



Albertina Sisulu
Executive Leadership
Programme in Health
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**THE ROLE OF COMMUNITY-BASED ORGANISATIONS AND WARD-BASED
OUTREACH TEAMS IN THE IMPLEMENTATION OF THE 90-90-90 HUMAN
IMMUNODEFICIENCY VIRUS TREATMENT STRATEGY IN THE AMATHOLE DISTRICT**

BY
NTOMBEKHAYA PHYLLIS MAKELENI
STUDENT NO. 201716813

University of Fort Hare
Together in Excellence

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DEGREE: MASTER'S IN PUBLIC HEALTH**

AT

**UNIVERSITY OF FORT HARE
FACULTY OF HEALTH SCIENCES**

SUPERVISOR

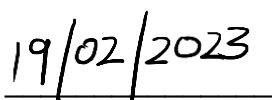
PROFESSOR DT GOON

DECLARATION

I, Ntombekhaya Phyllis Makeleni, declare that this mini-dissertation entitled 'the role of community-based organisations and ward-based outreach teams in the implementation of the 90-90-90 HIV treatment strategy in Amathole Health District in Eastern Cape Province, South Africa' submitted in fulfilment of the requirements of a master's in Public Health at the University of Fort Hare, East London Campus, is my genuine work. The dissertation was never previously entirely or partly submitted to any university for a degree.



NP MAKELENI



DATE



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CERTIFICATION

The dissertation entitled “The role of community-based organisations and ward-based outreach teams in the implementation of the 90-90-90 Human Immunodeficiency Virus Treatment Strategy in Amathole Health District” meets the principles central to the award of a master’s degree in Public Health at the University of Fort Hare and is acceptable for its contribution to scientific knowledge.



Prof DT Goon

Supervisor

20 January 2024

Date



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DEDICATION

This dissertation is dedicated to my husband, Lucky Makeleni for his encouragement and support while I was engaged with my studies. To my children Sibabalwe, Zena, and Siph'esihle, I will forever be grateful. I would not have succeeded without your support.



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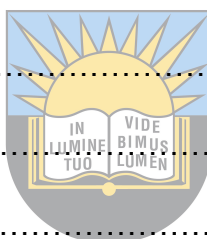
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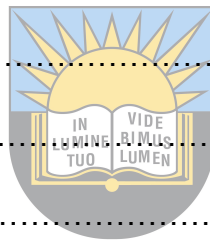
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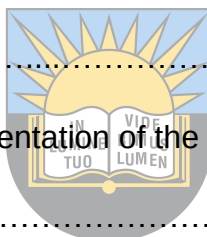
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ABSTRACT

Community-based services are vital to the achievement of goals set for ending HIV as a public health threat. Amathole Health District has not produced the desired results towards the achievement of the 90-90-90 HIV treatment strategy.

The aim of this study was to assess the role of community-based organisations and ward-based outreach teams (WBOTs) in the implementation of the 90-90-90 HIV treatment strategy in Amathole in the Eastern Cape, South Africa.

A qualitative design was followed by conducting face-to-face interviews with purposively selected ward-based outreach team leaders and managers of community-based organisations. Focus group discussions were held using an interview guide. Individual interviews included four ward-based outreach team leaders and five managers of community-based organisations. Focus group discussions were inclusive of four groups of community health workers from ward-based outreach teams (WBOTs) and five groups of community care givers from community-based organisations (CBOs).

The findings of the study were five common themes included: case finding where home visits and counselling were provided; linkage to care where referral of clients and tracing of defaulters was done; retention to care which included conducting follow-up visits and client monitoring; collaboration between CBOs, WBOTs, and health facilities and success achieved in the implementation of the 90-90-90 human immunodeficiency virus (HIV) treatment strategy which included viral suppression, decreased deaths, and tracing of defaulters.

It is concluded that the continuum of HIV care requires more efforts towards ensuring that there is synergy between community-based workers and public health institutions for the achievement of the 90-90-90 targets.

Keywords: 90-90-90 HIV treatment strategy, ward-based outreach teams, community-based organisations.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community-Based Organisation
CD4	Cluster of Differentiation 4
DHIS	District Health Information System
FPD	Foundation for Professional Development
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
NDoH	National Department of Health
NDP	National Development Plan
NSP	National Strategic Plan
PLHIV	People Living with HIV
PEPFAR	President's Emergency Plan for AIDS Relief
SANAC	South African National AIDS Council
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WBOT	Ward-Based Outreach Team
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION AND BACKGROUND

The Joint United Nations Programme on HIV and AIDS Strategy (UNAIDS) (2016-2021) can be defined as an attempt to reach the 90-90-90 treatment targets that aims to end the testing gap by protecting the wellbeing of the 22 million people living with HIV (PLHIV) with no access to antiretroviral treatment. This strategy aims to upscale interventions and ensure that the Acquired Immune Deficiency Syndrome (AIDS) ceases to be a public health threat by 2030 and ensure that no one is left behind (UNAIDS, 2015). Moreover, it sought to attain its goals by 2020 to precede the updated 95-95-95 HIV treatment target by 2025. The former goal was to make sure that 90% of people living with HIV know their (HIV) status; furthermore, it aimed to ensure that 90% of those diagnosed with HIV are introduced and maintained on antiretroviral therapy (ART) and 90% viral suppression for those on antiretroviral therapy. These targets serve as a milestone in the elimination of AIDS by 2030. Consequently, meeting these targets by 2020 would support the end of the AIDS epidemic by 2030. It is estimated that globally by 2018, 37,9 million people were living with HIV (Mahy, Marsh, Sabin, Wanyeki, Daher and Ghys, 2019). This figure indicates the magnitude of the burden that healthcare systems face with regard to this viral epidemic.

The above-mentioned 90-90-90 strategy was introduced in December 2013 and, as a result, South Africa adopted these global UNAIDS targets the following year. In September 2017, a change in eligibility criteria for the initiation of HIV positive clients on ART was introduced by the Minister of Health (Department of Health, 2016). The criteria, which aligned with the World Health Organisation's recommendations, requires that ART be initiated on people living with HIV, irrespective of their WHO clinical stage of disease and CD4 cell count (WHO, 2016). The adoption of the UNAIDS targets has set the tone for South Africa's National Strategic Plan (NSP) for HIV, TB and STIs 2017-2022. Goal 2 of the NSP sought to decrease morbidity and mortality through interventions for every district to reach the aforementioned targets (SANAC, 2017).

To achieve the NSP, a number of enablers were required; these include strengthening families and society by building strong community systems to decrease the risk of the spread

and to alleviate the impact of the epidemic (SANAC, 2017). However, these targets cannot be achieved by the public health sector alone because HIV cannot be treated as a mere health issue but must be addressed by a multi-sectoral collaboration between diverse stakeholders working towards a common goal is needed to facilitate a continuum of care that is beyond health facilities for people living with HIV. As such, all stakeholders must reach these targets in order to end the epidemic by 2030.

Strategic partnerships between the South African Government and its communities have produced approaches that have improved the provision of services. Stakeholders include community-based organisations (here after referred to as CBOs) and WBOTs. They are a segment mandated to be part of the 90-90-90 strategy and tasked with working towards ending the epidemic by the above-mentioned date. The term, CBO, refers to formal or informal grassroots organisations formed by local citizens working within the interests of the communities they serve. Ward-based outreach teams are part of Primary Health Care (PHC) facilities, and they provide a combination of services to households in a catchment area (Assegaai & Schneider, 2019).

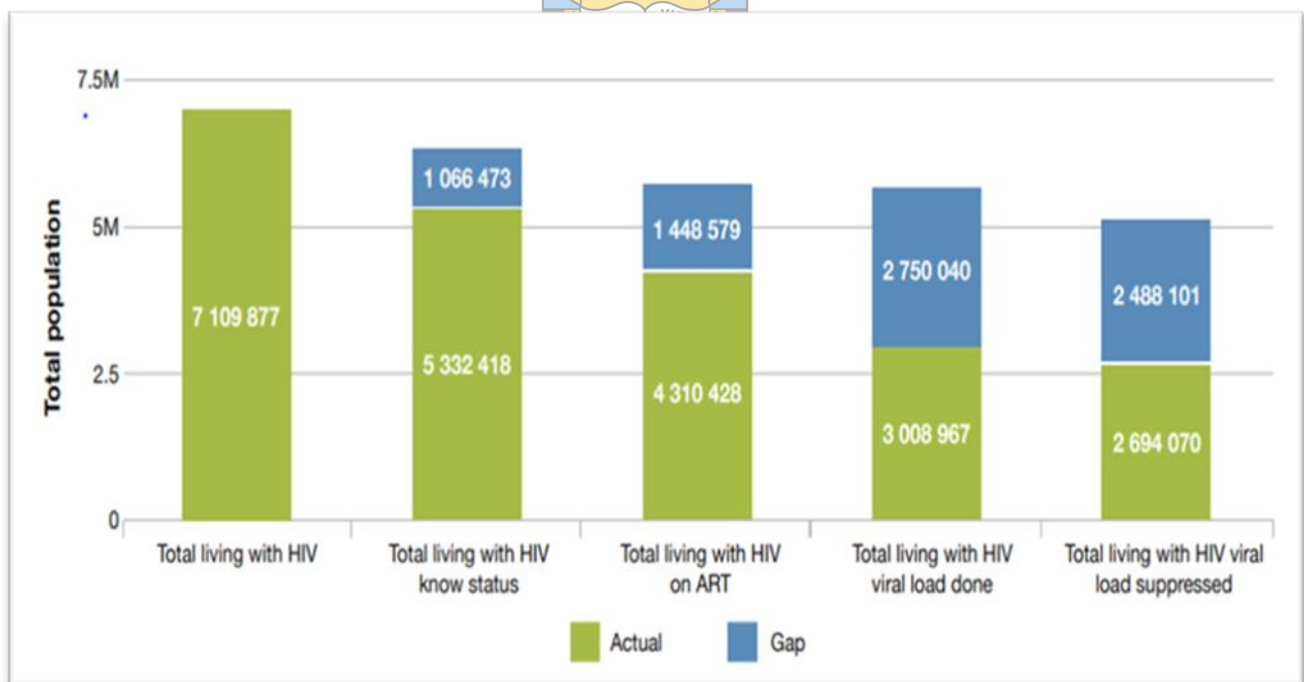


Figure 1.1: Total population HIV treatment cascade South Africa (Massyn et al., 2019)

According to UNAIDS (in Massyn, Pillay & Padarath 2019), HIV is most prevalent in South Africa. Figure 1.1 above is a representation of the country's HIV cascade against the 90-90-

90 targets, indicating just over 60% of PLHIV on treatment and a 36% viral suppression (Massyn et al., 2019).

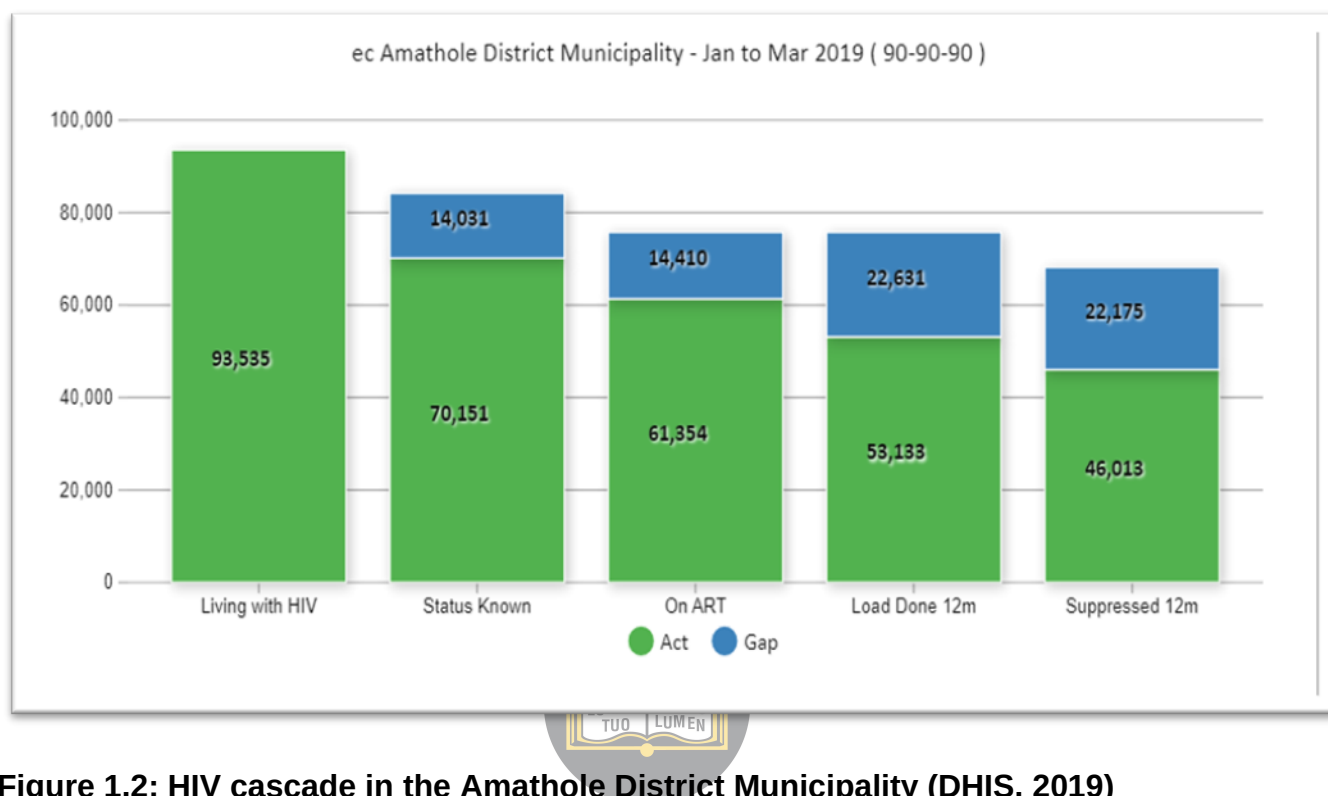


Figure 1.2: HIV cascade in the Amathole District Municipality (DHIS, 2019)

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South Africa is comprised of nine provinces with one of those being the Eastern Cape. This province is further divided into six districts and two metropolitan municipalities. The Amathole district is located within this area. It has four health sub-districts, namely Amahlathi, Mbashe, Mnquma, and Raymond Mhlaba. By March 2019, the estimated number of PLHIV in Amathole was roughly 93 535. Those LHIV who were aware of their status totalled 70 151, a 75% status known. Of these documented PLHIV 61354 were on ART, furthermore, when a viral load was done on 53133, 46013 were virally suppressed (District Health Information System, 2019/20).

For 2022, the NSP target of 81% of PLHIV on treatment translates to 75 763 people on ART in the Amathole District Municipality while by March 2019, the district had 63 939 clients on antiretroviral therapy. After 12 months of treatment the remaining in care rate for the 2019 cohort was at 71%, far below the national target of 96% while the viral load done and viral

load suppression for the same cohort was 86.2% and 85.4% respectively (District Health Information System, 2020/21). The district focuses on closing the gap between HIV-positive individuals and those with known HIV status, a move from 75% to 90% is required to achieve the first target. Other focus areas include attaining 94% on retention of clients on ART after 12 months of starting antiretroviral treatment, 100% viral load completion at 12 months of treatment and 90% viral suppression. Consequently, the present study sought to assess the role of CBOs and WBOTs as stakeholders in the implementation of the UNAIDS 90-90-90 strategy with specific reference to the Amathole District Municipality.

1.2 RESEARCH PROBLEM

Amathole Health District has not produced the desired results to achieve the 90-90-90 HIV treatment strategy. Seemingly, the role of CBOs and WBOTs in the implementation of the 90-90-90 HIV strategy is not well understood and key steps have yet to be taken by diverse stakeholders for HIV to cease to be a threat to society. Targeted support has been provided to the district by various developmental partners. Changes in eligibility criteria for the initiation of clients on ART were introduced by the National Department of Health to increase treatment coverage.

South Africa's NSP for HIV, TB, and STIs 2017-2022 demands a multi-sectoral structure that is inclusive and participatory in response to ensure that no one is left behind in moving towards the above targets. However, there seems to be no integrated efforts by all stakeholders to assertively reach these targets. Furthermore, there is limited data regarding the implementation of this strategy by WBOTs and CBOs. Moreover, in Amathole District, there exists a knowledge gap in terms of community-based interventions aimed at reaching these targets. This study, therefore, sought to assess the role of CBOs and WBOTs as stakeholders in the implementation of the 90-90-90 HIV treatment strategy in this region.

1.3 AIM OF THE STUDY

The purpose of the study was to assess the role of CBOs and WBOTs as stakeholders in the implementation of the 90-90-90 HIV treatment strategy in the Amathole District.

1.4 OBJECTIVES OF THE STUDY

- To describe the role of CBOs in the implementation of the 90-90-90 HIV strategy in the Amathole District.
- To explore the role of WBOTs in the implementation of the 90-90-90 HIV strategy in Amathole District.
- To identify and describe the enablers for effective collaboration between CBOs and WBOTs in the implementation of the 90-90-90 strategy in the above district.

1.5 RESEARCH QUESTIONS

- What is the role of CBO in the implementation of the 90-90-90 HIV strategy in Amathole District?
- What is the role of WBOT in the implementation of the 90-90-90 HIV strategy in Amathole District?
- What are the enablers for effective collaboration between CBOs and WBOTs in the implementation of the 90-90-90 strategy in Amathole District?



1.6 SIGNIFICANCE OF THE STUDY

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This study might contribute in determining the gaps in the implementation of the 90-90-90 HIV treatment strategy. An understanding into this within the HIV cascade would better equip stakeholders in dealing with the epidemic within their local contexts and create platforms to address community-related barriers to ending the HIV epidemic by 2030. In addition, the study aimed to assist the department identify the causes of the non-progressive implementation of the programme. The findings of the study could inform policies relating to HIV testing and differentiated care models. Moreover, health managers and other policy makers may use the results to draft policies and guidelines regarding collaboration with CBOs for the improvement of patient outcomes. The study sought to form the baseline for further research focussed on the implementation of the newly set HIV/AIDS target of 95-95-95.

1.7 DELIMITATIONS OF THE STUDY

The study was delimited to the role played by CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy in the Amathole district

1.8 DEFINITION OF CONCEPTS

The key concepts used in the study are as follows: assessment, CBOs, WBOTs, implementation, 90-90-90 HIV treatment strategy, district, and cascade. The definitions of these concepts are provided below.

1.8.1 Assessment

Cambridge Dictionary (2020) defines assessment as a process where the entire information about a situation or a person is considered. In this study the term referred to the process of gathering and discussing information from several and varied sources for a deeper understanding of what one knows and understands.



1.8.2 Community-based organisations (CBOs)

A CBO can be defined as a private or public non-profit organisation representing a certain community, working to meet the needs of that specific community. Most of CBOs provide services to people living with HIV (AIDS Info, 2020). In this study, CBOs means non-profit grass root organisations that provide HIV services to their community.

1.8.3 Ward-based outreach teams (WBOTs)

Ward-based outreach teams are part of Primary Health Care (PHC) facilities, and they provide a combination of services to households in a catchment area. The teams provide PHC to families/households. These services include community outreach services and preventative, promotive, curative, rehabilitative, and palliative education and care (Assegaai & Schneider, 2019). In this study, the term is defined as the same.

1.8.4 Community health workers (CHWs)

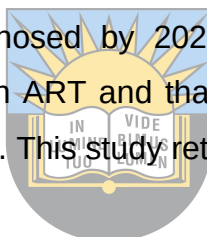
The above is an umbrella term utilised to describe a diverse group of unqualified healthcare staffs (van Ginneken, Lewin & Berridge, 2010). They are also called village health workers or community care workers. In this study, the term refers to a lay health worker.

1.8.5 Implementation

According to the Oxford Dictionary (2020) implementation is a process of putting a plan into effect. In this study, the implementation was the preparation of and putting into place the elements of the previously mentioned strategy.

1.8.6 90-90-90 HIV treatment strategy

This specific strategy refers to the global UNAIDS strategy, which seeks to ensure that 90% of HIV-infected individuals are diagnosed by 2020, furthermore, its goal includes the realisation 90% of such will be put on ART and that a further 90% will achieve sustained virologic suppression (UNAIDS, 2014). This study retained this meaning.



1.8.7 Cascade

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According to the Oxford Dictionary (2020), cascade is a series of stages in a process, each stage triggers the next. In this study, therefore, the term HIV cascade relates to the steps of care that PLHIV go through from diagnosis to attainment of viral suppression and shows the percentage of individuals living with HIV engaged at each stage.

1.8.8 District

The Cambridge Dictionary (2020) defines a district as an area of a country or town with fixed borders that are used for official purposes. In this study, the district refers to Amathole Health District in the Eastern Cape province of South Africa.

1.9 THEORETICAL FRAMEWORK

This study made use of the collaborative theory as its framework, which is a concept defined by Wood and Gray (1991) as a process involving shared norms and mutually beneficial interactions in which independent or partial-independent players cooperate through formal and informal negotiation, jointly creating guidelines and structures central to their relationships and ways to act or agree on the issues that brought them together. The researcher selected the collaborative theory because it is relevant to the study and reliable in describing the role of CBOs and WBOTs in the implementation of the 90-90-90 HIV strategy and further identify and describe the enablers for effective collaboration between entities in the implementation of 90-90-90 strategy in the Amathole District.

To ensure no individual is excluded, a multi-sectoral, inclusive, and participatory approach is needed in the implementation of the 90-90-90 HIV treatment targets. In this regard, collaborative governance is defined as a system where public agencies directly engage non-state participants in a shared decision-making process that is formal, consensus-oriented, and deliberative aiming to implement public policy and manage public programmes (Ansell & Gash, 2008). Stakeholders of this system can potentially influence the activities of public entities. Therefore, an opportunity exists for state institutions to engage with stakeholders, resulting in the achievement of global goals. The definition by Ansel and Gash (2008) highlights initiation by public institutions with a focus on public policy and participation should include non-state actors and decision-making is reached through consensus.

1.10 OUTLINE OF THE STUDY

CHAPTER	CONTENT
CHAPTER 1	OVERVIEW OF THE STUDY
CHAPTER 2	LITERATURE REVIEW
CHAPTER 3	RESEARCH METHODOLOGY
CHAPTER 4	PRESENTATION OF FINDINGS
CHAPTER 5	DISCUSSIONS, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS



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CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is a summary and understanding of current research regarding a topic of interest in order to put a research problem into context (Polit & Beck, 2017). Consequently, the purpose of this particular literature review was to place the relevant research into context in terms of its contribution to the understanding of the role of CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy. The relevant literature was sourced from articles published, internet publications, theses, dissertations, textbooks, journals, and reports from the National Department of Health by means of Google Scholar, PubMed, and the University of Fort Hare Digital Library. Documents that were reviewed include the UNAIDS databases and reports from UNAIDS.

In qualitative research, such as this study, the core literature review is delayed until data have been collected and analysed to avoid the biased analysis and interpretation thereof. Literature is discussed to either authenticate or disprove the findings and establish how other researchers have conceptualised and clarified similar findings or different findings (Brink, Van der Walt & Van Rensburg, 2018). The chapter, therefore, details the history of the 90-90-90 treatment strategy, global and local statistics of HIV/AIDS, HIV/AIDS statistics in South Africa, efforts to combat the scourge of HIV, the roles of stakeholders, CBOs, and WBOTs in combatting HIV/AIDS and collaboration between the latter in the implementation of the 90-90-90 HIV treatment strategy.

2.2 HISTORY OF 90-90-90 HIV TREATMENT STRATEGY

The study's review revealed that the former targets sought to accomplish incremental progress in response to the AIDS epidemic. As a result, 12.9 million people were receiving ART by December 2013 and the world was on track to reach the targets endorsed by the 2011 Political Declaration on HIV and AIDS seeking to reach 15 million people by 2015 (United Nations, 2011). Nonetheless, a final target was required to advance the fight, stimulate accountability, and connect various stakeholders in a shared effort to end the AIDS epidemic by 2030 (UNAIDS, 2014).

Consequently, the UNAIDS was called upon by its Programme Coordinating Board to support global efforts to launch new targets for HIV treatment progression beyond 2015 (UNAIDS, 2014). These ambitious global targets were that by 2020, 90% of people living with HIV should know their status by 2020, 90% of all people diagnosed with HIV infection should receive and be sustained on ART and that 90% of people receiving ART should be virally suppressed. This corresponds with 81% of all people living with HIV on ART and 73% of all people living with HIV virally suppressed with a strengthened immune system, decreasing the probability of their infections being transmitted to others (UNAIDS, 2014). In addition, modelling projected should these targets be achieved by 2020, the world would be able to end AIDS as a public health threat by 2030, and, in so doing, create health and economic benefits (UNAIDS, 2015).

2.3 GLOBAL AND LOCAL STATISTICS OF HIV/AIDS

The HIV/AIDS pandemic remains a public health threat globally despite major progress being made in the global response to it. The Sustainable Development Goals (SDGs) are a mandate to eliminate poverty and inequality, preserve the planet, and secure health, justice, and prosperity for all people. They are 17 goals, which are integrated and related and reflect how health is interlinked with other social goals. Subsequently, they are underpinned by the principle of ensuring that no one is left behind and are to be attained by 2030. Goal 3 seeks to ensure health and welfare for people of all ages. This is, similarly, further sub-divided into targets. Target 3.3 seeks to ensure the end the rapid spreading of AIDS, TB, malaria, waterborne diseases, and other transmissible diseases by 2030 (United Nations, 2015).

It is estimated that in 2018, 37.9 million people were living with HIV globally, of which 36.2 million were adults and 1.7 million were children under the age of 15 years. In this regard, 79% of all people living with HIV knew their HIV status while 8.1 million people were not aware that they were HIV positive. Moreover, PLHIV access to ART was estimated at around 62.2% for adults and 54% for children, aged 0-14 years. Of these, a further 53% were virally suppressed in the same year (UNAIDS, 2019). The global health sector strategy, 2016-2021 outlined what strategies countries and the World Health Organisation (WHO) committed to doing to eliminate the virus as public health threat by 2030 (WHO, 2016).

In 2020, 90-90-90-related targets were a significant milestone in achieving the 2030 global goals. However, within the eastern and southern Africa region, 20.6 million people were

estimated to be living with HIV two years before. The treatment coverage for the region varied from 9% in Madagascar to 92% in Namibia; consequently, there was a need for low-coverage countries such as Angola, Madagascar, Mauritius, and South Sudan, to increase the number HIV testing and treatment programmes of each. A major challenge in this regard was an increase in the linkage to care and retention of people living with HIV on treatment. In terms of HIV testing and treatment cascades, the region was estimated to possess 85-67-58, a gap of 1.1 million people not knowing their HIV status, the first ninety, a gap of 3 million people that are to be initiated on ART, second ninety, and a gap of 3 million people for viral load suppression, making up the third ninety. In addition, the progress differed pertaining these countries reaching the three 90s. In contrast Rwanda has achieved the first two goals and is closing in on the third (UNAIDS, 2019).

In terms of global targets, Sweden was the first country to reach them; contributing factors to the attainment of the targets included an obligation by patients to observe appointments and adhere to tests regarded as necessary by health workers (Gisslén, Svedhem, Lindborg, Flamholz, Norrgren, Wendahl, Axelsson & Sönnernborg, 2017). A study conducted in Botswana and Australia, a high and a low prevalence country respectively, on the developments towards achieving the UNAIDS 90-90-90 targets revealed that though these countries have made remarkable progress, certain disablers of adherence should be recognised and addressed (Marukutira, Stooval, Lockman, Mills, Gaolathe, Lebelonyane, Jarvis, Kelly, Wilson, Luchters & Crowe, 2018).

2.4 HIV/AIDS STATISTICS IN SOUTH AFRICA

The National Development Plan outlines specific goals to be achieved by 2030. It is a call for all South Africans to join forces through their actions to address the most pressing challenges facing country. Consequently, Chapter 10 of this plan focuses on promoting health to increase life expectancy by 2030 for both males and females to 70 years through the progressive implementation of evidence-based prevention and therapeutic interventions against HIV. It also aims to render a cohort of the under-20s that is mostly free of HIV. The achievement of these targets requires that all people living with HIV are put on ART (National Planning Commission, 2013).

As a country, South Africa is recognised as having the largest HIV epidemic and ART globally. In December 2014, the Ministry of Health adopted the 90-90-90 targets to ensure it achieves

HIV epidemic control. As a result, all public health facilities were mandated to increase their testing rates of those at risk of HIV, including men and adolescents; furthermore, it expects that they offer those who test HIV negative who are at risk of HIV, both information and support to ensure that they remain HIV negative. Moreover, they are tasked with extending antiretroviral treatment initiation to all PLHIV regardless of individual CD4. In addition, it emphasises newly diagnosed HIV-positive who are clinically ready and able to commit to lifelong ART (Department of Health, 2017).

90% of South Africans living with HIV knew their status, however there are differences between males and females. The percentage of females who were aware of their HIV status was 93%, while males were only 88%. The percentage of people living with HIV on treatment, namely, the second 90, was at 62% with variations among the two sexes. The percentage of females was 65% while males were at 56%. The viral load suppression percentage among people living with HIV was 54% with females and males being 58% and 47% respectively (UNAIDS, 2019). The targets are set to increase to 95-95-95 by 2025, thus, this will widen the identified gaps in the HIV treatment cascade.

Kim, Mukui, N'gan'ga, Katana, Koros, Wamicwe, De Cock and KAIS Study Group (2016) revealed that though impressive development has been made in the fight against HIV/AIDS epidemic in South Africa, more interventions are required to ensure that AIDS ceases to be an epidemic by 2030.



2.5 EFFORTS TO COMBAT THE SCOURGE OF HIV

As previously established, South Africa remains among the countries hardest hit by the scourge of the HIV/AIDS pandemic. Consequently, to achieve the 2030 targets, it must address the barriers delaying milestone targets set for 2020 and 2025. As a result, the South African cabinet established the South African National AIDS Council (SANAC) in January 2002 as the highest body to advise the government on all matters relating to HIV, TB, and STIs. The SANAC arranges this through the development of a 5-year term NSP on HIV, TB and STIs. The vision for NSP 2017-2022 is a South Africa free from HIV, TB, and STIs. Its mission is South Africa on target to ensure that HIV, TB, and STIs has ceased to be a public health threats by 2030 (SANAC, 2017).

The NSP principles include a participatory, people-centred and multi-sectoral approach that seeks to ensure that no one is left behind. This involves eight goals with each goal having

clear objectives, sub-objectives, and activities to realise its set goals. In this regard, Goal 2 seeks to reduce morbidity and mortality through the provision of HIV, TB, and STI treatment, care, and adherence support for all. Moreover, it should implement the 90-90-90 strategy for HIV and TB, as well as improve STI detection, diagnosis and treatment (SANAC, 2017).

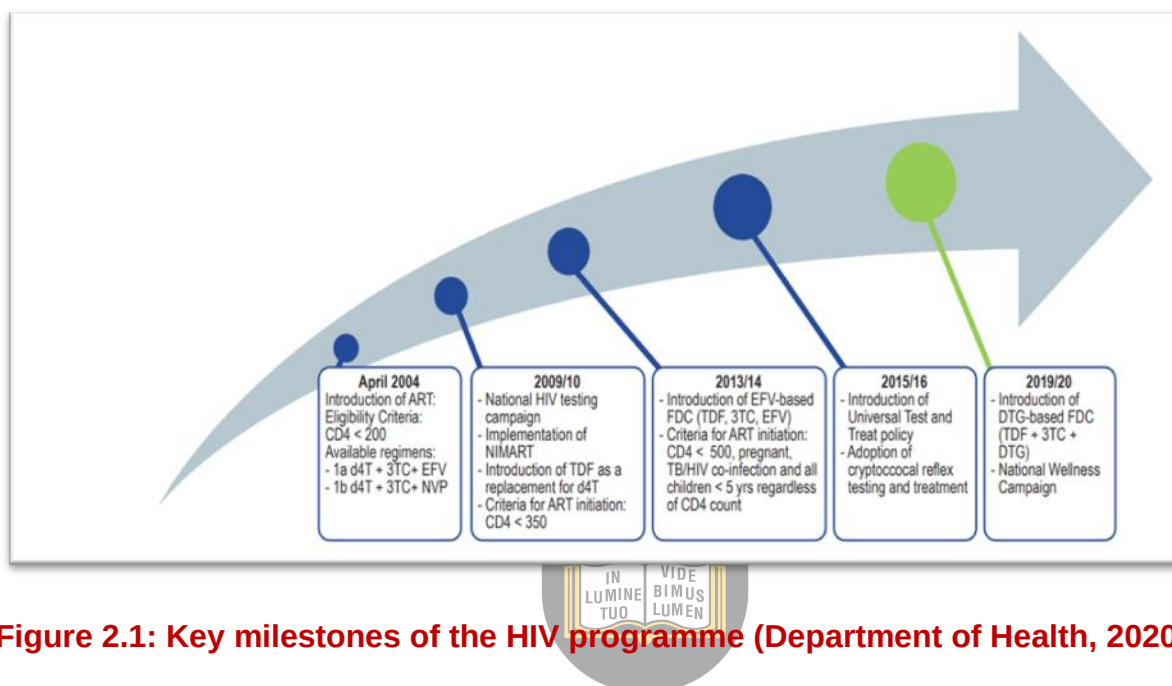


Figure 2.1: Key milestones of the HIV programme (Department of Health, 2020)

The first sign of a tangible response to HIV in South Africa came in April 2004 through the provision of highly active ART (HAART) by public health institutions. The service was mainly provided by hospitals with only single-agents drugs available. As such, clients that had a CD4 less than 200 cell/microliters were eligible for ART. The month of April 2009 was marked by the launching of the national HIV testing campaign and nurse-initiated and managed ART (NIMART). An efavirenz based fixed dosed combination (FDC) was later introduced during the 2013/14 financial year. The country introduced a universal test-and-treat policy and adopted cryptococcal reflex testing and treatment in 2015. Later, in 2019, it introduced a dolutegravir-based FDC and the national wellness campaign (Department of Health, 2020).

A 2017 study conducted by Johnson, Dorrington, and Moolla agreed that South Africa has made impressive progress towards the first UNAIDS 90% target but progress towards the second and third target has not been remarkable. Extending HIV testing, reinforcing speedy connection to care and increasing ART coverage are, therefore, required for South Africa to reach the 90-90-90 targets and better working approaches need to be investigated to

optimise linkage and retention in care and maximise patient on ART outcomes (Takuva, Brown, Pillay, Delpech & Puren, 2017).

Therefore, to achieve these targets, remarkable interventions have to be explored at each step of the HIV prevention, care, and treatment cascade; these should include PLHIV-targeted status strategies in which HIV-positive people are introduced to and sustained on ART, while those on ART are retained and reach viral suppression. While current studies have focused on how far countries are in terms of achieving the 90-90-90 UNAIDS targets, limited research has been done on the participatory role of other stakeholders. Since public health facilities cannot be solely the responsive for this continuum care, a diversity of stakeholders must play various roles within the HIV treatment cascade.

2.6 ROLE OF STAKEHOLDERS IN COMBATTING HIV/AIDS

Not only is HIV a health matter, it is also associated with severe social, political, legal, and economic consequences. In order to attain the set goals and improved outcomes, joint partnerships provide a platform for governmental and nongovernmental organisations, civil society, and CBOs. South Africa's NSP for HIV, TB, and STIs 2017-2022 utilises a multi-sectoral approach, as guiding principles to respond in a manner that is inclusive and participatory to meet the ambitious 90-90-90 targets. It is important, therefore, to identify the key stakeholders so that they may participate in the call to reduce morbidity and mortality by implementing the above strategy. In accordance with Goal 6 of the NSP: encouraging leadership and collective accountability for a sustainable response to HIV, TB, and STIs, civil society and community groups are expected to play a central role (SANAC, 2017). This shows that communities at large have a responsibility and a role to play in ensuring the realisation of goal six.

Communities were the first responders to the human immunodeficiency virus and remain vital in supporting vigorous responses to ensure it ceases to be a health threat. These include delivering services to everyone eligible and tackling HIV-related stigma and discrimination. Working in partnership with public health and other structures, community responses are key to the achievement and sustainability of the global response to HIV (UNAIDS, 2015).

2.7 ROLE OF COMMUNITY-BASED ORGANISATIONS IN COMBATTING HIV/AIDS

Community-based organisations (CBOs) are the not-for-profit, grassroots organisations that work at a local level to improve life for residents. They focus on the interest of their members and can be formal or informal. Their members of the group belong to the community they serve. CBOs are valuable means to transforming the lives of communities and in the advancement of sustainable development because they apply unified, people-centred, and developmental approaches through organising and mobilising communities to take steps towards combatting HIV. Three decades ago, communities were the first to respond and remain vital in advocating for a vigorous response to epidemic control by providing services that can be accessible to those in need while addressing HIV-related discrimination and stigma. Working alongside public health and other systems, community responses are critical to the success and sustainability of the global response to HIV (UNAIDS, 2015).

A review of CBOs in HIV/AIDS prevention, patient care, and control in Ethiopia indicates that HIV/AIDS is not primarily a medical condition, but rather, a socio-economic and developmental problem that requires a multidisciplinary response. According to Hushie (2016) national governments in developing countries are increasingly fostering collaborative arrangements with non-profit sectors of the HIV/AIDS response. An assessment of community based organisations in the implementation of the 90-90-90 HIV treatment strategy is limited.

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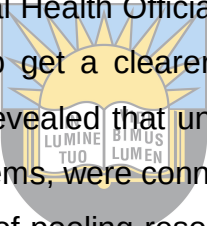
2.8 ROLE OF WARD-BASED OUTREACH TEAMS IN COMBATTING HIV/AIDS

Ward-based Outreach Teams (WBOTs) provide integrated services to households and individuals within their catchment areas are part of PHC facilities. Their intentions are to expand access to PHC services, by means of health promotion and disease prevention in South Africa (Assegaai & Schneider, 2019). Khuzwayo and Moshabela (2017) indicate that these teams provide a credible service but have to increase their service package to further expand public coverage to PHC services and be responsive to the health needs of the community. A study conducted by Le Roux, Le Roux, Mbewu and Davis (2015) on the role of community health workers in the re-engineering of primary health care in the rural Eastern Cape, concluded that community health worker home intervention is a potential model for the re-engineering of PHC. There are limited studies that look at the role of WBOTs through the lens of the attainment of the 90-90-90 targets.

2.9 COLLABORATION BETWEEN CBOS AND WBOTS IN THE IMPLEMENTATION OF THE 90-90-90 HIV TREATMENT STRATEGY

The South African Government has committed to moving from a largely curative and expensive delivery of health service to a service that is more accessible to communities and households and focuses on health promotion, prevention, and community involvement. In 2011, it started re-engineering PHC through launching three streams: namely ward-based primary healthcare outreach teams (WBPHCOTs) school health teams and district clinical specialist teams. Community-based health workers are to provide services to vulnerable communities in close cooperation with facility based health workers, other government departments, NGOs, and community structures, and the private sector. The WBPHCOT policy framework promotes the values and principles of inter-sectoral collaboration by ensuring delivery of services in a unified manner ensuring effective participation for sustainable community development (DOH, 2018).

The Association of State and Territorial Health Officials (ASTHO) conducted interviews with four health systems. The aim was to get a clearer understanding of the reasons these systems partnered with CBOs. This revealed that under-resourced communities, who may have not been engaged in health systems, were connected through community partnerships and that solid collaborations in terms of pooling resources and staffing may have a greater impact (ASTHO, 2020).

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2.10 SUMMARY

The 90-90-90 HIV treatment targets were set to be achieved in 2020 and were an important milestone in the elimination of HIV as a health threat by 2030. Newer targets, namely those like the 95-95-95, aim to be achieved by 2025. Though the core literature review is Chapter Five, this chapter discussed the history of 90-90-90 HIV treatment strategy, global and local statistics of HIV/AIDS, efforts to combat the scourge of HIV, and the role of stakeholders in combating HIV/AIDS including those played by CBOs and WBOTs. However, it is noted that there is a paucity of previous studies that have assessed the role of CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy. The next chapter focuses on this study's research methodology.

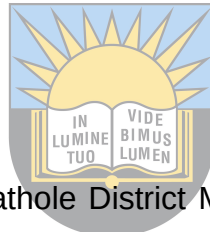
CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In the previous chapter, the researcher focused on the literature review related to the topic. This chapter details the research design and methodology used to describe the role of CBOs in the implementation of the 90-90-90 HIV strategy, explores the role of the WBOTs in the implementation of the 90-90-90 HIV treatment targets, and seeks to identify and describe the enablers of effective collaboration between CBOs and WBOTs in the implementation of 90-90-90 strategy in the particular area of the Amathole District. It focuses on the following aspects of the study: namely its research setting, research design, the population, the sample and sample procedure, the research instrument, ethical considerations, data collection procedures, data analysis techniques and trustworthiness employed.

3.2 RESEARCH SETTING



The study was conducted in the Amathole District Municipality, a Category C municipality situated in the central part of the Eastern Cape. In terms of chapter 7 of the Constitution of the Republic of South Africa, 1996, a Category C municipality refers to a municipality that has municipal executive and legislative power in an area that includes more than one municipality and Amathole Municipality is comprised of six local municipalities. This district has four health sub-districts, more specifically, Amahlathi, Mbhashe, Mnquma, and Raymond Mhlaba. In terms of the service delivery platform, the district has 144 clinics and 5 community health centres providing PHC services, 12 district hospitals and two specialised hospitals. The district has a population of 995 414 with a population density of 47.1 persons per km² and falls within Quintile 1, the lowest socio-economic group. The estimated medical scheme coverage is 4.3% while HIV and Tuberculosis were among the top causes of death for 55% of females and 41% of males aged between 25 and 49, during the period 2013-2015 (Massyn et al., 2020). Amathole is counted among the districts with a high HIV burden in the Eastern Cape (SANAC 2017).

3.3 RESEARCH DESIGN

3.3.1 Qualitative Approach

The study utilized a qualitative research approach to understand how participants perceive their role in the implementation of the 90-90-90 HIV treatment strategy in Amathole District (Ehrlich & Joubert, 2014). Brink et al., (2018) stated that a qualitative approach is used to study human experiences from the perspective of the research participants. Furthermore, a qualitative study deals with non-statistical method and is useful for exploring the full nature of a little-understood phenomenon. The selected design allowed participants to take part and give an insider's view in the context in which their actions take place (Brink et al., 2018). The qualitative design allowed the researcher to gain a rich understanding of the role WBOTs and CBOs in the implemented 90-90-90 HIV treatment strategy in Amathole District (Polit & Beck, 2018).

3.3.2 Exploratory Research Design

Exploratory design was relevant to allow the researcher to discover all possible perspectives in the role of CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy in Amathole District (Brink et al., 2018). Exploratory studies are undertaken when a new topic is being investigated.



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3.3.3 Descriptive Research Design

The descriptive design of this study enabled the researcher to acquire more information in the exact field about the phenomenon as it occurs naturally (Brink et al., 2018). Polit and Beck (2017) described the research design as the complete plan for finding answers to the research questions. Qualitative description research is a realistic approach which created an understanding of a phenomenon by getting the meanings participants assign them (Bradshaw, Atkinson & Doody, 2017). This type of design was suitable as the researcher wanted information about the role of WBOTs and CBOs in the implementation of the 90-90-90 HIV treatment strategy, in particular. Therefore, this design was used to describe the role of community-based organisations, explore the role of ward-based outreach teams in the implementation of the 90-90-90 HIV strategy, and identify and describe the enablers for

effective collaboration between CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy in Amathole District.

3.4 POPULATION

According to Polit and Beck (2018), the study population is the entire group of interest. To determine the sample, the researcher was guided by who would be an information-rich source and who would maximise the researcher's understanding of the topic being researched (Polit & Beck, 2018). The group of interest was CBOs and WBOTs involved in HIV care in Amathole district, Eastern Cape.

3.5 SAMPLE AND SAMPLING PROCEDURE

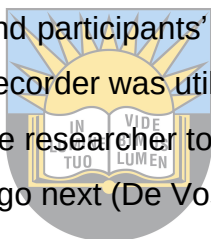
Qualitative research requires the data collected to be rich in description, and as such, the sample must consider the identification of sources rich in information (De Vos, Strydom, Fouche & Delport, 2011). Polit and Beck (2018) further states that in qualitative research, random samples are avoided, and non-probability sampling designs are used. This allows for the selection of people who are knowledgeable, articulate, insightful, and prepared to talk to the researcher. A purposive sampling process was followed to select the research participants who would provide information-rich data about the study's particular research topic. The four WBOTs and five CBOs selected were those in the proximity of high-volume facilities in terms of clients on ART as identified using 2017-2018 data from the District Health Information System (DHIS).

Brink et al., (2018) indicates that factors on size are based on purpose, sample used and the design. The semi-structured one-to-one interviews were inclusive of four ward-based outreach team leaders and five managers of CBOs. The focus group discussions were inclusive of four groups of community health workers from WBOTs and five groups of community care givers from CBOs. The researcher continued with interviews until data saturation was reached whereby there was no new information from the participants regarding the phenomenon under study.

3.6 RESEARCH INSTRUMENT

An interview guide was developed for semi-structured interviews and focus group discussions derived from the study's objectives. The researcher collected data by interviewing participants and facilitating focus group discussions. Semi-structured, face-to-face interviews were conducted with five managers of CBOs and with four ward-based outreach team leaders. Open-ended guiding questions were used for individual interviews. The same guiding questions were used to facilitate focus group discussions with community health workers and care givers from WBOTs and CBOs respectively. The focus group discussions, consequently, allowed the researcher to interview 6 individuals simultaneously.

Seidman (in De Vos et al., 2011) indicates that one conducts an interviews due to an interest in other people's stories. In this regard, interviews are defined as interactional events that demonstrated participants' internal pathway to create meaning. The main objective of semi-structured interviews was to understand participants' experiences and glean insight into the meaning they attach to them. A tape recorder was utilised to guarantee that responses were not overlooked or lost. This allowed the researcher to be more present during the interviews and guided them in terms of where to go next (De Vos et al., 2011).



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3.7 ETHICAL CONSIDERATIONS

"Ethics is a system of moral value that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to study participants" (Polit & Beck, 2018). To ensure that the research adhered to this, permission and informed consent were obtained; furthermore, confidentiality and anonymity were maintained during the study.

3.7.1 Permission to conduct the study

The researcher obtained an ethical clearance certificate (GON0201SMAK01) from the Ethics Committee of the University of Fort Hare and ethical approval to conduct the research was obtained from the Eastern Cape Health Research Committee. Permission to enter the health facilities and collect data was then obtained from the Amathole Health District Manager. Permission to interview CBOs was requested from leaders of CBOs. Due to the involvement

of human participants, it was imperative to follow stringent ethical principles (Brink et al., 2018).

3.7.2 The right to autonomy

The right to self-determination was observed through demonstrating regard to participants and ensuring that they took part in the study by their own choosing. Sufficient information about the research was given and participants were free to withdraw at any stage (Gray, Grove & Sutherland, 2017).

3.7.3 Informed consent

The participants were asked to give consent after a full explanation of the purpose of the research. Clear explanations about the study were provided and emphasised that their participation was voluntary and had no incentive attached to it. It was also made clear that there would be no adverse repercussions should they refuse to take part. The rationale for using the audio tape during the interview was explained (that it would ensure full capturing of what was said so that nothing would be missed). Participants consented by signing as evidence for the use of an audio recorder.



3.7.4 Confidentiality and anonymity

Participants' right to privacy was protected through confidentiality procedures. They were also informed of their right to confidentiality and anonymity. They were assured that the data they provided would be kept in strict confidence and safe record-keeping would be observed (Polit & Beck, 2017). Access to the data was restricted to ensure confidentiality. Data was collected, analysed, and reported without compromising the identities of participants. Anonymity, which is regarded as the most secure means of protecting confidentiality, was ensured by neither providing participants' nor sub-districts' names. Rather they were given numbers (Polit et al., 2018).

3.8 DATA COLLECTION PROCEDURES

Brink et al., (2018) defines data collection as a way in which the researcher approaches answering the research question. De Vos et al., 2011 asserts that the purpose of the research must guide researchers in the selection of the most effective data collection method in qualitative research. Furthermore, information that could not emerge in the one-on-one interview might surface during focus group discussion. A list of questions derived from research objectives was used as a guide to ensure participants' detailed description. Data were gathered during field visits, using an interview guide for nine focus group discussions. The same interview guide was used for individual face-to-face in-depth interviews.

On the day of the data collection the aim of the study was read. Field notes were taken. A tape recorder was used with participants' permission and consent was signed. A purposive sample to select four WBOT leaders, five CBO leaders as well as nine focus group discussions (four from WBOTs and five from CBO) were conducted. Information saturation was reached when no new insights were offered (Ehrlich & Joubert, 2014). Attention was given to ensure that a place offers privacy, protection against interruptions, and is adequate for recording the interview (Polit & Beck, 2017). Individual interviews with CBOs' managers were conducted in their offices while those with ward-based outreach team leaders took place in the facilities they report to.



3.9 DATA ANALYSIS

Effective data analysis requires one to be immersed in the hands-on process of finding the various meanings and relationships between the data (Brink et al., 2018). Due to the qualitative nature of the study, the data were collected using audiotapes, which were listened to several times, and the data transcribed. Taped material was transcribed and verified against the recorded interview. Use of the main interview guide as the theme was avoided and data was explored in detail for common themes. Themes were divided into particular units of meaning. Braun and Clarke's (2006) recommended six-phases provided an analysis as follows:

- Firstly, the researcher familiarised themselves with the depth and scope of the data;
- Secondly, the researcher generated an initial list of ideas on what is of interest in the data;
- Thirdly, the researcher analysed codes and considered how to combine them;

- Fourth, the researcher refined and reviewed the themes to understand how they fit together.
- Fifth, the researcher refined and named themes in order to identify the significance of each and which aspect they captured, these contained sub-themes gave useful structure to a particularly large and complex theme.
- Lastly, the researcher produced a report to provide sufficient evidence of the data-related themes to demonstrate each's prevalence.

The above-mentioned transcripts were then submitted to an independent coder for analysis. Themes and sub-themes emerged from this process.

3.10 TRUSTWORTHINESS

The goal of rigour in the study was observed by accurately representing the study participants' experiences, and by demonstrating that attention and confirmation of information discovered was accurate. Lincoln and Guba's framework of quality criteria, as illustrated by Polit and Beck (2018), was applied. This framework comprises four criteria to develop the trustworthiness of a study. These include credibility, dependability, confirmability, and transferability.



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3.10.1 Credibility

Credibility refers to the surety of the data and its interpretation. The study was carried out in such a way that readers would believe the findings (Brink et al., 2012). The credibility of this particular study was achieved by ensuring that the data collected, and emerging themes were identified and described accurately. The interviews were tape-recorded to accurately capture the answers of the participants. Tape recorded material was transcribed and translated after which the data that was transcribed was checked by listening to the audio tapes repeatedly to ensure accuracy.

3.10.2 Dependability

Dependability refers to the consistency of data over time and in various conditions (Polit & Beck, 2018). This meant that if the research was to be repeated with the same participants, in the same contexts, the findings would be similar. Field visits were conducted to gather

data. An interview guide was used for individual face-to-face interviews and focus group discussions. The services of an expert in qualitative research were sought by submitting raw data to review the research procedure and for the analysis of data and coding for findings to be rendered consistent and repeated. Raw data was archived.

3.10.3 Confirmability

Confirmability is concerned with ensuring that data represents the information provided by the participants. It seeks to establish the researcher does not apply any bias to the findings (Brink et al., 2012). Confirmability was guaranteed by clearly documenting all the steps involved in the study to form an audit trail. Confirmability was observed by accurately interpreting data obtained from the participants during data collection. The researcher collected sufficiently detailed descriptions of data in context. The data was reported in appropriate detail and with precision to allow evaluations about transferability to be made by the reader.



3.10.4 Transferability

The transferability of this study refers to the extent to which its findings can be applied to other settings or groups (Polit & Beck, 2018). The researcher was not concerned with generalising the findings but rather, focused on defining the study's relevant context-specific observations (Brink et al., 2018). In this study, sufficient detailed descriptions were collected within context and participants were selected purposefully to give a full range of knowledge for the phenomenon under investigation. Thus, strategies to strengthen transferability were observed through purposive sampling, detailed descriptions, and data saturation (Brink et al., 2018).

3.11 SUMMARY

In summary, this chapter presented the qualitative descriptive research method used for data collection. It dealt with the trustworthiness of the study and the manner in which ethical considerations were observed. The presentation of the findings is dealt with in the next chapter.

CHAPTER 4

PRESENTATION OF FINDINGS

4.1 INTRODUCTION

While the previous chapter focused on research methodology, this particular chapter aims to discuss the results of the particular data collected during focus group discussions and the semi-structured interviews with CBOs and WBOTs within the context of the Amathole District. Recorded information was listened to and transcribed. A thematic analysis was utilised to accurately analyse the data. Five themes and twenty sub-themes emerged and were tabled in Table 4.1 below.

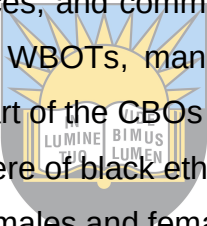
Table 4.1: Themes and sub-themes

Theme	Sub-theme
1. Case finding	Home Visits
	Counselling
	Health Education
	Refusal of HIV testing by clients
	Non-provision of HIV testing
2. Linkage to care	Referral of clients
	Tracing defaulters
	Collaboration with the health facility
3. Retention of care	Conducting follow-ups
	Monitoring of clients
	Health education
	Reduced treatment adherence
	Stigma and disclosure
	Distance to health facilities

4. Collaborations between CBOs, WBOTs and health facilities in the implementation of 90-90-90 treatment strategy.	Referral
	Positive relations included teamwork, and partnerships
	Negative relations were identified as poor coordination
5. Successes achieved in the implementation of the 90-90-90 HIV treatment strategy.	Suppressed viral loads
	Decreased deaths
	Traced defaulters

4.2 DEMOGRAPHIC DATA OF PARTICIPANTS

Participants included enrolled nurses contracted by the Department of Health as team leaders in ward-based outreach services, and community health workers contracted by the Department of Health as part of the WBOTs, managers of CBOs, and community care workers (CCWs). The latter forming part of the CBOs in the Amathole District, in the Eastern Cape, South Africa. All participants were of black ethnicity and their ages ranged from 25 to 50 years. Participants sexes included males and females.


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4.3 FINDINGS OF THE STUDY

The findings are revealed according to the themes and sub-themes generated from the data collected. The following themes describe the role of CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy and data analysis yielded five themes, namely: case finding, linkage to care, retention to care, collaboration between CBOs, WBOTs and health facilities in the implementation of the 90-90-90 HIV treatment strategy, and lastly, the success achieved in the implementation of this particular strategy. Twenty sub-themes were derived from these five themes, namely: home visits, counselling, health education, refusal of HIV testing by clients, non-provision of HIV testing, referral of clients, tracing of defaulters, collaboration with the health facilities, conducting follow-ups, monitoring of clients, reduced treatment adherence, stigma and disclosure, distance to health facilities, positive relations involving team work and partnership. Negative relations include poor coordination, suppressed viral load, decreased deaths and traced defaulters.

4.3.1 Theme 1: Case finding

Based on the data analysed, case finding emerged as a prominent theme. Participants expressed that they conducted home visits, counselling, and health education. They also revealed that some of their clients refuse to be tested, and furthermore, that they (participants) are unable to provide HIV testing in certain instances. The five relevant sub-themes are each discussed below.

4.3.1.1 Home visits

Participants highlighted that they conduct households visits to provide services. During the home visits, participants identify problems and areas requiring support. The following explanations came from different participants regarding home visits:

‘The first 90 is about testing everyone, we have got our monitors who do door-to-door and conduct household visits where they provide education and the people are their patients, they provide support and do pill count’ (Manager, CBO 1).

‘The sisters are able to tell them that, so and so has not come to fetch their treatment, and the healthcare worker is asked to go to the person’s home to check what is going on. Maybe the patient is not there, or they have moved to another place’ (Leader, WBOT 2).

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4.3.1.2 Counselling

In this study, participants highlighted the provision of counselling as a case-finding activity and mentioned that it assisted them to establish relationships with their clients.

Participants expressed that:

‘For the males, we are able to talk to them during the circumcision season. We do counselling sessions with them because when they attend clinics, they should be ready for testing. We start from the age of 15 years because when they reach 18 and it is the time for circumcision they must test and know the ailments in their bodies’ (CHW 1, FGD, WBOT 4).

Others said:

'This is where we try creating spaces for patients for debriefing sessions and we do this through appointments, we try to form relationships with the patients where we sit with them and try to find out what is going on with them' (CHW 2, FGD, CBO 2).

'We do the counselling again, the ongoing counselling. Each and every time we visit those people neh, we do the ongoing counselling so that they can come into terms with the situation that I am HIV-positive and I have to take my medication as soon as possible and on a regular basis' (Leader, WBOT 1).

4.3.1.3 Health education

In regard to health education, the participants revealed that they conduct such drives to promote community awareness and an acceptance of individuals' HIV statuses. These are some of the responses from the participants:

'We also do awareness campaigns, where we educate the community, without differentiating, about HIV & AIDS and TB because they go together. Before they know about their HIV status people first discover that they have TB. When they are tested for TB, they would then go for blood and discover that they are HIV-positive' (Manager, CBO 3).

Another stated:



'There is education that is done so that they accept and understand that this thing does not kill an individual and they can live for a long time when they have accepted it and they adhere and take their treatment properly. You can live for a long time, just like other people' (CHW 2, FGD, WBOT 3).

4.3.1.4 Refusal of HIV testing by clients

Participants also named the refusal of HIV testing by clients. Since these participants identify clients eligible to be tested and refer them to a clinic, they stated that their clients often refuse to attend clinics to get tested. Some participants responded as follows:

'Some do not want to be tested by people that conduct testing. They would go for testing somewhere else. They end up not going. Sometimes they refuse to go to their clinic for testing' (Leader, WBOT 2).

'We have noticed that people do not go to the clinic for testing. This is why we need a strategy where testing will be done in households' (CHW 3, FGD, CBO 4).

In addition, another maintained that:

'The challenge is that we talk to people, but people do not want to test. There are still those who do not want to test. We give out consent forms and you find that no parent consents for children to be tested for HIV' (CHW 3, FGD, WBOT4).

4.3.1.5 Non-provision of HIV testing

Participants indicated that they do not conduct the HIV test themselves within the local community but rather refer eligible clients to relevant clinics.

'We do not test. We test when we are with the sisters, but we do not perform the HIV test' (CHW 1, FGD, WBOT 2).

'In the community as we educate about HIV... After that, we ask if a person is interested in testing. If they are interested, we refer them to the clinic' (CHW 5, FGD, CBO 2).



4.3.2. Theme 2: Linkage to HIV care

The second theme that emerged from the data analysis was the linkage to HIV care. The three sub-themes forming part of this theme are the referral of clients, tracing of defaulters, and collaboration with health facilities.

4.3.2.1 Referral of clients

Participants tabled one of their roles as referring their clients to local health facilities. They further mentioned that their clients are referred to clinics as well as other departments where necessary for access health services. The following statements in this regard were made:

'.....we then refer them to the nearest clinic' (CHW 5, FGD, WBOT 3).

'For some getting food is difficult so we would try the department of social development to help them with grocery so that they know how to take treatment and their adherence' (Manager, CBO 4).

One participant emphasised the point by saying:

'Even though we do not do HIV testing, we encourage them to go to the clinic. There is what is called a referral....' (Leader, WBOT 1).

4.3.2.2 Tracing of defaulters

Tracing of defaulters also emerged from participants, which included clients that move from one clinic to another without informing their first clinic of it. This is problematic since the records of the original clinic may indicate lost while clients access medication in another facility. The following are some of the responses:

'We trace defaulters, lost to follow up, even those that go to a different clinic. Some will collect from this clinic another time they go to Clinic and some to ... Clinic. We try and keep track of them and try and get them to go back to their originally assigned clinic' (Manager, CBO 2).

Supporting this, one participant said:

'At the clinic, there is a list hanging on the wall to show that this care giver is responsible for S, at MK. They look at that list and see that this care giver is for N and this one belongs there, and so on.. The telephone numbers are on the list as well and they are able to phone you. Look for this person who is a defaulter. We last saw them on such and such a date and was supposed to come on such and such a date...., so that I can look for the person that they are looking for' (Manager, CBO 5).



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4.3.2.3 Collaboration with the health facility

Collaboration with the health facility surfaced as one of the sub-themes in linking clients to care. Participant revealed that:

'...we work well with clinics. We refer those who need to be referred and go to assist in the distribution of medication during adherence club days' (CHW 6, FGD, CBO 5).

Others further expressed that:

'Now that we have access through the clinics to look at the viral load.... there is a connection with the clinic to check if my client has a viral load that is suppressed. I think this is the main thing that assists to know that clients are not cheating because

they know that I will arrive. It does not end there it goes to the clinic, to the blood that will show that' (CHW 6, FGD, CBO 1).

In supporting the above quote, one participant said:

'We are able to work together as CHWs from the clinic and the ones that are outside. We would go together to the community, and they would do their organisation's work' (CHW 1, FGD, WBOT 1).

4.3.3 Theme 3: Retention in care

Based on the data analysis, the third theme to emerge was retention in care. Participants highlighted that providing support to clients improves their retention in care while related hindrances were also emphasised. In terms of hindrances, the following six sub-themes emerged, namely: conducting client follow-ups, monitoring of clients, health education, reduced treatment adherence, and, lastly, distances to health facilities.



4.3.3.1 Conducting follow-ups

Conducting follow-ups was mentioned by the participants as one of their roles. They mentioned that they follow up with their clients to check if they are taking their medication and/or when they have missed appointments at the clinic.

One is quoted as saying:

'So, once it is not suppressed then there has to be a follow up that is done and before leaving must make sure that the treatment is taken, and they (CHW) must make sure to dedicate themselves for a month to go every day at a certain time drink it and not to say I will drink it' (Leader, WBOT 3).

Another participant stated that:

'So CHWs need to do a follow-up also ensure clients go to the clinic because you cannot just give a person a referral without following up on them thereafter' (Leader, WBOT 1).

Furthermore, participants maintained that:

'You go and check for them and tell them that they did not go to the clinic because when I got there, the referral was not there. I asked about you and you were not known and did not go...' (CHW 4, FGD, WBOT 2).

4.3.3.2 Monitoring of clients

In this study, the monitoring of clients emerged as one of the roles implemented by CBOs and WBOTs. Participants revealed that monitoring their clients assisted them to detect any arising gaps in their caring of clients. Some of them indicated that:

'So, for the pill counts conducted, if you know that they have 28 tablets and you arrive and get there on the second day, the has to check the card from the clinic and compare if the number is the same' (CHW 2, FGD, CBO 3).

Another said:

'Then we make sure for the second 90 that those who are diagnosed start with treatment. So that we are able to start with follow-ups. We cannot follow up without achieving the first 90, everyone should know their status to reach goals one to eight. We again have to look at the second 90 and make sure people are initiated on treatment so that we can then follow up, once again we cannot reach the last 90 without making sure that those diagnosed are taking treatment' (Manager, CBO 1).

Moreover, a third stated that:

'We make sure that people take their medication according to the way they were told, the time and the dosage that should be taken, you know the date the medication was given, you know how many you are expecting....' (CHW 4, FGD, CBO 3).

4.3.3.3 Health education

Conducting health education was mentioned as one of their roles. Participants highlighted that they conduct this on the importance of continuing with treatment to maintain a suppressed viral load.

One is quoted as saying:

'The virus being undetectable does not mean that the virus is gone, it is important that they continue to take their treatment, the virus is undetectable because they are taking

their treatment the right way, and ought to still continue taking their treatment to suppress their viral load. This gives them confidence and motivation to continue with treatment when they keep testing for viral load' (CHW 3, FGD CBO 1).

4.3.3.4 Reduced treatment adherence

In this study, reduced treatment adherence was also mentioned a challenge to the implementation of the 90-90-90 HIV treatment targets. Participants revealed that there is reduced treatment adherence due to different reasons. The following are statements from participants:

'Some patients go and test and do not have treatment supporters. This becomes a challenge because some forget how to take it correctly or just forget altogether. Some even come back to us with their pill containers and ask how to take the pills again' (CHW 4, FGD, WBOT 4).

Others further expressed that:

'With us children are difficult. ... The challenge that we have with children is that alluvia is very bitter. You find out that mothers do not give the full amount because the child says it is bitter. We then must find a way to educate the mother because the child must take treatment. If they do not take the full amount, it means they are not taking it. This is the major problem among children. When they [children] have said I don't want it, the grandmother would leave it at that and say the child will not take the treatment' (Manager, CBO 2).

'They would site that they have had enough, they have been taking treatment for a long time and site that it has been years. They collect so that the folder is up to date. They have a problem with the different types of the same tablet' (CHW 3, FGD, CBO 3).

4.3.3.5 Stigma and disclosure

Participants stated that despite available health education stigma is still a challenge that perpetuates non-disclosure and vice versa.

One participant said the following:

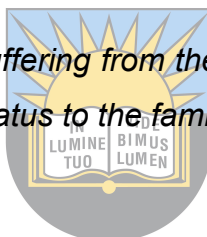
'The reason why people do not want to disclose to the families and communities is because of the stigma that we show as communities towards them. A person would then decide no, I cannot say anything about my status, and I'd rather keep quiet' (CHW 3, FGD, WBOT 1).

It was clarified by another who mentioned that:

'Sometimes we have people who do not want to be seen by Community Health Workers, and they do not want to disclose to us...They would be initiated on treatment, and they should then be linked to a CHW for support. They would refuse to be linked to CHW and this becomes a challenge as they would not do right on treatment, and you would be unable to visit them because they did not agree to be visited in the first place' (CHW 2, FGD, CBO 5).

. Another participant revealed that:

'still, in our days, people are suffering from the stigma... She is stigmatized because she did not disclose her own status to the family' (Leader, WBOT 4).



4.3.3.6 Distance travelled to clinics

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Participants revealed that the distances from where clients reside to their relevant clinics deters patients from remaining engaged in care. They further revealed that clients give up treatment, due to the distances they must travel to access the clinics.

One participant said that:

'distance from the facilities where a patient needs to go and collect their treatment. One would find that it is far to fetch treatment, so they would tell themselves that they are never going to fetch the treatment again' (Manager, CBO 4).

This was emphasised by another who stated:

'The challenge is the distance, firstly people are far from clinics and there is no transport' (CHW 6, FGD, WBOT 1).

4.3.4 Theme 4: Collaboration between CBO, WBOT and health facilities in the implementation of the 90-90-90 HIV treatment strategy

The fourth theme that emerged from the data analysis was the importance of collaboration between CBOs, WBOTs, and health facilities to implement the 90-90-90 HIV treatment strategy. This was further supported by three subthemes, namely: referrals; positive relations such as teamwork and partnerships; and lastly negative relations such as poor coordination. These are briefly discussed in the following section.

4.3.4.1 Referrals

Participants indicated that clients who have missed appointments are referred to them for tracking. In addition, they highlighted that they also refer their clients to clinics. The following are two statements concerning this issue:

'At the clinic, there is a list hanging on the wall to show that this care giver is responsible for S, at MK. They look at that list and see that this care giver is for N and this one belongs there, and so on. The telephone numbers are on the list as well and they are able to phone you. Look for this person who is a defaulter. We last saw them on such and such a date and was supposed to come on such and such a date...., so that I can look for the person that they are looking for' (Manager, CBO 3).

'We have healthcare workers that report to the clinic regarding the patients. When there is a problem with a certain patient, the sister goes back to the healthcare worker and speaks to them, then the healthcare worker will report back' (Manager, CBO 1).

Moreover, another also stated that:

'We refer those who need to be referred and go to assist in the distribution of medication during adherence club days' (CHW 4, FGD, WBOT 1).

4.3.4.2 Positive relations – teamwork and partnership

In this study, participants indicated positive relations among CBOs and WBOT and clinics. They maintained that they shared resources such as transport to reach their goals since both WBOTs and CBOs provide services in the same areas. Furthermore, they mentioned that

their activities also required their collaboration with the clinics by giving health education in a manner that reaches their clients. The following was revealed:

'I can say it is right because if they want to do an outreach, we always do it in partnership. We provide them with transport because most of the time they would not have transport' (Manager, CBO 3).

'We work together because they also conduct home visits. You would find that when we visit, they had also visited the same household. They have been to the house that you visit. Even with children, a mother would say the CHW has just left. We would look at our part and go. We do not have a problem with them' (CHW 3, FGD, WBOT 1).

Moreover, another stated that:

'We work well with clinics..... We give health education in clinics. As we get to the clinics and educate. They hear well when we are the ones doing the talk and not the nurses because we relate better with what they are going through' (CHW 3, FGD, CBO 5).

In addition, the distribution of resources was mentioned as part of the positive that exists between the participants and the clinic. Participants said:

'Then again, we distribute as we have village health workers, they take condoms from the clinic and distribute them so that HIV and AIDS instead of increasing may decrease' (Manager, CBO 5).

Another participant stated that:

'And we are distributing the condoms as well so that everybody must be safe you understand' (CHW 1, FGD, CBO 4).

Participants expressed how they communicate with the clinic and indicated that:

'We have healthcare workers that report to the clinic regarding the patients. When there is a problem with a certain patient, the sister goes back to the healthcare worker and speaks to them, then the healthcare worker will report back' (Manager, CBO 1).

'We as a CBO also work closely with the clinic as well as the village healthcare workers (VHW). The sisters for example know that a certain village healthcare worker has 5 patients that are on treatment. Then we are to meet with the operational manager

(OM)certain number has not been suppressed. This then means we need to put pressure on the VHW so that they educate the patients more' (Manager, CBO 2).

4.3.4.3 Negative relations – poor coordination

Participants also named negative relations such as poor coordination as a hindrance in reaching the set targets. They expressed that their clinic should recognise the work they do and that there is a need for better coordination by role players since they are working towards the same goals. A lack of resources and poor recording in health facilities was also highlighted. One participant stated that:

'the problem that I have realised is that as ... we going to these areas, we are trying to bridge the gap where the department is unable to reach. So somewhere somehow to realise that the partnership is there and not there. It is as if we must do the work for the clinics so that they are able to report. They are not able sometimes to meet us halfway and see that this is a 50-50 situation we are doing the same thing and we have one goal' (CHW 4, FGD, CBO 3).

Another maintained that:

'The ones who have given me problems are from They say that they have been employed by an They will not take their work to the Department of Health. They even go to say that if we want their work, they need to be paid by the Department of Health' (CHW 2, FGD, WBOT 2).

Furthermore, they highlighted their need for training to be able to be effective in their roles and also that they are not kept abreast of new developments. Participants made the following comments regarding training:

'Training in the sense that, as my sister has just said, we have certain information whereas things have changed' (CHW 5, FGD, CBO 3).

'Like most of the time the stationery. You will find that the stationery is not enough for the facility. We have to wait for the stationery to come from sub-district to come here. Because sometimes the machine is not working so that you photocopy the rest of the documents' (Leader, WBOT 1).

Another revealed that:

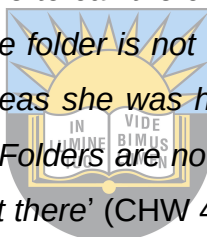
'We do not have the cooler boxes and stuff.... So, I usually use my own transport to take those who are failing to come to the facility and then negotiate with the facility team that there is this woman, and she does not take her medication properly and whereas she breastfeeds her baby' (Leader, WBOT 3).

Relating to the inadequate recording by health facilities, one participant said:

'When there is nothing written on the referral letter, you request the sister to write because they are supposed to write. You ask from the client which sister saw you. The client would tell you. You go to the sister so and so and inform them and request that they write on the referral letter. You request that they give it back to you so that you can count it' (CHW 6, FGD, CBO 4).

Another participant revealed that:

'The sisters in the facility, they will fail to record properly in the folder. So now there will be that duplication. You have to call the client time and again. Whereas she was here yesterday. Because of the folder is not written properly, then they will say she missed the appointment. Whereas she was here. Then you have to go back to the client and call the client again. Folders are not written but the client has shown up in the clinic. The information is not there' (CHW 4, FGD, WBOT 3).



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4.3.5 Theme 5: Success stories indicated by participants regarding the 90-90-90 strategy implementation

The fifth theme that emerged from data analysis was success in the implementation of the 90-90-90 HIV treatment targets. The sub-themes that emerged include suppressed viral load, decreased deaths, and traced defaulters.

4.3.5.1 Suppressed viral load

In this study, clients viral load of was determined to be one of the indications of successfully fulfilling their roles. Participants highlighted that many of their clients have suppressed viral loads:

'It is through the reports we get from the clinic that there aren't too many who are not suppressed in terms of the viral load. This is a success for us in that there are many

who adhere to treatment because when they do blood tests, there are not many who have high viral loads. That means a lot of work is being done' (Leader, WBOT 1).

'because most of our clients, their viral load is suppressing' (Leader, WBOT 4).

This was supported by another who said:

'Even their viral load went down and became LDL, and they were able to finish their TB treatment' (Manager, CBO 4).

4.3.5.2 Decreased deaths

Fewer deaths were highlighted as one of the successes of CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy. Some participants revealed that:

'Many people previously used to die, now they stay for longer years' (CHW 1, FGD, CBO 5).

Another indicated that:

'Fewer deaths, as well' (CHW 3, FGD, WBOT 2).



4.3.5.3 Tracing of defaulters

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Several participants mentioned that their ability to trace defaulters back to care is an indication of their success. Retention of clients in care is associated with a viral load that is suppressed. Some of them indicated that:

'We are doing well in terms of searching for our defaulters' (Manager, CBO 1).

This was supported by another that mentioned that:

'What I am proud of is the fact that there was a person we were working with who defaulted treatment. They used to be on and off treatment until they were bed ridden. They had given up on themselves. We visited them day and night until they stood up' (CHW 6, FGD, CBO 3).

4.4 Summary

In summary the chapter contained the study's findings as per the themes and sub-themes that emerged from the analysis of data. The five themes and twenty sub-themes are discussed, and participants' quotations were presented.

Though there are identified roles by CBOs, and WBOTs hindrances to effective implementation of the 90-90-90 HIV treatment targets were identified. Areas of collaboration between CBOs, and WBOTs and clinics as well as success stories were identified.



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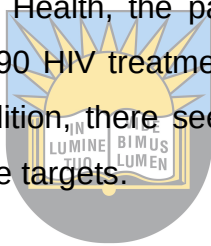
CHAPTER 5

DISCUSSION OF FINDINGS, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 INTRODUCTION

While the previous chapter focused on the presentation of findings, this chapter concentrates on a discussion of the study's major findings, limitations, conclusions, and recommendations as based on its data collection that was done through focus group discussions and interviews pertaining to role of CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy.

As previously established, HIV/AIDS remains a public health threat, both globally and locally. Despite targeted support provided by various developmental partners and strategies put in place by the National Department of Health, the particular district has not produced the desired results to achieve the 90-90-90 HIV treatment targets to eliminate HIV/AIDS as a public health threat by 2030. In addition, there seems to be no integrated efforts by all stakeholders to assertively reach these targets.



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5.2 DISCUSSION OF THE FINDINGS

5.2.1 Theme 1: Case finding

The findings of this study demonstrated that CBOs and WBOTs engage in case finding for HIV by conducting home visits, providing counselling, and giving health education. However, participants also indicated that clients' refusal to attend their local clinic when referred for testing, coupled with a lack of training hinders them from conducting the HIV tests during household visits. Their inability to conduct home testing is largely due to a lack of training on their part while clients' refusal to be tested for HIV limits their efforts in terms of case finding of HIV and their attaining of the set targets seeking to ensure that PLHIV are aware of their statuses.

While a recent study conducted by Kitchen, Bärnighausen, Dube, Mnisi, Dlamini-Nqeketo, Johnson, Bärnighausen, De Neve and McMahon (2020) identified various inhibitors of HIV testing and focuses on individuals occupying positions of power, this study assessed the role of community-based workers. In line with this study, Ssekalembe, Isfandiari, and Suprianto (2020) concluded that scaling up HIV case-finding knowledge through awareness creation about HIV, HIV counselling and testing, and intensifying the antiretroviral services is a much-needed strategy to reach the UNAIDS' 90-90-90 target. Furthermore, Madikizela, Matlala, and Mosikare (2021) maintain that CHWs who are adequately trained, provided with resources, and supported can offer community services that address behaviour changes, identifying eligible cases, and refer individuals for HIV testing or linkage to care in health facilities.

5.2.2 Theme 2: Linkage to care

The findings of this study revealed that CBOs and WBOTs, in particular, provide a linkage to care through referral of their clients, tracing defaulters, and collaborating with health facilities. Linkage to care is the process of supporting individuals testing for HIV and those positively diagnosed to encourage them to make use of the treatment and care services appropriate to their HIV status (DOH, 2020). Community health workers from CBOs and WBOTs refer their clients who are eligible for HIV testing to health facilities while these clinics refer those that have missed appointments to CHW for tracing and linkage back to care.

A study conducted by Naidoo, Railton, Jobson, Matlakala, Marincowitz, McIntyre, Struthers and Peters (2018) concludes that CHW provides an essential structure in the successful implementation of the HIV Programme in four ways. These include the prevention of HIV infection by providing health education; the linkage of care by health education and subsequent referrals; adherence support; and lastly the identification of individuals who are not adhering to treatment. Similarly, a study conducted by Khuzwayo and Moshabela (2017) states that WBOTs deliver a commendable service and emphasises the need to increase their service packages to intensify access to primary health care services for community health needs. Though these views are similar, the lens through which they are examined was not focused on the attainment of the 90-90-90 HIV treatment targets. It is, therefore, important

to ensure that community-based workers' activities are targeted and linked to their service delivery targets.

5.2.3 Theme 3: Retention to care

The findings of the study demonstrate that retention in care is conducted through follow-up visits, monitoring of clients, and health education. Participants also reveal that they conduct follow-up visits for clients that have an unsuppressed viral load to ensure that they take their medicine correctly. Their monitoring of clients included checking clinic cards comparing the dates medication was given to the number of tablets clients have left. In addition, they indicate that the long distances clients must travel to health facilities, as well as a non-disclosure of status due to fear of discrimination and stigma contributed to clients disengaging in the required HIV care and treatment. Furthermore, they mentioned that reduced treatment adherence occurred because a lack of treatment buddies; for children, in particular, the bitter taste of the medication is a deterrent in their treatment adherence. Treatment fatigue was also revealed as negatively affecting retention in care.



Bajunirwe, Tumwebaze, Akakimpa, Kityo, Mugenyi and Abongomera (2018) concluded that in order to achieve the UNAIDS targets, countries must identify barriers, address HIV stigma, and tackle the long distances clients must travel to health facilities. This must be done to increase access and utilisation of HIV-related treatment and clinics. Ayieko, Brown, Anthierens, Van Rie, Getahun, Charlebois, Petersen, Clark, Kanya, Cohen, and Bukusi (2018) agree that several hindrances to retention in care threaten the attainment of the UNAIDS targets. Similarly, a study by Ayieko et al., (2018) of the 90-90-90-related impediments and others observes multiple barriers to engagement to care and concluded that to reach epidemic control, efforts to combat stigma need to be enhanced.

5.2.4 Theme 4: Collaboration between CBOs, WBOTs and health facilities in the implementation of the 90-90-90 HIV treatment strategy

Although the study identified certain areas of collaboration between CBOs, WBOTs, and the clinic, it also noted areas of non-existent collaboration. For the achievement of the 90-90-90 UNAIDS targets and the elimination of HIV as a health threat by 2030, collaboration between

WBOTs and CBOs is paramount. In this regard, participants reveal that they all operate in the same areas by providing services to their communities. Furthermore, they highlighted both positive and negative relations between CBOs, WBOTs, and clinics. They indicated that there exists teamwork and partnership through CBOs sharing transport with WBOTs (due to transport limitations among WBOTs) to an extent; they also state that ward-based outreach team leaders use their own transport to do their work. CBOs and WBOTs provide health education in the same clinic waiting areas and participants emphasise that they are able to get their message across since they are not nurses but are seen as part of the community. As such, participants conduct regular awareness campaigns within their communities.

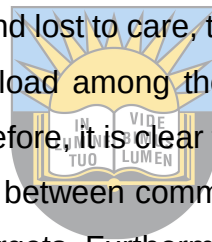
Working together in a collaborative environment to overcome barriers produce mutually beneficial results which are of great benefit to stakeholders. A synergic approach is required to effectively implement the 90-90-90 strategy, now the 95-95-95 strategy in the context of Amathole District. This entails the cooperation and inputs of relevant organisations and entities concerned the mitigation of HIV/AIDS scourge in the setting. Such approach would have two-prong advantages. First, it will promote and heightened awareness on HIV/AIDS. Second, the desirable outcomes of the 90-90-90 strategy might be attainable or achievable, thereby improving the lives of people living with HIV/AIDS. Thus, adopting this collaborative path resonates with Wood and Gray (1991) theory which emphasises the importance of working in harmony and cooperatively to achieve a shared goal or outcome, which in this context, the role of CBOs and WBOTs and other stakeholders in the implementation of the 90-90-90 HIV strategy in the Amathole District.

Poor coordination emerged as participants feel their hard work is not recognised by the Department of Health while some stated the need for improving the referral pathways. Poor record-keeping by health facilities was reflected as a challenge since their clients are sometimes regarded as defaulters, although they may have been collecting their antiretroviral treatment. In addition, they highlighted the need for better coordination, harmony, and training among themselves to keep abreast of new programme developments. Without collaborative efforts between the clinics and community-based interventions that are coupled with and breaking down targets for meaning at household level reaching the 90-90-90 HIV treatment targets might only be seen as a health issue.

Finding by Jinabhai, Marcus, and Chaponda (2015) indicate that WBOTs are neglected due to overburdened primary health care clinics and CBO carers are not working collaboratively with their WBOT counterparts. A latter study by Jobson, Grobbelaar, Mabitsi, Railton, Peters, McIntyre, and Struthers (2017) supports this study by emphasising that public health must examine ways in which collaboration functions and how dynamics between partner organisations affect the achievement of global health targets.

5.2.5 Theme 5: Success achieved in the implementation of the 90-90-90 HIV treatment strategy

The study identified various successes in the implementation 90-90-90 HIV treatment strategy. The targets are about closing the HIV testing gap, finding, and testing eligible clients for HIV, initiating, and retaining HIV-positive clients on ART and maintaining viral suppression for the clients that are on treatment. Participants specify that some success is achieved in tracking clients defaulting treatment and lost to care, the second 90. Another area of success indicated is the suppression of viral load among their clients, the third 90 as well as the decreased death of their clients. Therefore, it is clear that the continuum of HIV care requires more efforts to ensure that a synergy between community-based workers and public health institutions to achieve the 90-90-90 targets. Furthermore, sustaining clients on ART requires community-based interventions.



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A systematic review conducted by Dave, Peter, Fogarty, Karatzas, Belinsky and Pant Pai (2019) supports this by suggesting that the placement of community healthcare workers improves viral suppression significantly. Ware, Wyatt, Asiimwe, Turyamureeba, Tumwesigye, van Rooyen, Barnabas and Celum (2016) further illustrate the dependence of expanding the number of patients on ART on community health workers.

5.3 LIMITATIONS

This study is limited in that it was only conducted in the Amathole Health District. In addition, the literature regarding the roles of CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy is scarce as most studies focus on how far countries are in terms of reaching the global targets. Due to financial and time constraints this particular study focused exclusively on CBOs and WBOT operating within proximity of a high-volume of total clients on ART facilities. Consequently, these results should not be generalised to all provincial

districts. Notwithstanding, one of the strength of the study was the use of both face-to-face individual and FGDs interviews for data collection, which complement one another, and thus validate the creditability of the findings.

5.4 CONCLUSION

This study purposed to assess the role of CBOs and WBOTs as stakeholders in implementing the 90-90-90 HIV treatment strategy within the specific context of the Amathole District in the Eastern Cape of South Africa. Its findings indicate that the role of CBOs and WBOTs involve case finding of HIV, a linkage to care, and a retention to care. Moreover, it established the existence of collaboration between CBOs, WBOTs, and health facilities, and revealed the areas of success in terms of the implementation of the 90-90-90 HIV treatment strategy. Furthermore, findings indicate that there are deterrents to case finding, linkage to care, and retention to care. Poor coordination hampers collaboration between CBOs, WBOTs and health facilities.



5.5 RECOMMENDATIONS

The main findings of the study pertain to the roles of both CBOs and WBOTs in the implementation of the 90-90-90 HIV treatment strategy, the related challenges hindering the effective implementation, and the negative relations between WBOTs, CBOs, and the clinics. Consequently, this study recommends the following:

- Firstly, that targets are broken down to achieve set goals and be understood by community-based workers.
- Secondly, that the capacitation of both WBOTs and CBOs on the latest developments related to the HIV/AIDS programme, including testing for HIV, would greatly assist in taking services to households.
- Thirdly it found that the continuum of HIV care requires more efforts to ensure synergy between community-based workers and public health institutions to achieve the 90-90-90 targets. Furthermore, sustaining clients on ART needs a collaborative approach to reach the set targets.
- In addition, it determined that PHC nursing staff need to improve the completing of clinical patient records and referral letters to allow for accurate reporting on the 90-90-90 HIV treatment targets.

- Lastly, resources must be made available to WBOTs that need to access hard-to-reach in order to lower the long distances causing their clients to disengage in care.



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7. ANNEXURES

Annexure A – Ethical clearance certificate



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ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA LEVEL 01

Certificate Reference Number: **GON0201SMAK01**

Project title: **An assessment of the role of community based organisation and ward based outreach teams in the implementation of 90-90-90 HIV treatment strategy in Amathole district, South Africa**

Nature of Project: **Masters of Public Health**

Principal Researcher: **Makeleni NP**

Supervisor: **Prof DT Goon**

Co-supervisor: **N/A**

On behalf of the University of Fort Hare's Research Ethics Committee (UREC), I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instruments(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:

Note: The UREC is aware of the provisions of s71 of the National Health Act of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2003, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
 - o Any unethical principal or practices are revealed or suspected
 - o relevant information has been withheld or misrepresented
 - o regulatory changes of whatsoever nature so require
 - o the conditions contained in the Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principal investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office.

The Ethics Committee wishes you well in your research.

Yours sincerely


Professor Eunice Seekoe
Dean of Faculty of Health Science
26 October 2018

 06/11/2018
Professor Pumla Dineo Gqola
Dean of Research
26 October 2018



Province of the
EASTERN CAPE
HEALTH

Enquiries: Zorwabele Merile

Tel no: 083 378 1202

Email: zorwabele.merile@echealth.gov.za

Fax no: 043 642 1409

Date: 22 November 2018

RE: An assessment of role of Community Based Organizations and Ward Based Outreach Teams in the implementation of the 90-90-90 HIV Treatment Strategy in Amathole District. (EC_201811_018)

Dear Mrs N.P. Makeleni

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

ANNEXURE C: REQUEST TO DO DATA COLLECTION



19 St James Road, Southernwood, Medical Centre Building, East London, 5200, Eastern Cape
Private Bag x 002, Southernwood Post Office, East London 5200, East London, Eastern Cape
Tel No. +27 (0)43 707 6760 Fax No. +27 (0)43 707 6843: Website www.ecdoh.gov.za

To	Acting District Manager : Amathole Health District
From	HAST Manager: Amathole Health District
Subject	Request to do data collection in Amathole District
Date	3 December 2018

Purpose

To request permission to do data collection for research purposes in Amathole Health District.

Background

I am one of the students who were afforded with bursary to study Masters in Public Health with University of Fort Hare (ASELPH program). My research study is An assessment of role of Community Based Organizations and Ward Based Outreach Teams in the implementation of the 90-90-90 HIV Treatment Strategy in Amathole District. I will be conducting a qualitative study and the population is community based organization providing HIV services and Ward Based Outreach teams in Amathole District. The plan is to conduct the study from December 2018 to September 2019, the data collection process in January to March 2019.

Discussion

This correspondence therefore serves to request permission to conduct the qualitative study in the district.

The findings of the study could inform policies relating to HIV testing and differentiated care models. An understanding of the gaps in the HIV cascade would better equip stakeholders in dealing with the epidemic within their own local contexts and create platforms to address barriers within communities towards ending the HIV epidemic by 2030

The results will be shared with all the stakeholders in the district and the province on completion of the research. The ethical Clearance Certificate from the University of Fort Hare together with the approval from the Eastern Cape Health Research Committee is attached.

Recommendation

It is recommended that the permission is granted to conduct the study in the Amathole District.

Subject Request to do data collection in Amathole Health District

Yours in health.


.....

Ntombekhaya Makeleni

Deputy Director: HAST

03/12/2018
.....

Date

Approved/~~Not Approved~~


.....

Mzikazi Nteyi

Acting District Manager: Amathole

03/12/2018
.....

Date

ANNEXURE D: CONSENT FORM



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PARTICIPANT CONSENT FORM

APPROVAL REFERENCE: GON0201SMAK01

STUDY TITLE:

An assessment of role of Community Based Organizations and Ward Based Outreach Teams in the implementation of the 90-90-90 HIV Treatment Strategy in Amathole District.

Please note:

This form is to be completed by the researcher(s) as well as by the interviewee before the commencement of the research. Copies of the signed form must be filed and kept on record



Purpose of the study:

The study seeks to assess the role of community based organizations and ward based outreach teams as stakeholders in the implementation of the 90-90-90 HIV Treatment strategy.

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The **findings** of the study could inform policies relating to HIV testing and differentiated care models. An understanding of the gaps in the HIV cascade would better equip CBOs and WBOTs as stakeholders in dealing with the epidemic within local contexts and create platforms to address barriers within communities towards epidemic control by 2030

Please understand that you are not being forced to take part in this study and the choice whether to participate or not is yours alone. However, we would really appreciate it if you do share your thoughts with us. If you choose not take part in answering these questions, you will not be affected in any way. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way. Confidentiality will be observed professionally.

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

The interview will last around 30 minute. I will be asking you questions and ask that you are as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. I will be asking some questions that you may not have thought about before, and which also involve thinking about the past or the future. We know

that you cannot be absolutely certain about the answers to these questions but we ask that you try to think about these questions. When it comes to answering questions there are no right and wrong answers. When we ask questions about the future we are not interested in what you think the best thing would be to do, but what you think would actually happen.

If possible, our organization would like to come back to this area once we have completed our study to inform you and your community of what the results are and discuss our findings and proposals around the research and what this means for people in this area.

INFORMED CONSENT

I hereby agree to participate in research entitled: An assessment of role of Community Based Organizations and Ward Based Outreach Teams in the implementation of the 90-90-90 HIV Treatment Strategy in Amathole District.

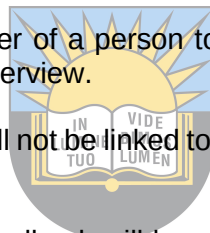
I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to my community on the results of the completed research.



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.....
Signature of participant

Date:.....

I hereby agree to the tape recording of my participation in the study

.....
Signature of participant

Date:.....

ANNEXURE E: INTERVIEW GUIDE



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GUIDING QUESTIONS TO ASSESS THE ROLE OF CBOs AND WBOTs IN IMPLEMENTATION OF THE 90-90-90 STRATEGY

Name of CBO:

Close-by Health Facility:

Sub-district:

Date:

Type of interview: KII FGD

Type of interviewee: Manager/Team Leader Field workers



1. What do you understand by the concept of the 90-90-90 HIV Treatment Strategy?
2. What activities does your CBO/WBOT do to address:
 - a. The 1st 90 (HIV testing)
 - b. The 2nd 90 (Treatment initiation)
 - c. The 3rd 90 (Viral load suppression)
3. Can you explain the working relations between your CBO/WBOT and the nearest health facility in trying to achieve the 90-90-90 HIV treatment targets?
4. What do you think are the problems hindering the effective implementation of the 90-90-90 HIV Treatment strategy in your area?
 - a. Resources needed (Counsellors, test kits, CBOs/WBOTs ability to mobilise hard-to-reach segments of the population, e.g., key populations, young people etc) **(1st 90)**
 - b. Ease of client referral for further management **(2nd 90)**
 - c. Feedback on referred clients
 - d. Collaboration to ensure ART clients adhere to treatment **(3rd 90)**
 - i. Counselling and education on the importance of ART adherence (proper training of CBO/WBOT field workers)

- ii. Establishment of Adherence club (facilities with needed resources like pharmacist, enough drug stock, personnel for filing and packaging of client medication, CBO/WBOT members as AC facilitators, etc)
 - iii. Support system for ART clients
 - iv. Assistance in tracking defaulting clients in the catchment area (door-to-door visits)
- 5. In the midst of these issues is there anything you could say is a success story pertaining to the 90-90-90 HIV Treatment
- 6. Can you describe the working relations between CBOs and WBOTs in this catchment area?
 - a. What can be done to improve the relations between CBOs and WBOTs?
- 7. Is there anything you would like to tell me about the implementation of the 90-90-90 HIV Treatment strategy



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ANNEXURE F: DATA ANALYSIS

FACULTY HEALTH SCIENCES

P.O. Box 1054
East London 5200
Tel: +27 (043) 7047475 | Fax: 0866282026
Date : 30/01/2020



REGARDING: Co-coding of analyzed data.

This is to confirm that I, Dr. Daphne Murray co-coded and analysed data for Masters Student N.P. Makeleni. Student no: 201716813. The processes that I embarked on are as follows:

I read her methodology chapter to understand the approach and the design of choice for the study so as to understand the objectives and the questions the participants had to answer. I thereafter read how she delineated the meaning units from the data transcripts. I examined the analysed data to understand how segments of meaning units were clustered. Co-coded all data and presented Themes and Sub-Themes. I then made suggestions with regard to how the researcher and her supervisor could modify categorization of some information so as to come up with the final themes and sub-themes where applicable.

I do have experience in qualitative data analysis and have been utilized by the Faculty of Health Science to co-code analyzed qualitative data for several studies and projects.

Dr.D.Murray

.....

...30th January 2020

APPENIX G: EDITING CERTIFICATE



EDITING CERTIFICATE

12 December 2022

To whom it may concern

DECLARATION OF LANGUAGE EDITING

Re: THE ROLE OF COMMUNITY-BASED ORGANISATIONS AND WARD-BASED OUTREACH TEAMS IN THE IMPLEMENTATION OF THE 90-90-90 HUMAN IMMUNODEFICIENCY VIRUS TREATMENT STRATEGY IN THE AMATHOLE DISTRICT. *(Master's dissertation submitted for the degree Master of Education in Comparative and International Education at the North-West University.)*

This serves to confirm that I, Tanya-Lee Ruby Stewart, a SATI-registered language editor and translator, undertook the language editing of the above-mentioned document on behalf of NTOMBEKHAYA PHYLLIS MAKELENI, UFH student number: 201716813, for the purpose of meeting the submission requirements of a Master's degree in Public Health at the University of Fort Hare.

Do note that I make no claims to the substantive matter covered by the document and have not altered the intent or research content drafted by the author(s). Furthermore, I can only provide a guarantee of linguistic accuracy, provided the relevant track changes were accepted and my advice followed. All changes and corrections were suggested by means of "track changes" and e-mails. However, the implementation thereof was left entirely up to the author. As such, I do not accept responsibility or liability for any inaccuracies, both linguistically and content-related, that may be present.

Should you have any queries, please contact me through the email address and telephone number provided in the above letterhead.

Yours sincerely

TR Stewart
Member: South African Translators' Institute
SATI registration no: 1003470

