

**THE IMPACT OF THE HOME-BASED CARE PROGRAMME IN
SKUKUZA CAMP OF THE KRUGER NATIONAL PARK ON
EMPLOYEES AND PEOPLE OF ADJACENT VILLAGES**

by

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Declaration

I make this declaration that the research conducted on the “The impact of the Home-Based Care programme in Skukuza Camp of Kruger National Park on Employees and People of Adjacent Villages” is my own work and has never been submitted to any other university before for any examination or degree. The sources I have used or quoted have been duly acknowledged as complete reference.



Name: Sibuyi S

Date: July 2011

Dedication

This mini-dissertation is dedicated to my wife, Tsakani Iglet, my three sons Nsuku, Thembinkosi and Dumisani, for their support and serving as a source of inspiration through those difficult moments of enriching myself with knowledge for self betterment.

Acknowledgement

I wish to acknowledge my supervisor, Dr. C Burman, for his guidance, mentoring and support.

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- All the communities wherein I conducted my study.

Abstract

Government departments and Non-Governmental Organizations are facing a serious challenge of dealing with the scourge of HIV/AIDS in South Africa and elsewhere. HIV/AIDS has reached a pandemic proportion. As such, the workforce suffers a setback given that companies are losing millions of Rands on pay leaves, incapacity, awareness campaigns and medicines. As part of their social responsibility, organizations like Skukuza, the main camp in Kruger National Park, are not only concentrating on the well-being of their workers in their awareness campaigns but also on communities that are located in the surrounding places. All this has developed into an interest for a scientific study. Since this is a social research, the present researcher adopted a qualitative approach for the study. The camp has committed itself to forming a Home-Based Care programme that will deal with the pandemic. If nothing is done, however, the impact of HIV/AIDS is likely to directly or indirectly affect the park. Besides the park being affected, it is its social responsibility to do something for the adjacent communities as the majority of the park's employees come from these villages. The general finding of this investigation is that people are responding well to the Home-Based Care programme and seem to have vast knowledge of HIV/AIDS related matters, yet new infections continue to emerge. The study will contribute to the area where it is conducted by providing unique insights into the HIV/AIDS challenges. The findings may also provide lessons that can be applied to other Home-Based Care programmes in other areas.

List of Abbreviation/Acronyms

HIV-	Human Immunodeficiency Virus
AIDS-	Acquired Immune Deficiency Syndrome
UNAIDS-	Joint United Nations Programme on HIV/AIDS
WHO-	World Health Organisation
TB-	Tuberculosis
UNICEF-	United Nations Children's Fund
STI-	Sexual Transmitted Infections
NAPWA-	The National Association of People Living with HIV/AIDS
TAC-	The Treatment Action Campaign
ALP-	The AIDS Law Project
ALN-	AIDS Legal Network
ILO-	International Labour Organisation
USAID-	United Nations Agency for International Development
UNGASS-	United Nations General Assembly
ADRA-	Adventist Development and Relief Agency
UNDP-	Nations Development Programme
AMDS-	The AIDS Medicines and Diagnosis
NGO-	Non-Governmental Organisations
G8-	Group of Eight
CBO-	Community Based Organisation

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CHAPTER 1

RESEARCH PROBLEM

1.1 Introduction

The discovery of HIV/AIDS two decades ago has brought to light one of the most lethal global epidemics witnessed in the 21st century. Africa has remained the most affected continent by the HIV/AIDS epidemic. According to the United Agency for AIDS (UNAIDS), over 50 million people have died of HIV/AIDS, since the disease was discovered in the early 1980s (UNAIDS, 2007:34). The Africa Medical Research (AMREF, 2007:1) indicates that nearly 65% of the indicated number of deaths comes from Sub-Saharan Africa. United Agency for AIDS (UNAIDS and World Health Organization (WHO) estimated that over 500,000 South Africans are infected by HIV/AIDS (UNAIDS & WHO, 2006:500). In view of the preceding, it is evident that unless urgent and concrete programmes are implemented, the effect of the infection is bound to be high with untold repercussions.

There has been some in-depth study regarding the impact of HIV/AIDS in South Africa, but nothing has been done on any part of the Kruger National Park, and yet the park has thousands of employees that are exposed to HIV/AIDS, and the majority of the employees are migrant workers. This means that they come from different parts of South Africa. Many of them have left their families behind. It is either the husband has been left behind or a wife. This exposes such kind of employees to HIV/AIDS.

It is against this background that the Skukuza Camp, which is part of Kruger National Park, has embarked on HIV/AIDS programme for its employees and the adjacent villages. The programme is run by the Home-Based Care Centre of this main camp. It focuses on Voluntary Testing and Counselling, condom distribution as well as rollout medication. The people working in this programme are voluntary workers as they are not employees of the park. The programme stretches its work to the adjacent villages of Huntington and Justicia. The Skukuza Camp understands its corporate social responsibility to prevent the spread of HIV/AIDS from its employees to the surrounding villages and vice versa. The programme was started in 2007 as an intervention strategy to address the spread of the HIV/AIDS epidemic.

1.2 Statement of the Problem

The rapid spread of HIV/AIDS in South Africa, especially in the employment sectors has made Skukuza Camp of Kruger National Park an interest of scientific study. The Camp harbours three hundred employees, of which the majority of them are migrant workers. In most cases, these categories of employees get into sexual relationship either with their own workmates or from the surrounding villages.

The spread of HIV/AIDS infection among the employees in the Skukuza Camp have exposed many of them to opportunistic diseases like Tuberculosis (TB) and other HIV/AIDS related diseases. The impact is bound to manifest itself in the stigma and discrimination against HIV/AIDS sufferers, low productivity due to employee absences and increased medical expenses for the camp.

1.3 Aims of the Study

The aim of this study is to investigate the impact of the Home-Based Care programme in the Skukuza Camp of the Kruger National Park on its employees and people from adjacent villages. The study aims to achieve the following

- Establish the impact of the Home-Based Care programme;
- Establish the challenges faced by the programme;
- Contribute to the body of knowledge of Home-Based Care programme on employees; and
- Suggest new areas of research.

1.4 Objectives of the Study

- To determine the impact of the programme on the employees and the surrounding villages.
- To unearth the challenges of the programme and possible solutions.
- To find out whether or not there is a comparison between the Skukuza Home-Based Care programme and similar programmes in other areas.

1.5 Research Questions

The main question is as follows:

What is the impact of Home-Based Care programme in the Skukuza Camp on its employees and people from adjacent villages?

Accompanying the main question are the following sub-questions:

- How has the Home-Based Care programme influenced sexual behaviour of employees in the Skukuza Camp and the surrounding villages?
- What has been the response of employees and people from surrounding villages towards the programme?

1.6. Significance of the Study

The study is significant in the following aspects, namely:

- It will provide unique insights into the HIV/AIDS challenges in the area;
- It will have policy implications in terms of the design and implementation of community-based HIV/AIDS intervention strategies, especially in the context of rural development;
- The findings may provide lessons that can be applied to other HIV/AIDS programmes; and
- The study could be used as a campaign tool to raise HIV/AIDS awareness and intervention programmes in the entire Kruger National Park

There are key concepts that would be frequently used in this study, hence the need for them to be defined.

1.7. Definitions

HIV

HIV is an acronym for Human Immunodeficiency Virus. It is a virus that attacks a particular set of cells in the human immune system known as CD4 cells, which organize the body's overall immune response to foreign bodies and infections (Whiteside & Sunter, 2002:7; Adesky, 2001:87; and Adrien, 2000:234).

AIDS

AIDS is the acronym for Acquired Immune Deficiency Syndrome. It is the clusters or syndromes of clinical conditions associated and observed in people with increasing viral load (Willis, 2002:19; and Brown, 2001:67). People are regarded as having AIDS when their CD4 count falls below 200 (Brutus, 2004:400).

AIDS ORPHANS

World Health Organization (WHO) and UNICEF define AIDS orphans, as children who lost their mothers to AIDS before reaching the age of 15 years. Some of these children have also lost, or will later lose their fathers (WHO & UNICEF, 2001:201).

HOME-BASED CARE

WHO defines Home Based Care as the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health including care towards a dignified death (WHO, 2003:98).

1.8. Area of Study

The target area of this study is the Skukuza camp and the surrounding villages. Skukuza is the largest camp in the Kruger National Park. It is situated on the southern banks of the Sabie River. It is closely surrounded by two villages, namely, Huntington and Justicia. There is close socio-economic relationship between the Skukuza employees and these two villages. Most of the employees in the camp are migrant workers from all over Southern Africa and, in most cases, stay away from their spouses for a long period of time. This situation has created a scenario in which employees have elicited sexual relationship, either with fellow employees or with people from the surrounding villages. This has exposed both the employees of the camp and the people of the adjacent villages to the HIV/AIDS epidemic. It is precisely against this background that the management of the Skukuza Camp established a Home-Based Care programme as an intervention tool to address the spread of the disease.

1.9. Research Design and Methodology

Welman and Kruger (2005:46) suggest that research design is a plan according to which the researcher obtains research participants (subjects) and collect information from them. The research design in this study is qualitative. Qualitative research refers to any kind of research that produces findings not arrived at by means of quantification. Qualitative research is not

only about persons' lives, stories and behaviour, but also about organizational, social movement, or intersectional relationship (Leedy & Ormrod, 2001:45).

1.9.1 Population and sampling

A population is the full set of cases from which a sample is taken (Strauss, & Myburg, 1999:240). Mouton (2001:134) defines a population as a collection of objects, events or individuals having some common characteristics that the researcher is interested in studying. In this study, the population will be employees of Skukuza Camp and community members from Huntington and Justicia. There are 300 people employed by the Skukuza Camp and about 4000 members of the communities of the two villages (BBR: IDP, 2008/2009:500). The majority of workers in the camp have socio-economic interaction with people from these villages; hence the programme is bound to have impact on both the camp and the two villages.

A sample is a part of target population that can be used to obtain required data (Welman & Kruger, 2005:46). Creswell (2003:33) suggests that the idea behind sampling is that the samples from which the inferences regarding a given population have to be drawn, must be selected in such a way that each member of the population being studied has an equal chance of inclusion in the sample.

In this study, the researcher chose purposeful sampling. Purposeful sampling is based on the assumption that the researcher wants to gain insight of the information and therefore the researcher needed to select a sample from which he can learn the most (Creswell, 2005:60). A sample of twenty employees and twenty villagers was be selected for interviewing. There are forty people currently participating in this programme and all of them will be taken. The participants are directly involved in the programme; hence have the information required by the researcher.

The researcher will establish telephone contact with the respondents. In the process, appropriate respondents were identified and requested to participate in the study. An appointment was made with the respondents by written letter. When the permission granted the researcher will have face-to-face interview with the respondents. The questionnaire was refined by conducting a pilot study. The purpose of the pilot study is to ensure that respondents would have no difficulties in answering the questions, and that there will be no

problems in recording the data (Saunders, Lewis & Thornhill, 2003:150). The pilot study was conducted with the respondents that will not be involved in the actual interview. Once the questionnaire was refined, the interview was conducted with the respondents.

1.9.2 Data collection

In a qualitative research, the process of collecting data is in essence the meeting of the researcher and the respondents (Mouton, 2001:67). A semi-structured interview was employed to collect data from the respondents. The data collected were triangulated by combining and cross checking the various data collection methods. No data were accepted before or after the closing dates to ensure consistency of the research results.

1.9.3 Data analysis

Data analysis can be viewed as a process by which a whole phenomenon is divided into its components and then resembled under various new rubrics (Ivancevich & Matterson, 2004:78). Data analysis is the process of bringing order, structure and meaning of the data (Walker & Avant, 2005:28). Data analysis goes hand in hand with data collection so that the researcher focuses on and shapes the study as it proceeds (Seale, 2002:80). Being a qualitative research study, a descriptive approach would be used. The data collected were examined in depth to provide a detailed description of setting, respondents and activities.

1.9.4 Trustworthiness

For any research to be believed and trusted, it should bear the insight and conclusion that it is truthful and trustworthy to general readers and other researchers in the field. A semi-structured interview was used to collect data from the respondents. This kind of method enables the participants to freely express their feelings and perception without the restriction imposed by structured interviews (Creswell, 2003:36).

The collected data were divided into small units of meaning. Each unit was coded according to the meaning it carried, then grouped together (categorized) to have all units that have the same codes. Each category was examined, according to how each respondent answer the research question.

1.9.5 Ethical Consideration

Ethics are moral standards that protect and direct the behaviour of individual (Merriam, 1998:67). Ethical guidelines are used as standards upon which a researcher evaluates his/her own work. In the case where the researcher deviates from ethical guidelines, it is either harmful or potentially harmful to all individuals involved in the research.

In view of the above background, the researcher adhered to the following ethical considerations in this research.

Permission To Conduct Research

The researcher sought permission from the Skukuza Camp management to conduct the research.

Introduction

The researcher introduced himself to the interviewees before the commencement of the interview process.

Participants' Consent

The researcher wrote a letter to the participants, clearly explaining the purpose of the research. He sought out participants' permission to interview and tape record them. The respondents were assured that the information collected from them would not be used for any purpose other than for the research study.

Statement Of Confidentiality

The researcher made sure that information collected from the respondents remains confidential and that their anonymity as individual respondents remains assured.

1.9.6 Exposition of the Study

Chapter one: This presents the introduction, background, the problem of the research, research methodology and design

Chapter two: This examines the relevant literature in-depth relevant to the research problem.

Chapter three: This deals with the research design, population and sample, data collection techniques and data analysis of the study.

Chapter four: This provides findings of the study

Chapter five: This presents the conclusion and recommendations of the research as well as future research opportunities.

1.10 CONCLUSION

This chapter presented an introduction to the research study with regard to its context, namely, background of the research, the problem, research design and methodology, and others. The researcher has formulated the statement of the problem and indicated the purpose and aims of the study. The researcher has adopted a qualitative research design as an appropriate methodology for the study. The researcher has explicitly explained why the qualitative method was adopted for the study.

The researcher hopes that the study will contribute to the body of knowledge in the area of HIV/AIDS in the Home-Based Care programme

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

HIV/AIDS is having a devastating impact in many African states and this impact is further exacerbated by the high levels of poverty that exist in those nations in multiple spheres of social life. Despite a wealth of natural resources scattered across the continent, the sustained 'brain-drain' in critical sectors such as health and education renders many nations poorly skilled to deal with the pandemic. Furthermore, the poverty levels and the strain of dealing with the household impact of HIV/AIDS leave many communities ill-equipped to deal with the impact of HIV/AIDS.

Poverty and HIV infection are deeply intertwined. Poverty and HIV are complex phenomena that are still not fully understood. Poverty has a very strong effect on people living with HIV/AIDS. It is much harder to teach people about HIV if they cannot read, or do not have television or radios. Changing sexual behaviour to prevent HIV infection is very difficult for people who live in desperate poverty.

According to UNICEF (1999:36), the UN system, UNAIDS and key partners must work with governments to ensure that the poverty-reduction plans linked to debt relief include significant contributions to the struggle against HIV/AIDS, including service provision for orphans and other children affected by the pandemic.

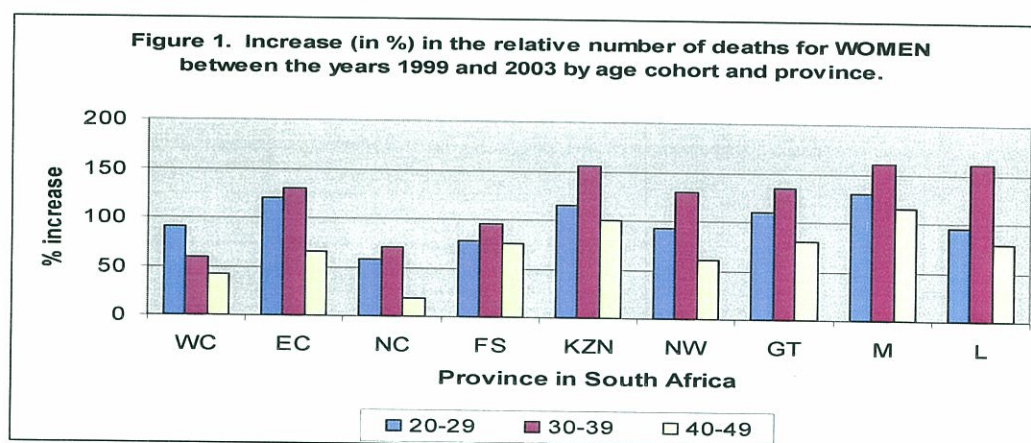
These are some of the reasons why, by December 2002, Sub-Saharan Africa had 29, 4 million adults and children infected with HIV. This is 70 percent of the world's total number of people living with HIV, compared with North America which has 980 000 people with HIV. In 2002, 2,4 million people in Africa died of AIDS. Poverty cannot cause HIV or AIDS, but poor people are definitely at risk of HIV infection, and developing disease more quickly (*Journal AIDS Fact file*, 2004:11). Deaths in countries with high levels of HIV/AIDS will cause huge losses of labour over the next decade (ILO, 2005:1). Unless urgent action is taken, it is estimated that by 2014, there will be 5.7 million AIDS orphans in South Africa (*AIDS Guide*, 2006:108). In fact, UNICEF (1999:36) has indicated that the disease is now a leading cause of death in Sub-Saharan Africa and it is estimated that as many as 16.3 million people have died from the disease since the epidemic began.

These statistics paint a bleak picture indicating that HIV/AIDS has now reached pandemic proportions in South Africa. The statistics that surround the debate are difficult to pin down precisely. For example, in 2002, Limpopo reported an AIDS prevalence rate of 15, 6 percent. In 2003, it increased to 17, 5 percent. In 2004, it increased from 17, 5 percent to 19,3 percent. There is a decrease in HIV prevalence among young pregnant women of the ages of 16 to 24 years of age. There is also a decline in new infections. There is also a decline from 15.9 percent in 2005 to 13.7 percent last year of the prevalence of the virus among the 20 year-olds and younger.

Despite claims of declines, other data tell a different story. For example, data published in the Institute of Democracy in South Africa's HIV/AIDS and Democratic Governance in South Africa report, 2004, indicated that between 1999 and 2003, Limpopo experienced a 160% increase in the relative number of deaths of women in the age cohort 30-39 of registered voters and almost a 100% increase in the age cohort 20-29 (HIV/AIDS and democratic Governance in South Africa, 2004).

Despite the difficulties with such data analysis, it is fair to say that the localized impacts of HIV/AIDS are being felt across most communities in South Africa and these impacts are significant enough to warrant continued concern.

Figure 1: Increase (in %) in the relative number of deaths for WOMEN between the years 1999 and 2003 by age cohort and province.



Sub-Saharan Africa and the international community have responded to the pandemic with a host of different prevention strategies with mixed results. The evidence from Africa does

suggest that the impacts of these educational prevention campaigns have had the scale of impact that has been hoped for.

2.2. Why are People Choosing not to Place Themselves in Safety?

Health education has for some time largely been based on the assumption that increased knowledge about the causal links (between disease agents, behaviour and lifestyle) would enable individuals to make rational decisions and avoid risks (Ahlberg, 2001:26). Public health initiatives have therefore treated people as rational actors in need of education about any particular disease and how to prevent themselves and others from infections (Chan, 2003:40). The belief has been that if people are armed with such knowledge they will choose to avoid risky sexual encounters (Ahlberg, 2001:23). However, empirical evidence demonstrates that sexual behaviour is largely not shaped by the conscious decisions of rational individuals (Campbell, 2003:7).

Many external factors influence the extent to which we are able to exercise our choices, such as who do we have sex with, our views about sexuality morality and even the objects of our sexual desire (Walker, 2004:22). This is not to suggest that people have no control whatsoever in making decisions about sex, but rather that our desires and actions cannot be explained in isolation of the broader context that informs the choices we make. Thus, Campbell (2003:7) argues that the forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about, health risks and the availability of medical services (Campbell, 2003:7). The following case study is used to emphasise this point.

2.3. Knowledge of Safe Sex yet Behaviour Change is Elusive

In order to increase condom use by sex workers in Durban, a project was undertaken wherein participants were asked to attend a workshop on prevention methods for HIV and STIs. Despite these efforts, post-enrolment increases in condom use were seldom sustained. Although condom use temporarily increased by 25%, it soon dropped again with sex workers reporting that it was difficult to negotiate condom use by customers who would pay a premium for 'flesh to flesh' (unprotected) sex.

In many contexts in South Africa, the picture is much the same: the technology required to reduce risky sexual encounters exist but are not necessarily applied so efforts to maintain

high levels of condom use have had only limited success (AIDS volume 14 Number 16, 2000:2555).

2. 4. Regional Variations in HIV Prevalence Rates

HIV prevalence in the general populations in Africa varies widely both within and between countries. The magnitude of the variation seems to be only partly explained by different sexual behaviour patterns. Circumcision has commanded significant interest of late to explain some of these variations. The hypothesis that male circumcision may reduce the risk of acquiring HIV infection was first suggested early in the HIV epidemic and many epidemiological studies have since included circumcision as a potential indicator of infection rate variations. There is substantial evidence that circumcision is associated with a reduced risk of ulcerative STD such as chancroid and syphilis. As STIs, both ulcerative and non-ulcerative, are known enhance the risk of acquiring and transmitting HIV, it is likely that circumcision has an indirect effect on HIV infection. Circumcision may also protect against HIV directly as viral entry may occur through micro-traumatic lesions or mini-ulcerations of the foreskin or through trauma to the non-keratinized inner mucosal surface of the foreskin. Male circumcision is practised in many parts of Africa, but there is wide regional variation. Within Africa, there is a broad correlation between areas where there is little circumcision and those with high HIV rates. This ecological association means little, however, without looking at individuals within populations, and taking into account other factors associated with circumcision status. There may be other factors associated with HIV risk that are less prevalent among circumcising than non-circumcising populations (Journal, Volume 14 Number 15, 2000:2361).

Sexually Transmitted Infections (STIs) are significant causes of morbidity in developing countries and they facilitate HIV transmission. Unfortunately, STI case management is frequently neglected, resulting in suboptimal care and continued disease spread.

2. 5. Overview of the HIV/AIDS in South Africa

South Africa has the world's fastest growing HIV pandemic. Despite a relatively late start, HIV has taken off in South Africa. The apartheid system may have delayed the onset of the epidemic, but its legacy is a fertile environment for HIV's rapid spread.

2.5.1. Multiple Concurrent Partnerships

Given that the main mode of transmission of HIV in South Africa is unprotected sexual intercourse, it would seem reasonable that the virus is spreading so quickly because of the level of sexual activity, and the type of sex or the range of partners. It is now unquestionably the case that the underlying behaviour pattern that sustains the pandemic in southern Africa is Multiple Concurrent Partnerships. This means that the sexual networks of many South Africans is thick and concurrent (i.e., both men and women have more than one partner and they are having unprotected sexual intercourse). The social upheavals of modern times have raised considerably the potential number of sexual partners that the average person is expected to have during his or her lifetime. Thus, the man who has a simultaneous sexual relationship with several women is more likely to transmit the virus than the man who practices serial monogamy, i.e., regularly changes partners but is faithful to one at a time. A mobile society as is the norm in South Africa, particularly along the main transport arteries, offers an ideal enabling environment for multiple concurrent partners (Whiteside & Sunter, 2002:59).

2.5.2. National Statistics

The national HIV prevalence rates from 1990 to 1998 illustrate how rapidly the epidemic grew: from less than 1 percent in 1990 to more than 22 percent in 1998 (MacFarlane, 2007:3). At the end of 2003, an estimated 21.1% of the adult population, or 5.3 million people, were infected with the virus. As a result, life expectancy was predicted to fall from 60 years to 40 by 2008. An estimated 370,000 adults and children died of AIDS in 2003.

2.5.3. Vulnerable Spheres

Particularly hard hit is the education sector where 4 000 teachers were lost to AIDS; 80 percent of them under the age of 45 years in 2004. With approximately 45 000 out of 356 000 educators being HIV positive, the education sector is going to continue to buckle under the strain (Journal-AIDS Fact file, 2005:12).

More generally, it is estimated that 26 percent of the total workforce in South Africa is HIV positive. The workforce will become smaller, younger, and less experienced.

2.5.4. Orphans

An estimated 1 100 000 children have lost their mother or father or both parents to AIDS. Children have suffered a tragedy of losing one or both parents to AIDS and many are growing up in deprived and traumatic circumstances without the support and care of their immediate family. There was a dramatic increase of HIV/AIDS orphans by 2005 to 1 200 000 (AIDS Guide, 2006:108). Unless urgent action is taken, it is estimated that by 2014, there will be 5.7 million AIDS orphans in South Africa. Resources and capacity are stretched to the limit, and the majority of those providing care are often already elderly, impoverished and might themselves have depended on the person who have died for physical and financial support. South Africa has a high proportion of children who are not continuously cared for by both parents, and very high rates of care by aunts and by grandmothers. This is due to the displacement of people to implement the radically segregated society envisaged during the years of apartheid, combined with the migrant labour system which democracy has done little to mitigate against. South Africa is witnessing the emergence of child-headed households and the conversion of facilities designed for early childhood education into de facto residential homes.

2.5.5. Gender

Women are at a greater risk of infection due to physiological, social, and economic factors. In 2004, 29,5 percent of women who consulted for pre-natal exams were found to be HIV positive (Overview of HIV/AIDS in South Africa, 2007:2). It is difficult to overestimate the suffering that HIV has caused in South Africa. South Africa's HIV epidemic has clear provincial and regional trends. Provincial data show that HIV prevalence is higher in the North and East, and lower in South and West. Within each province, HIV rates are higher in highways, border, mining, plantation, migrant and informal settlement areas. Rates are higher in KwaZulu's Empangeni highway and plantation area, Mpumalanga's Secunda highway and mining town, Gauteng's Carletonville mining town and Limpopo's Musina highway and border town. HIV is growing fastest among younger age groups. From 1997 to 1998, HIV grew by 65 percent among the youth under 20, by 32 percent among 20 to 24 year olds and by 48 percent among 25-29 year olds and by 48 percent among 25 to 29 year olds and by 48 percent among 25-29 year olds (Journal-AIDS Fact file, 2007:3). By 2005 people of ages 15-49 with HIV/AIDS were estimated at about 5 300 000. By 2006, there were no available data for newly infected persons. Adult HIV prevalence in percentages was 18.8 in

2005. Women between the ages of 15-49 years with HIV/AIDS were about 3 100 000 by 2005. Children with HIV/AIDS were estimated at 240 000 by 2005.

In countries where the general population's prevalence is high and women's social status is low, like South Africa, the risk of HIV infection through sexual violence is high. A survey of 1,366 women attending antenatal clinics in Soweto, found significantly high rates of HIV infection in women who were physically abused, sexually assaulted or dominated by their male partners. The study also produced evidence that abusive men are more likely than non-abusers to be HIV positive (UNAIDS, 2004).

2.5.6. Attitudes to HIV/AIDS in South Africa

In South Africa, people at first linked AIDS to gay men. But when a study in 1987 showed a relatively high level of infection amongst Malawian gold miners, the blame shifted to people from other African countries. Later, many people thought AIDS was a 'White' disease. Today, many White people think AIDS is a 'Black' disease. Sometimes, people in the apartheid government used to blame AIDS on 'terrorists' coming from other African countries. As a result of that, they did little to try and teach people about HIV/AIDS. Because of these kinds of attitude, many years were wasted and HIV began to spread very fast among all South Africans. In 1997, a National HIV/AIDS Review found that there was "widespread and systematic abuse of the basic human rights of people with HIV/AIDS in nine provinces of South Africa". It proposed that there should be a concerted effort to protect human rights, counter discrimination and reduce stigmatization (UNAIDS 2004).

President Thabo Mbeki has publicly questioned the link between HIV and AIDS. This has caused a lot of confusion in people's minds and AIDS educators say that when they run workshops now, they can see that the President's statements have set back years of education efforts about HIV/AIDS, and especially about the need for safer sex. This means that there is still a lot of fear and ignorance about HIV/AIDS. According to UNAIDS 2004, the fear and ignorance surrounding HIV/AIDS often leads to discrimination and violence against people living with HIV or AIDS, their families and partners.

2.5.7. From Discrimination to a Right Based Approach

Since 1994, South Africa has moved away from a culture of discrimination towards a culture of rights. Organizations have campaigned to educate society about the rights of people living with HIV/AIDS. The following are the organizing campaigns and education on HIV/AIDS:

- The National Association of People Living with HIV/AIDS (NAPWA) has members all over South Africa and is mobilization that represents their interest;
- The Treatment Action Campaign (TAC) is fighting to improve access to treatment for people with HIV and raise awareness and understanding about options for treatment;
- The AIDS Consortium is an umbrella organization of over 1000 organizations. It has widely publicized a Charter of Rights on HIV/AIDS; and
- The AIDS Law Project (ALP) and AIDS Legal Network (ALN) provide training, advice and legal assistance to people with HIV. They have helped to draft and promote policies and laws that are aimed at preventing discrimination. (UNAIDS Guideline, 2004:483)

The need to protect and promote human rights of people with HIV or AIDS has been widely accepted. It forms an important part of the government's HIV/AIDS and STD Strategic Plan for South Africa 2000-2005. In 1997, the United Nations Human Rights Commission and UNAIDS published International Guidelines on HIV/AIDS and Human Rights. These Guidelines have been sent to governments all over the world. In South Africa, they have been supported by the South African Human Rights Commission. This will help international efforts to stop discrimination (The Department of Health, 2004:44).

According to Shisana (2002:6), what the HIV prevalence results mean is that HIV is a generalized epidemic in South Africa, it affects people of all races, all ages and in all localities, it affects women more than men and 5,6 percent HIV prevalence among children aged 2-14 years was unexpected and requires further investigation. AIDS has thrown a harsh spotlight on the unequal divisions of household labour, particularly on the burden of AIDS care in South Africa. When the male head of a household becomes ill, wives provide care and take on additional duties to support the family. When women fall sick, older or younger

women step in to care for them and take responsibility for AIDS-affected children (Ogden, 2003:1).

According to Whiteside and Sunter (2002:66), as a result of the growth in HIV prevalence, and the failure to control the spread of HIV, South Africa faces a major AIDS epidemic. Instead of being able to focus purely, or even largely, on prevention activities, the country is about to have to deal with the consequences of large-scale conversion from HIV to AIDS. These will be far-reaching. In terms of impact, there is a great deal that is unknown. Nowhere in the world has the epidemic run its course and it will be many years before it does. Whiteside and Sunter (2002:73) further indicated that AIDS is a demographic issue because it affects the major demographic processes of mortality and fertility. The direct effects on mortality arise from the deaths of adults and children. The effects on fertility are indirect and less well understood. The accumulation of mortality and fertility effects leads to changes in the other demographic indicators like population growth and size. The most direct demographic consequence of AIDS is an increase in mortality. Without effective treatment of HIV infection, people develop AIDS and die. Recent advances in drug therapy have raised the hope that HIV infection may be controlled for some individuals. Progression to AIDS and death may be delayed or even averted. The high cost of the drugs and the difficulty in administering them are obstacles that still need to be overcome.

2. 6. Conceptualization of HIV/AIDS and Its Impact on Development

In 2003 alone, there were a staggering 370 000 deaths attributed to the disease in South Africa, and it is inevitable that these deaths resulted in a large number of children being orphaned. Children orphaned by AIDS face multiple stressors like parent illness and death; poverty; being taken out of school; multiple losses; stigmatization and social notation; and lack of adequate care and control (Willis, 2002:18). Willis (2002:18) further indicated that, according to clinical reports or descriptive research, orphans may suffer from depression, anxiety, survivor guilt, loneliness, isolation, low self esteem, and disruptive, antisocial, high-risk behaviours. According to the AIDS Guide (2006:109), unless urgent action is taken, it is estimated that by 2014, there will be 5.7 million AIDS orphans in South Africa. Willis (2002:22) projected that by 2010, life expectancy without AIDS will be 68 years of age, but life expectancy with AIDS will be 36 years of age. Willis (2002:22) estimated the impact of HIV in South Africa by the end of 2001, that almost 5 million people are living with HIV/AIDS, that about 20 percent of adults aged 15-49 are HIV infected, that about 25

percent of women delivering babies in public clinics are infected, and that approximately 660 000 children are orphaned by AIDS.

2.6.1. Financial Impacts

According to the research related to ASSA2002 model, in the middle of 2002 there were about 572 203 people who were AIDS sick. The financial impact that HIV/AIDS has on the people of South Africa is big because it affects the households due to, not only cost of medical care and treatment, but also due to the loss of income as a result of the fact that HIV mostly affects adults in the prime of their life (AIDS Guide, 2006:119). A study that was conducted to determine the impact of AIDS on the national economy in 1991 suggested that the major initial impact would be on the public health services. In the longer term, the epidemic was expected to pose a threat to ongoing economic growth, with some sectors being more seriously affected than others. However, the impact of AIDS is gradual, subtle, particular and incremental (Whiteside & Sunter, 2002:87). HIV/AIDS is eroding development by decimating the work force and destroying families. Avert (2001:1) indicates that as infections progresses to AIDS, there is an increase in total hospitalizations. Conflicts in Africa and elsewhere have led to the quick spread of HIV/AIDS that resulted in wide-range poverty, and this impacted negatively on development.

2.6.2. Impact on the workforce

According to ILO (2000:1), HIV/AIDS has become a major threat to the world of work and development. It is a major threat to worker's rights. People with HIV/AIDS are subject to stigmatization, discrimination or even hostility in the community and at work. The rights of people living with HIV/AIDS such as the right to non-discrimination, equal protection and equality before the law, to privacy, liberty of movement, work, equal access to education, housing, health care, social security, assistance and welfare, are often violated on the sole basis of their known or presumed HIV/AIDS status. Individuals who suffer discrimination and lack of human rights protection are both more vulnerable to becoming infected and able to cope with the burdens of HIV/AIDS. HIV/AIDS is also a threat to development because the pandemic has profound negative impacts on the economy, the workforce, the business, individual workers and their families. Economic growth could be as much as 25 per cent lower that it might otherwise have been over a 20-year period in high prevalence countries. Their population will be about 20 per cent lower by the year 2015 than they would have been

without HIV/AIDS, and their labour forces in the year 2020 will be between 10 and 22 per cent smaller.

HIV/AIDS also has a significant impact on the composition of the labour force in terms of age, skills and experience. The ILO further indicated that HIV/AIDS is a threat to enterprise performance. The world of work is affected by increasing costs due to health care, absenteeism, burial fees, recruitment, training and re-training. For smaller firms in both the formal and informal sectors, the loss of employees has major implications. In the rural sector, losses due to HIV/AIDS may reduce food production and food security. Enterprises in sectors such as transportation, tourism and mining are the most vulnerable. Overall, there will be a reduction of growth if rapid measures are not taken to prevent the impact of HIV/AIDS.

The projected AIDS deaths in a South African workforce are expected to increase so that, by 2015, almost four times as many deaths will occur than normal. Workers who are infected with HIV/AIDS provide the most obvious cause for a decline in productivity. HIV-positive workers with impaired immune systems are more susceptible to common illnesses such as tuberculosis, influenza, common colds and gastro-enteritis as well as other serious diseases, such as Malaria and Bilharzia (World Bank, 2000). Increased levels of illness will naturally result in increased requests for sick leave or, if these workers remain in the workplace, they will not be able to perform their duties to their full ability (UNAIDS, 2000). The net result is a decline in worker productivity.

AIDS deaths lead directly to a reduction in the number of workers available, and particularly workers in their most productive years. As experienced workers are replaced by younger, less experienced persons, productivity is reduced. A shortage of skilled workers leads to higher production costs and a loss of international competitiveness. Lower government revenues and reduced private savings can lead to slower employment creation in the formal sector, which is particularly capital intensive. As a result, some workers will be pushed into lower paying jobs in the informal sector. Expenditure increases on the monitoring of high-risk groups, the establishment of prevention strategies, the provision of health care and welfare. Pressure increases on the social security system, including life insurance and pension funds, which are important sources of capital for both the government and the private sector.

A second possible cause for a decline in productivity relates to workers who need to care for relatives and family members who may be infected with HIV/AIDS, or to attend the funerals of those who have died as a result of HIV/AIDS. Virtually every African society firmly embraces the concept of the extended family, where family-type relationships exist, for example, between men of example of the same circumcision group or men and women of the same tribal clan. In each of these examples, all the members of a group consider themselves to be related to one another and are able to call on the other for support and help in time of need (Centre for the AIDS study, 2003:8).

2.6.3. Gender Matters

HIV/AIDS is a threat to gender equality. Women are highly vulnerable to HIV/AIDS for both biological and cultural reasons. They are particularly affected by HIV/AIDS when a male head of household falls ill. The burden of caring for children orphaned as a result of the pandemic is borne mainly by women. Loss of income from a male income-earner may compel them to seek other sources of income, putting them at risk of sexual exploitation. ILO (2000:2) also indicates that HIV/AIDS increase child labour. The tremendous pressure on households and families often forces children to work. As a result, it is difficult for them to attend school, they do not receive proper care and guidance, and easily fall victim to all kinds of exploitation.

2. 7. Overview of Strategies to Address HIV/AIDS Challenges in Other Parts of the World

2.7.1. International Responses

In 2003, President George W. Bush announced an emergency plan for HIV/AIDS. The government of the United States of America's PEPFAR initiative was launched with a pledge of US\$15 billion aimed at:

- Providing treatment to at least 2 million infected individuals;
- To prevent seven million new infections; and
- Providing care and support to millions of people living with and affected by HIV/AIDS.

To attain these goals, the U.S. rapidly expands its programmes and engages new partners in 15 focus countries (UNSAID from the American People, 2006:1).

Funds from charity donations, private households, foundations and governments were committed to HIV/AIDS affected people from all over the world. Funds committed by top American US grant-makers in 2002 are, namely, the Gates Foundations, Bristol-Byers Squibb Foundation, The Henry J. Kaiser Family Foundations, Ford Foundation, Rockefeller etc (UNAIDS: 2004)

2.7.2. Leadership

As affirmed in the United Nations General Assembly (UNGASS) Declaration of commitment, strong leadership at all levels of society is essential for an effective response to the epidemic. Effective strategies to address HIV/AIDS can only be successful when leadership and commitment is a common thread in all countries with positive experiences in responding to HIV/AIDS Programme Goals. Drawing inspiration from the UNGASS Declaration, leaders in Action recognizes that if the epidemic is to be reversed, it is necessary to foster leadership at every level and sector. Leadership in Action brings a unique approach aimed at transforming the norms, values and practices that fuel HIV/AIDS and fostering the leadership needed to address and contain the epidemic. Leadership in Action is based on years in research and work with thousands of people, and has already demonstrated sustainable results in positive change for people, teams and organizations. As part of the overall strategy, UNDP began work with action in 7 key countries in different parts of the world during 2002. By the end of 2004, UNDP would have begun implementation of various parts of the leadership programme in over 35 countries (Willis, 2002:80).

2.7.3. Diverse Prevention Efforts

More than 1.2 million people in Africa and Asia have heard and seen lifesaving strategies in AIDS care and prevention through music and drama presentations conducted by over 1.500 Adventist Development and Relief Agency (ADRA) volunteers. Over 800 000 school notebooks, specially printed with AIDS prevention messages, have been donated to African school children. More than 350 African schools have AIDS education clubs for school children. They can learn about HIV/AIDS and how to relate and care for the HIV-infected without being afraid, while enjoying football or netball. Radio programmes featuring real-life situations help people deal with AIDS in their families and communities.

An internationally-recognized non-governmental organization, ADRA, is active in more than 120 nations. ADRA was granted general consultative status by the Economic and Social Council of the United Nations in 1997. ADRA is an independent humanitarian agency established with the specific purpose of individual and community development and disaster relief. Without regard to age, ethnicity, or political or religious association, ADRA assists around 20 million people annually (Willis, 2002:80). According to Willis (2002:79), all known measures that reduce the risk of HIV/AIDS should be encouraged. These include donating audio tapes and brochures on HIV/AIDS for taxi drivers, sponsoring family-life workshops involving parents and children, training young people to work with other young people using various life-skills, inviting professionals to speak about HIV/AIDS, give HIV/AIDS projects as homework to school children and having panel discussions on social issues related to HIV/AIDS in the community. According to UNAIDS 2004, there are key elements in comprehensive HIV prevention. They include the following:

- AIDS education and awareness;
- Behaviour change programmes, especially for young people and populations at high risk of HIV exposure, as well as for people living with HIV;
- Promoting male and female condoms as protective action, along with abstinence, fidelity and reducing the number of sexual partners,
- Voluntary testing and counselling;
- Preventing and treating sexually transmitted infections;
- Primary prevention of mother-to-child transmission;
- Harm reduction programmes for injecting drug users; and
- Measures to protect blood supply safety etc.

2.7.4. Access to Treatment

Peter Piot, the Executive Director of Joint United Nations Programme on HIV/AIDS (UNAIDS), indicated that the world must meet the challenge of expanding access to HIV treatment. This requires overcoming the formidable barrier of creating sufficient operational capacity, a key area where UNAIDS cosponsor, WHO must play a critical role. The world adopted a target of 3 million people on antiretroviral treatment by 2005, a massive challenge, but one the world cannot afford to miss. To ensure that no time is lost, WHO-led emergency missions have already been sent to several of the countries with the highest burden. Detailed and measurable national targets are being set to track progress. Long-term WHO teams will

be sent to key countries and health and community workers trained to deliver antiretroviral therapy. Simple, standardized guidelines are needed for testing, treatment, monitoring and evaluation. These are already being developed.

The AIDS Medicines and Diagnostic Services (AMDS) have been established to ensure that countries have access to good quality medicines and diagnostic tests at the best prices. Each of these measures requires rapid action and great flexibility. To achieve this, funding needs have been calculated, requiring resources mobilization on an international level. The strategy will continue to be adapted as it is implemented and as new evidence emerges. A global partnership is being designated and built, action is underway. This may be the toughest health assignment the world has ever faced. But it is also the most urgent. The lives of millions of people are at stake. Everyone involved must find new ways of working together and new ways of learning from what they do. This strategy is a step towards achieving that aim (The WHO strategy, 2003).

2.7.5. Funding and Priority Developments

In 1996, when UNAIDS was launched, available AIDS funding in low- and-middle income countries totalled US\$ 300 million. This amount represented contributions by bilateral donors, international nongovernmental organizations (NGOs), and the UN system, notably the World Bank. By 2002, this amount had jumped to US\$ 1.7 billion. By 2003, an estimated US\$ 4.7 billion was available for the AIDS response that year. The latter figure also includes the steadily increasing funding that comes from country governments and from 'out-of-pocket' spending by directly affected individuals and families (UNAIDS, 2004:2).

According to UNAIDS (2004:3), the following has to be done to deal with AIDS epidemic: Mass media campaign; Peer education for out-of-school youth; Condom social market; Outreach programmes for sex workers and their clients; Outreach programmes for men who have sex with other men; Harm-reduction programmes for injecting drug users; Prevention programmes for special populations; Public sector condom promotion and distribution; Prevention programmes for people living with HIV; Workplace prevention programmes; Post exposure prophylaxis; Safe medical injections; and Universal precautions.

In a world with AIDS, many young people's life choices easily vanish. The AIDS agenda for young people needs to translate the 2001 UN Declaration of Commitment on HIV/AIDS into concrete actions. These include the following:

- Creating a supporting environment so young people can obtain HIV and reproductive health information, education and services. Policies and laws need to ensure that available resources focus on advancing young people's rights to health care and on reducing all discriminatory structures and practices;
- Reaching out to those who influence young people. Parents, extended families, teachers, political, and community leaders and celebrities are strong influences on young people. When their mentors act as positive role models and provide safe environments, meaningful relationships and space for self-expression, young people take the initiative for responsible behaviour;
- Placing young people at the centre of the response. There is no age restriction for leadership. Young people are assets, not liabilities, their voices need to be heard and their talents cultivated so that they could be instrumental for change;
- Mobilizing the educational system to become a vehicle for comprehensive prevention and care programme for school-age youth;
- Mainstreaming HIV prevention and AIDS care for young people into other sectors. Young people are often interested in religion, workplaces, sports and the media. These sectors can be used to provide information and services;
- Addressing gender inequalities by improving young girls' opportunities to obtain education and skills training, by protecting their rights, and by boosting their income-earning prospects. There is also a need to change the damaging concepts of masculinity that define boys' lives and negatively affect those of girls and women; and
- Opening dialogue on sensitive issues. Adults and young people need to work together on adolescent sexuality, sexual roles and traditional practices (UNAIDS, 2006:7).

2.8. Global Response to HIV/AIDS in Developing Countries

Since 2001, intense international resurgence has put the focus on HIV/AIDS after a decade of world complacency. The earlier upsurges of public debates and activism on HIV/AIDS had

been concerned about the spread in the Northern countries, but with the availability of antiretroviral treatments, the level of the political advocacy in the North waned. The international community began to make HIV/AIDS a priority as the disease spread uncontrollably in the Southern countries, and the inaccessibility of the combination of therapy and antiretroviral drugs to most people living with HIV/AIDS became a central issue. This new surge of global activism has been spearheaded by the Southern nations, and by organizations in the South through an expanded framework for HIV/AIDS discourse, prevention and treatment.

The world community now approaches the disease in more comprehensive social contexts, by critiquing failed government policies, the socio-economic status of those living with HIV/AIDS, culture, gender relations and even spirituality. The new approach goes far beyond the promotion of condoms. Civil societies are challenging Northern drug companies and their governments for refusing to allow compulsory licensing of combination therapies. They are critiquing the injustices of the international framework of intellectual property rights and are pushing for the rights of people with HIV in developing countries.

The United Nations and other powerful governments began to work in solidarity with people infected and affected by HIV/AIDS, thus giving new energy to the campaign.

The UN General Assembly's special session convened on June 25-27, 2001 unanimously endorsed the concept of a Global fund for AIDS, TB and Malaria. In July 2001, the G8 leaders pledged \$1.3 billion in support of the fund. The fund was officially established in January 2002 with headquarters in Geneva, as a charitable Swiss Foundation to fight AIDS, TB and malaria. By July 2003, the fund had \$4.7 billion pledged by governments, corporations, foundations and individuals. By January 2004, the Fund itself had committed \$2.1 billion for programmes in 122 countries for two years. African countries are receiving 61% of funds and 64% of funds is being targeted at low-income countries (Chikwendu, 2004:245).

2.9. NGOs and Caring for Those Infected and Affected by HIV/AIDS

In the past two decades, different types of association groupings have increasingly stepped up their advocacy for the poor and sick HIV/AIDS victims. Religious organizations, trade unions, teachers unions, scholarly groups, neighbourhood and Community Based Organizations, both at the international and local levels, women's group and youth groups

began to express solidarity for the afflicted. The NGOs possess many positive characteristics that complement the work of governments in AIDS care. While governments have largely focused on the public health/epidemiological approach, NGOs have put more emphasis on the broader social approach to AIDS care, by addressing the social processes and inequalities driving the epidemic and intensifying its effects. AIDS care organizations have also worked to secure the human rights of AIDS sufferers, their rights to safe blood supplies, accurate information, care and treatment, dignity in dying and treatment, dignity in dying and decisions on reproduction. NGOs have lobbied to change government policies, provide services within and outside the hospital environment including housing, home-based care and counselling (Chikwendu, 2004:25).

2.10. Home-Based Care Programmes

According to Akintola (2004:1), there has been a gradual shift from hospital-based care of people living with HIV/AIDS to home-based care in Africa. People living with HIV/AIDS often constitute a large proportion, if not the majority of people seeking medical treatment at hospitals. Many hospitals do not have adequate resources to care for HIV patients. In response, hospitals and Departments of Health have implemented policies to promote home-based care of patients.

2.11. Scaling Up

The large number of HIV/AIDS infected and affected populations globally among the poor, call for organizations in HIV/AIDS care to, (a) enlarge the scale of their activities to make an impact in containing the spread of HIV/AIDS; (b) ensure broad and equitable access to the new anti-retroviral therapies against HIV/AIDS, and (c) provide care and support and treatment for opportunistic infections. There is a sense of urgency in the HIV/AIDS network for increased funding from both public and private sources. The international NGO community should concentrate on highly targeted programmes that take the best of what has worked in the past and combine these with innovative new approaches. With added resources local community care providers are able to expand from HIV/AIDS prevention to incorporate care and support. In other instances, community care providers of HIV/AIDS care have integrated HIV/AIDS work with income-generating work and micro-credit support for people living with HIV/AIDS (Dialectical Anthropology, 28:245).

2.12. Conclusion

The global response to HIV/AIDS has been multi-sectoral and has had mixed results. The worrying factor of the global response to the AIDS epidemic is that it has made a very unsatisfactory impact in some other parts of the world like the Sub-Saharan Africa. By 2004, 25,800 000 adults and children were living with HIV in this region. Sixty percent of people living with HIV are from Sub-Saharan Africa. By 2005, 2.4 million people in the Sub-Saharan Africa had died of AIDS (Journal-AIDS Fact file, 2005:2). However, in the developed world, national and local responses have had a more significant impact considering how low the AIDS prevalence is in these regions.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

In Chapter 2, an account of the literature study was given. In this chapter, the researcher discusses the methodology used in this study.

3.2 Research Design

Research design is the strategy, detailed plan and structure of conducting research and data collection procedures relevant to the research purpose (Leedy & Ormrod, 2001:100). Research design makes use of methods and techniques that suit the research problem; and should be able to provide the most reliable and valid data (Hopkins, in Isabirye, 2005:30). The research design details the framework for conducting the research, including the information required, the measurement procedures, questionnaire and data collection; sample and data analysis (Strauss & Myburg, 1999:55). Mouton (1996:175) defines research design as an exposition or plan of how the researcher plans to execute the research.

The research design used in this study is qualitative. Qualitative research refers to any kind of research that produces findings not arrived at by means of quantification. Qualitative research is about persons' lives, stories and behaviour, including organization functioning, social movement or intersectional relationships (Strauss & Corbin, 1990:17).

Two methods of collecting data were used, namely, literature review and semi-structured interviews. In the literature review, an aspect of the impact of Home-Based Care programme in the Skukuza Camp of the Kruger National park on its employees and people of adjacent villages is explored. This made it possible for the researcher to explore existing theories on the impact of HIV/AIDS on employees as indicated by experts. The formulation of the questionnaire used in the semi- structured interview was informed by the literature review in Chapter 2.

3.2.1 Population and sampling

A population is a collection of objects, events or individuals having some common characteristics that the researcher is interested in studying (Mouton, 1996:134). In view of this, a population is, therefore, examined in the context of persons, events, organization unit and other sampling units, which the research problem addresses. In this study, the total population consists of 300 employees of the Skukuza Camp and about 4000 members of the communities of the adjacent villages. Forty people from both the Skukuza Camp and the adjacent villages are currently participating in the Home-Based Care programme.

A sample is a part of the population that is used to obtain required data (Welman & Kruger, 2005:46). Mouton (1996:33) indicates that the idea behind sampling is that the samples from which the inferences regarding a given population have to be drawn, and must be selected in such way that each member of the population being studied has an equal probability of inclusion in the sample. The sampling technique of a research is influenced by financial support, time available to select the sample objective of the study, method data collection, research design and time available to process the data (Mouton, 1996:72).

For the purpose this study, purposeful sampling was adopted for forty respondents, namely, twenty employees of the camp and twenty members of the communities, currently participating in the programme. Purposeful sampling is based on the assumption that the researcher wanted to discover and gain insight on the information and therefore needed to select a sample from which he could learn the most (Morehouse, in Merriam, 1998:61).

The employees and members of the community that have been chosen are currently participating in the programme, hence were considered to be “information rich.” The purposeful sampling was also adopted in terms of the participants’ time and availability for the interview. The employees were diverse in nature, consisting of both male and females. This kind of a heterogeneous sample is not only information-rich, but also representative of the different views of the subjects under study (Maykut & Morehouse, in Isabirye, 2005:40). Any common patterns that emerge out a sample of this nature are of particular interest and value as they reflect the participants’ core experience and shared aspects (Merriam, 1998:98).

3.2.2 Data collection

Data are nothing more than ordinary bits and pieces of information found in the environment, and can be concrete and measurable or invisible. The process of collecting data is in essence the meeting of the researcher and the respondent, and difficult to measure (Merriam, 1998:67). The researcher is able to obtain data from the respondent in an effective way (Strauss & Myburg 1999:66). The strength of the information that becomes data in a research study depends solely on the interest and perspective of the researcher. The following are instruments used for data collection in this study:

3.2.3.. Literature review

Strauss and Myburg (1999:152) suggest that a literature review is a debate between the investigator and the audience that a particular problem is interesting and therefore worth investigating by means of specific methods. Vorster and De Meillon (in Nxumalo, 2001:120) indicate that literature review prepares the researcher thoroughly for the work he/she has to undertake. In a sense, it places the researcher in an advantaged position to establish how much research has been done on the subject in question, what results were obtained, what type of problems were experienced by other researchers and what instrument would be appropriate in the research at hand.

Mouton (1996:119) asserts that a literature review is a map of the terrain that the researcher is traversing. Merriam (1998:93) explains that review is an essential component of any study because it is the main access point or gateway to the relevant body of knowledge. In the context of the preceding, literature review is a fundamental element of research study, which serves as theoretical basis of both questionnaires and data analysis in this research. In this study, the literature review presented in Chapter 2 served as theoretical basis of both questionnaires and data analysis.

3.2.4. Semi-structured interviews

An interview is a purposeful discussion between two or more people, wherein an interviewer asks an interviewee a series of questions to obtain specific information (Walker, in Modiba, 2001:94). Interviews in most cases have the ability to yield information regarding the respondents' beliefs; feelings; attitudes; and behaviour (Silverman, in Isabirye, 2005:35). De Vos and Fouché (1998:300) contend that an interview enables an interviewer to obtain insider

information. The information collected from the interviews represents objectivity of the respondents and is therefore regarded as credible and believable, as long as the researcher did not interfere with the standard procedure (Merriam, 1998:35). For this study, the researcher made use of semi-structured interviews to obtain information from the employees and the villagers as required (Leedy & Ormrod, 2001:159).

The researcher requested permission from the management of the Skukuza Camp to interview the respondents that participated in the programme. The management granted the request. The researcher interviewed each participant individually. This proved to be a time-consuming exercise and yet important to obtain independent and objective data. The arrangement and execution of all data collection started on 02 June 2009 to 30 August 2009.

The semi-structured interviews were recorded on an audiotape. The researcher asked for permission from the participants to tape record the interview. Before the interview, the researcher assured the respondents that confidentiality would be maintained, and that no information would be attached to them personally. The use of the audio tape was explained to the respondents as a mere procedure to assist the researcher after the interview, since it is rather difficult to remember all that was said during the interviews. The request was approved but the researcher noticed some sort of uneasiness from most of the respondents. Verma and Mallick (in Modiba, 2001:100) contend that tape recording an interview is important because it provides both actual words of the interviewees and reflections of their voices which can have additional and valuable source of information. Tape recording interviews provides the researcher with a permanent record that he can refer to at a later date, long after the interview has taken place, for clarification and verification of facts. Mouton (in Modiba, 2001:100) asserts that a researcher should record the interviewees word by word and paraphrasing be used only when transcription is impossible.

3.3 Data Analysis

According to Le Compte and Preissle (1993:237), data analysis can be viewed as a process by which a whole phenomenon is divided into its components and then reassembled under various new rubrics. Data analysis is the process of bringing order, structure and meaning of the data collected (Marshall, 1989:112). Data analysis goes hand in hand with data collection so that the researcher focuses on and shapes the study as it proceeds. Being a qualitative

research study, a descriptive approach was used. The collected data were divided into small units of meaning and named (coded) according to the meaning it carried.

3.4 Trustworthiness of the Research

The integrity of any research methodology hinges on trustworthiness so that the research can stand the test of time, depending on whether the researcher followed the principles appropriate to these concepts (Mouton, 1996:100). The validity of the research refers to reality (events/behaviour/phenomenon), while reliability refers to the data collection and is influenced by at least the researcher/fieldworker; the respondent; and the context (Mouton, 1996:87). Qualitative researchers give a detailed description of the entire process, eventually indicating that their findings could be trusted by the readers (Isabirye, 2005:43).

Strauss and Myburg (1999:157) note that qualitative researchers have no single stance or consensus on addressing traditional topics such as validity and reliability. Qualitative researchers are more comfortable with the word trustworthiness of the research rather than validity and reliability. Modiba (2001:220) argues that trustworthiness of a research's effective strategy or approach can be used to establish the credibility of data and is critical to the accurate representation of the subjective human experience. In this study all forms of checks and research procedures were followed to ensure the trustworthiness of the research. The permission was requested from the management of the Skukuza Camp. Permission was also requested from the respondents before they were interviewed and tape recorded. Each respondent was assured that information collected from them would remain confidential and their anonymity as individual respondents would be assured.

3.5. Conclusion

In this chapter, the researcher has discussed the research methodology and design. The methodological paradigms available to the researcher have been considered, and the most appropriate ones have been selected. Qualitative data were collected from a small number of respondents.

The researcher made sure that the trustworthiness of the research was not threatened. All forms of checks and research procedures were followed to ensure the trustworthiness of the research.

The data analysis and interpretation are dealt with in Chapter 4

CHAPTER 4

DATA ANALYSIS AND PRESENTATION

4.1 Introduction

Data analysis is the final stage that a researcher is able to focus on what the respondents had said during the data collection process (Rubin & Rubin, 2004:355). During the data analysis process, the researcher is able to analyze the data collected. The process of data analysis is always informed by the research design and methodology used (Henning et al., 2004:130). In this research, the researcher made use of qualitative method.

4.2 Data Analysis

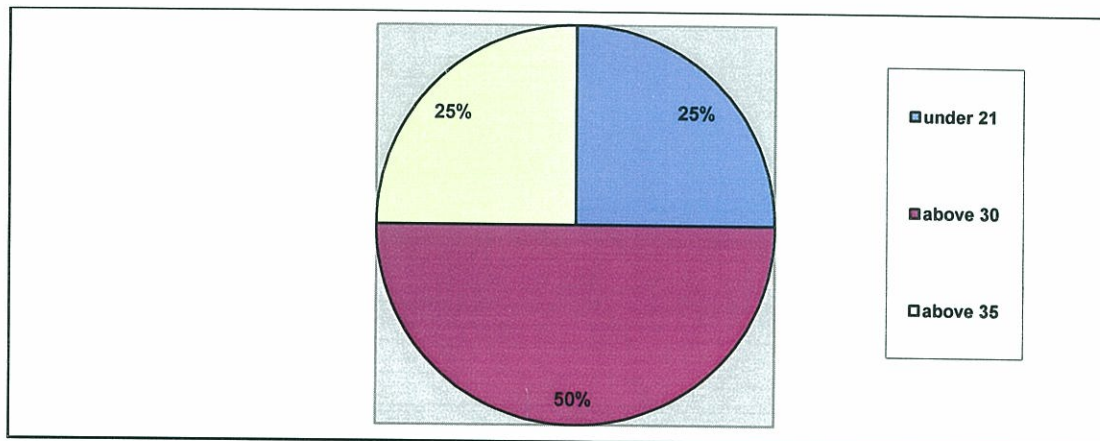
The qualitative method was adopted to gain an in-depth understanding of the impact of Home-Based Care programme in the Skukuza Camp of the Kruger National Park on its employees and people of adjacent villages as indicated in the research problem. The researcher made use of semi-structured questionnaires to obtain data from the employees and community members.

Semi- structured questionnaires was used to obtain data from forty (40) respondents and was divided into various sections addressing different aspects as discussed by literature review in Chapter 2. Question one (1) determined the age composition of the respondents. Question two (2) determined the gender composition of the respondents. Question three (3) tested the experience of the respondents on the programme. Question four (4) tested numbers of times the respondents attend the programme. Question five (5) tested lessons learned by the respondents from the programme. Questions six (6) to seven (7) determined how the programme has changed the lives of the respondents. Questions eight (8) to eleven (11) tested the respondents' feeling about the programme.

4.2.1 Composition of respondents

Question 1 was meant to establish composition of respondents.

Figure 4.1 Respondents age composition

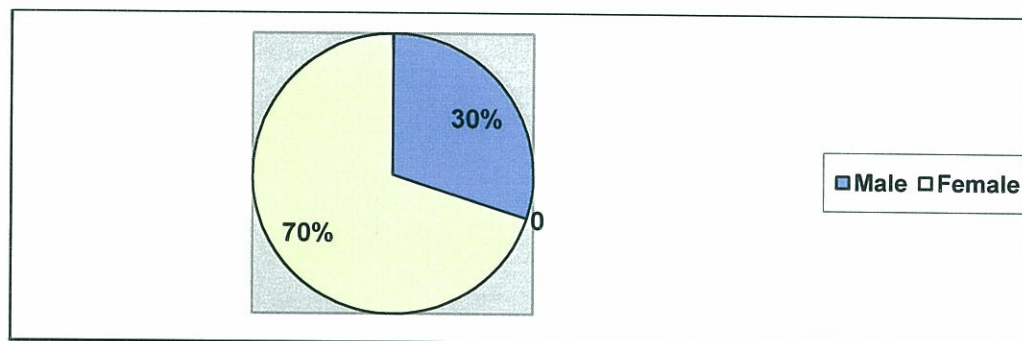


With reference to Figure 4.1 above, the researcher had an in-depth interview with forty (40) respondents from both the Skukuza Camp and the two adjacent villages as indicated in the research problem. Ten (10) or 25% of the respondents were under 21 years; twenty (20) or 50% were above thirty years; and ten (10) or 25% were above thirty-five years. The respondents represented people of different age groups, who are still sexually and economically active; hence seriously need the intervention programme to provide medication and also teach them how to change their lifestyle.

4.2.2. Demographics and reliability of data

Question 2 was designed to establish gender composition of the respondents.

Figure 4.2 Gender composition



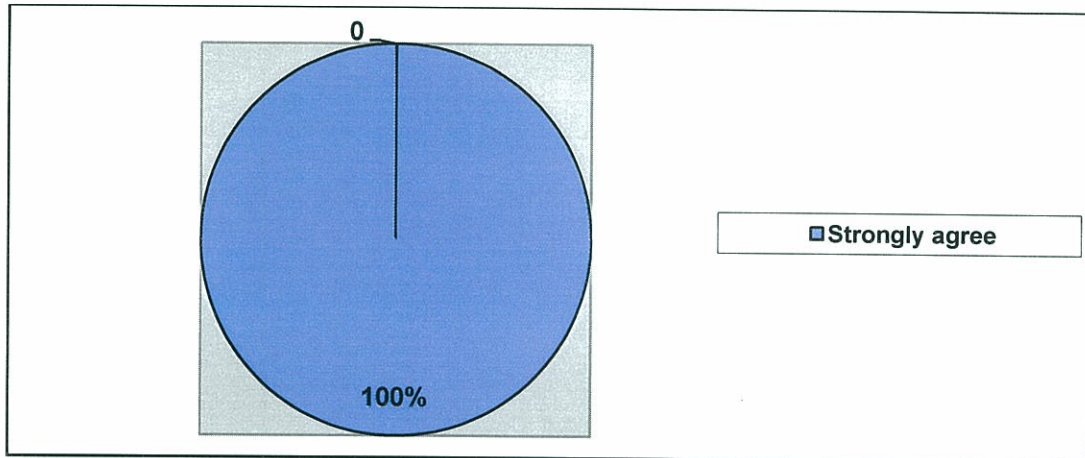
With reference to Figure 4.2, twenty-eight (28) or 70% of the respondents were women, while twelve (12) or 30% were men. This can be interpreted that more women than men are willing to get help from the HIV/AIDS intervention programme or the rate of HIV/AIDS infection in the area is much higher in women than men. This composition was considered

by the researcher to be of vital importance to the research, since it gives a picture of how vulnerable women are to HIV/AIDS infection.

4.2.3: Respondents' experience on the programme

Question 3 was drafted to establish whether the respondents have actually been on the programme, since it was started in 2007.

Figure 4.3 Respondents' experience and reliability of data

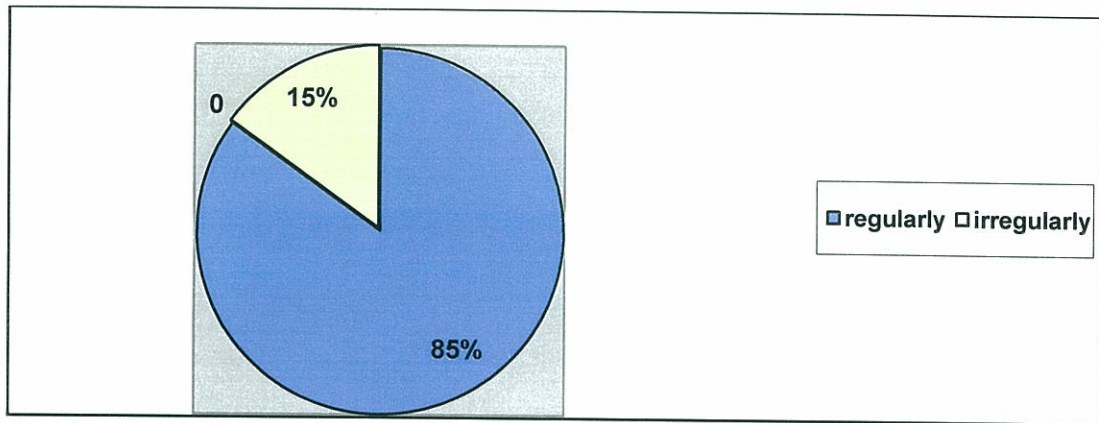


According to Figure 4.3, all or 100% of the respondents strongly agreed that they have been on the programme from 2007. This was very important for the researcher because the respondents had the experience and necessary information required by the researcher. It explains the willingness of the respondents towards the intervention programme. It further explains the rate of success of the programme, hence it makes the obtained data reliable and consistent, since the researcher dealt with the same sample.

4.2.4: Frequency of respondents on the programme

Question 4 was meant to find out how often the respondents have been attending the programme.

Figure 4.4 Respondents' frequency on the programme

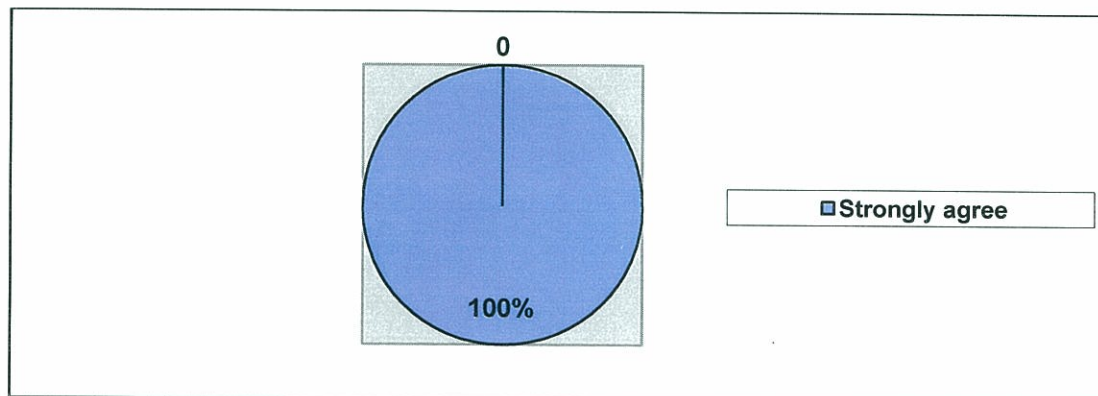


According to Figure 4.4, thirty-four (34) or 85% attend the programme regularly, while six (6) or 15% attend the programme irregularly. When asked to explain why they do not attend regularly, the answer was that they sometimes feel weak to attend the programme. This is an indication that some of the respondents are either not responding well to the programme or may be on the advanced stage of full blown up HIV/AIDS, therefore, are physically weak to attend. The big percentage that regularly attends the programme is an indication that the majority of the respondents are responding well to the programme, hence the programme can be said to be successful.

4.2.5 Lessons learned by respondents from the programme

Question 5 was to establish whether the respondents has learned anything vital from the programme

Figure 4.5 Vital lessons learned from the programme

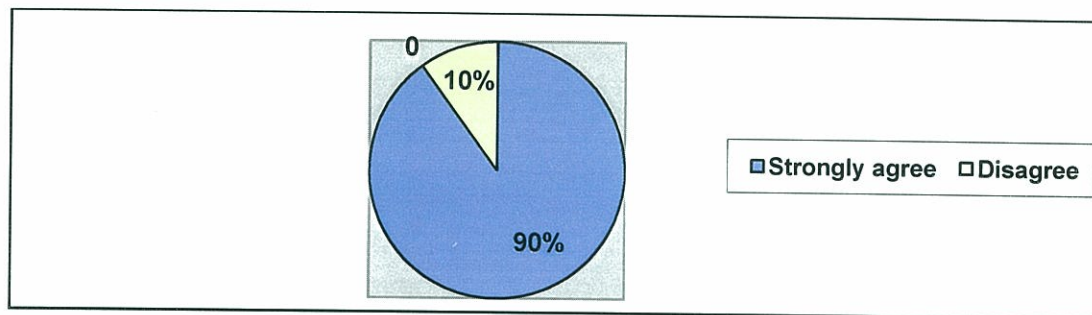


As reflected in Figure 4.5, all or 100% of the respondents strongly agreed that they have learned important lesson from the programme. In a follow-up question, the researcher did ask the respondents what specific lessons that they have learned. The majority of them indicated that they have learned how to have safe sex by using condoms. This implies that the programme has a positive impact on the life style of the target population.

4.2.6 Respondents lifestyle

Question 6 was to establish how the programme has affected the lifestyles of respondents.

Figure 4.6 Respondents' lifestyle

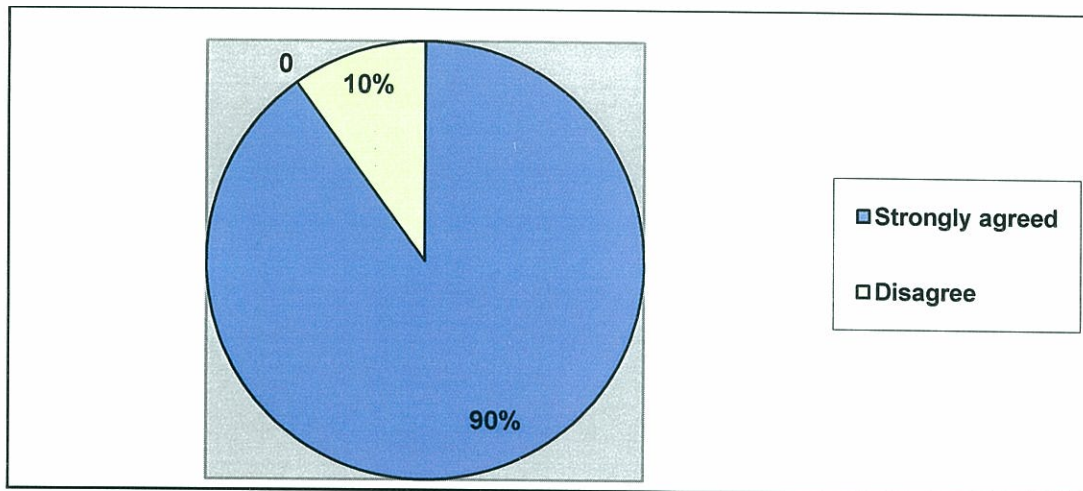


In view of Figure 4.6, thirty-six (36) or 90% of the respondents strongly agreed that the programme have affected their lives positively, while four (4) or 10% disagreed. In a follow-up question to why they disagreed, they indicated that they have lost friends and relatives who have perceived them as HIV/AIDS carriers. The explanation shows stigmatization of HIV/AIDS in certain quarters. This calls for more intervention programmes to distigmatised the disease.

4.2.7 Respond to medication by respondents

Question 7 was meant to test whether or not the respondents were responding to medication provided by the programme.

Figure 4.7: Respond to medication by the respondents

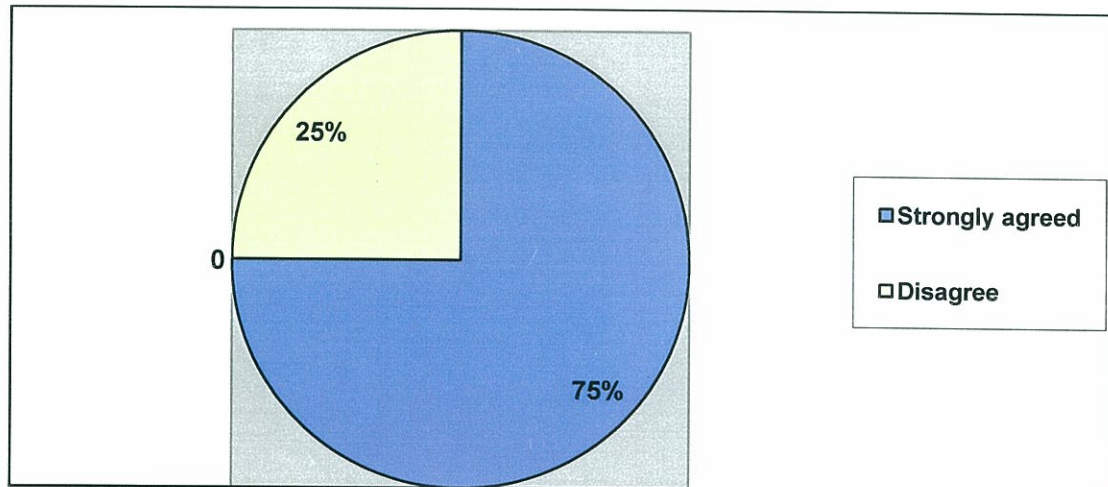


With reference to Figure 4.7, thirty-six (36) or 90% of the respondents strongly agreed that their bodies are responding well to the medication, while four (4) or 10% disagreed. When asked to explain why they disagreed, they indicated that they sometimes feel dizzy and weak after taking medication. This may not necessarily mean that the respondents are not responding to medication. It could be a side effect that may not have negative health effect on the respondents.

4.2.8 Satisfaction of respondents with the programme

Question 8 wanted to test whether the respondents were satisfied with the programme.

Figure 4.8 Satisfaction of respondents with the programme

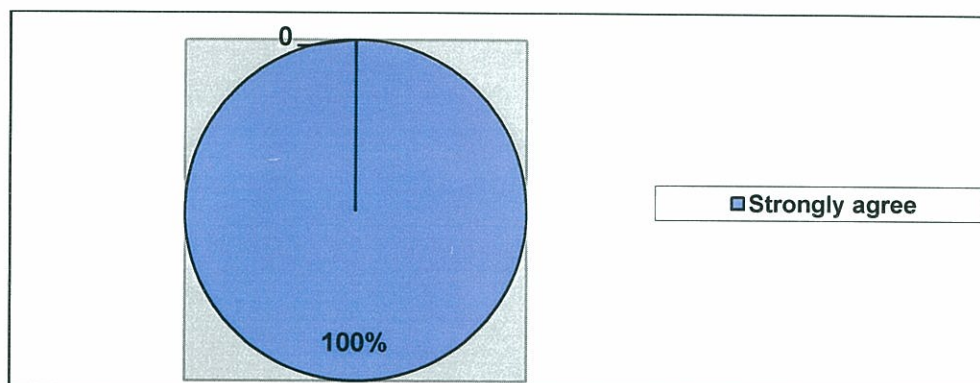


As indicated in Figure 4.8, thirty (30) or 75% of respondents strongly agreed that they are satisfied with the programme, while ten (10) or 25% disagreed. In a follow-up question to why they are disagreed, they responded that they were not allowed to default from the programme. The researcher considered this response to be very important, since it shows how the Skukuza Camp management is serious with the programme and prepared to make sure that it succeeds.

4.2.9 Recommend the programme to a colleague or friend by respondents

Question 9 desired to establish whether or not the respondents could recommend the programme to either friends or colleagues with similar problem.

Figure 4.9: Recommendation of the programme by the respondents to colleagues or friends

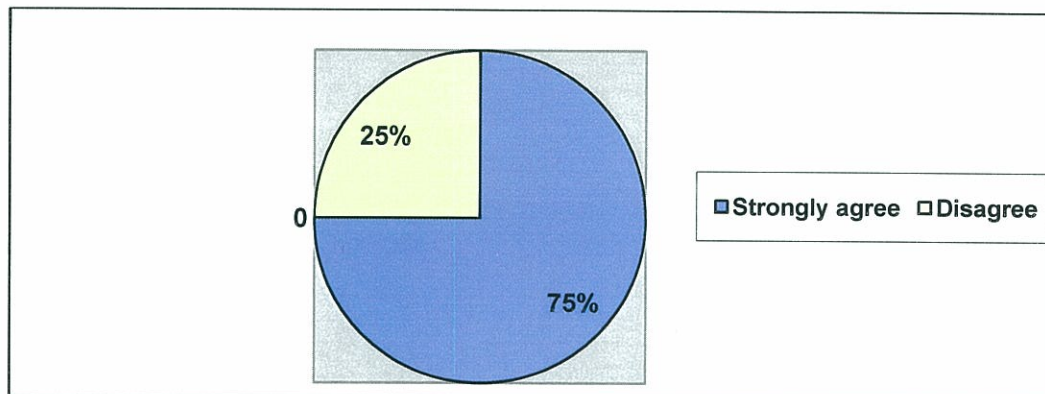


As reflected in Figure 4.8, forty (40) or 100% of the respondents strongly agreed that they would recommend their friends or colleagues to join the programme. In a follow up question when asked to whether they would recommend their immediate families to attend, fourteen (14) or 40% disagreed, while twenty-four (24) or 60% agreed. Those who disagree gave reason that they did not want their immediate families to know their HIV status. Asked to whether they were counselled before they were placed on the programme, the all agreed. This is an indication that stigmatization of HIV/AIDS victims is prevalent in many families, hence the respondents fear to disclose their HIV/AIDS status to their immediate families.

4.2.10 Continuation of the programme

Question 9 was meant to establish whether or not the respondents would prefer the programme to continue.

Figure 4. 10 Continuation of the programme

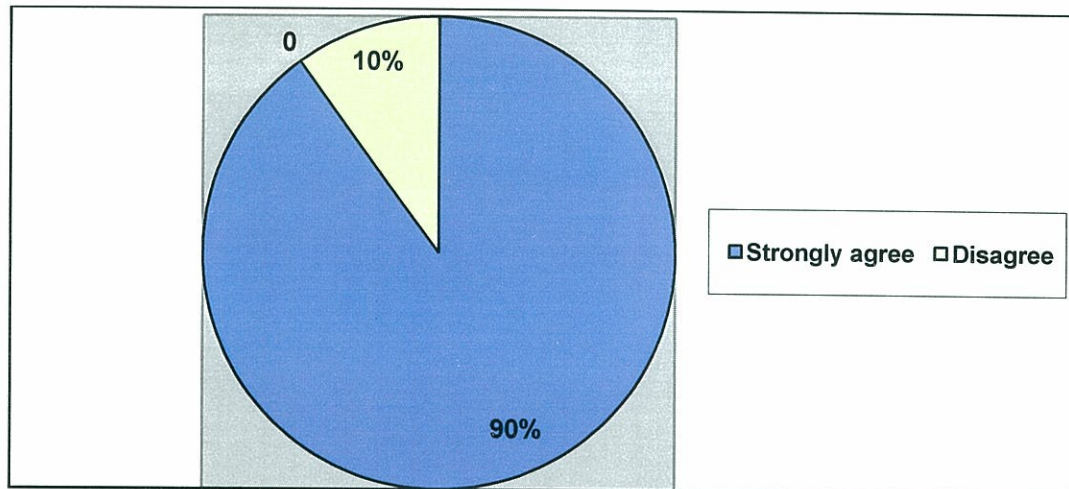


According to Figure 4.9, thirty (30) or 75% strongly agreed that it will prefer the programme to continue, whereas (10) or 25% disagreed. When asked why they disagreed, they complained of the strictness of the management that requires respondents to attend the programme without defaulting. This was considered irrelevant by the researcher, since it did not respond to the purpose of the programme.

4.2.11 Rating of the programme

Question 11 was to test how the respondents rated the programme

Figure 4.11: Rating of the programme



In reference to figure 4.10, thirty six (36) or 90 % of the respondents strongly agreed that the programme is successful, while four (4) or 10% disagreed. In a follow up question, when asked to explain the reason why they disagreed. They simply responded that they felt the programme is a failure. This explanation was disregarded by the researcher. It was considered not important and irrelevant, since there was no specific reason given by the respondents.

CHAPTER 5

RESEARCH OVERVIEW, RECOMMENDATIONS AND CONCLUSION

5.1. Introduction

The aim of this study was to investigate the impact of the Home-Based Care programme in the Skukuza Camp of the Kruger National Park on its employees and people from adjacent villages. The study further aimed to establish the impact of the programme, establish the challenges faced by the programme, contribute to the body of knowledge of Home-Based Care programme on employees and suggest new areas of research. The research questions enabled the researcher to establish the impact of Home-Based Care programme as well as listening on the views and role of communities on targeted areas. In this chapter, the researcher presents the overview on the entire study by indicating what was discussed in each of the chapters. Then, recommendations are given and suggestions for further research. Finally, the researcher gives the limitations of the study and concluding remarks.

5.2. Research Overview

In this study, the researcher set out to investigate the impact of Home-Based programme in the Skukuza Camp of the Kruger National Park on its employees and people of adjacent villages. The main question of the inquiry addressed the impact of the programme with regard to the containment of the scourge of HIV/AIDS. It was argued that the Skukuza Camp as a company has a social responsibility to play with regard to the containing the spread of HIV/AIDS. These imply that the Skukuza Camp has to ensure that its employees and people of adjacent villages know what HIV/AIDS is, how it is spread and how to prevent it. Home-Based Care programme in the Skukuza Camp must equip the employees and people of adjacent villages with knowledge on different HIV/AIDS related issues, including how to take care of those infected and affected.

Chapter 1 presented the background of the study, the problem of the research as well as the research design and methodology. The rapid spread of HIV/AIDS in South Africa, especially in the employment sectors, has made the researcher to conduct a scientific study in the Skukuza Camp of the Kruger National Park. The researcher then employed qualitative research design in this enquiry. The researcher further used purposeful sampling to select the sample. To collect data, the researcher used a semi-structured interview. A descriptive

approach was used to analyse data. The data collected were examined to provide the detailed description of setting, respondents and activities.

Chapter 2 examined the relevant literature in-depth relevant to the research problem. The researcher presented the overview of the HIV/AIDS, regional variations in HIV prevalence, attitude to HIV in South, financial and impact of HIV/AIDS on workforce as discussed by the relevant literature. The researcher further presented the overview of strategies to address HIV/AIDS challenges in other parts of the world.

Chapter 3 made a detailed discussion of the research design and methodology, population and sample, data collection techniques and data analysis of the study.

Chapter 4 dealt with the analysis of data. Data analysis is the last stage that the researcher is able to listen to what the respondents had said during data collection process. It can be viewed as a process by which a whole phenomenon is divided into its components and the reassembled under various new rubric. It is the process of bringing order, structure and meaning to the data collected. The qualitative method was adopted to gain an in-depth understanding of the impact of Home-Based Care programme in the Skukuza Camp of the Kruger National Park on its employees and people of adjacent villages. The researcher made use of semi-structured questionnaires to obtain data from the respondents. The questionnaires determined the age composition of the respondents. It also determined their gender; tested the experience of the respondents to the programme; tested the number of times the respondents attend the programme; tested the lesson learned by respondents from the programme; determined how the programme has changed the lives of the respondents; and tested the respondents feeling about the programme.

5.2.1. Discussion of the findings

The respondents, as analysed in Figure 4.1, represented people of different age groups, who are still sexually and economically active. About 25% is still under the age of 21; while another 25% is above 30; and 50% of them is above 35. It is against this background that there is a serious need of intervention programme to provide medication and to teach them about good lifestyle.

Figure 4.2 reflects the gender composition of people in the programme. It was established that 70% of female participate in the programme, while only 30% of males participate in the programme. This suggests that there is a serious need to reach out to males and teach them about the issues of HIV/AIDS.

To determine the respondents' experience in the programme, the researcher used Figure 4.3. All respondents (100%) strongly agreed that they have been in the programme since 2007. These showed how effective the programme could be to people who are already in it.

Figure 4.4 was meant to determine the frequency of the respondents to the programme. About 85% are regular, whereas 15% are irregular. It is uncertain why people did not attend regularly and this may be a question that the Home-Based Care programme needs to address. However, the regular manner in which the majority of them attend the programme is a promising indicator that the programme is important to the people in the community.

Figure 4.5 illustrated the vital lessons learned by the respondents from the programme. All of them (100%) indicated that they have learnt some vital lessons from the programme. This is an area of potential new research to better understand what lessons were being learnt and how those lessons have impacted on individuals, families and the broader community.

To establish how the programme has affected the lifestyle of respondents, Figure 4.5 indicated that 90% of the respondents strongly agreed that the programme has changed their lifestyle while only 10% alluded that it has never changed their lifestyle.

In view of Figure 4.6, 90% of the respondents strongly agreed that the programme has affected its lives positively while only 10% disagreed. Those who disagreed indicated that they have lost friends and relatives who have seen them as HIV positive. This suggests that there is an opportunity to undertake further research that focuses on HIV/AIDs and stigma because 90% of the respondents indicated that the programme has had a positive impact on its lives. As stigma and HIV is still a serious challenge to HIV prevention and care; such a high success rate is worthy of further investigation.

Reference to Figure 4.7, 90% of the respondents strongly agreed that their bodies are responding well to medication. Only 10% disagreed. There are a number of reasons why this

may be the case such as not adherence or poor diet. This issue was outside of the scope of this study but it is an opportunity for further investigation.

A question was asked to establish whether or not the respondents are satisfied with the programme. So, Figure 4.8 showed that about 75% of the respondents strongly agreed that it was satisfied with the programme, whereas 25% indicated that it was not satisfied. Furthermore, follow-up research would be useful in this area so as to improve the sustainability of the programme.

When respondents were asked whether they would recommend the programme to colleagues and friends, 100% of the respondents strongly agreed that that they would recommend their friends and colleagues to join the programme. A follow-up question was asked to establish whether they would like to recommend the programme to their families. Forty percent (40%) of the respondents responded that it would never recommend it to family members because they might know its HIV status. However, 60% said that it would definitely recommend family members to the programme. This is an interesting finding because it provides an indicator that stigma is a very serious concern for rural people living with HIV/AIDS.

Another question wanted to establish whether respondents would like the programme to continue. Seventy-five percent (75%) strongly agreed and 25% disagreed as illustrated in Figure 4.10.

The last question expected the respondents to rate the programme. With reference to Figure 4.11 about 90% of the respondents strongly agreed that the programme is successful while 10% disagreed.

5.3. Recommendations

Based on the findings of the study, the researcher has recommended the following:

- That the Home Based Care Centre should intensify the behaviour change programmes, especially for young people and populations at high risk of HIV exposure, as well as for people living with HIV. Programmes on behaviour change must be conducted to enable employees and people living in adjacent villages to begin to conduct themselves in a manner that does not expose them to HIV/AIDS. People must begin to live with one partner or practice safe sex.

- That leadership or management should be directly involved. It is crucial that the management of the Kruger National Park be committed to creating an environment that is free of HIV/AIDS stigma within their departments. One way of commitment that could be demonstrated is through direct leadership involvement in the Home Based Care programme. This would not only involve visible leadership but also active participation in the HIV/AIDS stigma-mitigation intervention at various levels. Managers need to be the face of the campaign and to lead by example.
- That the Kruger National Park should support the Home-Based Care Centre in Skukuza. The necessary supplies that should be provided in the home based care kits are often very inadequate. Any failures of Home Based Care often stem from the shortage of investment in the individuals and organisations that carry out the work (Avert, 2010:1). The park should also support the home based care givers because caring for someone whose mobility and bodily functions have deteriorated can place great demands on the health of caregivers.

5.4. Limitations of the Study

The study was conducted in the Skukuza Camp, which is found in the Kruger National Park and only two villages of Justicia and Huntington. The researcher was unable to get hold of the traditional leaders whom he initially had hoped to interview as they refused to participate in the study because they believe that it is taboo to discuss sex related matters with young people.

5.5. Conclusion

In this chapter, the researcher has discussed the research overview, recommendations and limitations of the study. In the research overview, the researcher reflected on the four chapters of the study. The researcher therefore, made some recommendations

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ANNEXURES

ANNEXURE A: Letter requesting permission to conduct a study in Skukuza Camp of Kruger National Park

P.O Box 847
Ximhungwe
1281

12 January 2010

The Director
SANparks
Skukuza

Sir/Madam

REQUEST TO CONDUCT A STUDY IN SKUKUZA CAMP OF KRUGER NATIONAL PARK

I hereby request for a permission to conduct a study in the Skukuza Camp of Kruger National Park from the 21st March 2010. In the process of collecting data, the issues of confidentiality, privacy and the right to refuse to respond to questions by respondents will be considered. The findings will be made available to the Skukuza Camp of the Kruger National Park.

I hope that you will find this in order.

Yours Faithfully

S. Sibuyi

ANNEXURE B:

A letter requesting respondents

(Sample selected from the employees of Kruger National Park and adjacent villages of Justicia and Huntington to participate in a study).

P.O Box 847

Ximhungwe

1281

02 February 2010

The respondent

REQUESTING A RESPONDENT TO PARTICIPATE IN A STUDY

I am hereby requesting you to participate in a study to be conduct in Skukuza Camp of Kruger National Park on 21 March 2010. In the process of collecting data, the issues of confidentiality, privacy and the right to refuse to respond to questions by respondents will be considered. The findings will be made available to Skukuza of Kruger National Park.

Thanking you in anticipation.

Yours Faithfully

Sibuyi, S.

ANNEXURE C :

QUESTIONNAIRE

INSTRUCTION TO RESPOND TO QUESTIONNAIRE

- **You can answer agree, strongly agree, disagree and strongly disagree, regularly, irregularly,**
- **When required to specify or clarify some issues please do so.**

1. How old are you?

a) under 21 b) above 30 c) above 35

2. Tick where it is appropriate to you.

a) Male b) Female

3. How long have you been on the programme?

4. How often do you attend the programme?

5. Would you say that you have learned an important lesson from this programme?

6. How has the programme affected your life style?

7. Can you say that your body is responding well to medications provided by the Programme? If you disagree, explain.

8. Are you satisfied with the way the programme is being implemented? If you disagree, explain.

9. Would you recommend the programme to your friends or colleagues with the same problem? If you disagree, explain.

10. Would you prefer the programme to continue or discontinue?

11. Can you say that the programme is successful? If you disagree, explain.