	(a) Risky sexual behaviour HIV infection, Violence, Fear, anger, frustration (a) Increased risk of alcohol abuse by young people
THEME 3 5.3.3 Facilitating actions to sustain community coalition	5.3.3.1 Organisational unity 5.3.3.2 Formalising the coalition 5.3.3.3 Trusting relationship 5.3.3.4 Transformational leadership 5.3.3.5 Access to financial resources	(a)Having a constitution, working for a common goal, Registration as an NPO (a) Recruit other organisational stakeholders to participate in the coalition i.e. Alcohol outlet owners, youth organisations (a)Trusting relationship between the researcher and organisational stakeholders (b) Trusting relationship among organisational stakeholders (c) Research project feedback (a)Trusted leadership, openness and transparency (a)Fundraising Diversify access to funds

5.3.1 THEME 1: A FRAGILE COMMUNITY COALITION THAT HAMPERS THE MANAGEMENT OF ALCOHOL MISUSE AS A RISK FACTOR OF HIV INFECTION

The salient issues from organisational stakeholders' reflective engagement were mostly consistent with findings from Phase One of the study, but a few new insights emerged during the dialogue sessions. The central theme identified in Phase One, namely that the community is characterised by a fragile community coalition that hampers the management of alcohol misuse as a risk factor of HIV infection, was confirmed. Organisational stakeholders confirmed that a high number of alcohol

outlets as well as social clubs contribute to alcohol misuse as a risk factor of HIV infection.

A new insight that emerged during dialogue sessions is that the fragile community coalition was partly evident in a lack of participation by organisational stakeholders from some of the key organisations, such as taverns and shebeens. Furthermore, despite the youth participation in dialogue sessions, organisational stakeholders were concerned that they were few and far outnumbered by adults yet they are the ones mostly affected by alcohol misuse as a risk factor of HIV infection. Lack of participation by alcohol outlets and the youth are discussed in the sections that follow. These three themes emerged from data analysis of the minutes of dialogue meetings.

5.3.1.1 Category 1: Lack of participation by key organisations - alcohol outlet owners

Organisational stakeholders were in agreement with findings from Phase One of the study that alcohol outlets contribute to alcohol misuse as a risk factor of HIV infection. Organisational stakeholders were also concerned that alcohol outlet owners were not taking initiatives to promote responsible alcohol drinking, hence contributing to a fragile community coalition to manage alcohol misuse as a risk factor of HIV infection. The lack of interest to participate in responsible alcohol drinking initiatives by alcohol outlet owners is thought to be due to the belief that participating in responsible drinking initiatives will compromise their business through a reduction in sales of alcohol. The quotes that follow from minutes of dialogue meetings and personal notes reflect how organisational stakeholders perceived participation by alcohol outlet owners:

> *"The tavern owners should be on board as they are the ones that cause alcohol abuse in the community." (Dialogue meeting 1)*

> *"Members present stated that tavern owners may be reluctant to participate as they fear that the project will affect their business by lowering sales of alcohol." (Dialogue meeting 6)*

"Tavern owners were invited to participate in the project (meaning this research study), however some of tavern owners have a perception that their business may be negatively affected by the project." (Dialogue meeting 8)

"Tavern owners should participate in our meetings so that they can help in dishing up condoms to people who drink in their taverns." (Dialogue meeting 7)

"Tavern owners do not want to attend our meetings but we want to distribute condoms in their places. They need to understand that we want to help our youth to get condoms in their taverns." (Dialogue meeting 9)

The findings from this study that alcohol outlets are places where alcohol misuse takes place along with possible risky sexual behaviour is consistent with findings by Letsela et al (2018:184); they discovered that exchanging alcohol for sex as well as having unprotected sex is considered an acceptable norm in alcohol outlet settings. Morojele, Kitleli, Ngako, Kekwaletswe, Nkosi, Fritz and Parry (2014:3) concur, stating that alcohol outlet settings are places where alcohol misuse is commonly linked with risky sexual behaviour and consequently HIV infection. Given the role of alcohol outlets as a potential driver of alcohol misuse as a risk factor of HIV infection, Setlalentoa et al (2015:95) suggest that it is vital for alcohol outlet owners to be included in efforts to manage alcohol misuse.

Despite one alcohol outlet owner participating in Phase One of the study, and various strategies to recruit alcohol outlet owners as described in Chapter 3, none participated in dialogue meetings. A study by Morojele et al (2014:5) shows that although alcohol outlet owners may have an interest in interventions to manage alcohol misuse as a risk factor of HIV infection, they were unable to participate in training workshop on responsible server practices due to, among others, lack of time and fear of financial effects on good server practices.

The absence of alcohol outlet owners during dialogue meetings is a missed opportunity to validate the view that they lack interest in managing alcohol misuse as a risk factor of HIV infection. It therefore remained unclear why alcohol outlets did not participate in regular dialogue meetings. However, contrary to the belief by organisational stakeholders that alcohol outlet owners did not support initiatives to manage alcohol misuse as a risk factor of HIV infection, alcohol outlet owners were supportive in the activity of distributing condoms in their drinking venues (See Chapter 6, Section 6.3.4).

5.3.1.2 Category 2: Lack of participation by key organisations - youth

The youth is defined in the National Youth Policy 2015-2020 as people between the ages of 14 to 35 years (South Africa 2015:10). In line with findings from Phase One of this study, in this phase organisational stakeholders identified that the youth – as victims of alcohol misuse – is a risk factor of HIV infection. Organisational stakeholders were concerned that the youth did not adequately participle in dialogue meetings. Although three youth organisations participated in dialogue meetings, they were represented by less than five people. In addition, some of these individuals did not consistently attend dialogue meetings. A possible explanation for the lack of participation by the youth could be due to peer pressure, rejection of parental advice, as well as the use of alcohol as self medication to reduce the pain of boredom.

> *"The youth especially school children are the main cause and victims of alcohol related problems such as violence, risky sexual behaviour and HIV infection." (Dialogue meeting 4)*

> *"The youth are considered to be mostly affected but do not attend meetings and workshops, there is a need to develop a strategy to attract them to attend meetings." (Dialogue meeting 4)*

> *"There is lack of participation by the youth in attending workshop meetings." (Dialogue meeting 4)*

"Members of health promotion from Madibeng sub-district felt that there was a need to gather more information about alcohol misuse and risky sex through community engagement and that the youth need to be involved." (Dialogue meeting 4)

"There is a challenge that the youth are still reluctant to attend meetings. At least there are two youth from Breaktrhough support group in the present meeting." (Dialogue meeting 6)

As described by Letsela et al (2018:175), the South African youth are vulnerable to both alcohol misuse and HIV infection. Given the vulnerability of the youth to alcohol misuse as a risk factor of HIV infection, it is imperative that they are engaged in community-based programmes affecting their lives (Bermea et al 2018:8). Bradley (2017:80) argues that involving the youth in substance misuse programmes is instrumental in sustaining coalitions.

5.3.2 THEME 2: SHARING COMMON CHALLENGES RELATING TO ALCOHOL MISUSE AS A RISK FACTOR OF HIV INFECTION

5.3.2.1 Category 1: Negative bio-socio and economic impact of alcohol misuse

Organisational stakeholders reflected that alcohol misuse as a risk factor of HIV infection is "*a serious problem … in the community and that this has become out of hands." (Dialogue meeting 1).* They identified the negative socio-economic impact of alcohol misuse as evidenced by violence, risky sexual behaviour and a higher risk for HIV infection, subsequently resulting in a decline in the emotional, social and financial wellbeing of members of this community.

The decline in emotional wellbeing as a result of these challenges manifest as feelings of fear, anger and frustration among community members. Similarly, a study by Khalid, Pan, Chai, Xu and Ghaffari (2018:658) found that people who misuse alcohol have more depression, anxiety and stress reactions compared to the normal population. Furthermore, Luquiens, Owens, Whalley, Rahhali, Laramée, Crawford et al (2017:12) argue that alcohol misuse is associated with poor living conditions, and

impairment such as loss of work, housing and financial difficulty. The following quotes are from dialogue meetings:

> *"Organisational stakeholders reflect that the negative effect of alcohol abuse, risky sexual behaviour and HIV infection in the community had a negative impact on parent's financial, social and emotional wellbeing." (Dialogue meeting 5)*
>
> *"When discussing about alcohol abuse, risky sex and HIV infection we have feelings of fear, anger, frustration and helplessness." (Dialogue meeting 5)*
>
> *"They spent most of their time in taverns and social clubs, doing what, dinking and having sex. You cannot tell them, they will tell you about their rights. This is unacceptable." (Dialogue meeting 4)*
>
> *"Where do they get money to buy alcohol, because they are not working, they use our own money, which was meant to buy for them bread." (Dialogue meeting 4)*

Findings from organisational stakeholders' reflective engagement were in agreement with results from Phase One of the study that the community is characterised by high levels of alcohol misuse as a risk factor of HIV infection. These high levels of alcohol misuse were identified as contributing factors to poor mental health, social and economic problems. A study conducted by Matzopoulos, Truen, Bowman and Corrigall (2014:127) has shown a link between alcohol misuse and public health and socio-economic problems. Alcohol misuse does not only affect individual users but also others in the family and the community in general (WHO 2018:11; Matzopoulos et al 2014:131). The harm may be related to poor physical and mental health such as injury and family members' anxiety, depression and spread of infection, aggression and violence, or economic due to money for family necessities being spent on drinking (WHO 2018:11; Matzopoulos et al 2014:131).

5.3.2.2 Category 2: Lack of parental guidance

Organisational stakeholders agreed with findings from key informant interviews that poor parental supervision contributes to alcohol misuse as a risk factor of HIV infection. Poor parental guidance manifested as poor communication on alcohol misuse and sexual activity issues.

> *"Some of the parents are to blame for poor youth supervision leading to alcohol misuse and risky sexual behaviour." (Dialogue meeting 4)*

> *"Parents drink in front of young people, what information you display to them, some go to an extent of sending them to buy alcohol for them." (Dialogue meeting 4)*

However, some organisational stakeholders reflected that although they are aware that the youth are engaged in abusing alcohol and practising unsafe sex, which may lead to HIV infection, they were not empowered to communicate with them about alcohol and sex-related issues.

> *"Some organisational stakeholder representatives stated that although they realise that the youth are engaged in abusing alcohol and unsafe sex which may lead to HIV infection they have a fear of talking to them." (Dialogue session 4)*

> *"Parents do not usually tell young people about safe sex which is a problem." (Dialogue session 4)*

Organisational stakeholders concur with findings from the situational analysis that some of the parents who drink alcohol may influence adolescents' use of alcohol. This is in line with findings by Sirera and Mwenje (2014:19) that parents who are heavy drinkers may influence their children's risk of alcohol misuse. Furthermore, parental alcohol misuse is associated with a likelihood of psychological and mental health problems among children (WHO 2018:6). In addition, valuable time that could

be spent on family development issues such as child care, is taken up by drinking activities (Sirera & Mwenje 2014:15).

5.3.3 THEME 3: FACILITATING ACTIONS TO SUSTAIN COMMUNITY COALITION

During this phase, organisational stakeholders were in agreement with findings from Phase One that unification is a facilitating action to sustain community coalition. Additionally, formalising the coalition, promoting a trusting relationship, supporting transformational leadership and strengthening access to financial resources were identified as facilitating actions to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection.

5.3.3.1 Category 1: Organisational unity

Organisational stakeholders were in agreement with findings from Phase One of the study that organisational stakeholder unity is essential for coalition sustainability. They expressed a need to unite all organisations in the community to work together for a common goal. To strengthen unity, organisational stakeholders suggested that all relevant affected organisations in the co2mmunity be invited to participate in the coalition to share a common understanding of alcohol misuse as a risk factor of HIV infection. The following quote is reflected in the minutes of the dialogue meeting.

> *"Members present stated that there was a need for a coalition of organisational stakeholders and used the term Umbrella to denote unity, and that trust is very important to ensure sustainability. They stated that it seem there are other stakeholders which need to be invited as there were few different organisations about five in the meeting and to their knowledge there are about 11 - 12 organisations in the community. It was suggested that another meeting be held to discuss with other organisational stakeholders." (Dialogue meeting 1)*

As recommended by organisational stakeholders, organisations that could potentially participate in the study included FBOs, tavern owners and the youth as they were

directly affected by alcohol misuse and HIV infection. However, organisational stakeholders were more concerned about participation by the youth in community meetings as they were viewed as most affected by alcohol misuse as a risk factor of HIV infection, as described in the previous section. In the reflective notes during a community dialogue meeting, I wrote:

> *"The youth are considered to be mostly affected but do not attend meetings and workshops, there is a need to develop a strategy to attract them to attend meetings." (Dialogue meeting 4)*

Findings from this study are in line with those by Enriquez (2014:161) that organisational unity is an important ingredient for coalition sustainability. According to Flood, Minkler, Lavery, Estrada and Falbe (2015:657), to promote unity and enable a successful health promotion impact, individual agendas must be replaced or amended to include a collective one. Brown et al (2015:3) argue that organisational unity makes participation in a coalition more enjoyable and helps to improve collaboration.

5.3.3.2 Category 2: Formalising the coalition

In line with findings from the situational analysis, organisational stakeholders suggested that to sustain the community coalition to manage alcohol misuse and HIV infection, it was important to formalise the coalition. Organisational stakeholders suggested developing a constitution that describes the aims and objectives as well as the role of coalition members.

> *"One organisational stakeholder proposed a formal structure which will ensure that there is a trusting relationship between organisational representatives. She proposed that organisational representatives from organisations, at least two, should be elected to by holding meeting, raise funds and come with strategy to prevent alcohol misuse and HIV infection." (Dialogue meeting 1)*

> *"It was also discussed that the previous meeting and today's meeting minutes should be printed out so that every member must have a copy. It was also*

discussed that on the 5th of next month a meeting is to be held at Ikhutseng Clinic." (Dialogue meeting 2)

"The other issue which organisational stakeholders agreed was to formalise the coalition through developing a constitution and registering as an NGO in order to apply for funding to help people with alcohol problems in the community." (Dialogue meeting 3)

"It was anonymously agreed through show of hands that Greater X Based Organisation will be the name of the project. Office bearers elected were as follows; (names of office bearers)" (Dialogue meeting 3)

"There was a discussion on who should form the executive of the organisations and how often will be meetings. One suggestion was that at least three representatives of stakeholders from each organisation be part of executive committee and meet once a month and give report back to members of organisations." (Dialogue meeting 3)

The findings from this study are consistent with findings from Berger (2013:19) that formalisation goals, expectations and objectives are associated with sustainability and success of coalitions. Cooper et al (2013:1) concur that the formalisation of coalitions plays a role in continued programme implementation. Christens and Inzeo (2015:431) add that formalisation of rules and procedures is associated with coalition effectiveness. More literature on formalising the coalition is explained in Section 2.4.5.

5.3.3.3 Category 3: Trusting relationships

Although a trusting relationship was not identified during Phase One as a key issue to sustain coalitions, it was evident during dialogue meetings. Organisational stakeholders claimed that developing and strengthening a trusting relationship is vital to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection. These trusting relationships were, firstly, between the researcher and organisational stakeholders, and secondly, among organisational stakeholder

representatives themselves. Organisational stakeholders expressed a need for trusting relationships between the researcher and organisational stakeholders based on a historical action undertaken by researchers in the area, who collected data in the community and disappeared without sharing findings with organisational stakeholders:

> *"The first question asked was - How will organisational stakeholders trust me as a researcher because in the past people used to come with projects and suddenly disappeared." (Dialogue meeting 1)*

The answer to the question raised by organisational stakeholders is related to how I described the nature of PAR in relation to working in collaboration throughout the research process. It became clearer to the organisational stakeholders that I was sharing findings of Phase One of the study and that there would be regular dialogue meetings.

With regards to trust among organisational stakeholders themselves, a trusting relationship was identified as significant, as reflected in the quotes that follow:

> *"One stakeholder representative stated that trust is very much important to sustain the project and that stakeholders engaged should always give them feedback about what is happening about the project from time to time." (Dialogue meeting 1)*

> *"Another stakeholder representative stated that organisational stakeholders elected to participate and lead the project should also be trusted people, who always provide organisational members' feedback." (Dialogue meeting 1)*

During this phase of the study, the trusting relationship was between the researcher and organisational stakeholders and among organisational stakeholders themselves. With regards to trust between the researcher and organisational stakeholders, a need to strengthen a trusting relationship was identified. Boaz, Hanney, Borst, O'Shea and Kok (2018:5) argue that in community-based research, researchers need to trust and respect organisational stakeholders as partners with knowledge

and expertise, and consider their needs and priorities. Trust is strengthened through openness and transparency, and findings from the research should be shared with organisational stakeholders according to PAR principles (Aitken, Cunningham-Burley & Pagliari 2016:718).

In line with critical theory and PAR principles, Jagosh, Bush, Salsberg, Macaulay, Greenhalgh, Wong et al (2015:10) conclude that trust-building contributes to sustainability and systemic transformation by increasing the knowledge of factors supporting successful organisational stakeholder and researcher partnerships. Trust further contributes to transforming contexts to improve conditions that determine organisational stakeholders' mental health status.

Inter-organisational trust builds on strengthening relationships in which organisational stakeholders can share and discuss their feelings as an important component of sustaining action research (Neal & Christens 2014:318). Berger (2013:41) concurs that developing trust and meaningful relationships between organisational stakeholders is essential for sustainability. Strategies for building trusting relationships between organisational stakeholders may involve integrating network opportunities into activities and creating time for informal socialising (Berger 2013:16).

5.3.3.4 Category 4: Transformational leadership

The leadership proposed by organisational stakeholder representatives is participatory in nature. A suggestion was made that the leadership should meet from time to time for planning and feedback to occur. The leadership was required in terms of forming an executive committee led by a chairperson. The quote that follows reflected the nature of leadership that organisational stakeholders proposed.

> *"Organisational stakeholders proposed a structure which will ensure that there is a trusting relationship between organisational representatives. It was proposed that organisational representatives from organisations, at least two, should be elected to by holding meeting, raise funds and come with strategy to prevent alcohol misuse and HIV infection. Those organisational*

representatives should always provide feedback to organisational stakeholder managers, who should in turn provide feedback to organisations. Those people should be trusted." (Dialogue meeting 1)

"During the second meeting organisational stakeholders proposed names of people who will be part of leadership of the project." (Dialogue meeting 2)
"The project needs an open and transparent leader who will ensure that the money is used properly." (Dialogue meeting 2)

"The leadership of a research organisation should lead by example by respecting people so that he in turn becomes respected." (Dialogue meeting 6)

"We needed to come up with the name of the project and that we needed to elect members to lead the project. Four names were suggested to lead the project" (Dialogue meeting 3)

Organisational stakeholders proposed a need for the nomination and election of leadership. Such a leader should be trusted as someone who always provides feedback. According to Nanjundeswaraswamy and Swamy (2014:1), leadership is a social influence process whereby the leader seeks voluntary participation of subordinates in order to reach organisational goals. Hoffart (2017:69) describes three types of leadership styles, namely transformational leadership, transactional leadership, and laissez-fair. The leadership style relevant to this study is transformational leadership. As described by Hoffart (2017:69), in transformational leadership a leader fosters organisational performance by virtue of the strong emotional attachment with his or her followers and a commitment to higher moral values. Transformational leadership has also been associated with increased levels of group influence (Nanjundeswaraswamy & Swamy 2014:2).

5.3.3.5 Category 5: Access to financial resources

Similar to findings from Phase One of the study, organisational stakeholders confirmed that access to financial resources was important in the sustainability of

community coalition. Unlike findings from Phase One of the study, in which key informants focused on seeking funding from governments, organisational stakeholders in this phase expressed a need to get funding from multiple sources, empowerment to seek funding, as well as empowerment on sound financial management practices.

As reflected in my personal notes

> "Organisational *stakeholders expressed a need to be empowered to apply for sponsorship from a number of organisations that includes MTN, Amalgamated Beverages Industries, and the Motsepe foundation"*

A proposal was made to organise an open day in the community, and invite potential funders to empower organisational stakeholders in the funding application process.

> "*Fund raising - There is a need to organise fund raising campaign." (Dialogue meeting 5)*

Although funding is needed to sustain a community coalition, organisational stakeholders stated that if not well managed, funding could contribute to hindering a coalition. Funding thus needs to be accompanied by sound management practices embedded in a trusting relationship as reflected in the field notes:

> *"Another issue raised was funding-One organisational stakeholder stated that although funding is needed to fund different project activities, it also pose a challenge, most of organisations fail to be sustained because when they have funds, there is corruption whereby the researcher or stakeholder representatives steal and share the money and disappear. The stakeholder stated that she once experienced that and that she does not want this to happen again." (Dialogue meeting 1)*

The issue of financial mismanagement was also raised in dialogue meeting 2 as follows:

"Organisational stakeholders asked questions such as how to prevent financial theft. The answer given was that organisation needs to trust its members and in return members to trust one another, and be transparent."

In order to overcome the challenges of financial mismanagement, one stakeholder reflected:

"Money is not easily stolen if about three people from different organisations are responsible for managing the finance by being signatories when banking or making a withdrawal. They should always inform organisations when there is money received from funders and these also could be linked to some members' telephone to record when the money is deposited in an organisational account." (Dialogue meeting 1)

"In terms of spending every cent must go to the task allocated for it because in that way it will stop financial mismanagement or theft." (Dialogue meeting 2)

"It was agreed that people who participate in the research study should be trusted and should not be aimed at misusing project funds." (Dialogue meeting 3)

Studies on coalition sustainably have found that access to financial resources has a positive contribution on organisational stakeholder sustainability. The implementation of activities to manage alcohol misuse as a risk factor of HIV infection requires funds for, among others, remuneration of staff and payment of travel expenses. A study by Johnson et al (2017:617) found that increased funding resources are associated with interventions being sustained. In line with findings from this study that organisational stakeholders suggest seeking funds from multiple sources, Flewelling and Hanley (2016:838) argue that reliance on multiple funding sources is positively associated with effective coalitions. Organisational stakeholders agreed that sound financial management, including constant monitoring and trusting relationships, is vital to sustain the coalition. In line with the plea made by organisational stakeholders to be empowered on how to seek funding, Wolfe and Price (2017:8) argue that

understanding the requirements of potential funders is also valuable to help community-based organisations secure funding.

5.4 CONCLUSION

The aim of Phase Two of the study was to answer the research question “what are organisational stakeholders' perspectives of a sustainable community coalition to manage alcohol misuse as a risk factor of HIV infection”. In line with PAR, organisational stakeholders were requested to reflect on the findings from Phase One in order to validate the findings and generate a deeper understanding on the management of alcohol misuse as a risk factor of HIV infection through consensus.

Organisational stakeholders were in agreement with findings from Phase One of the study, that there is a fragile community coalition to manage alcohol misuse and HIV infection. As reflected by organisational stakeholders, this fragile community coalition was due to a lack of participation by alcohol outlet owners in managing alcohol misuse as a risk factor of HIV infection, as well as exposure to alcohol among the youth. A lack of participation in dialogue meetings was caused by tavern owners’ fear that interventions targeted at alcohol misuse would interfere with their business.

Despite the youth being identified as victims of alcohol misuse as a risk factor of HIV infection, there was poor attendance in dialogue meetings. To sustain the coalition, organisational stakeholders suggested a need to recruit the youth to participate in dialogue meetings.

In conclusion, reflective engagement with organisational stakeholders through dialogue meetings generated a deeper understanding of the type and nature of the organisational stakeholders in the community, as well as their involvement and perspectives in the management of alcohol misuse as a risk factor of HIV infection. The community is characterised by a fragile community coalition to manage alcohol misuse as a risk factor of HIV infection. This fragile community coalition is due to, among others, non-participation by alcohol outlet owners and poor participation by the youth.

However, engagement with organisational stakeholders to reflect on the finding is not without challenges. Despite efforts to recruit all organisational stakeholders in the community, poor attendance of the youth and alcohol outlet owners was experienced. Full participation by alcohol outlet owners and the youth would possibly provide another perspective on the root cause of a fragile community coalition to manage alcohol misuse as a risk factor of HIV infection, as well as potential interventions to manage alcohol misuse as a risk factor of HIV infection.

Despite poor attendance by the youth and alcohol outlet owners, organisational stakeholders managed to reflect on the findings and were able to suggest action plans to manage alcohol misuse and HIV infection. To achieve this, a number of actions were suggested that include developing a constitution, formalising a coalition through registration with the Department of Social Development (DSD) as an NGO, the distribution of condoms in drinking venues, inviting alcohol outlet owners and the youth to participate in the coalition, and diversifying sources of funding. Planning and action steps are discussed in more detail in Chapter 6.

CHAPTER 6
PHASES THREE & FOUR: PLANNING AND ACTION

6.1 INTRODUCTION

In Chapter 5, I presented a narrative account and discussion on the findings of the situational analysis as described in line with the PAR design used in the study (Phase Two). This chapter provides a description of Phases Three and Four of the PAR cycle, in particular focusing on how organisational stakeholders participated in planning (Phase Three) and carrying out activities to manage alcohol misuse as a risk factor of HIV (Phase Four). This was deemed critical to generate a deeper understanding of "How organisational stakeholders can participate and sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection" in this community.

Reflection on the findings described in Chapter 5 informed these two phases of the PAR cycle. Critical theory served as a guideline for me to work in collaboration with organisational stakeholders to plan and act on issues that were viewed as important to affected people. Findings from these two phases served as a guide to construct and describe a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection, which is presented in Chapter 7.

6.2 DESCRIPTION OF PHASES THREE (PLAN) AND FOUR (ACT)

As discussed in Chapter 1, Section 1.3, planning and action related to this study involved exploring how organisational stakeholders could be involved in sustaining a community coalition to manage alcohol misuse as a risk factor of HIV infection, summarised in Figure 6.1.

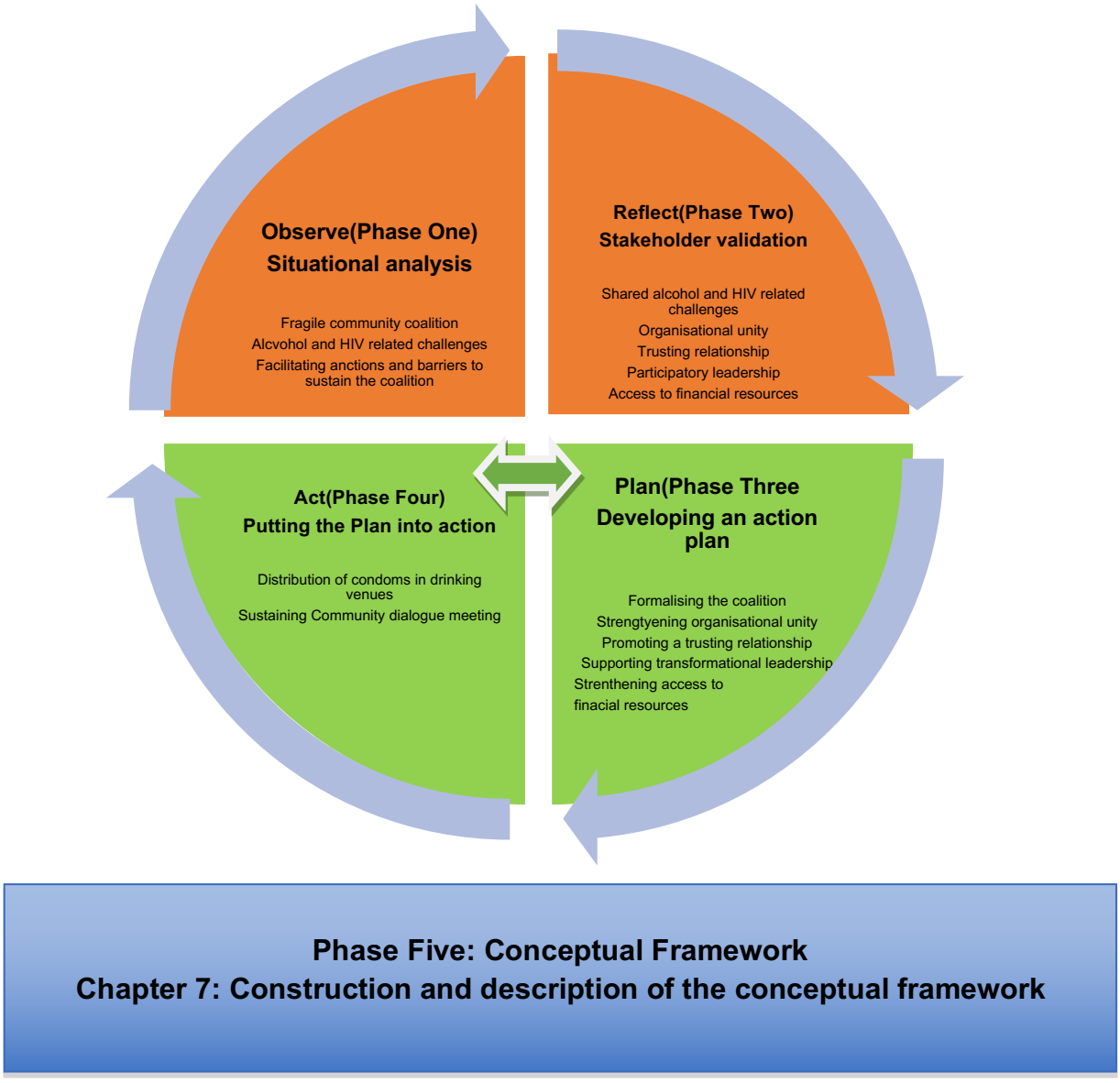


Figure 6.1: Phases Three & Four: Plan and act

The main objective of Phase Three was to explore how organisational stakeholders could be involved in sustaining a community coalition to manage alcohol misuse as a risk factor of HIV by involving them in the development of a plan of action. Phase Four focused on the implementation and evaluation of the chosen activities set out in the plan of action over a period of almost three years (August 2013 – May 2016). Reflexion was done at the end of each activity, such as at the end of distributing condoms to drinking venues and during the subsequent meeting.

In essence, organisational stakeholders were recruited as change agents to identify and prioritise problems and actions to be tried out to manage alcohol misuse as a risk factor of HIV infection. They were also helpful in implementing activities to manage alcohol misuse as a risk factor of HIV infection. In line with critical theory, the aim was to raise consciousness and aid organisational stakeholders in taking control of their own situation to transform their reality regarding alcohol misuse as a risk factor of HIV infection (Mash 2014:2). I describe these two phases concurrently since the phases overlapped; stakeholders discussed what should form part of the plan and how the activities should be activated in the same session. After dialogue sessions, organisational stakeholders implemented the chosen activities before the evaluation took place.

I remained conscious throughout my engagement with the organisational stakeholders that planning and acting should be participatory, collaborative and involve all relevant stakeholders through a mutual agreement in developing and finally implementing the action plan (Kasdan & Markman 2017:5). The planning and action phases entailed engagement with selected organisational stakeholders through organisational stakeholder dialogue sessions as well as carrying out activities to manage alcohol misuse as a risk factor of HIV infection.

Through dialogue meetings, organisational stakeholders proposed a number of activities to be undertaken to sustain the coalition to manage alcohol misuse as a risk factor of HIV infection. The proposed planned activities included: formalising the coalition through registration as an NPO, supporting transformational leadership, strengthening organisational unity, distributing condoms in alcohol outlets and schools, providing health education on substance abuse, particularly targeting the youth, strengthening access to financial resources, strengthening home-based care, as well as promoting sporting activities. In the section that follows, I discuss the proposed plan of action and how the activities were implemented.

6.3 PLANNING AND TAKING ACTION

Due to a high number of proposed activities, as well as limited resources to implement all the activities, organisational stakeholder representatives agreed to

prioritise by initially focusing on implementing fewer activities with the intention of expanding the scope of activities as the study progresses. A consensual agreement was reached that the following activities should be given priority; formalising the coalition through drafting a constitution (Annexure O) and registering the coalition partnership as an NPO, supporting transformational leadership, strengthening access to financial resources, and distributing condoms in alcohol outlets.

Sustainability planning and resource generation are some of the key activities that should be undertaken by organisational stakeholders early during the initiation of a programme. Findings from the study by Welsh et al (2016:12) suggest that sustainability planning should include an assessment of existing resources and facilitating their development. Collaborative planning among organisational stakeholders ensures that PAR is integrated into community programmes and that plans guiding the research are developed in collaboration with people who will use the research findings (Kasdan & Markman 2017:5). Formalising the coalition was one of the key priority issues identified by organisational stakeholder representative.

6.3.1 Formalising the coalition

Organisational stakeholder representatives suggested that to sustain the community coalition to manage alcohol misuse as a risk factor of HIV infection, they needed to formalise relationships among themselves. To achieve the formalisation process, organisational stakeholder representatives developed a constitution and registered as an NPO with DSD. The following are quotes I captured in the minutes from dialogue meetings that demonstrate Phase Three's planning to support formalising the coalition through developing a constitution and registering as an NPO.

> *"In order that the coalition succeeds there is a need to agree on a constitution and register an NGO with social development that will help us to work together" (Dialogue meeting 1)*

> *"We need to register the organisation with social development as an NPO." (Dialogue meeting 5)*

"It was also agreed that registration as an NGO and having an account number will ensure that money raised are deposited in the NGO account number not personal account in this case it is not easy to steal money as financial statement for NGOs are audited" (Dialogue meeting 6)

"There is a need to have a constitution, there is a need to register as an NPO." (Dialogue meeting 7)

"We need to register with Social development as an NPO, for these we need: a constitution which explains our aims, vision and mission. We need ID photos of office bearers. We need minutes of the meeting for designations." (Dialogue meeting 8)

A constitution was developed by organisational stakeholders to guide the representatives' roles in the coalition using the DSD template. It includes organisation name, body corporate, objectives, governing structure and mechanisms of governance, powers of the organisation, meetings, income and property, finances and reports, as well as guidelines for amendments to the constitution (refer to Annexure O). As outlined in the constitution, the objectives of the community coalition were to: mobilise stakeholders from multiple organisations to provide service to the community, families and individuals in the community regarding drug and alcohol abuse and HIV, and strengthen organisational stakeholder collaboration. The draft constitution was adopted in dialogue meeting 8, in which 11 organisational stakeholders from NPOs, NGOs, FBOs and local government were present.

Organisational stakeholder representatives believed that registering as an NPO would assist in strengthening the coalition through formal agreements with terms of reference, promote a trusting relationship among organisational stakeholders, and pool financial resources to sustain the coalition. This is in line with Cooper et al (2013:1), who claim that formal linkage among organisational stakeholders can play a role in continued programme implementation. Formal rules and procedures set the stage for how the coalition would think and act and is positively associated with coalition effectiveness (Berger 2013:28).

In South Africa, the legislation that governs the registration of NPOs is the Non-profit Organisation Act, 1997 (South Africa 1997:s2). The Act supports NPOs in their contribution to meeting the needs of the population, provides guidance in establishing an administrative and regulatory framework within which NPOs can conduct their affairs, and promotes the spirit of cooperation and shared responsibility within government departments, donors, and among relevant stakeholders (South Africa 1997:s2). An NPO is a trust, company or other association of persons established for public purpose, of which its income and property are not shared by its members except as reasonable compensation for services rendered (South Africa 1997:s1). NGOs and Community-Based Organisations (CBOs) are collectively known as NPOs.

Formal registration as an NPO encourages accountability, transparency and improves coalition governance as the registered NPO is expected to comply with the requirements of the NPO Act (South Africa 1997:s2). The NPO registration strengthens access to financial resources because it is a funding requirement for some potential funders that an organisation be registered. Furthermore, NPO registration increases the confidence of the public in terms of services rendered by an organisation.

As part of formalising the coalition, organisational stakeholders nominated executive committee members to lead the registration process. A total of six organisational stakeholder representatives from different organisations were nominated to serve on the executive committee and to action the registration process. The executive committee consisted of a chairperson, deputy chairperson, secretary, treasurer, and two additional members. The six elected executive members used a guideline obtained from the DSD to draft the constitution that was presented in a plenary meeting for inputs and adoption. The chairperson and the treasurer submitted the adopted constitution, as well as the application for registration to the DSD, for processing. In order to sustain the coalition, organisational stakeholder representatives agreed on strengthening organisational unity.

6.3.2 Supporting transformational leadership

To strengthen the coalition, organisational stakeholders suggested supporting transformational leadership. To achieve these, organisational stakeholders participated in electing their own leadership that consisted of the chairperson, vice chairperson, secretary, treasurer and two additional members.

> *"It was anonymously agreed through show of hands that Greater X Based Organisation will be the name of the project. Office bearers elected were as follows; (names of office bearers)" (Dialogue meeting 3)*

> *"There was a discussion on who should form the executive of the organisations and how often will be meetings. One suggestion was that at least three representatives of stakeholders from each organisations be part of executive committee and meet once a month and give report back to members of organisations." (Dialogue meeting 3)*

In PAR, it is essential that leadership is forthcoming to give organisational stakeholders an opportunity to be active players in finding solutions to key issues affecting them (Christens & Inzeo 2015:428). As described by Hoffart (2017:65), in transformational leadership the leader displays attributes of a role model, and inspires the organisation through action for change by recognising the inputs and needs of organisational stakeholders.

Sustaining community coalition requires transformational leaders who are good role models, trusted, and maintain a high standard of ethics and morality (Yasir & Mohamad 2015:312; Nanjundeswaraswamy & Swamy 2014:57). Transformational leadership embedded in an open and trusting relationship will ensure good management of human and financial resources, which is one of the key pillars of coalition sustainability (Welsh et al 2016:14).

6.3.3 Strengthening access to financial resources

To strengthen access to financial resources, organisational stakeholder representatives suggested to formally register the coalition as an NPO as described in the previous section. Organisational stakeholder representatives further suggested opening a common banking account with a local bank. In order to maintain the banking account, organisational stakeholder representatives suggested raising funds and inviting potential funders to empower them on funding application processes. Although the workshop on funding did not happen as planned, organisational stakeholders shared contact details of potential funders and shared their experiences of the funding application process.

> *"There is a problem in booking the community hall, the caretaker need money to pay for the hall, we should raise funds for that, or else negotiate so that we do not have to pay" (Dialogue meeting 9)*

> *"NGOs in the community lack funding. There is a need to invite potential funders like Coke and MTN." (Dialogue meeting 9)*

> *"Money is needed to fund activities to prevent alcohol misuse and HIV infection. There is a need to open an account for the organisation in other to attract and manage funds" (Dialogue session 10)*

> *"A suggestion was made those different organisations to bring about R20 every month for our organisation to ensure that the banking account remains active. We must invite sponsors to workshop us on how to apply for money." (Dialogue meeting 10)*

> *"Distributing condoms need money for travel, we need to collect condoms from the Department of Health, and to distribute to taverns. These need petrol." (Dialogue meeting 10)*

The sustainability of community coalitions is depended on access to financial resources to support activities to manage substance misuse and its related public

health and social problems (Welsh et al 2016:3). In line with Welsh et al (2016:3), organisational stakeholder representatives in the current study took the initiative to explore different strategies to diversify funding sources. Although financial sufficiency is critical in ensuring that community coalitions sustain operational activities, some activities can be achieved with limited financial resources (Anaf, Baum, Freeman, Labonte, Javanparast, Jolley et al 2014:555). Furthermore, aligning an intervention programme with already established service delivery platforms may contribute to sustainability with limited financial resources (Cooper et al 2013:2).

6.3.4 Distribution of condoms

Based on finding from the situational analysis that the community is characterised by high alcohol misuse which may contribute to the spread of HIV infection, organisational stakeholder representatives suggested a need to distribute condoms in identified areas such as alcohol outlets and schools. Initially there was a disagreement on the distribution of condoms at schools. Organisational stakeholders who were against distributing condoms in schools held the belief that distributing condoms in schools will have an unintended consequence of sending the wrong message to school children that they should engage in sex instead of encouraging abstinence. The following were recorded in minutes of a dialogue session meeting to reflect opinions against distributing condoms in schools.

> *"Issue of condoms given to school, why should we distribute condoms to schools due to their age. It seems we motivate them to have sex instead of encouraging them to abstain from sex. In another way we say go and have sex." (Dialogue meeting 6)*

> *"We should try to teach young people about abstaining. We should be open about sex. There should be age restriction about who to give condoms. They should display disease with pictures. A sport has been replaced by condoms. We need to return sports back to school." (Dialogue meeting 8)*

However, organisational stakeholders who believed that condoms should be distributed at schools argued that schoolchildren are sexually active anyway, as

seen by children as young as 11 years old falling pregnant. Furthermore, organisational stakeholders argued that young people at schools are taught life orientation that includes educating people about sex. Organisational stakeholders suggested that information about sex should be open to the youth. Some organisational stakeholder representatives strongly suggested that condoms should be distributed at taverns and schools.

The following statements from community dialogue sessions supported this view:

> *"People as young as below 11 falls pregnant, some test positive for HIV. We once taught people about HIV in schools but they misbehave. In clinics they just put condoms for people to collect" (Dialogue meeting 8)*

> *"Mrs X reiterated that we need to distribute condoms everywhere, prevention is better than nothing. We need to distribute condoms at schools and taverns." (Dialogue meeting 8)*

Ultimately, an agreement was reached through consensus that condoms should be distributed to alcohol outlets as it is a place where young people are at risk of alcohol misuse and risky sexual behaviour. A list of alcohol outlets was compiled and about 38 taverns were identified in which condoms were distributed. Condoms were collected from the National Department of Health by myself and presented in a community meeting before being distributed to the taverns.

Seven organisational stakeholders volunteered to participate in the distribution of condoms, including myself, three representatives from youth organisations, two representatives from an NGO working on community-based health promotion, two representatives from an FBO, and a representative from a local drug treatment centre. Condom distribution in drinking venues followed a structured activity that included introducing the project to the alcohol outlet owner at arrival, identifying the need for condoms by asking alcohol outlet owners and bar patrons about their views on condoms, and identifying the number of condoms needed. Upon distribution at each of the dinking venues, organisational stakeholders reflected on their views about condom distribution. At the end of distribution, organisational stakeholders

again had a debriefing session that lasted for about an hour to reflect on their views about distributing condoms in general in order to provide feedback during the following organisational stakeholder meeting.

There were two rounds of distributing condoms in drinking venues; the first was on 24 October 2015 in which male and female condoms were distributed to 28 taverns, and the second was on 8 January 2016 in which condoms were distributed to 22 taverns. Condoms were not distributed to the other six taverns as they were either closed on non-operational. During the second round, we counted how many condoms were left in order to establish how many condoms were needed. In most of the taverns it was found that no condoms remained from our last condom distribution. Data on interaction with taverns owners and bar patrons were documented in a condom distribution booklet. The following are quotes from that document:

> *"The condoms are needed in our taverns, although the following day we end up cleaning the mess (used condoms), but this shows that they are using them." (Tavern owner)*
>
> *"Condoms are very useful, but we want you to demonstrate how they work." (Bar patron)*
>
> *"There are no condoms, the last box was finished on Monday because there were socials" (Tavern owner)*
>
> *"These condoms called choice do not smell nicely, We need flavoured condoms" (Bar patron)*

Alcohol outlet owners reflected that there is a shortage of condoms in drinking venues and that condoms were needed as some patrons in taverns engage in risky sexual behaviour. Alcohol outlet owners suggested that distributing condoms should be extended to unlicensed alcohol outlets. Organisational stakeholders who distributed condoms felt that the activity of distributing condoms to alcohol outlets contributes to saving the lives of these patrons as reflected in the following quotes:

"*There is a general shortage of condoms in drinking venues, this project will help our people."*

"I like this activity, it will save life of many young people."

"I wonder what was going to happen in that tavern if we did not distribute condoms, especially because there are socials tonight. I feel pity for this young people."

Youth representatives helped in identifying taverns and distributing condoms in alcohol outlets. Organisational stakeholders managed to distribute condoms to 28 identified alcohol outlets. Although alcohol outlet owners did not participate in organisational stakeholder plenary meetings, they participated in condom distribution by allowing organisational stakeholders access to their establishments.

Alcohol misuse may contribute to impairment in decision making and risky sexual activities, such as sex without condom use which is a risk factor of HIV infection (WHO 2018:7). It is therefore imperative to distribute condoms in an environment characterised by alcohol misuse and risky sexual behaviour, such as alcohol outlets. In the study by Morojele et al (2014:6), an intervention for the distribution of condoms in drinking venues was found to be feasible and acceptable.

6.4 LESSONS LEARNED

6.4.1 Formalising the coalition

A coalition is more likely to be sustained when there is formalised organisational structure (Goldstein et al 2017:124). In this study, organisational stakeholders decided to formalise the coalition by agreeing on membership, meeting processes and procures, and drafting the constitution to clarify role expectations for each organisational stakeholders. Formalising a coalition may include defining formal roles within the coalition to help clarify individual roles and what organisational stakeholders can expect from the coalition. Berger (2013:20) argues that formalising goals, objectives and expectations are linked to the overall success of coalitions.

Johnson et al (2017:619) also suggest that the level of coalition formalisation predicts sustainability. Snyder (2014:15) concurs that coalition formalisation is positively associated with coalition functioning.

6.4.2 Trusting relationship

Building a trusting relationship between organisational stakeholders and the researcher and among organisational stakeholders themselves is essential for strengthening coalition sustainability. This trusting relationship is built on openness, transparency, sharing of findings, and working in collaboration with organisational stakeholders to utilise research findings to implement change. Boaz et al (2018:6) argue that researchers need to trust and respect participants as partners. Researchers should value their knowledge and expertise, and take into account their needs and priorities through collaborative research. Findings from the study by Aitken et al (2016:718) declared that openness about research practices, sharing of findings and informing participants how findings are used is essential in strengthening a trusting relationship between the researcher and research participants. Aitken et al (2016:721) argue that organisational stakeholders should develop trust in science; yet public participation should not be aimed at improving public trust in science, but rather improving trustworthiness of science.

With regards to trusting relationships among organisational stakeholders, Berger (2013:16) argues that developing trust and meaningful relationships between different stakeholders is essential for coalition sustainability. Burnett, Norman, Sycara and Oren (2014:23) concur that trust is essential to facilitate effective collaboration in coalition operations. Confidant relationships are built on trusting relationships (Neal & Christens 2014:318).

6.4.3 Election of leadership

Organisational stakeholders are motivated to work in collaboration if they are given an opportunity to elect their own leaders. In this study, participants elected their own leaders who were perceived to be transparent and trustworthy. Berger (2013:17) argues that effective leaders should be trustworthy, patient and confident in the

collaborative process and should come from the local community to support long-term capacity building.

6.4.4 Coalition sustainability

Organisational stakeholders identified the following pillars as important in sustaining a community coalition to manage alcohol misuse and HIV infection; sharing common alcohol and HIV-related challenges, strengthening organisational unity, developing a trusting relationship, transformative leadership, and access to financial resources.

6.5 CONCLUSION

This chapter presented how organisational stakeholders engaged in activities of planning and taking action to manage alcohol misuse as a risk factor of HIV infection. The planning and action phases of the study generated information on how organisational stakeholders could be engaged in planning and taking action through a coalition to manage alcohol misuse as a risk factor of HIV infection. Sustaining the community coalition to manage alcohol misuse and HIV infection had both successes and challenges.

As a success, organisational stakeholders were able to reach agreement through consensus on which activities to implement to manage alcohol misuse as a risk factor of HIV infection. A number of activities were reached by consensus decisions; these included formalising the coalition, registration of the coalition as an NPO, electing leadership and office bearers as well as distribution of condoms in alcohol outlets to address the scourge of alcohol misuse as a risk factor of HIV infection.

In conclusion, the chapter generated information to guide the construction and description of a sustainable community coalition conceptual framework to manage alcohol misuse as a risk factor of HIV infection. Having identified the key issues that need to be considered to construct and describe the conceptual framework, and through collecting data during Phases One to Four of PAR, in the chapter that follows I construct and describe the framework.

CHAPTER 7
PHASE FIVE: CONSTRUCTION AND DESCRIPTION OF THE CONCEPTUAL FRAMEWORK

7.1 INTRODUCTION

In Chapter 6, I presented a narrative account and discussion on Phases 3 and 4, (plan & act) of the study. The main focus of this chapter is to construct and describe a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor for HIV infection. The aim of this chapter is to answer the research question "What should a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor for HIV infection consist of?"

Based on the collected data and the findings from the cyclic PAR process, the outcome of this chapter is a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. The conceptual framework could be used by mental health practitioners to work in collaboration with organisational stakeholders to facilitate resources to manage alcohol misuse as a risk factor of HIV infection.

7.2 CONSTRUCTING THE FRAMEWORK

A conceptual framework is an outcome of bringing together related concepts to describe an event or give a broader understanding of the research problem (Imenda 2014:189). Findings from previous phases of the study (observe, reflect, plan, and act) served as a basis or foundation to construct and describe a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection.

7.2.1 Aim of the conceptual framework

Rakhudu, Davhana-Maselesele and Useh (2017:5) argue that a framework is used as a frame of reference by researchers to facilitate the design of collaborative interventions for the benefit of the participants. The conceptual framework in this study serves as a frame of reference for organisational stakeholders working in collaboration with mental health practitioners as secondary recipients to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection in a specific context.

7.2.2 Assumptions of the conceptual framework

Assumptions are statements that are not scientifically tested but considered to be true without verification (Polit & Beck 2017:9). The assumptions of the conceptual framework were deducted from insights gained from the empirical data and are linked to critical theory, PAR, Practice-oriented model, Bronfenbrenner's ecological framework, as well as theory generation criteria as described by Chinn and Kramer (2011).

- Knowledge is multiple and co-created by organisational stakeholders to take action for change.
- Organisational stakeholders have valuable knowledge of local issues affecting them.
- The production of knowledge is not objective or value-free.
- Organisational stakeholders will work in collaboration if they have developed a trusting relationship among themselves.
- Developing trust among organisational stakeholders takes time.
- Organisational stakeholders will be motivated to participate in a coalition if they believe that their voice will be taken into consideration to create change.
- PAR promotes ownership of the change process.
- Theory, practice and research are mutually interrelated and interdependent.
- Human beings create the specific environments in which they live, which will impact on their behaviour and development.

- Theory generation should take clarity, simplicity, generality, accessibility, and importance in consideration.

7.2.3 Description of the framework

Introduce Dickoff et al. 1968, first, practice oriented theory–describe this theory, before going into the framework.

Dickcoff et al (1968:415) describe the relation of theory, practice and research as mutually interrelated and interdependent. Theory reveals the facts about reality and forms the basis for constructing the conceptual framework. The framework in this study reflects Dickoff et al's (1968:423) thinking map with reference to the agent, recipient, dynamic, procedure, context and outcome/terminus. Table 7.1 reflects the application of these concepts to this study, followed by a graphic description of the conceptual framework presented in Figure 7.1. A discussion of each of the aspects follows as a building block to the framework.

Table 7.1: Applied thinking map adapted from Dickoff et al (1968:423)

Primary Agent Secondary Agent	Organisational stakeholders as agents of change Mental health practitioner
Primary Recipients Secondary Recipients	Community organisations affected by alcohol misuse as a risk factor of HIV infection Families and individuals in the community affected by alcohol misuse as a risk factor of HIV infection
Dynamic	Action to change to bring about sustainable change in community coalition to manage alcohol misuse as a risk factor of HIV infection
Procedure	The four basic functions and procedures of the management process namely; planning, organising, leading and control The procedure reflects an ongoing engagement and

	interaction between organisational stakeholders, individuals and families, as well as mental health practitioners to manage alcohol misuse as a risk factor of HIV infection
Context	The context of this framework refers to the immediate setting or the environment in which activities take place Context can be understood as a set of interrelated systems (i.e. microsystems, mesosytems, exosystems and macrosytems)
Outcome/Terminus	Empowered organisational stakeholders to sustain community coalitions to manage alcohol misuse as a risk factor of HIV infection

Figure 7.1 graphically depicts the elements and flow of the framework.

The arrows, shapes and colours in the conceptual framework have specific meanings. Arrows indicate pathways and the broken lines reflect permeability. Each circle presents a task within the system. Because a circle does not have a distinct beginning or end, it implies movement, and represents life and the lifecycle. Circles also suggest infiniteness and harmony, and send a positive emotional message of protection. The circles also represent unity and commitment in the community.

The green colour indicates the source of sustainable energy for organisational stakeholders, the purple colour depicts the power to be attained by organisational stakeholders as agents of change, and the yellow colour represents harvest in the form of benefits by organisational stakeholders, individuals and families in the community. The blue colour illustrates the procedure in the form of organisational stakeholders working in collaboration during planning, organising, leading, and controlling in order to work towards a common vision. The red colour represents emancipation of organisational stakeholders through empowerment, leading to the outcome of empowered organisational stakeholders to sustain a coalition to manage alcohol misuse as a risk factor of HIV infection. The description of each of the aspects of the conceptual framework is described next.

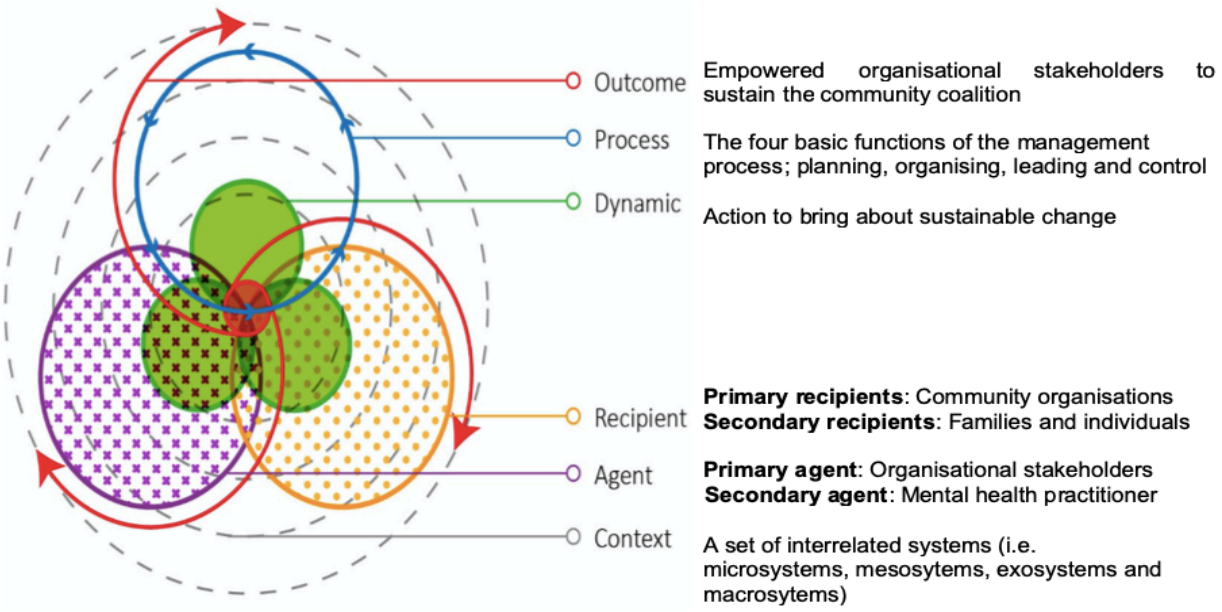


Figure 7.1: Sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection

7.2.3.1 Organisational stakeholders as primary agents of change

Organisational stakeholders in this conceptual framework, as summarised in Table 7.1 and depicted as a purple circle in Figure 7.2, represent the primary agents of change.

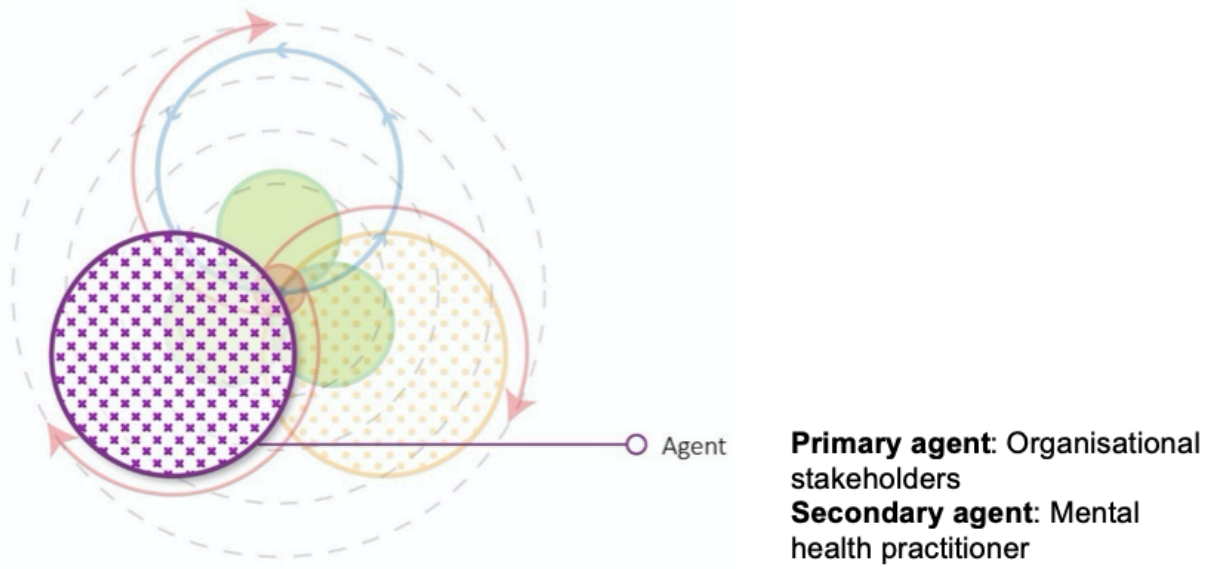


Figure 7.2: Organisational stakeholders and mental health practitioners as agents of change

Table 7.2 reflects the essential characteristics an organisational stakeholder must possess to fulfil this role, as it emerged from the findings of Phases Two to Four. The organisational stakeholders, as primary agents, should be able to motivate individuals and families in the community to participate in a coalition to take action for change, strengthen the mutual trusting relationship between organisational stakeholders and themselves and among organisational stakeholders, and demonstrate transformational leadership.

Table 7.2: Characteristics of organisational stakeholders as primary agents of change

Primary Agent Organisational stakeholders performing the activity should display the following characteristics
• **Motivation** • **Mutual trusting relationship** • **Transformation leadership**

According to Dickoff et al (1968:423), an agent is a person who performs the activity. In this conceptual framework, activity refers to actions undertaken by organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. Agents are organisational stakeholders from a variety of organisations such as FBOs, NGOs, NPOs, youth organisations, local drug treatment centres, and government departments that include the Department of Health, the Department of Police Services, and the local government.

Organisational stakeholders in this study, through their involvement in the PAR, participated in dialogue meetings that entailed – at a basic level – engagement in planning, organising, leading, acting, and taking control associated with the management of alcohol misuse as a risk factor of HIV infection in the community. Linked to these responsibilities, they engaged in specific activities relevant to the management function that is a key concept in this research in particular. The activities refer to (1) the sharing of both personal and professional experiences with other organisational stakeholders, families and individuals in the community on alcohol misuse as a risk factor of HIV infection during dialogue meetings, (2) the

distribution of condoms in alcohol outlets, as well as (3) sharing information about responsible drinking and sexual behaviour with alcohol outlet owners and their patrons.

The aforementioned activities were undertaken with the aim of facilitating sustainable action for change relevant to alcohol misuse as a risk factor of HIV infection in the community. Fältholm, Wennberg and Wikberg Nilsson (2016:11) refer to sustainable change as collaboration on equal terms with organisational stakeholders through the research process in order to provide greater opportunity to achieve sustainable development and change. During dialogue meetings, organisational stakeholders identified key issues to sustain the coalition as motivation to work together, developing a trusting relationship and adopting a transformational leadership style. In this conceptual framework, mental health practitioners need to work in collaboration with organisational stakeholders to continuously develop these attributes.

a) Motivation

Motivation is a driving force or energy directed at the goal of sustained action for change (Cook & Artino 2016:998). Motivation can either be intrinsic or extrinsic. Intrinsic motivation is taking some action for the satisfaction you receive and is from the individual's internal environment (Putra, Cho & Liu 2015:5; Cook & Artino 2016:1010). Extrinsic motivation is taking some action in order to obtain a reward or outcome, and comes from the external factors of the individual (Putra et al 2015:5; Cook & Artino 2016:1010). In this framework, motivation for organisational stakeholders to participate in a coalition is both intrinsic and extrinsic.

Organisational stakeholders participate in a coalition because of perceived benefits, such as enjoyment and satisfaction in participating in a coalition. Furthermore, organisational stakeholders participate in a coalition because of the reward anticipated in improving the quality of life of individuals and families in their communities, and helping to strengthen a trusting relationship among stakeholders. This is in line with findings by Bermea et al (2018:7), who state that emotional connection and needs fulfilment motivates organisational stakeholders to participate in a coalition.

Organisational stakeholders act as a Community of Practice (CoP). Cruess, Cruess and Steinert (2018:186) define CoP as sustaining a social network of organisational stakeholders who share knowledge, beliefs, values, and experiences. Mental health practitioners working in these communities can play a critical role in facilitating organisational stakeholders to acquire these attributes. The role of organisational stakeholders is discussed in the next section (Section 7.2.3.2).

b) Mutual trusting relationship

Mutual trust develops when organisational stakeholders have confidence in one another (Oetzel, Wallerstein, Duran, Sanchez-Youngman, Nguyen, Woo et al 2018:7). In this framework, a mutually trusting relationship can be enhanced through openness and transparency among organisational stakeholders, families and individuals in the community. Organisational stakeholders, as agents of change, should display mutually trusting relationships among themselves and with recipients of the activity. This relationship is essential to strengthening sustainability. As described by Berger (2013:41), sustained coalitions are built on a strong, trusting relationship.

Mutual trust occurs at two levels; firstly, among organisational stakeholders as change agents, and secondly between organisational stakeholders, families and individuals as recipients of the activity. It is through this trusting relationship of openness and transparency that organisational stakeholders and individuals in the community learn from each other about activities needed to sustain the coalition to manage alcohol misuse as a risk factor of HIV infection. The mutually trusting relationship can be facilitated through strengthening consistent interaction among organisational stakeholders, collaborative action plans to encourage organisational stakeholders to work together, and organisational stakeholders following through on commitments (Berger 2013:25). Strengthening a trusting relationship between organisational stakeholders and recipients will facilitate the acceptability of intervention programmes by the recipients.

c) Transformational leadership

In the context of this conceptual framework, transformational leadership is relevant to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection. As described by Hoffart (2017:65), with transformational leadership the leader displays attributes of being a role model, inspiring organisational stakeholders through actions for change for a common good by recognising the inputs and needs of organisational stakeholders. Transformational leadership has been associated with increased levels of group potency (Nanjundeswaraswamy & Swamy 2014:2). Organisational stakeholders, as agents of change, must display a transformational leadership style. Transformational leadership is described in more detail in Section 7.2.5.2.

7.2.3.2 Mental Health Practitioners as secondary agents of change

Mental health practitioners, as secondary agents of change, should facilitate motivation, mutually trusting relationships and transformational leadership. Mental health practitioners should work in collaboration with organisational stakeholders as secondary agents to facilitate resources to manage alcohol misuse as a risk factor of HIV infection. In order to achieve this, they need to create a context in which the aforementioned characteristics of the organisational stakeholders can be facilitated. Mental health practitioners should play a critical role in empowering organisational stakeholders through mentoring, counselling and training, as summarised in Table 7.3.

Table 7.3: Mental health practitioners as secondary agents of change

Mental Health practitioner as secondary agent
• **Facilitate resources** • **Mutual trusting relationship** • **Transformational leadership** • **Empowerment (Mentoring, counselling and training)**

7.2.3.3 Recipients of the activity

Recipients in this framework include community organisations as primary recipients, as well as families and individuals in the community as secondary recipients. These recipients are the beneficiaries of the activities (and interventions) and are represented in the framework as the yellow circle (Figure 7.3 and Table 7.4).

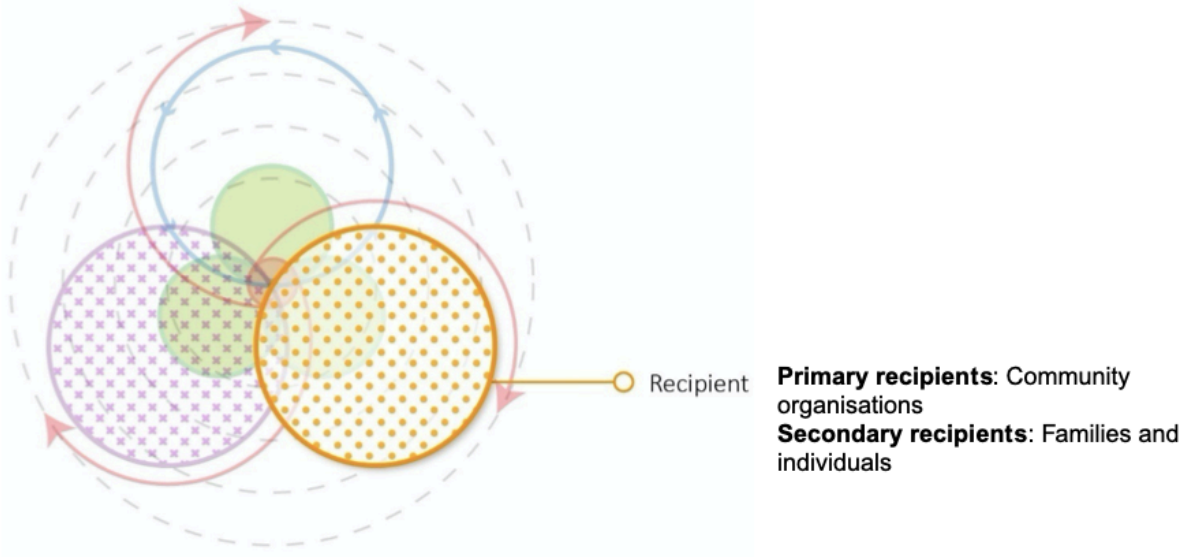


Figure 7.3: Recipients of the activity: Primary and secondary recipients

Community organisations, as primary recipients, as well as individuals and families as secondary recipients, are summarised in Table 7.4 followed by a full description of each.

Table 7.4: Recipients of the activity: Primary and secondary recipients

Recipient Recipients of the activity	
•Primary recipient •Secondary recipient	- Community organisations - Individuals and families

a) Community organisations as primary recipients

In this framework, three categories of organisations affected by alcohol misuse as a risk factor of HIV infection include organisations that increase the risk of alcohol misuse as a risk factor of HIV infection, organisations that are negatively affected by alcohol misuse as a risk factor of HIV infection, and organisations that manage alcohol misuse as a risk factor of HIV infection.

Organisations that increase the risk of alcohol misuse as a risk factor of HIV infection

Organisations that increase the risk of alcohol misuse as a risk factor of HIV infection were identified as alcohol outlets and social clubs. These organisations act as a driving force for alcohol misuse, thus potentially increasing the risk for the spread of HIV infection relevant to their patrons. Communities characterised by a high alcohol outlet density seemingly increase accessibility to and the availability of alcohol, consequently increasing the risk of alcohol misuse as a risk factor of HIV infection. Findings from this study are consistent with findings from previous studies that a high alcohol outlet density increases the likelihood of alcohol misuse (Letsela et al 2018:187: Nakkash et al 2018:2).

In this framework, empowering organisational stakeholders to participate and have a voice in decision making regarding alcohol outlets will contribute in reducing access to and the availability of alcohol, consequently reducing the risk of alcohol misuse as a risk factor of HIV infection. This could be achieved by creating awareness and understanding among organisational stakeholders of relevant policies such as the liquor policy and the Liquor Act to control availability and access to alcohol (South Africa 2016:s1; South Africa 2003:s2). Among others, the objectives of the Liquor Act (South Africa 2003:s2) encourage the public to participate in applications for registration to distribute alcohol. This is to empower the public to have a voice in decision making regarding the availability of and access to alcohol and its potential negative public health and social consequences. Organisational stakeholders, as agents of change, should facilitate information sharing sessions about alcohol-related legislation and policies to keep the public informed.

Organisations negatively affected by alcohol misuse as a risk of HIV infection

The high alcohol outlet density exists alongside organisations such as schools and FBOs in the community. Because these organisations share the same environmental space characterised by many alcohol outlets, there is increased exposure of alcohol to these organisations. Educational institutions' exposure to alcohol increases the risk of alcohol misuse as a risk factor of HIV infection among school learners.

A study by Milam et al (2014:12), on the effects of school learners' exposure to alcohol, found that the presence of alcohol outlets put school learners at risk of being offered alcohol. Seemingly, Nakkash et al (2018:2) found that alcohol outlets near school premises predispose children to alcohol misuse, consequently contributing to alcohol-related public health and social consequences. Organisational stakeholders should be empowered to play a role in decision making regarding where alcohol outlets should be situated and influence town planning so that alcohol outlets are not built in close proximity to schools.

High alcohol outlet density affects FBOs in two ways. Firstly, some FBO members are tempted to consume alcohol before church service; secondly, due to the close proximity of some alcohol outlets to church buildings, the noise of these alcohol outlets may interfere with church services. In order to minimise the church's exposure to alcohol, as a registration and licensing requirement, the National Liquor Policy prescribes that alcohol outlets be located at least 500 metres away from religious organisations (South Africa 2016:24). FBOs can play a meaningful role in the management of alcohol misuse as a risk factor of HIV infection through spiritual counselling, prayer meetings and health promotion messages. The role of FBOs in the management of alcohol misuse as a risk factor of HIV infection is described next.

Organisations that manage alcohol misuse and HIV infection

Four organisations that were identified as managing alcohol misuse as a risk factor of HIV infection include FBOs, NGOs, PHC, and police services.

FBOs manage alcohol misuse as a risk factor of HIV infection through the provision of counselling, caring for orphans and vulnerable children, providing home-based care and conducting awareness and educational campaigns and moral and spiritual teaching (Clarkson 2014:24). Findings from the study by Mash and Mash (2013:6) state that FBOs influence the management of alcohol misuse and HIV infection through moral and spiritual beliefs related to alcohol, rules of family life as well as sexual activity.

A study by Mash and Mash (2013:6) found a positive role played by FBOs on alcohol misuse and HIV prevention through spiritual teachings. However, the authors (Mash & Mash 2013:2) argue that the potential for FBOs to play a role in HIV prevention may be undermined by the FBOs' attitudes to discussing sexuality, condom use and stigma. Mash and Mash (2013:2) further state that some FBOs promoting sex before marriage and sticking to one sexual partner as a solution to HIV prevention is not realistic as it does not take into account the reality that most adolescents are sexually active, and having more than one sexual partner is a common practice. Organisational stakeholders, as agents of change, should involve FBOs in information sharing and training on sexuality and HIV. However, FBO intervention alone is not sufficient to address alcohol misuse and HIV problems, therefore a multisectoral approach involving all relevant stakeholders that include, among others, NGOs, is needed to strengthen the intervention.

NGOs contribute in the management of HIV infection through the Community Health Workers (CHW) programme by supporting people with HIV challenges, such as providing ARV medications at peoples' homes (Mottiar & Lodge 2018:55). Activities of NGOs in the community under study are mainly focused on HIV and TB while a focus on the prevention and management of alcohol misuse is lacking. Given the relationship between alcohol misuse and HIV infection, organisational stakeholders identified the need to integrate alcohol use management in the HIV programme. When addressing HIV and TB, alcohol misuse should form an integral part of health promotional activities among individuals and families in the community.

The PHC clinic plays a role in the management of alcohol misuse as a risk factor of HIV infection through primary prevention strategies such as screening and early

identification of alcohol misuse and HIV, health warning messages on alcohol misuse and HIV infection, as well as the distribution of condoms. It also includes secondary prevention strategies such as the provision of ARV's, and tertiary health promotional strategies by supporting NGOs in looking after victims of alcohol misuse as a risk factor of HIV infection (South Africa 2016:1). As described in the National Health Insurance (NHI) Policy (South Africa 2017:29), the role of PHC is to address health problems in the community by providing promotive, preventive, curative and rehabilitation services, including addressing alcohol misuse as a risk factor of HIV infection.

In an endeavour to create a safe environment, one of the police service activities includes curbing the substance abuse epidemic through enforcement of the liquor legislation. The Liquor Act controls the sale and consumption of alcohol by restricting alcohol outlets' operating times, prohibiting public drinking, and enforcing legal purchasing age (South Africa 2003:s10). Organisational stakeholders should be empowered to work in collaboration with the police service to ensure that alcohol outlet owners stick to operating times and do not serve alcohol to minors. Restricting operating times by regulating the time of sale of alcohol has been found to reduce alcohol-related public health and social consequences (WHO 2018:100).

7.2.3.4 Individuals and families as secondary recipients

In this conceptual framework, individuals and families are secondary recipients. Harm from alcohol misuse occurs at the individual and family level (WHO 2018:11). Parents who misuse alcohol in front of their children expose them to the risk of alcohol misuse (Miller, Curtis, Chikritzhs & Toumbourou 2015:6). Furthermore, parents who misuse alcohol may experience impairment in their ability to provide a nurturing environment for the development of their children (Sirera & Mwenje 2014:14).

Activities to combat alcohol use should focus on the individual, family, community and societal level. At an individual level, organisational stakeholders should be empowered to help individuals manage alcohol misuse as a risk factor of HIV infection. At the family level, targeted family-based alcohol use prevention such as

strengthening family relationships and empowering family members to provide guidance to their children about alcohol use and sexual behaviour will contribute to reducing alcohol misuse as a risk factor of HIV infection (Miller et al 2015:33). As outlined in the international standards on drug use prevention, enhancing family bonding, supporting parents to play an active role in their children's life, maintaining appropriate discipline and role modelling is associated with positive substance use prevention outcomes (United Nations 2015:14-15). Organisational stakeholders, as primary agents, should support families to strengthen family relationships through workshops and home visits.

7.2.3.5 Dynamics as a source of the energy activity

The dynamics are represented as three green, interrelated circles in the framework, as indicated in both Figure 7.4 and Table 7.5. Dickoff et al (1968:423) define the dynamics as the energy source of the activity.

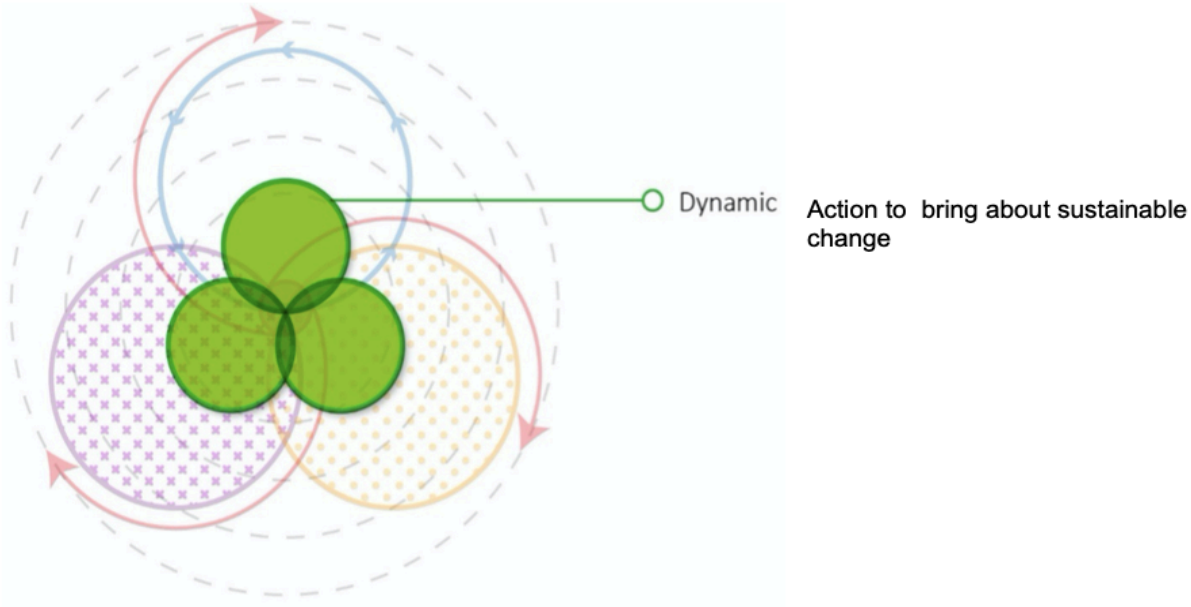


Figure 7.4: Dynamic as a source of energy activity

The dynamic, as the energy source of the activity, is described as an action for change by organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection.

Table 7.5: Dynamic as the energy source of the activity

Dynamic Dynamic is the energy source of the Activity
• Energy source of activity • Action for change in alcohol misuse as a risk factor of HIV infection

Dynamics is the energy source of the activity which can be physical, biological or psychological (Dickoff et al 1968:423). The psychological dynamics are relevant to this conceptual framework and refer, in particular, to action for change as a source of energy to sustain community coalition to manage alcohol misuse as a risk factor of HIV infection. In line with the PAR approach, the researcher worked in collaboration with organisational stakeholders to understand key issues in the everyday lives of organisational stakeholders to facilitate local action for change (Brooks & King 2017:2). Facilitating knowledge generation in collaboration with organisational stakeholders – through information sharing about alcohol misuse as a risk factor of HIV infection during dialogue meetings – is a source of power for organisational stakeholders to engage in activities to implement change.

7.2.3.6 Context in which the activity takes place

The context of this framework refers to the immediate setting or the environment in which activities take place (refer to Figure 7.5). The activities take place in a specific community of the North West Province composed of multiple organisational stakeholders, families and individuals who are experiencing alcohol misuse as a risk factor of HIV infection. In this framework, a holistic view demonstrates that factors driving alcohol misuse as a risk factor of HIV infection are interrelated. Determinants of alcohol misuse as a risk factor of HIV infection are described in line with Bronfenbenner's ecological theory under the following domains; microsytem, mesosytem, exosytem and macrosytem, to channel power in community organisations (Neal & Cristens 2014:315).

Bronfenbrenner's ecological framework for human development was first introduced in the 1970s as a conceptual model (Vélez-Agosto, Soto-Crespo, Mónica, Vizcarrondo-Oppenheimer, Vega-Molina & Coll 2017:901). The Bronfenbrenner ecological model examines human development by studying how human beings create specific environments in which they live. The model organises contexts of development into different levels of external influence. As described by Eriksson, Ghazinour and Hammarström (2018:419), the ecological environment is composed of systems at four different levels, the microsystem, the mesosystem, the exosystem, and the macrosystem. The Bronfenbrenner ecological framework has been used extensively in mental health and substance abuse research. For example, Van Zyl (2013:582) applied the framework to interpret the reasons for drug use by South African youths.

The ecological model was chosen as the theoretical framework for the current study because it provides a way to view organisational stakeholders from multiple dimensions to explain behavioural problems. The important aspects of the ecological model for the current study are organisational stakeholders' current environment in the community characterised by a high risk of alcohol misuse and HIV infection. In line with the assumptions of the current study, organisational stakeholders possess valuable knowledge on local issues affecting them and can be empowered to take action for change.

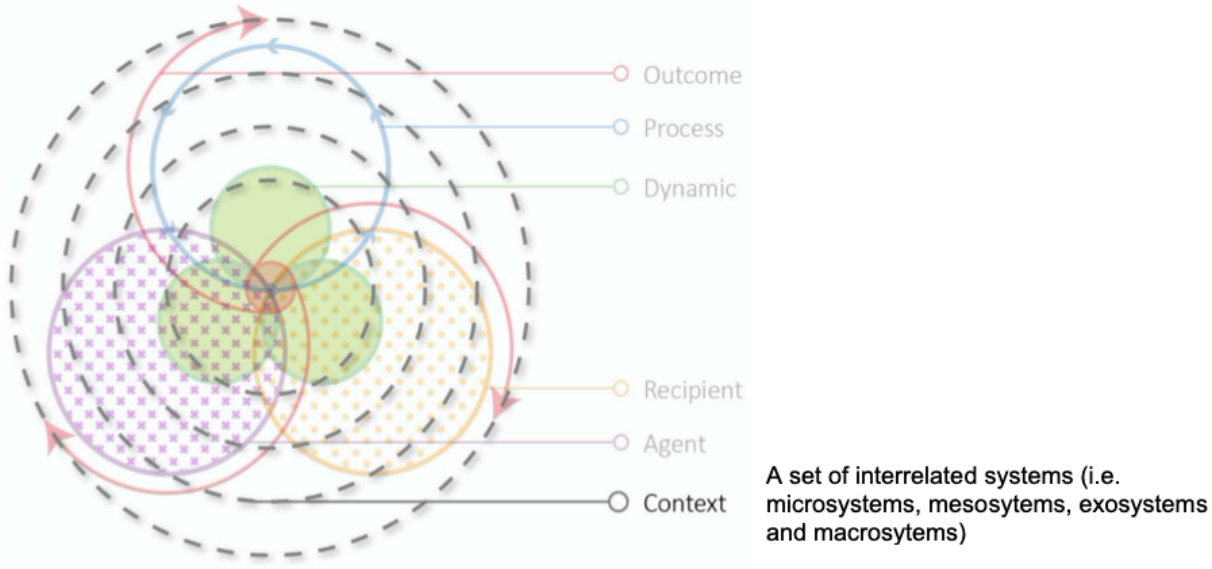


Figure 7.5: Context in which activities takes place

The context in which the activities take place is summarised in Table 7.6.

Table 7.6: Context in which activities takes place

Context Immediate setting or the environment in which activities take place
• A specific community in the North West Province composed of multiple organisational stakeholders, families and individuals experiencing a challenge of alcohol misuse as a risk factor of HIV infection • Microsytem • Mesosystem • Exosystem • Macrosytem

a) Microsystem

In this framework, issues within the individual that influence alcohol misuse include, among others, age and knowledge about alcohol use. Findings from this study reflect that alcohol misuse and engagement in risky sexual behaviour is prevalent among the youth. Letsela et al (2018:186) also found that alcohol misuse and HIV prevalence is a major public health problem, particularly among the youth. The youth is vulnerable to alcohol misuse due to easy access and the availability of alcohol (Letsela et al 2018:186; Nakkash et al 2018:2). Furthermore, the youth's vulnerability stems from the fact that they are in a phase of substantial experimentation (Basson & Tustin 2017:6). In the context of this study, alcohol misuse affects both the individual and the family. The WHO (2018:11) states that alcohol misuse not only causes harm to the individual drinker but also to those around him/her.

b) Mesosytem

The mesosystem reflects the interaction across different microsystems and involves linkages between individuals and family (Neal & Cristens 2014:315). The

mesosystem in this framework reflects the household and family influence on alcohol misuse as a risk factor of HIV infection. Within the family, parents remain influential in children's alcohol use and sexual behaviour through parental guidance (Sirera & Mwenje 2014). Family-based interventions are needed to empower parents to support their children's behaviour through open communication and guidance regarding alcohol use and sexual behaviour.

The family members can help to manage underage drinking by creating environments that reduce inappropriate access to and use of alcohol, and by refraining from supplying alcohol to the youth or under aged individuals (Basson & Tustin 2017:9). Alcohol misuse prevention programmes should be multidimensional and intergraded with other programmes in the community. Organisational stakeholders should be empowered to work together to manage alcohol misuse as a risk factor of HIV infection in a well-coordinated and integrated manner.

c) Exosystem

The exosystem includes an institutional organisational structure. In this framework, the exosystem includes policies that influence alcohol misuse as a risk factor of HIV infection. The focus is on controlling individuals' and families in the community's access to alcohol. Legislation and policies that regulate access to alcohol include, *inter alia*, licensing, monitoring the production and distribution of alcohol, regulating alcohol outlet density, outlet operating hours, age restriction on alcohol purchasing, and public drinking restriction (WHO 2018:99-104).

In South Africa, the Liquor Act 2003 (South Africa 3003:s11) prescribes regulations for the manufacture and distribution of liquor, which requires that alcohol outlet owners should register their businesses and alcohol should not be served to a minor. The liquor policy proposes increasing the minimum legal purchase age of alcohol to 21 years and prohibiting sales of alcohol within 500 meters from educational and religious institutions (South Africa 2016:s1). Despite existing legislation, findings from this study suggest that there are a number of alcohol outlets that serve alcohol to minors. Organisational stakeholders should be empowered to work in collaboration with law enforcement agencies to strengthen the implementation of the Liquor Act.

d) Macrosystem

The macrosystem consists of the culture and belief within a society that influences an individual's development (Obasi & Hill 2016:90). The macrosystem in this framework refers to broader cultural values and beliefs that contribute to alcohol misuse as a risk factor of HIV infection. The macrosystem include attitudes of organisational stakeholders, individuals and families in the community towards alcohol use and sexual behaviour. Findings from the current study are that public drinking and alcohol misuse – especially among the youth – has become common in the community. These attitudes influence how people drink alcohol and who consumes alcohol in the community.

7.2.3.7 Procedure

Procedure, in this conceptual framework, is indicated as a blue circle and refers to how the activity takes place. The procedure reflects the four basic functions and procedures of the management process, namely planning, organising, leading and taking control as it relates to the findings (Fadlallh 2015:246). The procedure reflects an ongoing engagement and interaction between organisational stakeholders, individuals and families, as well as mental health practitioners to manage alcohol misuse as a risk factor of HIV infection by sharing information. This is done through dialogue meetings, formalising the coalition, distributing condoms in alcohol outlets and sharing information about responsible drinking and sexual behaviour with alcohol outlet owners and patrons.

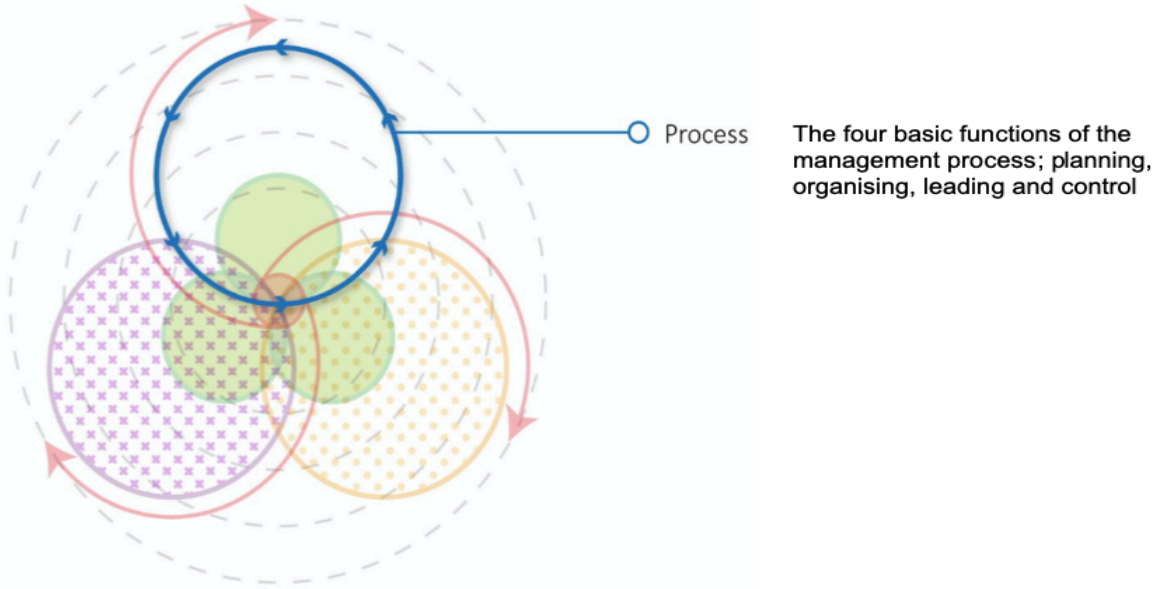


Figure 7.6: Procedure on how the activity takes place

a) Planning

Planning involves setting and determining the activities for achieving objectives which includes developing the common vision and objectives to manage alcohol misuse as a risk factor of HIV infection (Fadlallh 2015:247). Having a clear vision and plan early in the formation of a coalition helps support sustainability and change (Berger 2013:19). A common vision reflects the extent to which organisational stakeholders agree on the sustainable goals of the coalition. A coalition characterised by a shared vision with mutually agreed priorities contributes to the sustainability of a programme (Cooper et al 2013:9). Sharing a common vision also helps organisational stakeholders to share the future direction of the coalition (Berger 2013:21). Furthermore, a coalition from diverse community sectors who share a common vision is more likely to achieve targeted outcomes (Fagan & Hawkins 2015:15). A common vision can be developed through dialogue meetings to reach a consensus on the shared understanding of the desired future.

b) Organising

Organising refers to facilitating resources to ensure the accomplishment of a vision of organisations (Fadlallh 2015:247). It includes the execution of activities such as

the allocation and use of resources. Community organising is one of the core competencies relevant to social change (Wolfe & Price 2017:9). Organisational stakeholders in this framework should be capacitated to develop organising skills to facilitate resources to manage alcohol misuse as a risk factor of HIV infection. This could be achieved by sharing ideas and experiences, and offering training and mentoring on how to share resources in order to work towards achieving a common vision of sustaining a coalition to manage alcohol misuse as a risk factor of HIV infection.

c) Leading

Leadership is a process in which the leader seeks the voluntary participation of individuals in order to attain the vision of the organisation (Nanjundeswaraswamy & Swamy 2014:1) Leadership inspires change by providing strategic directions, building trust, and motivating people to take action for change. Hoffart (2017:69) describes three leadership styles; transformational leadership, transactional leadership and laissez-fair. In transformational leadership, the leader displays attributes of a role model and inspires action for change by recognising collective inputs and the needs of organisational stakeholders (Hoffart 2017:65). Hoffart (2017:20) suggests that transformational leadership entails open communication and shared decision making, which are important to encourage organisational stakeholders to work together for a common goal.

In this conceptual framework, a transformative leadership approach is relevant as it encourages organisational stakeholder representatives as actors, and individuals, families and communities as recipients, to participate collaboratively in taking action for change through shared leadership. Mental health practitioners should be empowered to enable organisational stakeholder representatives to understand and practice a transformational leadership style.

d) Control

Control refers to setting standards and ensuring that performance is in line with pre-determined standards (Fadlallh 2015:247). In this conceptual framework,

organisational stakeholders should be empowered in decision making on what needs to be implemented to manage alcohol misuse as a risk factor of HIV infection. They should set their own standards, and be able to monitor their performance against the standards set. They should, moreover, take corrective action or make adjustments to improve their activities to meet the standards set.

Organisational stakeholders in this framework should be empowered to have control over activities to be performed in managing alcohol misuse as a risk factor of HIV infection. They could decide what to do, such as distributing condoms in drinking venues, who is supposed to do it, and when. Although organisational stakeholders do not have control over policy decisions, such as determining drinking age limit and alcohol outlet licensing requirements, they can play an important role in influencing policy decisions during the consultation phase of policy development by providing input and suggestions. The mental healthcare practitioner should create awareness for organisational stakeholders to participate in a consultative process during policy development to ensure that they contribute to policy decisions. Procedure on how the activity takes place is summarised in table 7.7.

Table 7.7: Procedure on how the activity takes place

Procedure The Procedure reflects on how the activity takes place
• **The procedure reflect the four basic management process namely** • **planning,** • **organisisng,** • **leading, and** • **control**

7.2.3.8 Target outcome of the activity

The target outcome of the activity is presented as three red arrows in the conceptual framework. The outcome of the activity is reflected in Figure 7.7, and summarised in Table 7.8, followed by the description of the outcome.

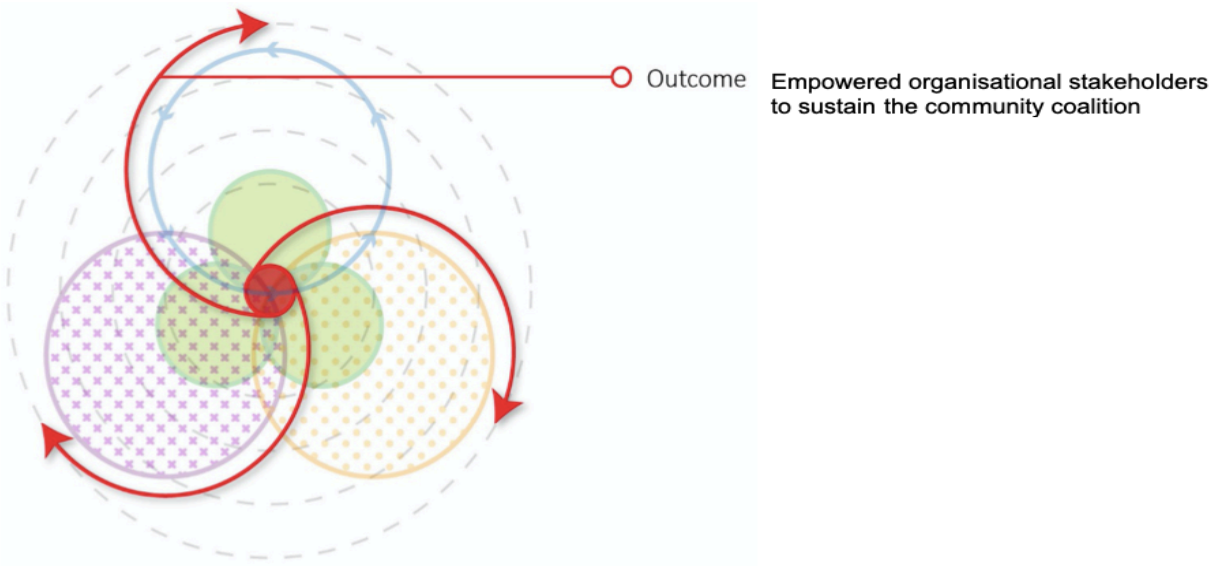


Figure 7.7: Outcome of the activity

The target outcome of implementing the conceptual framework is to empower organisational stakeholders to sustain community coalition to manage alcohol misuse as a risk factor of HIV infection as reflected in Table 7.8.

Table 7.8: Outcome envisioned of implementing the conceptual framework

Target Outcome: Outcome envisioned of implementing the conceptual framework to sustain community coalition to manage alcohol misuse as a risk factor of HIV infection
• The outcome envisioned of implementing the conceptual framework is empowered organisational stakeholders to sustain community coalition to manage alcohol misuse as a risk factor of HIV infection.

Empowerment is defined by Nelson, Verhagen and Noordzij (2016:365) as the belief that a person has, which includes their ability to perform a task well, and feeling in control over the situation. The targeted outcome of the activity is an empowered organisational stakeholder that will be able to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection. Organisational stakeholders

in this framework are empowered to understand the problem faced by the community and to take action to manage alcohol misuse as a risk factor of HIV infection.

7.3 EVALUATION OF THE CONCEPTUAL FRAMEWORK

The framework was presented to five experts in the field of substance abuse for evaluation by using an evaluation template as described by Chinn and Kramer (2011:197-205) in terms of clarity, simplicity, generality, accessibility, and importance. A four-point Likert scale was used to evaluate the conceptual framework, namely 1 'strongly disagree', 2 'disagree to some extent', 3 'agree to some extent', 4 'strongly agree' (see Annexure H). Furthermore, experts were asked to provide narrative comments on each of the concepts. The profile of experts is summarised in Table 7.9, followed by a discussion of each of the descriptors.

Table 7.9: Profile of the experts who evaluated the conceptual framework

Expert number	Highest qualification	Professional role
1	PhD	A senior lecturer and a professor in mental health nursing. She has experience in mental health and substance abuse. She currently serves on the Central Drug Authority (CDA) board, a body established to oversee the implementation of the National Drug Master Plan (NDMP)
2	PhD	A senior lecturer in mental health at the University of Pretoria. She has experience in conducting alcohol misuse related research. The focus area of her PhD degree is on alcohol misuse
3	Masters	A senior researcher at the SAMRC, Alcohol Tobacco and Other Drugs Research Unit (ATODRU). She has a master's degree in research psychology and experience in managing research studies on alcohol misuse as a risk factor of HIV infection
4	Masters	The fourth expert is a senior scientist in the SAMRC, ATORU. She has a master's degree and experience in working on alcohol and HIV research field. She is currently studying for PhD

Expert number	Highest qualification	Professional role
5	PhD	The fifth expert is a nurse manager at a psychiatric institution. She has a PhD in nursing science with a focus area on substance abuse.

7.3.1 Clarity of the conceptual framework

Hagran and Fakharany (2015:14) refer to clarity as the extent to which the definition of the concepts is clear and well defined, and that there is no excessive verbiage, narrative, or interchanging of words. Rakhudu et al (2017:8) concur that clarity is attained by using the same concept definitions throughout the framework description. I requested feedback from the experts about the clarity of the framework, thus, focusing on the general clarity, semantic clarity, semantic consistency, structural clarity and consistency. Semantic clarity refers to whether the conceptual framework is clear to understand and it was used to determine if they were of the opinion that the ideas presented in the framework are consistent (Chinn & Kramer 2011:198-201).

Three experts agreed to some extent, while two experts strongly agreed that the conceptual framework is clear and the ideas are consistently used throughout. Regarding the consistency of ideas, four experts strongly agreed while one expert agreed to some extent. Two experts strongly agreed that it is easy to understand the concepts while three experts agreed to some extent. All experts strongly agreed that the use of words is consistent and not inverted and that there is no excessive verbiage. Three experts strongly agreed that narratives are not excessively used while two agreed to some extent. Five experts strongly agreed that concepts are defined and that there is a consistent meaning during the use of concepts. Different views emerged about whether the relationship of concepts is clarified (one disagreed to some extent, two agreed to some extent, and two strongly agreed). The five experts strongly agreed that the aim of the conceptual framework is consistent with the components of the framework.

Different views emerged about whether the framework departs from clear assumptions (two disagreed to some extent, two agreed to some extent; one strongly agreed). I responded by refining the assumptions that are at present in the framework (see Section 7.2.2). Finally, the experts agreed that the framework displays structural clarity evident in the clear connectedness of the components, as well as structural consistency with reference to the connectedness of the structures of the conceptual framework.

7.3.2 Simplicity of the conceptual framework

Simplicity reflects the number of concepts and their interrelationships and that these should be kept to a minimum (Chinn & Kramer 2011:201-202). Rakhudu et al (2017:8) argue that structurally the components of the conceptual framework and relationship between categories and between concepts should be clearly explained and straightforward. Concepts used in this conceptual framework are simple, specific, described and supported by a diagram. The context, agents, recipients, dynamic, procedure, context and outcome are described in the framework. One expert agreed to some extent, while four experts strongly agreed that there are a number of manageable concepts in the conceptual framework (see Annexure H).

7.3.3 Generality of the conceptual framework

Generality refers to the width of scope of the framework and its application to a broad group of situations (Chinn & Kramer 2011:202-203). The scope of the concepts within the conceptual framework demonstrates that the framework has a broad scope of application in the field of substance abuse, particularly for mental health practitioners. Five experts strongly agreed that the scope of the concepts within the conceptual framework showed that the framework has a broad scope of application. One expert agreed to some extent and four strongly agreed that the aim within the conceptual framework showed that the conceptual framework has a broad scope of application. Similarly, one expert agreed to some extent and four strongly agreed that the conceptual framework applies to mental health professionals. Two experts agreed to some extent while three experts strongly agreed that the conceptual framework focuses on universal health outcomes (see Annexure H).

7.3.4 Accessibility of the conceptual framework

Chinn and Kramer (2011:203-204) suggest that the accessibility of the framework refers to the degree to which empiric indicators of the concepts can be identified by others in the field. Bunting (2016:331) concurs that accessibility of the conceptual framework addresses the extent to which empiric dimensions can be identified and that the aim of the framework can be achieved. The conceptual framework will be accessible to mental health practitioners and organisational stakeholders. One expert disagreed to some extent, while four experts strongly agreed that empiric dimensions of the conceptual framework could be identified. Regarding whether the aim of the framework can be achieved, two agreed to some extent while three strongly agreed (see Annexure H).

7.3.5 Importance of the conceptual framework

The importance of the conceptual framework is the significance of the conceptual framework (Chinn & Kramer 2011:204). The conceptual framework creates a reality that is important to mental health and substance misuse. The conceptual framework is useful to empower organisational stakeholders to participate in generating evidence-based knowledge. This is done through identifying their own problems and plans, and organising and taking control in the implementation of activities to manage alcohol misuse as a risk factor of HIV infection; subsequently contributing to improving the quality of life of community members. The five experts strongly agreed that the framework creates a reality that is important to mental health, and that the framework has the potential to influence mental health. Four of the experts strongly agreed that the conceptual framework is of value in enhancing the personal and professional growth of mental health practitioners, while only one expert agreed to some extent.

7.4 SUMMARY

This chapter described the sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. The thinking map of Dickoff et al (1968:423) with reference to the agent,

recipient, dynamic, procedure, context and outcome guided the construction and description of the conceptual framework. In Chapter 8, the overview of the research study, conclusion, recommendations, unique contributions, and limitations are described.

CHAPTER 8
CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

In Chapter 7, I constructed and described a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. In this chapter, I reflect on the overview of the study, potential contributions, limitations and practical challenges. I also present the conclusion and recommendations for mental health practice, mental health education, mental health research, and mental health policy. Finally, I offer my personal reflections on this research journey.

8.2 CONCLUSIONS TO THE STUDY

The overall aim of this study was to construct and describe a conceptual framework that can serve as a frame of reference for organisational stakeholders to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection in a specific community in the North West Province, South Africa. To achieve the overall aim of the study, a phased approach with specific objectives aligned to the PAR cycle was followed, namely: Phase One – observe, Phase Two – reflect, Phase Three – plan, and Phase Four – act. A literature review was conducted by critically assessing and synthesising existing empirical research from relevant peer-reviewed published research to contextualise the research phenomenon with existing evidence. Finally, data collected through the four phases were used to construct and describe a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. The conceptual framework was evaluated by five experts in the field of mental health and substance misuse for refinement (Phase Five).

These phases of the PAR were actualised through an exploratory, descriptive and contextual research design. I was guided and theoretically influenced by critical theory (Polit & Beck 2017:480-481) during my fieldwork engagements and in

constructing and describing the sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. In line with critical theory, my approach in this study was to work in collaboration with organisational stakeholders to create action for change for a period of five years (2013-2019).

The objectives of Phase One (observe) were to identify the organisational stakeholders that could be involved in the construction and description of a sustainable community coalition framework to manage alcohol misuse as a risk factor if HIV infection in a specific community in the North West Province, South Africa. The second objective was to identify the nature of the organisational stakeholders' current engagement in the management of alcohol misuse as a risk factor of HIV infection. The central theme that emerged during the 10 key informant interviews with the targeted organisational stakeholders or key informants is that the community is characterised by a fragile community coalition that hampers the management of alcohol misuse as a risk factor of HIV infection. The study succeeded in identifying organisational stakeholders in the community as well as their current engagement in the management of alcohol misuse as a risk factor of HIV infection. The key informant interviews guided me to identify organisational stakeholders that could be invited to participate in community dialogue meetings, in order to share the findings from Phase One of the study.

The objective of Phase Two (reflect) was to understand organisational stakeholders' perspectives on the construction and description of a sustainable community coalition conceptual framework to manage alcohol misuse as a risk factor of HIV infection. During this phase, data from Phase One of the study were shared with organisational stakeholders to reflect on the findings through a number of dialogue meetings. However, not all organisational stakeholders who participated in Phase One of the study were available to engage in this phase to reflect on the findings (Four of the key informants who participated in Phase One of the research study were available to participate in dialogue meetings). Furthermore, key organisational stakeholders such as tavern owners were not available to participate in the subsequent dialogue meetings.

The absence of some of the key organisational stakeholders (in particular, those that participated in the key informant interviews) throughout all phases of the research, reflects a missed opportunity for better understanding the current situation in the community from this specific stakeholder group's perspectives. However, based on the richness of the data that were generated throughout Phase Two of the study, I believe that sufficient information was generated to achieve the objectives of this phase. The salient issues from organisational stakeholder reflective engagements were mostly consistent with findings from Phase One of the study; the community is characterised by a fragile community coalition that hampers the management of alcohol misuse as a risk factor of HIV infection. This fragile community coalition was due to, among others, lack of participation by some of the key organisational stakeholders directly affected by alcohol misuse as a risk factor of HIV infection, such as alcohol outlet owners and youth organisations. Organisational stakeholders described facilitating actions to sustain the community coalition to manage alcohol misuse as a risk factor of HIV infection as formalising the coalition, strengthening organisational unity, promoting a trusting relationship, supporting transformational leadership and strengthening access to financial resources.

The objective of Phases Three and Four (Plan and Act) was to understand how organisational stakeholders can participate in sustaining a community coalition to manage alcohol misuse as a risk factor of HIV infection. During these phases, organisational stakeholders clarified what they do and how they were engaged in activities to manage alcohol misuse as a risk factor of HIV infection. Throughout these phases, organisational stakeholders collaborated during 10 community dialogue meetings to plan and act to manage alcohol misuse as a risk factor of HIV infection, formalised the coalition through registration as an NPO, and selected organisational stakeholders to distribute condoms in drinking venues. However, similar to Phase Two, in these phases not all relevant organisational stakeholders participated in dialogue meetings to plan and act, particularly tavern owners, despite being perceived to be the drivers of alcohol misuse as a risk factor of HIV infection.

The objective of Phase Five was to construct and describe a sustainable community coalition conceptual framework to manage alcohol misuse as a risk factor of HIV infection. During this phase, I constructed and described the sustainable community

coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection using data collected through Phase One to Four of the study. The framework reflects Dickoff et al's (1968: 423) thinking map, with reference to the agent, recipient, dynamic, procedure, context and outcome/terminus. The conceptual framework was evaluated by five experts in the field of substance misuse by using an evaluation template based on criteria of theory generation as described by Chinn and Kramer (2011:197-205), namely clarity, simplicity, generality, accessibility, and importance.

The five experts generally agreed with regards to the clarity of the framework. In terms of simplicity, one expert agreed to some extent, while four experts strongly agreed that there are a number of manageable concepts in the conceptual framework. There were mixed perceptions regarding the generality of the framework which ranged from 'agree to some extent' to 'strongly agree'. Most of the experts agreed that the framework is accessible. The five experts strongly agreed that the framework creates a reality that is important to mental health issues in terms of the inclusion of assumptions, and in describing the meaning of colours used in the framework. The recommendations were implemented.

Using PAR promotes ownership of the change process and increases the likelihood that the intervention will meet the needs of organisational stakeholders (Mash 2014:4). Organisational stakeholders who participated in this study developed skills and confidence, and were empowered to use evidence-based information to manage their own alcohol misuse and HIV-related problems, ultimately improving their quality of life (McDonald 2012:46).

8.3 POTENTIAL CONTRIBUTION OF THE STUDY

The contribution of this study has enhanced knowledge in the following areas; theory, methodology, and practice, with reference to coalition sustainability within the context of alcohol misuse as a risk factor of HIV infection. The main theoretical contribution of this study is that it adds knowledge to the collaborative engagement of researchers with organisational stakeholders as both participants and equal partners in order to take action for change. Such a collaborative relationship is

embedded in a trusting relationship between the researcher and organisational stakeholders, and among organisational stakeholders themselves through openness and transparency. But most importantly, it resulted in the construction of a sustainable community coalition conceptual framework for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. Mental health practitioners will be able to use this framework in their role as secondary recipients of the framework to engage in initiatives to build and sustain community coalitions in an attempt to manage alcohol misuse as a risk factor of HIV infection in community settings.

The methodological contribution of this study relates to negotiating organisational stakeholder participation in PAR. Organisational stakeholders are used to traditional research whereby researchers collect data from participants without sufficiently sharing information on the aim of the research study, the findings, and the use of the findings to benefit organisational stakeholders and the community in which the study is conducted. Such an approach has often created a negative attitude among organisational stakeholders towards research processes, as they do not see themselves as deriving benefits from the research study and findings.

This study contributes to clarifying key issues to consider in sustaining community coalitions in a real-life context and can thus improve the practice of organisational stakeholders and mental health practitioners. Factors to be considered to sustain the coalition were identified as; sharing a common vision, promoting a trusting relationship, formalising the coalition, transformational leadership, strengthening organisational unity, and access to financial resources. Sustainability should be stated at the onset of the study to prepare organisational stakeholders in advance on what to expect as the study progresses. A common vision should be developed through consensus as organisational stakeholders have diverse visions. A trusting relationship between organisational stakeholders and the researcher, and among stakeholders themselves, should be strengthened and maintained throughout the study.

8.4 LIMITATION AND PRACTICAL CHALLENGES OF THE STUDY

Although the current study makes an important contribution on issues to be considered for community coalition sustainability in the management of alcohol use as a risk factor of HIV infection, the study was limited to a specific geographical area of a community in the North West Province, therefore the findings cannot be generalised. However, the findings can be adapted to fit a specific setting, particularly since I adhered to the measures of transferability by keeping sufficient records on all aspects of the research process to enable other research users to evaluate the applicability of the findings to other settings (See Chapter 3, Section 3.5.3).

Furthermore, not all relevant organisational stakeholders in the community, such as alcohol outlet owners and the youth, fully participated in the coalition during Phases Two to Four of the study. Despite 10 key informants having participated in key informant interviews, only four of the participants continued to participate during dialogue meetings. Although one alcohol outlet owner participated in key informant interviews, she was not available for dialogue meetings.

Despite the limitations, this study generated information on issues to be considered by mental health practitioners to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection. The current study identified predictors of organisational stakeholder coalition sustainability which can be applied by researchers in other settings. To assist researchers in applying the findings to other settings, this research report contains a detailed description of the research process and context.

During the early action phase, I encountered the following challenges: earning the trust of participants, and lack of buy-in from alcohol outlet owners and the youth. However, the challenges were dealt with as the study progressed.

8.4.1 Earning trust

During the first dialogue meeting, organisational stakeholders verbalised mistrust towards me and among organisational stakeholders themselves. The trusting relationship between myself and organisational stakeholders was based on historical action undertaken by researchers in the area, who collected data in the community and disappeared without sharing the findings with organisational stakeholders. Similar findings from empirical research suggest building a trusting relationship as important in forming a confident relationship and sustaining coalitions (Neal & Christens 2014:318, Jagosh et al 2015:9, Curnin, Owen, Paton, Trist & Parsons 2015: 1). Neal and Christens (2014:18) argue that confident relationships are built on a trusting relationship.

Developing and maintaining trust between organisations from different backgrounds can be a challenge and takes time to develop (Curnin et al 2015:2). In this study, trust developed as the study progressed as evidenced by organisational stakeholders taking the initiative to plan dialogue meetings, inviting me to do a presentation at community health promotional events, and organisational stakeholder representatives working together to plan and implement health promotional events to observe health days in a calendar such as the world HIV day.

8.4.2 Lack of buy-in from alcohol outlet owners and the youth

Alcohol outlet owners did not participate in dialogue meeting despite several recruitment attempts. Organisational stakeholders were of the view that alcohol outlet owners were not interested in participating in the PAR process due to the perception that the study would negatively impact on their business by decreasing alcohol sales. Despite alcohol outlet owners not participating in dialogue meetings, they were supportive during the action phase of the study by providing organisational stakeholders access to distribute condoms in the alcohol outlets. The youth who initially did not attend community dialogue meetings started to attend dialogue meetings as the study progressed. The youth assisted in planning activities, such as helping in identifying alcohol outlets, initiating distribution of condoms in alcohol

outlets, and sharing experiences of substance abuse with their peers and organisational stakeholders.

Early participation by the youth and alcohol outlet owners would possibly provide another perspective on the root cause of a fragile community coalition to manage alcohol misuse as a risk factor of HIV infection. Such participation might also offer potential interventions to manage alcohol misuse as a risk factor of HIV infection.

8.4.3 Organisational stakeholder expectation from the researcher

Organisational stakeholders had great expectations of me in terms of the research process. Initially, organisational stakeholders hoped that the study was about bringing funds and employing people. While that was not the objective of the study, I shared information relevant to job opportunities and how to raise funds for community projects with organisational stakeholders. I also shared information on resources such as websites to search for potential employment opportunities.

Organisational stakeholders remained dependent on me and expressed difficulty in continuing with activities to manage alcohol misuse as a risk factor of HIV infection when I had to leave the research study site. Among the challenges were organising community dialogue meetings, distributing condoms, as well as raising funds to sustain the coalition. However, I linked organisational stakeholders with government departments, local drug action committee officials and potential donors to fund the coalition. At the time of reporting, I was still maintaining contact with organisational stakeholder representatives to share activities undertaken to manage alcohol misuse as a risk factor of HIV infection with them.

8.5 RECOMMENDATIONS

Mental health practitioners, in particular, could use the conceptual framework as a frame of reference to empower individuals, families, and the community to manage alcohol misuse as a risk factor of HIV. Additionally, other researchers may also use the findings of the study for subsequent research, thus generating knowledge and informing policy on the management of alcohol misuse as a risk factor of HIV

infection from an organisational stakeholder perspective. As proposed by Rehm et al (2017:4), there is a need for policy measures that successfully integrate alcohol interventions in HIV/AIDS management. The following recommendations are made in line with findings from the study with reference to mental health practice, mental health education, mental health research, and mental health policy.

8.5.1 Recommendation for mental health practice

Mental health practitioners working in communities have the potential to collaborate with organisational stakeholders in PAR to act for change since they have background training in mental health issues. They are in a better position to mobilise resources to implement activities to manage alcohol misuse as a risk factor of HIV infection. They should be empowered to collaborate and work with organisational stakeholders in planning and implementing activities to manage alcohol misuse as a risk factor of HIV infection in communities. Mental health practitioners should facilitate resources to create an enabling environment for organisational stakeholders to manage alcohol misuse as a risk factor of HIV infection. In line with critical theory and PAR, mental health practitioners should work in collaboration with organisational stakeholders to identify problems, and participate in planning and implementing evidence-based activities to manage problems faced by organisational stakeholders ultimately contributing to action for change.

8.5.2 Recommendation for mental health education

I propose that substance and alcohol misuse should form part of formal training for mental health practitioners. Furthermore, a subspecialty in substance misuse should be developed at the advanced level to empower mental health practitioners with advanced skills and competency to facilitate resources to develop, implement and evaluate programmes to manage alcohol misuse and its related health and social consequences, such as the spread of HIV infection. In order to keep abreast of new developments in the field of mental health and substance misuse, in-service training programmes and short courses should be ongoing. To sustain the coalition, mental health practitioners should provide organisational stakeholders with coaching and mentoring on alcohol misuse as a risk factor of HIV infection.

Organisational stakeholders should be empowered to learn basic skills of generating evidence to act for change. This can be achieved by encouraging organisational stakeholders to participate in workshops and dialogue meetings on mental health, substance misuse and HIV service. Dialogue meetings should be ongoing to share ideas and best practice in generating new knowledge and using the knowledge to improve their standard of living. Organisational stakeholders should be trained on substance misuse and its related health and social consequences such as the spread of HIV infection.

8.5.3 Recommendation for mental health research

Researchers intending to undertake PAR should apply the conceptual framework and adapt it to fit their setting, taking the needs of the community in which the study is to be conducted into consideration. Furthermore, researchers should note that conducting PAR has some challenges. One of the challenges is getting all relevant organisational stakeholders to participate in the research. In order to sustain and maximise participation by relevant organisational stakeholders, potential participants should be convinced about the benefits derived from participating in a coalition. The researcher undertaking PAR should holistically consider potential issues that can hinder community coalition.

Based on the findings of this study, further research is recommended on the following topics:

- What is the best practice to ensure maximum participation by all relevant organisational stakeholders in the initial stages of PAR?

- What is the best practice to ensure that organisational stakeholders sustain the coalition after the researcher exits the research project site?

- What is the accepted and feasible programme to empower organisational stakeholder to sustain activities to manage alcohol misuse as a risk factor of HIV infection?

- How the current conceptual framework could be applied and evaluated in other settings.

8.5.4 Recommendation for mental health policy

The selected policy interventions relevant to the findings of this study include:

- Strengthen restriction on the availability of alcohol by controlling alcohol outlet density through licensing regulations. Minimising alcohol outlet density will contribute to reducing easy access to alcohol, consequently contributing to reducing alcohol misuse (WHO 2018:99).

- Restrict marketing of alcohol in all media that includes, among others, television, radio, social media and outdoor advertising to address public health and social problems associated with alcohol misuse. Exposure to alcohol marketing increases the risk of alcohol misuse. Restrictions in alcohol marketing will contribute to a reduction in alcohol misuse and its public health consequences (Morojele, Lombard, Burnhams, Williams, Nel & Parry 2018:787).

- Alcohol outlet owners should have basic training on responsible server practice as part of their application for a licence. Responsible server training increases the knowledge of alcohol outlet owners on the dangers of alcohol misuse.

- Alcohol outlets should be required to display alcohol misuse and health warning messages inside and outside their premises. Health warning messages will enable bar patrons to make an informed decision in alcohol consumption and the dangers of alcohol misuse.

- Alcohol container labels should contain clearly visible health warning messages on alcohol misuse and its related public health and social consequences, such as the spread of HIV infection. Such information should be reinforced through other media such as television and social media. Health warning labels provide consumers with relevant information, and may help to remind them about the risks

of alcohol misuse to their health so that they can make informed choices about their drinking (WHO 2017:3).

8.6 PERSONAL REFLECTION AND CLOSING

Undertaking this study was a learning experience for me. It has been a journey with some opportunities and challenges. The first phase of the study, during which I conducted 10 key informant interviews, was very smooth and interesting. It helped me gain insight into the topic area in relation to alcohol misuse as a risk factor of HIV infection and how organisational stakeholders made efforts to work together to manage the problem. The challenges emerged when I started to engage with organisational stakeholders through dialogue meetings. During the first community dialogue meeting, organisational stakeholders displayed a sense of mistrust towards me based on past experiences with researchers who collected data in the community and disappeared without sharing the findings with participants.

An expression of mistrust to researches by organisational stakeholders was a learning experience to me that influenced my way of thinking throughout the research process. It laid a foundation for better understanding of the importance of building a trusting relationship with organisational stakeholders at an early stage of the study and maintaining the trusting relationship throughout the study. I witnessed how openness, transparency and sharing feedback of the study's findings contribute to strengthening a trusting relationship between organisational stakeholders and me. Sharing the research findings of Phase One, as well as presenting regular feedback to organisational stakeholders, strengthened my confidence in sustaining a trusting relationship. The presence of my research supervisor and co-supervisor, and support from organisational stakeholder representatives, was a source of energy as I felt that I was not alone in the journey.

8.7 CONCLUSION

The current study responded to a need for organisational stakeholders to sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection. A phased approach of the PAR cycle namely, observe, plan, reflect and taking action was undertaken to generate data in order to construct and describe a community coalition conceptual framework to manage alcohol misuse as a risk factor of HIV infection. Key issues identified in the study relevant to sustaining the community coalition to manage alcohol misuse as a risk factor of HIV infection include formalising the coalition, strengthening organisational unity, promoting a trusting relationship, supporting transformational leadership and strengthening access to financial resources. Sustaining a community coalition is complex and requires a holistic approach when considering the identified key issues.

The findings of this study provided practical issues to be considered by researchers, organisational stakeholders and mental health practitioners in sustaining a community coalition to manage alcohol misuse as a risk factor of HIV infection. At the time of finalising this thesis, organisational stakeholders had registered the coalition as an NPO with the DSD, and has formalised an organisational structure to carry out the activities to manage alcohol misuse as a risk factor of HIV infection.

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Annexure A: Recruitment of organisational stakeholder representatives

Enquiries: Jacobs Kgalabi Ngako
Tel: 073 598 7256
Email: Kgalabi2003@yahoo.co.uk

TO: All organisational stakeholders of [redacted] including: Health Services, Police Services, NGOs, NPOs, Faith Based Organisations, Alcohol outlet owners, Cultural Groups, Businesses and Local Government.

FROM: Jacobs Kgalabi Ngako

RE: Invitation to attend a meeting:

Background

Greater [redacted] Based Organisation, a coalition of stakeholders from different organisations in [redacted]- ward 36 is working on a project entitled:

Development of a sustainable community coalition framework for organisational stakeholders to prevent alcohol misuse as a risk factor of HIV infection.

The overall aim of the project is to develop a sustainable community coalition framework for organisational stakeholders to prevent alcohol misuse as a risk factor of HIV infection. As part of the project you are invited to attend a meeting as follows:

Date: **25/01/2014**
Time: **10H00- 12H00**
Venue: **Councillor's office** [redacted]

Your participation is highly appreciated.

Kind Regards

Annexure B: Key informant interview guide

Key informant interview guide

KII number	
Age of the Participant	
Gender of the Participant	
Date of Interview	
Role of the Participant in the Community	
Venue of the Interview	

1. Tell me about the type of organisations affected by alcohol misuse as a risk factor of HIV infection in this community._____
   _____
   _____

2. Tell me about the nature of organisations affected by alcohol misuse as a risk factor of HIV infection in this community._____
   _____
   _____

3. What are your views about alcohol misuse as a risk factor of HIV infection in this community?_____
   _____
   _____

4. What is it like to be a member of this community with a high incidence of alcohol misuse and HIV infection (referring to the role of a key informant)?_____
   _____
   _____

5. Tell me about activities undertaken by individuals from organisations in this community to manage alcohol misuse as a risk factor of HIV infection._____
   _____
   _____

6. How can individuals from organisations participate to establish and sustain a community coalition to manage alcohol misuse as a risk factor of HIV infection?_____
   _____
   _____

Annexure C: Transcribed data: Key Informant Interview 1(Setswana)

Key Informant Interview 1

KII number	1
Age	36
Gender	Female
Language	Stswana
Date	13/12/12
Role	Tavern Owner

Researcher: Ok ke lebogela go tsaya tshwetso ya gago go tsaya karolo mo patlisisong e. Ke tlile go go botsa dipotso ka ga dikakanyo tsa gago mabapi le bojalwa, HIV, mmogo le mekgatlo eo e leng teng mo motseng ne?

Respondent: Eng.

Researcher: Mekgatlo e ka nna mekgatlo ya go tshwana le dithabene, di NGO di Governmental organisations, fela fela jalo ne?

Respondent: Ya

Researcher: Ok. And than ne ke batla go utlisisa o ka bo o na le mengaga e mekae?

Respondent: Ke na le 36.

Researcher: Ok. And than ke karolo e e feng eo o e tsayang mo motseng?

Respondent: Mo Motseng? Ke tsaya karolo mo baneng, mo go thuseng bana ka soccer. Ba soccer.

Researcher: Ok.

Respondent: Ba soccer. Ga ngata, gore ba ska nna involved le di drugs.

Respondent: Ok.

Respondent: Almost bana ba ke ba thusang ba age of sixteen and about to 30, 30 years.

Researcher: Ok.

Respondent: Ke batho bao e leng gore ba bangwe ba kgona le go iperekela.

Researcher: Ok.

Respondent: And than but, a kere ka gore ba a bereka…

Researcher: Mh.

Respondent: Just ke a ba thusa gore ba kgone go fa bana ba bangwe but.

Researcher: Ok. And than mabapi le business?

Respondent: Mo businessesng?

Researcher: Mh. A go na karolo eo o e tseyang?

Respondent: Mo businesseng ke na le karolo eo ke e tsayang mo businesseng ya ka.

Researcher: Ok.

Responednt: Fo now ke santsane ke emenyana ka gonne ne go na le matsapanyana ko gae.

Researcher: Ok ke a utlwisisa. Ok. Potso ya ntlha ne, eo ke tlo e botsang. Ke kopa o mpolelele ka ga mekgatlo eo e leng teng, eo e ka amang ke tiriso eo e sa siamang ya bojalwa le tshwaetso ya HIV mo motseng o. Nka nna ka e botsisa le ka english gore e nwelle pila mo go wena. O a e utlwisisa potso?

Respondent: E botsise ka Setswana gape?

Researcher: Mpolelele ka mekgatlo eo e leng teng mo motseng. Mekgatlo, eo e leng gore o ka nna wa kreya e ama ke tiriso eo e sa siamang ya bjalwa, kampo ya angwa ke tshwaetsego ya HIV?

Respondent: Mekgatlo?

Researcher: Eng.

Respondent: Ke lebeletse e ka nna Dithabenas.

Researcher: Ok.

Respondent: Mo dithabenas gangata.

Researcher: Ok.

Respondent: Ya batho ba nwa jwala ga ba limite. And than o felletsa e le gore ba tsamaya fela. And than nna ke motho yoo o leng gore, Almost gangata mo thabeneng ba tla kreya e le gore go na le dicondomo. Sometimes ke di bea mo nna. A kere go na le batho bao baleng shy.

Researcher: Ok.

Researcher: Ba tshaba go ya ko boxeng ba ire, ba tseye dikhondomo. O kreye motho a le shy a re no ke a kopa but ke tshaba go ya mola, ke re e re ke go fe o be safe.

Researcher: Ok.

Respondent: Wa bona. Go na le batho bao e leng gore ba re no, ntho eo re tlileng ka yona, re tlile ka yone, tshwanetse re tsamaye ka yona (Thobalano). Ke re no ga go bolelwa jalo, ebile kaosane o tlile go itshwabela.

Researcher: Ok.

Respondent: Ka gore this thing a kere ba e bolela ka gore ga e so fitlhe mo go bone.

Researcher: Eng, eng.

Respondent: And than, ntho e e botlhoko, because nna ke a e itse. Ke fetile mo go yone.

Researcher: Ok.

Respondent: Ke gore gantshi, ke rata gore, ke rata go bua ka nna thata.

Researcher: Ok, ok ke a utlwisisa.

Respondent: Ke tsene mo nna?(Ke bue ka nna?)

Researcher: Ya ga go na bothata.

Respondent: Ya nna ke motho yo e leng gore since ke le positive(HIV positive) since 1997.

Researcher: Ok.

Respondent: And than ke rata go phela positive. I live positive, I eat positive, I hope positive.

Researcher: Ok.

Respondent: So sometimes I do not want another people gore ba fete mo ke fetileng.

Researcher: Ok.

Respondent: But I want gore ke ba encoureiche gore if you are positive, be positive and accept your status.

Researcher: Ok.

Respondent: Ka gore ge ba sa accepte the do the (not clear 0.03.56.2)

Researcher: Oh right.

Respondent: And because of that, and than, ne ke lebeletse thata mo reiting ya HIV.

Researcher: Ok.

Respondent: HIV the rest e causitswe ke alcohol.

Researcher: Ok.

Respondent: Ge o ka e lebella.

Researcher: Mh.

Respondent: Ka mo saeteng e nngwe, ke gore go na le bao e leng gore ga ba nwe mara ba ba positive but rate e tlile from ka mo alcoholong. Kwa dithabenaseng re ya dithabeneng. Ge re tswa mola re tswa re tshwere di partners re itsamaela fela. So nna ne ke lebeletse gore, gore re e fokotse.

Researcher: Mh.

Respondent: Ka go tlhama di support group tseo.

Researcher: Ok.

Respondent: Re kgone go bua and than le community, re kgone go ba le di meeting tsa community. Re shere. Re bue ka kokwanatlhoko e.

Researcher: Ok.

Respondent: Ka gore ba bangwe a kere ga ba tle mo dithabenaseng.

Researcher: Mh.

Respondent: And than ba kgona go ba positive.

Researcher: Mh.

Respondent: Ba kgona go kreya bolwetsi. So ne ke ipotsa gore ge re ka kreya di support group and thane ra kreya meeting le meyara maybe. Ra ira meeting wa community. And then we can share and then ra bua. Ra kgona go thusana gore re ka, re ka fedisa bjang rate ena, kokwanatlhoko e.

Researcher: Ke a utlwisisa ka mokgwa oo o neng o setse o buile. Ke na le dipotso mabapi le seo o se buileng ne. It is very much interesting. So go na le mekgatlo eo e setseng e simollotse go tsaya karolo ya go kgona go lwantshana le kokwanatlhoko kampo bojalwa.

Respondent: Nna. Nna by myself. Go na le, e teng NGO e nngwe mo Bheki (name of a place).

Researcher: Ok.Oh go na NGO?

Respondent: Eh ke sentse ke buile le ene ga ngata. Ke gore o a bona ba na le go thusa mo motseng, o kreye batho ba lwala, ba kgona go tsena ba mo thuse ba ire one, two, three.

Researcher: Ok.

Respondent: And than. Federe tseo ke di itseng ke di old age.

Researcher: Old age?

Respondent: E no ba tsona ga di na balwetsi ba ba positive (HIV positiove).

Researcher: Ok.

Respondent: Mo [redacted]. Ke bo koko, bana ba ba leng disabled.

Researcher: Ok ke a utlwisisa. Gapegape mekgatlo e mengwe, motlhomongwe ya puso, ba seponesa dikliniki?

Respondent: Mokgatlo o mongwe ke gore re tsenna mo hospital, mo Odi. But mo Mabopane go na le ba bangwe re ntse re shera le bona support group. Mo di U.

Researcher: Ok. Oh mo di U. Ok ke a utlwisisa. Go na le se sengwe seo o batlang go se bua mabapi le HIV/AIDS before key a ko potsong e nngwe?

Respondent: HIV/AIDS?

Researcher: Eng kampo alcohol. Ke utlwile o re alcohol o ka re e na le go tsaya karolo. E tsya karolo jang?

Respondent: Alcohol e tsaya karolo. E no ba e le gore go na le batho ba bangwe ga ba understande.

Researcher: Mh.

Respondent: Ba itira o ka re ba a understander and ga ba understande.

Researcher: Ok.

Respondent: Ke gore a kere. Ga ke e beye jaana. Ke go, ke go se tlhaloganye.

Researcher: Ok.

Respondent: Ke gore motho o ira fela, a re no, ka osane, ke gore ga a nagane le gore tomorrow will come a re no as long as nka kreya. Ge a bona a tshwere girl friend e smart a bona gore ene o a , o smart a re hae nka se kreye bolwetsi mo go ene, e re ke no ya fela. Dilo tsa go tshwana le tsona tseo.

Researcher: Mh.

Respondent: Ke basimane ,mind tsa bona ga ke itse gore ko bofellong o kreye e le gore, ke gore ba phela ba le negative.

Researcher: Ok.

Resoondent: So mind ya bona e phela e le negative mo e leng gore ko bofellong ba letsatsi ba a tlhakatlhakana and than ga ba kgone go kreya ansara.

Researcher: Ok. Ke utlwile o bua ka NGO le Old age ne?

Respondent: Mh.

Researcher: NGO e kabo e bopegile jang?

Respondent: Ne ke mo kopile gore a tle, jaanong go raya gre go na le matsapanyana. Ne ke mo kopile ke ene a ka tlhalosang.

Researcher: Ne a tla tlhalosa ne?

Respondent: Ge a ka tla. Ko teng sa le ka ya sometimes. Ne e le kabo 2005. Ke ge re tlhama support group kwa, so ya nna gore batho ba ko Bheki ba, eish.

Researcher: Ka mokga oo o buang go a kgatlisa gore o batla go foma support group. O buile ka NGO, wa bua le ka old age. A go na le mokgatlo o mongwe gape o o ka o gopolang o re ka thusanang gore o latiwe le ona gore re kgone go bereka together? Besides e mebedi eo o e boletseng?

Respondent: Eh.

Researcher: A go na le e mengwe eo o e gopolang?

Respondent: Eh.

Researcher: Ge o sa e gopole jaanong o tla mpolellella later ne.

Respondent: Eng.

Researcher: Ok. Re yako potsong e nngwe eo e latelang re a utlwisisa ne. Ok potso eo e latelang e re dikakanyo tsa gago ke eng mabapi le ka moo tiriso eo e sa siamang ya bojalwa e ka bakang tshwaetso ya HIV mo motseng mo?

Respondent: Ne o reng?

Researcher: Dikakanyo tsa gago ke eng mabapi le ka moo tiriso eo e sa siamang ya bojalwa e ka bakang tshwaetso ya HIV mo

motseng o? Nka nna ka e bala le ka sekgowa motlhomongwe e shorter?

Respondent: Ya.

Researcher: Ok ka sekgowa e re what are your views about alcohol misuse as a risk factor of HIV infection in this community? O bona o ka re di golgane bjang alcohol le HIV/AIDS?

Respondent: Ok e re ke e arabe so.

Researcher: Ya?

Respondent: Nna ka mo saeteng la ka. Ke araba ka gore, ka mo saeteng la alcohol. Ne ke batla gore re traye di meeting.

Researcher: Ok.

Respondent: Mo di thabenanseng.

Researcher: Ok.

Respondent: Mo dithabenaseng, re hoste di meeting le community.

Researcher: Ok

Respondent: We teach them gore no go tshwana le, especially batho ba ba ba leng mo di ARV treatment.

Researcher: Ok.

Respondent: Ga ba a tshwanna gore, do not drink too much. So ne re re at-least ba ithute go limita, their limit, and than maybe go tla nna betere. Ka gore motho o ka se mo limitele, wa mo limitela, ke tla kgona go mo limitela now and than o tsena mo thabeneng o nwa five beers, you go somewhere to another thaben you drink another drinks.

Researcher: Mh.

Respondent: So nna ne ke re at least ge re ka ba kreya, ntse re ba thitsa gore if o le mo di ARV, if o se mo di ARV gore o protecte masole a gago a mmele. Ntho e e dameija le masole a mmele.

Researcher: Ok ke bona. Ge o re ba limite o raya bjang?

Respondent: Ke gore motho a nwe limiti ke gore a nwe a itshiela. Ke gore a seke a nwa over dose.

Researcher: Ok. Overdose e ka ne e le eng?

Respondent: Ke gore overdose o ira dilo tseo e leng gore di tswile mo tseleng.

Researcher: Ok, ge o re dilo tse di tswileng mo tseleng, mo tseleng?

Respondent: Ke gore o roballana without condom. A re ene ga a ipona, hee, eng or e blastitse, e le ene a irileng dilo tsa go tshwana le tseo. Ba bangwe ba irisiwa ke bjalwa. Motho a nwe bjalwa ka gore ga a kgone gore a ka irang, a re no I will drink, I will need this and this because I am drunk.

Researcher: Mh.Ok. gape-gape bojalwa bo tsaya karo e e feng? Ke utlwa o bua ka masole mmele.

Respondent: Bo a dameja, bo a dameja.

Researcher: Masole a mmele?

Respondent: Ene le sebete se sengwa ke bjalwa.

Researcher: Ok. Ke utlwile o bua o golagana go nwa le di ARV go iragala eng ka ARV le go nwa bjalwa?

Respondent: Di ARV le bjalwa, A nkere bjalwa ke alcohol, Di ARV ke di drugs. Ga di, ga di nyalane

Researcher: Mh.

Respondent: Ga di nyalane because o nwa di drugs and than you drink lcohol. You make something terrible inside.

Researcher: Ok. Ke utlwile gape, dilo tse o di buang di a itumedisa. Fa o re di ira gore motho a ire dilo tseo di sa siamang o raya jang ge o re o kreye motho yo o nweleng thata a ira dilo tseo di sa siamang?

Respondent: A kere o kreye e le gore jaanong o no kgatlwa ke go fereya, o ya mo le mo, ke gore o no tsena mo gotlhe. Wa bona ene go na le basetsana ba e leng gore ga ba kgone go gana. Motho a re ka gore o bona a tshwere tshelete, o mo rekela di drinks, o mo rekela bojalwa. O a nwa o nwa bojalwa bola, after that they go and sleep, no condom.

Researcher: Ok.

Respondent: Because a bolaisa ke gore motho ola o tshwere tshelete and than ga a batle dikhondomo ka gore o mo reketse bojalwa, and than jaanong kwa bofellong ba letsatsi, ke gore wa itse le motho yo o nwang di ARV and than o irang, o a mo affecta, and than ge a affectegile ka di ARV tsela a se kgone go kreya thuso ge

ene a ile go stata go nwa di ARV tsela, Di ARV di mo damEgitse klaar. Ga a kgone gore a ka kgona go kreya thuso.

Researcher: Ka mokgwa oo o buang ka teng, o ka re tlhalosetsa gore tiragalo e mo [redacted] o bona o ka re e a diragala, e diragala bjang?

Respondent: E a iragala mo [redacted] ene e ira ke batho bao e leng gore ba mo bolwetsing. Gangata a kere nna bjaanong ke a ba bona, ko spetlele, but nna ke kgona go bua, a kere mybe somebody a ile go, and than he take treatment or she take treatment. And than ke a mmona. Do not drink savana, savana is no, six percent no.

Researcher: Mh.

Respondent: Take something down or energizer, So some of them they listen to me. Some say do not tell me this, who you are.

Researcher: Ok. A go teng mekgatlo e e leng teng mo motseng eo e lekang go ba thusa?

Respondent: Ke e mengata.

Researcher: A ba a utlwisisa gore ba ka fitlhela kae thuso?

Respondent: Ba bantshi ya, ba kgona go nlata. Nna ke kgona gore le motho ge a lwala, ba kgona go mpitsa I counsel him, or she or he. Ke a ba counsela and than ke kgona gore ke bue, a bue a be right, ke mo tseye ke mo ise hospital a kreye treatemente and after he come back to me, thank you. And than some of them ah.

Researcher: Ok, jaaka setse o buile especially ka tiriso eo e sa siamang ya bojalwa le tshwaetso ya HIV, o ka reng ka mesomelwana, tiriso ya mesomelwana, dikhondomo?

Respondent: Eh, dikhondomo that is why ke re ga ke rate gore ke di tlhoke ka gore ke rata gore ke thuse community.

Researcher: Ok.

Respondent: I want to help community ka di condoms. E bile ke re nke go kgonagala, ke tseya le ko spetlele, ba a itse. Ke kopa four box or six box at Odi hospital. If they come to me I want box, if I have, take and use it. Do not take and put it there.

Researcher: A kere motho yo o sa itseng [redacted] and than a sa itse gore bojalwa bo nwewa jang le gore bo ka amana jang le

kokwanatlhoko ya HIV/AIDS, o ka mo tlhalosetsa jang e le motho yo o sa itseng, e le moeng?

Respondent: Bjalwa le HIV di tsamaisana bjang? Gangata ke ka mokgwa oo ne ntse ke tlhalosa ke re bjalwa le HIV gore di nyalane, di tsamaisane ke go ignora, ke ignorance. Batho ba ira dilo ntse ba itse gore ko bofellong batlo kreya eng. Ba a te ignora. And than ko bofellong ba letsatsi, ga go nne monate.

Researcher: Fa o re ga go nne monate o raya jang?

Respondent: Ke gore ola o mongwe o nolwe bojalwa, o kopana le motho o a leng positive. O ntse go ya ko bofelelong ba positive kaofela. Ene o kreya e le gore motho wa batho o ne a se positive, or monna o ne a se positive o ikreela mosetsana ko bjaleng, o fitlha o mo fereya a nwe le ena bjalwa, gore ge go tsamaiwa o fitlhella dilo tsa go tshwana le tseo.O fitlhla ko bofellong ko bofellong ba irang.

Researcher: Ok. Ke eng so se dirang gore motho ge a nwele bojalwa ebe a no robalana a sa sebedise condomo?

Respondent: Tha is why ke re ke bo ignorant.

Researcher: Okay. Bo ignorance ge nka bo tlhalosa nka re ke eng?

Respondent: Ke gore nka re motho o irang? O ira selo a itse gore ntho e so, I do this, is wrong and I do this is right. But they ignore because I am drunk, I do not see anything.

Researcher: Pele key a ko potsong eo e latelang go na le se sengwe gape seo o batlang gore se botlhokwa o ka re o ka re se ka itsesiwe re ka se itse mabapi le relationship ya alcohol le HIV?

Respondent: Okay, nna mo ne ke rata gore o ka re nna le community re ka utlwisisana ra thitshana, but nna ne ke rata, ne ke rata thata, ke gore ke rata go thitsha batho bao eleng gore ba positive thata, bao ba phelang, gore ba phele bophelo bo bo positive ad do not drink too much, ba be le limit. If e le gore, ba ithabise nako e nngwe and than go felle moo. Ka gore sometimes you can drink. I can say I can drink once a month, or twice a month to be just happy. Do not everyday drink. It is not like that because I got a medicine, and than my treatment, I do not want to disturb my

treatment. My ARV I eat it. My health is my life, I Like it ad I am happy.

Researcher 2: OK sorry Jacobs maybe you did discuss this I am very curious, you clients, do you know who are HIV positive?

Respondent: Yes(smiling). I live positive I tell him, I tell them I am HIV positive and a live positive, and I do not want to be negative. They want people live positive life.

Researcher2: And do they tell you that they are positive as well.

Respondent: Ya I disclose my status with them.

Researcher 3: And they will disclose to you as well?

Respondent: Because I love myself and love.

Researcher2: So it sounds as if you must have very strong values because you want to run this business but in a responsible way?

Respondent: Sorry?

Researcher: Eh o raya gore go bonagala e ka re o batla go tsaya maikarabelo a mangata ge a re responsible, mabapi le this thing ya go thusa batho.

Respondent: Eng.

Researcher: Gore batho ba nne responsible banne le maikarabelo.

Respondent: Yes.

Researcher: Jut to follow up mo question eo ne ba e boditse, batho bao ba kgona go thesta, di facility tsa go testa o ka reng ka tsona?

Respondent: Eh, community ga ngata ge ke re ke a e lebella they do not go and test, no. Ba emela ba lwale. They wait to be sick and go and test.

Researcher: Okay.

Rspondent: So nna ne ke re at least maybe once a year or twice a year go be le eh, tente maybe go bitsiwe community go diriwe di teste. O mongwe le o mongwe a be open, ke gore like that. Ke nto eo nna ke filang gore o kare e ka irega.

Researcher: Ok ya go thesta HIV?

Respondent: Ya.

Researcher: And than bao ba go nwa thata ba kgona go thusiwa jang?

Respondent: Ba go nwa thata, that is why ne ke re, as ne re boletse ne, re le Dithabenas, re tlo ira di meetings tseo e leng gore re bitsa a community.

Researcher: Ok.

Respondent: Ya re ba botse re bue le bona and than re bue le bona, and than ke gore re tlo kenya le mokgatlo ya lona mo go bona, re kgone go ba tlhalosetsa gore go iragala eng go iragala eng.

Researcher: Okay ke a leboga. Potso ya boraro . Ke rata fela gore o re bolelele gore o ikutlwa jang go nna motho oo e leng gore o tsaya karolo mo motseng jaaka motho yo e lebeletseng business and gapegape o le motho yo o thusang batho bao ba ka bong ba tshwaeditswe ke kokwanatlhoko ya HIV/AIDs and gape-gape o le mo mokgatlong oo wa Dithaben owners. O ka ntlghalosetsa ka mowa oo wena o ikutlwang ka teng go tsaya karolo?

Respondent: Nna ke batla go tsaya karolo mo go thuseng thata go lwantshana le bolwetsi jo, gore bao ba setseng ba na le that virus ba phele positive life and than re thibele ba ba tlang gore ba ska kreya that virus. Gore e nne le rena gore ko bofellong ba letsatsi maybe re tla kreaya a cure. Gore all of us re tlo fola nna ke na le tshepo ya gore one day we will get a cure.

Researcher: Ok. Mo karolong eo o e tsayang mo motseng ne o ka ntlhalosetsa ka dithuso tseo di leng teng tse di kgonang go go thusa gore o tseye karolo ka mokgwa oo o batlang ka teng. A o ka ntlhalosetsa gore go diragala bjang? A di teng dithuso, di a tlhokega ke gore fa o ka ntlhalosetsa ka botlalo.

Respondent: Dithuso tsone re a di tlhoka but ga ke so di tseele matsapa go bua nnete ka gore ke, mara now ka gore ne ke boletse ka support group ke batla go kreya di fund, di, re raise di funds, re kgone go kreya di fundsnyana. Wa itse batho gangata ko support grouping, o kgona go ba caller gore come to support group, if they do not eat anything, next week they do not come back. So at-least maybe re ira a breakfast or a lunch. Re ira support group we talk, talk, talk, talk. Mathata a rona kaofela.

We can share our problems and than our status. And than I want to help some people to disclose, because some of them, they do not want to disclose and than ba gobala inside.

Researcher: Ok. Oh go na le batho ka mokgwa oo o buang ba, ga ba kgone go disclousa?

Respondent: Ya. Kgnthe nna ne ke lebeletse gore disclose ga se gore o tsamaya o bua. You can take this into outside. Gore o kgone go liva your life. Because if you live with a virus, positive and go like this, if positive you run, hei I am positive, no hae.

Researcher: Ok.

Respondent: Nna I am happy. To be positive is my life. And I like it.

Researcher: So support group tseo o buang ka tsone o bona di ka thusa bjang, mosola wa tsona?

Respondent: Mh mosola wa tsona?

Researcher: Mh.

Respondent: Thata ke gore support group se thusa thata gore batho ba kgone go idisclousa, ba kgone go phela bophelo bo bo positive. Ke gore le a tla re, ge tsamaya. Ge motho a bua a re motho yole o positive. A seke a labella ko morago. Ke gore o gatela step ko pele. A kere ke support group eo re tla bong re mo file, o tlo kreya di challenge tse so le so le so.

Researcher: Ok.

Respondent: Support group is a challenge. Ke gore o kgona gore ge o fitlhile mola o na le mathata a gago o a ntsha, o tsamaya o le happy. They share problems and live happy.

Researcher: Ok, and than jaaka gape o manager le business ya go rekisa bojalwa, batho ba kgona go utlwisisa bjang ge o ba bolelela gore ba nwe responsibly.

Respondent: Jo nna ke a ba bolella. My customers is my customers ke tlotla le bona(Smiling) Ya this is my customer, is my family.Ya is my family. If I do not want this, hey, ho! Do not drink, He, ga o sa nwa, go fedile, hei o ya gae. Or o kreye ke go felegetsa. Ya like that.

Researcher: Ok ke lebogile. Pele re ya ko potsong e nngwe, a go na le sengwe seo o batlang go se bua mabapi le karolo eo o e tsayang mo motseng eo e botlhoka motlhomongwe re e lebetseng eo o e gopolang.

Respondent: (not clear:0.28:07.3) Batho bao e leng gore ba ko tlase, re na le gore re ba thuse ge setse ba tlhageletse ke mathata, dilo tsa go tshwana le tseo, e no ba e le gore a kere ga ke so be ko godimo but ge dilo tsa ka di ka namela di ba right ke tlo, ke batla go tlo tsaya ditshuana tsotlhe, ke di agele mo gae. Ke batla bana ba ba ditshuana bommaabone ba tsamaile ka that virus le bo ntate ba bona, wa bona? Bo NGO, ke ye ka mo spetlele ko batle help. Le lona le tla nghelpa and than I can grow my vision.

Researcher: Any question before I move to another question (silence). Oh right ke ya ko potsong eo e latelang (phone ringing) O ka nna wa e araba.

Respondent: (Answes the phone)…Thank you.

Researcher: Ok ke a leboga ne ke ya ko potsong ya bone, re saletswe ke dipotso di le pedi. So re mo potsong ya bone. Ke kopa o mpolelele ka ga dikgato tseo di tsewang go thibela tiriso eo e sa simang ya bojalwa eo e ka bakang tshwaetso ya HIV mo motseng.

Respondent: (Silent).

Researcher: Ge o batla gore o e tlhaloganye hantle nka nna ka e ira ka dikarolo karolwana.

Respondent: Ka dikarolwana ya.

Researcher: Ya ntlha, ke dikgato tseo di ka tseang ke wena. Go na le dikgato tseo di ka tsewang ke wena, go na le tseo di ka tsewang ke ba bangwe, go na le tseo di ka tseang ke mekgatlo eo e itseng. So ya ntlha ke tlo re dikgato tseo di ka tsewang ke wena ne?

Respondent: Ka mo saeteng la bojalwa?

Researcher: Eng bojalwa, a kere o setse o tlhalositse gore batho bao ba nwang bojalwa ba ka nna ba se sebedise dikhondomo ebe ba tshwarwa ke tshwaetso ya HIV? So go na le dikgato tseo o di tseyang gore ntho eo e seke ya iragala?

Respondent: End dikgato tsone, ke gore gangata ke ntho eo e leng gore gangata, ke kgona gore batho bao ke ba itseng, especially ke kgone gore ke ba kgaleme ge ke ba bona ba ira ntho e wrong.

Researcher: Ok.

Respondent: Nna o ka se ire ntho e wrong mo pele ga ka ke go lebeletse especially if you have wife at home. Do not do mistake, because, ke a mo lata motho ke re no, do not do this.

Researcher: What do you mean by ntho e wrong?

Respondent: Ke gore ke bona gore, a kere ke a bona go na la banyana ba ba leng selfish, go na le bayana ba ba selfish ouside and than they come to tavern because of they want money and than wa bona le go distroya malapa a batho. Wa bona ge a itse ke ya go tseya monna wa mokete, ko mo is kae a seke a robala gae dilo tsa go tshwana le tsona tseo.

Researcher: Okay.

Respondent: So o kreye e le gore maybe ke a mmona gore monna o, mosetsana o ga a right. Ke kgona go mmitsa. Sorry e tla kwano, no o seke wa ira ntho e so. A kere o a itse gore o siile mosadi wa gago, after go home, wa bona dilo tsa go tshwana le tseo. Ke mo seifa mo dilong tse ngata. Ga ke batle gore ke mo kreye kaosane e be e le gore ge a lwala ke re a bona ne o irang. Ga ke batle o ira ntho e so. Ke batla gore a kgaogane le mathata a ma so ka a we. Wa bona ke gore ba ba ngata ke a ba seifa. Kaosane ba re eish o nthusitse. Ke re ah ga ke batle.

Researcher: Ok ke a utlwisisa, o tlhalositse ka ntho e wrong wa fa example ka mme a a tlang a tlo senyetsa lapa a tseya ntate wa lelapa. Gape gape sekai se sengwe?

Respondent: Eh, ke gore go tshwana ga ke re, ge o kreile ntate e leng o a senang motse, le ene ke kgona go mo kganela, no do not do this, wa bona gore o wela mo trabolong bjang? Kaosane tla be e le nna gape ke siana, tshwanetse ke tlo go cansela, ke tlo irang, ke gore ke a ba bolella gore no ga ke batle. Hee ge o batla, ge o na le tshelete e ntshi. Tsea tshelete ya gago o ntshwarise o ye gae o robala, o tla tla o e tsea tomorrow. Or tsamaya o ye gae.

A kere nako e nngwe o re tsamaya, ge a fetsa ga a tsamae o ya ko another tavern. Ge o mmiditse o kgona go mo seifa o re no ke tsea tshelete ya gago wa bona ke bokae? Ke e ngwala mo bukeng and than go. Ka gore banna ba berekisa banyana gangata ko bjaleng ka tshelete le bojalwa dilo tsa go tshwana le tsona tseo wa bona, go fitlhella le malapa a batho a thubega a thuba ke bojalwa.

Researcher: Ok ke utlwile o bua ka, especially ka mokgwa oo o thusang batho ba bomme ka teng. Batho ba bontate bona?

Respondent: Le bontate ke thusa both sides. A o utlwe gantshi ke re he ke tseba gore motho ge a na le mosadi, e le motho wa ntate. Ke kgona go mmitsa. Ke re no a kere wa itse gore o siile mosadi wa gago ko ntlung.

Researcher: Oh ke a bona.

Respondent: Le motho gangata basadi, ke gore ke rata ke batho ba bontate. Ene gantshi ke kgona go toloka le bona. Bomme gangata mo thabeneng go tla ba oo le oo and than a kere o a ba bona o bona mekgwa ya bona?

Researcher: Ok.

Respondent: O kgona gore no do not, stop it, do not go there. Wa bona dilo tsa go tshwan le tseo. O setse o ba bona mekgwa ya bona gore ba phela jwang.

Researcher: Ok ke a leboga, re buile ka dikgato tseo o di tsewang ke wena ne. Ke kopa go botsa ka dikgato tseo di tseang ke batho ba bangwe.

Respondent: Ga ke itse gore mo dithabeneng tse dinge gore ba bereka go tshwana le nna ka mokgwa oo ke berekang.

Researcher: Eng.

Respondent: Mara ba bangwe ge ba tswa ko dithabeneng tse dingwe, ba kgona go boa ba lla motho a re ke tshwerwe poo, ba tseere eng dilo tsa go tshwana le tsona tseo. Wa bona nna le this thing ya gore motho a ke re mo thabeneng(not clear: 0:35:12.4) I think gore re ba tseye re robale le bona. Ba fokotse le rate ela ya rape. Ka gore rape e le yona e na le ditlamorago tse di seng

monate. Because o a reipiwa, you get infection somehow wa bona dilo tsa go tshwana le tsona tseo. Wa bona ge re re re na le bomme ka mo dithabenseng or re setse le bontate re ba seife. A kere ke bontate ba babedi ke a ba itse. Motho o o sa mo itseng a kere o tshaba go robala le ene o sa itse gore o tlo go tsenela ka mo ntlung or bjang. But batho bao re ba itseng nna ne ke re at least re le Dithabenase ke ntho eo e leng gore re tlile go bua ka yona next year ge re bula. Re stata next year re le Dithabenase.

Researcher: So ka mokgwa oo o buileng ka teng especially ka thuso eo o thusang batho gore ba seke ba tsharwa ke kokwanatlhoko mo mabjaleng. A go na batho ba bangwe bao ba go boleletseng gore ba thusa batho ka mokgwa o mongwe?

Respondent: Ei nna mo [redacted], ga ke so ba kreya unless ke, gangata ke batho bao e leng gore ba tshwana le nna, ba a bua, re a bua ge re le support group. A kere ba bangwe ne ba kopanelana ko di support grouping, ba re hee re go bone ko support grouping, gape wa itse rona re na le mathata. A kere batho ba kgona go tlisa di problem tsa bona at support group. Support group ke sona seo se kgonang gore re a itsane re kgone go nna positive, re kgone go ba positive, re phela life e e positive. Ke yona support group ke gore the family house support group.

Researcher: Mekgatlo yona e teng go kgona gore support group tse di kgone go ba teng?

Respondent: Ya.

Researcher: O ka mpolella ka mekgatlo eo e leng teng?

Respondent: Ene mekgatlo, e ka nna, ke gore re kopa bo Thabo, Mmeyara gore a re thuse and than nna mokgatlo wa rona ga o a thubega just batho ba tswile fela, ba a boa.

Researcher: O ka ntlhalosetsa ka ona mokgatlo o wa lona?

Respondent: Eh ke Bokamoso support group.

Researcher: Bokamoso support group ne le dira eng?

Respondent: Ne re shera di problems, gangata re shera, re thusa bao e leng gore ga ba kgone go disclousa, ba felletse ba kgona go diclousa, ba kgone go amogela that virus.

Researcher: And tha o ka mpolella ka di challenges tseo di leng teng mo mokgatlong, kampo tseo di saleng tsa nna teng?

Respondent: Eng di challenges di nnile tse ngata. Ke gore ge ke lebella mo support grouping tsa rona, all of us gore re kgone go tswella, re na le di business, ba bangwe ba a sebetsa, ke gore ga sanka ra nna ra re re a kula. Ke di challenges tseo e leng gore sa le ra emella ra re ro iperekela ka matsogo, no HIV.

Researcher: Ok. O ka mpolella ka dilo tseo e leng gore o ka re di a le kgoreletsanyana mara motlhmongwe le nna le di phusetsa kwa thoko?

Respondent: Ok ke gore gantshi dilo tse di kgoreletsang batho ke dipolelo.

Researcher: Oh dipolelo?

Respondent: Ya that is why ke re support group se kgona go thusa gore do not look back, go forward and be positive, mind wa gago o be right, this is a support group.

Researcher: Ok ke a leboga pele ke ya ko potsong enngwe eo e latelang o na le se sengwe seo o batlang, motlhomong o bonang o ka re re ka bua ka sona?

Respondent: Seo o boning o ka re re ka bua ka sona?

Researcher: Especially dikgato tseo o neng o bua o re ne o di tsaya?

Reseapondent: Wa bona nna ke rata thata , a ke re ke batla gore le be teng. Ke gore next year ge re thoma re ira meeting ya rona ya community, ke tlo le contacta le be teng, re kgone go bua le community gore do not drink, and than ke gore ba seke ba nwa bojalwa go fetisisa tekano. Nna ga ke na problem le bojalwa, but ba limite seelo sa bona, limit, drink limited.

Researcher: Oh right.

Respondent: Ka gore ge ba nole over dose, eish do not do things right.

Researcher: Ok, ke a leboga re ya ko potsong ya bofelo ne. E re, ba maloko a mekgatlo ba ka tsaya karolo jang go nna go tswella pele ka mokgwa wa tshwaragano ya trisano mmogo go thibela triso eo e

a siamang ya bojalwa eo e ka bakang tshwaetso ya HIV, tirisanommogo eo e itshetlegileng, e sa teketeke, ka lereo la seeng re re e nne sustainable?

Respondent: Mh, wa itse gangata ge ke bolela ka maloko ankere gona jaanong maloko a rona ke Dithbenase. Waitse go na le, a kere re ka se tshwane, go na le bao e leng gore ba ikgogela ka kwa, go na le bao e leng gore ba ikgogela kwa.

Researcher: Eng?

Respondent: But ge re ka nna united, ra nna one big family. Re ka nna anything eo e leng gore e tlo thusa community ya rena.

Researcher: Ok. O raya jang ge o re one big family.

Respondent: Ke gore ba nna ntho e e one. Re utlwana ka seo re tla bong re se utlwanela.

Researcher: Ga re le ntho e one re le one big family ke eng seo se ka irang gore this one big family e nne sustained e nne e ntse e tswella pele?

Respondent: A kere ge re re re batla go thusa ntho e so, e e rileng, maybe nna re bua ka ntho tseo di leng teng. Go na le NGO, e thusa one, two, three. Ge rena re ka reka one, two, three, ra reka diaparo ra isetsa bana ba dikhutsana. Ke gore ra ya ka list ya bana ba dikhutsana, [redacted] as a whole. Ra itse number ya bona. And than re le dithabenase ra nna le sekhwama se re ntshang tshelete, ra kgona go rekela bana bale dijo, diaparo.

Researcher: Ge o bua ka sekhwama, sekhwama se re ka ira bjang gore se be teng?

Respondent: That is why ke re ge re ka nna e one big family, ra nna, ge re le united. Ra utlwana ke gore ra nna sit down and than ra bua, ra kgona go thusa. Nna ke rata go thusa. Ene ke a thusa mo ke thusang.

Researcher: Ok go na le dikgwetlo kampo di challenges tseo di ka nnang di ntse di re sitisa mo tseleng gore re seke ra itshetlega ra se nne sustained?

Respondent: A nna ga ke bone, ge re ikemiseditse ga ke bone go ka ba le ntho e nngwe.

Researcher: Ge o bua ka go ikemisetsa ke eng seo se ka dirang gore batho ba ikemisetse?

Respondent: Motho o a mo thitsha, o a mo ruta gore go na le ntho e, eh, o a mo ruta ka bolwetsi. Ge re ka tlela mo issung ya HIV, ka gore le bona ba tlo ba ilvolved ka gore ga ba ikitse. Maybe ba bangwe ba a ikitse, ba itse di status tsa bone. Some of them, and than some they know their status. But ke rata thata ge nka, re ke bua ka yona, le bona ba a itse. Le mo dimithing tsa rona ke gore ke phela ke le positive. Ga ke motho yo e leng gore, and I am not going to die anymore. Ke fitile di challenges tse ngata tsa bolwetsi ke fodile ge ke le jaana. So gangata ke ipoleletse gore challenge ke challenge.Wa utlwa e batla gore re growe up.

Researcher: Ok ke a utlwisisa, go tloga ntse re simolla re bua, ke utlwile o bua especially mabapi le support group, gape wa re re nne united gore re kgone go nna le mokgatlo. O bona o ka re ke dikgato tse di feng tse re ka di tseang gore re tsamaisane tsela bo botlhe. Re ka ira jang gore re kgone go foma mokgatlo o o tswellang pele?

Respondent: Ok. Gona jaanong that is why ke re ne ke batla gore re kopane le group e nngwe ela and than ge setse re kopane ebe re go bitsa re tla go bua. A kere nna nka se dire decision ke le one. E batla re le a group.

Researcher: Ke mekgatlo e mefeng e mengwe gape eo re ka kgonang go ya go buisana le bona ka mokgwa oo re busaneng le wena?

Respondent: Silent.

Researcher: Ok ge o sa gopole now o tlo nna o gopola and than o re tlhalosetsa? A go na le potso kampo sengwe so o batlang go se botsa, kampo seo o batlang go se gatella.

Respondent: Ok nna seo ke ratang go se gatella thata. Go raya gore rena re le Dithabenase, tshwanetse re itse di custom tsa rena. Tshwanetse re di limitele. Tshwanetse gore motho ge a nole, re kgone go mo kopa gore a ye gae. Unless o mo tseele cell phone, o mo tseele chelete eo a e tshwereng a be safe a ye gae. And tomorrow o di isa ko lapeng la gage. O re motho yo ke

tseere cell phone ya gagwe. I took their cell phone and money and go.

Researcher: Ok. Re fitlha mo bofellong ba diputsisano. Ke leboga matsapa a gago le nako ya gago eo o e tseereng. Fa o na le tshwaelo ya bofelo o ka nna wa tshwaela pele re tswalla?

Respondent: Nna potso, e re ke ire tshwaelo. Nna ge dilo tsa rena, a kere tsa ka, ka mokgwa oo ke reng ke batla go ira support group mo gae. Ge ke setse ke irile support group ke tlile go boa mo go lona ke tlo kopa thuso le nthuse ka everything maybe eo ke tla bong ke e shota but ga ke bone gore support group thata ga se neede tshelete. Se needa maele. Ke gore support group nna ke tlo batla gore se nthuse gore re kgone go thusa dikhutsana.

Researcher: Thank you very much ke leboga nako ya gago.

Researcher 2: Thank you very much for sharing your story with us. I thought it was a story of hope.

Researcher: Ok. Thank you very much for agreeing to take part in this research project. I will be asking you some questions about your views in relation to alcohol, HIV, and organisations which exist in this community?

Annexure D: Transcribed data: Key Informant Interview 1 (English)

KII number	1
Age	36
Gender	Male
Date	13/12/12
Role	Tavern Owner
Venue of the interview	

Researcher: Ok. Thank you very much for agreeing to take part in this research project. I will be asking you some questions about your views in relation to alcohol, HIV, and organisations which exist in this community?

Respondent: Yes.

Researcher: It can be Organisations like Tavern owners' association, NGOs or Governmental Organisations.

Respondent: Yes.

Researcher: Ok. And firstly may you please tell me your age?

Respondent: I am 36.

Researcher: Ok. And then what role do you play in the community?

Respondent: In this community?

Respondent: I participate in children. I help children with soccer.

Researcher: Ok.

Respondent: Soccer. Mostly, so that they are not involved in drugs.

Respondent: Ok.

Respondent: Almost young people whom I help are at the age of sixteen and about to 30, 30 years.

Researcher: Ok.

Respondent: Some are able to work for themselves.

Researcher: Ok.

Respondent: And then but, because they are working.

Researcher: MH.

Respondent: I was just helping so that they can help other children.

Researcher: Ok. And then in relation to business?

Respondent: In relation to business?

Researcher: MH. Any role you play?

Respondent: I have a role in my own business.

Researcher: Ok.

Respondent: For now I have stopped because I have some challenges at home.

Researcher: Ok I understand. Ok the first question I will be asking. Please tell me about organisations affected by alcohol misuse and HIV infection in this community. I can also ask the question in English?

Respondent: Ask in Setswana again?

Researcher: Please tell me about organisations affected by alcohol misuse and HIV infection in this community?

Respondent: Organisations?

Researcher: Yes.

Respondent: I am looking at, it can be a Taverns.

Researcher: Ok.

Respondent: In Taverns mostly. Yes people drink alcohol without a limit, and they end up just going. And then I am, people who mostly, in many occasions in this tavern they will find that there are condoms. Sometimes I put them by my side. The thing is there are people who are shy.

Researcher: Ok.

Respondent: They are afraid to go to a condom box and take condoms. You find that a person is shy, saying he want condoms but he is afraid to go there. Then I will say let me give you so that you are safe.

Researcher: Ok.

Respondent: You see there are some people who say, look, the thing that brought me here, must also take me away. *(I started to be alive because of sex and I will di because of sex.)* Then I say no, we should not talk like that, tomorrow you will regret.

Researcher: Ok.

Respondent: They talk like that because they never experienced the situation. And then, it is painful, because I know it, I have experienced it. The thing is I like to talk about myself.

Researcher: OK I understand.

Respondent: Should I talk about myself?

Researcher: Yes there is no problem.

Respondent: Yes I am a person who has been HIV positive since 1997.

Researcher: Ok.

Respondent: And then I like to live a positive life. I live positive, I eat positive, I hope positive.

Researcher: Ok.

Respondent: So sometimes I do not want other people experience what I have experienced.

Researcher: Ok.

Respondent: But I want to encourage them to be positive, and accept their status.

Researcher: Ok.

Respondent: That is if they do not accept they do the… (Not clear 0.03.56.2)

Researcher: Oh right.

Respondent: And because of that, and then, I am concern of the rate of HIV infection. HIV, the rest was caused by alcohol if you note.

Researcher: Mh.

Respondent: On the other side, that is there are people who do not drink but they are (*HIV)* positive, but the rate was due to alcohol. In Taverns, when we leave we leave having partners we just go. So I was looking at reducing it (Rate of infection), by forming support groups.

Researcher: Ok.

Respondent: So that we can talk and that the community, so that we share, speak about this virus.

Researcher: Ok.

Respondent: Because some do not come to Taverns. And then they can become HIV positive.

Researcher: Mh.

Respondent: They can get infected. So I was telling myself that if we can get support groups, and have a meeting with a mayor maybe. If we can have community meeting, and then we share, we talk, we help each other about how we can reduce the rate of this viral infection.

Researcher: I understand what you said, it is interesting. Are there some organisations which have already started to take part in the fight against this virus or alcohol?

Respondent: I. I by myself. There is, there is another NGO at Bheki.

Researcher: Ok. NGO?

Respondent: I have already talked to her in many occasions. They are able to help in the community. You find that when a person is ill, they are able to help and do one, two, and three.

Researcher: Ok.

Respondent: And then, further other organisations are for old age.

Researcher: Old age?

Respondent: Is just that, old aged organisation do not have HIV positive people?

Researcher: Ok.

Respondent: In [redacted] it is grannies who are disabled.

Researcher: Ok I understand. Other organisations, maybe governmental, police services or clinics.

Respondent: Another organisation is that we go to the hospital at Odi. But in Mabopane there are others whom we share support group at block U.

Researcher: Ok. Oh in block U. Ok I understand. Anything you want to talk about in relation to HIV/AIDS before moving to the next question?

Respondent: HIV/AIDS?

Researcher: Yes or alcohol? I heard you saying alcohol contributes, how does it contribute?

Respondent: Alcohol contributes. It is just that some people do not understand. They behave as if they understand but they do not understand.

Researcher: Ok.

Respondent: That is, let me put it in this way that is lack of underrating.

Researcher: Ok.

Respondent: A person just do it, he does not think of tomorrow. He does not think that tomorrow will come. He says no, as long as I get it. When he is having a nice girlfriend he think he will not get infected, let me just go without using protection. Things like that.

Researcher: Mh.

Respondent: These are the boys, I do not know that thing which is in their mind that makes them live mostly being negative. So their mind is always negative such that at the and they become confused and they are unable to find an answer.

Researcher: Ok. I heard you talking about NGO and Old age?

Respondent: Mh.

Researcher: What is the nature of the NGO?

Respondent: I asked the owner to come, now maybe she has some challenges, he could explain better.

Researcher: She could explain better?

Respondent: If he can come. I once went to the place during about 2005. We formed support group there, that people at Bheki eish.

Researcher: It is interesting that you want to form a support group. You talked about an NGO, and old age, is there any other organisation which you can think about so that we can work together besides the two mentioned?

Respondent: Eh….

Researcher: Any other organisations you can think of?

Respondent: Eh…

Researcher: If you do not remember, we can discuss later.

Respondent: Yes.

Researcher: Ok. We move to another question. The following question is, please tell us about your thoughts concerning alcohol misuse as a risk factor of HIV infection in this community?

Respondent: What were you saying?

Researcher: What are your thoughts about alcohol misuse as a risk factor of HIV infection in this community? Maybe I can ask in English?

Respondent: Yes.

Researcher: Ok in English it says what are your views about alcohol misuse as a risk factor of HIV infection in this community? How is alcohol related to HIV/AIDS?

Respondent: Ok let me answer like this.

Researcher: Yes?

Respondent: In my side. I answer like this, when it comes to alcohol. I wished we could try meetings in Taverns.

Researcher: Ok.

Respondent: In Taverns we should have meetings with the community.

Researcher: Ok

Respondent: We teach them that it is like, especially people who are on ARV treatment.

Researcher: Ok.

Respondent: They are not supposed to, do not drink too much. So we were saying at-least they should learn how to limit, their limit, and then maybe it would be better. Because you cannot enforce drinking limit to a person. I can enforce drinking limit now, but he will enter the tavern and drink five beers, he go somewhere to another tavern and drink another drinks.

Researcher: Mh.

Respondent: So I was saying if we find them, and teach them that if they're on ARVs, if they are not on ARVs so that they can protect their immune system. Alcohol also damages immune system.

Researcher: Ok I see. What do you mean by limiting alcohol drinking?

Respondent: That is a person has to drink up to the limit. That is he should not drink overdose.

Researcher: Ok. What is overdose?

Respondent: That is overdose you do things which are not right.

Researcher: Ok, if you say things that are not right what do you mean?

Respondent: That is having sex without using a condom. He will say he did not notice it *(having sex without using a condom)*, yes or he will

say it burst, he is the one who have caused this. Some it is because of alcohol. A person will deliberately drink alcohol so that he can do this thing and blame alcohol.

Researcher: Mh. Ok. What other role does alcohol play. I heard you talking about immune system.

Respondent: Alcohol damages, it damages.

Researcher: Immune system?

Respondent: And the liver is also damaged by alcohol.

Researcher: Ok. I heard you talking, linking alcohol and ARVs. What happens with alcohol drinking and ARVs?

Respondent: ARVs and alcohol, ARVs are drugs. Drugs do not combine with alcohol. They do not combine because you take drugs and then you drink alcohol. You make something terrible inside.

Researcher: Ok. It is interesting. What do you mean if you say they make a person do things that are not good?

Respondent: The thing is a person who is drunk will start proposing love, he goes here and there, and enters everywhere. You see, and there are some girls who are unable to refuse to fall in love. A person will say it is because he is having money, he buys drinks for her, and he buys alcohol. He drinks that alcohol, after that they go and sleep, no condom.

Researcher: Ok.

Respondent: Because of the fact that that person is having money and he does not like using condoms. Because he has bought him alcohol, and then now at the end of the day, that is you know that a person who is on ARVs and then what he does, he infect another person, and that person has been affected by ARVs. When that person has been affected by ARVs, he cannot get assistance, when he starts taking those ARVs. ARs have already damaged him.

Researcher: May you please tell me how does this happen in [redacted]?

Respondent: It happen in [redacted] and it is done by people who are ill. Mostly the thing is I always see them, in the hospital, and I am able to talk, let me say maybe somebody has gone to take their

treatment or she takes treatment. And then I see her. Do not drink savana, savana is no, six per cent of alcohol. No.

Researcher: Mh.

Respondent: Take something down or energize, so some of them they listen to me. Some say do not tell me this, which you are?

Researcher: Ok. Organisations in this community which tries to help?

Respondent: There are many organisations.

Researcher: What are people's understandings about getting assistance?

Respondent: Many people approach me. I am able to be called for counselling him or her. I counsel them. I am able to talk, so that he can talk and be right. I can take a person to hospital so that he can get treatment and after that he will come back to me and thank me. And then some of them ah.

Researcher: Ok, as you have talked about alcohol misuse and HIV infection. What can you say about condom use?

Respondent: Yes condoms that is why I say I do not like to have shortage of condoms because I like to help the community.

Researcher: Ok.

Respondent: I want to help the community with condoms. If possible I take condoms from the hospital, they know. I ask for four boxes or six boxes at Odi hospital. If they come to me I want a box, if I have, take and use it. Do not take and put it there.

Researcher: If a person does not know Klipgt, and does not know how people drink alcohol and how it related to HIV/AIDS, how can you describe to a person who does not know?

Respondent: How does alcohol and HIV relate? Mostly it is the way I was describing saying alcohol and HIV do not go hand on hand, they relate because of ignorance. People do things knowing that at the end what they will get. They ignore. And at the end of the day it is not nice.

Researcher: What do you men if you say it is not nice?

Respondent: That is that other person is drunk, he meet an HIV positive person. They all end up being HIV positive. And you find that that other person was not HIV positive or a man was not HIV

positive. He gets a girl in a drinking venue, he propose her and they both drink alcohol. They will than go together, such things. At the end what do they do?

Researcher: Ok. What is it that makes a person who is drunk have sex without using a condom?

Respondent: That is why I say to be ignorant.

Researcher: Okay. Ignorance, what is that?

Respondent: I can say what a person does? He does things knowing what is right or wrong. But they ignore because I am drunk, I do not see anything.

Researcher: Before going to another question, is there anything important that you will like us to know concerning relationship between alcohol and HIV?

Respondent: Okay, I wish that there could be an understanding between myself and the community, tech each other, I like teaching people who are HIV positive, so that they can live a positive life and not to drink too much, they should have a limit. If they want to be happy, it should end up there. Because sometimes you can drink. I can say I can drink once a month, or twice a month to be just happy. Do not drink every day. It is not like that because I got a medicine, and then my treatment, I do not want to disturb my treatment. My ARV I eat it. My health is my life, I Like it ad I am happy.

Researcher 2: OK sorry Jacobs maybe you did discuss this I am very curious, you clients, do you know who are HIV positive?

Respondent: Yes (laughing). I live positive I tell him, I tell them I am HIV positive and a live positive, and I do not want to be negative. They want people live positive life.

Researcher 2: And do they tell you that they are positive as well.

Respondent: Yes I disclose my status with them.

Researcher 3: And they will disclose to you as well?

Respondent: Because I love myself and love.

Researcher 2: So it sounds as if you must have very strong values because you want to run this business but in a responsible way?

Respondent: Sorry?

Researcher: She means it sounds as if you must have very strong values because you want to run this business but in a responsible way, helping people?

Respondent: Yes.

Researcher: So that people become responsible?

Respondent: Yes.

Researcher: Jut to follow up question which was asked, what can you say about HIV testing, what can you say about facilities for HIV testing?

Respondent: Yes what I see in the community people do not go and test, no. They wait to be sick and go and test.

Researcher: Okay.

Respondent: So I would say at least maybe once a year or twice a year there should be a tent, the community should be called. Everyone should be open, like that. That is what I feel should happen.

Researcher: Ok, HIV testing?

Respondent: Yes.

Researcher: And then those who drink excessively?

Respondent: Drinking excessively, that is why I was saying, as we said, as tavern owner, we will call meetings and invite the community.

Researcher: Ok.

Respondent: Yes we will call them and talk to them. We will also invite your organisation, and describe to them what happens.

Researcher: Okay thank you very much. Third question, may you please tell us how you feel playing a role a business women and helping people who are HIV positive, and being a member of tavern owners association?

Respondent: I want to play a role in helping these people to fight against this disease, so that people who are already infected by this virus should live a positive life, and then we prevent others not to get infected. So that at the end of the day maybe we will get a cure. All of us will get healed, I have hope that one day we will get a cure.

Researcher: Ok. In the role you play, may you please tell me about services which enable you to take part the way you wish? Please tell me what happens if you can explain to me in full?

Respondent: We need services, but I have not taken steps to tell the truth because, but now because I already spoke of support groups I want to have access to funds, we should raise funds, and have some funds. You know many people in support groups; you can call them to come to support meetings, if they do not eat anything, next week they do not come back. So at-least maybe if we had breakfast or a lunch. We have support group we talk, talk, talk, talk, and all our problems. We can share our problems and then our status. And then I want to help some people to disclose, because some of them, they do not want to disclose and then they got injured inside.

Researcher: Ok. Are there some people who are unable?

Respondent: Yes. I was looking as disclosing not meaning going around and talking. You can take this into outside. So that you can live your life. Because if you live with a virus, positive and go like this, if positive you run, hei I am positive, no hae.

Researcher: Ok.

Respondent: I am happy. To be positive is my life. And I like it.

Researcher: So how can support groups help?

Respondent: Their importance?

Researcher: Mh.

Respondent: Mostly the support groups helps people to disclose their status and live a positive life. That is when going around. When a person says that individual in HIV positive, he should not look back, he should take a step forward. The thing is the support group shall have given him, you will find so and so challenges.

Researcher: Ok.

Respondent: Support group is a challenge. That is you will find that you have you own problems, you take the problems out, you go being happy. They share problems and live happy.

Researcher: Ok, that you are managing alcohol serving business, how do people understand when you tell them to drink responsibly?

Respondent: Jo I talk. My customers are my customers I discuss with them (*Smiling)* Yes this are my customers, is my family. Yes is my family. If I do not want this, hey, ho! Do not drink, Hei, do not drink anymore, it is finished, go home, or I escort you. Yes like that.

Researcher: Ok. Thank you very much. Before we move to another question, please tell me anything you would like to talk about concerning the role you play in the community which you can think about.

Respondent: (not clear:0.28:07.3) People who are down we sometimes help them when they are already having problems, things like that, the thing is when I have never being up, but if my things can go up, and become right, I want to look after orphans, whose mothers and fathers have passed away because of the virus. I want to take all the orphans and build for them at home. I want all the orphans whose mothers have passed away because of the virus, and their father, you see? An NGO, I go to the hospital and ask for assistance, you will also help me to grow my vision.

Researcher: I wonder if there is any question before I move to another question. Oh right I go to the following question. *(Phone ringing)* You may answer the phone.

Respondent: (Answers the phone)…Thank you.

Researcher: Ok than you very much, we move to the fourth question. Please tell me about activities undertaken to prevent alcohol misuse as a risk factor of HIV infection in this community?

Respondent: (Silent.)

Researcher: If you want to understand the question better I will subdivide it.

Respondent: Yes subdivide the question.

Researcher: Firstly, which activities are undertaken by yourself, there are activities that can be undertaken by yourself, others, or organisations. So firstly which activities are undertaken by yourself?

Respondent: When it comes to alcohol?

Researcher: Yes alcohol. As we have said some people who drink they tend not to use condoms and end up getting HIV infection? So which activities are undertaken so that such things do not occur?

Respondent: Yes, activities, that is mostly, people whom I know I am able to advise them when they are doing wrong things.

Researcher: Ok

Respondent: You cannot do a wrong thing in front of me especially if you have a wife at home. Do not do a mistake, because I approach a person and say no, do not do this.

Researcher: What do you mean by wrong thing?

Respondent: That is I can see that there are ladies who are selfish, there are ladies who are selfish outside and then they come to tavern because of they want money. And then you see, also to destroy other people's family. You see when she says I am going to take somebody's husband, take him so that he does not sleep at his home, things like that.

Researcher: Okay.

Respondent: Ok you find that I see that man, that lady is not right. I am able to call him. Sorry come here; no do not do that thing. You know that you have left your wife at home, after, go home, you see such things. I save him from many things. I do not want to see him that tomorrow when he is sick then I say you see what you have done. I do not want you to do such things. I want him to be free from such problems. You see I save many people. Tomorrow they say you have helped me. I say I do not want.

Researcher: Ok I understand you describe a wrong thing and gave an example about women who comes to destroy other people's families by taking the husband, other examples?

Respondent: Yes, it is like, let me say, when you find a man who does not have a family, I also can destruct him, no do not do this; you see you will end up being in trouble? Tomorrow it will be I, running around for counselling, what I will do. I tell them that no I do not want. If you want and you have enough money. Let me have your money and safe it so that you go and sleep, you will come

and collect it tomorrow. Or go home. The thing is that sometimes you say go home, he goes to another tavern. If you have called him you are able to safe him, you say no I take your money you see how much? I record in a book than go. Because men use ladies mostly at drinking venues by alcohol and money things like that you see, and families break because of alcohol.

Researcher: Ok I heard the way you helped women, what about men?

Respondent: Men also, I help both sides. That is why I say mostly when I know a person has a wife, and is a man. I am able to call him. I tell him that you know that you have left you wife in the house.

Researcher: Oh I see.

Respondent: Mostly women, that is I am liked by men. Mostly I discuss with them. And mostly women are few and you can see their behaviour.

Researcher: Ok.

Respondent: You are able to say no do not, stop it, do not go there. You see such things. You see their behaviour, how they live.

Researcher: Ok thank you very much; we spoke about activities taken by yourself. Please tell me about activities undertaken by other people.

Respondent: I do not know if other people in other tavern work like me the way I work.

Researcher: Yes.

Respondent: But others when they come from other taverns, they come back crying, a person saying I have been robbed, they took this thing, things like that. You see with me this things let me say a person in a tavern (not clear: 0:35:12.4) I think that we can accommodate them to sleep at our places. This will reduce the rate of rape. That is the rape also has bad consequences. Because you are raped, you get infection somehow you see such things. You see when we say we have women in taverns or left with men we are safe. Let me say there are two men, I know them. A person whom you do not know, you are afraid to keep him in the house, because you do not know what will

happen during the night. People whom you know I thought at-least as tavern owner it is something we are going to talk about next year when we open. We start next year as tavern owners.

Researcher: So the way you said you help people so that they do not get HIV infection at drinking venues. Please tell me about other people who also help in some way?

Respondent: Ei me, in [redacted] I have never seen that, unless is, mostly it is people who are like me, they talk, we talk in support groups. Other people used to meet in support groups. They say we have seen you in support groups, you know we have problems. The thing is people are able to bring their problems at support groups. Support group is able to make us know each other, and be positive, live a positive life. That is support group, which is family house support group.

Researcher: Please tell me about organisations that enable existence of support groups?

Respondent: And organisations, that is we ask Thabo, Mayor so that he can help us and then with me our organisation is not broken down, it is just people have just left, they will return.

Researcher: May you please describe to me about the organisation?

Respondent: It is Bokamoso support group.

Researcher: What were you doing in Bokamoso support group?

Respondent: We were sharing problems, mostly sharing, helping those who were unable to disclose their status to be able to disclose their status, and accept that virus.

Researcher: And may you please tell me about challenges you had in the organisation?

Respondent: Yes there were many challenges that are when I look at support groups, for all of us to succeed, we have businesses, some are working, that is we never sat down and said we are sick. We stood up and said we will work with our own hands.

Researcher: Ok. May you please tell me about things that may interfere with your success?

Respondent: Ok that is things that interferes with other people are talks.

Researcher: Oh talks?

Respondent: Ya that is why I say support groups are able to help people that they do not look back go forward and be positive, your mind should be right, this is a support group.

Researcher: Ok than you very much. Before I move to another question, anything you want us to discuss?

Respondent: That you think we should discuss?

Researcher: Especially activities that you said you undertake?

Respondent: You see I like, let me say I like you presence. That is next year when we start to have community meetings, I will contact you, so that we are able to talk to the community, so that they should not drink, that is they should not drink over the limit. I do not have a problem with alcohol, but they should limit their drinking, limit, drink limited.

Researcher: Oh right.

Respondent: Because when they drink overdose, eish do not do things right.

Respondent: Ok, thank you very much we move to the last question that is, how can individuals from organisations participate to sustain working together to prevent alcohol misuse as a risk factor of HIV infection?

Respondent: MH, you know mostly I speak about members from organisations, our members are from Taverns. You know there is, we will never be the same, and there are those who drag another way.

Researcher: Yes?

Respondent: But if we can be united, and become one big family. We can be anything which will help our community.

Researcher: Ok. What do you mean by one big family?

Respondent: That is you become one thing. We agree with what we shall have agreed upon.

Researcher: If we are one big family what is it that will make the one big family to be sustainable and succeed?

Respondent: That thing is if we want to help such things, maybe I am talking about something that is there. There is an NGO, which helps,

one, two, three if we can say one, two, three, we can buy clothes for the orphans. That is we go according to the list of orphans in [redacted] as a whole. We will know the number. And then as tavern owners we have an account to contribute money, we are able to buy food and clothes for the orphans.

Researcher: If you speak about an account, how can we ensure that we have an account?

Respondent: That is why I said if we can be one big family, we become united. We agree by sitting down and then talk about, able to help. I like to help. And I am able to help when there is a need.

Researcher: Ok please tell me about challenges which can prevent us to sustain the project

Respondent: The way I see if we are serious I do not see any other thing.

Researcher: If you talk about being serious, what is it than can make people to be serious?

Respondent: You teach a person, you teach him that there is this thing, you teach him about illness. When coming to the issue of HIV, because they will also be involved, because they do not know themselves. Maybe some knows them; they know their (HIV) status. But I like that, we can talk about it, they also know. Even in our meetings, I live a positive life. I am not that person, and I am not going to die anymore. I passed many challenges of illness, I am now healed. So mostly I told myself that a challenge is a challenge. So we must grow up.

Researcher: Ok I understand. I heard you talking about support groups, and you also said we should be united so that we can have an organisation. Which activities can we undertake so that we can be together? What can be done to form an organisation that succeeds?

Respondent: Ok. Now that is why I said I want us to meet with that other group, and then after meeting will call you to come and talk. I cannot make a decision alone. It needs a group.

Researcher: Please tell me about other organisation which we can talk with the way we discussed with you?

Respondent: Silent.

Researcher: Ok if you do not remember now you will inform us after remembering. Is there any question, or something you want to stress?

Respondent: Ok what I want to stress mostly. That is we as tavern owners, we must know our patrons. You should enforce the limit. When a person is drunk, we should ask him to go home. Unless you take his cell phone, take the money he is having, so that he can be safe and go home. And tomorrow you take them (Money and cell phone) to his family. You say I have taken the cell phone of this person. I took their cell phone and money and go.

Researcher: Ok. We have reached the end of an interview. Thank you very much for your effort and time. You may have last comment?

Respondent: Question, let me comment. Our things, let me say mine, the way I say I want to form a support group at home. After forming a support group I will come back to you asking for your assistance, so that you can help me with everything hitch I may need, but a do not foresee a support group needing money. Support group needs advices. I want the support group to help me help the orphans.

Researcher: Thank you very much, thank you for your time.

Researcher 2: Thank you very much for sharing your story with us. I thought it was a story of hope.

Annexure E: Field notes

Sustainable community coalition framework for organisational stakeholders to prevent alcohol misuse as a risk factor of HIV infection

KII number: **1**
Date of interview: **13/12/12**
Participant: **Tavern Owner**

I went with research supervisor and co-supervisor to [redacted]. We left Unisa at about 09H00 and arrived at [redacted] at about 10:00. We met with a tavern owner at her business/house, introduced ourselves to the tavern owner. The tavern owner warmly welcomed us in her house and let us gets seated in lounge on sofas. There were some other people in the household at the building at the back one in the house in the kitchen. We provided the tavern owner background information about the study and invited her to participate in the study. The process of concern form was done by asking the participant language preference. Participant stated that she would prefer Tswana but would communicate in English when there is a need. The participant was given one copy of the consent form while I had another copy, and read the consent form word by word. After each paragraph there was a pause to give the participant an opportunity to ask question.

After going through the consent form the participant was given an opportunity to ask question. The participant stated that she understood and agreed to participate in the study and that the voice recording device may be used to record information. I also asked permission to write down some notes during the interview. The interview started at 10H30 until 11H15. I and the participant were seated in the lounge on sofas. The participant was free, maintained good eye contact and her affect was appropriate when talking. At the beginning of the interview the participant stated that she wished to disclose that she is HIV positive and has taken her diagnosis positively. Her words were supported by facial expression of a person who is happy about life and free to talk about her diagnosis as seen by a happy face accompanied by a smile.

The participant stated that she is highly motivated to form a support group to ensure that other people in the community do not undergo what she experienced. She stated that there are NGOs and Old age organisations in the community and that there is a support group for victims of HIV/AIDS which she is a member. She also stated that there is a group of tavern owners who meet every two weeks and that she is also a member. The participant talked freely and seemed motivated to give back to the community by forming support group and that in her tavern she tries her best to promote responsible drinking and responsible sexual behaviour. She stated that some people who consume alcohol are at risk of contracting HIV because of having multiple partners and not using condoms. During Question 4 her phone rang and was given an opportunity to answer her phone. She continued to participate in KII after answering the phone.

At the end of the last question she was given an opportunity to ask questions or to comment. She commented that there was a need for a support group and that there is a need to involve researchers. She said she was happy to be involved in a KII about alcohol and HIV and felt that the interview was therapeutic for her because of sharing her experiences. After an interview she offered us a cold drink and photos were taken. She stated that she will be happy to have a photo and to have a photo used in publications. 6000 condoms were distributed at the tavern as a continuation of monthly condom distribution. The tavern owner stated that she will need more condoms to share with other businesses.

The setting as in the participant‘s house. Before the interview the participant looked happy to accept us and accommodate us in her house. Her facial expression was for a person who seem happy and free to talk to us. We sited in a lounge, and I was closest to the participant. The three of us, myself and two research supervisors seem not top interfere with flow of information. At the beginning of the interview the participant disclosed her HIV status which helped her to freely discuss about HIV. During the time she disclosed her HIV status she was smiling and facial expression was showing a person who have accepted her HIV status. When telling us that she was positive about life, her strong voice, accompanied by happy facial expression was showing that the participant has accepted her status and that she was living a positive life. The participant was also concerned about orphans, and lack of funding

in the community to help support orphans. During the time she was speaking about orphans she spoke slowly with a soft voice suggesting that she was empathetic and concerned about welfare of victims of HIV. She also spoke softly with a low tone of voice when she stated that she does not want other people to go through what she has gone, implying that she once underwent a painful experience especially during first few days of knowing her status.

Throughout the interview participant fatigue was not observed as the participant continue to show facial expression appropriate to what she was saying, often smiling when talking about positive hope especially in her vision to form support group. Her happy face showed that she believed in herself and that she was positive that she will form a support group and give back to the community. At the end of the interview she offered us a cold drink as it is customary in the community of welcoming visitors with a drink, snacks or food. We later took pictures with the participant and she was happy to take pictures with us.

The participant knew me from a previous project of distributing condoms in drinking venues and therefore had already developed trust with me. At the start of the interview after a consent process the participant disclosed to us her HIV status. This gave the participant an opportunity of a feeling of acceptance and to freely discuss the topic.

I asked open ended questions from the stance of not knowing. I used probes to seek more clarity about some of the themes which seemed unclear. I maintained eye contact, my affect was appropriate with what the participant was saying such us smiling with the participant, asking questions softly when the participant was speaking softly to project empathy. Silence technique was also used to give the participant an opportunity to think about the topic and to recall facts.

I felt welcomed at the participant's house. At the beginning of an interview in the lounge the TV was on and loud , but the participant switched it off when the interview started. I also thought that privacy will not be easy to maintain as there were other people in the household. However throughout the interview process none of other people in the household came to the dining room. I thought that the presence of two

research supervisors will make the participant feel uncomfortable and not freely talk about her experiences of alcohol misuse and HIV infection. However this seemed not the case especially due to the fact that the two researchers were female and white, the participant developed trust on them and at the end of the interview was seen sharing smile with them and taking some pictures. After the interview I felt highly motivated to work with the participant in community coalition as she spoke positively about helping HIV victims and she also spoke about the importance of working together with other organisations.

Notes of meeting 4: 25/01/2014
Venue: Councillor's Office, [redacted] ward 36

Filed Notes

On 25/01/2013 I visited [redacted] ward 36 to have a meeting with representatives of organisations in the community. I arrived at 10H00 as planned. On arrival the chairperson of the organisation was already in the office. Some members were not in the meeting as they were attending the funeral locally but send an apology that they will come to the meeting after the funeral.

I and the chairperson agreed that we will wait until people are back from the funeral and attend the meeting. At about 11H00 about 8 people had already arrived in the meeting and the meeting started. Meetings on early Saturdays can be a challenge as people attend funerals but I understand if few people attend the meeting.

Before the meeting started there was an informal discussion about [redacted]. Members present were relating to each other about history of [redacted] and challenges facing the community as well as an area that has a potential for Tourism. It was very interesting to me to hear that [redacted] has natural resources which when they can be developed had a potential to attract tourism and investors for example they talked about a mountainous area which is having different types of snakes.

The chairperson declared the meeting open and my role was to facilitate the process by making resources available such as minutes of previous meeting, agenda, and stationery. The chairperson requested one of the organisational representatives to take minutes as the secretary was not present. I was happy that the representative volunteered to take the minutes of the meeting. I felt that if the meeting is chaired by member of the community and minutes are also taken by members of the community it promotes ownership of the project.

I asked permission to take some notes and was given opportunity to do so. I wrote in detail what was discussed in the meeting as a way of supplementing minutes taken by the secretary.

The chairperson seems very keen to drive the project forward. He allowed members present to come with ideas and gave them ample time to discuss ideas. Most of members present were actively involved in the discussion about how should the organisation be formed, and which activities to be done to realise the objectives of a strong organisation.

I felt that members present discussed some of the topics in more detail to give me a better understanding of dynamics in the community. For example when discussing correct time to have a meeting on Saturdays it became clearer that 10H00 was not a good time for meetings as people attend funerals. Some members mostly the elders felt that meetings should be at 14H00 while some felt that 14 H00 is too late especially for the youth who will want to go and entertain themselves with soccer at 14H00. Furthermore 14H00 it was felt that it was not good for the youth because by that some shall have already started to consume alcohol. An agreement was reached that meetings will be at 11H00. The ability of the group to make a decision on consensus made me feel that the group are able to reach decision on consensus.

The meeting was held in counsellor's office. Some community members when they saw an office open came to request for community service like a letter for proof of residence. Some members present were not comfortable with the visitors and stated that it was time of meeting not time of service delivery but later helped the visitors. I felt that it was good to help visitors because from their knowledge the office was there to serve them. If they see an office open they expect service for them.

At the closure of the meeting I was happy to engage with organisational representatives and some shared with me their success stories in their organisation, for example two organisations succeeded in getting land for their organisation. When sharing their success with me I felt that trust is developing between me and organisational stakeholders and my appreciation of their success made them understand that my interest is not only about the project for academic exercise but for the development of the community as a whole. The more I engage with organisational stakeholders I became more attached to the community and developed an interest in working with the community to achieve their objectives.

Commitments by organisational stakeholders to attend meetings and to be actively involved in the discussion made me feel that stakeholders were motivated to be involved in the project. During the meeting community representatives stressed a need to register the organisation with Social development as an NPO, something that I thought will contribute towards sustainability of the project as this will give it a recognised identity. Furthermore community members expressed a need to strengthen distribution of condoms which to me it meant that they have identified a need to prevent the spread of HIV infection and are prepared to take action.

The fourth meeting with organisational stakeholders made me develop a sense of belonging to the community. I realised that the more I developed an understanding of community needs was the more I was thinking of balancing my objectives about my involvement in the community, an academic exercise as well as putting more effort towards the development of the community. An ethical principle of beneficence kept on coming to my mind that in the project I attain my PhD, recognition and promotion, then what about community, what they will benefit, how they will benefit. I felt highly motivated in contributing towards improving the standard of living of the community.

Annexure F: Agenda and minutes of meeting

Greater [redacted]-based Organisation workshop Ethics in Community-based Participatory Research			
Date: 05/12/2013 Venue: [redacted] (Church) Time: 09H00-13H00			**Presenter**
1	**09H30-09H45**	Opening and Welcome The meeting was opened with a song and a prayer. Clement welcomed everybody in the meeting	[redacted]
2	**09H45-10H00**	Introduction Members present introduced themselves. Among the visitors were members of Break though support Group, Representatives from Medical Research,-Unisa Lecturers, members of Madibreng Subdistrict Department of health, health promotion, Local Government	All
3	**10H00-10H30**	Project Background Kgalabi gave backround information about the project that the Project is about Development of sustainable community coalition framework to prevent alcohol misuse as a risk fator of HIV infection. He said the aim is to bring together people from different organisations to work together to fight against HIV as a risk factor of HIV infection through participatory action research.	Kgalabi
4	**10H30-10H45**	Questions and Discussions Members present raised a concern that the youth are the ones that are causing problems in the community in relation to HIV and alcohol. They stated that there is a need to invite more youth members to attend the workshop.	Kgalabi
5	**10H45-11H00**	Tea break	

6	**11H00-12H00**	Ethics In Community-based Research Dr Visagie and prof Maritz presented ethics in Community-based Research through dialogue discussing the rights, roles and responsibilities as well as decision making. She discussed protection of own rights and rights of others.	Dr Visagie/ Prof Maritz
7	**12H00-12H30**	During discussions the following were identified Adults in the community are aware that there is alcohol abuse and spread of HIV infection especially among the youth. That they are living in fear of the youth who are uncontrollable That there is uncontrollable anger. That the youth are not working, faced with boredom and therefore tend to alcohol to relieve boredom. That the community is lacking facilities to ensure that the youth are kept busy. That interventions about alcohol they fear that tavern owners might not be interested. Other drugs like Nyaope was a problem in the community and that there is a lack of resources to deal with Nyaope i.e. the project is operated in the house as the NGO is struggling to get the land. Some were of the opinion that the grannies are to blame as they are the ones that protect their children and do not control them even if they come home late	Dr Visagie/Prof Maritz
8	**12H30-13H00**	Questions and Discussion	Dr Visagie/Prof Maritz
9	**13H00-13H15**	Way forward and Closure Members present expressed a need for other workshops involving the youth, tavern owners and other organisations which were not represented.	Kgalabi

Annexure G: Confidentiality agreement

Confidentiality Agreement

This Confidentiality Agreement is entered into by and between *Jacobs Kgalabi Ngako* the researcher and *Dr Annie Temane* the Independent Coder for the purpose of preventing unauthorised disclosure of confidential information on the data for the study entitled:

Development of a sustainable community coalition framework for organisational stakeholders to prevent alcohol misuse as a risk factor of HIV infection

The Researcher and Independent Coder ensure that the privacy of the participants will be protected. The data that will be coded will not be publicly linked to the participants. A coding report will not reflect any names or identification data that may be linked to participants.

_____ (Please print)
Researcher's name

_____ _____
Researcher's signature Date

_____ (Please print)
Coder's name

_____ _____
Coder's signature Date

Annexure H: Framework evaluation tool

Framework evaluation checklist

Descriptors	Criteria	Rating			
		Strongly disagree	Disagree to some extent	Agree to some extent	Strongly agree
How clear is the conceptual framework					
General clarity of the conceptual framework	The conceptual framework is clear to understand				
	Ideas are consistent				
Semantic clarity	It is easy to understand the concepts				
	The use of words is consistent and not invented				
	There is no excessive verbiage				
	Narratives are not excessively used				
Semantic consistency	Concepts are defined				
	There is consistent meaning during the use of concepts				
	Relationship of concepts is clarified				
	Purpose of the conceptual framework is consistent with the components of the framework				
	Assumptions are made and reflected in the conceptual framework				
Structural clarity	There is clear connectedness of the concepts				
	There is clear connectedness of the components				
	There is clear understanding and reasoning throughout				
Structural consistency	There is connectedness of structures of the conceptual framework				
How simple is the conceptual framework	There are a number of manageable concepts in				

Descriptors	Criteria	Rating			
		Strongly disagree	Disagree to some extent	Agree to some extent	Strongly agree
	the conceptual framework				
How general is the conceptual framework	The scope of the concepts within the conceptual framework showed that the framework has a broad scope of application				
	The purpose within the conceptual framework showed that the conceptual framework has a broad scope of application				
	The conceptual framework applies to mental health professionals				
	The conceptual framework focuses on universal health outcomes				
How accessible is the conceptual framework	Empiric dimensions of the framework can be identified				
	The purpose of the framework can be achieved				
How important is the conceptual framework	The conceptual framework creates a reality that is important to mental health				
	The conceptual framework has potential to influence mental health practice				
	The conceptual framework is of value in enhancing the personal and professional growth of mental health practitioners				

Annexure I: Approval from the University of South Africa

UNISA university of south africa

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

HSHDC/87/2012

Date: 17 October 2012 Student No: 0710-960-1

Project Title: Development of a sustainable community coalition framework for organizational stakeholders to prevent alcohol misuse as a risk factor of HIV infection.

Researcher: Jacobs Kgalabi Ngako

Degree: D Litt et Phil Code: DPCHS04

Supervisor: Dr RG Visagie
Qualification: D Cur
Joint Supervisor: Prof JE Maritz

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Roets

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure J: Approval from the Department of health North West Province

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

2ND Floor Tirelo Building
Dr. Albert Luthuli Drive
Mafikeng, 2745
Private Bag X2068
MMABATHO, 2735

Tel: (018) 387 1786
Fax: 018 392 6710
kshogwe@nwpg.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : **Mr J.K Ngako**

From : **Policy, Planning, Research, Monitoring & Evaluation**

Subject : **Approval Letter- Development of a sustainable community coalition framework for organization stakeholders to prevent alcohol misuse as a risk factor of HIV infection**

Purpose

To inform the researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to arrange in advance with the chosen districts or facilities, and issue this letter as prove that permission has been granted by the provincial office.

Upon completion, the department expects to receive a final research report from the researcher.

Kindest regards

Acting Director: PPRM&E
Mr. L Moaisi

20/08/2013
Date

DEPARTMENT OF HEALTH
PRIVATE BAG X2068
2013 -08- 20
SUPERINTENDENT GENERAL

Annexure K: Approval from the Sub-District

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

Private Bag x5084
Brits
Madibeng
0250

Tel: (012)2522355
Fax: (012)252 3460
imoloi@nwpg.gov.za
kmaponyane@nwpg.gov.za

MADIBENG SUB-DISTRICT

01 October 2013

To: Facility Manager
Ikhutseng Clinic

From: Mr. IM Moloi
Sub-district Manager

Re: Permission to do research at the facility

This serves to inform you that the Sub-district Manager's office has granted permission to Mr. Kgalabi Ngako to do research at the facility as part of his study entitled: **Development of a sustainable community coalition framework for organizational stakeholders to prevent alcohol misuse as a risk factor of HIV infection.**

For clarity please contact the manager's office.

Hope you find the above in order.

Yours truly,

Mr. IM Moloi
Sub-district Manager

Annexure L: Approval from the Local Government

The Ward Councillor

[redacted]

[redacted]

22 November 2012

Jacobs Kgalabi Ngako

P.O.BOX 1751

Silverton

0127

Dear Mr Kgalabi Ngako

I would like to confirm that I have given my permission for you to conduct a research project entitled: "**Development of a sustainable community coalition framework for organisational stakeholders to prevent alcohol misuse as a risk factor of HIV infection**" in [redacted]

Regards

T.S. RASEROKE

Ward Councillor's name

Signature

22/11/2012

Date

Welhemah Nmako.

Witness's name

Signature

22/11/2012.

Date

MADIBENG LOCAL MUNICIPALITY
WARD 36
Cllr: T.S. RASEROKE
Date: 22/11/2012

Annexure M: Participation leaflet and informed consent: Key informant interview (English)

DEAR PROSPECTIVE PARTICIPANT

I am Jacobs Kgalabi Ngako, a doctoral candidate from the University of South Africa. My supervisors are Dr. Retha Visagie and Prof Jeanette Maritz. I am inviting you to participate in the study entitled:

Development of a sustainable community coalition framework for organisational stakeholders to prevent alcohol misuse as a risk factor of HIV infection

Before you agree to participate you should know what is involved and this information leaflet is to help you decide. If you have any questions, which are not explained in this information leaflet, please feel free to ask me. You should not agree to participate in this research unless you are happy about all aspects of this study, which may affect you.

WHY AM I CONDUCTING THE RESEARCH?

Studies in other parts of the world and South Africa have shown that when people drink alcohol they often develop problems related to alcohol and that alcohol misuse can be linked to sexual risk behaviour and the spread of HIV infection. I am doing this research in order to develop a sustainable community coalition framework to prevent alcohol misuse as a risk factor of HIV infection in this community.

WHAT DOES THE STUDY INVOLVE?

I will be visiting this community to get information about existing organisations. I will be asking you to tell me your experiences about alcohol consumption and HIV in this community. Since I will not be able to remember everything you say during the

interview, I would like to ask you to allow me to record the interview using an audio-recorder.

HOW LONG WILL THE STUDY LAST?

The entire study will last for up to two years. Individual interviews will last for about one hour.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The Departmental Higher Degrees Committee, University of South Africa of South Africa has granted written approval for this study.

WHAT ARE THE RIGHTS OF THE PARTICIPANTS IN THIS STUDY?

You have a choice to take part in this study. You may refuse to take part and may stop at any time without giving a reason. You can also withdraw your consent at any time, before, during or at the end of the interviews and discussions. You will not receive any form of reimbursement for participating in this study.

WILL ANY OF THE STUDY PROCEDURES RESULT IN DISCOMFORT OR INCONVENIENCE FOR THE ORGANISATION OR THE PARTICIPANTS?

Although the researcher does not foresee any longer term individual risk being part of an interviews may make you feel uneasy as some of the questions deal with sensitive issues such as aspects of alcohol use and HIV. If you feel uncomfortable about certain questions you may refuse to answer them. If you feel the need to receive counselling I will refer you to organisations that offer counselling service free of charge.

WHAT ARE THE BENEFITS INVOLVED IN THIS STUDY?

This study will help you and I to understand what can be done to prevent alcohol misuse as a risk factor of HIV infection. The information that is gained from this study will help to develop policies and programmes aimed at preventing alcohol misuse as a risk factor of HIV infection in the community. Everyone who takes part in this study will get an opportunity to share their experiences about alcohol misuse and HIV prevention, and will be empowered on how to deal with challenges of alcohol misuse as a risk factor of HIV infection.

HOW CAN YOU GET MORE INFORMATION FROM THE RESEARCHERS?

You can contact Mr Kgalabi Ngako if you need more information or would like to discuss the study further. He can be reached at: 073 598 7256. Alternatively you can email him on: kgalabi2003@yahoo.co.uk.

You can alternatively contact one of my supervisors at the University of South Africa.

Dr. Retha G. Visagie	Prof. Jeanette E. Maritz
082 436 6630	082 788 8703

CONFIDENTIALITY

The interviews will be held in private and all information gathered during the course of this study will be kept confidential. The written information and the audio-tapes will all be stored in a locked filing cabinet in the office of the researcher if not in use. All forms will only be seen by members of the research team. After two years, all audio-tapes will be destroyed. We will write up the results of the study in reports and journals. However, we will not include the name of the community where the research was carried out, nor will we include the names of any people, names of organisations who take part in this study. If you are happy to participate in the study, please read and sign the attached consent form. 25

INFORMED CONSENT FORM TO PARTICIPATE IN THE STUDY

I hereby confirm that I have been informed by the investigator, Mr Kgalabi Ngako about the nature, conduct, benefits and risks of the study. I have also received, read and understood the Participant Information leaflet and Informed Consent regarding the study. I am aware that the results of the study, including any personal details regarding participants‟ sex, age, date of birth, initials, and address, and the name of this community in which the study will take place will not be stated in any study reports. I have also been informed that only relevant research team members will have access to the information.

I understand that I may, at any stage, withdraw my consent and participation in the study, without having to give a reason. I am aware that I will not suffer any consequence if I withdraw my permission at any time. I have had sufficient opportunity to ask questions. I freely declare myself prepared to participate in this research

_____ (Please print)

Participant's name

_____ _____

Participant's signature Date

I, Mr. Jacobs Kgalabi Ngako herewith confirm that the above participant has been informed fully about the nature, conduct and risks of the above study.

_____ (Please print)

Investigator's name

_____ _____

Investigator's signature Date

_____ (Please print)

Witness's name

_____ _____

Witness's signature Date

INFORMED CONSENT FORM FOR THE INTERVIEW TO BE TAPE-RECORDED

I hereby confirm that I have been informed by the investigator, Mr Kgalabi Ngako about the nature, conduct, benefits and risks of the study. I have also received, read and understood the Participant Information leaflet and Informed Consent regarding the study.

I have been informed that the interview will be audio-recorded. I understand that I may at any time withdraw my consent to have the interview recorded, without having to give a reason. I have also been informed that only relevant research team members will have access to the tape recordings.

I have had sufficient opportunity to ask questions. I give my consent to have audio recorder used during the interview.

_____ (Please print)

Organisation Stakeholder's Name

_____ _____

Organisation Stakeholder's Signature Date

I, Mr. Jacobs Kgalabi Ngako herewith confirm that the above participant has been informed fully about the nature, conduct and risks of the above study, and that the audio-recorder will be used.

_____ (Please print)

Investigator's name

_____ _____

Investigator's signature Date

_____ (Please print)

Witness s' name

_____

_____

Witness's signature

DEAR PROSPECTIVE PARTICIPANT

I am Jacobs Kgalabi Ngako, a doctoral candidate from the University of South Africa. My supervisors are Dr Retha Visagie and Prof Jeanette Maritz. I am inviting you to participate in the study entitled:

Development of a sustainable community coalition framework for organisational stakeholders to prevent alcohol misuse as a risk factor of HIV infection

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WHAT DOES THE STUDY INVOLVE?

I will be visiting this community to get information about existing organisations. I will be asking you to tell me your experiences about alcohol consumption and HIV in this community. Since I will not be able to remember everything you say during the interview, I would like to ask you to allow me to record the interview using an audio-recorder.

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The entire study will last for up to two years. Individual interviews will last for about one hour.

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WHAT ARE THE RIGHTS OF THE PARTICIPANTS IN THIS STUDY?

You have a choice to take part in this study. You may refuse to take part and may stop at any time without giving a reason. You can also withdraw your consent at any time, before, during or at the end of the interviews and discussions. You will not receive any form of reimbursement for participating in this study.

WILL ANY OF THE STUDY PROCEDURES RESULT IN DISCOMFORT OR INCONVENIENCE FOR THE ORGANISATION OR THE PARTICIPANTS?

Although the researcher does not foresee any longer term individual risk being part of an interviews may make you feel uneasy as some of the questions deal with sensitive issues such as aspects of alcohol use and HIV. If you feel uncomfortable about certain questions you may refuse to answer them. If you feel the need to receive counselling I will refer you to organisations that offer counselling service free of charge.

WHAT ARE THE BENEFITS INVOLVED IN THIS STUDY?

This study will help you and I to understand what can be done to prevent alcohol misuse as a risk factor of HIV infection. The information that is gained from this study will help to develop policies and programmes aimed at preventing alcohol misuse as a risk factor of HIV infection in the community. Everyone who takes part in this study will get an opportunity to share their experiences about alcohol misuse and HIV

prevention, and will be empowered on how to deal with challenges of alcohol misuse as a risk factor of HIV infection.

HOW CAN YOU GET MORE INFORMATION FROM THE RESEARCHERS?

You can contact Mr Kgalabi Ngako if you need more information or would like to discuss the study further. He can be reached at: 073 598 7256. Alternatively you can email him on: kgalabi2003@yahoo.co.uk.

You can alternatively contact one of my supervisors at the University of South Africa.

Dr. Retha G. Visagie
082 436 6630

Prof. Jeanette E. Maritz
082 788 8703

CONFIDENTIALITY

The interviews will be held in private and all information gathered during the course of this study will be kept confidential. The written information and the audio-tapes will all be stored in a locked filing cabinet in the office of the researcher if not in use. All forms will only be seen by members of the research team. After two years, all audio-tapes will be destroyed. We will write up the results of the study in reports and journals. However, we will not include the name of the community where the research was carried out, nor will we include the names of any people, names of organisations who take part in this study. If you are happy to participate in the study, please read and sign the attached consent form.

INFORMED CONSENT FORM TO PARTICIPATE IN THE STUDY

I hereby confirm that I have been informed by the investigator, Mr Kgalabi Ngako about the nature, conduct, benefits and risks of the study. I have also received, read and understood the Participant Information leaflet and Informed Consent regarding the study. I am aware that the results of the study, including any personal details regarding participants' sex, age, date of birth, initials, and address, and the name of this community in which the study will take place will not be stated in any study

reports. I have also been informed that only relevant research team members will have access to the information.

I understand that I may, at any stage, withdraw my consent and participation in the study, without having to give a reason. I am aware that I will not suffer any consequence if I withdraw my permission at any time. I have had sufficient opportunity to ask questions. I freely declare myself prepared to participate in this research

_____ (Please print)

Participant's name

_____ _____

Participant's signature Date

I, Mr. Jacobs Kgalabi Ngako herewith confirm that the above participant has been informed fully about the nature, conduct and risks of the above study.

_____ (Please print)

Investigator's name

_____ _____

Investigator's signature Date

_____ (Please print)

Witness' name

_____ _____

Witness's signature Date

INFORMED CONSENT FORM FOR THE INTERVIEW TO BE TAPE-RECORDED

I hereby confirm that I have been informed by the investigator, Mr Kgalabi Ngako about the nature, conduct, benefits and risks of the study. I have also received, read and understood the Participant Information leaflet and Informed Consent regarding the study.

I have been informed that the interview will be audio-recorded. I understand that I may at any time withdraw my consent to have the interview recorded, without having to give a reason. I have also been informed that only relevant research team members will have access to the tape recordings.

I have had sufficient opportunity to ask questions. I give my consent to have audio recorder used during the interview.

_____ (Please print)

Organisation Stakeholder's Name

_____ _____

Organisation Stakeholder's Signature Date

I, Mr. Jacobs Kgalabi Ngako herewith confirm that the above participant has been informed fully about the nature, conduct and risks of the above study, and that the audio-recorder will be used.

_____ (Please print)

Investigator's name

_____ _____

Investigator's signature Date

_____ (Please print)

Witness' name

_____ _____

Witness's signature Date

Annexure N: Participation leaflet and informed consent: Key informant interview (Setswana)

Pamphitshana ya tshedimosetso ya motsaya karolo le netefatso ya maitlamo a go tsaya karolo (Setswana)

MATSENO

Ke nna Jacobs Kgalabi Ngako, ke moithuti go tswa Unibesiting ya Afrika Borwa. Bakaedi ba me ke Dr. Retha Visagie le Prof. Jeanette E. Maritz. Ke go laletsa go tsaya karolo mo thutong ya setlhogo seo se latelang:

Development of sustainable community coalition framework for organisational stakeholders to prevent alcohol misuse as a risk factor of HIV infection

Pele ga fa o ka dumela go tsaya karolo o tshwanetse go itse gore go tlile go diragala eng. Pampitshana e ya tshedimoso ke ya go go thusa go tsaya tshwetso. Fa o na le dipotso, tseo di sa tlhalosiweng mo pampitshaneng e ya tshedimoso, ka kopo ikutlwe o lokologile go mpotsa dipotso. O seke wa dumela go tsaya karolo mo patlisisong e kwa ntle ga fa o itumela ka ga sengwe le sengwe sa thuto e, seo se ka go amang.

GORENG RE DIRA DIPATLISISO?

Dithuto mo dikarolong tse dingwe tsa lefatshe le mo Afrika Borwa di bontshitse gore fa batho ba nwa bojalwa ka dinako dingwe ba nna le mathata ao a amanang le bojalwa le gore tiriso eo e sa siamang ya bojalwa e ka amana le maitsholo ao a sa siamang a thobalano le go anama ga kokwanatlhoko ya HIV. Re dira patlisiso e gore re kgone go tlhagisa setshwantso se se tsepameng sa tshwaragano ya mekgatlo ya baagi mo go thibeleng go anama ga kokwanatlhoko ya HIV go go amanang le maitsholo a thobalano mo motseng o.

THUTO E E EKARETSA ENG?

Re tlile go etela motse o go fitlhela kitso ka ga mekgatlo eo e leng teng mo motseng. Re tlile go go kopa gore o re bolelela maitemogelo a gago ka ga tiriso ya bojalwa,tsa thobalano le kokwana tlhoko ya HIV mo motseng o. Ka ke se kitla ke kgona go gakologelwa sengwe le sengwe seo o tla se buang, ke kopa tetla ya go dirisa segatisamanswe.

THUTO E E TLILE GO TSAYA NAKO E E KANA KANG?

Thuto yotlhe e tlile go tsaya nako ya go ka fitlha go dingwaga di le pedi. Dipotso ka bongwe ka bongwe di tlile go tsaya nako e ka nna ura e le nngwe.

A THUTO E E AMOGETSWE GO YA KA SEMOLAO?

Komiti ya Lefapha la tsa bonetetshi la tsa maphelo mo Unibesiting ya Afrika Borwa mmogo le Komiti ya tsa maphelo ya North West Province ba re file tetla eo e kwadilweng ka ga thuto e.

DITSHIASMELO TSA BATSAYA KAROLO MO THUTONG E KE DIFENG?

O na le tshono go ka tsaya karolo mo patlisisong e. O ka nna wa gana go tsaya karolo kampo wa emisa go tsaya karolo nako nngwe le nngwe kwa ntle ga go fana ka mabaka. O ka nna ka nako nngwe le nngwe wa gogela morago tumelano, pele ga, ka nako kampo kwa bokhutlong jwa dipotso kampo dipuisano. Ga o kitla o amogedisiwa tuelo fa o tsaya karolo mo thutong e.

A NNGWE YA THULAGANO YA DITHUTO E KA DIRA GORE O SE IKUTLWE SENTLE KAMPO YA NNA SEKGORELETSI MO MOKGATLONG KAMPO MO GO BATSAYA KAROLO?

La fa mmatlisisis a sa bonele pele bothata go nna karolo ya dipuisano go ka nna ga dira gore o seke wa nnisega ka ntlha ya fa dingwe tsa dipotso di le ka ga mabapi le tiriso ya bojalwa le HIV. Fa o ikutlwa o sa itumele ka ga dipotso dingwe o ka nna wa

se di arabe. Fa o ikutla o tlhoka go ritibadiwa maikutlo mmatlisisi a ka go thusa go ritibatsa maikutlo gape a ka go thusa go fitlhelela mekgatlo e mengwe eo e thusang ka ga go ritibatsa maikutlo.

MAUNGO A GO TSAYA KAROLO MO THUTONG E KE A MAFENG?

Thuto e e tlile go go thusa mmogo le nna go utlwisisa gore go ka diriwa eng go thibela go anama ga kokwanatlhoko ya HIV go go golaganeng le tiriso eo e sa siamang ya bojalwa. Kitso eo e tla fitlhelwang mo thutong e e tla thusa go ka tlhoma melawana le diporogorama tseo di ikaeletseng go thibela go anama ga HIV go go golaganeng le tiriso eo e sa siamang ya bojalwa mo motseng o. Mongwe le mongwe yo o tsayang karolo mo thutong e o tlile go fitlhelela monyetla wa go aroganelana maitemogelo ka ga thibelo ya HIV, maitsholo a thobalano ao a sa siamang, le tiriso eo e sa siamang ya bojalwa mme ba itemogela dithata tsa go lebagana le dikgwetlo tsa thibelo ya HIV eo e golaganeng le tiriso eo e sa siamang ya bojalwa.

RE KA FITLHELELA JANG TSEDIMOSETSO E NNGWE GO TSWA GO BABATLISISI?

O ka nna wa ikgolaganya le rre Jacobs Kgalabi Ngako fa o batla tshedimosetso e nngwe kampo o rata go ka buisana le ene ka ga thuto e. A ka fitlhelwa mo: 073 598 7256. Gape o ka mo tshwara mo emeiling e e latelang: kgalabi2003@yahoo.co.uk.

Gape o ka ikgolaganya le mongwe wa batsamaisi kwa yunibesiting ya Afrika Borwa.

Dr. Retha G. Visagie
082 436 6630

Prof. Jeanette E. Maritz
082 788 8703

SEPHIRI

Dipotso di tlile go diriwa mo sephiring gape kitso nngwe le nngwe eo e tla fitlhelwang ka nako ya thuto e e tla diriwa khupamarama. Kitsiso eo go tlileng go kwadiwa ka ga yone le digatisa mantswe di tlile go lotlelelwa ka mo khabineteng eo e lotlelwang mo kantorong ya mmatlisisis fa di sa dirisiwe . Diforomo tsotlhe di tlile go bonwa fela ke maloko a dipatlisiso. Morago ga dingwaga di le pedi, digatisa mantswe tsotlhe di tlile gosenngwa. Re tlile go kwala maduo mo makwalo dikgannyeng a bonetetshi, mme re ka se akaretse leina la motse o, mo dipatlisiso di dirilweng teng, kampo leina la gago, maina a mekgatlo bao ba tseereng karolo mo patlisisong e.Fa o itumela go tsaya karolo mo thutong e, ka kopo buisa o bo o saena foromo ya maitlamo.

FOROMO YA MAITLAMO

Ke netefatsa gore ke boleletswe ke mmatlisissi, rre Jacobs Kgalabi Ngako ka ga tlhago, maitsholo, ditlamorago le maungo a thuto e. Gape ke amogetse, ka buisa ka bo ka utlwisisa pampitshana ya tsedimosetso le foromo ya maitlamo mabapi le thuto e. Ke a lemoga gore maduo a thuto e, go akaretsa le maina a me, aterese, le leina la mokgatlo mmogo le leina la motse o, mo thuto e diriwang teng ga go kitla go buiwa mo direporotong. Ke boleletswe gape gore ke babatlisisi fela ba ba maleba bao ba tla nnang le tetla ya go fitlhelela kitso e.

Ke a utlwisisa gore nka nna, ka nako nngwe le nngwe, ka gogela morago maitlamo a go tsaya karolo kwa ntle ga go fana ka mabaka. Ke a lemoga gore ga nkitla ke nna le ditlamorago fa ke ikgogela morago ka nako nngwe le nngwe. Ke nnile le nako eo e lekaneng go ka botsa dipotso. Ke lokologile go tsaya karolo mo patlisisong e.

_____ (Ka kopo gatisa)

Moemedi wa mokgatlo

_____ _____

Mosaeno wa moemedi wa mokgatlo letlha

Nna, rre Jacobs Kgalabi Ngako ke netefatsa gore motsaya karolo o tlhaloseditswe ka botlalo ka ga tlhago,maitshwaro , ditlamorago le maungo a thuto e.

_____ (Ka kopo gatisa)

Mmatlisisi

_____ _____

Mosaeno wa Mmatlisisi Letlha

_____ (Ka kopo gatisa)

Leina la paki

_____ _____

Mosaeno wa paki Letlha

NETEFATSO YA MAITLAMO A GORE DIPUISANO DI GATISIWE MO SEGATISA-MANTSWENG

Ke netefatsa gore ke filwe tsehedimosetse ke mmatlisisi, Jacobs Kgalabi Ngako ka ga tlhago, maungo le dikotsi tsa thuto e. Gape ke amogetse, ka buisa ka bo ka tlhaloganya tshedimosetso eo e kwadilweng mabapi le thuto e.

Ke itsisistwe gore dipuisano di tlile go gatisiwa. Ke a utlwisisa gore nka nna ka nako nngwe le nngwe ka gogela morago go dumela gore dipuisano di gatisiwe ka segatisa-mantswe., kwa ntle ga go fana ka mabaka. Ke bolelelтswe gape gore ke fela babatlisisis bao ba amegang bao ba tlileng go fitlhelela digatisa-mantswe.

Ke nnile le tshono eo e menaganeng ya go botsa dipotso.Ke neelana ka tumelelano ya tiriso ya segatisa-mantswe ka nako ya dipuisano.

_____ (Ka kopo gatisa)

Moemedi wa mokgatlo

_____ _____

Mosaeno wa moemedi wa mokgatlo letlha

Nna, rre Jacobs Kgalabi Ngako ke netefatsa gore motsaya karolo o tlhaloseditswe ka botlalo ka ga tlhago,maitshwaro, ditlamorago le maungo a thuto e. Le gore gio tla dirisiwa segatisa-mantswe

_____ (Ka kopo gatisa)

Mmatlisisi

_____ _____

Mosaeno wa Mmatlisisi Letlha

_____ (Ka kopo gatisa)

Leina la paki

_____ _____

Mosaeno wa paki Letlha

Annexure O: The constitution

Greater [redacted] Based Organisation

CONSTITUTION

1. Name

1.1 The organisation hereby constituted will be called: Greater [redacted] Based Organisation

1.2 Its shortened name will be [redacted].

1.3 Body corporate

The organisation shall:

- Exist in its own right, separately from its members.
- Continue to exist even when its membership changes and there are different office bearers.
- Be able to own property and other possessions.
- Be able to sue and be sued in its own name.

2. Objectives

(a) To mobilise stakeholders from different organisations to provide community service to all the communities regarding Drug and alcohol abuse, HIV/AIDS, STIs and other related diseases and their conditions

(b) To ensure sustainable community coalition for organisational stakeholders to manage Drug and alcohol abuse, HIV/AIDS, STIs and other related diseases and their conditions

(c) To work in collaboration with other organisations that mainly deal with health transformation, education and research

3. Income and property

3.1 The organisation will keep a record of everything it owns.

3.2 The organisation may not give any of its money or property to its members or office bearers. The only time it can do this is when it pays for work that a member or office bearer has done for the organisation. The payment must be a reasonable amount for the work that has been done.

3.3 A member of the organisation can only get money back from the organisation for expenses that she or he has paid for or on behalf of the organisation.

3.4 Members or office bearers of the organisation do not have rights over things that belong to the organisation.

4. Membership and General Meetings

4.1 If a person wants to become a member of the organisation, she or he will have to ask the organisation's management committee.

4.2 Members of the organisation must attend its annual general meetings. At the annual general meeting members exercise their right to determine the policy of the organisation.

5. Management

5.1 A management committee will manage the organisation. The management committee will be made up of not less than 6 members. They are the office bearers of the organisation.

5.2 Office bearers will serve for one year, but they can stand for re-election for another term in office after that. Depending on what kind of services they give to the organisation, they can stand for re-election into office again and again. This is so long as their services are needed and they are ready to give their services.

5.3 If a member of the management committee does not attend three management committee meetings in a row, without having applied for and obtaining leave of absence from the management committee, then the management committee will find a new member to take that person's place.

5.4 The management committee will meet at least once a month. More than half of members need to be at the meeting to make decisions that are allowed to be carried forward. This constitutes a quorum.

5.5 Minutes will be taken at every meeting to record the management committee's decisions. The minutes of each meeting will be given to management committee members at least two weeks before the next meeting. The minutes shall be confirmed as a true record of

proceedings, by the next meeting of the management committee, and shall thereafter be signed by the chairperson.

5.6 The organisation has the right to form sub-committees. The decisions that sub-committees take must be given to the management committee. The management committee must decide whether to agree to the not at its next meeting. This meeting should take place soon after the sub-committee's meeting. By agreeing to decisions the management committee ratifies them.

5.7 All members of the organisation have to abide by decisions that are taken by the management committee.

6. Powers of the organisation

The management committee may take on the power and authority that it believes it needs tube able to achieve the objectives that are stated in point number 2 of this constitution. Its activities must abide by the law.

6.1 The management committee has the power and authority to raise funds or to invite and receive contributions.

6.2 The management committee does, however, have the power to buy, hire or exchange for any property that it needs to achieve its objectives.

6.3 The management committee has the right to make by-laws for proper management, including procedure for application, approval and termination of membership.

6.4 The organisation will decide on the powers and functions of office bearers.

7. Meetings and procedures of the committee

7.1 The management committee must hold at least two ordinary meetings each year.

7.2 The chairperson, or two members of the committee, can call a special meeting if they want to, but they must let the other management committee members know the date of the proposed meeting not less than 21 days before it is due to take place. They must also tell the other members of the committee which issues will be discussed at the meeting. If, however, one of the matters to be discussed is to appoint a new management committee member, then those calling the meeting must give the other committee members not less than 30 days' notice.

7.3 The chairperson shall act as the chairperson of the management committee. If the chairperson does not attend a meeting, the members of the committee who are present choose which one of them will chair that meeting. This must be done before the meeting starts.

7.4 There shall be a quorum whenever such a meeting is held.

7.5 When necessary, the management committee will vote on issues. If the votes are equal on an issue, then the chairperson has either a second or a deciding vote.

7.6 Minutes of all meetings must be kept safely and always be on hand for members to consult.

7.7 If the management committee thinks it is necessary, then it can decide to set up one or more sub-committees. It may decide to do this to get some work done quickly. Or it may want a sub-committee to do an inquiry, for example. There must be at least three people on a subcommittee. The sub-committee must report back to the management committee on its activities. It should do this regularly.

8. Annual general meetings

The annual general meeting must be held once every year, towards the end of the organisation's financial year. The organisation should deal with the following business, amongst others, at its annual general meeting:

- Agree to the items to be discussed on the agenda.
- Write down who is there and who has sent apologies because they cannot attend.
- Read and confirm the previous meeting's minutes with matters arising.
- Chairperson's report.
- Treasurer's report.
- Changes to the constitution that members may want to make.
- Elect new office bearers.
- General.
- Close the meeting.

9. Finance

9.1 An accounting officer shall be appointed at the annual general meeting. His or her duty is to audit and check on the finances of the organisation.

9.2 The treasurer's job is to control the day to day finances of the organisation. The treasurer shall arrange for all funds to be put into a bank account in the name of the organisation. The treasurer must also keep proper records of all the finances.

9.3 Whenever funds are taken out of the bank account, the chairperson and at least two other members of the organisation must sign the withdrawal or cheque.

9.4 The financial year of the organisation ends on 31March each year.

9.5 The organisation's accounting records and reports must be ready and handed to the Director of Non-profit Organisations within six months after the financial year end.

9.6 If the organisation has funds that can be invested, the funds may only be invested with registered financial institutions. These institutions are listed in Section 1 of the Financial Institutions (Investment of Funds) Act, 1984. Or the organisation can get securities that are listed on a licensed stock exchange as set out in the Stock Exchange Control Act, 1985. The organisation can go to different banks to seek advice on the best way to look after its funds.

10. Changes to the constitution

10.1 The constitution can be changed by a resolution. The resolution has to be agreed upon and passed by not less than two thirds of the members who are at the annual general meeting or special general meeting. Members must vote at this meeting to change the constitution.

10.2 Two thirds of the members shall be present at a meeting ("the quorum") before a decision to change the constitution is taken. Any annual general meeting may vote upon such a notion, if the details of the changes are set out in the notice referred to in 7.3

10.3 A written notice must go out not less than fourteen (14) days before the meeting at which the changes to the constitution are going to be proposed. The notice must indicate the proposed changes to the constitution that will be discussed at the meeting.

10.4 No amendments may be made which would have the effect of making the organisation cease to exist.

11. Dissolution/Winding-up

11.1 The organisation may close down if at least two-thirds of the members present and voting at a meeting convened for the purpose of considering such matter, are in favour of closing down.

11.2 When the organisation closes down it has to pay off all its debts. After doing this, if there is property or money left over it should not be paid or given to members of the organisation. It should be given in some way to another non-profit organisation that has similar objectives. The organisation's general meeting can decide what organisation this should be.

This constitution was approved and accepted by members of Greater [redacted] Based Organisation

At a special (general) meeting held on ----------
Day/Month/Year

---------- ---------- ----------
Chairperson Secretary
Date Date

Annexure P: Editing certificate and Turnitin report

Between the lines editing

Leatitia Romero
Professional Copy-Editor, Translator and Proofreader
(BA HONS)

Cell: 083 236 4536
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www.betweenthelinesediting.co.za

15 December 2019

To whom it may concern:

I hereby confirm that I have edited the thesis entitled: "A SUSTAINABLE COMMUNITY COALITION FRAMEWORK FOR ORGANISATIONAL STAKEHOLDERS TO MANAGE ALCOHOL MISUSE AS A RISK FACTOR OF HIV INFECTION". Any amendments introduced by the author hereafter are not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations made by the editor, and it remains the author's responsibility at all times to confirm the accuracy and originality of the completed work.

Leatitia Romero

Affiliations

PEG: Professional Editors Group (ROM001)
EASA: English Academy of South Africa
SATI: South African Translators' Institute (1003002)
SfEP: Society for Editors and Proofreaders (15687)
REASA: Research Ethics Committee Association of Southern Africa (104)

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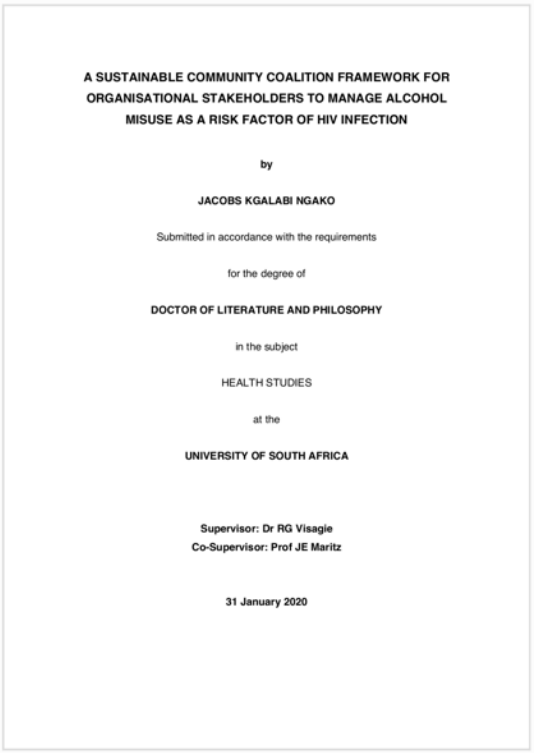

A SUSTAINABLE COMMUNITY COALITION FRAMEWORK FOR ORGANISATIONAL STAKEHOLDERS TO MANAGE ALCOHOL MISUSE AS A RISK FACTOR OF HIV INFECTION

by

JACOBS KGALABI NGAKO

Submitted in accordance with the requirements

for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

Supervisor: Dr RG Visagie
Co-Supervisor: Prof JE Maritz

31 January 2020