

The Perceptions of a Farming Community in the Limpopo Province on HIV and Aids

By

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DECLARATION

Student number: 23307430

I declare that the dissertation:

THE PERCEPTIONS OF A FARMING COMMUNITY IN THE LIMPOPO PROVINCE ON HIV AND AIDS

is my own original work, it does not contain material that has been previously submitted for the purposes of any degree or diploma at any university. Where use has been made of the work of others, it has duly been acknowledged and referenced in the text and bibliography.

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NTOMBIFIKILE KLAAS

.....

DATE

DEDICATION

I would like to dedicate this dissertation to the following people who supported and encouraged me to complete my studies:

- My late brother Themba Ngubeni, who use to encourage me to excel in everything I do by saying “*Imfundo iyisikhali, futhi ayikhulelwa*”.
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ABSTRACT

THE PERCEPTIONS OF THE FARMING COMMUNITY IN THE LIMPOPO PROVINCE ON HIV AND AIDS

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South Africa has been seriously affected by the HIV and Aids pandemic, with the agricultural sector being no exception (Zvomuya, 2005: 33). The Department of Health (DOH, 2007: 4) identified that inadequate health care capacity particularly in rural areas is one of the factors contributing to the disproportionate provision of good quality care and targeted development. Therefore, in South Africa, the farming community is one of the sectors with disproportionate provision of health care especially in HIV management. Among the farming communities in general, awareness, treatment and prevention has been utilized as components of a strategy intended to empower the farm employers and employees (Zvomuya, 2005: 33).

The objective of this study was to explore and describe the perceptions of the farming community on HIV and Aids. A qualitative, exploratory and descriptive research design was followed to explore and describe the perceptions of the farming community on HIV and Aids in the Limpopo Province. The study the population consisted of the farm owner, farm managers and farm employees both males and females above the age of eighteen (18) years in the Limpopo Province. A purposive sampling method and a convenient sampling were used in this study. The researcher used in- depth one on one interviews to collect data so as to explore and describe the perceptions of the farming community on HIV and Aids and field notes were taken. Data was analysed according to Tesch's analysis method. Categories, sub categories and themes were identified and verified by means of literature control. The following seven categories were identified and described: Emotions linked to HIV and Aids, individual characteristics and experiences, behavior cognition and

affect, human resource issues, lack of recreational facilities, health care needs, and support as a health promotion strategy.

The researcher recommended that educational programmes such as effective risk reducing programmes and awareness, as well as support structures, should be made available to all farming community. Due to the scarcity of information on HIV and Aids in the farming community, a variety of methods like audio visual media in a form of radio and television and printed media in a form of posters, charts, pamphlets and booklets can be used to disseminate the knowledge. However, this knowledge is not limited to hosting educational sessions, training workshops, community meetings, focus groups, and wellness programs by peer educators and community leaders. Based on the above recommendations, further research in other areas to explore the perceptions of the farming community on HIV and Aids in depth is relevant.

In conclusion, regular training on HIV and Aids is therefore crucial given that the findings of this study showed that, despite the HIV awareness campaigns going on in South Africa, some segments of the population do not get the message, specifically the farming community. The universal access of health care services which most of us take for granted are not accessible in the farming community due to their long working hours and the fact that the mobile clinics which use to provide basic PHC (primary health care) services were no longer coming.

Key terms: HIV, Aids, Farms, Farm employees, Farming community, Perceptions and Regional migration.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
DOH	Department of Health
HAART	Highly Active Antiretroviral Treatment
HIV	Human Immunodeficiency Virus
MDG	Millennium Development Goals
NGO	Non- governmental Organization
NSP	National Strategic Plan
PLWHA	People Living with HIV and Aids
PMTCT	Prevention of Mother to Child Transmission
UNAIDS	Joint United Nations Program on HIV and Aids
UNESCO	United Nations Educational Scientific and Cultural Organization
WHO	World Health Organisation

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

This chapter introduces the topic and provides the background to the study. The problem statement, significance and purpose of the study, objectives, research question, definition of terms and assumptions will be presented. The ethical considerations will also be introduced in this chapter.

The origins of the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (Aids) have puzzled scientists ever since the illness first came to light in the early 1980s. For over 20 years, it has been the subject of fierce debate and the cause of countless arguments, with everything from a promiscuous flight attendant to a suspect vaccine programme being blamed. The first recognised cases of Aids occurred in the USA in the early 1980s (UNAIDS, 2010:99; Conradie, 2010:7; Nzimande, 2004: 36-37).

In the mid-1980s, HIV and Aids were virtually unheard of in Southern Africa—it is now the worst affected region in the world. Of the 11 Southern African countries (Angola, Namibia, Zambia, Zimbabwe, Botswana, Malawi, Mozambique, South Africa, Lesotho, Swaziland, Madagascar) at least six are estimated to have an infection rate of over 20% (UNAIDS, 2010: 24; WHO Global Programme on Aids 1993: 6–7; Shrestha, 1994:10).

Sub-Saharan Africa is more heavily affected by HIV and Aids than any other region of the world. An estimated 22.5 million people are living with HIV in the region - around two thirds of the global total (UNAIDS, 2010: 73). In 2009, around 1.3 million people died from Aids in Sub-Saharan Africa and 1.8 million people became infected with the virus. Since the beginning of the epidemic, 14.8 million children have lost one or both parents to HIV and Aids (UNAIDS, 2010: 73; DOH, 2007: 7; Nicolay, 2009: 6 - 8).

During 2009 alone, an estimated 1.3 million adults and children died as a result of Aids in Sub-Saharan Africa. Since the beginning of the epidemic more than 15 million Africans have died from Aids (UNAIDS, 2010:78; Aids in the South African Agricultural Sector, 2008: 8-9). The number of people living with HIV rose from around 8 million in 1990 to 33 million by the end of 2009.

South Africa has been seriously affected by the HIV and Aids pandemic, with the agricultural sector being no exception (Zvomuya, 2005: 33). The Department of Health (DOH, 2007: 4) identified that inadequate healthcare capacity particularly in rural areas is one of the factors contributing to the disproportionate provision of good quality care and targeted development. Therefore, in South Africa, the farming community is one of the sectors with disproportionate provision of healthcare especially in HIV management. Among the farming communities in general, awareness, treatment and prevention has been used as components of a strategy intended to empower the farm employers and farm workers (Zvomuya, 2005: 33).

Prisons and rural areas, including farming communities, are the hardest hit by the HIV and Aids pandemic. Agriculture currently accounts for 24% of the world's output, and uses 40% of land area (Chucks, 2008: 90; Kuponyi, 2008: 13). HIV and Aids undermines agricultural systems and affects the nutritional situation and food security of rural families since the rural areas have the largest population of people living with HIV and Aids. The pandemic represents an enormous crisis for the agricultural sector and rural livelihoods (Chucks, 2008: 90; Kuponyi, 2008: 13).

According to the Food and Agriculture Organization (FAO) cited in Chucks (2008: 90; Saliu & Adejoh, 2010: 219), it is estimated that in the 25 most affected Sub-Saharan African countries, HIV and Aids has killed 7 million agricultural workers between 1985 and 2001 and could kill an additional 16 million, or up to 26% of the agricultural labour force. There is limited research on farm worker households with regards to their poor economic and social situation as well as the impact of the pandemic. The abovementioned statement is supported by the absence of the latest statistics of HIV and Aids in Sub-Saharan Africa's agricultural sector. The statistics available are based on provinces where research has been conducted.

South Africa is one of the countries with the highest prevalence of HIV and Aids with about 20% of the adult population being infected. According to the Food and Agriculture Organization of the United Nations (FAO) cited in Lemke (2005: 844 – 845), in South Africa, the projected loss in the agricultural labour force through HIV and Aids from 1985 to 2020 will be 20%, making South Africa one of the hardest hit countries in the world (Lemke, 2005: 844 – 845; HIV and Aids in the South African Agricultural Sector, 2008: 12).

A study conducted by Mushwana (2010: 13) on the “impact and challenges of implementing the National Counseling and Testing Campaign in Limpopo” revealed that Limpopo has around 400 000 HIV positive people. This accounts for around 7% of the population and 14% adults between the ages of 20 and 64 were HIV positive in 2008 (Mushwana, 2010: 13). However, the abovementioned statistics can be generalised to the population of the Limpopo Province including the farming community. According to research conducted among farm workers in the Limpopo and Mpumalanga Provinces, a total of 2798 farm workers were tested for HIV. Among this number, 1106 participants were found to be HIV positive while 1692 were found to be HIV negative. The figures show that the prevalence of HIV is very high among farm workers with almost four (4) people out of every ten (10) being HIV positive. This is said to be the highest prevalence ever published in Southern Africa among a working population (International Organization for Migration (IOM), cited in Mushwana, 2010: 23).

The epidemic in Limpopo has not reached a mature phase yet and is still growing with new infections almost double the number of Aids-related deaths (IOM, cited in Mushwana, 2010: 23). There is a vast increase in the statistics of new HIV infections despite the programmes in place. This alarming statistic, however, proves that there is an urgent need of an in-depth research to explore and describe the perceptions of the farming community on HIV and Aids.

Poverty, food insecurity and HIV and Aids are among the most pressing social issues in South Africa. Many families in developing countries have been and are still living in poverty. The Aids pandemic kills the most productive and reproductively active members of society, thus increasing the number of dependant household members as well as the number of orphans and child-headed households who

engage to commercial sexual transactions in order to survive, thus leading to a vicious cycle of poverty and HIV and Aids (Lemke, 2005: 846; Chucks, 2008: 90-91).

Food insecurity is embedded within the context of poverty. This means living in physical and social environments that are not supportive of good health, including access to healthcare. There is a link between poverty and food insecurity (Lemke, 2005: 846; Chucks, 2008: 90 - 91). Most adults in poor families pay for their medical expenses “out of their pocket” since they do not have insurance coverage. This is a drain on household’s money to cover living expenses. In addition, illness due to HIV and Aids means time off from work and most low-wage workers including farm workers are not paid if they miss work.

Thus, illness due to HIV and Aids leads to poverty. Since food is about the only flexible part of a poor family’s budget, food expenditure is reduced as the breadwinner falls ill and the result is food insecurity. In the Limpopo Province, a large number of people dying from Aids-related illnesses exacerbate poverty, which in turn leaves individuals vulnerable to adverse effects of HIV. Lack of adequate food and nutrition leaves individuals less able to cope with HIV if they are infected, as effective treatment depends on a good diet (UNAIDS, 2010: 107; Chucks, 2008: 90; HIV and Aids in the South African Agricultural Sector, 2008: 12).

The large number of Aids-related illnesses and deaths are weakening the government’s capacity to deliver healthcare and other social services, with serious consequences for food security, economic growth and human development (UNAIDS, 2010: 107; Chucks, 2008: 90; HIV and Aids in the South African Agricultural Sector, 2008: 12). Therefore, the findings of this research will assist agricultural policy makers in considering the farming community for the decision they undertake. HIV and Aids is not simply a problem for Ministry of Health to address. To lessen the spread and the consequences of HIV and Aids requires a coordinated approach involving governmental and non-governmental stakeholders. Policy makers responsible for agriculture, health, finance, trade and commerce should therefore work together.

Productivity is initially reduced when the infected person is ill, and the supply of the household labour declines even further with the death of that person. In addition,

household members devote productive time to caring for the sick and traditional mourning customs, which can last as long as 40 days for some family members, may lead to adverse effects on the availability of labour. Besides the loss of labour, there is also loss of agricultural skills and knowledge as the adult dies before passing on his/her farming knowledge to their children (Chucks, 2008: 90-92).

In the study conducted by Lemke (2005: 845) on the “implications among farm worker households on nutrition security, livelihoods and HIV and Aids,” it was concluded that farm worker households were among the most vulnerable of all social strata with regard to income, health status, household nutrition, security and education (Lemke, 2005: 844–845; HIV and Aids in the South African Agricultural Sector, 2008: 12). However, the impact of HIV and Aids can be generalised to all South African farm workers within the Limpopo Province’s farming community being no exception. While there is a vast amount of literature on the health-related issues, the impact as well as the effectiveness of the strategies on HIV and Aids, there is very limited research on the perceptions of the farming community on HIV and Aids.

The impact of Aids will remain severe for many years to come. HIV prevention in Africa including the farming community is the only solution since there is no cure for the pandemic. The alarming number of new HIV infections highlights the urgent need to intensify and expand proven prevention methods, and further, to identify and implement new methods of HIV prevention. Male circumcision is one of the most common and cost effective surgical procedures globally, it is a potentially new HIV prevention method, along with vaginal microbicides, pre-exposure as well as post-exposure prophylaxis (DOH, 2007: 19).

In South Africa, the government's failure to respond to the AIDS crisis has led to an unprecedented number of people living with HIV (DOH, 2007: 19). The strategies to prevent HIV transmission include among others: the Millennium Development Goals (MDGs), National Strategic Plan (NSP), Prevention of Mother to Child Transmission (PMTCT), HIV and Aids Counseling and Testing (HCT). These strategies are programmes that run concurrently in various healthcare centres. The Millennium Development Goals (MDGs) were officially established following the Millennium Summit held in 2000, where all world leaders adopted the United Nations Declaration from which the eight goals were derived. The aim of the MDGs focused

on measurable targets to be achieved by 2015, and these targets focused on encouraging development by improving social and economic conditions in the world's poorest countries by eradicating poverty, environmental protection, human rights and protection of the vulnerable. The sixth Millennium Development Goal focuses at combating HIV and Aids, malaria and other diseases by 2015; however, it shows that even though the prevalence of HIV and Aids is still high in South Africa, it has stabilised (Geyer, 2010: 9; Millennium Developmental Goal Country Report, 2010: 18).

The HIV and Aids and STI Strategic Plan (2007-2011) were adopted in 2007 and involved extensive and inclusive stakeholder consultations at all levels of the national HIV response. The NSP focused on clear targets to be achieved by 2011, and these targets focused on the reduction of new infections by 50%. In addition, it was indicated that antiretroviral therapy (ART) had to be provided to 80% of eligible patients (DOH, 2007: 7; Tempelman & Vermeer, 2008: 35–38).

The Prevention of Mother to Child Transmission (PMTCT) focused on increasing the awareness of the risks of mother-to-child HIV transmission and knowledge of the risks of breastfeeding. PMTCT is a critical area as new infections amongst babies are almost entirely preventable. New government guidelines on the initiation of antiretroviral therapy (ARV) for pregnant women with a CD4 count of 350 at 14 weeks has substantially reduced HIV transmission during pregnancy and labour. Safer infant feeding practices would complete the picture in terms of giving HIV positive mothers a better chance of rearing HIV-free children thus reducing the number of infant and child infections (Mushwana, 2010: 17 – 18; DOH, 2010: 2 - 3).

South Africa has the largest antiretroviral programme in the world. Despite this, almost half the people in need of antiretroviral treatment still do not receive it, with the farming community being no exception. Under South Africa's updated treatment guidelines, most patients on first-line ARV regimens should now be receiving a combination treatment. South Africa has made impressive progress in scaling up access to treatment. Given the rollout of a single dose pill by the Minister of Health in April 2013, adhering to antiretroviral therapy is as simple as taking daily birth control

tablets. More effort is still needed to provide for universal, reliable treatment (Louw, 2013: 20).

The National HIV Counseling and Testing Campaign Strategy (HCT) was introduced in 2010 to assist in achieving the targets of the NSP on HIV, Aids and sexually transmitted diseases by testing 15 million South Africans over a period of 15 months (Geyer, 2010: 9; Mushwana, 2008: 9). Expanding the availability and use of HIV testing and counseling services focused on ensuring access to services and interventions for prevention, treatment and care of HIV. Eight months since the introduction of the policies and the launch of the HCT campaign, various challenges emerged. These challenges included among others: insufficient human capacity due to enormous demands for testing, a weakened health system and sectors of society that continue to show little change in their behaviour towards preventing HIV infections (Geyer, 2010: 9).

Despite the involvement of governmental as well as non-governmental organisations in HIV and Aids awareness programmes, the farming community is still the most under-serviced labourers in South Africa. Poor access to health-care and health-related information is partly due to their remote location of work. The high incidence of poverty and low level of education makes the farm worker even more vulnerable to the impact of HIV and Aids. The researcher realised an urgent need to conduct an in-depth study by exploring the perceptions of the farming community on HIV and Aids due to the alarming statistics of HIV and Aids among the farming community despite the programmes available in most farms in the Limpopo Province. These programmes include among others: Prevention-related activities like condom provision, health-related education with a focus on HIV and Aids, sexually transmitted diseases and tuberculosis; setting up of peer support on farms; voluntary HIV Counseling and Testing (HCT); care and support for HIV positive clients; provision of antiretroviral treatment as well as adherence management (HIV and Aids in the South African Agricultural Sector, 2008: 20).

1.2 PROBLEM STATEMENT

South Africa is among the countries with the highest prevalence of HIV and Aids with about 20% of the adult population being infected. According to the Food and Agriculture Organization of the United Nations (FAO) cited in Lemke (2005: 844 – 845), in South Africa, the projected loss in the agricultural labour force through HIV and Aids from 1985 to 2020 will be 20%, making South Africa one of the hardest hit countries in the world (Lemke, 2005: 844 – 845; HIV and Aids in the South African Agricultural Sector, 2008: 12).

There is an alarming increase in the rate of new HIV infections among the farming community despite efforts by farming managers to prevent the spread of HIV and Aids in the Limpopo Province. About 1.1 million farm workers are employed on commercial farms and they are by far the poorest in the country (Lemke, 2005: 844 – 845; HIV and Aids in the South African Agricultural Sector, 2008: 12).

The study conducted by Colvin (cited in South African HIV Clinicians Society Nursing Magazine, 2011: 6), on the HIV infections among the farm workers in Malelane, Tzaneen and Musina showed that 39.5% of 2798 workers in the 23 Limpopo farms where HIV programmes are already implemented are infected with the virus, suggesting that the picture could be much worse in the rest of the province. The 39.5% infection rate in these 23 farms is twice the UNAIDS national prevalence percentage of 18.1% in South Africa (Geyer, 2011: 7). It is also the highest prevalence ever reported among a working population. A multitude of factors such as concurrent partnerships, transactional sex among women, irregular condom use and sexual violence were highlighted. Even participants who knew that they were infected still did not use protection (Geyer, 2011: 7).

Poor living and working conditions, separation from families, physically demanding work with low wages, limited access to and inadequate healthcare services and working conditions and a high rate of illiteracy and polygamy among the farming community predisposes them to HIV and Aids. The study further found that farm workers are infected at twice to three times the rate of their counterparts in their home countries. Transactional sex in exchange for money, food or gifts fuelled by

poor wages may play a role (HIV and Aids in the South African Agricultural Sector, 2008: 14 – 16).

The researcher selected the farming community in the Limpopo Province for the study due to curiosity regarding the alarming statistics of the new HIV infection rate in the farming community. The researcher's curiosity started when she was still a student nurse who trained in the military setup. It was mandatory for student nurses to be deployed in different provinces should a need for primary healthcare services arise especially in rural areas. She was, therefore, deployed to all the provinces except for the Limpopo Province and this led to increasing curiosity when she discovered that the farming community's health issues are neglected in general. Literature proves that the farming community in the Limpopo Province has the highest prevalence of HIV ever reported among a working population. In order to address the current situation, a study is necessary to establish methods of assisting and supporting those affected and infected with HIV and Aids in the farming community. This will be achieved by conducting qualitative interviews to explore the perceptions of the farming community on HIV and Aids. Furthermore, literature shows that there is limited research on farm worker households with regards to their poor economic and social situations as it was mentioned in the background that farm workers are by far the poorest in the country (Lemke, 2005: 844 – 845; HIV and Aids in the South African Agricultural Sector, 2008: 12).

1.3 THE SIGNIFICANCE OF THE STUDY

HIV and Aids are invading the rural communities and pose a great threat to agricultural production and food security. According to previous research, there is an alarming increase in the rate of new HIV infections among the farming community despite the efforts by the government and non-government bodies to prevent the spread of HIV and Aids in the Limpopo Province. The farming community is at risk of contracting HIV due to their poor living and working conditions, separation from families, physically demanding work with low wages, limited access to and inadequate healthcare services, and also a high rate of illiteracy and polygamy among the farming community predisposes them to HIV and Aids (HIV and Aids in the South African Agricultural Sector, 2008: 14 – 16).

The crucial factor in selecting a problem to be studied is its significance to health and contributing to the body of knowledge (Brink, 2002: 78). The exploration of the perceptions of the farming community on HIV and Aids has significance to the health sciences.

The findings of this study will be valid not only for the South African context, but by addressing issues that are entailed in the Millennium Development Goals also for other societies that are experiencing similar problems. The results will provide baseline knowledge and understanding of the underlying causes for the alarming new infection rate in the farming community, they will also contribute in strengthening the existing initiatives of the farming managers with regard to HIV prevention. The researcher believes that the recommendations of the study made to the general manager and the owner of the Levubu farm will contribute to a solid foundation that will assist in eradicating the pandemic in the farming community.

1.4 PURPOSE OF THE STUDY

The primary purpose of this study is to promote understanding of the perceptions of the farming community on HIV and Aids in the Limpopo Province.

1.5 OBJECTIVE OF THE STUDY

The objective of this study is to explore and describe the perceptions of the farming community on HIV and Aids in Limpopo Province.

1.6 RESEARCH QUESTION

Burns and Grove (2007: 87) describe a research question as a “concise, interrogative statement worded in present tense and usually with one or more variables”. Therefore, the following research question is deemed relevant to the study, and is structured according to the purpose and objective of the study:

- What are the perceptions of the farming community in the Limpopo Province on HIV and Aids?

1.7 DEFINITION OF TERMS

1.7.1 AIDS

Acquired Immune Deficiency Syndrome is a communicable disease in which the body's cellular immune system is suppressed leaving it defenseless against invasion by bacteria, viruses, fungi and parasites (Blackwell Dictionary of Nursing, 2004: 11).

In this study, Aids refers to a condition that has been confirmed medically that weakens the immune system of the farming community in the Limpopo Province.

1.7.2 FARMS

Farms refer to both commercial farms and small holdings where farm owners perform small scale farming as an additional income (Lemke, 2005: 844; Concise Oxford English Dictionary, 2011: 516).

In this study, farms refer to both commercial and small holding farms in Levubu.

1.7.3 FARM EMPLOYEES/ WORKERS

Farm workers constitute a wage-earning category with the productive labour services rendered to the farm owners (Lemke, 2005: 844).

In this study, farm workers refer to all the people employed (the managers, supervisors and employees) in the Levubu farms in the Limpopo Province.

1.7.4 FARMING COMMUNITY

Farming community refers to landowners, farm managers and farm workers and others living on the land; all of whom are engaged in the primary function of farming activities for the purpose of production and profit (Lemke, 2005: 844).

1.7.5 HIV

Human Immunodeficiency Virus is a lentivirus that causes Aids (Concise Oxford English Dictionary, 2011: 629).

In this study, HIV refers to the medical status of the farming community in the Limpopo Province that has been confirmed medically at the Levubu or Tshakhuma clinic or in any other medical setting.

1.7.6 PERCEPTIONS

Perceptions refers to the capacity to view or understand which serves as the basis for formulating opinions or judgment on phenomena or any prevailing state of affairs (Oxford Advanced Learning Dictionary, 1996: 859; Concise Oxford English Dictionary, 2011: 1063).

In this study, perceptions refer to the opinions as well as the understanding of the farming community on HIV and Aids.

1.7.7 REGIONAL MIGRATION

Regional migration refers to patterns of human mobility from one region to another (Oxford Advanced Learning Dictionary, 1996: 987; Concise Oxford English Dictionary, 2011: 906).

In this study, regional migration refers to one of the causative factors of the spread of HIV and Aids in the Limpopo Province as most of the farm workers are migrant workers. Massive migration of young unmarried adults from presumably “conservative” rural environments to more sexually permissive African cities in recent years is regarded as the underlying cause of the spread of HIV and Aids.

1.8 PARADIGMATIC PERSPECTIVE

The philosophical perspective of this study was based on an interpretive paradigm also referred to as constructivist paradigm. Interpretive research is fundamentally concerned with meaning and it seeks to understand social member’s definitions and understanding of phenomena. Its purpose is to gain in-depth understanding of the perceptions of a specific group. The interpretivists emphasise that we continuously interpret, create and give meaning to define, justify and rationalise our actions as humans (Henning, 2004:19- 22; Burns & Grove, 2007: 37; Creswell, 2007: 20).

Hofstee (2009: 88; Creswell, 2007: 19) identifies “assumptions” as “objects acceptable as true without prior verification and have an expectation of readers believing them without confirmation”. Polit and Beck (2008: 748; Creswell, 2007: 19) agree that assumptions are strong beliefs that influence one’s action having being accepted as correct based on their correctness and logic without further proof.

Accordingly, every individual perceives the world, their living environment or the phenomenon differently. In this study, it is assumed that the perceptions of the farming community on HIV and Aids can only be studied through their individual, personal description thereof.

The foundational assumption of the interpretivists is that most of our knowledge is acquired through social constructions such as language, consciousness, shared meanings, documents and other sources. Interpretive research attempts to understand phenomena according to meaning that people assign to them (Creswell, 2007:19; Henning, 2004: 20).

The constructivist paradigm assumes that reality is socially constructed and that there are multiple interpretations of a single event. In this study, the researcher attempted to explore and describe the perceptions of the farming community on HIV and Aids in Limpopo Province. The researcher gathered information through in-depth interviews so as to be able to explore and describe the perceptions of the farming community on HIV and Aids.

1.8.1 THE FOUNDATIONS OF THE RESEARCH STUDY

The theoretical framework of this study is based on Pender’s Health Promotion Model (HPM). A conceptual framework broadly represents an understanding of the phenomena of interest and it explains relationships between phenomena (Burns & Grove, 2007: 179 -181; Polit & Beck, 2005: 151 -152; Polit & Beck, 2008: 141 -150; Wimpenny, 2002: 351).

Health promotion is the process of enabling people to increase control over the determinants of their health and thereby improve their health and wellbeing. To reach a state of complete physical, mental and social wellbeing an individual or group must be able to identify and realise aspirations, to satisfy needs and to change

or cope with their environment. Health promotion involves the entire population in the context of their daily lives, rather than focusing on individuals at risk for specific diseases, and is directed towards taking action on either the determinants or causes of health (Wimpenny, 2002: 351; Davidson, 2006: 51). However, achieving this goal requires an optimal mix of responsibility from all involved: individuals, families, communities, a wide variety of health professionals as well as government and non-government sectors which is crucial in the management of HIV and Aids.

The three major constructs of the HPM include: individual characteristics and experiences, behavior-specific cognition and affect, and behavioural outcomes.

1.8.1.1 INDIVIDUAL CHARACTERISTICS AND EXPERIENCES

Individual characteristics and experiences are crucial to assess in order to provide in-depth understanding of the individual. The farm worker as an individual can be at risk of contracting the virus due to an exposure to a high risk environment. The individual's perception, knowledge and understanding can have an influence in engaging in high risk activities. Their personal circumstances can be influenced by other factors such as mental status, religion, culture as well as the presence of risk factors like alcohol, drugs and unsafe sexual practices (Burns & Grove, 2007: 180; Polit & Beck, 2008: 142). In this study, it was evident that knowledge and understanding of HIV and Aids has an influence in engaging in high risk activities. Alcohol and unsafe sexual practices were also common.

1.8.1. 2 BEHAVIOR SPECIFIC COGNITION AND AFFECT

Immediate competing demands have direct impact on the participation of health-promoting behaviours, and for the farming community, these demands include poverty, low income, basic needs like food and safety must be addressed before health promotion needs can become a focus (Burns & Grove, 2007: 182; Polit & Beck, 2008: 142). The farm workers are earning low wages thus they cannot meet basic needs which results in them engaging in transactional sex as an extra source of income (HIV and Aids in the South African Agricultural Sector, 2008: 14 – 16). In this study, the participants raised some of these demands, which included among others: poverty and low income, which led to them engaging in transactional sex or even not using protection during sex provided they were going to be paid.

1.8.1.3 BEHAVIOURAL OUTCOMES

Accessibility of healthcare services and adequate knowledge of the importance of health-promoting behaviours and recognition of its value can have positive influences on the farming community to practice health behaviours (Burns & Grove, 2007: 182; Polit & Beck, 2008: 142). If opportunities to engage to health-promoting behaviours are not readily available, this includes the availability of condoms, posters on HIV and Aids as well as educational programmes on HIV; it is unlikely that the farming community will practice safe sex (HIV and Aids in the South African Agricultural Sector, 2008: 14 – 16). In this study, it was evident that the healthcare facilities were not accessible and the basic healthcare services which were provided by the mobile clinic were no longer available thus leading to lack of condoms and no training of HIV and Aids.

1.9 OVERVIEW OF RESEARCH METHODOLOGY

A brief overview of the methodology will be discussed and a detailed methodology will follow in the next chapter. By using a qualitative approach an attempt was made to explore and describe the farming community's perceptions from a subjective perspective of the individuals involved. An exploratory and descriptive design was followed to explore and describe the perceptions of the farming community on HIV and Aids in the Limpopo Province.

This study was conducted in a natural setting, the Levubu farming community in the Vhembe District of the Limpopo Province. The study population was made up of the farm owner, farm managers, supervisors and both male and female farm workers above the age of 18. The researcher used in-depth one-on-one interviews to collect the data to explore and describe the perceptions of the farming community on HIV and Aids. Communication techniques such as probing, paraphrasing and reflection were used. Data was collected until information was deemed "redundant" or theoretically saturated which was demonstrated by repeated themes.

Data analysis was conducted according to Tesch's analysis method. All participants were individually interviewed, personally by the researcher and an experienced research assistant aided with translating from the language of preference to English.

Categories, sub-categories and themes were identified through clustering of descriptive phrases from the transcriptions. Chapter 2 contains a comprehensive discussion of the research methodology of this study.

1.10 ETHICAL CONSIDERATIONS

Ethics are a set of guidelines drawn up to protect the rights of the research subjects. Three basic ethical principles to guide researchers are principle of respect for human dignity, principle of beneficence and principle of justice (Polit & Beck 2008: 170; Burns & Grove, 2007: 201).

Polit and Beck (2008: 170-174; Burns & Grove, 2007: 201) emphasise the importance of adhering to ethical considerations in research as it affects all stages of the researcher's planning as well as the process of data collection. They refer to it as research etiquette and stress that it has to be maintained during the research as well as after completion thereof. Participants must be treated with respect, while their human dignity must be protected and maintained at all times.

After getting permission from the Ethics Committee at the Faculty of Health Sciences University of Pretoria as well as institutional consent from the respective farms, a meeting was arranged with all the employees by the human resource managers. The purpose of the research was explained thoroughly to all the participants and they were given a chance to ask questions. Those who volunteered were requested to sign a consent form prior to data collection. Three basic ethical principles that guided the researchers are: principle of respect for human dignity, principle of beneficence and principle of justice.

1.10.1 RESPECT FOR HUMAN DIGNITY

The principle of respect of human dignity includes the right to self-determination and the right to full disclosure (Polit & Beck, 2008: 171; Burns & Grove, 2007: 203).

- **The Right to Self determination**

Humans should be treated as autonomous agents, capable of controlling their own activities. The principle of self-determination means that participants have the right to

decide voluntarily whether to participate in a study, without risking any penalty or prejudicial treatment. It also means that people have a right to ask questions, to refuse to give information or to withdraw from the study (Polit & Beck, 2008:171; Burns & Grove, 2007: 204). In this study, the researcher informed participants that they have a right to decide voluntarily whether or not to participate in the study; they have a right to withdraw at any time and to refuse to give information especially in a sensitive issue like HIV and Aids. It is for this particular reason that the farm owner, managers and supervisors were not persuaded to take part in this study.

- **The right to full disclosure**

The principle of respect for human dignity encompasses people's right to make informed voluntarily decisions about study participation, which requires full disclosure. Full disclosure means that the researcher has fully described the nature of the study, the person's right to refuse participation, the researcher's responsibilities, and the likely risks and benefits (Polit & Beck, 2008: 172; Burns & Grove, 2007: 204). The participants were informed about the nature of the study and that they have a right to refuse to participate.

- **Informed consent**

Informed consent means that the participants have adequate information regarding the research, are able to comprehend the information and have power to free will, enabling them to consent to or decline participation voluntarily (Polit & Beck, 2008: 176; Burns & Grove, 2007: 205 - 208).

The researcher addressed the farm owner, managers, supervisors and farm workers of the Levubu farming community about the topic, nature and purpose of the study during the information session, and then anyone who meets the inclusion criteria and volunteered to participate had to sign the consent form individually because of the sensitivity of the research topic. Those who could not write their names on the space provided in the form were encouraged to cross "X" next to the space allocated for the signature in the informed consent form. Prior to collecting the data, the participants were given a chance to ask questions about the study and they were reminded of their rights regarding participation.

1.10.2 PRINCIPLE OF BENEFICENCE

The principle of beneficence involves an effort to secure the well-being of persons. Researchers should make an effort to protect participants from discomfort and harm that can be physical, emotional, spiritual, social, or economical (Polit & Beck, 2008: 170; Burns & Grove, 2007: 214). The principle of beneficence covers the right to freedom from harm and discomfort and the right to protection from exploitation (Polit & Beck, 2008: 170; Burns & Grove, 2007: 203).

In this study, the researcher tried by all means to minimise psychological harm and discomfort by informing the participants that participation in the study was voluntary. Privacy of the participants was ensured by interviewing the participants individually. The researcher ensured the availability of psychological even medical intervention post interview should a need arise.

- **The right to protection from exploitation**

Involvement in a research study should not place participants at a disadvantage or expose them to situations for which they have not been prepared (Polit & Beck, 2008: 171; Burns & Grove, 2007: 216). The researcher reassured the participants that the information that they reveal will not be used against them in any way. The researcher prepared the participants about the possibility of a follow-up study should a need arise.

1.10.3 PRINCIPLE OF JUSTICE

Participants have a right to fair selection and treatment, and their right to privacy. This was ensured by treating participants with courtesy and with respect at all times (Polit & Beck, 2008: 173; Burns & Grove, 2007: 213). The principle of justice includes the right to fair treatment and the right to privacy.

- **Right to fair treatment**

Participants were selected fairly based on research requirements not because they are vulnerable (Polit & Beck, 2008: 173; Burns & Grove, 2007: 214). Participant's right of refusal to participation or withdraw from the study was respected and there

were no penalties. The researcher demonstrated sensitivity and respect for the norms, beliefs, and lifestyles from different backgrounds and cultures.

- **Right to Privacy**

Virtually all research with humans involves intruding into personal lives. The researcher ensured that privacy is maintained throughout the study (Polit & Beck, 2008: 173; Burns & Grove, 2007: 214).

Private information such as the participants' attitude, beliefs, behaviour and opinions was withheld from others. Anonymity was ensured by using research numbers instead of names. Confidentiality was ensured by locking away all field notes and tapes (Burns & Grove, 2007: 212; Polit & Beck, 2008: 173). The researcher tried by all means to conduct the interviews in a private environment but it was very difficult.

1.11 RISKS OF THE STUDY

Participants may experience emotional outbursts from previous encounters, and may be forced to remember past experiences which they wish to forget (Polit & Beck, 2008: 174; Burns & Grove, 2007: 216). An HIV trained counselor was arranged with the Levubu Clinic prior to starting with the interviews for participants who might need intervention post interview. The researcher liaised with the healthcare worker at the Levubu Clinic to refer one participant who needed counseling.

1.12 BENEFITS FROM THE STUDY

The benefits from the study will be indirect. The researcher emphasised to all participants that the benefits of the study would be more than the risks involved, because the findings of the study would increase the levels of HIV and Aids awareness among the farming community.

1.13 ORGANISATION OF THE STUDY

The organisation of the chapters is summarized below:

Chapter One: Orientation to the study

This chapter introduces the topic and the background to the study. The problem statement, significance of the study, purpose and objective of the study, research question, definition of terms assumptions will be presented. The research questions, aim of the study, limitations and ethical considerations will also be introduced in this chapter.

Chapter Two: Research methodology

The chapter describes the research methodology and design, proposed research instruments, data collection methods and in-depth data analysis as well as methods to ensure trustworthiness.

Chapter Three: Discussion of the results and Literature Control

Chapter three focuses on discussion of the findings and literature review conducted to validate the findings.

Chapter Four: Conclusion, Recommendations and Limitations

Chapter four addresses the conclusion, recommendations, implications, and limitations of the study.

1.14 CONCLUSION

In this chapter, the background to the problem, problem statement, summary of methodology on the perceptions of the farming community on HIV and Aids were discussed. The concepts were defined and described and the assumptions were made. A detailed discussion of the methodology of this research is in the next chapter.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

In this chapter, the researcher will present the research methodology in detail. The methodology included the research design, research setting, population as well as sampling. The study objective focuses on exploring and describing the perceptions of a farming community in the Limpopo Province on HIV and Aids.

2.2 CONTEXT OF THE STUDY

The study was conducted in a rural context. Context refers to the setting of the study area relative to its surroundings. Its importance comes in understanding "outside" effects on the study, contribution either in positive terms or in negative terms. HIV transmission does not depend solely on sexual or drug-using behaviour but also its context. Mahadev (2006: 20) states that HIV and Aids like other infectious diseases are also greatly influenced by social and economic context. The susceptibility of the farming community to HIV infection includes gender dimensions, poverty and the standards that society sets for itself (Mahadev, 2006: 20).

Levubu is a rural area situated in the north eastern part of Limpopo Province. It is 356km northeast of Pretoria. Its sub-tropical conditions are conducive for growing sub-tropical crops such as bananas, avocados, mangos, macadamia nuts, litchis and guava. The climatic conditions and soils lead many of the commercial farmers in the area to regard the Levubu as the "finest farmland in the world", with one claiming that "if you fail to farm successfully in Levubu you will not farm anywhere in the world (Manenzhe, 2007: 6; Basu, 2009: 7).

2.2.1 THE HISTORICAL BACKGROUND OF LEVUBU

Levubu was the scene of many early battles involving the local tribes and colonialists. Military strength of the local tribes and the prevalence of malaria in the

area were among the reasons for the relatively late occupation of the area by the white settlers, starting in the 1920s (Manenzhe, 2007: 7; Nemangaani, 2011: 16). The Levubu irrigation scheme was established in 1930 and became fully operational in 1950s when Albasini Dam was constructed (Manenzhe, 2007: 8; Nemaangani, 2011: 16). In the 1930s, the government of South Africa began to establish irrigation schemes through coordinated programmes of the Departments of Lands, Water, and Agriculture (e.g. Vaalharts and Loskop, Pongola, Riet River, and Sterk River), that became known as 'Section 29' schemes (in terms of the Land Settlement Act of 1956) (Manenzhe, 2007: 8 ; Nemangaani, 2011: 16). The farmers began as "probationary lessees" and received training and farmed under continuous supervision and mentoring for a period of two years. Only those farmers who met the requirements would then be granted permission to farm on a lease-purchase basis, according to which they would have to exercise their purchase option within the prescribed number of years, e.g. 5 or 10 years. Those who failed to meet these requirements would be replaced by new settlers (Manenzhe, 2007, 6-7; Nemaangani, 2011: 18).

The Levubu Settlement Scheme was another example of a Section 29 scheme, albeit a relatively small one. It was meant to accommodate some of the struggling livestock farmers from the north of the Soutpansberg range who were to be relocated by government in order to give them a new start in Levubu. The government initially purchased four properties and subdivided them and by 1943, there were 43 holdings/plots of which 21 were allocated to farmers. The main challenge for the new farmers was inadequate water supply; a decision was taken to build the Albasini Dam, which was started in 1947 and completed in 1952 (Manenzhe, 2007: 7; Nemaangani, 2011: 16; M'marete et. al, 2009: 44). Another 50 holdings were then demarcated and allotted. By 1960, there were 116 "holdings" in total with another 17 in the process of being developed (Manenzhe, 2007: 7; Nemaangani, 2011: 16; M'marete et. al, 2009: 44).

Allocation of holdings to white farmers occurred at the expense of African land holders who were displaced from their land in order to make way for the scheme. In some instances, communities were permitted to remain on condition that they provided labour on the farms, however limited (Manenzhe, 2007: 7-12). The

historical background of the Levubu region is summarised in the table below (see Table 2.1). This table summarises the historical background of Levubu and its implications to the farming community.

Table 2.1: SUMMARY OF THE HISTORICAL BACKGROUND OF LEVUBU

YEAR	CHARACTERISTIC	IMPLICATIONS FOR LABOUR
1913–1950	Land dispossessions and removal of black communities from Levubu to parts of the former Venda and Gazankulu Bantustans; establishment of irrigation scheme for white commercial farmers and support to these new white farmers	A large section of people who used to farm on a subsistence basis were semi-proletarianised, selling their labour power to the newly established irrigation scheme/commercial farms. Some continued to live on the farms as labour tenants of white commercial farmers
1950-1970s	Expansion of cultivated areas was associated with the use of tractors instead of draught oxen for ploughing. Increased productivity and market integration	Farmers source more labour from the neighbouring communities of Tshakhuma, Valdezia and Mashau.
1980-1990	Larger areas could be managed and more labour was required for harvesting; shift from vegetables to nuts and sub-tropical fruits; increased demand of labour; increased mechanisation.	Labour intensive farming system, with labour supplied by the neighbouring communities and some workers living on the farms; recruitment of labour was the sole responsibility of the farmer

1990-2000	New democratic government and introduction of labour laws to regulate conditions of employment; new tenure legislation and land restitution programme; land claims lodged.	Labour regime: minimum wage, statutory regulation of the basic conditions of employment and labour relations; more workers from neighbouring communities commute to farms daily
2005-2007	Gazetting of land claims and negotiations over the future of the farms and how they would be used. Introduction of various inclusive business models or joint ventures (Strategic Partnership)	Assurance of job security for farm workers, promises for a Workers Trust (shareholding in the new joint ventures). Failure to establish the Workers Trust. Labour sourced from claimant “communities” and CPAs are responsible for recruitment of labour. Tensions amongst workers (non-claimants vs. claimants)
2008 to date	Collapse of strategic partnerships and formation of new forms of farm management governed by management contracts entered into between a commercial farmer and the land owning entity or “community”	Loss of employment; tensions on what profit should be used for (distribute to community members or reinvest in production)

Source: Manenzhe, 2007: 12

2.2.2 GEOGRAPHY, CLIMATE WATER SUPPLY

According to M'marete et. al, (2009: 44) the surrounding region receives little rain, while the Soutpansberg mountains themselves have an annual rainfall of nearly 2000mm in places, the best rainfall in South Africa.

Major rivers in the region are the Limpopo River in the north and the Olifants and Letaba Rivers further south, all of which drain eastward. Other rivers are the Livuvhu and the Crocodile. The Limpopo only flows strongly occasionally, while the Olifants and Letaba are heavily utilised for irrigation, especially east of the escarpment (Basu, 2009: 3; Manenzhe, 2007: 2-3).

The greatest part of the province is very dry, however, with few large dams. State-of-the-art irrigation systems pump water from the Levubu and Lotonyanda Rivers, and water is also supplied by canals from the Albasini Dam and the two rivers (Manenzhe, 2007: 2-3; Basu, 2009: 3).

2.2.3 HEALTH CARE INSTITUTIONS

The Levubu farm comprises of the Tshakhuma, Tshitwani, Masakona, Tshivhazwaulu and Ravele communities. These scattered communities' healthcare needs are serviced by the Tshakhuma and Levubu Clinic, based at Tshakhuma village as well as the Hamutsha Clinic which is based at the Tshitwani farming community (Talbot, 1995: 93). The distance between these healthcare centres ranges between 5 and 40km away from these communities. The local hospitals are Tshilidzini, Donald Fraser and Elim hospital .The farming community has limited access to and inadequate healthcare services and this is a reason why this communities' healthcare is rendered by the mobile clinic. Due to their long working hours, they rely on the services brought to them by the mobile clinic.

2.2.4 DEMOGRAPHY AND TRANSPORT

According to Statistic South Africa (2011: 20), the population of Limpopo Province is 5 404 868 and it has the largest number of females (53.3%).This figure includes the farming community in Levubu.The majority of the employees in the Levubu farming community walk to and from work; very few people have cars. Buses and taxis are used to travel to Thohoyandou. The roads leading to most farms are rural roads. In

addition, some of the roads in the district do not have route names and numbers. They also do not have appropriate road signs (e.g. speed limits) as well as signs indicating distances between destinations.

2.3 RESEARCH METHODOLOGY

A qualitative paradigm was followed to explore and describe the perceptions of the farming community on HIV and Aids in the Limpopo Province. Qualitative research is a way to gain insights through discovering meanings by understanding the whole. By understanding the whole we are able to explore the depth, richness and complexity of the phenomenon under study (Burns & Grove, 2007: 67). To get to the depth of the respondent's perceptions, the researcher will use in-depth interviews to collect the data.

By using a qualitative approach an attempt was made to explore and describe the farming community's perceptions from the subjective perspective of the individuals involved because the complexities, richness and diversity of their lives can only be captured by describing what really goes on in their everyday lives incorporating the context in which they operate (Creswell, 2007: 287; Henning, 2004: 36).

2.3.1 RESEARCH DESIGN

The research design is the overall plan for obtaining answers to questions being studied and for handling some of the difficulties encountered during the research process (Polit & Beck, 2008: 66-70; Polit, Beck & Hungler, 2001: 470). In a qualitative study, the research design is often referred to as an emergent design, which is a design that emerges during the course of data collection (Polit & Beck, 2008: 66-70; Creswell, 2007: 39).

A qualitative, exploratory, descriptive study was conducted because the researcher intended to explore and describe the perceptions of the farming community in the Limpopo Province on HIV and Aids. Exploratory, qualitative research is designed to shed light on the various ways in which a phenomenon manifests itself and on the underlying processes (Burns & Grove 2005:27).

- **Exploratory design**

As the name indicates, exploratory studies set out to explore a relatively unknown field in order to gain insight and understanding. It leads to insights and understanding rather than the collection of accurate and replicate data, thus involves the use of in-depth interviews (Henning, 2004: 144; Polit & Beck, 2008: 752).

In this study, the perceptions of the farming community on HIV and Aids were explored until data was saturated and this was demonstrated by repeated themes. This was ensured by using semi-structured, one on one in-depth interview to explore the perceptions of the farming community in depth. During the interviews, probing questions were used mostly to identify challenges faced by those infected and affected by HIV and Aids. Participants were encouraged to talk freely about events, behaviour and beliefs in relation to HIV and Aids.

- **Descriptive design**

A descriptive design describes situations and events. The researcher observes and describes what was observed. Its purpose is to provide a picture of a situation as it naturally happens (Burns & Grove, 2007: 240; Polit & Beck, 2008: 752; Steubert-Speziale & Carpenter, 2007: 86).

In this study, the perceptions of the farming community on HIV and Aids were described in general. The researcher obtained a profile of the individual participants to understand the participants better. It was crucial for the researcher to understand the individual participants' own perceptions, attitudes, beliefs, views and feelings, the meanings and interpretations given to events and things, as well as their behaviour; how these are put together into frameworks, which make sense of their experiences. In return, the researcher's understanding and knowledge of the participants' perceptions was utilised in developing recommendations to the farm owner, farm manager and the health care system in the Limpopo Province that can be utilised to curb the spread of new HIV infections in the farming community.

2.3.2 RESEARCH SETTING

The setting is the location in which the study is conducted. The three settings for conducting research are natural, partially controlled and highly controlled (Burns &

Grove, 2007: 29; Polit & Beck, 2008: 57). The Levubu farming community in the Vhembe District of the Limpopo Province was studied. The Levubu farm comprises of the Tshakhuma, Tshitwani, Masakona, Tshivhazwaulu and Ravele communities. These scattered communities' healthcare needs are serviced by the Tshakhuma and Levubu Clinic, based at Tshakhuma village as well as the Hamutsha Clinic which is based at the Tshitwani farming community (Talbot, 1995: 93).

The researcher ended up studying three communities (Masakona, Ravele and Tshakhuma) instead of the five communities as initially planned in the proposal due to time constraints as there was a delayed response from the managers of the two communities to respond to the researcher's application to conduct a study.

2.3.3 POPULATION

According to Polit and Beck (2008: 67) as well as Burns and Grove (2007: 40), a population is all the individuals with the common defining characteristics. In this study, the population consisted of the farm owner, farm managers and both male and female farm workers above the age of 18 in the Limpopo Province. The reason for choosing this age group was that they are the most vulnerable age group for HIV infection as stated in the South African HIV and Aids statistics. Also, the Constitution of South Africa Act 108 of 1996 Section 12(20) states that this group has rights to sign for themselves not to be subjected to medical or scientific experiments without their informed consent (Constitution of South Africa, 1996: 1249).

The study population was made up of the farm owner, farm managers, supervisors and both male and female farm workers above the age of 18 in the three communities mentioned. The farm owner and managers did not take part in the study; they (managers) approved the application to conduct the study on their farms and assisted with the organisation of the smooth running of the interviews by allowing the supervisors and farm workers who volunteered to take part in the study during working hours.

2.3.4 SAMPLING

A sample is the subset of the population (Polit & Beck, 2008: 340). Purposive and convenient sampling methods were used in this study. Purposive sampling or

judgmental sampling is based on the belief that the researcher's knowledge about the population can be used to handpick sample members, based on personal judgment about which ones will be most informative. In convenient sampling, the sample is selected from participants who are easily accessible and are "in the vicinity" during data collection. It saves time and effort (Polit & Beck, 2008: 343; Burns & Grove, 2007: 40; Rossouw, 2003: 114).

2.3.4.1 Inclusion criteria

The inclusion criteria were determined by certain characteristics identified by the researcher that must be present for the participants to be included in the study. The inclusion criterion was males and females above the age of 18 because according to the Constitution of South Africa this age group can sign the informed consent (Constitution of South Africa, 1996: 1249). Participants in this age group were selected because of their vulnerability for contracting HIV according to South African HIV and Aids Statistics cited in the Country's Progress Report on the Declaration of Commitment on HIV and Aids (2010: 11). The inclusion criteria employed in the selection of participant was as follows:

- Male and female older than eighteen (18) years irrespective of their HIV status;
- The educational background and marital status of participants did not preclude them from participation;
- Participants were of any nationality;
- In the case of the farm managers, they should be employed as a farm manager or farm workers for at least six (6) months;
- In case of the farm owners, they should be owners for at least twelve (12) months;
- The farm owners, managers and farm workers who are affected by HIV and Aids.

In this study, the researcher purposively and conveniently selected five (5) participants from the Masakona, Ravele and Tshakhuma farming community. Anyone who met the inclusion criteria and was willing to participate was selected.

2.3.4.2 Exclusion criteria

For this study, the sample criteria excluded:

- Anyone younger than eighteen (18) years,
- Anyone employed as a farm manager or farm worker for less than six (6) months

2.3.4.3 Identifying data of the participants

The profile of the 15 participants included in this study comprised of seven (7) males and eight (8) females between the ages of 28 and 49. Two of the 15 participants were supervisors and the rest were farm workers. No farm owner or manager volunteered to participate in this study. The duration of the participants' employment ranged between seven (7) months and ten (10) years. Table 2.2 summarises the profile of these participants.

Table 2.2: IDENTIFYING DATA OF THE PARTICIPANTS

PARTICIPANT	GENDER	AGE	JOB TITLE	DURATION EMPLOYED
P1	Male	36	Farm worker	7 months
P2	Female	47	Farm worker	5 years
P3	Female	37	Supervisor	6 years
P4	Female	41	Farm worker	6 years
P5	Female	49	Farm worker	7 months
P6	Male	32	Farm worker	6 years
P7	Male	37	Farm worker	6 years
P8	Female	42	Supervisor	7 years
P9	Male	48	Farm worker	10 years
P10	Male	45	Farm worker	10 years

P11	Male	40	Farm worker	7 years
P12	Female	44	Farm worker	10 years
P13	Female	28	Farm worker	6 years
P14	Female	45	Farm worker	5 years
P15	Male	43	Farm worker	10 years

2.4 DATA COLLECTION

Data collection refers to the process where the researcher gathers information from the selected participants in order to answer the research question (de Vos et al., 2005: 299; Polit & Beck, 2008: 765). Data was collected through individual interviews supported by the tape recorder and field notes.

The data were collected between October and November 2012. An information session was conducted a week prior to the actual data collection process. The researcher made arrangements with the general manager and human resource manager to meet with all the employees prior to data collection. Those who volunteered to participate and met the inclusion criteria were included irrespective of their HIV status. Confidentiality was maintained throughout the study. An audiotape was used during the interviews to capture all the data after obtaining permission from the participants.

2.4.1 ONE-ON-ONE INTERVIEW

In a qualitative research, an interview is an unstructured oral communication between the researcher and the participant during which information is obtained for a study (Burns & Grove, 2007: 544; de Vos et al., 2005: 292; Polit & Beck, 2008: 324). The one-on-one interview was used. A one-on-one interview is an in-depth interview used to determine the individual's opinions, perceptions, facts and potential solutions to a problem (Burns & Grove, 2007: 544; de Vos et al., 2005: 292; Polit & Beck, 2008: 324). In this study, semi-structured individual/one-on-one interviews were

conducted. Interviews were organised in three phases namely: preparatory phase, interview phase and post-interview phase (Rossouw, 2003: 146).

2.4.1.1 Preparatory phase

The preparatory phase refers to the initial phase of data collection during which the researcher prepares for data collection. Various preparations were made by the researcher and these included: accessing participants, information session and pilot testing.

- **Access of participant**

During access of participants, the researcher visited the Levubu farms for the first time together with the co-supervisor who introduced her to the human resource managers as well as the general managers of the respective farms with whom she liaised with throughout the data collection process. A schedule of appointment dates was drawn with the human resource managers and it was as follows: To meet with all the employees a week after the first visit to give information about the study; Pilot testing was done two days after the information session; Data was collected a week after the information session.

The researcher made appointments with the human resource managers of the respective farms; their contact details were recorded and the researcher provided the human resource managers with hers should a need for rescheduling the appointments arise. It was difficult to secure venues that were comfortable and free of distractions in some of the farms.

- **Information session**

During the information session, the researcher met with the participants. Rapport was built by being punctual; the researcher introduced herself and made eye contact where culturally appropriate and respect was shown. The nature, purpose, benefits and risks of the study were explained to the participants. The participants were briefed that the number of visits will be determined by the saturation of data and that there might be a need for follow up visits. The participants were reassured that confidentiality and respect will be maintained throughout the process. The

researcher asked permission to use the tape recorder during the actual data collection process.

The information session was conducted with all the participants but the consent form was signed individually by everyone who met the inclusion criteria and volunteered to participate because of the sensitivity of the research topic. This was done prior to data collection. Questions were allowed. After the participants had agreed to participate in the study, the researcher's further contact with them was in giving and receiving information via the human resource managers. The researcher gave the participants the assurance that they may withdraw at any time without any intimidation or penalties and that support from the psychologist or a trained counselor from the Levubu Clinic was organised prior to the data being collected should a need to talk to someone arise. An information session was conducted a week prior to the actual data collection process.

- **Pilot testing**

Pilot testing is a smaller version of a proposed study conducted to develop and refine the methodology such as the data collection process to be used in the larger study (Burns & Grove, 2007: 549).

A pilot study was conducted two days after the information session in the respective farms. The researcher selected two participants residing in the compounds of the respective farms instead of five as planned in the research proposal before commencing with the actual data collection process. The aim of pilot testing was to test the interview questions for their complexity so that problems due to understanding could be rephrased/ corrected before conducting the actual study. Participants used in the pilot study were excluded from the actual study.

Challenges picked up during the pilot study were that the participants misunderstood the concept of the perceptions of the farming community on HIV and Aids. The researcher ensured that the interviews were conducted in the participant's languages of preference. Therefore, the researcher was assisted by an experienced research assistant who was fluent in both the Xitsonga and Tshivenda the languages that the researcher was not fluent in. The researcher noticed that even the younger

participants misunderstood the concept of “perceptions” and they appeared more uncomfortable than the older participants to talk about HIV and Aids.

2.4.1.2 Interview phase

The interview phase is when the actual data collection process commences. During the interview phase the participants were greeted and welcomed, they were made comfortable and anxieties were allayed. The researcher and the research assistant introduced themselves and their roles were explained. The tape recorder was switched on after permission was granted by the participants and the in-depth one-on-one interviews were conducted. The following main question was asked:

- What are the perceptions of the farming community in the Limpopo Province on HIV and Aids?
- Based on the above question, the following sub-questions were used to guide the process: What are your perceptions regarding HIV and Aids in this community?
- What are the challenges experienced by some of you who are affected or infected by HIV in this community?
- What strategies are in place to support those affected and infected by HIV and Aids?

The interviews were conducted in the participant’s preferred languages which included Tshivenda, Xitsonga, Setswana, Sepedi, Isizulu and English to ensure that the participants understood the research question and are free to express themselves in the language of their choice. Therefore, the researcher was assisted by an experienced research assistant who was fluent in Xitsonga and Tshivenda as they are the languages that the researcher is not fluent in. The role of the research assistant was to ensure that the participants understood the nature of research as well as the purpose of the study.

The interview phase differed from farm to farm; in some of the farms the researcher was given an office where she interviewed individual participants. One of the challenges experienced during the interviews were a lack of complete privacy due to interruptions by co-workers or supervisors. The researcher tried by all means to

maintain the privacy. In some of the farms, the researcher conducted the interviews under a tree and the challenge was that it was noisy. Some of the participants requested to be interviewed during their lunch break as they were more comfortable and there were fewer interruptions in the compound (hostels where the farm workers reside). Due to the fact that data was collected in their natural setting, in some of the farms the researcher had to go to the field where the employees were working. The healthcare worker who was in charge of the mobile clinic was also interviewed during follow-up visits so as to verify some of the information given by the participants of the respective farms. Due to time constraints, she was interviewed telephonically. Various communication skills such as probing, paraphrasing and reflecting were used by the researcher and the research assistant during the interview process.

- **Probing**

Probing was used when responses lacked sufficient detail, depth and clarity. The original question was asked and there were no interruptions to avoid affecting the nature of the responses. For example, “Can you tell me more about what you mean when you say these farms are now owned by Africans?” (de Vos et al., 2005: 293; Rossouw, 2003: 144; Merriam, 2009: 100).

- **Paraphrasing**

Paraphrasing was used to pose the research question clearly and the participants were expected repeat the ideas contained in the question clearly and concisely. This method was used frequently during the interviews to ensure that the participants understood the question clearly. For example: “Let me just make sure, you are saying that it is common that male supervisors get more wages than female supervisors?” (de Vos et al., 2005: 293; Rossouw, 2003: 144).

- **Reflection**

Reflection was used by the researcher in order to remind the participants of what has already been said so as to link it with subsequent interviews (de Vos et al., 2005: 293; Rossouw, 2003: 144). Reflection echoes the participant’s own words and the aim is to encourage the participant to elaborate on what s/he said. For example: “It

makes you feel sad, helpless and neglected that the mobile clinic has not been coming for the past four months, does it?”

The interview method helped the researcher obtain the first-hand information about the constructions of events, activities, feelings, motivations, claims and concerns. The researcher’s ability to assume a helping attitude like being empathic, congruent and accepting enabled the respondents to tell their story face-to-face without feeling threatened. This led to one infected participant to disclose his status. Interviews allowed the researcher to clarify responses that were not understood fully, by probing them in more depth, paraphrasing and reflecting.

The major disadvantage of interviewing was time consumption. The interviews required more time than questionnaires. The researcher spent up to thirty (30) minutes interviewing one of the participants. Participants easily lost focus during the interviews. Although the researcher explained to all the participants the benefits of the study during the time of obtaining consent to participate in the study, she noticed that some participants continued to perceive her as one coming to help find solutions to their problems.

2.4.1.3 Post interview phase

This occurs at the end of the interview. During this phase, the researcher thanked the participants for their cooperation after each interview so that should a need arise for follow-up interviews participants should be willing to give more information if needed (Rossouw, 2003: 146).

2.4.1.3.1 Tape recording

A tape recorder was used by the researcher to record interviews during data collection (de Vos et al., 2005: 298; Burns & Grove, 2007: 81; Merriam, 2009: 109).

The interviews were recorded once permission was granted by the participants. Tape recording was used because it allows for much fuller record keeping than notes taken during an interview, and it ensures that the researcher concentrates on the interview itself as well as observing nonverbal responses. The tape recorder was tested before use. Anonymity was ensured by not recording the names of the participants during the interviews.

2.4.1.3.2 Field notes

Field notes refers to a written account of the things that the researcher hears, sees, experiences and thinks in the course of collecting the data or reflecting on the data obtained during the study (de Vos et al., 2005: 311; Polit & Beck, 2008: 407; Merriam, 2009: 129). After the interview, the researcher highlighted as much of the conversation as possible and she included themes that are striking as well as nonverbal responses. Field notes were taken by either the research assistant or the researcher depending on which language the participant understood. The researcher noted field notes based on observational, personal as well as methodological reflections.

The researcher's verbal and nonverbal cues were recorded. The language barrier was a challenge she faced and she struggled to fit in as she felt like an outsider due to her inability to speak the language especially Tshivenda. Environmentally, she struggled to adjust to the extreme heat; basic facilities like the toilets were not working at times and she had to use the pit-toilet. The researcher struggled to maintain empathy especially when she was interviewing the female employees. Despite all this challenges and experiences, the researcher managed to maintain professionalism and conducted the interviews successfully.

2.5 DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data. It is an ongoing process which involves continuous reflection about the data, analytical questioning and note taking throughout the study (Polit & Beck, 2008: 751; Burns & Grove, 2007: 536; Creswell, 2003: 192).

The taped interviews were transcribed verbatim on the same day or the following day after data collection. Anonymity was ensured by not recording the names of the participants during the interviews. The tapes will be kept at the researcher's residence for a period of 15 years and will then be destroyed as stipulated by the University of Pretoria's policy on storage of data.

Data analysis was conducted according to Teschs' analysis method (Polit & Beck, 2008: 751; Burns & Grove, 2007: 536; Creswell, 2003: 192). The researcher was assisted by an experienced research assistant, to transcribe and translate the data since the interviews were conducted in Tshivenda and Xitsonga -- languages of which the researcher is not familiar with. The researcher picked one interview which she deemed most interesting and brief and jotted down ideas that came to mind. After completion of several participants' responses, a list of all similar topics that merged was made. The topics identified were then abbreviated into codes, then the most descriptive wording for similar topics was identified and categories were formed. A final decision on the abbreviation of each category was made and assembling the data belonging to each category was made; finally, a preliminary analysis was be done by the researcher. Categories, sub-categories and themes were identified through clustering of descriptive phrases from the transcriptions. In order to avoid bias, the transcriptions together with field notes were sent to an independent coder for validation (Polit & Beck, 2008: 751; Burns & Grove, 2007: 536; Creswell, 2003: 192).

2.6 METHODS TO ENSURE TRUSTWORTHINESS

Trustworthiness, which is the degree of confidence used by qualitative researchers, led to the development of Lincoln and Guba's model which aims at ensuring the reliability and credibility of the qualitative research. The four aspects of trustworthiness as outlined by Guba's model are namely: credibility, confirmability, dependability and transferability (Polit & Beck, 2008: 196; Rossouw, 2003: 180; Krefting, 1991: 215).

2.6.1 CREDIBILITY

Credibility refers to the truth value and compatibility of the data and its interpretation. A qualitative study is credible when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would immediately recognise the descriptions thereafter (Krefting, 1991: 216; Rossouw, 2003: 180). The credibility of the findings was ensured through prolonged engagement, triangulation, member checking and peer examination. Lincoln and

Guba (cited in Rossouw, 2003: 180) describe the measures to ensure credibility as follows:

2.6.1.1 Prolonged engagement

Prolonged engagement means that the researcher has to be entrenched in the field of study and has to have prolonged interaction with the participants. The aim of prolonged engagement is to understand the values of the target group so that misconceptions could be eliminated and rapport could be built with the participants, but above all it is to ensure the credibility of the study (Rossouw, 2003: 180; Krefting, 1991; 216- 217).

The researcher did two weekly follow-up visits for one month to collect data in the Levubu farming community throughout the study. Each of the three farming communities were visited at least twice a week for a period of four weeks with each of the three visits to ensure prolonged engagement. The researcher conducted the interviews in the participants working environment while at the same time observing their day-to-day activities in their natural setting which enabled the participants to be familiar with the researcher.

2.6.1.2 Triangulation

Triangulation of data as described by Polit and Beck (2008: 36; Krefting, 1991: 217) refers to the use of multiple sources to draw conclusions with regard to what constitutes the truth. Various data collection methods like interviews and observations were used and field notes were taken to ensure triangulation.

2.6.1.3 Member checking

Member checking was ensured by playing summaries of taped interviews to the participants for checking their responses after each interview to ensure that there was no additional information that the participant would like to add. The researcher wrote an exhaustive description during data analysis and did follow-up meetings with some of the participants for data verification.

2.6.1.4 Peer examination

Peer examination was used to check the truth value of the data by involving a coder who assisted the researcher in analysing and interpreting the data collected (Krefting, 1991: 217; Rossouw, 2003: 181). Consensus between the coder and the researcher was reached regarding the themes.

2.4.2 CONFIRMABILITY

Confirmability refers to objectivity, accuracy, relevance or meaning of data. This was ensured by withholding the researcher's opinions and perspectives during the interviews (Polit & Beck, 2008: 196; Krefting, 1991: 218). Confirmability was ensured by triangulation and using bracketing to avoid contamination of data. Richness of the data was preserved by using quotations.

2.4.3 DEPENDABILITY

In qualitative research, dependability refers to the researcher's need to account for ever-changing context within which research occurs (Mushwana, 2010: 29; Krefting, 1991: 221). If another researcher were to conduct a similar study after some time from the same participants of the farming community s/he should find similar results. Dependability was ensured by taking field notes and observing nonverbal cues throughout the interviews. A literature control was conducted to compare the findings with other relevant studies.

2.4.4 TRANSFERABILITY

Transferability refers to the generalisability of the data meaning that the findings of the researcher should be applicable in other settings or group (Polit & Beck 2008: 539; Krefting, 1991: 220). In this study, transferability was ensured by various interviews, taking of field notes and observations made during the interview were noted.

2.5 CONCLUSION

The focus of this chapter was the research methodology used for the study. These included the research design, study population, research setting, sampling, data

collection methods and data analysis methods to ensure the truth value of the study. The implementation of the above led the researcher to obtain rich data, which will be presented and analysed in the next chapter of this study. Methods to ensure trustworthiness were also discussed to ensure the credibility of the findings.

CHAPTER 3

DISCUSSION OF RESULTS AND LITERATURE

CONTROL

3.1 INTRODUCTION

The previous chapter focused on the research methodology followed in this study. The exploratory and descriptive design was used to explore and describe the perceptions of the farming community in the Limpopo Province on HIV and Aids. This chapter will address the results of the data collected and the use of literature to support the discussion.

3.2 SUMMARY OF DATA COLLECTION

Data was collected through unstructured individual interviews by the researcher together with an experienced research assistant who assisted by translating the participants' views during the interview process. A tape recorder was used during the interviews which were then transcribed verbatim and field notes were taken. Observational and personal notes were taken. Observational notes are a description of events experienced by watching and listening while personal notes are the researcher's emotions, expectations and prejudices which helped with the final product (De Vos, 2002: 33; Polit & Beck, 2008: 407; Merriam, 2009: 129).

3.3 PROCESS OF DATA ANALYSIS

The researcher commenced with the analysis independently by highlighting the words and phrases representative of the participants' perceptions on HIV and Aids from the verbatim transcriptions. The tape recorded interviews were transcribed verbatim. A comparison between the recorded interviews and transcripts were made and key phrases were highlighted. Tesch's method of data analysis was used to

analyse the data as cited in Creswell (2003: 192; Burns & Groove, 2007: 536). The researcher read all transcriptions repeatedly; ideas were jotted down as they came to mind. Universal categories were identified and sub-categories and themes were developed as the analysis proceeded.

3.4 DISCUSSION OF RESULTS AND LITERATURE CONTROL

The results of the data collected and literature control will be discussed here. Literature searches of the MEDLINE and CINAHL search engines were conducted to identify pertinent articles used to support the discussion. Data was categorised into categories, sub-categories and subsequently themes were identified. The 15 transcribed interviews and copy of unmarked transcriptions together with field notes were given to an independent coder who is an experienced qualitative researcher. Consensus was reached between the coder and researcher.

The researcher identified the Health Promotion Model (HPM) used by Nola Pender as a framework to study the perceptions of the farming community on HIV and Aids. Nola Pender's HPM was created to serve as a "multivariate paradigm for explaining and predicting health promoting component of lifestyle" (Pender, 1996: 326). The model was used to assess an individual's background and perceived perceptions of self among other factors to predict health behaviours. In this study, the discussion of the results and the analysis were guided by the HPM. The components of Pender's HPM were compatible with some of the categories in this study like category 2, 3 and 7. According to Rossouw (2003: 167) categories are meaningful compartments of which analysis is based. Sub-categories are subsections of categories whereas themes are ideas, concepts, behaviours or phrases used to give meaning to words (Rossouw, 2003: 167). Seven categories were identified, namely: emotions linked to HIV and Aids, individual characteristics and experiences, behavior-specific cognition and affect, human resource issues, lack of recreational facilities, healthcare needs and support as a health promotion strategy.

A summary of categories, sub-categories and themes is presented in Table 3.1 below.

Table 3.1: SUMMARY OF CATEGORIES, SUB-CATEGORIES AND THEMES

CATEGORIES	SUB-CATEGORIES	THEMES	
1. Emotions linked to HIV and Aids	1.1.Pleasant and unpleasant emotions	1.1.1. Fear	
		1.1.2. Pain, pity and sympathy	
		1.1.3.Acceptance	
		1.1.4.Concern and neglect	
2.Individual characteristics and experiences	2.1.Personal biological factors	2.1.1.Gender inequality and exploitation of women	
		2.2. Personal socio-cultural factors	2.2.1. Poverty and low wages
			2.3. Personal psychological factors
3. Behaviour-specific cognition and affect	3.1.Perceived benefits of action	3.1.1. Multiple partners and use of sexual protection	
		3.2. Perceived barriers to action	3.2.1. Low wages and long working hours
			3.2.2. Alcohol intake increases the risk of contracting HIV

		3.2.3. Insufficient knowledge on HIV and Aids due to lack of training
4. Human resource issues	4.1.Unfair dismissal and retrenchment	4.1.1.Retrenchment of those with regular follow-ups
	4.2. Migrant labour	4.2.1. Lack of jobs leading to migrant labour
5. Lack of recreational facilities	5.1 Boredom	5.1.1.Engaging in sexual activities after work due to lack of recreational facilities
6. Healthcare needs	6.1.Mobile clinic and shortage of staff	6.1.1.Cessation of healthcare delivery and increased workload
7.Support as a health promotion strategy	7.1.Healthcare support	7.1.1.Provision of PHC services by mobile clinic
	7.2. Emotional support	7.2.1. Emotional support by family
		7.2.2. Emotional support by management and government

3.4.1 CATEGORY 1: EMOTIONS LINKED TO HIV AND AIDS

The first category that emerged was the emotions linked to HIV and Aids. The only sub-category that emerged under this category was pleasant and unpleasant emotions.

3.4.1.1 Pleasant and unpleasant emotions

Pleasant and unpleasant emotions emerged as the first sub-category. The following themes were identified under this sub-category: fear, pain, pity and sympathy, acceptance, concern and neglect. Each of these themes will be discussed below and illustrated by quoted examples to preserve the richness of the data.

- **Fear**

Participants expressed fear explicitly, fear of being infected with HIV, fear of contracting HIV from their spouses as expressed by participant 5 and participant 13 or their kids contracting the virus when playing with infected kids. Some participants feared getting tested, whereas participant 11 feared to be retrenched if he missed work due to follow-up appointments to collect antiretroviral treatment. Stigma and prejudices associated with Aids can not only undermine attempts to identify, treat and control the disease but also the opportunity to offer sufferers the care and compassion they deserve.

This is evident from statements such as:

“HIV is a killer disease” (*vhulwadze ha HIV vhu a vhulaya*) (participant 3, 4 & 14)

“People are scared to test for HIV” (*vhathu vha a shavha u lavheleswa nga vha mutakalo*) (participant 4)

“HIV is finishing people” (*HIV ifhedza vhathu*) (participant 9 & 12)

“HIV kills” (*HIV i ya vhulaya*) (participant 5)

“It is scary to see people dying like this” (*swa chavisa ku vona vanhu vafa hixitalo*) (participant 10)

“My partner is far away from me” (*partner ya nga i kule na nne*) (participant 5)

“People do not want to work with you because of fear that you might infect them” (participant 1)

Literature control: Fear

Gossip and fear within communities leads to isolation of HIV positive people and discourages many from seeking testing, treatment or support services. Fear of being seen and having their HIV status disclosed caused many people to avoid seeking health and support services. Many will not approach Aids service organisations because they are afraid of being seen by a member of their community. This may lead to a particular avoidance of services geared specifically to African communities. Fear and avoidance are the predominant reactions to HIV (Lawson et al., 2006: 32-33; Collison, 2010: 42).

People are often afraid to discuss HIV. It was clear in this study that the majority of the participants still perceive talking about HIV as taboo. Some of the participants even used the word “this thing...” when referring to HIV. Fear is related to images and notions of suffering, shame and death, being dependent on others to take care of you, being rejected and feeling alone. Stigmatisation, social rejection and the scaring nature of HIV and Aids prevented some people from carrying out the HIV and Aids tests. The Human Development Report (2004: 95) also agrees that about 70% of infected individuals are unaware of their HIV and Aids status. This implies that an infected individual who is unaware of his or her HIV status and has failed to go for HIV test may still engage in active unprotected sexual behaviour thereby spreading the disease in multiple folds (Saliu & Adejoh, 2010: 220; HDR, 2004: 95). The literature supports some of the narrative statements expressed by the participants about fear of HIV testing.

- **Pain, pity and sympathy**

Pain, pity and sympathy emerged as the second theme under the sub-category of pleasant and unpleasant emotions. The emotion of pain, pity and sympathy was verbalised when someone falls ill or dies due to HIV-related illnesses. This is evident from statements such as:

“It is painful to see people dying like this (*zwi khou vhavha hu vhona vhathu vha tshi fa nga vhulwadze hovhu*) (participant 3)

“This disease makes me feel pain, and I don’t want to hear about it” (*hovhu vhulwadze vhu a mmbaisa, a thi nyagi na u pfa tshithu nga vhulwadze hovhu*) (participant 13)

“I feel pity and pain for those who have this thing...” (*ngibezwela ubuhlungu abantu abaphethwe yilento*) (participant 2)

“If you are ill, you are ill, maybe tomorrow it can be me” (*uma ugula, uyagula, mhlawumbe kusasa kungaba yimi*) (participant 2)

“I hate HIV, my aunt died because of it, I pitied her but I was compelled to accept it when she died” (*ngiyayizonda ingculaza, ubabekazi wami wabulawa yiyo, bengimzwela ubuhlungu kodwa ngaphoqeleka ukwamukela ngenkathi eshona*) (participant 13)

As much as most of the participants verbalised that they still don’t talk about HIV and Aids, there was a general feeling of pain and sympathising with those (co-workers and family members) who had signs of HIV. The emotion of pity was further explored during follow-up interviews, participant 14 verbalised that Aids is a hateful disease, but when her aunt contracted it, she pitied her; she had to change her attitude and accept it. She cared for her aunt until her death and when she died she felt relief and accepted that she had to die.

The majority of the participants felt that they cannot just talk about it freely instead they would advise anyone with the signs of HIV to go to the clinic. This is demonstrated by statements like:

“We don’t talk about HIV and Aids but people must go to the clinic to be checked and know their status” (*a ri khou amba nga HIV na Aids fhedzi vhathu vha a ya clinic vha tshekhwa nyimelo ya vho nga ha tshitshili tsha HIV*) (participant 5)

“I don’t talk about HIV at work or at home” (*aai...a ri khou amba nga HIV mushumoni na hayani*) (participants 1, 2, 3, 9, 10, 11, 13 &15)

Literature control: Pain, pity and sympathy

According to UNAIDS (2011: 99), millions of people around the world know people close to themselves who are living with HIV. They are likely to feel pain, pity and sympathy and be fearful and upset over how the disease could affect their loved ones or their relationship, worry about how they can best support that person and even feel guilt for feeling the way they do. Sometimes family and friends will find it more difficult than the patients themselves to come to terms with the diagnosis. Again, there are no ideal ways to cope. Discussing feelings with others including friends, family and support groups, learning about HIV, being healthy, and making space and time to relax and take part in other activities can help (UNAIDS, 2011: 99).

Mudzusi, Netshandama & Maselesele (2007: 139) mentions that although emotional pain and grief or bereavement are inevitable among people whose loved ones are living with, ways can be found to moderate their impact. This is not to say that the goal of finding ways to deal with emotions should be to eliminate such feelings – everyone should feel free to grieve or mourn for as long as they wish – just that such feelings can be managed so they do not continue to be overwhelmed. It follows that people in mourning should not feel guilty if they find something that helps them relieve their suffering and come to terms with the death.

Diminished feelings of bereavement or “moving on” should not be seen as reflecting lessened feelings of love for the deceased relative or friend (Maldonado et. al, 1996: 3; Mudzusi, Netshandama & Maselesele, 2007: 139).

Family members and friends share these feelings, but they also struggle with their own adaptation to the devastating changes which their loved ones go through. As supportive as they may want to be, friends and relatives must deal with their own fears of contamination with the deadly virus. Often they feel inadequate about how to relate to the patient. This is frequently translated into various forms and levels of withdrawal, leaving patients feeling even more isolated (Maldonado et. al, 1996: 2-3; Mudzusi, Netshandama & Maselesele, 2007: 139; Jantjie, 2009: 94).

The above literature confirms narrative statements expressed by participant 13 whose sister is infected. The sister hasn't disclosed her status but the participant can

see the symptoms from the child who is presenting with the same symptoms like the aunt who died due to Aids related diseases.

- **Acceptance**

The third theme that was identified under the sub-category of pleasant and unpleasant emotions was acceptance. Participant 11 opened up even before the interview about his status; he expressed that he has accepted that he is infected. He asked a lot of questions about how to live a healthy lifestyle and during probing the researcher discovered that the participant still needs counseling as much as he said he has accepted his status. He was referred to Tshakhuma Clinic for counseling. Permission was given by the participant prior to referral.

The emotion of acceptance was further explored during follow-up interviews. Participant 13 verbalised that Aids is a hateful disease, but when her aunt contracted it, she pitied her and had to change her attitude and accept it. She cared for her aunt until her death; when the aunt died she was relieved and accepted that she had to die. The following expressions below are relevant:

“HIV kills but I take it like a cold” (*vhulwadze ha HIV vhu a vhulaya, fhedzi ndi i dzhia sa mukhuswane*) (participant 11)

“I hate HIV, my aunt died because of it, I pitied her but I was compelled to accept it when she died” (*ngiyayizonda ingculaza, ubabekazi wami wabulawa yiyo, bengimzwela ubuhlungu kodwa ngaphoqelega ukwamukela ngenkathi eshona*) (participant 13)

Literature control: Acceptance

According to Lawson (2006: 49) and Mudzusi, Netshandama & Maselesele (2007: 260), there are many reasons why HIV patients feel the need to retain a strong and composed attitude. Some of these come from outside pressures. Partners and family members may unintentionally communicate the wish that the patient be strong, because it helps them to cope with their own feelings of helplessness and fear. More internal reasons for wanting to remain strong and in control may involve concerns about being overwhelmed with fear and anxiety. The goal of supportive-expressive group therapy is for these patients to be able to express all emotions, whether they

be positive or negative. With unencumbered emotional expression, the patient experiences relief, encouragement and acceptance as he or she finds that the emotions are tolerable (Lawson et al., 2006: 49, Mudzusi, Netshandama & Maselesele, 2007: 260).

After being diagnosed, people confronted with their HIV-positive status are highly stressed and uncertain, despite the availability of HAART and their lives may be devastated by the need to deal with the new medical, personal and social situation. Research on the psychosocial aspects of a HIV-positive status show that living with HIV is associated with a large measure of stress and depression. People with HIV and Aids must also manage the stigma associated with HIV and Aids. Moreover, they must tolerate treatment with adverse side effects, deal with rejection and social discrimination, and confront the deaths of others in their social networks. Being HIV positive generally makes HIV part of a person's identity. The social stigma that surrounds HIV may have adverse repercussions not only for the individual, but also for their family (Van Empelen, 2005: 10; Setswe, 2010: 28; MDG Country Report, 2010: 74).

In this study, it was evident that continuous counseling of infected patients is crucial especially when patients say they have accepted their status. Participant 11 discovered that he was infected after his wife was diagnosed during pregnancy. It was later discovered during follow-up interviews that this participant was still in denial but he was pretending to have accepted his status so as to support the wife.

- **Concern and neglect**

Concern and neglect emerged as the fourth sub-category under the pleasant and unpleasant emotions. Most participants raised a concern that people are still not using protection even if they know they have the virus. Some spread it intentionally. The study indicated that most participants expressed mostly unpleasant emotions when they start talking about HIV and Aids. Participant 11 raised a concern that since he is infected he is concerned about who will support his family financially once he becomes sick. Participant 14 emphasised the fact that the government does not care about the farm workers otherwise they would come and see what is happening at the farms. The majority of participants expressed that even the healthcare workers

do not care about them because the mobile clinic no longer comes to the farms. Concern and neglect was confirmed by the narrative statements quoted below that the farming community is neglected and no one cares about them including the government.

“It is tough in the farms, people are neglected by the government and they are sick” (*dzi a vhuya ha fha maburasini, vha muvhuso a vhana thogomelo na rine, na u ri vhathu vha a lwala*) (participant 3)

“When it comes to HIV it is difficult” (*eish..., mafhungo a HIV a ya konda*) (participants 3 & 6)

“My people will die because of lack of knowledge, the people in the farms do not have knowledge about HIV” (quote from the Bible) (*vhathu vhanga vha do lovha nga u shaya ndivho, vhathu vha maburasini a vhana ndivho nga vhullwadze ha HIV*) (participant 13)

“This disease is a reality here in the farms” (*hovhu vhulwadze vhu hone hafha maburasini*) (participants 5, 6 & 12)

“People are sick here” (*hu a lwalwiwa ha fha fhethu*) (participant 13)

“That is a tough one, people are stubborn, they don’t use condoms” (*mhmm... zwi a konda, vhathu vha oma thoho, ha vha vhathu a vha shumishi khondomu*) (participant 3).

“We blame the government, they don’t care about us” (*ri sola vha muvhuso, nga u ri a vha ri thogomeli*) (participant 5)

“For us to be cured, doctors must come to the farms” (*i ku tshunguriwa marabji kurima hela madokotela mafanela ku ta a maburasini*) (participant 10)

“People in the farms are neglected, they don’t have entertainment places and the mobile clinic has not been coming for the past four months” (participants 1 & 15)

In reference to the above quotes the participants emphasised that people in the farming community are still dying because of HIV simply because they are neglected

by the government and their healthcare needs are not attended to. However, concern and neglect was not raised by the farm workers only, but also by the health care worker who was in charge of the Voluntary Counselling and Testing (VCT) and the mobile clinic. She raised a concern that as VCT counsellors they were not only focusing on VCT but also on other routines of the institution, like attending to other PHC services and school health programmes.

Literature control: Concern and neglect

The study conducted by Lawson on “HIV and Aids, stigma, denial, fear and discrimination” emphasises that several participants in the study expressed their concern about who will look after their children if they are unable to do so. The participants also discussed wanting to ensure that their children grow up with a sense of security and well-being (Wouters et.al, 2009: 357; Lawson et al., 2006: 36).

The above literature confirms that some of the farm employees are still denying that HIV exists; it is often associated with witchcraft. The following statement is a clear indication of the participant number 7’s feelings:

“Some of them still don’t believe that HIV exists, they say “ndiza vhaloyi ezo”

Farm owners and farm workers often have a relationship that goes back generations and extends far beyond that of the normal employer/employee relationship. While some owners are dismissing HIV and Aids as “the government’s problem”, others are extremely concerned, but are hampered by a lack of information, financial constraints, lack of assistance from the Department of Health and other governmental departments, and the impression that there are no tools in place to “fix the problem” (HIV and Aids in the South African Agricultural Sector, 2008: 17).

Pharoah (2005: 27) raised a concern that even though some of the institutions have the prevention programmes in place, one of the major challenges faced by prevention programmes is that they are poorly attended by senior management and professionals. However, everyone is potentially at risk of contracting HIV, and it is vital that activities should target all employees including middle and senior management. This was evident in the farming community because the farm owners

and farm managers did not take part in this study (Pharoah, 2005: 27; Ugwu, 2009: 1617).

Collinson (2010: 2) emphasises that in rural areas the HIV epidemic is advanced and health problems of the past have not disappeared. A health transition is underway adding a burden of non-communicable disease. There are some government services and programmes aimed at addressing poverty and developing health systems, but many communities feel neglected by the new democratic government, and development has been slow (Collinson 2010: 2).

However, concern and neglect was not raised by the farm workers only, but also by the healthcare worker who was in charge of the Voluntary Counselling and Testing (VCT) and the mobile clinic. She raised a concern that as VCT counsellors they were not focusing only on VCT but also on other routines of the institution, like attending to other PHC services and school health programmes. The findings of this research were consistent with the findings of a study conducted by Mudzusi, Netshandama & Maselesele on “nurses’ experiences of delivering VCT services for people with HIV and Aids in the Vhembe District, Limpopo Province” where it was mentioned that the VCT counsellors do not get any emotional support from the supervisors and no incentives from the government (Mudzusi, Netshandama & Maselesele. 2007: 259).

3.4.2 CATEGORY 2: INDIVIDUAL CHARACTERISTICS AND EXPERIENCES

Individual characteristics and experiences is one of the components of the Pender’s HPM. According to Pender, individual characteristics and experiences are predictive of a given behaviour and shaped by the nature of the target behaviour being considered. The importance of an individual’s unique personal factors or characteristics and experiences depends on the target behaviour for health promotion. Individual characteristics and experiences were identified as the second category. Under this category, three sub-categories were identified namely personal biological, sociocultural and psychological factors. The findings of this study were guided by the conceptual framework of this study. Personal factors are independent variables that directly influence behaviour-specific cognitions and also directly influence the specific health promoting behaviour. Perceptions of self and influences

on the individual directly influence commitment to a plan of action which then leads to the health-promoting behavior (Wu et. al, 2003: 94).

3.4.2.1 Personal biological factors

Personal biological factors include variables such as age, gender, body mass index, pubertal status, strength and balance. Gender inequality and exploitation of women was the only theme under this sub category.

- **Gender inequality and exploitation of women**

Gender equality is a fundamental human right, a commonly shared value and a necessary condition for the achievement of the internationally agreed development objectives, including all MDGs. The gender division is one of the most significant inequalities and it cuts across all social and income groups. Gender inequality was classified as the second sub-category under human resource issues. The only theme identified under this sub-category was exploitation of women.

Exploitation of women was identified as the only theme under the sub-category of gender inequality. Participant 2 raised an issue of exploitation of women and gender inequality irrespective of qualifications and experience. An issue emphasised by participant 12 was that some women end up in a relationship with a manager or supervisor simply because they want to work less and have more money; they want to secure their employment. Some females end up in such relationships because they are scared that if they do not get involved with the managers or supervisors they might be victimised and there are no unions to protect the farm workers. The following comments are relevant:

“Iyoo, mhmm dzyabuya..., if you are a woman and you are a supervisor a man in a similar position gets more money than you” (participant 3)

“People want to have less work, by becoming the “girlfriend” of a supervisor for the season because it guarantees better working conditions” (vhathu vha funa u shuma mishumo mituku , nga uri vha vha na vhudzekani na vhahulwane mushumoni) (participant 3)

“There are no unions in the farms, people are expelled at work” (*a huna vhaimeleli vho no bva kha dzi union maburasini, vhatu vha a pandeliwa mushomoni*) (participant 14)

“If you are a woman you don’t have a say, even the women in management positions don’t support us” (participant 3)

Literature control: Gender inequality and exploitation of women

Gender relations play an important role in the general well-being of members of South African households, especially for women and children. Male dominance is still very prevalent in the majority of relationships and there are high levels of conflict mainly about income and other resources within households. Violence against women, including sexual violence and rape, is still a very real and widespread problem on farms. Around the world, as many as one-in-every-three women has been beaten, forced into sex, or abused in some other way. In Sub-Saharan Africa, 59% of those living with HIV are women, and young women aged 15 and above are at least three times more likely to be infected with HIV than men of the same age (UNESCO, 2008: 2).

Farm workers in South Africa are disempowered in a variety of ways. Their history of slavery and ongoing disadvantaged socio economic conditions compounds the problem of violence against women on farms. Many male farm workers struggle with a childhood history of violence and alcoholism, have low self-esteem, are habitual drinkers, have low levels of education and feel insecure due to various uncertainties in their lives and they in turn abuse women (UNESCO, 2008: 2).

Mahadev (2006: 28) states that sexual violence is seen as a contributing factor in the spread of HIV and Aids. Dealing with sexual violence is considered as a key factor in the fight against Aids. Not all women have the opportunity for education, and there also exists low levels of education among many girls and women, because they are being pulled out of school early to perform household duties or care for sick relatives. This means that they cannot access HIV information. Young women are kept ignorant about sex, as this is viewed as a sign of innocence. This in turn makes them totally unprepared for sexual relations and equally unable to negotiate for safe sex. This sentiment is also echoed by UNESCO (2001: 15) which states that women are

at greater risk of HIV infection because they lack the power to determine when, where and whether sex takes place (UNESCO, 2001: 15).

Perhaps the biggest story of HIV and Aids in Africa today is the feminisation of the epidemic; more women than men have HIV and Aids in Africa. Women are also becoming infected at a faster rate than men are. The reasons are many. In very general terms, they stem from women's physiological vulnerability to HIV infection, and to gender disparities. Gender inequalities mean that women are less educated and poorer than men, their decision-making and negotiating power is diminished, and they are particularly susceptible to sexual violence and other harmful practices. These same gender disparities are also harmful to men in spite of the fact that they tend to favour men. For example, men are expected to have multiple sexual partners, which increases their risk of contracting (and transmitting) HIV. Although there has been considerable progress in public health circles about understanding the roles of gender and sexuality in HIV and Aids, there is still little public awareness and discussion about it (UNAIDS, 2001: 33; UNAIDS, 2012: 64; Brophy, 2010: 56).

According to IRIN-Plus News (2007) cited in HIV and Aids in the South African Agricultural Sector, 2008: 15), it is stated that with the arrival of the seasonal workers, the possibility of HIV transmission increases. Desperate to secure employment for the duration of the harvest, it is not uncommon for young women to have sex with male supervisors, known as "indunas", in exchange for a job; becoming the "girlfriend" of a supervisor for the season can guarantee accommodation on the farm and better working conditions. "I can promise a job to a woman in exchange for sleeping with her," one male supervisor told IRIN-Plus News. "A lot of the supervisors have maybe 10 girlfriends through the season". The IOM survey found that 52% of female workers interviewed on farms in the Limpopo and Mpumalanga provinces had exchanged sex for food, clothing, gifts or money. Compared to their male counterparts, female workers had lower levels of knowledge about HIV and Aids, and were about half as likely to use condoms in casual sexual relationships. One of the main reasons they gave for not using condoms was that their husbands or boyfriends did not like them (HIV and Aids in the South African Agricultural Sector, 2008: 15).

The absence of trade union organisations and limited means of legal protection from human rights violations and work-related abuses resulted in farm workers and their families being “trapped” on farms, lacking the skills to engage in the wider economy and having no possibilities of advancement. Studies focusing on the health status of farm workers’ stress that they continue to represent a seriously and tragically under-served worker population whose health is adversely affected by occupational hazards in agriculture, migracy, social discrimination and poverty (Lemke, 2005: 846-847).

Poor labour conditions and non-compliance with labour legislation was reported by trade union representatives of farm workers in the Western Cape to the South African Human Rights Commission’s inquiry (2003:63) and it was found that the unequal treatment of women was prevalent as well as non-compliance regarding overtime, leave, information regarding remuneration, illegal deductions, notice pay, child labour, contravention's in respect of dangerous chemical substances regulations, driven machinery and unfair dismissals. Workers were said to “not speak about their labour problems for fear of intimidation by their employers and the subsequent loss of their jobs.” Very few farm workers are members of a union in the area and the reasons given include intimidation by employers, fear of dismissal, discrimination against those who are members, inability to afford union fees and farmers refusing to allow union officials entry onto their property (SAHRC, 2003: 65, Brophy, 2010: 55).

The recent news on SABC channel was that the employees at Masakona farm did not receive salaries for the past three months. This is an indication of workers who fear that they will be intimidated or even lose their jobs if they raise such issues (SABC News, February 2013).

Women farm workers are extremely vulnerable, as they are discriminated against, in terms of access to employment, receive lower wages and are completely dependent on the men for housing and access to employment (SAHRC, 2006: 4). Trade unions reported that housing and permanent employment for single women on farms is seldom ever a possibility (SAHRC, 2006: 4). This extreme dependency, says Parenzee and Smythe (2003: 30), increases their vulnerability as they are reluctant to use the legal system because of the very real risk of losing their work and home.

“Men control every aspect of women’s lives” and “face precarious livelihoods of profound insecurity” due to the historical location of commercial agriculture within paternalism, says Shabodien (2005: 32-33). On the study on farms in the Stellenbosch district, Falletisch (2008: 85) found that male labourers negotiate terms of agreement with the farm manager on behalf of their wife, daughter or girlfriend, as in most cases women are only allowed on the farm by virtue of their relationship with a man. This vulnerability increases their risk of being abused, as the perpetrators know their dependency and they have fewer options, should they try to break away from an abusive relationship (Parenzee & Smythe, 2003: 48).

We have known for at least three decades that gender and sexuality (and patriarchy) are significant factors in HIV transmission and we now know that they influence treatment, care and support. Patriarchy renders women powerless. Power imbalance between men and women restrict women’s sexual autonomy and expands men’s sexual freedom. Both these factors increase men and women’s vulnerability to HIV. Economic, social and cultural factors in South Africa render women and girls more susceptible to HIV infections. These factors result in gender inequality (UNAIDS, 2011: 46; Pienaar, 2003: 12).

3.4.2.2 Personal socio-cultural factors

Personal sociocultural factors include variables such as race, ethnicity, education and socioeconomic status. The second sub-category classified under individual characteristics and experiences was personal socio-cultural factors. The only theme identified was poverty.

- **Poverty and low wages**

There are strong bi-directional linkages between HIV and Aids and poverty in resource-poor settings. In this study the participants expressed that poverty is carried over generations. The issue of poverty was expressed by participant 12 that its effects are carried over from generation to generation. There was a lot of self-pity regarding the farming community’s poverty.

The majority of the participants verbalised that they were underpaid and linked low wages to transactional sex thus increasing the risk for contracting HIV. Participant 14

verbalised that her niece contracted HIV from the mother because she breastfed the child simply because she could not afford to buy formula milk. The following narrative statements are deemed as relevant:

“If you have two boyfriends you are increasing your money/income” (*ha o na le boyfriend tse pedi, o oketsa tjhelete*) (participant 3)

“There is no money in the farms” (*ayikho imali emapulazini*) (participant 2)

“My parents are poor, I am poor; the farming community is poor” (*vhabebi vha hone ndi zwisiwana, I am also poor, it is from generation to generation... vhathu vha maburasini ndizwisiwana*) (participant 12)

“My sister was advised not to breastfeed, but she had to breastfeed because she couldn’t afford formula milk” (*moratho wa nga vha ngo mu adviser hu ri asingo mamisa ngwana, mara amu mamisa asina maswi*) (participant 13).

Literature control: Poverty and low wages

HIV and Aids is both a manifestation of the poverty conditions that exist, taking hold where livelihoods are unsustainable and the result of the unmitigated impact of the epidemic on social and economic conditions. HIV and Aids is at the same time a cause and an outcome of poverty and poverty is both a cause and an outcome of HIV and Aids. At a global level, cross-country evidence indicates strong and significant associations between HIV prevalence and aspects of socioeconomic performance. In general, the higher the level of HIV, the lower the level of economic performance (UNAIDS, 2005: 12).

Poverty, food insecurity and HIV and Aids are among the most pressing social issues in South Africa. Many families in developing countries have been and are still living in poverty. The Aids pandemic kills the most productive and reproductively active members of society, thus increasing the number of dependant household members and also the number of orphans and child-headed households who engage to commercial sexual transactions in order to survive, thus leading to a vicious cycle of poverty and HIV and Aids (Lemke, 2005: 846; Chucks, 2008: 90 - 91).

Most adults in poor families pay for their medical expenses “out of their pocket” since they do not have insurance coverage. This is a drain on household’s money to cover living expenses. In addition, illness due to HIV and Aids means time off from work and most low-wage workers including farm workers are not paid if they miss work. Thus, illness due to HIV and Aids leads to poverty. Since food is about the only flexible part of a budget for many poor families, food expenditure is cut back with the illness of the breadwinner and the result is food insecurity. In the Limpopo Province, a large number of people dying from Aids-related illnesses exacerbate poverty, which in turn leaves individuals vulnerable to adverse effects of HIV. Lack of adequate food and nutrition leaves individuals less able to cope with HIV if they are infected, as effective treatment depends on a good diet (UNAIDS, 2010: 107; Chucks, 2008: 90; HIV and Aids in the South African Agricultural Sector, 2008: 12).

HIV and Aids in the South African Agricultural Sector (2008: 15) further emphasises that environmental factors like poor living and working conditions, separation from families, physically demanding work with low wages, exploitation, poor accommodation facilities and limited recreational facilities further exacerbates the spread of HIV on the farms.

Government adopted a comprehensive approach to eradicating extreme poverty and hunger. This approach combines cash transfers with social wage packages including clinic-based free primary healthcare (PHC) for all, compulsory education for all those aged 7-13 years, and provision of subsidised housing, electricity, water, sanitation, refuse removal, transportation, and transfer of township housing stock those who have been resident in these properties for a set minimum period of time (MDG Country Report, 2010: 23).

3.4.2.3 Personal psychological factors

Health-promoting behaviours can lead to a patient’s overall sense of well-being as well as protection from disease and chronic illnesses. Pender’s health promotion theory offers a holistic view of the patient, assessing the patient’s background and self-perceptions. Self-esteem, self-motivation and personal competence are examples of psychological factors. Stigma and social isolation leading to non-disclosure was the only theme identified under this sub category.

- **Stigma and social isolation leading to non-disclosure**

Stigma associated with Aids is defined as a feeling of rejection and grief that resulted from the Aids status becoming known. Stigma and social isolation leading to non-disclosure was identified as the only theme within personal psychological factors.

The seventh participant raised an issue that those that have the virus do not disclose because of fear of social isolation. It was evident that despite the basic knowledge that the farming community has on transmission of HIV stigma and social isolation is still prevalent. The quotations below are relevant:

“When people start getting ill they say it is TB of the bones” (*vhathu ha vha thoma hu lwala vhari ndi lufhia lamarambo*) (participant 7)

“People don’t disclose their status because most people will judge you if you tell them you have HIV” (participant 15)

Literature control: Stigma and social isolation leading to non-disclosure

Since the onset of Aids the gap between the rhetoric and reality is experienced as very wide. The spread of the pandemic has increased not only violence against the body of a person; it also exercises violence against the societal existence of the person, as well as causing marginalisation and discrimination of the person and his health condition. Stigmatisation takes place in specific contexts of culture and power; it has a history which influences its appearance and the form it takes, and it is used by individuals, communities and the state to produce and reproduce social inequality. HIV and Aids-related stigma refers to prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV or Aids, and the groups and communities with whom they are associated (Lawson et al, 2006: 8; Cantisano, Rime & Sastre, 2012: 3).

Disclosure is a process, one that is positively linked to counselling, care and support. Disclosure of one’s HIV status to sexual partners is an important prevention goal emphasised by the World Health Organization (WHO) and the Centres for Disease Control and Prevention (CDC). Disclosure offers a number of important benefits to

the infected individual and to the general public. In addition, HIV status disclosure may lead to improved access to HIV prevention and treatment programmes, increased opportunities for risk reduction and increased opportunities to plan for the future. A person's ability to effectively prevent HIV transmission and acquisition is supported by knowledge of their personal and partner's HIV status (Erku et. al., 2012: 87).

Counselling and testing for HIV combined with disclosure of HIV status to sexual partners can enable people living with HIV and Aids (PLWHA) to seek appropriate care and treatment. Additionally, it can allow both PLWHA and uninfected persons to make informed choices about their sexual behaviour. Despite public health benefits of disclosure, there are a number of potential risks, including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and disruption of family relationships. These risks may lead one to choose not to share his/her HIV test results with their friends, family and sexual partners. In the study conducted by Erku on "predictors of HIV status disclosure to sexual partners among people living with HIV and Aids in Ethiopia", the reason for their nondisclosure of HIV sero-positive status to sexual partners was perceived as a lack of communication skills, fear of loss of confidentiality, fear of accusation of infidelity and fear of abandonment. These reasons were similar to studies done in different developing countries like Uganda, South Africa, Tanzania and Kenya (Erku et. al., 2012: 87).

The racialisation of HIV as a Black or African disease by mainstream cultural media and institutions has a detrimental impact on one's willingness to approach health or support services and on HIV knowledge and awareness. HIV stigma intersects with other forms of stigma and discrimination, and suggests that its impact is especially heavy on gay men, women, and poor people (Lawson et al, 2006: 8; Cantisano et. al., 2012: 3).

3.4.3 CATEGORY 3: BEHAVIOR SPECIFIC COGNITION AND AFFECT

Behaviour-specific cognition and affect is one of components of Pender's HPM. Pender's HPM emphasises behaviour-specific cognitions and affect have major motivational significance for acquiring and maintaining health-promoting behaviours.

Anticipated benefits or outcomes affect the person's plan to participate in health-promoting behaviours and may facilitate continued practice.

The assumptions predicted by the Health Promotion Model (HPM) which was used as the theoretical framework of this study confirms that it is a common practice to have multiple partners for monetary purposes. In this model under behavior-specific cognition and affect, it is stated that the immediate competing demands have direct impact on the participation of health-promoting behaviours, and for the farming community, these demands include poverty, low income, basic needs like food and safety must be addressed before health promotion needs can become a focus (Burns & Grove, 2007: 182; Polit & Beck, 2008: 142). Behaviour-specific cognition and affect emerged as the third category. Two sub-categories were identified under this category namely: perceived benefits of action and perceived barriers to action.

3.4.3.1 Perceived benefits of action

Anticipated benefits or outcomes affect the person's plan to participate in health-promoting behaviours and may facilitate continued practice. Prior positive experience with the behaviour or observations of others engaged in the behaviour is a motivational factor. The first theme that was identified under this sub-category was multiple partners and use of sexual protection.

Multiple partners and use of sexual protection

The theme emphasises that multiple partners and not using sexual protection is still common in the farming community. The following narrative statements bear evidence:

"They must not sleep around" (*vanga tsutsuma-tsutsumi*) (participant 10)

"People have multiple partners here in the farms" (*vhathu vha khou ita zua vhudzekani na vhathu vhanzi apfa maburasini*) (participant 6)

"People don't want to use the condoms, they say it is not nice to use them" (*vhathu a vha dzi funi dzi khondomu vhari a zwi difhi*) (participant 3)

“There are people with HIV in Levubu farms, it’s not a secret, I’m married but I have a girlfriend” (*HIV I hone maburasini a Levubu, it’s not a secret, I am married but I have a girlfriend here*) (participant 6)

“HIV is not controlled because people don’t use protection” (*HIV ayi hawuleki hi ku vanhu ava tirisi xisirhelelo*) (participant 10)

“People say they don’t want condoms to be used on them” (*vhathu vha ri a vha shumishelwi khondomu*) (participant 3)

“People must use condoms in order to prevent HIV infection” (*vhathu vha fanela u shumisa condom uri HIV and Aids i songo vha kwama*) (participant 5)

“In order to use condoms correctly, we must be taught how to use them” (*hi nga tirhisa ti condom kumbe hi dondisiwa*) (participant 10)

“People don’t take care of themselves leading to the spread of HIV” (*vhathu a vha di fhari zwavhudi, HIV i do phadalala*) (participant 9)

“Sometimes there are no condoms here in the farms” (*sometimes a huna dzi khondomu ha fha maburasini*) (participant 7)

“Some people will tell you that they give you money if you don’t use a condom” (*Abanye abantu bazothi, hhayi mina ngizokunikeza imali, asingasebenzisi ikhondomu*) (participant 2)

“One female has two or three boyfriends here in the farms” (*umfazi oyedwa uba namadoda amabili noma amathathu lapha emapulazini*) (participant 2)

“They say it is not nice to have sex if you use a condom” (*bathi akumnandi ukuya ocansini uma usebenzisa ikhondomu*) (participant 2)

“Most people still have sex without protection” (participant 1)

“People overlook the issue of protection especially when they are not in their sober senses” (participant 15)

The above narrative statements generally indicate that there is some form of HIV and Aids awareness among members of the farming community; although the technical and medical aspects were not necessarily well-articulated. The farming community needs more formal HIV and Aids prevention, treatment and training interventions, so that they could make use of protection seriously.

Literature control: Multiple partners and use of sexual protection

The assumptions predicted by the Health Promotion Model (HPM) which was used as the theoretical framework for this study confirms that it is a common practice to have multiple partners for monetary purposes. In this model under behaviour-specific cognition and affect, it is stated that the immediate competing demands have a direct impact on the participation of health-promoting behaviours, and for the farming community, these demands such as poverty, low income, basic needs (food and safety) must be addressed before health promotion needs can become a focus (Burns & Grove, 2007: 182; Polit & Beck, 2008: 142).

The conceptual framework emphasises that anticipated benefits or outcomes affect the person's plan to participate in health-promoting behaviours and may facilitate continued practice. Prior positive experience with the behaviour or observations of others engaged in the behaviour is a motivational factor. Low wages predispose the farming community to having multiple partners and not being in a position to negotiate condom use thus increasing the risk of contracting HIV.

In a study conducted by Lawson on "HIV and Aids, stigma, denial, fear and discrimination", it was discovered that female participants in the Caribbean and African focus groups discussed difficulties they face negotiating condom use with men. Most HIV positive women raised the difficulty of using condoms with their husbands (Lawson et al., 2006: 38).

Multiple sexual partnering creates a favourable environment for unsafe sex practices to flourish. The context of gender and economic inequalities that encourages the practice of transactional sex and compromises young women's ability to negotiate safer sex, calls for structural, socioeconomic interventions that provide women with alternatives (such as conditional cash transfers) that are linked to behaviour change and that alter the social environment within which they make decisions about their

sexual practices. Creative strategies that redefine and link ideas of pleasurable, profitable sex to sexual health and safety are also relevant. To optimise the viability and success of such strategies, the full engagement of young women and men as partners in the development, implementation and evaluation of interventions that target them is necessary (Lawson et al., 2006: 38; Zembe et al., 2012: 96).

According to Morris and Kretsch, cited in Shisana et al. (2008: 2- 3), concurrent sexual partnerships, where sexual relationships overlap in time are noted as being a major contributing factor in the rapid growth of HIV.

UNAIDS (2010: 68) emphasises that in most countries, a minority of males and females report having had sex with more than one partner in the last year. Trend analysis shows a general decline in the percentage of people who had more than one partner in the past year in Sub-Saharan Africa, with some exceptions, such as Botswana, Congo, South Africa and Uganda. In Uganda, men older than 25 years are increasingly reporting multiple partners, while the number of women reporting sex with more than one partner has remained fairly stable (UNAIDS, 2010: 68).

Shisana emphasises that although male and female condoms are readily available in South Africa, male condoms have been more widely available as a product of cost and other logistical concerns. Although there has been an overall marked increase in condom use, condom use is primarily low among primary partners. Low use, inconsistent use and non-use are also noted to occur among people with multiple partners (Shisana et. al., 2008: 2).

The findings of a study conducted by Zembe et. al (2012: 95) indicated that the highly significant association between inconsistent condom use and a high number of partners in a short period of time suggests that multiple sexual partnering creates a fertile environment for unsafe sexual practices. The finding also highlights the importance of interventions that emphasize partner reduction among populations where multiple sexual partnering is a norm.

The findings of a study conducted by Netangaheni entitled “the hidden cohort: HIV and Aids amongst the farming community” indicated that 73% of the participants mentioned that there were no condoms distributed at their workplace. His findings were similar to the findings of this study because the participants verbalised that

even if they want to use the condoms, the mobile clinic no longer comes to the farms, and therefore they end up having unprotected sex (Netangaheni, 2008: 139).

3.4.3.2 Perceived barriers to action

A person's perceptions about available time, inconvenience, expense, and difficulty performing the activity can act as barriers (imagined or real) to the individual's commitment to a plan of action. Low wages and long working hours, as well as alcohol intake increase the risk of contracting HIV and insufficient knowledge on HIV due to lack of training were identified as themes under the sub-category perceived barriers to action.

- **Low wages and long working hours**

The farm workers are the least paid members of the workforce according to literature and they are subjected to long working hours. Participant 13, who disclosed his status, raised a concern that there is no time to visit the clinic due to long working hours that the farm workers are subjected to. The following narrative statements are deemed as relevant:

“There is no time to go to the clinic; we are working from 7am - 5pm and on Saturday its overtime” (*a huna tshifhinga tsha u ya kliniki nga u ri vha shuma vhukati ha iri ya sumbe na iri ya vhumanu nga madekwana, nga Mugivhela vha shuma tshifhinga tsho engedziwawo*) (participant 4)

“There is no time to go to the clinic” (*a huna tshifhinga tsha u ya kliniki*) (participant 4)

Literature control: Low wages and long working hours

Mudzusi, Netshandama & Maselesele (2007: 260) discovered that intentional exposure to contracting HIV is still a common practice for the sake of getting the disability grant. It is further stated that most clients who came for VCT wanted to be infected so that they could get disability grants. This encouraged other people who were unemployed to want to get infected because of the perception that it is better to be killed by HIV which will kill you later, instead of being killed by hunger immediately (Mudzusi, Netshandama & Maselesele, 2007: 261).

The above literature supports the immediate competing demands for the farming community which include demands poverty, low income, basic needs like food and safety that must be addressed before health promotion needs can become a focus.

The farm workers get paid low wages; they cannot meet basic needs and therefore, end up engaging in transactional sex as an extra source of income (HIV and Aids in the South African Agricultural Sector, 2008: 14–16). It is further stated under behavioural outcomes that if opportunities to engage to health promoting behaviours Aids as well as educational programmes on HIV, it is unlikely that the farming community will practice safe sex (HIV and Aids in the South African Agricultural Sector, 2008: 14 – 16).

Lemke (2005: 846) mentions that South African farm workers are the most vulnerable members of the South African workforce, earning the lowest wages with women earning even less than men. Although the government introduced minimum wages for farm workers in 2003 to improve their economic situation, in practice this sometimes means that farmers cut previous benefits such as housing subsidies and food portions, leaving farm workers with even less than before. The above statement is supported by the strike of the North West Province farm workers in January 2013 due to low wages (Lemke, 2005: 846).

- **Alcohol intake increases the risk of contracting HIV**

Alcohol is the most commonly abused substance in Sub-Saharan Africa, and people with HIV are more likely to use alcohol than the general population. Alcohol intake was identified as the second sub-category within the main category of challenges experienced that are related to behaviour linked to HIV and Aids. The only theme identified under this sub-category was alcohol intake increases the risk of contracting HIV.

In this study, participants acknowledged that alcohol intake increases the risk of contracting HIV. The narrative statements below demonstrate that the two participants link alcohol with unprotected sex thus increasing the risk of contracting the virus.

“People overlook the issue of protection especially when they are not in their sober senses” (participant 15)

“If you don’t have something to do you will drink and have unprotected sex” (participant 1)

Literature control: Alcohol intake increases the risk of contracting HIV

Several studies in Sub-Saharan Africa suggested strong links between alcohol and risky sexual behaviour such as having multiple sex partners, having unprotected sex and engaging in sex for money. Indeed alcohol functions in similar mechanisms in which there is impairment of judgment and decision making which leads to risky behaviour. The increase in risky behaviour in turn increases the risk of contracting HIV (Shisana et al., 2008: 4; Mahadev, 2006: 44; Zembe et. al., 2012: 100).

Alcohol use causes diminished perception of risk, which increases the likelihood that a person would put him or herself (or his/her partner) at risk of HIV infection by engaging in unsafe sexual practices, such as having multiple sex partners, unprotected intercourse, sex with high risk partners (e.g., injection drug users, prostitutes), and exchanging sex for money or drugs. Sexual promiscuity triggered by alcohol abuse also increases the risk of acquiring other sexually transmitted diseases and people with STDs are at risk for both transmitting and acquiring HIV (Pandrea et. al, 2010: 204).

A study conducted by Pandrea et. al on “alcohol’s role in HIV transmission and disease progression” affirms that HIV patient compliance to ART is a function of numerous parameters, including age, socioeconomic status, gender, drug abuse, anger, persistent symptoms, mental problems, and complexity of treatment. Given the historical association of alcohol abuse with failure to comply with medical treatment, it is not surprising that several studies have demonstrated that alcohol consumption is associated with failure to adhere to prescribed ART (Pandrea et. al, 2010: 206).

Collins et. al., (2010: 1890) states that more than one million people in the United States are living with HIV, and about 56 000 people are newly infected each year. Approximately half of those who have had positive test results for HIV consume

alcohol. Drinking in this population is associated with poor treatment adherence, disease progression and the spread of the virus through risky sexual activity. Thus, reducing drinking and problem drinking among HIV-positive individuals is an important public health goal (Collins et. al., 2010: 1890).

Mahadev (2006: 57) asserts that being under the influence of drugs and alcohol makes a woman totally unprepared for sexual relations, and unable to negotiate safe sex. Women are at risk because of a lack of power to determine when, where and whether sex takes place. This situation is exacerbated by the use of drugs. The lack of recreational facilities in farms predisposes the farming community to consuming alcohol and engaging in unprotected sex.

- **Insufficient knowledge on HIV and Aids and lack of training**

Literature proves that the urban population have better knowledge about HIV and AIDS than their rural counterparts, due to the difficulty in running education campaigns in remote areas. Understandably, the gap in knowledge levels is greatest between illiterate women with no education and women with secondary education and above. Insufficient knowledge on HIV and Aids and a lack of training as a theme were classified under the sub-category perceived barriers to action. Lack of training emerged as the only theme. As much as most participants have basic knowledge about the signs of HIV, it was clear that there are still some gaps when it comes to HIV and Aids. The narrative statements below demonstrate basic knowledge on HIV and Aids:

“You will experience hair loss” (*mavhudzi a ya fhelela*) (participants 3, 4 & 6)

“You will develop sores in the body” (*u vha na zwilonda*) (participant 3, 6 & 9)

“You will cough a lot” (*u ya hotola nga maanda*) (participant 7)

“You will develop diarrhea” (*u ya tshuluwa*) (participant 1, 2, 6 & 9)

“You will develop Tuberculosis” (*u vha na lufhia*) (participant 6)

“They have insufficient knowledge on HIV” (*ndivho ya vho ndi thukhu*) (participant 7)

“People need training on HIV” (*vhathu vha fanele u funziwa nga HIV*)
(participant 5, 7 & 9)

“People must come together and be trained about HIV and Aids” (*vhathu vha tea u da vha gudiswa nga vha HIV and Aids*) (participant 5 & 9)

“Some of them they still don’t believe there is HIV; they say ndiza vhaloyi ezo...” (*Some of them don’t believe there is HIV; they say you are bewitched*)
(participant 7)

“HIV awareness and training in farms is needed” (participant 15)

“Problem is lack of knowledge, people are not educated” (participant 1)

These are some of the narrative statements raised by the participants to prove that that they need more training on HIV and Aids. This demonstrates that there is an urgent need for frequent training on HIV and Aids in the farming community. Healthcare workers raised an issue of lack of support from farm managers and owners when they want to provide training to employees. It was said that some of the farm owners give them 20 minutes to do a training session in their farms.

Literature control: Insufficient knowledge on HIV and Aids and lack of training

The most common prevention programmes and activities in Africa include HIV and Aids education in schools, peer education for high risk groups (e.g., out-of-school youth, commercial sex workers, drug users), widespread communication campaigns (via the radio, pamphlets, posters, etc) against risky behaviour, HIV testing for pregnant women (plus counselling and treatment if the HIV test result is positive), and free condom distribution. More programmes tailored to women, especially those with low education levels and those from rural areas, are required. However, these programmes also need to address sociocultural influences on sexuality.

Peu (2008: 24) emphasises that healthcare has traditionally been disease orientated. Currently, there is a great emphasis on healthcare, which includes health promotion because people live in a time where there is an increase in communicable and chronic diseases. To reduce the number of hospital admissions, nurses need to provide health education aimed at reducing diseases and other health problems to

the community. The provision of good healthcare should be regarded as a priority by all from government down to the individual client who needs to be informed through health education that healthcare leads to wellness (Peu, 2008: 24). However, if the healthcare workers, farm owners and farm workers can work together in identifying peer trainers/educators so as to preach the gospel of health promotion then the alarming statistics on HIV and Aids in the farming community can be minimised.

In a study conducted by Lawson on “HIV and Aids stigma, denial, fear and discrimination”, participants frequently commented that many in their communities did not have enough knowledge about HIV. Most had very little knowledge about HIV before learning of their diagnoses. Some participants worry that others in their community may be infected and not know it (Lawson et al., 2006: 14; Mudzusi, Netshandama & Maselesele, 2007: 257).

Not all women have the opportunity for education, and there also exists a low level of education among many girls and women, due to being pulled out of school early to perform household duties or care for sick relatives. This means that they cannot access HIV information. This in turn makes them totally unprepared for sexual relations, and equally unable to negotiate for safe sex (Shisana et al., 2008: 136).

UNAIDS (2010: 68) states that opportunities to improve HIV prevention knowledge and behaviour still abound. Less than half of the young people living in 15 of the 25 countries with the highest HIV prevalence can correctly answer five basic questions about HIV and its transmission (these include Botswana, Burundi, Cameroon, Central African Republic, Chad, Congo, Cote d’Ivoire, Guinea-Bissau, Kenya, Malawi, Nigeria, South Africa, Togo, United Republic of Tanzania and Zambia). Young people aged 15–24 years old showed gradually improving knowledge about HIV in these 25 countries but still fall short of the global targets for comprehensive knowledge set in 2001 (UNAIDS, 2010: 68).

The findings of the study conducted by Netangaheni on “a hidden cohort: HIV and Aids amongst the farming community”, 75% of the participants indicated the need for a full time HIV and Aids trainer on the Levubu farms. Netangaheni (2008: 135) recommended that a full-time trainer should be appointed because such appointment would especially alleviate the shortage of the healthcare workers who are expected

to provide training on HIV and Aids in the Levubu farms. This study was conducted in 2008 and it was recommended to the farm owners that the employees raised a need of having a full-time HIV and Aids trainer in the Levubu farms but to date, there has been no trainer instead of the healthcare workers who used to offer basic PHC services and train the farming community on HIV and Aids were no longer coming.

3.4.4 CATEGORY 4: HUMAN RESOURCE ISSUES

The fourth category that emerged was human resource issues. Two sub-categories were identified under this category namely: unfair dismissal and retrenchment and migrant labour.

3.4.4.1 Unfair dismissal and retrenchment

Unfair dismissal and retrenchment of the farm workers without even a written warning is still a common practice in South African farms. All employees are protected by the Labour Relations Act, which states that should there be a need for retrenchment then the rule “first in last out” should apply to all employees. Unfair dismissal and retrenchment emerged as the third sub-category and the only theme identified was retrenchment of those with regular follow-ups.

- **Retrenchment of those with regular follow ups**

Retrenchment of those with regular follow-ups was identified as the only theme under the sub-category unfair dismissal and retrenchment. A concern was raised by participant 11 and participant 14 that those with frequent follow-ups are retrenched first since the farms are now owned by Africans not whites like before. Participant 14 raised an issue that 300 employees were retrenched in 2011 alone; she further added that at times they do not even get a full salary. This might be an indication that the collapse of strategic partnerships and formation of new forms of farm management and farms being owned by Africans who are still struggling to make ends meet who could not pay full salaries to the employees at times. The following quotes bear evidence:

“You lose your job, and you are the first one to be retrenched if you go to the clinic frequently” (mushumo u wa fhela wa do vha wavha wa uthoma u pandelwa mushumoni) (participant 11)

“These farms are now owned by Africans, you lose your job if you have frequent clinic visits” (amapulazi aphethwe abantu abamnyama, umsebenzi uyaphela uma uhlale uya e kliniki) (participant 14)

Literature control: Retrenchment of those with regular follow ups

The latest news on retrenchment of South African farm workers following the recent strike for low wages is that at least 2000 farm workers were issued with retrenchment notices in February 2013 following the announcement by the minister of labour. The announcement follows violent strikes by farm workers, especially in the Western Cape, since November 2012. Farm workers had demanded a minimum wage of R150 a day. The report highlighted that the average wage base of farm workers is R84.90 per day while the new minimum wage announced by the minister was R105 per day (Farmers Weekly, 2013).

However, the minimum wage announced by the minister is not implemented yet, this is demonstrated by a strike where more than 100 farm workers from a community-managed farm in Levubu went on strike after a third month of non-payment. The workers, who are all employed by the Masakona Community Property Association (CPA), claimed that they had not been paid since December 2012. As a result, they say, they had to start borrowing from a “matshonise” (loan sharks) to make ends meet. At an interest rate of 50%, all their funds were quickly tapped dry. The workers decided to march to their head office in Levubu when they did not receive their salaries. According to the workers, they did not receive payment for December, January and February. In addition, workers did not receive any other gratuities in December. In the middle of February, the CPA board of directors promised them that they would get double pay by 28 February. To seal this promise, the workers were each given a 25kg bag of mealie meal. On the promised date, however, the workers only received an amount that was the equivalent of one month’s salary. This spurred them on to cease working and holding meeting with the CPA (Venter, Zoutpansberger Newspaper: 2013).

According to the Labour Relations Act (Act no 66, 1995:2), employees’ rights must be protected and they should participate in decision-making through the

establishment of workplace forums. Should there be a need for retrenchment then the rule “first in last out” should be applied by all the employers.

The absence of a trade union organisation and limited means of legal protection from human rights violations and work-related abuses resulted in farm workers and their families being ‘trapped’ on farms, lacking the skills to engage in the wider economy and having no possibilities of advancement (Lemke, 2005: 846- 847).

During the current process of land restitution in favour of previously discriminated and marginalised population groups, and consequent legal uncertainty and expectations attached to land ownership, farms have become sources of conflict and increasing poverty, thus increasing the vulnerability to retrenchment and consequently high-risk behaviour with regard to HIV and Aids (Lemke, 2005: 847; Chucks, 2008: 94).

Atkinson (2007: 279) found that downsizing and the resultant widespread trend to retrench workers has left farm workers homeless with a slim chance of being reemployed in the agriculture sector and with inappropriate skills to find work in already overcrowded urban areas to which they are inevitably forced to migrate.

3.4.4.2 Migrant labour

Migrant labour was identified as the fourth sub-category under human resource issues. Lack of jobs leading to migrant labour was the only theme that emerged under this sub category.

- **Lack of jobs leading to migrant labour**

Many people in developing countries face extreme poverty and lack of jobs. This causes them to migrate from rural to urban areas seeking better job opportunities. Unemployment rates are increasing in South Africa with the agricultural sector being no exception. Unemployment results in a vicious cycle of poverty, crime, disease and death. Lack of jobs leading to migrant labour emerged as the only theme under the sub-category migrant labour. The following quotes expressed by participants bear evidence:

“Most people leave their wives at home and get girlfriends here” (participant 1)

“Most people left their families at home” (participant 15)

“My husband works far away from home (“munna wa nga u kule na nne”) (participant 5)

“Most people leave the rural areas and seek jobs in the city because of low wages in the rural areas” (abantu abaningi basuka emapulazini baye emadolobheni beyofuna umsebenzi ngoba imali ayikho emapulazini) (participant 2)

Literature control: Lack of jobs leading to migrant labour

The migrant labour system, exacerbated by the arrival of job seekers from neighbouring countries as well as seasonal workers, increases risky behaviours such as polygamous relationships and unprotected sexual practices. Lack of jobs in rural areas predisposes the farming community to migrating to urban areas thus leaving spouses at home. Massive migration of young unmarried adults from presumably “conservative” rural environments to more sexually permissive African cities in recent years is regarded as the underlying cause of the spread of HIV and Aids (Lemke, 2005: 845).

According to Collison (2010: 9) migration is a risk factor for the increased likelihood of high-risk sexual partnerships which places households of origin at risk. One of the key factors driving this is the selection itself, which means that the migrants as individuals may have more risk-taking tendencies. Another factor is spousal separation, which results in sexual relations outside marriage or long-term relationships (Collison, 2010: 9).

Migrant labour, whether internal or foreign, is particularly vulnerable to HIV and Aids, for the following structural factors: migrant labourers often come from areas of high unemployment and social and political upheaval, which are themselves conditions that encourage the spread of infection; limited development and implementation of labour rights frameworks for migrants; limited provisions for work permits and gender inequality (HIV and Aids in the South African Agricultural Sector, 2008: 15).

The migratory tendencies of infected individuals from urban to rural areas further complicate rural life for people with HIV and Aids. Previous studies of migration patterns have noted that HIV-infected individuals often return to their home village in order to be closer to relatives that can provide and care for them while they are ill. This process, in turn, may increase the risk of transmission to others in home villages. Migration patterns among travelling labourers also impacts the spread of HIV and Aids in rural communities, particularly by young male workers. Researchers were able to describe a pattern in which workers would leave their rural homes in search of work in the city by modelling the movement of workers in rural South Africa. Once in the city, there was a tendency for workers to engage in high-risk sexual behaviour; therefore increasing the risk for disease acquisition by others. Once infected, their return to their rural homes increases the risk of transmission to their partners and to other members of their village (Oramasionwu et al., 2011: 2970).

According to the latest figures released by Stats SA in the second quarter of 2012, 1.3 million people aged between 15-24 were unemployed. Another 1.9 million between the ages of 25-34 were also jobless, making the unemployment figure in the country to reach 3.2 million. At the end of 2012, there were approximately 3.2 million non-searching unemployed and 4.5 million searching (official) employed. The strict (official) rate of unemployment was 24.9% and the broad (or expanded) rate 35.9% (Statistics South Africa, 2012). The Employment Equity Act 1998 (Act No 55 of 1998) promotes the constitutional right to fair employment practices to ensure equal job opportunities for all.

3.4.6 CATEGORY 5: LACK OF RECREATIONAL FACILITIES

Workers and dwellers on farms and forests continue to live without adequate decent shelter, without amenities like recreational facilities, healthcare and educational facilities, and without services like running water and electricity. The fourth category that emerged was lack of recreational facilities. Boredom was the only sub-category that was identified under this category.

3.4.6.1 Boredom

Boredom refers to an emotional state experienced when an individual is left without anything in particular to do and not interested in their surroundings. The only sub-category identified within recreational facilities was boredom. Engaging in sexual activities after work was the only theme identified.

- **Engaging in sexual activities after work**

The first participant expressed that the lack of recreational facilities in the farms led to boredom and most people end up keeping themselves busy with sex after hours thus increasing the risk of contracting HIV. The researcher explored boredom further during her follow-up interview and most participants expressed that those who are staying in the farm residence (the compound) rarely have money to buy radios let alone the television sets. So they either keep themselves busy by going to the village to drink alcohol or engage in sexual activities. The following quote bears evidence:

“No recreational facilities, people get bored and end up doing sex, sex sex after work” (participant 1)

“Most people sleep or drink alcohol after work because there is nothing to do in the ‘compound’ after work” (*abantu abaningi bayalala noma baphuze utshwala uma sebashayisile ngoba ayikho into ongayenza la enkomponi*) (participant 2)

“There is no television, if you cannot afford a radio then the best thing to do is to go to the village and drink traditional beer” (participant 15)

Literature control: Engaging in sexual activities after work

Poor living and working conditions, separation from families, physically demanding work with low wages, exploitation, poor accommodation facilities, and limited recreational facilities lead to boredom and increased engagement in risky behaviour (HIV and Aids in the South African Agricultural Sector, 2008: 15). Zwelinzima Vavi’s address to the National Farm workers Summit (2010) emphasised that it cannot continue to happen that workers and dwellers on farms and forests continue to live

without adequate decent shelter, without recreational facilities, healthcare and educational facilities, and without services like running water and electricity.

The results of a study by Brophy (2010: 34) showed that a lack of recreational facilities is a concern in the farms. Farm workers in the Limpopo Province also expressed that a lack of recreational facilities on farms was problematic and a causative factor in increasing HIV and Aids, sexual violence and substance abuse.

3.4.6 CATEGORY 6: HEALTHCARE NEEDS

Healthcare needs are important for individuals and families. These needs need to be fulfilled in order to have optimum health. The fifth category that emerged was healthcare needs; the first sub-category identified was mobile clinic and shortage of staff.

3.4.6.1 Mobile clinic shortage of staff

The mobile clinic and shortage of staff were classified as the only sub-category within the category healthcare needs. Cessation of healthcare delivery and increased workload was the only theme that emerged under this sub-category.

- **Cessation of healthcare delivery and increased workload**

All participants expressed that the mobile clinic had stopped coming since April 2012. When the healthcare worker in charge of the mobile clinic was interviewed during follow-up visits, she mentioned that they have two mobile cars and one driver responsible for transporting staff to workshops, meetings, school health visits and cover the entire Levubu area including farms. The region has ten healthcare workers to cover seven local clinics, all farms in Levubu and all the local schools. From the interviews as well as the researcher's observation it was evident that the farming community is situated remotely from the healthcare facilities and lack of infrastructure is a challenge. The following narratives are relevant:

“The mobile clinic is no longer coming for the past 3 - 4 months” (participant 1 & 3)

“The mobile clinic last came in April 2012” (participant 6)

“The clinic is no longer coming, it use to come once a month but for the past 4 months they are not coming anymore” (*vha mobile kliniki a vha vhone fano mabulasini, vho vha vha tshi da luthihi kha nwedzi, fhedzi kha minwedzi mina a vho ngo tsha vhone*) (participant 5,6,9, 12&14)

“The mobile clinic is no longer coming to the farms” (*Umahamba ngendlwana akasezi emapulazini*) (participant 2)

“When the mobile clinic comes we all assemble in one farm” (*Uma umahamba ngendlwana eza, sihlangana epulazini elilodwa sonke*) (participant 2)

Literature control: Cessation of healthcare delivery and increased workload

Healthcare is affected by a lack of access to health services. In the Western Cape this is also hampered by a situation where it is unclear as to whether provincial or local government departments are responsible for which healthcare services. The inquiry into the human rights of farm workers (South African Human Research Council, 2003: 70) found that the new health system is not adequate and does not meet the needs of rural areas while HIV and Aids and Tuberculosis are becoming serious problems amongst farm dwellers.

According to the Health Act (2003: 42) every metropolitan and district municipality must ensure that appropriate municipal healthcare services are effectively and equitably available in their respective areas. This is no exemption to the farming community. Health is the most obviously affected sector. The rise in illness and death associated with the epidemic increases the demand for health services at a time when health professionals are themselves affected. Again, it is the double impact of increased demand at a time of reduced supply. Governments have difficult decisions to make with regard to the health sector. Even if steps are taken to maintain supply by training additional staff to replace those lost, prioritisations will have to occur. Health services in most countries heavily affected by HIV and Aids were strained even before the increase in demand. If the capacity to meet the new demands is limited, decisions on who and what to treat will need to be made. The Aids epidemic may affect the health of those infected as well as of others in the community (UNAIDS 2008: 59).

Despite facing a higher burden of ill health, the available evidence suggests that the poor individuals and households have lower access to appropriate healthcare services than more affluent individuals and households. Such inequalities in access arise from a number of financial and non-financial barriers including distance, lack of awareness, sociocultural factors, the direct and indirect costs and the actual lower quality of healthcare (Coll – Black, Bhushan & Fritsch, 2007: 247).

Many low- and middle-income countries face growing health inequities and have made insufficient progress towards the millennium development goals (MDGs). This has been attributed to the poor performance of the health system as well as barriers to care experienced by poor and vulnerable communities. The lack of access to transport, clean water, sanitation, and nutrition limit health promotion. International calls for greater focus on the social determinants of health have highlighted the importance of services capable of responding to the complex intertwined social causes of ill health experienced by marginalised communities (Coll – Black, Bhushan & Fritsch, 2007: 247).

Health and human rights are interconnected and complementary approaches to sustainable development. On a social and economic level, good health creates and sustains the capabilities that poor people need to escape from poverty. Citizen's rights to healthcare in South Africa are safe guarded by the national service delivery standards. According to the Batho Pele principles all individuals have a right to access healthcare services they are entitled to and this includes the farming community (Andersson et.al, 2004: 381).

3.4.7 CATEGORY 7: SUPPORT AS A HEALTH PROMOTION STRATEGY

Support of farm workers as a health promotion strategy emerged as the seventh category. Two sub-categories were identified under this category namely: healthcare support and emotional support.

3.4.7.1 Healthcare support

In South Africa, citizens are entitled to equal access to the healthcare services, and this is no exception for the farming community. Healthcare support was the first sub-category of the two identified under support of the individual in order to promote their

health as the main category. The theme that emerged was provision of PHC services.

- **Provision of PHC services**

PHC is an essential service that should be available, acceptable and afforded by the consumers. There was a general feeling among the participants that initially, the mobile clinic was coming twice-monthly providing primary healthcare services, chronic care, consultation, VCT and group as well as individual education and this was helpful because of the long working hours of the employees and fear of retrenchment if they miss work frequently. The disproportionate availability of, and access to healthcare facilities increases the risk for the spread of HIV and Aids in the farming communities. Peer support was done by one participant who has a car, who fetches the condoms at the clinic and gives them to co-workers. Infrastructural under-development of the farming communities, remote situatedness and long working hours of the farming community deprives them of basic healthcare services. The following quotes are relevant:

“Mobile clinic is no longer coming since April 2012” (participant 7, 9)

“Mobile clinic last came in April” (participant 1)

“The clinic is no longer coming, it use to come once a month but for the past 4 months they are not coming anymore” (participant 3, 7, 9.

“The clinic is no longer coming, it use to come once a month but for the past 4 months they are not coming anymore” (*vha mobile kliniki a vha vhonele fhanu mabulasini, vho vha vha tshi da luthihi kha nwedzi, fhedzi kha minwedzi mina a vho ngo tsha vhonele*)(participant 3, 5, 13)

Literature control: Healthcare support

Farm workers low wages and distances from services hampers their ability to utilise assistance that authorities could provide. They also are restricted in accessing services because of long working hours, not easily getting time off and lacking the financial resources for transport to access services. These factors all compound the victims in using the healthcare and legal or social support systems.

The South African Human Rights Commission (2006: 5) listed the following challenges faced by victims regarding access to healthcare and relevant services; lengthy distances needed to travel to primary healthcare centres, financial constraints and lack of transport, lack of access to healthcare services after hours, employers not allowing workers to access services during working hours and telecommunication not being readily available (Brophy, 2010: 42).

Zvomuya (2005: 31) emphasises that the need to investigate the state of HIV and Aids occurrence among the farming communities is long overdue; firstly because these are areas where risk factors such as poverty and inadequate access to healthcare facilities are relatively high. Secondly, the government itself (through the DOH) realises that there is a disproportionate availability and delivery of primary healthcare services between urban/metropolitan and rural communities; which adversely impacts on communities in high-risk areas. To the latter effect, major gaps in health status among racial, socioeconomic and under-served populations need to be targeted to reduce the underlying causes of illness, injury and disability.

South Africa's transition to democracy in 1994 was accompanied by the development of progressive policies in all sectors to address the past structural inequities inherent in the apartheid system and entrench the far reaching rights in the Constitution (i.e. 'the progressive realisation of the right to healthcare, housing and education') (Nxumalo, Goudge & Thomas, 2012: 219).

Since 1994, South Africa has made considerable investment in PHC through increased infrastructure, rapid expansion of TB, HIV, and maternal health-related programmatic interventions. This has been coupled with an increase in utilisation of services and the re-emergence of the community health worker (CHWs). However, these efforts and investments have not resulted in the expected improvements in the MDGs and other health outcomes due to the complex and growing burden of disease, and the failure to develop and implement an efficient district health system (DHS), responsive to local needs. The increasing numbers of service delivery protests by local communities around the country, after 18 years of democracy, demonstrate the frustration of many who have yet to benefit from the provision of basic services disease (Nxumalo, Goudge & Thomas, 2012: 219; MDG Country Report, 2010: 88).

Community health worker (CHW) programmes were initiated in the 1970s by non-governmental organisations (NGOs) in response to the inadequate and intentionally inequitable PHC services under the apartheid government. Although these programmes have gone through a range of changes, many of the programmes still remain active. In contrast to CHW programmes in countries such as Iran and Brazil, where there are more formalised and structured programmes, those in South Africa remain diverse, and for the most part, fragmented, unstructured, and unregulated disease (Tsai et al., 2009: 59; Nxumalo, Goudge & Thomas, 2012: 220).

These CHW programmes are primarily run through NGO intermediaries. This sector is largely funded by the government. Many of the international and national NGOs and community-based organisations developed in response to HIV and Aids-focused funding. Current health sector reform in South Africa is focused on strengthening the district and sub-district level, including the formalisation and integration of community based services. In the draft 2011 policy document on strengthening (PHC), community outreach teams of CHWs led by a nurse will be responsible at the local level for preventative and promotive care, adherence and psychosocial support, with an overall focus on maternal and child health, HIV and TB, and chronic non communicable disease (Mudzusi, Netshandama & Maselesele, 2007: 258; Nxumalo, Goudge & Thomas, 2012: 220).

Community health worker (CHW) programmes aim to improve access to care by providing outreach services. Operating at the interface between health systems and communities, CHWs have a crucial role in assisting households to overcome barriers to care. Although there is growing evidence of the effectiveness of CHWs to facilitate improvements in certain health outcomes programmes often fail because of insufficient skills or support. Information about successful outreach programmes is needed to guide policy and implementation (Mushwana, 2011: 12; Nxumalo, Goudge & Thomas, 2012: 219).

The assumptions of the HPM which formed the theoretical framework of this study under behavioral outcomes emphasised that accessibility of healthcare services and an adequate knowledge base of the importance of health promoting behaviours and recognition of its value can have positive influences on the farming community to practice health behaviours (Burns & Grove, 2007: 182; Polit & Beck, 2008: 142). If

opportunities to engage to health promoting behaviours are not readily available, this includes the availability of condoms, posters on HIV and Aids as well as educational programmes on HIV, it is unlikely that the farming community will practice safe sex (HIV and Aids in the South African Agricultural Sector, 2008: 14–16).

While HIV and Aids are causing an increased demand for health services, large numbers of healthcare professionals are being directly affected by the epidemic. Botswana, for example, lost 17% of its healthcare workforce due to Aids between 1999 and 2005. A study in one region of Zambia found that 40% of midwives were HIV-positive. Healthcare workers are already scarce in most African countries. Excessive workloads, poor pay and migration to richer countries are among the factors contributing to this shortage (Mudzusi, Netshandama & Maselesele, 2007: 255; Nxumalo, Goudge & Thomas, 2012: 229).

Although the recent increase in the provision of antiretroviral drugs (which significantly delay the progression from HIV to Aids) has brought hope to many in Africa. It has also put increased strain on healthcare workers. Providing antiretroviral treatment to everyone who needs it requires more time and training than is currently available in most countries (Tsai et al., 2009: 60).

As the HIV prevalence of a country rises, the strain placed on its hospitals is likely to increase. In Sub-Saharan Africa, people with HIV-related diseases occupy more than half of all hospital beds. Government-funded research in South Africa has suggested that, on average, HIV-positive patients stay in hospital four times longer than other patients. Hospitals are struggling to cope, especially in poorer African countries where there are often too few beds available. This shortage results in people being admitted only in the later stages of illness, reducing their chances of recovery (Nxumalo, Goudge & Thomas, 2012: 230; Mudzusi, Netshandama & Maselesele, 2007: 260).

Mushwana (2011: 44) mentions that the challenges faced by the farming community include lack of resources such as more mobile clinics, shortage of doctors and nurses, the overburdening of health workers and care givers with work load, trauma and stigmatization. Caregivers run a risk of contracting TB as they do Direct

Observed Treatment (DOT) and are stigmatized as they are perceived as being HIV positive. The health care worker indicated that there is only one mobile clinic available and due to poor staffing has led to only one counselor being outsourced from the local NGO. The findings of his study are concurrent with the researcher's because even though there are two mobile clinics but there is only one driver who is expected to multi-task (Mushwana, 2011: 44).

3.4.7.2 Emotional support

The concept of patient support covers all the activities aimed at supporting the patient when faced with the disease and treatment; this goes beyond the medical aspects of care. Patient support is a continuous process which can either be individualised or in the form of support groups aimed at ensuring that the patient understands and accepts his/her status or disease, adapts his/her behaviour and adheres to treatment. Since this a continuous process it is crucial that the patient gets emotional support from the family, peers and the employer. Emotional support was identified as the second sub-category under support of the individual as a health-promotion strategy. Under this sub-category two themes namely, emotional support by family and emotional support by management and government, were classified as the two themes.

- **Emotional support by family**

In order to receive material and emotional support for living with HIV and Aids, one must disclose his/her status to significant others. Disclosing to family members is one of the key factors in fostering and maintaining ART adherence. Emotional support by the family was the first theme identified. Participant 11, who is infected, verbalised that he receives support from his wife, mother and sister. Participant 13, whose sister is infected, confirmed that even though she did not disclose her status to the family, they support her emotionally and financially in order to raise her son.

“At home I am getting emotional support” (*hayani vho tanganedza*)
(participant 11)

“Me and my dad support her” (*nne na mune wanga ri a mu tikedza*)
(participant 13)

Literature control: Emotional support by family

Family members are important caregivers, with mothers and close friends being the most important caregivers, providing social (emotional and instrumental) support for members infected with HIV. Findings from several studies done on emotional support by the family have proven that a person diagnosed with HIV will undergo considerable psychological distress. It is crucial to have support from the family.

Research findings further prove that those patients who have extensive networks of support tend to cope better. The social stigma that surrounds HIV has adverse repercussions not only on the individual, but also for their family. The impact of HIV depends on which family member is infected. HIV has an impact on partners and their relationship (Van Empelen, 2005: 11).

Caregiving is associated with stress and Aids-related stigma. Individuals infected with HIV, and their family members may be socially stigmatised by overt or covert behaviour such as rejection by friends or subtle gestures such as diminished visits from neighbours or children not being invited in the parties. The benefits of emotional support are that it buffers stress, improves adherence to HIV treatment and results in fewer symptoms of depression while improving the quality of life (Van Empelen, 2005: 13).

Family support is vital for proper management of HIV and Aids in the farming community. It might also suggest that, as constituting an important aspect of tradition, family support for each other is crucial. Hence in most traditional families, the aged, frail, ill and poor are not relegated to geriatric homes instead they remain part of both the core and extended family structures until they die (Wouters et al., 357).

The family structure is viewed as a place of care, and people bear children so that the children can take care of them in their old age and when they are frail and sick (Mulaudzi & Makhele, 2012: 104).

- **Emotional support by management and government**

Disclosing one's status to either the peers or family members doesn't guarantee increased social support because patients might face rejection, stigmatisation and even violence after revealing their status. Emotional support by management and government was classified as the second theme under the sub-category emotional support. There were mixed feelings about emotional support by management and government. Some participants emphasised that the government doesn't care about healthcare needs of the farm workers. Some of the participants confirmed that they receive emotional support from management. Mixed feelings were evident; some participants felt that management was supportive while others denied it. Exploitation of females by managers and supervisors and lack of unions to protect the workers were verbalised by female participants. Those who had regular follow-ups are the ones most likely to be retrenched first. In addition, management does not offer light duty even if you are ill. Some participants verbalised that those who are ill are transported by management and are given full pay if one has a sick note whereas others denied this. This is supported by the following expressions:

“They guide you if you are sick” (*vha a ri sumbedza ndila musu u tshi lwala*)
(participant 4)

“They support us a lot when we are sick and must go to the clinic or hospital, they also give us time to be educated by the nurses when they come to the farms, we as workers all assemble in one farm when the mobile clinic is coming” (participant 1 & 9)

“If you have a sick note you get full pay” (participant 3 & 7)

“They use the company vehicle to transport you home or to hospital when you are ill” (participant 1)

Below are some of the narrative statements quoted from the participants about lack of support from management.

“These farms are now owned by Africans, we sometimes don't get a full salary and if you are sick they you don't get a salary” (*amapulazi la*

asephethwe abantu abamnyama, kokunye sithola uhafu womholo wethu, uma ugula awulitholi iholo lakho (participant 14)

“You lose your job if you are sick for a long time” (*mushumo u a fhela arali u tshi lwala lwa tshifhinga tshilafpu*) (participant 11)

“You will work harder than others if you refused to be the supervisor’s girlfriend” (*vha do shuma nga maanda arali vho hana u vha na vhudzekani na muhulwane mushumoni*) (participant 3 & 12)

“We blame the government it does not care about us” (*ri sola vha muvhuso, a u na ndaba na rine*) (participant 5)

“For us to be cured, doctors must come to the farms” (*i ku tshunguriwa marabji kurima hela madokotela mafanela ku ta a mapurasini*) (participant 10)

“People in the farms are neglected by the government” (participant 1)

The participants raised a concern that they are neglected as farm workers. Some participants felt the government should visit the farms to assess the situation and support the farm workers in terms of healthcare needs. Lack of financial support and utter poverty due to low wages was also raised by the participants who felt the government does not care about them.

Literature control: Emotional support by management and government

Lemke (2005: 846) mentions that the present-day situation of people working on farms has to be seen in the context of South African history. Unlike most countries in Sub-Saharan Africa where households draw on a diverse portfolio of activities and income sources that enhance nutrition security, health, social networks and savings and furthermore bridge the rural-urban division, in South Africa, as a result of racial and political inequalities, people were uprooted from the natural resource basis of their livelihoods destroying subsistence farming and contributing to household food insecurity. The absence of trade union organisations and limited means of legal protection from human rights violations and work-related abuses resulted in farm workers and their families being “trapped” on farms, lacking the skills to engage in the wider economy and having no possibilities of advancement. Despite the

involvement of government as well as non-governmental organisations in HIV and Aids awareness programmes, the farming community is still the most under-serviced labourers in South Africa. Poor access to healthcare and health-related information is partly due to their remote location of work. The high incidence of poverty and low level of education makes the farm worker even more vulnerable to the impact of HIV and Aids (HIV and Aids in the South African Agricultural Sector, 2008: 20).

3.5 DISCUSSION OF FIELD NOTES

Field notes were made as an adjunct to interviews by the researcher. Participants were able to express how they feel about HIV and Aids in the farming community. Observational, theoretical, methodological and personal notes were discussed (de Vos et. al., 2005: 311).

Observational notes are descriptions of events experienced through watching and listening. They contain the “who”, “what”, “where” and “how” of a situation and contain as little interpretation as possible (de Vos et al., 2005: 311; Polit & Beck, 2008: 407; Merriam, 2009: 129). The table below summarises the observational and theoretical notes.

Table 3.2 Observational and theoretical notes

Observational Notes	Theoretical Notes
1. The younger participants seemed to take longer to talk freely about HIV, some were never comfortable	1. This trend illustrated the possibility that the issue of HIV and is still a taboo in the farming communities especially by the youth.
2. The younger participants could barely understand the researcher when she was addressing them in English, some could not even sign the consent form.	2. This might be an indication that most of the farm employees are still illiterate.
3. The older and younger participants were barely aware of the date, month and time of the day.	3. This might be an indication that they do not have a life outside of the farms especially because the majority was living in the compound.
4. Very few had cell phones and watches were rarely seen. They relied on the supervisor to tell them it was lunchtime or the bell/siren that rings when it is lunch time and when it is over.	4. This might be an indication that they were used to taking instructions from supervisors and had no say at all. Lack of means of communication might be associated with low wages and thus cannot afford much except for meeting their basic needs.
5. Participants expressed self-pity and helplessness about poverty and exploitation of the farm workers.	5. There was plenty of self-pity regarding their own poverty, feeling helpless and being unable to defend themselves when exploited by farm owners. Failure by government to make sure that

	they receive basic healthcare services and better salaries.
6. Most participants showed a willingness to be interviewed in order to voice out their concerns.	6. There was a desperate wish to tell their stories. From the management side, the owners, managers and supervisors showed little interest in the study.
7. It was observed that the participants feared to voice out their concerns because they felt that they could be the first ones to be retrenched.	7. The collapse of strategic partnerships and formation of new forms of farm management and farms being owned by Africans who are still struggling to make ends meet; they could not pay full salaries to the employees at times might be the cause of retrenching the workers.
8. Poor living conditions	8. Those staying in the compound; it was small and there was nothing inside. This might be an indication of utter poverty. In some of the farms they were still using pit toilets
9. There were visible differences in security systems, the roads leading to the farms and fields between the farms owned by whites and Africans.	9. It was evident from a distance that if the farm owner was an African or a white owner, the security system, roads leading to the farms as well as the fields themselves could tell a story that as much as the African farmers have repossessed their land they had a lot of damage control to do before the farms could run smoothly again. This might be an indication that most of the African farmers needed training on how to manage the farms and

	make profits.
10. Various nonverbal cues noted during the interviews.	10. The sighing, pausing, not willing to participate in the study might indicate that the participants were not ready to disclose their status because of denial or were in emotional pain.
11. The management was not willing to participate.	11. This might be an indication that the participants saw the researcher as an intruder and the fact that she could not speak their language might have worsened the situation. Alternatively, it was simply because of the sensitivity of the topic or even due to the fact that some of the managers and supervisors were exploiting the females.

3.5.3 Methodological notes

Methodological notes are instructions to oneself, critiques of one's tactics and reminders about methods that might be fruitful.

The researcher summarised components of the interview like opening statements, research questions, helpful probes and closing statement, on the front page of each participant (de Vos et al., 2005: 311; Polit & Beck, 2008: 407; Merriam, 2009: 129).

3.5.4 Personal notes

Personal notes are about the researcher's own reactions, reflections and experiences (de Vos et al., 2005: 311; Polit & Beck, 2008: 407; Merriam, 2009: 129).

The most striking personal experience of the researcher was the difficulty to remain neutral in the face of obvious respondents' need for intervention and help. The researcher was saddened by the low wages that these farm workers get after such a

difficult and demanding job. The researcher was left feeling very sorry for terminally ill patients who die in such poverty, rejection and great stigma. Exploitation of women by men and their will to secure their employment was the worst feeling.

Lastly, the experience gained from the research study evoked in her a need to personally contribute in one form or another towards helping alleviate their problems.

3.6 CONCLUSION

The results of the field research have been presented and analysed in this chapter on the perceptions of the farming community and HIV and Aids. The analysed data was confirmed by literature control.

CHAPTER 4

CONCLUSION, RECOMMENDATIONS, IMPLICATIONS AND LIMITATIONS OF THE STUDY

4.1 INTRODUCTION

Chapter three discussed the research findings and literature control. This chapter focuses on the conclusion, recommendations, implications and limitations of the study entitled “The perceptions of the farming community in the Limpopo Province on HIV and Aids”.

4.2 OBJECTIVE OF THE STUDY

The objective of the study was to:

- Explore and describe the perceptions of the farming community in the Limpopo Province on HIV and Aids.

4.3 CONCLUSION OF THE STUDY AND SUMMARY OF CATEGORIES

A qualitative, exploratory and descriptive research was conducted to explore and describe the perceptions of the farming community on HIV and Aids. The population in the study constituted of the farm owner, managers, supervisors and the farm employees but only the supervisors and employees volunteered to take part in this study. Purposive and convenient sampling methods were used to select the participants. Semi structured one-on-one interviews were used to collect the data. The perceptions of the farming community on HIV and Aids were explored and described. Tesch’s method of data analysis was used. Seven main categories were identified namely: emotions linked to HIV and Aids; individual characteristics and

experiences; behaviour specific cognition and affect; human resource issues; recreational facilities; healthcare needs; and support as a health promotion strategy. These categories were further supported by literature; the categories which emerged will be summarised below.

4.3.1 Emotions linked to HIV and Aids

The participants expressed pleasant and unpleasant emotions when surveyed. However, mostly unpleasant emotions emerged when exploring their perceptions on HIV and Aids. The pleasant emotion expressed was acceptance of one's status once infected and to be accepted and supported by their family members. Literature proves that after being diagnosed with HIV, HIV-positive people are highly stressed and uncertain about their lives as they may be devastated by the need to deal with the new medical, personal and social situation despite the availability of HAART. The findings on the psychosocial aspects of a HIV-positive status show that living with HIV is associated with a large measure of stress and depression. It is evident that people with HIV and Aids must also manage the stigma associated with HIV and Aids. Moreover, they must tolerate treatment with adverse side effects, deal with rejection and social discrimination, and confront the deaths of others in their social networks. Being HIV positive generally makes HIV part of a person's identity. The social stigma that surrounds HIV may have adverse repercussions not only for the individual, but also for their family (Van Empelen, 2005: 10; Setswe, 2010: 28; MDG Country Report, 2010: 74).

The findings of this study are consistent with the findings of Van Empelen (2005:10) and Setswe (2010: 28); it was evident that continuous counseling of infected patients is crucial especially when patients say they have accepted their status. Participant number eleven discovered that he was infected after the wife was diagnosed during pregnancy. It was later discovered during follow-up interviews that this participant was still in denial but he was pretending to have accepted his status so as to support the wife.

The most prominent unpleasant emotions expressed by the participants were fear, pain, pity and sympathy, concern and neglect. Fear was expressed as fear of being infected with HIV, fear of contracting HIV from their spouses and fear to test for HIV.

People are often even afraid to discuss HIV. It was clear in the study that the majority of the participants still perceived talking about HIV as taboo. Some of the participants even used the word “this thing...” when referring to HIV. Fear is related to images and notions of suffering, shame and death, being dependent on others to take care of you, being rejected and feeling alone. Stigmatization, social rejection and the frightful nature of HIV and Aids prevented some people from undergoing the HIV tests (Saliu & Adejoh, 2010: 220; HDR, 2004: 95). The literature supports some of the narrative statements expressed by the participants about fear of HIV testing.

As much as most of the participants verbalised that they still do not talk about HIV and Aids, there was a general feeling of pain and sympathy for those (co-workers and family members) who had signs of HIV. The majority of the participants felt that they cannot just talk about HIV freely instead they prefer to advise anyone with the signs and symptoms of Aids to seek medical care.

Family members and friends share these feelings, but they also struggle with accepting the devastating changes their loved ones go through. As supportive as they may want to be, friends and relatives must deal with their own fears of infection with the deadly virus. Often they feel inadequate about how to relate to the patient. This is frequently translated into various forms and levels of withdrawal, leaving patients feeling even more isolated Maldonado (1996: 2-3; Mudzisi, Netshadama & Maselesele, 2007: 139; Jantjie, 2009: 94). The above literature is consistent with the findings of this study.

Concern and neglect was expressed by the participants in this study. They mentioned that the government does not care about the farm workers otherwise they would come and see what is happening in the farms. The majority of participants expressed that even the healthcare workers do not care about them because the mobile clinic is no longer available for the farms. Literature proves that farm owners are dismissing HIV and Aids as “the government’s problem”, while others are extremely concerned but are hampered by a lack of information and assistance from the Department of Health and other governmental departments, financial constraints, and the impression that there are no tools in place to “fix the problem” (HIV and Aids in the South African Agricultural Sector, 2008: 17).

4.3.2 Individual characteristics and experiences

Individual characteristics and experiences is one of the components of HPM. The HPM proposes that for the individual to take action to avoid risky behaviour, the individual needs to believe that he or she is susceptible to suffer the consequences related to risky behaviours. According to Pender (1996: 65), individual characteristics and experiences are predictive of a given behaviour and shaped by the nature of the target behaviour being considered. The importance of an individual's unique personal factors or characteristics and experiences depends on the target behaviour for health promotion. The findings of this study were guided by the conceptual framework, the HPM.

According to Pender cited in Wu (2003: 94), personal factors are independent variables that directly influence behaviour-specific cognitions and directly influence the specific health-promoting behaviour. Perceptions of self and influences on the individual directly influence commitment to a plan of action which then leads to the health-promoting behaviour. The purpose of this study was to explore and describe the perceptions of the farming community on HIV and Aids. Reasons for selecting the HPM for this study were that HIV and Aids is incurable and in order to minimise the risk of contracting the virus an individual has to have a thorough understanding of the disease process, thus modes of transmission as well as living a healthy lifestyle once one is infected are crucial in promoting one's health. However, it is crucial to explore the perceptions of the farming community on the pandemic to understand the individual characteristics that exposes them to the disease.

The researcher focused on biological, socio-cultural, and psychological factors as a basis for the study. Within the study, gender inequality, poverty, low wages and stigma and social isolation leading to non-disclosure were significant variables. The literature consulted proves that women are becoming infected at a faster rate than are men. The reasons are many. In very general terms, they stem from women's physiological vulnerability to HIV infection, and to gender disparities. Gender inequalities mean that women are less educated and poorer than men, their decision-making and negotiating power is diminished, and they are particularly susceptible to sexual violence and other harmful practices. These same gender disparities are also harmful for men in spite of the fact that they tend to favour men.

For example, men are expected to have multiple sexual partners, which increases their risk of contracting (and transmitting) HIV. Although there has been considerable progress in public health circles about understanding the roles of gender and sexuality in HIV and Aids, there is still little public awareness and discussion about it (UNAIDS, 2001: 33; UNAIDS, 2012: 64; Brophy, 2010: 56).

Farm workers in South Africa are disempowered in a number of ways. Their history of slavery and ongoing disadvantaged socioeconomic conditions is compounded with the problem of violence against women on farms. Many male farm workers struggle with a childhood history of violence and alcoholism, have a low self-esteem, are habitual drinkers, have low levels of education and feel insecure due to various uncertainties in their lives and they in return abuse women (UNESCO, 2008: 2).

The findings of this study are in line with the above mentioned literature. Exploitation of women and gender inequality were verbalised by the female participants. Participant number two, a supervisor, raised the issue of exploitation of women and gender inequality irrespective of qualifications and experience. An issue emphasised by participant number twelve was that some women end up in a relationship with a manager or supervisor simply because they want to work fewer hours, have more money and secure their employment. Some women end up in such relationships because they are scared that if they do not get involved with the managers or supervisors they might be victimised, as there are no unions to protect the farm workers.

Poverty as a personal socio-cultural factor was also significant in this study. There are strong bi-directional linkages between HIV and Aids and poverty in resource-poor settings. In this study, the participants expressed that poverty is carried over from generation to generation. The majority of the participants verbalised that they were underpaid and linked low wages to transactional sex thus increasing the risk for contracting HIV.

HIV and Aids are both a symptoms of the existent poverty conditions manifesting where livelihoods are unsustainable and resulting in the unmitigated impact of the epidemic on social and economic conditions. HIV and Aids is at the same time a cause and an outcome of poverty and poverty is both a cause and an outcome of

HIV and Aids. At a global level, cross-country evidence indicates strong and significant associations between HIV prevalence and aspects of socio-economic performance. In general, the higher the level of HIV, the lower the level of economic performance (UNAIDS, 2005: 12).

Stigma and social isolation leading to status non-disclosure was identified as a personal psychological factor in this study. The participants in this study raised a point that those who have the virus do not disclose because they fear social isolation. It was evident that despite the basic knowledge that the farming community has on the transmission of HIV stigma associated with HIV infection and social isolation of those affected is still prevalent in the farming community.

4.3.3 Behaviour specific cognition and affect

The HPM was selected as the framework for the study because it is an empowering, holistic, competence-based model. Pender's HPM emphasises that behaviour-specific cognitions and affect have a major motivational significance for acquiring and maintaining health-promoting behaviours. Anticipated benefits or outcomes affect the person's plan to participate in health-promoting behaviours and may facilitate continued practice.

The assumptions predicted by the Health Promotion Model (HPM) which was used as the theoretical framework of this study confirms that it is a common practice to have multiple partners for monetary purposes. In this model under behaviour-specific cognition and affect it is stated that the immediate competing demands have a direct impact on the participation of health-promoting behaviours and for the farming community, these demands include poverty, low income, basic needs such as food and safety must be addressed before health promotion needs can become a focus (Burns & Grove, 2007: 182; Polit & Beck, 2008: 142).

The conceptual framework emphasises that anticipated benefits or outcomes affect the person's plan to participate in health-promoting behaviours and may facilitate continued practice. Prior positive experience with the behaviour or observations of others engaged in that behaviour is a motivational factor. Low wage earners in the farming community are predisposed to having multiple partners and not being in a position to negotiate condom use thus increasing their risk of contracting HIV.

It was evident from the narrative statements of the participants that polygamous relationships and not using condoms is still common in the farming community. According to Morris and Kretsch, cited in Shisana et al. (2008: 2-3), concurrent sexual partnerships, where sexual relationships overlap in time are noted to be a major contributing factor in the rapid growth of HIV. Shisana emphasises that although male and female condoms are readily available in South Africa, male condoms have been more widely available as a product of cost and other logistical concerns. Although there has been an overall marked increase in condom use, condom use is primarily low among primary partners. Low use, inconsistent use and non-use are also noted to occur among people with multiple partners (Shisana et al., 2008: 2).

Mudzusi, Netshandama & Maselesele (2007: 260) discovered that intentional exposure to contracting HIV is still a common practice for the sake of getting the disability grant. It is further stated that most clients who came for VCT wanted to be infected so that they could get disability grants. This encouraged other people who were unemployed to want to be infected because of the perception that it is better to be killed by HIV because it will kill you later after being famous and getting the grant, instead of being killed by immediate hunger (Mudzusi, Netshandama & Maselesele, 2007: 261).

The above literature supports the immediate competing demands, which include demands poverty, low income, basic needs like food and safety, must be addressed before health promotion needs can become a focus of the farming community.

In this study, participants acknowledged that alcohol intake increases the risk of contracting HIV. Several studies in Sub-Saharan Africa suggested strong links between alcohol and risky sexual behaviour such as having multiple sex partners, having unprotected sex and engaging in sex for money. Alcohol functions similar to other mechanisms where judgement and decision making is impaired leading to risky behaviour. The increase in risky behaviour in turn increases the risk of contracting HIV (Shisana et al., 2008: 4; Mahadev, 2006: 44; Zembe et.al., 2012: 100).

4.3.4 Human resource issues

The unfair dismissal and retrenchment of the farm workers without even a written warning is still common practice on South African farms. All employees are protected by the Labour Relations Act which states that should there be a need for retrenchment then the rule “first in last out” should be applied by all the employers.

Retrenchment of those with regular clinic appointments and unfair dismissal was raised by the participants in this study. Atkinson (2007: 279) found that downsizing and the resultant widespread trend to retrench workers has left farm workers homeless with a slim chance of being re-employed in the agriculture sector and with inappropriate skills to find work in already overcrowded urban areas to which they are inevitably forced to migrate.

In this study, participants mentioned that lack of jobs in the rural areas led to migrant labour. Lack of jobs in rural areas leads members of the farming community to migrate to urban areas while their spouses are left at home. Massive migration of young unmarried adults from presumably “conservative” rural environments to more sexually permissive African cities in recent years is regarded as the underlying cause of the spread of HIV and Aids (Lemke, 2005: 845).

4.3.5 Lack of recreational facilities

The underlying motivation for using the HPM as the framework for this study is because health promotion stems from the need to avoid illness, receive early detection, and have optimal functionality within the confines of the illness. It is therefore crucial for those infected and affected to have recreational facilities in order to avoid high risk behaviour like alcohol consumption which will predispose them to unprotected sex.

The participants linked the lack of recreational facilities on the farms to boredom resulting in most people engaging in recreational sex after hours and increasing the risk of contracting HIV. Poor living and working conditions, separation from families, physically demanding work with low wages, exploitation, poor accommodation facilities and limited recreational facilities lead to boredom and an increase in

engaging in risky behaviour (HIV and Aids in the South African Agricultural Sector, 2008: 15).

4.3.6 Healthcare needs

The HPM upon which the framework of this study is based emphasises that in order for the individuals to engage in health promotion, they must first overcome barriers to health promotion. Barriers to healthcare identified in this study were distance to clinic, long working hours, unavailability of condoms and the mobile clinic not coming to the farms anymore.

Cessation of healthcare delivery and the increased workload for the healthcare workers was raised by the participants in this study. All participants expressed that the mobile clinic was no longer coming to their community since April 2012. Health care is affected by lack of access to health services. The inquiry into the human rights of farm workers (SAHRC, 2003:70) found that the new health system is not adequate and does not meet the needs of rural areas thus resulting in HIV and Aids and Tuberculosis becoming serious problems amongst farm dwellers. Healthcare workers face challenges in their work environment such as occupational stress, bereavement overload, over identity with their patients, stigma whether internal or external and burnout.

4.3.7 Support as a health promotion strategy

Pender's theoretical assumption that interpersonal influences such as family, peers and healthcare providers can affect one's commitment to and engagement in health-promoting behaviour. In this study, the support from the family is crucial since Aids is a chronic disease. In order to receive material and emotional support for living with HIV and Aids, one must disclose his/her status to significant others. Disclosing to family members is one of the key factors in fostering and maintaining ART (antiretroviral treatment) adherence.

There was a general feeling among the participants that initially the mobile clinic was available twice a month providing primary healthcare services, chronic care, consultation, VCT and group as well as individual education. This was helpful because of the long working hours of the employees and fear of retrenchment if they

frequently missed work. The disproportionate availability of, and access to, healthcare facilities increases the risk for the spread of HIV and Aids in the farming communities. Farm workers' low wages and distances from services hampers their ability to utilise assistance that authorities could provide. They are also restricted from accessing services because of their long working hours, difficulty in getting time off and their lack of financial resources for transport and services. These factors all compound the victims in to using the healthcare and legal or social support systems (Brophy, 2010: 42).

4.4 RECOMMENDATIONS

The recommendations of this study will be guided by the conceptual framework. Based on the findings of this study the following recommendations were reached:

4.4.1 INDIVIDUAL CHARACTERISTICS AND EXPERIENCES

- Development of support groups for those infected and affected to promote the health of the farming community.

4.4.1.1 Behavioural outcome

- Increasing HIV and Aids awareness and overcoming the stigma of disease in all sectors of rural life is imperative to ultimately attaining prevention. Programmes should ensure people understand what HIV and Aids is; how it is transmitted; how it affects daily living; and how one can promote his/her health once infected. This knowledge can be disseminated by a variety of methods including, but not limited to, hosting educational sessions, training workshops, community meetings, focus groups, and wellness programmes run by peer educators and community leaders.
- Regular training and workshops to be put in place by the Ministry of Health working together with the farm owners in order to educate the farming community about the prevention, care and management of HIV and Aids. This will require identification of peer trainers by the farm owners and managers who will be trained to preach the awareness of HIV and Aids so as promote the health of the farming community.

- Distribution of condoms as a health promotion strategy by healthcare providers and provide training on how to use both male and female condoms.

4.4.1.2 Behaviour specific cognition and affect

- Strengthening of the programmes that promote safe sex in the farming community and encouraging voluntary testing to overcome the barriers of high risk behaviour.
- The farm owners should consider increasing wages and reducing working hours and providing recreational facilities, which reduce high risk behaviour that predisposes the farming community to contracting HIV.

4.5 RECOMMENDATION FOR FURTHER RESEARCH

- It is recommended that further research should be done in the farming community in order to explore the perceptions of the farming community in depth.

4.6 IMPLICATIONS OF THE STUDY

The study highlighted that HIV is the fastest growing epidemic in South Africa. The following implications are therefore relevant.

4.6.1 IMPLICATIONS FOR THE GOVERNMENT

A multidisciplinary approach between the government, Ministry of Health and healthcare professionals in the Limpopo Province should work hand-in-hand in order to control the spread of HIV especially in farming communities. More healthcare professionals should be trained to meet the high demands of the farming communities. Regular visits to the farms by the health minister are deemed relevant in order to address the current challenges. More support, funding and recognition needs to be given, by the government, the NGO sector and sponsors to organisations that already exist to assist with awareness campaigns in the farms.

4.6.2 IMPLICATIONS FOR HEALTHCARE PROFESSIONALS

The focus of behaviour change programmes, as expressed by the participants, is that most farm workers still have multiple partners and do not use condoms. They should be given the option to speak to someone of their own or a different culture and should be able to choose whether they are ready for individual or group intervention. The farm workers have a right to equal access to healthcare services as stated in the Constitution of South Africa; therefore, it is the responsibility of the healthcare workers to provide the basic healthcare services to the farming community.

4.6.3 IMPLICATIONS TO THE FARM OWNERS AND MANAGERS

The farm owners must consider increasing the living wage of the farm workers so that they the farm workers can improve their living conditions and avoid risky behaviour such as engaging in transactional sex in order afford the basics needs.

The farm owners must address the needs of the farm workers by maximising the strengths and resources that are available. The potential for maximising these resources lay with counsellors that could be trained in the farms and NGOs to promote awareness campaigns in the farming community. By creating a forum where men and women on farms, colleagues, employers and employees can come together and develop an understanding of their common humanity and the empowerment will benefit everyone through mutual respect and power-sharing.

4.6.4 CONTRIBUTION TO THE BODY OF KNOWLEDGE

The researcher generated recommendations, which can empower the farm owners and other healthcare workers to facilitate a better understanding of HIV and Aids amongst the farming community. These recommendations could also be useful for programme planners and other stakeholders involved in designing interventions to assist the farming community in HIV and Aids awareness.

4.7 LIMITATIONS OF THE STUDY

Various limitations of the study apply. The study was conducted in the Levubu farming community in the Limpopo Province. The size of the sample was drawn from the three farming communities in Levubu and it is therefore not representative of the general population. It cannot be taken for granted that the findings of this research can be generalised in other contexts.

Other limitations of this study were conditions inherent in qualitative studies. Open-ended questions gave much discretion to participants and the researcher. The conversational tone had a potential to prompt particular responses or direct answers; this unconscious process is difficult to avoid.

The study was conducted in the participant's indigenous languages which included Tshivenda, Xitsonga and Isizulu. The transcribed interviews had to be translated into English. This was difficult and time consuming because the researcher as a Zulu-speaking individual, was more fluent and conversant in English. Emotional concepts such as pity, pain and sympathy do not have a direct translation in the above mentioned languages. Words and expressions of various emotions are easily available in English but unavailable in Tshivenda, Xitsonga and Isizulu. The researcher had to make assumptions that some of these verbalisations meant pain and that HIV is a killer disease. This fact calls for further research regarding the use of indigenous languages in phenomenological interviews.

4.8 FINAL CONCLUSION

The purpose of this study was to promote the understanding of the perceptions of the farming community on HIV and Aids. The objective was to explore and describe the perceptions of the farming community on HIV and Aids. A qualitative, exploratory and descriptive paradigm was used and seven categories were identified. These categories were used to develop recommendations for the farming community.

Regular training on HIV and Aids is therefore crucial given that the findings of this study showed that, despite the ongoing HIV awareness campaigns in South Africa,

some segments of the population do not get the message, specifically the farming community.

It is evident that the universal access of healthcare services which most of us take for granted is not accessible to the farming community due to their long working hours and the fact that the mobile clinics that are used to provide basic PHC services were no longer coming. These findings have significant implications for the Ministry of Health and healthcare professionals who are concerned and responsible for educating the farming community about HIV and Aids and providing basic health services in order to reduce the spread of HIV and Aids. Farm workers are the most under-served workers in South Africa. According to the findings of this study, poor access to healthcare and health-related information is partly due to their remote location of work. Rural people are therefore less likely to know how to protect themselves from HIV, and if they fall ill, less likely to get care. The high incidence of poverty and the low wage level makes the farm worker even more vulnerable to the impact of HIV and Aids.

Multiple factors influencing the increased HIV infection rate in farming communities warrant concern. It was revealed that factors that lead to HIV vulnerability include: poverty, a lack of access to appropriate information, education and communication materials on HIV, cultural attitudes and practices, beliefs in HIV myths, gender-based violence, very few interventions from government and non-governmental organisations targeting farm workers, lack of incentives or facilities to test for HIV and lack of access to condoms. Almost all government interventions on HIV and Aids transmission are communicated to the general public in the form of mass media. These include, among others, the Love Life campaign and the Soul City television series. Due to the low levels of education and literacy in rural areas, farm workers might interpret the messages these campaigns are conveying differently. This makes them more susceptible to HIV infection.

5 BIBLIOGRAPHY

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ANNEXURE A- H

ANNEXURE A

LETTER REQUESTING PERMISSION TO CONDUCT THE STUDY IN
TSHAKHUMA FARMING COMMUNITY

ANNEXURE B

LETTER REQUESTING PERMISSION TO CONDUCT THE STUDY IN MASAKONA
AND RAVELE FARMING COMMUNITY

ANNEXURE C

LETTER REQUESTING PERMISSION FOR STUDY LEAVE FROM 1MILITARY
HOSPITAL

ANNEXURE D

APPROVAL LETTER UNIVERSITY OF PRETORIA ETHICS COMMITTEE

ANNEXURE E

APPROVAL LETTER FROM TSHAKHUMA FARMING COMMUNITY

ANNEXURE F

APPROVAL LETTER FROM MASAKONA AND RAVELE FARMING COMMUNITY

ANNEXURE G

INFORMATION LEAFLET AND INTERVIEW SCHEDULE

ANNEXURE H

TRANSCRIPTIONS OF INTERVIEWS

TRANSCRIPTS OF ONE ON ONE INTERVIEW

PARTICIPANT NUMBER THREE: 36 year old female, employed as a supervisor for six (6) years.

This one on one semi- structured interview was conducted in October 2012. The interview was conducted under the tree in one of the farming communities, as per prior agreement, the farm employee's name was kept anonymous.

Researcher: Good morning, thank you for taking part in this study.

Participant: Good morning

Researcher: Since you have been working in this farm for the past six years and you are staying in this community, what is your understanding and feelings about HIV?

Participant: Eish...I feel pain and pity because I see people dying every day because of this disease. People are stubborn, they still have multiple partners and they don't use condoms. And most of the time those who have this disease get angry when the mobile clinic comes here because they don't want to test.

Researcher: So if one refuses to test does it mean he/she is infected?

Participant: Of course, if you were testing all along and now out of a sudden you lose weight, you start coughing, you have diarrhea and then you refuse to test? Most of this people are the ones with more than one boyfriend here at work, so yes I think it is because they have the disease.

Researcher: Ok, so what are the challenges that you are facing here at work since you said most people are dying and some are sick?

Participant: It is really tough because the workload increases

Researcher: I heard you mentioning that most people still have more than one partner and they don't use condoms, can you tell me more about this?

Participant: Most people are spreading HIV intentionally even if they know that they are infected, they don't use condoms. Sometimes there are no condoms here

Researcher: Who brings the condoms? Do you have femidoms as well?

Participant: The mobile clinic use to come twice a month, and they will bring condoms but I have never seen femidoms. For the past four months the mobile clinic hasn't been coming though

Researcher: So if the mobile clinic has not been coming for four months, do you get time off to go to the clinic?

Participant: No, we don't have time to go to the clinic because we are working from Monday to Friday from 7-17h00 and on Saturday one must do the washing or work overtime, Sunday I go to church and the clinic is closed, so there is no time at all.

Researcher: So do you always work overtime on Saturday?

Participant: I don't have a choice because the money that we are getting is very little

Researcher: Ok, according to you, do you think there is any link between HIV and multiple partners?

Participant: Of course there is people have more than one boyfriend to try and increase they income, if you have three boyfriends and each gives you R100, then that is R300 extra.

Researcher: The management, how does it support those who are ill for a long period of time?

Participant: Mhmm...They assist if you have a sick note they give you a full salary, if you are sick for a long period of time they will advise you to apply for a grant at the clinic

Researcher: As a female working in the farm, what are the challenges that you face at work?

Participant: Iyoo... it is very difficult, if you are a female and you are have the same qualifications as a male, being in the same position, females get less money than males. And you have no say as a female. Even the females who are in management positions do not support us they exploit us even more. And if a supervisor or manager proposes you and you refuse, they he makes your life difficult ate work

Researcher: So what have you done about it? What about reporting them at the unions?

Participant: There are no unions here only CCMA when you are retrenched.

Researcher: Is there something else that you want to talk about?

Participant: Yes, fair treatment of women.

Researcher: Thank you.