THE COMMUNICATIVE ROLE PLAYED BY SOCIAL WORKERS IN THE INTRODUCTION AND UPTAKE OF ORAL PRE-EXPOSURE PROPHYLAXIS (ORAL PREP) IN VULINDLELA.

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DECLARATION

I, Buyisiwe Lorraine Dlamini make the declaration that the work presented in this dissertation is my own research work in all its aspects with exceptions for work comprised in the extant literature and research methods adopted, which work has been duly acknowledged and referenced.

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ABSTRACT

Since the discovery of HIV and Aids many efforts to reduce the spread of the virus have been taken, these include biomedical interventions such as male circumcision, male and female condoms and PrEP. Several HIV prevention methods have been effective to curb the spread of HIV infections, with Voluntary Male Medical Circumcision (VMMC) and PrEP, have shown impact in overall reduction of HIV transmission. (Moodley, et al., 2016). PrEP has been shown to reduce the risk of HIV infection from unprotected sex by over 90 percent, and from injecting drugs by more than 70 percent (CDC, 2019).

Biomedical interventions have been shown to be more effective when implemented in conjunction with behavioral interventions, and where contextual factors such as cultural context are considered in the implementation of such interventions (Baxter & Karim, 2016) A key factor that surfaces from the various studies considered here is that, biomedical interventions have less efficacy when used independently but works best with behavioral interventions rooted in various social and cultural contexts of those targeted. Such behavioral interventions including peer education, mass media communication, school-based sex education programmes, socioeconomic interventions and behavioural counselling, have opened up a greater scope for clinical social work in South Africa, and have been demonstrated to be instrumental in targeted awareness among adolescents and young adults (Baxter & Karim, 2016; AVERT, 2019; Morojele, et al., 2006).

Biomedical HIV prevention technologies, such as antiretroviral pre-exposure prophylaxis (PrEP) hold huge potential to substantially reduce HIV acquisition in high-risk populations globally (Giovenco, 2019). Although many people who could benefit from PrEP are still unaware of its existence hence the need for social workers to raise awareness through education and interventions directed at socio-structural change in the communities.

This dissertation provides an understanding of the communicative role played and can play by social workers in the future uptake and introduction to HIV prevention methods in Vulindlela. This study investigates the level of knowledge amongst social workers working with HIV clients. By employing a culture-centred approach (CCA) and the Social Ecology Model of communication and Health Behaviour (SEMCHB), this dissertation seeks to reach a holistic understanding of how social workers communicate with their clients about HIV prevention methods and their level of knowledge about HIV prevention methods such as PrEP. A phenomenological approach was adopted for this research study. Three interviews were held separately with social workers working in Vulindlela using semi – structured questionnaires

to collect data. Thematic analysis was used to develop themes that emerged from the data collected.

Key findings of the study revealed that social workers were heavily integrated in the communities in which they work and therefore have increased community exposure to play an important communicative role in the introduction and uptake of oral PrEP. The study overall found that HIV interventions does not need to be largely concentrated with nurses and primary health care facilities but can be extended to social development interventions in communities as well.

LIST OF KEYWORDS AND ACRONYMS

AMFAR	American Foundation for AIDS Research
ARV	Antiretroviral Therapy
CCA	Culture Centred Approach to Health Behaviour
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
PLHIV	People Living with Human Immunodeficiency Virus
PrEP	Pre-Exposure Prophylaxis
SANAC	South African National Aids Council
SEMCHB	Social Ecology Model of Communication and Health Behaviour
STATSA	Statistics South Africa
TasP	Treatment as Prevention
UNAIDS	United Nations Acquired Immuno-Deficiency Syndrome
WHO	World Health Organisation

CHAPTER 1

1.1. Introduction

In this study, an attempt was made to examine the communicative role played by social workers in introducing and increasing the uptake of a novel HIV prevention method known as Oral Pre-Exposure Prophylaxis (PrEP) in the rural community of Vulindlela in KwaZulu-Natal South Africa. The study was designed to be a qualitative inquiry and approached from a deductive perspective in which concepts and empirical theories were adopted from previous research studies which investigated similar issues in different and similar settings. The study was based on two primary theoretical foundations, the Social-Ecological Model of Communication and Health Behaviour (SEMCHB) and the Culture Centred Approach (CCA). The former focused on the social determinants of behavioural outcomes in health while the latter focused on intrinsic and interpersonal qualities of people, that originates and perpetuates patterns of being that mediates in observed health outcomes and behaviours.

Following the concepts and constructs from these foundational theories, a critical review of the literature was undertaken (Chapter 2), to investigate how these various explanations of health behaviour determinants were discussed in the extant literature. To this end, the constructs were demonstrated and then the ways in which they influence health behaviour were discussed. The qualitative research methodology was implemented as a phenomenological study and focused on the experiences of social workers who according to designated criteria have been incumbent at institutions located in Vulindlela. Within this setting, the participating social workers were interviewed, with the recordings and transcriptions of the interviews producing the qualitative data which was subjected to thematic analysis to obtain the findings of the study presented in Chapter 5. The discussion in Chapter 6, positioned the findings of the study within the existing body of knowledge, as well as the study's contribution to the knowledge base in the form of constructs.

1.2. Background of the Study

As of 2014, South Africa was positioned as the leader in the recorded cases of global HIV prevalence, with the largest numbers of people living with HIV and Aids (Whiteside & Strauss, 2014). In the critical review of literature presented in this study, HIV prevalence was traced to the historical response to the HIV epidemic in the country, from negligence during the apartheid

era, or the epidemic being relegated as a case for homosexual men. The case for heterosexual transmission would come to be understood later, as the dominant fuel of HIV transmission (Karim & Baxter, 2010). Policy responses, however, were very slow until 2003, with the Treatment Action Campaign protests resulting in macro policy changes that resulted in the initial large rollout of Antiretroviral therapy (ARV) (Karim & Baxter, 2010). Since then, research has demonstrated the importance of understanding both societal and cultural context that defines the conditions of subsistence for individuals and households and communities and the need for evolution of the understanding of the epidemic, as studies have continued to lead to new and improved therapies to prevent the rising incidence of the epidemic (Karim & Baxter, 2010).

Within these developments, the role of social workers was seen as instrumental in bridging the gap between understanding the socioeconomic and cultural conditions of communities (RSA, 2006). HIV surveys by organisations such as the United Nations in South Africa, as early as 2009 found that there was a relationship between adverse contextual factors and vulnerabilities to HIV (UNAIDS, 2010). Other findings included cultural practices and patriarchal systems that promoted male infidelity and multiple sexual partners, gender-based violence and intimate partner violence, alcohol abuse ad common behavioural factors in other studies (Govender, 2011; Karim & Baxter, 2010; UNAIDS, 2010b). These findings led to the policy options that medical interventions needed to be combined with societal interventions, as well as the need for effective awareness, education and community participation in the fight with HIV, and more importantly arresting the stigma of HIV and the prevailing negative sentiments concerning novel and evolving therapies designed to arrest the HIV epidemic (UNAIDS, 2010).

The communicative role of social workers working inter-alia medical and health practitioners became instrumental in community outreach, education and awareness concerning HIV and AIDS in rural and remote areas, which had less access to information and were ignorant concerning HIV (UNAIDS, 2019; Kharsany, 2018). Through their communicative roles and proximity to targeted communities, social workers were viewed as better placed to change social attitudes about HIV and AIDS, improve communities' understanding of HIV & AIDS, how it can be prevented as well as the use of evolving laboratory therapies (Tong, et al, 2017). However, despite this increased role of social workers, HIV and AIDS incidence has continued to rise with incidence remaining entrenched in spatially displaced societies particularly in KwaZulu-Natal (AVERT, 2018; Kharsany, 2018). This is despite recent innovations in HIV treatment which has

seen novel procedures and therapies as well as more education and information dissemination on HIV and AIDS.

Against this background, this study sought to provide an understanding of the importance and effectiveness of the role of social workers in communicating novel HIV prevention methods in spatially displaced regions. Using a qualitative inquiry, a phenomenological study design was employed to study the perspectives of social workers in the Vulindlela area, and how they carry out their work in the communities, their challenges and opportunities as well as the contextual factors that have been instrumental in shaping their role as communicative agents of HIV prevention strategies (Bello, et al, 2019; SANAC, 2017, Nota, 2015). Among these new strategies and innovations in HIV treatment, has been oral PrEP, which is a pre-exposure drug that is taken before engaging in sexual activity and prevents the transfer of HIV infection from one person to another. Given the socioeconomic and cultural contexts of most rural and remote areas in South Africa, particularly in KwaZulu-Natal, oral PrEP was perceived as an important innovation, which could significantly transform the incidence of the epidemic in these regions (WHO, 2019).

This study as such sought to understand the factors that improve or negate the role of social workers in increasing the uptake of oral PrEP. Given the demographic profile of HIV in Vulindlela, which has been observed to be highly prevalent among the younger age cohorts in the transition to adulthood, among the discussed benefits of oral PrEP, it was seen as empowering their decision making since its intake in non-negotiated. However, studies have shown that generally, uptake of oral PrEP has been very low, with various factors being given with lack of awareness, knowledge and negative perception of novel medicines being most common challenges (AMFAR, 2013; Norton, et al, 2013). There was, therefore, a need to understand the factors that facilitate the success of the communicative role of social workers or inhibit it, in the communication of oral PrEP to the Vulindlela community to increase its uptake by community participants particularly the at-high risk community segment.

1.3. The rationale for the study

In the year 2012, a medical review outlined the shifting focus of addressing the HIV epidemic with more inclination towards HIV treatment (Dageid et al, 2012). Universal HIV testing and immediate antiretroviral therapy for infected individuals was proposed then as an effective way of reducing HIV transmission and consequently bringing the HIV epidemic under control (Cohen et al, 2012). The shift in focus was influenced primarily by the emergence of medical

interventions, and emerging knowledge through clinical trials and procedures. For instance, a 2011 HPTN 052 clinical trial demonstrated that ART reduced the risk of infection transmission among heterosexual HIV-serodiscordant couples by 96%, thus decisively confirming the impact of treatment on heterosexual transmission (Cohen et al, 2011).

Following these findings, policy focus shifted greatly towards tackling the epidemic through medical interventions with large commitments of financial resources, intersectoral collaborations between governments and private sector and other NGOs in the upscaling of treatment provision (Dageid et al, 2012). The debate in policy circles had also been active as early as 2006 concerning the distribution of funding between treatment therapies and towards HIV prevention strategies. While these debates have continued it has become evident that treatment and prevention are necessary strategies in addressing the HIV epidemic (ICAD, 2008; Kurth et al, 2011; AVERT, 2015).

This consensus today can be seen in methods that combine both perspectives on treatment and prevention, such as Treatment as Prevention (TasP), where HIV prevention methods and programmes utilising ART to decrease the risk of HIV transmission are combined. The upscaling of ART uptake has however been slow, particularly concerning rural and remote regions where HIV incidence remains high in South Africa. Some challenges that have hampered these upscaling efforts include inadequate resources for HIV prevention at both the organisational level and household level, where access to effective therapies not subsidised by the government such as PrEP prevents individuals from effective access (Baxter & Karim, 2016; AVERT, 2019; Bello & Ndagurwa, 2019). Added to these constraints are poor planning, prioritization and targeting programs, capacity constraints particularly human resources and infrastructure, use of disjointed programmes, reliance on ineffective interventions such as abstinence programmes, inadequate implementation of interventions and approaches proven to be effective and challenges of stigma and lack of access to information concerning novel HIV treatment and prevention procedures (Martinez, 2014).

These issues raise concerns of the nexus between medical interventions and programmes directed at influencing behavioural outcomes in communities, which are important contextual factors influencing the profile of HIV AIDS in South Africa (Kharsany, 2018). Since 2010, South Africa has expanded its ART programme to be the largest in the world, with further expansion having

been promoted under the test and treat campaign guidelines. The country was also the Sub-Saharan Africa pioneer in approving PrEP which by 2020 is available for people at high risk of HIV (AVERT, 2020). However, despite these efforts, HIV prevalence remains high at 20.4 % an increase from the adult prevalence level of 18.8% recorded in 2012 with factors such as homosexual relations, transgender relations, sex work, drug use, intimate partner violence and constraining socioeconomic dynamics being the observed catalysts (AVERT, 2019).

Given these factors, it is imperative that an understanding of the factors shaping behaviour that places individuals at risk be understood, so that interventions can be more aligned with the social, economic, cultural and behavioural realities. Furthermore, there is a need to have an understanding of factors that might be negatively affecting the uptake and use of novel therapies such as oral PrEP and other factors that might affect how these therapies work, so that interventions can best be aligned to the realities within communities most at risk, or showing a high prevalence of HIV. This study seeks to address this knowledge gap, by focusing on the communicative role of social workers, who have been working for an extended period in Vulindlela, an area with high adult HIV prevalence. The overarching objective is to examine factors that have been influencing the effectiveness of the social workers' communicative role in promoting the uptake of oral PrEP, by analysing the perspectives of the social workers concerning the communities they serve, their perspective about their work and the realities of HIV prevention within the community. An understanding of such knowledge is important, as it assists in bringing into perspective three key issues:

- the capability of the social workers and its effects on their communicative role
- explanations concerning why oral PrEP has not seen increased uptake in high-risk areas even though the government approves and subsidises it for individuals at high risk of HIV and
- the impact of contextual factors influencing the uptake of oral PrEP from the perspective of the social workers themselves.

1.4. Problem Statement

As highlighted in the foregoing sections, since HIV was first discovered in South Africa in the late 1990s (Cohen, et al., 2012), the role of health care workers in the fight against the epidemic has been studied quite extensively and its importance outlined (David et al, 2002; Fatti et al,

2010). Concerns of lack of human resources to fight against HIV incidence in South Africa, particularly under the contemporary test and treat campaign, has focused on the role of frontline healthcare workers (Hansoti, et al., 2019). The role of social workers particularly their instrumentality in bridging the gap between medical interventions and communities' contextual dynamics has not been studied comprehensively (Hansoti et al, 2019).

In South Africa, the role of social workers has been defined concretely within the scope of social service disbursement, such that when connected with HIV and AIDS, the focus has been on social issues of those infected or those living with HIV infected persons. The broad framework of the HIV/AIDS and STI strategic plan for South Africa (2007-2011), a multisectoral approach toward addressing HIV infection and focusing on prevention and treatment, care and support, human and legal rights and research and surveillance, relegated the role of social workers to care and support to HIV positive individuals and relaying information with institutional precincts to medical facilities (David et al, 2002). Social workers roles focused on campaigns directed at ensuring that those infected with HIV are encouraged to adhere to treatment guidelines and schedules (South Africa, 2006). An elaborate project by UNAIDS published in 2017, examined the role of social workers globally in the fight against HIV. Focus issues in the project were on social workers' role in promoting the welfare of children in Sub-Saharan Africa (Lombe et al, 2017); challenges experienced by social workers in placing children with HIV in foster care (Muchanyerei, 2016); emotional costs of caring for patients living with HIV, experiences of caregivers (Masson & Mangena, 2017) and understanding the role of social workers in promotion and uptake of prevention of mother to child transmission of HIV in Zimbabwe (Muchacha & Matsika, 2017). Other studies of a similar nature focused on more or less the same issues. A study by Ntshwarang and Musamba (2011) focused on the role of social workers working with HIV and AIDS in health care settings in Botswana. The study concluded that social workers make a holistic assessment addressing mental, emotional, physical and environmental needs, influencing the challenges and successes of HIV clients (Ntshwarang & Musamba, 2012).

Social workers promote social change, problem-solving in human relationships and the empowerment and liberation of people to enhance wellbeing (The International Federation of Social Workers, 2001). In South Africa, social workers carry out casework by working with their clients using a multilevel problem-solving approach that empowers the primary client and advances change within the community (Nicholas, Rautenbach, Maistry, 2010). The role of a medical social worker is different from that of a general social worker. Social workers in the

health care sector are involved in preventive care and promoting health in a medical setting such as a hospital, outpatient clinic, hospice, long-term care facility, or community health agency, their duties include assessing a patient's social, emotional, environmental, financial, and support needs (Nicholas, Rautenbach, Maistry, 2010).

Medical social workers assume a role of being an educator by providing prior counselling, post counselling and information about the progression of the diseases, drug treatment, stress management, positive lifestyle choices and safe sex practices (Kirst-Ashman, 2003). According to the International Federation of Social workers (2012), -"Social workers have the responsibility to continuously update their knowledge about all aspects of HIV, including new prevention strategies, treatment and care models, medications, research, and policies" (International Federation of Social Workers, 2006).

Increased knowledge among social workers about new HIV prevention technologies such as oral PrEP can promote uptake and adherence to oral PrEP as an HIV prevention method. In Michael, Christopher, Mitchel's (2002) study, it was revealed that "Most of the social workers in the sample provided minimal to no HIV-related services in their clinical practice". Primary care providers who are not familiar with antiretroviral medications, may not feel comfortable prescribing it, thus making it difficult for people at high risk of HIV infection to access oral PrEP. Primary healthcare providers need to continuously be aware and well informed about oral PrEP as an HIV prevention method (Sanchez, 2017). This study explores how social workers can play a role in oral PrEP introduction among vulnerable population groups.

Often HIV prevention interventions (campaigns, training, and programmes) directed at curbing the diseases include most health care workers such as Doctors and Nurses, counsellors and community caregivers but neglects social workers (Davids et al, 2002). A need for training on HIV prevention methods for social workers exists; however, this training should keep up with the recent HIV prevention messages to ensure its relevance to clients. Training social workers on recent prevention methods will yield in shaping the client's mindset and influence receptiveness to accept and use HIV prevention methods.

These studies all focused on the supportive role of social workers, however, the autonomous role of social workers in promoting and influencing adoption of novel treatment strategies has not been evaluated particularly concerning the capability and the perspective of the social workers themselves. Therefore, this study aims to contribute to the body of literature on the role social

workers play in the uptake and introducing their clients to HIV prevention methods (PrEP). Using Vulindlela as a focus area, the study investigates the capabilities and perceptions of social workers about their role in promoting the uptake of novel therapies such as oral PrEP to spatially displaced locations and their diverse socioeconomic and cultural contexts.

1.4.1. Aim of the research study

Given the above-mentioned problem statement, the main aim of the study is to explore the role social workers play in the uptake and introduction to HIV prevention methods (PrEP) to their clients.

1.4.2. Objectives of the study

i. To explore the level of knowledge among social workers about HIV prevention options?
ii. To understand the level of knowledge and the attitudes of social workers towards oral PrEP as an HIV prevention method
iii. To explore how medical social workers communicate about oral PrEP to clients
iv. To understand the importance of a communicative role of social workers for oral PrEP uptake or promotion.

1.4.3. Research questions

i. What is the level of knowledge among social workers about HIV prevention options?
ii. What are the attitudes of social workers towards oral PrEP as an HIV prevention method?
iii. How can medical social workers communicate about oral PrEP to clients?
iv. What is the importance of a communicative role of social workers for oral PrEP uptake or promotion?

1.5. Methods: Framework and Research Design

In seeking to understand the communicative role of social workers, the study employed an integrated framework of the Social determinants of health behaviour (SEMCHB) and the Culture Centred Approach (CCA) to health. The CCA is based on the premise that health communications are influential and have efficacy when there is inter-exchange between those planning health interventions and the recipients if those interchanges occur within settings where there is co-construction of meanings and perspectives and where information is negotiated and incorporated mutually (Dutta, 2015). Applied to this study, the model suggests that social workers must engage their communities in seeking a shared understanding of interventions they are advocating while

also integrating cultural contexts of societies they seek to influence. The SEMCHB model focuses on the social determinants of health behaviour which define the context within which individuals make decisions that affect their observed health outcomes (Ngwenya et al, 2017). Applied to this study, the model implies that, aspects such as poverty, low socioeconomic settings, marginalisation, social violence and disempowerment and so forth are important forces that negate the capacity of individuals to utilise or negotiate decisions that promote their health. In this study, however, the CCA-SEMCHB framework is an integration of these two frameworks, with the understanding that both culture and social determinants of health behaviour affects community participants differently, such that cultural elements and social dynamics important for adolescents are not necessarily influential for those advanced in years. According to the framework, elements of the SEMCHB model such as institutional factors, community factors and public policy determines the structural underpinnings of societies which participants grapple with. The model further postulates that culture is shaped by intrapersonal factors, interpersonal factors and institutional factors. Finally, the agency (capacity of individuals to make health influencing decisions) is determined by structure and culture. This integrative framework was adopted in this study as a comprehensive approach to understanding the communicative role of social workers in increasing the uptake of oral PrEP in the Vulindlela community.

This integrated framework was adopted within a phenomenological study design, which the researcher sought to provide a description, understanding and explanation of the communicative role of social workers in Vulindlela and how their communicative role can influence the introduction and uptake of oral PrEP. The researcher thus incorporated social workers in the study, who were interviewed concerning their experiencing in addressing HIV in the Vulindlela community where they have been incumbents for some years. The outcome of this interaction was the interview data, which was transcribed and then analysed using thematic analysis to provide the findings of the study which supported the conclusions made in this study.

1.6. Significance of the study

This study will add to the body of literature on the communicative role social workers play on HIV prevention because it provides an understanding of their experiences and knowledge. The knowledge gained from the study can be used by key government sectors like the Department of Social Development and the Department of Health to formulate relevant policies for social workers. Egger (2012) found that social sciences research can help in reforming sectors that are critical by identifying challenges and providing possible solutions for socio-economic issues.

Therefore, social workers and other community workers can also use the outcomes of this study for proper service delivery.

1.7. Dissertation outline

Chapter 1: In this chapter, the research study is introduced and the major issues that brought about the need for the study outlined in the rationale of the study. The research problem, aims, objectives and research questions are presented. This is followed by an introduction to the theoretical premise and research design with the chapter concluding with the structure and significance of the study.

Chapter 2: This is the literature review chapter covering the following major sections: Landscape of HIV and AIDS in South Africa; behavioural and social factors that influence new HIV infections, which are poverty, intergenerational relationships, multiple sexual partners and gender-based violence (GBV) or intimate partner violence (IPV). This chapter also discusses the history of Social work and HIV and AIDS. The chapter concludes by focusing on the role of medical social workers in HIV prevention methods, particularly with Oral PrEP.

Chapter 3: This chapter has the two main theories that are the framework of this research study which are: The Culture Centred Approach (CCA) and the Social Ecology Model of Communication and Health Behaviour (SEMCHB).

Chapter 4: This is the methodology chapter which includes the research paradigm; research design; sampling procedure; data collection and analysis; ethical issues and study limitations.

Chapter 5: This chapter provides an analysis of research findings and discussion. The findings are analysed under the following themes: the level of knowledge among participant social workers concerning existing HIV prevention options; existing knowledge of social workers concerning oral PrEP as an HIV prevention method; ways of communicating about oral PrEP within a cultural-human ecological model and contextual factors affecting the effectiveness of the communicative role of social workers in Vulindlela.

Chapter 6: Chapter six focuses on the discussion of findings, conclusions and recommendations.

Chapter 2: Literature Review

2.1. Introduction

This chapter discusses the landscape of HIV in South Africa. The discussion focuses on behavioural and social factors that influence new HIV infections, which are poverty, intergenerational relationships, multiple sexual partners and gender-based violence (GBV) or intimate partner violence (IPV). This chapter also discusses the history of social work and HIV and AIDS. The chapter concludes by focusing on the role of medical social workers in HIV prevention methods, particularly with Oral PrEP.

2.2. Overview of HIV and AIDS in South Africa

The 1980s marked the first discovery of the Acquired Immune Deficiency Syndrome (AIDS) in the United States of America (USA), which was deemed as a homosexual disease but later found in other population groups. By 1983, the first case of HIV was reported in South Africa (Karim and Baxter, 2010) and since then the epidemic has been vastly spreading throughout the world. Globally, South Africa has the largest number of people living with HIV and AIDS (Wabiri & Taffa, 2013). Similarly, the first phase of the HIV epidemic in South Africa was restricted to a few hundred cases of men who have sex with men and persons receiving unsafe blood transfusion (Karim & Baxter, 2010). Heterosexual transmission became a dominant fuel of HIV infections in the early 1990s and initially, the apartheid regime undermined the seriousness of the virus and as a result, they were few HIV & AIDS awareness and educational programmes in South Africa in the early 90s (Karim and Baxter, 2010). A decade later, Thabo Mbeki former president of South Africa finally approved the provision of free antiretroviral therapy in public health services after about 330 000 people had died from AIDS (Karim and Baxter, 2010). After the 2009 elections and the progress on the antiretroviral rollout programme, there was the optimism of curbing the epidemic. Initially, several surveys and statistics have been conducted in South Africa to track the HIV epidemic (Shisana, 2012). By 2012, about 12.2 per cent of the population translating to over 6 million people were living with HIV which was an increase of 1.2 million people living with HIV (PLHIV) compared with the reported statistics for the year 2008 (Shisana, et al., 2012). The increase in the number of new HIV infections created an impression that South Africa is failing to curb this epidemic. The surveys conducted by the Human Sciences Research Council (HSRC) between 2002, 2005, 2008, 2012 and 2017, have all showed an increase in the numbers of people living with HIV and new HIV infections (Simbayi, et al., 2017). According to Statistics South Africa (2017), the overall number of PLHIV increased by 7.6 million by 2017,

which is a rapid increase in new HIV infections. The upward trend in HIV statistics has been against the backdrop of increased government efforts towards HIV prevention and curbing the spread among the population.

The South African National HIV Prevalence, Incidence, Behaviour and communication report for 2017, stated that overall incidence on young people between the ages of 15-24 was 1.0 per cent which translated to 88 000 new infections and the incidence was three times higher among females (1.51 per cent translating to 66 000 new infections) when compared to males (0.49 per cent translating to 22 000 new HIV infections (HRSC, 2017). This probably is connected with the environmental factors that shape the behaviour of males and females at turning points in their lives, particularly adolescence (Govender, 2018). Though South Africa's National strategic plan for HIV, TB and STI 2017-2022 stated its primary goal to decrease new HIV infections by more than 60 per cent by 2030, the 2018 annual report showed that there were still 270 000 new HIV infections annually (SANSP, 2018).

To fast track the response to HIV and AIDS, UNAIDS 90-90-90 targets and the universal test and treat strategy has been adopted in South Africa. The 90-90-90 targets strategy is directed at ending the AIDS epidemic by bringing HIV treatment to all segments of the population that needs it (UNAIDS, 2014b). To this end, targets were established for 2020 to ensure that 90 per cent of the population undergo HIV testing and counselling, that 90 per cent of those diagnosed with HIV are provided with sustained antiretroviral therapy and that 90 per cent of those people receiving antiretroviral therapy will have viral suppression (UNAIDS, 2014b). Moreover, there is a need to critique past approaches and interventions to explore the most effective evidence-based HIV prevention strategies, particularly emerging interventions such as oral pre-exposure prophylaxis (PrEP) (Zuma, et al, 2016). Govender (2011) postulates that the response to HIV should review all levels of interaction ranging from the individual, social community and societal factors that influence behaviour change and adoption of health interventions.

Progress on the 90-90-90 targets in South Africa has been positive due to South Africa's large scale antiretroviral therapy programme which is domestic financed (Kharsany et al, 2019). National life expectancy was recorded at 63 years in 2018, a significant improvement from 56 years earlier in 2010 (AVERT, 2018). This data was also corroborated by epidemiological studies published in 2019, which showed the declining share of HIV incidence of young women aged 15-19 years, with declines being remarkably marginal or unchanged among both men and women in other age cohorts (Kharsany, et al., 2019). HIV prevalence, however, remains high among

women overall, with HIV prevalence among women over the same period being nearly four times observed prevalence rates for males. In the same year, at least 69000 young females showed new HIV infections compared with at least 28000 young males, with females three times more likely to contract HIV infections compared with their male counterparts. This difference was observed to be more pronounced among the 10-19 years age cohort, with over 33,000 adolescents contacting new HIV infections in 2018 compared to at least 4500 boys (Kharsany et al, 2019; Govender, 2018). These statistics were largely attributed to social characteristics attributed to intergenerational relationships between older males and young females, with the male category being characteristic of high HIV prevalence, thus driving the cycle of infections (AVERT, 2018). According to the World Health Organisation (year), Africa is the most affected region by HIV/AIDS statistics globally, particularly among young women. Although the number of new infections has declined by over 30 per cent in the past decade, young women in Africa have been observed to exhibit the highest HIV incidence rates (Poku, 2015).

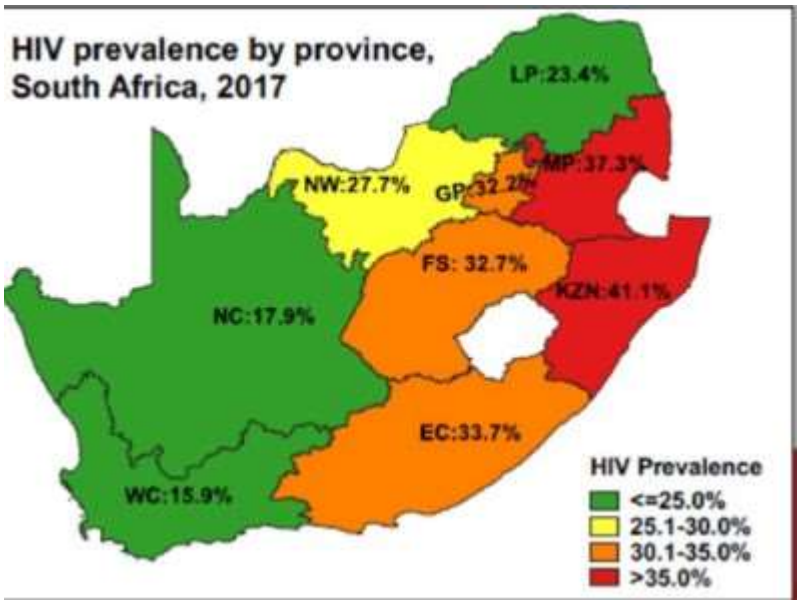
A cross-sectional study of the effectiveness of antiretroviral therapy in reducing HIV incidence in uMgungundlovu district of KwaZulu-Natal in 2015/2016, showed that every percentage increase in ART coverage led to a percentage and a point reduction in HIV incidence (Grobler, et al., 2017). The study also corroborated the UNAIDS with predictive analytics that achieving UNAIDS 90-90-90 targets by 2020 would attain at least 73 per cent viral suppression in the population living with HIV & AIDS and would end the AIDS epidemic by 2030. The study found higher HIV prevalence among women (44 per cent) compared to men (28 per cent), with 31 per cent of men aged 21-33 years and 18 per cent of women aged between 16-20 years self-reporting never being tested for HIV/AIDS. More importantly, the study found that the first 90 per cent testing target, to increase knowledge of one's HIV status was lower in both men and women and is much lower among people younger than 25 years, than among those in older age groups (Grobler, et al., 2017). The need for education and campaigns to promote testing and awareness of one's status, particularly among men was proposed among the recommendations of the study.

Reaching these UNAIDS 90-90-90 goal will be extremely difficult given the currently rising number of new infections. In another study, HIV prevalence was seen to be on an upward trajectory despite active preventative and educational programmes and interventions (Govender, 2018). These rising statistics of HIV prevalence observed in recent studies have demonstrated the need for new HIV prevention strategies that incorporate characteristics of the diverse populations of South Africa if reductions in the HIV/AIDS epidemic are to be achieved based on earlier set projections (Karim & Baxter, 2016).

Arkermaan and De Klerk (2010) have argued that past educational campaigns on HIV prevention have focused solely on using condoms, abstaining from sex, and staying faithful to one partner but failed to take into consideration the reality of women's lives and the environmental factors that make them susceptible. Approximately 20 per cent of South African women in their early reproductive ages (15-49) are HIV positive (STATSA, 2018). The fact that females are mostly exposed to the HIV epidemic has been observed in studies (Vandormael, et al., 2017). Despite attempts to reduce the spread of HIV infections, the HIV incidence has continued to increase particularly among young women in the province of KwaZulu-Natal (Vukapi, 2016: 3). Recent statistics show disparities in the spread of HIV infections within provinces and further age and sex differences were observed in relation to the representation of new infections (Stats SÁ, 2018).

In South Africa, the province of KwaZulu-Natal bears the greatest burden of HIV infections as seen in the map below and in keeping with regional trends, prevalence is higher among African women in the age group between 15–25 years (Zuma, et al., 2016). The spread of the infections differed according to the setting either rural or urban. Geographical differences were found by locality type and by province with rural and informal settlements recording the highest infections compared to urban settings or communities (Shisana 2014).

Figure 2.1 Map: Geographic distribution of HIV incidence in South Africa



Source: National Antenatal Sentinel HIV Survey 2015-2017[1]

[1] https://www.researchgate.net/profile/Selamawit_Woldesenbet2/publication/334883856/figure/fig1/AS:787384

Results in a survey conducted in KZN Vulindlela found that "HIV prevalence was related with ages 25 years or older, incomplete education, lower household monthly income, relationship status, absence of condom use at first sex, a higher number of lifetime sex partners, ever used alcohol, history of pregnancy, and past diagnosis of tuberculosis or sexually transmitted infections" (Kharsany, et al., 2019:6,7). Therefore, a strong focus on intrapersonal, interpersonal, community and health level communication strategies that address the HIV epidemic is vital (Babalola et a., 2017). These factors influence the rapidly growing number of new HIV infections. Given the complexity of HIV infection, it is becoming evident that it cannot be addressed solely from the perspective of an individual through focussing on individualised reasons for HIV infection but there is growing need to adopt a comprehensive approach to dealing with HIV focussing on the social and structural factors (Nota, 2015).

Globally, it has become obvious that HIV/AIDS communication interventions have not been sufficient in addressing health communication during the epidemic (Govender 2011). Recent research focusing on health communication has shifted from focusing solely on behaviour as crucial drivers of this epidemic to a more effective response to HIV/AIDS which inclusively explore the different levels of influence including the individual, social, community and society and move beyond just a narrow focus on the infection (Govender, 2011). Several critics of the predominantly western theories of behaviour change have noted that behaviour change does not occur in isolation but through a comprehensive approach that extends focus from the individual to consider other behavioral influences (Kaufman, et al., 2014; Bello & Ndagurwa, 2019; Vandormael, et al., 2017). Research conducted in the field of HIV has made progress in identifying HIV as not only a health challenge that affects an individual and require individualized interventions but rather as social challenge that requires a holistic approach to address it (Ford et al, 2003).

2.3. Social and behavioural factors that drive HIV infections

The aforementioned HIV prevalence statistics are a product of various social and behavioural factors that give rise to new HIV infections in South Africa. These factors briefly discussed below, pay particular attention to contextual factors that promote the spread of HIV. HIV surveys in South Africa and elsewhere have shown the association between contextual factors and vulnerabilities to HIV (Govender, et al., 2019). This understanding has contributed to the adoption of a comprehensive response which considers the relationship between behavioural,

887152640@1564738594038/Change-in-provincial-HIV-prevalence-estimates-2015-2017-antenatal-survey-South-Africa.png

structural and biomedical factors (UNAIDS 2010b). Some studies conducted in South Africa proposed the presence of multiple sexual partners, unprotected sex, use of alcohol before sex and exposure to sexual violence as among common socio-behavioural factors (Govender, et al., 2019; David, et al., 2002; Bouare, 2009).

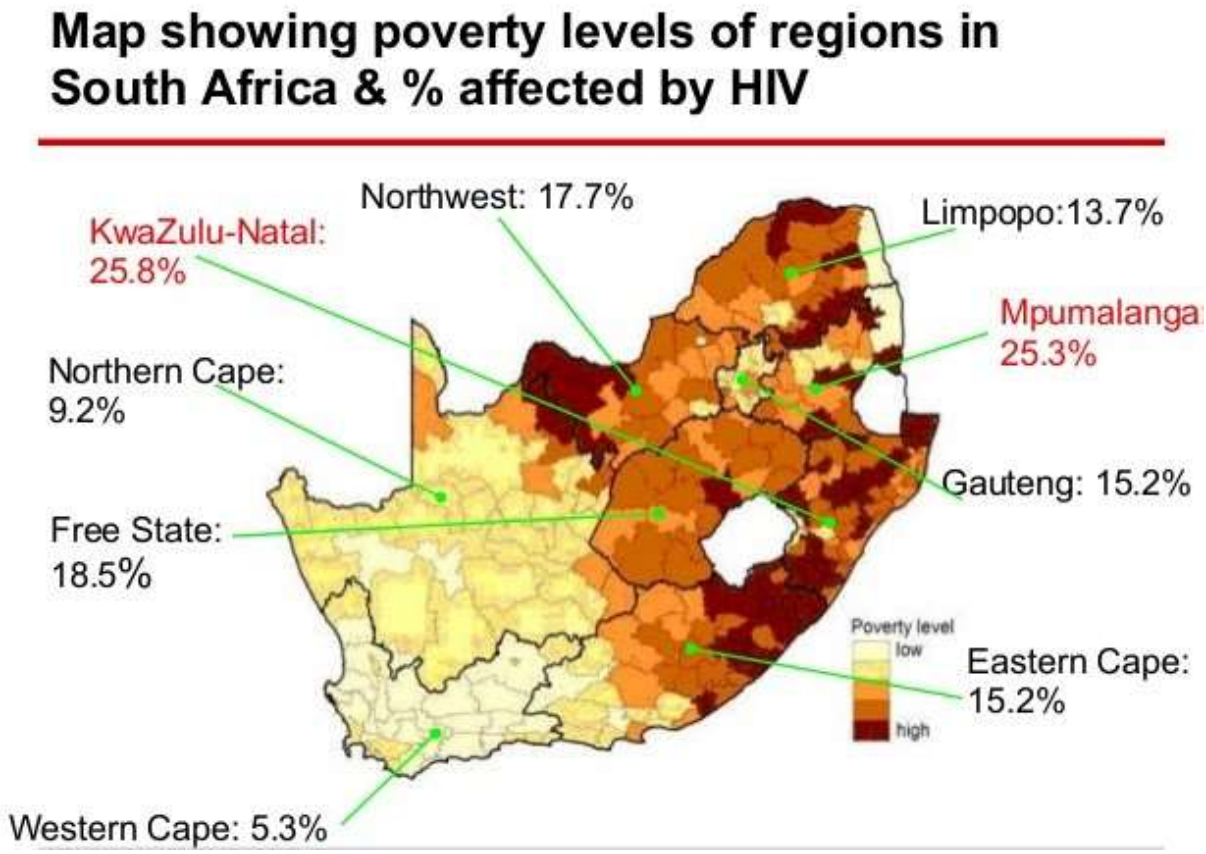
Socio-cultural factors were observed in social norms of institutionalized behavioural patterns that were observed to be supportive of male superiority and sexual privilege, which increases the vulnerability to HIV among adolescents and young adult women (Mabaso, et al., 2018). Empirical evidence has demonstrated that these socio-cultural norms have engendered other vulnerability intensifying conditions such as gender inequities and disparities and unequal power dynamics making females less capable of negotiating safe sex thus leading them to participate in risky sexual behaviours (Mabaso, et al., 2018). Among young adolescent women, high-risk behaviours cementing the observed high HIV prevalence include early sexual debut, limited and inconsistent condomisation, multiple sexual partners, intimate partner assaults, and transactional and intergenerational sexual activity (Govender, et al., 2019; Mabaso, et al., 2018). Other factors are socio-demographic, such characteristics of the population such as gender dynamics, age, marital status and marital composition in the given population, literacy and education level, employment availability and spatial dynamics which determine the aerial socio-economic characteristics, and provide many explanations for the empirically observed differences in HIV prevalence in diverse communities, particularly in the area under study in South Africa (AVERT, 2018; Govender, et al., 2019; Mabaso, et al., 2018).

2.3.1. Poverty

Poverty, the level of subsistence below a defined poverty datum income, which measures an expected basic standard of living, has been instrumental in increasing engagement in risky behaviours such as transactional sex or prostitution among young females (Mabaso, et al., 2018). Govender (2011) suggests that understanding the dynamics of HIV transmission cannot be alienated from a broader context of poverty, inequality and social exclusion. The circumstances of poverty, particularly poverty of long/ extended duration limits the options and depletes the assets available to people, thus subjecting individuals and households to dynamic and multiple vulnerabilities (Kharsany, et al., 2019). Intergenerational transfers of poverty particularly observed among individuals and households in chronic poverty conditions have been associated with the presence of chronic diseases prevalent among which is HIV/AIDS (Veenstra, 2006; Wabiri & Taffa, 2013).

There is strong evidence that HIV-infection rates are increased by structural drivers, food insecurity and informal housing (Cluver, 2016). In South Africa, poverty is linked to various adverse socioeconomic outcomes, such as various forms of community and social exclusion, non-participation and marginalization, nutritional insecurity, poor health outcomes, low levels of human capital particularly education, poor access to modern forms of safe energy, water and other amenities and facilities, residential overcrowding, low income and insecure forms of employment and household fragmentation and other adverse psycho-social issues, heightening individual vulnerability particularly among females (Dageid, et al., 2012; Aliber, 2003; AVERT, 2018). Moreover, chronic poverty incidence in South Africa (see Figure 2.3.1), exhibits an ethnic profile, with the African race group having the highest incidence historically, which has roughly retained its structure even after decades of post-democratic development (Aliber, 2003; Wabiri & Taffa, 2013). This accounts for the observed high prevalence of HIV among African males particularly those subsisting in conditions of chronic deprivation (Dageid, et al., 2012).

Figure 2.2 MAP: Chronic poverty and HIV incidence in South Africa



Source: National Antenatal Sentinel HIV Survey 2015-2017

Empirical studies have shown the continued heightened incidence of HIV and AIDS in the black African population, particularly among the early adult population, with the need for designed

interventions to affect a curtailing of the observed incidence (Steinert, et al., 2016; David, et al., 2002; Tallis & Reddy, 2012; Govender, 2018). Steinert, et al.'s (2016) study also revealed that the prevalence of AIDS illnesses was high in rural areas when compared with urban areas corroborating other study outcomes on socioeconomic influence and HIV prevalence in Southern Africa (AVERT, 2018). This demonstrates that efforts directed at addressing HIV/AIDS that do not incorporate socioeconomic interventions have minimum potency particularly in socioeconomically disadvantaged spatial locations, and this is heightened by the fact that recent studies have maintained the same observations from much earlier empirical studies (Aliber, 2003; Dageid, et al., 2012; Wabiri & Taffa, 2013; Simbayi, et al., 2017).

According to UNAIDS 2019 data for South Africa, the HIV/AIDS incidence rates remain entrenched in spatial dynamics with people living in rural areas and informal settlements exhibiting a higher incidence for HIV and AIDS (Bello & Ndagurwa, 2019; SANAC, 2017). According to Kharsany (2018), a high proportion of households had tangible infrastructure facilities of clean drinking water and electricity yet lacked adequate sanitation facilities in KwaZulu-Natal Vulindlela which has the highest HIV prevalence. These factors might not have a direct causal association with HIV acquisition and transmission but highlight the health and social development challenges facing communities, which could lead to risk-taking behaviours. Major structural and socioeconomic barriers potentially lead to psychological stress, poor living conditions, and disrupted social cohesion within families and communities (Kharsany, 2018).

In the light of the high HIV prevalence and incidence in informal settlements, it was recommended by the government that SANAC and its partners, especially the NDOH and the Department of Social Development, design and roll-out a comprehensive combination package of HIV-prevention and treatment interventions that are targeted at residents of informal settlements. Together with other government departments, SANAC should seek to reduce the poor housing conditions, poverty and unemployment that characterise informal settlement areas and create an HIV-risk environment (SANAC, 2017).

In earlier research on chronic poverty, the gender bias attached to chronic conditions disadvantaged women, who were seen to carry much of the burden of adverse social ills and affected by HIV and AIDS conditions (Tallis & Reddy, 2012; Wabiri & Taffa, 2013). Recent evidence has shown that women are still experiencing disproportionately both the burden of poverty (high incidence of female-headed households in rural and remote South Africa) and HIV infection or living with AIDS (UNAIDS, 2019). Thus, the conditions of poverty and more

importantly chronic poverty in South Africa, have been seen to be influential in the prevalence of HIV/AIDS particularly among the black African population, with a gender dynamic that disproportionately places the burden, both of infections, of living with HIV/AIDS and being affected with HIV/AIDS (living with people affected with it).

2.4. Cultural Factors and HIV/AIDS Incidence

The United Nations alludes the continued high prevalence of HIV/AIDS in African societies and South Africa in particular to cultural practices, prominently gender inequalities, matrimonial inheritance systems in highly conservative societies in rural areas, and other traditional and primitive sexual orientations and customs (Opiyo, 2019). Matrimonial inheritance commonly practised in East African communities in which after the decease of husband, the young widows are married by the husband's brother to perpetuate family line and ensure family upkeep (Bello & Ndagurwa, 2019). While socially/culturally beneficial, in most cases, it has also resulted in HIV transmission particularly where one partner was infected and unknown (Opiyo, 2019), especially among men who statistically show aversion to HIV testing and counselling (Bello & Ndagurwa, 2019).

Polygamy is another cultural practice in which a man marries multiple women and has been closely linked to the high prevalence of HIV/AIDS in Africa in both urban and rural areas. Polygamous relationships have been associated with high levels of partner infidelity when compared to monogamous relationships. This heightens the risk of HIV transmission in a similar fashion to multiple sex partners. The infidelity means that the partners introduce the HIV infection into their marriages, which gets transmitted to all involved partners (Opiyo, 2019). However, from a statistical perspective, the data to cement this standpoint has been inconsistent and sparse, and further challenges by empirical observations from other countries such as Ghana, with low HIV prevalence while reporting higher rates of polygamous marriages (Opiyo, 2019).

The absence of effective discussion on cultural practices has undermined responses and interventions to HIV and AIDS wherever they exist (Klu & Morwe, 2013). To this end, there exists a need for focused discussions to raise awareness of the potency of cultural practices and norms in raising the risk of HIV infection. Culture has been reported in studies to limit the effect of government implemented programmes directed at imparting information sex, sexuality and reproductive health (Klu & Morwe, 2013; Dutta, 2015). While HIV/AIDS is transmitted in various ways, engagement in unprotected sex, particularly in areas riddled with culture averse to medicine and medical interventions in community practices, has been the key factor in the

observed spread of HIV/AIDS in Sub-Saharan Africa (Klu & Morwe, 2013). Efforts directed at combating the spread of HIV/AIDS such as promoting abstinence, faithfulness and condomisation are hampered by certain cultural beliefs and practices which reinforces risky behavioural practices (Klu & Morwe, 2013; Veenstra, 2006; UNAIDS, 2019).

Thus, to be effective in reducing the spread of HIV/AIDS, interventions must necessarily culturally sensitive, as culture defines, regulates and maintains behavioural practices in the contexts of health and HIV/AIDS and sets the standard of what is acceptable and what is not acceptable (UNAIDS, 2019). Cultural practices are generally understood to manifest through ways of life/lifestyle, traditions and beliefs, general representations or understanding of health and disease, sexual norms, values and practices, gender relations, and power dynamics, family structure and arts and creativity (Klu & Morwe, 2013; UNAIDS, 2019). Taking this understanding, more patriarchal societies have been seen to be associated with higher incidences of HIV/AIDS and other related infections as women tend to have limited bargaining power over sexual practices (Bouare, 2009).

Among young adolescents, HIV/AIDS is also driven by peer engagement in sexual practice influence by what is termed the relationship between love-sex and desirability. While, young people are allowed to form intimate relationships by their cultural beliefs, especially in South Africa, where the developmental stage plays an important role in influencing one's sexuality (Lim, et al., 2017). Sex is often viewed as a demonstration of one's commitment among females, while among boys, it is a demonstration of manliness often with grave consequences given the rampant exposure to pornographic material which has been seen to be correlated with engagement in unprotected sex among users (Klu & Morwe, 2013; Lim, et al., 2017). Initiations and rites of passage which are undertaken as indications of maturity have associated challenges, as they normally lead to or expose participants to contracting HIV/AIDS (Lim, et al., 2017). In a 2010 KwaZulu-Natal study, the researchers observed that young females were unable to negotiate safe sex or use of condoms (Dageid, et al., 2012). Other practices women engage in, such as taking various concoctions that are inserted into their reproductive organs to make their vagina's tighter, the immediate danger is that the tightness frequently led to tearing increasing the risk of blood contact during sexual intercourse (Klu & Morwe, 2013). Thus, cultural and contextual factors are also instrumental in increasing the incidence of HIV, and the salience of such is being exacerbated by other aspects such as access to pornography, early sexual engagement among young people, among others.

2.4.1. Intergenerational relationships between older men and young women

Intergenerational relationships between older men and younger women are understood to be driving a cycle of infections (SANAC, 2017). Sexual partnering between young women and older men, who might have acquired HIV from women of a similar age, is a key factor driving transmission (SANAC, 2017). The National Strategic HIV Plan has centred its approach to HIV prevention around interrupting this cycle. Several elements contribute to social factors, which influence women's vulnerability to HIV infection, such as gender violence, limiting sociocultural circumstances, disempowerment and economic vulnerability (Nota, 2015). Women carry the disproportionate burden of HIV prevalence by 44·1 per cent compared with men 28·0 per cent (Kharsany, 2018). Women's susceptibility to HIV infection is due to numerous socio-economic factors including disempowerment and economic/financial vulnerability and biological factors such as women's role in reproduction that increases unsafe sex practices amongst females (Nota, 2015).

Vukapi (2015) stated that most young women get into relationships with older men known as sugar daddies for materialistic life and end up having no autonomy to negotiate safe sex, which leads to a high risk of unplanned pregnancy and HIV infection. Dunkle et al. (2004) as cited in Nota (2015) argues that there is a greater chance for women to become infected with HIV when they are in a relationship that is marked by gender power inequality and who experience sexual violence.

The Human Sciences Research Council (HSRC) (year) further postulate that the community needs to strengthen efforts to alter the widely held community norms that accept gender-based violence. Since age-disparate relationships have been associated with financial gain, it is necessary to ensure that girls and young females are empowered and have access to education and employment to break the cycle of poverty (HSRC, 2012). Negotiating safe sex practices in these conditions become a great challenge for women and consequently, rarely transpires. HIV prevention methods and technologies need to consider these social factors when designing and developing new products or campaigns for women (Nota, 2015). In a survey conducted by Shisana et al. (2014), they found that HIV was prevalent amongst women, and teenage girls aged between 15-19 were most likely to have sex more than their male counterparts, but not with their peers but with older sex partners.

The South African National survey on HIV quoted in Shisana et al, (2012), alluded to the observed among the factors associated with a high prevalence of HIV, age-disparate relationships as a major behavioural risk factor associated with increasing HIV infections (Shisana et al, 2012).

Several studies have suggested for female-initiated HIV prevention methods where women will be able to protect themselves against HIV infections, STIs and unplanned pregnancies (Nota, 2015, Vukapi, 2015). Stoebenau et al. (2011) assert that most transactional sex-based relationships, conventionally are often within the context of highly unequal gendered power and position, indigent women portrayed as victims, resort to 'survival sex' to acquire basic needs. Vicci Tallis (2012: 40) confirms this assertion that context of some sex work in Africa is survival sex, where sex work is a means to make money for women and their families to remain alive. In this way, survival sex is a form of small-scale informal money-making.

In 2016, the government launched a national campaign to try and improve these health outcomes for women. This campaign, 'She Conquers', focused on decreasing teenage pregnancies, preventing gender-based violence, keeping girls in school, and increasing economic opportunities for young women (SANAC, 2017). All of these would protect women from falling into this cycle of transmission.

A study about transactional sex among women in Soweto, South Africa on prevalence and risk factors associated with HIV infection reported the role of transactional sex highly associated with females, who also reported high on the incidence of intimate partner violence by male partners, problematic alcohol and drug use, spatial location and household income dynamics (Dunkle et al, 2004). Women who reported delayed first coitus, being married, or having post-secondary education were less likely to report a history of transactional sex (Dunkle, et al, 2004).

In a study on socio-economic equity and HIV infection incidence and risk, the author found that amongst 3516 adolescents aged 10 to 17 (56.7 per cent female) who were interviewed in 2009/2010 and followed up a year later (2011/2012) were at heightened risk of HIV infection (Cluver, et al., 2016). Within two South African provinces, Mpumalanga and the Western Cape, two urban and two rural health districts found that HIV risk behaviours included 3.3 per cent for transactional sex, 2.8 per cent for age-disparate sex, 14.9 per cent for debut in the past year, 12.3 per cent for inconsistent/no condom use, 2.1 per cent for casual sex, 11.4 per cent for multiple partners, 3.3 per cent for sex while using substances (Cluver, 2016). It is clear from these statistics that the major drives for HIV infection start from an early age not only older people are affected. Campbell, et al. (2016) argues that "Youth need to be singled out as a marginalized group in addition to women and the poor in talking about the role of social exclusion in both facilitating HIV transmission and undermining prevention".

These factors such as the contextual conditions of women (indigence and likelihood to engage in transactional sex), conditions of deprivation or powerlessness, early engagement in sexual activity, the existence of large age gaps between intimate partners all demonstrate the impact of contextual factors in increasing HIV/AIDS incidence. Furthermore, these statistical findings combined with the discussion on cultural factors show that the powerlessness of women can be aggravated in circumstances where cultural norms hold strongly thus putting spatial dynamics into contextual factors and HIV prevalence. This partly explains the high incidence of HIV/AIDS in culturally dense areas such as Vulindlela.

2.4.2. Multiple sexual partners

Numerous sexual partnerships tend to expose individuals to HIV infection by growing sexual networks and having concurrent sexual partners (Halperin & Epstein 2007; Mah & Halperin 2010; Shelton 2009). It has been argued that concurrency does not fully explain the high HIV epidemic in sub-Saharan Africa as concurrent partners do not raise an individual's risk of acquiring HIV any more than having a non–concurrent partner (Lurie & Rosenthal 2009; Sawers 2013; Sawers & Stillwagon 2010). Although the contributory effects of concurrency are diminished in high HIV-prevalence settings, it is still important to decrease the number of sexual partners irrespective of concurrency (Tanser, Barnighausen, Hund et al, 2011). The reduction of sexual partners is crucial in the reduction of the HIV spread (Shisana, 2012).

Sexual behaviour has been identified as a key driver driver of the epidemic in South Africa, and this is informed or influenced by different forces including, individual, interpersonal, cultural and structural (Karim & Karim, 2010). Karim and Karim (2010) further explains that these forces have shaped the way people perceive their choices when it comes to sexual behaviour such as cultural norms, traditions, and shared beliefs that the society has adopted which confer power imbalances along with gender, social status and privilege markers (Karim & Karim, 2010).

The Fifth South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (2017) reported that sixty-eight per cent of young males (15-24 years) with multiple partners reported condom use at last sex compared to 47.3 per cent of females of the same age which shows that females have taken the lead. Among the key populations at increased risk of infection that were reported to have sexual engagements with more than one partner within a period of 12 months, people who use drugs from 15 years of age and above (32 per cent), 32.9 per cent people who take alcohol excessively, 21.1 per cent were African males aged 25–49 years people living with disabilities from 15 years and above represented 15.9 per cent (Shisana, 2012).

Since HIV is spread predominantly through sexual contact, sexual behaviour has been the major research focus. Research has proposed that concurrent sexual relationships those that overlap in time are a major driver of the HIV epidemic in sub-Saharan Africa (Shisana, 2012). Concurrency can drive an epidemic stem from the insight that HIV will spread more rapidly in sexual networks with more partnerships that overlap in time compared to networks in which serial monogamy predominates (Shisana, et al., 2014).

The South African National (2012) survey found higher HIV prevalence and incidence among unmarried compared to married persons. The survey findings suggest that there was a strong association between marital status and multiple sexual partnerships, with unmarried persons having higher rates of multiple sexual partners. Sexual behaviour is the main driver of in terms of age-disparate relationships, 18.2 per cent of sexually active respondents aged 15 and older across the metros reported having had partners at least five years older than themselves in the last 12 months. The finding that key populations who are at higher risk of HIV exposure do not perceive themselves to be at risk and that they continue to engage in high-risk behaviour suggests that SANAC should ensure that targeted interventions are designed and are systematically and vigorously implemented among these groups. To minimise the risk of sexual transmission of HIV, there has been a sustained effort to make condoms accessible through the free condom distribution programme funded by the government. It is estimated that over 399 million male condoms are distributed annually through this programme (Health Systems Trust, 2013; Shisana, Rehle, Simbayi, et al., 2005, 2009; Shisana & Simbayi, 2002).

Studies indicate that HIV in South Africa is unequally spread among these categories or sub-populations: age, sex, race, type of dwelling and province (Simbayi et al., 2009; Shisana & Simbayi 2002). These socio-demographic variables are the main reporting domains for describing the patterns and spread of the HIV epidemic in the country as well as for evaluating the impact of programmatic interventions that have been implemented. For example, by tracking the prevalence of HIV by age over three or more national surveys, it has been possible to show success with some age groups (i.e., children under two years old) where a decrease in HIV prevalence was reported in 2008 as well as in 2017 (Bello & Ndagurwa, 2019). Similarly, the previous surveys have identified their key populations with a higher risk of HIV exposure among whom the country needs to put more focus. These key populations include black African females aged 20–34 years, black African males aged 25–49 years, and those living in informal settlements (Bello & Ndagurwa, 2019).

Recent data on HIV prevalence in South Africa has noted that although HIV affects all races, the most affected are black people compared to others, coloured people follow second on the prevalence but for Indian or Asian and Whites it was less than a percentage point (SANAC, 2017). The 2012 National survey found significant differences in HIV prevalence between people who lived in urban informal areas and those living in the other three locality type. Residents in the rural informal areas have a significantly higher HIV prevalence when compared with those living in urban formal areas because …. (Shisana, 2012). Karim, et al. (2010) argues that the explanation of HIV risk behaviour will not be enough without referring to poverty and social marginalisation which are pervasive factors in the lives of the people of South Africa. The authors also added that theories with a superior ability to identify the factors influencing risk behaviour will lead to more efficacious interventions, developing and applying these behavioural and social theories has a potential to contribute to reducing sexual risk behaviour and improving public health.

2.4.3. Gender-based violence/ Intimate partner violence

Ending intimate partner violence (IPV) and reducing gender inequalities are recognised as critical to "ending AIDS" by 2030 (UNAIDS, 2019). Amongst women, experiencing IPV has been shown to increase HIV infection, reduce women's ability to use HIV prevention strategies and reduce adherence to ART-based interventions (Poku, 2016). Intimate partner violence generally happens within relationships where males are more dominant and women are overtaken by the feeling of continuous fear of the man. Moreover, the evident patriarchal culture is society tends to condone the use of violence towards women as a manner of instilling discipline (Sedaat, et al., 2009). The study by Eaton et al., (2009), further argues that men are mostly perpetrators of intimate partner violence and this behaviour stems from their eagerness to show masculinity and the societal norms that compel them to be superior to their female partners (Eaton, et al., 2014). Karim and Baxter (year: page number) also emphasized on this "although gender-based violence is a violation on women's rights and inequity society condones it because it is rooted from socially acceptable gender inequity and discrimination".

The Human Sciences Research Council (HSRC) postulate that the community needs to strengthen efforts to alter the widely held community norms that accept gender-based violence (HSRC, 2012). A cohort study amongst young women in South African found that relationship power inequity and intimate partner violence increase risk of incident HIV of infection in young South African women (Jewkes, 2010). Universally, it is likely that 1 in 3 females from age 15 and above have experienced gender-based violence in their lifetime (WHO international, 2014 and Palermo, et al., 2014). According to UNAIDS, gender-based violence alone contributes 20 to 25 per cent

of HIV infections (UNAIDS, 2016). Studies undertaken around South African have proven that women from the ages of 14-49 experience violence from their partners hence South African government runs an annual campaign between 25 November and 10 December since 1998 called 16 Days of Activism an awareness-raising campaign that promotes no violence against women and children (Karim and Baxter, 2016). Although there is such an intervention woman still succumb to HIV infections and gender-based violence.

Nota (2015) argues that women continue to carry the disproportionate burden of HIV prevalence because of gender-based violence, despite the sexual and domestic violence legislation South Africa continues to witness the high number of women who are being sexually harassed (raped, forced sex or coerced sex which results in vaginal or anal tearing or bruising. In South Africa, the gendered trends of HIV incidence with women disproportionately affected can be attributed to socioeconomic factors such as high unemployment among females and poverty which results in women dependence on males, as well as gender-based violence and the powerlessness it induces on women. These social dynamics are therefore contributory to the high gender-biased incidence of HIV infection in South Africa, particularly in regions with adverse socioeconomic developments or entrenched in traditional cultural practices (Baxter & Karim, 2016; Dageid, et al., 2012).

Karim and Baxter (2016: page number) also stated that "Studies have shown that women who have been subjected to GBV often adopt risky behaviours such as alcohol abuse, which in turn can lead to more unprotected sex and an increased risk of acquiring HIV". They also argue that women who experience intimate partner violence through inequality and controlling behaviour from their partners increase their chance to be susceptible to HIV infection placing them in an inferior position to have sexual options such as condom use, monogamy and unwanted sex hence they are constricted to control HIV risk (Karim and Baxter, 2016). Women who have been subjected to GBV have been observed to often adopt risky behaviours such as alcohol abuse, which in turn can lead to more unprotected sex and an increased risk of acquiring HIV (Karim and Baxter, 2016).

Jewks et al (2008) assessed the impact of the stepping stones an HIV and intimate partner violence prevention programme which was aimed at addressing the sources of HIV risk rooted in gender inequity to improve sexual health among young women. Furthermore, through building a stronger, more gender-equitable relationship with better communication between partners and to reduce interpersonal violence and frustration in the Eastern Cape where 20 young men and 20

young women between the age of 16-23 from each cluster which compromised of 64 villages and six townships. The assessment concluded that the intervention reduced sexual risk-taking and the perpetration of intimate partner violence among men and did not impact on women's risk behaviour and that the intervention did not reduce the incidence of HIV but had an impact on several risk factors (Maurice, 2014; Mabaso et al., 2018).

2.4.4. Alcohol use

Alcohol consumption is a social problem in South Africa, with a heightened incidence of adverse social outcomes have shown a steady increase for the past decades (Rehm et al., 2003; Ngwenya et al, 2014). Heavy alcohol consumption is also a major health concern in the country (Morojele et al, 2006. Studies have proven an association between alcohol use and sexually transmitted infections including HIV and AIDS in Southern Africa, which is the region that carries the disproportionate HIV burden compared to the whole world (Kalichman et al, 2007; Pandrea et al., 2010; Simbayi et al., 2004). The researchers further articulate that risky sexual behaviour reduction interventions are needed for men and women who drink alcohol or who have partners who drink before sex and that these interventions should target alcohol establishments (Kalichman et al, 2007)

A study in Cape Town for men and women who were attending sexually transmitted infections clinic found that men's sexual enhancement alcohol expectancies were associated with drinking before sex and having sex partners who drank before sex, they believed that alcohol consumption before sex will enhance sexual pleasure (Kalichman et al, 20007). Simbayi et al, (2004), and Mojorelo, (2006) are of the view that there is a strong correlation between alcohol use and sexual risk. Simbayi et al (2004: page number) further held that "Problem drinking was associated with greater numbers of sex partners in the past month, history of condom failures and lifetime history of having an STI, as well as lower rates of practising risk reduction skills".

Extant literature has been consistent on the relationship between alcohol consumption and Shebeen patronage in South Africa, which has furthermore been associated with sexual behaviour (Scott-Sheldon, 2014; Kalichman, 2008; Setshedi, 2011). Scott-Sheldon et al. (2012) found that among drinkers, 60 per cent of men and women reported five or more drinks per occasion at least weekly (Scott-Sheldon et al., 2012). Reports of heavy alcohol use have been linked to greater sexual risk-taking among both men and women in South African townships (Kalichman, Simbayi, Jooste, Vermaak, & Cain, 2008b; Pitpitan et al., 2012b). Research on understanding the high rates of HIV transmission in this country has identified alcohol use as a critical factor in driving the HIV epidemic (Eaton et al, 2014; Cain et al., 2012).

Chersich (2010) also affirms what other researchers have found that South Africa has a massive burden of HIV and alcohol disease, and these epidemics are inseparably linked. Much evidence indicates that alcohol independently influences decisions around sex and undermines skills for condom negotiation and correct use. Thus, not surprisingly, people with problem drinking in Africa have a twofold higher risk for HIV than non-drinkers. Also, sexual violence incidents often correspond with heavy alcohol use, both among perpetrators and victims (Chersich, 2010). People with a drinking problem have a twofold higher risk for HIV than non-drinkers (Fisher, Bang, & Kapiga, 2007). One study has also shown that a history of childhood sexual abuse is significantly associated with problem drinking among South African men (Icard et al., 2014).

2.5. History of Social work

2.5.1 Social Work in South Africa

Social work in South Africa was the only regulated, approved profession addressing social welfare issues since 1937 (RSA, 2006). After 1994 the social development paradigm of welfare was adopted which is a people's-centred approach to social and economic development to redress past imbalances in the country (RSA, 1997). Social work plays a major role in promoting the development and social well-being of individuals, families, groups and communities (RSA, 2006; RSA, 1997). In terms of the South African Council for Social Services Professions code of ethics in South Africa, social workers are directly responsible to all peoples of South Africa. They are guided by values and ethics found in the Social Services Professions Act, No 110 of 1978, they improve social services including prevention, early prevention, statutory, residential and alternative care, reconstruction and aftercare services (RSA, 2006).

"Social workers promote social change, problem-solving in human relationships and the empowerment and liberation of people to enhance wellbeing" (The International Federation of Social Workers, 2001). In South Africa, social workers carry out casework by working with their clients using a multilevel problem-solving approach that empowers the primary client and advances change within the community (Nicholas, Rautenbach, Maistry, 2010). Strug, Grube, and Beckerman, (2002:7) postulate that social workers will increasingly become involved in primary prevention efforts as medical intervention alone is insufficient to prevent new infections. Infected persons will need a wide variety of medical and psychosocial support services as HIV/AIDS becomes a chronic condition for persons living with the disease.

Vourlekis, et al. (2001: page number) stated that "Social work has never been a dominant profession in health care, and therefore understanding our most valuable roles and functions, explaining our presence, and demonstrating our contributions has been, and most probably always

will be, strictly up to social workers". Hence, the term medical social work was introduced in the health care setting which gave social workers a proactive role in health. Social workers in the health care sector are involved in preventive care and promoting health in a medical setting such as a hospital, outpatient clinic, hospice, long-term care facility, or community health agency, their duties include assessing a patient's social, emotional, environmental, financial, and support needs (Nicholas, Rautenbach, Maistry, 2010).

Clinical social workers represent a high proportion of behavioural health practitioners in the nation HIV endpoint-driven clinical trials in Africa enrol women who are at heightened risk of acquiring HIV. In 2017, the South African Medical Research Council recommended the provision of oral pre-exposure prophylaxis (PrEP) in HIV prevention trials, at which time the Evidence for Contraceptive Options and HIV Outcomes trial was ongoing and began to provide PrEP on-site at some trial sites. We interviewed 132 women who initiated PrEP on-site at the Durban, South Africa trial site to explore PrEP use, and conducted phone-based interviews 4–6 months post-trial exit to explore post-trial PrEP access. PrEP uptake was high (42.6%). Among women initiating PrEP on-site, 87.9% felt at risk of acquiring HIV. Most women (> 90%) heard of PrEP for the first time from study staff and three-quarters who initiated PrEP on-site continued at trial-exit. PrEP use declined post-trial exit with more than 50% of women discontinuing PrEP, and barriers relating to access emerged. (Beesham et al., 2020)(Mogorosi, 2018). They are often the first to diagnose and treat people with mental disorders and various emotional and behavioural disturbances (National Association of Social workers, 2005). Social workers and social development practitioners are in the frontline in alleviating the hardships and challenges that people, communities and societies face (Lombard, 2015). According to Hampton et al (2015), "Social workers have an active role to play in helping people at risk of becoming HIV positive be more mindful of how HIV may impact their lives, and better manage that risk by engaging in healthier sexual practices". Likewise, People living with HIV (PLHIV) or people receiving a new diagnosis of HIV can be assisted in attaining optimal wellness goals by being aware of their HIV status, knowing what ART options are available, and how to get the best results from treatment. Internationally, social workers have also played an essential role in developing programs and other interventions to educate others and prevent the spread of HIV (Hall, 2007).

2.5.2. Social Workers and the fight against HIV/AIDS

Social workers provide HIV/AIDS prevention and early intervention services in a range of practice settings, including child welfare, schools, criminal justice, substance use treatment, mental health centres, primary care clinics, hospitals, and private practice (Bencun-Roberts,

2020). Social workers have the skills, opportunity, and commitment to engage clients in HIV/AIDS prevention, care, and treatment utilizing a comprehensive bio-psycho-social approach (NASW, 2015). Social workers have been change agents from the outset, uniquely placed to advocate for social, cultural, and clinical change. Social work profession has been fundamental to the HIV response. In a qualitative study amongst 114 Grade nine learners in eThekwini (Durban), KwaZulu-Natal schools (rural and urban) which explored their experiences on the National Life-skills and HIV/AIDS education programme, learners suggested inclusion of social workers in schools (Ragina, 2011). According to Strug, et al., (2002) "school-based social workers are in an excellent position to work with youth and their parents to facilitate clear communication about sex as a step towards helping adolescents adopt and maintain protective sexual behaviours".

Since the early days of the HIV epidemic, social workers have advocated for clients' rights, participated in policy and program development (Hampton, et al., 2015). Social work practitioners across the nation provide skilled interventions that support the goals of the National HIV/AIDS Strategy: reducing new HIV infections, increasing access to care and improving health outcomes for people living with HIV/AIDS, reducing HIV-related disparities and health inequities, and achieving a more coordinated national response to the HIV epidemic (NASW, 2015). Strug, et al. (2002) suggest that "social workers will increasingly participate in the primary intervention and behavioural change projects aimed at reducing and eliminating high-risk behaviours, particularly in minority ethnic communities. This work will take place more and more at the grassroots level, will be interdisciplinary, and will require role flexibility".

The current HIV/AIDS epidemic in South Africa poses major challenges to all professions and, in particular, to the social work profession. The focus of social work falls on the improvement of the social functioning of people in interaction with their environment. Social work deals with the needs and problems that people experience in their effort to cope with the demands of their environment and emphasise the idea of "ubuntu" (namely that people will always need other people to realise their humaneness and individual potential) (Sheafor, Horejsi & Horejsi, 1994:6 in Potgieter, 1998:27).

2.5.3. Stigma and discrimination

As with other HIV services, stigma and discrimination hurt uptake and adherence to PrEP. In some settings, PrEP is associated with high-risk sexual activity (Beesham et al., 2020). It also has the stigma of being related to HIV (which may also relate to other stigmas, such as homosexuality, sex work, and/or drug use) and the stigma of PrEP being an alternative to condoms (as condom

use is often associated with responsible sexual activity) (Haire, 2015). For these reasons, PrEP uptake may be hindered by fears of being seen as engaging in stigmatised behaviours such as same-sex sexual activity or drug use (Aids Map, 2019).

In serodiscordant couples, its use by one partner may also be rejected for fear it may identify the other as HIV positive. Respondents prioritised HIV serodiscordant couples for PrEP. However, the potential for the stigma associated with ARV use was seen as something that would significantly discourage uptake (Idoko, 2015). PrEP-related stigma has also been reported by trial participants at a range of sites among different key affected populations spanning several countries (Sidebottom et al., 2018). Authorities may also persecute sex workers for the possession of PrEP pills as evidence of sex work (UNAIDS, 2015).

A study of around 240 US-based, HIV-negative, men who have sex with men found that participants who recently engaged in transactional sex were more likely to report that anticipated stigma from primary and casual partners would deter them from using PrEP, suggesting that those who face multiple stigmas may need more focused interventions to enable them to access PrEP (Biello, et al., 2017).

PrEP can offer effective protection against HIV infection and represents an alternative preventative measure that can be recommended for HIV-negative people at high risk of acquiring HIV infection (Sidebottom et al., 2018). Different studies show that the PrEP strategy is effective and safe for the prevention of HIV infection in people at high risk of contagion, such as MSM and TGW, as well as heterosexual adults, partners of infected individuals with HIV and IDU (Haire, 2015). The safety and efficacy for PrEP have been demonstrated since its first approval for use in 2015. Studies conducted at various locations around the world show practical examples of how PrEP can be performed with positive results. Treatment adherence is particularly important to ensure its effectiveness (Mesquita, Costa and Araújo, 2018).

2.5.4. Need for knowledge among Social Workers

According to Zastrow (2004:529), the social worker in the health field requires skills and knowledge about how to counsel people with regards to a wide variety of medical conditions. Social workers need to understand how the clinical trials process works and what they can do to facilitate the process for their clients, whether explaining this option to a client being seen for other reasons or offering screening and counselling during a trial (Eaton, et al., 2014). Social workers provide a service concerning, not only direct casework with patients and their families, but also group work with certain patients, consultation, and training of other professionals.

Strug et al., (2002) postulate that social workers will increasingly become involved in primary prevention efforts as medical intervention alone is insufficient to prevent new infections. Infected persons will need a wide variety of medical and psychosocial support services for long periods. Since HIV/AIDS becomes a chronic condition for persons living with the disease, understanding the contextual circumstances and experiences of people living with HIV and AIDS becomes a key aspect of addressing and treating HIV infection (Iwelunmor et al., 2006; Cloete et al., 2010). Since the emergence of the Strug et al., (2002) study, other research papers have also postulated the existence of socioeconomic circumstances and dynamics that tend limit the impact of medical interventions by themselves in addressing and treating HIV and AIDS (Cloete et al., 2010; Heuveline, 2004; Iwelunmor et al., 2006). Oramasionwu et al., (2011) in a study focusing on environmental and social influences of HIV/AIDS in Sub-Saharan Africa, proposed factors such as diminished labour assets at the household level, chronic poverty conditions as having transformed the structure of many households particularly in the rural areas (Oramasionwu et al., 2011). Strug et al., (2002), argued that changes to social work practice in HIV/AIDS as a consequence of the introduction of novel and more effective medication to combat the disease. A study conducted in 2012 assessing how the role of the social worker had transformed in combating HIV and AIDS in Botswana concluded that the emerging complexity and consequences of the pandemic results in complex implications to every aspect of life of those living with the infection, or living with those infected (Ntshwarang and Malinga-Musamba, 2012). As such the authors proposed that social workers undertake holistic assessments which are directed at assessing the mental, emotional, physical and environmental needs, challenges and successes off their clients, thereby broadening the skillsets required of social workers in combating HIV/AIDS (Ntshwarang and Malinga-Musamba, 2012).

The Botswana study furthermore, suggested that social workers should be employed within the primary health setting to decrease congestion in hospitals and ensure that social workers become more conversant with the cultural issues of local people (Ntshwarang and Malinga-Musamba, 2012). The study also emphasized that clinics are found in most areas of the country as opposed to hospitals which are found in major villages and urban areas. Therefore, posting in clinics will enable them to understand how diverse cultures influence HIV and AIDS issues (Poloko & Musamba, 2012).

Medical social workers often assume the role of educators by providing prior counselling, post counselling and information about the progression of diseases, drug treatment, stress management, positive lifestyle choices and safe sex practices (Kirst-Ashman, 2003). Increased

knowledge amongst social workers about new HIV prevention technologies such as oral PrEP can promote uptake and adherence to oral PrEP as an HIV prevention method. This argument follows from the understanding proposed in a study that oral PrEP should be mediated within a holistic intervention approach, acknowledging other needs of the targeted demographic to maximise acceptability which work social workers are best placed to undertake (Sidebottom et al., 2018). Cowles (2000:133), postulates that for the social worker to claim a place in the interdisciplinary team, the claim must be based on expertise. The social worker in ART settings, as a member of the multidisciplinary healthcare team, should possess the necessary experience, knowledge and skills as well as those skills that distinguish it from the other professions. He/she must possess a clear knowledge base of social work in general, as well as social work with regards to health, HIV/AIDS and ART (AVAC, 2019). Collaborative skills are essential to be recognized and render a meaningful service. Without this expertise, the role of the social worker will be confused with that of other role players.

Research by Wolf & Mitchell, (2002) found that "most of the social workers in the sample provided minimal to no HIV-related services in their clinical practice". Primary care providers who are not familiar with antiretroviral medications, may not feel comfortable prescribing it, thus making it difficult for people at high risk of HIV infection to access oral PrEP Primary healthcare providers need to continuously be aware and well informed about oral PrEP as an HIV prevention method (Wolf and Mitchell, 2002).

According to the South African Council for Social Service Professions (SACSSP), (2015), there are 11 803 registered social workers in South Africa, not all of whom are actively involved in service rendering within the profession or related to HIV/AIDS matters. South Africa has an estimated 5.54 million people living with HIV; of these 5.54 million, 500 000 are estimated to have AIDS and are thus in need of ARV and HIV prevention methods. Without the involvement of the social worker, the patients are denied the specialized knowledge and skills that would otherwise facilitate their treatment (SACSSP, 2015).

In a clinical review, Maurice (2014) alluded to the effective role of social workers who have the opportunity to become involved in mobile prevention outreach projects, and to work alongside other professionals delivering services to groups such as gay and bisexual young men, drug users and their sexual partners, and prostitutes. Prevention effort by social workers and other outreach team members to contact members of high-risk groups such as the homeless, runaway youth or school drop-outs, will increasingly be carried out in such non-traditional social work settings as

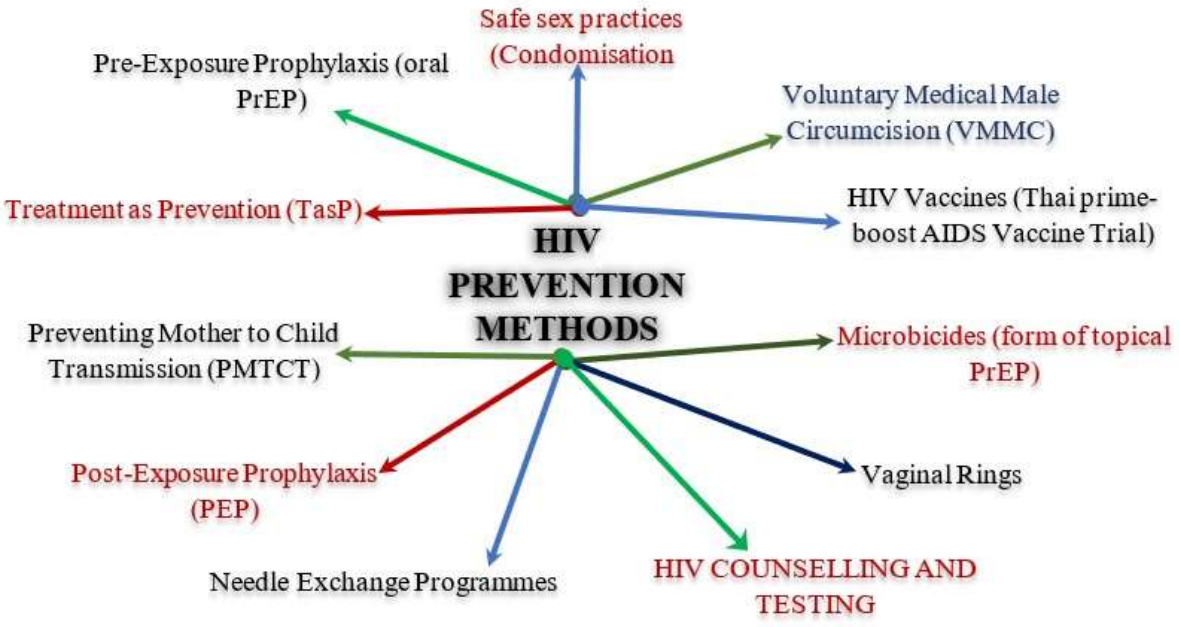
apartment buildings, parks, street corners, and at other public spaces (Sesane & Geyer, 2017; Maurice, 2014).

Having examined and discussed the various roles that social workers undertake in combating HIV and AIDS, and also has highlighted how the role of social workers has evolved with the transition in the medical treatments and prevention methods. This section now turns to a consideration of the various methods for HIV prevention, which are at the disposal of social workers in their day to day work in combating HIV and AIDS in various communities.

2.6. Various HIV prevention methods

Over the past decade the South African government has responded to the epidemic mainly in reductions of risk-taking behaviours which included mass awareness campaigns through media, life skills education, drug risk education and programs to enhance young people's capacity to ask for and negotiate protection (Bello & Ndagurwa, 2019). In combination with health communication, the government has also been focusing on prevention methods that target specific key populations through new strategies such as microbicides, male circumcision, treatment of STIs, male and female condoms, PrEP etc. (Bello & Ndagurwa, 2019).

Figure 2.3 Diagram showing HIV prevention methods



Source: (Tong, Mascolini, & Bass, 2017)

2.6.1. Biomedical HIV Prevention

Biomedical HIV preventative interventions refer to a mix of clinical based and medical approaches to curtail HIV spread and infection (AVERT, 2019). Among these include, male circumcision, condom use, treatment as prevention, preventing mother to child transmission, testing and needle exchange programmes. Medical male circumcision where the foreskin of the male's reproductive organ is cut is efficacious in achieving up to 60 per cent prevention of HIV transmission during unprotected heterosexual sex (AVERT, 2019). Biomedical interventions are more effective when implemented in conjunction with behavioural interventions, and where contextual factors such as cultural context are considered in the implementation of such interventions (Baxter & Karim, 2016). For example, male circumcision's effectiveness can be hampered when males are not made aware of the need for regular HIV testing and receive education and counselling on benefits of condom usage and safer sex practices (AVERT, 2019).

Other researchers and groups list the full range of biomedical interventions as male and female condoms, sex and reproductive health services, voluntary medical male circumcision, antiretroviral therapy to prevent mother to child transmission, pre-exposure prophylaxis, PEP and TasP, HIV testing and counselling, early testing and treatment of sexually transmitted diseases, needle and syringe exchange programmes, and blood screening (Tong, et al., 2017; Warren, et al., 2018; Moodley, et al., 2016). A clinical trial investigating Voluntary Male Medical Circumcision (VMMC) and PrEP, has been shown to have a partial impact in an overall reduction of HIV transmission (Moodley, et al., 2016). The authors also concluded that multifaceted combination prevention methods would be effective in combating the advancement of the epidemic. In South Africa, observational data and randomized controlled trials have demonstrated conclusively that circumcised males demonstrated a significantly reduced incidence/risk of acquiring HIV infection. The studies have demonstrated that VMMC has a strong epidemiological evidence base, its biological basis for HIV prevention has been deemed plausible and it has been seen to be a significantly cost-effective intervention. As of 2012, several studies reporting an observed low coverage rate of VMMC, have reported the potential for significant gains that can be made in the reduction of HIV burden through the increased rollout of biomedical interventions particularly VMMC (AVERT, 2019; Moodley, et al., 2016).

A key factor that surfaces from the various studies considered here is that biomedical interventions have less efficacy when used independently but works best with behavioural interventions rooted in various social and cultural contexts of those targeted. Such behavioural interventions including peer education, mass media communication, school-based sex education

programmes, socioeconomic interventions and behavioural counselling, have opened up greater scope for clinical social work in South Africa, and have been demonstrated to be instrumental in targeted awareness among adolescents and young adults (Baxter & Karim, 2016; AVERT, 2019; Morojele, et al., 2006).

2.6.2 Oral Pre-Exposure Prophylaxis

According to the World Health Organization (2016), oral PrEP therapy for HIV prevention is the daily in-take of drug by individual with a HIV negative status with the aim of preventing infection. Over 10 clinical trials have been conducted to assess the efficacy of using PrEP in the prevention of HIV infections particularly among sero-discordant couples in which only one partner is positive and the other negative, it was also trialed among men who have sex with men, transgender women, individuals elevated risk of HIV infection, and people who inject drugs (WHO, 2019).

In 2015, South Africa was the first African country to approve PrEP as a national HIV program (Avert, 2019). The World Health Organization recommends the use of PrEP among populations at increased risk of HIV infection and it is recommended as part of comprehensive HIV prevention package (WHO, 2007). ARV-based pre-exposure prophylaxis has been demonstrated in a study to have the potential to prevent new infections of HIV in heterosexual sexual partners (Stankevitz et al., 2019). While PrEP is effective and recommended for many people it is more relevant for use among population who are social excluded and tend to face legal barriers to accessing health care or HIV services and these mainly include key populations (Patrick, et al, 2017).

According to the World Health Organization community educators and advocates are needed to increase awareness about PrEP in their communities (WHO, 2017). WHO modules provide up-to-date information on PrEP that should be considered in community-led activities that aim to increase knowledge about PrEP and generate demand and access. Counsellors are required who counsel people as they consider PrEP or start taking PrEP and support them in addressing issues around coping with side-effects and adherence strategies. Those who counsel PrEP users may be lay, peer or professional counsellors and healthcare workers, including nurses, clinical officers and doctors (WHO, 2019).

2.6.3. Groups that are targeted for PrEP

According to the Department of Health (year), oral PrEP should be considered for people who are HIV-negative and at significant risk of acquiring HIV infection. Other people are:

1. Any sexually active HIV-negative MSM or transgender person who wants PrEP

2. Heterosexual women and men who want PrEP

3. People who inject drugs

4. Adolescents and sex workers

5. Especially vulnerable: young MSM and adolescent girls (Mabaso, et al., 2018)

2.6.4. Oral Pre-Exposure Prophylaxis and other medical interventions

PrEP is the first effective biomedical HIV prevention method and indicates a new era of HIV prevention and policy (Ramjee, 2012). PrEP is an HIV prevention method that women can use without a partner's active involvement or consent and has the potential to prevent a considerable number of new HIV infections in women (Stankevitz, et al., 2019). Positioning PrEP with key messages relating to a women's ability to maintain the secrecy of product use, the product benefit of increased protection against HIV infection, and offering enabling opportunities for women who have limited options to reduce their HIV risk of infection can significantly contribute to a women's willingness to consider PrEP (Warren, et al., 2018). This study by Warren et al., (2018) also highlighted institutional limitations in the implementation of biomedical interventions such as readiness of primary health care institutions to provide women and adolescents with PrEP, particularly in those communities exhibiting high HIV incidence. Institutional readiness requires also the rightly trained personnel, such as nurses and social workers to ensure successful implementation of programmes directed at dispensing PrEP to AGYM (Warren, et al., 2018; Moodley, et al., 2016).

Biomedical HIV prevention technologies, such as antiretroviral pre-exposure prophylaxis (PrEP) hold a huge potential to substantially reduce HIV acquisition in high-risk populations globally (Giovenco, 2019). Although many people who could benefit from PrEP are still unaware of its existence hence the need for social workers to raise awareness through education and interventions directed at the socio-structural change in the communities (Giovenco, et al., 2019). PrEP has been shown to reduce the risk of HIV infection from unprotected sex by over 90 per cent, and from injecting drugs by more than 70 per cent (CDC, 2019). Findings from in-depth interviews with female sex workers as part of the Treatment and Prevention for Sex workers (TAPS) Demonstration Project in South Africa, looked at people's lived experiences and perceptions of taking up and using PrEP (AVERT, 2019). A lack of trust in the existence and/or effectiveness of PrEP influenced the motivation of women to access PrEP and to keep using it

(Eakle, 2019). In South Africa, the CAPRISA 082 observational study, which began in 2016 and is expected to be finalized in 2021; targets adolescent girls and women aged between 18 and 30 years and is evaluating demographic data, perception of HIV risk, behaviour and adherence to and acceptability of therapy (Cowan, et al., 2016). PrEP has shown positive results reaching high protection rates both in trials and in real life. More than 15 trials of oral PrEP have shown that, when taken consistently and correctly, PrEP is very effective and reduces the chances of HIV infection to near-zero (Fonna, et al., 2016; Mc Mcormack, et al., 2014; Baeten, et al., 2012; Grant, 2010).

Clinical studies on oral PrEP in 2017 while finding no significant adverse effects for young women taking oral PrEP, also found that there was a significant decline in the use and adherence to oral PrEP on the same group over 12 months (Athena Network, 2017). These findings were important in planning and rollout of oral PrEP because PrEP is only fully effective when it is adhered to exactly as prescribed and also does not protect against other STIs, it needs to be delivered as part of a comprehensive package of HIV/STI prevention services based on an individual's circumstances (Frankis, 2015). These might include condoms and lubricants, safer sex counselling, frequent STI check-ups and treatment and regular HIV testing (amfAR, 2013).

A range of models for delivering PrEP have been proposed, including STI clinics, primary care clinics, and community-based organisations with links to clinics (Norton, 2013; Cohen, 2013; Hosek, 2013). However, each of these options presents challenges. For example, while STI clinics serve a population at risk of HIV infection, most operate on a drop-in or urgent care basis and do not provide ongoing care and monitoring (Norton et al, 2013). Conversely, primary care clinics are experienced with ongoing care but need to be able to identify people eligible for PrEP and offer risk reduction and adherence counselling (Norton et al, 2013).

Skovdal (2019) suggests that to effectively implement biomedical HIV prevention technologies successfully, service planners should not assume that people can make informed and rational health decisions themselves to constantly use and adhere to HIV prevention methods. Skovdal (2019) further proposes that they should consider how factors such as political, social, cultural and ethical issues are influencing uptake adherence on young people. Also, to effectively engage HIV prevention methods, we have to meet young people where they are at and discover underlying issues which impede their uptake and adherence to these technologies. Biomedical approaches, alone, have not and cannot meaningfully reduce the spread of HIV for this priority population. However, incorporating biomedicine into comprehensive prevention programs that

also address structural and behavioural factors, is likely to have a larger impact on reducing the number of new infections in the most vulnerable (Skovdal, 2019).

2.6.5. Male and female condom

According to the World Health Organization (2017), "correct and consistent use of male and female condoms during vaginal or anal penetration can protect against the spread of sexually transmitted infections, including HIV". The World Health Organisation (2017) study further showed that male latex condoms have an 85 per cent or greater protective effect against HIV and other sexually transmitted infections (STIs). While latex condoms have been demonstrated to be very effective, use has been limited by economic considerations primarily. While male latex condoms have been widely distributed, cost of producing female latex condoms and associated higher costs of acquisition has seen unequal distribution between male and female latex condom distribution in South Africa (Tallis & Reddy, 2012).

To minimise the risk of sexual transmission of HIV, there has been a sustained effort to make condoms accessible through the free condom programme funded by the government (Health Systems Trust, 2013). It is estimated that over 399 million male condoms are distributed annually through this programme (Health Systems Trust 2013). High levels of condom distribution have also been correlated with increased levels of reported use of condoms at last sexual encounter in successive national surveys (Shisana, Rehle, Simbayi et al. 2005, 2009; Shisana & Simbayi, 2002).

According to Nota (2015), "even though the female condom was designed to empower women to take the initiative in protecting themselves against sexually transmitted diseases, the lack of access to these condoms has been a very big challenge and almost defeats the purpose of having a prevention method that women can control". Condoms and circumcision are male-centric strategies with little or no decision-making options for women (Kharsany, et al., 2018). They further argue that the main comprehensive packages of evidence-based approaches which are the main tools to reduce acquisition such as constant use of a condom. Male circumcision and knowledge of status, as well as the ARV rollout, have not affected HIV epidemic and therefore PrEP is important because it will provide one of the first opportunities for a high-impact woman-initiated HIV prevention option in this generalized, hyperendemic epidemic setting (Kharsany, 2018).

2.6.6. Voluntary medical male circumcision (VMMC)

Medical male circumcision, when safely provided by well-trained health professionals, decreases HIV risk within men in heterosexual relationships by about 60 per cent. MMC is adopted in many countries as an effective prevention option for men and been proved to be effective in African countries where HIV incidence was high while circumcision completions low (Shisana, et al., 2014).

While male circumcision has been found to reduce the female-to-male sexual transmission of HIV, circumcised men can still become infected with HIV, and if HIV-positive, can infect others. The WHO makes it clear that male circumcision should never replace other known effective prevention methods and should always be considered as part of a comprehensive prevention package, which includes the correct and consistent use of male or female condoms, reduction in the number of sexual partners, delaying the onset of sexual relations, and HIV testing and counselling (WHO, 2007).

A study by Govender (2018) in South Africa sought to assess 'risk compensation' – an increase in sexual risk behaviours and a corresponding decrease in self-perceived HIV risk among young men (16-24 years). It documented the sexual practices of around 500 circumcised and 500 uncircumcised young men in 42 secondary schools in a sub-district of KwaZulu-Natal, an area with a high HIV prevalence. The study found no significant difference between the two groups concerning HIV risk perception, the number of reported sexual partners and condom use. Significantly, only around 39 per cent of young men in both groups reported using condoms consistently in the previous month, underscoring the need to view VMMC as a potential entry point for other HIV prevention and sexuality education interventions (Govender, 2018).

2.7. Conclusion

In conclusion, the literature review has clarified that the prevalence of HIV and AIDS globally and in South Africa, has come with diverse challenges particularly the socio-economic outcomes to the families that are affected by it, low-income families and household. While medical treatment has been instrumental in improving health and extending the productive lives of those infected thus ameliorating the negative psychological, health and socioeconomic outcomes to families affected, preventive measures were seen to be beneficial across multiple platforms at the local, regional and international level. The review of the literature showed that it is fundamentally important to track the spread of HIV and develop new prevention strategies to curb the epidemic.

In South Africa, research on HIV and AIDS has advanced steadily and been instrumental in the effectiveness of current treatment and provision of medicine and treatment procedures. The review of literature also indicated that even though successes have been noticeable in South Africa, high prevalence of HIV and AIDS is still characteristic of some regions and areas, such that better methods of prevention would be much instrumental in curbing this high prevalence. While social workers have been instrumental in South Africa through social engineering programmes and educational campaigns, their communicative role in the uptake of novel methods of HIV prevention has not been sufficiently discussed and researched. In the review, it was demonstrated that with the evolution of modern medical interventions in the treatment of HIV, the role of social workers has also broadened. While these aspects were stated and discussed in the studies, the nature and practice of the communicative role of social workers have not been addressed particularly concerning marginal areas which in most cases may be underserviced. This communicative role of social workers in bringing knowledge to communities and displacing stigma and disinformation within a dynamic environment riddled with socioeconomic circumstances and cultural determinants is the focus of this present study. This is directed at seeking an understanding of how these various factors, those endemic to the social workers themselves as well as those from the immediate external environment mediate to influence the success of social workers advocacy in reception and uptake of modern medical interventions to combat HIV/AIDS.

Chapter 3: Theoretical framework

3.1. Introduction

In this section, the two main theories that are the framework of this research study are presented and discussed and these are The Culture Centred Approach (CCA) and the Social Ecology Model of Communication and Health Behaviour (SEMCHB). The CCA focuses on the application of cultural variables in health communication, to develop more effective health communication solutions (Dutta, 2015). The SEMCHB is based on the understanding that there are social variables that affect health outcomes, termed, the social determinants of health, which are shaped by the social, economic, political and environmental factors that define human community ecology. The SEMCHB offers a framework for thinking and understanding how these social determinants of health influence and maintain health outcomes. This framework also explains how interventions can be shaped and how social problems are produced and maintained within and across various social sub-systems (or that, an individual's health decisions and behaviour is a function of their interactions with their social and physical surroundings) (Max, et al., 2015). These two theoretical approaches are outlined and discussed with an explanation of

how they are used in this study. The chapter progresses as follows: the CCA is outlined and discussed, followed by the SEMCHB and then the application of these theories to this present study is outlined.

3.2. The Culture Centred Approach

The CCA to health communication is based on the argument that health challenges in the world can only be understood in the context of the various structural inequities and conditions that constitute those observed health experiences and outcomes (Dutta, 2015). It represents a complete overhaul in thinking about health communication moving communication from a message based behavioural (top-down approaches based on universalist assumptions about health outcomes) approach towards one premised on community advocacy and/or building communicative infrastructures (Dutta, 2017; Dutta, 2015). This approach places the cultural context and cultural practices at the centre of health discourse. It argues for the creation of avenues for cultural voices to provide articulation about their health demands and needs. Essentially grounding health discourse and outcomes in culture means that when establishing avenues for cultural voices, those are engaged with what is understood in terms of signs, existing evidence and overarching structures and finding sites of community organizing to best organize requisite institutions and structures to enable the health of target communities (Dutta, 2015). Privileging the narratives that emerge through conversations with members of marginalized communities, this theory highlights the interaction between culture, structure, and agency. The culture-centred approach to health communication satisfies the interactive and integrative programme by emphasising the voices of cultural participants and by offering community engagement as a key building block for developing interpretive frameworks and health communication applications (Dutta & Basu, 2007; Ford & Yep, 2003).

Culture centred approach suggests that to gain insight or understanding of a community the researcher should initiate dialogue and give voice to cultural members of the society who have been previously silenced (Dutta, 2008). The theory also underscores the importance of participation by community members in identifying health problems as a first step towards achieving meaningful change to members of the community. Therefore, spaces of communication to foster dialogue need to be created and sustained (Guha 1998; Guha and Spivak 1988). The culture-centred approach presents a shift in the role a researcher plays from being an interventionist who alienates himself from the community by planning and executing a project to a listener and a participant who also engages in the community dialogues together with the members of the community (Dutta, 2008). Freire (1970:46) further articulates, “Being dialogic is not invading, not manipulating, and not imposing orders. Being dialogic is pledging oneself to the constant transformation of reality”. Dutta also validates the point Freire made by adding that a cultured centred approach seeks to narrate these dialogues to achieve social change by listening to the voices of those marginalized into the discursive space (Dutta, 2015).

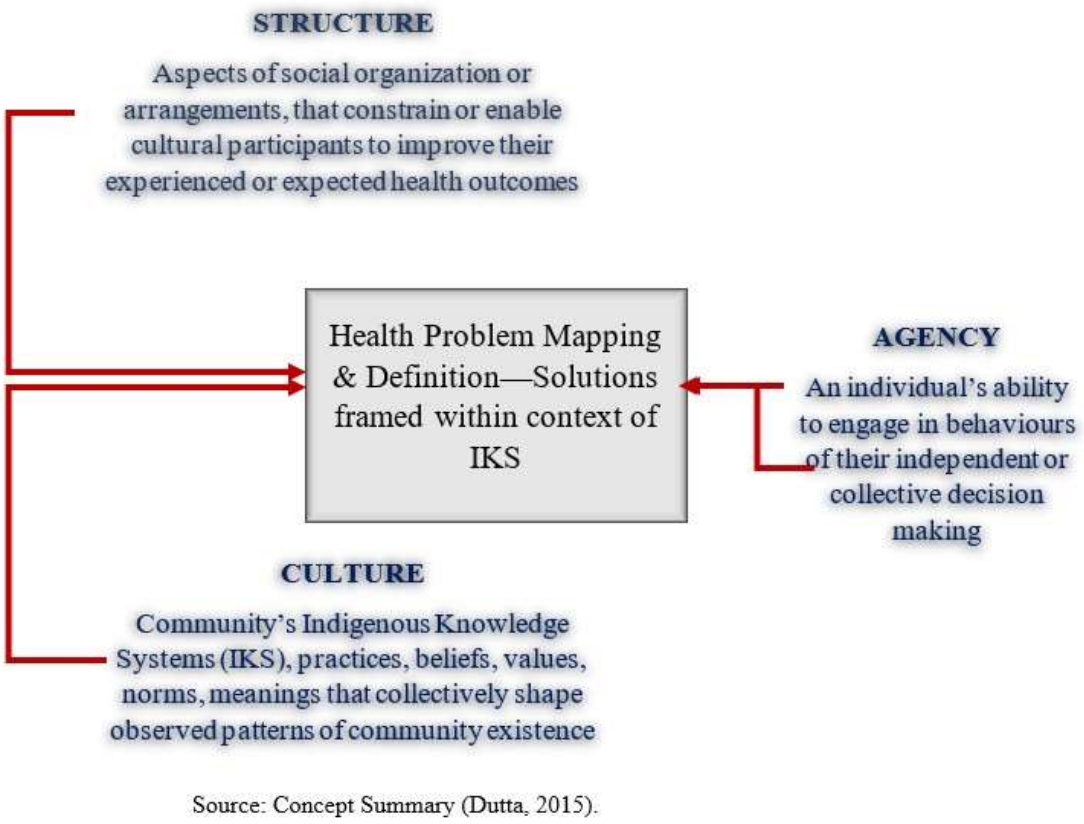
Cultural participants can actively engage and identify critical problems to their communities by engaging in dialogues and the outcome mapping of the critical problems drive the formulation of solutions and

interventions instead of the problem being defined by external entities. The engagement of community participants provides space for participation of subaltern participants, who reside outside common power conclaves or hierarchical structures, thus resulting in a holistic conception of the experienced health problems within a given community. The CCA attempts to afford space and voice to the communities in order to better understand health issues within localised contexts and the community members themselves being active in the (Dutta 2015). Furthermore, Dutta (2015) notes that engaging subaltern voices are a way of writing health communication from an alternative perspective, demonstrating the gaps in current theory and practice and showing alternative strategies that might be adopted in health communication as those emerging from the dialogic engagement with communities.

The emphasis on the culture centred approach is on creating a communicative space for dialogue with subaltern participants and not representing the subaltern position of being a spokesperson but rather the CCA builds on dialogue between the researcher and the community being researched (Dutta, 2008). Instead of attempting to provide solutions through interventions, the culture centred approach focuses on gaining a sense of understanding of subaltern perspectives based on these dialogues with the community. The researcher is as much a part of these dialogues as are the subaltern participants, she/he engages in dialogue with, as it is through engagement that the CCA perspective brings about an understanding of how health meanings are constructed in communities.

These ideas can be summarized as presented in the conceptual construct figure 3.1 below:

Figure 3.1: CCA Conceptual Summary



Source: Concept Summary (Dutta, 2015).

The importance of understanding health in the context of culture is stated in Dutta (2007), where the author proposed that health is a cultural construct and consequently health theorizing and practice must be grounded in cultural codes and meanings, inherently connected to values. These values were observed to be important as they define the transient framework of an individual's everyday existence. Embedded in and influenced by these underlying values are the notions of community rules, traditions, health beliefs, socioeconomic ability, societal power arrangements, education, religion, spirituality, gender dynamics and exposure (Dutta, 2015; Dutta, 2017). Helman (1986) in Dutta (2015) proposed that beliefs and practices related to health in every human society/community form the central features of that culture and both the conception and presentation of illness and how people respond to it, are largely determined by socio-cultural factors (Dutta, 2015:15).

Conventionally, cultural differences were conceptualized and understood as barriers to effective health communication efforts, and against this understanding, the prospective health communicator's challenge was to develop communication systems that would address these perceived barriers and overcome them. The CCA moves away from this perspective, and places upon health communicators the challenge of identifying barriers to effective health communication and consequently incorporating these into

successful messages that would target these identified limitations (Dutta, 2015). To effectively accomplish this synergy and integration, the CCA proposes that the prospective health communicator must understand the immediate structures, decision making power of the agencies and the associated culture and integrate these in designing interventions aimed at communicating health-improving solutions to the recipient communities.

3.2.1. Structure

Structure as a construct of the CCA "looks at aspects of social organization that constrain and enable the capacity of cultural participants to seek out healthy choices and engage in health-related behaviours" (Dutta, 2008). Structure refers to services that are crucial to addressing health challenges within communities these include the availability of health services, access to transport, access to food and others (Dutta, 2008). It is greatly linked to tangible resources and how they are accessible to the local communities in easing the process of healthcare access and behaviour change (Dutta, 2008). In addition, structure influences the allocation of resources within communities' thereby decreasing accessibility of services to community members. Marginalized community members do not have access to resources and lack thereof translates to reduced access to services which generally favours economically viable communities and individuals. As a result of this, members of poor communities have limited power and say over the social order (Dutta, 2008). The voices of people from these communities are usually suppressed and not allowed space to participate in issues that involve their own well-being. Drawing from these challenges faced by subalterns within their communities, the CCA proposes or adopts an approach that gives value to the voices of the subalterns and making them active participants in issues that affect them. Structure refers to organizations and systems that determine how society is organized, how it functions, and who gets access to healthcare services. Structure refers to organizations and systems that determine how society is organized, how it functions and who gets access to healthcare services (Phiwe, 2019).

3.2.2. Culture

Culture refers to the dynamic interplay of meanings created by members of a community. Culture determines how people define and understand the illness, health, and wellbeing are influenced largely by their cultural context. "Culture provides the context of life that forms knowledge-making, observations, sharing of meanings, and performance changes" (Dutta, 2011). Obregon and Airhihenbuwa (2000), postulate that culture is people's ability to control/dominate their environment. The CCA recognizes culture as the strongest framework for providing the context of life that shapes knowledge creation, perceptions, sharing of meanings, and behaviour change (Dutta, 2011). Within the CCA, culture is framed concerning the context in which individuals come, the emphasis is on the importance of the day-to-day practices of individuals and how they interpret health. CCA acknowledges the importance of designing culture-specific health programs, compatible with the culture and lifestyles of the recipients.

3.2.3. Agency

Agency refers to the ability of human beings to relate to structures to produce meanings (Dutta, 2008). Such meanings provide scripts for marginalized individuals interacting with the structures to sustain and transform them. Agency is an active procedure through which individuals, groups, and communities participate in actions that trial the structures that contain their lives (Dutta, 2008). It is through the agency that cultural members can participate in influencing health communication strategies, providing health care that caters to everyone. Participation requires an active voice and dialogue, which is fundamental to CCA. Agency is the ability of members of a community, groups, or individuals to participate in a variety of actions to challenge the structures that constrain their lives (Dutta, 2008).

3.3. Applying the CCA to the study

The three components of CCA, these structure, agency and culture, uncover the bankruptcy of behaviour change models; the lack of understanding that preventing HIV and AIDS is based on cultural norms, which often reconcile individual decisions in ways the individuals, may not continuously comprehend (Obregon and Airhihenbuwa, 2000). Therefore, culture-centred approaches to prevention, care, and support are increasingly recognized as an important strategy (Airhihenbuwa and Webster, 2004). This is the premise from which this study finds the CCA relevant, as it involves the active participation of those who wish to bring about change within the different communities. This study explores the role social workers play around the issues of HIV prevention linked to high rates of new HIV infections amongst key populations, especially in KZN Vulindlela. The CCA thus becomes relevant for its cultural perspective as it can enhance social workers' capacity to engage, from their own experiences and opinions about Oral PrEP and high rates of HIV infection.

The underlying objective is to use the CCA as an entry point to gain a deeper insight into the perceptions and perspectives of social workers positioned in Vulindlela on their perspectives on HIV infections and prevention methods and how they would go about to introduce and promote PrEP to their clients in the community of Vulindlela, KwaZulu-Natal. Based on the evidence that documents the effectiveness of pre-exposure prophylaxis (PrEP) as a method for reducing HIV infection, the culture-cantered approach (CCA), a community based dialogically driven participatory health communication framework, is offered as a lens for understanding the role of communication about PrEP in underserved communities that bear disproportionately higher risks of HIV infection. In the realm of PrEP program implementation in marginalized communities, the commitment to dialogue calls for opening up participatory spaces that are transparent and accountable to community members because of the continual sharing of evidence on the benefits, risks, side effects, and costs. The community-wide sharing drives reflexivity, referring to the continual evaluation of key decisions in the backdrop of the ongoing evidence, and evaluation of evidence as it keeps emerging through the participatory processes.

Given the potential for PrEP as a prevention strategy among high-risk populations, it is important to consider its value for communities that have been marginalized systematically such as sex workers, Men

who have sex with men (MSM), and injecting drug users. CCA notes that the erasure of materially disenfranchised communities from communication infrastructures lies at the heart of health disparities. CCA suggests that the discussion regarding the effectiveness of PrEP for a specific marginalized community needs to rest in the hands of the community in conversation with other stakeholders and based on evidence. Therefore, not only is it important to consider domains of access to scientific health information among underserved communities, but it is also important to build local capacities for community participation in scientific decision-making processes.

Therefore, the costs, risks, and benefits of PrEP provision in addressing disparities in HIV infection can be evaluated meaningfully by fostering participatory spaces for engagement with communities in evidence-based science. Building community capacity to engage with comparative data on effectiveness, risks, and costs for guiding community decisions is an essential first step. These community-driven participatory strategies may be utilized in local as well as national networks of decision-making.

Empowerment is also a critical factor that can either limit or enhance agency. In line with this study, the key demographics (disempowered people such as women and adolescents) which according to the statistics in KZN are at greater risk of contracting HIV will be empowered by receiving Oral PrEP and receive extensive counselling from social workers to know their strength, to exercise agency by protecting themselves against infection. However, if people at risk are not empowered to exercise agency, they will remain vulnerable to HIV infection. Vicci Tallis, (2012:52) states that "an empowered person can make free and informed decisions, and act according to these decisions". Therefore, empowering people at high risk of HIV infection to exercise agency and be able to take Oral Prep and protect themselves from contracting HIV will inform their decisions within sexual relationships, contextual and cultural factors that hinder participation in communication strategies. It will also encourage young women who are also the most vulnerable to HIV infection to negotiate structural factors that are a barrier to exercising agency.

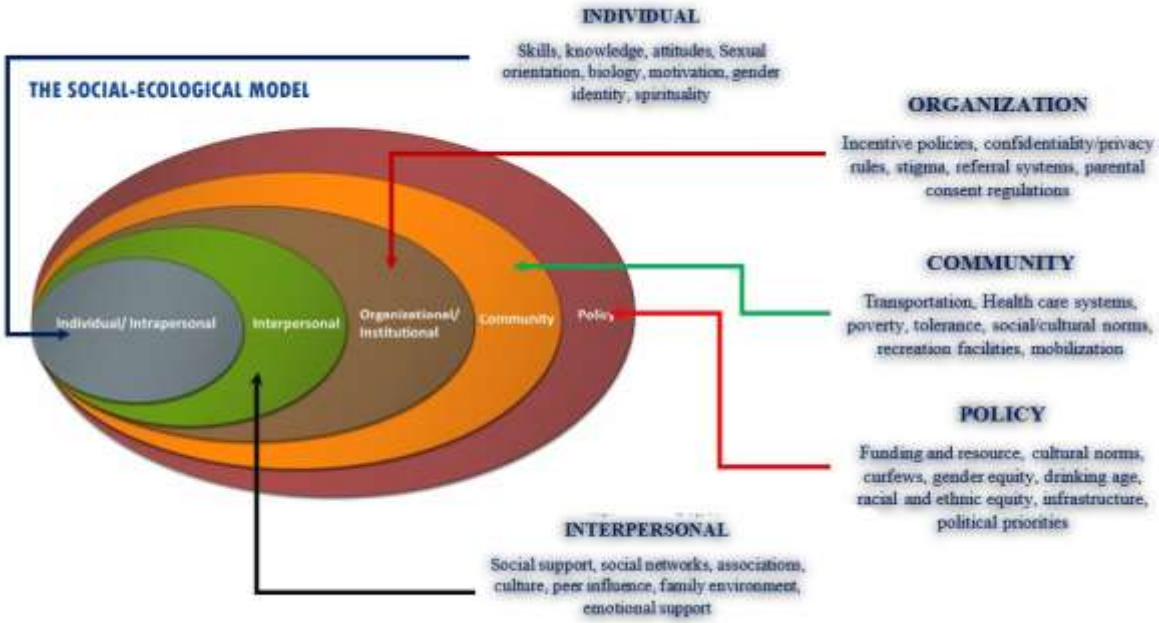
3.4. The Social Ecology Model of Communication and Health Behaviour (SEMCHB)

As postulated in the introduction, the SEMCHB (termed Socio-ecological model here-to-fore), centres on the existence of observed social determinants of health within human ecological arrangements. The Socio-ecological theory enables the exploring, understanding and addressing of social determinants of health at various levels. The Socio-ecological model thus encourages researchers to move beyond a focus on individual behaviour and towards an understanding of the broader factors that influence community health outcomes. The social determinants of health refer to the circumstances or conditions in which people are born and raised, live and work and the arrangements established to support health care. These circumstances are shaped by the wider social, economic, political, technological and environmental forces and their associated processes (Max, et al., 2015).

The Socio-ecological model provides a framework for understanding how the social determinants of health influence and maintain health and issues related to health outcomes. Understanding these aids decision-makers, and planners in identifying promising points of intervention and yields a better understanding of how social problems are reproduced and sustained within and across diverse sub-systems. Thus, the observed high incidence of HIV/AIDS in Vulindlela can be analysed within the broader framework of the broader forces that influence observed and expected health outcomes. The Socio-ecological model as such focuses on the development of strategies to address the social variables that affect the health of the community/population under consideration (Max, et al., 2015).

The socio-ecological model takes into consideration the operation of different forces at different levels of human existence: thus, it is proposed that the contextual forces that shape social determinants of health for adolescents are different from those that shape health outcomes for the elderly. The socio-ecological model demonstrates that behaviour is the outcome of knowledge, values and attitudes of individuals as well as associated social influences such as relational influences (interpersonal), institutional arrangements and the nature of communities where people inhabit. Thus, at the heart of the socio-ecological model is the conception that there are environmental and external influences that shape, interact with and affect observed or outcome human behaviour. In other words, specific environmental and external forces can be associated with specific observed individual behaviours (Ngwenya, et al., 2014). Since significant and dynamic interactions exist among these different levels of determinants of health, interventions will likely be more efficacious when they address these determinants at all levels. In the socio-ecological model, individual health status behavioural outcomes are influenced by factors such as public policy, immediate community, institutional factors, interpersonal and primary groups and intrapersonal factors (Ngwenya, et al., 2014). These aspects are summarized in the figure 3.2 below.

Figure 3.2: The Socio-Ecological Model



Source: Adapted from McLeroy, Bibeau, Steckler (1988) & modified by Researcher

3.4.1. Understanding the elements of the socioecological model

Intrapersonal factors are characteristics of the individual which shapes and influences how the individual responds to stimuli in the external environment. These individual factors are knowledge (what is known and aptitude to learn and experience new things), individual's attitude, observed behaviour, the conceptualization of the self, skills and developmental history. These factors influence the mental and response configuration of the individual, the internal mechanism or apparatus with which they respond to the information that is introduced externally (Obregon & Waisbord, 2012). To these can also be added factors such as one's gender orientation, religious identity, racial/ethnic identity, sexual orientation, economic status, values, life goals, expectations, age, genetics, resiliency, time management skills, coping skills, health literacy and accessing health care patterns and stigma of accessing counselling services (Ngwenya, et al., 2014). These factors makeup and define, what is termed the social context of intrapersonal health outcomes and affects health choices by influencing how one perceives the range of options available for health improvement or maintenance.

Interpersonal factors, processes and primary associations refer to formal and informal social arrangements and groups and social support systems that include family, workgroup and friendship networks that form the larger immediate context within which individual behaviour is deliberated, shaped, co-constructed and influenced either for good or bad outcomes (Obregon & Waisbord, 2012). It includes immediate collectives such as roommates, supervisors, resident advisors, rituals, customs, traditions, economic forces, diversity, athletics, recreation, clubs etc (Poux, 2017). These relationships and social networks

that an individual participates in have a great influential role in shaping their decision-making processes that affect/influences observed individual behaviour. This sphere referred to as the exosystem does not directly influence the individual but exerts both negative and positive interactive forces on the individual such as social networks and community contexts (Kilanowski, 2017).

Institutional factors are influences on individual behaviour stemming from social institutions with organizational characteristics and formal (or informal) rules, policies, regulations and legislation for operations. In other words, institutional factors define the legislative environment within which behaviour is expressed. Factors within this environmental can include, campus climate (tolerance /intolerance), financial policies, class schedules, competitiveness etc (Kilanowski, 2017). Institutions or organizations are instrumental in the shaping and development of behaviours as they often enforce behaviour determining regulations and restrictions (Poux, 2017). For instance, schools control the dissemination of knowledge and this influence is vital when it comes to communicating information about safe health practices (Max, et al., 2015).

Community is concerned with relationships among organizations, institutions and informal networks within delimited and defined boundaries. Thus, the focus is placed on spatial location within the community, the built environment, neighbourhood associations, community leaders' type of businesses, commuting, transportation and recreational centres (Poux, 2017). The focus as such is between networks across organizations and institutions that make up the greater community. Such institutional or community structure is important in determining how populations behave and what customs are commonly practised. It is this of importance to understand institutional or community-level factors to determine the source and origin of health behaviours (Poux, 2017).

Public policy is concerned with the local state, national, regional, inter-regional, global laws and policies. The sphere of the public include such factors as a resource allocating policies to establish and maintain coalitions that serve as mediating structures linking individuals and larger social environments. Some policies are behaviour restricting, such as tobacco and alcohol restrictions and sale thereof in public spaces, and those that incentivize behaviour, both adverse and affirmative such as increased taxes on alcohol and cigarettes. Other policies may relate to social injustice, violence, green policies, the national economy, global warming and foreign affairs (Kilanowski, 2017). The importance of these policies lies in their capacity to impact large numbers of people, and are of longer duration, and involve substantial commitments of resources and political will, consider for instance the policy directive to provide free condoms across South African provinces (Ngwenya, et al., 2014).

3.4.2. Applications and limitations of the SEMCHB

The model allows researchers to understand the multi-environmental contexts that shape human behaviour and so provides important tools to understand the ways individuals interact with their communities and environments (Poux, 2017). Thus, the model explains observed individual behaviour as the outcome of

the various processes and characteristics of individuals, communities, nations and levels between these. In examining these levels and their associated interactive mechanisms and overlap, public health experts can generate strategies to promote individual well-being. The socio-ecological model makes it clear that interactive levels overlap which discourages the implementation of independent interventions. However, the model makes it clear that those interventions that encompass and target a broader range of perspectives provide the best public health strategies. Public health organizations may thus be limited in their capacity to promote healthy habits in a community if they do not account for other factors that influence the behaviour of the community as a whole. The socio-ecological model thus acknowledges and emphasizes the main influences on health service utilization behaviours (Ngwenya, et al., 2014).

The major limitation of the socio-ecological model however is that it focuses on the interpretive role of the health expert to make sense of observed behaviour in designing societal health interventions. Thus, there is a heavy reliance on expert knowledge, and while yielding a broader understanding of the multifaceted factors that influence observed social behaviour, the social participants themselves seem not to be considered in shaping health interventions and communications that affect them (Ngwenya, et al., 2014). Furthermore, the model lends itself to inferential analysis, in which specific aspects of the overlapping spheres and levels are considered, one can make inferences about individual behaviour, characterized by broader mechanisms and processes operating at various levels (Poux, 2017). However, these inferences can be important if the knowledge thus gained can be employed in aiding the implementation of frameworks that integrates community participants in shaping health interventions that affect them. It is against this background that this study combines the SEMCHB and CCA models to understand how health communications and interventions can be effective in changing individual and collective health outcomes. Yet despite these limitations, the SEMCHB describes the complexity, interrelatedness and wholeness of the components of a complex adaptive system, rather than just particular components in isolation from the system. The model also implies that if the individual change is facilitated and supported by social changes at higher levels, it has a higher probability of being self-sustainable. Individuals who seek to operate against prevailing norms, who attempt to change without support (social capital) and complementary change from family members or immediate social systems or who defy local community leaders or power brokers will find it difficult to maintain new behaviour even if highly motivated to change (Obregon & Waisbord, 2012).

3.4.3. Utilization of Socio-ecological model in empirical studies

Storey and Figueroa, (2012) argue that early modern history of communication theory including its application to health issues overemphasized individual-level behaviour change. Studies examined presented a lack of attention to structural factors in social change (Obregon & Waisbord, 2012; Kilanowski, 2017). In response, more structural orientated theories of change have arisen and have led health communication practitioners to account for all levels of social engagement from individual action to structural change and interactions among them, meaning that they can no longer attempt to understand

the behaviour of individuals without accounting for the context of the individuals (Storey and Figueroa, 2012). In the present, it can be agreed that in this strand of thinking, social workers in Vulindlela must have an understanding of structural factors that affect and determine the individual behaviour of their clients.

Psychosocial theories such as Albert Bandura's (1977) Social Cognitive Theory (SCT) were used in interventions and behaviour change programs; however, they overemphasized that the individual factors only were responsible for accounting for the observed individual's behaviour. Although research confirmed the prognostic values of these theories, it became clear that there were omitted theoretical elements, notably community-level processes, and how they contribute to health outcomes (Storey and Figueroa, 2012). This clarity led to the introduction or rather the integration of ecological models into behaviour change programs. The SEMCHB is a model that recognizes the relevance of dialogue and context when one wants to understand the behaviour of individuals.

The SEMCHB was developed in the 1960s and 1970s; it was applied in campaigns concerning the harmful effects of tobacco (Sallis et al., 2008; Stokols, 1996). To understand the model, it is significant to firstly understand the terms that describe it. In turn, when studying how individuals live and interrelate within the environment, they find themselves, the term ecology is applied. The relationships and interactions of individuals vary from one environment to another, and this is what makes the SEMCHB a multidisciplinary meta-theory. The term social ecology is used to concentrate its attention on the social and physical settings contextualizing behaviour as well as the interplay between human actors and exterior factors modelling their agency (Panter-Brick et al., 2006). The purpose of social ecology viewpoints is to observe relations among people within their social and physical settings, over time and across several levels of analysis: personal, familial, cultural and institutional (Panter-Brick et al., 2006).

Behaviour change has proven over the decades to be a complex phenomenon that has caused great reservations in the field of health communication as to how to approach it. To be successful, interventions and health programs that aim at specific behaviour change should look at past interventions and where those interventions have lacked. This should reveal what it is that leads them to unsustainable behaviour change. Looking closely at past interventions, it is evident that they aimed at addressing health issues at the individual level, without carefully studying the environment and the context in which people come from. These interventions did not consider factors that influenced an individual, but rather the focus was retained on bringing change in behaviour through educating people; this is substantiated by Fourier (2011), stating that information alone does not guarantee development.

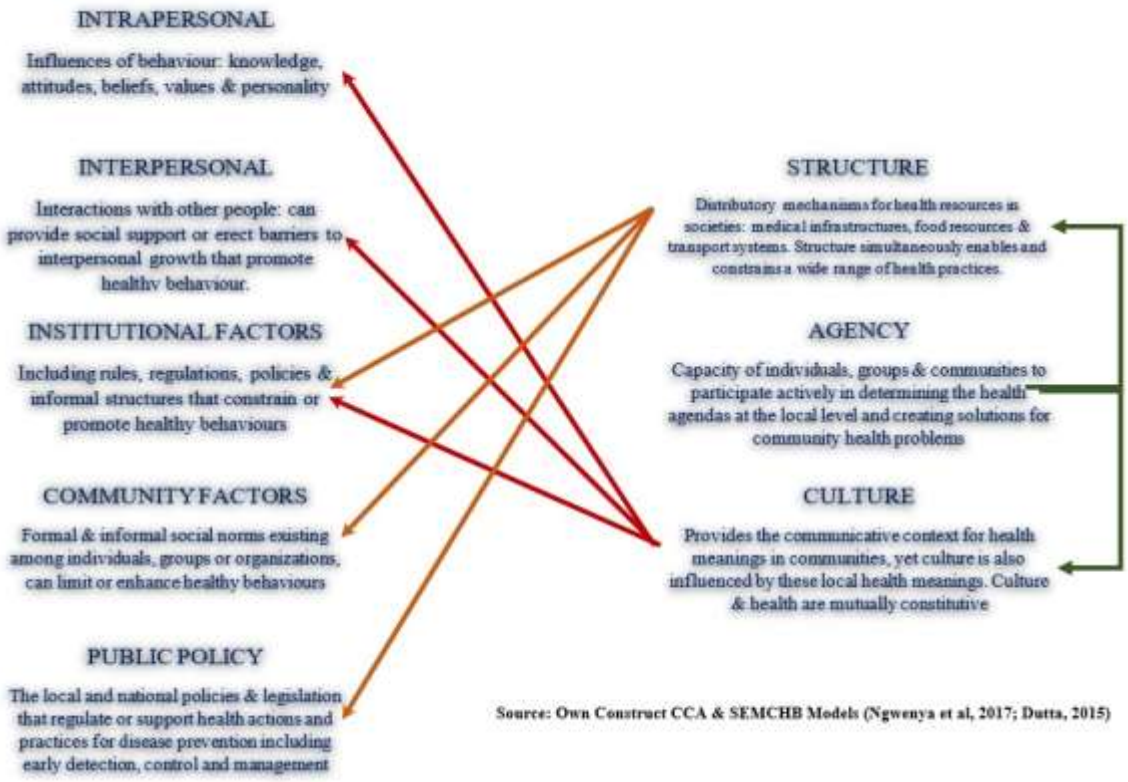
The issue of context has been a determining factor that leads to past interventions and health campaigns that were aimed at behaviour change, to be ineffective. Nevertheless, it is important to note that the SEMCHB as a framework can also be adopted by the HIV prevention campaigns that seek to address not only behaviour at an individual level but to also understand the context of the individual. Hence, this study

investigates how social workers facilitate change on their clients as well as on structural factors, which can hinder Oral PrEP uptake and adherence. The SEMCHB labels the density, interrelatedness, and totality of the components of a complex adaptive system, rather than just particular components in seclusion from the system (Kincaid et al., 2007). It assists in understanding that people are part of a larger complex social ecology (Sallis et al., 2008). Also, the SEMCHB has four spheres that influence health behaviour (McLeroy et al., 1988).

3.5. Integrating SEMCHB and CCA in the present study.

In applying these two theoretical frameworks to this present study, an attempt is made to integrate the two approaches so that they complement the limitations of each separate approach to simplify their practical application, particularly in data collection. Structures within which individuals operate are argued to be shaped by existing institutions, community and arrangements and public policy factors. Agency expressed in the making and execution of decisions at the level of the individual is determined by the underlying culture and the structural underpinnings of the human ecology under investigation. With these assumptions, which can be reasonable, the integrated approach is presented below:

Figure 3.3: Integrated approach of CCA & SEMCHB



This approach thus applied seeks to integrate the key premises of the two underlying approaches explained in the foregoing sections. The CCA is premised on the assumption that health communications can have instrumental outcomes only when there is co-construction of the meanings and perspectives on health between the researcher/policymaker and the target community and its cultural participants. To this end, the researcher must seek to engage the community in dialogue and find ways of designing interventions based on the co-constructed understanding of what constitutes health problems and expected health outcomes. External knowledge systems should necessarily be incorporated into the cultural approach, through the conceptualization of health according to the identified cultural meanings (Dutta, 2017). The SEMCHB, on the other hand, is based on the proposition that there exist multiple influences on specific health behaviour called social determinants of health. The importance of this approach can be seen in the observed difference in health outcomes among different cohorts or demographic groups of the population. To this end, the approach emphasizes that these social determinants of health must be investigated and understood if community health outcomes resulting from behavioural patterns are to be understood and effective interventions designed and implemented (Ngwenya, et al., 2014). Thus, while the policymaker or researcher seeks to understand the broader socio-structural determinants of health, the co-construction of this understanding and problem definition is instrumental only as he/she integrates community or cultural participants as co-creators of the knowledge, meaning, concepts and expected outcomes through deliberative and discursive consensus.

3.5.1. Level of knowledge among social workers

The study envisions the social worker as the primary contact with the communities whose health outcomes are to be influenced through specific health communication intervention. In this case, the role of social workers in communicating HIV prevention methods to achieve a reduction of incidence of HIV prevalence and its effects in Vulindlela. The effectiveness of the health communication through social workers will only be assessed through the targeted outcomes, that is, the change in the rate of uptake of oral PrEP and change in other observed behaviours in the community that reduces the risk of exposure to HIV/AIDS. The CCA-SEMCHB approach suggests that the social worker must aim to align their knowledge within the context of the community. In this study, the social workers' knowledge was investigated for its embeddedness with the shared meanings and understandings of what constitutes a healthy community from the perspective of the community participants, whom the social workers engage with daily. Thus, the focus is placed much on the lived experiences of the social workers interacting in the provisioning

of Vulindlela community social welfare and well-being and achieving community health developments.

3.5.2. The knowledge and attitude of social workers towards oral PrEP

Social workers in this study are incorporated in their communicative role, through educating and communicating health-related information to the communities in which they are positioned. According to the operational theoretical premises of the study, external interventions have efficiency only as they are incorporated and assimilated within the socio-structural and cultural underpinnings of the target societies. To this end, the knowledge and attitude of the social workers to the usefulness or effectiveness of oral PrEP is influenced by their understanding of the societies or communities in which they operate. Their understanding, of the social processes underlying the societies, the individual behaviours they grapple within their everyday work, the social and economic characteristics of the people which they aim to target with the new interventions. Thus, for instance, oral PrEP can be very effective as demonstrated elsewhere, but the cost might be a cause for negative attitude for its promotion in say Vulindlela which is characterized by very poor social and economic conditions. When unemployment, low levels of education and illiteracy can be a great hindrance and that combined with costs of obtaining the medicines, or even where there exist cultural limitations that curtail the capacity of some population segments to make decisions that ensure or improve their health outcomes. The cultural and socio-ecological underpinnings achieved through shared understanding or co-construction of knowledge and understanding becomes the motivating factor in the uptake of campaigns and community action plans the social worker assumes towards any given intervention.

3.5.3. Social workers' health communication to communities about oral PrEP

The CCA-SEMCHB approach as utilized in this study describes the social context within which a given social worker, juxtaposes their targeted work in any given society. Obviously from the SEMCHB model, it is apparent that an understanding of the broader social context that influences observed health behaviour assists in disaggregating communicative tasks and contextualizing the scope for the social worker's communicative role. Secondly, cultural contexts define value systems, effective ways of communication and the institutional apparatus and parameters through which such communication can be done. Thus, the model directs contextual communicative systems as against universalistic or generalized models of communication, as understanding the social and cultural contexts of communities makes each context unique and demands that interventions and communications be designed and communicated as pertaining to each given social-ecological and cultural context. In this study, the recruitment of social workers in various

contexts and examining their experiences and challenges within diverse contexts coupled with their understanding of the challenges they face forms the central premise of application of this model to understand how social workers communicate about oral PrEP with their immediate communities.

3.5.4. Understanding the importance of the role of the social worker

The ecological model as explained in the foregoing sections provides a framework for mapping the multifaceted levels within societies and how individuals and the environment interact within those observed systems. Different factors and determinants exist at all levels of health, enabling prevention, control and intervention to be most effective when the model's suggested elements are all addressed holistically. This means that within a community, participant observation is required for a nuanced understanding of the broader social processes operating within any given social system, and also understanding of the cultural influences that shape behaviour and health outcomes that are to be changed through targeted interventions. Social workers positioned within these various societies can interact and develop relationships of trust and mutual interaction across various levels, thus achieving the needed understanding of the various operations and socio-cultural processes within these societies, thus reaching shared meaning and understanding through dialogue and deliberation and shared experiences within the communities within which they are positioned. It is this understanding of the role of the social worker, that in this study, required data was collected by recruiting social workers as the study participants.

3.6. Chapter Summary

The foregoing sections have presented the case for the utilization of the integrated CCA and SEMCHB model in this study. The main argument proposed was that these two models used together allow a deeper understanding of the operations of communities and societies that shape human behaviour as it is observed in its health-promoting or health destroying manifestations. The arguments of the theories were connected on the premises that while SEMCHB model focuses on the broader social structural determinants of health, the CCA model focuses on the cultural influence which shapes structural arrangements at the different levels. The integrated models further showed that social workers participating at various levels or in their capacity to integrate at various levels within the communities they operate provides the operational space for the execution of the concepts of these models. This also is the premise on which they are recruited as study participants to investigate, how health communication through social workers, can be instrumental in achieving increased uptake of oral PrEP in Vulindlela, KwaZulu-Natal.

CHAPTER FOUR: RESEARCH METHODOLOGY

4. Introduction

This chapter gives a detailed outline and discussion of the research methods and procedures which are used in this study, in the philosophical perspective on truth, the conceptual framework, sampling, measurement of variables and methods of data analysis. The methods implemented in actual data analysis, the thematic analysis method is discussed and finally, the limitations of the study are outlined.

4.1. Description of the Study Setting.

Vulindlela is a rural community located in the Msunduzi Municipality in Pietermaritzburg in KwaZulu-Natal. As of 2016, a municipal draft document report criticised the need for a local area plan for the Community, designed in efforts directed at overcoming the separate development policies for communities in this area. The local area plan initially proposed in 2015 was finalized in 2016, outlining the need for development in the area to cover several developmental challenges affecting the incumbent communities. Included among these are poor levels of public service (being the ex-homeland of KwaZulu, the area and its people have remained under-developed translating to high levels of unemployment, poor levels of education, youthful population profile with limited access to income-generating opportunities); and rising population density over a limited land area, creating a complex mix of local demographics. Mpumuzi clinic shown by the pin in the map insert above is one of the six small clinics serviced by one of the social workers interviewed in this study, provide basic medical care and public medicine dispensing to the Vulindlela area. A greater part of the land area falls under the Ingonyama Trust Board with five Chiefs (Amakhosi) overseeing settlement and land distribution based on traditional practices. It is against this backdrop of an undeveloped, poor serviced area, characterized by an expanding youthful population within strictly traditional settings that the lived experiences of social workers were documented, who work and seek to achieve reduce HIV infection rates in these area characterized by high HIV incidence (IES, 2016).

Figure 4.1 Source: Google Earth Images, 2020[2]

4.2. Research Paradigm

In seeking to provide an understanding of the communicative role of social workers within a CCA-SEMCHB approach in the design and implementation of health-improving interventions in Vulindlela, this research study is based on the interpretivist paradigm. The interpretivist paradigm is based on the perspective that reality is best understood from the subjective experiences of the individuals (Dean, 2018). Reality as thus understood is an intersubjective co-construction through meanings and understanding arising from experience and social interaction. Interpretivism also entails transactional epistemology based on the assumption that the researcher cannot be alienated from his inherent knowledge and meaning while undertaking research work. The investigator and the phenomenon under consideration are interlinked such that who we are and our conception of the world is a central aspect of how we understand ourselves, others and the world around us. With these assumptions, understanding of truth can be established through deliberation, negotiation and dialogue (Dean, 2018).

[2] Mpumuza Clinic, Pietermaritzburg South Africa

The interpretivist paradigm is implemented in a qualitative study to understand how communicative roles of social workers can improve the uptake of new interventions in influencing positive outcomes in the fight against HIV/AIDS in the Vulindela community. According to the CCA approach, social workers can better influence the communities they work in through having a shared understanding with the observed cultural participants, through dialogue, deliberation and shared experience. This need for deliberation to better understand how interventions can be shared to influence the introduction and uptake of oral PrEP are incorporated through interviews with social workers working in Vulindela to understand their shared knowledge and understanding with the communities they are working to influence. This is accomplished through face-to-face interviews with social workers in Vulindlela to obtain an in-depth understanding of their experiences as they are best placed within the communities they seek to influence.

In terms of methodology, the interpretivist approach allows the researcher to use inductive and naturalistic methods in data collection and analysis, such as interviews directed at finding an in-depth knowledge of the communities under consideration (Dean, 2018). Interviewing and observation are naturalistic methods that can be implemented within the framework of the interpretivist paradigm. The use of these methods ensures that the adequate dialogue and deliberation between researchers and those whom they interact with collaboratively resulting in co-construction of meaningful reality, knowledge and understanding (Mutinta, 2008).

These summarized attributes of a qualitative research strategy were instrumental considerations in the paradigmatic approach of this study. Since HIV is a disease of extended duration, understanding the accounts and perspectives of social workers who have been in contact with people living with HIV enables the researcher to gain valuable insight into the nature and evolution of interaction between providers and consumers of care, delineating more clearer the roles and influence of each of the parties. Such accounts of people's experience with in-depth information can yield the valuable explanatory position of the nature of interactive relationships, which can be useful in shaping the design of policies and programmes directed at welfare improvement. This is important to the current study, which explores an issue directed at achieving increased uptake of HIV prevention medicines to curb the spread of HIV in Vulindlela.

The relevance of an interpretative paradigm within qualitative research can be further argued from the nature of the analysis and the information required to substantiate the objectives of this study. Introduction and subsequent uptake of health interventions particularly novel approaches

are shaped particularly by knowledge, beliefs, values, social conditions and perceived pervasiveness of the health issue in any given society. While some of these issues may be quantitative, such as income for example as a proxy indicator of social conditions, yet in this study, the focus is on qualitative aspects at the micro-level influencing decisions that individual agents undertake in positively/negatively responding to implemented health interventions.

Thus, the adoption of a qualitative research paradigm sets this study as one of such studies providing contextual conditions of how the communicative role of social workers can be instrumental in improving HIV prevention by increasing uptake of preventative methods and procedures and their varied limitations. The focus in qualitative research is to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values, beliefs and experiences of individuals or groups in their natural or constructed settings (Kumar, 2014).

In exploring the communicative role of social workers about HIV prevention through the use of oral PrEP and level of awareness about HIV, the study sought answers to the following research questions.

1. What is the level of knowledge among social workers about HIV prevention?
2. What is the level of knowledge and what are the attitudes of social workers towards oral PrEP as an HIV prevention method?
3. How can medical social workers communicate about oral PrEP to clients?
4. What is the importance of a communicative role of social workers for oral PrEP uptake or promotion?

4.3. Interpretive Research Design

According to Thyer (1993: 94), "a traditional research design is a blueprint or detailed plan for how a research study is to be completed -operationalizing variables so they can be measured, selecting of interest to study, collecting data to be used as a basis for testing hypotheses, and analysing the results". This study was designed to be an interpretive qualitative design in which the researcher sought to provide a description and understanding of the communicative role of social workers in Vulindlela and how their role can be critical in influencing introduction and uptake of oral PrEP in efforts directed at reducing the incidence of HIV/AIDS in the local community and nationally. A qualitative interpretive paradigm seeks to gain an empathetic understanding of people's experiences and the deeper meanings and reasons for their behaviours

(Rubin and Babbie, 2013). An interpretive researcher is concerned with developing an in-depth understanding of participants' lives (Rubin and Babbie, 2013). Rubin and Babbie (2013:56) further state that "…interpretive researchers believe that the best way to learn about people is to be flexible and subjective in one's approach so that the subject's world can be 'seen' through the subject's own eyes". In interpretive study design , the researcher allows participants to give perceptions to their own realities or experiences , The study design underpins the fact that there is no single reality, meaning or knowledge is not there to be discovered but individually or social constructed (International journal of Higher education, Vol. 6, No. 5; 2017).

A way of experiencing something means that the context of the research is the individual as an agent, in responding to their environment as they engage with it, based on their knowledge, values, beliefs, social-structural systems and so forth. These issues are at the core of both the CCA and the SEMCHB models, which argue for the contextual factors of the individual as key in shaping interventions that are effective in influencing public health outcomes (Dutta, 2015; Poux, 2017). A way of experiencing can be further thought of as a way of being aware of something, which is observed through the observed relationship between an individual and the phenomenon under consideration. Furthermore, there is a disjuncture between the way of experiencing a phenomenon and the categories created to describe those ways of experiencing. The former becomes constitutive of the research unit of analysis, while the latter, the categories of a description constitutes the outcomes of the phenomenological research (Mutinta 2008:612). It is this division that forms the basis of the design of this research, the study integrates social workers as the units of analysis, whose lived experiences are considered, assessed, described and analysed. The research outcome are a grouping of the findings in categories under various emergent themes to seek to understand various factors influencing the communicative roles of social workers, both from their experiences and from the interpretive context of the primary researcher.

It can thus be seen and as further explained below, that interaction with the research units through interviews, surveys, or dialogue, are tools at the disposal of the researcher to take a tour into the lived experiences of the researcher units. This is bolstered by importing meanings and concepts from other fields into the interpretive context to have a broader understanding of the experiences of the social workers within a limited context, to a broader conceptual development and understanding inter-linked with other local contexts, importing ideas, solutions, frameworks of thinking and interventions to explain the case of the local context within a broader context. That this does not take the researcher outside the confines of

phenomenology can be established by the argument that while ways of experiencing are specific and derived from the individual (the contextual experiences of the social workers in Vulindlela), categories of description have reference to the collective level (when the broader questions are asked as to how the local findings can be aligned within other similar research studies, or within the same topic of public health concerning HIV/AIDS). The latter therefore gives insight into the qualitatively different ways in which a phenomenon may appear or be experienced by different groups (Mutinta, 2008).

4.3.1. Implementing the interpretivel methodology

In many instances where the Interpretivist paradigm is chosen, data gathering methods follow a grounded theory approach, which is well suited to generating a theory from real life occurrences in which the social processes and what they mean are explained. It is based on symbolic interactionist theory (Strauss & Corbin, 1990).

4.3.2. Sampling procedure and sample size

In the recruitment of participants in the study, purposive sampling a method in which the researcher uses his/her judgement to purposefully select respondents for interviewing or any other form of participation in a given study was used in this study (Mutinta, 2008). The choice of purposive sampling was influenced by the need for recruiting a few knowledgeable participants into the study, who have been engaged in social work, particularly with HIV/AIDS in various communities. To this end, a short criterion was implemented in selecting participants, with every participant being selected who met the following criteria:

I. The social worker was to be based (living) in Vulindlela
II. The social worker was supposed to be working with local clinics in Vulindlela
III. The potential social worker was/had worked with clients at risk of contracting HIV/AIDS, or those living with HIV/AIDS.

Utilizing these defined criteria, three (3) social workers were selected and successfully recruited in the study, as they met all the elements of the criteria. These social workers were working with local clinics in Vulindlela, identified as Mafakathini, Songonzima, Taylor, Sondelani, Mpumuza and Mpophomeni. These social workers were interviewed with their responses being the source of data informing the reported findings of this study. The social workers were recruited through the local Non-Profit Organization (NGO) (Comosat) whom the researcher was in contact with.

4.3.3. Data Collection

In most phenomenological studies, collection of data has been through the interview (Mutinta, 2008), video recordings have also been used and in some instances, document analysis to a

lesser extent (Sundler, et al., 2019). The selection of interviewees has mainly been guided by the objective of collecting rich material about the phenomenon of study and to identify and describe variation in experiences of this particular phenomenon. Similar studies examined in Chapter 2, made use of large numbers of participants, with smaller studies exhibiting a very strong trade-off between richness of data (mainly influenced by the background of participants and interviewing length) and sample size (reference). The idea thus was to have a small but very rich sample of participants, recruited into the study based on researcher's judgment and selection criteria (Mutinta, 2008; Sundler, et al., 2019). These were the main considerations as noted in the foregoing discussion in sampling and informed the data collection process.

It should also be noticed that in most phenomenological studies, interviews are guided by semi-structured questionnaires. In preparation of these, the researcher(s) ensures that they thoroughly delineate and penetrate the phenomenon under study to penetrate its crust and core structure, the various possible conceptualizations of the phenomenon and various variables that may be linked to the phenomenon in various contexts or situations (Sundler, et al., 2019). While this is efficient, it potentially compromises the three stages in which phenomenological method is implemented as explained in foregoing chapters, furthermore, it restricts the application of qualitative data analysis methodologies that depend on data capable of yielding emergent themes and undefined patterns, that is the naturalistic order of reducing data and surfacing meaning from it in thematic analysis (Mutinta, 2008). This is why a simple interview guide with a few open-ended research questions was adopted in the collection of data in this study. With these considerations, the data collection process in this study is explained.

The data collection process was undertaken through the use of interviews conducted by the primary researcher. A short interview guide composed of broadly open-ended questions was designed and utilized by the interviewer in audio-recorded interviews, which were then transcribed to provide the qualitative data which was analysed and formed the basis for the reported findings of this study.

The advantages of interviewing as a method of data collection in this study were primarily related to its naturalness and spontaneity, flexibility, control of the environment and direct contact with the participants (Babbie and Mouton, 2001). A voice recorder was used to keep a full record of the interview without having to be distracted by detailed note-keeping (Terre Blanche et al., 2006). All participants consented to be voice recorded. To ensure flexibility and remove limitations in the dialogues the English and Zulu languages were used as the

participants saw fit in communicating their ideas, and responses, this multi-language design of the study was seen as necessary to ensure that responses were given most naturally without restricting communication-based on language limitations.

Participants were first informed about the purpose of the interview and were allowed to ask questions about the research. The researcher also explained the content of the interview before the commencement of the interview sessions. It was at these preparatory sessions that oral PrEP was explained to the participants. In addition to consenting to the interview, participants' consent was also obtained to voice record the interviews.

All three interviews were conducted in the offices at the local social development department in Vulindlela in November 2019 because it was a convenient space for the participants and it is where they work daily and get referrals from the six clinics. The interviews lasted approximately 45 minutes for each participant. All three interviews were completed, translated and transcribed to check if any changes needed to be made to the interview guide and if more probing was needed. The small sample size also enabled the researcher to have prior engagement timeously with the participants which were effective in creating an open environment for communication and exchange of ideas and proved advantageous to yielding the needed depth of information for the study. The study aimed to obtain rich deep qualitative data which was supported by a thorough review of literature which informed the data analysis. This was essential since a big trade-off was made between the depth of information and sample size, thus essentially restricting participation to a few highly knowledgeable and experienced social workers within the community of Vulindlela. The interviews were also long enough to ensure that dialogues were comprehensive and more information was exchanged between the participants and the interviewer throughout the interviewing process. Furthermore, the focus on lived experience implies that it is not the world as such that is the basis of exploration in this study. However, it is the world as experienced by the social workers, or how the phenomenon of communicative health intervention appears to them as they interact with the communities they work in and seek to positively influence.

4.4. Data Analysis

Thematic analysis is defined and conceptualized as a method of analysing qualitative data, through data reduction (Mutinta, 2008). This method is applied to research texts such as open-ended interviews or transcribed recordings etc. The research closely investigates and examines the qualitative data identifying patterns exhibited by common themes, topic, ideas, even words/concepts conveying meaning and emerging from the qualitative data (Sundler, et al.,

2019). The objective of phenomenological analysis as described earlier is to identify and provide a description of the variation of experiencing a phenomenon as a goal of research. The outcome of the analysis, that is the findings of the research are presented in several limited categories of description that illustrate the variety of experiences concerning the phenomenon under consideration (Mutinta, 2008). The application of this process is explained in ensuing discussions. Furthermore, the method of thematic analysis was used to complement the phenomenological research design as discussed in the sections below.

4.4.1. The Thematic Analysis method

The method of thematic analysis was deemed relevant and naturally applicable to this study in analysing the communicative role of social workers drawing from their knowledge and perceptions as obtained through in-depth interviews. Thematic analysis requires the researcher to familiarise themselves with data, code the emerging themes, patterns and integrate the themes into constructs/categories and then the present these as findings of the study. The interpretive influence of the researcher can be seen, that what is considered an integrative code is determined by the researcher, yet this influence is shaped by the theoretical basis of the research, which guides the data analysis processes. With these considerations, the thematic analysis method as applied in this study is explained.

The study uses thematic analysis which is a data reduction and analysis strategy in which qualitative data is segmented, categorized, summarized and reconstructed in such a way that captures the important dimensions and concepts in the underlying data. This enables the researcher to find patterns of meaning and embedded understanding that assists in painting a picture of the underlying issues being addressed in a qualitative study (Mutinta 2008). Thematic analysis is primarily a strategy for describing the data that facilitates a search for patterns of experience and interaction within a qualitative dataset. This enables the researcher to interpret the data, identifying, reporting and analysing patterns which are discovered through themes developed from the primary codes created during the data analysis process (Braun and Clarke, 2006). The thematic analysis enables the researcher to undertake pattern recognition and analysis through thematic coding, the main strategy for thematic analysis through which data are segmented and categorized for thematic analysis.

The outcome of thematic analysis is a description of those patterns in the data and the overarching design that unifies them, in this case, the various communicative roles of the social workers and the factors that influence the exercise of those roles and their outcomes.

4.4.1.1. Thematic coding

Theoretical coding is the method by which the qualitative data is segmented and categorized for thematic analysis (reference). In this coding process, the analysis begins with anticipated or known themes (obviously from the extant theories considered, which gives the analyst preliminary themes, which he/she looks for as they initially work through the data) to be found in the data (Mutinta 2008: 867). In this study, some preliminary codes were informed by the CCA-SEMCHB integrated model which provided the mapping concepts of culture and human ecology centred health communication, thus some of these concepts were used in the initial organization of data. These initial codes simply served as receptacles for ideas due for further analysis after initial coding. This second stage or heuristic coding engaged these preliminary codes in a rigorous process of analytic induction both within and across categories thus yielding sub-themes and constructs under the parent categories.

Thus, coding as used here was instrumental in facilitating the development of themes, whilst at a second stage, development of themes facilitated coding. The portions of data separated from their immediate and original context were labelled so that data bearing the same label were retrieved and investigated together. Thus, in this usage, thematic analysis as applied in this study was an operationalization of the phenomenological data analysis method at a micro level. For instance, some major themes that were observed in the CCA-SEMCHB model focused on knowledge, beliefs, roles and values of the participants. These were incorporated in the coding of the data, with sub-coding grouped under themes such as: lived experiences of social workers; nature of social work; Communicative role of social workers; general roles of social workers; social issues connected with HIV/AIDS, design of programmes involving HIV prevention, knowledge about HIV and knowledge about oral PrEP among others. These initial themes where further subjected to second stage coding yielding sub-themes (as presented in the constructs in Chapter 5: Presentation of Findings).

4.4.1.2. Thematic Coding and Elaboration

It can be seen that thematic analysis coding as implemented in the analysis of data in this study was a two-stage process, at which stage the researcher increasing their familiarization and engagement with the data. Initially broadly defining container/receptacle themes and then the second stage rigorous analysis of categorized data. This enabled the researcher to achieve thematic elaboration, that is further analysis of the data in the categorized, employing further data reduction and coding using comparative analysis in which themes were deepened, reconstituted or destroyed. During this process, the researcher also effectively used memoing,

where the various reasons codes were changed or reconstituted were recorded to ensure that the resulting material is substantive to the detailed description of the phenomenon under consideration. Memoing took the form of describing the initial categories and their contents since second stage coding, essentially entailed decontextualizing data from the original interview and contextualizing it into a theme, which then formed the basis of reporting in the presentation of the findings. There was a necessity to ensure that these second stage themes were not disconnected from the original data, and the original intended meaning by the research participants. Thus, reduction of the data was enriched while at the same time, without losing the original meaning intended by the interviewees thus safeguarding the integrity and scientific nature of the findings from the analysis as proposed in the research literature (Mutinta, 2008).

The elaboration stage was essential as initial coding categories were renamed, contextualised, some codes were discarded due to lack of relevance following second-stage analysis, while others were reorganized. For example, there were two categories one containing material on general roles of social workers, and other containing materials on the role of social workers in HIV prevention and care. The two after second stage analysis were merged into one category as they essentially had the same effect in understanding communicating roles of social workers. This was also true of categories containing general knowledge about HIV and HIV prevention which were connected merged. This also is a strength of thematic analysis that categories once defined are not static nor inviolable but can be further subjected to thorough analysis for alternative interpretation or even disconfirming their reported evidence (Mutinta, 2008). This stage of analysis was further instrumental in reducing the number of sub-themes reported in the findings, as can be seen in the final analysis tables that are attached in the appendix section of this dissertation.

4.4.1.3. Thematic Integration

Coding and data management as discussed above formed the initial stages of the analysis, with effective memoing of analytical procedures yielding important information particularly in interpreting the themes resulting from the analysis although with the presentation of the rest of the memos being communicated in the discussions sections of the study. Second, stage rigorous analysis was the process used in determining the major themes to be used in communicating the major findings from and the analysis. Thus, identification and arrangement of patterns were the major analytical efforts which constituted the final stages of data analysis. At this stage, the analysis was essentially directed at thematic analysis, the comparison of the constituted themes after rigorous coding, by analysing the contents of the themes, and reading the notes in the

memos (and also assessing the context of the extracts that were organized as composing those identified codes or sub-themes). This analysis also resulted from the researcher's consideration of the relevance of the themes to the main questions and objectives of the research, as discussed in the following section. Thus, major themes were finalized depending on their relevance to the main research questions and the observed relationships among the categories. Data that initially was decontextualised through rigorous coding is made to maintain connections with its sources, thus leading to the context of case-based generalization characteristic of phenomenological qualitative research design as discussed earlier. This connection of the themes through thematic integration to the source (context), to the theoretical premises of the study and the main study questions, were the primary reasons that ensured thematic analysis addresses the envisioned outcomes of phenomenological analysis.

4.4.1.4. Computer-assisted qualitative data analysis

The foregoing discussion shows clearly that thorough data analysis characteristic of thematic analysis required effective data management strategies capable of handling coded data in ways that were both flexible and robust. There was a need for easy recognition and organization of codes and categories with search and retrieval capacities which enabled ease of comparative analysis and management of numerous pages of transcripts. This complexity was addressed by using NVIVO 12 qualitative data analysis software, which provides a single interface for analysis of qualitative data, with access to both transcripts and the various themes and codes, enabling easy interactive analysis and reassessments of the original contexts of the categories within the transcripts thus eliminating errors in analysis or grouping of themes. This need for efficiency and ease of data management, handling and analysis was the primary consideration in the use of computer-assisted methods of implementing thematic analysis on the qualitative data. The resulting data analysis log file has been securely housed by the researcher for future reference.

4.4.2. Validity

The premises of validity concerning the findings of this research stemmed from interconnected aspects of data quality; ensuring the richness of the data as discussed in data collection, the scientific nature of data analysis method, which methods were followed closely to ensure that the findings were based on the themes, and concepts of meaning which emerged from the material analysed and not imposed by the researcher.

Analytical integrity refers to the nature of the methods used in the analysis of data and how the methods are employed consistently with the scientific foundations which underpin such

methods (Mutinta, 2008). In this study analytical integrity is ensured by the transparency with which the research methods have been clearly outlined, particularly in data collection, analysis and interpretation which methods can be reapplied under similar circumstances and reproduce the similar findings, as they are free from researcher's interference and bias. The quality of the data was also ensured in the design of the interview guide whose questions were designed to accomplish three purposes:

I. Illustrate a key feature of the key variables of the phenomenon under study
II. Clarify the different aspects of the phenomenon that was being investigated during the interviewing process, to enable interviewees to avoid repeating information unnecessarily while comprehensively communicating the needed data, and
III. To ensure efficiency and guidance in the interviewing process while ensuring interviewees flexibility in communicating their experiences—the open-ended nature of the questions and the use of dual languages in the interviewing process.

4.4.3. Credibility and transferability

4.4.3.1. Credibility

Credibility in qualitative research is concerned with the extent to which the findings of a research inquiry can be linked with reality to demonstrate the truthfulness of the research findings (Mutinta, 2008). The credibility of this study's findings can be assessed from the method of thematic analysis as used in this study and instrumental in producing the findings in this study. The foregoing sections clarified thematic analysis as operationalized in this study, inadequate detail such that the procedures can be replicated even in the quality of the data collection to produce data that meets the requirements for inductive thematic analysis have been stated. Thematic analysis as used in this study cannot be assessed on its own merits as it was applied with a phenomenological analysis, to investigate meaning in the lived experiences of social workers in Vulindlela. A pre-requisite for this kind of analysis then was that data must be inductive and must focus on the lived experiences such as interviews or narratives. These requirements were met as discussed, in both the implementation of the phenomenological method, the sampling procedure and the collection of data.

The themes reported in the findings of the data analysis are grounded in data, or derived from the data, which was composed of the lived experiences of the participants, which were reported as the patterns emerged. While in efforts to reduce data and reorganize themes to bring out the complexity in the data, bias may be introduced. The process of reintegration and connecting

the findings with the source context ensured that the final themes were simplified constructs of the original ideas communicated by the interviewees.

4.4.3.2. Transferability

This measure of trustworthiness of qualitative research studies focuses on the degree to which the results of this research are transferrable to other contexts or setting with other respondents (Guest, et al., 2012). As explained during the data collection process, the trade-off between small sample size and in-depth interviewing of a few participants yielded data aimed at providing a thick description of the lived experiences of social workers in Vulindlela. This enabled the researchers to observe the variations in human experience among the social workers themselves who exhibited different levels of conception even for the same variables demonstrating that the findings are transferrable in the context of the concepts measured and operationalized in thematic construction and analysis. The findings in and of themselves can be subjected to change depending on the specific characteristics of the recruited participants. Thus, concepts in the early stages of analysis can be transferrable as they were influenced directly by theoretical concepts of the study, while the second stage rigorous concepts are substantive and contextualized by the informed judgement of the researcher, and would require the memo notes of the researcher explained earlier to understand how specific themes were retained while other discarded. This thick methodological approach composed of first and second stage analysis and extensive use of memos is the basis on which transferability of this study can be assured to yield consistent findings.

4.4.3.3. Confirmability

This aspect of trustworthiness is concerned with the extent to which data and interpretations of the findings can be established as having been derived from the data (Guest, et al., 2012). This as explained in this study was ensured through careful and detailed documentation of the methodological procedures. Furthermore, comparison of the content on which the codes were developed with the sources of data in transcripts ensured that the original context of the ideas was not lost during subsequent stages of thematic analysis. This was further bolstered by incorporation of theoretical concepts and constructs to ensure that the researcher's judgement during analysis was influenced by established theoretical positions. These conditions ensure that the findings of this study can be compared and demonstrated to be the product of data analysis.

4.5 ETHICAL CONSIDERATIONS.

Babbie and Mouton (2001) state that the researcher's right to search for information, should not compromise the right to privacy of a participant. According to Ngcobo (2011), the essential purpose of ethical research planning is to protect the welfare and the rights of research participants, although many additional ethical considerations should be addressed in planning and implementing research work.

Ethical clearance from the University of KwaZulu–Natal Ethics committee was obtained under BREC with application number BE500/17, and the ethics approval letter listed in the appendix section of this dissertation (see Appendix 3).

Permission to collect data in the community was obtained through a local NGO COMOSAT in Vulindlela from Mavundleni. Social Workers are governed by ethics, as stipulated by the South African Council for Social Services profession (SACSSP)[3], thus Social Work ethics guided the study.

In consideration of the sensitivity of HIV related issues and social workers' perspectives and experiences, the following ethical obligations were performed:

4.5.1 Obtained informed consent from the participants

In this study, the participants signed an informed consent form for research participation, which outlined the conditions of their participation, its voluntary nature and the exercise of their right to provide or withhold information during any part of the interviewing process, or any information they deemed sensitive or they did not feel at liberty to respond to. The consent form provided the aims of the research study and the voluntary nature of participation. The consent forms were in English which is a language that social workers understand.

4.5.2 Ensured confidentiality of data

The participants were assured that their identifying information (such as names and places) would not be included in the study report and that pseudonyms would be used instead of their real names. In the analysis of the data and reporting of the findings in Chapter 5, the interviewees were referenced as Reference (Number), with the focus of the analysis being the information that was contained in the interview transcripts. The audio recording and the transcripts are all safely stored in a password protected computer storage media at the CCMS Department, accessible only to the primary researcher, and will be subjected to destruction save

[3] www.sacssp.co.za

only the transcripts with pseudonyms for confirmation of the study analysis and findings should need to arise in the future. Other than these, all interviewee materials will be subject to deletion five years from the date of publication of this research.

4.5.3 Voluntary involvement in the study and no monetary gains

The researcher exercised openness, honesty, and transparency about the voluntary nature of participation in the study. The participants were neither promised any reward for their participation nor threatened with punishment for their refusal thereof. Besides, respondents were alerted about their right to withdraw from participation at any phase of the interview.

4.5.4 Permission to use the voice-recorder

Participants were provided with the option to allow or disallow the use of a voice recorder. None of the participants disallowed the use of the voice recorder.

4.5.5 Respect of participants

Respect was maintained by being culturally sensitive, using the language that was comfortable to participants and using an office that was empty to maintain confidentiality.

4.6. LIMITATIONS OF THE STUDY

The phenomenological premise of the study enabled the researcher to adopt the methods of a field that has continued to be effective in empirical research in health. It has been applied much in fields such as understanding lived experiences of people with chronic health conditions, education and literacy analysis among different classes of people, and this study follows this strand applying the phenomenological method to the case of social workers in Vulindlela in KwaZulu-Natal. While the methods have been demonstrated as relevant and meeting precisely the needs of the research inquiry in all its aspects, several limitations may affect certain premises of the research concerning application beyond the context of the study.

- In the discussion under-sampling, it was stated that in the study a significant trade-off was made between the adopted sample size of 3 participants and the depth of information in the time allocated to interviewing of the selected participants. The smallness of the sample enabled the building of good rapport between the researcher and the participants as multiple engagements were possible before the actual interviews were undertaken. However, the smaller sample delimited diversity of perspectives and opinions which could have been overcome should a larger sample had been used. The few respondents in the study showed much variation which meant that most of the

themes did not achieve enough depth to create more substantive themes, which could have been possible if there was a larger sample been utilized with the same depth of interviewing.

- The findings cannot be generalizable, neither the concepts except those established under strictly theoretical premises. This follows from the limitation above of the fact that too much variation which was observed in the findings means that the concepts developed cannot be substantive since they did not have as much saturation as to solidify their premises. As a result, while the methodological premise of the research has been demonstrably sound, a larger sample size can lead to reinterpretation or reconstitution of some of the concepts developed through rigorous thematic analysis.
- The phenomenological design of the study is severely limited by the fact that in core issues of the study, concerning various aspects especially concerning oral PrEP, the primary researcher had more information that the research participants, even concerning other HIV preventative measures. This partly affected the integrity of the data since the researcher had to explain various aspects of HIV prevention to the participants, in a way influencing the nature of their responses. This is exacerbated by the size of the sample, that if one of the participants was influenced this way, that is strictly speaking 25 per cent researcher's bias and influence into the study.

4.7 Conclusion

In this chapter, the study setting and the operational research methodology that was implemented in answering the research questions were discussed. The interpretivist research paradigm explained how it was applied in this research. Similarly, the relevance and practical usefulness of the phenomenological research design within this interpretive context was discussed in its model assumptions and the way it was operationalized in this study. The data collection and data analysis aspects were explained in a detailed manner with a clear outline of the implication of the design of the research on the outcomes of the research inquiry. A summary of the data analysis was briefly outlined. However, elaboration of the findings of the study is presented in the next chapter.

Chapter 5: Findings

5.1. Introduction

The study sought to answer three primary questions, and these were the primary focus of the data analysis processes, which have been the crux of the foregoing discussions. In this section, each question is considered and explanations are provided on how the demands of the questions were addressed through data analysis findings.

The analysis of the data showed two major categorical groupings that yielded information concerning the knowledge of social workers on known HIV prevention strategies. These two themes were coded as *HIV prevention strategies* and the other capturing social workers' experiential knowledge through the different programmes that they implemented in communicating about HIV/AIDS in Vulindlela, coded as *programmes that involve HIV prevention.* Known HIV prevention strategies observed among social workers included *HIV awareness campaigns, need for educating and strengthening those already infected or born with HIV; increasing the reach of current practices, routines and information on HIV prevention; increased HIV counselling and testing; social workers demonstrative capacity such as recourse to HIV testing; encouragement of lifestyle changes and programmes aimed at HIV prevention for children.* What was interesting though was the silence of the social workers on medical methods of HIV prevention, which reflected possible lack of information as confirmed by analysis of the social worker's knowledge of oral PrEP. There was a need for further analysis of contextual factors that influenced social worker's knowledge and thus their effectiveness in their communicative roles in Vulindlela.

The second theme contained knowledge concerning the programmes that social workers implemented in their work towards combating HIV/AIDS in Vulindlela. Among these programmes included *guideline programmes (which were designed to influence the behaviour of adolescents, directed at children at local schools with social workers themselves as facilitators); Community caregivers (CCGs) programmes (directed at changing the perspectives of life of various children—argued to be influencing observed risky behaviours, educating to prevent mother-to-child transmission of HIV by early intake of medication) and the YOLO programme—which needed refinement yet (involved children as participants, teaching about antiretroviral therapy and the necessity of medication adherence, and addressing issues for children living with HIV induced morbidity) which programme was reported as successful for influencing behavioural change among adolescents.* These findings

from the analysis were able to communicate the inherent knowledge of the social workers on HIV prevention methods as well as their practice of this knowledge through the various programmes they implemented in seeking to bring about change in the fortunes of their focus communities in Vulindlela.

5.2. Level of knowledge concerning HIV prevention options.

The main thrust around the theme of knowledge was based on knowledge of social workers about oral PrEP as a precondition for their effective communication of it in their communities. The analysis yielded information on the knowledge and attitudes of social workers concerning the use of oral PrEP as an HIV prevention strategy. Social workers were observed to be generally ignorant of medical methods, with most of their programmes directed at non-medical methods of HIV prevention. There were two thematic groups, which were essentially combined into one larger grouping, the one contained information on social workers' *knowledge about oral PrEP* and the other concerning the social workers' knowledge about *how oral PrEP works*.

5.2.1. HIV prevention strategies

Interview data showed that HIV awareness campaigns at schools, community that are aimed at HIV prevention for children, increase reach of current routines, practices and giving out more information on HIV prevention and increased HIV counselling and testing are among the key HIV prevention strategies at the disposal of the social workers. It was observed that through such programmes, social workers were able to engage better with the communities in which they work.

Furthermore, support systems were necessary for children infected or born with HIV, to help them understand that they are just as normal as all the other children are. Encouraging lifestyle changes for both the infected and those living with HIV while promoting the use of protective care procedures for the uninfected and maintenance of responsible lifestyle habits and choices were further methods directed at communitywide HIV prevention. Through social workers demonstrative capacity, such as being tested, the social workers pointed out that they can use their influence to enable communities to normalize and value regular testing and routine checks to maintain health and know one's status.

"Ok, we go to primary and high schools and we undertake HIV awareness campaigns and programmes designed to educate children concerning HIV, and how they can prevent from being infected" Participant 1

"Although we know that some children have been infected and have been born with HIV so we give them love and support, so we give hope and strength to stay alive…" Participant 1

"It is the same routine as the prevention method we used before which is to give more method of prevention to clients" Participant 2

"Mmmh when you talk about HIV and testing its whereby …ohk If I have a partner and I go and test it doesn't mean I live a reckless life (having multiply partners or anything), it simply mean that you have a partner but you don't know what kind of a lifestyle they live so every year I go to the clinic for a check-up to see if I'm still on the right track because I may have one partner but I don't know how many partners he has" Participant 2

"My plan was that 1st of December (World AIDS Day) this year we get people from clinics to come and get tested, Social worker must also get tested but whatever results that you get will be confidential. This is just to show clients that as a social worker you do not just talk about these things, you also do it" Participant 3

5.2.2. Knowledge about HIV and educating others

Through the interviews it was observed that concerning knowledge about oral PrEP as a method of HIV prevention, social workers had at best *hearsay and very limited information to never heard about it and not being sure what oral PrEP was all about, although perceived to be an effective method of HIV prevention.* The social workers also indicated their need for training on oral PrEP as the social workers had not received any training concerning oral PrEP.

Figure 5.1. Knowledge about HIV

Source: Own construct using interview data

The issue of knowledge was the overarching issue with social workers. These entailed access to knowledge and the ways they conceived of knowledge both to themselves and to the communities in which they work. Importance of knowledge about one's health status was pointed out as imperative in ensuring one's health. Participant 1 stated that *"Ok, mina nje, personally engikwaziyo ukuthi kubalulekile ukuthi njalo kumele ngihlale ngiteste ukuze ngazi ukuth isimo sam sempilo sihamba kanjan. Uma kuwukuthi ngithola ukuthi sengi positive (ie if I find that I am HIV positive, I can be educated as how to take the treatment the right way)".* Regular testing and checking to find one's status were pointed out as key to commencing treatment early and therefore ensuring one's health. Other forms of knowledge include knowledge of methods of HIV prevention.

"Although I am educated I know I need to protect myself from getting the virus, there are ways to protect yourself from being infected (there are ways to protect yourself from infection)" Participant 2

"Yes, ngiyakholelwa ukuthi nginayo information but ngisadinga enye (I do have information but I still need more) ukuze ngizi (in order to empower myself so I can empower others in the community I work in (ngisadinga olunye ulwazi ukuze ngiludlulisele kwabanye nasemphakathini engisebenza kuwo" Participant 3

Lack of information greatly hampered the efforts and work of social workers. Another interesting concept that came up was the ways the social workers conceived of information,

information among is seen as empowerment, as an asset and as the tool for battling against the virus.

5.3. Levels of knowledge concerning oral PrEP as an HIV prevention method.

The level of knowledge on HIV prevention options as well as PrEP more specifically varied among the interviewed social workers. Among the social workers interviewed, knowledge concerning oral PrEP was reported to be ranging from no knowledge at all to hearsay and very limited information. The first social worker pointed out that she had heard about oral PrEP through hearsay and was little informed about it although she had heard that it is an oral pill to be taken before engaging in sexual intercourse.

"..so oral PrEP helps umuntu to take their medication before they engage in sexual activities to prevent contracting HIV if it happens that they come in sexual contact with someone who is infected". Participant 1

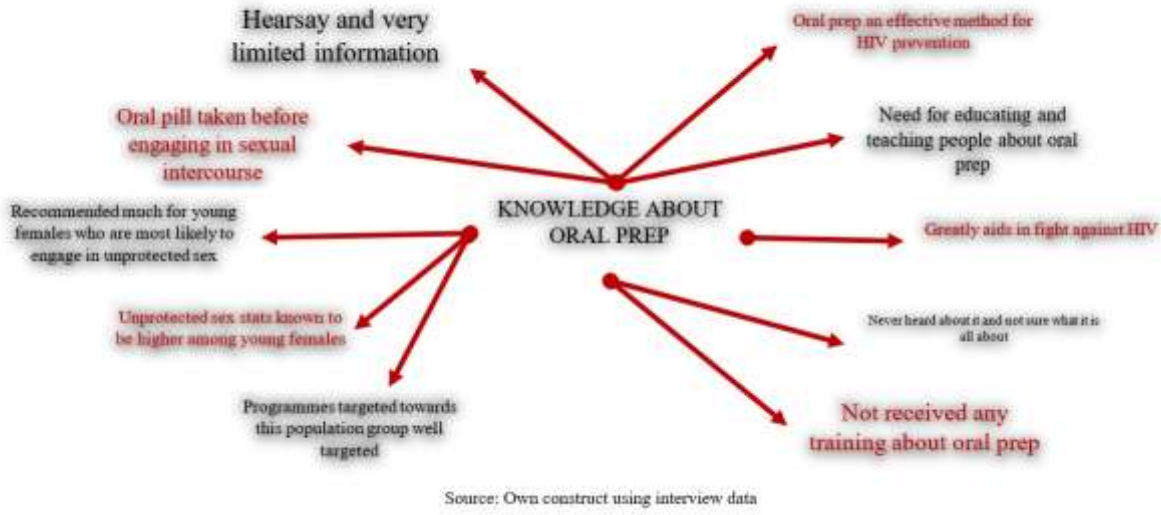
The second participant indicated that even though she has little knowledge about oral PrEP, in her perspective oral PrEP provides an effective method for HIV prevention among young females who are known statistically to be more likely to engage in unprotected sex.

"So in my perspective oral PrEP provides a great opportunity in aiding the prevention of HIV. Therefore, we must teach and educate people about it, as it greatly aids in the fight against HIV" Participant 2

The third participant did not know at all about oral.

"No, I have not heard about it" Participant 3

Figure 5.2. Knowledge about oral PrEP



Some of the contributing factors limited to no information at all about oral PrEP were because there has not been any training for the social workers directed specifically to inform them about the novel and effective preventative measure. As was pointed out earlier in the foregoing findings, communication resources can improve access information without additional costs. The discussion on oral PrEP yielded another insight into the currently known information about the young female cohort. It was stated by Ngwenya et al (2014) that young females are known statistically to likely engage in unprotected sex, which shows excellent targeting in the programmes the social workers currently undertake directed at this age group. The social workers indicated that among the methods they currently employ in HIV prevention, oral PrEP presents a more effective approach at HIV prevention and given the high prevalence might be instrumental in curbing the high-recorded prevalence of HIV and AIDS in Vulindlela. There can be great scope for positive gains in influencing HIV statistics in Vulindlela through knowledge disbursement of oral PrEP and improving social worker access to information.

5.3.1. How does oral PrEP work

The social workers interviewed as observed earlier had little to no knowledge of oral PrEP, or how it works. Most of the ideas thus communicated during the interview were based on hearsay or information heard in passing. The limited information though has some very interesting

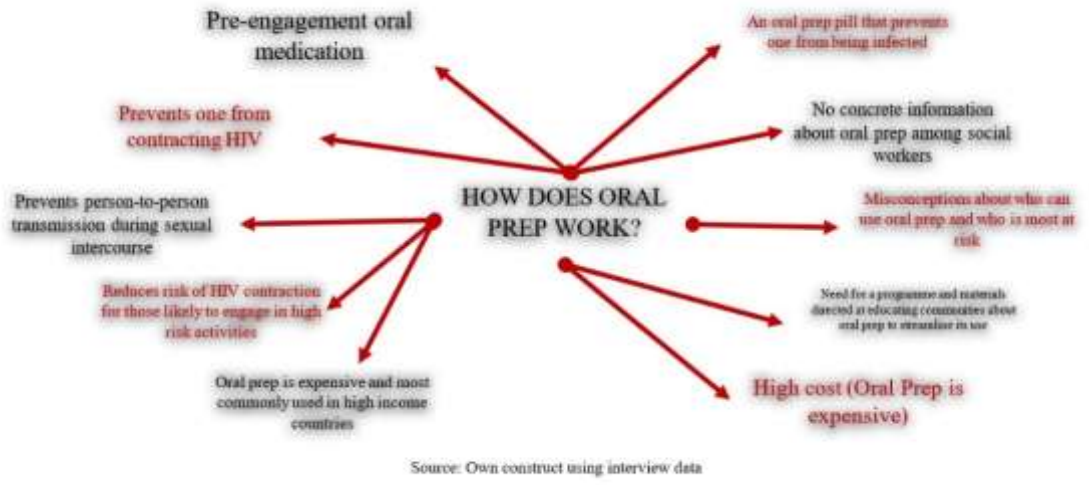
insights. Among the details shared by the social workers, they understood oral PrEP as pre-engagement oral medication before engaging in sexual intercourse and works to prevent person-to-person transmission of HIV. For it to work it has to be taken before sexual intercourse and was understood to reduce the risk of HIV contraction for those likely to be characterized by high-risk activities.

"So oral PrEP helps umuntu to take their medication before they engage in sexual activities to prevent contracting HIV if they come in sexual contact with someone who is infected" Participant 1

"Ok, oral PrEP (Pre-exposure prophylaxis) is a way for people who do not have HIV but who are at high risk of getting HIV to prevent HIV infection by taking a pill every day. As you know people who are using injection for drugs, people of same-sex relationship and prostitutes, we once had them at Vulindlela but we ran out of funds but in other countries, they are using it to prevent the spread of HIV" Participant 2

"Is it a pill that you once used it and engage in an intercourse with an HIV positive person but you do not get an infection due to taking off or PrEP I once heard about it before but I didn't get a full name of it but I heard that it is not easy to get them because it is expensive" Participant 3.

Figure 5.3 how oral PrEP works.



Source: Own construct using interview data

Misconceptions, however, existed about who can use oral PrEP and who is most at risk and these misconceptions further undermined the possibility of social workers actively promoting the uptake of PrEP with full understanding and knowledge of the product and who is eligible.

"Oral PrEP is a pill taken by people who are at risk of getting HIV before sexual contact especially those who have sexual intercourse with people pf the same sex, children, young women of which research has shown that they are at high risk of getting infected as well as people that practice drug abuse using needles, people that make incisions etc." Participant 3

Overall, the social workers interviewed had limited knowledge regarding PrEP and how it works. This had effects on how they would be willing to support and promote its uptake among their clients. While the social workers were open to the idea of learning more about PrEP the extent to which this could be implemented and promoted in their sessions was quite limited.

5.4. Social workers and observed avenues of communicating about oral PrEP.

The data showed that social workers who participated in the study did not have knowledge concerning oral PrEP and were thus unable to communicate about oral PrEP to their communities. As a result, even though social workers in Vulindlela had effective communicative roles with well-established communicative processes, their lack of knowledge of oral PrEP makes them ill-equipped to facilitate its introduction and uptake through health communication. Thus, according to the data analysis, at least concerning the interviewed social workers in Vulindlela, it was observed that their communicative roles were severely limited by their lack of knowledge both on how oral PrEP works and its use as an HIV prevention strategy.

5.4.1. Communicative role of social workers

The data showed that social workers take the communicative role in which they providing education concerning HIV to their radial communities communicate information through campaigns and awareness programmes and improve information uptake through encouraging social/public discursive platforms on HIV outcomes and prevention. One of the social workers interviewed explained social education as the groundwork for the needed social revolution that can redress HIV high prevalence.

"*While educator people are not as important as human educators, they are with the revolution. The more people are aware of the information the more people are going to be talking about the more information uptake that may result" Participant 1*

Another social worker communicated that information dissemination was important to seeding the revolution. This makes the role of social workers as effective communicators of necessary information vital to social change that may yield positive results for curbing the spread of HIV and its prevention.

"So in my perspective oral PrEP provides a great opportunity in aiding the prevention of HIV. So we must teach and educate people about it, as it greatly aids in the fight against HIV" Participant 2

Figure 5.4. Communicative role of social workers

Source: Own construct from interview analysis

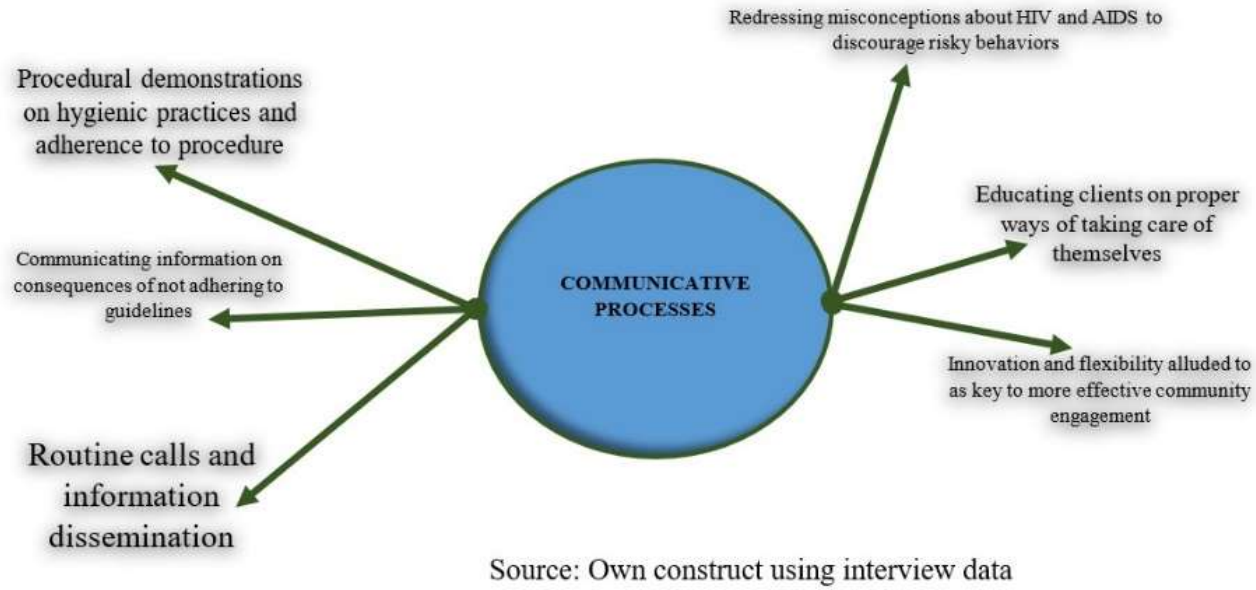
The communicative role of social workers was designed to achieve increased awareness of HIV related issues and is a numbers-based strategy—the more the number of people who talk about the issues publicly the more effective the outcomes. Thus, the apparent importance of numbers can be seen, however, an analysis of the demographics and spatial circumstances of Vulindlela can be seen to undermine the strength of the numbers-based strategy. The social workers are more in tune with the revolution than the more educated people working with the

medical profession and believe that communication about HIV issues is central to effectual HIV prevention. In this drive, they undertake to teach and educate the masses about oral PrEP, bridge the gap between those who have information and the consumers of the information thus bringing information to the masses.

5.4.2. Communicative processes

Assessing the communicative role of the social workers revealed that client cases were influential in the various communicative roles and mediums used. Generally, through counselling and consultation, social workers communicate through educating clients on proper ways of self-care to maintain health and this is coupled with procedural demonstrations on hygienic practices and adherence to procedures. They also communicate information on consequences of not adhering to treatment guidelines, to this end telephonic calls to maintain a regular check-up with clients through routine calls were highlighted as among the primary communicative channels.

Figure 5.5 Communicative Processes



Source: Own construct using interview data

"I often encourage clients about cleanness and going to the nearest clinic, checking or testing for HIV and if tested positive, is a must to go for counselling and start to take treatment and

follow the proper routine and I give more information about consequences when not following a proper routine of treatment and informing them to be committed about the regular test" Participant 1

"It is the same routine as the prevention method we used before which is to give more method of prevention to clients" Participant 2

The data also revealed that social workers engage in communicating information that is designed to dispel client's misconceptions about HIV and AIDS which may foster irresponsibility or careless or indulgence in risky behaviour or even to not seriously consider preventative measures to protect oneself. One of the social workers pointed to a case where a client had come whom she was counselling concerning HIV/AIDS, and she raised the issue of a couple in which the husband was diagnosed and had died of AIDS, but the wife years later was still alive. How the issue was raised seemed to have been communicating a counter-argument to the social worker's position on the need for prevention against infections. To this issue, the social worker provided adequate information on what could make that case rare and a possibility.

"*These couples are called serodiscordant couples when one partner is HIV positive and the other is HIV negative. It depends on your blood type; some blood types are stronger than others (blood type A) are and can fight the disease" Participant 3*

Thus, dissemination of such information represents one of the important of the communicative roles and processes social workers adopt particularly in regions of limited information such as the rural area where such exceptional cases can be used as justification for complicit behaviour and attendant problems.

5.5. Contextual factors influencing the effectiveness of the communicative role of social workers in Vulindlela.

There were direct references to materials which responded to the primary inquiry of the research as revealed in the response of the findings from the data analysis to the central questions of the research. There was an extenuating factor that was observed during data analysis that influenced the lived experiences of the social workers in their communicative roles and behaviours in their various communities in Vulindlela. The major themes under which these contextual factors included, *the lived experiences of the social workers; the nature*

of social work, social issues connected with HIV/AIDS, and influential factors. These factors were seen to be in alignment with the various concepts brought about in the CCA-SEMCHB model as delimiting the context in which social/health workers can be effective in communicating interventions directed at influencing positive health outcomes in the communities they live and work in. These issues are elaborated further in Chapter 5, under the same heading.

5.5.1. Lived Experiences of the social workers

The social workers' experiences were characterized by several factors, which emerged from the analysis of the qualitative data. These are working with limited knowledge and information concerning various aspects of HIV and methods of HIV prevention, the need for personal empowerment with information to place them at an advantageous position to empower the communities they work in and their participation within the communities they work, which they aim to socially empower and develop to break the high prevalence of HIV.

"Yes, ngiyakholelwa ukuthi nginayo information but ngisadinga enye (I do have information but I still need more) ukuze ngizi (in order to empower myself so I can empower others in the community I work in (ngisadinga olunye ulwazi ukuze ngiludlulisele kwabanye nasemphakathini engisebenza kuwo" Participant 1

Figure 5.6 Lived experiences of social workers

Source: Own construct from interview data

The social workers also reported that their clients were mostly from HIV influenced disadvantaged circumstances, low socioeconomic status making it necessary to provide nutrition through food stamps for families that were affected by HIV. Most of these low socioeconomic status households were also households with no parents required the presence of foster parents to ensure that they eliminate adverse social development for the remaining orphans who are become exposed to HIV through risky behaviours. The social workers also made it clear in their responses that dealing with adverse social realities such as poverty, low socioeconomic challenges were effective means that must be combined with direct disease prevention methods, thus combating the spread of infections and lessening the effects of HIV mortality realities on the local societies.

"Yes, I believe I have information but I still need some information (to empower myself so I can empower others in the community I work in (I still need some information to pass on to others and the community I work with)" Participant 2

"Yes, I do a lot because most of the children that we work with are orphaned their parents died due to HIV and we even organize the program even at our local schools addressing children and adults about the spread of HIV and how to prevent a disease, even teaches about sign and symptoms of HIV" Participant 3

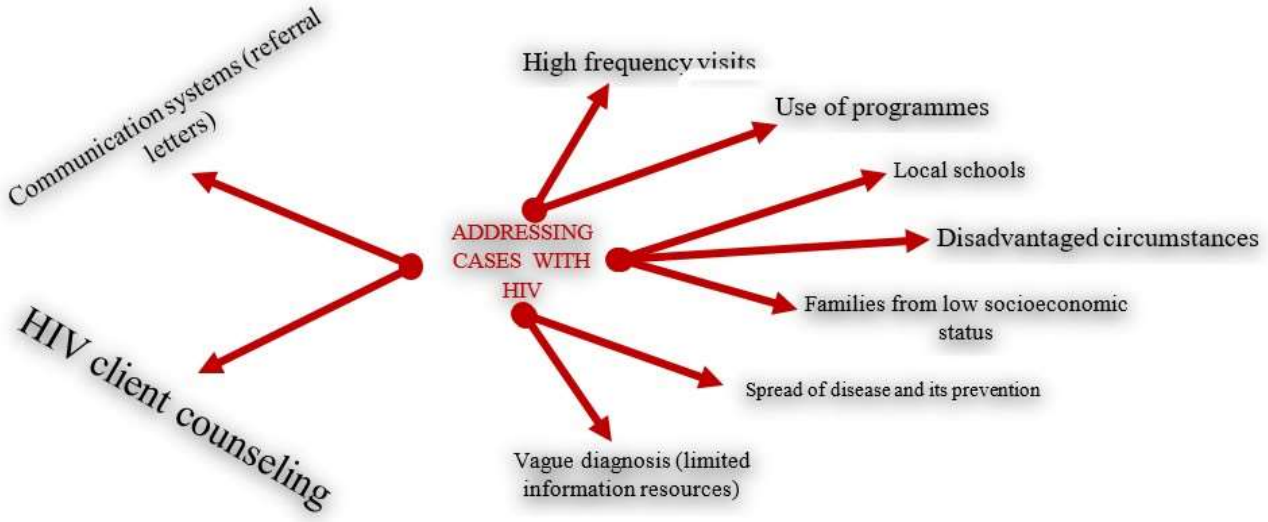
It can be seen that the social workers are working at a disadvantaged position in terms of resources such as information given the large communities that they serve. Campaigning and counselling on disease prevention and counteracting the spread of HIV are efforts greatly impeded by the social circumstances of the communities in which they are operating. Low socioeconomic settings at household level expose young females to risky behaviours, lack of parental guidance for orphaned families are worsening conditions for families left behind which deeply engross the HIV morbidity realities that characterize the lived experiences of the interviewed social workers.

5.5.2. Addressing cases with HIV

Though there are notable challenges in the ability and of social workers to effectively communicate PrEP as a viable HIV prevention option for their clients, there is still a need to consider their role addressing the increasing infection rates in the community of Vulindlela.

Social workers were interviewed about the HIV programmes that they support within the communities they serve in an attempt to explore what their role is and could be in the promotion of PrEP uptake in Vulindlela.

Figure 5.7 Addressing cases with HIV



Source: Own construct from interview data

The social workers pointed out that they frequently meet cases of clients either living with HIV or findings out their HIV positive status for the first time. They reported that most of these families were from low socioeconomic settings and the majority of cases particularly those affected with HIV were children.

"Yes, I do a lot because most of the children that we work with are orphaned their parents died due to HIV and we even organise the program even at our local schools addressing children and adults about the spread of HIV and how to prevent a disease, even teaches about sign and symptoms of HIV" Participant 2

While the use of awareness programmes at local schools was instrumental in educating masses both young and old people to counteract the spread of HIV and undertake disease prevention, such methods have not been as highly effective when numbers are involved since they reported the high frequency of dealing with HIV related cases. Mostly preventive education and campaigns are about signs and symptoms of HIV. As discussed in the living experiences of the

social workers, socioeconomic conditions present a limiting constraint on effective of education-based preventive measures and programmes. Furthermore, some social workers reported that they were under-skilled and had to give referrals to clients with a vague diagnosis of their underlying conditions due to limited information. This revealed the lack of both informational resources and the absence of effective communication systems that can aid the sharing of informational resources or the availability of tools to enable the social workers to undertake better diagnoses.

"Yes, all the time "ngoba siyazi ukuthi" Participant 1 (Response when asked whether they frequently interacted with HIV infected or affected clients".

"Not that much, when they come to us we refer them, we write a referral letter to the clinic asking them to assist this client as he/she is not sure what is wrong with them and we also ask them to offer the clients counselling if they can." Participant 3

Thus, from the social workers perspective, the challenges of addressing HIV related conditions are affected by the lack of resources both informational and material. Material resources can greatly improve efforts to educate and communicate with clients, provide better diagnoses or be able to get access to better information where they are working with novel cases or complex cases. Furthermore, local clinics are their main points of contact to which they write referrals for clients. In some studies (Bekker et al., 2016; Ngwenya et al, 2014), these have been seen to poorly staffed and under-resourced, which sometimes seemingly transfer the problem from one place to another. These factors can be instrumental in explaining the high reported prevalence of HIV in Vulindlela.

5.5.3. Nature of social work

An investigation into the nature of social work was instrumental in understanding the communicative role of social workers. These were issues not directed probed into during the interviews however were emergent in the open responses of the participants as they sought to elaborate on various issues and were thus analyzed and presented. The nature of the work which the social work is undertaken is in dealing with social trauma and restorative counselling particularly directed at people who find out that they have the infection and become confused as to the next step to take. Such information and its consequent unexpected conditions bring a

different future to the client as such information changes one's conception of self, as such restorative counselling was seen as important.

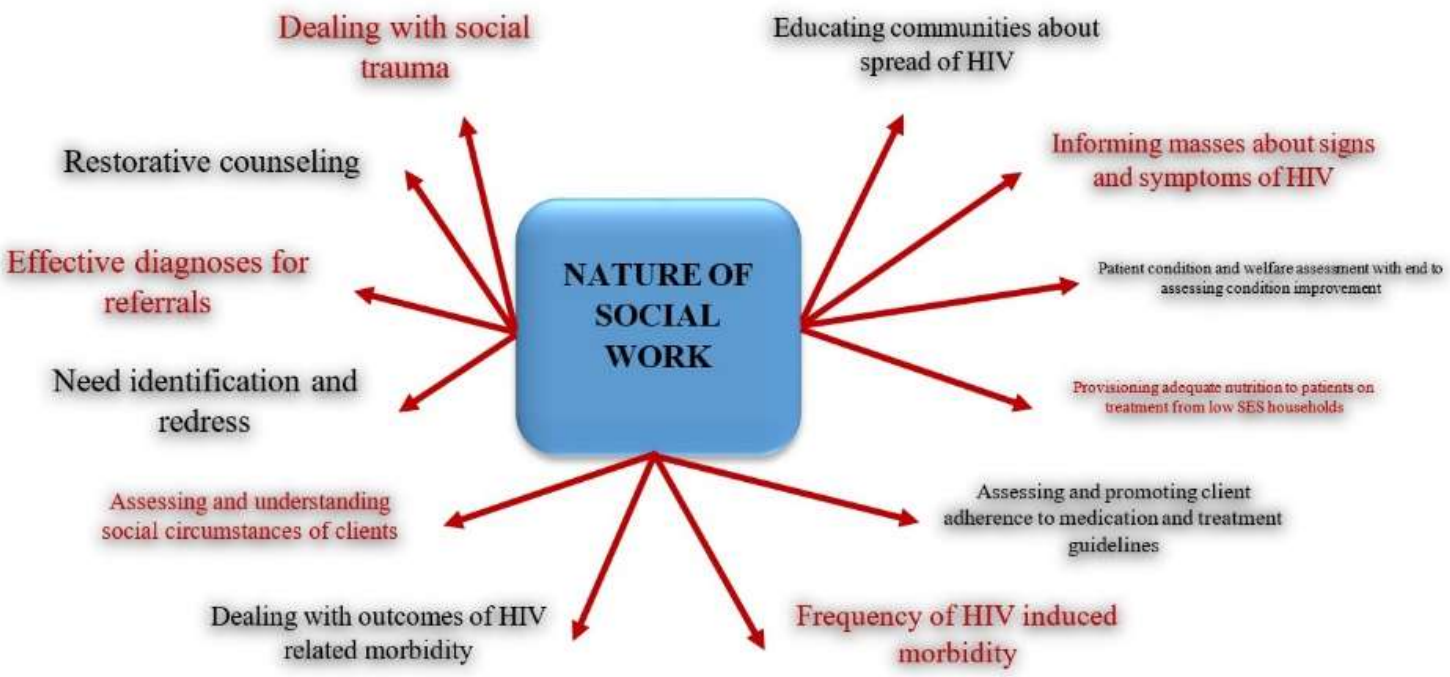
The social workers also engage in need identification and redressing within their immediate communities through checking client socioeconomic, family and other necessary background information thus assessing and understanding the clients' social circumstances. It was also seen that they follow on to find the source of the observed social circumstances and background of clients, this was more important since most affected clients as observed by the social workers were mostly children who were faced with the outcomes of HIV related morbidity. *"Because when the patient comes to the clinic, they find out about their unexpected conditions and then as social workers we counsel them if a need arise, we also refer them to other professions for further assistance" Participant 1*. The challenges of chronic illnesses in low socioeconomic communities usually leave dependents without any savings, thus in conditions of poverty and sometimes extreme deprivation *"Yes, I do a lot because most of the children that we work with are orphaned their parents died due to HIV and we even organize the program even at our local schools addressing children and adults about the spread of HIV and how to prevent a disease, even teaches about sign and symptoms of HIV" Participant 2*

"We also do follow up to check the welfare of the patients until their condition improves" Participant 2.

"But we have come up with food vouchers so that clients taking treatment can have food as they continue to take the medication or treatment at home but most of the time client/ patients they eventually die so, as social worker be there for their children and make sure if both parents have died and they have no relatives, we provide foster parents for them" Participant 3

In some studies, these conditions have been seen to result in other adverse developments such as low household human capital development, poor skills stocks, asset depletion that entraps households in debilitating chronic poverty conditions (Aliber, 2003).

Figure 5.8 Nature of Social Work



Source: Own construct using interview data

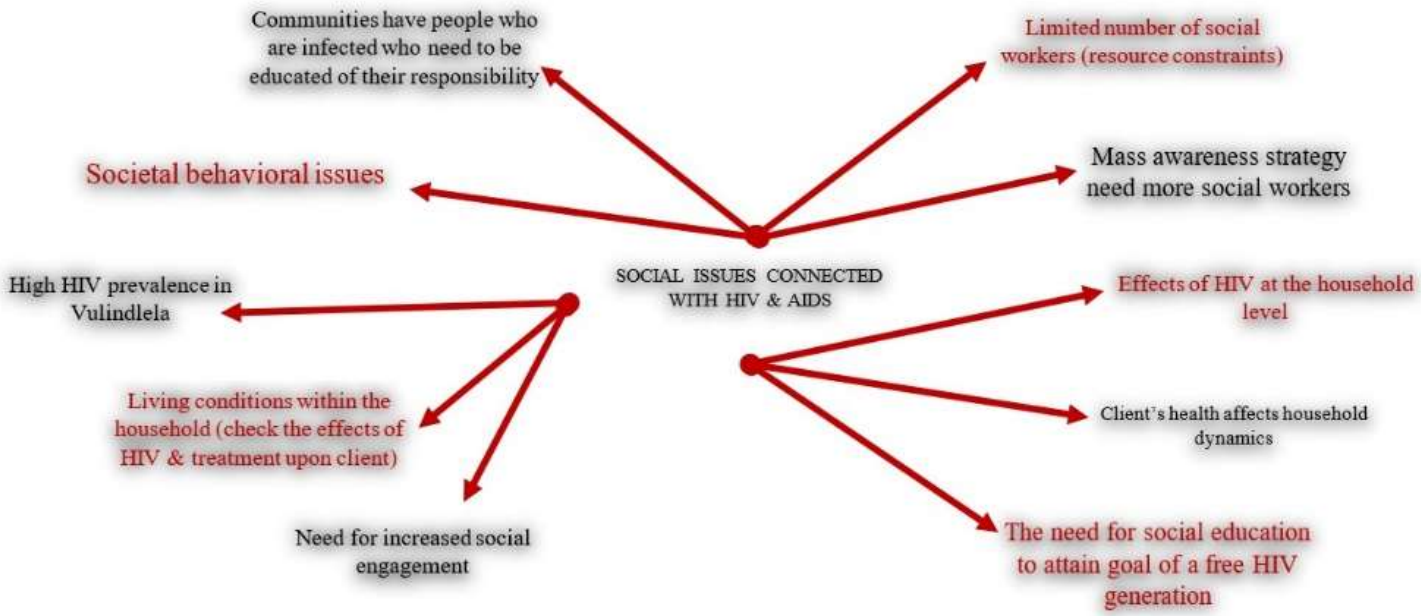
The work was also observed in educating children and adults about how HIV is contracted and spreads to infect others, what conditions promote its spread and informing masses about signs and symptom of HIV. The social workers engaged in patient welfare assessments with the end of assessing condition improvement. Such condition improvement assessment based on assessments of adequate nutrition intake and continued use of medication or adherence to treatment. While this is a holistic approach, it is resource-dependent. They further engage in provisioning adequate nutrition to clients on HIV treatment by providing food vouchers, assessing and promoting client adherence to medication and treatment guidelines. During their course of work, the social workers also reported the frequency of morbidity related to HIV as they reported that most of the time the clients or patients under treatment dies. They work to assure the welfare of orphaned households, finding foster parents for the left behind orphaned children thus influencing the shape and outcomes of the long-term social structure. Thus, an investigation of the nature of social work revealed the depth and extent of the engagement of the social workers with both their clients and their immediate communities enabling them to

undertake an effective communicative role in introducing and increasing the update of oral PrEP.

5.5.4. Social issues connected with HIV

HIV has outcomes for families and communities. In the data, the analysis shows that there are effects of HIV at the household level as well as at the community level. A consideration of literature on people living with HIV shows that such effects can be related to family income dynamics, the emotional toll on family particularly as HIV advances over time, for poor households medicinal costs can expend and redirect household limited means. According to social workers, there is a need for social education, which was reported, be presently constrained by a limited number of social workers, there is under-staffing given the size of the region of Vulindlela. While the social workers have the goal of a free HIV generation, the present high prevalence of HIV in Vulindlela was seen to be worrying. The immediate communities have infected people who need to be educated of their responsibility to stop the spread of HIV through being taught responsible behaviours.

Figure 5.9 Social issues connected with HIV



Source: Own construct using interview data

"i.e. for we know that HIV affects us all, our families, loved ones and our friends (bakhona abantu abasuke bethelelekile), so kubaluekile ngampela ukuthi njalo sihlale siaddresser, sibafundise nendlela yokuziphatha "how they can take care of themselves so that we can achieve an HIV free generation, ..., as currently the HIV prevalence is very high in Vulindlela" Participant 1

"There are few social workers available for a community as large as Vulindlela, they should be more social workers who will be able to go to the community and do awareness campaigns" Participant 2

"If a patient is not health enough, automatically the disease affect the social living of a client as well as the living of their family's even community amongst them if they do not practice the precautions when cleansing those clients" Participant 3

Between increased campaigns and the need for increased social engagement, and the high prevalence of HIV over a large geographical area, resource constraints affect mass awareness strategies, which require more social workers. Social issues connected with HIV are not adequately addressed which might help explain the high prevalence of HIV. While the nature of social work provides an effective platform for a more nuanced communicative role for social workers with their communities evidently, the lack of social workers limits the extent of social coverage.

5.5.5. Programmes that involve HIV prevention

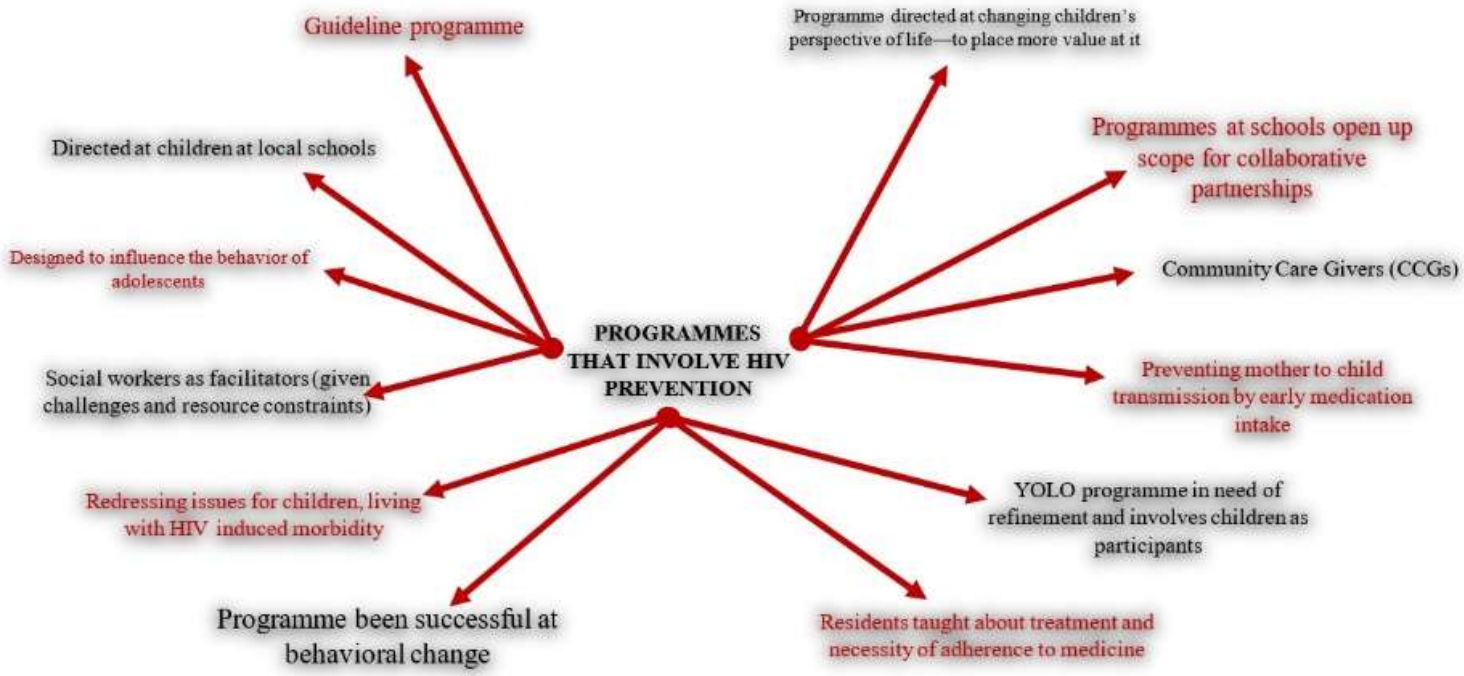
As part of the work that social workers do in the community is to support HIV prevention programmes as they mentioned during the interviews. The programmes are implemented in collaboration with community partners which are donor funded and with health facilities. The social workers interviewed directed the researcher's attention to two programmes, one directed at adolescent children at local schools and another one directed at people living with HIV and AIDS.

"Yes, we do have a program, which we call YOLO (you only live once) that we only use on children from 13 years and above, which we have used throughout the school ... it's more like thorough and work as our guideline program, ... how we must refine our program, ... as what is expected of us as a facilitator" Participant 1

"As a social worker, we have a program based on HIV and AIDS including CCG (caretakers) which are living around the community, who often help around the community and those infected patients" Participant 2

"Yes, we do have them. We combine them with parenting skills programmes. Most people who live in rural areas are not educated enough about HIV so in these programs we teach them to take their medication early if they have tested HIV positive to avoid mother to child transmission" Participant 3

Figure 5.10 Programmes aimed at HIV Prevention



Source: Own construct using interview data

The former called YOLO an acronym for "You Only Live Once" is directed at changing the perspective of adolescents on life teaching them to take responsible behaviour and place much value of their lives and their actions. The latter called Community Care Givers (CCG) is directed at assisting communities and families living with HIV and AIDS on proper care and treatment of those infected to reduce stress upon the families and ensure the welfare of the

affected households. According to the social workers, YOLO is a thorough guideline programme directed at up-skilling the adolescents regarding HIV prevention and has been seen to be effective by assessors and teachers of the children at school at the behavioural level. The programme was seen as instrumental in effective adolescent behavioural change. The programme such exhibits the scope for collaborative partnerships between social workers and teachers and the rest of the community, since the social workers themselves are the facilitators of the programme, hence aiding their communicative ability within the communities they work. While directed at schools, the social workers did not shed light on children who might not be at school, which the researcher assumed might be reached probably by other community social programmes, however, lack of these may indicate that such a class of children are not reached by social work-based programmes, at least early enough.

Through the CCG programme, the social workers work in conjunction with caregivers who reside in the societies and help to identify a need and notify the social workers concerning those infected. The programmes are effective in aiding the communicative role of social workers through providing space for collaborative partnerships; the YOLO programme facilitates collaboration with teachers and student assessors (counsellors) who can give feedback to social workers, which information will be instrumental in refining the programmes, adapting them to dynamic needs and challenges. The CCG programme enables social workers to work with community-based caregivers, who reside within the concentric communities and can provide guidance and input into the programmes undertaken by social workers as well assisting them with need identification and directing of aid. Finally, collaborating with parents through the parenting skills programmes connects the social workers with the family unit, which is the foundation of society. Thus, the data shows that social workers can maintain collaborative relationships with the main institutions of their immediate societies, solidifying their communicative roles in the introduction and uptake of oral PrEP. However, other factors especially when such programmes are considered in context become important, such as the frequency with such programmes are undertaken, feedback mechanisms, community attitude to programmes etc., which factors seem to not have been highlighted during data collection.

5.5.6. Working conditions of social workers

On arriving at the sites where the interviews were undertaken, the researcher observed that some of the social workers did not have office space at all and some shared space in small

mobile offices, which is a critical resource particularly when there is a need to keep a portfolio and data.

"There was no office space, social workers work in mobile offices they are sharing offices which means there are less confidentiality" Researcher's Notes

This was observed to be a possible explanation for the lack of advanced communicative equipment or the information access disadvantage the social workers were working with. Some information concerning HIV prevention and treatment can easily be accessed on online databases, however, with no office space, this becomes difficult to achieve. Shared office space means no confidentiality among the social workers and more importantly between social workers and clients assigned to them, in rural areas this can be a great inhibiting factor for residents to access such areas, as stigma still exists over infected people. Concerning some issues, the social workers were not informed and preferred such questions be directed to nurses, however with the researcher's background, such issues, which were probed during the interviews, were within the scope of the clinical social worker's skill set. As such, as far as clients were concerned about the consultative efficacy of the social workers were severely delimited by limited information endowments.

"Social workers that I interviewed preferred that I interview nurses because they don't know much" Researcher Notes

"Now that you understand what oral PrEP is, as a social worker what would you do to encourage people to take it or let them know about it?" Researcher

"I would create a programme, sit down with them and talk, get pamphlets that they take home and read" Participant 3

5.5.7. Training of social workers

On being asked concerning whether there were any formal training platforms provided for them, the social workers all alluded to generalized training workshops covering diverse issues; however, they have not received any specific training directed towards oral PrEP (*Pre-exposure prophylaxis)*. Workshops were pointed out to be generic, covering many general to specific issues. They were pointed however as limited in not being adapted to the diverse needs of the social workers who worked with different sections and community issues. Furthermore, most of the

social workers were not able to attend most of the workshops depending on feedback and notes from those who would have attended. The generic nature of the workshops levies them to be of limited impact with novel methods in HIV Prevention and education. The researcher also observed that low costs innovation is needed and can be instrumental in information dissemination to help increase access to information for social workers in Vulindlela.

"I would like to be not specific about my answers but we do get workshops even though we are so many social workers in a field with different sections most of the time, they take those workers who deal with HIV and AIDS to workshops that cover most of HIV talks but they do inform us about minutes of the meetings and give us the feedback about workshop discussions" Participant 1

"We have not received any training about or PrEP but yes, we do get training" Participant 2

5.5.8. Role of Social Workers

The role of social workers in general was explored to better locate them within the HIV prevention field and to further understand the role they could play in the promotion of PrEP uptake. As reported by the social workers most of their roles revolved around psychosocial support with limited focus on HIV programmes specifically though they participate in HIV prevention programmes at times.

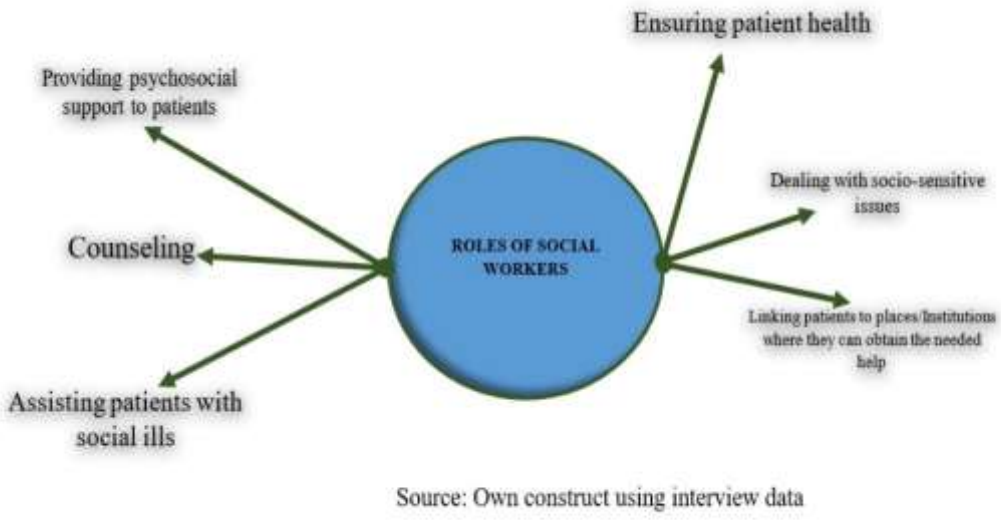


Figure 5.9 Role of Social Workers

Interviews with the social workers indicated their roles differed depending on whether they worked within clinical settings or not. Furthermore, some roles were specific, while other roles

were contingent depending on the varied circumstances presented by the communities they work in. To this end, it was observed that the social workers in Vulindlela worked on flexible schedules and adaptive depending on the circumstances of their clients and their immediate communities.

"So, the role of the social worker at the clinic is to provide psycho-social support to patients who happen to be our clients, through counselling" Participant 1

"The social worker has only one role in a clinic or wherever is to help people with different social ills that they face which may come with many situations which they are facing, so clinical health of a patient is a priority" Participant 2

"I'm not sure about a social worker in clinics but we work with them, for example, let's say there is a child that has been raped we go to the clinic with a form M36 and they take the child to the doctor to test if the child was not infected when he/she was raped and they also offer their patients counselling that is as far as I know about social workers in clinic" Participant 3

"We give them counselling and refer them to other places where they can get the help that they need" Participant 3

The tasks that were reported by the social workers include providing psychosocial support to patients who visit the clinics for treatment and counselling, assisting patients with social ills, ensuring patient health and patient counselling. Their work includes dealing with socio-sensitive issues such as assisting patients suffering induced psychological trauma such as victims of rape, whom they have to ensure that their cases are lodged with the respective centres of health and that they are given proper medical attention. Thus, the roles of the social workers enable them to interact and engage with clients in diverse ways and also engage with other institutions and professions in servicing clients who frequent clinical institutions where they are based.

5.5.9. Assisting clients living with HIV and AIDS

The social workers indicated during the interviews that they frequency attend to issues about and concerning people infected and those living with HIV and AIDS. The researcher then probed into the various ways in which they assist their clients living with HIV and AIDS to which information dissemination, pre-and post-testing counselling, regular checkups and

routine calls to ensure adherence to treatment and treatment guidelines, were among the prominent responses. Thus, the social workers provide counselling to clients on the benefits of HIV treatment, adherence to treatment for those who test positive and counselling on the need for regular testing checkups and ensuring that the clients have access to all needed information.

"*Ok, we assist...ngokuthi sibanikeze ithemba lokuthi, like basabangakwazi ukuthi baphile, ikhona itreatment esebenziswayo which right for them and the government is supporting people who are taking treatment kufuneka baqikelele ukuthi itreatment yabo bayidla ngendlela efanele, so minake as a social worker...ngingenelela ngokuthi ngenze amavisits, like make amaphone calls to check up on our clients to ascertain how well they are doing in adhering with their treatment guidelines.*

*Ok, we help ... by giving them hope that, as long as they stay on the treatment they can live longer and healthier lives, there is utilization that is right for them and the government is supporting people who are taking treatment. ..I get in touch with making videos, like making calls to check up on our clients to ascertain how well they are doing in adhering with their treatment guidelines" Participant 1 [**direct translation of above extract]***

Figure 5.11 Assisting clients living with HIV

Source: Own construct using interview data

According to one of the social workers, sources of clients' information and assistance include government information, access to public health dispensaries as the South African government is actively involved in ensuring access HIV treatment medicines and information dissemination through awareness campaigns. To do this work effectively, the social workers have to maintain an updated client database, with updated information on clients so that routine calls and routine upkeep checkup is maintained. However, given the problems of office space discussed earlier, such tasks are not maintained optimally and worsened further by limited resource bases the social workers were working with.

*"*Yes, I do a lot because most of the children that we work with are orphaned their parents died due to HIV and we even organize the program even at our local schools addressing children and adults about the spread of HIV and how to prevent a disease, even teaches about sign and symptoms of HIV" Participant 2

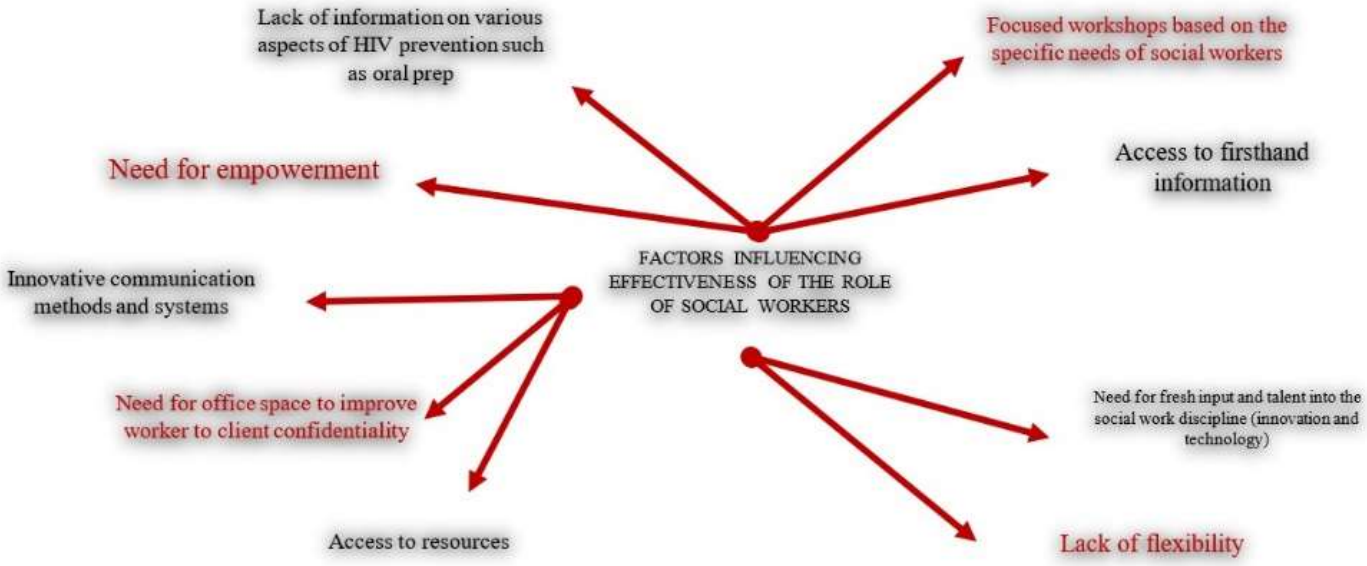
"I often encourage clients about cleanness and going to the nearest clinic, checking or testing for HIV and if tested positive, it is a must to go for counselling and start to take treatment and follow the proper routine and I give more information about consequences when not following a proper routine of treatment and informing them to be committed about the regular test" Participant 3

"We give them counselling and refer them to other places where they can get the help that they need" Participant 3

Other ways of assisting clients include redressing issues for children living with HIV induced morbidity, educating on ways the disease spreads and combating the spread of disease in the community, educating on the signs and symptoms of HIV and encouraging communities to know their HIV status. Furthermore, they educate communities on good hygienic practices, the need for utilization of clinical services such as counselling, checking and testing for HIV. As discussed earlier also restitutive and restorative counselling for people who upon regular testing discover that they are HIV positive to help them grapple with their new reality and transition to a new lifestyle and to help them see their new condition not as different from their previous existence but that they can still live and maintain healthy lifestyles. Finally, they also give clients referrals to other institutions where they can obtain help and further clinical services when needed.

5.6. Factors influencing the effectiveness of the role of Social Workers

Figure 5.12 Figure 1Factors influencing role of social workers in Vulindlela



Source: Own construct using interview data

Several factors as shown negatively affects the role of social workers in Vulindlela. These factors include lack of information on various aspects of HIV prevention such as oral PrEP. Such information according to the social workers was important if they were to be able to empower the communities in which they work. The social workers need to be empowered which includes direct access to workshops and training platforms that are directed for their specific needs. Information is vital given the changing dynamics of the social environment.

"Yes, I believe I have information but I still need some information (to empower myself so I can empower others in the community I work in (I still need some information to pass on to others and the community I work with)" Participant 1

"Social workers that I interviewed preferred that I interview nurses because they don't know much about Oral PrEP" Participant 1

"I would like to be not specific about my answers but we do get workshops even though we are so many social workers in a field with different sections most of the time, they take those workers who deal with HIV and AIDS to workshops that cover most of HIV talks but they do

inform us about minutes of the meetings and give us the feedback about workshop discussions" Participant 2

5.7 The CCA-SEMCHB Model in the findings

The CCA-SEMCHB model suggests that the social worker must aim to align their knowledge within the context of the community. In this study, the social workers' knowledge was investigated for its embeddedness within the shared meanings and understandings of what constitutes a healthy community from the perspective of the community participants, whom the social workers engage with daily. The idea was to understand from the lived experiences of the social workers in their interactions with their respective communities and what they have come to conclude as the possible problems associated with observed health outcomes. According to this study's findings on the investigation of the lived experiences of the social workers in Vulindlela, it was revealed that they were working with limited information in their related fields which constrained their capacity to effectively influence their communities on various aspects of HIV prevention (sub-section, 5.5.1). Furthermore, while some socio-structural elements were observed (figure 5.5.1), the existence of shared dialogue or knowledge about the community reached through shared dialogue was not found in the interviews even though the data was clear on observed social determinants of health outcomes.

External interventions have efficiency only as they are incorporated and assimilated within the socio-structural and cultural underpinnings of the target societies. To this end, the knowledge and attitude of the social workers on the effectiveness of oral PrEP is influenced by their understanding of the societies or communities in which they operate. The application of the CCA-SEMCHB model was justified in this study by the fact that this kind of experiential knowledge requires a participatory approach in which the influencing agents have to incorporate themselves within the context of those groups they want to understand and influence. Thus, social workers working in Vulindlela are placed in a favourable context to understand both the cultural and social underpinning of observed health behaviour. This knowledge can also be seen shaping their programmes and what they reported to be the requisite course of action. However, there was no demonstration from the findings of whether there was any co-construction of programmes or meanings in health interventions between the social workers, other agencies and the community of Vulindlela.

The cultural and socio-ecological underpinnings achieved through shared understanding or co-construction of knowledge and understanding becomes the motivating factor in the uptake of campaigns and community action plans the social worker assumes towards any given

intervention. The model directs contextual communicative systems as against universalistic or generalized models of communication, as understanding the social and cultural contexts of communities makes each context-specific, and demands that interventions and communications be designed and communicated as pertaining to each given social-ecological and cultural context. The findings of this study were able to demonstrate this proposition by showing how the social workers took the demographic and social dynamics of the Vulindlela community into account in the design of their HIV prevention and awareness campaigns. They also demonstrated awareness of information needs for the community and reported on various psychosocial aspects that required redress. The findings further demonstrated that in addressing cases of people with HIV, social workers had at their disposal HIV counselling and testing through local clinics, communication systems (such as the use of referral letters) combined with addressing cases of young people at local schools, use of programmes, addressing cases of people from disadvantaged circumstances, families from low socioeconomic status households and working to halt the spread of disease and its prevention through novel methods (which the findings have demonstrated that the social workers have very limited information concerning leading to vague diagnosis due to these limited information resources.

Furthermore, the study uses the CCA-SEMCHB theoretical framework within an interpretivist-based study design. These tools of analysis combined focus on the interpretivist role of the health expert, with the resultant understanding of a community emanating from it being highly subjective to the knowledge, skills and experience of the observer. There is therefore a heavy reliance on expert knowledge and while yielding a broader understanding of the multifaceted factors that influences observed social behaviour. The social participants themselves seem not to be considered in shaping health interventions that affect them. In the study, this was observed from the data as the participants focused on responses that focused on their knowledge and their individual experience in addressing social problems in Vulindlela which are contributory to the high HIV prevalence. There is no single social worker interviewed who highlighted having held dialogues with incumbent communities for creating shared understanding concerning the potential health challenges.

5.8. Conclusion

These data findings have revealed that the social workers interviewed carry out several dynamic roles in the communities in which they work, in which they influence the social issues of those communities about HIV and AIDS. In these roles, it was observed that they influence their communities mainly through information dissemination, programmes designed at community engagement and through collaborative partnerships with various institutions, schools and social institutions. However, their roles were seen to be affected by poor resource endowments, lack of access to important information on HIV prevention and other measures. However, the findings showed clearly that the social workers were heavily integrated with the communities in which they work and thus have the potential to play an important communicative role in the introduction and uptake of oral PrEP. To this, however, there is a need for education and access to information for the social workers concerning oral PrEP.

Chapter 6: Discussion of Findings, Conclusions and Recommendations.

6.1. Introduction

In this section, the findings of the study presented in Chapter 5 are discussed with an assessment of how the research questions of the study have been addressed. To accomplish this, the major questions of the research are stated and the findings of the study are discussed in light of these questions. The discussion of the findings also draws from existing literature as well as the concepts presented in the theoretical framework, to assess how the model has been adequately applied in the study. This will also demonstrate how this study aligns with findings in the existing body of literature, as well as the novel contributions of this present study to the existing body of knowledge. This chapter also outlines the main conclusions of the study and provides recommendations.

6.2. Study findings and the research questions

6.2.1. What is the level of knowledge among social workers about HIV prevention?

Concerning knowledge endowments of social workers, it was suggested in the review of literature that social workers require skills and knowledge to carry out their duties in counselling patients with regards to medical conditions (Zastrow, 2004). This knowledge endowment was also seen to be important in their capacity to educate and train other people who may be influential in increasing uptake of HIV prevention interventions (Eaton et al, 2014). It was also suggested that as social workers become increasingly involved in primary prevention of HIV, their knowledge is expected to evolve. This followed from the theoretical position that medical interventions by themselves are not sufficient to prevent new infections, given the non-medical contextual factors that propagate risky behaviours or expose people to HIV, to be effective collaborators with medical practitioners and position their work more effectively, it follows that the knowledge of social workers should evolve. This evolution must necessarily include both the changing dynamics of the disease, its contextual environment and the associated demography of new infections (Strug, Grube & Beckerman, 2002).

Another study by Poloko & Musamba (2012) also postulated that knowledge of social workers concerning HIV prevention strategies is important as it has relevancy to the cultural contexts of those who are targeted by those preventative interventions (Poloko & Musamba, 2012). Knowledge was observed to be important since social workers do not prescribe antiretroviral medications, they were not familiar with or had no knowledge to comfortably advise or promote PrEP as a viable option, making it difficult for patients at high risk of HIV infection to access oral PrEP The knowledge thus deemed important and instrumental in the optimal disposal of duty is contextual knowledge of HIV prevention within the contextual settings of

the social worker. In other words, the knowledge that is applicable within the social context of the individual social workers and the structural determinants of that knowledge.

The data analysis showed that social workers had some knowledge capabilities as well as limitations. Thus, in alignment with the existing literature (Poloko & Musamba, 2012; Strug, Grube & Beckerman, 2002), social workers in the study knew needed to carry out their duties as well as the constraints they faced due to limited knowledge in other aspects of their work concerning HIV prevention and community education. These constraints included not being able to communicate novel HIV prevention methods they were not familiar with due to limited access to information or training. The study demonstrated through the findings the importance of knowledge of one's health as influential to the individual choice to commence treatment or adhere to preventative methods. Thus, without sufficient knowledge on HIV prevention and methods, social workers cannot adequately fill in this gap for those who want to improve their health outcomes within incumbent communities.

In line with existing literature (Poloko & Musamba, 2012; Strug, Grube & Beckerman, 2002) the study found that there was lack of knowledge concerning various aspects of preventative interventions particularly the novel ones among social workers in Vulindlela. The social workers to this end saw such knowledge acquisition as empowerment needful for improvement in carrying out of their duties as educators of the community. The extent of the usefulness of existing knowledge that the social workers had was demonstrated by the reported activities they undertook in the community of Vulindlela which included HIV awareness campaigns, programmes aimed at HIV prevention for children, provision of education and training for those living with HIV infection and increased HIV counselling and testing which at best they could promote as the work was carried out by medical nurses at medical centres in Vulindlela whom they worked in conjunction with. Thus, these collaborations between social workers and medical healthcare workers were seen as important in overcoming the limitations of access to important knowledge or the existence of disempowerment. This followed from the argument of one social worker who saw knowledge as empowerment both to social workers and to the community, thus a lack of it, is structural disempowerment.

Other activities carried out by social workers in Vulindlela reflecting their knowledge endowment included community outreach programmes where community participants were encouraged to undertake lifestyle changes whether they were infected or not, undertake regular counselling and testing. However, these are conventional methods with broad targeting

demonstrating ineffective outcomes as demonstrated by the existing statistics that Vulindlela had higher than average infections rate as compared to similar geographical locations in South Africa, owing to the demographics of the area. The fact that social workers have been considering this in their planning and programme execution can be seen in that the majority of the programmes that comprise their HIV prevention strategies broadly target the young demographics (Figure 5.2.1).

The knowledge levels of the social workers as demonstrated in the tools and strategies available to them in their campaigns in Vulindlela does not seem to have evolved to include new and emerging preventative methods. This could be the factor accounting for the high HIV prevalence among the young demographic cohorts in particular. The findings summarized in Figure 5.3.1, also showed that the social workers demonstrated very little knowledge of novel preventive methods and interventions particularly oral PrEP. This extends the conclusion by Pokoko and Musamba (2012) that social workers were observed in a study to not feel comfortable with advising clients on medical intervention, solutions or procedures they were not sufficiently informed about or were succinctly knowledgeable of, or cannot relate to no matter how effective. Thus, community awareness becomes relegated in knowledge and methods to the best-communicated information. Knowledge and information access were thus demonstrated from the study to be a key factor in how social workers effectively communicate HIV prevention strategies, the absence of which adversely affects the effectiveness of their roles to their communities.

6.2.2. What is the level of knowledge and what are the attitudes of social workers towards oral PrEP as an HIV prevention method?

In the foregoing section, it was shown from the extant literature that social workers were seen to be constrained in their fight against HIV if they lacked knowledge concerning new or emerging HIV preventive methods which are designed in light of increasing information and understanding of HIV and AIDS (Eaton et al, 2014). According to the extant literature, social workers would be better placed in carrying out their duties, if they had an understanding of clinical trials and associated processes and what they can do to facilitate the process for clients, in adopting novel HIV preventions such as oral PrEP for example. These clinical trials were observed to provide information on emerging preventive measures for fighting HIV and AIDS, which can be useful to clients. Oral PrEP, a drug taken by HIV uninfected persons to block the acquisition of the virus, was demonstrated to be highly effective, with South Africa becoming

the first African country to approve its use as an HIV prevention therapy (Avert, 2019). A study also demonstrated that key populations who are most at risk of HIV infection and most likely to benefit from these therapies face many social, legal and behavioural and other barriers to accessing these therapies (Patrick et al, 2017).

The findings of this study showed that the social workers interviewed did not possess any knowledge of oral PrEP (Figure, 5.3.1). Their knowledge ranged from limited to hearsay, fragmented knowledge to complete ignorance and having received no training concerning oral PrEP. The limited knowledge concerning oral PrEP which the social workers reported during the interviews, completely agrees with the reported findings in empirical studies on the use and effectiveness of oral PrEP such as its use as pre-engagement therapy. Given the structural disadvantages that young females were reported to face in Vulindlela, such as the existence of wide age gaps with intimate partners which limits their capacity to negotiate safe sex. Oral PrEP is user-initiated and can be taken by young females without negotiation from intimate partners can be effective in helping the young females to uphold their health even in the context of powerlessness and limited bargaining power over their health.

The level of knowledge concerning oral PrEP among social workers is very limited and constrains the efforts to target and reach the demographic at most risk of HIV infection, the young females who are at risk because of contextual, socio-economic and other factors. Absence of training can signal a lack of concerted efforts at the institutional level in maintaining the stock of knowledge concerning new preventive measures among the social workers. Lack of knowledge inevitably results in social workers not educating the community about oral PrEP.

6.2.3. How can medical social workers communicate about oral PrEp to clients?

In the findings, the various avenues for the social workers to communicate information about oral PrEP were noted, among these were awareness campaigns, community education and individual counselling. These avenues were demonstrated to be made effective by ensuring that the social workers have access to the requisite information, through training and similar avenues that ensured that social workers have more access to information and necessary developmental opportunities. Figure 5.2.2., demonstrated the various ways in which social workers reported how they were being affected by limited access to information.

It was also demonstrated in the findings that the available communication processes available to social workers coupled with their communicative roles provide the avenues for

communicating about oral PrEP to the communities. These communicative processes included procedural demonstrations, routine calls and information dissemination, use of community programmes and use of referral letters (Figure, 5.5.2).

In the extant literature, the use of community educators and advocates were pointed as having an increasingly important role in raising awareness about oral PrEP in their communities, with WHO advocating for use of its updated information on PrEP to be considered in community-led activities aimed at increasing knowledge and awareness of PrEP thereby generating demand and access (WHO, 2019). These conclusions in the literature thus align with the methods observed in the data as the available means for social workers in communicating about oral PrEP to their communities. It is also interesting to notice that extant literature generally agrees with the idea that increased awareness, is the most effective avenue to generating demand and consequently increased access to these effective therapies given the cost of accessing them.

6.2.4. Why is the communicative role of social workers important or not important?

The role of social workers in the extant literature is stated, they advocate for and promote social change and problem-solving in human relationships and community empowerment to enhance people's wellbeing (International Federation of Social Workers, 2001). In South Africa, social workers were observed to carry out casework working with their clients using multilevel problem-solving approaches that empower the primary client and advances change within the community (Nicholas et al, 2010).

The study findings demonstrated the role of social workers in assisting clients living with HIV and AIDS. Social workers were shown to undertake various roles such as providing counselling on the benefits of HIV treatment, encouraging adherence to treatment and healthy living, organising awareness campaigns, educating clients on signs and symptoms of HIV and redressing issues for children living with HIV (Figure 5.5.8). Thus, intervening at these various levels and servicing their incumbent communities', social workers can influence change through their communicative roles. The extant literature found these roles to be important in the prevention of new infections, as infected persons were seen to require a wide variety of medical and psychosocial support service (Vourlekis, et al, 2001).

The findings further demonstrated that various factors influence the effectiveness of social workers in carrying out their roles. These factors include access to resources, empowerment, innovative communication methods and systems, access to important information and focused workshops based on specific needs of the social workers (Figure 5.6). In the roles of social

workers, it was also shown in the findings (Figure 5.5.7), that some duties in the fulfilment of these roles transcend any limited identification of social workers whether as medical social workers (Nicholas et al, 2010). Social workers working with social development practitioners are at the forefront of alleviating the hardships and challenges that peoples, communities and societies face (Lombard, 2015). In line with these observations, the findings also showed that social workers meet these needs through their active role in counselling, ensuring patient health, dealing with sensitive social issues, assisting patients with social ills and linking patients to institutions where they can obtain the needed help (Figure 5.5.7). Thus, social workers are demonstrated to fulfil important roles and bridge gaps between providers of care and recipients of care, thus ensuring increased health outcomes and welfare in the communities they work in.

6.3. The findings and the CCA-SEMCHB

6.3.1. Discussion on the CCA

The CCA is premised on the assumption that health communication can have instrumental outcomes only when there is co-construction of meanings and perspectives on health between the researcher/policymaker and the targeted community and its cultural participants (reference). To this end, the researcher must seek to engage the community in dialogue and find ways of designing interventions based on the co-constructed understanding of what constitutes health problems and expected health outcomes (Dutta, 2017). In the analysis of the communicative roles of social workers, the findings of which are reported in Figure, 5.4.1, social workers were seen to fulfil a role of bridging the gap between institutions and communities, in which their duties connect social infrastructures and institutions with the communities they serve. Through social engagement and meaningful dialogue, by social/public discursive platforms, the social workers in Vulindlela were demonstrated to be more in tune with the revolution and are in a better position to communicate on issues central to HIV prevention. Thus, through teaching and educating the masses they engage with those with information and the consumers of information, thus connecting with the masses in alignment with the CCA, that dialogue results in shared communication and co-constructed dialogue where the exchange of meanings and ideas happen.

The CCA presented the idea of subaltern participants, characterised residing outside the established structures of power, or hierarchical structures, resulting in their voices being left out in conventional methods of health intervention (Dutta, 2015). The study established the effectiveness of the role of social workers in Vulindlela in incorporating marginalised sections of the community through strategic communications and programmes directed towards such.

For instance, the existence of community hierarchies, unequal distribution of power along gender lines resulting in powerless, or those experiencing HIV induced morbidity and subsisting in conditions of deprivation or low socioeconomic conditions. These aspects have been demonstrated in a study to engender social exclusion or non-participation from social and economic life (Aliber, 2003). Social workers thus in their integrating programmes and community work, bridges this gap and incorporates the powerless and marginalised to the centre of the discourses determining their health outcomes.

The CCA proposes that cultural elements in a community are important in creating effective communication and shared understanding between the communicants (for instance, the social workers in this study) and the recipients (the targeted community of Vulindlela) of the information. The idea is that culture shapes values, beliefs and behaviours that influence health outcomes and various studies have demonstrated that cultural symbols tend to show salience and resilience in rural as compared to urban/more developed settings. However, it is the socioeconomic, political and environmental dynamics that differentiate the two spatial geographies (Max et al, 2015). The reported findings demonstrated that social workers in Vulindlela were aware of the need to create synergies between knowledge and HIV awareness campaigns and programmes; with the underlying processes and knowledge systems associated with cultural definitive values of the local population. The findings (Figure 5.4.1) showed that the social workers aimed to use information dissemination which they described as a numbers game, such that the more people in the local population discussed these issues, the more effective the communication would be. But the uptake of the discourse around these issues within the local population depends on the design of the communicated information and the consequent capacity of the prospective communications to align with the cultural symbols, meanings and discourses of the local community. This factor of CCA furthermore aligns well with the idea of structure and its implications for communities in making choices or engaging in health affecting behaviours. Since the structure was argued to limit access to resources and opportunities for participation for marginalised communities. Thus, social workers in Vulindlela can be argued to provide an effective structural bridging role in shaping health outcomes for the marginalised and powerless, effectively giving them a voice and a representation (Figure 3.2.1).

The CCA approach postulates that structural inequities such as poverty are associated with observed health experiences and outcomes (Dutta, 2017). This argument agrees with the SEMCHB which adopts a multifaceted approach to health communication and behavioural

change. Through this approach, social determinants including structural inequities that define the context within which decisions are made that affect health outcome are considered. The extant literature was clear on the finding that poverty and other adverse socioeconomic welfare conditions have been precipitating risk behaviours observed among young females in Vulindlela (Bouare, 2009). The findings from this current study concurred with the presence of contextual factors, which needed to be addressed if health interventions were to be successful, among these were the existence of clients from disadvantaged backgrounds and circumstances, families from low socioeconomic backgrounds and the disempowered and marginalized segments (Subsection, 5.5.1).

Cultural practices are at the centre of health discourses and understanding is shared which is the outcome of dialogue (reference). This suggests a shift in the role of social workers from an external interventionist planner to a listener and participant who engages in community dialogue. Social workers pledge themselves to the constant transformation of reality. Through listening to the voices of the marginalised/disempowered in the community space who are identified as having sub-normal experiences (Dutta, 2015). Beliefs and practices related to health in every human community form the central features of that culture, with sociocultural factors determining how people respond to illness.

According to the CCA, health communication must identify barriers to health communication and incorporate these into successful communication that targets identified limitations. The social workers in Vulindlela identified the presence of adverse socioeconomic developments among different households and reported that majority of clients were from disadvantaged circumstances requiring nutritional support particularly for families living with HIV (where either family members are living with an infected person, or the entire family is living with the infection). Some of these households were also found to have families with no parental support, with the remaining orphans being exposed to risky behaviours. The social workers in light of this also proposed that dealing with these adverse social realities such as poverty, low socioeconomic challenges were effective means that must be combined with direct disease prevention methods thus combating the spread of new infections and lessening the effects of HIV mortality realities (sub-section 5.5.1).

6.3.2. Discussion on the SEMCHB Model

The SEMCHB model is based on the proposition that there exist multiple influences on specific health behaviour called social determinants of health (reference). The importance of this model

can be seen in observed differences in health outcomes among different cohorts or demographic groups of the population. To this end, the model emphasizes that these social determinants of health must be investigated and understood if community health outcomes resulting from behavioural patterns are to be understood and effective interventions designed and implemented (Ngwenya, et al., 2014). The extant literature showed that the existence of unequal intimate relations between young females and older men, resulted in diverse challenges such as the inability of the young women to negotiate safe sex, intimate partner violence and engagement in risky sexual behaviours such as peer pressure or alcohol intake before sex (Giovenco et al, 2019; Fisher et al, 2007; Veenstra, 2006). The findings of the study demonstrated that the majority of the programmes undertaken by the social workers in HIV awareness and education were designed and strategically directed towards young adolescents in high schools who they perceived to be at the risk of increased HIV infection through these psychosocial variables and pressures (sub-section 5.5.5). This finding aligns with the proposition of the SEMCHB model's focus on the development of strategies to address social variables that affects a given community's health (Max, et al, 2015), which role the social workers were seen as addressing and catering to the broad grouping of Vulindlela community, the general community and adolescents.

The SEMCHB argues that social elements affect health outcomes and these elements referred to as, the social determinants of health are shaped by social, economic, political and environmental forces that shape the context within which the agents make decisions that affect their health outcomes (Dutta, 2017). Social determinants according to this framework are the broader factors that transcend individual factors/behavioural factors and influence health outcomes. Sub-section 5.5.4, of the findings, showed that Vulindlela is a community with high HIV prevalence, with client health affecting household dynamics. Furthermore, the low levels of literacy among most of the population limited the extent to which they can make use of information to improve their health outcomes. According to social workers, communities have people who are infected and who need to be educated about their responsibility. This immediate need is counterbalanced by the presence of very limited numbers of social workers in the area while mass awareness strategies required more social workers.

According to the SEMCHB model, different forces are operating at different levels of human existence within communities such that contextual factors that shape social determinants of health for adolescents are different from those that shape health outcomes for the elderly. Behaviour then becomes the outcomes of knowledge, values and attitudes of individuals as

well as social influences such as relational influences, institutional arrangements and the nature of the communities where people inhabit. In summary, the model postulates that there are environmental and external influences that shape, interact with and affect the observed outcomes of human behaviour, while specific environmental and external factors are associated with a specific observed individual or group behaviours. To this end, public health institutions and intervening agencies will be constrained in their capacity to promote healthy habits in a community if they do not account for other factors that shape and influence the behaviour of the community as a whole (Ngwenya, et al, 2014).

According to the study's findings, the social workers were aware of the need to engage in mass awareness campaigns with the object of ensuring that discussions on HIV prevention feature more prominently in discursive platforms (Subsection 5.4.1). The idea advanced was that the more information people were exposed to and made to discuss, the more the uptake of information on HIV prevention will be realized. Coupled with this was also directed focus on general community education (figure 5.4.1). Taking this together with the observation presented that social workers had programmes and strategies directed towards school-age community participants, suggests a dual approach: one focusing on the general population and the other specifically on school-going children, who were represented as being at higher risk through various contextual factors. Thus, there seems to focus on two levels with diverse strategies to reach them, which are premised on the most effective strategies that could be adopted. Social workers thus in line with the SEMCHB model, demonstrated an understanding of directed approaches which are cohort-specific taking into context the way information dissemination can best influence each targeted group.

6.4. Conclusions of the Study

The study investigated the communicative role of social workers in Vulindlela using the CCA-SEMCHB framework, which combines cultural determinants and social determinants of health behaviour and it was observed that:

Social workers can be effective in their communicative roles if they align their knowledge within the context of their incumbent communities. In other words, they need an understanding of the prevailing contextual environment and the contextual factors that shape observed behaviour resulting in health outcomes. The data collected for the study failed to demonstrate that the social workers had embedded their understanding of health within the socio-cultural context of the Vulindlela community. This could be attributed to two factors associated with

the study design: firstly, the data sample consisted only of social workers and did not include the community participants, which effectively curtailed any interactive analysis by including perspectives from a different sample of respondents. Secondly, the design of the interview guide placed focus on the knowledge, the experiences, the role and duties of the social workers. There was no extension of the focus on how the social workers positioned themselves within the context of the incumbent communities they undertook their work and related duties because data of that nature was not collected. Thus, this is the outcome of a design limitation that future studies can remedy by including both social workers and community participants in the data sample.

The observed failure of social workers to embed their knowledge within the context of their incumbent communities (at least based on the findings from this study's participants) seems to be contributory to the high prevalence of HIV in Vulindlela with other contributing factors taking into consideration years of community outreach and social work. Interventions through social workers could be limited by the fact that there is no consensus in understanding between what constitutes problems and solutions since there is not negotiated and shared understanding between social workers and the communities they cater for. The theoretical model proposed that external interventions have efficiency only as they are incorporated and assimilated within the socioeconomic and cultural underpinnings of the target communities. There was a demonstrated level of understanding of local dynamics in programme planning such as a focus on local schools in designing HIV awareness campaigns and programmes. However, there was no report, of any exchange of ideas between the Vulindlela community and social workers' knowledge systems that informed programmes and campaigns.

Concerning subjective knowledge of social workers about HIV prevention, based on the findings it was concluded that social workers knew other methods and preventive options. However, their reported knowledge was very limited when novel and evolving HIV prevention methods and therapies are concerned. This was particularly the case with oral PrEP, which is the focus of the study since the investigation centred on the communicative role of social workers in promoting and increasing uptake of oral PrEP. The limitations of their knowledge concerning oral PrEP was seen to limit their ability to communicate and educate the community concerning effective therapy. This demonstrated that under-equipped personnel can fail to be instrumental in influencing positive health outcomes, due to the inability to close the gap in information access to their incumbent societies. This, as stated in the recommendations, can be

addressed through ensuring that social workers have access to requisite information, and acquire updated knowledge through training and information access.

According to the study, social workers can communicate about oral PrEP through mass awareness. The study concluded that this was a very efficient method since it could position such novel preventive methods within the local discursive platforms, and circles. If the right information is available and communicated then the benefits of these therapies can be appreciated and consequently, uptake can be improved. However, there is a need to connect technical understanding and professional knowledge with indigenous knowledge systems. Sometimes local communities are riddled with negative communications about the effects of new drugs, which may affect their attitudes towards them, which knowledge social workers must understand to counteract constructively. However, as stated earlier, it was not demonstrated whether social workers embedded such local knowledge systems or sought to counteract any of these influences since they were not reported.

Disempowerment resulting from limited access to information can be overcome through effective collaborations between clinicians and social workers working conjointly in the disbursement of HIV related services such as counselling and testing, and community education of novel HIV preventative methods.

Social workers were observed to cover multiplicative role which was multidisciplinary including both medical (prescribing medical preventive measures), social (dealing with socio-economic issues of their clients, such as nutritional provision) and anthropological (addressing cases for children living with HIV, or the nature of community relations) work, which presents an extensive portfolio given the physical spatial coverage required. The work of social workers can be best improved through task redesign and focus on specific areas, which might require additional staffing and social workers into the field.

6.5. Recommendations of the Study

Training and development of social workers in Vulindlela: The findings of the study demonstrated that the social workers in Vulindlela lacked knowledge and skills in various aspects of their work in the community. It was observed that their knowledge of oral PrEP was very limited to be of use at a practical level. To this end, there is observed the need for well-concerted training and development of social workers, to equip them with effective knowledge concerning oral PrEP, how it works and how to train their communities in its use as an effective HIV prevention strategy. Access to information on oral PrEP, government-assisted and

mediated training, periodical workshops and reskilling are possible effective aids that can improve the work of the social workers in Vulindlela in fighting against HIV and in similar communities.

While oral PrEP was the main focus of the study, as there was a need to understand how social workers can be effective communicators of the novel oral PrEP in the fight against HIV. The study also investigated general knowledge of the social workers on existing HIV prevention interventions. The knowledge of the social workers was demonstrated through the findings to be general with no mention of recent advances in HIV prevention. To this end, there is a need for training and development tailored towards this area, since the communicative efficiency of the social workers is directly influenced by their stock of knowledge. Thus, the more knowledge social workers have, the more effective they can be at their communicative roles.

Innovation information access: conventional methods of information access and training can be facilitated through workshops, conferences and designed courses and so forth. However, digital platforms and avenues, such as computer-based tools and platforms, use of internet-based technologies and online teams, can be effective tools in developing the stock of knowledge and making it accessible to social workers. This is imperative given the fact that most social workers in rural regions tend to work within resource-constrained settings, and both the study's findings and the extant literature confirms this position (Kitchen and Brook, 2005; Vourlekis, 2001). This should mean that training and empowerment of social workers through knowledge must not only be restricted towards knowledge about HIV prevention methods, whether novel or conventional but should extend to empowering them in use and implementation of innovative methods that are transforming how societies engage with both information and institutions.

In the findings, it was stated that innovation and flexibility are key to more effective community engagement. The pervasiveness of information technologies in societies today and in the near future provides an effective ground for the adoption of such technologies in various aspects of social work, and concerning access to essential information and knowledge, such platforms should be incorporated into social work practice. To this end, there is a need to find effective means for resourcing these resource-deprived stations with requisite technologies that assist with access to knowledge and information and enable continuous learning among social workers.

There is a need for increased medical social workers in Vulindlela: The nature of social work in Vulindlela is vast and ranges from dealing with social trauma, restorative counselling, effective diagnoses for referrals, need identification and redress, assessing and understanding social circumstances of clients and dealing with increased frequency of HIV induced morbidity. The work of social workers is extensive and multidisciplinary and requires many delegations and task decomposition for the work to be effectively done and clients' needs better addressed. To this end, it is suggested that more medical social workers and general social workers dealing with other aspects of social work can be instrumental in effectively addressing the needs of the communities in Vulindlela. In sub-section, 5.5.4, social workers reported that there is need for social education, which was reported at the time of the interviews to be covering very limited ground due to the limited number of social workers, and therefore under-staffing concerning the size of the Vulindlela spatial geography remains a challenge. Given the reported prevalence of HIV in Vulindlela and the reported socioeconomic dynamics of the area, there is a need for an improved social worker to community coverage area ratio if improved results are to be realised. These HIV statistics have been reported in some very recent publications and reports which can be seen as implying that it is an issue that needs to be redressed with urgency (Giovenco, 2019; Avert, 2018).

6.6. Chapter Summary and Study Limitation

In the foregoing discussion, an attempt was made to provide a discussion of the research findings while also making drawings from the extant literature and the established propositions from the CCA-SEMCHB framework. The discussion concerning the findings and the extant literature showed that there was relative alignment between the findings of the extant literature and the findings of this study. In the discussion concerning the theoretical propositions and the findings, there was some general alignment. However, at deeper levels, issues such as co-construction of knowledge requirements of the combined CCA-SEMCHB model, the findings were inadequate, hence the study could not locate the applicability of the propositions in that regard.

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Appendix 1: Interview guide

Interview questions

1. What is the role of a social worker in the clinic?
2. Do you often have to address cases of HIV with your clients?
3. What do you know about HIV prevention and testing?
4. Do you belief that your have sufficient knowledge in HIV?
5. What would you like to learn more about?
6. How do you assist their clients who are affected by HIV?
7. How are social workers involved in HIV prevention strategies?
8. What programmes do social workers have for HIV prevention methods?
9. Have you heard of Oral PrEP?
10. Introduce PrEP to social work here.
11. How can you play a communicative role in the uptake and introduction to Oral PrEP as an HIV prevention method?
12. Is there any training social workers in the clinical setting receive on HIV prevention methods such as Oral PrEP?

Appendix 2: Informed consent form

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

I wish to state that your participation in this research is voluntary , and you may withdraw participation at any point by serving a notice of withdrawal a week to actual exit date , and in the event of a refusal or withdrawal of participation , you will not incur any penalty or loss of treatment . However, a withdrawal may exclude you from being part of a team that is working to provide solution to promote the welfare of humanity. However, your participation may be terminated immediately if its discovered that you will disclose the identity and content of the interview to a third party.

You will not incur any cost as a result of your participation but reimbursement of R50 as a token of appreciation.

The following steps will be taken to protect the confidentiality of the personnel:

1. This consent letter will be signed by me and the participants , that their confidentiality is guaranteed.
2. The electronic device used for recording would be provided by me
3. The recording devices will be retrieved after the transcription and stored with CCMS office for onward storage at the library and classified.

CONSENT

I ……..have been informed about the study entitled Exploring the communicative role of social workers in the introduction and promotion of oral PrEP for HIV prevention: A case study of rural Vulindlela , KZN by Buyisiwe Lorraine Dlamini.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 073 792118.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion	YES / NO
Video-record my interview / focus group discussion	YES / NO
Use of my photographs for research purposes	YES / NO

_____ _____
Signature of Participant **Date**

_____ _____
Signature of Witness **Date**
(Where applicable)

_____ _____
Signature of Translator **Date**
(Where applicable)