Building capacity to facilitate policy implementation: A short course in adolescent and youth health in South Africa

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Abstract

In order to respond more effectively to the health of young people in South Africa, in 2017 the National Department of Health of South Africa released the National Adolescent & Youth Health Policy. The Policy focused on a range of health problems and recommended interventions for delivery through multiple settings and government departments. It also included specific recommendations to empower and involve young people in policy and programme implementation. Adaptation of a short course on adolescent health in low- and middle-income countries, organized annually by the London School of Hygiene and Tropical Medicine and the World Health Organization, was piloted in 2017 as one means of contributing to the implementation of the Policy. The Adolescent & Youth Health Policy short course was subsequently offered in 2018 and 2019, attracting 96 participants working on adolescent health in various organizations at national and provincial levels throughout the country. Most participants (75%) successfully completed the course, as assessed by the completion criteria that had been defined. The range of topics for the assignments selected by the participants over the 3 years reflected both the content and intent of the Policy. The evaluations of the short course indicate that it helped to create legitimacy and strengthen the capacity of various constituencies, both of which are important prerequisites for policy implementation.

Introduction

The call to 'leave no one behind' in the Sustainable Development Goals (SDGs) of 2015 was particularly important for adolescents, because in many countries they are a large and growing population with insufficient concerted and resourced attention.

Adolescents (defined as 10–19-year-olds) form an estimated 18.5% of the population in South Africa.[1] The National Department of Health (NDoH) 2001 guidelines and policy for adolescent and youth health were updated in 2012 and further revised in 2014, guided by evidence on effective interventions and informed by intensive consultations with stakeholders, including young people. The resulting National Adolescent & Youth Health Policy (hereafter referred to the Policy), released in 2017,[2] focused on a range of health problems and recommended interventions for delivery through multiple settings supported by several government departments. It also included specific recommendations to involve young people in policy and programme implementation.

For policies to lead to action, as a first step they need to not only be disseminated, but also to be understood and owned by the people who are going to implement them, through the development of capacity and confidence.[3] Three factors contributed to realizing this for the Policy: first, momentum within South African academic institutions, non-governmental organizations (NGOs), and bi-lateral partners regarding adolescent and youth health; second, willingness by the London School of Hygiene and Tropical Medicine (LSHTM) and the World Health Organization (WHO) to enable adaptation of its short course on adolescent health (https://www.lshtm.ac.uk/study/courses/short-courses/adolescent-health) in the Southern African context; and third, an interested funder - ViiV Healthcare's Positive Action for Adolescents initiative, with a goal to strengthen partnerships that improve young people's health in South Africa. These converging interests created an enabling environment to support implementation of the Policy.

This article will focus on the contributions of an Adolescent & Youth Health Policy short course, organized by the Desmond Tutu Health Foundation at the University of Cape Town (UCT) and the

LSHTM in collaboration with the NDoH in 2017, 2018 and 2019, to the implementation of the Policy. The aim of the course was to support staff of governmental and non-governmental organizations in South Africa, in the dissemination and implementation of the Policy and allied national policies.

The preparation of this manuscript did not require ethics approval as it was not a research study. The information included was from evaluations and quality improvement of educational activities.

Background and description of the course

Planning for the short course began in late 2016 with a meeting convened by NDoH with the participation of relevant NGO representatives and academic institutions in South Africa. Discussions included: the experiences so far of adapting the LSHTM/WHO course in other countries (Ghana, India, Nigeria); agreement on appropriate course participants; the potential for blended/staggered learning, accreditation and/or institutionalization; and the course curriculum.

We conducted a review of the websites of universities and training institutions in South Africa in 2017. This showed the availability of two programmes in youth development, but no evidence of specific attention to young people in health sciences or public health training.

The University of Cape Town, led by the Desmond Tutu Health Foundation, agreed to organize a pilot short course based on the LSHTM/WHO course, with financial support from ViiV Healthcare. The pilot, designed with the assistance of an adult education specialist from the LSHTM, included a thorough evaluation and planning for sustainability.

The short course had the following learning objectives:
i. to demonstrate knowledge of key health problems affecting young people
ii. to demonstrate knowledge of the principal objectives and content of the Policy
iii. to apply this knowledge through a review of the participants' work plans to identify ways to strengthen interventions included in the Policy
iv. to improve the implementation of the Policy through an assignment during the 3 months following the taught portion of the course
v. to provide an opportunity for reflection on the participant's work and professional development through a Portfolio of Evidence (hereafter referred to as the portfolio) submitted with the assignment.

The short course was advertised widely through universities and NGO websites, government departments and organizations providing technical support to adolescent programmes across the country. Applicants were required to be employed as managers in government/NGO adolescent/youth focused programmes, with likely responsibilities for the implementation of the Policy. In addition, a balance was sought in the selection of participants taking into considerations factors such as organizational affiliations, geographical location and gender. Faculty were recruited from institutions across the country based on expertise related to specific subject matter in the curriculum.

The curriculum of the didactic portion of the course covered concepts in programming frameworks and adolescent health and development, interventions to address health problems and delivery settings and programming elements. The course included interactive lectures of 60–90-minute duration, using a variety of methods: paired or group work, role play, and videos. The course content was reinforced through site visits to local organizations implementing adolescent and youth programmes. Each day participants were asked to consider, in written form, their lessons learned with particular emphasis on application to their work (Table 1).

During the five-day in-person course, participants were supported in the planning of their assignments to be undertaken in their respective workplaces after the in-person course. The assignment was intended as an opportunity for participants to apply the course content to their own work setting, with the support of a faculty assigned mentor. The expectation was that the assignment would take approximately 5 days in total to complete. Participants were required to have prior written agreement from their line managers to undertake an assignment. In addition, all participants were required to share an overview of the course content with their colleagues, thereby disseminating information about the Policy as well as their learnings from the course. Evidence showing this had taken place formed part of the portfolio.

The support from the mentor consisted of face to face or virtual consultations over a three-month period. Participants were required to write and submit a description of and reflection about the assignment in their portfolio. The portfolio consisted of questions intended to prompt deeper reflection, with evidence that the activity had taken place attached as appendices. The assignment was not graded – however, mentors were asked to use their discretion to judge whether a portfolio should be signed off as satisfactorily completed, taking into consideration whether or not the participant had:
i. engaged with the process by attending mentoring sessions and progressing on agreed action plans between meetings,
ii. applied their lessons and experiences from the didactic component to the practical activity,
iii. demonstrated their ability to reflect upon and self-critique their understanding and practice.

In 2018 and 2019, applicants were encouraged from Zambia and Zimbabwe with a view to stimulating their interest to

Table 1. Overview of the content of a blended programme.

In-person taught portion over 5 consecutive days	
Context and concepts	What is special about adolescents; Frameworks for programmes; Health situation of young people in South Africa; *the Adolescent & Youth Health Policy*
Health issues	Mental health; Sexual and reproductive health; HIV, sexually transmitted infections, tuberculosis; Nutrition and physical activity; Substance use; Intentional & unintentional injuries
Programming	Situation analysis; Programme monitoring; Adolescent participation; Programming in schools; Scaling up health service provision to adolescents Advocacy; Social protection; Site visits to 6 local organizations; *Social media; Comprehensive sexuality education; Parenting programmes.*
Practical application	Daily reflections on the implications of the course content for their own work; 5 days post-taught mentored assignment over a 3-month period

Note: sessions in italics were added based on recommendations made by course participants.

adapt the short course in their countries.

The course was evaluated through an anonymous daily public comment board available to participants; 3 faculty in attendance who provided written feedback on each session; immediate anonymous surveys that were completed by participants and faculty following completion of the didactic portion and an online anonymous survey completed by participants in 2018 and 2019 that focused on the relevance, progress and impact of their assignments.

More recently, we sought to explore how the topics selected by participants for their assignments (i) reflected the overall aims of the Policy (ii) contributed to its implementation and (iii) stimulated reflective thinking about the Policy and their adolescent health work in general.

In order to do this, we aligned the assignment topics selected over the 3 years with the 6 objectives of the Policy and the 3 themes underpinning the Policy and the short course (Tables 2 and 3). We randomly selected one assignment from each of the 3 most frequently aligned topics for each of the 3 years (for a total of 9 assignments) and undertook a thematic qualitative review to explore the participants' reflections on their assignments, as documented in the portfolios. Specifically, we extracted material from the 9 portfolios which articulated a) their expectations of how the assignment could be of benefit to themselves, their organizations, and young people b) the relationship of the assignment to their work, and the Policy's implementation, and the short course c) factors influencing completion of the assignment.

Experiences over 3 years

Participants and faculty

Ninety-six participants were selected from 262 applicants over the 3 years. Ninety-four persons attended the didactic portion of the short course. The majority were female, with approximately 40% working in government (Department of Health and Department of Basic Education); 23-39% worked in NGOs and the remainder in technical support organizations, research, or training institutions. Participants came from all provinces, although a predominance were based in Gauteng, KwaZulu Natal and Western Cape. Eight participants were from outside South Africa (6 from Zimbabwe and 2 from Zambia) to facilitate future adaptation of the short course in these countries (Table 4). Full and partial bursaries were provided by ViiV Healthcare to 26 persons to support their participation in the courses. Others were either funded by their place of work or

by themselves.

The faculty for the course included 35 people over the 3 years (15-18 persons per year) from a range of institutions UCT (several departments); University of Western Cape; University of Witwatersrand; University of Pretoria; Medical Research Council; National and Provincial (Kwa Zulu Natal, Western Cape) Departments of Health and Basic Education; UNFPA (regional office); ECTA Creative Solutions; and the LSHTM. Eight to ten faculty volunteered to mentor participants each year and 6 persons taught in all 3 courses.

Course completion

Over the 3 years, 75% of the participants completed the course *i.e.,* they attended 80%+ of the didactic component, shared the course contents and learnings with others at their workplaces, and undertook a work-based practical assignment documented in the portfolio submitted to and approved by their mentors. On completion of all three components, participants received a certificate from UCT, as well as Continuing Professional Development points for those eligible. In the first year, which was a pilot, fewer participants completed the course (*i.e.,* 21 of 31 participants) due to some confusion about the assignments and the portfolios. Responses to the online survey that year showed an important proportion (27%) of the participants reported that the guidance they received in selecting an assignment topic needed improvement. In subsequent years, specific sessions were therefore organized during the didactic portion to improve understanding and expectations of their assignments, which resulted in improved course completion (*i.e.,* 24 of 30 participants in 2018 and 27 of 33 participants in 2019).

Course evaluation

The didactic component of the course was consistently rated 'excellent' or 'good'. A few rated the sessions as 'needing improvement'. Reports were prepared each year summarizing details of the evaluations including comments by participants that could help to improve and add to subsequent course functioning and content. For example, in response to requests from participants, new sessions were added in 2018 (a detailed overview of the Adolescent & Youth Health Policy, comprehensive sexuality education; social media) and 2019 (parenting programmes). Comments made by participants about individual sessions were communicated to faculty so that they could revise content, as necessary, and improve delivery the subsequent year. The

site visits were consistently rated across 3 years as valuable opportunities to apply their learnings in "the real world" (and this was the focus of a reflective exercise undertaken after the site visits).

The most common areas identified as needing improvement included increased focus on the practicalities of implementation *e.g.,* more examples of the application of priority interventions in existing programmes and more opportunities to share experiences of positive lessons learned. Three sessions were thought to require substantive review and modification: the session on adolescent participation which needed to deal with adolescents' actual involvement in programming processes rather than adolescent engagement more generally, the Policy session: more examples of it being implemented across the country, and the inclusion of successful interventions in nutrition & physical activity session.

Assignments

Several of the assignments were a catalyst for the initiation of activities, in support of the national implementation of the Policy. These included an analysis of provincial adolescent and youth health indicators; the establishment of the Adolescent and Youth Advisory Panel for the National Department of Health (as stipulated in the Policy); and a review of the Ideal Clinic (introduced in 2013 to address deficiencies in quality of PHC services) primary health care (PHC) facilities' role in strengthening adolescent and youth friendly health service (AYFS) implementation.

The post-assignment surveys highlighted areas that the participants were interested to explore further. Three themes emerged:

i. Activities related to the assignment *e.g.,* "I managed to set up an advisory panel at the national level and need assistance with reporting tools and report format for submission to my principals".

ii. Areas of new interest *e.g.,* "…health frameworks and nutrition"

iii. Improved programming *e.g.,* "I would like to partner with the district to develop monitoring systems especially for trained implementers"

A further survey question enquired whether the assignments had contributed to participants' professional performance and development. Responses were grouped into the following themes:

i. Specific skills or knowledge gained *e.g.,* "The assignment equipped me with the critical and analytical thinking in the application of theory relating to intersectoral collaboration".

ii. Building on learning from the short course *e.g.*, "I incorporated some of the readings on adolescent and youth health into trainings".

iii. Opportunities to strengthen practice *e.g.*, "…information gained and knowing to work with other directorates".

The 3 most frequently aligned assignment topics to the Policy over the 3 years were those related to objectives 1 (innovative youth-oriented programmes and technologies) and 6 (youth empowerment), and to the theme of multi-sectorality. The findings from the qualitative review of a selection of 9 portfolios showed that:

i. All participants thought the material presented in the short course was relevant, sometimes inspiring, and improved their appreciation of adolescents' needs and how the work of their organizations could contribute to meeting these needs, thus contributing to the implementation of the Policy.

ii. There was an anticipation that assignments to advance multi-sectoral collaboration would improve adolescents' access to health services, and that those assignments seeking to engage adolescents would enhance adolescents' skills and experiences. Participants expected

Table 2. Participants' assignments aligned to the objectives of adolescent and youth health policy.

Adolescent and youth health policy objective	Assignment topics 2017	Assignment topics 2018	Assignment topics 2019
Objective 1: Use innovative, youth-oriented programmes to promote adolescent and youth health.	• Review of prevalence of mental health among adolescents and service availability. • Assessment in 4 facilities of mental health screening. • Scoping of structure & functions of proposed adolescent network among grantees. • Set up of adolescent clinic for trial *e.g.* youth representatives, operational features.	• Develop curriculum for 2-day training for 40 health workers on communicating with adolescents. • Collect information from 200 learners about desired features of the future youth clinic. • Develop quality improvement plan for the implementation of AYFS in Bojanala district from interviews with adolescents attending services in in 2 PHC facilities.	• Assess the experience of educators in dealing with learners that experience mental health issues. • Conduct 4 AYFS workshops to clinic management, to non-clinical and clinical staff of Umlazi clinic. • Identify available and needed resources to improve mental health of HIV positive adolescents of Vergenoeg community, in John Taolo Gaetsewe district. • 'Be Part' endeavours to be a youth friendly one-stop shop linked to an enhanced innovative program – developed for the youth, by the youth – which can be multiplied and reach 100-fold numbers via social media.
Objective 2: Provide ASRH services integrated HIV & TB.		• Establish intersectoral stakeholder forum to devise a plan to reduce adolescent pregnancy in 5 secondary schools in Limpopo.	• Reduce sexual exploitation and abuse of children that result in teenage pregnancy in Harry Gwala District. • Identify and dismantle barriers to accessing contraceptive services in Ward 21 adolescent clinic (specifically current user of PrEP or ART). • Conduct a situational analysis of integrated SRH programs being implemented at Ivan Toms youth clinic to identify gaps and challenges. • Strengthen parent-adolescent communication re. SRHR in eThekwini.
Objective 3: Prevent, test, treat HIV & TB.			• Assess the current linkage to care/treatment status of young adults who have tested HIV+ve at clinic or research centre in Masiphumelele, • Conduct a situation analysis of lifeskills HIV/AIDS Programme in 11 Orange Farm secondary schools.
Objective 4: Prevent violence and substance use.	• Follow up of nurse training in 27 clinics on the use of job-aid to assist with post violence care of adolescent clients.	• Devise a means to provide support to 'Facilitator Interns' who have experienced trauma in their lives yet inspire the adolescents they work with. • Document perceptions of young women re. public transport & GBV: experiences and potential as an intervention site in Khayelitsha.	
Objective 5: Promote healthy nutrition and reduce obesity			• Strengthen nutrition awareness of in and out of school adolescents to reduce non communicable diseases that are the cause of death in rural south coast KwaZulu Natal.
Objective 6: Empower young people to engage in programming.	• Identify and train a nurse to support the work of peer educators. • Establish an Adolescent and Youth Advisory Panel to serve as an advisory panel for the NDoH. • Create 2 youth advisory teams to support the development, implantation and evaluation of adolescent programmes in the organization. • Undertake audits in 5 facilities of involvement of vulnerable adolescents in clinic committees.	• Use peer navigators to understand barriers of providing health services in schools (2 participants). • Collect information from 200 learners about desired features of the future youth clinic. • Initiate a youth advisory panel for NGO youth programme. • Stimulate participation female adolescents in formulation of programmes.	• Improve youth participation at the AYFS forum in Khayelitsha Eastern Substructure in Cape Town. • Ensure staff/peer navigators can communicate the information shared in an adolescent friendly manner. • Develop a Youth Ambassador Program to assist with the AYFS activities that can have a positive impact on the Adolescent Youth and Health programmes in KwaZulu Natal. • Preparation for a large-scale roll out of a multi-dimensional youth engagement intervention to address HIV in schools

gains in concrete experience in engaging partners to address social determinants, to use evidence for advocacy and develop a more nuanced understanding of the dynamics between adolescents and adults. Articulations of participants expectations reflect a more in-depth understanding of programming processes as well as the challenges faced in undertaking them.

iii. All the assignments were related to participants' work responsibilities reflecting the specific attention that was paid to the selection of topics during the didactic portion of the course and the fact that participants could express the benefits of their assignments to their workplaces, thus implicitly facilitating Policy implementation.

iv. The potential benefits of the assignments to their organizations included an expanded scope of programmes to address mental health concerns; more substantive inclusion of adolescents in actual programming; and improved strategies for better performance and scale up.

v. The implementation challenges of the Policy were appreciated through the undertaking of several assignments with respect to the recognition of the shortage of resources for mental health and the weak execution of adolescent and youth friendly services. Participants acknowledged the necessity of shared responsibility among sectors, the alignment of efforts at different levels and their own roles in translating the Policy into practice.

vi. The role of the mentors in providing a supportive environment to reflect upon their assignments was universally appreciated in the short course evaluations. The review of this sample of portfolios showed that mentors also provided specific assistance by toning down expectations and in the planning of the assignments, particularly in terms of the insufficiency of time and unforeseen unavailability of resources.

Discussion and conclusions

Worldwide there has been an accelerated interest in the development and implementation of policies and programmes for adolescent health.[4,5] At the same time, concern has been expressed about the often-limited capacity of those responsible for the execution of the policies and programmes that are developed. A review of available educational standards, competencies, and curricula that have been developed across the world to support education and training in adolescent health and medicine found

Table 3. Participants' assignments aligned to the themes of adolescent and youth health policy.

Adolescent and youth health policy objective	Assignment topics 2017	Assignment topics 2018	Assignment topics 2019
Theme 1: Multi-sectorality	• Facilitate establishment of working partnerships between DoH & DBE in Mpumalanga to implement the Policy. • Disseminated Policy to multiple stakeholders (5 participants).	• Develop standard operating procedures for health services in schools in support of the DBE policy on HIV/AIDS, STI and TB and ISHP. • Organize a jamboree for multisectoral (over 300) stakeholders from 4 districts in Tshwane to strengthen health promotion in schools. • Resolve bottleneck in providing HIV prevention services in schools enabled by DOE and DOH collaboration in UMgungundlovu district. • Establish a functional DOH/DSD/DOE/DSR municipal steering committee to oversee She conquers, Safeguard young people, ISHP and OSS activities. • Establish and maintain stakeholder forum and DOH school health teams working with youth friendly champions and partners to ensure bi-directional referrals in uMgungundlovu. • Intersectoral Workshop for Life Orientation educators with local representatives from health, social development & police in King Cetshwayo District.	• Establish structures for ISHP · To strengthen and support the provision of school health services to secondary school learners through collaboration with relevant partners. • Establish a coordination platform for AGYW activities in the Eastern Cape province. • Set up a structure for the piloting and implementation of SRHR in Eastern Cape (Ingquza Hill Lusikisiki and Flagstaff schools); To strengthen and support the provision of school health services to secondary school learners. • Advocate for adolescent health and ISHP to parents and principals: meeting school health coordinators, principals and parents, education programme officials.
Theme 2: Integration interventions into existing systems.	• Analyse indicators of the Policy over 5 -month period for 6 provinces. • Comparison of ideal clinic and AYHS standards in PHC clinics.	• Scale up implementation of adolescent programmes in eThekwini district health facilities. • Develop a data management system for Goals for Girls programme. • Review the alignment of interventions in Policy to the workplans of CINDI in KZN and HIVSA in Gauteng thereby increasing attention to adolescents.	• Strengthen the inclusion of adolescents into the Community Health Workers In-service Skills Development Training Course in Khayelitsha. • Create an adolescent friendly clinic in an office of Partners in Sexual Health. • Conduct training on comprehensive sexuality education for staff of Desmond Tutu Youth Centre for community of Masiphumelele.
Theme 3: Implementation of the Adolescent & Youth Health Policy	• Include discussions about the Policy in AFYS training (4 participants).	• Adapt the Adolescent and Youth Health Policy Short Course 2018 to the Zambian context (2 participants). • Cascade the Policy to operational Nurse Managers and Nursing Service Managers for 114 clinics in eThekwini. • Commence the planning for adaptation of short course to Zimbabwe (2 participants).	• Assess the level of the Policy's implementation in uThukela district. • Hold workshops to present Policy's key objectives.

that while some highly innovative approaches to pedagogy exist, most of them have been developed in high income countries.[6] The authors note the striking lack of adolescent health curricula and training standards in LMIC, which is paradoxical given the greater burden of disease in adolescents and the rate of growth of the adolescent population in these countries.

Another review finds that while there are a number of easily accessible high quality curricular materials primarily developed by the WHO, there is limited evidence of their use in LMIC, and there are gaps in subject areas such as mental health and substance use.[7] While the curriculum of the short course in South Africa benefited from the WHO materials, it was enriched by the considerable capacity of South Africans researchers and programme implementers working in adolescent health. The course facilitated collaborative effort between academics and implementers and benefited from a committed and expert faculty based on partnerships across South African institutions and government.

We consciously selected participants working with young people's health who were in a position to support the implementation of the Policy – not young people themselves. Cognizant of the focus of the Policy on youth involvement and the importance of having the voices of young people heard, several young people contributed to the adolescent participation sessions in 2018 and 2019. Although this was unanimously commended by participants, course organizers struggled with the content of this specific session and with ways to incorporate young people's involvement more generally. A recent review of experience of youth involvement, particularly in research activities in South Africa, provides useful lessons for a future short courses and programming.[8]

The short course formed part of the reflective process, where participants are encouraged to consider "What was supposed to happen? What actually happened? Why were they different? What did I learn ?".[9] The creation of a supportive environment is one of the the most important elements in enabling the development of reflection and reflective practice in health professional education.[10] This was one of the main purposes and roles of mentors, and the feedback from participants about the value of their assignments illustrated the value of the mentors and other processes that encourage reflection during the course.

We believe that the organization and convening of the short courses has contributed to the implementation of the Policy through creating legitimacy and building constituencies to act, both of which are important pre-requisites for policy implementation.[11] Since the participants came from different geographic regions of South Africa, it is likely that the course contributed to disseminating the Policy across the country.

Participants were purposefully selected to represent different sectors to strengthen multi-sectoral thinking and action, a key theme of the Policy and there was considerable interest by the participants to tackle sectoral collaboration in their assignments. The necessity of, and challenges related to multi-sectorality have frequently been highlighted in the literature on programming for adolescent health in the country and in the region.[1,12,13] However, the course organizers experienced persistent difficulties in attracting participants from the social development sector, a concern that had been raised by both participants and faculty.

Finally, since the Policy was only released in 2017, continued orientation and education are likely to be required to assist in its execution: a key strategy to support policy implementation is strengthening relevant training for those tasked with executing the Policy.[14] Due to the arrival of the coronavirus, a more limited online short course was organized in South Africa in 2020 and 2021, and funds have been secured for the adaptation and running of a short course in Zimbabwe in 2021 and 2022.

Table 4. Participants in the adolescent and youth health policy short course.

	2017	2018	2019
Total no. applied	80	119	63
Total no. accepted	32	26 (+2 Zimbabwe,+2 Zambia)	30 (+4 Zimbabwe)
Total no. attended	31	30	33
Gender	Females (87%) Males (13%)	Females (80%) Males (20%)	Females (90%) Males (10%)
Age	18-29 years (13%) 30-44 years (44%) 45+ years (43%)	18-29 years (6%) 30-44 years (47%) 45+ years (47%)	18-29 years (10%) 30-44 years (50%) 45+ years (30%) No answer (10%)
Sector (South Africa only)	Government (DOH 39%) NGO (39%) Training institution (3%) Technical support organization (3%) Research institution (3%) Other (13%)	Government (DOH 37%, DBE 13%) NGO (23%) Technical support organization (20%) Research institution (7%)	Government (DOH 37%, DBE 13%) NGO (30%) Training institution 3.5%) Technical support organization (13%) Research institution (3.5%)
Geography	National (20%) Eastern Cape (7%) Free State (4%) Gauteng (17%) KwaZulu Natal (22%) Limpopo (4%) Mpumalanga (2%) Northern Cape (4%) North West (17%) Western Cape (4%)	Free State (3%) Gauteng (30%) KwaZulu Natal (30%) Limpopo (3%) Western Cape (20%) Zambia (6%) Zimbabwe (6%)	Eastern Cape (17%) Gauteng (10%) KwaZulu Natal (27%) Northern Cape (7%) Western Cape (27%) No answer (13%) Excludes Zimbabwe

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