

**A PARTICIPATORY HEALTH COMMUNICATION STRATEGY  
FOR SUSTAINABLE DEVELOPMENT: HIV/AIDS IN  
POTCHEFSTROOM**

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With this I declare, James Ross Smith that this research is my own work.

James Ross Smith

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## Opsomming

'n Deelnemende gesondheidskommunikasie-strategie vir volhoubare ontwikkeling: HIV/VIGS in Potchefstroom

Deelnemende kommunikasie is 'n relatief nuwe en innoverende benadering wat aangewend word om ontwikkeling en betrokkenheid in 'n bepaalde gemeenskap te bewerkstellig. As 'n kommunikasiemedium verskil die deelnemende benadering baie van die tradisionele benadering omdat die laasgenoemde gebruik maak van 'n horisontale benadering tot kommunikasie wat aanvaar dat die gemeenskap waarop die ontwikkeling gemik is, weet wat die beste vir hulle probleem is. Dit skep die illusie dat die gemeenskap betrokke is by die beplannings- en implementeringsfase van die ontwikkelingsprojek. Aangesien die HIV/VIGS kwessie aangespreek word in die studie, is dit belangrik dat deelnemende kommunikasie bespreek word vanuit 'n gesondheidsperspektief. Dus is die deelnemende benadering, spesifiek vir gesondheidskommunikasie bespreek as die mees gepaste kommunikasiemetode vir gesondheidskommunikasie binne die konteks van hierdie studie.

'n Omvattende literatuurstudie het getoon dat vorige studies rakende deelnemende kommunikasie uitgevoer is, maar geeneen van die studies het spesifiek op deelnemende kommunikasie binne die gesondheidskonteks gefokus nie. In hierdie studie is die Potchefstroomse Munisipale Gesondheidsowerheid en die Plaaslike VIGS-Raad gebruik, met die oog op die identifisering van stappe wat toegepas kan word, ten einde 'n deelnemende gesondheidskommunikasie-strategie binne die Potchefstroomse gemeenskap te bewerkstellig. Die algemene doelwit was dus om die stappe te beskryf, sodat 'n stel riglyne aan die Potchefstroomse Munisipale Gesondheidsowerheid voorgelê kan word, wat kan bydra tot die implementering van die gesondheidskommunikasie-strategie in die gemeenskap. Die afleiding is gemaak dat indien die gemeenskap nie deel het aan die deelnemende gesondheidskommunikasie-strategieproses nie, die deelnemende kommunikasie benadering, asook die kommunikasieproses, beëindig sal word. Dit sal dus 'n nie-volhoubare ontwikkelingsinisiatief, met betrekking tot die HIV/VIGS situasie in die Potchefstroom gemeenskap, tot gevolg hê.

Daar is gebruik gemaak van verskeie navorsingsmetodes, soos inhoudsanalise, onderhoude en 'n literatuurstudie, ten einde triangulasie te kan toepas. Die beskikbare literatuur is bestudeer om vas te stel watter riglyne, en karaktereenskappe gestel is vir die deelnemende benadering,

spesifiek binne 'n gesondheidskonteks. Die Nasionale, sowel as die Provinsiale beleidsdokumente is ontleed. Daar is gekonsentreer op die spesifieke vereistes, en die fokuspunt van die gesondheidskommunikasie-strategie, spesifiek met betrekking tot die HIV/VIGS epidemie soos wat dit voorgehou is deur die owerheid. Die resultate van die inhoudsanalise is vergelyk met die bevinding van die onderhoude wat gevoer is met twee lede van die Potchefstroomse Munisipale Gesondheidsowerheid en die Plaaslike Potchefstroomse VIGS-Raad.

Na 'n ontleding van die literatuur is breë riglyne vir deelnemende kommunikasie binne 'n gesondheidskonteks saamgestel. Die studie stel riglyne voor vir 'n deelnemende gesondheidskommunikasie-strategie op gemeenskapsvlak vir HIV/VIGS in Potchefstroom.

## **Abstract**

A participatory health communication strategy for sustainable development: HIV/AIDS in Potchefstroom

Participatory communication is a relatively new and innovative means through which development in the community can be achieved. As a communication medium it differs substantially from the traditional approaches in that it practices a horizontal approach to communication and assumes that the community at whom the development is directed knows best what they require. It advocates the inclusion of the community into the planning and implementation phases of the development project. Focusing on HIV/AIDS, it is required that participatory communication is discussed from a health perspective. Therefore the participatory approach for health communication is discussed as the most suitable communication for health communication pertaining to the context of this study.

An extensive literature study revealed previous studies on participatory communication had been done but none specifically focused on participatory communication in a health context. With the present research the Potchefstroom Municipal Health Authority and the Local AIDS Council had been selected, in order to identify the steps that need to be followed in implementing a participatory health communication strategy in the community. The general aim of the study was to describe these steps in order to propose guidelines to the Potchefstroom Municipal Health Authority that would assist in the implementation of this strategy to the community. The assumption was made that without buy-in from the community into the participatory health communication strategy, the communication strategy would end and this would end the communication process, resulting in an unsustainable development initiative with regard to HIV/AIDS in the Potchefstroom community.

Content analysis, interviews and literature review as research methods had been used during the study in order to triangulate the findings made. The available literature had been analysed to find the guidelines on the unique characteristics of the participatory communication and the role of health communication. The National and Provincial HIV/AIDS policy documents had also been analysed focusing on the requirements from government and determining what the participatory health communication strategy should focus on with regard to the HIV/AIDS pandemic. The results of the content analyses were compared to the findings made in the

interviews conducted with the members of the Potchefstroom Municipal Health Authority and Potchefstroom Local AIDS Council.

After an in-depth review of the literature the broad guidelines regarding participatory communication in a health context were established for a participatory health communication strategy at community level for HIV/AIDS communication.

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## CHAPTER 1

### PROBLEM AND ORIENTATION

#### 1.1 INTRODUCTION

During the last two decades, the HIV/AIDS pandemic has entered the consciousness of the world as an incomprehensible calamity that threatens the very essence of mankind's existence. The pandemic has already taken a terrible human toll, laying claim to millions of lives, inflicting pain and grief, causing fear, uncertainty and threatening economic devastation. Statistics show that the pandemic has been at its severest in developing countries causing untold deaths and still continues to inflict chaos related to the HIV/AIDS pandemic (Whiteside & Sunter, 2000:47-68).

According to the Joint United Nations Programme on HIV/AIDS (UNHIV/AIDS) and the World Health Organisation (WHO), the number of people world-wide living with HIV by the end of 2002 was estimated to be 40 million. In Sub-Saharan Africa, more than 28.5 million people out of an estimated total of 40 million people world-wide have been affected by the pandemic. It was estimated that 2.3 million people were dying of HIV/AIDS in 2002, which accounted for more than 40% of all adult deaths (15 yrs – 49 yrs) in South Africa alone. Assuming that no cure is found, it is estimated that the number of adults and children newly infected with HIV/AIDS in 2003 would be 10 million, and of these 10 million, 4 million of those infections would be found in South Africa (Burton, 2002:54; Whiteside & Sunter, 2000:49-68; WHO, 2000). In South Africa alone, four out of every ten people are HIV positive resulting in nearly four million South Africans infected and living with the disease. Furthermore an estimated 1 800 infections were taking place daily in 2002, with around 8 000 people dying each year from the pandemic (Department of Health, 2002; Actuarial Society of South Africa [ASSA], 2002). It is predicted by ASSA (2002) that the population growth rate is declining and is at present at 1.8% with a rate which is projected to drop to 0% in 2011.

At a provincial level in the North West Province, the supposition is strengthened by the findings, that in the whole of the North West Province during 2002 there was an estimated population of 3 864 204 people of which 582 089 were estimated to be HIV positive. Furthermore, 56 407 of these succumbed to cumulative AIDS deaths and 38 153 were infected with HIV/AIDS related sicknesses. The Southern Region of the North West Province, the area where Potchefstroom is situated, had an HIV prevalence of 28.4% during 2002, the highest in the province. However an

average of 36 infant mortalities and an average of 55 child mortalities due to HIV/AIDS also occurred during 2002 laying claim to the fact that Potchefstroom is seriously affected by the HIV/AIDS pandemic (ASSA, 2002; Dorrington & Bradshaw, 2003).

From a South African perspective, the issue of health development, especially concerning the HIV/AIDS pandemic is of essential importance. A question regarding HIV/AIDS in South Africa is: How can the government successfully implement the prevention strategies contained within the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*, and curb the spread of HIV/AIDS and the treatment thereof at a national, provincial and local level? This issue has come to the point where President Mbeki, under pressure from opposition parties, had considered declaring South Africa as in a State of Emergency with relation to the HIV/AIDS pandemic during 2001 (Koopman, 2001; Anon, 2001a; Anon, 2001b).

According to Tabane (2001), "...by 2010, South Africa would experience a negative population growth with more people dying than being born because of HIV/AIDS". He further argues "...the fumbling and bumbling of the government's approach to HIV/AIDS has certainly contributed to the spread of HIV/AIDS to where it is now". The government's approach is encompassed within the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*. The above strategy emphasises a multi-sectoral approach, pulling together resources of all sectors in fighting the developmental challenge of HIV/AIDS. Organisations and stakeholders are encouraged to use this document as the basis to develop their own health communication strategy, so that all initiatives in the country can be harmonised to maximise efficiency and effectiveness in fighting the HIV/AIDS pandemic. The above strategy also identifies several major areas for the active attention of the country, namely: prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance.

According to Mr. Sefularo Kgomotso (2001), co-ordinator for HIV/AIDS in the North West Province, no "real" health communication strategy exists, specifically on the issue of HIV/AIDS in the North West Province. According to Kgomotso (2001) the North West Province has refined the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* (The national HIV/AIDS Strategy Policy Document for South Africa) into the *Provincial Council on AIDS, North West Working Document* (The provincial HIV/AIDS strategy Policy Document). He expressed his concern that there is a great need for the creation and implementation of a health communication strategy, not only provincially and locally, but also on a national level in South Africa. However, the *Provincial Council on AIDS, North West Working Document* (The provincial

HIV/AIDS strategy Policy Document), is still the policy, which eventually needs to be implemented through the Municipal Health Authorities and LAC's (Local AIDS Council) throughout the province. Mr. Mahesh Roopa (2001), Health District Manager for Potchefstroom, reiterated what was said by Kgomo, stating that within the Municipal Health Department in Potchefstroom, no real health communication strategy is in place to deal with the HIV/AIDS pandemic and to implement the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* or the *provincial Council on AIDS, North West Working Document Policies*. As a result, the lack of a health communication strategy leads to a fragmented approach in dealing with the HIV/AIDS pandemic in the Potchefstroom area.

The *Constitution of the Republic of South Africa (1996)*, *The Green Paper on local Government (1997)* and the *Municipal Systems Bill (1998)*, instruct local government in the form of municipalities, that they should:

- **Implement sustainable development** - The Potchefstroom Municipal Health Authority should create understanding at grass-roots level, informing the population of the projects on HIV/AIDS, illustrating the advantages and recommending that the projects are supported;
- **Implement on their own initiative, subject to national and provincial legislation** - The Potchefstroom Municipal Health Authority should take national and provincial policy documents and apply them as they see fit according to the current situation prevailing in the community. The national and provincial documents are the guidelines that the Potchefstroom Municipal Health Authority can follow in order to bring about developmental activities in their community with regard to HIV/AIDS;
- **Ensure the local environment is sustainable** - Potchefstroom Municipal Health Authority should set about processes that will ensure that people's basic needs are met, furthermore ensuring that the community's resources are conserved, that there is a sustained population level and that the environmental concerns of HIV/AIDS are integrated with the people's needs, as well as that the decision-making process will lead to empowerment of the community to take control of their own development with regards to HIV/AIDS; and
- **Involve the community and other partners in a participatory way** - Potchefstroom Municipal Health Authority should aim to listen to the needs of the community and other role-players that they serve, including them in the design of communication campaigns that are aimed at developing the community and

empowering them to take control of their own development.

The Constitution and the other legislative documents, the *Constitution of the Republic of South Africa (1996)*, *The Green Paper on local Government (1997)* and the *Municipal Systems Bill (1998)*, make provision for the development of the community to take place; however it is only the initial step towards achieving the necessary change required in a deprived community. With regard to HIV/AIDS, the above-mentioned then needs to be the guidelines whereby the Potchefstroom Municipal Health Authority creates organisational structures within the local government sphere that provide the people with the means to sustain their own development to try and combat the HIV/AIDS pandemic. These development initiatives should be based on either the national or provincial HIV/AIDS (*HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*, *provincial Council on AIDS, North West Working Document*) policies, allowing for access by all people in the community in the development of the initiatives. For that reason the policies of the national and provincial government are the agents (agents can be seen as the means by which development initiatives are stimulated, they bring the development to the people), which would present the guidelines by which the local health authority, namely Potchefstroom Municipal Health Authority, would then implement the development initiatives regarding HIV/AIDS.

It is essential then that the Potchefstroom Municipal Health Authority with regard to the HIV/AIDS pandemic in the Potchefstroom community do something to curb the spread of the pandemic. It can be argued, in light of the afore-mentioned that the pandemic should be addressed by the national Government and initiatives (*HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005*, *provincial Council on AIDS, North West Working Document*) set up to combat the pandemic. These initiatives currently exist, but need to be communicated to the people affected by the pandemic, by the Potchefstroom Municipal Health Authority.

However, the problem is that no known health communication strategy exists for the local health authority in Potchefstroom (Roopa, 2001; Kgomotso, 2001), and the need is to create a health communication strategy framework based on participation (as set out in the *Constitution of South Africa (1996)*, *The Green Paper on local Government (1997)*, the *Municipal Systems Bill (1998)* and the literature in Chapter 2), based on the national and provincial HIV/AIDS policies (*HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*, *provincial Council on AIDS, North West Working Document*) for the Potchefstroom Municipal Health Authority.

In summary, the issue dealt with in this study is that of health communication. A health communication strategy is required to communicate the specific health issues surrounding HIV/AIDS. However, participatory communication is required in a health communication strategy, firstly to abide by the national legislation and secondly to bring on board the participating members (receivers of the HIV/AIDS message) within the community, empowering them to take control of their own development. If the participants of the health communication strategy do not buy into the process, it is argued that this could result in the end of the communication process. Furthermore if no real participation is present in the health communication strategy, it would mean the end to any sustainable outcomes. Only once full participation is achieved, will the health communication strategy lead to sustainability and a more unremitting outcome to the HIV/AIDS pandemic.

Therefore in the light of the above-mentioned, a specific problem statement can be stated for this study.

## **1.2 PROBLEM STATEMENT**

The problem addressed in this study is the lack of a health communication strategy for HIV/AIDS management at local municipal level in Potchefstroom. Consequently, the need of this study is to describe a health communication strategy framework, which is based on the principles of participatory communication that is inclusive of all role-players and the community in the Potchefstroom area (as required by Government Legislation). Furthermore, the participatory health communication strategy should include the principles as set out in the national and provincial policy documents on HIV/AIDS, in addition to implementing the strategies contained in either the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* or the *provincial Council on AIDS, North West Working Document*. In doing the above-mentioned it is hoped to describe an effective participatory health communication strategy that would contribute towards a more sustainable manner in dealing with the HIV/AIDS problem in the Potchefstroom area.

This problem statement is used to determine the specific research questions in order to determine the final outcomes for this study.

### **1.3 RESEARCH QUESTIONS**

The following research questions are asked derived from the problem statement:

#### **1.3.1 General research question**

Based on the requirements set out in the national and provincial HIV/AIDS policies, would a participatory health communication strategy framework for HIV/AIDS management at local level in Potchefstroom, contribute towards a more sustainable manner in dealing with the HIV/AIDS problem?

#### **1.3.2 Specific research questions**

1. What are the requirements according to the literature for a participatory health communication strategy, within a developing environment?
2. To what extent do the national and provincial HIV/AIDS policies comply with the guidelines of participatory communication?
3. To what extent have the policy documents been implemented and used in practice by the Potchefstroom Municipal Health Authority
4. What will a proposed health communication strategy be for the Potchefstroom Municipal Health Authority?

### **1.4 RESEARCH OBJECTIVES**

The research questions that pertain to this study are translated into the following research objectives:

#### **1.4.1 General objective**

To propose a framework for a participatory health communication strategy for HIV/AIDS management at local level in Potchefstroom based on the requirements as set out in the national and provincial HIV/AIDS policies, aiming to contribute towards a more sustainable manner in dealing with the HIV/AIDS problem.

#### 1.4.2 Specific objectives

1. To describe the requirements, according to the literature, for a participatory health communication strategy in a developing environment.
2. To describe the extent to which the national and provincial HIV/AIDS policies comply with the guidelines of participatory communication.
3. To describe how the policy documents are being implemented and used in practice by the Potchefstroom Municipal Health Authority.
4. To propose a framework for the proposed health communication strategy, intended for the Potchefstroom Municipal Health Authority.

#### 1.5 CENTRAL THEORETICAL STATEMENT

The development of a participatory health communication strategy would contribute significantly towards a sustainable manner in dealing with the HIV/AIDS problem. In essence, participatory communication aims at:

- **Participation at all levels** (national, provincial, local and even further to the grass-roots people at whom the development is aimed);
- **Allowing for the inclusion and the emanating of the health communication strategy from the receivers themselves** (As was the case in the Mbonambi programme, but applying it to the Potchefstroom area, allowing the people living with and threatened by the HIV/AIDS pandemic to speak their minds on the situation they find themselves in, making them more accountable for the type of action needed, in essence allowing for more of a self-management process to take place); and
- **The focus on process and the content of the exchange of meaning** (Meaning that emphasis moves away from the local Potchefstroom Municipal Health Authority as the communicator to the local community to form a more 'receiver-centric approach', where meaning and information is sought rather than information transmission taking place solely by the Potchefstroom Municipal Health Authority) (Servaes, 1996).

## **1.6 METHODOLOGY**

### **1.6.1 Literature study**

The following databases were consulted prior to the study being started, namely: Nexus, RSAT, ERIC, ISAP, Ebscohost, Social Sciences, Humanities and Business Periodical indices, University library catalogue, and various Internet sources. This was done to determine if previous studies had been done on the same topic and if there was sufficient literature available to conduct the research. The information gathered showed that there were sufficient sources available to carry out the research. Many studies on participatory communication have been done previously, but few studies that apply specifically to the context of this study were found (Participatory Health Communication for HIV/AIDS) and applied to Potchefstroom. The same searches revealed that the above-mentioned sources could be used for reference purposes, as many of the research projects articulated were very successful. (The results of the literature study are discussed in Chapters 2 and 3). The literature study specifically answers objective 1 of the study.

### **1.6.2 Qualitative research**

Qualitative research allows for empathetic research that aims for subjective understanding rather than control (Tandon, 1981:33; Sarantakos, 1994:45), which is what this study aims for. It is also characterised as impressionistic in nature rather than a precise science (Bowman & Ellis, 1979:43). Essentially, the core of this study would be to propose a framework for a participatory health communication strategy for HIV/AIDS management at local level in Potchefstroom, which will then be based on the national and provincial HIV/AIDS policies, as well as the literature. This participatory health communication strategy would contribute towards a more sustainable manner of dealing with the HIV/AIDS pandemic in Potchefstroom. Qualitative research will also allow for an holistic view of the factors influencing the communication strategy process, which is then used in chapter 5 to draw up a participatory health communication strategy framework.

From the very start of the research planning phase Roopa gave assurances that the Potchefstroom Municipal Health Authority would give the researcher access to the information, documents and time within his compass (especially time for the interview) via the government, local government and community structures. Roopa was chosen for his intensive knowledge on

HIV/AIDS, as well as being the most authoritative figure to give advice on the proposed health communication strategy in the Potchefstroom area.

Two methods were used in the qualitative research:

- **Qualitative Content Analysis**

During this phase a qualitative content analysis will be done on the two policy documents concerning HIV/AIDS prevention, treatment and action initiatives. The documents are the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005*, and the *Provincial Council on AIDS, North West Working Document*. The emphasis is on describing whether the policy documents are following a specific participatory health communication strategy both at national and provincial level, and whether they comply with participatory communication principles. Furthermore it also aims to describe the strategy guidelines that need to be addressed by the participatory health communication strategy. The content analysis will be used to answer objective 2.

- **Interviews**

Phase 2 will result in the conducting of the semi-structured interviews with Health District Manager for Potchefstroom, Mr Mahesh Roopa, and the co-ordinators of the LAC (Local Aids Council), Mr. Kenneth Motholosa and Mr. James Mabotja, to determine the reasons, aims, successes or failures and expectations of a health communication strategy concerning HIV/AIDS for Potchefstroom Municipal Health Authority. Open-ended questions will be asked to address queries like possible shortcomings of a health communication strategy, what recommendations were possible for a health communication strategy for HIV/AIDS, and what the needs would be from each stakeholder with regard to this participatory health communication strategy. The same questions will be asked to all three respondents. The interviews are used to answer objective 3.

## **1.7 EXPLANATION OF CONCEPTS**

This study has three key concepts, namely that of participatory communication, health communication and sustainable development. As mentioned previously in Section 1.1,

participation is a required element in any developmental programme or initiative as required by government; in dealing with HIV/AIDS, it required that communication from a health perspective is applied, in order to address the issues of HIV/AIDS; and thirdly, sustainability needed to be addressed as part of being the second requirement of the government when dealing with development and as part of the outcomes of the participatory health communication strategy in dealing with the HIV/AIDS pandemic over a significant period of time.

### **1.7.1 Participatory communication**

Participatory communication tends to highlight small rather than large media, horizontal versus the vertical, collective self-reliance rather than dependence and action rather than theory based inquiry (Servaes, 1996; Servaes & Arnst, 1993; Freire, 1983:76). Specific definitions are varied and diverse, adjectives such as “popular”, “participatory”, “indigenous”, “self-governing” and “emancipatory” are all used to characterise it. Fuglesung and Chandler (1987:62) and Roodt (1996:315), argued that *“recognition of shared interests, accountability, and facilitating decision-making processes in a shared milieu of interests constitute true communication and participation”*. However, the definition of participatory communication emphasises, *“knowledge sharing and creating beneficiary comprehension of the benefactor’s intentionality”* (Ascroft, 1987:45; Ayee, 1993:162-163).

Furthermore, Nair and White (1993:51) view participatory communication as an information source mediated by the development communicators, therefore participatory communication is defined as *“the opening of dialogue, source and receiver interacting continuously, thinking constructively about the situation and acting upon it as they see fit”*.

These definitions describe a new emphasis in development communication on two-way, dialogic process. The definitions also overlap with one another to varying degrees, each with its own differing conceptual focus. However, it should be mentioned that no one definition has been accepted and systematically been elaborated on. For the purpose of this study, participatory communication will be seen as a conglomeration of the above-mentioned.

Hence participatory communication is then defined as the process of participation at all levels, nationally, provincially, locally, and individually. This process is not only inclusive but largely emanates from the receivers of the HIV/AIDS message. Allowing for collaboration at all levels (between Potchefstroom Municipal Health Authority - initiator of the message - and the

community - the receivers of the message), giving the community the encouragement to discern what is best for them by allowing for participation in the decision-making process, eventually transforming their society in the fight against HIV/AIDS.

Focussing on HIV/AIDS makes it a health issue, thus to be able to communicate the issues surrounding HIV/AIDS correctly, health communication needs to be defined as part of the process.

### **1.7.2 Health communication**

These are some of the more obvious problems facing health care exclusively in South Africa. Prior to the 1994 election health care was a privilege enjoyed exclusively by some South Africans. The challenge is to prevent crises in order to increase the proper management of health services. In line with global trends this entails that the causes of ill health need to be tackled through preventative rather than curative health care. Communication strategies between health care professionals, patients and their support groups play a key role in determining and assessing health outcomes.

According to Verwey and Crystal (1998) effective health care and health promotion are guided by relevant health communication. Communication is thus clearly the primary process used in health care to gather and disseminate health communication. Communication is essential in the provision of social support (by health care providers, participants in formal and informal support groups, family and friends). Communication is also fundamental in co-ordinating healthcare treatment and activities of various interdependent providers and consumers. According to Kaplan (1997:75-82) communication is perhaps the most essential ingredient in effective health care.

Furthermore, the health communication strategy should be sustainable in its approach and its outcomes, this is discussed next.

### **1.7.3 Sustainable development**

Sustainable development is the outcome envisaged for the participatory health communication strategy and is discussed concisely as the aim of the study to provide the reader with what the effect of the participatory health communication strategy should be. Thus the outcomes should be sustainable over a long period of time and aimed to eradicate the influence the HIV/AIDS

pandemic is having on the community and the country (refer to section 1.1).

This aspect is discussed briefly as it is an excellent topic for future research studies (refer to section 5) and discussing it in depth in this study will only serve to draw away the focus of the final outcome of the study, hence the participatory health communication strategy.

## **1.8 STUDY FRAMEWORK**

The first chapter provides an orientation that addresses the overall problem statement of the study. Thereafter, the study is divided into different components. The first component forms part of the literature study that deals with participatory communication in a developing environment and the relation between participatory communication, health communication, and sustainable development as it is found in chapter 2 and 3.

The second component, which comprises chapter 4, deals with the methods that were used to address the problem of the study, as well as processing the data that was collected to allow the researcher to make conclusions as described in chapter 1. The results of the study are contained in chapter 5. Finally chapter 6 presents the conclusions and recommendations for the study.

## **CHAPTER 2**

### **PARTICIPATORY COMMUNICATION AND SUSTAINABLE DEVELOPMENT WITHIN THE HEALTH COMMUNICATION ENVIRONMENT**

#### **2.1 INTRODUCTION**

The demise of modernization led to the emergence of other paradigms that over the years constituted the field of development studies in the West and the Third World. One of these paradigms is the post-modernist approach of participatory communication. Although participatory communication has not assumed the status of a full-fledged theory, it has been successful in expressing a different philosophical approach to the problem of underdevelopment. Participatory communication is emblematic of this post-modernist approach in that it has realised that dialogic communication is an important part of development. At the same time one cannot help but note the diverse meanings, connotations and conditions attached to the notion of participatory communication which is central to health communication.

Linked to the notion of participatory communication is the outcomes model (bio-psychosocial model) for health communication. Similar in its approach to participatory communication, the model aims to change health behaviours to the extent that individuals are empowered with effective psychological tools that promote the learning of appropriate health behaviours. For any health communication strategy to succeed, participatory communication is required within the strategy, aiming to bring on board the community in the development of the participatory health communication strategy. If there is no buy-in from the community into the health communication strategy, it would mean an end to the communication process. However if the health communication strategy is participatory in nature, there will be bigger buy-in from the community, which would lead to a longer sustainability with regard to HIV/AIDS in Potchefstroom.

Sustainable development in this chapter will be discussed from a local authority perspective. This section aims to explain how sustainable development can be achieved and maintained by the Municipal Health Authority with regard to the health communication strategy. Arguments will be backed by the Constitution of the Republic of South Africa as well as the White Paper of Local Government (1997), which are the legislative structures in place on which the Municipal Health Authority should base all new development initiatives.

The following sections will attempt to answer the first research question of the study. The theoretical aspects regarding the participatory communication strategy are discussed below.

## **2.2 PARTICIPATORY COMMUNICATION**

The participatory communication approach was conceived more than two decades ago (Midgley, 1986:13). Since then, its principles have enjoyed increasing influence over the work of development communicators (Ponsioen, 1962:53). Today, these principles drive the work of a significant number of communicators from the NGOs, and to a lesser extent, the strategy of government agencies. Included in this study, participatory communication aims to describe a health communication strategy based on these principles as required by government policies.

### **2.2.1 Early history**

According to Yoon (2000) and (Holdcroft, 1978:18), the roots of participatory approaches in development communication can be found in the early years of the 1970s. This was as a direct consequence of people in the development community beginning to question the hierarchical top-down approach of development that was dominant in the 1950s and 1960s. This top-down approach targeted the economic growth of countries as its main goal, came to be known as modernization. Modernization during the 1950s and 1960s was accredited with the success of the developed countries and was portrayed to the rest of world as the model to be used for successful development. Development was thought to be triggered by the wide-scale diffusion and adoption of modern technologies these modernization theories were planned in the national capitals under the guidance and direction of experts brought in from developed countries (Yoon, 2000). Modernization, as a development initiative, was then used to embody the governments programmes intended to encourage local schemes for community self-development efforts (Cornwell, 1986:16; Holdcroft, 1978:20). Development often arrived unexpectedly, people in the villages who were the "objects" of development plans would first learn of the new "development" that was about to take place when strangers from the city turned up unannounced, surveying land for the proposed development.

To promote "modernization", mass communication was employed to promote the ideas to the people at who the development was aimed. With radio being the most widely accessible by all, it soon became the medium most widely used. Public leaders, bureaucrats, and experts were soon broadcasting from the city centres to the masses located in the rural areas about how the

new ideas used in foreign countries would bring about change to their daily lives. Anything from farming methods, cure of medical problems, importance of schooling, family planning to stable government practices were broadcast all with the aim of providing development to the people in a simplified manner. Later mobile cinema was also introduced. These mobile cinemas were introduced to the local communities and soon became a desired diversion sought after by the local populations. It was a ploy easily used because by showing cartoons and comedy first the developer could easily attract the crowds to the cinemas, where after they would then stay to watch the newsreels and agricultural extension productions which followed later after the main entertainment. The printed media also played a part, of which posters, leaflets, and other publications made up another significant mechanism used as part of this approach (Rogers, 1983; Brokensha & Hodge, 1969:40-41; Yoon, 2000).

According to Kleinhans (1995:24), Freire (1983:22) and Yoon (2000) the participatory approach is related to post-modernism and as such the following variables need to be addressed:

According to Yoon (2000), the overall approach to modernizing the developing world eventually ran into problems. Development experts found out that development was not limited merely to social upliftment practices of building roads, piping water, and distributing electricity. Furthermore many of the agricultural extension projects failed because farmers were reluctant to abandon their time-tested ways for strange new methods farming methods from the foreign countries. The farmers were not comfortable in planting the new exotic crops which they could not eat but had to sell for money with which to buy food from the market. When piped water arrived, it was frequently used for washing rather than drinking and cooking because the people disliked its taste thereof (Yoon, 2000).

Superseding the unfamiliar information communicated to the people was a serious issue. As the development had not been planned at a ground roots level, but rather centrally without prior consultation of the people been affected by it, erroneous information was often given to the affected communities. For example; live-in farmers, tending the farms of rich were given advice of how to improve the soil of land they did not own and were often in danger of being evicted from. In addition mothers were given courses on family planning, lectured on the bliss of two-child families, when their husbands were often insistent of having larger families in order to help with labour on the farms.

Ownership of local development plans was diminished by central planning. People no longer had the ownership of the development plans that affected them personally. In other words, development became a government responsibility. While in the past, farmers could collectively maintain the long-established water sharing systems that they collectively owned, workers of irrigation establishment found in the governments, now built the new channels and dictated the discharge and cessation of the water supply. As the irrigation waterways broke down, farmers just waited for these irrigation workers to repair them rather than repair the problem, deeming that the system did not belong to them. If the workers failed to arrive and solve the problems, the system was simply abandoned (Yoon, 2000).

The failures of the top-down, mechanistic approach were seen to be costly and were noticed more and more in the cities. More and more activists began to criticize the top-down, mechanistic approach loudly as merely focused on the symptoms and not the causes of deficiency in social standards. The top-down communication of the modernization approach tended to fracture the delicate developing community by undermining indigenous knowledge, beliefs, and social systems. In addition, the activists were also displeased with the way the development plans centered more around the interests of the high powered in the developed communities, rather than catering for the issues at hand in the developing communities (Servaes, 1995; Yoon, 2000).

Meanwhile, other activists started to question the basis of the modernization approach. According to the activist of the participatory approach, the solution to underdevelopment does not pivot around the adoption of Western technologies; it however needs to come from the tried practices of the developing countries. Instead, it rested on the way the whole world was structured, which saw the developed countries (also the former imperial powers) progress and benefit at the expense of the poorer countries (also the former colonies). The developed countries were more powerful than the developing countries, and the latter had to depend on the former for their well-being (Yoon, 2000).

At the macro level in the community, the dependency issue led to the communicators making concerted efforts at steering information flow away from the traditional gate keeping junctions located in major centres of London, Paris, Madrid, and New York. Third World news networks and agencies were established specifically to bring to the world articles written by people from the developing countries for themselves (Yoon, 2000; Servaes, 1995).

### 2.2.2 Ascendancy of participatory approaches

In reaction to modernization and to a degree the realisation of global structural imbalances, gave birth to the rise of the various participatory approaches. These new participatory processes shared the intent of actively involving the people who were the "subjects" of development in the developing countries, in shaping the process for their own needs. In most cases, however, the similarity ends and endless differences begin to show. People participation became defined in many different ways, and this in turn led to numerous unresolved disagreements (Korten, 1986:481; UNDP, 1998; Yoon, 2000).

Four different levels of participation can be distinguished in development projects claiming to be participative (Uphoff 1985; Jones & Wiggle, 1987:110-111; Yoon, 2000):

- **Participation in implementation** - People are actively encouraged and mobilized to take part in the actualization of projects. They are given certain responsibilities and set certain tasks or required to contribute specified resources;
- **Participation in evaluation** - Upon completion of a project, people are invited to critique its success or failure, they are invited to give examples of success and state how thing can be improved on also on where things have gone wrong;
- **Participation in benefit** – People in the community participate in the benefits of the development initiative. This might include such benefits such as such as the ability of pumping water from a hand pump, medical care in the form of mobile clinics, a truck to transport produce to market, or community meetings in the new community hall; and
- **Participation in decision-making** - People initiate, discuss, and plan activities as a community. These decision making activities may be related to more common development areas such as building schools or applying for land possession. Others may be more political, such as removing corrupt officials, supporting parliamentary candidates, or electoral education activities. Many other activities may be cultural or religious in nature — organizing a traditional festival, marriage ceremonies, big parties, or just to have a good time.

Therefore the following theoretical statement can be deduced from this piece of literature. It is summarised below.

### **Theoretical statement 1**

**Allowing people participation in the implementation, evaluation and decision-making process, concerning the health communication strategy for HIV/AIDS, will empower them to benefit from / partake in the development process, enabling sustainable outcomes to the HIV/AIDS pandemic and mutual benefits for the community and Health Authority.**

### **2.2.3 Participatory communication takes over**

During the era of modernization, the communicators reacted to the move to participation in development by echoing new approaches in their work: thus participatory communication was born. According to Sussman (1980:115) it turned out to be a complex beginning. Activists had only advocated the idea of at conceptual and ideological levels; no plans were established on how to make participatory communication work in the real development setting. To further complex the challenge of implementing participation, much of the decisive thinking had focused on the interpersonal processes - the mass media had not been assigned any real role in the new approach of participatory communication. The broadcast technology of that period probably contributed to this sidelining of the "big media". Radio and television equipment was marooned in city studios located far from most of the people in the villages. Outside broadcast facilities was still been developed and many of the rural practitioners were unable to afford the expensive equipment.

It must also be remarked that development communication was for the first time no longer the restricted domain of the communication practitioners. Idyllically, participatory communication was supposed to be practiced impulsively by the people without mediation in very natural settings (Holdcroft, 1978:3; Kleinhans 1995:22).

Communicators were no longer the neutral movers of information, but were dominantly active in triggering the changes aimed at the encouragement of people's participative resources. For practitioners, communication ceased to be the simple transfer of information anymore. The major questions moved toward issues of who initiated the communication, and how the decisions were made leading up to the communication initiatives. The "techniques" of communication had not changed, what had changed were in fact the ideologies and philosophies behind the practice of the techniques (Batten, 1957: 50; United Nations, 1955:6; United Nations, 1963:13-14).

According to Swanepoel (1985) and Veneklassen (1990:131) the importance of the interpersonal and traditional systems encouraged the growth and use of these communication methods. Street theatre, folk-songs, speech, plays and group activities became vital and useful channels for participatory communication. Large-scale national communication activities were put aside in support of the small, localized, and intimate strategies that were taking place in the developmental initiatives in the rural areas.

#### **2.2.4 Participatory communication**

There is no ideal widely accepted model for participatory communication. Each development initiative where participatory communication is present varies significantly from each of the other. Most development initiatives address different needs, so participatory communication needs to be adjusted accordingly to address those specific needs. Thus, if no ideal model is possible, some common characteristics of participatory communication that one would like to see more often in those projects and initiatives that claim they have participatory components can be included in the implementation of participatory communication.

Communication and participation are actually two words sharing the same concept. Etymologically the Latin *communio* relates to participation and sharing. Modern languages have given different meanings to the word *communication*: it is very often considered synonymous with the word information. There is confusion, mostly by English speakers, between communication: the act or process of communicating, and *communications* with an 's': the means of sending messages, orders, etc. (Lozare, 1989:4).

According to Yoon (2000), when trying to design a profile of participatory communication, it is important to be conscious about the political implications of participation in development, and moreover of participatory communication:

- **An issue of power:** The democratisation of communication cuts through the issue of power. Participatory approaches contribute to put decision-making in the hands of the people. It also consolidates the capability of communities to confront their own ideas about development with development planners and technical staff. Within the community itself, it favours the strengthening of an internal democratic process.
- **An issue of identity:** Especially in communities that have been marginalised, repressed or simply neglected over decades, participatory communication contributes to install

cultural pride and self-esteem. It reinforces the social tissue through the strengthening of local and indigenous forms of organisation. It protects tradition and cultural values, while facilitating the integration of new elements.

The main elements that characterise participatory communication are related to its capacity to involve the human subjects of social change in the process of communicating. The theoretical framework for participatory communication owes much to Freire. Other models of communication for development, which have been implemented particularly around health issues, often fail to organise their strategy and their values from the perspective of the communities that are the end beneficiaries.

These are some of the issues that distinguish participatory communication from other development communication strategies in search of social changes (Servaes, 1995; Veneklassen, 1990:130-132; Yoon, 2000):

- **Horizontal vs. Vertical:** People are dynamic actors, actively participating in the process of social change and in control of the communication tools and contents; rather than people perceived as passive receivers of information and behavioural instructions, while others make decisions on their lives.
- **Process vs. Campaign:** People taking in hand their own future through a process of dialogue and democratic participation in planning communication activities; rather than expensive unsustainable top-down campaigns that help to mobilise but not to build a capacity to respond from the community level to the needs of change.
- **Long-term vs. Short-term:** Communication and development in general is conceived as a long-term process which needs time to be appropriated by the people; rather than short-term planning, which is seldom sensitive to the cultural environment and mostly concerned with showing results for evaluations external to the community.
- **Collective vs. Individual:** Urban or rural communities acting collectively in the interest of the majority, preventing the risk of losing power to a few; rather than people targeted individually, detached from their community and from the communal forms of decision-making.
- **With vs. For:** Researching, designing and disseminating messages with participation; rather than designing, pre-testing, launching and evaluating messages that were conceived for the community, and remain external to it.

- **Specific vs. Massive:** The communication process adapted to each community or social group in terms of content, language, culture and media; rather than the tendency to use the same techniques, the same media and the same messages in diverse cultural settings and for different social sectors of society.
- **People's needs vs. Donors' musts:** Community-based dialogue and communication tools to help identify, define and discriminate between the felt needs and the real needs; rather than donor-driven communication initiatives based on donor needs (family planning, for example).
- **Ownership vs. Access:** A communication process that is owned by the people to provide equal opportunities to the community; rather than access that is conditioned by social, political or religious factors.
- **Consciousness vs. Persuasion:** A process of raising consciousness and deep understanding about social reality, problems and solutions; rather than persuasion for short-term behavioural changes that are only sustainable with continuous campaigns.

None of the policies selected for this study can claim to have a profile that comprehends to all of the above strengths of participatory communication, but they all contribute to some degree to shape a collective profile, which gives much hope for the future of communication, participation and social change.

#### **2.2.4.1 Background**

The participatory model incorporates the concepts in the emerging framework of multiplicity / another development. It stresses the importance of cultural identity of local communities and of democratisation and participation at all levels - international, national, local and individual. It points to a strategy, not merely inclusive of, but largely emanating from, the traditional 'receivers' (Servaes, 1995). Freire (1983:76) refers to this as the right of all people individually and collectively to speak their word: 'This is not the privilege of some few men, but the right of every man'.

To share information, knowledge, trust, commitment, and a right attitude in development projects participation is very important in any decision-making process for development.

*'This calls for new attitude for overcoming stereotyped thinking and to promote more understanding of diversity and plurality, with full respect for the dignity and equality of people living in different conditions and acting in different ways' (International Commission for the Study of Communication Problems, 1980:254).*

This model stresses reciprocal collaboration throughout all levels of participation. Listening to what the others say, respecting the counterpart's attitude, and having mutual trust are needed. Participation supporters do not underestimate the ability of the masses to develop themselves and their environment as described by Servaes (1995).

*'Development efforts should be anchored on faith in the people's capacity to discern what is best to be done as they seek their liberation, and how to participate actively in the task of transforming society. The people are intelligent and have centuries of experience. Draw out their strength. Listen to them' (Servaes, 1995)*

#### **2.2.4.2 Cultural identity, empowerment and participatory communication**

According to Servaes (1995), authentic participation directly addresses power and its distribution in society. [Participation 'may not sit well with those who favour the status quo and thus they may be expected to resist such efforts of reallocating more power to the people' (Lozare, 1989:2).] Therefore, development and participation are inextricably linked. Participation involves the more equitable sharing of both political and economic power, which often decreases the advantage of certain groups. Structural change involves the redistribution of power. Many communication experts agree that structural change should occur first in order to establish participatory communication policies. Mowlana and Wilson (1987:143), for instance, state:

*'Communication policies are basically derivatives of the political, cultural and economic conditions and institutions under which they operate. They tend to legitimise the existing power relations in society, and therefore, they cannot be substantially changed unless there are fundamental structural changes in society that can alter these power relationships themselves.'*

Since dialogue and face-to-face interaction are inherent in participation, the development communicator will find himself / herself spending more time in the field.

The UNDP (1998) and Servaes (1996:17-18) note that participation is commonly seen either as an end or as a means to an end. In participation as a means, communication is seen as a process where local people co-ordinate or collaborate with externally introduced development programmes or projects. The term 'participatory development' is more commonly used to describe the participatory communication approach. Crawley (1998:24) says the approach to participation as a means is most recommended by advocates and practitioners of participatory rural appraisal who see it as 'empowerment' of those in need of development.

It will take some time to develop rapport and trust. Continued contact, meeting commitments, keeping promises, and follow-up between visits is important. Development of social trust precedes task trust. Both parties will need patience. It is important to note that when we treat people the way we ourselves would like to be treated, we learn to work as a team, and this brings about rural commitment and motivation too. Thus honesty, trust, and commitment from the higher ups bring honesty, trust and commitment for the grass-roots as well. This brings about true participation, and true participation brings about appropriate policies and planning for developing a country within its cultural and environmental framework.

Consequently the perspective on communication has also changed. It is more concerned with process and context, that is, on the exchange of 'meanings', and on the importance of this process, namely, the social relational patterns and social institutions that are the result of and are determined by the process. 'Another' communication favours multiplicity, smallness of scale, locality, de-institutionalisation, interchange of sender-receiver roles (and) horizontality of communication links at all levels of society' (McQuail, 1983:97). As a result, the focus moves from a 'communicator' to a more 'receiver-centric' orientation, with the resultant emphasis on meaning sought and ascribed rather than information transmitted.

With this shift in focus, one is no longer attempting to create a need for the information one is disseminating, but one is disseminating information for which there is a need. Experts and development workers respond rather than dictate, they choose what is relevant to the context in which they are working. The emphasis is on information exchange rather than on the persuasion in the diffusion model. This is relevant to this study in that there is a need for information that would help curb the spread of HIV/AIDS.

### **2.2.4.3 Two major approaches to participatory communication**

There are two major approaches to participatory communication. The first is the dialogical pedagogy of Freire (1983:18), and the second involves the ideas of access, participation and self-management articulated in the Unesco debates of the 1970s. Every communication project, which calls itself participatory, accepts these principles of democratic communication. Nonetheless there exists today a wide variety of practical experiences and intentions. Before moving on to explore these differences it is useful, briefly to review the common ground.

The Freirian argument works by a dual theoretical strategy. He insists that subjugated peoples should be treated as fully human subjects in any political process. This implies dialogical communication. Although inspired to some extent by Sartre's existentialism - a respect for the autonomous personhood of each human being - the more important source is a theology that demands respect for otherness - in this case of another human being. The second strategy is a moment of Utopian hope derived from the early Marx that the human species has a destiny which is more than life as a fulfillment of material needs. Also from Marx is an insistence on collective solutions. Individual opportunity, Freire (1983:22) stresses, there are no solutions to general situations of poverty and cultural subjugation.

These ideas are deeply unpopular with elites, including elites in the Third World, but there is nonetheless widespread acceptance of Freire's notion of dialogic communication as a normative theory of participatory communication. One problem with Freire is that his theory of dialogical communication is based on group dialogue rather than such amplifying media as radio, print and television. Freire also gives little attention to the language or form of communication, devoting most of his discussion to the intentions of communication actions (Yoon, 2000).

The second discourse about participatory communication is the Unesco language about self-management, access and participation from the 1977 meeting in Belgrade, Yugoslavia. The final report of that meeting defines the terms in the following way: Access refers to the use of media for public service. It may be defined in terms of the opportunities available to the public to choose varied and relevant strategies and to have a means of feedback to transmit its reactions and demands to production organizations (Servaes, 1995; Yoon, 2000).

Participation implies a higher level of public involvement in communication systems. It includes the involvement of the public in the production process, and also in the management and planning of communication systems.

Participation may be no more than representation and consultation of the public in decision-making. On the other hand, self-management is the most advanced form of participation. In this case, the public exercises the power of decision-making within communication enterprises and is also fully involved in the formulation of communication policies and plans (Servaes, 1995; Freire, 1983:35).

These ideas are important and widely accepted as a normative theory of alternative communication: it should involve access and participation. However, one should note some differences from Freire. The Unesco discourse includes the idea of a gradual progression. Some amount of access may be allowed, but self-management may be postponed until some time in the future. Freire's theory allows for no such compromise. One either respects the culture of the other or falls back into domination and the 'banking' mode of imposed education. The Unesco discourse talks in neutral terms about 'the public'. Freire talked about the oppressed. The Unesco discourse puts the main focus on the institution. Participatory radio means a radio station that is self-managed by those participating in it (Yoon, 2000).

#### **2.2.4.4 The guidelines for participatory communication at community level**

Some of the most successful participatory communication programmes were tested at the village community level. The small size of the community permitted the intensive use of interpersonal channels, as well as other folk and traditional media (USAID, 2002; The Communication Initiative Partnership, 2002). Described below, according to USAID and The Communication Initiative Partnership, are the steps followed by many NGOs in implementing their programmes. These steps have drawn ideas not only from development communication methodologies, but also from participatory development, and non-formal education.

- **Entering the community**

The first step of any participative communication project is the identification of a community partner through which the development can take place by means of a partnership. This is achieved by identifying communities that the NGOs have worked with in the past, or are currently working in. The advantages of approaching the

development process in this fashion are two-fold. There is a working relationship in place and secondly has relationship has already established a feel for what the community requires with regards to developmental projects. This then allows for the organization align its goal in accordance with the community needs and objectives.

When a community is identified, a process of “getting-to-know” the community must be initiated. This process should not be linked to any specific organizational aims and thus the first meeting should happen spontaneously with NGO being introduced to the community and the specific community leaders. In many instances the NGOs live within the community for a period of time in order to become accepted by the community members and thereby also gain a good understanding to the community dynamics. It is then during this period that the NGO is allowed evolve by its interactions with the members of the community.

According to Yoon (2000) the success of this crucial first step lays with the NGO workers and partly on the standing that the NGO has within the community itself. Credible NGOs with a good proven track record within the community will greatly be helped by the goodwill that this trustworthiness brings. The most crucial task during the first period of entering the community is listening to the community what it wants and what development it is ready to accept.

The relevance of the NGO's in this study is that they make up a vast majority of the members Local AIDS Council (LAC). This is dictated by the National Government in the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Document* policy documents. Therefore, the NOG's are required to work in collaboration the Local Government to achieve the aims of the LAC by government policies.

- **Preparing to plan action**

Initial periods of listening and "getting-to-know-each-other" should in essence lead to a decision to collaborate, yet in many instances this is not the case and the decision is made not to collaborate. In the case of the former, the next step is often planning the extent of the collaboration. Communication plays a vital role at this stage. Meetings with the community are good starting points, this allows for as many people as possible from within the community to be involved with the opportunity to participate in the planning

process. During this meeting the purpose of the planning exercise can be explained and debated, the people can be involved, introduced to each other, and the process for development can be decided upon (Yoon, 2000).

Formal community meetings must happen in a timorously fashion as in many of these communities this way doing things may be alien to many community members and the people should not be rushed into it. A lengthy time period should be allocated to the informal discussions and dialogue; the suggestion to meet formally should ideally develop from these consultations.

This phase will also be characterised by the emergence of the leader who would drive this process. Facilitators of the process should certify that leaders are eventually elected by a majority and meddling by the community in the choice of the leaders be reduced to a minimum. Discussions of the desired attributes that are required by a leader should also be quantified into meetings before the formal election of the leader. Contenders who have lost during the election of becoming a leader may decide to leave the group with a great possibility of taking with them their family, friends, and supporters. The group reaction to this loss is of vital importance for setting the tone for future interactions between the group and the departing members.

- **Planning what to do**

According to Yoon (2000) the first step is a reflection upon the current conditions, problems, aspirations and resources faced by the community. Media can and must play a catalytic role in this phase. Traditional and folk media should be targeted as the media types that can be used effectively to gauge these conditions in the community. In many communities the members or the local theatre group prepare and present to the community, "a play about a fictitious place where conditions are similar to those in the village". The performance that follows does not have any conclusions. During the performance the members of the community act out the ending or suggest what the ending should be. What makes this medium so effective is the fact that it is entertaining and easy to participate in partly because of the indigenous setting. It also acts as a non-threatening and minimally belligerent situation as the issues that may be prevailing in the community are being dealt with through a proxy that is offered by the fantasy characters in the performance.

Formats such as small-format videos, have also been used effectively in participative development. The most famous is the "Fogo Process" (Williamson, 1991:78-92; Yoon, 2000). This process involves the video being used as a "mirror" to reflect issues and ambition of the people living in the remote rural communities. The production of the video is left the people themselves, they are directly responsible for the executing and production of the video. Processes like editing, deciding what to cut and what to leave, are also dictated by the community members. These videos help the community reflect and enhance the communication factor between the community and outsiders. These outsiders receive frank, honest messages from the communities' through these videos. The videos convey intense emotions often moving the outsiders to action within the community. Outsiders receive accurate and candid messages from the people through these videos, and because they often convey intense emotions, they are also effective in moving outsiders to action.

"Photo novella" is another similarly effective medium that can be used in the development process. Still cameras are distributed to the community, which they are free to photograph anything they want in order to make a pictorial novel about themselves in their daily community lives. The pictures that are taken are displayed and arranged into an order through a combined effort of the members in the community. These picture stories help with reflection and communication with the outsiders measuring progress of the co-operative efforts that have taken place within the community. An example of the latter was provided by a group of villagers living on a mountainside threatened by serious landslides which were robbing the farmers of scarce arable land. The solution, learned from neighbouring villages, was to build retaining walls with large boulders — a back-breaking and long-term project (Yoon, 2000).

- **Supporting action**

As the development phase evolves, there would be a likely hood that that community has advanced to the stage of action, a group would've evolved that would ensure that the communication activities of the community would be taken care of. According to Yoon (2000), it would probably comprise of the opinion leaders like religious and traditional leaders, teachers, folk musicians, actors, and others involved with the interaction between the community members.

The village communicators may be offered training in communication methods by the NGOs. Such training should emphasize the principles of participation and the supportive role of communication in triggering participative development within the community (Yoon, 2000; USAID, 2002). Traditional and folk media should be used. Space for mediums like newspapers, posters, video, plays and static displays may also be introduced to help stimulate the development process. However the emphasis should be on interpersonal methods of communication like speech, group discussions, and presentational skills (to peers as well as outsiders, like government officials) as these communicators will constantly be involved in the community interaction on a interpersonal level with a variety of community members. Matching the goals of participatory communication, training should be focussing communication as the instrument by which empowerment of the people can be achieved rather than a mere means of expressing information. Yoon (2000) implies that communication for the facilitation of action may aim at a number of objectives, these objectives are as follows:

- to create a understand of the proposed action;
- to gather feedback to determine if the route of action is acceptable by all; or alternatively find other alternatives;
- to communicate the course of action to the community;
- to provide support and publicity as the actions are being implemented;
- to keep the members of the community informed of progress of the initiatives and to gather their reactions to these initiatives;
- to report the impact of the action on the community; and
- planning for the next round of action.

The action described must take in a logical sequence. This sequence must follow with the most urgent or most manageable, and then moving on to others after it has been completed. In this way of iterating the process provides the community with the opportunity to learn and become familiar with the process. Interaction also facilitates increasing degrees of participation among members of the community as they learn to work with each other, and develop confidence and loyalty for each other.

- **Withdrawing from the community**

According to Yoon (2000), NGO workers who help set up participatory communication projects should plan their withdrawal from the communities as soon as the people

indicate their readiness to take complete charge. The groundwork for withdrawal should be stated on and included in the initial meetings and planning preparations between the community and the NGO, so that the people can prepare for it while the development process is on the go. In addition the withdrawal phase signals to the community that the ultimate goal is for them to take control over the development and actions that affect them. Withdrawal must be phased in gradually. According to Yoon (2000) it should begin with the handing over of roles normally carried out by the NGO.

The workers should relocate from the community (if she or he has been living there) and return for visits only or when requested by the community. Frequency should be gradually reduced or even stop with the NGO inviting members of the community to visit them any time they need too. Withdrawal does not indicate a break of interest by the NGO in the community, it should signal the handing over of control to the community in partnership. Therefore the NGO should keep track of the progress of the community in order to learn from it and guide it in times of need. The tracking should continue as long as possible as participatory communication evolves continuously over periods of time building on the relationship already built during the development phase.

Therefore the following theoretical statement can be deduced from this piece of literature. It is summarised below.

**Theoretical statement 2**

**A participatory approach to a health communication strategy should comprise the following: entering the community; preparing to plan action; planning what to do; supporting action; and withdrawing from the community, by facilitating community participation in all levels of the development process.**

**2.2.5 Critical considerations**

Ayee (1993:175) and Yoon (2000) state that participatory communication must function from praxis, it must imitate ideological, cultural and any other context which it supports. If communication is observed to be participative, therefore as interactive, mass media becomes one of many sources of significant messages enabling the participative approach to differ from the

non-participatory in not being insensitive to the change of the context and enabling learning to be a component of the evolutionary process of development.

After experimentations of more than two decade, many development communication practitioners and researchers believe that they have found in participatory communication the most appropriate concept to guide their work in the developing world. However, participatory communication is a theory that has provided to be enormously difficult in application. This is the challenge which communication practitioners working in close partnership with researchers should take up. According to Yoon (2000) some of the critical considerations this partnership should aim to study and identify with are suggested below:

- **Preconditions:** are some communities better placed to apply participatory communication than others because of the favourable conditions they enjoy? If so, what are these preconditions that they enjoy?
- **Leadership:** participatory communication comes to life when facilitated by the right people. They are the "new leaders" who possess special attributes that nurture participation. What are these qualities? Can they be learned?
- **Conflicts:** is a frequent "by-product" of participation. What is the cause of conflict? How does one deal with and resolve the conflict in develop situations? What is the impact: on traditional communication systems when participatory processes take over.
- **Appropriate action:** when, and for what reason are specific participatory communication means best suited?

Therefore the following theoretical statement can be deduced from this piece of literature. It is summarised below.

**Theoretical statement 3**

**When planning the participatory communication strategy, the following critical considerations need to be part of the planning phase; preconditions, leadership, conflicts, and appropriate action.**

## **2.3 HEALTH COMMUNICATION**

As mentioned in chapter 1, communication is clearly the primary process used in health care to gather, disseminate, and co-ordinate every aspect of health care. Focusing on HIV/AIDS in this study, it necessitates that a health communication orientation is followed. As HIV/AIDS has such a wide ranging affect on not only the individual, but the family as well, communication is therefore essential in the provision of social support to those suffering from the pandemic (by health care providers, participants in formal and informal support groups, family and friends) (Verwey & Crystal, 1998). Therefore communication is perhaps the most essential ingredient in effective health communication strategies. Kaplan (1997:74) and Sharf and Street (1997:7-19) have identified two approaches to the management of health care: a biomedical model, also referred to as the "find it - fix it" model, and the outcomes model, where the ultimate outcome is not a measure of the disease process, but a patient orientated approach focussing on achieving a meaningful solution to the patient's ailments. This is in accordance with the participation as a means approach (see section 2.2.4).

For the purpose of this study, the outcomes model is discussed for the use in the health communication strategy. First the outcomes model is used, as it aims for a solution to the patient's ailment (In this case the National Health Authority is looking for an outcome to the HIV/AIDS pandemic faced by the South African population, which in turn is wanted at a provincial level and syphons down to Potchefstroom Municipal Health Authority); and secondly, this model is closely linked to participatory communication. Therefore the integration between the two models would result in a participatory health communication strategy for the Potchefstroom Municipal Health Authority aiming for buy-in by the community. However, if there is no real participation by the community in the health communication strategy process, the communication process could end, resulting in sustainability not being achieved by the Potchefstroom Municipal Health Authority (Participation is discussed in Section 2.3). Focus is now directed to the health communication strategy which is discussed in terms of the outcomes based model.

### **2.3.1 The traditional model (biomedical) vs. the outcomes model (bio-psychosocial model)**

According to the traditional model (biomedical), diseases have a clear biological basis. The role of the physician is to identify illnesses and provide remedies. Once the problem has been

identified, an arsenal of effective medical treatments is available. The appropriate remedy is selected and the patient is cured (Kaplan 1997:75).

Traditionally emphasis was placed on acute medical care where the 'fix-it' model was used regularly. Kaplan (1997:76) suggests, however, that we are now faced with problems for which this medical care system was not designed (The issue of the HIV/AIDS pandemic which is threatening the very structure of our community - refer to section 1.1.). Being a chronic disease, there is no known cure to the HIV/AIDS pandemic. As the biomedical model aims to provide treatment in order for the patient to become cured, it is not applicable to this study. The biomedical model will not succeed in providing a treatment to the HIV/AIDS pandemic.

In this type of interaction, communication is limited to a mechanistic view where the emphasis is on the transfer of information, as opposed to the establishment of mutual understanding through dialogue. Rimal, Ratzan, Arntson and Freimuth (1997:62) note that traditional illness-centred models assume that health professionals '*know*' what is in the patients' best interests, and research questions centre on factors that inhibit or promote rates of compliance with the health professional's diagnosis. Communication is conceptualised as a one-way-flow (from the doctor to the patient) in which information is used as an instrument to bring about change (compliance). This is the concept which the health communication strategy envisaged in this study, needs to move away from. Focus should be placed on an open approach where '*dialogical*' communication and interaction between health professional and patients can take place. Such a process is the outcomes model.

At the heart of the outcomes model is the assumption that health behaviours can be changed only to the extent that individuals are empowered with effective psychological tools that promote learning of appropriate health behaviours. Current trends in health communication strategies present a more dynamic role for the provider and the consumer of health information (Rimal, *et al.* 1997:62). According to Arnston (1989:29) it recasts health as a wellness-centred phenomenon by conceptualising health as a multifaceted concept that includes biomedical, psychosocial and environmental determinants. Applicable to HIV/AIDS this is then defined that a wide variety of factors influence HIV/AIDS in the community.

Issues like awareness and treatment and prevention all influence how people perceive the pandemic. According to Rimal, *et al.* (1997:62) a wellness-centred approach is adaptable to problems faced by the population in the latter half of the century, especially chronic diseases (HIV/AIDS). Sharf and Street (1997:7) view this model as one in which health outcomes are

defined, not only from the mortality and morbidity perspectives of medical and public health practitioners, but also in patient-initiated terms that give more attention to dimensions such as quality of life, respect and advocacy, physical and psychological wellbeing, attention to individuals' preferences, values, and expanded choice making (concepts which are key to participatory communication, refer to section 2.2).

Therefore the following theoretical statement can be deduced from this piece of literature. It is summarised below.

**Theoretical statement 4**

**The outcomes model (bio-psycho-social model) for health communication is most suited for the basis of the health communication strategy, as it ascribes to elements key to participatory approach such as interaction, dialogical communication, attention to individuals' preferences, values, and expanded choice making.**

**2.3.2 Reasons for the shift from the biomedical to the outcomes paradigm**

The biomedical model reinforces the power imbalance that is propagated between the physician and the patient (An issue which participatory communication aims to reduce). It therefore highlights the power of the practitioner, relegating the patient's experiences and interpretations to a secondary role. Unfortunately, in this kind of medical setting, the social concerns of patients, about their health status, are repeatedly marginalised and ignored. Sharf and Street (1997:20) suggest that the hierarchical power ascribed to physicians needs to be shared with the patients. This will result in a more active and co-equal role for the patient. The traditional imbalance of power also results in an imbalance of control. This creates a context where the structural and cultural hegemony implicit in health-related discourses is to a large degree ignored. The power imbalance of the biomedical model (traditional model) is once again reinforced, as power is often conceptualised in a vertical manner. The dominance of the biomedical model has led to a one-sided power base lying with the physician and the institutions of medicine (Bennett & Irwin, 1997:65).

As Kaplan (1997:76) states,

*'One-way communication could suffice in an acute care situation, but two-way communication is the central component of chronic care. Our health care system, grounded in the acute care paradigm, is poorly equipped for this interaction'.*

In chronic illnesses, the exchange of information will influence the patient's outcomes as much as medicines and surgeries. The key element here is thus the building of relationships which is totally dependent on the presence of transactional communication. For this reason, participatory communication within a health communication strategy is needed. Participatory communication will in essence then continue the exchange of information between patient and health professionals allowing for the patient to give their input. In other words, participatory communication stresses the reciprocal collaboration, listening to others and respecting the counterpart's beliefs, resulting in mutual trust (This is discussed in greater detail in Section 2.2).

According to Rimal, *et al.* (1997:62) one of the primary criticisms that can be levelled at the biomedical approach, is that the multiple goals present in the physician-patient encounter are ignored. Sharf and Street (1997:4) highlight the need to reposition the concept of 'patient' in order to achieve an increased understanding of the patients' role and influence in health related interactions. This would ensure that the direct and indirect factors that shape an individual's health would be taken into account as opposed to focusing on the individual only. An exclusive focus on individuals, places the responsibility for change on individuals and disregards the wider societal-level factors that can inhibit change. By implication, those who do not practise healthy behaviour are perceived to be irresponsible, unmotivated or incompetent. Rimal, *et al.* (1997:63) believe that if environmental constraints are not taken into account, then we run the risk of 'blaming the victim'.

Lammers and Geist (1997:45) reinforce this belief by writing that managed care further inhibits a dialogue between health provider and health receiver. They believe that this managed care can be characterised as a paternalistic view of communication, where there is 'an inability to capture the context, complexity and consequence of communication, and a narrow focus on the biology of health that excludes the psychological, social, cultural and spiritual'. It is imperative to acknowledge the impact of the integrated environment on the health of the individual.

Therefore the following theoretical statement can be deduced from this piece of literature. It is summarised below.

### **Theoretical statement 5**

**The health communication strategy should not exclusively focus on those individuals already infected with HIV/AIDS, but focus should also be directed on those individuals not infected with HIV/AIDS.**

The problem is that physicians do not know and do not ask what the patient knows about specific ailments and health in general (Vanderford, Jenks & Sharf, 1997:22). The physician does not take the time or effort to sort through the patient's existing information about health care, which may be confusing, conflicting or misleading. Health providers need to expand their understanding of how individuals experience and make use of health information. In the words of Vanderford, *et al.* (1997:22):

*'Knowing the ways in which patients use information and create meaning can help the medical community to guide that process more fully, clarifying differences that may hamper mutual understanding and co-operation.'*

Patient-centred research will thus help the physician to understand how the patient moves through and uses a variety of sources. This would go a long way towards recognising the impact of patients' perceptions in the health decision-making process, minimising the degree of misunderstanding and dissatisfaction that is often the outcome of doctor-patient interaction.

What is needed therefore is a shift in orientation to one that acknowledges and heightens the understanding of the patient's role and influence in health-related interactions. Sharf and Street (1997:5) assert that it is important to draw a distinction between making the patient a central construct, as opposed to the ailment as the central construct. When the importance of the patient is recognised, an opportunity is created for making choices and decisions (Bennett & Irwin 1997:87), as patients will be more active, knowledgeable and informed. This would result in greater patient participation in the health care process. A growing body of research suggests that once the patient's preferences and involvement in determining therapeutic regimes and related forms of decision-making have occurred, there is a resultant increase in the improvement in health outcomes and a reduction of health care costs (Sharf & Street 1997:2).

What is needed then is an approach that 'rather than conceiving the patients as recipients of and reactors to the message of others, it is proposed that focus is directed on the patients as active

interpreters, managers, and creators of the meaning of their health and illness' allowing for sustainability with regard to the HIV/AIDS pandemic.

This would then be central to the health communication strategy for the Potchefstroom Municipal Health Authority. Patients, in this case the recipients - both infected with HIV/AIDS and uninfected - would be empowered to decide what is relevant to them in the health communication strategy. Not only does this then lead to empowerment in the decision-making process, but will also lend itself to the awareness that attitudes and lifestyles towards the HIV/AIDS pandemic need to be changed in order for an outcome towards the HIV/AIDS to be achieved. This would result in the buy-in required by the community for the communication process to be sustained and lead to sustainability. To achieve this, the health communication strategy needs to follow specific guidelines.

### **2.3.3 Characteristics of a health communication strategy**

The health communication strategy should follow certain guidelines in order for it to succeed in principle. According to USAID (2002) and facilitated by The Communication Initiative Partnership (2002), a quality health communication strategy is one that comprises the following:

- **It is evidence based**

Strategy, planning and management decisions in relation to the communication intervention are significantly based on data and information from quality research exercises and strategy evaluations (USAID, 2002). These research exercises will have measured the impact of communication interventions on a health issue. Applied to the context of the study, *the Potchefstroom Municipal Health Authority would need to conduct small research exercises to determine what effect the health communication strategy would have in the community.* The findings would then be applied to further enhance the health communication strategy.

- **Focuses on promoting informed dialogue and choice**

Stimulates and / or strengthens informed public and private dialogue and debate on the main issues at the centre of the health and development issue[s] or problem[s] that are the focus of the health communication strategy. It would support people making an informed choice concerning their responses to those issues and problems. This applies to this study in the following ways:

- a. The health communication strategy is based on the introduction of responses with a provable scientific base (What are the causes of HIV/AIDS infection, how can it be avoided and what treatments are available?) – where dialogue is essential to engage, inform and educate a community of the issues surrounding the HIV/AIDS pandemic; and
  - b. Health communication hinges on matters of values, opinions, culture and politics – where the overall response needs to be generated and agreed within countries, communities, and families and amongst friends.
- **Effectively 'frames' an issue(s)**  
Positions the debate in terms that resonate with the people the communication strategy intervention wishes to engage in dialogue with. The health communication strategy needs to determine the requirements for the community and more specifically that part of the community whom it wishes to target with the health communication strategy.
  - **It works in partnership**  
Prioritises negotiating and facilitating partnerships that are not dependent on the provision of financial support, with organisations that have extensive communication capacity and links with the key population groups. *Focus here for the Potchefstroom Municipal Health Authority would be to determine which of the Non-governmental Organisations within the LAC would help them achieve the goals of the health communication strategy.* In many cases these organisations have direct contact with the community and more specifically those living with HIV/AIDS. These partnerships will be based on:
    - a. Identifying and meeting the central interests of each of the partners (with reference to LAC, each of the organisations represented on the council are directly involved in prevention, awareness and treatment campaigns surrounding the HIV/AIDS pandemic. Therefore resulting in an effective partnership that will further promote both the aims of the Potchefstroom Municipal Health Authority as well as those of the NGOs);
    - b. Identifying and building on the strengths of each of the partners (again each of the NGOs have specific strengths and this should be incorporated into the health communication strategy, to achieve the aims of the strategy);

c. Placing those strengths in a collective framework that gives overall strength to the communication intervention.

- **It supports local "ownership"**

Includes a strategy and specifies progress towards ownership of the communication intervention lying with local or national people and organisations - where the intervention has been initiated by a development agency (Potchefstroom Municipal Health Authority) external to that community. Involving people from the groups most affected by the issues being addressed in the process of making the key strategic decisions related to the communication intervention. Therefore empowering the community to take control of their own development with regard to the HIV/AIDS pandemic.

- **It works for sustainability**

Identifies and seeks to achieve goals and objectives that ensure long-term rather than temporary changes in the issues being addressed. Includes a strategy for attracting the diversified and continuing financial and human resources required to sustain the communication intervention until its long-term goals have been achieved.

Therefore the following theoretical statement can be deduced from this piece of literature. It is summarised below.

**Theoretical statement 6**

**A participatory health communication strategy should follow the USAIDS guidelines.**

## **2.4 SUSTAINABLE SOCIAL DEVELOPMENT AT LOCAL GOVERNMENT LEVEL**

### **2.4.1 Introduction**

Sustainable social development refers to the processes that will ensure that people's basic needs are met. That a country's resources are conserved and that there is a sustained population level, which the environmental concerns, are integrated with the peoples needs and that the decision-making process will lead to empowerment of the community (Fitzgerald, 1997:3-4). Sustainable development for this study can be achieved by getting the community to buy into the

communication strategy process, allowing for participation. Hence, if there were no participatory communication in the health communication strategy that would allow the community to buy into the health communication strategy, sustainability would not be possible to be achieved.

The complexity and multifaceted nature of the relationship that exists between participation and empowerment is explained in terms of sustainable development. Repetto (1986:15) defines sustainable development as:

*'...a developmental strategy that manages all assets, natural resources, and human resources, as well as financial and physical assets, for increasing long-term wealth and well-being. Sustainable development as a goal rejects policies and practices that support current living standards by depleting the productive base...'*

Empowering people is one approach to attain sustainable social development, with regard to the HIV/AIDS communication strategy.

#### **2.4.2 The concept sustainable social development**

As mentioned in Chapter 1 section 1.1; sustainable social development and HIV/AIDS are closely related issues. Addressing HIV/AIDS is a major area of concern, as maintaining a sustained population level is a core design of sustainable social development. HIV/AIDS is currently negatively affecting the population growth rate of South Africa, which is declining and is at present at 1.8% with a rate which is projected to drop to 0% in 2011, providing the need for a maintained and sustained population growth.

Sustainable social development in the context of this study entails the improvement of the overall quality of health information with regard to HIV/AIDS in order to provide a sustainable manner for curbing the HIV/AIDS pandemic. The one possible way of doing this is to give people authority to decide on the specific issues affecting the HIV/AIDS pandemic by means of empowerment. This then in theory ensures that the communities' needs regarding the HIV/AIDS pandemic are being met not by the municipalities alone but also by the initiative of the people.

Sustainable social development implies, *inter alia* (Fitzgerald, 1997:2):

- Self-sufficient and cost-effective sustainable social development project;
- Access to primary basic needs; and
- Empowerment of people to help themselves.

Sustainable social development for this study can be described as the establishment and management of organisational units within municipalities to empower communities to address their own basic needs in a sustained manner and to promote cost-effective social development projects providing a sustainable procedure for dealing with the HIV/AIDS pandemic in the community.

### **2.4.3 Sustainable social development and the legislation**

Legislation in South Africa forms the foundation and point of departure for creating an environment that is sympathetic and conducive to sustainable social development matters. Legislation further provides the researcher with the steps that need to be followed, could be followed, or taken to create organisational entities that ensure that the contemporary issues are addressed such as sustainable social development. Starting with the Constitution of the Republic of South Africa (1996), the following come to mind:

- Par 151(3) of the Constitution of South Africa states that a municipality has the right to govern, on its own initiative the local government affairs of the community subject to the national and provincial legislation.
- Par 152 (b) determine that a local government should ensure the provision of services to communities in a sustained manner.
- Par 152 (e) determines that local government should encourage the involvement of the communities and community organisations in matters of local government.

Therefore it can be stated that the Constitution of the Republic of South Africa (1996), provides ample room for local government in whatever form (Municipal Health Authority) to take the necessary steps to:

- Govern local matters (HIV/AIDS Initiative) to improve sustainable social development.
- Ensure the delivery of health services for the community with regard to HIV/AIDS in a sustained manner.
- Assist communities and community organisations to create structures (LAC) to secure sustainable social development.

Analysis of the White Paper on Local Government (1997), emphasises the following with regard to sustainable social development:

- Par.2.6. There has been a shift in the role of local government regarding service delivery. Instead of providing all the services directly to communities, they should rather concentrate on creating the right conditions for others to deliver the services.
- In order to achieve (sustainable) development, there are several areas that a municipality should focus on. The more important ones are: basic service delivery and housing, the creation of structures of communication (the aim of this study, hence the participatory communication strategy) between municipality and the community.

Making this relevant to the sustainable social development means that the Municipal Health Authority should play a leading role in promoting sustainable social development, without delivering the actual product. Therefore the Municipal Health Authority should be responsible for creating the right conditions so that sustainable social development can take place. One way of achieving this is adhering to the legislation [Constitution of Republic of South Africa (1996), White Paper on Local Government (1997)], which provides municipalities and their respective authorities and department with the opportunity to create organisational structures to address sustainable social development matters. Furthermore, legislation tasks municipalities to empower people. Par.152. (e) determines that local government should encourage the involvement of the communities and community organisations in matters of local government. Interpreting this people are therefore empowered to actively take part in the decision-making process (The Municipal Health Authority therefore needs to include this into any new initiative regarding HIV/AIDS).

## 2.5 SUMMARY

The chapter answered the question of what the requirements for a participatory health communication strategy for a developing environment is. Looking at the literature on health communication followed by participatory communication, it was found that the similarities between health communication and participatory communication were very close. Health communication provided the basis for the participatory health communication strategy. Participation on the other hand, provides the means of achieving the objectives of health communication and establishing sustainability by getting the community involved in the process, allowing for the communication to exist and reaching sustainability through this communication process.

The scope covered by participatory communication has broadened considerably in recent years. Many practitioners have tried to draw on the experience of a number of disciplines other than development communication. In the process, they have contributed to the start of a long-overdue convergence of experience in the education, communication, and development sectors. This chapter has been an attempt to survey a small number of issues in the vast pool of experience offered by these three sectors. It has, however, set out to provide answers to the first research question of the study. This chapter has determined the requirements for a participatory health communication strategy according to the literature in sections 2.2 and 2.3.

Having discussed the health communication strategy in terms of the outcomes model, the following has been determined. Health behaviours can be changed by empowering the individual with effective tools that will promote the learning of the appropriate health behaviours. Chronic illness cannot be cured. Therefore chronic illness (HIV/AIDS) requires long-term interactions between providers and patients. The key element is the building of a relationship with the community that is totally dependent on the presence of transactional communication (Two-way process between the Potchefstroom community and Potchefstroom Municipal Health Authority). Therefore a shift in orientation to one that acknowledges and heightens the understanding of the community's role and influence in the health-related interaction is required, rather than conceiving the community as recipients of and reactors to the message of the Potchefstroom Municipal Health Authority. Focus should then be directed on the community as active interpreters, managers, and creators of the meaning of their health and illness, allowing for sustainability with regard to the HIV/AIDS pandemic.

To achieve this participatory communication will be used in conjunction with health communication to provide the participatory health communication strategy. The elements required to achieve the above-mentioned as discussed was determined in section 2.2.

Establishing a sustainable social development initiative within the Municipal Health Authority is one way of ensuring that communities are empowered to uplift themselves with regard to the HIV/AIDS pandemic. The expansion of the Municipal Health Authority to accommodate the sustainable social development should be done according to the real needs of the community by whom is affected with the HIV/AIDS pandemic. Once these needs have been established, it is then important to appoint the officials who are equipped with managerial skills who can efficiently manage the initiative in a sustained manner.

So, for the participatory communication strategy to fulfil the requirements for sustainable development, any initiative that they enter needs to be sustainable in all manners of speaking. Furthermore the Health District Manager for Potchefstroom then needs to manage the health communication strategy so that it takes into account the needs of the people of the community, allowing them to be empowered in the process, to take control of their own destinies with regards to HIV/AIDS. Finally the Health District Manager for Potchefstroom should manage the health communication strategy so that the outcomes achieved would be sustainable and contribute to curbing the HIV/AIDS pandemic in a sustained manner.

Therefore, participatory health communication strategy is defined in this study as the process of disseminating information regarding HIV/AIDS and issues related to the pandemic for both people infected and not infected by the pandemic, on issues such as awareness, treatment and prevention. This is achieved by participatory means, involving the community in the development phase and empowering them to take control of their own development. This then should lead to sustainability.

## CHAPTER 3

### THE PRESENT NATIONAL AND PROVINCIAL HIV/AIDS STRATEGIES

#### 3.1 INTRODUCTION

For the purpose of the study (as not to create confusion) from now on the term “plan” in the title of the *HIV/AIDS/STD Strategic Plan for South Africa 2002* policy document, will be referred to as strategy. This is done as the focus of the study is a participatory health communication strategy, and a participatory health communication plan for sustainable development. A plan refers to a solution to the problems faced and therefore provides a detailed method of action to remedy the problem. The aim of the study is not to give forth a method of action but provide a possible strategy from which key aspects can be taken and used where applicable by the Potchefstroom Municipal Health Authority.

This section gives an overview of the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* designed to guide the country’s response to the epidemic. It is recognised that no single sector, ministry, department or organization is by itself responsible for addressing the HIV-epidemic. The strategy emphasises a multi-sectoral approach, pulling together resources of all sectors in fighting the developmental challenge of HIV/AIDS.

Organizations and stakeholders are encouraged to use this document as the basis to develop their own strategies so that all initiatives as a country, as a whole can be harmonised to maximise efficiency and effectiveness. The strategy identifies four major areas for the active attention of the country, namely prevention, treatment, care and support; human and legal rights; and monitoring, research and surveillance.

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* document is a broad National Strategy designed to guide the country’s response as a whole to the epidemic. It is not a strategy for the health sector specifically, but a statement of intent for the country as a whole, both within and outside government (Anon, 2001c).

The importance of discussing *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*, is to describe (as set out in chapter 1, section 1.3.2) whether the policy documents comply with the guidelines of participatory communication.

## **3.2 HEALTH INITIATIVES CONCERNING THE HIV/AIDS PANDEMIC**

### **3.2.1 The National strategies for HIV/AIDS**

The development of *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* was initiated by the Minister of Health, Dr. Nkosazana Zuma, in July 1999 in response to President Mbeki's, challenge to all sectors of society to become actively involved in initiatives designed to address the HIV/AIDS epidemic, beginning with a meeting in July 1999 to review the current HIV/AIDS prevention, treatment, and care efforts in South Africa. The meeting was attended by representatives of faith-based organizations, people living with HIV infection and AIDS, human rights organizations, academic institutions, the civil military alliance, the Salvation Army, the media, organized labour, organized sports, organized business, insurance companies, women's organizations, youth organizations, international donor organizations, health professionals and health consulting organizations, political parties, and relevant government departments (HIV/AIDS/STD Strategic Plan for South Africa 2002-2005, 2000:6).

After priority areas for future efforts were discussed and agreed upon, a committee was charged with developing a five-year HIV/AIDS and STD strategic strategy. Task teams were established to review current goals and objectives for the designated priority areas. The priority areas are prevention; treatment, care and support; legal and human rights; and monitoring, research and evaluation.

In September 1999, the then Minister of Health and the nine Provincial MECs for Health reconfirmed the previous priority areas. This was followed in October 1999 by a two-day National AIDS meeting where Provincial AIDS coordinators, the National HIV/AIDS/STD Directorate, representatives of the AIDS Training and Information Centres (ATICs) and representatives of several other organizations discussed progress in the five-year HIV/AIDS/STD strategy.

The above-mentioned information was determined, through informal meetings held with Mr. Roopa (2001) and Mr. Kgomotso (2001), Health District Manager for Potchefstroom and co-ordinator for HIV/AIDS in the North West Province respectively. They did not provide all the information that was required. Therefore the researcher had to consult the National Health Department Website to verify the information that was presented by Roopa and Kgomotso. Some historical notes were also picked up during the content analysis.

In October and November 1999 the task teams met to further develop their goals and objectives. Task teams were expected to review the *National AIDS Plan for South Africa, 1994*, the Department of Health *White Paper for the Transformation of the Health System*, the *1997 Annual HIV/AIDS/STD review*, and reports from the September meeting of the Provincial MECs for Health, and the National AIDS meeting. In November 1999 a draft document was presented to the Inter-Ministerial Committee on AIDS, and additional comments were solicited from all government Ministers. The final document was completed in January 2000 (South Africa, 2000).

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* is the policy document that is seen as the foundation for HIV/AIDS programmes in South Africa. Many of the Provincial Health Authorities have taken the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*, and simply made it the basis for their own HIV/AIDS Policy documents.

The *North-West Provincial Council on AIDS, Working Document Policy* is one of those policies largely based on the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*. In the sections that follow the current strategies in place to address HIV/AIDS in South Africa will be discussed. From the National with regard to the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* to Local Level where the *North-West Provincial Council on AIDS, Working Document* plays a major role in dictating awareness programmes.

The purpose of this study into strategies available in dealing with HIV/AIDS is to determine a vehicle for the participatory health communication strategy. This vehicle would carry the participatory health communication strategy through the community. Not only is this crucial but it must also be determined what the current approaches are towards HIV/AIDS.

Essentially it aims to find the strategies in place to help the Potchefstroom Municipal Health Authority with the implementation of the participatory health communication strategy to the community, since it has been argued that if there is no real participation by the community, then no real development can take place in the community.

### 3.2.2 Current National strategies to address HIV/AIDS

The mission statement of the National HIV/AIDS and STD Programme is stated as the following:

*“To reduce the transmission of STDs (including HIV infection) and provide appropriate treatment, care and support for those infected and affected, through collaborative efforts within all levels of government, using the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005” (Anon, 2001c).*

The foremost National strategy can be seen as the National Potchefstroom Municipal Health Authority, which then separately has the National HIV/AIDS/STD Directorate as branch of the Potchefstroom Municipal Health Authority. The Directorate aims to set up new initiatives with regard to HIV/AIDS and aims to guide the Provincial and Potchefstroom Municipal Health Authority with implementation and management of the pandemic.

The expanded National response is also managed by different strategies at all levels within the National government. According to Roopa (2001) and the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* (2000), it is envisaged that each government ministry will have a focal person and team whose responsibility will be to plan, budget, implement and monitor HIV/AIDS interventions within that ministry area. It is also recommended that all other sectors, including parastatals, NGOs, the private sector, faith-based organizations, youth, and women will also have dedicated HIV/AIDS focal persons, and be integrated in the process.

The following presents a brief overview of some of the important strategies at National and Provincial levels and their specific role and functions relating to HIV/AIDS. This list is by no means exhaustive, and only provides information on some of the current strategies that play a role in the HIV/AIDS and STD arena (Anon, 2001c):

- **Cabinet:** The Cabinet is the highest political authority in the country. The Cabinet meets weekly, but HIV/AIDS issues are not regularly discussed at this level, as this has been deferred to the South African National AIDS Council;
- **South African Potchefstroom Municipal Health Authority:** The Potchefstroom Municipal Health Authority with its HIV/AIDS/STD Directorate pass out directives with regard to new approaches and initiatives that are required; and

- **South Africa National AIDS Council:** The South African National AIDS Council is the highest body that advises government on all matters relating to HIV/AIDS. Its major functions are to: (a) advise government on HIV/AIDS/STD policy, (b) advocate for the effective involvement of sectors and organizations in implementing programmes and strategies, (c) monitor the implementation of the strategy in all sectors of society, (d) create and strengthen partnerships for an expanded National response among all sectors, (e) mobilize resources for the implementation of the AIDS programmes, and (f) recommend appropriate research. This body is chaired by the Deputy President of government, and consists of 16 government legislative bodies and 17 civil society representatives.

The assessment can be made that *HIV/AIDS & STD Strategic Plan for South Africa 2000 – 2005* is also a national strategy which should be used in developing National, provincial and local operational strategies. Yearly operational strategies should be based on realistic objectives. These should be developed taking into consideration existing financial and human resources, the capacity thereof, the process of recruitment as well as the political commitment in each of the provinces. The setting of national goals will allow for inter-provincial comparisons and ensure a measure of unity regardless of the relative autonomy of the provinces.

The provinces should then take these national goals and objectives and present them to key role players within the province to ensure that communities buy into what would be a participatory health communication strategy for HIV/AIDS at a local level. The content analysis must then determine whether this strategy meets the requirements of participatory communication.

The National Potchefstroom Municipal Health Authority recognised that no single sector, ministry, department or organization is by itself responsible for the addressing of the HIV epidemic (Anon, 2001c). Specifically the document envisages that all government departments, organizations and stakeholders will use the document as the basis to develop their own strategies so that all initiatives in the country can be harmonised to maximise efficiency and effectiveness of all HIV/AIDS programmes.

This involves reviewing and developing where necessary strategies at all levels, from national, provincial, local, and community levels. The concept of appropriate national strategies such as the IDC and SANAC should be considered for duplication within provinces, keeping in mind the

importance of delivery within communities. The most important structures to create a guide to the implementation of the strategies are:

- A National AIDS Council, with duplicate bodies in each province; and
- Interdepartmental Committees on HIV/AIDS in every province.

One of the functions of the Interdepartmental Committees within the provinces would be to define each government department's unique and generic responsibility within the HIV/AIDS and STD strategy. Equally important is the establishment of appropriate strategies at district level to ensure the implementation of the HIV/AIDS and STD Strategy. According to Anon (2001c) it is thus recommended that District HIV/AIDS Committees be established. These district strategies should include community-based committees that represent major role-players within the relevant community in the field of HIV/AIDS. These committees should include local government to ensure the integration of HIV/AIDS/STD issues and development strategies. It is vital that this include non-health issues as part of HIV/AIDS/STD planning, such as transport and poverty alleviation.

The HIV/AIDS and STD Strategy provides a broad framework for government, NGOs, business, labour, women and all sectors of society. Each sector should develop more specific strategies based on their role in society, activities and their specific strengths. These strategies should be based on each sector's comparative advantage in implementing the planned activities. Sectors are encouraged to establish technical AIDS committees, which will be responsible for advocating, for managing and co-ordinating the implementation of HIV/AIDS activities within that sector. The sectoral AIDS committees will also be responsible for liaison with other sectors and the Directorate: HIV/AIDS and STDs. The recommended role of the sectors will be as follows:

- Identify determinants of the spread of HIV/AIDS/STDs specific to the sector;
- Identify strengths and weaknesses with respect to HIV/AIDS/STDs;
- Identify obstacles to the response within the sector;
- Integrate HIV/AIDS/STD's activities in their yearly strategies;
- Formulate specific HIV/AIDS sectoral plans and budget for their implementation;
- Mobilise resources for the interventions;
- Document best practice within the sectors and share information; and

- Prepare and submit quarterly reports to the SANAC

All Ministries, including the MOH (Ministry of Health), will submit quarterly reports to the SANAC on their HIV/AIDS activities.

This is the make-up of the National strategy in place to combat HIV/AIDS at national level. This is carried over to the provincial level. This is discussed in Section 3.2.3.

### **3.2.3 The North West HIV/AIDS strategy**

As mentioned in Section 4.3.2 the *HIV/AIDS & STD Strategic Plan for South Africa 2000 – 2005* is the National Strategy which should be used in developing national, provincial and local operational strategies. The North West Province has integrated this strategy into their own provincial strategy.

The development of the *HIV/AIDS and STD Working Document for the North West* was in response to the National Strategic strategies set out by National Government in their *HIV/AIDS and STD Strategic Plan 2000 – 2005* and the setting up of AIDS councils in December 1999 to specifically deal with the HIV/AIDS pandemic (Anon 2001b).

The document sets out specific information as to how the Councils should be set out and who should be included in the Council. It is very much a carbon copy of the *HIV/AIDS & STD Strategic Plan for South Africa 2000 – 2005*, just a less detailed strategy of action, which has very much copied the objectives of the *HIV/AIDS & STD Strategic Plan for South Africa 2000 – 2005*. It does, however make provision for the Local AIDS Councils (LAC) to be set up at local level throughout the Province. This LAC is a copy of the South African National AIDS Councils. Their task is very similar to that of the National AIDS Council, except that it functions at provincial level in the following way:

- a) Counsel provincial government on HIV/AIDS/STD policy at local level;
- b) Advocate for the effective involvement of sectors and organizations in implementing programmes and strategies;
- c) Supervise the implementation of the strategy in all sectors of society, especially at grass roots level;
- d) Generate and strengthen partnerships for an expanded local response among all sectors;

- e) Mobilise resources for the implementation of the AIDS programmes; and
- f) Recommend appropriate research to the Provincial Government.

The LAC then does this for the Provincial AIDS Council, which in turn briefs the National AIDS Council as to what is happening from the grass root up to the provincial level.

### **3.2.4 Integration: a participatory health communication strategy and the local Potchefstroom context**

As presented in the previous sections the aim of this section is to provide an integration of strategic management of the participatory health communication strategy and the Potchefstroom Municipal Potchefstroom Municipal Health Authority. The aim therefore of this section is to describe the Potchefstroom context in order to analyse the guiding principles for the recommendations to be made for the participatory health communication strategy in the concluding chapter, chapter five.

As mentioned in section 3.2.1, strategic management is a systematic and scientifically based process that is linked to the master strategy of the organization, so that management can have a clear vision for the organization. It is a dynamic process where the choice of strategy is largely determined by the phase of development that the organization is experiencing at that point. Part of this strategic management process is the strategic planning process of which strategic communication is a sub-process. When designing a strategic planning model the strategy of the process is very important. The strategies should be logical and easy to follow. Communication thus binds the elements that keep the various interdependent parts of the strategic planning process together: without communication there can be no successful strategic planning process and hence no organizational activity (Myers, 1982).

Furthermore the constraints (participatory communication is not suitable for solving all problems in all contexts or time frames; short-term solutions and intervention are also needed; the apparently opposing concepts of "participation" and "manipulation" can be viewed from many perspectives; and the price people have to pay for taking part in participatory processes is often overlooked. The social communicator should take this into consideration when dealing with the community) and characteristics (shifting away from vertical approaches based on the unilateral transmission of information and persuasion to more creative approaches based on exchanges of knowledge and experiences, development communication provides space for groups and

communities to diagnose their own problems, identify possible solutions, make well-informed decisions, acquire necessary skills, mobilize for action, and assume responsibility for their own development) of the participative approach will also affect the way in which the strategic management is carried out and also critically affect the design of the participatory health communication strategy. The process for participative approach towards development is important; it is also essential then that the above-mentioned aspects are noted during the formulation process (refer to section 2.3.4 for a more in-depth look at the characteristics of participatory communication).

In addition it must also be noted that the evaluation of the policy documents is concerned with the determination of whether the policy documents ascribe participatory communication principles to the development initiative concerning HIV/AIDS. The policy documents give guidelines for an organization to implement or carry out objectives that the organization has seen fit to be integral to its future. In the case of this study the National Potchefstroom Municipal Health Authority has set an outline policy for the combating of HIV/AIDS in the community (refer to section 4.3.2). This policy has also indicated the long-term strategies for the Potchefstroom Municipal Health Authority and where it would like to be by the year 2005.

Having stated the aim of the Potchefstroom Municipal Health Authority thus is to clearly define the systematic planning required to adapt to the changes experienced in the local authority, and to utilise every possible situation that comes the way of the local authority. Not only will the strategic management element within the management of the Potchefstroom Municipal Health Authority assure continuous organizational success but it will also provide a basis from which the participatory health communication strategy can be launched and sustained in the community. Nevertheless for a participatory health communication strategy to succeed in the community there needs to be sufficient communication processes within the local authority. It is also of importance that the local authority has a clear vision of their organization's future and community objective as it is there to serve the community. This should be the ultimate goal of the strategy.

Therefore the Potchefstroom Municipal Health Authority needs to have the following process in place for it to (refer to section 3.2.2) have a successful participatory health communication strategy. The Potchefstroom Municipal Health Authority would first require a strategic direction and strategy formulation. This simply means that the Potchefstroom Municipal Health Authority would need to define for whom the planned development would be in the community and

describes a strategy specifically aimed at this group. Walker, Boyd and Larreche (1995:24) and Kotler and Fox (1995:105) contend that it would be important that the present and planned objectives to take into account the capabilities of the Potchefstroom Municipal Health Authority analysis with regard to strategically handling a participatory health communication strategy in the community to promote awareness of the HIV/AIDS pandemic and the competitive environment in which the specific capabilities of the organization are offered to clients.

The competitive environment must be analysed to establish a fit between the capabilities offered and existing opportunities. Essentially this initial phase would include the targeting phase and positioning in the community of the Potchefstroom Municipal Health Authority and its proposed aims. For all intents and purposes the phase of critical importance is the strategy formulation. This concept will further be defined in chapter 5.

Referring back to section 3.2.2, the next phase in the process would be the formulation of the communication strategy. The formulation process is similar to the initial process as it tries to define a strategy by which it intends achieving its aims. It is important that in this phase the strategic direction of the Potchefstroom Municipal Health Authority is integrated and made clear in the communication process. Following this would be the delivering of the participatory health communication strategy in the shape of implementing it in the Potchefstroom Municipal Health Authority and the Potchefstroom community that it serves.

Finally, the process of maintaining communication between the department and the community as a process of monitoring the participatory health communication strategy. There needs to be a constant process of evaluation and as will be mentioned in chapter 4, the participatory health communication strategy must allow for adaptation if it is going to follow a participative approach. By allowing it to be adaptative in nature it will be in accordance with the principles envisaged by the participative approach. However, this is not the only requirement for it being adaptative, it allows for the realisation that there are going to be problems along the way with the participatory health communication strategy and that the strategy would not always be able to address specific needs that arise. By being adaptative it allows for situations where the inevitable may occur, and it must therefore aim to be all inclusive.

Thus having given the process it is vital to remember that the *HIV/AIDS & STD Strategic Plan for South Africa 2000 – 2005*, *HIV/AIDS and STD Working Document for the North West*, the Constitution of the Republic of South Africa (1996) and the White Paper on Local Government (1997), and the Municipal Organization Act (117/1998) all provide frameworks for the local

government organization of South Africa for handling developmental programmes in the community. Not only does it provide a broad framework for government, NGOs, business, labour, women and all sectors of society. Nevertheless it envisages that each sector should develop more specific strategies based on their role in society, activities and their specific strengths. These strategies should be based on each sector's comparative advantage in implementing the planned activities. Sectors are encouraged to establish technical AIDS committees, which will be responsible for advocating for, managing and co-ordinating the implementation of HIV/AIDS activities within that sector.

Having stated this participatory health communication strategy must realize these objectives as set out in these documents and integrate them into the strategic formulation. It is important that this is done as these documents are the building stones for what can and cannot be done in the South African community, not only this, the Potchefstroom Municipal Health Authority as sub-branch of a bureaucratic arm in South Africa is bound to follow these processes for its day to day running.

In conclusion having mentioned the policy documents of South Africa, a major directive they set out in these policies is the consultation of the local authority with the community when initiating development programmes. This then brings the reader to the next issue in this study, that of a participatory approach. Chapter 2 attempted to explain the participative approach and its major implication in development issues and the role of sustainable development as an outcome of the proposed participatory health communication strategy.

### **3.3 SUMMARY**

The HIV/AIDS and STD Strategic Plan is a living document and will be subjected to regular critical review. This will be undertaken at the National, Provincial and District levels with inputs from all stakeholders. A mid-term review will be conducted and the strategies modified in accordance with the findings.

Applied to both the public and private sectors of Potchefstroom, Mersham (1993:113) states, for these sectors to cope with the changes that have come to South Africa, especially in anticipation of and since 1994 elections, the public and private sectors have changed from a "top-down/centre-periphery transmission, pro-source, pro-persuasion approach that was authoritarian and pro-literacy", to a "shift in focus to the grass roots", even where in practice the mode of

communication as practised remains distinctly in need of being more dialogical. Participative decision-making needs to be seen in relation to the sharing of knowledge and resources on a co-equal, but culturally sensitive basis (Mersham, 1993:113) in these sectors. Applied to the HIV/AIDS context, the approach needs to be directed to the community at the grass roots level in order for them to partake in the communication process, as opposed to the traditional method of determining what was required without the interaction of the community in the decision-making process. This interactive process of information sharing and knowledge is then required to gain the buy-in of the community in order to obtain sustainability with regard to HIV/AIDS. If there is no buy-in from the community the communication process will break down and this would mean the end of the participatory health communication process.

But it would appear that, as argued earlier, the community is far from being an equal player in the participatory approach. In addition, Kleinhans (1995:23) states that the 'alliance' referred to in the model can be substituted for by 'social contract'. This substitution strengthens the argument that this model does not specifically value the community as such, since the 'social contract' in Potchefstroom can be taken to refer commonly to the agreements between labour, government and business. It is even said by Kleinhans (1995:25) that there is a "break-even point" where it is believed the community will be able to participate as equals in the determination of what happens with the project - clearly this is not conducive for this approach to be as participatory as Kleinhans (1995:26) claims it to be.

Participation costs time and money, which could be spent on the products and services to be rendered in situations of poverty, which arguably relegate it to the status of a luxury. So in South Africa, at the moment it could be said that the cost of participatory activities in dealing with the AIDS pandemic are not necessary, as argued by some in the Presidential Commission on HIV/AIDS (DOH, 2001). However, the other activities not participative in nature are not yielding any remarkable results either. What is the argument that a participatory health communication strategy will not attempt to understand and explain the process better, by which the community is made aware of HIV/AIDS?

Participation is prone to destabilise existing socio-political and other systems (as is the case with the Presidential Commission on HIV/AIDS). In Potchefstroom, it is often the case that the disruption of existing systems for the development of new systems is a desired aim, for example as witnessed in the establishment of the Broad Transformation Forums in tertiary institutions currently happening in South Africa.

A major complicating factor for the participation is that communication systems, processes and views are richly interlinked with the views of the dominant group in society. To a significant extent communication can be seen as legitimising and reinforcing this dominant group against opposition that in the Marxist interpretation of history would be the poor that the participatory approach assumes to promote. The participatory approach can thus be criticised as being opium for the people, much in the same manner as trade unions are part of the machinery of the hegemonic elite. This strongly related criticism was in significant part responsible for the demise of community development whose roots were wedged in colonial history (Taylor, 1994:958; Ayee, 1993:138-141).

In Potchefstroom, application of the participatory approach by powerful business to further and maintain their hegemonic position seems to suggest that community development and the participatory approach are processes that mirror the change from imperialism to capitalism as suggested by the Marxist view of dependency. Used by the public sector (National and Local Government) whose task it is to develop the underdeveloped, the participatory approach to development does hold various advantages as mentioned in Sections 3.1 and 3.2 of this chapter, and those are advantages the study aims to integrate with the communication.

Whereas and even though, in simple analysis, it is clear that the participatory approach does not indicate a methodology to achieve community involvement and ownership of the projects. Yet, of logical conjecture, it can be seen that participatory communication attempts to overcome various problems related to mass communication as the main agent of communication in modernisation theory since it is a multi-media approach. The disadvantages of mass communication media include the inherent inequality of the source and the receiver.

The critical analysis of the participatory development could be elaborated on quite sufficiently, since the approach attempts to deal with the entire spectrum of human development issues. Instead, it is sufficient to conclude the analysis with the words of Pateman (1970:216) who states that the ultimate test of participatory development rests in the results.

This section (Section 3.4) does not attempt to negatively lay criticism against the participative approach, but simply tries to highlight to the reader that there are discrepancies in the participatory approach that need attention in order for it to succeed. Notice must be taken of these discrepancies in order for the proposed participatory health communication strategy not to fall into the same loopholes.

The relevance is that they need to find the requirement of the participatory health communication strategy; these discrepancies need to be noted, to add to the strategy in order for it to work. And it is the researcher's intention to incorporate these shortcomings into the final participatory health communication strategy in order for it to be useful in its approach to the community.

## CHAPTER 4

### METHOD OF RESEARCH

#### 4.1 INTRODUCTION

This chapter will explain the research methods and procedures used further in this study. Chapter 1 already gave an overview of the qualitative research methods used; therefore this chapter will provide the finer details (See Chapter 1, Section 1.6.2) of the methods used in the study. The theoretical statements made in chapter 2 will also guide the research methods used. These theoretical statements will be used to analyse the content of the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Document* to determine the framework within which a participatory health communication strategy can be designed (refer to section 1.6.2). These policy documents were discussed in Chapter 3. Qualitative content analysis was done on the strategy documents in order to determine the extent to which the policy documents ascribe to the principles of participatory communication. Interviews were used to determine what the current situation is with regard to the implementation of the policy documents in the community, the results of which are discussed in chapter five.

#### 4.2 QUALITATIVE RESEARCH

Creswell (1994:1) defines qualitative research methods as “an inquiry process of understanding a social or human problem (discovering something that was previously not documented, or to prove certain ideas and hypotheses in order to give them substance), based on the complex building of a holistic picture by means of words, of the informants in a natural setting”. Furthermore, literature studies are also seen as part of the qualitative research process. Literature studies also further help the researcher to formulate the hypotheses and help in formulation of ideas. The characteristics of qualitative research are discussed in section 4.2.1.

##### 4.2.1 Characteristics of Qualitative Research

Taylor and Bogdan (1984:1) and Denzin and Lincoln (1994:2) stress that the natural setting is of importance, if the researcher is to make sense or interpret phenomena in terms of the meanings that people have assigned to them. Qualitative research includes a variety of research methods

of which the semi-structured interview and qualitative content analysis were used in this study. A further aspect of qualitative research is the understanding thereof, this is discussed in section 4.2.1.1. In the rest of the section, general qualitative characteristics will be highlighted and it will be shown how they were present in this study.

#### **4.2.1.1 Understanding qualitative research**

The most important axiom of qualitative research is the understanding of phenomena (Berg, 1995:8; Sarantakos, 1994:12; Neuman, 1997:34; Anderson, 1987:27). In contrast to the quantitative approach, the phenomenologist strives for what Max Weber called 'verstehen', understanding on a personal level the motives and beliefs behind people's actions, an emphatic insight into others' attitudes (Collins & Makowsky, 1993:120; Kaufmann, 2000:467). The phenomenologist is committed to understanding social phenomena from the actor's own perspective. This implies that the researcher has to be part of the data in order to understand the reasons and motives behind the research subject's behaviour. Thus the research tries to share experiences with the research subjects in order to broaden his/her understanding of the situation at hand (Mason, 1996:4).

In this study an understanding of the function of the Municipal Health Authority's approaches to HIV/AIDS was essential. For that reason semi-structured interviews were set up with the Municipal Health Manager of Potchefstroom and the co-ordinators of the Local AIDS Council (LAC), enabling the researcher to become part of the research process, and understand the unique context that the Potchefstroom Municipal Health Authority and the LAC was operating in to achieve its goals. It also aims to determine the extent to which the policy documents are implemented in practice by the Potchefstroom Municipal Health Authority (refer to section 1.4.2).

Qualitative research should allow for flexibility in the research design where necessary. This discussed further in section 4.2.1.2.

#### **4.2.1.2 Flexibility**

Since the phenomenologist takes on different kinds of problems and seeks different kinds of answers, their research design is often formulated during the research process. Designs are changed frequently as it is often not possible to predict the outcome of the research.

Consequently the research design needs to be flexible in order to accommodate new insights and better understanding of the research problem. This, however, results in the researcher having to work in a systematic manner, documenting every procedure that was followed (Sarantakos, 1994:45; Mason, 1996:5). The qualitative research process therefore involves a researcher who gradually becomes part of the phenomena that s/he is examining.

Being a relatively new topic being researched and with little having been researched previously about the topic (refer to section 1.6.1), the researcher could make no predictions about the research beforehand (it is not the intent of the study to make predictions on the research process, but rather provide a framework of guidelines that could be used to set up participatory health communication strategies in the future). A broad theoretical statement was formulated beforehand and as the literature study was being conducted more specific theoretical statements were formulated.

Qualitative research must be conducted in a natural setting. This is discussed further in section 4.2.1.3.

#### **4.2.1.3 Natural Setting**

A further axiom of qualitative research is that it needs to be conducted in a natural setting relative to the study. For this reason the researcher tried to become part of the normal flow of events, without trying to control or manipulate the situation (Lindlof, 1995:21; Sarantakos 1994:45). The policy documents were analysed in their original state, without manipulation or any control measures at hand. The interviews were conducted in the natural surroundings of the interviewees (i.e., in the office of the Health District Manager for Potchefstroom) and this was also without control or manipulation. All questions asked were open-ended in order not to lead the interviewees to specific answers. The same questions were asked to all three interviewees.

Following the broad discussion of qualitative research, the advantages and disadvantages are discussed in section 4.2.1.4.

#### **4.2.1.4 Advantages and disadvantages of qualitative research**

Qualitative research has obvious advantages and disadvantages as is the norm with any research paradigm. The examination of the behaviour of the researched (in the case of this study, the three interviewees) in the natural setting is an advantage when compared to that of the

artificiality of many of the quantitative research designs to be found. Furthermore the qualitative research design focuses on an understanding of the phenomena, especially when the phenomenon has not yet been investigated. Likewise, when exploring the new research area, qualitative research further allows for flexible research methods whereby the researcher can explore new areas of interest without having to identify issues before the research had been commenced as was shown earlier in the section (Bloor, 1997:26; Lindlof, 1995:44-51, 143).

As far as disadvantages for qualitative research, samples used are often too small for the researcher to make generalizations beyond the sample. Often the external validity of the qualitative data is problematic for some researchers. However, it must be mentioned that the qualitative researcher often does not have the objective to generalize its findings. Even if all the data gathered may not be applicable for all situations, the researcher is still obligated to record the procedures followed, so that other researchers may follow the line of reasoning and the conclusions that were reached in specific studies (Dahnke & Clatterbuck, 1990:69; Sarantakos 1994:39).

The aim of the study was to determine a framework for participatory health communication from which a strategy could be designed which can then be applied to the Potchefstroom context. To achieve this content analysis was done on the HIV/AIDS policy documents. However, to understand the unique problems the Potchefstroom Municipal Health Authority faces with regard to the HIV/AIDS pandemic and the implementation of the HIV/AIDS policy documents in the community, interviews were conducted with a member of the LAC and the Potchefstroom Municipal Health Authority (refer to sections 4.4 and 4.5).

Having given an overview of qualitative research, the objectives are presented to the reader to give an indication of what objectives will be addressed by what research method.

The issue of validity and reliability in the study and how it is handled is discussed below in section 4.2.2.

An important issue with qualitative research is that of reliability and validity of the data. This is questioned because of the involvement of the researcher in the research environment. Often in this environment the researcher records behaviour in a manner that another researcher would do differently, thus bringing up the debate as to qualitative research being “subjective” in

comparison to quantitative as being viewed as “objective” (Neuman, 1997:327; Mason, 1996:69; Dahnke & Clatterbuck, 1990:78).

Conversely in qualitative research internal validity is enhanced by conducting the research within the natural setting in comparison with the artificial settings of quantitative research, as mentioned earlier in the section (Lindlof, 1995:44-51, 166).

Furthermore, internal validity is strengthened by including multiple sources of data collection in a research study to increase the reliability and validity of the results. By using more than one source of data (known as triangulation) it becomes possible to compensate for the limitations of another method (Anderson, 1987:27; Du Plooy, 1995:33; Sarantakos 1994:45; Bloor, 1997:39).

Triangulation can be applied in many different ways in order to prevent the possibility that qualitative research might be subjective. Furthermore the use of triangulation leads to a sense of trustworthiness to the research and the researcher. In this study data triangulation was applied as more than one data source was used, as well as methodological triangulation, as more than one research method was applied during the study.

#### **4.2.2 Reliability and Validity in this study**

For the purpose of this research two methods were used to collect the information, namely the qualitative content analysis and semi-structures interviews.

##### **4.2.2.1 Qualitative Content Analysis**

The content analysis done in this research study is likened to research done in a natural setting, as the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Documents* were analysed unobtrusively in order to enhance the validity of the documents. As they were available to the public freely over the Internet for downloading and at the various Municipal Health Offices across the country as paper copies, enhanced the reliability of the sources as it was directly available from the Department of Health and the various health offices across the country. Therefore the contents, as it appeared in the policy documents, was not manipulated in an artificial environment in order to complete the research. The method will be discussed in greater detail in section 4.4.

#### **4.2.2.2 Semi-structured Interviews**

During the semi-structured interview it was the objective of the researcher to conduct it as close as possible to a natural setting, for the benefit of the interviewee as well as for the validity of the interview results. The interview was conducted in the Potchefstroom Municipal Health Manager's office at the district clinic in Potchefstroom; this constitutes a natural work environment. This behaviour should also then be described in the context in which it occurred. Meaning is then determined by the contextualisation of the behaviour that had been studied, as meaning could occur differently in different situations and contexts. Subjectivity during the interview would be handled by following up on what was said during the interview by the respondent in the policy document this would then serve to enhance the reliability of the responses provided by the interviewees. This follow-up process would then ensure that what was being said by the respondent was indeed correct and not a personal comment. By doing this, it was then ensured that the correct information would be collected, that was relevant to the study. This method is discussed in greater detail in section 4.5.

#### **4.2.2.3 Research process**

A study was conducted in order to ensure the reliability and validity of the study as well as assuring the researcher that the methodology would be well suited for the intended use it was aimed for. The study was conducted by means of an interview with Roopa, the manager of the Potchefstroom Municipal Health Authority. This was then seen as the interview that would guide the main interviews to be conducted with all three interviewees. This initial interview was useful to the researcher in identifying loopholes in the design of the initial interview questions. These included the key concept of what is meant by participatory health communication as well as what is meant by a formal communication strategy. After an explanation was given to Roopa, he understood. However, this lead to changes being made to the interview question design. Therefore this was changed to accommodate a more simplified approach to asking the questions. Section 4.3 describes the steps followed in the design of the research for this study.

### **4.3 RESEARCH QUESTIONS, OBJECTIVES AND THE RESEARCH DESIGN**

The research questions were derived from the objectives of the study. In answering the questions it can then be assumed that the objectives of the study were fulfilled in chapter 5. For an outline to the questions asked refer to Table 4.1.

With the research design in place aiming to fulfil the objectives of the study and the study focusing on a framework for a participatory communication strategy for sustainable development in Potchefstroom, it was only obvious that the main aim would therefore be the analysis of the policy documents to determine the framework from which a participatory health communication can be designed. There was no sample for this as there were only two documents that could be analysed for the purpose of determining the guidelines for the framework, namely the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Documents*.

Once it had been decided that the Potchefstroom Municipal Health Authority would be used as a case study in this research to determine the extent to which the policy documents were implemented in the community, it was then required that permission was asked as to whether the Municipal Health Authority would agree to take part in the research study. The Health District Manager for Potchefstroom, Roopa, was contacted and a meeting was arranged where permission was asked and the objectives of the study were explained. Roopa unhesitatingly agreed to partake in the study and also immediately made his services available to the researcher. Furthermore, the researcher was invited to attend the LAC meetings once a week and Roopa suggested that interviews be held with the co-ordinators of the LAC as well.

After the Potchefstroom Municipal Health Authority had agreed to take part in the research, the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Document* were analysed by means of content analysis. Furthermore, the date for the interview with Roopa was finalized. He was also helpful in setting up the interviews with the two co-ordinators of the LAC.

The various methods that were being used in this research, is explained in section 4.3.2 and 4.3.3. But first an overview of the problem statement, objectives and theoretical statements given on page 66.

**Table 4.1 Overview: Problem statement, research objectives and theoretical statements**

**PROBLEM STATEMENT**

The problem addressed in this study is the lack of a health communication strategy for HIV/AIDS management at local municipal level in Potchefstroom. Consequently, the aim of this study is to describe a health communication strategy framework, which is based on the principles of participatory communication that is inclusive of all role-players and the community in the Potchefstroom area.

**RESEARCH OBJECTIVES**

The research questions that pertain to this study are translated into the following research objectives:

**General objective**

To propose a framework for a participatory health communication strategy for HIV/AIDS management at local level in Potchefstroom based on the requirements as set out in the national and provincial HIV/AIDS policies, aiming to contribute towards a more sustainable manner in dealing with the HIV/AIDS problem.

**Specific objectives**

1. To describe the requirements, according to the literature, for a participatory health communication strategy in a developing environment.
2. To describe the extent to which the national and provincial HIV/AIDS policies comply with the guidelines of participatory communication.
3. To describe how the policy documents are being implemented and used in practice by the Potchefstroom Municipal Health Authority.
4. To propose a framework for the proposed health communication strategy, intended for the Potchefstroom Municipal Health Authority.

**Table 4.1 (Continued)**

**THEORETICAL STATEMENTS**

**Theoretical statement 1**

Allowing people participation in the planning, implementation, evaluation and decision-making process, concerning the health communication strategy for HIV/AIDS, will empower them to benefit from / partake in the development process, enabling sustainable outcomes to the HIV/AIDS pandemic and mutual benefits for the community and Health Authority.

**Theoretical statement 2**

A participatory approach to a health communication campaign should comprise the following: entering the community; preparing to plan action; planning what to do; supporting action; and withdrawing from the community, by facilitating community participation in all levels of the development process.

**Theoretical statement 3**

When planning the participatory communication strategy, the following critical considerations need to be part of the planning phase; preconditions, leadership, conflicts, and appropriate action.

**Theoretical statement 4**

The outcomes model (bio-psychosocial model) for health communication is most suited for the basis of a health communication strategy, as it ascribes to elements key to participatory approach such as interaction, dialogical communication, attention to individuals' preferences, values, and expanded choice making.

**Theoretical statement 5**

The health communication strategy should not exclusively focus on those individuals already infected with HIV/AIDS, but focus should also be directed on those individuals not infected with HIV/AIDS.

**Table 4.1 (Continued)**

<b>Theoretical statement 6</b> A participatory health communication strategy regarding HIV/AIDS should follow the USAIDS guidelines.
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Table 4.1 provides the reader with the summary of the theoretical statements, research questions and the research methods. This is relevant to orientate the reader again as to what the objectives of the research are.

The following table provides a summary of the theoretical statements, research questions and the research methods used in the study.

**Table 4.2 Summary of the theoretical statements, research questions and the research methods**

<b>Summary of the Theoretical Statement, research questions and the Research Methods</b>		
<b>Question</b>	<b>Theoretical Statement</b>	<b>Methods</b>
Question 1	None	Literature Study
Question 2	Theoretical Statements 1; 2; 3; 4	Content Analysis
Question 3	Theoretical Statement 1	Interviews
Question 4	Theoretical Statements 1; 2; 3; 4; 5; 6	Synthesis on Questions 1, 2 and 3

The above two table's gives an overview of the theoretical statements, research questions and the research methods used. Having done the summary the discussion of the research methods (Content Analysis and Semi-structured Interviews) follows in section 4.4 and 4.5.

#### **4.4 ANALYSIS OF THE POLICIES**

Content analysis is a research method that can be used to reach a scientific conclusion on content from books, magazines or any other written content like Internet webpage's. It attempts to determine the presence of words, ideas, thoughts, concepts and themes that the writers are attempting to portray to the reader (Wigston, 1995:69). Although the content analysis can be used quantitatively, it is used qualitatively in this study only as an indicator of meaning as opposed to the role that it plays in the quantitative research of quantifying and measuring. The

use of qualitative content analysis is explained in the following section. The policies analysed were the following, *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* (Annexure A) and the *Provincial Council on AIDS, North West Working Document* (Annexure B) (see Annexure A and B).

#### **4.4.1 Qualitative content analysis**

Naudé (2001:102) citing Berelson (1952:114-128) and Wimmer and Dominick, (1991:46) give insightful ideas that help the researcher distinguish between the qualitative and quantitative content analyses.

- **Quasi-quantitative**

In many cases, qualitative analyses are described as “quasi-quantitative”, as they still contain quantification in a rough format. Descriptions of this may include the following: “repeatedly”, “rarely”, “never”, “often” and many others. These statements are not as precise as that of quantitative research where specific numbers will be used, but the implication is that the method used to reach these frequency statements should also be different. A more precise statement would need a more careful and precise method whereas the less precise and broad statement would use a more impressionistic method.

In this study use was made of qualitative principles, as the content analysis did not make use of any method of quantification. As only two HIV/AIDS policies were studied, the emphasis was determining the presence of the participatory approach in the policy documents, in order to be used to set a framework that could be used to design a health communication plan.

- **Presence-absence of content rather than frequencies**

Focus in qualitative content analysis is often directed at the presence or absence of content (Wimmer & Dominick 1991:46). This study will focus on the absence or presence of the participatory health communication principles and initiatives with regard to HIV/AIDS in the policy documents. It will also focus on the requirements of such initiatives to be implemented by the local government at grass roots level in the community in the fight against HIV/AIDS.

- **Small samples**

According to Naudé (2001:103), qualitative content analyses usually focus on small or incomplete samples or use the full population if it is very small, for example a case study. This often leads to problems with external validity, because of the issue with generalizations that cannot be made. There was no sample in this study; it made use of the only two relevant HIV/AIDS policies namely: *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* (The National HIV/AIDS Strategy Policy Document for South Africa) and the *Provincial Council on AIDS, North West Working Document* (The North West Provincial HIV/AIDS strategy policy document), in order to determine the presence of the participatory approach in the documents.

- **Less formalized categories**

Qualitative research makes use of less formalized categories as precise quantification is not the objective of the research. This study identified categories which were loosely defined; other categories were added as the study progressed. In light of this, this study may seem to make use of less systematic and less precise analysis, but it could be argued that it in fact makes use of more precise and relevant analysis, as it was not defined, according to rigid sets of categories and definitions. Therefore the interpretations are more subtle and individualised as the researcher is part of the content and not estranged by the categories (Sarantakos 1994:45; Naudé 2001:104).

The policy documents were analysed according to the categories in order to sort the data into broader themes and issues according to the research objectives of the study (Maxwell, 1996:78, Badenhorst, 2002:56).

At the start of the content analysis specific categories were set up, according to the specific theoretical statements of the study (see section 3.3.2.1). Following this the main categories in the framework were described and broadly defined taking into account the theoretical background of Chapter 2. This process proved sufficient for the studies' objectives, and therefore the categories and definitions were set for the analysis of the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* and the analysis of the *Provincial Council on AIDS, North West Working Document*.

As had been mentioned before the content analysis had not been to focus on counting or measurement, or coding as such. The categories were broad and were meant to classify specific aspects applicable to the theoretical foundation of this study.

#### **4.4.1.1 Category guidelines**

According to Badenhorst (2002:57) and Mason (1996:77), the category guidelines serve the same purpose as the data sheet would serve in a quantitative content analysis. The category guidelines helped the researcher take into account all the relevant aspects with regard to the content in the policy documents and comparing it with the research objectives.

Table 4.3 on page 72, provides a summary that enables the reader to see the linkage between the theoretical statements found in chapter 2 and the content analysis categories found in section 4.4.1.2 of this study.

#### **4.4.1.2 Broad definitions**

The following four categories are defined according to the aforementioned literature. They have been formulated into tabular format for easy reading. The categories are as follows: *Planning and strategy selection*, *Requirements of participatory communication*, *Elements of a health communication strategy* and *Critical considerations with regard to health communication*. Table 4.3 on page 72, identifies the sub-indicators which will be used in order to determine the presence of these categories in the policy documents. Table 4.4 on page 74 provides a summary to show the linkage between the Theoretical Statements and the category guidelines in Table 4.3.

This contextualizes the categories for the content analysis to orientate the reader as to what the researcher was looking for in the policy documents. The table also provides the sub-indicators which will help identify the key categories of the content analysis.

**Table 4.3 Categories used in the analysis of the policy documents**

<b>Category</b>	<b>Indicator</b>	<b>Sub-Indicator</b>	
<b>1</b>	<b>Planning and strategy selection</b>	<b>Planning</b>	What is the process to be followed?
			What are the requirements for the planning?
			What are the aims of the planning?
			What is the final product of the planning phase to be?
		<b>Decision making</b>	What type of interaction is going to take place?
			What are the focus areas for the decision-makers?
			What are community's needs?
		<b>Who is involved</b>	Will the target group be involved in the process?
			Is it to be community members?
			What is the role of the Health Authority and Local AIDS Council?
		<b>How is it going to be implemented?</b>	Is it going to be implemented by the Local AIDS Council?
			Is it going to be implemented by the People living with AIDS?
			Is it going to be implemented by the Non-governmental Organizations?
			Is it going to be implemented by the Community Based Organizations?
	<b>How will it be evaluated?</b>	How will the outcomes be measured?	
		Are the outcomes achieved?	
		What is the process for evaluation?	
		What are the aimed successes?	
<b>2</b>	<b>Requirements of participatory communication</b>	<b>Entering the community</b>	Is there research done before to determine needs?
			Is a relationship built with the community?
			Interaction between Authority and community?
		<b>Preparing plan</b>	Are the needs of the

			community integrated in the initial plan?
			Does the planning revolve around the communities needs?
		<b>Planning what to do</b>	How will the communities' needs be addressed?
			What will process entail?
		<b>Supporting action</b>	Will there be support to the community once the strategy in place?
			Will there be assistance and follow-ups with the community to determine progress?
			In what shape will this assistance be?
		<b>Withdrawal</b>	Is the community then allowed to handle the process?
			Is provision made for the Health Authority to hand over the process to the community?
<b>3</b>	<b>Elements of a health communication strategy</b>	<b>Will there be interaction?</b>	Is interaction a requirement?
			What types of interaction encouraged?
			What are the aims of the interactions?
		<b>Is dialogical communication a requirement?</b>	Must dialogue exist between community and Health Authority?
			What will the dialogue entail?
			What must be achieved by the dialogue?
		<b>Are the individual's values important?</b>	What are values?
			What is the role of the values?
		<b>Expanded choice by the individual in the process</b>	Is free choice present?
			Does the individual get to choose what they need?
<b>4</b>	<b>Critical considerations with regard to health communication</b>	<b>Individuals already infected but also those individuals not yet affected</b>	Who are the target groups at whom the strategies should be directed?
			Will the focus be on

			awareness or prevention?
			What are the aims of the HIV/AIDS policies?

Table 4.3 provides the categories used in the content analysis as well as the sub-indicators that helped identify the main categories in the policy document. Table 4.4 provided the linkage between the theoretical statements and the category guidelines of the content analysis.

The following table provides a summary of the theoretical statements and the category guidelines used during the content analysis.

**Table 4.4 Summary of the theoretical statements and the category guidelines used during content analysis**

<b>Summary of the Theoretical Statements and the category guidelines used during Content Analysis</b>	
<b>Category Guidelines</b>	<b>Theoretical Statements</b>
Planning and strategy selection	Theoretical statement 1 (p 18)
Requirements of participatory communication	Theoretical statement 2 (p 30)
Elements of a health communication strategy	Theoretical statement 4 (p 34)
Critical considerations with regard to health communication	Theoretical statement 5 (p 36)

The above two tables have summarized the content analysis guidelines and the link between the theoretical statements. Having concluded the content analysis, semi-structured interviews is discussed in section 4.5.

#### **4.5 SEMI-STRUCTURED INTERVIEWS**

Interviews in the qualitative research paradigm should not be viewed as purely questions that are asked to the interviewee to derive some sort of reaction. Rather, it must be viewed as a conversation that has an end purpose. Since it has a feel of a conversation between friends or peers, it should be loose, informal, interactive, open-ended and emphatic (Mason, 1996:35; Pitout, 1995:111). For the purpose of this study, semi-structured interviews were used to answer research question 3. It aimed at determining the extent to which the policies have been implemented and used in the community.

Viewed broadly, interviews follow many aspects of an ordinary conversation; there are turns for speaking and listening, smooth transition between subjects and people. However, key differences between ordinary conversation and interviews can be summed up as follows: the interviewee is expected to do more of the talking in order to provide in-depth information. If the interviewer is not satisfied with the answer there are usually follow-up questions to show the interviewee the depth of the information that is required. Furthermore, during the course of the interviewing process the interviewer will take notes or tape recordings which are normally not present in a normal conversation (Rubin & Rubin, 1995:124,125; Badenhorst, 2002:78; Severin & Tankard, 1985:26).

In addition, the interviewer acts as a participant observer. This exchange of communication between the interviewee and interviewer contains a lot more information than the physical act of communicating. Non-verbal cues and a variety of other contexts influence the way the communication process takes place. During the process the interviewer has the task of determining the course of the conversation (Mason, 1996:38; Badenhorst, 2002:78; Neuman, 1997:57).

Since one of the aims of the study was to determine what the requirements would be for a participatory health communication strategy for HIV/AIDS, the semi-structured interview would allow the researcher to ask open-ended questions that allow for elaboration on responses given by the interviewee. During the interview, the respondent was constantly asked to give examples, or illustrate their responses in order to show the researcher that the interviewee had understood the question. Further it served to ensure the researcher also understood what was being implied by the interviewee (Rubin & Rubin, 1995:125-127; Badenhorst, 2002:79).

The procedures used during the interview are explained in greater detail in Section 4.5.2. The interview questions are provided in section 4.5.1 on page 76.

#### 4.5.1 Interviewing questions

##### **Semi-structured interview questions**

- 1) Does the Municipal Health Authority have a communication strategy? If yes, what does it entail and how is it implemented? If no, how does the Municipal Health Authority communicate HIV/AIDS initiatives?
- 2) If no to Question 1, then would you say that the Municipal Health Department would benefit from a proper communication strategy with regard to HIV/AIDS?
- 3) Who developed / created the existing communication strategy / initiative (individual / team / involvement of communication specialist)?
- 4) Was any research done to ascertain what would work in such a strategy?
- 5) Can you please describe your view of the current communication process between your organization (Municipal Health Authority) and the community with regard to the HIV/AIDS pandemic?
- 6) Would you say that the Municipal Health Authority had any successes (if any) with the current communication strategy / initiative used?
- 7) Does the Municipal Health Authority monitor the communication /strategy/initiative? If yes, how is it done? If no, would the Municipal Health Authority benefit from monitoring the communication strategy / initiative?
- 8) Does the Municipal Health Authority follow the guidelines set out in either the HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005 or the Provincial Council on AIDS, North West Working Document? If so how is this done?
- 9) How important would the following aspects be with regard to communication strategy for the Municipal Health Authority? For example participatory communication / needs and interests of ordinary people?
- 10) What would the Municipal Health Authority's expectations be with regard to a communication strategy for HIV/AIDS?

#### **4.5.2 Procedure followed during the interview**

Three interviews were conducted, one with the Manager of the Potchefstroom Municipal Health Department, Mr. Mahesh Roopa, one with each of the two co-ordinators of the LAC Mr. James K. Motholosa and Mr. Kwena Mabotja. The interviews with the three respondents were held at the Municipal Health Department Manager's Office at the local clinic. It must be mentioned that meetings were held with the Manager prior to the study being started in order to determine the feasibility of the study and to acquire background information on the implementation of the policy documents in order to write the proposal for the study. Furthermore the researcher was invited to LAC meetings where the Manager was chairperson for the Councils. It was at these LAC meetings that Roopa introduced the researcher to the two co-ordinators of the LAC. Roopa also helped arrange the interview with the two co-ordinators of the LAC. All these meetings held prior to the actual interview for the research study, built a rapport with the Potchefstroom Municipal Health Department Manager and the co-ordinators of the LAC, and gained their trust.

Each was conducted over a period of one day. Time intervals between the interviews were lengthy due to the researcher making notes of the content gathered during the interviews. This is recommended by Rubin and Rubin (1995:126) so allowing the researcher to remember what was said during the interview as well as highlighting key concepts presented by the interviewee.

Starting the interview, the aims and objectives were explained, and how the Potchefstroom Municipal Health Department would benefit from the study. After the introduction and the explanation of the aims and objectives the study and interview, the interview was started.

The only problems experienced during the interview process were detected during the initial study (refer to section 4.2.5). Key terms such as participatory health communication and communication strategy were not immediately recognizable for the Health District Manager (refer to section 4.5.2.1). Hence, no other problems were experienced with the interviews and therefore the process can be seen as achieving the objectives determining what the framework for a proposed health communication strategy should be according to the principles contained in the literature on participatory communication and the National and Provincial HIV/AIDS policies and to what extent do the National and Provincial HIV/AIDS policies comply with the guidelines of participatory communication.

#### **4.5.2.1 Interview 1 – Mr. Roopa**

As mentioned previously the Health District Manager for Potchefstroom was co-operative and willing to provide the required documentation and information for the completion of the study. During the interview Roopa willingly answered all the questions even though the interview was relatively time-consuming (+/- 80 minutes). It must be noted that the interview was held in a discussion format, where the interview was a process of speaking and listening, smooth transition between subjects and interviewer and interviewee, with many follow-up questions to show the interviewee the depth of the information that is required. Furthermore, having built an understanding with Roopa beforehand facilitated the interview to be held in the above-mentioned conversational manner.

As in most cases Roopa elaborated on certain questions which then automatically progressed to the other questions. The Health District Manager for Potchefstroom was not stopped but was allowed to carry on, explaining the issues or ideas as was wished. In many cases when responses were unclear the researcher probed Roopa for more elaborate answers and in many instances requested that the Health District Manager make use of examples to illustrate certain points.

#### **4.5.2.2 Interview 2 - Mr. Motholosa**

The interview with Motholosa was without incident. During the interview Motholosa willingly answered all the questions. He answered the questions quickly and to the point, often requiring the researcher to prompt him for further elaboration, as his responses were limited to yes/no responses and “I don’t know”. Motholosa’s interview lasted approximately 30 minutes. The atmosphere the interview was conducted in was very formal and the same openness as was experienced with the Roopa interview was not present in this interview. The interviewee seemed as if he was pressed for time and didn’t really want to be part of the interview. Motholosa did not provide any relevant information to the study. All the information supplied by Motholosa was a repetition of the information collected during the interviews with Roopa and Mabotja.

#### **4.5.2.3 Interview 3 - Mr. Mabotja**

The interview with Mabotja on the other hand was very different, and was in many cases an exact opposite the interview conducted with Motholosa. An open atmosphere was evident throughout the interview. Mabotja often made jokes and it can be said that he thoroughly

enjoyed the process. Yet it must be mentioned that although the mood was jovial at times, when discussing matters of importance, Mabotja was serious and provided the required information. Time wise the interview took roughly about 40 minutes to complete. There were no problems experienced. Mabotja was keen to elaborate and often the researcher had to intervene to prevent the interviewee (Mabotja) from discussing other important issues but ones not relevant to the current study.

## **4.6 PROBLEMS ENCOUNTERED**

### **4.6.1 Content analysis**

No problems were experienced during the content analysis. The documentation was freely available on the Internet (<http://www.doh.gov.za/doc/policy-f.html>) and from the offices at the Municipal Health Department. The policy documents (*HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* and *Provincial Council on AIDS, North West Working Document*) were analysed before conducting the interview so as to determine categories and research questions for the interviews.

### **4.6.2 Interviews**

No problems were experienced during the interviews. The interviewees were willing to participate in the study and arranging the specific date for the interview to take place was also not a problematic issue. It must be mentioned that the interviewees were helpful and did not mind providing the interviewer with information and content for the study. The initial categories for the interview questions for the study were sufficiently represented in the documentation and no more categories could be identified. The interviews were conducted smoothly and the interviewees understood what was being asked. Some confusion was found in interviewees' response that necessitated the need for follow-up questions to the interviewees so that clarity could be gained on the response that was given.

## **4.7 SUMMARY**

Chapter four described the method used to carry out the research for this study. During the study use was made of a qualitative research paradigm. Qualitative content analysis and semi-structured interviews were the data collection methods used in this study.

The Policy documents of the National Government and the Local Government (*HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005, Provincial Council on AIDS, North West Working Document*) were analysed. After this method, semi-structured interview was discussed as it was to determine to what extent the policy documents had been implemented by Potchefstroom Municipal Health Authority in the community to deal with HIV/AIDS. This method was discussed in detail in section 4.5.

The data gathered during the interview and the content analysis stage is discussed in chapter 5.

## CHAPTER 5

### DISCUSSION OF RESULTS

#### 5.1 INTRODUCTION

Various research methods (See Chapter 4, Section 4.3) were used in this study to collect the necessary information, in order to answer the research questions as stated in Chapters 1 and Chapters 4. Three different sources namely; the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*, the *Provincial Council on AIDS, North West Working Document* and three interviews were conducted to determine the guidelines for a health communication strategy in a developmental context. Furthermore, an analysis of the policy documents (*HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*, *Provincial Council on AIDS, North West Working Document*), were conducted to obtain background and provide the lawful existence from which the participatory health communication strategy would be based.

It was also done in such a manner to obtain whether these policies comply with what is stated in the literature. The results of the content analysis are discussed according to the categories identified in chapter 4 (See Table .4.3). As a penultimate step, semi-structured interviews were conducted with the Health District Manager for Potchefstroom and the co-ordinators of the Local AIDS Council (LAC) in Potchefstroom. These interviews were conducted to lessen any uncertainties that might occur, as well as to verify information that was obtained by the other methods used.

The information that was collected by the above-mentioned methods, were integrated and the findings are interpreted according to the specific objectives set out in the beginning of the study (refer to section 1.4) in order to prevent any overlapping of information.

The conclusion and final integration for the study is done in chapter 6, whereby the general objective of this study is discussed (refer to section 1.4.1) and final recommendations are made.

## **5.2 FINDINGS**

Potchefstroom Municipal Health Authority is part of the Potchefstroom City Council which is located on the south eastern border of the North West Province, 116 km from the rapidly growing Gauteng Province.

The Potchefstroom Municipal Health Authority serves the following communities in the area, Ikageng, Promosa, and Mohadin as well as the greater Potchefstroom Area. Focus is given to the Ikageng community by the Health Authority because according to the Development Research Unit at the University of Potchefstroom (2000:3), Ikageng faces the largest threat from HIV/AIDS, in the greater Potchefstroom Area.

Information collected from the interviews with the Health District Manager for Potchefstroom, indicates that the southern region of the North West Province, where Potchefstroom lies, had the highest HIV prevalence of 28.4% during the year 2002. In light of this then the Health Authority focuses the majority of its attention on the Ikageng community. The Potchefstroom Municipal Health Authority also heads the Potchefstroom LAC as set out in the Provincial Council on AIDS, North West Working Document Policy.

The results are discussed according to the research methods used. This is done in sections 5.2.2 and 5.2.3.

### **5.2.1 Content Analysis**

The results that were determined by means of the content analysis will be discussed according to the categories defined in section 4.4.1.2 and in Table 4.3. The results have been structured in order to show whether the specific categories have been answered by the content analysis.

#### **5.2.1.1 Planning and strategy selection**

This category aimed to determine what the requirements would be in the planning and strategy selection phase. The categories of planning, decision-making, who is involved and how is it going to be implemented? And how will it be evaluated? Will be used to identify what is required during the planning and strategy selection phase.

- **Planning**

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* policy regarding participation as a approach to development that includes all role-players' in the development process. Not only that, before any new development enterprise is initiated, there must be a planning phase where the needs of the community is assessed on a grass roots level. Once the needs have been assessed, all the role-players need to be integrated to empower the community to take hold of the development process. It must also be noted that the policy documents don't give specific steps as to how to achieve the participative process. It is stated that the process must be based on its own initiatives.

Also the documentation and the literature both state the role-players must liaise first with the community before the development is implemented to determine their needs and requirements. Furthermore the role-players in the LAC must also implement the development programmes and monitor if the programme is succeeding in what it aimed to achieve.

- **Decision-making**

Since the study focuses on participatory health communication in dealing with development, the participative element is included in the planning process as part of the environmental analysis, identification of key issues, strategy implementation and evaluation and monitoring, this has also been identified in the two policy documents analysed. All these factors would require an organisation to interact with the community to first identify the key issues within that community, secondly how the strategy would be implemented (hence the role of the LAC in the process) and lastly the evaluation and monitoring phase, which would require the organisation to interact on a grass roots level to determine the success of their strategic planning.

- **Who is involved?**

All documentation and especially the *Constitution of the Republic of South Africa 1996* (refer to section 1.1) state that when the governmental institutions are planning developmental initiatives they need to make provision for participative development initiatives that must be at their own initiative. The Municipal Structures Act (117/1998) goes even further in stating that the participative development process must include all the role-players and peoples at grass roots. Furthermore the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* together with the

*Provincial Council on AIDS, North West Working Document*, make provision for the inclusion of the community and all role-players to combat HIV/AIDS.

All these role-players are allowed to participate in the AIDS Councils on a National, Provincial, and Local level. However, there is no specific reference made to the community having a place on these councils; they are to be represented by the NGOs (Non-Governmental Organisations) and CBOs (Community Based Organisations).

- **How is it going to be implemented?**

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* policy makes provision for the establishment of LAC which are designed to gain information from the NGOs and the other role-players on community needs. It is also the tool used by government to implement new programmes from a national level, again because of the influence the various role-players have in the community.

Nevertheless it must be noted that the literature states that participatory communication should be part of the health communication process (refer to section 2.2 and 2.3), and for the communication strategy to happen the strategic planning process must first be in place, as this phase identifies the objectives, mission and vision of the organisation without which the organisation would have no direction. Once this has then been set up the participatory health communication strategy will then be utilised to reach these goals.

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* lays out the structure for the LACs and what the major focus areas are for these LACs in the fight against HIV/AIDS. It also establishes basic conditions that must be met within the period that the strategic plan was set up for. It determines that the youth are the major target for development initiatives with regard to the HIV/AIDS pandemic as the youth are the future for South Africa.

- **How will it be evaluated?**

The policy makes provision for the evaluation of how the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* is implemented by the Local Councils to occur every 3-4 months. The aim being that the Local Councils will be evaluated and provided with a evaluation point which would count in its allocation of funds from the Health Ministry. This would require the Local

Councils to implement the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* policy in their communities.

#### **5.2.1.2 Requirements of participatory communication?**

This category aimed to determine whether the categories of *entering the community, preparing plan, planning what to do, supporting action, and withdrawal* are present in the policy documents to determine if participatory communication requirements are present in the document. The results determined by this category can, however, not be discussed according to the various sub-indicators as no specific details are present for the individual indicators. Hence, it is summarised and the details are provided below.

The *Provincial Council on AIDS, North West Working Document*, however, focuses on the structure of the LACs and who should be represented on them. It also takes the objectives outlined in the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* and proposes that the LACs incorporate these objectives in their structure and that they achieve these objectives within the five year period as envisaged by the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*. The other documentation makes no reference to the LACs and policies on HIV/AIDS. This objective is only highlighted in terms of the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* and *Council on AIDS, North West Working Document*, and these are the only two documents focusing on HIV/AIDS specific to this study.

However, it is envisaged in the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* that the LAC will encompass all the major elements as described in the category indicators. This being, entering the community, preparing the plan, planning what to do, supporting action, withdrawal.

*“...its major functions are to: (a) advise government on HIV/AIDS/STD policy, (b) advocate for the effective involvement of sectors and organisations in implementing programmes and strategies, (c) monitor the implementation of the Strategic Plan in all sectors of society, (d) create and strengthen partnerships for an expanded national response among all sectors, (e) mobilise resources for the implementation of the AIDS programmes, and (f) recommend appropriate research...”*

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* also makes provision that monitoring, research and surveillance is part of the four priority areas of the strategy. When setting up a strategy, it identifies the process by which the priority can be achieved and is set out below. The process as set out in the policy documents doesn't following the same chronological order as set out in the policy documents. The chronological order used below is relevant for the proposed application of strategy guidelines in this research. Therefore Priority 1 is identified as research, monitoring and surveillance.

### **Priority Area 1: Research, monitoring and surveillance**

Goal 1: Ensure AIDS vaccine development

Goal 2: Investigate treatment and care options

Goal 3: Conduct policy research

Goal 4: Conduct regular surveillance

\* Please note that Priority area 1 as used in this study is referred to as Priority area 3 in the policy document (*HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*). Goals 1, 2, 3 and 4 are referred to as Goal 10, 11, 12 and 13 respectively in the policy document as well.

These are the key areas in the strategy process with regard to participatory communication strategy. The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* policy does not go into detail about withdrawal from the community, supporting action and planning what to do.

Thus the document broadly ascribes to a participatory approach, but does not give any detail on how participatory communication could be achieved.

#### **5.2.1.3 Elements of a health communication strategy**

The category identified what the requirements would be of a health communication strategy. The content analysis identified the following with regard to the health communication strategy.

- **Will there be interaction?**

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* policy stated that interaction at all levels was critical for any strategy to succeed. It went further in stating that strategies must aim to develop holistic approaches aiming for education and care in a sustained manner. All the

sections of government and civil society must be involved in the strategy creation and implementation. Any strategy aiming at HIV/AIDS must accelerate capacity building empowering the individual to take control of the situation. Most important though was the statement that:

*“...people with HIV/AIDS must be included at all levels of the strategy creation and implementation as well as full community participation in prevention and care...”*

This statement therefore reinforced the concept of participation at all levels must be present and it must include those individuals living with HIV/AIDS and those not infected with the pandemic yet.

- **Is dialogical communication a requirement?**

Dialogical communication was mentioned, but it was not elaborated on in depth in the policy document. The policy document simply stated that dialogical communication must be present in the strategy creation phase. It did not elaborate on what must be achieved by the dialogical communication, neither how it must be implemented.

- **Is the individuals values important?**

The individual's choice is more centred towards the choice of the individual in deciding whether they want to “*Come out*” into the open as being HIV positive. No mention is made of freedom of choice to participate and interact in the decision-making process.

Values are critical to the policy. In terms of the category identified, individual values are key to the policy. All strategies should aim to change values and attitudes of people infected as well as those not infected by HIV/AIDS. Most importantly the strategy must make provision to track changes in the values and attitudes of the people. As identified the policy also states that people's attitudes to those infected with HIV/AIDS must also change. There must be a social acceptance of those infected by the community they live in. This needs to be a critical consideration in any strategy.

Not only is this a critical consideration, it is an issue that is repeated continuously throughout the policy document.

- **Expanded choice by the individual in the process**

The *Provincial Council on AIDS, North West Working Documents* policy only mentions that all sectors of the civil society must be involved in the implementation of response programmes and strategies in the prevention and mitigation of the impact HIV/AIDS has on the North West Province. It also goes as far as stating that partnerships for an expanded response among government agencies, NGOs, donors, the private sector, and people living with HIV/AIDS must all get involved in actively forming alliances to fight the pandemic. No mention is made per se about the individual choice in the process. It does, however, allow for expanded choice by the community that can then be viewed as the individual expanded choice in the process as the communities' values and beliefs can be based on what the individual is feeling.

These statements were, however, stated in the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*. However the *Provincial Council on AIDS, North West Working Documents* does state that the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* will be used as a reference guide to guide the North West province in their strategy creation process.

#### **5.2.1.4 Critical considerations with regard to health communication**

This category only identified one sub-indicator. There is only one sub-indicator identified because it is required to determine what the critical considerations are when dealing with those individuals already infected as well as those not yet infected. It is an issue that must be dealt with in a whole as opposed to two different problems. The result for this category is discussed below.

- **Individuals already infected but also those individuals not yet affected**

This category identifies the need to determine what the critical consideration would be when planning the participatory health communication strategy. The need was to determine whether the focus will be on those individuals already infected or whether the focus was to be on those not yet infected. Therefore when the content analysis was done, it aimed at guidelines to the above category by determining who the target groups would be of the health strategy, where the

focus would lie of the health communication strategy (prevention or awareness) and what the main aims of the policy were with regard to the health communication of HIV/AIDS.

In light of the above the following was identified in the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* policy.

Youth below the age of 18 are the main target groups with regard to both prevention and treatment campaigns, but with major emphasis on the prevention of HIV/AIDS and to curb teen pregnancies. However, it was also identified that attention must also be given to reduce the impact of HIV/AIDS amongst the family members, community members and individuals already infected with HIV/AIDS.

The document also states that strategies must aim to be structured in such manners that that they are specifically set up for prevention, treatment, care and support. These are the key aims of the strategy and must be carried through all other strategies stemming from the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*.

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* policy document further identifies priority areas which strengthen the ideal that emphasis must be placed on both prevention and treatment of HIV/AIDS. As mentioned in section 5.2.2.2., the way the priority areas are set out in the policy documents does not follow the same chronologic as the guideline of the content analysis. The priority areas are outlined as follows in the policy document and provide guidelines as to how to achieve these priorities (refer to the Annexure A; p18 – 24):

**Priority area 2: Prevention**

Goal 5: Promote safe and healthy sexual behaviour

Goal 6: Improve the management and control of STDs

Goal 7: Reduce mother-to-child transmission (MTCT)

Goal 8: Address issues relating to blood transfusion and HIV

Goal 9: Provide appropriate post-exposure services

Goal 10: Improve access to Voluntary HIV Counselling and Testing (VCT)

\* Please note that Priority area 2 as used in this study is referred to as Priority area 1 in the policy document (*HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*). Goals 5, 6, 7, 8, 9 and 10 are referred to as Goal 1, 2, 3, 4, 5 and 6 respectively in the policy document as well.

### **Priority area 3: Treatment, care and support**

Goal 11: Provide treatment, care and support services in health facilities

Goal 12: Provide adequate treatment, care and support services in communities

Goal 13: Develop and expand the provision of care to children and orphans

\* Please note that Priority area 3 as used in this study is referred to as Priority area 2 in the policy document (*HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*). Goals 7, 8 and 9 are referred to as Goal 11, 12 and 13 respectively in the policy document as well.

These priorities will therefore be used as part of the broader strategy guidelines in chapter 6.

The *Provincial Council on AIDS, North West Working Documents* policy document, however, does not go into as much detail as the *HIVAIDS/STD Strategic Plan for South Africa 2002-2005*. However, what it in fact does is make direct references to the *HIVAIDS/STD Strategic Plan for South Africa 2002-2005*, stating that the policy document will be used as reference and as a guideline when planning any new HIV/AIDS initiative. Its main focus is also on ensuring that attention is paid to prevention, information, education, communication and social mobilisation.

These aims are the same as stated in the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*; the only difference is that it is worded differently. It also does not make direct reference as to whom the target groups would be, but it can be argued that it does reference back to the national HIV/AIDS policy document, the *HIVAIDS/STD Strategic Plan for South Africa 2002-2005*, therefore their focus would be the youth as well.

In conclusion, the two policy documents can be summarized as follows. The *Provincial Council on AIDS, North West Working Documents* itself does not make direct reference to targets within the policy document. What it does do is reference back to the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* for more in-depth help when setting up a strategy.

The *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* on the other hand gives and in-depth guide as to what the main priorities are with regard to a HIV/AIDS strategy. It identifies who the key target groups would be and also states that prevention and treatment must be key to the strategy. It also provides a detailed guide as to how the priorities are to be achieved.

Therefore, when planning a participatory health communication strategy, youth below the age of 18 must be seen as the main target group. Focus must be on prevention in the target groups specifically aimed at the prevention of pregnancies in teenagers. It must further also aim to lessen the impact that HIV/AIDS has on the community, family and individual living with HIV/AIDS. This can be viewed in terms of treatment, which can take the form of counselling, education or social mobilisation as stated in the *Provincial Council on AIDS, North West Working Documents*.

#### **5.2.1.5 Summary**

As mentioned in previous sections the policy documents did recommend that dialogue-oriented strategies be used in the development of strategies in the fight of HIV/AIDS.

To summarise the following can then be deducted and concluded;

- The Health Authority has to integrate the objectives; mission and vision of the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* into its own strategy to form part of its mission and vision (refer to 2.2.2). In order for it to formulate a strategic plan it must have a mission and vision.
- Thereby the National Government has set out certain objectives which the Health Authority can then integrate into its existing mission and vision objectives.
- The *Council on AIDS, North West Working Document* then provides the framework for the LAC which can be integrated in the Health Authority Strategic planning framework by providing the tool by which the Health Authority does its environmental analysis, identification of key issues, strategy implementation and evaluation and monitoring. In the final recommendation this aspect will be discussed further.

The Potchefstroom Municipal Health Authority has the LAC in place, therefore it can utilise it as it was envisaged to be specifically for the use in a strategic function in combating HIV/AIDS by utilising all facets of the environment, if the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* is studied thoroughly.

## 5.2.2 Semi-Structured Interview

The results that were determined by means of the semi-structured interview will be discussed according to the interview schedule defined in section 4.5.1.

Since the study was aiming to determine what the requirements would be for a participatory health communication strategy for the HIV/AIDS, the semi-structured interview allowed the researcher to ask open-ended questions that allow for elaboration on responses given by the interviewee. These responses would also serve to establish the validity of the results established in the content analysis section, as well as determining to what extent the policy documents are used in the Municipal Health Authority.

The answers were transcribed by the researcher during the three interviews. The results are now discussed in the sections below according to the transcribed notes taken during the interviews.

### 5.2.2.1 Question 1 - Does the Municipal Health Authority have a communication strategy? If yes, what does it entail and how is it implemented? If no, how does the Municipal Health Authority communicate HIV/AIDS initiatives?

It seems as if the Potchefstroom Municipal Health Authority had based its objectives on the two policy documents as set out by the National and Provincial governments according to the interview conducted with Mr. Mahesh Roopa, Health District Manager for Potchefstroom. One important factor that did come out of this question though was the fact that Potchefstroom Municipal Health Authority makes use of dialogue-oriented approaches as set out in the policy documents, by the means of the LACs and the various sectors involved in the Council. The main advantage is that language can be tailored more closely to the needs of the audience, and there is an opportunity for 'receivers' to ask questions that are directly related to their own context. However according to Roopa,

*“...the Potchefstroom Municipal Health Authority realises the objectives that are set out in the various policy documents, but the Potchefstroom Municipal Health Authority as such has no specific guidelines or communication strategy in place for the implementation of the development programmes, let alone a communication strategy. There is a realisation from the Authority that to combat HIV/AIDS a participative strategy needs to be followed...”*

This sentiment was echoed by Mr. Kenneth Motholosa and Mr. James Mabotja, the two co-ordinators of the LAC. The answers provided by the interviewees are the same as set out in the two policy documents *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* and the *Council on AIDS, North West Working Document*.

The two co-ordinators of the LAC, stated that by means of the LAC they were able to implement the new objectives set out in the policy documents, but in most cases the approach was unco-ordinated and the process eventually broke down. This led to objectives that were already achieved to be discarded as there was no way of co-ordinating the process and the achievements. According to the two co-ordinators of the LAC this results in that there are no means of building on previous achievements.

#### **5.2.2.2 Question 2 - If no to Question 1, then would you say that the Municipal Health Department would benefit from a proper communication strategy with regard to HIV/AIDS?**

It was also mentioned by Roopa, that a participatory health communication strategy will greatly contribute in solving this issue that is currently being faced by the Potchefstroom Municipal Health Authority, and also if the participatory health communication strategy could address the integration of the LAC into the planning, implementing and monitoring phase that would be even better as the Potchefstroom Municipal Health Authority does not have resources and thus by utilising the various agents in the Potchefstroom Municipal Health Authority at least then the Authority would be able to manage the situation successfully.

Furthermore he stated,

*“...a clear communication strategy is required in order to maximise the implementation of a strengthened care and support programme for South Africa. This communication needs to be effective and conducted at different levels: individual level; community and facility levels. Different strategies will be necessary to deal with the various levels. Similarly, different media and contents should be used for effective communications. Intensive and active communication would be required from the moment a decision to introduce new campaigns is taken. Significant efforts will be required to continuously emphasise the benefits of early diagnosis, and to reinforce the message that everyone should know their HIV status – stressing that early diagnosis allows early provision of nutritional support,*

*and Anti-retroviral vaccines, both of which can potentially defer the onset of illness. One clear message at community level for example should be that not all HIV positive persons require ARVs. Given the experience in the USA and Europe, it will also be essential to stress that there remains no cure for AIDS. Key to the communication at individual level will be the need to continuously emphasise the necessity to adhere to therapy and the help that could be found in disclosing HIV status to a close family, community member or treatment supporter. In facilities like the clinics and hospitals, communication should target providers and users..."*

Furthermore, he stated that there is no real representative element of the community in the LAC that could represent the communities' needs. He stated that if the participatory health communication strategy would put this in place the objectives of the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005, Provincial Council on AIDS, North West Working Document* could be achieved.

Motholosa, reiterated what he had mentioned in his answer to question 1. He stated that had there been a communication strategy in place, the approach to HIV/AIDS would be more co-ordinated, resulting in a sustained manner in dealing with prevention and care in the community. It would then be possible to build on the successes of previous initiatives culminating in a progressive attitude in the community to combat HIV/AIDS.

Mabotja, however, was not as outspoken as the other two interviewees. He simply stated that in his opinion:

*"...there needs to be a communication strategy, whether participatory in nature or any other approach, which would successfully help to integrate initiatives to combat HIV/AIDS in the community and in South Africa..."*

All three interviewees reiterated that a communication strategy is required and that such a communication would greatly help to integrate the current initiatives and help particularly the Potchefstroom Municipal Health Authority and the LAC to co-ordinate the prevention and treatment campaigns set out in the policy documents.

**5.2.2.3 Question 3 - Who developed / created the existing communication strategy / initiative (individual / team / involvement of communication specialist)?**

According to Roopa, the current communication process followed when communicating HIV/AIDS campaigns was not set up by anyone specifically, but was a culmination of efforts by the various role-players (NGOs, CBO; Government Sectors) represented on the LAC. Each role-player takes the objectives that is stipulated by the Potchefstroom Municipal Health Authority and implements it as they see fit. It is, however, discussed at the LAC meetings, where Roopa, and his department highlight the key objectives that need implementation. The various role-players then implement it in the community and the various sectors in which they operate. So in essence no one in particular set up the current communication strategy.

In the words of Roopa,

*“...we use the HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005, Provincial Council on AIDS, North West Working Document as our manual when communicating HIV/AIDS initiatives in the community...”*

Motholosa, said that he knew of no such person or team that was involved in designing the current communication strategy. He was under the impression that the current communication was based on the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005, Provincial Council on AIDS, North West Working Document*.

Mabotja, however, provided the answer to this question for his colleague. He stated what Roopa said in his interview, he said that the LAC used the *Provincial Council on AIDS, North West Working Document* policy document as their framework from which to guide them in their strategy guidelines. Also that they made use of the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* as the main manual from which they determine priorities for South Africa and the community with regard to HIV/AIDS.

**5.2.2.4 Question 4 - Was any research done to ascertain what would work in such a strategy?**

All three interviewers stated that no research was done. They did not elaborate on their particular answers. The answer in two of the three interviews was a plain no. This was the

answer of the two co-ordinators of the LAC, Mabotja and Motholosa. On questioning the interviewees to elaborate they said they couldn't as there was no research done and they didn't know whether research beforehand would have helped.

Roopa, stated that no research was conducted prior to the current process of communicating to the community on HIV/AIDS initiatives. He would have liked to have had this in place as the initial step before planning any new initiative. This he said would enable the Potchefstroom Municipal Health Authority and the LAC to determine beforehand what would be needed by the community, thus helping them to set the strategy according to the needs of the community.

According to him;

*“...monitoring, evaluation and research will be an essential component of any successful communication strategy. Significant resources will be required to conduct a range of monitoring and evaluation activities, including:*

- *Monitoring of programme implementation success and problems*
- *Evaluating programme outcomes*
- *Evaluating programme costs and efficiency*
- *Rapid learning, sharing and dissemination of implementation lessons...*”

Mabotja, mentioned in his interview that the LAC did try to do some research once, but due to the time constraints experienced the whole project was aborted and no research was carried out. The communication initiative was implemented and the results set the council back in the outreach to the youth in the Potchefstroom area.

It is with this in mind that he calls for research to be an integral part of the communications strategy. It is a sentiment that is echoed by all three respondents.

**5.2.2.5 Question 5 - Can you please describe your view of the current communication process between your organization (Municipal Health Authority) and the community with regard to the HIV/AIDS pandemic?**

The interview with Roopa, highlighted the very same information that was presented in the policy documents (refer to section, 5.2.2.1). What the interview highlighted that was not present

in the policy documents were the actual process as described by Roopa, of how the Potchefstroom Municipal Health Authority currently communicates with the community with regard to HIV/AIDS. This is the process:

*“..the current process involves liaising with the NGOs and CBOs on strategies that can be implemented in the community. Furthermore the Potchefstroom Municipal Health Authority also requests that NGOs go out and find what the community needs with regard to HIV/AIDS, before any new development is implemented. There is also a lack of resources from the Potchefstroom Municipal Health Authority’s side to conduct the grass root research on community needs; therefore we use the NGOs in the process. It was mentioned that the NGOs normally have more influence than the Potchefstroom Municipal Health Authority as they are the ones busy in the community and are trusted more by the community than the Potchefstroom Municipal Health Authority...”*

According to the Roopa, the LAC is basically how the participative process is put into action.

The interviews with the co-ordinators of the LAC reiterated what was said by the Health District Manager for Potchefstroom. According to the co-ordinators, the LAC pools the resources of the various NGOs and CBOs to fulfil the objectives of the Potchefstroom Municipal Department and then on a sub level, actually fulfil the individual objectives of the CBOs and NGOs in the process of fulfilling the Potchefstroom Municipal Health Authority. This then results in a mutually beneficial partnership between all the organisations involved in the LAC.

The whole LAC is designed to gain information from the NGO’s and the other role-players on community needs. It is also the tool used by government to implement new programmes from a National level, again because of the influence the various role-players have in the community.

**5.2.2.6 Question 6 - Would you say that the Municipal Health Authority had any successes (if any) with the current communication strategy / initiative used?**

Roopa admits that the current manner in which the HIV/AIDS pandemic is handled is poor and does not achieve what it sets out to achieve with regard to HIV/AIDS. He also mentions that the Potchefstroom Municipal Health Authority also initiates strategies, which they never follow up on as there is currently no co-ordination of all the projects that it is initiating.

But even though the current manner is poor and uncoordinated, there have been few successes. Roopa, provides a few examples.

- **Example 1**

*“...government, in partnership with community and sectoral organisations, including labour and the private sector, has implemented various outreach projects designed to facilitate access to services for groups whose lifestyle puts them at increased risk of STI and HIV infection. These groups, which are more prone to casual and multiple sexual relations as well as unprotected sex, include sex workers, migrant workers and long-distance truck drivers. The outreach projects include a educational component, condom distribution, STI treatment and voluntary counselling and testing for HIV. Under an initiative called **Trucking against AIDS**, six roadside clinics have been established at major truck stops in a co-operative venture involving the Road Freight Association, trade unions and various government departments. Additional funds have been allocated to the HIV/AIDS conditional grant to provinces from 2003/04 onwards to focus specifically on outreach projects amongst commercial sex workers, with a significant increase of prevention activity envisaged amongst this crucial risk group...”*

- **Example 2**

*“...the programme for prevention of mother-to-child transmission of HIV is expanding rapidly through:*

- *An increasing number of sites that offer a comprehensive package of care.*
- *Hospitals offering a more limited service to clients on a case-by-case basis in accordance with the Constitutional Court ruling.*
- *Various communication initiatives that aim to communicate to pregnant mothers about the advantages of the Nevirapine.*

*The package of care available at maternity services in designated sites includes targeted communication on HIV, voluntary counselling and testing, the provision of Nevirapine to mother and child (where necessary) and the option of free formula feed for babies who receive Nevirapine and whose mothers choose this feeding option...”*

This was reiterated by Mabotja, who stated that a more integrated process was required if the HIV/AIDS pandemic was to be stopped in the Potchefstroom area. He also provides the researcher with an example of a successful communication initiative that has had some success in the community.

*“...promoting safer sex is an exercise that combines mass communication, more direct educational and behaviour-modification methods and the mass supply of free condoms. It is a well-established aspect of the Government HIV/AIDS programme that has grown in magnitude and quality over time, winning recognition from international organisations in this field of work. Recent research – both by the Department of Health and the Human Sciences Research Council – indicates that there is not only a high level of public awareness of HIV/AIDS, but that there are gains in terms of safer sexual behaviour – condom use, periods of abstinence and maintaining a single sexual partner. National and provincial departments are engaging in a wide range of campaigns. The multi-media loveLife campaign approved by Cabinet and funded through the innovative partnership has been successful in leveraging substantial private sector sources. The Soul City Campaign and many other sector specific campaigns have focussed on a wide range of target groups including women, youth, sports, public service, armed forces etc. Provincial Education departments have mainstreamed Lifeskills programmes and these are taught in schools widely across the country...”*

Though the current communication strategy has been poor and un-coordinated, it was commented by Roopa, and Mabotja, that there have been success but they can't help but believe that a if a more co-ordinated communication strategy is followed and is present for the Potchefstroom Municipal Health Authority and the LAC, it would results in more success.

**5.2.2.7 Question 7 - Does the Municipal Health Authority monitor the communication / strategy / initiative? If yes, how is it done? If no, would the Municipal Health Authority benefit from monitoring the communication strategy / initiative?**

According to Roopa, the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Document* are excellent in the way that they established the LAC's for the combating of HIV/AIDS in the community by combining resources, Potchefstroom Municipal Health Authority and Organisations as such into one central

administrative point. Having the LAC in place allows the Potchefstroom Municipal Health Authority to implement the directives from National Government more successfully and more quickly than the Potchefstroom Municipal Health Authority trying to implement these initiatives themselves.

*“...government also subscribes to the view that research and monitoring plays a vital role in shaping the HIV/AIDS programmes. Central to this effort will be improved effectiveness and targeting of prevention messages, the training and re-training of health professionals in the appropriate use of standard treatment guidelines, and the introduction of more effective processes for quality improvement and monitoring, as well as effective measures for counselling and treatment communication. A well designed monitoring and evaluation framework for the programme is therefore essential...”*

According to Roopa, Mabotja and Motholosa, government insists that monitoring occur every 3-4 months, while the Municipalities and LACs across the country recommended that they be conducted at entry at 3 months and thereafter 6 monthly; focussing on patient education, media and consumer organizations and the community awareness. Counselling and monitoring should therefore be incorporated into the implementation programme for the communication strategy. They also commented that it be as follows:

- Monitoring and evaluation of pharmaceutical services: supplies, stock control, etc.
- Define and co-ordinate a human resource development strategy to support programme implementation
- Planning and coordination of training activities
- Engaging and structuring partnership with NGOs and CBOs, in particular those of people living with HIV and/or AIDS
- Compilation of clinical guidelines
- Setting up of quality control mechanisms
- Ensuring appropriate lab services for monitoring
- Ensure procurement and EDL issues are addressed
- Ensure that Communication guidelines are set up in order to implement the above mentioned.

Furthermore it was mentioned that monitoring, evaluation and research is to be an essential component of any successful programme. Significant resources will be required to conduct a range of monitoring and evaluation activities, including:

- Monitoring of programme implementation success and problems;
- Evaluating programme outcomes;
- Evaluating programme costs and efficiency;
- Surveillance of emergence and patterns of drug resistance; and
- Rapid learning, sharing and dissemination of implementation lessons.

Lastly it was also mentioned that National Government and the Ministry of Health also aim to establish a national programme implementation structure (at national and provincial level), to oversee and support all implementation activities, to ensure equity in service development, and to monitor and review all aspects of the AIDS treatment programme including the communicative aspects surrounding HIV/AIDS.

**5.2.2.8 Question 8 - Does the Municipal Health Authority follow the guidelines set out in either the HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005 or the Provincial Council on AIDS, North West Working Document? If so how is this done?**

According to Roopa, the beginnings of a coordinated public policy response to HIV/AIDS date back to 1992, with the formation of the National AIDS Coordinating Committee of South Africa (NACOSA). Progress in implementing the NACOSA plan was assessed in 1997 by the South African National STD/HIV/AIDS Review. This review identified the major strengths in the response to HIV/AIDS, but also highlighted areas for substantial strengthening and improvement.

Building on this review and an extensive consultation process, government launched its five-year strategic plan for HIV/AIDS in 2000. This plan provided the framework within which interventions geared towards initiating and executing a comprehensive response against the epidemic were undertaken.

The strategic framework, identified four key areas of interventions in this context i.e. prevention; treatment; care and support, research, monitoring and evaluation as well as legal and human rights. Halfway into the implementation of the five-year strategic framework, the programme is embarking on a review to evaluate the response thus far and to inform future steps.

Critical to this review is the evaluation of the extent to which the four areas have been addressed. It comes at a time when positive trends in terms of prevention efforts are beginning to emerge, credited largely to the wide scope of IEC interventions and campaigns among the youth. According to Roopa, it is important to note that the evolution of the HIV/AIDS epidemic itself and of the policy response to the epidemic can both be characterised as highly dynamic, requiring constant review and revision of policy to meet changing circumstances.

According to this then, Roopa, stated that the *HIV/AIDS/STD Strategic Strategy for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Document* are implemented with the aim of following the objectives of prevention; treatment; care and support, research, monitoring and evaluation.

*“...this needs to be implemented as there is evaluation been done by the National Government to determine the extent to which Municipal Health Authorities have implemented the objectives of the policy documents and then score a rating point for this implementation. Therefore the Municipal Health Authority is required to implement the policy and does so to the best of its ability...”*

Another factor that was brought to light during all three interviews under question eight was the issue that the role-players are the only real representatives of the grass root community, except for the PWA's (People with AIDS). However PWA's don't really represent the broad community as they are already infected with AIDS, there is no single organisation that truly represents the broader community. Thus the need was expressed that the community be involved more in the LAC, as currently the information from the community is carried through the NGOs and CBOs, and does not directly come from the community.

**5.2.2.9 Question 9 - How important would the following aspects be with regard to communication strategy for the Municipal Health Authority? For example participatory communication / needs and interests of ordinary people?**

Motholosa and Mabotja, are both of the concurrence that a participatory health communication strategy would greatly improve the approach towards HIV/AIDS in the community and greatly improve the management of the LAC to achieve the objectives of the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Document*. This would lead to greater participation by the community in the process to enable the LAC to ensure the community at grass roots level needs are truly encompassed in the HIV/AIDS initiatives.

They both realise that the interest of the ordinary people are of paramount importance, as any strategy would need to be designed to address those needs. And further they realise that if development and awareness is to be achieved, ordinary people must have a say in the development of their own lives. But most importantly government states that ordinary people must partake in the participatory manner to solve issues with the community that affect them.

For this to be achieved though, they realise that attitudes about the pandemic must change therefore they need to focus on prevention and awareness and that attitudes surrounding the pandemic must be changed if there is truly going to be a change in their community.

**5.2.2.10 Question 10 - What would the Municipal Health Authority's expectations be with regard to a communication strategy for HIV/AIDS?**

According to the interview conducted with Roopa, the expectations from the side of the Potchefstroom Municipal Health Authority with regard to a health communication strategy would be the need to assess the needs of the community and define the health communication strategy according to those needs. Furthermore it will also have to be determined how the participatory health communication strategy would be communicated to the community and through which mediums. The Potchefstroom Municipal Health Authority would have to experiment to determine which approach would be best suited to reach their objectives with regard to the participatory health communication strategy.

Roopa, sums it up as follows:

- Identifying prevalent risk factors that predispose South Africans to HIV infections;
- Determine HIV prevalence in the population of South Africa using linked anonymous HIV saliva tests;
- Link the risk factors with biological measures to determine the association between the two;
- Model the prevalence data and forecast probable infection levels for the next ten years;
- Identify the social, economic, political, structural and cultural contexts within which behaviour occurs, obstacles to risk reduction, and whether current mass media educational efforts take these factors into account;
- Determine the extent to which current prevention, education and awareness programmes and campaigns reach all sectors of South African society, including the most vulnerable sectors of the population;
- To determine if aspects of treatment and awareness as well as prevention reach all sectors of the community; and
- Determine whether media messages are being understood and accepted in the population, and by whom.

Mabotja and Motholosa both focus on dialogue and direct experience as a major requirement for the communication strategy for HIV/AIDS.

*“...purposive support systems; health systems; religious and cultural systems; sexuality, gender; legal and rights framework; direct experience of HIV/AIDS; HIV/AIDS-related dialogue, must be part of the communication strategy for HIV/AIDS. All these aspects can be used to establish precise community needs and therefore establish a strategy that will encompass all the sectors in the community thereby establishing a strategy that will ensure the aspects of care and counselling are key to the well being of those already infected with HIV/AIDS and that there is enough moral support for those who have family members infected. Not only this but also the necessity for awareness will be present and be implemented by means of those sectors actively involved in the community...”*

In conclusion, all three respondents have provided the key elements that they think are critical in what is required in the health communication strategy for the Potchefstroom Municipal Health Authority. It is crucial that these aspects are noted and included in the guidelines for the health communication strategy.

#### **5.2.2.11 Summary**

Finally, a health communication strategy within a framework that integrates all various role players would contribute to the idea of a more sustainable manner in dealing with the problem. However, participatory communication is required in the health communication strategy, first to abide with the National legislation and secondly to bring on board the participating members (receivers of the HIV/AIDS message) within the community to empower them to take control of their own development.

If the participants of the participatory health communication strategy do not buy into the process, it is argued that this could result in the end of the communication process. Furthermore if no real participation is present in the health communication strategy, it would mean the end to any sustainable outcomes. Only once full participation is achieved, will the health communication strategy lead to sustainability and a more sustained outcome to the HIV/AIDS pandemic.

### **5.3 CONCLUSION**

In light of the aforementioned, the conclusions that can be drawn are the following:

- The Potchefstroom Municipal Health Authority is implementing a participative development process as set out in the Policy documents;
- The participation is based on the interaction with LAC and the various role-players;
- The Potchefstroom Municipal Health Authority initiates the development strategy according to the needs expressed by the NGOs and other role-players of the community;
- When the Potchefstroom Municipal Health Authority requires the implementation of certain strategies the NGOs are used; and the
- NGOs are used specifically for their wide influence in the community.

Having said all this, it is important that guidelines are to be described, that the Potchefstroom Municipal Health Authority can follow for the implementation of health programmes aimed at combating the HIV/AIDS pandemic. Because of the very fact that there is no specific set of guidelines to follow there is an uncoordinated approach to HIV/AIDS initiatives. With the specific guidelines in place a system of co-ordination and monitoring can be in place to lead to a sustainable outcome to strategies. The Potchefstroom Municipal Health Authority is following a participative approach but having a strategy in place will allow for co-ordination of the strategy on a permanent basis. More will be mentioned in the recommendations (see chapter 6).

The Potchefstroom Municipal Health Authority should comply with different requirements of the participatory health communication strategy in order to successfully implement the communication strategy at local grass roots level, as the communication strategy will determine the success of the new communication strategy that will be implemented by the National Structures of the South African Government. Chapter 6 will discuss the final conclusions and final integration of the results into the participatory health communication strategy.

## CHAPTER 6

### CONCLUSION AND RECOMMENDATIONS

#### 6.1 INTRODUCTION

Different research methods (See Chapter 3, Section 3.3) were used in this study to collect the necessary information in order to answer the research questions. The analysis of the policy documents, *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005*, and the *Provincial Council on AIDS, North West Working Document*, was conducted to obtain background and provide the legitimate existence on which the communication strategy would be based. As a penultimate step, in-depth qualitative interviews were conducted with the Health District Manager for Potchefstroom.

The information that was collected by the above mentioned methods, was integrated and the findings are interpreted according to the various specific objectives set out in the beginning of the study (refer to section 1.4) in order to prevent any overlapping of information. The conclusion and final integration for the study is done in Section 6.2 of this Chapter, whereby the general objective of this study is discussed (refer to section 1.4.1) and final recommendations are the made.

#### 6.2 CONCLUSION

In light of the results that were found in chapter 5, the following conclusions can be draw from these results by the researcher. The specific objectives are discussed individually under separate headings with a conclusion of the problem statement and the specific objectives been made as well.

Firstly a summary of the detailed problem statement and specific objectives in chapter 1 will be given to orientate the reader for the discussion ahead. This will then lead to the conclusions prepared according to the specific objectives of the study.

## **PROBLEM STATEMENT**

The problem addressed in this study is the lack of a health communication strategy for HIV/AIDS management at local municipal level in Potchefstroom. Consequently, the need of this study is to describe a health communication strategy framework, which is based on the principles of participatory communication that is inclusive of all role players and the community in the Potchefstroom area (as required by Government Legislation).

## **GENERAL OBJECTIVE**

To propose a framework for a participatory health communication strategy for HIV/AIDS management at local level in Potchefstroom based on the requirements as set out in the National and Provincial HIV/AIDS policies, aiming to contribute towards a more sustainable manner in dealing with the HIV/AIDS problem.

### **6.2.1 Objective 1**

To describe the requirements, according to the literature, for a participatory health communication strategy in a developing environment.

In order to determine objective 1 the literature study had to be done in order to determine the requirements.

No participatory health communication strategy is present in the Potchefstroom Municipal Health Department currently to tackle the issue of the HIV/AIDS pandemic in the Potchefstroom area. All efforts thus far have been limited in the success they have experienced due to the Potchefstroom Municipal Health Authority having no real formulated strategy to guide them in their endeavours with regards to the development in the community and the fight against HIV/AIDS. The Potchefstroom Municipal Health Authority do however try and apply participatory communication, but don't necessarily see it as been participatory in nature, and therefore are presently not succeeding in their efforts as they have no formulated process from which to base their efforts.

Therefore in light of the literature study, having found the requirements for the participative health communication strategy, theoretical statements would be formulated to better structured

the proposed guidelines for the study. The Potchefstroom Municipal Health Authority should in fact follow the guidelines established by the theoretical statements in the literature study. This would then lead to a more coordinated approach to the HIV/AIDS pandemic at the local level in Potchefstroom. As no previous strategy was available these theoretical statements can serve the Potchefstroom Municipal Health Authority in their effort to communicate more effectively on any HIV/AIDS initiatives. It can further communicate forth the initiatives dictated by the National government in the National and Provincial HIV/AIDS policies to the communities and include the community in the strategy planning and implementation phase.

This point then lead to the conclusion on objective 2, which deals with the finding made on the policy documents

### **6.2.2 Objective 2**

To describe the extent to which the National and Provincial HIV/AIDS policies comply with the guidelines of participatory communication.

To prove the extent to which the National and Provincial HIV/AIDS policies comply with the guidelines of participatory communication a content analysis had to be done as well judging the objective against the theoretical statements ascribing the requirements for participatory communication.

The theoretical statements ascribing to participatory communication is summarized as follows:

- **Theoretical Statement 1**

Allowing people participation in the planning, implementation, evaluation and decision-making process, concerning the health communication strategy for HIV/AIDS, will empower them to benefit from / partake in the development process, enabling sustainable outcomes to the HIV/AIDS pandemic and mutual benefits for the community and Health Authority.

- **Theoretical Statement 2**

A participatory approach to a health communication campaign should comprise the following: entering the community; preparing to plan action; planning what to do;

supporting action; and withdrawing from the community, by facilitating community participation in all levels of the development process.

- **Theoretical Statement 3**

When planning the participatory communication strategy, the following critical considerations need to be part of the planning phase; preconditions, leadership, conflicts, and appropriate action.

- **Theoretical Statement 4**

The outcomes model (bio-psychosocial model) for health communication is most suited for the basis of a health communication strategy, as it ascribes to elements key to participatory approach such as interaction, dialogical communication, attention to individuals' preferences, values, and expanded choice making.

In the content analysis it was not always clear whether the policies ascribed to the principles of participatory health communication (refer to chapter 5, section, 5.2.2.). However the principles of participatory communication are prevalent in the policies once a thorough analysis had been done as well as determining before hand what was required by theoretical statements as being participatory. It must then be said that the policies are vague in their expression of their needs and how the Potchefstroom Municipal Health Authority is supposed to determine what needs to be done at the community level with regards to the HIV/AIDS pandemic, but it does ascribe to participatory communication principles. It must however be formulated in a more direct manner in order for the Potchefstroom Municipal Health Authority to note what is expected from them in order to implement participative communication principles.

The policies still require to be implemented by the Potchefstroom Municipal Health Authority, whether they are vague or not. There needs to be integration of the principles set out in the policy documents and what the Potchefstroom Municipal Health Authority is currently doing with regards to the HIV/AIDS pandemic in the community. The policy documents note that there needs to be focus on both those living with HIV/AIDS and those not yet infected with the pandemic. It therefore believes that focus must be directed towards awareness campaigns which need to be directed at the youth of the country. Furthermore, the policy documents also make provision for the establishment of the Local AIDS Councils (LAC) which are required to help further the aims of the Potchefstroom Municipal Health Authority.

As the literature on participatory health communication stated that there needs to be partnerships within important role-players that can work towards a common goal while still retaining and fulfilling their respective goals within the community. The LAC's are in place but currently function in a unfragmented manner with each doing its own thing in the community, instead of them pooling together their resources and working towards the objectives as set out in the policies. Therefore the LAC's need to work in a more coordinated fashion where they need to focus on the needs of the Potchefstroom Municipal Health Authority while also in fact fulfilling their in the process.

The conclusion that can be drawn from the results can be summarized as follows. The policy documents do ascribe to participatory communication however, the Potchefstroom Municipal Health Authority needs to evaluate both the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Document*, more closely to determine exactly what is stated in the document. This needs to be done in order to integrate their current communication initiatives with regards to the HIV/AIDS pandemic. The focus must be on treatment but also on awareness and prevention campaigns that target the youth. To achieve this, the Potchefstroom Municipal Health Authority needs to group their resources and coordinate the members of the LAC to work towards the common goals of the National and Provincial policies. The conclusion however exists in the coordination of these LAC members in achieving the goals of the policies.

In light of the above stated, the Potchefstroom Municipal Health Authority would therefore require some formal guidelines by which these policy document goals can be achieved. This then requires that the conclusion be drawn on objective 3, which aims to determine the specific guidelines of the participatory health communication strategy. This is discussed below.

### 6.2.3 Objective 3

To describe how the policy documents are being implemented and used in practice by the Potchefstroom Municipal Health Authority

In order to prove third objective, interviews were used in conjunction with theoretical statement 1.

Although no formal strategy existed, there were guidelines that would be used to describe the participatory health communication strategy for this study.

The interviews did conclude that participatory communication is required for the implementation of the participatory health communication strategy in the community. All the interviewees were agreed that participatory communication was the means to achieve penetration into the community with regards to HIV/AIDS awareness and education. There the proposed framework would then be based on participatory health communication.

The conclusion drawn is that although no real strategy exists in the literature, or as a practical manual from which the Potchefstroom Municipal Health Authority can based their communication activities, there needs to be an integration of the findings from the literature study and the content analysis to determine what the requirements for the establishment of a formal strategy would be.

The recommendation would then be to formulate the guidelines in manner that can add value to the Potchefstroom Municipal Health Authority. This is dealt with in objective 4.

### 6.3.4 Objective 4

To propose a framework for the proposed health communication strategy, intended for the Potchefstroom Municipal Health Authority.

The statements encompass the key elements of the literature and therefore it can be seen as answering objective 4, yet as the other 3 objectives for this study was also proven to be valid for the requirements of the participative communication strategy, objective four is fully proven. It is

therefore now the recommendation to set up the guidelines for the participatory health communication.

The theoretical statements are therefore summarised as follows.

- **Theoretical Statement 1**

Allowing people participation in the planning, implementation, evaluation and decision-making process, concerning the health communication strategy for HIV/AIDS, will empower them to benefit from / partake in the development process, enabling sustainable outcomes to the HIV/AIDS pandemic and mutual benefits for the community and the Potchefstroom Municipal Health Authority.

- **Theoretical Statement 2**

A participatory approach to a health communication campaign should comprise the following: entering the community; preparing to plan action; planning what to do; supporting action; and withdrawing from the community, by facilitating community participation in all levels of the development process.

- **Theoretical Statement 3**

When planning the participatory communication strategy, the following critical considerations need to be part of the planning phase; preconditions, leadership, conflicts, and appropriate action.

- **Theoretical Statement 4**

The outcomes model (bio-psychosocial model) for health communication is most suited for the basis of a health communication strategy, as it ascribes to elements key to participatory approach such as interaction, dialogical communication, attention to individuals' preferences, values, and expanded choice making.

- **Theoretical Statement 5**

The health communication strategy should not exclusively focus on those individuals already infected with HIV/AIDS, but focus should also be directed on those individuals not infected with HIV/AIDS.

- **Theoretical Statement 6**

A participatory health communication strategy regarding HIV/AIDS should follow the USAIDS guidelines.

There having proved all the above statements the statements therefore can be used to formulate a framework for the participatory health communication strategy. The final recommendation for objective4 will then be to provide a set of guidelines for the participatory health communication and how it can be achieved by the Potchefstroom Municipal Health Authority.

This final integration will be discussed in the recommendations below (Section 6.3).

### **6.3 RECOMMENDATIONS**

According to the research conducted the proposed specific participatory health communication framework is based on a health communication strategy found on the internet that was applied to the communication of STD (Sexually Transmitted Disease) (<http://www.cdc.gov/stopsyphilis/CommPlan.htm>) in the United States of America. The health communication strategy had much success and is still been used in the United States of America today. By integrating the findings made in the content analysis and interviews integrated with the literature, it is believed that the objectives and framework set out in this study (refer to chapter one, section 1.3. and section 1.4), The research conducted by means of the interviews and the literature study and analysis of documents identified that certain requirements for participatory communication were not presently practised by the Potchefstroom Municipal Health Authority, hence leading to the unfragmented manner in dealing with HIV/AIDS. The current process does not allow for the community to buy into the process resulting in a break down of the communication process.

The participatory health communication strategy that is recommended for the Potchefstroom Municipal Health Authority is based largely on what is happening currently but also incorporates the requirements that were set out during the literature study in chapter 2. Thus this study will only serve to conclude that a participatory health communication strategy framework is required when dealing with HIV/AIDS in the community from the Potchefstroom Municipal Health Authority, in which the LAC is key in achieving. This study will then aim to describe a formal set of guidelines that can be implemented when planning the participatory health communication

strategy for the Potchefstroom Municipal Health Authority. In the concluding section more will be said about future research topics.

The analysis of the policy documents did not provide any specific guidelines for the communication strategy, it only stated that it must be conducted in a participative manner incorporating the community into any decision making process concerning development initiatives. Therefore guidelines from these policy documents as well as guidelines set out in the literature studied for this research study was used to describe the framework that would outline the participatory communication strategy for the Potchefstroom Municipal Health Authority concerning HIV/AIDS. The research did conclude that guidelines used and implemented by the Potchefstroom Municipal Health Authority were largely featured in the literature: There was however no formalised structure in place that documented this process.

It must be mentioned that even though the Potchefstroom Municipal Health Authority had no formal communication strategies into the community, it was applying certain rules as mentioned in the literature, thus serving to reinforce the views in the literature concerning a health communication strategy and the participative approach towards development. The Potchefstroom Municipal Health Authority can therefore apply the guidelines set out in this study without having to compromise the development nature of current initiatives and without appearing to be superior towards the community in claiming to know beforehand what their needs are.

The requirement for the participatory health communication strategy is discussed according to the theoretical statements made in chapter two of this study (see section 6.2.1). Following this, the theoretical statements will be applied to provide the framework for participatory health communication strategy (see section 6.3).

### **6.3.1 Recommendation 1**

Recommendation 1 aims to provide a solution to objective 1 of this study. The recommendation made with regards to objective 1 would be for the Potchefstroom Municipal Health Authority to critically evaluate their needs with regards to a participatory health communication strategy. As there is no real communication strategy in place the Potchefstroom Municipal Health Authority would need to do some research in order to determine what is required with regards to planning this participatory health communication strategy.

They would need to determine what currently exists and that could practically be used for the formulation of the strategy. Ideally the Potchefstroom Municipal Health Authority would then need to look at studies like this one to determine what can be used for the strategy formulation process and how it should be conducted. It can even critically evaluate the participatory communications strategies of other municipal health authorities and take out what is applicable to the situation in Potchefstroom.

However while doing the research to determine what the requirements are for a participatory health communication strategy the requirements from government in the form the National and Provincial policy documents (*HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* and *Provincial Council on AIDS, North West Working Document*). This is discussed in recommendation 2 below.

### **6.3.2 Recommendation 2**

Recommendation 2 aims to provide an answer to objective 2 of this study. As mentioned in section 6.2.2, the Potchefstroom Municipal Health Authority would need to evaluate both the *HIV/AIDS/STD Strategic Plan for South Africa 2002-2005* and the *Provincial Council on AIDS, North West Working Document*, in order to determine what the participatory communication elements are in the policies. This needs to be done to integrate the elements of the policies with that found in the literature, other communication initiatives and research found by Potchefstroom Municipal Health Authority to ensure that Potchefstroom Municipal Health Authority provides an effective means to communicating on the HIV/AIDS pandemic that is also legitimately based on the requirements of the National Health Authority.

Having the legitimate basis allows the strategy to be used on a national basis if the results achieved by the communication strategy are successful. The Potchefstroom Municipal Health Authority should aim to achieve success that can be used at a national level as this is also what is required by the policies. Local Municipal Health Authorities should in conjunction with LAC and work towards effective solutions to the HIV/AIDS pandemic which can then be communicated back to the National Authority for implementation at a national level in South Africa.

To achieve this, the Potchefstroom Municipal Health Authority would need a set of guidelines that would guide them in the formulation of their participatory health communication strategy.

Below recommendations are described that could guide the Potchefstroom Municipal Health Authority in this process.

### **6.3.3 Recommendation 3**

Although the various role-players in the LAC do implement the policy documents and use it to guide them in the planning there is no formal plan in place to ensure that process followed is co-ordinated.

Therefore, in order for the policy documents to be implemented correctly in order to yield the desired results as envisaged in the policy document by the Potchefstroom Municipal Health Authority, a more co-ordinated approach will be required by all parties involved in the LAC. A formulated set of guidelines will have to set up and then be implemented to specifically handle the issue of HIV/AIDS in the community.

The formal set of guidelines is described by Recommendation 4 below.

### **6.3.4 Recommendation 4**

Recommendation 4 aims to provide guidelines for the participatory health communication strategy as envisaged in objective 4 of this study. As mentioned in Chapter 2, the following steps should ideally be part of the communication strategy for the Potchefstroom Health Authority on HIV/AIDS. The steps are critically evaluated from the perspective of describing what the framework must be from which the Potchefstroom Municipal Health Authority can formulate any new strategy. It is critically evaluated and is then integrated into the results of the study.

- ***Stage 1: Planning and strategy selection***

In the initial phase the Potchefstroom Municipal Health Authority must establish what is already known about the health problem. In the case of the Potchefstroom Municipal Health Authority a lot is already known about the HIV/AIDS pandemic, the focus then should be on the rate of infection in the community, deaths due to the pandemic, how the family members are affected by the pandemic and issues like nutrition and well being of the infected people. The Potchefstroom Municipal Health Authority should also look at the success experienced by other municipal

authorities in their fight against the pandemic to determine what could possibly work and how they approached the problem in their own communities. It must also be remembered that every participatory communication strategy is different and normally cannot be applied in other situations (refer to chapter 2), This they can judge not only if past strategies have worked but also what new issues the strategy should address.

The following step would be the identifying of the target audience, as already stipulated in both the policy documents (HIV/AIDS/STD Strategic Plan for South Africa 2002-2005 and Provincial Council on AIDS, North West Working Document). The youth should be targeted first, as they are the future of the country, following this, the next target group would be areas in the community where the HIV/AIDS rate has dramatically increased (severely). The focus would be on what is specifically known about the group and why there is a need to specifically target them.

According to the principles of the outcomes health communication model, attention should not only be directed at those affected by the HIV/AIDS (meaning those currently infected by the pandemic) but attention must also be directed at those not infected by the pandemic (people oblivious to the effects of the pandemic) and those affected but not infected by the pandemic (family members, friends and community member surrounded by people living with HIV/AIDS) (refer to chapter 2, section 2.3.1. and 2.3.2) Therefore, the Potchefstroom Municipal Health Authority should take note not only of strategies targeting those people living with HIV/AIDS, but they should also look at strategies that focus on awareness, prevention and support for those not infected, but living with the psychological impact of the pandemic.

If the youth have been identified the Potchefstroom Municipal Health Authority should focus on the family of the youth as its main focus. Awareness campaigns should be envisaged making the youth aware of the issues surrounding HIV/AIDS. Furthermore the family members must be included in these awareness campaigns as a means of supporting the youth and making them aware of the dangers that they may face in engaging in unprotected sex, and other acts of sexual contact.

Following this the Potchefstroom Municipal Health Authority must consult with the community on their specific needs and what the strategy should address specifically from their point of view. It is essential that this consulting is done with the community as it is set out in the White Paper on Local Government (1997), and the Municipal Structures Act (117/1998), and the

HIV/AIDS/STD Strategic Plan for South Africa 2002-2005. Not only should there be consultations with the community but the community should be approached (as if) in such a manner as not to impose the development on them. A mutual trust needs to be built and the trust of the community must be gained.

In light of what has been mentioned, the Potchefstroom Municipal Health Authority will then have to determine the needs of those living with HIV/AIDS and those not infected (yet) and those who have family members who have been infected by the pandemic.

When the above mentioned has been identified the Potchefstroom Municipal Health Authority can set about establishing the goals of the strategy. Here they can identify what the strategy must aim for, the deadlines, and how they are going to implement the strategy. Following this the specific communication plan must be formulated and how the success of the communication strategy is going to be measured. The Health department in the initial phase will also start implementing the process of how the strategy is going to be evaluated and monitored. Therefore this phase can be summarized by the following points:

- **What is known about the health problem?** – Current situation with regard to HIV/ADS is severe and has a major impact on the youth of the Potchefstroom Area (refer to section 1.1, paragraph 3)
- **Who are the target audiences of the communication initiatives?** – The target audience should be the family who should not only play a role in supporting the youth but also in making them aware of the issues surrounding HIV/AIDS
- **What is known about the community at whom the communication initiatives are directed?** – This will then be determined as the Potchefstroom Municipal Health Authority consults with the NGO's at the LACs and also with the community, as they are systematically included into the planning and implementation phase.
- **What are the strategy goals of the Potchefstroom Municipal Health Authority?** – As the program is planned and the consultation is done with the various role players (Community and the NGO's), the strategy goals will be determined. However these goals must be aligned with goals set out in the National and Provincial HIV/AIDS Policy Documents.

The first phase must be categorized by the Potchefstroom Municipal Health Authority approaching the community and planning what must be done with help from the community in what their needs are. These needs should then be aligned with the goals described in the National and Provincial HIV/AIDS Policy Documents.

- ***Stage 2: Selecting channels***

The second phase will identify the existing channels that are already in place for the implementation of the strategy or whether they can be adapted to the current initiative. It can even be that the Potchefstroom Municipal Health Authority can evaluate past communication strategies that were successful and use the channels and materials from those strategies, adapt them and use them to implement the new strategy. It is up to the Potchefstroom Municipal Health Authority to determine what can and has worked in the past. It should not try to re-invent the wheel as such but build on the initiative that has worked in the past.

No previous communication strategies are in place in the community for the implementation of the HIV/AIDS issues and awareness. Thus the Potchefstroom Municipal Health Authority will have to describe a new participatory health communication strategy. But currently the LAC is made up of various NGOs that interact with the community and can be used as a channel to communicate with the community. Not only can they communicate with the community they can interact to determine their needs and hence, filter it back to the Potchefstroom Municipal Health Authority through the LAC meetings. As mentioned in chapter 2 of the study, section 2.2.4.4, the NGOs especially if they belong to influential organizations can have a tremendous effect in the community. But most important is their ability to listen to the community and give forth information.

It should also be realized by the Potchefstroom Municipal Health Authority that the format for the strategy must be determined beforehand, in order to address the correct audiences, channels and messages. During the process they should remember that not all formats will work for all audiences. Therefore they need to interact with the NGO's at the LACs, to determine how they see the needs of the community. More importantly they need to make provision for the inclusion of community representatives to provide first hand what the community themselves require. This is something that currently needs to be addressed by the Potchefstroom Municipal Health Authority. Full community representation is required in the planning phase (as set out in chapter 2, 2.2). By having full community representation on the LACs, they would then be able to, by

means of the input from the community representatives have first hand information on whether the previous initiatives have succeeded or not.

- ***Stage 3: Developing the participatory health communication strategy and pre-testing it***

The third phase in the strategy planning phase is the pre-testing of the message and developing materials or the strategy. Developing materials in the context of the Potchefstroom Municipal Health Authority can mean the training of the members of the LACs in the implementation and monitoring of the strategy. In this context developing materials is the developing of the various members of the LAC.

Because the LAC is made up of various NGOs who already perform specific tasks within the community (Ranging from health care, support groups, educational functions etc.), the Potchefstroom Municipal Health Authority can utilize the tasks of the NOG's for mutual gain with regard to communicating the information to the community as mentioned in section 2.3.3. Therefore they can establish working partnerships to combat the spread of the pandemic.

The next step would be the participatory health communication strategy. Here issues like audience reaction, message clarity, recall, acceptance, and value need to be established in order for the strategy to have any real impact on the community that it is targeting. If the message does not succeed in this pre-testing phase the changes that have been identified need to be made. If the Health Authority does not do any pre-testing the message is not likely to succeed. This aspect also links up to the participatory approach, in that it needs the approval of the community before it is implemented. Pre-testing in this case is part of the interaction with the community for their approval on matters that affect them.

Pre-testing can be done by interacting with community leaders to identify areas in the community where such tests can be done. The testing should then be done by the community members who have been trained to test the strategy in the community. Feedback should be provided to the Potchefstroom Municipal Health Authority at the LAC meetings by the local community leader. The NGO's can also be included in the process by providing support to the community while they are testing the communication strategy. They can then also provide feedback to the Potchefstroom Municipal Health Authority if the communication strategy has been well received by the community.

Developing the message and pre-testing should then include the community actively partaking in this process of empowerment to eventually take hold of their own development when the Potchefstroom Municipal Health Authority withdraws from the community. This must be done by empowering community leaders and individuals in the testing process so as to educate them of the process to come. They should test this participatory health communication strategy in conjunction with help from the Potchefstroom Municipal Health Authority and the NGOs. Feedback should also be provided to the Potchefstroom Municipal Health Authority by the community leader as to what is happening.

- ***Stage 4: Implementation of the participatory health communication strategy***

The fourth stage in the process is the implementation phase. Here the Potchefstroom Municipal Health Authority must determine whether the message has reached the desired target group, and whether it has made it through the right channels of communication. The important factor here is whether it has made it through the right communication channels. If the right communication channels are not followed then the strategy is failing in its aims and objectives. This is important as if the right communication channels are not followed there can be message distortion and the message can be interpreted wrongly by the recipient of the message.

There must also be a realisation from the Potchefstroom Municipal Health Authority that if the above mentioned does indeed happen there must be some means of changing the channels or added new channels in case of message overload. The Potchefstroom Municipal Health Authority must realize that modifications on the message and strategy might be required once the process is running. This might happen if there are some unknown factors that were not accounted for during the first phase. The Potchefstroom Municipal Health Authority should have a Plan B so to say on to fall back on if such problems arise.

- ***Stage 5: Assessing Effectiveness of the participatory health communication strategy***

Phase five is characterized by determining whether the communication strategy has succeeded in its objectives. Here the Health Authority must determine if the specific communication objectives it set up beforehand were met by the strategy. If the objectives were not met it needs to assess the affect thereof and why it did not succeed. Even if the communication objectives were met by the Potchefstroom Municipal Health Authority, would they still need to assess the success thereof to implement these successes into future communication strategies?

The answer is a definite yes. By tracking this success the Potchefstroom Municipal Health Authority will be empowered to make a better informed choice next time around when confronted with a similar situation. Furthermore, this tracking will enable the success to be shared at a National and Provincial level in order to find a sustainable means of dealing with the HIV/AIDS at a National level for South Africa. Working towards the good of the Southern African population would seem the logical thing to do since the HIV/AIDS pandemic is negatively affecting the growth of the population and lead to serious economic problems for the future of the country.

Furthermore the changes that did happen in the community would also need to be assessed to determine whether they were specifically brought about by the communication strategy or by other external factors. If this is not specifically done by the Potchefstroom Municipal Health Authority, it may implement the strategy later into some other strategy and not have the same success. These factors can then be included in the initial assessment phase.

- ***Stage 6: Feedback to refine strategy***

This stage should be characterised by linking lessons learned back into the strategy; make necessary minor changes, and use the plan to steer the course, and "move the needle" with the target audiences. Everything in the communication arena must be directed at the target audience and objectives. Channelling messages to reach other audiences will divert them from the target and waste strategy resources. As more information is gathered about the target audiences, the strategies should be refined to reflect the new information.

This can only be done if there is a feedback system in place to provide the Potchefstroom Municipal Health Authority with the information to update participatory health communication strategy. It is also important for the Health Authority to keep in mind the following points when planning initiatives:

- The objectives, strategies, and tactics all relate to communications. They identify where communication can contribute to the overall HIV/AIDS strategy. Strategy objectives are included in the document only to provide context. Not all strategy objectives will require communication activities. However, in some instances, strategies are discussed and may need to be conducted in order to implement the communication objectives. Currently this is lacking and hardly any of the current goals of the HIV/AIDS/STD Strategic Plan for

South Africa 2002-2005 and Provincial Council on AIDS, North West Working Document are communicated to the community in communication initiatives.

- The communication strategy must be dynamic and flexible to allow for changes over time. It must be responsive to changes in the treatment of HIV/AIDS and the new awareness campaigns envisaged by the National Health Authority, to scientific advances in testing and treatment, to changes in resources available for elimination efforts, and to feedback generated throughout the implementation of the communication strategy. The Potchefstroom Municipal Health Authority should be open to these new advances and initiatives and constantly update the communication strategy to address these issues as they arise.
- The strategies and tactics proposed are by no means exhaustive. They provide a framework for action, and are based on experience working with other National, Provincial, and community-based health communication strategies, as well as current available resources. They can be expanded and added to as additional resources become available. The Potchefstroom Municipal Health Authority must be seen to be constantly interacting with the community as they learn new ways of doing things. The participatory health communication strategy should not be mutually inclusive but must aim to be flexible to allow for new initiatives that may increase the successes that are required with regard to the Provincial Council on AIDS, North West Working Document and HIV/AIDS/STD Strategic Plan for South Africa 2002-2005, policy documents.
- The implementation of the HIV/AIDS communication strategy will require the commitment and involvement of many individuals and organizations. Especially important will be the involvement of staff from National, Provincial and Potchefstroom Municipal Health Authorities. Also the community must be empowered to feel that they are required in the process and that they themselves can take control of the implementation and control of the participatory health communication strategy.

In conclusion, the Health Authority would need to manage the system and the role-players to effectively reach the desired outcomes. More importantly, the key to this study would be to empower the community to take control of their own development with regard to HIV/AIDS pandemic. This would involve the community partaking in the process of the planning, implementation, feedback and constant monitoring of the participatory health communication

strategy. Key to all this would be evaluation. Evaluation of the participatory health communication strategy will be discussed below.

#### **6.4 FINAL COMMENTS**

This study has focused on describing the framework for a participatory health communication strategy that would lead to sustainable outcomes with regard to HIV/AIDS attitudes in the community. It aimed at providing the Health Authority with a framework that would allow for the integration of the various role-players in the LAC in participatory fashion with the members of the community in determining what the current needs, attitudes and trends towards HIV/AIDS are.

The study did note that the participatory approach to communication is not the most established development theory to deal with HIV/AIDS, as it does have certain theoretical and practical flaws, but what it does allow for is that the individual at the development initiative to engage in the development programme allowing them to have a say in what they require for their own development.

The study did not focus on the implementation of the participatory health communication strategy; neither did it focus on the evaluation and monitoring phase of the communication strategy. These are areas that are identified for possible future studies in this field. What is more the interaction and communication process followed by the various role-players is another area that would make a good study for future reference, even taking it as far as focusing on the interaction and communicative process between the Health Authority and the NGO.

Finally, the stages recommended in section 6.3.3, set out to comply with the objectives specified in the title of this study. These steps then form the basis for the proposed participatory health communication strategy for sustainable development.

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## **ANNEXURE A**

**HIV/AIDS/STD STRATEGIC PLAN FOR SOUTH  
AFRICA  
2000-2005**



**AIDS HELPLINE  
T 0800-012-322**

**MAY 2000**

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## **Acronyms**

<b>AIDS</b>	<b>Acquired Immune Deficiency Syndrome</b>
<b>ANC</b>	<b>Antenatal Care</b>
<b>ATIC</b>	<b>AIDS Training and Information Centre</b>
<b>BHF</b>	<b>Board of Health Funders</b>
<b>CBOs</b>	<b>Community-based Organisations</b>
<b>CGE</b>	<b>Commission on Gender Equality</b>
<b>CMA</b>	<b>Civil Military Alliance</b>
<b>DENOSA</b>	<b>Democratic Nursing Organisation of South Africa</b>
<b>DOE</b>	<b>Department of Education</b>
<b>DOF</b>	<b>Department of Finance</b>
<b>DOH</b>	<b>Department of Health</b>
<b>DOHA</b>	<b>Department of Home Affairs</b>
<b>DOJ</b>	<b>Department of Justice</b>
<b>DOL</b>	<b>Department of Labour</b>
<b>DOME</b>	<b>Department of Minerals and Energy</b>
<b>DOT</b>	<b>Department of Transport</b>
<b>DOTS</b>	<b>Direct Observed Therapy Short Course</b>
<b>DOW</b>	<b>Department of Welfare</b>
<b>EDL</b>	<b>Essential Drug List</b>
<b>GCIS</b>	<b>Government Communication and Information Systems</b>
<b>IDC</b>	<b>Interdepartmental Committee on AIDS</b>
<b>IMC</b>	<b>Inter-Ministerial Committee on AIDS</b>
<b>HCW</b>	<b>Health Care Worker</b>
<b>HIV</b>	<b>Human Immunodeficiency Virus</b>
<b>HRC</b>	<b>Human Rights Commission</b>
<b>HSRC</b>	<b>Human Sciences Research Council</b>
<b>IEC</b>	<b>Information, Education, and Communication</b>
<b>MEC</b>	<b>Member of Executive Committee</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MRC</b>	<b>Medical Research Council</b>
<b>MTCT</b>	<b>Mother-to-child transmission</b>
<b>MTEF</b>	<b>Medium Term Expenditure Framework</b>
<b>NACOSA</b>	<b>National AIDS Co-ordinating Committee of South Africa</b>
<b>NGOs</b>	<b>Non-Government Organisations</b>
<b>NPPHCN</b>	<b>National Progressive Primary Health Care Network</b>
<b>PEP</b>	<b>Post-exposure prophylaxis</b>
<b>PWA</b>	<b>People living with HIV infection or AIDS</b>
<b>PHRC</b>	<b>Provincial Health Restructuring Committee</b>

<b>SAIMR</b>	<b>South African Institute of Medical Research</b>
<b>SALC</b>	<b>South African law Commission</b>
<b>SAMA</b>	<b>South African Medical Association</b>
<b>SANAC</b>	<b>South African National AIDS Council</b>
<b>SAPS</b>	<b>South Africa Police Service</b>
<b>SADC</b>	<b>Southern Africa Development Community</b>
<b>SANDF</b>	<b>South African National Defence Force</b>
<b>STDs</b>	<b>Sexually Transmitted Diseases</b>
<b>SM</b>	<b>Syndromic Management</b>
<b>TB</b>	<b>Tuberculosis</b>
<b>UNAIDS</b>	<b>Joint United Nations Programme on HIV/AIDS</b>
<b>VCT</b>	<b>Voluntary HIV Counselling and Testing</b>
<b>WHO</b>	<b>World Health Organisation</b>

## **1. INTRODUCTION**

During the last two decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV/AIDS has already taken a terrible human toll, laying claim to millions of lives, inflicting pain and grief, causing fear and uncertainty and threatening economic devastation.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), the number of people living with HIV by the end of 1998 was estimated to be 33,4 million, a 100% increase compared to 1997. In Sub-Saharan Africa, more than a quarter of young adults are infected with HIV.

Assuming that no cure is found, it is estimated that more than 40 million people globally will be living with HIV by 2000. The impact of the epidemic on the economy is already being felt in most countries. Life expectancy has been significantly reduced as many people in the 15-49 year age group are now dying of AIDS.

Many countries both in Africa and Asia have taken urgent steps to curb the epidemic with varying degrees of success. In South Africa, despite our efforts, the HIV infection rate has increased significantly over the past 5 years. This increase in the infection rate calls for a renewed commitment from all South Africans.

### **1.1 PURPOSE OF THE STRATEGIC PLAN**

This document is a broad national strategic plan designed to guide the country's response as a whole to the epidemic. It is not a plan for the health sector specifically, but a statement of intent for the country as a whole, both within and outside government. It is recognised that no single sector, ministry, department or organisation is by itself responsible for addressing the HIV epidemic. It is envisaged that all government departments, organisations and stakeholders will use this document as the basis to develop their own strategic and operational plans so that all our initiatives as a country as a whole can be harmonised to maximise efficiency and effectiveness.

### **1.2 DEVELOPMENT OF THE STRATEGIC PLAN**

The development of this strategic plan was initiated by the Minister of Health, Dr. Manto Tsabalala-Msimang in July 1999 in response to President, Mr Thabo Mbeki's, challenge to all sectors of society to become actively involved in initiatives designed to address the HIV/AIDS epidemic.

It began with a meeting in July 1999 to review the current HIV/AIDS prevention, treatment, and care efforts in South Africa. The meeting was attended by representatives of faith-based organisations, people living with HIV infection and AIDS, human rights organisations, academic institutions, the civil military alliance, the Salvation Army, the media, organised labour, organised sports, organised business,

insurance companies, women's organisations, youth organisations, international donor organisations, health professionals and health consulting organisations, political parties, and relevant government departments.

After priority areas for future efforts were discussed and agreed upon, a committee was charged with developing a five-year HIV/AIDS and STD Strategic Plan. Task teams were established to review current goals and objectives for the designated priority areas. The priority areas are prevention; treatment, care and support; legal and human rights; and monitoring, research and evaluation.

In addition, the Minister of Health held bilateral meetings with several important sectors including traditional leaders, faith-based organisations and business to obtain their views and to discuss ways to facilitate their active participation.

In September 1999, the Minister of Health and the nine provincial MECs for Health reconfirmed the previous priority areas. This was followed in October 1999 by a two-day National AIDS Meeting where Provincial AIDS Co-ordinators, the National DOH HIV/AIDS/STD Directorate, representatives of the AIDS Training and Information Centres (ATICs) and representatives of several other organisations discussed progress in the five-year HIV/AIDS/STD strategic plan.

In October and November 1999 the task teams met to further develop their goals and objectives. Task Teams were expected to review the *National AIDS Plan for South Africa, 1994*, the Department of Health *White Paper for the Transformation of the Health System*, the *1997 Annual HIV/AIDS/STD review*, and reports from the September meeting of the Provincial MECs for Health, and the National AIDS meeting.

In November 1999 a draft document was presented to the Inter-Ministerial Committee on AIDS, and additional comments were solicited from all government Ministers. The final document was completed in January 2000.

## **2. BACKGROUND**

### **2.1 SITUATION ANALYSIS**

#### **The South African picture of the epidemic**

Recent estimates suggest that of all people living with HIV in the world, 6 out of every 10 men, 8 out of every 10 women, and 9 out of every 10 children are in Sub-Saharan Africa. These figures provide sufficient evidence to make HIV/AIDS both a regional and a national priority.

Data from the DOH's annual National HIV Seroprevalence Surveys of Women attending Antenatal Clinics for the past 10 years provides a good estimate of HIV prevalence and trends over time in South Africa (See figure 1).

**Figure 1: National HIV survey of women attending antenatal clinics of the public health services in South Africa, 1990 – 1999**

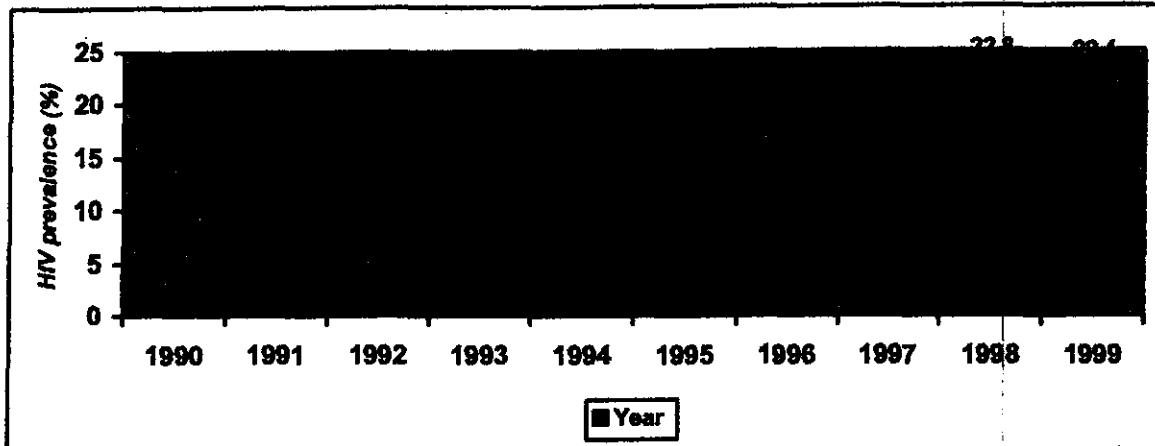
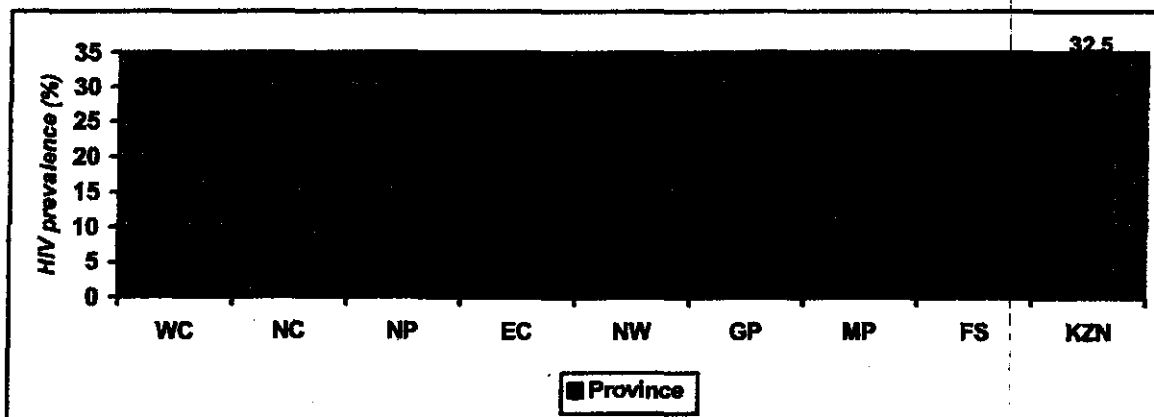


Figure 2 presents HIV prevalence in women attending antenatal clinics by province in 1998. These data show that there are geographic disparities in the distribution of the HIV/AIDS epidemic in South Africa.

**Figure 2: HIV prevalence in pregnant women attending public antenatal clinics by Province, South Africa, 1998**



Key<sup>1</sup>: KZN = KwaZulu-Natal Province; MP = Mpumalanga Province; FS = Free State Province; GP = Gauteng Province; NW = North West Province; NP = Northern Province; EC = Eastern Cape Province; NC = Northern Cape Province; WC = Western Cape Province

Additional information from the survey reveal that:

- The HIV epidemic in South Africa is one of the fastest growing epidemics in the world;
- Young women aged 20-30 have the highest prevalence rates; and
- Young women under age 20 had the highest percentage increase compared to other age groups in 1998 and 1999 compared to 1997.

These and other data clearly indicate that the HIV epidemic is severely affecting the young, black, and economically poor populations of South Africa.

Currently there are approximately 3.5 million South Africans living with HIV. It is estimated that in 1998 over 1,600 people were infected with HIV each day – translating to more than 550,000 people infected each year. It is estimated that by the year 2005, there will be 6 million South Africans infected with HIV and almost 1 million children under the age of 15 whose mothers will have died of AIDS.

AIDS is currently not a notifiable disease in South Africa and voluntary reporting seriously underestimates the number of people with AIDS. It is estimated that there were approximately 165,000 people living with AIDS and 120,000 AIDS deaths in 1998. Projections indicate that by 2002 a quarter of a million South Africans will die of AIDS each year, and that this figure will rise to more than a million by 2008. Average life expectancy is expected to fall from approximately 60 years to 40 years between 1998 and 2008.

#### **Major causes and determinants of the epidemic in South Africa**

The immediate determinants of the epidemic include behavioural factors such as unprotected sexual intercourse and multiple sexual partners, and biological factors such as the high prevalence of sexually transmitted diseases.

The underlying causes include socio-economic factors such as poverty, migrant labour, commercial sex workers, the low status of women, illiteracy, the lack of formal education, stigma and discrimination. The national HIV/AIDS & STD Strategic Plan must address all these immediate determinants and underlying causes.

#### **Tuberculosis and HIV/AIDS**

Closely linked to the HIV/AIDS epidemic, is a Tuberculosis (TB) epidemic which is fuelled by HIV infection and which is also the most frequent cause of death in people living with HIV. In South Africa, approximately 40-50% of TB patients are infected with HIV. In some hospitals in South Africa, the HIV prevalence in TB patients has been recorded as over 70%.

#### **Sexually Transmitted Diseases**

There is compelling evidence of the importance of STDs as a major determinant of HIV transmission. There are approximately 11 million STD episodes treated annually in South Africa, with approximately 5

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<sup>1</sup> See Annexure 1 for map

million of these managed by private general practitioners. Even without the HIV epidemic, STDs pose an important public health problem.

## **2.2 RESPONSE ANALYSIS**

A detailed description of the country's response to the HIV/AIDS epidemic is beyond the scope of this plan. However, a summary of the key responses and constraints include the following:

- ✘ In 1992 the National AIDS Co-ordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV/AIDS. Cabinet endorsed this strategy in 1994. The goals of this plan were to (a) prevent HIV transmission; (b) reduce the personal and social impact of HIV infection, and (c) mobilise and unify, provincial, international and local resources.
- ✘ A South African National STD/HIV/AIDS Review was conducted in 1997 in respect of the goals outlined in the NACOSA plan. This review indicated the following strengths in South Africa's response to the epidemic:
  - High level of commitment from the MOH;
  - Collaboration initiated by the DOH at various levels to ensure an interdepartmental and inter-sectoral response;
  - Highly motivated and active NGOs and CBOs, albeit operating with limited resources;
  - Adequate drug supply and accessibility for STD management in most clinics; and
  - Improvements in TB services.

The following constraints were noted:

- ✘ Major restructuring of national and provincial departments delayed the appointment of personnel. Both human and financial resources at all levels were limited.
- ✘ District structures had not been established.
- ✘ Lack of structured referral systems and continuity of care, home based care, and terminal care facilities.
- ✘ Lack of integration of STD/HIV/AIDS and TB care.
- ✘ Lack of visible commitment outside the DOH to effective interdepartmental implementation of the programme.
- ✘ Continued high levels of discrimination and human rights abuses of people infected and affected with HIV/AIDS.
- ✘ Lack of provincial policies, guidelines or management protocols for comprehensive care and counselling.
- ✘ Health promotion materials were not always available in the vernacular and were not client sensitive or user friendly.

Following this review of both the strengths and weaknesses in addressing the HIV/AIDS epidemic, the

following recommendations were made:

- ⌘ Increase resources and build capacity at provincial and district levels to manage, organise, and implement the HIV/AIDS/STD Programme. Provincial authorities should designate co-ordinators responsible for HIV/AIDS/STD in every Province and District;
- ⌘ Secure political leadership from the Deputy President and to increase political commitment and public leadership;
- ⌘ Strengthen interdepartmental and inter-sectoral response to the epidemic;
- ⌘ Develop concerted effort by all stakeholders to protect human rights, counter discrimination and reduce stigmatisation;
- ⌘ Support and strengthen PWA initiatives and increase full involvement of PWAs in program design, implementation, and evaluation;
- ⌘ Increase collaboration between the HIV/AIDS/STD and TB programmes.

Subsequent to the 1997 Review, some of the recommendations have been addressed by the following actions:

- ⌘ Appointing HIV/AIDS Co-ordinators in each province and supporting regular training and meetings to facilitate programme implementation;
- ⌘ Establishing an Inter-Ministerial Committee on AIDS. This Committee consisted of Ministers and Deputy Ministers and met on a monthly basis to discuss HIV/AIDS and provide political direction and policy guidance to the HIV/AIDS & STD Directorate. Late in 1999 there was a Cabinet decision to dissolve all Inter-Ministerial Committees and to take issues into the Governance Cluster meetings. In the case of HIV/AIDS this was also facilitated by the creation of the South African National AIDS Council;
- ⌘ Launching the Partnership against AIDS by the President in 1998 that seeks to broaden and formalise the participation by all sectors in the response to the epidemic;
- ⌘ Developing an HIV/AIDS policy by the Department of Education for learners and educators. This makes HIV/AIDS education a component in the curricula of all secondary schools;
- ⌘ Developing other national policies including, the Syndromic Management of STDs and post-exposure prophylaxis (PEP) following occupational exposure to HIV;
- ⌘ Establishing the South African AIDS Vaccine Initiative in 1998. This initiative seeks to develop an effective, affordable preventive vaccine for universal use in South Africa and SADC countries by 2005;
- ⌘ Establishing the South African National AIDS Council (SANAC), a multi-sectoral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan. The SANAC facilitates collaboration between government and all other sectors;
- ⌘ Establishing a national Interdepartmental HIV/AIDS Committee that has worked to develop HIV/AIDS workplace policies and minimum HIV/AIDS programmes for all government departments;
- ⌘ Developing a Strategic Framework for a South African AIDS Youth Programme; and
- ⌘ Improving collaboration between HIV/AIDS/STD and TB programmes in the area of policy formulation and advocacy.

This Strategic Plan aims to address those recommendations that have not been adequately attended to since 1997, and provides a strategic framework for the country's response to the HIV/AIDS and STD epidemic.

#### **Initiatives in the Southern African Development Community (SADC) countries**

South Africa is the current chair of and host of the Health Desk of SADC, which has 14 member states: Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

A regional response to HIV/AIDS and STDs is essential in curbing the spread, and to this end a SADC HIV/AIDS/STD task force has been formed and has prepared an HIV/AIDS/STD plan for 1999 - 2003. The three broad goals of the programme are to achieve:

- A better co-ordinated and harmonised response to HIV/AIDS/STD among Member States.
- A multi-sectoral response to HIV/AIDS/STD.
- Improved quality and coverage of the response to HIV/AIDS/STD both at national and regional level.

These initiatives will be important in ensuring that South Africa and its regional partners have a more co-ordinated response to the HIV/AIDS epidemic. SADC thus forms an important link in the mechanisms and structures available to the country.

### **3. CURRENT STRUCTURES IN SOUTH AFRICA TO ADDRESS HIV/AIDS**

The expanded national response will be managed by different structures at all levels. It is envisaged that each government ministry will have a focal person and team whose responsibility will be to plan, budget, implement and monitor HIV/AIDS interventions. It is also recommended that all other sectors including parastatals, NGOs, the private sector, faith-based organisations, youth, and women will also have dedicated HIV/AIDS focal persons. (See the diagram on the following page).

The following presents a brief overview of some of the important structures at national and provincial levels and their specific role and functions relating to HIV/AIDS. This list is by no means exhaustive, and only provides information on some of the current structures that play a role in the HIV/AIDS and STD arena.

#### **CABINET**

The Cabinet is the highest political authority in the country. The Cabinet meets weekly, but HIV/AIDS issues are not regularly discussed at this level, as this has been deferred to the South African National AIDS Council.

#### **SOUTH AFRICAN NATIONAL AIDS COUNCIL**

The South African National AIDS Council is the highest body that advises government on all matters relating to HIV/AIDS. Its major functions are to: (a) advise government on HIV/AIDS/STD policy, (b) advocate for the effective involvement of sectors and organisations in implementing programmes and strategies, (c) monitor the implementation of the Strategic Plan in all sectors of society, (d) create and strengthen partnerships for an expanded national response among all sectors, (e) mobilise resources for the implementation of the AIDS programmes, and (f) recommend appropriate research.

This body is chaired by the Deputy President, and consists of 16 government representatives (see list below) and 17 civil society representatives (see list below).

#### **Government**

Ministers of Health; Education; Welfare and Population Development; Agriculture; Arts, Culture, Science and Technology; Transport; Labour; Finance; Provincial and Local Government; Defence; Minerals and Energy; Correctional Services; Public Service and Administration; the Deputy CEO of the Government Communication and Information Systems; the Chairperson of the Portfolio Committee on Health; and the Chairperson of the Select Committee on Social Services.

#### **Sectors represented**

One representative each from Business; People living with HIV/AIDS; Non-government organisations; Faith-based organisations; Trade Unions; Women; Youth; Traditional healers; Traditional leaders; Legal and Human Rights; Disabled People; Celebrities; Sport; Media; Hospitality Industry; NAPWA, and Local government.

#### **Technical Task Teams**

The SANAC is assisted in its deliberations and decisions by technical task teams comprising experts in the following five areas: a) Prevention; b) Care and Support, c) IEC and Social Mobilisation, d) Research, Monitoring, Surveillance and Evaluation; and e) Legal Issues and Human Rights.

#### **INTERDEPARTMENTAL COMMITTEE ON AIDS (IDC)**

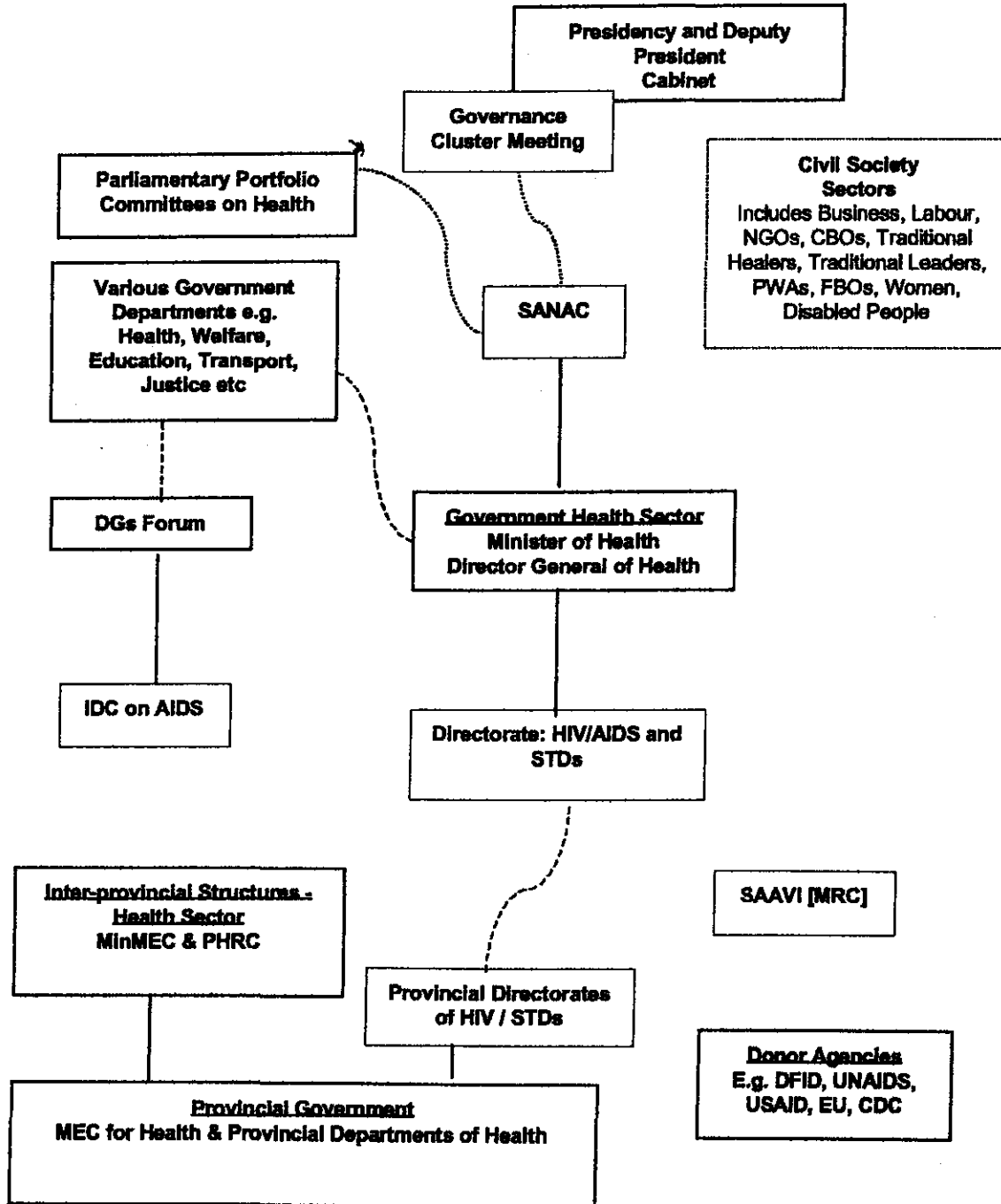
This committee consists of representatives from all government Departments who co-ordinate HIV/AIDS activities. The IDC meets monthly to review government programmes and to fulfil requests from SANAC. Goals of the IDC include facilitating the development of HIV/AIDS workplace policies in all Government Departments, ensuring that all Government Departments allocate financial resources to HIV/AIDS; and developing minimum HIV/AIDS programs for all Government Departments.

#### **MINMEC**

The MinMEC consists of all Provincial Health MECs and the national Minister of Health. The MinMEC meets every six weeks, and is the body that approves national policies and guidelines. HIV/AIDS is a standing item where reports on national and provincial programmes are discussed.



**Diagram 1: Relevant National and Provincial Structures**



#### **PROVINCIAL HEALTH RESTRUCTURING COMMITTEE (PHRC)**

This committee consists of all Provincial Heads of Health and meets on a monthly basis to discuss the strategic issues of national and provincial importance. HIV/AIDS is a standing agenda item where reports from the National HIV/AIDS/STD Directorate and Provincial HIV/AIDS Co-ordinators are discussed. Once the PHRC has discussed and approved documentation, it is referred to the MinMEC for the political approval.

#### **DIRECTOR-GENERALS FORUM**

This forum consists of Director Generals from all the National Government Departments and meets regularly. HIV/AIDS is a standing agenda item where reports from the IMC are discussed.

#### **HIV/AIDS AND STD DIRECTORATE, DEPARTMENT OF HEALTH**

HIV/AIDS issues are brought to the attention of the above national bodies by the Department of Health's Directorate of HIV/AIDS and STDs. This Directorate prepares briefing documents for these national forums, and attends meetings to provide further information to aid decision-making in these national committees and bodies.

#### **4. GUIDING PRINCIPLES**

The following principles for HIV/AIDS and STD prevention, treatment and care efforts for South Africa have been previously adopted in the *National AIDS Plan for South Africa, 1994 – 1995*, and the Department of Health *White Paper for the Transformation of the Health System in South Africa, 1997*, and are reaffirmed.

- ⌘ People with HIV and AIDS shall be involved in all prevention, intervention and care strategies;
- ⌘ People with HIV and AIDS, their partners, families and friends shall not suffer from any form of discrimination;
- ⌘ The vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection;
- ⌘ Confidentiality and informed consent with regard to HIV testing and test results shall be protected;
- ⌘ Education, counselling and health care shall be sensitive to the culture, language and social circumstances of all people at all times;
- ⌘ The government has a crucial responsibility with regard to the provision of education, care and welfare of all people of South Africa;
- ⌘ Full community participation in prevention and care shall be developed and fostered;
- ⌘ All intervention and care strategies shall be subject to critical evaluation and assessment;
- ⌘ All sectors of government and other stakeholders in civil society shall be involved in the fight against HIV/AIDS;
- ⌘ A holistic approach to education and care shall be developed and sustained;

- ⌘ Capacity building will be emphasised to accelerate HIV/AIDS prevention and control measures; and
- ⌘ STD prevention and control are central elements in the response to HIV/AIDS.

## **5. GOALS, OBJECTIVES, STRATEGIES AND LEAD AGENCIES**

The primary goals are to:

- ⌘ Reduce the number of new HIV infections (especially among youth); and,
- ⌘ Reduce the impact of HIV/AIDS on individuals, families and communities.

The following general strategies will be stressed:

- ⌘ An effective and culturally appropriate information, education and communications (IEC) strategy;
- ⌘ Increase access and acceptability to Voluntary HIV Counselling and Testing;
- ⌘ Improve STD management and the treatment of opportunistic infections and promote increased condom use to reduce STD and HIV transmission; and
- ⌘ Improve the care and treatment of HIV positive persons and persons living with AIDS to promote a better quality of life and limit the need for hospital care.

The Strategic Plan is structured according to the following four areas:

- ⌘ Prevention;
- ⌘ Treatment, care and support;
- ⌘ Human and legal rights; and
- ⌘ Monitoring, research and surveillance.

In addition, the youth will be broadly targeted as a priority population group, especially for prevention efforts.

### **NATIONAL SET OF PRIMARY INDICATORS AND SURVEILLANCE DATA FOR THE COUNTRY**

South Africa as a whole needs a set of key indicators that can be used to track the overall response of the country to the epidemic. This means not only tracking the course of the epidemic over the next five years, but also tracking changes the attitude, social values, health care practices, socio-economic conditions and behaviours that act as predisposing factors of the epidemic.

The following list of indicators are proposed as a combination of various indicators, that collectively can be used to judge how well the country is doing in terms of tackling the HIV epidemic. Where necessary, mechanisms to collect the required data will be developed.

#### ***General trend of the epidemic***

1. Prevalence of HIV amongst ante-natal clinic attendees (using national sentinel surveillance procedure)

### **Youth**

2. Prevalence of HIV amongst ante-natal clinic attendees below the age of 18 years (*using national sentinel surveillance procedure*)
3. Teenage pregnancy incidence and rate

### **Prevention**

4. Proportion of STD cases effectively managed using syndromic treatment in a) the public sector; b) the private sector
5. Percentage of sexually active women using condoms
6. Proportion of children leaving primary school who are fully informed of the causes and methods of transmission of HIV

### **Socio-economic indicators predisposing to HIV transmission**

7. Proportion of household living below the minimum poverty line
8. Unemployment rate

### **Abuse of women**

9. The number of reported rape cases
10. The number of cases of workplace legislation abuse related to employees contracting HIV

### **Social values, human rights and acceptance in the community**

11. The number of VCT clients
12. The number of homeless children, as a proxy indicator of the capacity of society to care for AIDS orphans.
13. The number of people "coming out" as people living with AIDS

The following section focuses in more detail on those strategies to be pursued in the next 5 years in order to bring about meaningful change in the spread of the HIV/AIDS epidemic in South Africa.

#### **PRIORITY AREA 1: PREVENTION**

Goal 1: Promote safe and healthy sexual behaviour

Goal 2: Improve the management and control of STDs

Goal 3: Reduce mother-to-child transmission (MTCT)

Goal 4: Address issues relating to blood transfusion and HIV

Goal 5: Provide appropriate post-exposure services

Goal 6: Improve access to Voluntary HIV Counselling and Testing (VCT)

#### **PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT**

Goal 7: Provide treatment, care and support services in health facilities

Goal 8: Provide adequate treatment, care and support services in communities

Goal 9: Develop and expand the provision of care to children and orphans

**PRIORITY AREA 3: RESEARCH, MONITORING AND SURVEILLANCE**

Goal 10: Ensure AIDS vaccine development

Goal 11: Investigate treatment and care options

Goal 12: Conduct policy research

Goal 13: Conduct regular surveillance

**PRIORITY AREA 4: HUMAN AND LEGAL RIGHTS**

Goal 14: Create an appropriate social environment

Goal 14: Develop an appropriate legal and policy environment

**PRIORITY AREA 1: PREVENTION**

**GOAL 1: PROMOTE SAFE AND HEALTHY SEXUAL BEHAVIOUR**

<b>Promote improved health seeking behaviour and adoption of safe sex practices</b>	<ul style="list-style-type: none"> <li>a) Produce and disseminate IEC material and messages to different stakeholders</li> <li>b) Implement life skills education in all primary and secondary schools</li> <li>c) Increase the number of trade unions who have implemented HIV/AIDS &amp; STD policies and programmes</li> <li>d) Facilitate and support the trucking industry's AIDS High Transmission project</li> </ul>	DOE, DOH, NGOs, Trade Unions, DOL, DOH Youth Sector, DOHA
<b>Broaden responsibility for the prevention of HIV to all sectors of government and civil society</b>	<ul style="list-style-type: none"> <li>a) Develop sector-specific policies and plans for the prevention of HIV/AIDS/STDs, focussing specially on the following sectors: Government sectors: Health; Education; Welfare; Local Government; Transport; Justice; Police; Correctional Services; Home Affairs; Civil society sectors: Traditional leaders; Youth; Faith-Based Organisations; Business; Entertainment and media.</li> </ul>	DOH, SANAC, All Sectors
<b>Implement HIV/AIDS prevention for migrants</b>	<ul style="list-style-type: none"> <li>a) Develop an health programme with an HIV focus as part of the Maputo corridor project</li> <li>b) Facilitate cross-border interventions</li> <li>c) <u>Work in partnership with other SADC countries</u></li> </ul>	DOH, SADC, UNAIDS
<b>Develop and implement counselling and care programmes for all national government departments</b>	<ul style="list-style-type: none"> <li>a) Create public awareness of HIV/AIDS &amp; STDs in all government departments</li> <li>b) Identify, train, and support peer educators</li> <li>c) Distribute condoms in all government department buildings</li> </ul>	DOH, Government Departments
<b>Improve access to and use of male and female condoms, especially amongst 15-25 year olds</b>	<ul style="list-style-type: none"> <li>a) Expand condom distribution through non-traditional outlets</li> <li>b) Improve access to condoms in high transmission areas (e.g. truck stops, borders, mines and brothels)</li> <li>c) Increase acceptance, attitudes, perceptions, efficacy and use of condoms as a form of <u>contraception among the youth</u></li> </ul>	DOH, All Sectors

**GOAL 2: IMPROVE THE MANAGEMENT AND CONTROL OF STDs**

Objective		
Ensure effective syndromic management of STDs in the private sector	<ul style="list-style-type: none"> <li>a) Investigate granting dispensing licences to nurses for STD treatment</li> <li>b) Monitor and regulate the quality of care in the private sector</li> <li>c) Training on syndromic management within the private sector</li> <li>d) Review Medical Schemes regulations to ensure minimum reimbursement for treatment of STDs</li> </ul>	DOH <sup>2</sup> , SAMA, Board for Health Funders, Health Professions Council of SA
Ensure effective Syndromic Management (SM) of STDs in the public sector	<ul style="list-style-type: none"> <li>a) Training in syndromic management undergraduate / basic curricula of all nurses, doctors and pharmacists</li> <li>b) Regular in-service training of HCWs</li> </ul>	DOH, SANC, Nurse training institutions, Medical Schools
Collaborate with traditional healers to improve health care seeking behaviour for STD treatment	<ul style="list-style-type: none"> <li>a) Develop, print and distribute training manuals in various languages</li> <li>b) Conduct capacity building workshops with THs</li> <li>c) Sensitise the health sector regarding traditional medicine</li> <li>d) Consider referral systems between traditional and western medicine</li> </ul>	DOH, Traditional Healer Organisations; CONTRALESA
Increase access to youth friendly reproductive health services – including STD management, VCT and rapid HIV testing facilities (special focus on youth, women, and migrant workers)	<ul style="list-style-type: none"> <li>a) Make clinics and HCWs “youth friendly”</li> <li>b) Make schools places where youth can access friendly and supportive counselling services</li> </ul>	DOH, DOE, Youth Sector

**GOAL 3: REDUCE MOTHER-TO-CHILD HIV TRANSMISSION (MTCT)**

Objective		
Improve access to HIV testing and counselling in ANC clinics	<ul style="list-style-type: none"> <li>a) Develop counselling guidelines</li> <li>b) Train counsellors</li> </ul>	DOH, Women's Sector, NGOs
Improve family planning services to known HIV positive women	<ul style="list-style-type: none"> <li>a) Train reproductive health providers on HIV/AIDS counselling</li> <li>b) Improve access to comprehensive reproductive health services for HIV positive women</li> </ul>	DOH, Women's Sector, NGOs, NPPHCN
Implement clinical guidelines to reduce the transmission of HIV during childbirth and labour	<ul style="list-style-type: none"> <li>a) Train all relevant midwives and medical practitioners</li> </ul>	DOH, Nursing Training Institutions, Medical Schools

<sup>2</sup> In section 5, DOH refers to both the national and provincial health departments

**GOAL 4: ADDRESS ISSUES RELATING TO BLOOD TRANSFUSION AND HIV**

Objective	Sub-objectives	Responsible
Maintain a safe blood transfusion service	<ul style="list-style-type: none"> <li>a) Monitor implementation of current guidelines on blood transfusion</li> <li>b) Develop national guidelines on HIV and blood transfusion</li> <li>c) Improve the recruitment of low-risk blood donors</li> </ul>	DOH, SA Blood Transfusion Service

**GOAL 5: PROVIDE APPROPRIATE POST-EXPOSURE SERVICES**

Objective	Sub-objectives	Responsible
Provide services for needlestick injuries and occupational exposure	<ul style="list-style-type: none"> <li>a) Ensure appropriate policies for needlestick exposure in the private sector</li> <li>b) Ensure the supply of anti-retroviral drugs to treat occupational exposure in public health facilities</li> <li>c) Reduce exposure to occupational exposure through the appropriate disposal of medical waste and sharps</li> </ul>	DOH, DOL
Investigate options to reduce HIV/STD transmission and pregnancies resulting from sexual assault	<ul style="list-style-type: none"> <li>a) Review research on use of ARV to prevent HIV transmission following sexual assault</li> <li>b) Assess services for women and men following sexual assault</li> </ul>	DOH, Research Institutions

**GOAL 6: IMPROVE ACCESS TO VOLUNTARY HIV COUNSELLING AND TESTING**

Objective	Sub-objectives	Responsible
Increase the number of Voluntary HIV Counselling and Testing sites	<ul style="list-style-type: none"> <li>a) Introduce counselling service in all new testing sites</li> <li>b) Expand use of rapid testing methods</li> <li>c) Increase the proportion of workplaces that have on-site counselling and testing services</li> </ul>	DOH
Increase the number of persons seeking voluntary testing and counselling services	<ul style="list-style-type: none"> <li>a) Promote access to VCT services, especially for the youth</li> </ul>	DOH, All Sector

**PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT**

**GOAL 7: PROVIDE TREATMENT, CARE AND SUPPORT SERVICES IN HEALTH FACILITIES**

Objective	Strategies	Responsible Parties
Improve treatment, care and support for people living with and affected by HIV/AIDS	<ul style="list-style-type: none"> <li>a) Develop guidelines for the treatment and care of HIV/AIDS patients in health facilities and the community</li> <li>b) Ensure uninterrupted supply of appropriate drugs for the treatment of opportunistic infections and other related conditions</li> <li>c) Build capacity of health professionals to provide comprehensive HIV/AIDS/STD/TB treatment, care and support</li> <li>d) Establish strong links between health facilities and community-based support programmes</li> <li>e) Improve prevention and treatment of TB and other opportunistic infections</li> </ul>	DOH, Training Institutions, PWAs
Establish poverty alleviation projects to address the root causes of HIV/AIDS/STDs and TB	<ul style="list-style-type: none"> <li>a) Incorporate HIV/AIDS/STDs and TB as indicators of poverty</li> <li>b) Involve relevant government departments and the private sector in poverty alleviation projects</li> </ul>	Agricultural sector, Government departments, NGOs, Business
Ensure appropriate practices in the private sector and medical insurance industry for the care and treatment of HIV positive clients	<ul style="list-style-type: none"> <li>a) Review international and regional practices relating to HIV and medical insurance</li> <li>b) Lobby the medical schemes industry to review benefits and coverage for HIV positive clients</li> <li>c) Standardise a minimum package of treatment and care for people living with HIV/AIDS in the public and private sector</li> </ul>	DOH, BHF

**GOAL 8: PROVIDE ADEQUATE TREATMENT, CARE AND SUPPORT SERVICES IN COMMUNITIES**

Objective	Strategies	Responsible Parties
Develop and implement models of community/home-based care in all provinces	<ul style="list-style-type: none"> <li>a) Develop appropriate home-based care implementation guidelines</li> <li>b) Promote the establishment of intersectoral task teams at community level to develop community/home-based care</li> <li>c) Reduce stigma of HIV/AIDS in communities and develop IEC materials targeted at communities</li> </ul>	DOH, DOW, NGOs
Increase acceptability to community/home-based care	<ul style="list-style-type: none"> <li>a) Use media for more exposure to the issues of home-based care in communities</li> </ul>	DOH, DOW, NGOs, Media, all sectors

**GOAL 9: DEVELOP AND EXPAND THE PROVISION OF CARE TO CHILDREN AND ORPHANS**

Objective	Strategies	Responsible Parties
Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS	<ul style="list-style-type: none"> <li>a) Promote advocacy of all relevant issues that affect children</li> <li>b) Mobilise financial and material resources for orphans and child-headed households</li> <li>c) Investigate the legal protection of child-headed households</li> <li>d) Provide social welfare, legal and human rights support to protect educational and constitutional rights</li> </ul>	DOH, DOW, DOJ, NGOs, Business

Objective		
Implement measures to facilitate adoption of AIDS orphans	<ul style="list-style-type: none"> <li>a) Investigate the use of welfare benefits to assist children and families living with HIV/AIDS</li> <li>b) Subsidise adoption of AIDS orphans</li> </ul>	DOW, DOE

### **PRIORITY AREA 3: RESEARCH, MONITORING AND SURVEILLANCE**

#### **GOAL 10: ENSURE AIDS VACCINE DEVELOPMENT**

Objective		
Support efforts to develop a Clade C HIV vaccine	<ul style="list-style-type: none"> <li>a) Conduct biological and behavioural research to support the development of an AIDS vaccine</li> <li>b) Support the South African AIDS Vaccine Initiative</li> <li>c) Develop South African ethical guidelines for vaccine research</li> </ul>	DOH, MRC, Research Institutions

#### **GOAL 11: INVESTIGATE TREATMENT AND CARE OPTIONS**

Review and revise policy on anti-retroviral use for reducing mother-to-child HIV transmission	<ul style="list-style-type: none"> <li>a) Review, monitor and evaluate current research on the use of anti-retroviral therapy to reduce mother to child HIV transmission</li> <li>b) Identify and implement additional areas of research</li> <li>c) Review and update national policies to reduce MTCT</li> </ul>	DOH, Academic Institutions, Research Institutions, Women's Sector
Conduct research on the cost-effectiveness of other forms of non-retroviral treatment and prophylaxis	<ul style="list-style-type: none"> <li>a) Review international research</li> <li>b) Facilitate local research</li> </ul>	MRC, DOH, Research Institutions
Conduct research on the effectiveness of traditional medicines	<ul style="list-style-type: none"> <li>a) Conduct clinical trials</li> <li>b) Review international research</li> <li>c) Collaborate with traditional healers</li> </ul>	Traditional Healers, MRC, DOH

#### **GOAL 12: CONDUCT POLICY RESEARCH**

Conduct HIV/AIDS studies in selected departments and provinces	<ul style="list-style-type: none"> <li>a) Commission research</li> </ul>	DOH, DOF, Government Departments
Conduct research to determine HIV incidence	<ul style="list-style-type: none"> <li>a) Conduct HIV incidence surveys in narrow age groups to approximate incidence</li> </ul>	MRC, DOH

**GOAL 13: CONDUCT REGULAR SURVEILLANCE**

<p><b>Develop mechanisms for long and short-term training to improve the capacities of provincial and district staff to conduct HIV/AIDS/STD related operations research, surveillance, and research</b></p>	<p>a) Training for provincial and district staff on research and surveillance in collaboration with research and training institutions</p>	<p>DOH, Academic Institutions</p>
<p><b>Conduct National Surveillance on HIV and STD risk behaviours, especially among youth</b></p>	<p>a) Conduct behavioural sentinel surveys, with a focus on youth  b) Conduct routine STD surveillance  c) Conduct surveillance of AIDS morbidity and mortality  d) Conduct national HIV infections surveillance in selected populations and groups, including STD and TB clients, hospitalised patients, men, and youth</p>	<p>DOH, HSRC, GCIS, MRC, Youth Sector</p>

**PRIORITY AREA 4: HUMAN RIGHTS**

**GOAL 14: CREATE AN APPROPRIATE SOCIAL ENVIRONMENT**

<p><b>Develop a National Inter-Sectoral Campaign on Openness and Acceptance of People Living with HIV/AIDS</b></p>	<p>a) Promote open discussion of sexual practices in various sectors of society  b) Promote voluntary testing and counselling services  c) Target awareness regarding rights and responsibilities of people living with HIV/AIDS in 4 key areas: employment rights, education, health care and social service rights</p>	<p>SANAC, Government Departments, NGOs, all Sectors, SABC</p>
<p><b>Create a legal and policy environment which protects the rights of all persons infected and affected by HIV/AIDS by 2005</b></p>	<p>a) Review existing legislation and ensure the protection of rights of people living with HIV/AIDS  b) Develop policy on the management of mentally challenged HIV positive persons  c) Review and enact new Children's Law to take into account the needs of children infected and affected by HIV/AIDS</p>	<p>DOJ, DOH, SALC</p>
<p><b>Monitor human rights abuses and develop enforcement mechanisms for redress</b></p>	<p>a) Statutory commissions (HRC and CGE) to set up a discrimination database to collect information on the nature and extent of discrimination against people affected by HIV/AIDS  b) Improve access to justice for people infected / affected by HIV/AIDS</p>	<p>DOJ, HRC, CGE</p>

**GOAL 15: DEVELOP AN APPROPRIATE LEGAL AND POLICY ENVIRONMENT**

<b>Develop policy and legislation relating to HIV/AIDS and employment</b>	<ul style="list-style-type: none"> <li>a) Finalise the Code of Good Practice on HIV/AIDS in the Workplace, and accompanying regulations, to enforce workplace HIV/AIDS policies</li> <li>b) Support the development of workplace HIV/AIDS policies</li> </ul>	DOL, DOH
<b>Develop policy and legislation relating to HIV/AIDS, commercial sex workers and sexual assault</b>	<ul style="list-style-type: none"> <li>a) Develop criminal law mechanisms which protect the rights of victims of sexual violence</li> <li>b) Investigate the provision of PEP to the victims of sexual violence</li> <li>c) Investigate decriminalising commercial sex work</li> </ul>	DOJ, DOH, SALC

**6. YOUTH AS A TARGET GROUP**

As indicated earlier in this document, youth is a specific focus area in the fight against HIV/AIDS as people between the ages of 14 –35 the most vulnerable to HIV infection. In addition, the youth are an important target group to protect against future HIV infection as they represent both the present and future economic powerhouse of the country.

In this section those strategies that relate to youth will be replicated to once again emphasise the need for all sectors of society to focus a significant amount of their resources and energies on this age group.

**Objective: Promote improved health seeking behaviour and adoption of safe sex practices**

- ⌘ Produce and disseminate IEC material and messages to different stakeholders
- ⌘ Implement life skills education in all primary and secondary schools

**Objective: Broaden responsibility for the prevention of HIV to all sectors of government and civil society**

- ⌘ Develop sector-specific policies and plans for the prevention of HIV/AIDS/STDs, focussing specially on the following sectors: ... youth ...

**Objective: Improve access to and use of male and female condoms, especially amongst 15 – 25 year olds**

- ⌘ Expand condom distribution through non-traditional outlets
- ⌘ Improve access to condoms in high transmission areas (e.g. truck stops, borders, mines and brothels)
- ⌘ Increase acceptance, attitudes, perceptions, efficacy and use of condoms as a form of contraception among the youth

**Objective: Increase access to youth friendly reproductive health services – including STD management, VCT and rapid HIV testing facilities**

- ⌘ Make clinics and HCWs “youth friendly”
- ⌘ Make schools places where youth can access friendly and supportive counselling services

**Objective:** Increase the number of persons seeking Voluntary HIV Counselling and Testing services

- ⌘ Promote access to VCT services, especially for the youth

**Objective:** Develop and Implement programmes to support the health and social needs of children affected by HIV/AIDS

- ⌘ Promote advocacy of all relevant issues that affect children
- ⌘ Mobilise financial and material resources for orphans and child-headed households
- ⌘ Investigate the legal protection of child-headed households
- ⌘ Provide social welfare, legal and human rights support to protect educational and constitutional rights

**Objective:** Implement measures to facilitate adoption of AIDS orphans

- ⌘ Investigate the use of welfare benefits to assist children and families living with HIV/AIDS
- ⌘ Subsidise adoption of AIDS orphans

**Objective:** Conduct National Surveillance on HIV and STD risk behaviours, especially among youth

- ⌘ Conduct behavioural sentinel surveys, with a focus on youth
- ⌘ Conduct national HIV infections surveillance in selected populations and groups, including youth

## 7. WAY FORWARD

Implementing the HIV/AIDS & STD Strategic Plan is essential to ensure the achievement of the national goals. Broad principles for implementation include the requirement that activities and practices are appropriate and cost effective for South Africa. Activities should be based on known evidence based practices.

Key critical areas for effective delivery include:

- A. Authority and political will at all levels
- B. Structures:
  - Delivery and implementation
  - Co-ordination
- C. Resources:
  - Financial Resources
  - Human Resources
  - Technical Resources
- D. Capacity:
  - HIV AIDS & STD understanding
  - Management
  - Monitoring and evaluation
- E. Communication:
  - National ⇔ Provincial & Provincial ⇔ National

- Provincial ⇔ Provincial
- Provincial ⇔ District ⇔ Community
- Government ⇔ Civil society

## **7.1 EFFECTIVE IMPLEMENTATION OF THE HIV/AIDS AND STD STRATEGIC PLAN**

To achieve this, the following issues will be addressed:

**a) Approval of the HIV/AIDS & STD Strategic Plan by national bodies such as SANAC and the National HIV/AIDS & STDs Directorate, followed by provincial and local structures**

The HIV/AIDS & STD Strategic Plan should be used in developing national, provincial and district operational plans. Yearly operational plans should be based on realistic objectives. These should be developed taking into consideration existing financial and human resources, the capacity thereof, the process of recruitment as well as the political commitment in each of the provinces. The setting of national goals will allow for inter-provincial comparisons and ensure a measure of unity regardless of the relative autonomy of the provinces. The provinces should then take these national goals and objectives and present them to key role players within the province to ensure all buy into what would be a Provincial Strategic AIDS Plan.

**b) Improve structures for delivery**

This involves reviewing and developing where necessary structures at all levels, from national to community. The concept of appropriate national structures such as the IDC and SANAC should be considered for duplication within provinces, keeping in mind the importance of delivery within communities.

The most important structures to create to guide the implementation of the Strategic Plan are:

- ⌘ A National AIDS Council, with duplicate bodies in each province
- ⌘ Interdepartmental Committees on HIV/AIDS in every province. One of the functions of the Interdepartmental Committees within the provinces would be to define each government department's unique and generic responsibility within the HIV/AIDS and STD Strategic Plan.

Equally important is the establishment of appropriate structures at district level to ensure the implementation of the HIV/AIDS and STD Strategic Plan. It is thus recommended that District HIV/AIDS Committees be established. These district structures should include community-based committees that represent major role-players within the relevant community in the field of HIV/AIDS.

These committees should include local government to ensure the integration of HIV/AIDS/STDs and TB issues and development plans. It is vital that this include non-health issues as part of HIV/AIDS/STD planning, such as transport and poverty alleviation.

**c) Establish acceptable standards for provinces with respect to resources**

**Financial Resources:** It is important to ensure that adequate funding is available at national and provincial levels within the healthcare environment to ensure delivery. One method is to establish an agreed resource standard for all provinces to directly place financial resources into HIV/AIDS. This is currently (in 1999/2000 prices) set as R10 per person per year or a total of R400 million per year for the whole country.

Related activities include:

- ⌘ Audit financial resources for HIV/AIDS activities within Provinces over the preceding three years.
- ⌘ Compare resources between provinces on a per capita and per HIV infected population.
- ⌘ Agree on standards or conditions by National bodies such as MinMEC, PHRC for allocating dedicated HIV/AIDS funding from National bodies.
- ⌘ Cost the HIV/AIDS and STD Strategic Plan and Programmes.
- ⌘ Agree on the continued funding by the National DOH of activities and products [such as condoms] that have a major cross provincial impact.

Funds for HIV/AIDS should be devolved to provinces from the national government only on the condition that certain standards are met. These include:

- ⌘ Presence of an Inter Departmental Committee on HIV/AIDS;
- ⌘ Commitment to "ringfence" funds for direct HIV/AIDS activities within provinces;
- ⌘ Commitment to distribute funds according to the HIV/AIDS & STD Strategic Plan;
- ⌘ Commitment to spend over 80% of the funds in one financial year;
- ⌘ Commitment to roll funds over funds into the new financial year without risk of penalty;
- ⌘ Commitment to prioritise the process of HIV/AIDS spending within the provinces;
- ⌘ Commitment to ongoing national and provincial communication;
- ⌘ Regular review of the implementation of HIV/AIDS Plans; and
- ⌘ Establishing realistic goals and objectives that can be implemented within provinces and districts.

**Human Resources:** It is vital to the success of this Strategic Plan that adequate human resources are available to ensure delivery. The constraint on action is arguably capacity rather than funding. The current standard suggested is one dedicated employee per 100,000 population. To evaluate the availability of human resources, it will be necessary to audit the existing human resources at national, provincial, regional and district levels. This audit should inform the process of establishing standards of personnel at district, regional and provincial levels of management.

**d) Regularly review the implementation of the strategic Plan**

The HIV/AIDS Strategic Plan must be reviewed every 12 months at national and provincial levels, with quarterly reports to be submitted to provincial and national structures.

The National DOH has overall responsibility for the implementation of the Strategic Plan within the provincial structures. Specific measurable targets and indicators will be developed for each objective and reported in yearly operational plans. The Strategic Plan will be monitored by these objectives and supplemented with additional monitoring including national, provincial and local behavioural surveys. These surveys will measure changes in HIV related risk behaviours including condom use, delay of sexual initiation among youth, HIV incidence, and the number of sexual partners.

Another important point is to establish a mechanism of constant and consistent feedback and reporting by provinces to national structures and vice versa. Information from the regular review should be used to serve as an information tool in communication between provinces of successes, as well as to other stakeholders to provide guidelines on activities to be involved in.

## **7.2 THE ROLE OF SECTORS**

The HIV/AIDS and STD Strategic Plan provides a broad framework for government, NGOs, business, labour, women and all sectors of society. Each sector should develop more specific plans based on their role in society, activities and their specific strengths. These plans should be based on each sector's comparative advantage in implementing the planned activities. Sectors are encouraged to establish technical AIDS committees, which will be responsible for advocating for, managing and co-ordination, the implementation of HIV/AIDS activities within that sector.

The sectoral AIDS committees will also be responsible for liaison with other sectors and the Directorate: HIV/AIDS and STDs. The recommended role of the sectors will be as follows:

- ⌘ Identify determinants of the spread of HIV/AIDS/STDs specific to the sector
- ⌘ Identify strengths and weaknesses with respect to HIV/AIDS/STDs
- ⌘ Identify obstacles to the response within the sector
- ⌘ Integrate HIV/AIDS/STD's activities in their yearly plans
- ⌘ Formulate specific HIV/AIDS sectoral plans and budget for their implementation
- ⌘ Mobilise resources for the interventions
- ⌘ Document best practice within the sectors and share information
- ⌘ Prepare and submit quarterly reports to the SANAC

All Ministries, including the MOH, will submit quarterly reports to the SANAC on their HIV/AIDS activities.

## **7.3 MONITORING AND EVALUATION**

The effective implementation of the activities outlined in the Strategic Plan will largely depend on the availability of human, financial and institutional resources. The sustainability of the response will depend

on an efficient monitoring process in the areas of policy development, institutional strengthening and service delivery.

Monitoring will ensure that activities are being implemented according to the plan and that each implementing agency and all partners contribute to the accomplishment of policy aims. This activity should be seen as mutually beneficial for the implementing agencies to assess their performance and seek corrective measures, and for government to formulate appropriate policy.

Effective monitoring and evaluation tools will be developed and customised for each intervention. These tools will identify strengths and weaknesses in the response programmes and activities and identify areas that need the redirection of resources. The cost effectiveness of selected interventions will be determined through special operational research.

#### **7.4 CONCLUDING REMARKS**

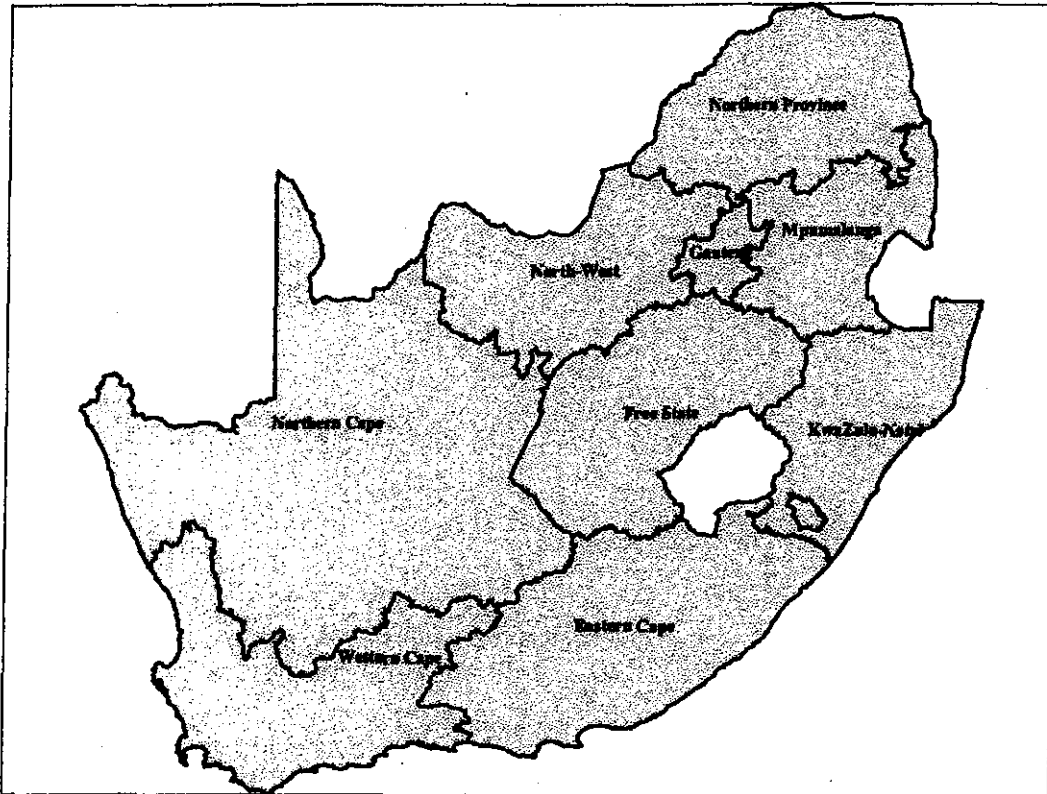
The HIV/AIDS and STD Strategic Plan is a living document and will be subjected to regular critical review. This will be undertaken at the National, Provincial and District levels with inputs from all stakeholders. A mid-term review will be conducted and the Strategic Plan modified in accordance with the findings.

## **ACKNOWLEDGEMENTS**

The development of this *"HIV/AIDS/STD Strategic Plan for South Africa: 2000 – 2005"* would not have been possible without the immeasurable assistance from countless individuals and organisations. Our thanks goes to every individual who took the time and effort to assist in the development of the document, be it through drafting sections or reading and commenting several times to improve the quality.

**Map of South Africa**

The following map represents the nine provinces that make up South Africa.



## **ANNEXURE B**



**PROVINCIAL COUNCIL ON AIDS**



**North-West**

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**ESTABLISHED 8 OCTOBER 2000**

**C.A. WORKING DOCUMENT**

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## Acknowledgement

*The development of this "HIV/AIDS & STDS working document for the North West Province would not have been possible without the immeasurable assistance from departments who were part of the planning committee for the launch of the Provincial Council on AIDS. Our thanks go to every individual who took the time and effort to assist in the development of this document, be it through drafting sections or reading and commenting several times to improve its quality. We would like to thank the Premier of the Province: Premier Popo Molefe for his support and leadership in the fight against HIV/AIDS in the Province.*

*Our special thanks to the MEC of Health: Dr. Molefi Sefularo for his guidance throughout the preparation for the launch of the Provincial Council on AIDS. We also wish to thank all government departments for their invaluable contributions.*

*Individuals representing different stakeholders in this fight, who agreed to serve on this Council are thanked heartily. Their contribution will ensure true civil participation and community ownership to all efforts to fight the scourge.*

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# Foreword

*HIV/AIDS is the most serious and devastating disease the world faces today. Research shows that developing countries are the most affected. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 95% of people currently infected with HIV/AIDS and 95% of the lives claimed by AIDS since the beginning of the epidemic, are in developing countries (UNAIDS, 1999).*

*Over the last few years the national and international response to the HIV/AIDS pandemic has increased dramatically. This, in addition to observations that the epidemic can be slowed down with appropriate interventions, is giving hope to its challenges.*

*The HIV/AIDS epidemic is the most important challenge facing South Africa since the birth of our new democracy. This challenge therefore, comes at a time when the country is faced with many other competing needs; redressing the imbalances of the past, transformation of our society, as well as integrating our country in the global economy are some of the many challenges.*

*Failure to respond to this epidemic, however, will reverse all the developmental gains, made in the last five years. The Government has therefore made the fight against this scourge a top priority. In so doing, it has chosen a multi-sectoral approach as a lead strategy in combating the HIV/AIDS epidemic.*

*Many organisations, communities and individuals have contributed a lot in the country's response and their efforts are applauded. There is however, an urgent need to bring in more partners and to consolidate our efforts for maximum impact. This Strategic Plan has been developed with the participation of many stakeholders. Key priority areas have been identified and sectors are expected to plan their interventions in line with these priorities.*

*The implementation of this working document and the North West Strategic Plan will require enormous resources. Therefore, all sectors including Government Ministries, Non-Governmental Organizations, the private sector, religious organizations, People Living with AIDS and donor organizations are urged to devote resources towards the fight against HIV/AIDS.*

*South Africans have fought and won many difficult wars before. We have the ability as a country to do the same with this epidemic. Let us 'Break the Silence' around HIV/AIDS. Let us break the AIDS chain.*

**Premier: Popo Molefe  
North West Province**

# 1. Introduction

In December 1999, the National Government introduced the concept of AIDS Councils to deal with the ever-increasing problem of HIV/AIDS. This is a group of prominent Citizens who will drive the process. This process has to cascade down to the Provinces and other structures such as Regions, Districts, Local Authorities, Schools, Churches etc. The prevalence of HIV/AIDS in the North West Province has been on the increase since the first antenatal care surveillance of 1991. Whereas in 1991, the prevalence of HIV among pregnant women was 1 % by 1998 it was 23% (23 pregnant women out of a hundred). Furthermore whereas there were only 3 cases of AIDS disease in 1987 by the end of 1998, there were more than 3 000 cases. The government approached the HIV epidemic using a 5-pronged approach namely.

*Behaviour modification  
Life skills education (in and out of school)  
Care and support for the infected and affected.  
STD management using a syndromic approach.  
Community mobilization.*

Despite all our efforts to stop the spread of the epidemic the impact has still not been felt. With the epidemic clearly out of control a new approach is necessary. To bring all sectors together, share ideas and resources and fight against HIV/AIDS with a common goal. The Provincial approach in the establishment of AIDS Councils was a bottom-up approach, thus building from the Local level to the Provincial level. The creation of Provincial and Regional and Local AIDS Councils is a way of having everyone involved and also helping in mobilizing every sector of the community. These structures will be more representative of the people at all levels. Furthermore the process used to appoint members is more democratic to ensure equitable representation. This ensures more information sharing and distribution to all the stakeholders. In most structures, information flows in only one direction. The bottom-up structure allows for a two-way information system, which in essence is better communication.

## 2. Mandate for the North-West Council on AIDS

*To advise government on HIV/AIDS/STDs and related matters.*

*To involve all sectors of civil society in the implementation of response programmes and strategies for the prevention of HIV/AIDS and the mitigation of its impact on the North West Province.*

*To monitor and co-ordinate implementation programmes and strategies of the North West Province multi-sectoral response to HIV/AIDS developed within the framework of the National five year Strategic Plan.*

*To provide overall guidance on the implementation of the National HIV/AIDS/STD Strategic Plan.*

*To create and strengthen partnerships for an expanded North West Province response among government agencies, NGOs, donors, the private sector, and people living with HIV/AIDS.*

*To ensure periodic review of the North West Province HIV/AIDS/STD Strategic Plan with the view of revising strategies in line with the prevailing and emerging scientific and socio-economic information of HIV/AIDS.*

*To mobilize resources for the implementation of the AIDS programmes and strategies in the Province*

*To recommend appropriate researches in the Province.*

*To facilitate the strengthening of institutional capacity for the implementation of the North West Province response to HIV/AIDS.*

*To guide Regional and Local AIDS councils  
To monitor the activities of all AIDS councils*

## 3. Membership

*Chairperson:* The Premier

### *Other members*

*MEC Traditional and Corporate Affairs.  
Chairperson of the Cluster Cabinet Committees  
MEC Health  
Chairperson of the all Standing Committees  
Private Medical Doctors' Representative.  
Faith Based Organizations  
NGO Coalition.  
Youth Commission  
Political Parties in the Province  
NNP  
UCDP  
NORWELOGA  
NAPWA  
North West African Farmers Union  
Sports Representatives  
Performing Arts  
Member of the House of the Traditional Leaders Association.*

*4 Chairpersons of the Regional AIDS councils  
MEC Education  
MEC Economic Affairs.  
Business Sector Representatives.  
Chamber of Mines  
Hospitality Industry  
Labour Movements  
SAC Military Alliance  
ANC  
DP  
FF  
Civic Organizations  
North West Agricultural Union  
Member of the Traditional Healers.  
Lawyers association  
Media Representatives*

## 4. Term of Office

The term of appointment will be two years.

## 5. Technical Task team

The North West Provincial Council on AIDS will be assisted in its deliberations and decisions by technical task teams to be established by the Provincial Council on AIDS, and should be composed of experts in the following five areas:

*Prevention, Information, Education, Communication and Social Mobilization*  
*Treatment, Care and Support*  
*Research, Monitoring, and Surveillance*  
*Legal Issues and Human Rights*  
*Advocacy and funding*  
*Workplace policies*  
*Support and Monitoring to Regional and Local councils*  
*The membership of these technical task teams will also be multi-sectoral.*

## 6. The structure of the North West Council on AIDS

It is proposed that the Provincial Council on AIDS in the Province should be run as a statutory body. The council will run as an entity controlled by a committee chaired by the Premier and composed of all the members as stipulated in the document on the establishment of the Provincial Council on AIDS.

A management team composed of the following people will support the council.

*One chief executive officer*  
*One secretary*  
*One administrative officer*  
*One administrative clerk*

Functions of the management team:

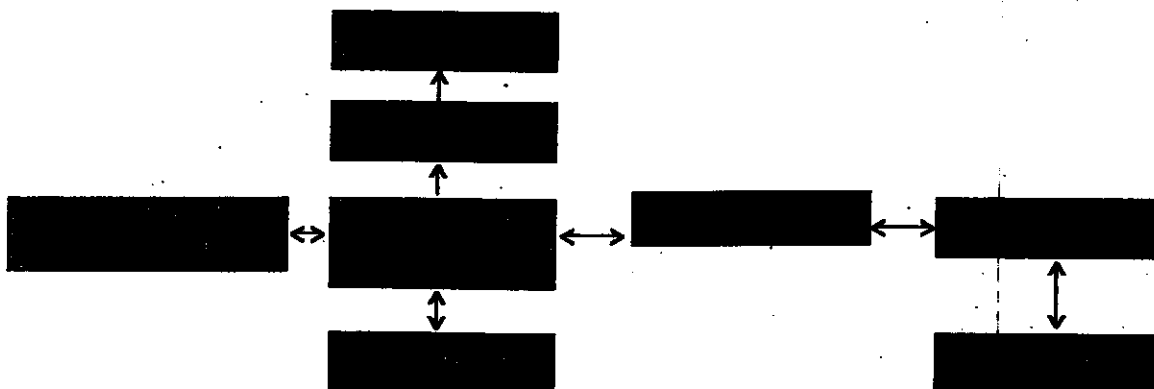
*To raise funds from all sources*  
*To manage the available funds and channel it appropriately*  
*To act as the secretariat for the Council Committee*  
*To address all issues pertaining to HIV/AIDS*  
*Assist all sectors in addressing HIV/AIDS issues*  
*To monitor the performance of all sectors in their endeavor to fight HIV/AIDS*

The Council will operate from an independent office with all office equipment. It is proposed that the Council have a toll free number, for easy access by all in the Province.

## 7. Financial Support

The North West Legislature will appropriate funds as part of the annual budget allocation to the Council. The Chief Executive officer will be the accounting officer of the Council. The council will raise some funds from individuals and non-Governmental donors. All donated funds have to be kept by the Council in their own budget. The Accounting Officer will be accountable to the Premier. The NW PCA will control all the funds in accordance with the Public Finance Management Act.

## 8. Lines of Accountability



## 9. Monitoring and Evaluation

The Department of Health in the Province has been designated by the Executive Council as the lead department to make sure that these Councils are functioning. The Department also has to ensure that monitoring and evaluation are enforced at all the levels of the Councils.

## 10. Management and Accountability

The Department of Health will facilitate the formation of these Councils. Furthermore when they are formed, it will also be the responsibility of the department to give the necessary technical support. It might be necessary to form technical support teams for the five programmes mentioned above.

Once established the Local AIDS Councils will be responsible to the Regional AIDS Councils, which in turn is responsible to the North West Council on AIDS.

## 11. Levels of AIDS Councils

To have AIDS Councils at all three levels of society, namely the Local level, the Regional level and at the Provincial Level.

### 1ST LEVEL

#### 11.1. Local Level

The composition of Local at this level will be the following

*Mayor of local council  
District health committee representative  
Representative of ministers fraternal  
Significant NGOs involved in AIDS work  
Representative of civics organization  
Representative of NAPWA  
Representative of traditional healers association*

*Chairperson of EXCO of local council  
Representative of local chamber of business  
Representative of NGOs  
Representative labour movement  
Representative of youth organization  
Representative of traditional leaders  
Any other stakeholder which is playing a significant role in HIV/AIDS*

This Council will have an executive committee and other sub-committees that will address HIV/AIDS along the following lines:

*Advocacy and Lobbying  
Care, support and Counselling  
Workplace programmes and policies  
Social Mobilization  
Home based care*

#### **Functions of the Local AIDS Council**

*Situation analysis of the local area and planning intervention according to the situation  
Community mobilization  
Mobilization of other sectors and stakeholders to become partners in the fight against HIV/AIDS  
Soliciting for funds from every stakeholder for HIV/AIDS education programs and other interventions.  
Capacity building  
Door-to-Door campaigns  
Involvement in Life skills education for in-and-out of school youths  
Any other issue relevant to HIV/AIDS.*

### 2ND LEVEL

#### 11.2. Regional Level

This will have to be created in the Regions in line with the new demarcations and be made up of four (4) Councils in line with these demarcations.

#### **Composition of the Regional AIDS Council**

Same as the Provincial Council on AIDS with the addition of the following:

*Two Representatives from each local council one being the Chair person  
Representative from Tertiary Institutes of education (Technicon, University etc)  
Labour at the regional level  
Major structures at the regional level  
Other key Stakeholders*

**Secretariat:** The Health Regional Office

**Functions of the Regional AIDS Council**

- Mobilization of funds*
- Monitoring the local councils*
- Information sharing at all levels*
- Capacity Building and Training*
- Policy Development and formulation.*
- Identification of critical issues such as research etc.*

**3RD LEVEL**

**11.3. Provincial Council on AIDS**

(See page 1 of this document)

**12. The Role of Different Sectors in the Fight Against HIV/AIDS**

**12.1. Faith Based Organizations**

Churches are found in all communities in South Africa and globally. They exert a significant level of cultural, political, social, educational and economic influence. The church is the largest, most stable and most extensively dispersed non-governmental organization in any country of the world. Churches are respected within communities and most have existing resources, structures and systems upon which to build. They possess the human, physical, technical and financial resources needed for the care and support of the affected and infected. The churches can support and implement small and large-scale HIV/AIDS initiatives. They can undertake these actions in a very cost-effective manner, due to their ability to leverage volunteer and other resources with minimal effort. These Church resources and expertise should be considered part of the solution and/or driving force in the fight against HIV/AIDS. Religious leaders and institutions have a powerful voice in society. They are able to encourage greater focus on belief and value modification efforts, promote policy making that includes the whole "family unit", and foster and provide access to care for those affected and infected by HIV/AIDS.

In countries where the churches have been involved in HIV/AIDS, notably Zambia, Zimbabwe, and South America, they have encouraged voluntarism and leveraged resources especially for home based care. Many Christian NGOs/CBOs, churches and parishes, as well as Christian networks and /or Christian hospitals have stepped forward to combat the epidemic. Churches can fill an important gap in the lives of people living with HIV/AIDS, that of responding to their spiritual needs and questions about guilt, suffering, and death.

In the absence of a cure or a vaccine, AIDS remains an overwhelming crisis for infected and affected individuals. Thus, there is a greater need for emotional and spiritual support. Local churches may be the only place where people receive understanding, compassion and answers to their complex questions and situations. Collaboration between health workers and people from the religious sector must advocate for a holistic approach to address a variety of needs of people living with HIV/AIDS, especially the integration of spiritual and emotional needs with the bio-medical ones. All churches whether Catholic, Protestant, and Evangelical or Episcopal must work together and commit to concrete inter-denominational actions.

Religion plays a central, integrating role in social and cultural life in most developing countries. There are many more religious leaders and helpers than other resources. They are in closer and regular contact with all age groups in society, and their voice is highly respected. In traditional communities, religious leaders are often the most influenced than local government officials or secular community leaders. In South Africa many churches especially those affiliated to the South African Council of Churches, were a very strong force against apartheid. They command great respect from the people of South Africa especially the underprivileged.

The Religious institutions have had longevity and stability, and have existed in communities for centuries despite changing political and cultural situation.

***Role of Faith Based Organizations in HIV/AIDS Prevention***

***Promotion of abstinence and the delay of onset of sexual relationships particularly among the youth.***

This is a very important aspect of HIV/AIDS prevention as it is 100% safe. Further the Youth is presently experiencing the fastest growing epidemic in South Africa.

***Encouraging mutual faithfulness in partnerships and especially in marriage.***

Research shows that up to 80% of women, who are infected annually in Africa, have never slept with any one besides their one partner; the church must encourage marriage partners especially men to become faithful so as to protect themselves and their spouses.

***Care and support for infected and affected people.***

Throughout its history the main religions like Christianity, Islam, Hindu or Bhudisim has always cared for the sick. Even in the Bible Jesus himself cares for the sick. Leaders of these faiths based organizations also ran the first hospitals in virtually every country of the world including most African countries.

#### ***Provision of pastoral and psychological counseling to family members.***

The affected people are usually neglected when it comes to counseling either due to shortage of human resources. The religious organizations with their abundant human resources and expertise in soul counseling and pastoral care could lend an important hand. Once a person has been diagnosed HIV positive, the church can integrate him into support groups and influence his family and community to continue accepting supporting him.

#### ***Educating children and the family in sexual issues.***

One cannot talk about fidelity and marriage without going into sexuality. Many youths in Africa belong to faith based organizations, and therefore can be reached much more easily than elsewhere. It is hoped that if the messages came from the Church, the youth would accept them more readily.

#### ***Becoming involved with Local Human Rights, Labour, and/or policy issues related to HIV/AIDS in a community.***

The history of apartheid in South Africa and other African countries has clearly shown the role of the religious leaders in protecting people's Human Rights. The Faith Based Organizations should continue this process and be a pressure group for the affected and the infected. Further with their massive Human Resource they can mobilize communities about their rights and explain policies to them. Every weekend some ten million people visit churches in South Africa, mosques, synagogues and temples, making it easy to mobilize communities.

#### ***Funding and collecting donations***

Many churches have collected and donated funds to various charities and care groups. The AIDS epidemic in Africa will leave many people desperate and the religious community will be needed to help these people.

#### ***Help changing values and behaviour among communities.***

Changes in values and behaviour are critical to slowing down the spread of HIV/AIDS, and indeed, value modification and change of behaviour are closely related. Internalized values can help shape human behaviour both in life affirming or in societal group; religious groups have tremendous resources for fostering changes in values, and ultimately, changes in behaviour.

#### ***Counseling and educating couples before and during marriage ceremonies***

Most people in Southern Africa get married in places of worship. They undergo marriage counseling and education before they take their vows. This is an opportune moment for leaders of the faith based organization to talk about, HIV/AIDS, fidelity and good parenthood etc. Couples need to be told how to respect one another and how to create an environment of trust, respect and understanding. They also should be taught how to bring up their children in a world, which protects them from teenage pregnancy, sexually transmitted diseases including HIV etc.

## **12.2. Traditional Healers**

Every traditional healer, prophet and everybody using traditional medicine or herbs should have the knowledge about STDs; HIV/AIDS; TB and all opportunistic diseases surrounding HIV/AIDS.

*Advise clients on health services rendered STD/HIV/AIDS/TB.*

*Educate clients on HIV/AIDS/STD*

*Distribute condoms at their places of work as well as in the community setting*

*Provide STD/HIV/AIDS/TB counseling.*

*Provide Home Based Care.*

*Encourage clients to voluntarily test for HIV.*

*Motivate communities to accept people living with HIV/AIDS.*

*Organize workshop sessions for the communities.*

*Planned community projects in line with programs in place around HIV/AIDS.*

*Assist Government in identifying local health problems prevailing in locality.*

*Distribute promotional material.*

*Co-operate with the Department of Health in the treatment of diseases*

*Attend workshops with the Department of Health using different clinics, health centres and hospitals.*

*Sharing information on the treatment of diseases*

*Establish a clear referral mechanisms to and from health facilities*

*Render home based care to the affected individuals*

*Render comprehensive counseling services*

*Offer community support for the families*

*Render financial support to the affected community*

*Advise Government on traditional cures for opportunistic diseases and other health problems*

## **12.3. Private Medical Practitioners and Hospitals**

The Private Medical Practitioners and hospitals treat many people in the North West Province. Their role in the fight against HIV/AIDS will have a tremendous effect on the country. Most significantly they treat persons with medical insurance. These are people from the leadership, professionals and economically productive sections of the society

*Involvement in AIDS related community activities, like involvement in community development projects*

*Working towards improvements in the treatment strategies*

*Providing holistic treatment strategies.  
Provide Prevention measures-safe sex and hygiene education.  
Treatment of opportunistic infections.  
Provide Anti-retroviral treatment when appropriate and affordable.  
Support to HIV/AIDS research in the Province.  
Education and advocating for social support to the infected and affected.  
Developing and strengthening partnerships between AIDS focused Organizations in the Private and public sectors*

## **12.4. The Business Sector**

### **Roles within the work place**

Develop a clear understanding, by management and labour of the company/workplace, of the current and changing state of the epidemic, new developments and approaches to managing it in the workplace

Quantify the prevalence of HIV infection in the workforce. Projecting this prevalence into the short and medium term future provides essential information for managing the likely impact of the disease on the workplace.

Carry out a Knowledge, Attitude and Practices survey to identify key issues to be addressed, establish behaviour and attitude changes and evaluate the effectiveness of the intervention.

Develop a proactive strategic plan and establish appropriate policies to deal with HIV/AIDS-related issues. Part of this process should be a thorough assessment of where and how HIV might affect a workplace; on its operations and related costs, and strategic ways developed to counteract the threat.

Ensure that employee benefits are adjusted appropriately to withstand the impact of the epidemic and develop appropriate healthcare packages and systems for management of the health care funds.

Establish an HIV managed-care approach for HIV- Infected members

Assess the possible impact of the epidemic on the company's markets and business

Monitor HIV-related deaths, known cases of HIV/AIDS, cases of TB, and absenteeism.

Provide necessary training and education of key human-resource and health care personnel in managing HIV/AIDS- related problems

Provide on-site care for STDs and TB.

Provide a comprehensive and visible AIDS awareness and programme. Skilled base peer education has proved effective.

Provide technical preventive options such as condoms

Establish a care and support programme for HIV-infected employees, as this becomes needed

Regularly review, audit and evaluate the AIDS initiatives, progress and state of the epidemic.

### **Roles outside the workplace**

The community at large, institutions (Schools, Colleges, Technikons and Universities) all are the main sources of supply of both skilled and unskilled labour to the business.

Business to fund and adopt AIDS programmes of Non-Profit Organizations, Non-Governmental Organization, Community Based Organizations, etc. to enhance effective and community based HIV/AIDS programmes, home based care etc.

Business should commit itself to equally invest on the workforce and the community at large. It is much cheaper to deal with HIV/AIDS awareness and prevention programmes rather than to deal with the cost implications of the results of HIV/AIDS both to our business and community.

## **12.5. Traditional Leaders**

*Organize community awareness in collaboration with other structure.  
Advice Government of health problems prevailing in their communities.  
Encourage communities to fight the spread of HIV collectively.  
Implement HIV/AIDS Provincial Policy.  
Encourage community debates on HIV/AIDS issues publicly.  
To protect the rights of people infected and affected with HIV/AIDS.*

- Encourage community to do voluntary counseling and testing.*
- Develop HIV/AIDS programme in consultation with the community.*
- Budget for HIV/AIDS programme.*
- Encourage community participation in all programs related to HIV/AIDS.*
- Support all initiatives geared towards prevention.*
- Support and be involved in HIV/AIDS related programmes and projects.*
- Organize advocacy and lobbying campaigns.*
- Discourage culture practices, which directly or indirectly contribute to the spread of HIV/AIDS and strengthen those which contributed to prevention.*

## **12.6. Organized Labour**

- To provide training on how to prevent exposure to HIV at work*
- To help members get protection if exposed to blood on the job*
- To ensure enforcement of occupational safety and health standards*
- To educate co-workers who fear contact with someone who has HIV/AIDS.*
- To organize and sponsor workshops on AIDS in the workplace*
- To educate all members on the spread of HIV/AIDS.*
- To provide parents with prevention information for their children.*
- Through workplace policies, unions can help these members by protecting the worker's job if they have to take extended leave for family members.*
- Unions can help by providing information and referrals on support for care givers.*
- To help in behaviour modifications of all workers in the work place*

### **Protecting workers' benefits by staying on the job after being infected with HIV/AIDS**

*One of the most important things unions can do to support a member with HIV/AIDS is to help the worker stay on the job. Staying on the job means a worker keeps his or her livelihood, pride, dignity and benefits. Workers with HIV/AIDS should be able to stay on the job and do their work as long as they are able. The kind of casual person-to-person contact that occurs between workers is not a risk for exposure to HIV.*

*Unions can negotiate contract language or work with management to develop an employee benefit plan to address the needs of workers with long-term illnesses. The plan could include:*

- Granting sick leave to go to the doctor*
- Granting long-term disability leave to those who need extended medical leave*
- Establishing a disability bank or sick leave bank where any worker can donate a percentage of his or her unused sick leave or vacation time for use by co-workers with long-term illnesses. These banks allow workers to take extended time off after their personal vacation and sick leave time are used up.*

- Ensuring that health plans cover home care, hospice care, extended care, drugs, and treatments.*
- Providing paid family leaves for workers who care for family members with a long-term illness.*
- Establishing flextime.*

## **12.7. The Role of the Media**

The media play a vital role in shaping a population's attitudes and opinions regarding HIV and AIDS. There has been no other Provincial crisis, which is more, affected by under reporting than the HIV/AIDS epidemic. This can be attributed, in part, to the "hidden" spread of HIV.

Amongst others these are some of the roles:

- Broadcast discussion, debates and talk shows on HIV/AIDS related topics.*
- Commission and broadcast drama productions which integrate HIV/AIDS relevant issues. Refuse drama productions that project misconceptions about HIV/AIDS.*
- Provide free airtime for HIV/AIDS related messages on broadcast media.*
- Give special prominence to HIV/AIDS related news items.*
- Air weekly phone in programmes on HIV/AIDS related topics on radio*
- Establish that all presenters, hosts and anchors on television programmes wear the red ribbon as a symbol of solidarity and support for people living with HIV/AIDS.*
- Provide free space for HIV/AIDS-related messages in print media*
- Print regular columns, frequent commentaries, human interest stories and editorials on HIV/AIDS related topics*
- Integrate HIV/AIDS education into the training for all journalists/reporters.*
- Ensure editor's forums and media organizations keep the debate on HIV/AIDS alive and that all journalist and editors have sufficient skills to deal with the complexity of the HIV epidemic.*

## 12.8 The Role of Government

Government employs close to 1 million people and will thus be affected by HIV/AIDS like any other employer. With one in seven civil servants already being infected with HIV, AIDS will impact on employee benefits, absenteeism, productivity and recruitment and training costs. AIDS is going to impact on the service needs of communities, for example, by putting additional pressure onto already overstretched health and welfare budgets. Each government department must develop a better understanding on how exactly HIV/AIDS is impacting on its line function.

Amongst others these are some of the roles:

*Develop and HIV/AIDS workplace policy that addresses HIV/AIDS specific HR and employment issues.*

*Conduct HIV/AIDS awareness programmes for employees, for example by exhibiting and distributing media, showing videos and giving presentations.*

*Organize the training of peer educators on HIV/AIDS and conduct in-house HIV/AIDS peer education programmes.*

*Make condoms available and accessible to all officials.*

*Identify local counselling and STD services and establish a referral mechanism. Alternatively large departments can set up in-house counselling services and STD services.*

*Conduct an impact assessment to determine what HIV/AIDS will do to line functions and to the capacity to deliver services.*

*Conduct a strategic planning workshop during which the findings of the impact assessment are translated into a strategic vision and where the necessary policy changes are identified.*

*Use the inter-face with the public, with parastatals and with organs of civil society to communicate HIV/AIDS related messages and to distribute media and condoms.*

*Print the red ribbon as a symbol of compassion and solidarity on all official letterhead and include HIV/AIDS messages in all official correspondence.*

*Budget for an internal and external HIV/AIDS programme.*

## 12.9. The Role of Non-Governmental and Community Based Organizations

Communities have tremendous powers and resources and the ability to find appropriate solutions to their problems. Community based organizations (CBO's) enjoy a high degree of credibility and can mobilize large numbers of people. Non-Governmental Organizations (NGO's) are usually formed to address a particular problem. Their operational principles are flexible and usually appropriate to the task at hand.

International experience has shown that HIV/AIDS programmes are likely to succeed if they enjoy a high degree of community involvement and support. CBO's and NGO's are key partners of government in the fight against HIV/AIDS. CBO's and NGO's are well placed -to raise the awareness of HIV/AIDS in communities before the harsh realities of the epidemic become more evident.

NGO's and CBOs can shape people's attitudes, and modify risky sexual activity. NGOs and CBOs can also provide community-based care and help communities cope with the psychosocial consequences of the HIV/AIDS epidemic.

These are some of the roles:

*Provide community based HIV/AIDS awareness by giving talks organizing discussions and distributing media and condoms.*

*Mark commemorative days, such as world Aids Day through rallies and cultural events.*

*Establish community based HIV/AIDS peer education programmes.*

*Provide technical assistance and support on HIV/AIDS related matters.*

*Provide out reach, education and training services to marginalised groups, which are hard to reach by Government but are particularly vulnerable to HIV (such as commercial sex workers and prisoners).*

*Run cost effective services such as Home Based Care programmes and counselling services.*

*Mobilize, educate and train members on HIV/AIDS related matters.*

*Include HIV/AIDS related messages in public speeches made by leaders of civil society, to ensure the epidemic is kept high on the public agenda.*

*Create alliances and networks between AIDS NGO's and CBO's and those working in other fields to bring the AIDS message to wider constituents.*

*Ensure NGO and CBO umbrella organizations act as links between the Government AIDS programme and local communities for an integrated response.*

## 12.10. Sports, Arts and Entertainment Sectors

The arts and entertainment industries, arts, culture and sports target mainly the young section of society, which is most at risk of HIV. Sporting personalities are powerful role models with the ability to influence attitudes of societies; (E.g. Magic Johnson in the USA)

The arts and entertainment sectors are in an ideal position to communicate HIV/AIDS messages. Sports and entertainment both produce heroes, who can positively influence the behaviour and attitudes of young people.

These are some of the roles:

*Print HIV/AIDS related messages on advertising boards and display them on the electronic score boards in stadiums.*

*Include HIV/AIDS education in sports development programmes.*

*Encourage and support sporting and entertainment celebrities, who may be infected, to publicly disclose their HIV status. Alternatively the role models from sport, art and entertainment can make public statements on HIV prevention and the acceptance of people living with HIV/AIDS.*

*Encourage personalities to wear the red ribbon (a symbol of compassion and solidarity for people living with HIV/AIDS at all public appearances.*  
*Encourage personalities and their respective organizations to get involved in fundraising for HIV/AIDS programmes.*  
*Make condoms and HIV/AIDS media available at places of entertainment and at sporting events.*  
*Ensure that arts and culture organizations run competitions and exhibitions on HIV/AIDS related matters.*  
*Make HIV/AIDS the subject of songs, drama, pictures and films.*  
*Celebrate days such as World Aids Day and Youth Day with major music, or sports festivals.*  
*Ensure that sportsmen and women travelling abroad receive life-skills education as part of their preparations for international competitions and become international HIV/AIDS ambassadors for South Africa.*

## **12.11. The Role of Women's Organisations**

The strategies undertaken to prevent the spread of HIV have focussed mainly on the promotion of condom use, the reduction of numbers of sexual partners and the treatment of STD's. Many of these responses, however, have failed to address the social, economic and power relations between men and women. Women continue to bear the brunt of the AIDS epidemic: women are physiologically more vulnerable to HIV infection; stereotyping and blaming of marginalized groups; such as sex-workers, contribute to blaming women for the spread of HIV. Low social status and economic dependence prevent women from controlling risk situations and negotiating safer sex practices. As care-givers, women often carry the psychological and physical burdens of AIDS care. Therefore Women's Groups play an important role in sensitizing their constituents and lobbying for AIDS strategies, that are more gender sensitive.

These are some of the roles:

*Provide community based HIV/AIDS awareness by giving talks, organizing (including the female condom).*  
*Mark event days, such as World Aids Day and Women's Day with rallies and information dissemination, regarding AIDS and gender issues.*  
*Establish community Based HIV/AIDS peer education programmes, workshops, trainings, and role-plays.*  
*Encourage and support HIV positive women and men to speak openly about living positively with HIV and AIDS.*  
*Provide outreach, education and training services to marginalised constituencies which are hard to reach by Government but are particularly vulnerable to HIV (such as commercial sex workers)*  
*Run cost effective services such as Home based care programmes and counseling services.*  
*Mobilize educate and train the members of women's organizations on HIV/AIDS related matters.*  
*Encourage leadership of civil society to include HIV/AIDS and gender sensitive messages in public speeches thereby ensuring that the epidemic, and its impact on gender, is understood.*  
*Identify the linkages between the work done in women's organizations and the issues around HIV/AIDS and address these issues in general communications. Network with AIDS NGO's and CBO's.*  
*Create links between the Government AIDS Programme and local communities, communicating both ways: informing communities about developments in the AIDS programme and linking them with resources, as well as channelling policy input and concerns from communities to Government.*

## **12.12. The Role of Individuals**

The reality of the HIV/AIDS epidemic is that it can only be averted by individual behavior change. Any intervention made has to be done with the aim of enabling an individual to avoid high-risk behavior. Therefore every individual has to internalize his or her own risk of contracting HIV. The virus knows no age, gender, race, or status boundaries. Every man, woman and child is at risk.

These are some of the roles:

*Get Informed -know your own personal risks*  
*Call the AIDS helpline for information or counseling*  
*Talk openly about HIV and AIDS with family, community and colleagues*  
*Practice safer sex - abstain from sexual intercourse*  
*Be in a mutually faithful relationship*  
*Use Condom correctly and consistently during every sexual act.*  
*Live healthily and be aware of good nutrition and support if HIV+*  
*Volunteer your time to Aids work e.g. peer education, counselling, or hospice care.*  
*Practice non-discrimination against those affected and infected*  
*Lobby for greater Aids information, care and health services*  
*Get tested if you have had unprotected sex in the last 10 years and so be aware of your HIV status, inform new sexual partners if HIV+*  
*Have your STD'S treated immediately - STD's increase the risk of HIV infection.*

## **12.13. The Role of PWA'S in the Fight Against HIV/AIDS**

HIV/AIDS has infected and affected many individuals and families. Despite our efforts to curb the rapid spread of HIV infection, the HIV infection rate has increased significantly. Facts indicate that the HIV epidemic in South Africa is one of the fastest growing in the world. Thus the increase in the infection rate calls for a renewed commitment from all South Africans. It is recognized that no single sector is by itself responsible for addressing the HIV/AIDS epidemic. The PWA community has been and is still part of the broader partnership that is up in arms in the fight against HIV/AIDS.

### **Involvement of PWA'S**

In the past PWAs were not regarded as people who could make a significant contribution in the fight against HIV/AIDS. However, national and international experience and studies have shown that the involvement of PWAs can contribute significantly in the fight against HIV/AIDS. Moreover, the national AIDS plan for South Africa, as its first principles, states that PWAs must be

involved in all prevention, intervention and care strategies. Secondly, that PWAs, their partners, families and friends should not suffer any form of discrimination (NAPWA 2000 proposal).

### **Specific Roles of PWA's**

#### **Mobilization of People Living with HIV/AIDS:**

PWAs are organized to be visible and to be able to voice their needs and rights. Through PWA movements such as the national association of people living with HIV/AIDS (NAPWA) PWAs are mobilized into support groups where they share their problems, concerns, experiences and challenges.

#### **Care and Support:**

One of the most important contributions of PWAs is to provide and facilitate care and support for other PWAs and to provide counseling for those who need it.

#### **Advocacy and Lobbying:**

PWAs are involved in the fight against HIV/AIDS by ensuring that a conducive environment that is not discriminatory is created and maintained and advocating and lobbying for the interests of PWAs at all levels.

#### **Disclosure and Acceptance Campaign:**

PWAs around the country are involved in a programme called disclosure and acceptance campaign. This campaign aims at putting a face to the epidemic. It highlights the realities of HIV/AIDS and makes certain that people understand the existence of HIV/AIDS by seeing PWAs disclosing their status. The main objective of public disclosure is to destigmatise the epidemic so that communities can accept and support PWAs.

#### **General HIV/AIDS Awareness Campaign**

Many PWAs are carrying out voluntary work at local level, i.e. clinics, hospitals, schools, churches etc, educating people about HIV/AIDS. When there are general HIV/AIDS public awareness campaign PWAs are often called in to make presentations.

#### **Contribution in the HIV/AIDS Policy Development**

PWAs through PWA movements such as NAPWA, also participate in policy development processes. There are a number of HIV/AIDS national policy formulations where PWAs have made significant contributions.

#### **Home-based Care**

Some PWAs are involved in home-based care. They do this by visiting sick PWAs at home. In other areas of the country PWAs assist in the distribution of food parcels and clothing.

PWAs have and are still contributing in the fight against HIV/AIDS. Their willingness to disclose about their positive status has put a human face to HIV/AIDS.

# APPENDIX 1

## FIVE YEAR HIV/AIDS STRATEGIC PLAN FOR THE NORTH WEST PROVINCE

### Background

This document is a broad Provincial strategy derived from the National strategic document as a way of customizing it to the Province. A task team was working on this document to make it as it is now for better collaborative action by all sectors in the North West Province.

### Rationale

The rationale for a strategy in the Province is to give a broad outline which all Governments departments, organizations and stakeholders will use as a basis to develop individual strategies and plans. The strategy aims to solicit provincial collaboration in the fight against HIV/AIDS. It calls for sectoral support, partnership and co ordination in dealing with the epidemic in the North West Province.

### Applicability

The strategy is composed of objectives core strategies, support strategies and the agencies to implement those strategies with time frames for monitoring purposes.

#### GOAL 1. PROMOTE SAFE AND HEALTHY SEXUAL BEHAVIOUR

##### STRATEGIES

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Promote improved health seeking Behaviour and adoption of safe sex Practices.	Produce and disseminate IEC material and messages to different stakeholders.  Implement life skill education in all primary and secondary schools; modify curriculum to deal with HIV/AIDS issues.	Increase the number of trade unions who have implemented HIV/AIDS & STD policies and programmes  Facilitate and support the trucking industry's AIDS High Transmission project.	Education Labour Transport Public Works & Roads, Sectors	Yearly Review
2. Broaden responsibility for the prevention of HIV to all sectors of government and civil society.	Develop sector-specific policies and plans for the prevention of HIV/AIDS/STDs, focusing specially on the following sectors: Government sectors: Health; Education; Welfare; Local Government; Transport; Justice; Police; Correctional Services; Home Affairs; Civil Society sectors: Traditional healers; Youth; Faith-Based Organizations; Business; Entertainment and media.		DOH, PCA All sectors.	Yearly Review
3. Implement HIV/AIDS prevention for Migrants	Develop HIV/AIDS prevention plans.	Facilitate cross-border interventions	DOH All Departments	Yearly Review
4. Develop and implement counseling and Care programmes for all government Departments	Create public awareness of HIV/AIDS & STDs in all government departments  Identify, train, and support peer educators	Distribute condoms in all government department buildings.	DOH Government Departments All sectors	Yearly Review
5. Improve access and use of male and female condoms, especially amongst 15-25 year olds.	Expand condom distribution points to more clinics, shops, taverns etc.  Improve access to condoms in high transmission areas (e.g. truck stops, borders, mines, hotels and brothels)	Increase acceptance, attitudes, perceptions, efficacy and use of condoms as a form of contraception among the youth.  Institute Employment Assistant Programmes	DOH All sectors All Departments	

**GOAL 2. IMPROVE THE MANAGEMENT AND CONTROL OF STD**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Ensure effective Syndromic management of STDs in the Province.	Investigate granting dispensing licenses to nurses for STD treatment Monitor pathogens and Drug resistance Monitor and regulate the quality of care in the Province. Ensure mass treatment campaigns Training on syndromic management within the Province. Review Medical Schemes regulations to ensure minimum reimbursement for treatment of STDs		DOH	Yearly Review on Progress  Yearly
2. Collaborate with traditional healers to improve health care seeking behaviour for STD treatment	Develop, print and distribute training manuals in various languages in the Province Sensitize the health sector regarding traditional medicine Consider referral systems between traditional and western medicine	Conduct capacity building workshops with Traditional Healers	DOH Traditional Healers Council Departments	
3 Increase access to youth friendly reproductive health services including STD management, VCT and rapid HIV testing facilities (special focus on youth, women, and migrant workers)	Make clinics and HCWs "youth friendly" Establish two VCT centres in all districts	Make schools places where youth can access friendly and supportive counselling services.	DOH, DOE, Youth Commission and Sectors	

**GOAL 3. REDUCE MOTHER-TO-CHILD HIV TRANSMISSION (MTCT)**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Improve access to HIV testing and counselling in ANC clinics	Train Counsellors		DOH, Women's Sector	
2. Improve family planning services to known HIV positive women	Train reproductive health providers on HIV/AIDS counselling. Improve access to comprehensive reproductive health services for HIV positive women		DOH NGOs	
3. Implement clinical guidelines to reduce the transmission of HIV during childbirth and labour.	Train all relevant midwives and medical practitioners in the Province.		DOH	
4. Implement pilot project on MTCT in the Province	Monitor the development in all MTCT sites in the Province		DOH	

**GOAL 4. ADDRESS ISSUES RELATING TO BLOOD TRANSFUSION AND HIV**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Maintain a safe blood transfusion service	Monitor implementation of current guidelines on blood transfusion. Develop Provincial guidelines on HIV and blood transfusion Improve the recruitment of low-risk blood donors		DOH,	

**GOAL 5. PROVIDE APPROPRIATE POST EXPOSURE SERVICES**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Provide services for needle stick Injuries and occupational exposure	Ensure appropriate policies for needle stick exposure in the private and Public Sectors.	Reduce exposure to occupational exposure through the appropriate disposal of medical waste and sharps	DOH, DOL All sectors	
2. Investigate options to reduce HIV/STD transmission and pregnancies resulting from sexual assault.		Assess services for women and men following sexual assault.	DOH, All Departments and Universities	

**GOAL 6. IMPROVE ACCESS TO VOLUNTARY TESTING AND COUNSELLING**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Increase the number of voluntary HIV testing and counselling sites	Introduce counselling service in all new testing sites. Expand use of rapid testing methods	Increase the proportion of work-places that have On-site counselling and Testing services  Increase the proportion of work-places that have on-site counselling and testing services.	DOH, All Departments	
2. Increase the number of persons seeking voluntary testing and counselling services	Promote access to VCT services, especially for the youth.	Promote access to VCT Services, especially for The youth.	DOH, All sectors	

**GOAL 7. PROVIDE TREATMENT, CARE AND SUPPORT SERVICES IN HEALTH FACILITIES**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Improve treatment, care and support for people living with and affected by HIV/AIDS	Develop guidelines for the treatment and care of HIV/AIDS patients in health facilities and in the community.  Ensure uninterrupted supply of appropriate drugs for the treatment of opportunistic infections and other related conditions.  Build capacity of health professionals to provide comprehensive HIV/AIDS/STD/TB treatment, care and support  Establish strong links between health facilities and community-based support programmes  Improve prevention and treatment of TB and other opportunistic infections.		DOH, Training Institutions, PWAs	
2. Establish poverty alleviation projects to address the root causes of HIV/STDs and TB		Incorporate HIV/AIDS/STDs and TB as indicators of poverty.  Involve relevant government departments And the private sector in poverty alleviation Projects.	Agricultural sector, Government departments, NGOs, Business Arts, Culture, Sports	
3. Ensure appropriate practices in the private sector and medical insurance industry for the care and treatment of HIV positive clients	Review international and regional practices relating to HIV and medical insurance.  Lobby the medical schemes industry to review benefits and coverage for HIV positive clients			
	Standardize a minimum package of treatment and care for people living With HIV/AIDS in the public and private sector			

**GOAL 8. PROVIDE ADEQUATE TREATMENT, CARE AND SUPPORT SERVICES IN COMMUNITIES**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Develop and implement models of community/home-based care in all Districts or Regions.	Develop appropriate home-based care implementation guidelines. Establish one HBC per District Promote the establishment of intersect oral task teams at community level to develop community/home-based care. Reduce stigma of HIV/AIDS in communities and develop IEC materials targeted at communities.	Support NAPWA activities in the Province Avail resources for the groups in the Province	DOH, Sectors Arts, Culture Sports and Welfare DOH, NGOs, Media All sectors Departments Sectors	2001 Yearly review
2. Increase acceptability to community/home-based care	Use media for more exposure to the issues of home-based care in communities.			
3. Establish support groups in the communities in the Province	ca			

**GOAL 9. DEVELOP AND EXPAND THE PROVISION OF CARE TO CHILDREN AND ORPHANS**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS	Investigate the use of welfare benefits to assist children and families living with HIV/AIDS	NGOs, Welfare Business DOH Subsidize adoption of AIDS orphans Mobilize financial and material resources for orphans and child-headed households Investigate the legal protection of child-headed households Provide social welfare, legal and human rights support to protect educational and constitutional rights Investigate the use of welfare benefits to assist children and families living with HIV/AIDS Subsidize adoption of AIDS orphans	NGOs, Welfare Business DOH Justice Welfare Welfare DOE	Yearly

**GOAL 10. ENSURE AIDS VACCINE DEVELOPMENT**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1 Support efforts to develop a Clade C HIV vaccine	Support the South African AIDS Vaccine Initiative		All Departments and Sectors	Yearly

**GOAL 11. INVESTIGATE TREATMENT AND CARE OPTIONS**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1 Review and revise policy on anti-retroviral use for reducing mother-to-child HIV transmission.	Review, monitor and evaluate current research on the use of anti-retroviral therapy to reduce mother to child HIV transmission.	Identify and implement additional areas of research	MRC Research Institutions, Universities DOH All Departments	Yearly

**GOAL 12. CONDUCT POLICY RESEARCH**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Conduct HIV/AIDS studies in selected departments and provinces		Conduct behavioral research in the Province Conduct research on gender issues Commission research	All Department All Sectors	
2. Conduct research to determine STD and HIV incidences	Conduct HIV incidence surveys in narrow age groups to approximate incidence Conduct STD and HIV incidence		DOH, institutions	
3. Review and revise policy on anti-retroviral use for reducing mother-to-child HIV transmission	Review, monitor and evaluate current research on the use of anti-retroviral therapy to reduce mother to child HIV transmission Identify and implement additional areas of research pilots. Review and update national policies to reduce MTCT.		DOH	
4. Conduct research on the cost-effectiveness of other forms of non-retroviral treatment and prophylaxis		Review international research Facilitate local research	All Departments and sectors	
5. Conduct research on the effectiveness of traditional medicines	Conduct clinical trials	Review international research Collaborate with Traditional healers	DOH Traditional Healers All Departments	

**GOAL 13. CONDUCT REGULAR SURVEILLANCE**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Develop mechanisms for long and short-term training to improve the capacities of provincial and district staff to conduct HIV/AIDS/STD related operations research and surveillance.		Training for provincial and district staff on research and surveillance in collaboration with research and training institutions.	All Departments Academic institutions	
2. Conduct National surveillance on HIV and STD risk behaviours, especially among youth	Conduct routine STD surveillance Conduct surveillance of AIDS morbidity and mortality Conduct Provincial HIV infections surveillance in selected populations and groups, including STD and TB clients, hospitalized patients, men, and youth	Conduct behavioural sentinel surveys, with a focus on youth	All Departments DOH	

**GOAL 14. CREATE AND APPROPRIATE SOCIAL ENVIRONMENT**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Develop a National inter-sectoral campaign on openness and acceptance of people living with HIV/AIDS	Promote voluntary testing and counseling services Target awareness regarding rights and responsibilities of people living with HIV/AIDS in 4 key areas: employment rights, education, health care and social service rights	Promote open discussion of sexual practices in various sectors of society	PCA All Department NGOs All sectors	
2. Create a legal and policy environment which protects the rights of all persons infected and affected by HIV/AIDS by 2005	Develop policy on the management of mentally challenged HIV positive persons	Review existing legislation and ensure the protection of rights of people living with HIV/AIDS Review and enact new children's Law to take into account the needs of children infected and affected by HIV/AIDS	DOJ DOH SALC	

3. Monitor human rights abuses and develop enforcement mechanisms for redress		Statutory commissions (HRC and CGE) to set up a discrimination database to collect information on the nature and extent of discrimination against people affected by HIV/AIDS  Improve access to justice for people infected/affected by HIV/AIDS	DOJ All departments	<b>TIME Frame</b>
4. Develop policy for combating HIV/AIDS in Prisons		Conduct surveys in Prisons  Develop policy based on the results of the survey	All departments	2001

**GOAL 15. DEVELOP AN APPROPRIATE LEGAL AND POLICY ENVIRONMENT**

**STRATEGIES**

OBJECTIVES	CORE STRATEGIES	SUPPORT STRATEGIES	AGENCIES TO IMPLEMENT	TIME Frame
1. Develop policy and legislation relating to HIV/AIDS and employment	Finalize the Code of Good practice on HIV/AIDS in the Workplace, and accompanying regulations, to enforce workplace HIV/AIDS policies  Support the development of workplace HIV/AIDS policies.	Finalize the Code of Good practice on HIV/AIDS in the Workplace, and accompanying regulations, to enforce workplace HIV/AIDS policies  Support the development of workplace HIV/AIDS policies.	DOL, DOH	
2. Develop policy and legislation relating to HIV/AIDS, commercial sex workers and sexual assault.		Develop criminal law mechanisms which protect the rights of victims of sexual violence  Investigate the provision of PEP to the victims of sexual violence  Investigate decriminalizing commercial sex work	DOJ, DOH, SALC and all sectors	

## APPENDIX 2

### MEMBERSHIP OF THE NORTH WEST COUNCIL ON AIDS

<p><b>Chairperson</b> Premier: Popo Molefe</p> <p><b>Other Members</b> MEC for Traditional &amp; Corporate Affairs: Mr. J Thibedi</p> <p><b>Chairpersons of the Cluster Cabinet Committees:</b> MEC M Sotlalo MEC Z P Tolo MEC B Molewa</p> <p><b>Chairperson of all standing committees:</b> Mr. R Mosepe</p> <p><b>Chairpersons of Regional AIDS Councils</b> Mrs. MP Bokgwathle Mr. K Moraka</p> <p><b>Business Sector Representatives.</b> Mr. H Schutte</p> <p><b>Private Medical Practitioners Representatives.</b> Dr. S Labello</p>	<p><b>Faith-Based Organization. Representatives</b></p> <p><b>Chamber of Mines Representatives.</b> Dr. J Andrews</p> <p><b>NGO'S Coalition Representatives.</b> Mr. D. Hirsh</p> <p><b>Labour Movements</b> COSATU NACTU</p> <p><b>Youth Commission</b> Mr. B Mosepe</p> <p><b>Main Political Parties</b> ANC : Mr. S Ngwenye DP : Ms M Terblanche NNP : Mr. A Verter FF : Mr. Groenewald UCDP : Kgosi L M Mangope</p> <p><b>NAPWA</b> Mr. P Nhlapo</p>	<p><b>North West African Farmers Association</b> Traditional Healers Representatives. Mr. Monedi</p> <p><b>Traditional Leaders Representatives</b> Kgosi Motaetsi</p> <p><b>Sports Representatives.</b> Mr. J Monnkgotla</p> <p><b>Tertiary Institutions Representatives</b> Prof. Sabiti Mrs M Watson.</p> <p><b>Arts, Culture and Music Industry</b></p> <p><b>Private Health Association</b></p> <p><b>Lawyers Association</b></p> <p><b>Hospitality and Entertainment</b></p>
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# APPENDIX 3

## MEMBERSHIP OF THE REGIONAL AND LOCAL COUNCILS

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6. Mr. KHUDUGA SEPOTOKOLE
7. Mr. JOSEPH MAKUDUBELE
8. Mr. DAVID DIKOKO
9. Mr. MOAKETSI MAHLATSE
10. Mr. MESHACK MBABALALA
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12. Mr. G. MODISE
13. Mrs. CLARICE SEPHEI
14. Mr. M. MASEKWA
15. Ms. N. MOJANAGA
16. Mr. WILLIAM MATINYANE
17. Ms. MARIA RAMPA
18. Mr. LESEGO BOIKANYO
19. Mrs. TESSY SELLO
20. Mr. ISHMAEL MOHUTSIWA
21. Mr. RICHARD MALINGA
22. Ms. SARAH NKATLO
23. Mr. MAFULAKO
24. REV. MOOKETSI
25. Mr. SIMON AFRICA
26. Mr. JOSEPH MOHONO
27. Mr. PAUL MOTSEKI
28. Ms. MARIA SESI RAMPA
29. Ms. CLARICE SEPLAI
30. Ms. LETTY MANGENG
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4. Mr. D. SEKUTI (TREASURER)
5. Ms. B. MOLEFE
6. Mr. P. L. MOCHWENENG
7. Mr. K. K. MOTLHABANE
8. Mr. O. E. MOSIMANEGAPE
9. Mr. K. LOBELO
10. Mr. L. G. HOELE
11. Mr. Z. S. HOTTIE
12. Mr. T. V. MOTHIBI
13. Mr. N. L. DICHABE
14. Ms. L. T. MARUPING
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16. Ms. K. SHOMANG
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19. Ms. B. MANGOEGAPE
20. Mr. G. D. SEBEGO
21. Mr. G. H. GALENG
22. Ms. T. S. NTSHEKANG
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27. Mr. BODIKALOGA
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29. Ms. O. J. HLAKUDI
30. Mr. O. PELOENG
31. Mr. A. CHABAETSILE
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7. Mrs. L. H. METHI
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9. Mr. P. MASILWANE
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11. Mrs. J. DE. JONG
12. Mr. P. MOCKE
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16. Mr. T. TINYE
17. Ms. G. VILAKAZI
18. Ms. D. JANSEN
19. Mr. H. MOGOTSI
20. Mr. B. XUNGU
21. Mr. D. MTWETI
22. Mr. N. ZWEDALA
23. Ms. N. SEDUMEDI
24. Mr. T. C. NTSIZI
25. Ms. P. ZOZI
26. Mr. J. RAMETSI
27. Mr. L. MMEKWANE
28. Mr. L. S. KUMALO
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30. Mr. S. C. MPENYA
31. Ms. NELA MOJAPELO

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7. T. MOLEFE
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11. REV. TSHAILANE
12. REV. MAMPA
13. QUEEN MQAMQOO
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16. B. THOMAS
17. AMOS LEGOETE
18. DAN MOTLADILE
19. M.K. RAMPIE
20. Dr. RAMABUMO
21. REV. ROMAN
22. P. PHATSOANE
23. KAPE RAMABOA
24. PULANE MAHOMED
25. VINCENT PHUPHUMA
26. MOKGADI MATHOBELA
27. FRANCINE HAARDE
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29. MARTHA LEKGETHO
30. DAN MOENG
31. LUCKY TYAMZASHE
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8. IEZEL BASSON
9. SANET HUM
10. MIEG VAN NIEKERK
11. AUL MOTSEKI
12. OSEPH MOHONO
13. PHY RAMPOU
14. ANGIE MOTLOUNG
15. R. ARY NZO
16. HARLEY COME
17. ALLET ELOF
18. THELMA KUKUDI
19. r. MOKGETHI
20. ARTIE VAN HEERDEN
21. K. VAN DER BERG
22. NA MEYER
23. BRIAN HARVEY
24. J. SEODI
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26. STAFF MYENI
27. CAROLINE
28. IDY PHAMODI
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33. B. H. HARVEY
34. JAMES K. MOTHOLOSA
35. FOUZA JACOBS
36. REFILWE KITI
37. THABISO L. MORAPEDI
38. NTHABISENG MAKHOALI
39. ELNA WEBER
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7. KGOSI MOTHIBI
8. Ms. T. LENGOE
9. CAPT. O. E. CWAILE
10. Mr. L. CHABASELE
11. Mr. J. MOKUBUNG
12. Mr. J. MOLEFE
13. Mr. H. S. TLHABATHABA
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20. Mrs. C. NTORWE
21. Ms. M. PULE
22. Ms. S. RAPOO
23. Mr. R. GASELAHWE
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8. Mr. B. S. PHEKO
9. Ms. M. H. KAOTSANE
10. Mr. M. M. MONALE
11. Ms. K. L. MOSALA
12. Mr. Z. C. KRAAI
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14. Mr. O. P. SEPHIRI
15. Mr. T. MOCUMI
16. Mr. NELS
17. Mr. THOMAS
18. Mr. J. TLOU
19. Mr. A. MEREMENTSI
20. Mr. J. GAETSOSIWE
21. CAPT. K. KOOS
22. Mr. JARVIS
23. Mr. M. HANTISE
24. Mr. P. HAAJ
25. Mr. WILKINSON
26. Mr. V. SETHIBE
27. Mr. T. THARE
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29. Mr. O. C. MOETI

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6. Mr. P. MOROKANE
7. Mr. T. MOROKE
8. Ms. RUTH POOE
9. MAYOR MABOPANE
10. MAYOR GARANKUWA
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12. M. SEKGOITHE
13. W. MOLEELE
14. THEMBA MAIPHULOLA
15. SUZAN NTHANGENI
16. GLORIA RAMOSHABA
17. THANDI NGOBENI
18. JIMMY NGOBENI
19. ZAMANE T. NTSOE
20. GONTSE JOHANNA RAMPENG
21. ELAH N. MOGOATLHE
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23. M. S. MATSEI
24. M. M. LEBALLO
25. LORRAINE PHOPHI
26. JOHANNES MAHLANGU
27. LORRAINE APHANE
28. MARIA RAMOREI
29. RUTH KOKELA
30. JIMMY PETE
31. SALOME BONOKO
32. VICTOR MODISE
33. P. MOTHAPI
34. PULE MOROKE
35. SUZAN KUNENE
36. HELLY NGWANA
37. MERRIAM MOGOROGA
38. JOYCE HLATSWAYO
39. THABO BEBENTSI
40. DAVID GADO
41. DOLLY LEDWABA
42. MAHLAKE MATLALA
43. JOHN MASEKO
44. GODFREY LESITLA
45. PHILLIP MDHLULI
46. PETERSON SEKONYANE
47. NAOME TLHONLE

48. MIEMER PHADI
49. ABRAM NKOANA
50. JOHANNES DIALE
51. DUDLEY MMOLEDI
52. R. S. NTSOKO
53. PATRICIA MOLOFE
54. OUPA MOTHULENI
55. ESTHER MOTHAPI
56. ISRAEL MALULEKA
57. DANKIE NKOANE
58. MATTHEWS MPOFU
59. HERRIET MOSIA
60. LEAH THAGE
61. SYLVIA TSHIGO
62. TSHILINTZI TUMANI
63. SONNYBOY MLOTSIWA
64. BRENDA MONKGE
65. IDA DANTI
66. MERRIAM MOBOHLOANE
67. MELMOIR PABI
68. J. SELIKSHO
69. J. S. MOTAUNG
70. E. G. MONAMANE
71. ELISA MOKOENA
72. MAGAUTA NKGE
73. REBECCA MOKOENA
74. DIKELEDI PITSE
75. R. KANYANE
76. M. D. MOTAUNG
77. T. TSHEOLE
78. JACOB SONO
79. D. MONARE
80. S. RAMAHLA
81. S. M. RAMAHLA
82. E. M. MPSHE
83. M. M. THWANE
84. JULIA NKANYANE
85. KAFE MOSESE
86. PATRIC S. LEDWABA
87. LUCKY MOSANA
88. G. R. MOKONOTO
89. PULE MOOKE
90. T. MORAKANE
91. MATRON MATJANE

**GANYESA**

TEL : (053) 998-3356 FAX : (053) 998-3385

- |                            |              |
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| 3. Ms. B. NQUNDE           | AIDS TEAM    |
| 4. Mr. M. TAU              | AIDS TEAM    |
| 5. Ms. M. MOKGOTHU         | AIDS TEAM    |
| 6. Mr. D. MARUMO           | TREASURE     |
| 7. Mrs. MOTSEKI            |              |
| 8. Mr. T. RABANYE          |              |
| 9. Mr. M. A. PHOLOGOTSWENG |              |
| 10. Mr. G. T. OLIPHANT     |              |
| 11. Mr. M. F. KAMANYANE    |              |
| 12. Mr. T. MOTHIBI         |              |
| 13. Mr. J. LEGALAMITLWA    |              |
| 14. Mr. N. THALI           |              |
| 15. Mrs. CHICHINDWA        |              |
| 16. INSPECTOR MOLEFE       |              |
| 17. Mr. LETHLOGILE         |              |
| 18. Mr. BOBOKO             |              |
| 19. Mrs. E. MAKWATI        |              |
| 20. Mrs. N. ASSGAI         |              |
| 21. MR. S. LENKOPANE       |              |
| 22. Mrs. LEPEDI            |              |
| 23. Mrs. M. MAMPE          |              |
| 24. CAPTAIN MOLOBI         |              |
| 25. Mrs. BOLOKWE           |              |
| 26. Mrs. F. GABEDI         |              |
| 27. Mrs. MATSIME           |              |
| 28. Mr. P. MABOE           |              |
| 29. S. S. NKATLO           |              |
| 30. Mr. D. MOOKETSI        |              |
| 31. Mrs. A. IMMELMAN       |              |
| 32. Ms. M. S. SEAKGOA      |              |

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| 3. Mr. BEN SENTSHO      | SECRETARIAT |
| 4. Mrs. PAULINE MOTSEPE |             |

5. Ms. KENILWE TSHUPE
6. Mr. RABANA MODISANE
7. Mrs. VIVIAN MOREMI
8. PASTOR MANAS KABELO
9. Ms. JANE MOKWENA
10. Dr. SOBANTU NKOSI
11. Ms. FIKILE IAOTSE
12. Mr. HASSAN MEKGOE
13. Ms. M. A. MOLUBI
14. MOSES MOSENGWA
15. BOTSHELO NGWATO
16. CONSTANCE KGWASA
17. VIOLET BUTJI
18. CONNELL MASISI
19. MONAMODI
20. M. A. MOLUBI
21. MORWESI BODUTU
22. LEDIGA P. A. M
23. P. M. MATSHEGO
24. FIDELIA TAJUNYANE
25. FLIPPIE FOURIE
26. ABIGAIL PHOLELE
27. ENNNECIA MABIA
28. PETER DITSELE
29. ANDRE VILJOEN
30. LORRAINE FOSS
31. P. MATHOPE
32. R. M. KAU
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34. SINAH MORUJANE
35. RUTH MOREMI

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3. Mr. R. SELOGELO
4. Mr. K. Z. V. KAMANYANE
5. Mr. T. S. MELAMU
6. REV. I. J. PUDULE
7. Ms. R. PHOKANE
8. Ms. A. N. MAKGALE
9. Ms. K. G. SHOMANG
10. Mr. M. LECHOLO
11. Ms. K. SENNA
12. Mr. P. V. CHWENE
13. Mr. C. MOGALE
14. Ms. O. NTSHEKANG
15. Mr. O. J. LEGALAMITLWA
16. Mr. L. M. DIEGAARDT
17. Mr. C. OTLETSENG
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3. Mr. T. NARE
4. Mrs. L. L. RADEBE
5. Mrs. F. MAISE
6. Mrs. J. MANGANYE
7. Ms. O. SETSHEDI
8. Ms. O. SETSHEDI
9. Mr. D. B. NDLOVU
10. Ms. T. MOREMI
11. Mr. S. NGAKANE
12. Mr. K. MORAKA
13. Mr. D. MOOKANENG
14. Mr. L. MOTSAMAI
15. Mr. J. TSHISI
16. Mr. V. LESOMO
17. Mr. T. SEABOCHA
18. Mr. A. A. MUTOLA
19. Ms. N. RAMATLHAPE
20. Mrs. B. MALEKA
21. Mrs. L. MOTENE
22. Ms. L. MOKGOSI
23. Mrs. S. S. MOABI
24. Mrs. D. R. TLABYANE
25. Mrs. S. KGOADIGOADI
26. Mr. C. MODISE
27. Ms. A. DIRE
28. Ms. E. MORAKE
29. Mrs. O. N. SEPHOTI

30. Mrs. K. S. MAKGALE
31. Mr. J. G. MOLOKWANE
32. Mr. T. KEBALEPILE
33. Mr. M. RAKGASE
34. Mr. P. MONYEKI
35. Mr. S. D. MOSITO
36. Mr. B. BAFSHOE
37. Mr. C. TEMA
38. Mr. D. PILANE
39. Mr. C. MABALE
40. Mr. C. TWAYI
41. Mr. J. B. MALWALE
42. Ms. L. RAMABULANA
43. Ms. M. LEKETE
44. Ms. T. MABUSE
45. Mrs. M. DIPUDI
46. Mrs. N. SESINYI
47. CAPTAIN MOLEFE
48. M. K. TSHENYE
49. KGOMOTSO MATABOGE
50. JOHANNA MOLEMA
51. VICTOR MODIMAKWE
52. J. J. JALVAN
53. I. M. NKOTSOE
54. M. M. SETSHEDI
55. E. T. MMUTLE
56. S. MOTAUNG
57. C. K. MOLOKWANE
58. S. MOTHULWE
59. L. MOKGETHI
60. J. NYNENDA
61. D. KGASOANE

**ZEEERUST DISTRICT**

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| 2. INSP. W. RANTSOGANE    | ASS. CHAIRPERSON |
| 3. Mrs. M. MBOWENI        | SECRETARY        |
| 4. Ms. T. RANKUDU         | ASS. SECRETARY   |
| 5. Ms. M. MAFORA          | TREASURE         |
| 6. Mrs. LOOTS             |                  |
| 7. Mrs. MONEI             |                  |
| 8. Ms. J. L. SITHOLE      |                  |
| 9. Ms. M. SEBIGI - NTOYI  |                  |
| 10. Ms. F. GAOTJME        |                  |
| 11. Ms. C. LEKATE         |                  |
| 12. Ms. E. S. MAKGALA     |                  |
| 13. Ms. P. L. LESTHUPI    |                  |
| 14. Ms. R. LETLOLE        |                  |
| 15. Ms. N. M. KHUTSWANE   |                  |
| 16. Mr. O. C. MANYAAPPELO |                  |
| 17. Mr. R. BODIGELO       |                  |
| 18. Mr. K. C. MIERAFE     |                  |
| 19. Mr. M. S. TLHAKO      |                  |
| 20. INSP. S. E. MAGONARE  |                  |
| 21. Mr. J. MOTSWAKAE      |                  |
| 22. Mr. A. MOKELEDI       |                  |
| 23. Mrs. S. GUNIKA        |                  |
| 24. Ms. MOSUPI            |                  |
| 25. Mr. RATSHIKANA        |                  |
| 26. REV. MALETSWA         |                  |
| 27. Mrs. S. SAUNDER       |                  |
| 28. Mr. PITSO             |                  |
| 29. KGOSI PUPSY SEBODI    |                  |
| 30. Mr. A. THALE          |                  |
| 31. LESEGO PULE           |                  |
| 32. NOMSA DUBE            |                  |
| 33. Mrs. N. GWAI          |                  |
| 34. Ms. J. ME NO          |                  |
| 35. Ms. SHEZI             |                  |

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3. LENA MOKONYANE
4. PAPI LOSIE
5. HOFNEY GERBEN
6. DINEO MOTSOMI
7. MOTHERI KWETLE
8. CAROLINE OLIPHANT
9. Mrs. SABIRA HAFEEJE
10. MAMISI MERE
11. KENNETH LETEBELE
12. PATRICK DINTWA
13. DIMAKATSO VILJOEN

14. KGOTSO MANGWEGAPE
15. Mr. HAFEEJE

**WOLMARANSTAD**

TEL : (018) 5962526/5962844

FAX : (018) 5962861

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| 2. S. S. NKATLO             | CHAIRPERSON        |
| 3. D. MOOKETSI              | SECRETARY          |
| 4. Z. M. MWELI              | PUBLICRELATIONS    |
| 5. A. A. IMMELMAN           | TREASURER          |
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| 7. J. SELEKE                |                    |
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| 9. G. BOTHA                 |                    |
| 10. B. D. THABENG           |                    |
| 11. K. P. MOKHUTSANE        |                    |
| 12. T. K. ZENANI            |                    |
| 13. R. MAITSHOTLO           |                    |
| 14. O. MOLELEKI             |                    |
| 15. W. GUMEDE               |                    |
| 16. M. F. SHUPING           |                    |
| 17. P. J. MOKONYANE         |                    |
| 18. M. M. CHACHA            |                    |
| 19. J. K. MOTLASHUPING      |                    |
| 20. M. MADIKOE              |                    |
| 21. A. MMOLAWA              |                    |
| 22. J. KGOSIYAGAE           |                    |
| 23. S. J. MAFULAKO          |                    |
| 24. H. S. MMUALIFE          |                    |
| 25. M. G. KOAHO             |                    |
| 26. T. MOTHABI              |                    |
| 27. M. MOABI                |                    |
| 28. M. M. MOSOANG           |                    |
| 29. D. NGADA                |                    |
| 30. Dr. C. J. VAN DER MERVE |                    |
| 31. W. SEBALO               |                    |
| 32. L. J. MAFULAKO          |                    |
| 33. K. R. MKHENDANI         |                    |
| 34. RINA MOKAODI            |                    |
| 35. B. MODISANE             |                    |
| 36. W. GUMEDE               |                    |
| 37. P. PELELE               |                    |
| 38. J. B. BOTHA             |                    |
| 39. T. K. KGOBE             |                    |
| 40. S. M. SEREKWANE         |                    |
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| 43. J. SMIT                 |                    |
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| 45. D. P. NAMANE            |                    |
| 46. M. S. KGOKONG           |                    |
| 47. M. MADITO               |                    |
| 48. P. MONEWANG             |                    |
| 49. B. PRINCE               |                    |
| 50. M. G. LETHLAKANE        |                    |
| 51. P. MAHURA               |                    |
| 52. D. THABENG              |                    |
| 53. J. SEKENG               |                    |

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2. Ms. ALTA COETZEE
3. Mr. DAVID MAKGEMA
4. Ms. D. MANDLA
5. Mr. J. LEDINGWANE
6. Mr. F. RATHLAGA
7. Ms. R. MASILO
8. Ms. M. CHILINCHI
9. Mr. T. MOLOBI
10. Ms. MAGANO
11. Ms. M. MOKOMELA
12. Ms. SUTANA
13. Mr. MASILELA
14. Mr. H. DU PLESSIS
15. Mr. J. LEDINGOANE
16. Ms. M. MOKOENA