A SURVEY ON THE PERCEPTIONS AND ATTITUDES OF PEOPLE LIVING WITH AIDS/HIV TOWARDS HEALTH CARE PROVIDERS AND COMMUNITY MEMBERS OF THE RUSTENBURG AREA

BY

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SUBMITTED IN PARTIAL FULLFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL SCIENCES (CLINICAL PSYCHOLOGY) IN THE DEPARTMENT OF PSYCHOLOGY IN THE FACULTY OF HUMAN AND SOCIAL SCIENCES AT THE UNIVERSITY OF NORTH WEST

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DATE OF SUBMISSION: DECEMBER 2000

ACKNOWLEDGEMENTS

First, I would like to thank God Almighty for the wonderful things He has done for me, particularly the strength to finish this thesis.

I also wish to express my sincere appreciation and gratitude to:

My supervisor, Mrs. Victoria Segami for her guidance, patience, suggestions and unending encouragement throughout. My co-supervisor Prof K. Mwaba for his encouragement, suggestions and critical expertise.

The George Stegman Hospital staff members, for their support and patience with me, and the people living with AIDS/HIV at the hospital for their willingness to be part of this study.

My Honorary father and lecturer Mr. L.P. Direko (a registered Psychologist) for his undying and dedicated support and encouragement in times of difficulty and discouragement and for his creative ideas and suggestions.

Tumelo Rasibitse and Sello Boshomane for teaching me basic computer skills, and Mr. Dan Tlholoe for assisting me with the spss data analysis methods.

All those who made valuable contributions to make this study a success.

Finally and most important my family: my mother and role model Nnoko Pilane for her regular and incomparable love and support, my aunt Bonene Sedumedi and my uncle Mmuso Pilane for their inspiration and support, my younger brothers and sisters Tshiamo, Lerato, Malome, Ona, Mmabanyana and Refilwe, my best friend Jerry Motshegare for his support and inspiration.

DECLARATION

I declare that this thesis in Clinical Psychology in the department of Psychology at the University of North West has not been previously submitted by me for the degree at this or any other University, that it is my own work in design and execution and that all the material contained herein has been duly acknowledged.

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ABSTRACT

This study was designed to investigate the perception and attitudes of people living with AIDS towards community members and health care providers of the Rustenburg area. The aim of the study was to determine the attitudes and perception of the people living with AIDS towards health care providers and community members. To determine the attitudes of people living with AIDS towards feelings of isolation, rejection, blame and discrimination by society and to suggest more information on how to handle people living with AIDS.

The subjects were 20 male and females between the age below 20 and above 40 years admitted at George Stegman Hospital, Saulspoort, Rustenburg area.

The results indicated that a large proportion of the sample indicated that the health care providers are supportive and taking good care of them. Thus, they perceive them as good, and that they are not discriminatory, rejecting and isolating them. They hold a positive attitude towards them.

However, community members were perceived as rejecting, isolating and discriminating against them. The subjects indicated that the only support they receive from the community members is from their family members and sometimes from friends.

The respondents also mentioned that they had information about the disease before their diagnosis. Their reactions towards the diagnosis differed, and this included feelings such as shock, guilt, confusion and the desire to commit suicide. Findings regarding their sexual intimate relationships were different as others were involved in multiple or casual relationship and others were only committed to one partner. Regarding the issue of how they learnt about their condition, they indicated that they learnt after conducting a blood test.

A large proportion of the respondents also indicated that a condom is the only effective method to reduce the spread of AIDS as there is no cure for AIDS. They also mentioned that education is of importance to inform people about AIDS, people living with AIDS must also teach people about it.

CHAPTER ONE

1.1. INTRODUCTION

Since the first identification of Acquired Immune Deficiency Syndrome (AIDS) by the center for Disease Control (CDC) in 1981, AIDS has continued to wreak havoc as one of the most serious epidemic of our time. AIDS is described as being one of the most serious health problems and it is estimated that by the year 2000, 40 to 50 million people will be infected with HIV (Evian, 1995).

A decade has passed since the discovery of human immune deficiency virus as the cause of AIDS (Seligson & Peterson, 1990); however, there is no cure for AIDS (Anderson, 1994). In the absence of a vaccine or any cure, prevention seems to be the only method for avoiding the devastating effects of the disease.

Based on available data other research findings have concluded that AIDS is transmitted through various ways i.e., social contact, blood or other body fluids (Flitzpatric & malligan, 1987). However, most of the research shows that AIDS is in the majority of the cases transmitted sexually. To reduce the spread of AIDS people have to fundamentally change their lifestyles including the most intimate ones. In this regard education can play a significant role to the effect to request change.

The study is of the idea that all of us are living with AIDS. Some of us have HIV, others have fully-blown AIDS, and others are HIV negative. Nonetheless, all of us as members of our society are living with the realities of HIV and AIDS, either directly or indirectly.

However, AIDS discrimination and rejection by community members become serious problem. According to Farthing, Brown and Staughton (1988), few diseases are as frightening to patients as AIDS and yet, as well as the fear of death, the AIDS patient often have to face a cruel rejection by their friends and society. Blaming the victim too has a long and a dishonorable

tradition. Blame is most strong for AIDS patients as the disease is also associated with behaviors or lifestyle that are widely disparaged (WHO, 1991).

The study was promoted by the concern of the researcher with regard to the alarming increase in the number o people becoming infected by the virus daily throughout the whole world. While they are infected, they have to face discrimination, isolation, rejection and prejudice from the society.

1.2. MOTIVATION FOR THE STUDY

Although research about AIDS in social science has increased, it should be pointed out that little is being done in the psychology profession especially the clinical psychology profession. Previous studies conducted on the issue of AIDS seemed to pay attention on the knowledge, attitudes and perceptions of community members, school children and health care providers regarding HIV/AIDS. No noted research has been conducted regarding the attitudes and perception of people living with HIV/ AIDS towards community members and health care providers.

The present study aim at arriving at how people living with AIDS are affected cognitively, emotionally and behavioral, regarding the way they are handled by their families, partners, friends, work colleagues, and health care providers. The study also strives to determine the development and maintenance of the attitudes and perceptions of people living with HIV/AIDS towards community members and health care providers.

Furthermore it is hoped that the study will contribute information to the available literature for the understanding of AIDS in relation to sexual behavior and how people living with AIDS are isolated, rejected and discriminated against in our society.

1.3. THE STUDY AREA

The North West Province is one of the nine provinces forming the new South Africa. The province is semi-urban, however most parts of the regions are rural. The researcher will consider Saulspoort in Rustenburg to be the target area. According to the AIDS statistical records, 21,3% of people in the province are already infected with HIV (Statistics South Africa, 2000).

1.4. STATEMENT OF THE PROBLEM AREA

AIDS could be one of the leading causes of death in South Africa within the next ten years. According to Centre for Disease Control (CDC, 1987) in many regions, the number of persons infected with the AIDS virus is at least hundred times greater than the reported cases. Because of its rapid spread, AIDS has become a threat to human society. Like other contagious disease throughout history, AIDS has not always been very creditable. According to WHO (1991), the victims of contagious diseases such as AIDS have frequently been abandoned, isolated and rejected from the rest of society and blamed for their own condition.

In order to influence people's attitude and behavior towards people living with AIDS, education campaigns should be facilitated. The other effective route to reduce its spread is through changing sexual behaviors (Becker & Joseph, 1988).

In this regard recent studies (Acher, 1989, Judson, 1989, Becker & Joseph, 1988) as cited in Simbayi (1993) found that majority of people living with AIDS were knowledgeable of the disease, however they have misconceptions and poor correlation between knowledge of the disease and behavior change. According to Judson (1989) as cited in Simbayi for example, the vast majority of new cases of HIV infected may occur to individuals who have adequate knowledge to prevent infection.

1.5. OBJECTIVES OF THE STUDY

The objectives of the study are as follows:

- To determine the attitude and perceptions of people living with AIDS towards community members and health care providers,
- To determine the attitude of people living with AIDS towards feelings of isolation, rejection, blaming and discrimination by society, and
- To suggest more information on how society can handle people living with AIDS.

1.6. ASSUMPTIONS FOR THE STUDY

The following assumption is held throughout the study:

People living with HIV/AIDS are subjected to discrimination and rejection by family members, friends, work colleagues, insurance schemes and partners.

1.7. LIMITATION OF THE STUDY

As a result of conducting this study the following limitations can be noted:

- Due to the sensitiveness of the research topic, the researcher was forced to conduct a self-administered questionnaire (where respondents fill in the questionnaire on their own), instead of a personal interview as it afforded one greater flexibility in an attempt to elicit information.
- Because the study will not cover the entire population, inferences cannot be made about the general population, but only adult's females and males and not young children.

1.8. DELIMITATION

The study was delimited in the following way:

- The subjects of the study were Black females and males between the age below 20 and above the age of 40 years staying at Saulspoort, in the Rustenburg area.

1.9. DEFINITION OF CONCEPTS

The following concepts are defined as they are used in the study:

- **Attitudes** – refers to a learned predisposition to behave in a consistent evaluative manner towards a group of people, an object or a group of object (Morgan, King & Robinson, 1981).
- **Perception** – is a process by which sensory cerebral areas receive, organize, and interpret patterns of stimuli from inside the body, or from the environment in order that the individual may be aware of present data (Fisher, 1991).
- **HIV** – is an acronym for human immune deficiency virus. This virus is managing to take over a battalion and invade and destroy just as the invaders do. It destroys the natural defenses and can spread from one person to another through a variety of routes (Lerole, 1994).
- **AIDS** – is the acronym for acquired immune deficiency syndrome.
- **Acquired** - means to get especially by one's own efforts or qualities (universal Dictionary, 1986).
- **Immune** – refers to a defense function of the body that produces antibodies to destroy invading antigens (Lerole, 1994)
- **Deficiency** – refers to a quality or condition of being deficient 9Universal Dictionary, 1986).
- **Deficient** – means lacking an essential quality or element, a shortage or insufficiency (Universal Dictionary, 1986).
- **Syndrome** – refers to the combination of different abnormalities making up this condition (Lerole, 1994).
- **Acquired Immune Deficiency Syndrome** – can be defined as the end – stage disease manifestation of an infection with the virus called HIV (Schoub, 1994).

- **Patient** – is a person receiving medical treatment from a doctor and / or in a hospital (Oxford Dictionary, 1987).
- **Community** – is a group of people living together and / or united by sharing interest, religion, nationality, etc. (Oxford Dictionary, 1987).
- **Member** – is a person belonging to a club, group, etc. (Oxford Dictionary, 1987).
- **Health care providers** – include a broad array of persons from a variety of professions who care for the sick (Kaplan, Sadock & Wilkins, 1991).
- **PWAs** – is an acronym for people living with AIDS.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

The purpose of this chapter is to give a brief background of the disease, the origin and the extent of the problem worldwide. It will also look at the dynamic process of all the phases of the disease and various ways in which the disease is transmitted. The perception and attitudes of the people living with AIDS towards community members and the health care providers will also be discussed.

AIDS AN OVERVIEW

2.2. AIDS ITS BACKGROUND INFORMATION

Although the history of AIDS can be dated from back to 1981 at the Center for Disease Control (CDC) in Atlanta Georgia, the first cases were seen in 1978 (Bezel, 1988 in Mwale & Burnard, 1992). The disease was first described in America in 1981, after a number of men had developed a rare pneumonia caused by a parasite called pneumocystisis carinii. These men were previously healthy, between 20 and 45 years of age and homosexual - oriented (Evian, 1995). With in a short time, similar cases had been reported in New York and San Francisco, while other reports included cases of perianal herpes and uncontrollable diarrhea, all unresponsive to treatment and occurring in homosexual man. Other cases followed rapidly on the heels of the first reports.

In 1982, AIDS was therefore defined as Kaposi's sarcoma (KS) in a person under 60 years of age or an opportunistic infection suggestive of a defect in cell mediated immunity occurring in a person with a no known cause for a diminished resistance to the particular disease with which they presented (Farthing, Brown & Straughton, 1988).

In September 1982, the Centre for Disease Control (CDC) named the new disease Acquired Immune Deficiency Syndrome (Gee & Moran, 1985). A new disease is considered as such, when it has a unique set of characteristics for which there are no preexisting categories or labels. AIDS falls under that category because it fatally affected many people.

The Centre for Disease Control (CDC) produced a provincial case definition of AIDS in the autumn of 1982. AIDS was defined on the basis of its occurrence of unusual infections or cancer such as pneumocystisis carinii and Kaposi's sarcoma in previously healthy individuals due to an immune deficiency of unknown cause.

Since 1982 or 1983 more cases were identified. Data received by CDC offices from investigators showed that the incidence of AIDS was roughly doubling every six months (Pratt, 1988). Certain aspects of the disease such as, its origin or causes was unknown at that time as well as its means of spread were especially alarming.

Soon afterwards in Central Africa, health care providers were discovering a new disease causing severe weight loss and diarrhea (Evian, 1995) that according to Mpati (1990) was called the slim disease. The same disease was reported in countries like Zaire, Uganda and Rwanda. It seems likely that the disease found in Africa was as the new AIDS identified in western countries.

The causative agent of AIDS was discovered in 1984. The virus was named Human Immuno Deficiency Virus (HIV). Immediately after the causative agent was discovered, diagnostic test for the virus were developed. The different ways in which the epidemic was spreading also became clear.

Over 46000 cases had been reported to the CDC up to 18 December 1987 (CDC – update, 1987). The Centre for Disease Control further predicted that more people would be infected and would die of AIDS as years went by. It was also during 1987 that the World Health Organization (WHO) mandated by United Nations, recognized the seriousness of the emerging AIDS epidemic. According to Hubley (1992), a special program on AIDS was established to respond to the growing threat of AIDS. In this program the WHO was mandated to provide the global leadership in the fight against AIDS.

Even if the program was established world – wide, the goal of controlling HIV seemed as distant as ever before. It seems as if the global battle against HIV/ AIDS has been lost. There in no cure, no effective treatment or no vaccine for AIDS, and there seems very little significant progress in the near future. Even in 1999 a cure and treatment for AIDS still remain illusory.

This section merely gave the background information on AIDS. The following section will attempt to answer the question of the origin of AIDS.

2.3. THE ORIGIN OF AIDS

Where does AIDS originate? The simple answer is that no one knows for sure. The origin of the HIV virus and AIDS is still a mystery. There are many theories, but none so far has proved the origin of the virus. The origination of AIDS has been argued at great depth, however a consensus has never been reached, but instead it aroused considerable controversy and hatred. At present the answer to the origin of the disease remains as unresolved as when the question was first posed.

Based on literature, the disease AIDS was first recognized in the USA and only somewhat later was the epidemic as such observed in Europe and the African continent. Although no one knows where AIDS started, there are theories that attempt to answer the question of the origin of AIDS.

The first theory as stated by Whiteside (1996) emphasizes that it is a common belief in African communities that whites are in some way responsible for the virus, and that it is a plot to reduce the black population and / or prevent them from having fun.

The spread might have been facilitated by political development in Africa. Fan, Conner and Villareal (1996), states that, HIV resulted from a plot between Israel and South Africa that spread could also have been as the result of international travel between countries, the results of sexual revolution and the widespread drug administration.

This theory seems to be unacceptable. Given the rapid spread of the disease, it is hardly likely that the virus could have circulated in humans as far much before the late 1950s and still remained unrecognizable. This is also corroborated by reports of doctors with many years of clinical work experience in Africa, who agreed that the damage caused by AIDS on the physical body of the victim is too great that it would have been most unlikely that the whole epidemic could have existed unnoticed.

A variation of this theory is that the human immune deficiency virus originated from animals. To corroborate on this fact, Fan, Conner and Villareal (1996) who stated that, HIV resulted from sexual relations between humans and sheep and also between humans and monkeys. However, this theory states that in animals the virus did not cause the disease but was transferred to humans where it caused the disease. The animal that has received the most attention as a possible source has been the African Green Monkey (Hubley, 1992), which has simian immune deficiency virus.

The information that appeared to support this theory is that the virus SIV is genetically similar to (HIV2). However, Schoub (1994) stated that SIV under natural conditions only infects monkeys and not humans. Furthermore, it has been proved that the original AIDS epidemic is been based on HIV1 that is distinct from HIV2, which only appeared at a later stage. Thus, the Green Monkey theory leaves the origin of the HIV1 unexplained.

The other theory mentioned by Hubley (1992) and that incidentally does not implicate Africa is that HIV was produced by the so – called the American military germ. The theory has been criticized by the American Government, as the technology for genetic engineering did not exist in the early 1970s. Thus, HIV would make a highly unsuitable pathogen for germ warfare.

The last view – point on the origin of AIDS that holds more truth is that AIDS is a new disease. It began in humans in the 1970s and early 1980s and has ever since increased in extent. Supporting this theory are studies that have revealed very little prevalence of infections with HIV in USA, Europe and Africa before the late 1970s and 1980s (Schoub, 1994).

2.4. AIDS AS A GLOBAL PROBLEM

The society is now confronted with a global problem that is not only a specific challenge but also a threat to human existence. Lachman (1995) stressed that a global strategy for AIDS prevention incorporates the concept that no country will be able to stop AIDS until it is stopped in all countries.

AIDS is now a true pandemic and it is evident that the worst is yet to come according to Dr Micheal H. Marson the Director of the WHO (Tanne, 1992). The cumulative number of HIV infections to date exceeds 17 million worldwide (WHO, 1995). If present threads continue the figure will be more than double to reach 30 to 80 million by the year 2000 (Evian, 1995). Further estimates indicate that for every case of AIDS, there may be between 50 to 100 other people who are infected but because of being unaware of the fact they may possibly spread the disease to others. This will suggest that merely judging the extent of the cases reported will be misleading.

Since a cure for AIDS has not been found, the most important task left is to strengthen preventative strategies. All health care providers have an obligation and responsibility to ensure the promotion of a healthy life style. This is an urgent matter, especially in Africa since the number of AIDS cases is rising rapidly. People of Africa need to be informed and educated so as not to obviate the adoption of preventative behaviors. This would be further discussed in the following section.

2.5. AIDS IN AFRICA

It is generally accepted that, Africa is the Continent hardest hit by AIDS. According to WHO, the AIDS problem in Africa is outstripping the rest of the world (Steinberg, 1993). It is estimated that 13,5 million Africans have died of AIDS , representing 85% of those who have died of AIDS - related illnesses worldwide (World Bank Report, 2000). Although AIDS is evident in all African countries, there are substantial differences within Africa. Research shows that the level of AIDS is highest where AIDS was first recognized i.e. central and Eastern Africa.

There are factors which seem to worsen the incidence of AIDS I Africa:

- The fact that Africa is the third world developing continent which does not have enough resources and infrastructures of health services, contribute to the rapid spread of the AIDS virus. As Lachman (1993) estimates that, about 60 percent of people in Africa are without access to basic health services, with the most acute problems occurring in Sub – Saharan Africa. Therefore people in remote rural Africa are less likely to be informed about AIDS.
- Due to the scarcity of resource there is a tremendous movement of people from rural to urban areas. This movement ensures a more rapid spread of AIDS in these countries. For Whiteside (1992), the high numbers of workers whose wife lives in rural areas tend to increase the number of partners and thus the rate of the spread of the virus.

- Factors such as poverty and malnutrition, lack of sanitation and potable water may also contribute to the spread of the virus. These factors may contribute to the reduction of the body's immune and the general level of health that will make it easier for the AIDS virus to enter the blood stream and infect a person.

Thus, the contribution of all the aforementioned factors may expose people of Africa to AIDS, which without any doubt is one of the major challenges facing Africa.

2.6. AIDS IN SOUTH AFRICA

According to Evian (1995), South Africa was one of the last countries in Africa to be affected by the epidemic. However, the AIDS epidemic seems to be rapidly a growing problem for the country. Speaking at a graduation ceremony at the Northern Gauteng Technikon , the Health Minister Dr Manto Tshabalala – Msimang stated that, every fifth person in the audience was HIV positive, according to the current estimates (Sowetan, Monday, August, 30, 1999). There is consensus among analyst that South Africa is currently entering a period of explosive growth of the Aids disease. This will definitely be the case as long as no vaccine or effective curative agent is developed.

In order to contextualize the present research, the AIDS disease – scenario in South Africa requires specific analysis. The first cases of AIDS in South Africa were recognized on two homosexual men in Pretoria in 1982 (Becker, 1986). Research conducted by S.A.I.M.R. in 1983 – 1985 showed that, the number of people with AIDS increased to 21 (Sher, 1986) after the discovery of the disease in 1982. Up until November 1988, 174 cases were diagnosed. At the end of 1994, 5641 people were reported as having AIDS in South Africa (Epidemiological comments, 1995).

The current status of the disease in South Africa is alarming. It is estimated that 2 million people are presently HIV infected. According to Evian (1995) this figures are expected to rise to 3 – 5 million HIV infected people in the year 2000. Thus, currently it is estimated that more than 2 – 3 million people are infected with HIV. In this regard experts calculate that 500 people get infected each day. South Africa therefore is challenged by the prospect of a vast and growing burden of illness and death associated with AIDS.

Research shows that the majority of people having AIDS in South Africa are blacks (Epidemiological comments, 1995). Furthermore, the highest rates of AIDS statistics reflect that blacks are possibly more vulnerable to AIDS in South Africa. However, it should be noted that blacks are the majority population group in the country and will therefore proportionately reflect a greater number. The statistics also show that the majority of people who are contracted are women than men (Epidemiological comments, 1995).

It should be noted that AIDS statistics are provided not buy all government departments, but mainly by hospitals. Thus, the truth is that the figures provided may be inaccurate as is estimated that a great number of AIDS cases remain undiagnosed.

2.7. AIDS IN THE NORTH WEST PROVINCE

As one of the nine province of South Africa, North West is also experiencing an AIDS epidemic problem as other provinces. The first cases in the North West were reported in 1987. The number of reported AIDS cases has increased from 6 in 1987 to 1020 in 1994. In 1995, 1364 cases were reported in the entire province. Of the 1364 cases reported in 1995, 98 cases were AIDS related death (Department of Health, North West Province). In 1997 it was estimated that 18,1% of the population of North West Province was infected with HIV. According to Statistics South Africa (2000), 21, 3% of people in the province are already infected with the virus.

CONCLUSION

The question was, were does AIDS originate? The answer may be, this section has established that the origin of AIDS is unknown, and AIDS is rapidly increasing. South Africa as other countries worldwide has also entered the epidemic phase where the rapid spread of AIDS will be experienced. Therefore, the review of the background of AIDS emphasis that the health professionals, community workers, and the society at large will have to play a more important role in the prevention of AIDS as prevention is better than cure.

UNDERSTANDING THE DISEASE

This section intends to discuss in detail the dynamic process of all the phases of the disease and various ways in which the disease can be transmitted. The researcher felt the need for this section as most of the people understand content of AIDS and the HIV, but its process being neglected. The section will also look at the people who are regarded to be at a greater risk of infection.

2.8. THE VIRUS (HUMAN IMMUNNODEFICIENCY VIRUS)

It is a well established fact that HIV is the causative for AIDS. The virus is the most recent member of the newly discovered family of virus known as retroviruses. These organisms are called retroviruses because they reverse the usual flow of genetic formation (Gee & Moran, 1985). This clearly indicates that HIV is unique and deadly. It attacks a key group of cells which co – ordinate the body's immune defense system (Gee & Moran, 1985).

More importantly it leaves the body open to infection that can ultimately result in death.

2.9. HIV INFECTION

HIV infection is a process that undergoes various phases.

The phases are as follows:

PHASE A: THE SILENT PHASE

HIV attacks the defense system in the body known as the immune system directly and undermines the efficiency by attacking most of the important cells of the body. Thereafter the person moves to the first phase of infection. The typical time between transmission of the virus and appearance of antibodies directed against the virus had been estimated to be 6 – 8 weeks (Evian, 1995). During this stage tests for the detection of viral antigen in the blood are usually negative. The clinical condition is referred to as sero – conversion illness because the problem is non – advances to the next phase.

PHASE B: THE ANTIBODY PHASE

After infection and the silent phase, there follows the phase of antibody positive phase. This means that a persons antibody become positive. The infected person during this phase looks and feels very well but, as times goes on, the viral load increases, thus the patient progresses to the next phase 9Pratt, 1987).

PHASE C: THE SYMPTOMATIC PHASE

According to Evian (1995), after 3 – 7 years of infection a number of virus particles are produced which consequently destroy enough of the immune deficiency. At this stage it becomes difficult for the body to defend itself against many infections. In time, most infected persons develop a variety of indicators of ill health. Today, these indicators are known as AIDS Related Complex (ARC). According to Evian (1995), individuals with ARC usually appear chronically ill. The immune system at this stage continues to deteriorate, and this ultimately in many patients leads to the next phase namely AIDS.

PHASE D: AIDS PHASE

It is not yet clear whether all infected persons will progress to the AIDS phase. However, according to Evian (1995), research conducted in all parts of the world shows that, approximately 80 percent of HIV carriers will most probably develop AIDS within 2 years of infection. According to Mpati (1990), research also shows that 20 percent of ARC victims develop fatal full – blown AIDS during the next 2 years. In this regard insignificant organisms cause life – threatening infections associated with severe immune – deficiency.

PHASE E: PERIODS OF REMISSION

Periods of remission alternate with new opportunistic disease (that is phase D) and eventually the patient advances to the last phase. In this phase, treatment of opportunistic disease encountered in AIDS is included. The treatment might result in a period of remission and relative good health.

PHASE F: THE TERMINATION PHASE OF THE ILLNESS

At this stage the body becomes progressively weaker with reported infections and tumors. Commonly, the patient's appearance premature, graying of hair and wrinkling of the skin. Death usually occurs 6 months to 3 years after developing AIDS defining illnesses (Evian, 1995).

2.10. MODES OF TRNSMISSION

People worldwide are afraid of AIDS. Much of their fear surrounding AIDS is due to lack of understanding of how AIDS is transmitted. Scientists throughout the world are of the view that, HIV is transmitted through sexual contact, blood as well as from infected mother to child. Despite intense international scientific scrutiny, no evidence has emerged to suggest any other modes of transmission.

Epidemiological studies concluded that HIV may be transmitted by infected individuals in any stage of illness, as the virus is found in a variety of blood fluids and substances such as semen, vaginal secretions, tears, saliva, and urine. However, although HIV is sometimes present in fluids such as tears, saliva, and urine, they are not considered

significant routes of infection because they are considered as fluids with low viral concentration.

The HIV virus can be transmitted to most people through body fluids that are considered as fluids with high concentration. Those fluids are blood, semen and vaginal secretions.

2.10.1. BLOOD

Infection with HIV through blood takes place when infected blood enters into the body of another person. For infection to take place, HIV infected blood must bypass the barrier of the skin and enter directly into the body. Infection occurs in most cases if someone's skin has a cut, since neither blood nor virus can penetrate an intact skin. Transmission through blood is apparently not a real risk for most people. However, the most important factor to note is that transmission of HIV virus through blood is possible.

Following a different ways in which the blood infected by the virus can be passed from one person to another.

A. BLOOD TRANSFUSION

Receiving blood contaminated with HIV will mostly probably lead to infection. Many people in other countries have contracted HIV from blood transfusion (Hubley, 1992), but this was before the introduction of screening of all blood donations. Thus, the screening of blood then reduced the likely - hood of one contracting the virus through blood transfusion.

Mann (1988) point out that, the introduction of testing blood is conducted in many countries. Thus, the numbers of AIDS cases through blood transfusion have decreased.

Although the testing of blood is useful, there are still some problems encountered. Looking at the fact that, it takes weeks after infection for the body to produce antibodies, it can be later found that the blood of the infected person donated during this period, and the results can likely be negative. In this regard the test used does not remove all the possible risks for transmission but reduce it.

B. NEEDLE AND SYRINGE SHARING

According to Senyaapelo (1994), abuse of drugs is becoming an increasing problem among young people in South Africa. This, according to Schoub (1994) may increase the rapid spread and high prevalence of infection, as HIV epidemic in intravenous drug abusing population has often been characterized by a very rapid high prevalence of infection.

When drug dependents inject drugs, they frequently draw a small amount of blood into the syringe. If the same needle is used by another person, the blood together with any HIV infection is conveyed to the next person. That is how contaminated blood can bypass from person to person through intravenous drug injection. Taking this in to consideration, intravenous drug users may be considered a group at risk.

C. INJECTIONS

According to Schoub (1994) to date, twenty eight (28) doctors have been documented to have contracted AIDS through using syringes and needles that are not properly sterilized. This is because health workers frequently came in contact with HIV infected persons and ca accidentally prick themselves with injection needles. In practical, according to Kaplan and Sadock (1991) only a very few cases of infection of health care workers have been reported. There are also precautionary measures that are introduced, which also decrease the possibility of transmission.

2.10.2. SEMEN AND VAGINAL SECRETIONS

According to Hubley (1992), HIV has been found in semen as well as seminal fluid. Thus, men in general who are HIV infected can infect other people by ejaculating their infected semen into the vagina or rectum. This seems to be the main route for infection during sexual intercourse. Women with HIV in their vaginal secretion can also infect other people during sexual intercourse.

As the virus can also be found in seminal fluid, the act of artificial insemination can also be a source of infection. According to Green and Miller (1986), the majority of Australian women who underwent artificial insemination in the eighties, were found to be infected with HIV. Although this was a problem, in the past, it is apparently no longer a threat as all semen donors are properly screened to ensure that they are free of HIV infection.

It is now considered world – wide that the predominant mode of HIV infection is sexual intercourse. Research shows that 90 percent of all HIV cases world – wide are as a result of sexual intercourse (Evian, 1995). This is an acceptable statement as sexual intercourse is considered a normal part of human existence. In fact, the need for sexual intimacy is regarded by Maslow (1969) as a basic need of the human being.

In contrary, with the emergence of AIDS, sexual intercourse has become a major threat to the survival of human beings.

Having sexual intercourse with a person infected by HIV virus may result in the other person being infected. Hubley (1992) emphasizes that a single sexual encounter can be sufficient to transmit HIV. Although the risk of a single sexual act is said to be low by some researcher, the greater the likelihood of transmission. The likelihood of HIV transmission during sexual intercourse depend on factors which are as follows:

A. HETEROSEXUAL INTERCOURSE

At present heterosexual intercourse is the most common way in which the HIV virus is transmitted. It has been identified as the most preferred method of sexual intercourse (Evian, 1995). At the moment the virus has a strong base among heterosexuals. If that base continues to rise as statistics confirm, many people will be infected resulting into a disaster. According to Nifbrik (1994), vaginal intercourse is a common route for transmission among heterosexuals. Damage or trauma to the vagina increases the changes of transmission of HIV.

The aforementioned facts make heterosexual intercourse a major risk activity for HIV transmission.

B. ANAL INTERCOURSE

Anal intercourse also known as rectal intercourse is defined as "sexual intercourse were the penis is inserted into the other person's anus" (Universal Dictionary, 1988). This method is also said to be the major risk activity for HIV transmission.

According to Schoub (1994), the receptive partner is especially in danger of acquiring infection because of high frequency of damage to the mucosal lining of the rectum during rectal intercourse. Mouli (1992) points out that although anal intercourse is most common among male homosexual, it is also practiced among heterosexuals. This also implies that some women might be infected in this particular manner.

C. ORAL SEX

There has been no evidence as yet that the virus can be transmitted by means of oral sex. However, during oral sex which takes place into the mouth of the other partner, ejaculation may take place into the mouth of the other partner that may lead to HIV infection. The possibility of infection is even high if there are sores in the mouth of the recipient. Green and Miller (1986) suggest in this regard that oral sex should be avoided until this matter has properly been researched.

2.10.3. VERTICAL TRANSMISSION - MOTHER TO CHILD

According to Scoub (1994) HIV infection may be transmitted while fetus is still in the uterus or during delivery process. Infection may also take place after birth or as the baby ingest milk from the mother. According to Hubley (1992) the overall risk of vertical transmission is approximately 30%. The transmission from being infected to the development of AIDS and

death is much faster with babies than with adults (Hubley, 1992). According to Evian (1995) most of the children who are HIV infected will die within the first 2 years of life, while some may remain well for a long time and only begin to develop symptoms 2 – 3 years after birth.

2.10.4. MASTURBATION

This sexual act involves the stimulation by hand of the sexual organs "the act of exciting the sex organs by handling, rubbing, ect". Masturbation can either be self stimulation or mutual stimulation where stimulation takes place between two partners. There is no risk of transmission from self masturbation, provided that the semen or vaginal fluids do not come into contact with the sexual organ of another person. Mutual masturbation on the other hand is vulnerable activity. Added to the later, Hubley (1992) highlights that there is a risk if the hand used to stimulate the other person's sexual organ has a cut or sores.

2.10.5. SEXUAL TRANSMITTED DISEASES (STDs)

Sexually transmitted diseases increase the probability of HIV transmission (Hubley, 1992). Sexually transmitted diseases include among others, cancroids, gonorrhea, syphilis and granuloma.

Following the discussion on ways of transmission is the discussion of ways in which HIV cannot be transmitted through, that is called casual contact.

2.11. CASUAL CONTACT

Because HIV is so fragile outside the body, transmission requires direct contact of two substances: fluid containing infection from an infected person and susceptible cells (usually via blood stream) of another person. Thus, the virus cannot infect or be transmitted to another person through casual contact.

According to Fan, Conner and Villareal (1996), casual contacts are defined as "the type of ordinary, everyday, nonsexual contacts between and among people". These include acts or activities such as shaking hands, hugging, kissing, sharing eating utensils, sharing towels, sharing napkins, using the same telephone, using the same toilet seat, ect.

Because HIV is quickly inactivated outside the body and it cannot penetrate normal intact skin, and does not readily enter through a healthy mouth, eyes, or ears (Evian, 1995), it cannot survive in the open air or in water.

Following the discussion on casual contact will be a discussion on people that are regarded to be at a greater risk of infection.

2.12. RISK GROUPS

Risk group id defined by Hubley (1992) as "a population exhibiting risk factors related to the disease occurrence." The researcher has identified two of such vulnerable groups, which are as follows:

A. SCHOOL CHILDREN

Today's children become sexually active in their early teens, according to Senyaapelo (1994). The youth consider teenage years as a time of sexual experimentation. These unfortunately result in many unwanted pregnancy as well as HIV infection. Therefore, they are regarded as a risk group of acquiring AIDS.

B. PROSTITUTES

The spread of HIV among prostitutes provides a good indicator of the spread of AIDS especially among the heterosexual population. The prostitutes and their clients are therefore regarded

traditionally as the most vulnerable group for AIDS infection because of their unusual sexual behavior (Ruitenberg, Van der Boom & Jager, 1992) on account of the larger number of changing sexual contacts within the prostitute world, HIV can be transmitted to a larger number of clients.

CONCLUSION

In this section it was clear that the main modes of HIV transmission are through sexual contacts and blood, and casual contacts are of no risk to HIV transmission. It was also indicated that heterosexual contacts are said to be the main contributors towards HIV even though they were regarded as normal contacts. Two most vulnerable risk groups that may spread the disease seems to be prostitutes and school children.

ATTITUTES AND PERCEPTION OF PEOPLE LIVING WITH AIDS, HOW THEY ARE DEVELOPED AND MAINTAINED

This section intends to discuss how people living with AIDS developed and maintained their attitudes and perceptions towards health care providers and community members. It will also pay attention to HIV/ AIDS as a terminal ill disease, and how people living with AIDS can cope with the disease. The psychological intervention in helping people living with AIDS will also be discussed.

2.13. THE ATTITUDES AND PERCEPTION OF PEOPLE LIVING WITH HIV / AIDS (PWAs)

The concept of attitude has been of interest to many social scientists over years. Words such as feelings, tendencies to react, fears, treats, prejudice and biases have been used interchangeably with or to refer to attitudes. Although there are many definitions of attitude, Ashmore (1975) maintains that, all of this has three common elements namely: that attitude is not directly

observable, that it is an evaluative response, and lastly that attitude in conjunction with individual and situational variables influences behavior.

Lefton (1969) defines attitude as "an enduring pattern of feelings, beliefs and behavior tendencies toward other people, ideas or objects." Furthermore attitudes are established through learning often early in life. They are learned in response to a need for reaction to particular circumstances and tend to be internalized. There are a number of factors that determine attitudes of people. These factors are discussed below with reference to AIDS specifically regarding PWAs.

As the potential magnitude of the AIDS epidemic becomes more widely understood, there has been an outpouring of public fear and concern expressed in a range of responses (Blendon, 1992). Merely mentioning the acronym for Acquired Immune Deficiency Syndrome (AIDS) arouses fear into people. AIDS is an emotive issue because it id associated with high mortality rate that is colloquially referred to as "AIDS is a death sentence."

Now one can ask himself a question "How people will respond or act to one being HIV positive or being a person living with AIDS." According to Evian (1995), most people living with AIDS usually cope with being HIV positive or being ill, but they cannot cope with the bad attitude of people towards them. Thus, they may also develop a negative attitude towards people who are regarded as HIV negative, "those who are not infected."

Attitude of people living with AIDS may also be influenced by the way people perceive the disease. Gilman (1988) in Lesley (1992) states that, people living with AIDS are socially construed as "others in the society." That is, many people believe that AIDS happens to someone else or another group rather themselves or other groups.

Change of attitudes may be affected by denial. According to Silgerson and Peterson (1990), most human beings and PWAs are still faced with a "denial syndrome" of saying "I have no chance of being infected." This therefore makes prevention strategies very difficult to implement. It also makes PWAs not to take precautionary measures for the spread of HIV to other people. Perception is defined by Plotnik (1993) as "the experience of a meaningful

pattern or image that our brain assembles from normally changed, biased, colored, or distorted by once unique set of experience. Perceptions cover the entire sequence of events from the presentation of a physical stimulus to the phenomenological experiencing of it. These include the physical, psychological, neurological, sensory, cognitive and affective components."

According to Reber (1985) perceptions are "collectively those processes that give coherence and unity to sensory input." AIDS is becoming a global problem, and people living with AIDS on the other hand bear a terrible burden. They perceive the community as becoming judgmental and moralistic towards them, and these results in discrimination, rejection, alienation and blame of affected people. According to WHO (1991), on a wider scale discrimination against people with HIV is common. As Dr Jonathan Mann, the then director of WHO AIDS program said "As anxiety and fear cause some to blame others, AIDS has unveiled thinly disguised prejudices about race, religion, social class, sex and nationality."

Even if AIDS discrimination is seen as a serious problem, there have been allegations made to human rights bodies over the past years despite the fact that:

- Most people did not know that AIDS was a prohibited ground of discrimination,
- Some human rights bodies did not accept complains from those who where feared to be HIV positive
- Many people living with HIV / AIDS are afraid to complain for fear of discrimination, and
- Many people simply did not complain, they are more concerned to get accommodation or to seek alternative source of income or health care than they are to take task the person responsible for the discrimination (http://www.bccla.org./position/aids/conclusion.html/).

The media coverage also had an impact on the subject of discrimination against people living with AIDS. In early headlines according to Almond (1990), AIDS was referred to as a "plague." The word plague refers to bubonic / pneumonic plague. Two discrete aspects of plague as an infectious disease are implied by the term: one is that it is contagious, being very easily passed from person to person in a casual setting. Secondly, "plague" also has a connotation of a nasty disease, it kills." So the use of the word implicate conveys separate notions.

Only one of these is applicable to HIV and AIDS. AIDS is a very unpleasant typically fatal disease resulting from HIV infection, but HIV is not contagious like plague, it is only transmitted in specific setting of human contact, typical setting of implicit or explicit consent. Thus, the effect of the media become that, people received distorted information which lead to people living with AIDS be discriminated against.

Instead of providing distorted information, the media has to provide accurate information on how the virus is transmitted and how it is not, and also to educate people in all aspects regarding the disease. The media can continue to broadcast stories such as Phamokate, a Sotho version story about AIDS, Soul City an educative program etc., which may provide people with accurate information about AIDS.

People living with AIDS do not only face discrimination, but also suffer stigma and blame. Sir Donald Acheson, Chief Medical Officer at British Department of Health, said in 1986 "Stigma, as we have seen in relation to epilepsy, TB, and leprosy, is an enemy of public policy. It does nothing to help real problems (Almond, 1990).

According to Herek and Glunt (1988), people living with AIDS are given less respect than other people suffering from other serious illnesses. Why is this so? For one reason, because AIDS is a communicable disease, it is easier to blame AIDS victims for being irresponsible. Second, AIDS is often associated with stigmatized people in our society. Another reason for blaming AIDS victims is to rationalize our own fears. By "blaming the victim" we can externalize the devastating disease and pretend it cannot happen to us (Kleinke, 1986) as cited in Ahmed (1992).

Blame according to WHO (1991) is most strong when the disease is associated with behaviors or lifestyles that are wider disparaged. Thus, the widespread prejudice against homosexuals and drug users have lead to HIV and AIDS be seen as just recompense for leading a "deviant" lifestyle or even a punishment from God. Perhaps the most prominent British exponent of this view is Mr. James Anderton, who referred to AIDS as a "self – inflected scourge" and went to claim that "gay men and injected drug users were swirling round in human cesspit of their own making" (WHO, 1991).

Being named as a victim is said to be much painful than anything else in this world. This was indicated by Mark Feldman before his death in 1982. He mentioned that "on November 1 1982, I was just a person, a human being. On November 23, my medical diagnosis and so much of the world labeled me a "victim", then it proceeded to call me a "patient" with AIDS. "Well as many of you know, I am in the process of defining myself. I am a person with AIDS, a human being, not a victim and only a patient when I am in a hospital (Altman, 1986) as cited in (Catalan, Burgess & Klimes, 1995).

Even if the PWAs perceive the society as judgmental and moralistic, they still belong to our society. They need to be loved, cared for and have a sense of belonging to the community as human beings. According to Abraham Maslow (1969), a person who receive love and a sense of belonging will be motivated on these levels, and thus he will long for affectionate relationship with other people, for a place in his or her family and or reference group. Accordingly they will f eel keenly the pangs of loneliness, social ostracism, friendliness and rejection especially when induced by the absence of friends, relatives, a spouse or children.

The aforementioned information outlines the fact that PWAs are discriminated against by our society. Thus, each of us in our society must agree that, efforts to reduce discrimination must remain a priority, because people are still discriminated and isolated, blamed and rejected because they are infected. We need to love them and make them to belong to our society.

The following discussion will be on the effects of AIDS / HIV on people living with AIDS.

2.14. THE EFFECTS OF HIV/ AIDS ON PEOPLE LIVING WITH AIDS (PWAs)

According to Longman Dictionary (1987) effects are "the results or a condition produced by a certain cause." The effects of AIDS / HIV will be discussed paying attention on how they affect them psychologically, physically and socially.

A. PSYCHOLOGICAL EFFECTS

People living with HIV / AIDS are said to experience many emotions which may be confusing and scary. Appendix B outline some of the emotions associated with HIV / AIDS infection. According to Richardson (1989), most people feel shock and disorientation when they discover that they are HIV positive.

They may refuse to accept the diagnosis and become angry. Alternatively, they may blame themselves and feel depressed. They may also feel anxious and anxiety is said to be severe and long lasting. They may become hopeless (Evian, 1995). Denial, isolation, bargaining and acceptance are also some of their emotions (Poos, 1982). Following is a detailed outline of such emotions:

- Living with uncertainty

Uncertainty can be described on three general levels according to Miller (1987). The first concerns the uncertainty felt by people who are HIV positive over, whether they will develop disease related to their infection in the future, and whether they can do something to avoid this. To corroborate on this Evian (1995), mention that, people who are HIV positive have many answered questions such as, when will I become ill, and what illness will I get. The second one concerns the progress of the disease once it has been diagnosed. For Evian (1995), the person may ask themselves whether there will be any treatment for them.

The third level is that uncertainty can also be seen concerning the reaction of the world around the patient to his or her "new" HIV related status (Miller, 1987). Many people had sais that, they fear the response or how people will react when they tell them that they are HIV positive (Evian, 1995). This fear can create just as much misery and psychological distress as the infection itself, particularly if they know that their employers, colleges, friends, lovers are negative in their view concerning HIV / AIDS.

- **Anxiety and Stress**

Anxiety is defined by Sarason (1972) as, "an unpleasant emotional state accompanied by physiological arousal and the cognitive elements of apprehension, guilt and a sense of impending disaster."

It is distinguished from fear because fear is an emotional reaction to a specific or identifiable object. Stress on the other hand, is defined as "a nonspecific response by an organism to demands made on it" (Lefton, 1985).

Anxiety and stress for those who are HIV positive is unavoidable. According to Miller (1987), the stresses facing anyone in life – threatening situations are numerous and often complex. They need to arise simply from the way a person feel about their health, other people will sometimes contribute to or generate stress by the nature of their own reactions.

The important thing about anxiety is that they can mislead the sufferer into thinking that he or she is becoming much worse physically as a result of the infection, when it is actually anxiety that provides the complications. According to Miller (1987), the severity of symptoms experienced may also increase the task undertaken at work, in the home, and socially become harder and less appealing, and take progressively longer to complete. Thus, it becomes a panic attack.

- **Depression**

According to Coleman and Broen (1972), depression is "an emotional state of dejection, gloomy ruminations, feelings of worthlessness and guilt, and usually apprehension." It is inevitable from time to time, and the best thing is to get out of it as quickly as possible, because it is destructive to one's, physically, mentally and emotionally.

Like stress and anxiety, depression is one of the most common human states. Miller (1987) indicates that, it is one of the most common psychological reactions in HIV positive people, especially in the period after infection is first detected.

They become depressed of the following reasons:

- The apparent inevitability of physical decline and future ill – health,
- The absence of a cure, which result in a feeling of hopelessness and powerlessness,
- The limits that the infection and or disease can place on a person's lifestyle, and
- The actual or anticipated social, occupational, emotional and or sexual rejection (Miller, 1987).

However, severe depression can make adjustment to the disease more difficult or long to achieve. This in itself may be problematic as the person may be unable to make important decisions about future conduct.

- **Denial**

Freud says, "no one believes in his own death" and that, "in the unconscious every one of us is convinced of his mortality." This may well be nature's defense in the face of the unacceptability of total personal decay and extinction (Fisher, 1972).

Denial according to Reber (1985) is "a defense mechanism that simply disavows, or denies thoughts, feelings, wishes or needs that cause anxiety." According to Evian (1995), people living with AIDS often have greater difficulty believing or accepting that they have a serious condition. These often result in people not returning for follow – up or continuing with unsafe sexual practices.

Denial may also cause feelings of hopelessness and worthlessness, which may result in thoughts of suicide. For Miller (1987), a person who knows his diagnose, and reasonably informed about the poor prognosis, may develop feelings of denial and depression , which may lead him to make decisions of either to commit suicide or to have the means to do so, if he considers his

situation intolerable. These may be collaborated by the that research reveals that 20% of HIV positive individuals consider suicide during the year following the diagnosis or test results (Farthing, Brown & Staughton, 1988).

- **Sex and sexuality**

Psychoanalytic theory emphasis that sexual energy is the basic motivator of human behavior and is apparent in all human beings (Katchadourian & Lunde, 1980). Thus, the expression of sexuality is a fundamental human need and particularly is driven by biological forces that are difficult but possible to regulate. However, being HIV positive often means, having to make major changes to one's sexual behavior and or the way one have sex. According to Evian (1995), this in itself can be extremely difficult and can stress relationships with lovers and partners. Thus, HIV men and women may need to adjust to different ways of relating to each other.

- **Coping with losses**

People living with AIDS suffer from losses. They loss their health, independence and many years of life. They may also lose their lover or spouse, their job, their financial security, and their usual life and lifestyle. They also need to change their sexual habits (Evian, 1995). This may create feelings of depression, hopelessness and isolation that may affect them emotionally.

- **Coping with death, dying and bereavement**

Few diseases are as frightening to the patients as AIDS and yet, as well as they have to face cruel rejection by their friends, and society, they also have fear of dying and death (Farthing, Brown & Staughton, 1988). According to Poss (1982), when people receive the news that they are HIV positive, they go through a series of emotions. Reaction to the diagnosis may also vary from tears to hostility (Farthing et al, 1988). It may take days or weeks for the person to acknowledge the diagnosis.

According to Bartlett and Finkbeiner (1996), people living with AIDS have other natural responses to the thought of death. They fear the moment when life stops. Most of the fear is actually about what will happen before death. They are afraid that while they are dying, they will be abandoned. They are afraid of loneliness at that time also worry about people they will leave behind, and about relationships left unresolved.

The fact that AIDS occurs primarily in young people makes the prospect of death even more difficult to accept (Parry, 1989). For many, however, the fear of death is not as great as the fear of dying a slow and painful death, isolated from people they know and care about (Richardson, 1989).

Whether death is viewed positive or negative, it can be associated to three constellations as grouped by Farthing et al. (1988):

- The first constellation includes loss, that is, losses of function, health independence, financial security, standard of living, social support, sexual freedom, mental functioning and normal life.
- The second constellation is stress which is related to rational and irrational fears of rejection, abandonment, pain, disability, loss of mental control and transmission of HIV.
- The third one focuses on fear of death and dying. A person who perceives death a peaceful escape from mortal existence will respond differently than a person who sees death as painful punishment or an empty punishment.

Thus, Frankl mentioned that people may face pain, guilt, despair, and death, and in the confrontation challenge the despair and thus triumph (Yalom, 1980).

The fact of death or dying may also develop to a psychosomatic problem. According to Richardson (1989), some people are so consumed by thoughts of death or dying that they may watch daily for symptoms of AIDS. In some cases, the anxiety produced by such thoughts is so great that it develops in to an obsession. Throughout the terminal crises, both hope and fear prevail. The fear of dying often reflects a fear surrounding some aspects of life (Poss, 1982).

According to Yalom (1980), if we defend ourselves against the reality of our eventual death, life become inspid and meaningless. Death and life are interdependent, and though physical death destroy us, the idea of death saves us. Thus, people living with AIDS have to view death positively so that they can lead a meaningful life which Frankl view as a coping skill because it help us understand why we exist. For him a sense of life meaning provides a reason for enjoying good times and tolerating bad ones. Thus, living with your death can clarify the part of your life and increase the quality of satisfaction with living (Almond, 1990).

B. THE PHYSICAL EFFECTS

People living with AIDS are repeatedly ill and their health is deteriorating. According to Evian (1995), HIV slowly damages the immune system, and the appearance and manifestation of the disease is usually related to the degree of immune – deficiency. The person who is infected will usually go through various clinical stages that occur over a long period of time, usually 5 to 12 years.

The stages are outlined by Evian (1995) as follows:

The HIV infected person usually experience a period of good health in which the virus remains "silent", or latent. The phase may last between 3 and 7 years or even up to 10 years. However, even though the infection is clinically silent, the virus is active in the body and the person is able to spread the virus during this phase.

Research shows that between 3 and 7 years after infection, some individuals may develop "minor" symptoms and signs secondary to the HIV infection. These may include signs and symptoms such as, weight loss, occasional fever, chronic swelling of the lymph nodes, which are commonly felt in the neck, axilla and below the jaws often called persistent generalized lymphadenophathy or shrinking of previously enlarged lymph nodes, persistent diarrhea, weight loss – more than 10% of usual body weight, reactivation of tuberculosis may also be associated with this stage of infection, especially in people from low socio – economic communities, where tuberculosis is common.

The symptomatic phase described earlier usually progress over the next years or 18 months into the fully developed AIDS phase of the disease.

From the abovementioned information it is clear that AIDS is not a single disease with a characteristic set of signs and symptoms. It consists and may present with a variety of signs and symptoms. Thus, people living with AIDS often go through stages of being very sick with sever disease, to being reasonably well again due to treatment, and the body becomes progressively weaker with repeated infections. Because of this, they become physically impaired.

C. THE SOCIAL EFFECTS

PWAs are not only affected psychologically and physically, but they also suffer socially. According to Corey (1986), people living with AIDS loss their income, accommodation, they have difficulty in getting access to health and public services. They also lose their jobs and face eviction (Hall & Lindzey, 1970). For Tross and Hirsch (1988), they are often denied policies and other services and suffer prejudice from insurance companies. It is no wonder that people living with AIDS feel like "walking time bombs existing in limbo."

Financial issues form a major worry for the person living wit HIV. According to Miller (1987), there are direct issues such as the difficulty that will arise if knowledge of infection or the impact of disease results in being excluded from regular work, and thus, a regular income. There are also indirect issues of the subsequent status of HIV positive person regarding life insurance, mortgage policies and even retirement or pension benefits. Some people have considered pretty drastic funds raising measures such as, selling their home and or their cars to pay their bills or avoid future worries about paying bills or to help them in settling dept that cannot otherwise be squared.

Some workers have been fired, suspended or involuntarily retired or made redounded as a result of pressure from colleagues, spouse who irrationally fear for the welfare of their children and company. A question may arise, should the employee be diminished, either because he is perceived as being at risk of AIDS or the virus, or because he has shown to be HIV positive?

According to Almond (1990), this can be done if only the employer could either rely on a defense that the employee's sickness and absence fro work justified dismissal, or that there was other substantial reasons for ending employment, such as that other employees were refusing to work with the particular individual. In such a case it may be better to refer the matter to a recognized industrial reconciliation procedure.

The outlined discussion indicates that people living with IDS are really affected even socially because of their diagnosis.

Following is the discussion on how PWAs can manage their disease, perception and attitude towards community members and health care providers.

2.15. THE MANAGEMENT OF AIDS AS A DISEASE, AND THE ATTITUDE AND PERCEPTION OF PWAs TOWARDS COMMUNITY MEMBERS AND HEALTH CARE PROVIDERS

The word management is used often when a person is engaged in doing something that he or she wants to accomplish at the end. According to Reber (1985), management is "the carrying out of functions of planning, organizing and directing any enterprise."

There are a number of factors that one may involve in managing his or her problems, which may be specific to that problem. These factors are discussed below with reference to how PWAs can manage AIDS as a disease and their attitude and perception towards community members and health care providers.

- **Confidentiality**

It is important to maintain confidentiality when working with people living with AIDS. Confidentiality according to Siegal (1979) is an ethical standard that protects clients from disclosure of information without their consent (Sue, Sue & Sue, 1994). The most grisly concern

regarding HIV / AIDS is, should we maintain the confidentiality of the therapeutic relationship or inform others about one being HIV positive? If we choose to disclose this information, just what to tell?

According to Gostin (1996), the HIV epidemic has posed two powerful and conflicting legal and ethical obligations. The first obligation is to respect the privacy of the person with HIV infection. The second obligation is the duty to inform the person who may be exposed to HIV.

According to Gostin (1996), there are strong ethical reasons that exist for protecting the privacy of person who is HIV positive. An important justification for privacy reside on the principle of respect for autonomy. To respect the privacy of person with HIV / AIDS is to respect their wishes not to be observed or to have intimate information about themselves made available to others.

Privacy also enhance the development of trust in the physician. It is one of the defining characteristics of the physician - patient relationship, that involves the sharing of private information (file://A:\confide.html.). Failure to respect the confidentiality of patients may drive them away from HIV testing, counseling and treatment and discourages patients from confiding in their physicians.

Unwanted disclosure of intimate health information can also cause patients a great deal of emotional, social and economic harm. Stigmatization can be a consequence of such disclosure, particularly when HIV infection reveals the person's sexual orientation or use of illegal drugs. Disclosure can cause embarrassment, social isolation, loss of employment or employability, insurance or insurability or housing (file://A:\confide.html.). Thus, confidentiality must be maintained in order for PWAs to manage their illness as well as their attitudes and perception regarding community members and health care providers.

The issue of confidentiality regarding HIV/ AIDS seems to be a controversial aspect. As much as confidentiality must be maintained, the people who may be exposed to HIV on the other hand must be informed. According to Gostin (1996), the privacy principle is being repeatedly tested

with many political bodies in the United States, clamoring for a right to know. For them, one must imagine a variety of circumstances in which such a right is asserted:

- Should a woman has sex or shares injection equipment's with an injection drug user be informed?
- Should a surgeon, obstetrician, or emergency department nurses who risk exposure to a patient's blood be informed?
- Should a police officer, prison guard or the emergency workers be informed of potential risk, particularly if he or she has sustained a needle stick injury?, and
- Should a woman who has been sexually assaulted be informed of the accused serological status?

The strongest claim to a right to know exist where there is an ongoing sexual or needle – sharing relationship. In such cases, the law should give health care professionals a power not a duty to disclose if in their judgment it is necessary to avert a significant risk of transmission. Accordingly, the right to confidentiality should be near absolute in the case in which risk of contracting HIV is remote. Thus, many ethicists believe that, claims by health care professionals, emergency workers, prison guards and others, for this sensitive information should be denied if the patient refuses to consent to the disclosure.

The decision to breach confidentiality according to Hoffman (1991), has three important criteria:

- There must be an identifiable potential victim. Remember the duty to warn extends only to identifiable victims rather than all person's whom the client could conceivably infect.
- Anonymous partners or casual partners who are unknown to the counselor would not fall within the duty to protect principle. Partners who live with the person under a monogamous or exclusive relationship would most likely meet the criterion.
- The assessment of dangerousness must be made. Three factors which need to be clarified under this criterion:

a. The certainty of an HIV infection in the client,
b. The extent to which the client engages in behaviors that carry a high risk of HIV transmission, and
c. The use or nonuse of safe sex techniques.

- **Counseling**

Counseling is the generic term that is used to cover the several processes of interviewing, testing, guiding etc. designed to help an individual to solve problems, plan the future, etc. (Reber, 1985). Counseling PWAs will be of importance to them, as HIV/ AIDS leads to ill health and often to emotional, psychological and social problems. HIV/ AIDS also raised many difficult issues of families and even communities. The infected people and their families, partners or close friends often need support and counseling during this difficult time.

Some of the psychological and social problems according Evian (1995) that may need counseling which affect PWAs are:

- Having an HIV test and coping with the result of the test,
- Coping with feelings of fear, guilt, anger, depression, shame and sometimes blame,
- Adjusting to safer sexual practices,
- Adjusting to the fact of having acquired a serious – life threatening disease,
- Coping with the many uncertainties about AIDS,
- Denial of being HIV infected,
- Coping with illnesses and its effect such as unemployment, etc.,
- Dealing with dying, death and bereavement, and
- Coping with loss.

More information regarding the issue of counseling will be discussed in detail under psychological intervention, that is, how psychologists can help people living with HIV / AIDS.

- **Social support from families, organizations and health care providers**

Many studies show that, social support can lesson or totally eliminate the negative effects of problems one is experiencing (Sutherland & Cooper, 1990). People with a good social support system believe that they are,

a. Cared for and loved,
b. Esteemed and valued, and

c. Belong to a network of communication where others can be counted on to help.

According to Louw (1993), individuals who lack support from family, friends and the community have more symptoms of physical and psychological ill health than those with support. The family is widely accepted as the primary socialization agent. Therefore, Lombard (1990) views the family as the foundation for high morals. Good values must be established at home by parents within the family environment. A prominent feature of an African society is that life is organized around the family. Thus, the family is entrusted with the responsibility of promoting health and improving the quality of life of all its members.

Early involvement of significant others according to Kaplan and Sadock (1991), can strengthen the AIDS support system if cognitive symptoms develop and further impair the patient's functioning. Home care is also promoted as an alternative, particularly in developing countries, but the home is not necessarily the safest place for PWAs as discrimination often happens at home (Evian, 1995). Alternatively, it is important to consider arranging visits by community nurse or a day care centers or hospices organization if they are available.

The organization on the other hand, may also provide social support for PWAs. According to file://A:\behavior/html., organizations develops programs that are often articulated around the following issue:

- Training and counseling for individuals and families,
- Information and discussion on stressful situations in the family,
- Sex after diagnosis, and
- Care of the dependents, children in particular.

Furthermore, the organizations provide with legal assistance, and social welfare advises. According to Kaplan and Sadock (1991), mental health providers are also said to provide social support to PWAs. There are often enlisted in helping patients to deal with legal matters, such as making a will and taking care of hospital and other medical expenses, and they ensure that these matters are addressed satisfactorily.

However, some of the health care providers still have a high degree of concerned about contracting AIDS from patients under their care, in spite of the fact that AIDS cannot be spread

by casual contact. Kaplan and Sadock (1991) states that, these professionals must be identified and allowed to withdraw from caring for AIDS patients if they cannot master their anxiety about working with PWAs.

- **Methods available for physical support**

Even if there is no cure for AIDS, there are drugs that are said to treat opportunistic infection, thus the virus will not destroy the immune system very fast. Drugs such as Azidothymidine (AZT) also called Zidovudine or Retrovir is said to be the only major antiviral agent effective in AIDS (Fan, Conner & Villareal, 1996). According to them, previous laboratory had show that the drug could block HIV infection in isolated cultural systems, and the drug was tested in a clinical trial, which can also be considered an intervention epidemiological study.

This drug has now been shown to reduce the peri – natal HIV transmission to new – born infants. According to Evian (1995), in 1994, research in America and France showed that, the HIV transmission rate was reduced by 66% if AZT was given to:

- The woman during pregnancy from 14 weeks of life,
- The woman during labor, and
- The infant for the first 6 weeks of life.

However, there is still also some concern as to any possible long – term side effects to the infant or to the mother, which still further research. But the results of AZT given at different stages during pregnancy may offer even more hope to HIV positive women and their families. Highly active anti – retroviral treatment (HAART) also appear to be an important therapy for the treatment of HIV / AIDS. Researcher findings indicate that in France, person on treatment increased from 60 to 90% (file://A:\ behavior 1: html.).

The most drawback in the use of AZT and HAART is the problem of affordability of these treatment especially for developing countries. According to Evian (1995), the cost of drugs such as AZT is still a major problem. It is mentioned that in Mexico, AZT cost less than $o,50, while it is almost $7 in Brazil (file://A:\behavior 1: html.).

One may hope that the prices will in future be reduced and make the drug more widely spread as Dr Jonathan Mann states that, "the two most powerful prevention agendas for HIV / AIDS today were finding an effective vaccine and creative social change based on human rights" (Gostin, 1996).

Not only drugs can be of importance in the wellbeing of PWAs, but also self care and the wellbeing program which will be discussed below. Self care and a "wellness' program is also of importance to the wellbeing of the PWAs.

Living with HIV / AIDS means adopting a positive strategy of action, rather than a passive strategy of waiting for the worst. The discussion following will contain tips which will offer ways for developing a working tolerance for the disruptions that infection and disease can bring. Consideration of sensible health measures will be made.

According to Evian (i995), it is important for people living with AIDS to support and help their body to remain well as long as possible. This means that they should try to live a healthy lifestyle. The following are some of the recommended things to do:

- **Lots of rest and sleep**

The PWAs must try to rest regularly and get enough sleep. According to Miller (1987), sleep helps the body to "recharge its batteries" – if we do not get enough sleep, we simply drain our resources. There are times when one cannot get enough sleep, perhaps because of a period of intense socialization or entertainment, and there is always the issue of balancing pleasure to be gained from such activities against the disappointment of not being involved. It is after all, important to enjoy one's life whenever possible, irrespective of circumstances. However, if there are times when doing other things, get in a way of a regular sleep cycle, the PWAs must make sure that there is time made later to catch up on sleep lost. Sleep will also help one to avoid too much stress (Evian, 1995).

- **A healthy diet**

From the moment a person is infected, HIV starts to affect nutrition negatively. The person with HIV is said to use up energy in their attempt to keep the virus at bay and deal with its effects on their body. As a result, the resting energy needs of a person with HIV are 20% higher than a healthy person without HIV (Health.co.za.).

If possible, people living with AIDS should try to eat healthy food, with lots of fruit and vegetables, and a balance diet (Evian, 1995). Research shows that, many people living with AIDS have taken up a new diets in believe that they can boost their immune efficiency by eating certain foods and avoiding others. According to Miller (1987), many people living with AIDS / HIV have take on macrobiotic, vegan, vegetarian, anticancer and other diets, and most reports that, their new food regime makes a significant difference to the way they feel. Their diet excludes red meat, pepper, caffeine, alcohol, sugar and artificial flavorings or preservatives. As a general guideline, a diet plan has been prepared by the Nutrition Department at St Mary's Hospital and is reproduced in Appendix C (Miller, 1987).

By taking control of the eating habits, people can improve the quality of their life enormously. Under nourishment can itself suppress the immune system and cause medication intolerance, complicating HIV virus even further. As research into the effect on HIV on nutrition and the management of HIV through nutrition is still in the early stages, there is much controversy. There is a lot more to know and do.

- **Keep fit and well exercise**

According to The South African Health and Medical Search Engine (1998), it is a well known fact that exercise combats depression and stress. Many researchers have found that, regular exercise helps to lift depression and a general sense of well – being results. What is less known is that, exercise aids the immune system and is an important aspect of nutrition. Exercise helps one to breath, sweat, to get oxygen to all parts of the body, and to build muscles. The exercise and fitness help to keep the body in a good shape and will help the person to feel well and strong (Evian, 1995).

Note that, do not over do it however, (Miller 1987), but it is recommended that exercise must be at least three or four times a week for at least 30 minutes at a time (Health.co.za). Before starting an exercise program, discuss it with a doctor. Exercise should not painful, one should feel great after exercise, not dizzy or tired (Health.co.za – HIV, 1998).

- **Reducing recreational drugs**

From the earliest days of HIV epidemic, the use of recreational drugs such as alcohol and tobacco was thought to be one of the possible causes of AIDS, mainly because using such chemicals creates temporarily lowered immune efficiency (Miller, 1987). Drugs such as tobacco, harms the lung's immunity, thus, respiratory infections account for a large proportion of opportunistic infections. Too much alcohol is often harmful especially to the liver. For Evian (1995), it is important to keep the liver and lungs as healthy as possible.

Other researchers have noticed as association between immune suppression and these drugs. The essential point therefore is that, any drug should be taken only in moderation. Indeed, it is best to avoid their use altogether. People living with HIV / AIDS who have a dependency on "hard" drugs such as heroin or cocaine should ensure that they receive regular advice and support to enable them to withdraw. The use of such drugs is a serious medical matter quite independent of the issue of living with HIV / AIDS, and therefore requires serious medical attention.

- **A positive mental attitude, enjoying yourself**

Many health care workers believe that, a positive mental attitude helps to keep people living with AIDS well for longer (Evian, 1995). Thus, according to Miller (1987), it may sound trite and misplaced, but hundred of people living with AIDS / HIV have affirmed that, their circumstances do not mean the "end of the world' for them. However, once they come in to terms with their diagnosis, it is as though the live of PWAs is starting all over again, with new rules and goals. They enjoy themselves and they take this challenge to heart. They describe this process as "learning to put one self first."

- **Seek early treatment**

It is important for people living with AIDS to seek treatment for medical problems as soon as possible. Thus, many of the conditions will be effectively treated if they are caught early enough. According to Evian (1995), people living with AIDS need to be encouraged to come for treatment as soon as they notice any problem. She further mentioned that, the treatment can keep them well and in a healthier state for longer than it would have been expected.

Now that AIDS is a reality, we expect men and women especially those living with AIDS to make fundamental choices concerning their health lifestyle choices that cannot be made for them – the kind of choices they have not been encouraged to make in the past.

Following is the discussion on the Psychological Intervention, that is, how psychologists can be of help to PWAs.

2.16. THE PSYCHOLOGICAL INTERVENTION

It is a widely acceptable fact that AIDS is a social as well as a psychological problem. It has emerged as a threat to both health, social and psychological well – being of millions of individuals, families and communities. This therefore gives sufficient reasons for psychologist to be actively concerned about this disease and its implication.

Psychology from its earliest beginnings has embraced to recognize a wide variety of behavioral problems such as anxiety, depression, memory disturbance, drug addiction, perceptions, attitudes and other psychologically related problems. The purpose of psychology is to manage people with these problems and in many cases to treat them by various forms of psychotherapy.

Furthermore, the psychologist knowledge about human development and psychological environment places them at a good advantage of helping PWAs with their problems. The most common way to help that can be provided is counseling.

Counseling is defined by Reber (1985) as "a generic term that is used to cover the several processes of interviewing, testing, guiding, advising, etc. designed to help an individual solve problems, plan the future etc.

Tschudin (1991) on the other hand, define counseling as " a way of relating and responding to another person, so that, that person is helped to explore his thoughts, feelings and behavior to reach clearer self – understanding, and then is helped to find and use his strength so that he copes more effectively with his life by making appropriate decisions, or by taking relevant action." Essentially then, counseling is a purposeful relationship in which one person helps the other to help himself.

Counseling will be more important as HIV infection and AIDS leads to emotional, psychological as well as social problems. According to Evian (1995), these problems can cause relationship problems and can arise many difficult issues for families and even communities. The infected people, their partners, members of their families or close friends need support from counselors during this difficult time.

The initial encounter focusing on the needs of the client has its own primary purpose. One of this is to establish a good working relationship between the counselor and the client, which will last throughout counseling (Tschudin, 1991). Relationship will be of vital importance when working with PWAs, as it is mentioned that, they are discriminated against, rejected, isolated, victimized as well as blamed for their condition by our society (Glunt, 1988).

According to Brammer and Shostrom (1968), the relationship is important in counseling because it constitutes the principal medium for eliciting, recognizing and handling significant feelings and ideas which are aimed at changing the client behavior. Thus, the quality of the relationship determines not only the nature of the personal exchanges, but whether counseling will continue at all.

To collaborate on this, Smith (1975), mentioned that, the manner in which the counselor approaches the client in the early minutes of the counseling process can either "make" or "break" the relationship and counseling itself.

According to Cottle and Downie (1970), the relationship must be based on sincere desire to help, by accepting the client as a person worthy of respect and as a person who possess unused capacities for change when the counselor creates a climate where there this change can begin. The client needs to feel that the counselor is expressing verbally and nonverbally "You are good and I like you." Too, the client needs to feel early in the encounter that the counselor is profoundly interested in him with his concern in life (Smith, 1975).

A well established relationship is said to enable the counselor to put the client at ease, so that discussion can take place. The client will be reasonably comfortable physically and psychologically. PWAs need to feel comfortable and relax as most of them experience an ill health with a lot of pain (Evian, 1995). After being made comfortable, the counselor begins with the process of creating a climate of confidence and trust (Evian, 1995). The confidence and the trust must last through the counseling process.

A climate of trust may be created by implementing the skill of confidentiality. When a counselor is able to perceive one's feelings, emotions, problems, etc. accurately, then confidentiality is that which keeps the trust (Egna, 1983). For Tschudin (1991), sometimes the counselor may need to give clients the assurance beforehand that anything said between him is indeed between him only. This will enable the client to trust their counselors, and be able to talk about themselves. Much has been said about this issue, especially with specific reference to PWAs.

As one aspect of helping leads to another and depends on another, so it can be seen that empathy is necessary after exercising confidentiality to the client.

The word empathy is used a great deal these days, like the word counseling it is often used and understood strongly. According to Rogers (1959), empathy is "the abilityto perceive accurately the feelings of another with accuracy, and with the emotional components and meaning which

pertain thereto, as if one where the other person, but without ever loosing the "as if" condition. Basically is, putting yourself in another person's shoes and seeing the world through their eyes or from their point of view.

According to Evian (1995), when counseling people living with AIDS, the counselor need to be sympathetic, as this people are faced with a life – threatening disease. But for psychology, being sympathetic will not bring good results for therapy.

This is outlined by Truax and Carkhuff (1967) who mentioned that, a counselor who excursus sympathy to his client will move quickly or too deep into the troubled aspects of the client's world, thus, counseling will not be affective and appropriate.

As a counselor being empathetic helps you to understand your clients much better. According to Truax and Carkhuff (1967), it gives you the ability to sense the clients "private world' as if it was your own. It also involves more than just the ability to know what the client means, and both the sensitivity to current feelings and the verbal facility to communicate this understanding in a language attuned to the client's current feelings.

If the client trusts you as a counselor, he will be able to part with information regarding his problem. Thus, the counselor will be able to collect information regarding the client problem, as Egan (1986) indicates that, much of counseling particularly in the early stages depends on information. According to Tschudin (1991), when seeking or collecting information, the most obvious tool used is questioning. By questioning the counselor does not only seek facts, but also seek to understand the world of the client. The counselor must observe the client directly when collecting information that will show his feelings and values, interest, attitudes and goals (Cottle & Downie, 1970).

During counseling, the counselor – client relationship involves many things. This may include special relationship problems such as, resistance, transference and counter transference. According to Brammer and Shostrom (1968), transference, countertranference and resistance are said to be the three conditions that may help or hinder the process depending on how they are expressed and handled.

According to Smith (1975), typically, an individual enters counseling with ambivalent feelings. He may be resistance to change and oppose the idea of counseling. Because they feel helpless and hopeless, and some are consumed by thoughts of death and dying, people living with AIDS may resist counseling (Richardson, 1989). Resistance may be viewed as a special defensive form of transference (Brammer & Shostrom, 1968). It is a characteristic of the client's defense system that opposes the purpose of counseling. All the resistance represents the client's refusal to be self – supportive.

By resisting, the client may be avoiding the confrontation of his feeling especially intense negative feelings. For people living with AIDS, confrontation of feelings may be avoided as many of them experience negative feelings concerning life itself and their infection (Evian, 1995). The client - counselor relationship will be enhanced if the counselor is able to exhibit patience, kindness and tolerance as the client struggle wit resistance. The counselor must let the client to perceive him as a compassionate human being and this will encourage him to move from resistance to trust and commitment (Smith, 1975).

Transference as one of the relationship problems, stated by Brammer and Shostrom (1968), may happen without being acknowledged by either side and it is easily disguised. According to Oslo Dorland (1969), transference is the shifting of an affect from one person to another or from one idea to another, especially the transfer by the client to the counselor of emotional tones, of either affection or hostility, based on unconscious identification.

When working with people living with AIDS, the counselor must guard against transference, as HIV / AIDS is associated with behaviors or lifestyle that are disparaged (WHO, 1991). In some instances, the client may perceive the counselor as a negative person who is judgmental and moralistic (WHO, 1991), as other people who are said to be HIV negative. However, if such feelings can be faced and used positively, then they can become integral part of the helping process and lead the client to own the past and the present with a view to being a more whole and "potent" person in the future (Tschudin, 1995).

As transference means that a client projects a feeling on the counselor, counter transference on the other hand refers to "the emotional reaction and projections of the counselor to the client. Cohen as cited in Brammer and Shostrom (1968) or defended hypothesized that, anxiety,

immaturity, prejudice, objects of disgust and punitive tendencies, either felt or defended by the counselor, is the prime source of counter transference behavior. According to Evian (1995), counter transference from the counselor in many instances is a result of religious believes. For her, most counselors who cannot deal effectively with people living with AIDS is because of prejudice of the disease.

Therefore, it behooves the counselor to be aware of the influence which his personality or behavior has on the therapeutic relationship. The counselor should endeavor to provide a permissive atmosphere in which the client and he can express their true and real feelings without fear of being judged or punished.

Transference and counter transference of positive feelings may be viewed as the expression of genuine love relationship between the counselor and the client. The client will begin to love the counselor as soon as he realize that he has found someone – possibly for the first time in his life – who really understand and accepts him just as he is (Smith, 1975). Thus, a reciprocal love relationship between the counselor and the client is posited as the viable replacement for the transference – counter transference model (Egan, 1983).

Many people living with AIDS feel very isolated with their feelings and think that they are alone in the whole wide world, suffer the particular problem and that nobody can understand them (Tschudin, 1991). As a counselor you need to encourage, listen, attend, empower and share with them their experience and problems. The counselor must also reflect their feelings.

Listening is the beginning, the middle and the end of the helping process. According to Brammer and Shostrom (1968), it is something active. Active listening means listening to both the verbal and nonverbal messages of those who came for help. By listening the counselor present to the client that "I am with you, and I want to help you (Moorey & Greer, 1989). By listening to people living with AIDS, the counselor will be able to get a clear picture of the kind of lifestyle they lead and also the problems they encounter.

When troubled emotions appear to be taking over, there is a tendency to "send for the expert" (Scrutton, 1989). We ask for the pain to be taken away. For Scrutton (19890, unlike pain,

feelings cannot be removed with pills. It is only when the individual owns the feelings and takes responsibility for them that they can be dealt with. People living with AIDS are said to experience many emotions (Evian, 1995), after receiving the news that they are infected. Reflection is perhaps the most widely known and useful skill of helping (Tschudin, 1991). According to Egan (1983), reflection means throwing something back and causing it to rebound.

By attending the counselor according to Smith (1975) will be orientating himself towards the client. The counselor will be with person in body, mind and spirit, imparting the sense that the your client is the only person that matters at that moment. What matters is that you are there. Paying attention to the client's body language is the other side of the coin (Moorey & Greer, 1989). Notice his posture, facial expression, breathing, nervousness, eye contact, ect. According to Tscudin (1991), the counselor must also pay attention to what is said and how it is said. This can give him insight that is useful without being aware of it, he gets the insight for free.

Anything unexpected, particularly illness and loss, usually leads to some loss of confidence. People living with AIDS are aware of their illness, in this way they are in touch with negativity, darkness and helplessness (Tschudin, 1991). In many instances they suffer from discouragement, a sense of failure, and loss of hope both in themselves and in life (Smith, 1975). The counselor can employ encouragement as a primary technique with this people. By encouraging, you are gradually putting before them a different mode of life and behaving and out of this, change can happen.

The clients who wants and needs to be helped is helped to see what are the strengths, resources and means already there. As it has been mentioned above, people living with AIDS are hopeless (Tschudin, 1991), they need to be empowered, to be able to live more resourceful and satisfying. This means that they will acquire some self – help skills (Egan, 1986). Empowering is about fostering these skills and making the client independent and ceasing to rely on others.

After being empowered, people living with AIDS need to explore, discover and clarify ways of living a more satisfying life. With the exploration goes discovery. Frankl (1962) believes that meaning is only ever discovered, not created by a person. In order to discover the meaning, a considerable amount of exploration is needed. According to Skinner (1953) as cited in Smith

(1975), when the counselor employs positive reinforcement in the counseling process, he presumes that if the client behavior is followed by immediate rewards, the probability of the client's behavior occurring again is increased.

The body and mind are not the only areas that need care. Often the need for spiritual support as well. The counselor may use bibliotherapy as a strategy for addressing this issue. According to Smith (1975), inspirational literature can be a source of nurture and motivation to the despondent client. Bibliotherapies can be of use as a form of symbolic social modeling to enable clients to see how other individuals cope with the same problem that they have. Evian (1995), mentioned that, the counselor must avoid suggesting this to the client, as it frequently creates anxiety related to imminent death. The request should come from the client.

Coming in terms with one's mortality may rises questions about spiritual and religious matters. According to Kirkpatric (1988), for many people living with AIDS, this is not something with which they are familiar. The client may talk to the counselor about God, and that is not an easy subject for the counselor. The genuineness, warmth and empathy required for all counseling is most needed here too, where often one's bias and own needs are most obvious. According to Carkhuff (1969), counseling is always for better or for worse it is neutral. Egan (1986) is quite sure that, it is not the helping process that is at fault, but the helper.

When counseling has not been successful, when the client gets worse rather than better, then it is easy to take all the blame as the counselor. According to Tschudin (1991), it is very important to be as possible when helping, so as to be able to distinguish between what is your problem and what is the client's. No situation is totally black or white, but a great factor according to Moorey and Greer (1989) involved in counseling include the personality involved, the environment, the health or illness present, etc. Failure, sometimes need to be accepted, and it is painful for both parties. The difficulty is, only when it is allowed to become a blockage to further growth.

Not only individual therapy may help in helping people living wit AIDS, but the counselor may also use group therapy as another method of help. According to Skidmore, Thackeray and Farley (1991), group therapy is a method of working with people in a group (two or more

people) for the enhancement of social functioning and for the achievement of socially desirable goals.

According to Schurink (1990), a group consisting of HIV infected people is of importance. The value of this group is that it is based on the shared experiences and mutual support of the people with the same problem. Tschudin (1991) indicated that, group therapy may be used as a media for assisting the already functional person to achieve greater self – awareness. This awareness in turn can lead to increased effectiveness, greater humanness and further actualization of his potentials.

There are skills or strategies that can be used buy the counselor when working with people living with AIDS in a group setting, and they can be discussed as follows:

According to Brammer and Shostrom (1968), the going – around technique is often used as a warm – up device by the counselor to pitch the communication at a more emotional and less intellectual level. Each member describes his feelings about how his problem affects him emotionally (Brammer & Shostrm, 1968). This will help them to ventilate their problems so that other group members can know and understand their problems.

Modeling is essential as it provides an opportunity for the client to change his behavior by observing and imitating the behavior exhibited by another person (Smith, 1975). Role playing as a skill can also be used.

According to Smith (1975), role playing has many variations but consists essentially of the acting out of exchanges between the counselor and the client concerning anxiety provoking situations in the client's world or life (Wolpe, 1973) as cited in Smith (1975). The immediate objective of the playing is to enable the client to rehearse a new or more effective mode of behavior as often as necessary without anxiety about it consequences. The ultimate aim is to prepare the client to live or function without self – defeating fears and anxieties in his real life. According to Brammer and Shostrom (1968), role playing as a counseling technique often helps the client to gain a better perspective of himself and others.

AIDS is a terminal disease (WHO, 1991), and according to Evian (1995), the counselor may be required to counsel a client about death and dying. Thus, counseling may also be needed for children, lovers, families and friends. The clients and their families often want to and need to talk about dying. The counselor must be open while talking to the client and close relatives about fears, worries, concern and dying (Evian, 1995), especially to the client and family members.

Often a husband, wife, lover, child or close friend may suffer from anxiety, fear, depression and stress. As a counselor you have to keep a lookout for signs of these problems and try to provide counseling.

CONCLUSION

AIDS is not the fail of God. We must not be judgmental of those who suffer from AIDS, but we must try to help them. They are men and women like us, who need our love and care and the help of our society. We must bear in mind that as members of the society, we will not catch AIDS from those we help if we follow sensible rules. What we will catch is an awareness of their loneliness and their loneliness and their rejection by many of our fellow men and women. Even if they feel rejected, there are still methods available for treating the opportunistic infection and the treatment of emotions, thus, the virus will not destroy the immune system very fast. What those who suffer from AIDS will teach us is that, we need to think about our own attitudes towards sex.

CHAPTER THREE

METHODOLOGY

The research methods that are used to accomplish the purpose of the study are as follows:

3.1. RESEARCH DESIGN

Research design refers to the overall plan in which include every aspect of a proposed research study from the conceptualization of the findings (Grinnel, 1988). The descriptive research design was used in this study. The study had to seek to describe the level of attitudes and perceptions of people living with AIDS towards community members and health care providers.

3.2. METHODS OF DATA COLLECTION

Data may be collected through questionnaire, interviews, observation of direct interaction and using available material such as case records and statistical data (Reid, 1984).

- Personal administered questionnaire – an instrument that could be used to observe beyond the physical reach is the questionnaire. Polansky (1976) defines a questionnaire as a common research instrument that comprises a series of questions that are filled by all participants in a given sample. In this study a questionnaire consisting of approximately 28 questions was developed by the researcher (see appendix A).

The questionnaire was compiled in a way that it was composed of attitude statement questions and multiple choice questions where the respondents were allowed to choose one response from several fixed alternatives.

- Experience survey – the researcher contacted the supervisors and the North West Department of Health for more information on the subject.

3.3. SAMPLING

According to Lo – Biondoo – Wood and Haber (1980), sampling is a process of selecting a portion of the designated population to represent the entire population. Subjects who participated in this study were taken from people living with AIDS admitted at George Stegman Hospital in Saulspoort, Rustenburg, North West.

Sampling procedure was a convenient sample of people living with AIDS who were chosen randomly and become part of the practice research experience.

3.4. RESEARCH PROCESS

Before the questioners were administered for the purpose of this study, the researcher had to first familiarize herself 9rapport building) with the people living with AIDS. Rapport building was done through group work. The purpose of building rapport was to enable the PWAs and the researcher to get used to one another and to make PWAs to fell at ease with the researcher so that during the administration of the questionnaire they can easily open – up without hiding much, if any, information.

The process of building rapport took 2 sessions of an hour or more. After getting used to the PWAs, the researcher then administered the questionnaire individually. During the administration, confidentiality was emphasized and the subjects were encouraged to relax.

3.4. DATA ANALYSIS

Data analysis is the categorizing, ordering, manipulating and summarizing of data to obtain answers to research questions (Kerliger, 1980) as cited in (Reid, 1984). Content analysis method and basic descriptive statistical procedures were used to analyze the gathering of data. Content analysis as explained by Reber (1985) is a method for analyzing a discourse, message or document for varying themes, ideas, emotions, opinions etc. while basic descriptive statistics is a procedure for describing, organizing and summarizing sample data.

3.5. ETHICAL CONSIDERATIONS

According to Mc Guigan (1990), the researcher should make a careful evaluation of the ethical acceptability of the research. The researcher should seek ethical advice and observe stringent safeguards to protect the rights of the participants. For this study, the participants were assured of anonymity with no identifying information.

CHAPTER FOUR

RESEARCH RESULTS

INTRODUCTON

Most research studies that have to do with phenomenon of AIDS are often interpreted and discussed with caution, particularly those results that involve the interview of people living with AIDS themselves. Therefore, this study like any other AIDS study is of no exception to the rule of cautionary interpretation and discussion of the research.

The reason for interpreting and discussing AIDS research results with caution include among others, the following: Firstly, AIDS is a controversial issue which has to be treated with caution. Secondly, according to Gostin (1996), there are strong ethical reasons that exist for protecting the privacy of a person who is HIV positive. To respect the privacy of a person with HIV / AIDS is to protect their wishes not to be observed or to have intimate information about themselves made available to others. The issue of confidentiality may put the researcher and the respondent in a state of not providing and receiving more information.

Thirdly, the people living with AIDS may give invalid and unreliable information to the interviewer because they may be suspicious or evoke sympathetic feelings. However, what should always be borne in mind when gathering, interpreting and discussing data obtained from people living with AIDS is that the accuracy of information obtained is largely dependent on the relationship between the researcher and the respondent.

Taking in to consideration the above reservations, a general analysis of the data obtained in this study indicates that the perception and attitudes of people living with AIDS towards health care providers and community members are different in nature. The difference is due to the fact

that similar and different circumstances influence different people living with AIDS regarding their perception and attitudes towards to health care workers and community members.

The themes that emerged from the interviews of people living with AIDS regarding their perception and attitudes towards health care providers and community members were as follows:

4.1. FACTORS RELATED TO HIV / AIDS

4.1.1. Knowledge about the disease

Most of the subjects interviewed reported that they had the knowledge about HIV / AIDS. The subjects interviewed mentioned that they learnt about HIV / AIDS from the media, formal education from school, clinics and churches, magazines and from HIV / AIDS campaigns. The reports given by the interviewed subjects are as follows:

"I first learnt about AIDS at the clinic. Afterwards at school and through media" reported a 20 – year old female who was diagnosed January 2000.

"I learnt about AIDS at work. We were given an educational talk by an AIDS counselor. I also read about it from the magazines. The television also has dramas that taught us about AIDS" reported a 27 – year old male who was diagnosed in 1999.

A 24 – year old female who was diagnosed in 1997 reported that, *"I learnt about this disease AIDS at the hospital. I also read about it from books and magazines".*

"I learnt about AIDS from AIDS booklets, the media and AIDS campaigns held in our town" reported a 30 – year old male who was diagnosed in 1998.

4.1.2. Reaction towards the diagnosis

Reactions towards the diagnosis were reported in different ways by the subjects interviewed. The reactions were reported as follows:

"I was shocked. I felt like killing myself as I thought there is no future ahead" reported a 25 – year old male who was diagnosed in 1996.

A 20 - year old male who was diagnosed in 1999 reported that, *"I felt guilty especially when thinking about the girls I have infected without knowing that I am HIV positive".*

"I cannot tell how I felt that time. I was confused" reported a 26 – year old female who was diagnosed in January 2000.

"if I did not kill myself that time, I will never do it" reported a 21 – year old female who was diagnosed in February 2000.

4.1.3. Sexual intimate relationship before the diagnosis

The sexual intimate relationship of the subjects interviewed before the diagnosis differs. Some were engaged in with casual or multiple partners and others committed to one partner. The reports regarding the sexual relationship of the subjects interviewed before the diagnosis are as follows:

A 24 – year old male who was diagnosed in 1995 reported that, *"I was moving from one girl to another and I was not using a condom".*

"As a young girl, I was moving from one guy to another in searching for Mr. Right. I was never committed to one partner, but this does not mean I was promiscuous" reported a 22 – year old female who was diagnosed in 1999.

"I was engaged I a lot of relationships. I never had a stable relationship" reported a 25 – year old male who was diagnosed in 1997.

4.1.4. Learning about the condition

The majority of the subjects interviewed learnt about the condition through a blood test. The reports are as follows:

"I was ill, I went to a general practitioner who advice me to go for a blood test" reported a 35 - year old female who was diagnosed in March 2000.

"I learnt about my condition after a blood test" reported a 29 – year old male who was diagnosed in 1999.

"I was pregnant, and after giving birth the doctor told me that I was HIV positive. I did a re – test to confirm and the test came being positive" reported a 30 – year old female who was diagnosed in 1998.

"I went for a blood test and they revealed that I am HIV positive" reported a 20 – year old male who was diagnosed in March 2000.

4.2. PERCEPTIONS AND ATTITUDES

4.2.1. Feelings about AIDS as a disease

Seventy five percent (75%) of the subjects interviewed reported that they felt that AIDS was a disease for other people and not them. The reports of the subjects interviewed are as follows:

"Before I learnt about my condition I felt that AIDS was for other people and not me" reported a 39 – year old female who was diagnosed in March 2000.

"I never thought I will be HIV positive because it was said that AIDS is for prostitutes and the gay people" reported a 25 – year old male who was diagnosed in 1999.

"AIDS for me was a disease for white people and not blacks" reported a 27 – year old male who was diagnosed in January 2000.

"People living with AIDS deserved it according to me. I thought they were careless. I never thought I will be one of them" reported a 35 – year old female who was diagnosed in 1999.

4.2.2. Support from family members

The majority of subjects interviewed (60%) reported that their families are supportive to them especially their parents. The reports of the subjects interviewed are as follows:

A 23 – year old male who was diagnosed in 1998 reported that, *"After being diagnosed HIV positive, I was unable to tell my family about my condition. I feared that they will reject me, but after telling them they were there for me especially my parents".*

"At first my family was not supportive. After they got more information about AIDS, they started to care and support me" reported a 30 – year old male who was diagnosed in January 2000.

"My family is supportive, I do not feel rejected or isolated at home" reported a 37 – year old female who was diagnosed in 1999.

"Sometimes I forget that I am HIV positive because of the support I get from my family" reported a 28 – year old female who was diagnosed in 1996.

4.2.3. Feelings towards community members

Most of the subjects interviewed (70%) feels that the community members are not supportive. They feel rejected, isolated and discriminated against. They also reported that they feel shun because of their condition. The reports of the subjects interviewed are as follows:

"I do not feel accepted in the community I am staying in" reported a 19 year old male who was diiagnosed in February 2000.

A 29 – year old male who was diagnosed in 1998 reported that, *"I feel rejected and isolated in my community. I feel they shun me because of my condition."*

"When I feel like going to work I feel like crying as I can sense the rejection there. The community reject, isolate, and discriminate against us people living with AIDS" reported a 27 – year old male who was diagnosed in 1997.

"People living with AIDS are not accepted in our community. People shun us because of our condition" reported a 23 – year old female who was diagnosed in 1999.

4.2.2. Feelings towards health care providers

Majority (90%) of the subjects interviewed reported that they feel accepted, care for and supported by health care providers. They reported that they are provided with pre – test counseling and post- test counseling and knowledge about their condition. The reports of subjects interviewed are as follows:

A 26 – year old female who was diagnosed in 1995 reported that, *"The health care providers are supportive. They provided me with counseling before and after the diagnosis and also with knowledge about my condition".*

"The health care providers are doing their job. They provided me with counseling and knowledge about my condition" reported a 25 – year old female who was diagnosed in 1997.

"I was provided with counseling, support and care by health care providers" reported a 21 – year old female who was diagnosed in March 2000.

A 39 – year old male who was diagnosed in 1996 reported that, *"at the hospital I was provided with care, support, medication and knowledge about my condition. They also gave me information about good nutrition and precautionary measures to reduce the spread of AIDS."*

4.3. PRECAUTIONARY MEASUES

4.3.1. The most effective precautionary measures to prevent the spread of HIV / AIDS

A condom was reported by the majority (60%) of the subjects interviewed as the effective precautionary measure of reducing the spread of HIV / AIDS. The reports of the subjects interviewed are as follows:

"I think a condom is the only precautionary measure that can help to reduce the spread of HIV." reported a 22 – year old male who was diagnosed in 1997.

"I believe that a condom can help in reducing the spread of HIV / AIDS" reported a 33 – year old male who was diagnosed in 1999.

"The most effective method that can reduce the spread of HIV / AIDS is a condom" reported a 36 – year old female who was diagnosed in March 2000.

"Only a condom can help in reducing the spread of HIV as many people cannot abstain from sex" reported a 20 – year old female who was diagnosed in 1996.

4.3.2. Best way of informing people about HIV / AIDS

The best way of informing people about AIDS was reported by the majority (75%) of the subjects interviewed as formal education. The subjects also reported that people living with AIDS must also engage in teaching the community about AIDS. The reports of the subjects are as follows:

"People must be given proper information and not myths about AIDS. As people living with AIDS, we must also teach the community about AIDS as we are experiencing it ourselves" reported a 27 – year old female who was diagnosed in 1996.

"Education is the best method of teaching people about AIDS. What most of the people know are myths about AIDS and not the truth" reported a 29 – year old male who was diagnosed in 1998.

"I think education is the best way of informing people about JIV / AIDS" reported a 39 – year old male who was diagnosed in 1999.

4.4. ADDITIONAL INFORMATION

None of the interviewed subjects gave any additional information they considered significant or that was left – out by the interviewer. Finally, all the subjects interviewed reported that the interview itself was alright when asked to respond bout the whole interview.

CHAPTER FIVE

INTERPRETATION AND DISCUSSION

INTRODUCTION

No research studies have been conducted in South Africa about the attitudes and perceptions of people living with AIDS towards community members and the health care providers. Thus, it must be taken into consideration that this is the first research known to the researcher.

The findings of the research may be biased or unreliable as the researcher could not cover a large population, only a small sample of men and women staying at Saulspoort, in the Rustenburg area.

However, what should be borne in mind when gathering, interpreting and discussing data obtained from people living with AIDS is that, the accuracy of information obtained is largely dependent on the relationship between the researcher and the participant. This is because most of them are likely to give incorrect information to the interviewer. This may be because they may try to protect themselves from the sordid reality of their past and present existence. They may also treat the researcher with suspicion and hostility.

Taking into consideration the above factors, a general analysis of the data obtained in this study indicates that people living with AIDSA have different attitudes and perceptions towards health care providers and community members. These differences are due to the fact that people living with AIDS do not react to the disease in similar ways and also they are not treated the same by community members. Thus, people living with AIDS perceive the health care providers and the community members differently, and hold different attitudes towards them. This will be discussed below:

5.1. FACTORS RELATED TO HIV / AIDS

A large proportion of the subjects interviewed indicated that they had knowledge about HIV / AIDS before their diagnosis. According to Judson as cited in Simbayi (1990), the vast majority of the new cases of HIV infection may occur in individuals who have adequate information about the disease and how to prevent it.

Reaction towards the diagnosis was reported as different depending on each subject. The reactions included feelings of shock, guilt, confusion and desire to commit suicide. According to Richardson (1989), most people feel shock and disorientation when they discover that they are HIV positive. They may refuse to accept the diagnosis and become angry. Alternatively, they may blame themselves and feel depressed. They may become hopeless (Evian, 1995). According to Poss (1982) denial, isolation, bargaining and acceptance are also some of their emotions.

Findings regarding sexual intimate relationship revealed that there were some differences in hoe the subjects were involved. Some of the respondents indicated that they were involved in multiple or casual relationship, when others indicated that they were committed to one partner. Regarding the issue of how they learnt about their conditions, the findings were that most of the respondents learnt about their condition after conducting a blood test.

5.2. PERCEPTION AND ATTITUDES

Feelings about health care providers

According to Kaplan and Sadock (1991) mental health providers are said to provide social support to the people living with AIDS. They are often enlisted in helping to deal with matters such as making will and taking care of hospital and other medical expenses, and they ensure that these matters are addressed satisfactory. A large proportion of the sample stated that the

health care providers provide them with care and support. Thus, they perceive them as good and they hold a positive attitude towards them.

Feelings towards community members

According to Herek and Glunt (1988), people living with AIDS are given less respect than other people suffering from other serious illnesses. This is also because we rationalize our own fears. By "blaming the victim" we can externalize the devastating disease and pretend it cannot happen to us (Klienke, 1986). The research results indicate that people living with AIDS perceive the community as non – supportive and not accepting them, which implies that people living with AIDS may hold a negative attitude towards community members.

Support from family members

According to Lombard (1990), the family is entrusted with responsibility of promoting health and improving the quality of life of all its members. Early involvement of significant others according to Kaplan and Sadock (1991) can strengthen the AIDS patient support system if cognitive symptoms develop and further impair the patient. The research findings indicated that people living AIDS perceive the family as supportive especially their parents. Thus, they hold a positive attitude towards their family members.

Feelings about AIDS as a disease

Before contracting the disease, people living with AIDS were ignorant and careless. After contracting the virus, they indicated that they felt ashamed of being HIV positive, and they believe that people are negative towards them. Thus, the people living with AIDS had a negative feeling towards as a disease and also towards people who were infected. However, they felt that they should teach the community about the disease as a way of preventing the rapid spread of the disease.

5.3. PRECAUTIONARY MEASURES

The most effective precautionary measure to prevent the rapid spread of AIDS is a condom. According to Evian (1995) the best method of reducing the spread of AIDS is a condom. While a condom prohibits the transmission of HIV, its effectiveness as a risk reduction strategy is dependent on the proper and consistent use.

The subjects also indicated that formal education can be the best method of informing the people about HIV/ AIDS. The findings also revealed that people living with AIDS must be involved in teaching the community about AIDS, they must be included in the AIDS campaigns, talks and any other means of teaching the people with AIDS.

CHAPTER SIX

RECCOMENDATIONS

INTRODUCTION

A considerable number of attempts at reducing the spread of AIDS have gained little success. People are still ignorant, careless and do not practice safe sex. As the test findings indicate that most of the PWAs are of the view that they must teach the community about AIDS, the researcher is of the opinion that this will be one of the effective ways of spreading the gospel of AIDS. According to people living with AIDS, prevention may also be the most effective way of reducing the spread of HIV.

6.1. PREVENTION

In the absence of any cure or vaccine, prevention is the only hope for overcoming the fatal disease. Prevention of infection with the AIDS virus requires people to exercise control over their own sexual behaviors. Social efforts designed to control the spread of AIDS have centered mainly on the public about how the AIDS virus is transmitted and how to safeguard one against such infection. Unfortunately information alone does not necessarily exert much influence on health – impairing habits. It has not slimed the obese, eradicated cigarette smoking and it certainly will not make the sexually active people celibate.

To achieve self – directed change, people need to be given not only reasons to alter risky habits but also the means, resources and social support to do so.

In everyday usage "prevention" is a catchall, sufficiently global term embracing three qualitative different strategies, namely: primary, secondary and tertiary prevention strategies (Zak & Cowen, 1976).

Tertiary strategies are programs designed to reduce the effects of AIDS on the HIV infected person. This includes supportive services for AIDS victims and mutual aid groups. The tertiary programs enable the victim of AIDS to cope with the stress of daily living. Although necessary, these programs have little effects on prevention of HIV because they are implemented after infection has taken place. Furthermore, focus is on the victims rather than people who are at risk to contract the virus.

Since the research focus on people living with AIDS, more information has been said concerning tertiary programs. The researcher felt that other strategies would be of importance as AIDS affect everybody.

Secondary prevention on the other hand focuses on medical strategies that seek to reduce the spread of the disease (Cowen, 1983). This involves screening of blood (HIV test) to determine the health status of a person. A common element in all secondary prevention efforts is the sense that systematic early findings will enable people to practice safe sex hence not to spread the disease. However, Hubley (1990) is of the opinion that knowing that one is HIV positive may propel a person to spread the disease possibly because of anger or fear of dying alone. This may increase rather than decreasing the rate of infection.

The alternative approach to prevalence reduction is an attempt to reduce the rate at which new cases of AIDS develop. This approach is formally known as primary prevention. This approach focuses on reducing the rate of infection through promoting healthy sexual behaviors in the community (Mafora, 1991).

Primary prevention of AIDS / HIV may include the following strategies:

Bower (1979) defines primary prevention as "getting children through health, family and school institutions smelling like the rose." This author has outlined a detailed framework for pursuing primary prevention. Primary prevention does not seek to prevent a specific person from being infected, instead it seek to reduce the risk for the entire population. This contention is emphasized by Rea – Grant (1979) who stated that, the primary prevention aim at reducing the incidence of new cases of diseases and improving the quality of life in the target populations.

The most important way to prevent the spread of AIDS is for people to ensure that their sexual life – style do not put them at risk to contract the AIDS virus.

There are three major changes of sexual behaviors that are needed namely: the reduction in number of sexual partners, the use of protective measures during coitus and abstinence.

A. Reduction of sexual partners

Safer sexual practice means having as few sexual partners as possible. In fact there seems to be a general consensus that among experts that sticking to one partner is one of the major ways of reducing the AIDS spread on condition that it is important for both partners to maintain a faithful sexual partnership. Although essential, faithfulness is not enough especially if one partner is already infected with HIV. Therefore, it is a must for a person to know his sexual partners, his state of health, his life – style and his sexual habits (past and present) before engaging in any sexual relationships. This implies that people should avoid having sexual intercourse with people they know little about.

Although reducing the number of sexual partners or delaying sex until marriage is contemplated, the act does not completely remove the risk of infection. It is not impossible to tell from appearance that one is infected or not. In this regard the aforementioned author state that the most effective way of ensuring that a partner is free of AIDS is through testing. Undertaking HIV blood test enable people to know their health status.

B. Preventing the exchange of body fluids during coitus

The AIDS virus is transmitted in the semen and vaginal fluids. If these fluids are prevented from entering the body of the other sexual partner the possible spread of AIDS is minimized. Condoms to a larger extent are the only way to prevent this exchange of body fluids if used correctly during coitus.

While condoms prohibited the transmission of HIV, their effectiveness as a risk reduction strategy is dependent on proper and consistent use. A number of studies show that condoms rupture and slip on even when used properly (Evian, 1995). Furthermore, the risk of busting of condoms increases dramatically to more than 30% of users especially when it is stored in very hot conditions. Other factors such as lubricants (e.g. Vaseline) can destroy the condoms ability to protect.

Although condoms do not provide absolute protection, most researchers believe that when used properly they offer some protection. Unfortunately, increasing the consistent use of condoms has been a formidable challenge. In their studies Seenhant (1992), Kau (1992) and Simbayi (1993) found that the use of condoms is extremely unpopular. It was also revealed that people fail to use condoms because of fear of losing the opportunity for pleasurable sex and romance. The reason for failure emphasize the importance of education.

C. Abstinence

Abstaining completely from sexual intercourse is the safest way of avoiding infection (Hubley, 1992). Although sexual abstinence is the most effective method to prevent the spread and the transmission of HIV, few people adopt to this HIV – preventative behavior. This contention is supported by Sapire (1990) who stated that, the delay in engaging in sexual intercourse is rare in many societies. If a cure for AIDS is not found, this method is will be last option people are left with.

6.2. THE AIDS EDUCATION PROCESS

Informing people about AIDS is not a simple task but a process comprised of five stages. The stages described below are based on those offered by Lombard (1990) in his discussion of facilitating AIDS education.

Stage one (Choosing the target group)

This involves identifying groups that need to be reached in the community. Every target group has different information it needs and will require separate and distinct approaches. For example, adolescents or school children who are said to be the risk group. Therefore, education about safer sexual relationships can be offered to this group.

Stage two (Awareness)

After a target group has been identified, the process of creating awareness can begin. This stage is based on the assumption that once people are made aware of the dangers of the disease, they could start thinking about how to protect themselves. Geen and Moran (1985) support the above contention by starting that awareness is characterized by an increased interest in making the situation better.

Stage three (Dissemination of knowledge)

Once people are made aware of the disease, a need for knowledge is created. Before giving information Lombard (1990) emphasizes that the educator should first determine the present knowledge of the audience and whether they have any misconception or special needs concerning the topic. This can result in alteration of knowledge where they are misinformed.

Stage four (Motivation)

Creating awareness and giving information is not enough to change human sexual behavior. Ways to motivate people to act on the information are also of great importance. Individuals should therefore be motivated to modify their sexual lives in order control the possible spreading of the disease. Lombard (1990) states that, recognizing the value of life and the reality of death can motivate people to change their unsafe sexual habits.

Stage five (Sustainability)

Finally, education need to be innovative and sustained. Messages about AIDS should be ongoing and repetitive. This could be achieved by combining different strategies such as giving talks, seminars, workshops as well as using the mass media. Given the fact that AIDS education should not be treated in isolation, there is a need that education should be incorporated into other various structures other than the school.

6.3. MASS MEDIA – BASED – PREVENTION

Although there are other channels for dissemination of health messages, the mass media remain particularly important since it can in its various forms reach many people. Mass communication includes broadcasting (television and radio programs), print (magazines, newspapers, direct mail etc.) and displays (bill boards and posters).

A. Television

Television is often regarded as a powerful medium resource for delivering messages to the people. The AIDS messages can be delivered in many ways on the television depending on the length and format of the particular program. For example, the effects of the HIV infection may be dramatized in a single episode of a regularly scheduled program.

B. Radio

This is also a major resource for AIDS educators and one that is rather underrated and underused. The radio is probably the only other channel that can reach a large number of people. People who cannot afford a television sets are likely to possess a radio (Mafora, 1991).

C. Local newspaper, magazines and direct mail

Printed communication channels have played a key role for many years as a means for dissemination of information. The advantage of this means of communication is its potential to reach people who do not own a television and a radio. However, the press is not interested in dry facts or unattractive information. To tell the truth AIDS threat requires writing about fairly technical matters with many qualifications and much circumspection. This therefore makes the dissemination of accurate information about AIDS not newsworthy in comparison with more urgent crisis news items. Despite the above mentioned constraints, the press can be used to advertise special events such as seminars and workshops on AIDS to interest people.

For preventive programs in AIDS disease to be successful, the people's participation is vital. There is no doubt that communities can adopt preventative behavior. What is required of educators is to increase their awareness and emphasize on behavioral changes.

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APPENDIX A

QUESTIONAIRE

TOPIC

A SURVEY ON THE ATTITUDES AND PERCEPTIO OF PEOPLE LIVING WITH AIDS TOWARDS COMMUNITY MEMBERS AND HEALTH CARE PROVIDERS OF RUSTENBURG AREA IN THE NORTH WEST PROVINCE

Dear Participants

Briefly, this questionnaire is designed by the researcher to investigate the attitudes and perceptions of people living with AIDS in Saulspoort, Rustenburg are towards the community members and health care providers. The researcher is doing this research for her practical work of her Masters degree in Clinical Psychology. Do not write your name, your responses will be anonymous to make the research confidential.

Your cooperation will be highly appreciated.

Lorna Pilane

INSTRUCTIONS

1. Use x to mark the appropriate block.
2. Choose only one answer.
3. Please try to answer all questions.

A. DEMOGRAPHIC QUESTIONS

1. Sex of the respondent

- Male
- Female

2. Age group

- Less than 20 years
- 21 – 30 years
- 31 – 40 years
- 41 and above

3. Demographic area

- Rural
- Urban

B. PERCEPTION AND ATTITUDE QUESTIONS

1. Which year where you diagnosed HIV positive?

- 1995 – 1996

- 1997 – 1998
- 1999 - 2000

2. How did you learn about your condition?

- Voluntary conducting a blood test
- General check up
- Advice from a practitioner

3. How did you contract the virus?

- Sexual relationship
- Blood transfusion
- Sharing of needles and syringes

4. How did you react towards the diagnosis?

- Were you feeling guilty
- Were you shocked
- Were you ashamed

5. Before you learn about your condition, did you feel that people living with AIDS are:

- Ignorant
- Unfortunate
- Careless

6. Did you have any knowledge about AIDS before contracting it?

- Yes
- No

7. Which precautionary measures did you use to prevent HIV or unwanted pregnancy?

- Condoms
- Abstinence
- Masturbation

8. How was your sexual intimate relationship before?

- Casual
- Multiple partners
- Committed to one partner

9. What type of sexual relationship were you involved in before the diagnosis?

- Homosexual relationship
- Prostitution
- Heterosexual relationship

10. Was it easy to tell your family that you are HIV positive?

- Yes
- No

11. Who specifically is supportive in your family?

- Parents
- Siblings
- All family members

12. People are ignorant about HIV / AIDS?

Strongly Disagree	Disagree	Agree	Strongly Agree

13. People living with AIDS must be treated the same as other people suffering from other diseases?

Strongly Disagree	Disagree	Agree	Strongly Agree

14. I see my family as being supportive.

Strongly Disagree	Disagree	Agree	Strongly Agree

15. I believe people shun me because I am HIV positive.

Strongly Disagree	Disagree	Agree	Strongly Agree

16. I feel accepted and supported by community members especially my friends.

Strongly Disagree	Disagree	Agree	Strongly Agree

17. I think the health care providers talk openly and honestly to me about my condition.

Strongly Disagree	Disagree	Agree	Strongly Agree

18. I see myself as more knowledgeable and understanding my condition.

Strongly Disagree	Disagree	Agree	Strongly Agree

19. I think people living with AIDS are provided with pre – test and pos- test counseling by counselors.

Strongly Disagree	Disagree	Agree	Strongly Agree

20. AIDS awareness campaigns are effective.

Strongly Disagree	Disagree	Agree	Strongly Agree

21. It is good that people living with AIDS should teach the community about AIDS.

Strongly Disagree	Disagree	Agree	Strongly Agree

22. I have to inform others about my condition.

Strongly Disagree	Disagree	Agree	Strongly Agree

23. Does the society you are living in care about people living wit AIDS?

Strongly Disagree	Disagree	Agree	Strongly Agree

24. Are you ashamed of your condition?

Strongly Disagree	Disagree	Agree	Strongly Agree

25. To you own knowledge, which precautionary measure or method is the most effective to prevent the spread of HIV/ AIDS?

- Condom
- Abstinence
- One partner

26. As a person living with AIDS, what do you consider to be the best method of informing other people about HIV / AIDS?

- Media
- Formal education
- Campaigns

27. In your own opinion, what do you think can be done in our society to prevent the spread of AIDS?

- Prevention
- Education
- Other (specify)

28. Whose fault it is, that your HIV positive?

- Partner
- Myself
- Other (specify)

APPENDIX B

SOME COMMON SHOCK REACTIONS TO DIAGNOSIS OR INFECTION

EMOTIONAL

Numbness / "Stunned" Silence / Disbelief

Confusion / distractibility / uncertainty – about the present and future circumstances

Denial ("It can't be true", "Don't worry things will be fine")

Despair ("Oh my God, every thing is ruined")

Anger – towards health staff, loved ones, etc, over impact on life and circumstances

Fear – of pain, death, disability, loss of bodily / mental functioning, loss of confidentiality / privacy

Guilt/ self recrimination – over the association of infection or illness with sexual activity, or being gay or a drug abuser

Acute and sever anxiety

Emotional liability – moving quickly and unpredictably from tears to laughter (and vice versa)

Sadness and morbid concern – for the future, work, lover / spouse / family, health

Suspicion – over the actions and behavior of staff / loved ones / helpers

Relief – at knowing the cause of recent illness is

BEHAVIORAL

Crying – episode an often unpredictable

Anger and irritability – towards anybody, often "sparked off" by trivial and important events (may be physical and / verbal)

Withdrawal – distancing from the present issues and circumstances, reluctance to become involved in conversation, activities or plans for treatment

Self - denigration – referring to self as being "deserving of this plague", worthless, unclean and dirty"

Impulsiveness – acting without thought for consequences

Bodily checking – for "signs" of further infection or physical deterioration

Questioning – for reassurance, further information

APPENDIX C

CHOOSING FOOD FOR A HEALTHY LIFE (COURTESY St Mary's Hospital Nutrition and Dietetic Department)

Healthy eating means eating the right foods in the right balance and the right amount. Food provides you with **energy, protein, vitamins and minerals.**

WHAT ARE THE BEST FOODS TO CHOOSE?

Protein Foods. Protein plays an important part in the growth and the repair of the body tissue. Protein foods are: meat, fish, eggs, cheese, milk pulses (e.g. kidney and haricot beans) and nuts. These foods also provide you with a valuable source of iron, especially red meat and offal. Iron is needed for health blood. Milk and dairy product are also good source of calcium, which is needed for growing bones and teeth.

Vegetables and Fruits. These foods provide vitamins, particularly vitamin C, for vitality and to keep the body tissue in good repair. They also include many minerals. Buy fruits and vegetables fresh whenever possible, but frozen vegetables do provide a good alternative. Dietary fiber is also present in many vegetables, including frozen and canned peas and beans, and in fruit.

Fats and oils. Oils, margarine, butter, lard, etc. these foods are high in calories. Butter and margarine provides vitamin A and D. "Hidden fats" are also found in chocolate, crips and salad dressings.

Starchy foods. Bread, cereals, potatoes, rice, pasta, breakfast cereals etc. These foods provides energy, iron, calcium, protein and B vitamins. They are also a very good source of dietary fiber and you should aim to:

USE THIS FOODS	INSTEAD OF
Whole meal flour	White flour
Whole meal bread	White bread
Whole grain breakfast cereals	
Whole grain biscuits	
Crisp bread	Rich tea, cream crackers
Whole meal pasta	White pasta
Brown rice	White rice

Beans and pulses are also a very good source of dietary fiber

Liquid. Aim to drink plenty of liquid each day, especially water. It is essential for all body functions.