AN INVESTIGATION INTO THE KNOWLEDGE & ATTITUDES OF THE COMMUNITY TOWARDS PEOPLE LIVING WITH HIV/AIDS

BY LORNAH REFILWE MPHO RAKOMA

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL SCIENCES IN SOCIAL WORK IN THE DEPARTMENT OF SOCIAL WORK IN THE FACULTY OF HUMANITIES AND SOCIAL SCIENCES AT THE UNIVERSITY OF NORTH WEST

SUPERVISOR : PROF. W.W. ANDERSON

DATE : JANUARY 2001

MMABATHO, 2001

TABLE OF CONTENTS

CHAPTER TWO

LIST OF TABLES

DECLARATION

I declare that the dissertation for the degree of Master of Social Science in social work at the University of North West hereby submitted, has not been accepted in any previous application for a degree at this or any other university, that is my own work in design and in execution and that all material contained therein has been duly acknowledge in the bibliography.

L.R.M. Rakoma

ABSTRACT

The study investigated the knowledge and attitudes of the community towards people living with HIV/AIDS. The 1994 World Health Organisation (WHO) statistics showed that 50% of all people living with HIV/AIDS worldwide are aged 15 – 24. Statistics from all Sub-Saharan countries on HIV show the same trend. The South African youths are of no exception; they are therefore an important intervention strategy group since they are part and parcel of the community. Most of the people who are living with HIV/AIDS are rejected, ostracized and discriminated against by their families, friends, relatives and their partners. Many such people living with HIV/AIDS have been abandoned. In the years to come people must in addition expect a huge influx of people living with HIV/AIDS due to the absence of a cure or a vaccine to prevent people contracting HIV. The findings that the community still lacks the right information on HIV/AIDS. They also have a few misconceptions about the epidemic.

The study recommended that government has to come up with a legal framework to deal with issues related to AIDS. There is also a need to set up fund scheme for people living with HIV/AIDS. Communities need to mobilise support for relief schemes for people living with HIV/AIDS and encourage care and support. The NGO's need to embark more on lobbying and advocacy for law, legislation, policies, and regulations governing the welfare of people living with HIV/AIDS and their rights in general.

ACKNOWLEDGEMENTS

I wish to express heart felt thanks, sincere gratitude and appreciation to the following people and institutions for making this study a success and for allowing me to reach my goal.

Thanks to the Almighty God for giving me sustenance throughout my study. I am indebted to my ever-present and generous supervisor Professor W.W. Anderson for helpful and stimulating guidance.

I am also indebted to Dr Chipfakacha and Mr Bob Moepie for reading this research and for offering valuable suggestions.

I must also thank the University of North West especially the Department of Social Work for allowing this research information to be carried out.

I thank my parents, Johannes & Elizabeth Rakoma for their extremely precious support and inspiration in the time of difficulty when I needed them most and for taking care of my child Tlotlo while I was absent from home completing my study. I also thank my younger sisters Gloria, Jennifer & Portia, who invaluably supported me in this arduous endeavour.

Finally, my profound gratitude to Mrs Thandi Manong for her secretariat support, and Mr. Andrew Duvel for editing this manuscript.

Miss L.R.M. Rakoma

Phokeng

ADDENDA

Addendum (i) A Questionnaire For The Community Including Hospitals, Business and Schools.

Addendum (ii) Application letter requesting assistance in gaining information regarding the knowledge and attitudes of the community towards people living with HIV/AIDS from hospitals.

Addendum (iii) Application letter requesting assistance in gaining information regarding the knowledge and attitudes of the community towards people living with HIV/AIDS from business sectors.

CHAPTER 1

1. GENERAL INTRODUCTION

It has been over 19 years since the discovery of the Human Immunodeficiency Virus (HIV) as the cause of Acquired Immune Deficiency Syndrome (AIDS). It is well established that HIV is acquired from the transmission of infected body fluids from one individual to another by sexual contact, contaminated blood or blood products or contaminated or unsterilized instruments. Infants can acquire HIV from infected mothers during pregnancy, at birth, or through breast-feeding. It is well documented that HIV is not transmitted by casual person-to-person contact at home, at work or socially. In particular, HIV is not transmitted through physical contact (such as hugging, cuddling or caressing) that does not give an entry to sexual secretions. HIV has not been shown to be transmitted by mosquitoes or other insects to date.

Despite hope that a cure for AIDS would be developed or an effective vaccine found, the outlook of either of these developments in the near future appears very unlikely. Although a cure or vaccine has not been developed, improvements in the past several years have been made in the treatment of early HIV infection to help prolong and improve the quality of life. Early diagnosis offers early intervention with antiviral drugs along with medicines to prevent or delay some of the AIDS related infections. Prevention remains the primary focus for curbing this expanding epidemic and renewed effort must be made in this area (Health & Medical Information Booklet, 1999:53).

So much has been said about the HIV/AIDS epidemic but the fact remains that it is the number one disease that threatens the existence of human lives on earth. Worldwide, there are an estimated fifteen million people infected with HIV and this number is predicted to increase by the year 2000. The majority of people infected now and those likely to be infected in the future are young adults between the ages of 25 and 44. They are South Africa's present and future workforce. In fact, 50 percent of our nation's 121 million workers are in this largest age group at risk. Particularly at risk for HIV infection are adolescents due to the combination of a tendency to experiment with sex and drugs coupled with a personal sense of invulnerability. This is a great concern. Even with preventive programs to educate adolescents about the risk factors of HIV infection, they frequently fail to translate knowledge into action (Health and Medical Information Booklet, 1999:55).

Therefore, AIDS is everyone's issue. As a result, it requires a response rooted in a commitment to challenge all our attitudes, assumptions, fears and prejudice and traditional approaches on every related issue and to come up with truly new solutions which are in everyone's interest. The more you know, the safer you will be. It is crucial that we all, regardless of who we are, understand the disease. This disease is on the loose and gains momentum gradually due to the fact that there are many prevalent misconceptions attached to it and as a result many lives are at stake.

Without minding the reported number of cases, there is little doubt that, without a change in personal habits and practices, AIDS could read epidemic proportions. The following section focuses on the statement of the problem.

2. STATEMENT OF THE PROBLEM

The problem area in this research centres around the attitudes of the community towards people living with HIV/AIDS. People living with HIV/AIDS are probably discriminated against and relegated to a position of nothingness once it becomes known that they are infected with the disease. These problems include discrimination which is common at the workplace, in hospitals, in schools and the community in general.

A study undertaken by the Alexander Forbes AIDS Consulting Unit, on behalf of Lonrho Platinum Division revealed that the first cases of HIV infection among Lonrho Mine employees probably started in the 1980's, growing to approximately 1722 HIV positive cases by 1986. The company reasonably assumed that the first AIDS cases started presenting themselves in the late 1980's, rising to approximately 270-350 cumulative cases by the year 2000 and about 2000 cases by 2004 and to approximately 5000-5500 cumulative cases by 2009/10. The future implications of the above HIV/AIDS epidemic statistics are very serious. There is likely to be a massive loss of employees in the years ahead especially in this year 2000 and onwards. Furthermore, in the workplace, employers may be reluctant to employ people living with HIV/AIDS as this will impact negatively on the productivity of such a person per sè and the company or agency to a large extent.

Although at present it may seem that the educational authorities have not taken a definite stand on the admittance of learners in schools, learners with HIV/AIDS are admitted at different schools. Hospitals may also not afford to contain a terminally ill AIDS person having in mind the expenses to be incurred in the attempt to manage the disease. Furthermore, medical personnel may find it difficult to examine such a

patient for fear of being infected and thus choose to keep a safe distance. The community may attach a stigma to an AIDS victim such as blaming the victim for his or her own demise.

In the years to come it is quite possible that each one of us will know or love someone with AIDS. According to figures recently released, by the turn of the century, the situation will be far worse with an estimated 3,4 - 4,1 million infected people in South Africa and 203 000 deaths from AIDS. By the year 2005, the death rate from AIDS will have risen to over 2,3 million and between 18% and 24% of the adult population will be infected (AIDS Bulletin, August 1992: Vol. 1 No. 1). The greatest increase in HIV prevalence has been in the North West Province, where the rate rose from 8,3% to 13% (AIDS Analysis Africa, June/July 1997: Vol. 8 No. 1). The HIV/AIDS epidemic is still growing in the North West Province with 18% out of every hundred people that are diagnosed positive.

The following are goals and objectives of the study.

3. GOALS AND OBJECTIVES OF THE STUDY

Generally speaking, the purpose of this study is to generate knowledge that can be applied to the field of HIV/AIDS in order to bring about constructive change. It is envisaged that insight into the knowledge and attitudes of the community towards people living with HIV/AIDS and HIV/AIDS per sè, will help improve intervention strategies and lead to the creation and administration of effective orientation and training programmes for people living with HIV/AIDS. However, this research study will be confined to the actual collection, analysis and interpretation of data relating to attitudes towards people living with HIV/AIDS in the Molopo District. It can be

regarded as an applied research rather than a pure research study.

3.1 GOAL

The main goal of the study is to explore and describe contemporary attitudes of the community towards people living with HIV/AIDS and to make recommendations regarding appropriate ways of working together to create positive attitudes towards people living with HIV/AIDS.

3.2 OBJECTIVES

Well-formulated objectives play a decisive role in the achievement of successful implementation. Therefore, the objectives of this research study are as follows:

1. To determine the nature and extent of the AIDS epidemic.
2. To determine the knowledge and attitudes of the community towards people living with HIV/AIDS.
3. To devise measures to create a better understanding of the disease and a greater acceptance of people living with HIV/AIDS by the community.
4. To identify intervention measures to assist people living with HIV/AIDS so as to improve their social functioning.

4. ASSUMPTION/HYPOTHESIS

A hypothesis is a tentative assurance made in order to draw out and test its logical or empirical consequence; it is a tentative explanation. A hypothesis proceeds from a statement of the research problem. It serves as a point of departure and as a

directive for the planned research. It also serves as an instrument for control or measurement which the researcher can use to determine whether he/she is collecting relevant data. In this research study, it is assumed that:

1. People living with HIV/AIDS are discriminated against by the general community.
2. Knowledge of the community about HIV/AIDS infection is minimal despite its wide publicity.
3. People living with HIV/AIDS are unfairly treated in the community.

5. SIGNIFICANCE OF THE RESEARCH

Given the complexity of issues regarding HIV/AIDS and the provision of services to HIV positive individuals, it can be seen that research is needed regarding the attitudes of the community towards people living with HIV/AIDS. Currently little information is available regarding the attitudes of the community towards people living with HIV/AIDS and therefore, the researcher is of the opinion that there is a need for more accurate information pertaining to the attitudes of the community towards people living with HIV/AIDS.

The community needs to accept the fact that people living with HIV/AIDS are on the increase. These people, who are still part of the community, should be assisted to continue functioning. If the attitude of the community towards people living with HIV/AIDS is scientifically determined, purposeful action can be taken to:

- convince schools, employers, hospitals and the community at large not to discriminate against these people.
- create a better acceptance by the general public.

- assist people living with HIV/AIDS to more effectively maintain themselves within the community.

- initiate and maintain an intervention service to people living with HIV/AIDS. Iin this regard it would seem that the social work profession has a major role to perform. By means of the research the researcher hopes to arrive at ways in which discrimination and stigmatisation of people living with HIV/AIDS could be reduced or eliminated.

6. DEFINITION OF CONCEPTS

In the context of this research the following concepts are defined:

6.1 ACCEPTANCE: According to Wolman (1989:3) acceptance refers to a positive attitude towards an idea or judgement. A relationship or attitude that involves recognition of an individual's worth without condoning or condemning the person's behaviour or verbatization and without implying emotional attachment.

6.2 ATTITUDE: Attitude being an abstract concept is difficult to define. However from literature the following explanations became evident:

- An attitude refers to a learned, stable disposition, general or specific, negative or positive towards classes of behaviour, people or things. Attitudes are often seen in terms of affective, cognitive and behavioural dimensions (Golden, 1984:71).

- A way of regarding a disposition or reaction to situation (Oxford

-

- Reference Dictionary, 1986:52).

Eagly and Chaiken in Lippa (1994:214) define an attitude as a learned evaluative response, directed at specific objects, which is relatively enduring and influences and motivates our behaviour towards these objects.

Attitudes are general evaluations people make about themselves, other persons, objects or issues. A tendency to respond toward or to a react against any idea or object (Van Rensburg, 1991:20). An attitude is a positive or negative orientation toward an object, and it can be strong or weak (Weisberg, Krosnick & Bowen, 1996:13).

Attitudes are made up of:

- a belief
- a feeling
- a way of behaving

People's attitudes are expressed as opinions and beliefs, that is, how they evaluate what they perceive, and how they are likely to respond. An attitude is one of the important elements on which a culture is built.

Attitudes are enduring non-verbal features of the social and physical world. They are acquired through experience and exert a directive influence on subsequent behaviour. They have been shaped by means of socialization, including classical conditioning, operant learning and observational learning.

This study focussed specifically on contemporary attitudes of the community towards people living with HIV/AIDS.

Although formal definitions of attitudes vary, most contemporary theoriests agree that the characteristic attribute of attitude is its evaluative (positive-negative) dimension (Oskamp in Kerb & Schmidt, 1993:41).

6.3 COMMUNITY

Swill (1982), cited in Social Work Practice Vol. 2, 95, highlights three levels at which the term community may be used:

- Geographical community: Representing people within a defined geographical boundary, for example, an informal settlement could be called a geographical community.
- Functional community: This refers to specific groups which exist within defined geographical communities, for example women or youths within an informal settlement.
- Communities of common interest: These communities are made up of defined specific groups across geographical boundaries, for example, members of a saving club who do not necessarily live in the same areas.

6.4 EMPLOYER: - A person or concern that employs persons for wages or a salary (Universal Dictionary, 1988:506).

6.5 EMPLOYEE: - A person who works for another in return for financial or other compensation (Universal Dictionary, 1988:506).

6.6 EMPLOYMENT: - The act of employing - The state of being employed. The work in which one is engaged, a business or a profession (Universal Dictionary, 1988:506).

6.7 HOSPITAL: - An institution providing medical or surgical care and treatment for people who are ill or injured, obstetric treatment for pregnant women, psychiatric treatment for mentally ill, and the like (Universal Dictionary, 1988:745).

6.8 SOCIAL FUNCTIONING

Social functioning includes the activities that are essential in satisfying relationships in the variety of social experience of daily living. Interaction among individuals, groups and social systems is a continuous process. Any obstacle to role performance creates a problem in social functioning (Skidmore, 1988:25).

6.9 WORKPLACE/BUSINESS

The occupation, work or trade in which a person is engaged. Commercial, or professional dealings, the buying and selling of goods or services. Any commercial establishment, such as a shop or factory (Universal Dictionary 1988:220).

7. LIMITATIONS

Although the research study has some significance, it also has limitations. Limitations are obstacles that the researcher can come across and such obstacles can affect the research outcome. It is accepted that an early identification of stumbling blocks helps

the researcher to adjust his/her plan of action.

Due to the sensitivity of the research study it is possible that the respondents were not truthful in giving their responses. Presumably most respondents gave their responses based on what they thought was the right answer and therefore truthful answers may not have been given.

It was further accepted that most of the respondents have never seen a person suffering from full-blown AIDS, therefore their responses were not based on practical experiences. With greater exposure to AIDS cases the responses may have been different.

There is lack of information and insufficient literature on the knowledge and attitudes of the community towards people living with HIV/AIDS. The researcher therefore had to rely to a greater extend on her own empirical findings.

8. RESEARCH METHODOLOGY

According to Mitchell (1979:25) methodology refers to the techniques that a particular discipline uses to manipulate data and to acquire knowledge. Bailey (1987:37) has indicated that methodology is the philosophy of the research process. Included in this philosophy are the assumptions and values that serve as a rationale for research standards or criteria the researcher uses for interpreting data and reaching conclusions.

The research method in this study was primarily descriptive in nature in the sense that it goes further than simply generating ideas and tentative hypothesis about the

research questions. It seeks to accurately describe certain aspects of the community's attitude towards people living with HIV/AIDS.

Given the scarcity of local literature and research findings available on the specific subject, one can assume that the subject of the study is relatively new and unstudied and requires further exploration to yield new insights. The research methods and procedures that were used to accomplish the purpose of the study are as follows:

8.1 RESEARCH DESIGN

The research started with the identification of gaps in knowledge and problem formation. In order to establish guidelines for the investigation of the problem a set of planning decisions become important. Planning decisions form the design of the study which make up a logical strategy for accomplishing the purpose of the study. Rubin & Babbie (1993:334) add that a survey design is probably the best as it provides the most available data to the social scientist interested in collecting original data for describing a population too large to observe directly. Furthermore, they point out that surveys are "excellent vehicles" for measuring attitudes and orientations in a large population.

The descriptive research design was used in this study. A descriptive research design is the one which describes the characteristics of a population when the characteristics of interest are known (Reid, 1984:71). It is used by investigators in order to make accurate statements about the characteristics of the individual situation. When using the descriptive approach the researcher does not manipulate any of the variables but instead, the researcher is

interested in describing what is or what was (Bush, 1988:68).

Since the present study is basically descriptive it will seek to describe the level of knowledge and attitudes of the community towards people living with HIV/AIDS.

8.2 METHODS OF DATA COLLECTION

According to Reid (1984:9) data may be collected from questionnaires, interviews, observation of direct interaction and using available materials such as case records and statistical data. In addition literature review and experience surveys can be used to gather available data. McKendrick (1992:232) is of the opinion that efforts should be made to select appropriate measuring instruments for the problem area and to develop validity and reliability for the measuring instruments. The following methods of data collection were implemented in gathering data.

8.2.1 LITERATURE STUDIES

There is a lack of information and insufficient literature on the knowledge and the attitudes of the community towards people living with HIV/AIDS. But for the purpose of this study data was collected from literature that concerns itself with the subject under study, even though the information was insufficient. The major focus in literature is to understand what different authors/researchers have done in regard to the community's attitudes towards people with HIV/AIDS.

Furthermore, literature studies assisted the researcher to gain extensive knowledge of the related issues. This also acquainted the researcher with the previous inquiries into the subject. According to Babbie (1992:11) review of literature can be defined as the systematic identification, location and analysis of documents containing information related to the research problem.

8.2.2 EXPERIENCE SURVEYS

Because of insufficient knowledge and literature it was imperative to interview experts. Interviews were held with the following people:
The researcher held an interview with Prof. Hill from February 2000 to May 2000 and with Prof. Anderson several times between 1999 and the year 2000.

8.2.3 PERSONALLY ADMINISTERED QUESTIONNAIRES

The researcher also employed the questionnaires for data collection. Polanskey (1976:62) defines a questionnaire as a common research instrument which comprises a series of questions that are filled by all participants in a given sample. Singleton (1988:247) stated that personally administered questionnaires may be hand delivered and filled in groups or individually. For the benefit of this study, the respondents filled the questionnaires individually to avoid outside influences. The questionnaires were directed to the ordinary community members including schools, hospitals and employers. They

were pre-structured, made up of attitude statements, knowledge questions and multiple choice questions.

9. VALIDITY OF THE MEASURING INSTRUMENTS

According to Grinell (1988:112) validity is the degree to which the measuring instrument measures what it intends to measure. For the purpose of this study content and face validity were used. Content validity is concerned with the representativeness of the contents of the measuring instrument (Grinell, 1988:112). The researcher utilized content validity because it helps the researcher to reach the objectives and also to work in line with the objectives. Face validity is an assessment of whether or not the measure appears to measure what it claims to measure (McKendrick, 1990:27).

10. SAMPLING

Sampling is a process of selecting a portion of the designated population to represent the entire population (Lo-Biondoowood and Herber, 1980:207). Furthermore sampling determines the extent to which the research findings from the study sample can be generalised to the larger population from which the sample was drawn . Subjects who participated in this study were taken from a population of the community at large, comprising of hospitals, businesses and schools in the North West Province. A simple is a group of subjects selected from a larger group including less than all the subjects in that larger sample.

The type of sample which the researcher utilized was probability sampling. The

sampling method refers to the general term for a sample selected in accord with probability theory, typically involving some random selection mechanisms. Specific types of probability samples include area probability sampling, simple random sampling and systematic sampling .

In this regard, sampling was divided into four groups, namely the general community, hospitals, employers and schools.

10.1 SAMPLING PROCEDURE

A list of all appropriate businesses was secured from the Department of Social Work. From the total number of businesses, 20 businesses were selected by means of a simple random sampling procedure.

A sample of 50 schools in the North West Province were systematically selected where the questionnaires were personally administered with principals.

Personally administered questions were conducted with Matrons and Nursing sisters of the Bophelong, Victoria and Thusong hospitals. In this event judgemental sampling was utilized.

A sample of 104 general community members was selected. Simple random and cluster sampling were utilized in this regard.

11. DATA ANALYSIS

Analysis of data answers the question of "How shall I arrange and order my findings". As this study is basically descriptive in nature, the researcher used descriptive statistics and tables in presenting data. According to Behr (1988:12) descriptive statistics are procedures that are concerned with summarizing or describing data. Descriptive research includes both qualitative and quantitative descriptions of the phenomenon under investigation (McKendrick, 1990:257). Both qualitative and quantitative methods involve using observation and analytic description.

Data describing the frequencies for all responses was arranged as frequency distributions in order to obtain information about the respondents and identify the number of responses received. The responses according to each item were converted into a percentage value and were interpreted. Uni-variate as well as by bi-variate distributions were used.

12. PRESENTATION OF DATA

The study is arranged as follows:

The present chapter is an introductory chapter. It outlines the purpose and research methodology of the study.

Chapter two (2) presents the nature and extents of the AIDS epidemic.

Chapter three (3) concentrates on the knowledge and attitudes towards AIDS.

Chapter four (4) deals with the measures to improve the life-style of people living with HIV AIDS.

Chapter five (5) presents the analysis of empirical data.

The discussion of the major findings, conclusions and recommendations are in chapter six (6).

CHAPTER TWO

2. THE NATURE AND EXTENT OF THE AIDS EPIDEMIC

2.1 INTRODUCTION

Since the 1980s, despite efforts to curb its dissemination, Human Immuno Virus has spread rapidly and silently around the world. By the spring of 1991, the World Health Organisation estimated the number of HIV infections worldwide at 9-11 million. This figure is projected to quadruple by this year 2000, and only one third of the increase may realistically be prevented by a globally co-ordinated control effort (Atlas of AIDS, 1992:38). At the same time, in the absence of a vaccine, probably 5-6 million people will progress to full-blown AIDS, while many more will develop severe, delibitating manifestations of HIV infection.

AIDS is potentially a crisis of global proportions. What gives AIDS a particular power is its ability to represent a host of fears, anxieties and problems in our current, post permissive society. This will definitely be the case as long as no vaccine or effective curative agent is developed and made generally available.

As we are at the beginning of the 21st century, society finds a very formidable public health challenge with the AIDS virus. In many ways AIDS is like most other illnesses which devastate individual lives. AIDS itself is not a disease in the biomedical sense but a syndrome, a complex of symptoms and diseases which results in some, if not all of those infected by HIV, no longer being able to resist infections.

Given the extent of this epidemic people should not imagine that they are divided into those who have HIV/AIDS and those who do not. In fact people are divided into those who know that they are affected by HIV/AIDS, those who do not know or are certain that they are not affected (Berer, 1993:5). This virus and its defeat belong to all people. It is a disease that affects anybody. Since AIDS affects the general population of sexually active adults and adolescents, narrowly focussed prevention strategies are not likely to stop the spread of infection.

2.2 THE NATURE OF AIDS

It is well established that the HIV virus is the causative agent of AIDS and that HIV is a member of a family of viruses known as retroviruses. Species of retroviruses have long been known to infect men and animals and are characterised by the insidious onset of the disease they cause (Cross, 1993:4). Lymphocytes enter into the blood-stream and invade specific blood cells (T-Lymphocytes) which constitute the single key factor in the production of antibodies aimed at resisting disease. Once HIV has established itself within a T-Lymphocyte the virus is capable of altering the normal functioning of the cell and induces the T-Lymphocytes to produce more HIV's at the expense of antibody production (Cross, 1993:4).

2.3 THE PROCESS OF AIDS

The process of AIDS is characterised by six phases.

2.3.1 THE SILENT PHASE/SEROCONVERSION

The body has a vast array of defences against diseases which are

known collectively as the immune system. HIV attacks the system directly and undermines its efficiency by attacking most important cells of the body. Thereafter, the person moves to the first phase of the infection. AIDS is associated with a long incubation period. The typical time between transmission of the virus and appearance of antibodies directed against the virus has been estimated to be 6-8 weeks (Evian, 1995:14). During this stage a person remain infectious simultaneously whilst the virus replication is occurring even though it may not be apparent on testing the blood (Schoub, 1994:88).

During this phase individuals may develop an acute glandular fever, although to others this acute reaction can go unnoticed. The clinical condition is referred to as the seroconversion illness because the problem is non-specific (Evian, 1995:25). Sooner or later the patient emerges to the second phase.

2.3.2 THE ANTIBODY PHASE

Immediately after the silent phase, the infected person moves to the antibody positive phase. This clearly shows that the person becomes antibody positive. During this phase, the infected person looks and feels very well but as time goes on, the viral blood load increases thus the patient progresses to the next phase (Pratt, 1989:43).

2.3.3 THE SYMPTOMATIC PHASE

After three to seven years of infection, a large number of virus particles are produced which consequently destroy enough of the immune system (Evian, 1995:6). At this stage it becomes difficult for the body to defend itself against many infections and cancers. During this time most infected people develop a variety of indicators of ill health. These signs and symptoms are usually referred to as opportunistic diseases. This is because they take opportunities provided by the lowered immune system to infect the body. The immune system at this stage continues to deteriorate and this ultimately in many patients leads to the following phase namely AIDS.

According to Evian (1995:25) it is yet not clear whether all infected people will progress to AIDS, but research conducted in all parts of the universe shows that approximately 80% of HIV carriers will most probably develop AIDS within 2 years of infection.

2.3.4 THE AIDS PHASE

At this stage, the immune system has been severely damaged. Patients are normally treated for a variety of infections and tumours. These conditions are therefore referred to as "AIDS defining illnesses" and are listed in the World Health Organisation's staging system for HIV infection and disease. The time from antibody phase to full blown AIDS ranges from one week to fifteen years and probably longer (Cross, 1994:4). Most people diagnosed with AIDS die within a couple of years (Little, 1973:79).

According to Mogotsi (1996) the period of remission includes treatment of opportunistic diseases encountered in AIDS. Treatment might result in a period of remission and relative good health. The period of remission will alternate with new opportunistic diseases and eventually the patient proceeds to the last phase.

2.3.6 THE TERMINAL PHASE OF ILLNESS

During this phase the body becomes progressively weaker with repeated infections and tumours. Commonly the patients experience premature greying of the hair and wrinkling of the skin. Death usually occurs six months to three years after developing AIDS defining illness (Evian, 1995:13).

It is important to remember that there is a distinction between being infected with HIV and having AIDS. So far, not everyone who has been infected with HIV has developed AIDS. At present it is unknown as to what proportion of people infected with HIV will go on to develop AIDS.

Once infected, it is likely that a person carries the virus for life and therefore can transmit the virus. An interesting feature in relation to immunity is that on the one hand some individuals, even after repeated sexual contact with HIV infected people, have not shown signs of being infected with the virus. On the other hand, there are cases where infection has occurred after only one sexual contact (Gordon and

2.4 THE ORIGIN OF AIDS

The simple answer is that no one knows for sure where AIDS originated from. According to Gottlieb et al. (1989), the history of the AIDS pandemic (occurring worldwide) can be divided into three periods which are terminated as the silent period, initial discovery of AIDS and its global mobilization. The dominant feature of the first period was silence because the HIV virus was unknown and transmission was not accompanied by signs or symptoms. It is pointed out that this period started from the 1970's until 1981 when AIDS was first identified in the United States of America. Since then there has been quite remarkable progress in understanding the disease.

The discovery period according to Whiteside (1990), started in mid 1981 with the first description of AIDS in the United States. In addition, Hubley (1990) stated that AIDS was first discovered in urban populations and not in rural people. He further said that where AIDS has been found in remote populations, it would seem to have been as a result of contact with outsiders.

As the theory, that AIDS was an old disease of Africa, become increasingly untenable, researchers put forward another explanation for the African origin of AIDS. A virus similar to the one which causes AIDS in humans was discovered to be endemic in the African green monkey. The virus seems to have few ill-effects in green monkeys but in a different species of the monkey, macaques, it causes an immuno deficiency syndrome resembling human AIDS (Richardson, 1989:3). The evidence that appeared to support this is that the virus HIV-2 which was found in that animal, was genetically similar to a virus that was found in AIDS victims in California.

Several theories were put forward suggesting ways in which the monkey - AIDS virus could have found its way into humans. One suggestion is that the virus may have been transmitted as a result of people being bitten or scratched by green monkeys, another by eating the meat or even "unnatural" sexual intercourse (Richardson, 1989:9). A common theory is that the virus spread from a breed of monkeys in Central Africa to humans while they were being hunted and skinned for meat.

However, the recognition of a new health problem always has a remarkable story and AIDS was not an exception. According to Jimmy & Bayle (1992) the discovery period (1981-1985) was characterized by relatively rapid scientific advances in understanding of HIV/AIDS, emerging from intense effort by a steadily expanding group of scientific investigators. During this period, the application of already existing concepts and tools to the new problem rapidly provided information from which a realistic world view of HIV/AIDS could be constructed.

Gottlieb et al. (1989) further stated that the third period in global AIDS, and global mobilization started immediately after the first international conference on AIDS in Atlanta (USA) in 1985. However, the global AIDS context in late 1985 and early 1986 was in many ways chaotic. Therefore Hubley (1990) saw the debate about the origin of AIDS as being helpful because it has diverted attention from the important task of prevention.

During this period, according to Lachman (1991:18) the global AIDS strategy of the World Health Organisation was drafted and reviewed in 1987. It was at

broad objectives, namely: prevention of HIV infection, reduction of the personal and social impact of HIV infection and finally, unifying national and international efforts against AIDS.

In summary, there are at least three possible origins of the AIDS virus: (I) it is a human-made virus, perhaps from a germ warfare laboratory; (ii) it originated in the animal world and crossed over into humans; (iii) HIV has existed in small isolated human populations for a long time and given the right set of conditions, it escaped into the larger population.

The following section presents the extent of the AIDS epidemic:

2.5 THE EXTENT OF AIDS EPIDEMIC

AIDS was fist recognised in 1981 in the United States of America in young homosexual men who had kaposi sarcoma and serious infections predominantly pneumocystis carinii pneumonia that were unusual in men in this age group with no underlying disease. Several million individuals throughout the world are now infected with the Human Immuno Deficiency Virus (HIV), which is the causative agent of AIDS. Of these, a large proportion (30-50%) are expected to die within the next 5-10 years of acquiring the infection (Mann, Colebunders & Wabitsch, 1992:2).

By the end of 1981, the year in which AIDS was first diagnosed, 180 cases were reported by the US centers for Disease Control (CDC). Six months later CDC had reported 403 cases from 24 of the 50 United States. Around this time 200 AIDS cases had been noted in Europe, 42 of them in people of

AIDS was initially labelled Gay Related Immune Deficiency Syndrome or GRIDS.

Researchers had by then realised that other individuals besides homosexuals were also at risk as it was found in Africa that the majority of infections were caused by heterosexuals. During the year 1982, the Morbidity and Mortality Week Report stated that the number of cases of AIDS reported in the USA was doubling every six months. The Centre for Disease Control set up a field survey to study the clusters of the disease. They found that all the patients had severe immunological deficiencies and a wide range of opportunist infections and cancers of the tissues of the lymphatic system(s).

In April 1985, an international conference on AIDS sponsored by the US Department of Health and Human Services together with the World Health Organisation declared AIDS to be of epidemic proportions (Panos, 1989:29). It was a new infection but of such importance that Dr Waldemar Pruzanki, Professor of Medicine at the University of Toronto, told a meeting of health care professionals that future historians will have to deal with the disease (Denning, 1992:2).

Few human tragedies in recent history have attracted the world's attention as the HIV/AIDS pandemic. For Africa the spread of the disease comes at a time when many nations are ill-equipped to respond. Crippling famines, internal strife, economic misfortunes and shortage of resources have made AIDS potentially more serious in Africa than on any other continent of the world (Miller & Rockwell, Vol. 10).

The first cases of AIDS were identified in South Africa in 1982 in homosexual men. At that stage, the epidemic resembled the Type I epidemic found in western countries where the majority of infections were amongst homosexuals and bisexual men with a few cases being attributed to intravenous drug use and blood transfusions. Within a short time however, the epidemic began to reflect the Type II epidemic found in developing African countries with the majority of infections occurring as a result of heterosexual transmission associated with increasing numbers of paediatric infections (Monogram for Department of Health, April 1999).

Whilst the epidemic in South Africa initially lagged behind that of neighbouring countries, the situation in many provinces has now reached proportions similar to those found in countries such as Zambia and Uganda which is up to the ratio 1:4 adults infected in some cities (Monogram of Department of Health, April 1999).

In particular there has been a dramatic rise of people living with HIV/AIDS in the North West Province since the beginning of the epidemic in the 1980s. Statistics from the 1988 surveillance on pregnant women shows that the North West Province had moved to position one with regard to the prevalence of HIV. By 1998 more than 35 percent of AIDS cases were reported in the North West Province (Monogram for Department of Health, April 1999). The latter figure reveals an alarming high predicted prevalence of AIDS in the North West Province with serious implications for the future such as the massive loss of people.

2.6 TRANSMISSION OF HIV / AIDS

Many people are concerned about how the HIV, the virus of AIDS, is spread. No one has actually witnessed HIV going from one person to another and so all the evidence of its spread is based on epidemiology. However, much of this evidence is absolutely first class and its findings have gained widespread acceptance (Salus, 1991:6).

Based on available data, scientists have concluded that throughout the world HIV is transmitted through sexual contact. For HIV to be transmitted, infected body fluids must enter the bloodstream of an uninfected person. The only infectious body fluids are semen, blood, vaginal secretions and breast milk. The virus can enter the body through the lining of the vagina, vulva, penis, rectum or mouth during sex. Furthermore HIV can be transmitted through blood as well as from infected mother to child. The above mentioned modes of transmission are the well-known modes of transmission throughout the world and no other evidence has emerged to suggest different modes of HIV transmission. The person is only in danger if he/she comes into contact with these infected body fluids and they enter his/her bloodstream. Body fluids known to be infected with HIV are clearly identified in the following subheadings:

2.7 BODY FLUIDS KNOWN TO BE INFECTED WITH HIV

A. Higher concentration/most people

(i) Semen and vaginal secretions

(ii) Blood

B. Low concentration/some patients

(i) Saliva

(ii) Tears

(iv) Breast milk

(v) Amniotic fluid

According to Mogotsi (1996:36) it is clear that from the above mentioned categories HIV is mostly present in semen as well as vaginal secretions and blood which comprise the most important fluids in which the virus can be transmitted. It is therefore important to look at each of these categories in detail and in the process to also consider ways in which transmission can possibly be avoided.

2.7.1 SEMEN AND VAGINAL SECRETIONS

HIV has been found in greatest numbers (100 to 10.000 infection units per millilitre) within the blood cells of vaginal fluids and semen. This suggests that artificial insemination can also be a source of infection. According to Richardson (1989:65) in 1985, four Australian women who had been artificially inseminated were found to be infected with HIV. This is no longer a problem as it used to be in the past because all semen donors are properly screened to ensure that they are free of HIV infection.

Many researchers believe that the risk of the virus being transmitted from a man to a woman during sexual intercourse is greater than the other way around. This seems to be the main route for infection during sexual intercourse, because semen carries significantly larger numbers of HIV than vaginal fluids. Therefore, men in general who are HIV infected can infect other people by ejaculating their infected semen into the vagina or rectum. Women with HIV in their vaginal secretions can also infect other people during sexual intercourse.

According to Evian (1995:17) 90% of all HIV cases world wide are as a result of sexual intercourse. Therefore sexual intercourse is considered as the predominant mode of HIV transmission. According to Mogotsi (1996:39) this is an acceptable statement as sexual intercourse is considered a normal part of human existence. Maslow (1969) further stated that the need for sexual intimacy is a basic need of the human being. Sexual intercourse has become a major threat to the survival of human beings because AIDS is contacted through unprotected sexual intercourse.

During sexual intercourse, a number of organisms pass from one partner to the other. Having sexual intercourse with a person who is HIV infected may result in the other person being infected. It follows that the more sexual partners one has, the more likely it would be to associate with an infected partner. Sexual promiscuity has been identified as a major factor in the rapid spread of AIDS (Mogotsi, 1996:39).

Laboratory findings, along with overwhelming empirical observations, support the scientific conclusion that the major route of HIV transmission is through human blood and sexual activities involving exchange of semen and vaginal fluids (Stine, 1993:166). The following subheadings are some of the factors through which HIV transmission can result during sexual intercourse.

2.7.1.1 ANAL INTERCOURSE

According to the universal dictionary (1988:310) anal intercourse also known as rectal intercourse is defined as "sexual intercourse where the penis is inserted into another person's anus". Although the pattern of

heterosexual activities, it appears that of all sexual activities, anal intercourse is the most efficient way to transmit HIV. James Segars (1989) reported that the highest rates of anal sex occur among teenagers who use drugs and older married couples who are broadening their sexual experiences.

According to Richardson (1989:93) the walls of the rectum are designed to absorb fluids readily and are very thin. They can easily be damaged during anal intercourse, allowing the virus to enter the bloodstream, carried either by semen or by blood from an injury to the penis. Even if there is no tissue damage, it may be possible for semen infected with HIV to get into the bloodstream during anal intercourse. Schoub (1994:90) states that the receptive partner is especially in danger of acquiring infection because of the high frequency of trauma to the mucosal lining of the rectum during rectal intercourse.

2.7.1.2 ORAL SEX

Only a few cases of HIV infection have been reported where oral sex was the only risk related sexual contact between men or women. Semen, vaginal and rectal mucus and possibly menstrual blood in the mouth or swallowed could cause HIV infection (Berer, 1993:117). This form of transmission could occur when a man or woman sucks or licks a partner's genitals or anus. Transmission risk may be higher if the mouth, gums or throat are irritated, inflamed and/or have open sores, lesions or bleeding, if reproductive track infection is present, or as immune deficiency increases in the partner. The precise risk of oral

practices as well.

2.7.1.3 MASTURBATION

This sexual act involves the stimulation by hand of the sexual organs. Masturbation can either be self stimulation or mutual stimulation where stimulation takes place between two partners (Mogotsi, 1996:42). There is no risk of HIV transmission from self masturbation provided that the semen or vaginal fluids do not come into contact with the sexual organs of another person. Mutual masturbation on the other hand is a vulnerable activity. As mentioned by previous writers there is a slight risk if the hand used to stimulate the other person's sexual organs has cuts or sores. Reducing the chance of infection means eliminating behaviour that could result in contact with HIV.

2.7.1.4. SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases increase the probability of HIV transmission. Sexually transmitted diseases such as syphilis, herpes, chlamydia or gonorrhoea appear to make someone more susceptible to acquiring HIV infection during sex with an infected partner.

The link between HIV and sexually transmitted infections has raised the profile and underlined the urgency of preventing and controlling sexually transmitted infections. It is estimated that approximately four million episodes of sexually transmitted infections occur each year in South Africa. Data on sexually transmitted infections provide an indication of the burden of disease in approximately 60.000 women

Hlabisa is infected with at least one sexually transmitted infection. Of these, 48 percent are asymptomatic, 50 percent are symptomatic but not seeking care and only 2 percent seek care during an illness episode.

Of the handful of women who seek care, only two out of three women are adequately treated. Lack of access to health care services, the judgemental attitudes of health care workers and the stigma associated with seeking treatment (particularly for women), are some of the issues that have adversely influenced the control of sexually transmitted infections in S.A.

2.7.1.5. HETEROSEXUAL INTERCOURSE

Despite the early association of AIDS with gay men/homosexuals and bisexual males, heterosexual intercourse at present is the most common way in which HIV is transmitted, both from men to women and from women to men. The rate at which people are becoming infected through heterosexual contact is increasing faster than in any other category (Little, 1978:82). By the end of September 1990, more than 7,700 such cases had been reported since the beginning of the epidemic.

Heterosexual vaginal intercourse is also an efficient means of virus transmission due to both potentially infected semen and vaginal fluids as well as cervical secretions containing infected lymphocytes. Furthermore damage or trauma to the vagina increases the chances of

Heterosexual intercourse has been identified as the most preferred method of sexual intercourse (Evian, 1995) and therefore HIV transmission is most prevalent among the heterosexual population in South Africa. Furthermore the World Health Organisation stated that 75% of worldwide HIV transmissions occurred heterosexually (Stine, 1993:172). The major risk activity is therefore heterosexual intercourse.

2.7.1.6. FEMALES

Many researchers believe that it is easier for a man to transmit the virus to a woman during intercourse than it is for a woman to pass it on to a man (Richardson, 1989:5). According to Green and Miller (1986:111) the reason for this is that the semen remains in the vagina for a longer period of time. In addition, there are many receptors in the vagina which create a greater possibility for HIV infection. These receptors enable the virus to successfully attach and gain entry into the body cells (Evein, 1995:11). This fact makes females more susceptible to AIDS.

Mogotsi (1996:41) further stated that it is a well known fact that a woman infected with HIV will harbour the virus in her menstrual blood. Sexual intercourse during menstrual periods will therefore increase the possible spreading of the disease.

2.7.2 VERTICAL TRANSMISSION-MOTHER-CHILD

The most biologically intimate association between two individuals is that

newborn baby. HIV infection may be transmitted while the foetus is still in the uterus or during the delivery process. Infection may also take place after birth as the baby ingests milk from the mother.

Hubley (1992:42) stated that the overall risk of vertical transmission is approximately 30%. There is no way of telling in advance which babies will be infected. This is why women who are infected are advised not to have any further babies. The transition from being infected to the development of AIDS and death is much quicker with babies than adults (Hubley, 1992:23) as the child who is HIV infected is attacked by many childhood infections.

The following discussion is based on ways of HIV transmission on people that are regarded to be more vulnerable to infection.

2.8 RISKS GROUPS

Risks groups are populations exhibiting risk factors related to the disease occurrence. The following are such groups that are more vulnerable to the disease and it's transmission.

2.8.1. PROSTITUTES

Prostitutes and their clients are traditionally regarded as the most vulnerable groups for AIDS infection because of their unusual sexual behaviour. In addition, the spread of HIV among prostitutes provides a good indicator of the spread of AIDS among the heterosexual population. Furthermore, prostitutes may not want to inform their clients about their health, and instances of unprotected sex may occur which may result in HIV infection. On account of

can be transmitted to a large number of clients.

2.8.2. SCHOOL CHILDREN

Mogotsi (1996:43) stated that "Today's youth become sexually active in their early teens". They consider teenage years as a time of sexual experimentation. This unfortunately results in many unwanted pregnancies as well as HIV infection. Teens therefore are at risk of acquiring AIDS.

2.9 BLOOD

Evidence available to date suggests that blood may play a role in the transmission of AIDS from one human being to another. Infection through blood takes place when HIV infected blood from one person gains entry 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 bloodstream of the body. Since neither blood nor virus can penetrate an intact skin, infection is highly unlikely, however, infection can occur if someone's skin has a cut. Fortunately the process that protects cuts against infection occurs very rapidly after injury and therefore the likelihood of infection is decreased (Mogotsi, 1996:37).

People should avoid sharing of any device that is used to puncture or cut the skin, for instance, sharing of toothbrushes or wet-shave razors, unless they have been properly sterilized because many people bleed from their gums or may cut themselves when shaving.

Different ways in which the HIV infected blood can be passed from one person to

2.9.1. BLOOD TRANSFUSION

Receiving blood contaminated with HIV will most probably lead to infection. Prior to the screening of blood for evidence of HIV infection and before the introduction in 1985 of heat-treating techniques to destroy HIV in blood products, HIV was transmitted through transfusions of contaminated blood or blood components. Today, the risk of acquiring HIV from such transfusion is extremely small. This has been confirmed by research conducted in many countries which showed that since the introduction of testing blood the number of AIDS cases through blood transfusion has decreased.

Although the testing of blood is very helpful, there are some problems that are encountered. In this regard the tests presently used do not remove all the possible risk factors for transmission. This is because it takes weeks after infection for the body to produce antibodies. If blood of the infected person is donated during this period it is likely that the result may appear to be negative. However, the testing of donated blood, reduces the risk of HIV infection (Mogotsi, 1996:38).

2.9.2. INJECTIONS

The use of syringes and needles that are not properly sterilized may also be a possible route of infection. However, the use and re-use of contaminated syringes is a common practice in several African health institutions where disposable syringes cannot be afforded. According to Schoub (1994:14) to date, twenty-eight doctors have been documented to have contracted AIDS through this way.

being stuck with needles containing HIV infected blood or less frequently, after infected blood contacts the workers open cuts or splashes into mucous membranes (for example, eyes or the inside of the nose). There has been only one demonstrated instance of a patient being infected by a health care worker which involved HIV transmission from an infected dentist to six patients (Journal of American Medical Association, 1997:2). However, the transmission from patient to health care worker or vice versa via accidental pricks with contaminated needles or other medical instruments is rare.

According to Klouda (1989:15) needle-stick injuries undoubtedly present one of the greatest risks of infection for health care personnel. They are often due to lack of attention to the procedure and generally occur when the needle cover is placed over the needle. Recent studies indicate that about 0.4 percent of needle stick injuries result in transmission of HIV (Klouda, 1989:15). This is because health workers frequently come into contact with HIV infected persons and can accidentally prick themselves with injection needles. To prevent accidental injuries, universal blood precautions have been introduced. Since the introduction of precautionary measures the possibility of transmission has decreased.

2.9.3. NEEDLE AND SYRINGE SHARING

HIV is frequently spread among injection users through the sharing of needles or syringes contaminated with minute quantities of blood of someone infected with the virus. Contaminated blood can be passed from person to person through intravenous drug injections and therefore individuals who misuse

contracted HIV infection. However, it should be emphasised that when unsterilized needles are shared by infected intravenous drug users, the risk of transmission is very high indeed. This may be because blood is commonly sucked back into the syringe and then re-injected. If the same needle is used by another person, the blood together with any HIV infection are conveyed to the next person. According to Schoub (1994:112) the "HIV epidemic in the intravenous drug abusing population has often been characterized by a very rapid spread and high prevalence of infection".

2.10 CASUAL TRANSMISSION

Some people fear that HIV might be spread by casual contact. However, no scientific evidence has been found to support these fears. Although researchers have detected HIV in the saliva of infected individuals, no evidence exists that the virus is spread by contact with saliva (Journal of American Medical Association, 1997:1-2). Therefore it would seem that people infected with HIV will not spread the disease to others through saliva, such as through kissing (a deep kiss). However, the risk of infection from so-called deep kissing, involving the exchange of large amounts of saliva is unknown. Scientists also found no evidence that HIV is spread through tears, urine and faeces.

According to Salus (1991:6) studies of families of HIV infected people have shown clearly that HIV is not spread through casual contact such as sharing food utensils, towels and bedding, swimming pools, telephones or toilet seats. HIV is not spread by biting insects such as mosquitoes or bedbugs.

According to the same source mentioned above, even in communities where many

infection. The primary school children are entirely exposed both to mosquitoes, bedbugs and often inadequately sterilized injections. If any of the latter were at all important, some of these children would have been infected with HIV. These studies give us a great deal of confidence in the non-importance of mosquitoes, bedbugs and ordinary social contact as ways of spreading HIV (Salus, 1991:6).

If HIV was being transmitted through other routes (for example through air, food, water or insects), the pattern of reported AIDS cases would have been markedly different from what has been observed so far, and cases would be occurring much more frequently in people who report no identified risk for infection (Journal of American Medical Association, 1997:2).

2.11 SIGNS AND SYMPTOMS OF AIDS

AIDS is composed of many different diseases, and its signs and symptoms vary with the type and severity of the disease process. Many of the symptoms of AIDS are similar to those that occur in common illnesses such as colds, bronchitis and stomach flu. However with AIDS these symptoms are usually more severe and last for a long time. Generally speaking, the following are the common signs and symptoms of AIDS.

2.11.1 PERSISTENT FEVER OR NIGHT SWEATS

Fever is frequently the first sign that something is wrong with the body, usually an infection. The body's temperature is regulated by complex brain mechanisms. Normal body temperature is considered to be 98.6°F, taken orally, but can range from 97°F to 99.6°F. It also varies with age, body location, and time of day. A person may/will have a fever when his/her

may accompany the fevers. Drenching night sweats are characteristics of tuberculosis and frequently occur with AIDS (Gong, 1985:36).

2.11.2 SEVERE FATIQUE

Everyone goes through periods of tiredness. This may be due to a variety of stresses - overwork, emotional problems, dietary changes and many others. Profound fatique, which lasts for weeks, with no obvious cause may be an early signal of a serious illness (Richardson, 1989:21).

2.11.3. PERSISTENT DIARRHOEA

Diarrhoea is frequent and loose bowel movements. Usually signifying an attempt by the body to rid itself of an irritant or harmful substance. It may be due to toxins, infections, cancers, diet, emotional stress or a host of other causes. Persistent diarrhoea (longer than one week) is not normal and may lead to severe dehydration and loss of essential body salts (Gong, 1985:38). Continuous diarrhoea may be a sign of AIDS.

2.11.4. SKIN RASHES AND SPOTS

Lumps, bumps and rashes on the skin always cause concern and create anxieties about possible cancer. In AIDS, the fear of kaposi sarcoma (KS) is especially prevalent. New pink or purple, flat or raised blotches (usually painless) occur anywhere on the skin, including on the mouth or eyelids. In many cases lesions can also be found internally, such as on the membranes of the lung, intestine or rectum. Initially they may look like blood blisters or bruises, but they do not pale when pressed and do not disappear. They are

2.11.5 THRUSH (CANDIDA)

Thrush is creamy white blotches or sores in the mouth or throat. It may be painful and cause difficulty in swallowing, but rarely involves other internal organs. Thrush is a common vaginal infection among women, causing an irritating white discharge. In men, thrush may appear as irritating white spots on the end of the penis or as a white discharge from the rectum (Richardson, 1989:21).

Other symptoms include amongst others unexpected weight loss, swollen glands, shortness of breath and bruising or bleeding.

It does not mean that when persons have these signs and symptoms that they are HIV/AIDS infected. There can be lots of other reasons for nearly all of these symptoms. For instance, swollen glands can be a sign of glandular fever and tiredness; and fever and weight loss are much more likely to be symptoms of stress, exhaustion or of a cold coming on. Some of these conditions are treatable if diagnosed early enough.

2.12 PREVIOUS RESEARCH STUDIES REGARDING HIV/AIDS

Due to the alarming increase in the number of people becoming infected with HIV everyday throughout the entire world, research has been carried out to investigate the knowledge, attitudes and sexual practises regarding AIDS (Anderson et al, 1991). Although some of the studies have examined these issues among members of the general public, the majority of the studies have been conducted on populations considered to be more at risk of HIV infection due to their behaviour such as intravenous-drug users, homosexuals, poor people or those belonging to

health professionals (Simbaya, 1993:8).

Information obtained from such studies has been useful in assisting in the development of intervention programmes suitable for each specific type of the risk population by imparting the necessary knowledge and ultimately promoting the desired changes in their behaviour, beliefs and attitudes concerning AIDS (Liskin et al., 1989).

According to Simbaya (1983:8) some of the studies which were carried out in the third world countries have found the levels of AIDS knowledge ranging from low to moderate mainly as a result of misconceptions concerning the transmission routes of the disease. Furthermore, studies carried out in the Western world have generally found high levels of knowledge of AIDS, for example in Australia (Ross et al., 1990).

Some of the studies have also looked at cross-cultural comparisons, for example, in one study Eskander, Jahan and Carter (1990) found Americans to be well informed and middle Eastern African groups to be least informed on the current facts about AIDS. In a study undertaken by Temoshok, Sweet & Zich (1990) it was found that similar levels of knowledge in samples of people drawn from San Francisco, New York and London were revealed. Such results may perhaps be a reflection of differences in the levels of literacy as well as the quality of information on AIDS which is disseminated to the public. With regard to sexual practises, both Third world countries and Western countries reported that there had been generally little or no change in sexual behaviour patterns (Simbayi, 1993:4).

To date, only a few studies on AIDS carried out locally in South Africa have been

health care professionals regarding AIDS (Eagle & Bedford, 1992). Furthermore studies have looked at students' knowledge and attitudes as well as practices concerning the disease (Basson et al., 1990; Perkel et al., 1991). The study conducted by Matthews et al. (1990) found black high school students in the Cape Town area to be relatively ignorant with regard to AIDS. Studies which utilized mostly white and coloured students from the Universities of Free State and Western Cape as well as white medical professionals in the Johannesburg area and at the University of Natal Medical School in Durban found that their participants were mostly well-informed on the main facts about AIDS (Eagle et al., 1992; Schlebusch et al., 1991).

Two of the local studies carried out on students, that is, those by Breytenbach et al. (1990) and Mathews et al. (1990) also revealed that there had been no major changes in students' sexual practises in response to the danger faced by being infected with HIV (Simbaya, 1993:7-8).

By far the largest majority of the studies done throughout the world on the knowledge and attitudes towards people with AIDS have utilized college and university students as participants. Concerning the attitudes held by the students towards AIDS in general and towards those afflicted by it, the majority of the studies showed that the students generally held positive attitudes. As regards sexual practices, most of the studies have reported little or no change at all in the students as most of them were still engaging in unsafe sex practices while others had misconceptions about their personal risks. College students undoubtedly offer convenient samples which are easily accessible. The proliferation of AIDS research on this special population group is mainly because they are regarded mostly as a high risk AIDS population.

However, according to Lachman (1991:183) whatever the level of knowledge, sex education should be available to both male and female students at an early, more easily interventional stage, even in primary school.

In this regard recent studies (Diclemente, 1992:6; Mogotsi 1994:62; Kaya and Kau, 1993:10) found that the majority of adolescents were knowledgeable of the disease, however, they have many misconceptions which make them highly vulnerable. Despite the knowledge held by students very few changed their unsafe sexual practises. These findings suggest that there is a need for research to investigate how AIDS knowledge can be translated into effective self protection action against HIV infection.

The reason why students are mostly chosen for research purpose is because they are most frequently involved in sexual activities and have the potential for multiple sexual partners. In addition to that, by being better educated than the general public, and more likely to be single and concerned with sex, college students are more attuned to the issue of AIDS as well as more likely to the issue of AIDS as well as more likely to changes in their behaviour (Simbayi, 1993:7-8).

With the exception of one American study carried out by Goodwin & Roscoe (1988) it was revealed that there was only a moderate level of knowledge of AIDS and its transmission routes. All other published studies using tertiary students have generally reported high levels of knowledge about AIDS, although most of the studies also reported that some of the students do have some misconceptions about the disease.

2.13 AIDS IN AFRICA

As devastating as the AIDS epidemic has been to the United States, its impact in Africa has been far worse. Millions of people have contracted HIV, and in some cities more than 20% of the adult population is infected (Little, 1978:86). Moreover, in contrast to the spread of AIDS in the USA, the primary mode of transmission in Africa is through heterosexual, instead of homosexual sex. One reason for this, the Times reported, may be the largest share of individuals on the continent infected with other types of STD's. The result appears to be a huge number of people suffering from genital lesions that, in turn, make it easier to transmit the AIDS virus when one partner is also carrying HIV. In addition, widespread poverty in Africa has forced many women into prostitution which also facilitates the spread of AIDS (Little, 1978:86).

As long as there is no known cure for the disease, the only way to avoid the risk of infection is to avoid exposure. In Africa and increasingly elsewhere, especially because HIV transmission appears to be largely heterosexually transmitted, reducing exposure means changing a basic biologically driven behaviour. Globally, the majority of persons infected with HIV and developing AIDS, presently and in the foreseeable future will be heterosexuals (Little, 1978:86).

Until such time as effective vaccine or cures are developed and made available on a global scale, the only viable recourse to slow the pandemic is preventive education programmes directed towards changing human behaviour patterns and cultural traditions known to facilitate infection with the HIV virus.

2.15 HIV/AIDS IN SOUTH AFRICA

South Africa has one of the fastest growing epidemics in the world. It is estimated

that up to 1500 new infections (in men, women and children) occur each day. The annual antenantal sero-prevalence survey shows that there has been a fourteen-fold increase in HIV prevalence in the past six years. At the end of 1998, the prevalence of HIV infection amongst pregnant women was found to be 25% on average, though there are wide variations throughout the country(5.9% in the Western Cape to 33.3% in Kwa-Zulu Natal)(Monogram for the Department of Health, April 1999).

Mother to child transmission of HIV (before, during or after birth-from breastfeeding) ranges from 38.8% (Durban) to 46%(SOWETO) where all the babies were breastfed in the SOWETO study and the majority were breastfed in the Durban study. In 1998 Kayalitsha k22 up to 60% of pregnant women were HIV positive.

Surveillance data from STD clinic attendees in Carlentonville, a mining community, demonstrated an increase in HIV prevalence from 8% in 1991 to 44% in 1996. This reflects the high rate amongst migrant workers (Monogram for the Department of Health, April 1999).

In a Durban STD clinic in 1996, 2% of men with a discharge were co-infected with HIV and 61% of women. Co-infection in TB patients is even higher though it is variable across the country.

Regarding other STDs, it is estimated that approximately 4 million episodes of STDs occur each year in South Africa. Tuberculosis (TB) is the most common opportunistic infection and the biggest killer of people living with AIDS. Tuberculosis is often the first aids-defining illness which changes a person's status from HIV infected to full

blown AIDS. Because of the effect on the immune system, HIV infection makes a person 30 times more likely to progress from TB infection to TB disease. It is estimated that 25% of the 160 000 TB cases in South Africa in 1996 were attributed to HIV.

The importance of writing about South Africa is that it is part of Africa and on this continent the disease is spreading very rapidly in impoverished communities which depend on human labour for survival and where the levels of national poverty are already so great that the resources for dealing with the care of the sick and the orphans are already extremely scarce (Barnett, 1992:5).

2.15.1 HISTORY OF HIV/AIDS EPIDEMIC IN SOUTH AFRICA

The first cases of AIDS were identified in South Africa in 1982 in homosexual men. At that stage, the epidemic resembled the Type I epidemic found in Western countries where the majority amongst homosexual and bisexual men with a few cases being attributable to intravenous drug use and blood transfusions. Within a short time however, the epidemic began to reflect Type II epidemic found in developing countries with the majority of infections occurring as a result heterosexual transmissions associated with increasing numbers of paediatric infections (Monogram for the Department of Health, April 1999).

Whilst the epidemic in South Africa initially lagged behind that in neighbouring countries, the situation in many provinces has now reached that found in countries such a Zambia and Uganda which is up to 1:4 adults infected in some cities.

The majority of HIV transmission in South Africa occurs heterosexually (as stated above).

There are however identifiable groups who are at an increased risk of acquiring HIV from various reasons. These include:

- Women, who are vulnerable as a result of their physiology as well as their position in society which frequently prevents them from taking precautions to protect themselves from exposure.
- Infants born to infected mothers.
- Street children who may have risk sex as a survival strategy.
- Migrants who live apart from their families for extended periods of time.
- Persons with sexually transmitted diseases, such as genital ulcers which particularly facilitate the transmission of HIV.

- Sex workers who have frequent partner changes, high rate of STDs and who do not, or are not able to practise safer sex.
- Prisoners who may engage in or be coerced into sexual practices.
- Long distance truck drivers, construction workers and members of the armed forces all of whom work in situations which predispose to having multiple partners.

2.16 CONCLUSION

In sum then, this chapter deals with the nature and extent of the AIDS epidemic, and its transmission as well as signs and symptoms related to HIV/AIDS infection. It also looked at the previous studies on the level of knowledge concerning this disease. It is evident that from previous research that the level of literacy and the quality of AIDS information are some of the crucial matters to be looked at in order to teach people about the transmission and nature of the epidemic.

CHAPTER THREE

3. KNOWLEDGE AND ATTITUDES TOWARDS AIDS

3.1 INTRODUCTION

In this chapter an attempt is made to define the concepts knowledge and attitude. However, there are words such as feelings, tendencies to react, values, thoughts, fears, threats, prejudices, ideas and biases, and convictions that have been used interchangeably with or to refer to attitudes. It is important to distinguish clearly between attitudes and values. Although some theorists have argued that the have one and the same meaning, people tend to regard attitude as broader, and at times less personal than values. Because of the confusion that often results from usage and/or substitution of these related terms for attitude, an attempt to define the more closely related terms will be made prior to a definition of the concept attitude.

3.2 DEFINITION OF CONCEPTS

To clearly understand or conceptualize the term attitude, it is necessary to explain the following definitions.

3.2.1 A VALUE

Rockeach (1973) defined a value as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct

end-state of existence which is probably as close as people are likely to get to an acceptable definition". A value is an important life goal or a standard of behaviour for a person, a standard in which the individual has strong positive attitudes. Values are the most important and central elements in a person's system of attitudes and beliefs. They are ends rather than means, they are the goals towards which a person strives, and which help to determine many of his/her attitudes an beliefs (Oskamp, 1977: 13). Three basic characteristics of a value are distinguished in this definition, namely that the individual is positively related to his/her value system; that the individual's value system determines what kind of attitudes and beliefs the person will have; and that it is an absolute concept that defines for an individual what ends or means to an end are desirable.

Values may be consciously felt and are capable of being articulated or may be unconsciously held. Psychologically, values serve to clarify the purpose and meaning of life and setting standards of culturally acceptable behaviour. Given a variety of opportunities on which to act, values can be viewed as guideposts against which one evaluates directionality and risk-taking. Although values have a very direct influence on attitudes, they are more abstract, and act as underlying standards and motives, which means that attitudes,

specific ideas or objects can often be seen to be related to the values that people hold. (Hayes, 2994: 605).

3.2.2 BELIEF AND OPINION

According to Rokeach (1973), the content of a belief may describe an object or situation as true, false or evaluate it as good or bad, or advocate a certain course of action as desirable or undesirable. The verb "believe" generally expresses a significantly weal degree of opinion. For example "where is your friend?", "gone to Pretoria, I believe". The response means that the speaker is far from certainty. A strong positive form of belief is expressed when the probabilities concerning an event seem so strong that the logical certainty makes no room for doubt.

Fishbein and Ajzen (1975) maintain that it is only in its strong form that a belief provides the basis for the formation of an attitude towards an object, and that attitudes are often measured by assessing a person's beliefs. Beliefs are central to the concepts of attitudes and values. They are considered intellectual operations that predispose one to visible action.

3.2.3 ATTITUDE

An attitude is a relatively enduring organisation of interrelated beliefs held by persons that describe, evaluate and advocate options with regard to an object or situation. Attitudes show

variation between individuals and cultures. Although attitudes can be described, they are relatively resistant to alternation. They cannot be directly observed, but must be inferred from motor expressions, verbal statements of opinion, or physiological

changes because of exposure to the object of attitude (Rokeach, 1973; Wilson, 1972; Chapman and Chapman, 1975).

Attitudes are an integral and important part of everyday life and everyone has attitudes towards many different objects in their environment. The concept of attitude is very important because attitudes can be used to explain why people behave in certain ways and can also be used to predict people's future behaviour. Attitudes can vary in terms of how strong they are held. Generally attitudes which are formed as a result of direct contact with the attitude object, tend to be stronger, as are attitudes which are often repeated or rehearsed. In addition, if an issue is seen to be directly relevant to us in that it might affect us in some way, then too our attitudes tend to be stronger. As we might expect strong attitudes are better predictors than weak attitudes.

There are two possible reasons why strong attitudes influence behaviour more. The first is that strong attitudes are more salient, people are more conscious of them and remember them more easily, whereas weaker attitudes are more easily overlooked. If people are particularly aware of an attitude, it seems likely that it will exert a greater influence on their behaviour. The second

relates to the fact that different behaviours vary in terms of how difficult it is to perform them or to put it another way, in terms of their costs.

One of the biggest problems in studying attitudes is how to measure them. Attitudes are complex cognitive structures and assessing them requires the analysis of a number of different dimensions. Attitudes structure people's perceptions of the world they live in and how people act in it, because as the world changes, so do attitudes (Banyard, 1994: 381). There are also some attitudes which operate on a much more individual level. People's attitudes towards particular types of illness for instance can influence their actions quiet considerably towards the people who have those illnesses (Banyard, 1994: 382). For example, during the last 1980's, a random sample of licensed psychologists in the United States were asked to read a passage about a male college student who was diagnosed as having a terminal illness. The passages were identical, except that the student was described as either heterosexual or homosexual and as having contracted AIDS or leukaemia.

When they had read the passage, the psychologists were asked to complete a number of attitude scales. When they analysed the results, St Lawrence et al. (1990) found extremely negative attitudes towards the AIDS patients which were not applied to the leukaemia patient. The AIDS patient was considered to be more

responsible for his illness, more dangerous to other people and thus deserving quarantine and sometimes even to be a person for whom suicide is the best solution. By comparison with the leukaemia patient, they also expressed less willingness to see a AIDS patient professionally, to work in the same office, to continue

a past friendship or to allow children to visit him or her (Banyard, 1994:383).

Although there are many definitions of attitudes, according to Ashmore (1975) an attitude has four common elements namely, "that an attitude is an internal psychological response; that an attitude is not directly observable; that an attitude is an evaluative response, that is a good - bad approach - avoidance response; and that an attitude in conjunction with other individuals and situational variables influences behaviour towards the attitudes from these definitions". It can therefore be concluded that the views which an individual has on an event or an object, is affected by his/her previous experiences, by an understanding of the world or environment, and by what has been learned from others. Although the concept of attitude alone does not seem to offer a promising framework for understanding the orientation of an individual towards health behaviour as a general phenomenon, some theoretical explanations may be of value in this regard.

3.3 ATTITUDES TOWARDS AIDS

As the potential magnitude of the AIDS epidemic is more widely understood, there has been an outpouring of public fear and concern expressed in a range of responses (Blendon, 1992: 267). Merely mentioning the acronym for Acquired immune Deficiency Syndrome arouses fear into people. AIDS is an emotive issue because of its associated high mortality rate which is colloquially referred to as "AIDS is death sentence".

According to Mogotsi (1996: 62) attitudes towards life and death determine the value placed on health by individuals. In view of conditions such as poverty, a person's attitudes towards life may generally be negative. For example, an impoverished youth whose hope for the future is not promising because of lack of financial assistance may be affected to an extent that he/she cares less about his/her own health.

Attitudes of people towards AIDS, may also be influenced by the way they perceive the disease. Gilman (1988) as mentioned by Lesley (1992: 42) states that people 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 than themselves or their group. People, especially the youth, have a tendency to project AIDS away from themselves into other groups.

Denial also has an effect regarding change of attitudes. According to Silgerson and Peterson (1990: 123) most human beings are still faced with

a "denial syndrome" of saying "I have no chance of becoming infected". This therefore makes it difficult for people to change their attitudes.

3.4 KNOWLEDGE WITH REGARD TO AIDS

To date AIDS is the most talked about disease in South Africa. Perhaps the most talked about disease of the century. Despite the fact that AIDS receives much focus and attention the spread of the disease is still increasing. Simbayi (1993: 1) states that many published studies on students have generally reported a high level of knowledge about AIDS. However some studies such as those by Kau and Kaya (1993: 10) and Mogotsi (1994: 4) revealed that although students are knowledgeable many misconceptions about the contents of the disease still exist (Mogotsi, 1996: 59).

According to the same source mentioned above, the fact that a person can be infected with HIV and not have AIDS is one of the many misconceptions people are not clear about. Thus it raises the issue of whether education campaigns have done enough in informing people about AIDS. Due to the complexity of the topic and lack of knowledge on the part of most people, it is questionable whether or not people will be able to change their unsafe sexual behaviours.

The above mentioned author further stated that, another important issue which has raised many questions is that of the HIV antibody test. A study conducted by Schrunik and Schrunik (1990: 21) found that many people

prefer not to know whether they have AIDS or not. However, what people prefer not to know whether they have AIDS or not. However, what people need to know is that these tests do not determine whether one has AIDS or not but they only show whether one is HIV infected or not. The same author also mentioned that "knowing that you are antibody positive gives one a chance to cut his life-style in ways that may possibly reduce the risk of developing AIDS", as research in many countries has indicated that not all people with HIV develop full-blown AIDS.

The negative aspect of knowing that one is HIV positive may lead some people to deliberately spread the disease as a result of anger or fear of dying alone. As uncontrolled sexual intercourse has been cited in literature as one way of increasing the spread of AIDS, it emphasises the importance of pretesting - counselling (Mogotsi, 1996: 59).

Another reason why people are reluctant to know about their health status is that there is no cure for AIDS. According to Evein (1993: 73) many people are of the opinion that there is little to be gained in undergoing the test because there is no effective treatment for those who discover that they are antibody positive.

Mwale and Burnard (1992: 76) in their study on rural women and AIDS found that women have knowledge that promiscuous behaviour is the quickest mode of HIV transmission. Furthermore they indicated that sticking to one partner and using condoms are the most effective ways to prevent the AIDS spread. It is clear from the above observations that many women know how and what should be done to prevent AIDS.

However, experts are of the opinion that no matter how accurate the information people may have about AIDS, it has not led to long term behaviour changes (The Star, 11 July 1991).

Although it is evident that there is a growing favour of fundamental changes in sexual behaviour, the norms of sexual behaviour such as having multiple sex partners can only change if attitudes are changed. For safe sex to be a socially acceptable behaviour, attitudes toward safe sex play a major role (Mogotsi, 1996: 60).

3.5 THE KNOWLEDGE AND ATTITUDES OF THE COMMUNITY TOWARDS PEOPLE LIVING WITH AIDS

3.5.1 INTRODUCTION

Acquired Immuno Deficiency Syndrome has become a prominent and permanent fixture in our daily language. This is because the AIDS epidemic continues to grow unlike most of other infectious diseases that have been controlled by a combination of clinical and public health measures. As panic and irrationality increase, victims are ostracized and people avoid contact with AIDS patients. They do not even have casual contact with them. AIDS patients are considered less desirable, more responsible for their illness and less deserving of sympathy (Social Work Abstract December 1997 Vol. 33 No. 4).

Fear and discrimination have affected virtually every aspect of our culture. Also the fear of HIV infection and the ignorance about its causes have created bizarre behaviour and at times barbaric practices, strange rituals and attempts to isolate those afflicted with the disease. People have become very judgmental and moralistic towards people with AIDS which lead to discrimination, rejection, blame, labelling and alienation of affected people. There are many myths, misconceptions, untruths, and rumours spread about people with AIDS. As a result of insufficient contractual education concerning HIV/AIDS, families and communities have experienced a wide range of reactions. Because of misleading and unscientific

information that has given rise to misconceptions regarding HIV/AIDS, people with AIDS, therefore prefer to keep their condition a secret and do not practice safe sex for fear of being "found out" (Evian, 1995: 235). In addition, al individuals with AIDS and many of those associated with them are experiencing extreme rejection and isolation due to the public's fear of contamination (Caputo, 1985: 36).

In some cases people have been evicted from their homes or lost their jobs once it became known that they were antibody positive or have AIDS. Insurance companies are unwilling to provide life cover. There are reports of people living with AIDS being abandoned by their friends, relatives and lovers, and of children being excluded from schools and of doctors refusing medical care (Richardson, 1989: 115).

AIDS is everyone's issue. As a result, it requires a response rooted in a commitment to challenge all our attitudes, assumptions, fears, prejudices and traditional approaches on every related issue and to come up with truly new solutions which are in everyone's interest (Herbst, 1991: 83). HIV/AIDS patients need support from their families, friends, colleagues and different organisations. This will help the afflicted person to reduce anxiety, alleviate depression, lessen self-destructive impulse and help people to cope with mental and physical stress associated with the need of living with others.

3.6 THE KNOWLEDGE AND ATTITUDES OF THE COMMUNITY TOWARDS PEOPLE LIVING WITH AIDS

Each country, and each group and person in the country develops an individual approach to the disease, depending not only on the number of patients and spread of the disease, but also on reactions and adaptation to it. The fear of acquiring AIDS is apparently linked to an attitudinal complex leading to stigmatisation of the person living with AIDS. The fear is multi-dimensional. Individuals are anxious about the possibility of becoming infected with the virus, while those who are already infected fear potential discrimination and are concerned about the poor prospect of living and dying with dignity.

The past history has affected our community to an extent that at a certain stage AIDS was identified as a potential instrument by government trying

to scare the black community into not having to give birth so as to keep the population in balance (AIDS and your response, 1992: 143). To the broader community this was an accepted message to use AIDS as a political tool by government to continue its undemocratic running of the country without the majority having a democratic right to the high echelons of the government. It will take both the government and the political actors some time to wipe out the past and start on a new slate. A massive drive on mass campaigns against AIDS is needed for the positive response of the various communities.

There have been many misconceptions about AIDS resulting from transmittal of inaccurate or incomplete information which often resulted in the stigmatization of groups afflicted with AIDS. However, because of the stigma that AIDS has, some families hide the fact that their loved one have the HIV virus. AIDS further frustrates to such an extent that people living with AIDS find it difficult to tell even those close to them for fear of rejection (Public Health Nursing, February 1998: 31). In addition, AIDS creates a unique type of stress for all those who might come into contact with the disease. It is the fear of the unknown coupled with the potential to unwittingly contract a terminal illness which causes people to avoid possible HIV/AIDS infected patients.

Misinformation about the basic factors of AIDS is responsible for attitudes of prejudice, fear and aggression against people with AIDS and their relatives. In one case, a man dying of AIDS could not sell his car because potential buyers were afraid of infection. The man was also asked to stay

at hoe and not mix with his neighbours (American Journal of Nursing, 1986: 47).

There are other wrong beliefs about AIDS. Despite many effects to educate people, the myths do not die out. These myths were sown in Drum (1997: 21) that some men believe keeping a condom under the pillow during sex or that if you do not breath deeply while making love will keep AIDS away. According to Leclerc-Madlala (Sunday Times, 4 April, 1999) more and more girls are being raped by men who believe this will "cleanse" them of the disease (AIDS). Leclerc-Madlala continues to state that "according to 19th century beliefs, sex with a child was thought to provide a cure for syphilis .. quack doctors kept special brothels in Liverpool since 1827 to provide for this cure". This myth still exists that

sex with a virgin is a cure for AIDS. The existence of this myth was found by researchers in KwaZulu-Natal, Zambia, Zimbabwe and Nigeria. It is further indicated that this myth is more prevalent than local authorities in South African and AIDS educators are prepared to acknowledge. Furthermore that it may also be significant factor in the reported rapid rise in the past years of sexual abuse and HIV infection among young girls. Even the courts in KwaZulu-Natal are feeling the effects of this new crises (Anderson, 1999).

Ashen Singh, a magistrate at Campersdown says that at least five child rape victim cases are being dealt with every day and that some of the accused admitted that they believe that by raping a virgin they will get rid of AIDS (Anderson, 1999). A stanger court prosecutor, Ayesha Bissessar,

says they deal with between 50 and 80 cases of child rape a month. According to her "its the same story here. Most of the alleged rapists tell us that having sex with virgins is a cure for AIDS. Some say that they wanted to avoid contracting AIDS and felt safer having sex with young children". The overwhelming silence over AIDS and the lack of real discussion about sexuality among Africans is according to Leclerc-Madlala where the real problem lies (Anderson, 1999).

Some people belief that contracting AIDS is a punishment from what they define as immoral behaviour. People who develop AIDS are stigmatized heavily because of such judgements. One of the most cruel "punishments" that a society can inflict on people with HIV/AIDS is withdrawal of intimacy, and sexuality from their lives. Some infected people are even accused of deliberately spreading HIV through unsafe

sexual practices. The practical consequences of AIDS can also elicit profound emotional disturbance, especially with regard to financial difficulties, involuntary health or lifestyle restrictions and reduced social outlets. Moreover, the patients experience persistent hopelessness in the awful reality of no cure for AIDS (Nursing for Republic of south Africa, 1990: 26).

Because of the significant fear of contamination people living with AIDS are regarded with suspicion and the social stigma attached to AIDS leaves patients vulnerable to moral condemnation. These discriminatory practices have affected the relationship between the general community and people living with AIDS. In this regard people become very

judgmental and moralistic towards others with HIV/AIDS and this results in discrimination, rejection, labelling, alienation and blame of affected persons.

With the AIDS epidemic in its second decade, anger, fear, disgust and mistaken ideas about transmission of HIV/AIDS still persist among many people (Pollak et al., 1992: 24). According to Pollak et al. (1992:25), however, the general public appears to lack knowledge concerning the disease. This knowledge deficiency may be responsible for insufficient prevention measures as well as prejudice and human rights violations against people living with AIDS.

As an illness, AIDS is a likely candidate for high levels of stigmatization. Surveys show that people with AIDS are perceived differently to other people with fatal illnesses or diseases. This is the major criterion

differentiating the perception of cancer from AIDS patients (Pllak et al. 1989: 24). Where there is a stigma against people with HIV/AIDS, people with HIV/AIDS will go underground. They will be segregated. These people, being underground, become more dangerous than the virus itself. A stigma discourages the infected and affected people with HIV/AIDS and their families from seeking counselling. Eliminating stigmas must be central. It is about breaking silence, and breaking silence means breaking secrecy, not confidentiality about AIDS.

Some people living with HIV/AIDS feel that everybody around themselves blames them for their condition. They too develop a stigma towards

themselves, the disease and other people. According to Metlife (September 30, 1999), if the current trend continues, more than 40 million people will be infected with HIV/AIDS as people enter the new millennium. In view of the seriousness of the AIDS epidemic, steps are needed more than ever before to ensure that people living with AIDS receive the best assistance possible to enable them to cope with the epidemic of AIDS. This includes skilled and compassionate counsellors who are equipped to comfortably deal with a myriad of AIDS related issues. The researcher is of the opinion that increase knowledge of AIDS among high risk groups can decrease the incidence of infection. Furthermore, the researcher believes that an increase in scientific knowledge of the disease will also encourage public tolerance of those who have become infected with the virus.

There should be a community commitment to receive people with HIV/AIDS with respect and dignity without discrimination or rejection.

Everyone has the potential to do something to minimize the spread and the impact of the epidemic, a potential to care and be concerned, a potential to teach and educate, a potential to prevent one or more persons from becoming infected and infecting others. In addition, the community should respond positively to the already AIDS affected victims, people should stop calling them names and ostracizing them from the community. Counselling officers who are well trained in AIDS should be given opportunities to give lecturers and guidance in all institutions including at the grass root level.

HIV is an illness which , if left unmanaged will become catastrophic to all South Africans. The days when those who were in so-called low risk groups could sit back and view this illness at a distance are now gone. Personal responsibility and empowerment are desperately needed on all levels of our country. The real message taught by HIV/AIDS is that it does not discriminate, it will invade and attach whenever people allow it to. HIV/AIDS is not something people can avoid and pretend that it will go away. It will not go away unless people say no to indiscriminate and unsafe sex. It also teaches us about personal responsibility in relationships, personal responsibility in ensuring that the health care infrastructure in this country is corrected and personal responsibility to insist on positive action by our political leaders, the business and the community in which people live.

It has become necessary to do research on the knowledge and attitude of the community towards people living with HIV/AIDS as AIDS is affecting people at an alarming rate. The diagnosis of AIDS itself is a catastrophic

trauma. The manner in which AIDS patients are being discriminated against especially in the hospitals, workplace, schools and the community at large, also has an impact on their stress levels and low immune functioning. The increasing number of people infected by AIDS and their reluctance in sharing their HIV positive status is a warning signal that people need to change their attitudes towards people with HIV/AIDS.

All members of the communities, in the educational institutions, in the workplace, in schools, in the media, in financial institutions, hospitals,

places of worship and recreation must work together to eradicate the discrimination that denies support and dignity to those who are living with HIV/AIDS. The community can only win against HIV/AIDS if it comes together to save the nation.

3.7 KNOWLEDGE AND ATTITUDES OF THE HOSPITALS TOWARDS PEOPLE LIVING WITH HIV/AIDS

Human Immuno Virus disease has presented the medical community with tremendous challenges. Investigations into the phenomenon of HIV related discrimination often observe that it seems to reach its greatest intensity within medical institutions and in the practice of health care professionals. Complaints about discrimination in health care, nursing and social services have predominated in recent years (Aggleton, 1995:20). However, research demonstrated that similar to the public, medical and health professionals hold negative stereotypes and beliefs about individuals with HIV/AIDS disease (Nursing Education, 1999:20).

Since medical practitioners and nurses are often the first line staff who deal with AIDS cases, their attitudes towards these patients are meaningful for treatment and prevention purposes. Health care workers should be prepared to show acceptance of alternative lifestyle and openly discuss sexual issues. The quality of care is often determined by the way a nurse feels about a patient. Subtle feelings such as blame, judgement and condemnation are nearly always detected by a patient and can add to their distress. In contrast, communicating one's unconditional positive

regard for another person is one of the healer's most powerful therapeutic skills.

The diagnosis of AIDS has the potential to elicit a negative judgement about the patients and unease among people on whom they may depend for their physical care, emotional and social support. Negative attitudes to patients with HIV infection, no matter their cause or origin, are likely to associate with reduced quality of care and sometimes with the actual denial of care. Doctors in primary care with less positive attitudes or less understanding of the psychological and social consequences of HIV infection preferred less ethical involvement with such patients over the long term, found it difficult to obtain help for patients with HIV infection from other health workers, believed that counselling patient's partners was not their duty and would prefer not to have known patients with HIV infection (Psychology Medicine of HIV infection, 1995: 171).

Fear and concern about acquiring HIV infection is widespread among health workers. Knowledge about occupational transmission and inactivation of the virus is also limited (Sibbad & Freeling, 1988). Fear of occupational infection s often associated with overestimating the risk of

casual transmission of HIV, and ignorance about infection control measures. There appear to be health care professionals whose perceptions of personal risk associated with providing care to AIDS patients have led to attempts to refuse or avoid giving care.

Such perceptions create fear in health care providers and give some what they think are ethically justifiable reasons to refuse the provision of care. Blumefield & Colleagues (1987: 132), for example, reported a high percentage of nurses they surveyed who said that they would seek a transfer from their assigned unit if they were required to work with AIDS patients on a regular basis. In addition, the advent of AIDS is accompanied by uneasiness, anxiety and even panic among health care professionals. In many instances these reactions persist, despite an abundance of literature supporting the low probability of harm. Because of significant fear of contamination, patients are regarded with suspicion and the social stigma attached to AIDS leaves patients vulnerable to moral condemnation (Nursing Republic of South Africa, 1990: 2).

To illustrate, ambulance drivers have refused to transport people living with AIDS, leaving some to die at home and humiliating others in front of neighbours. Emergency Room Staff have overreacted to the diagnoses, isolating and neglecting patients and mistreating their families, giving misinformation such as "go home and burn everything the person living with AIDS has touched" (American Journal of Nursing, 1986: 47).

There is presently no AIDS vaccine or cure. Therefore health care professionals must consider how to alley fears and provide the general

public with productive options to reduce risk. AIDS has proved to be a severely stigmatising illness. There have been cases of nurses refusing to change bedpans, feed, wash or even talk to someone in their care who has AIDS (Richardson, 1989: 14). In this regard, patients become

depressed because of the hopelessness of the illness and treatment, death and separation from loved ones as well as loss of contact with the outside world (Nursing of Republic of South Africa, 1990: 39).

By genuinely listening to and acknowledging the patient's fears and concerns, the nurse can provide support to an individual who is probably feeling hopeless, powerless, confused and frightened. Sometimes just being there for the patient is helpful, allowing them time or providing physical contact, comfort and even distraction through music or reading.

The studies of health workers' knowledge and attitudes towards HIV/AIDS, point to a need for continuing staff training and education, both for their own and the patient's benefit. Exposure to professional acquaintances with HIV positive people promotes better attitudes towards their care and a more realistic assessment of the risk of HIV transmission in the hospital.

3.8 THE KNOWLEDGE AND ATTITUDES OF EMPLOYERS TOWARDS PEOPLE LIVING WIT HIV/AIDS

HIV/AIDS is feared, misunderstood and controversial. Modern health and safety professionals need to know about AIDS and be prepared to use these facts to make the workplace safer. There is a great deal of misunderstanding about how AIDS is transmitted. This can cause

inordinate fear among fellow employees working with HIV-positive workers. Modern health and safety professionals should know enough

about how AIDS is transmitted to be able to reduce employees' fear that they might be infected through casual contact with an HIV infected person (Goettsch, 1993: 506-507).

HIV/AIDS is South Africa continues to grow at a rapid rate. It has become critically important for companies to assess and appraise the likely threat of the epidemic on its workplace and on its operations in general. Steps need to be taken to minimize the spread amongst employees and the overall impact of the epidemic's progression allows reasonably accurate short and medium projections to be made for the particular strata of the workforce.

Because having AIDS is considered a mark of discredit, anyone who contracts the disease is stigmatised. The identification of an employee living with AIDS may result in discriminatory practices by employers in the workplace. People with AIDS report harassment, discrimination, physical violence and even termination of their services. Some employers have had to terminate the employment of a productive person with AIDS because of threats to the business once it is publicly known there was an AIDS infected employee. Some people have had to leave work because their infection or disease has identified them as being homosexuals or bisexuals. Others have had to leave their work because the presence of a person with HIV/AIDS is regarded as being bad for the image of the firm as it may scare clients or customers away, so the reasoning goes.

To understand the underlying dimensions of ethical issues regarding AIDS at the workplace, one must bear in mind the myths and misunderstanding

that form the basis for many assumptions abut the virus. In spite of documented evidence to the contrary, many individuals, including public and private managers, believe that AIDS can be contracted by casual, nonsexual contact. This is simply not the case as there have been no documented cases of infection resulting from such casual contact. In fact, studies of family members and loved ones caring for AIDS patients have shown no cases of infection due to this contact.

Concerns about the ability to hold a job and the stress associated with AIDS are significant. There can be out-right discrimination in the workplace, with refusal to hire or to terminate when a person's HIV positive status is discovered by the employer. Also, more insidious discrimination occurs as the HIV-positive individual is not given assignments or promotions at the same pace as his co-workers. The management's concern is that he may not always be counted on to be at work in the future. This concern is also significant for the employee as absence due to opportunistic infection means that work will be shifted on to co-workers adding to their workloads and generating hostility (Ross, 1989:55). Many employers find themselves in a difficult situation which requires choices between alternatives which in general are anticipated to negatively impact their workforce and business.

AIDS can have a variety of influences in the workplace. The obvious one is on the individual employee who is diagnosed with HIV. The probability of sickness and death obviously affects the individual and his/her ability to

continue to contribute to the organisation's activities and goals (Stine, 1993:359).

Employees' fear of AIDS can create a wide-spread los of teamwork and productivity and create an environment that is inhumane and insensitive toward the infected employee.

As the incidence of HIV/AIDS increases, the impact on organizations will obviously increase as well. While there are important logical and moral reasons for ensuring that infected people are not discriminated against, there are also practical reasons for addressing the employee HIV/AIDS problem (Stine, 1993: 359).

South African managers need to be aware of the potential impact of AIDS on their organisations, their employees and productivity. The way in which managers address AIDS in the workplace will determine whether companies can survive the first decade of the 21st century. South African statistics show that the workforce is likely to be 20% HIV positive by the year 2000. There will also be 580 000 new cases a year and a life expectancy of just 38 by 2010. There are 9 million AIDS orphans in South Africa alone, an increasing potential for a next generation. According to Iclinic (August, 1999:29) South Africa could loose about 20% of its workforce within the next six or seven years. Many companies are already losing 3% of their workforce annually to the disease.

According to the Journal on Community Health in South Africa (March, 1990:30), AIDS need to be confronted on two fronts:

Firstly, an education programme to reduce the potential incidence of reaction to AIDS. Secondly, the major need at present is to prevent further spread of infection by ensuring that people know how it is transmitted. In industry there is a particular need to put various groundless fears at rest by proving the facts about AIDS and to prevent discrimination against individuals.

Furthermore HIV/AIDS has a negative financial impact on almost every employer. The nature and extent of the financial impact will be dependent on the nature of the organisation and its response to the epidemic. Proactive and focussed strategies are required to secure and maintain short and long term business objectives; whilst at the same time not impinging o the employers' basic legal rights and progressively increasing contribution by organisations and employees. Strategies, policies and procedures will be necessary in all spheres of business. To facilitate efficient organisational strategic planning, accurate and responsible predictions are key elements to every employer. Employees should be made aware of the HIV/AIDS policies of their workplaces and they should know where or to whom in the company they can turn with questions. All employees should be made aware of the equal employment opportunity laws that govern fair workplace and opportunities. Knowledge of the legal rights and policies can help foster a compassionate environment which is free from rumour and fear. HIV/AIDS education that is mandatory communicates to the work force that the employer is serious about maintaining a fair, healthy and safe workplace for all employees. Informed employees then have the tools to protect themselves, to educate their families, and to provide leadership within the community.

AIDS is an employment issue and cannot be ignored until there is an incidence of AIDS in the organisation. Besides the legal, ethical and economic considerations, employers need to recognise that they are going to have to deal with prejudice, ignorance and fear. It is therefore important to be proactive and to formulate a policy on AIDS prior to being confronted with the problem of an employee who has been exposed to HIV/AIDS (Community Health in South Africa, March 1990:29).

According to the same source as mentioned above, the following issues need to receive consideration when embarking on an awareness programme within the organisation:

- Consider informing employees of the company's standpoint on AIDS;
- Educate employees on the low risk of contracting AIDS in the workplace;
- Evaluate work practices as to their risk potential for contracting AIDS;
- Clearly identify the rights and duties of employers and employees;
- Scrutinize company policies which are of relevance, for instance: insurances, pension benefits, selection, screening, medical aid, workers' compensation and grievance procedures.

A case of AIDS in an organisation is a highly emotional experience which is likely to cause dispensation, fear and disruption if employees are uniformed and management unprepared to deal with the situation. It is

preferable to formulate a standpoint and determine how the situation should be approached whilst there is time to evaluate such a situation objectively and the organisation is not suddenly confronted with a crisis.

It is equally important that all employees are reached and that implications of the infection are clearly outline. It s of paramount importance that the employee representatives and their organisations (Unions and shop stewards) are informed of the potential risk and danger to their constituencies and that they be integrally involved in all initiatives and steps to deal with AIDS issues (Evian, 1996: 8). A special effort will be required to convince employee representatives of the issues and to enlist their commitment and support to contain the epidemic. Failure to do so will almost surely result in the epidemic following its predicted course with little hope of reducing the future size of the epidemic.

The strategy requires the full and active commitment of both top management and the employee association leadership. As such the process must be inclusive and participative with full consultation among all stake holders and representatives. According to the Journal on Community Health in South Africa, (1990: 29), the following should be considered when introducing an AIDS policy in the workplace. As AIDS is rapidly becoming a significant workplace concern with the potential to disrupt the conduct of business and to create problems at the interface between employees and medical expenditure, a preventive and pro-active corporate strategy is called for. A corporate response to AIDS in the workplace requires the adoption of a multifaceted approach which includes a policy for dealing with AIDS victims and HIV positive employees with

clear guidelines for managers and supervisors on how to deal with extensive in-house education of management and employees at all levels (Journal on Community Health in South Africa, March 1990:30).

According to the same source as mentioned above, companies which have had to deal with AIDS in the workplace suggest that from their experience there are three basic concerns which must be addressed.

Should the company have a formal policy to deal with all future cases of AIDS? What are the legal and ethical consequences of discrimination if the company decides to isolate an employee with AIDS or exclude/dismiss the person from the workplace? What should a manager or supervisor do when confronted with an employee with AIDS or with his/her colleagues who are concerned about the disease?

In order to ameliorate the stigma of AIDS, workplace policy should find means to maintain confidentiality and reduce prejudice towards people living with AIDS. Nobody should lose their jobs due to wrong information about how AIDS is transmitted. Nobody should be denied a job, no health insurance should be denied an individual on the basis of being in the racial or marginalised group of society. Human rights have to be evident for all with no prejudice shown on the basis of race or colour. Realistic prevention can take place when people see that there is a consistent policy toward the disease (AIDS and Your Response, 1992:5).

An educated work force who is aware of the facts regarding diagnosis, testing, treatment and transmission of HIV can have a positive impact on

the overall health of all employees. People are more inclined to openly acknowledge their HIV status and to seek treatment when assured of a supportive workplace environment which in turn will increase productivity (Stine, 1993: 359).

3.8.1 HIV TRANSMISSION IN THE WORKPLACE

The idea of contracting HIV from a fellow employee generates fear in many employees regardless of their jobs. It is believed that most people in the United States have been exposed to information on the route of HIV transmission and on how to practice safer sex. But remote possibilities remain worrisome to many in the job force. Many still believe that HIV can be transmitted casually via hand shakes, coffee cups and food handling.

Employees fear that AIDS can create a widespread loss of team-work and productivity, and create an environment that is inhumane and insensitive toward the infected employee (Stine, 1993: 359).

It is the anxiety of uncertainty that engenders suspicion about the possibility of HIV infection in the workplace - an anxiety that HIV/AIDS scientists could be wrong about the routes of HIV transmission.

As one of the employees, Judith Wilson Ross, stated "we have spent our lives in a culture in which infectious diseases do not represent a significant threat (Stine, 1993: 359) and thus we had consigned living in fear of life-threatening contagious diseases to the pages of history books". She further mentioned that today, HIV/AIDS forces people to re-examine their

faith in the certainty of science. "We want to believe, we want to accept, but fear of death prevents complete surrender to education" (Stine, 1993:359).

3.8.2 COMBATTING DISCRIMINATION AGAINST PEOPLE WITH HIV/AIDS IN WORKPLACE

HIV/AIDS in South Africa continues to grow at a rapid rate. It has become critically important for commerce and industry to assess and appraise the likely threat of the epidemic on its workforce and on its operations in general. As far as possible, steps will also need to be taken to minimize the spread amongst employees and the overall impact of the epidemic on the company in general.

The perception that people with HIV/AIDS are a danger to colleagues, clients or the public, or that they are unproductive, has been the major cause of unfair discrimination in employment. It has repeatedly undermined the Constitutional right held by everyone in South Africa to "fair labour practices". Irrational fear and ignorance is the cause of unfair discrimination.

Discrimination of one kind or another takes place everyday in human relations. Some kinds of discrimination are fair and acceptable, others are unfair and must be challenged. Discrimination against a person who is known or thought to have HIV is unfair because generally this fact has no influence on his/her ability to do the job (HIV/AIDS & The Law, 1997:72).

Most employees experience HIV-related discrimination. The discrimination is often by employers, supervisors or other employees. In this regard the New Constitution gives all employees the right to be treated fairly at work. The Constitution's Bill of Rights says "Everyone has the right to fair labour practices" (HIV/AIDS & The Law, 1997: 71). Together with the Equity clause in the Constitution, this means that in the private and public sector your employer cannot unfairly discriminate against you because you are a woman or because of things like your race, religion, political beliefs or disability.

Furthermore, the Constitution and the Labour Relations Act protect people living with HIV or AIDS from being treated unfairly in employment. This is because both laws make it unlawful (against the law) to unfairly discriminate against a person if he/she has a disability. There are other acts that govern relations between employers and employees. Although none of these acts refer directly to HIV/AIDS they are important because they deal with issues like safety at work, compensation and minimum standards. According to HIV/AIDS & The Law (1997: 80) the following acts are of importance in this regard:

- the Basic Conditions of Employment Act No. 75 of 1997
- the Occupational Health and Safety Act No. 85 of 1983
- the Mine Health and Safety Act No. 72 of 1997
- Compensation for Occupational Disease and injuries amendment Act No. 61 of 1997
- the Employment Equity Bill 21 November 1997

Although a person with HIV/AIDS is no risk to other employees, fear and prejudice sometimes lead to demands for the firing of a person who is known or suspected to be HIV positive. But it is an unfair labour practice and thus unlawful to dismiss an employee with HIV, even if all the employees of a company refuse to work with that person. The best way to prevent this kind of situation from happening is for an employer and employee(s) to jointly write a company AIDS policy and to organise education at the workplace for employees (and if possible their families) about HIV/AIDS & The Law, 1997: 81).

3.8.3 UNIVERSAL PRECAUTIONS THAT SHOULD BE ADOPTED AT THE WORKPLACE

According to HIV/AIDS & The Law (1997:82) universal precautions are practical steps that can be taken to make a workplace safe. The South African Law Commission has recommended that universal precautions should be applied in every workplace.

Universal precautions include:

- Education about the risk of transmission of blood borne pathogens (agents and cause disease) and why it is important to treat all blood and fluids as being possibly infectious;
- the use of proper protective clothing (e.g. rubber gloves, face marks) which may be needed if an occupational accident takes place;

- appropriate,accessible protective clothing in places where it can easily be reached;

- education about how to clean up safely after an accident.

3.8.4 EDUCATION, AWARENESS AND PREVENTION PROGRAMMES

Information, education and prevention programmes should be developed jointly by employers and employees and should be accessible to all at the workplace. Education on HIV/AIDS should, where possible, incorporate employee families. Essential components of prevention and management of STD's, condom promotion and distribution and counselling of high risk behaviour. Furthermore, workplace AIDS programmes should co-operate with and have access to resources of National AIDS Programmes.

Education programmes should go hand in hand with regular assessments of the knowledge and attitude of employees and education should be aimed at the gaps and deficiencies in the knowledge base of employees. Regular updating and support of peer educators should also form part of an ongoing assessment.

In addition to the above statement, HIV/AIDS awareness programmes need to be ongoing and sustained. These need to be properly targeted and carried out by the most appropriate individuals in appropriate languages and within working time. Peer educators, i.e. trusted and respected representatives of the workforce should be carefully selected

and trained as peer educators to promote AIDS awareness and to assist with the comprehensive strategy. Innovative methods of raising awareness need to be used, such as educational theatre, comic booklets, puppetry shows etc. Visibility of the epidemic, via posters and regular distribution of other media, together with presentations to all levels of staff by experts and by people who have HIV/AIDS.

Outreach to teenage dependants and spouses of employees is equally important. Assessment of knowledge and attitudes of employees should be done prior to commencing the programme in order to evaluate the success achieved with their undertakings.

Persons affected by or believed to be affected by HIV/AIDS should be protected from stigmatisation and discrimination by co-workers, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection. Where employers and employees agree that there has been adequate information, education and provision for safe work, then disciplinary procedures should apply to persons who refuse to work with an employee with HIV/AIDS.

HIV status should not be a factor in job status, promotion or transfer. Any changes in job status should be based on existing criteria of equality of opportunity, merit and capacity to perform the work to a satisfactory standard HIV/AIDS & The Law 1997:83).

Government, employers and employee representatives should ensure that occupational benefits are non discriminatory, sustainable and provide support to all employees including those with HIV infection. Such occupational benefit schemes should make efforts to protect the rights and benefits of the dependants of deceased and retired employees. Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the employer or any other party to affect any other aspect of the employment contract or relationship.

Medical schemes and health benefits linked to employment should be non-discriminatory. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status. Counselling and advisory services should be made available to inform all employees of their rights and benefits from medical aid, life insurance, pension and social security funds. This should include information on intended changes to the structure, benefits and premiums to those funds.

Every sexually active adult is at some risk of HIV infection. Nobody is immune (completely protected). The workplace gives us all an excellent opportunity to educate ourselves abut HIV/AIDS, and about how transmission does and does not take place. This is why it is so important for every workplace (no matter how big or small) to have an AIDS policy programme.

3.8.5 EMPLOYER AND EMPLOYEE RESPONSIBILITIES

Employers, employees and their respective organisations should agree on HIV/AIDS education and prevention programmes and ensure that they are conducted at the workplace. These programmes must be conducted in different languages, and take into account levels of education/literacy that are appropriate for the workplace.

Educational strategies should be based on consultation between employers, employees, their representative organisations and where appropriate, government and non-governmental organisations with expertise in HIV/AIDS education, counselling and care. Regular evaluation and reviews to be agreed upon by all parties.

Education is an important way of combating discrimination and irrational responses to HIV/AIDS in the workplace. Attendance at such programmes should therefore be compulsory for all employees (including management). They should take place during paid working hours. Educational programmes must utilise strategies that are non-stigmatising and that promote safer sex practices.

Educational programmes need to inform employers and all employees of the provisions of employment codes on HIV/AIDS and the rights and duties of persons with HIV/AIDS. The (government approved) code of good practice should also be available in every workplace.

Employers and employees have a right to continuing education and information about the modes of transmission of HIV, the means of preventing such transmission, the need for counselling and care, and the social impact of infection on those affected by HIV/AIDS.

Where possible, and if appropriate, employers should assist in providing education and support systems for the dependants of employees and surrounding communities.

Employers and employees should ensure that education programmes support the Department of Health's HIV/AIDS and STD prevention campaigns by making condoms, information brochures and details of local services for persons affected by HIV/AIDS, available at the workplace.

Where an employer is unable to ensure that non-discriminatory policies are followed, the employer should seek to ensure that the policies are changed, or should find an agency which provides the same benefits on a non-discriminatory basis.

In conclusion, each and every employer will be affected by the AIDS epidemic. The nature of an organisation's operations will require differing responses to maintain the stability and viability of their business within the norms of human compassion. This really shows that employers are faced with an enormous challenge. Instead of closing the door of the workplace to those who are HIV infected, a commitment is needed to welcome all into the workplace and provide a humane and supportive environment to infected employees. Turning away potential breadwinners will only

enhance the cycle of poverty which in turn fuels the epidemic (HIV/AIDS & The Law 1997: 84).

3.9 KNOWLEDGE AND ATTITUDES OF SCHOOLS TOWARD PEOPLE LIVING WITH HIV/AIDS

HIV/AIDS can be accurately describes as a social disease because it is spread by sexual contact from person to person. Further it is highly influenced by many social factors affecting the very nature of human relationships. Man is the only animal who routinely contracts and harbours HIV. Negative attitudes definitely play a role in the spread of HIV which has been on the increase since 1981.

People have differing attitudes towards different situations, some are objective and some subjective. AIDS as a contemporary epidemic also elicits these two types of attitudes. People living with HIV/AIDS are given a social stigma of being dysfunctional and therefore people have negative attitudes towards them.

Despite being aware of AIDS, many people choose to ignore its presence. The spread of AIDS will adversely affect the most productive sector of the population. Information alone does not change behaviour by itself and therefore people usually change when those around them are changing. By influencing as many people as possible, including organisations and institutions, the attitude of people towards those living with HIV/AIDS will create a community response and a fashion for change.

Schools are one of the institutions in society which are regularly attended by most young people. Moreover, virtually all youth are in schools before they initiate risk taking behaviours that may expose them to HIV. Thus schools are perceived as the public institutions with the broadest opportunity for reducing HIV risk taking behaviours.

As a nation we are shocked to discover HIV in children and horrified at its morbidity and mortality rates. Arguments began over whether infected children should be allowed to attend school or play with other children. Confidentiality issues with respect to reporting the virus spawned heated debates as parents of HIV positive children sought to shield them from rejection, isolation and prejudice as they enrolled them in schools and Day-Care centres. School officials argued for their right to know which students were infected. Teachers and school administrators feared that infected children might transmit the virus to other students and teachers or that HIV positive children would be affected by discrimination (Public Health Nursing, August 1998: 256-257 Vol. 15 No. 4).

According to the You Magazine (1997: 19) two children infected with HIV/AIDS, one from Durban and the other from Johannesburg, were refused admission at school by the school principal. This is an indication of how people living with HIV/AIDS are being discriminated against. Herek and Glunt (1989) also cited that knowledge of the cause of the disease, its progression and the activity of the virus itself is solely lacking. As a result, a considerable fear exists in the general public coupled with a negative reaction towards those being affected and even those being suspected of being infected.

Some adolescents who are HIV positive prefer to remain in school to continue and have a sense of normality in their lives. Often, they keep their HIV status a secret from family and close friends believing that if it becomes known they will be ostracized. Some refused to notify their sexual partners and some admit using the virus as a form of vengeance against people.

In another case, a mother whose young son has AIDS sent cupcakes to his classmates on his birthday. School officials would not permit the children to eat the cupcakes. The elementary school principal said the school had a policy against homemade food because it could spread diseases such as AIDS (Stine, 1993: 350).

According to Stine (1993:348) hate-mongers torched the house of the Ray family and their three HIV positive haemophilic children in Arcadia, Florida and someone shot a bullet through the window of Ryan White's home to let the teenager know he should not attend the local high school. After he died his 6 foot 8 inch gravestone was overturned four times and a car ran over his grave.

In some communities, parents protested when HIV infected children were permitted to attend school. In one instance, a family with a HIV infected child was driven from town by having their home burned down (Klipe, 1993: 550).

Recent studies in South Africa show that the youths are sexually active from an early age and in most cases have multiple partners. The youth therefore have an increased risk of exposure of HIV infection. This is an

important factor when considering suitable measures for prevention of HIV infection in South Africa. However, data from a variety of high school sex education classes offered across the country indicate that teenagers are learning the essential facts but they are not practising what they learn (Stine, 1993: 357). They do not do what they know. Risky sexual behaviour is widespread among teenagers and has resulted in high rates of STD's.

According to the World Health Organisation about half of all infections of HIV worldwide so far have occurred in young people between the ages of 15 & 24. In South Africa youngsters under the age of 25 now account for up to three quarters of all new infections. Newly infected women tend to be slightly younger than newly infected men. Up to 60% of all infections in women are among teenagers. The youth are therefore a very important HIV/AIDS education target group in South Africa (Stine, 1993:357-358).

A recent survey run by People Magazine (1999) indicated that 90% of high school students and 99% of college students know that HIV is spreading through the heterosexual population. However, the majority of these students stated that they continued to practise unsafe sex. Combined data from surveys performed in 1988-1989 indicated that among sexually active teenagers only 25% used a condom (Stine, 1993: 358). If HIV becomes widespread among today's teenagers, there is a real danger of losing tomorrow's adults.

Available data suggests that teenagers have not appreciably changed their sexual behaviour in response to HIV/AIDS information presented in

their schools or from other sources (Kegeles et al., 1988). Jonathan Mann, past director of the World Health Organization, estimated that world wide there are between one and two million HIV infected teenagers (Stine, 1993: 358).

As a result of incorrect journalism, there was and still is public panic and hysteria. In five states children with AIDS were barred from attending local public schools (Stine, 1998: 347).

According to a research study conducted by Chipfakacha (1997; 13) in Botswana, the youth of Botswana comprise 45% of the total population. The research indicated that they are the most affected age group. They therefore need to receive health education on HIV/AIDS. Health education should start at a very early stage, especially at school. The grade 1 to grade 6 age group is very important since they do basic science which allows them to understand the biology of the human body. They in turn become vehicles for health education to their parents and out-of-school youth. School curricula should therefore have HIV/AIDS components especially in sciences.

HIV/AIDS information is not supposed to stir fear in the receivers otherwise it will only increase irrational behaviour. The students surveyed in the above research study in Botswana were definitely frightened of HIV/AIDS. This is clearly shown by their response to the question, "how would you react if you or your partner was found to be HIV positive?" There were responses of suicide, rejecting partners etc. Further most were of the opinion that people living with HIV/AIDS should be ostracized

and rejected. This kind of behaviour has however been witnessed globally. It is also possible that the students have been receiving the wrong information on HIV/AIDS. The use of radios and newspapers might be responsible for this since it is a one way communication which cannot answer questions (Chipfakacha, 1997: 13014).

The students were also convinced that casual contact such as kissing, touching and sitting next to someone with HIV, created the risk of contracting HIV. This myth, if widely accepted, may further lead to the rejection of people living with HIV. People living with HIV/AIDS need tender loving care from friends, relatives, teachers and other people with whom they come into contact on a regular basis. Research has shown that people living with HIV/AIDS who have been rejected by society succumb and die faster than those who are accepted and cared for.

The research study conducted in Botswana showed that most students, despite having a knowledge of HIV/AIDS, were ignorant about the transmission and prevention of the disease. The majority of the students greatly fer the disease. This state of affairs needs redressing. Fears breed irrational behaviour which will not help AIDS prevention campaigns. Further, they had a number of misconceptions about HIV/AIDS: for instance they believe HIV could be transmitted though casual contact and were not sympathetic to those affected by the virus.

Those affected with HIV will not live positively in shunned by society. Students as teenagers are the group most at risk of getting infected with AIDS and therefore have the right to sufficient information on the disease.

The introduction of AIDS in the science curricula of secondary schools is a welcome step, but information should be given to primary schools is a welcome step, but information should also be given to primary school pupils. The students require more and accurate information to become better vehicles of health education to the community at large and other youth out of school (Chipfakacha, 1997: 15-16).

Schools should be included in a National AIDS programme. AIDS education should be introduced into schools before the children become sexually active and before there is peer pressure to experiment with sex. It is much more difficult to change people who have already accepted a certain way of life; therefore the emphasis on school children before they adopt risk behaviour (AIDS & your response, 1992: 149).

The training of teachers is also vital for the successful implementation of an AIDS educational programme. The needs of the teachers should be assessed and appropriate training programmes should be developed in order to have amore significant impact on the knowledge, skills and attitudes of their students in their care. The aim of AIDS education in schools is to reduce the risk of HIV transmission. It is important that the education given should form part of an integrated National AIDS Prevention and Control Strategy designed for that purpose (AIDS Prevention Through Health Promotion, 1991: 68).

Many countries have examined the role of schools in providing education of this type. Schools may or may not be the most appropriate agency, depending on local circumstances. Often, the challenge of providing AIDS

education in schools has been too great because of the sensitive nature of the subject matter (AIDS Prevention Through Health Promotion, 1991: 61).

Commitment is urgently needed in the educational institutions to start addressing the issue in the primary and secondary schools, in the teacher training colleges, and at the tertiary education level. It is important that AIDS education in schools be aimed particularly at students younger than the age group likely to have risk behaviours. If many students leave school before this age it may be appropriate to target even younger students. All other students also need to be targeted (AIDS Prevention Through Health Promotion, 1991: 70).

Everyone must know and act on the fact that a wrong decision about having sexual intercourse can take away the future. For example, a young college student had a three year non-sexual friendship with a local bar tender. She was bright, well educated and actually aware of AIDS. After drinks one evening as their friendship progressed towards sexual intercourse, she asked him if he was "straight" (a true heterosexual) and he said yes. It was a single sexual encounter. She graduated and left town. She later found that the bartender died of AIDS three years later. She did not think much of it until she was diagnosed with AIDS five years after their affair. This young, talented, bright and personable girl lost her future. This brings home the point that it is difficult to change something as complex as personal sexual behaviour regardless of knowledge. It also brings up at least one other important point in personal relationships: telling the truth (Stine, 1993:358).

3.9.1 COMBATTING DISCRIMINATION AGAINST PEOPLE WITH HIV/AIDS IN SCHOOLS

The New Constitution says that everyone has the right to basic education. The South African Schools Act says that every public (government) school "must admit learners and serve their educational requirements without unfairly discriminating in any way". It also adds that in private and public schools, it is unlawful to discriminate against any student depending on "any test" (HIV/AIDS and The Law, 1997: 125).

The Bill of Rights also says that everyone has the right to basic education. If a child is stopped from going to school because of hie/her HIV status, this is unlawful and can also be challenged in court (HIV/AIDS & The Law, 1997:125). HIV is never transmitted through casual contact. This is why it is very difficult for children of any age to get HIV from everyday social contact at school. Therefore, the risks of infection of other children cannot be used as a reason to exclude children with HIV from a school.

3.9.2 RIGHTS TO SEXUALITY EDUCATION/EDUCATION LEVEL

One of the important decisions regarding sexual and AIDS education, is the time at which this education should be started. Sapire (1990:47) states that although it is tempting to leave AIDS education until children are in secondary and high schools, it may prove to be too late. The above statement is based on the presumption that many children begin experimenting with sex at an early age in their lives which may even be years before they attend high school. In addition, there are some students

who do not advance to high schools because of a variety of reasons (Mogotsi, 1996:70).

Sexuality education includes teaching learners abut safer sexual practices to prevent HIV and other STDs. Children can only be taught about safer sex if they have an understanding of things like:

- what sex is
- their physical anatomy (what their body parts are and their uses)
- how they can respond to feelings for another person
- why and how to use condoms and other contraceptives

A child should have access to (a way of getting) information that will help the child to develop his/her physical and emotional well being. Sexuality education and information on HIV/AIDS will certainly help a child to develop his/her physical and emotional well-being.

South African educational departments have said that they support this type of education. The children's charter of South Africa has an Article which says that children have a right to be educated on issues like sexuality and AIDS. South African children therefore have a right to sexual education.

In support of the above mentioned statements, the ANC views the development of comprehensive education programmes for school

children, adolescents and teachers as fundamental for the success of any strategy to prevent the transmission of HIV (AIDS Analysis Africa Vol. 6 No. 6, April/May 1994: 1). The NP shares this view as it sees HIV/AIDS education in schools as essential. It claims to have drawn up models regarding HIV/AIDS and has made them available to the Department of Education and Training. The DP sees HIV/AIDS education in schools as essential arguing that it is through educating the youth that significant in-roads can be made on the threat posed by HIV. Furthermore, the CP believes that a crash course on HIV/AIDS in schools in sufficient (AIDS Analysis Africa 4 (6) April/May 1994: 2).

There are many ideas on what should be included into a sexual education programme. Sexuality and AIDS education is only one part of a broad life-skills programmes helping to cope with the many challenges of life (HIV/AIDS and The Law, 1997: 128).

Considering the aforementioned facts, it is suggested that sex and AIDS education need to be initiated at the elementary or primary level where the majority of young people are not yet exposed to sexual activities.

3.9.3 YOUTH AND HIV/AIDS

Being young involves exploring new ideas and feelings. Youth often involves a certain measure of recklessness, a defiance of norms and rules and a taking of risks. As the adolescent approaches sexual awareness and curiosity peaks varying degrees of experimentation begin. In the era

of HIV/AIDS sexual experimentation without appropriate precautions can be deadly (HIV/AIDS & Human-Development South Africa, 1998: 91).

Many young people do not take precautions because they perceive themselves to be at low risk of contracting the disease. Given the invisible nature of the virus, and the "I'm gonna live forever" mentality that is almost inherent in young people, interventions clearly need to focus on addressing this fundamental blind spot. Young people need to be taught to be less fearless. They need to learn to perceive themselves being at "risk". Without this fundamental shift in attitude HIV will continue to be a major impediment to the achievement of both adulthood and the broad-based development goals of the nation (HIV/AIDS & Human Development - South Africa, 1998: 92).

3.9.4 METHOD OF TEACHING

According to Mogotsi (1996: 70) AIDS education should not be treated in isolation but should be incorporated into health education, sex education and into life-skills education. Subjects such as biology, drama, music and religious education can also serve as a means of providing this education. This can effectively be accomplished in primary schools where basic concepts such as health, disease and human relationships are taught gradually, as children grow older, progress can be made to more detailed information.

Creative involvement of children is essential if programmes are aimed at changing behaviours. Learners need to feel that they are given credit for

their own insight and their own ability to generate innovative solutions. In this regard Mogotsi (1996: 70) is of the opinion that education should not be prescriptive but allow for broader participation.

The ability to learn by social modelling provides a highly affective method for increasing human knowledge and skills. A special power of modelling is that it can simultaneously transmit knowledge as well as valuable skills to large numbers of people (Bandura, 1986 as quoted by Diclemente, 1992: 103). Applications of modelling principles to AIDS prevention should focus on how to manage interpersonal situations and one's behaviour in ways that afford protection against the abuse of one's body. Both self-regulative and risk reduction strategies for dealing with a variety of risk situations should be modelled to convey general guides.

3.9.5 DEVELOPING POLICY GUIDELINES IN SCHOOLS

HIV/AIDS policies need to be drawn up for educational institutions. These policies could help ensure non-discrimination against children and youth with HIV, and assist prevention efforts in schools.

The following are some of the factors that a policy can ensure: -

- The best interests of the child must always guide decisions made about the child;
- The principle of non-discrimination;
- No forced HIV testing of children and teachers;

- Respect for confidentiality and privacy;
- Carrying out HIV/AIDS education programmes for staff, pupils, parents and communities; and
- Universal, precautionary guidelines in the management of all blood or body fluid accidents for all staff and learners.

For a policy to be carried out effectively, there must be consultation with all the stake holders who could be affected. Parents, staff, pupils and governing bodies should be involved in drawing up and commenting on the policy. This will help to avoid future conflict (HIV/AIDS & The Law, 1997: 126).

3.9.6 THE ROLE OF TEACHERS IN AIDS EDUCATION

Children spend most of their time in schools and therefore teachers are in regular contact with school children over several years. Because teachers are in the school all the time offering education and guidance to students, they are in a better position to offer aids education. Teachers however, need further training to disseminate accurate information (Mouli, 1992:26). Before teaching others, teachers themselves must be comfortable with sufficient knowledge and the terminology to be used. Teachers must be aware that various cultures use different terminology for certain terms. For example, in some parts of Africa condoms are referred to as gumboots and raincoats.

According to Zazayokwe (1992: 7-8) the use of academic terms may embarrass the students or make education distant and remote.

Furthermore, words such as condom to not exist in any Black language. To prevent possible mis-communication the use of polite local expressions has proved to be more useful (Mogotsi, 1996: 73).

Teachers should also serve as good role models for their pupils. Bandura (1986) in Declemente (1992: 103) is of the view that people judge their own capabilities in part from how well those whom they respect exercise control over various situations. Teachers are encouraged to regulate control over their sexual behaviours. Students might be sceptical of messages such as "delay sexual intercourse", "have only one sexual partner" etc., if teacher's actions differ with such messages. They may see teachers as trying to deny them the pleasure that adults enjoy.

Because of the potential magnitude of the AIDS disease, additional resources are needed to intensify the school-based programmes. These include skills and knowledge of other professionals and interest groups.

3.9.7 COMPREHENSIVE SCHOOL-BASED PROGRAMMES

AIDS education is not a function limited to teachers, nor is it exclusively the responsibility of the school. In this regard Motang (1992: 16-19) stated that efforts by one discipline without the involvement of others will certainly fail. Extensive collaboration should take place between the teacher, the physician, the public health practitioner, minister of religion and other special interest groups (Mogotsi, 1996: 74).

When using the inter-disciplinary team approach, all participants use their skills, knowledge, techniques and approaches to reinforce behaviour change. Education involves much more than the mere giving of information and therefore the team needs to discuss all aspects of AIDS and be fully supportive of one another. The success of the team approach depends on the attitudes of the members, their willingness to participate and to respect each other (Sineloff, 1982).

Apart from professionals, comprehensive school programmes should include other role models found in the society. It is an established fact that people listen to people whom they admire and respect. Role models such as musicians, football players and actresses need to be involved. According to Mouli (1992: 26) these people are regarded highly by young people and could play an important role in influencing behavioural changes.

Furthermore, young field workers can also play an important role in the team. Adolescents are strongly influenced by their peers. In this regard peer pressure can be used positively to change unsafe sexual habits. This approach has been successfully used in addressing other problems such as alcohol and drug abuse. For example, in South Africa TADA (teenagers against the use of drugs. In order to avid duplication, the same groups may be encouraged to adopt AIDS education as one of their objectives. By using these groups of young people it is hoped that other teenagers will be able to give them an ear, especially because the message comes form people of the same age group (Mogotsi, 1996: 75).

Young people are at increased risk of HIV infection, therefore, education needs 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.

CHAPTER FOUR

4. MEASURES TO IMPROVE THE LIFESTYLE OF PEOPLE LIVING WITH HIV/AIDS

4.1 INTRODUCTION

HIV/AIDS in South Africa continues to grow at a rapid rate. It has become critically important for people to assess and appraise the likely threat of the epidemic. As far as possible, steps need to be taken to minimise the spread amongst community members and the overall impact of the epidemic on the entire community in general.

HIV/AIDS is an epidemic of prejudice therefore it is necessary to prevent the disease so as to prevent people from being prejudiced. Prejudice and discrimination have been exacerbated by the identification of infected persons. These irrational fears and negative discriminatory responses of the public and tragically those of some health care workers, teachers and employers also present a constant problem to people living with HIV/AIDS, their families and those concerned with their care. The family may experience distress by a conflict between their love of the people living with HIV/AIDS and the humiliation and social embarrassment of being closely associated with AIDS.

The social and emotional problems associated with HIV infection are the reflection of the social stigma which has been attached to the disease (Piane, 1988:67). HIV/AIDS is not only an incurable life threatening condition but also an epidemic of selfishness, prejudice and discrimination.

Herek and Glunt (1988:46) referred to this phenomenon as an AIDS related stigma, which resulted in an increase in stress levels and low immune functioning of people living with HIV/AIDS. In general HIV positive individuals are extremely reluctant to share their health status with other people. The person living with HIV/AIDS might keep this secret until it is absolutely necessary to disclose it, like when hospitalization occurs or once appearance betrays his/her condition.

There is no known cure for AIDS, no vaccine available for prevention, and no proven method for eliminating the infertility of the HIV carrier. For these reasons, great emphasis must be placed on preventing the transmission of HIV. In the absence of a cure for AIDS it is crucial to determine appropriate and effective means of prevention.

Everybody should now be aware that neither a vaccine nor an effective medical treatment will be available within the short to medium term to combat HIV/AIDS. In the mean-time AIDS continues to ravage the world. The pandemic will, however, be halted as soon as people do alter their life-styles. Unless social interventions do change behaviour or an HIV vaccine is found, the number of persons who will become HIV infected in South Africa will be measured in millions by the year 2000.

Herek and Glunt (1988:19) purports that the knowledge of the general public regarding the cause of the disease, its progression and the activity of the virus itself is solely lacking. As a result of considerable amount of fear exists in the general public as well as a negative reaction towards those being

affected and even those living suspected of being infected. The concern about the impact of AIDS-related issues, is not just to human suffering, the consequence of health care and the associated costs but also to the social context of the problem. AIDS leads to panic reactions among the population, risk groups and care providers. Among other things AIDS could lead to ostracism and discrimination.

Herek and Glunt (1988:46) referred to this phenomenon as AIDS related stigma, which resulted to an increase in stress level and low immune functioning of people living with HIV/AIDS. In general HIV positive individuals are extremely reluctant to share their health status with other people. These irrational fears and negative discriminatory responses of the public and tragically those of some health-care workers, teacher and employers also present a constant problem to people living with HIV/AIDS, their families and those concerned with their care. The family may experience distress by a conflict between their love of the people living with HIV/AIDS and the humiliation and social embarrassment of being closely associated with AIDS.

As the problem of AIDS affects more and more countries and greater numbers of people, provision of information and education should become a major weapon against the disease. Educational programmes should become a means of increasing knowledge of AIDS and changing attitudes and beliefs about AIDS. AIDS education is not only a form of disease prevention but is also a means of combatting fear and ignorance surrounding the disease which leads to the discrimination of people living with HIV/AIDS. To be

effective, educational programmes must target the specific behaviours that place people at risk of HIV infection. To cope with the most diverse and complex issues related to AIDS, people need not only to receive sporadic information but a continuous educational process that is able to bring to fullness the values of life (World AIDS, 1999:9).

Although education may not be the only strategy for combatting AIDS, it cannot be neglected especially in a deprived society where some of the people still do not know what AIDS is, and doubt its existence (Journal of Comprehensive Health, January/March 1996, Vol. 7 No. 1). In order to reduce its rate of spread, people everywhere, whatever their cultural or religious perspectives must face the challenges posed by HIV. It is a challenge that requires each member of society to respond positively to the pandemic.

Educational programmes to facilitate behaviour change should be a long term effort with multiple and repeated strategies to initiate and sustain behavioural change over time. They should involve publicity regarding the avoidance of shared needles for addicts and "safe" anal sex for homosexuals. Emphasis should be directed to heterosexual sex where anal sex is more prevalent than it was previously admitted. Specifically, it is important to maintain those general and targeted educational programmes designed to modify societal norms. However, according to Lachman (1991:183) it is important that sex education should be available to both males and females at an early stage and should preferably start at primary school level. Stine (1993:194) is also of the opinion that the leading prevention strategy is education whereby people

are taught how to adjust their behaviour to reduce or eliminate HIV exposure. Here the responsibility rests with the individual. Because the vast majority of HIV infections are transmitted through consensual acts between adults, Stine (1993:195) states that the individual has a choice as to whether to risk infection or not.

The absolute best way, as Stine (1993:197) has indicated, is through sexual abstinence. The next best way is a mutually monogamous sexual relationship and the use of male and female condoms or rubber dams.

According to Lachman (1991:182) the spread of HIV and thus AIDS is the product of human behaviour enacted in social contests. Thus according to him, the only preventive strategy is the continuing health educational programmes aimed at possible alteration of human behaviour.

Furthermore, AIDS prevention can be improved through behavioural skills training and developing specific interventions that target the peer group environment, rituals, partner relationships and lifestyles of drug users (Social Work, December, 1997:37 Vol. 33 No. 44).

In addition to the above Williams (1992:333) states that the future control of prevention strategies for Africa should consider at least three fundamental problems. The first problem is the control of sexually transmitted diseases and their effective treatment. These include diseases such as syphilis, gonorrhea and herpes to mention but a few. The second problem is control of other communicable diseases particularly those which are responsible for

immune dysfunction and suppression, facilitating progression of HIV infection to AIDS. The third and last problem is the provision of adequate resources for basic and applied research required for the prevention and treatment of the immune deficiency state in Africa due to retroviral infections and their associated squeal. William (1992:333) believes that these three issues are formidable. In order to solve them, the author advocates that the collective political will of all African governments must be energized and synchronised with the global efforts which are in full swing to combat this epidemic through education, information search, communication and development.

The key to prevent AIDS is to stop the transmission of the virus before it enters the human body. Unfortunately it is a given fact that while people clearly understand the risk and the means of preventing it, they are still resistant to change.

4.2 MEASURES TO IMPROVE THE LIFE-STYLE OF PEOPLE LIVING WITH HIV/AIDS

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 behaviours. Social efforts designed to control the spread of AIDS have centred mainly on informing the public about how the AIDS virus is transmitted and how to safeguard oneself against such infection. Unfortunately, information alone does not necessarily exert much influence on health-impairing habits. 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. According to Gordon and Klouda (1988:106) people with AIDS need a friend with whom they can share the grief, fears and joys. They need nursing when they have infections and practical help with domestic and economic issues.

What can be attempted in addition to providing information and making specific recommendations on practical issues, is to help people to cope with and contain their anxieties. Most commonly, this can be accomplished by structured discussions which help to lessen stress and demote AIDS from a concern of frightening and overwhelming proportions to one which has defined limits and can be ranked among the many other problems with which individuals and families have to cope.

The International Planned Parenthood Federation (IPPF) (1989:49) indicates that HIV/AIDS will place a heavy burden on the psychological support and physical care of infected persons. Therefore social workers, health care services and family planning associations will not be able to meet this need alone but could act as catalysts for community support systems. They may be able to train community counsellors and carers, link people with HIV/AIDS with available resources and help families accept and cope with members living with HIV/AIDS. Furthermore, family planning workers who are involved in health care, may offer advice on home care such as oral dehydration

therapy and tepid sponging and on the protection for the carers (IPPF, 1989:41).

Furthermore, in order to improve the social functioning of people living with HIV/AIDS, our new Constitution has a Bill of Rights. According to HIV/AIDS and the law: A resource manual of (May, 1997:36) a Bill of Rights is a list of fundamental rights that all South Africans have as human beings. These rights are for all people and must be respected by the courts, government, parliament, private organizations and even individual persons. The Equality Clause is one of the most crucial rights in the Bill of Rights. This clause does not allow any unfair discrimination against any person. As a result the Equality Clause (Section 9 of the Bill of Rights) is extremely important for people living with HIV/AIDS.

These rights amongst others also include people living with HIV/AIDS which implies that they deserve the same rights that all people have. For instance, they are entitled to intimacy because if condoms are used, there should be no risk of them infecting others. HIV is not transmitted by just touching someone or through the air. Connections with their families and friends should be retained. If "Universal Blood Precautions" are followed, HIV will not be passed on. If someone is separated from their family they feel isolated, sad and miss out on love and support. They have the right to have jobs, or to go to schools. They have the right to live in their own town and also have the right to be cared for.

Infected people experience considerable psychological stress, which is aggravated by the social stigma and discrimination. In challenging this discrimination, there must be a representative for the people living with HIV/AIDS, who will represent their concerns at national, provincial and community levels. AIDS representatives should ensure that there is a recognition of the fundamental human rights, that is, at school, workplace, hospitals and within the community at large and that these rights should be encouraged and be practised by all.

There must be encouragement and support for the development of self-held groups and networks where people with HIV/AIDS will be able to share the difficulties they are having and to listen to the way in which others have dealt with their difficulties. People living with HIV/AIDS miss some affection and therefore cannot reveal their HIV status. Once they do that, they lose friends and relatives. AIDS patients should be given moral support, encouragement and unconditional love in order to accept their status and to cope properly with life situations. Social workers and other authorities need to influence policy to suit the needs of people living with HIV/AIDS. Miller et al, (1986:133) also maintain that support groups fulfil important social needs as well as providing a context in which the common diagnosis can be discussed without fear or intolerance and fearful isolation can therefore be overcome.

Discrimination against people living with HIV/AIDS could also be challenged through workshops on AIDS. Peer educational models

could be used where people living with HIV/AIDS may share their experiences with their communities, thereby contributing to the prevention of the spread of the virus. This model may be the most innovative, energetic and successful method of educating people about AIDS as well as changing people's attitudes towards people with AIDS.

Unless sexuality and drug abuse are viewed by society as part of the human condition and a health problem respectively and until problems of poverty, racism and violence are considered not as individual failures or attitudes but as our greatest national priority, HIV infected people will continue to be discriminated against and blamed for the disease (Dan, 1994:184).

4.3 HEALTH BELIEF MODEL (HBM)

This model is the oldest of the health behaviour change models and grew out of researchers' initial investigations into the reasons for the widespread failure of people to take actions to prevent asymptomatic diseases. The Health Belief Model proposes that there are several factors which determine the individual's readiness to take action and engage in health-related behaviours in respect of a particular health condition. The HBM assumes that beliefs are primary determinants of behaviour and that there are six types of beliefs that may influence people in terms of preventive health behaviour (Seligon & Peterson, 1992:123).

- Certain cues of action;

- Perceived seriousness of the disease;
- The perceived barriers to preventive behaviour;
- Knowledge of the disease and preventive behaviour;
- The perceived individual susceptibility and beliefs regarding the disease; and
- Perceived benefits and costs of engaging in preventive behaviour.

4.3.1 PERCEIVED SUSCEPTIBILITY

According to Mogotsi (1996), the success of the public health strategy in dealing with an epidemic like AIDS depends to some extend on the role played by people's relative ideologies. The difficulty in getting the AIDS message across to the people, especially in Black communities, is complicated by the misconception that AIDS is a white homosexual disease. This makes it necessary to present information which accommodates black cultures and traditions (Tiba, 1990:9). For a black person whose health belief does not accommodate the acceptance of AIDS as a sexual disease in terms of the above mentioned definition, a possible alternative explanation may be a belief in the active, purposeful intervention of a witch or supernatural being. Recognition of this belief becomes important to the social worker when the patient makes contact with a hospital, since it may affect his/her attitude and adherence to the prescribed regime/method.

4.3.2 DEDUCTIONS

Deductions about individuals' behaviour in respect to AIDS:-

- People may choose not to consult a doctor at all, or they may consult a traditional healer because they fear embarassment and isolation that is associated with AIDS. Again since this is a terminal illness, it may not matter to the individual where he/she goes for help if he/she decides to do so.
- Because of factors as socio-economic status, individual roles in society, the rationalisation taught at school, and the impact of health care workers, black persons may later seek the help of a traditional healer if the treatment does not seem to help.
- Because AIDS is a terminal disease, chances are that an affected person may at one point during hospital care decide to test and evaluate alternative medicine (traditional healer) in the hope that a traditional healer can understand the disease better.

- Understanding patients' beliefs and perceptions may help social workers to develop helping strategies and skills that accommodate such beliefs. Social workers may enlighten other members of the medical team who may be ignorant of such beliefs and perception and the role they may play in whether or not the patient will follow the doctor's instructions.

The Health Belief Model has been useful in predicting health behaviour both before and during the illness. There is reason to believe that there

is a wide range of social implications that are the result of lay beliefs in respect of AIDS. Therefore there is a need for control of the disease based on thorough understanding of the beliefs and practices that put people at risk.

Suchman's Health Belief Action Model (1967) incorporated only the factors of physiological readiness, but also the need for social approval and the characteristics of the recommended health action itself. This model proposes that individuals and groups be assessed according to the following three factors: personal readiness factors, social control factors and situational factors.

The first criterion includes factors such as recognition of the seriousness of the problem, acceptance of personal vulnerability, predisposition to take action, motivation to act, ability to act, knowledge of the desired action and the belief in the desired action. The second criterion refers to the influence of the environment and includes factors such as social pressure to act and incorporation into role performance and acceptability beliefs and value system. The last criterion, the situational factors, encompass attributes of the agents such as effectiveness of the action, pleasure or attractiveness of the action, and positive previous experience with the desired action, or action suggests that the action be presented in an environment favourable to its use.

4.4 BEHAVIOUR MODIFICATION

Behaviourism as a school of thought developed by John Watson (1916) is also applicable. Basically behaviour modification is concerned with the unlearning of negative and undesirable behaviour through reinforcement and maintenance of desirable behaviour.

Through behaviour modification people can be helped to abandon their risky sexual styles which can make infection possible and adopt the safe styles of behaviour. It concentrates on the problem in its present form. Facing the HIV/AIDS problem, which is increasing everyday, people could be taught and encouraged to fight this fatal disease, for example, people can be taught the ABC method for combatting AIDS. A stands for abstinence, B for being faithful and sticking to one partner and C stands for condomize.

The AIDS pandemic is manifesting itself increasingly and it has important implications for the prevalence as well as the prevention of the disease. Van Rensburg (1992:190) indicated that researchers are no longer dealing with HIV which is restricted to a small subgroup or subculture within the South African population, but with the HIV which is endangering virtually the entire heterosexual population. Furthermore, the combating of the problem is entirely reliant on prevention, since at the present moment, there is no cure of immunization for the disease. The most important way to combat this disease and infection is by means of behaviour modification, especially

at the sexual level. This again is strongly linked to the values and norms of the communities.

Although behaviouralists can assist individuals, groups and communities, they acknowledge that events in the past contributed to the origin of unacceptable behavioural patterns and problems. However, looking at what happened in the past would do very little to solve the problems, but looking at the problem in its present form as behaviour modification suggests, will most probably prove to be more successful.

4.5 HOLISTIC APPROACH

Kleinman (1978:53) indicated that according to a holistic perspective, the mind or spirit and the body are viewed as inseparable and both are relevant in diagnosis and therapy. According to this theory, there is a believe in the inherent wisdom of the body and its natural potential to maintain health, with the result that holistic health care utilises the naturopathic moralities of therapy rather than pharmacological agents or any other artificial interventions. Particularly important is the fact that this type of care acknowledges and bears out the fact that health is the individual's own responsibility and that the patient should be an active participant in therapeutic endeavour. Kleinman 91978:54) indicated that the main goals of this approach are on prevention of disease and promotion of health rather than the treatment of a

disease. Furthermore this model concentrates on the total individual, that is on the physical, spiritual, mental, behavioural, emotional, nutritional, ecological and any other factors that can influence man's well-being.

The following section focuses on the role of social workers with regard to HIV/AIDS prevention

4.6 THE SOCIAL WORK BASE FOR PREVENTION

Social work is the purposeful and ethical application of personal skills in interpersonal relationships directed towards enhancing the personal and social functioning of an individual, family or neighbourhood, which necessarily involves evidence obtained from practice to create a social environment conducive in the well-being of all (Timms, 1982:183-184). According to Thomas (1988:107) the social work practitioner seeks to combine knowledge and skills in the best interest of service to the client.

Social work has been defined by the American National Association of social workers, in Matshego's research (1991:39) as the professional activity to help individually, groups and communities enhance and restore their capacities for social functioning while creating societal conditions favourable to their goals. Pincus & Minahan are reported by Matshego (1991:40) as seeing the purpose of social work as being:

- the enhancement of people's capacities in problem solving and coping;
- linking people with systems which provide them with resources, services and opportunities;
- promoting the effectiveness and human operation of those systems; and
- contributing to the development and improvement of social policy.

The purpose of social work is to address problems occurring within the community in which their clients live (Motang, 1992:6). It is a given fact that AIDS is a social problem. It has come as a threat to both health and social development as well as the survival of millions of individuals, families and communities. This, therefore, gives sufficient reason for social workers to be actively concerned about the disease and its implications.

Furthermore, the social worker's knowledge about human development, human diversity and social environment, places him/her at a good advantage to help in the prevention of the spread of AIDS. Preventive social work is defined by Bracht (1978:20) as "an organized and systematic effort to a manner as to enhance and preserve the social and mental health of the community".

In support of the above mentioned statement social work also seeks to enhance the social functioning of individuals, singly and in groups by

activities focussed upon their social relationships which constitute the interaction between man and his environment. These activities can be grouped into three functions, restoration of impaired capacity, provision of individual and social resources and prevention of social dysfunction (Skimore & Thackery, 1982:7).

These activities are discussed as follows:

4.6.1 RESTORATION OF IMPAIRED CAPACITY

Social workers in hospital settings seek to restore patients to socially acceptable functioning through the elimination of imbalance between their perceptions of the satisfaction of their needs and those of the larger society which they form part of.

4.6.2 PROVISION OF INDIVIDUAL AND SOCIAL RESOURCES

The social work profession promotes the effective and humane operation of medical, social and educational systems that link people to resources and services, educates them to better utilize them and contributes to the development and improvement of social policies and programmes (Muma & Lyons, 1994:203). In the medical setting social workers are involved in the evaluation of patients' coping abilities, support networks, resource systems and their basic needs including financial, emotional, employment and adjustment needs.

The initial evaluation done by a social worker is a complete psycho-social history that may include a personal history, family history, dynamics of relationships, educational and employment history, understanding of the medical situation, past and present coping strategies, and mechanisms employed and resources presently being used to meet the patient's needs. With this information the professional social worker will be able to assess:-

1. The level of understanding the HIV positive individual has of his/her medical condition;
2. Make-up and dynamics of personal support systems and networks;
3. Past coping mechanisms with focus on what is needed to handle the present situation;
4. Level of financial security and resource needs; and
5. Advocacy and educational needs within medical resource systems.

This evaluation, combined with the social worker's knowledge about the roles and duties of other professionals (i.e physicians, nurses, physician assistance and rehabilitation specialists) involved, allows the social worker to provide direct interventions such as counselling, education, advocacy and referral (Muma & Lyons, 1994:204). The social worker also provides consultative services to other members of the team regarding the special needs or social circumstances of the individual patient, family or significant others.

Furthermore social workers can be effective in reducing public hysteria and negative attitudes towards the victims of AIDS through education and advocacy. In a broader sense, by serving as advocates of better health care, social workers can assist the public in developing less judgemental attitudes towards people living with AIDS based on one of the cardinal social work values: namely, that all human beings have intrinsic work, irrespective of their past or present behaviour, beliefs, lifestyles, race or status in life (Dhooper, 1988:10).

Because of the stigma of the disease within segments of the population that have traditionally been discriminated against, there is an erosion of basic human and civil rights of all people with HIV infection and even those presumed to be carrying this virus. The social worker's advocacy in thus often required on the individual and community level to counteract HIV related discrimination.

The current HIV epidemic represents a multidimensional crisis for those directly affected by HIV, their families, friends and communities. The incidence severely threatens the economic viability of individuals and their families and it heavily taxes available health and social service resources. As the number of people with HIV infection increases more and more people will be personally and significantly affected by the epidemic. In South Africa, hundreds of thousand are infected and tens of thousands each year are expected to become ill and die. In response to this epidemic, social workers in all settings

should provide exceptional leadership and the much needed social services.

According to the New York City Chapter of NASW Recommendations (May 1993:1-2) the following guidelines are applicable to social workers:

1. All persons diagnosed with HIV infection or the presumption of HIV should have access to services offered by professional social workers. The obligation of all social workers is to provide the necessary services to the above people should be comparable to the ethical obligation to provide services to people regardless of their sexual orientation, race, colour, country of origin, creed, gender, age and disability.

2. Social workers in all practice settings and different levels of authority are obligated to become knowledgeable about transmission of HIV and
the disease process and be prepared to educate and counsel peers, other professionals and clients.

3. All social workers are obligated to update continually both their scientific knowledge about the HIV disease and their skills in effectively working with people with HIV infection, their family members, friends and others.

4. Social workers should encourage and support the development of written agency guidelines and procedures for their practice with people affected by HIV infection.

5. All social workers are obligated to respect the confidentiality of al written and oral communication regarding HIV disease and their clients. Special attention must be given to assuring the availability of anonymous HIV antibody testing.

6. Social workers should practise with other groups to lobby actively at the local, state and federal levels on behalf of people with HIV infection to improve the quality of their lives and to protect their civil liberties. Social workers must also advocate for increased funding for appropriate education, prevention, interventions, treatment services and research.

7. Social workers should be especially concerned about the emotional impact for people taking HIV antibody test, as well as the possible threat to their civil liberties. Attention should be taken to assure that pre and post test counselling standards are maintained. Supportive counselling and referral should be offered by social workers or other skilled professionals. All social workers should advocate, when necessary, for access early medical care and other needed psycho-social resources.

8. All social workers are obligated to keep up to date information on communities and community resources and how to access them. This includes mental health services, legal assistance, income maintenance, housing, hospices long term care, schooling and community participation and access.

9. Social workers should not be denied employment based on their HIV status or their presumed HIV status.

10. Social work practice with people affected by HIV-infection is highly stressful due to the increasing caseloads, bereavement overload, and a lack of on-going training and supervision. It is therefore important that social workers have supportive supervision, work time, staff support groups, peer consultation and respite from the strain of the work.

To date social workers have participated in the development of resources for HIV infected patients. They have played a major role in the identification of public assistance programmes and enabling of patients to become users of Medicare, medical aid, housing and the like.

To stop AIDS we clearly need every resource at our disposal. Most of all we need people - women and men, boys and girls, people living with HIV, people affected by AIDS and people who believe in change

(AIDS Analysis Africa Vol. 4-6 No. 1-6, 1993-1995:10). Unfortunately the epidemic is dynamic and continues to spread.

4.6.3 PREVENTION OF SOCIAL DYSFUNCTION

Social workers today are faced with a tremendous responsibility in assisting the ever-increasing number of AIDS patients. It goes without saying that discrimination against AIDS patients can cause serious dysfunctioning of the patient. Therefore social work practise consists of professional interventions that will enhance the development, problem solving and coping capacities of people (Muma & Lyons, 1993:103). To prevent social dysfunctioning, social workers provide professional services which aim at helping the patient to cope and function more effectively. The goal of the social worker could thus be seen as one who guides the patient to develop problem solving skills, to enhance and strengthen his emotional and social needs, and to enable the patient to cope in life. Without the necessary professional services AIDS patients in particular may feel isolated, ostracized and rejected and find it difficult to cope with their own life situation. This, therefore, gives sufficient reason for workers to be concerned about this disease and its social implications.

It has become apparent that on every level in social work education, in the development and administration of more programmes, and in practice, social workers need to become more concerned with the area of AIDS. Social workers, particularly those in the health fields where they are obliged to work interrelated with may other professional

disciplines, ought to make their contributions highly visible. They need to write, to think, to take part in research and to be action-oriented about social problems. Without this visibility, social workers will not be able to serve the clientele that desperately requires their services (Maforah, 1991:148).

Furthermore, social workers, particularly in South Africa, can no longer be bound in isolation with their clients. Their primary concern must be with solutions to extensive social issues. Every social worker must assume a broader stance and value his/her professional contribution highly enough for others to appreciate it. As noted by Bracht (1978:208), "the century old concerns of social workers for individual and family well being and for policies that will bring about a better infrastructure for service delivery in health and social welfare, clearly point to the need for more attention to prevention and the improvement of practice in this area". It is hoped that the social work profession will be prepared to rise to the challenge and provide vital leadership in obtaining creative help for clients with HIV/AIDS related problems.

With the emergence of AIDS, the primary goal of preventive social work is to translate health knowledge into effective self protection against HIV infection. This goal is based on the premise that AIDS is completely preventable with adequate information and the adoption of appropriate and acceptable behaviours. Unfortunately, most studies have indicated that there is still a

great deal of ignorance surrounding AIDS. With this lack of knowledge it becomes imperative that social workers be involved in AIDS education.

As the Acquired Immune Deficiency Syndrome (AIDS) epidemic continues to grow dramatically, social workers increasingly need solid knowledge and training to serve persons infected with HIV and those close to them (Social Work Abstract, March 1996 Vol. 32 No. 1). The history of service provision to the poor, the under-privileged, the sick and the outcast of society seems clear with regard to AIDS, at both the micro and macro level.

One way in which social workers can be more sensitive and responsive to the needs of clients is through person-to-person communication. Because of their knowledge of casework, social workers may encourage a relationship where individuals can feel comfortable to express deep-seated emotions and fears about contracting AIDS. The aim of counselling, is to help them to take the necessary actions to ensure that they do not become infected with HIV.

Furthermore, the main aim of individual counselling of AIDS patients and their families is to help them to come to terms with the socio-psychological impact of AIDS on their lives. The AIDS patients experience several emotions. The patients become angry, depressed and stress-laden. The only therapeutic measure with which the worker

must arm him/herself is of a sound worker-client relationship. This will facilitate ventilation and openness in their relationship. The social worker should provide the AIDS patients with current information necessary for coping with the disease (Caputo, 1985:363). The knowledge that one is going to die, brings about a great deal of anxiety and anger into the helping process. The patient may show this by being unco-operative towards the health-care officials and even refuse treatment.

Therefore the primary objective is to steer the patient towards existing services that can be beneficial to him. In this case the social worker has to enable the patient to reach a set goal that is accepting of medical treatment.

The social worker will do this by exploring the patient's view of the problem as well as their abilities and weaknesses. Workers should take the enabler role when their intervention activities are directed towards assisting patients to find the coping strength and resources within themselves.

Groupwork as a method of social work can also be used by social workers to discuss issues of human sexuality and HIV/AIDS with high risk people with a greater degree of confidence. It provides a non-threatening environment for growth, learning and prevention. This method emphasises mutual sharing of feelings, mutual support and integration of solutions (Heap, 1985:16). In group situations learners

can encourage one another to practise safe sex, to be assertive and also to gain skills to negotiate safe sex with their partners.

One of the techniques that is used extensively vulnerable groups is role play. According to Reid (1991:228) role play is used for the purpose of learning in the sense of acquiring new behaviour patterns. Role play demonstrates or illustrates particular behaviour and in so doing provides objective information. Diclemente (1992:29) stated that educators should demonstrate how to use condoms correctly. In this regard role playing can be particularly helpful.

Assertiveness training is also an important skill frequently taught in skill oriented groups Mogotsi (1996:81). It involves direct expression of both positive and negative feelings, at the risk of disapproval from other people. Because peer group pressure is a powerful force in determining behaviour especially female learners need/require this skill in decision-making.

Community work can also be used by social workers. Because of their knowledge of the community, they can link learners and the community at large with sources of information. In community work, it is usually emphasised that the worker must use the resources within the community, and if they are not available, they must be created (Henderson, 1985:11). A valuable approach is to involve all people in educational programmes. By involving the communities, social workers

are consistent with the professional principles of individualism, self-determination and self-help. Involving others increases the effectiveness of their intervention.

Social workers must mobilise resources within the community that can be of value to the AIDS patients. Social workers may be in a better position to serve as educators or information officers to impart knowledge to the community at large. The worker may provide educational services to the patient's family, companions, hospital staff and outside agency personnel with whom the patient system interrelates (Caputo, 1985:362). Offering information will not only help the community to be aware of AIDS, but will also help in the prevention of the disease.

Social workers, after establishing the congruency between the expressed and identified needs of the community with regard to AIDS can mobilise the community to form auxiliary committees of volunteers. These committees may end up as self-help groups.

Close liaison with the family planning clinics will provide fruitful results. The strategy of a family planning clinic is prevention, the watchword in this battle is prevention, because there is no cure (Albrecht, 1987:81).

It is hoped that AIDS will eventually be under control, if not with medicine or vaccination, then with knowledge, faithfulness in sexual relationships and by using condoms (Hammer 1987:30). Albrecht

(1987:81) in his precautionary measure also emphasised the use of condoms.

There is a need for social workers to be involved in research. This method will help social workers to analyse the life-styles and beliefs in respect of this disease, and to determine how these factors may influence people's behaviour in responding to the disease. Understanding people's beliefs and perceptions may help social workers to develop helping strategies and skills to accommodate such beliefs. For social workers to be effective they need to have thorough understanding of human behaviour, beliefs and practices that put people at risks.

This chapter clearly demonstrated that the practising social workers, particularly in South Africa can no longer be bound in isolation with their clients. Their primary concern must be with solutions to extensive social issues.

The above discussion has established that social workers have a meaningful role to play in education and prevention responsibilities. However, for social workers to be effective they need to have a thorough understanding of human behaviour, beliefs and practices that put people at risk.

CHAPTER 5

INTRODUCTION

Referring to the attitudes of the community concerning HIV/AIDS, the researcher had to decide who the respondents would or should be to fully portray and represent the feelings of the community. To be representative of the community and especially to measure the acceptance of HIV/AIDS persons by the broader community, the researcher decided to question ordinary people in the community, hospital, staff, employers and school principals.

1. ATTITUDE OF THE COMMUNITY

The following tables indicate the information collected from the community with regard to their knowledge and attitudes towards HIV/AIDS persons.

1.1 PERSONAL PARTICULARS OF THE SAMPLE GROUP

Of the 104 community members interviewed a total of 37.5% respondents were males and 62.2% were females. The majority of the respondents (80.7%) were in the age group 25-35 years. Fifty percent of the respondents had tertiary education and were administrators/clerical workers. Because of the respondents' age group and educational level it was accepted that they were able to portray the general attitude of the community at large regarding HIV/AIDS persons.

1.2 KNOWLEDGE AND ATTITUDE

Table No. 1 indicates whether the community member can identify an HIV/AIDS infected person.

TABLE NO. 1

Identification of an HIV/AIDS infected person.

Response	Number of respondents	Percentage
Identifiable	13	12.5
Not identifiable	91	87.5
Total	104	100

According to the above table the majority of the respondents (87.5%) were completely honest by saying that they will not be able to identify an HIV/AIDS person. Therefore this is why people with HIV/AIDS are possibly still accepted because they cannot be identified. This also creates a danger because people may indulge in sexual acts without realising that one of the partners may be HIV positive. Furthermore full-blown AIDS patients are not as yet generally visible in South Africa; therefore the disease passes through without much societal concern. The 12.5% of the respondents who mentioned that they will be able to identify an HIV/AIDS person have already come into contact with an AIDS patient.

1.3 Respondents were asked whether HIV/AIDS infected people should be marked in order to more easily identify them. The majority of the respondents (73.1%) were of the opinion that people living with HIV/AIDS should not be marked and that their status should remain confidential. This is an indication that people still respect the rights of people living with HIV/AIDS.

1.4 The following data is an indication whether AIDS should be declared a notifiable disease.

TABLE NO. 2

AIDS to be declared a notifiable disease.

Response	Number of respondents	Percentage
To be declared a notifiable disease	79	76.0
Not to be declared a notifiable disease	12	11.5
Uncertain	8	7.7
No response	5	4.8
Total	104	100

According to the Oxford Study Dictionary (1991:468) notifiable means to be notified/make shown. Notifiable diseases are those diseases that must be reported to the public health authorities. The majority of the respondents (76.0%) were of the opinion that AIDS should be included in the list of notifiable diseases which amongst others include diseases such as gonorrhoea, syphilis and choncroid.

1.5 In an effort to measure the knowledge of the community with respect to HIV/AIDS, they were asked to identify the main symptoms of HIV/AIDS infection. In reaction they mentioned the following symptoms: loss of body weight, diarrhoea, swollen glands and neck, vomiting and marks on the skin. They were further asked how HIV/AIDS is transmitted and they indicated the following routes of transmission: sexual acts, blood transfusion, same needles for drugs and breast feeding. From the responses it was clear that the community is well versed in the basic knowledge of HIV/AIDS.

1.6 The following table indicates whether the respondents are of the opinion that people may purposefully spread AIDS when they discover they are HIV/AIDS infected.

TABLE NO. 3

Response	Number of respondents	Percentage
Spread the disease purposefully	44	42.3
Do not spread the disease purposefully	21	20.2
Uncertain	39	37.5
Total	104	100

The above table indicates that the majority (42.3%) of the respondents believe that when people discover that they have AIDS they may purposefully spread the disease. This also gives a clear indication that people do not trust HIV positive people because they deliberately, knowing that they are HIV positive, may spread the disease. Furthermore 37.5% of the respondents were uncertain about the issue.

1.7 The following table is an indication whether people think that people with HIV/AIDS are themselves responsible for what happened to them.

TABLE NO. 4

HIV/AIDS infected people are responsible for what happed to them.

Response	Number of respondents	Percentage
Responsible	28	26.9
Not responsible	55	52.9
Uncertain	19	18.3
No response	2	01.9
Total	104	100

A great number of the respondents (52.9%) felt that people living HIV/AIDS are not responsible for what happened to them. Contrary to the above mentioned figure 26.9% of the respondents felt that people living with HIV/AIDS are responsible for what happened to them. The probably confusion concerning responsibility for the disease is attributable to the prevailing life-style of the community concerning their sexual practices which they are not prepared to forfeit because of the disease.

1.8 The following responses states whether it is scaring to the man in the street to realise that there are so many people living with HIV/AIDS in our midst.

TABLE NO. 5

Alarming statistics concerning HIV/AIDS.

Response	Number of respondents	Percentage
Scaring	71	68.3
Not scaring	15	14.4
Uncertain	13	12.5
No response	5	4.8
Total	104	100

Reflected in the above table the majority of the respondents (68.3%) were of the opinion that the increase of people living with HIV/AIDS is scaring. Despite the scaring aspect of the disease it would seem that people continue with their sexual practices and therefore the constant increase of the disease.

1.9.1 Respondents were asked what their own reaction would be when they realise that they are HIV infected.

TABLE NO. 6

Reaction after learning that the person is HIV infected.

Response	Number of respondents	Percentage	
Commit suicide	15	20.8	
Deny it	16	22.2	72.1%
Isolate oneself from other people	21	29.1	
Spread the disease purposefully	20	27.7	
Total	72	99.8	

The majority of the respondents (72.1%) were of the opinion that if they should realize that they are HIV positive they will either commit suicide, deny it or isolate themselves from other people. Contrary to the aforementioned figure 27.7% of the respondents indicated that they will purposefully spread the disease. Referring to Table 3 this ratio of nearly 1:3 people who exclaimed that they would purposefully spread the disease if they should find that they are HIV positive, is a most uneasy attitude. This finding to a great extent proveS the vengeance people reveal towards people who consciously or unconsciously spread the disease.

1.10 Respondents were asked whether they would allow their children to go out and associate with HIV/AIDS infected people (friends).

TABLE NO. 7

Permission to go out with an HIV/AIDS infected person.

Response	Number of respondents	Percentage
Will not grant permission	58	52.0
Will permit the child	48	46.0
Uncertain	2	2.0
Total	104	100

The majority of the respondents (52.0%) reacted that they will not allow their children to go out with an HIV/AIDS infected person. This indicates that people with HIV/AIDS are discriminated against. The evidence indicates, however that 46.0% of the respondents who indicated that they would not mind if their child is dated by a HIV infected person have either accepted a laissez faire attitude towards their children or they are not aware of the dangers of the disease. Furthermore their reason was that

they will encourage their children to take precautionary measures to protect themselves from being infected.

1.11 In an effort to determine people's attitude towards HIV/AIDS patients from a practical point of view, the respondents were asked whether they would mind sharing a bathroom with an infected HIV/AIDS person or having such a person as a boarder. The responses were as follows:

TABLE NO. 8 (a)

Sharing a bathroom with an HIV/AIDS infected person.

Response	Number of respondents	Percentage
Will share	70	67.3
Will not share	14	13.4
Uncertain	20	19.2
Total	104	99.9

A great number of respondents (67.3%) said that they do not mind sharing a bathroom with someone who is HIV/AIDS infected. They indicated that it has been proven that casual contact with an HIV/AIDS infected person does not cause infection. This indicates that people with HIV/AIDS are still accepted within the community.

TABLE NO. 8(b)

Rejection/acceptance of an HIV/AIDS infected boarder.

Response	Number of respondents	Percentage
Accept the boarder	50	48.0
Reject the boarder	30	28.8
Uncertain	24	23.0
Total	104	99.8

The majority of the respondents (48.0%) indicated that they will accept an HIV/AIDS infected boarder in their houses. They further mentioned that the HIV status of a person is not used as a criteria to choose people we want to associate with. However, 28.8% of the respondents were of the opinion that they will not allow an HIV infected boarder in their house.

1.12 The following data will give an indication whether a close family member who is HIV/AIDS infected will be allowed to remain in the household.

TABLE NO. 9

Retainment of a close family member who is HIV/AIDS infected.

Response	Number of respondents	Percentage
To remain	80	76.9
Ask him/her to go away/reject him/her	12	11.5
Uncertain	12	11.5
Total	104	99.9

According to the above responses it is clear that the majority of the respondents (76.9%) will allow a family member who is living with HIV/AIDS to remain in the household. Although it would seem that people in general are wary with regard to people infected with HIV/AIDS, they are still prepared to accept a close family member despite the threat of the disease.

1.13 When asked whether they would assist an injured stranger the following were their response.

TABLE NO. 10

Assisting an injured stranger.

Response	Number of respondents	Percentage
Will refrain from assisting	38	36.5
Will not refrain from assisting	64	61.5
Uncertain	2	2.0
Total	104	100

It is clear from the above table that people are still concerned about other people and that they will therefore assist people whenever necessary. However, HIV/AIDS in the majority of cases is not identifiable and therefore people will assist without realizing the risk or take the necessary precautionary measures.

1.14 In an effort to determine people's attitude towards HIV/AIDS infected people, the respondents were asked whether they would mind being given first aid by a stranger.

TABLE NO. 11

Reaction of people towards strangers.

Response	Number of respondents	Percentage
Feel bad	10	9.6
Go for blood test	50	48.0
Cannot get infected	40	34.4
Uncertain	4	3.5
Total	104	95.8

Reflected in the above table 48.0% of the respondents were of the opinion that they will opt for blood test to find out whether they are HIV infected or not. 9.6% of the respondents said they will feel bad and 34.4% said that they cannot get infected because HIV/AIDS is not contracted through casual contact.

1.15 Again to test the practical attitude of community members towards people infected with HIV/AIDS, the question was asked how they will react if they should find that the teacher at their children's school is HIV/AIDS infected.

TABLE NO. 12

The reaction of parents towards HIV/AIDS infected teachers.

Response	Number of respondents	Percentage
Worried	10	9.6
Not worried	80	76.9
Uncertain	14	13.4
Total	104	99.9

Looking at the above table it is clear that the majority of the respondents (76.9%) are or will not be worried about HIV/AIDS infected teachers in the schools. However, they indicated that they will educate their children about HIV/AIDS and how to protect themselves against infection. This is an indication that teachers with HIV/AIDS are not being discriminated against by the community members.

1.16 Respondents were asked what they consider to be the most effective measures to combat or prevent the spread of AIDS.

TABLE NO. 13

Prevention of the spread of AIDS.

Response	Number of respondents	Percentage
Regular blood tests	29	13.2
Usage of condoms	68	30.9
HIV infected mothers should be sterilized	25	11.4
AIDS should be a notifiable disease	24	10.9
Isolation of AIDS patients	3	1.4
Educational campaigns	54	24.5
Other	17	7.7
Total	220	100

It is most obvious according to the above table that the majority of the respondents (30.9%) opted for the usage of condoms followed by 24.5% who considered purposeful educational campaigns as important and 13.2% mentioning regular blood tests. Despite educational campaigns the two main suggestions refer to measures based on the continuation of people's sexual practices. In other words bearing in mind their life-style which includes their sexual practices they mainly opted for the use of condoms and regular blood tests.

2. KNOWLEDGE AND ATTITUDE OF HOSPITALS

Information concerning the prevalence of HIV/AIDS was directed to hospitals with specific reference to matrons and nurses in an effort to determine their policy, knowledge, attitudes and precautionary measures with regard to the disease.

2.1 The following table manifests the hospital policy with regard to people living with HIV/AIDS.

TABLE NO. 14(a)

Hospital policy with regard to HIV/AIDS.

Response	Number of respondents	Percentage
To treat all patients as potentially HIV positive	3	8.5
To maintain confidentiality	10	28.5
Not to discriminate against HIV/AIDS patients	9	25.7
Offering appropriate counselling	6	17.1
To treat patients with respect and dignity	4	11.4
No hospital policy	3	8.5
Total	35	99.7

In the absence of a specific hospital policy regarding HIV/AIDS patients, HIV/AIDS patients are treated the same as any other patients in hospitals. Therefore health workers are bound to the same policy which govern all hospital patients, like-wise patients was bound by the same policy. The responses from the above table state that the emphasis in hospital concerning HIV/AIDS patients are placed on confidentiality (28.5%), whereas 27.7% of health workers emphasised that HIV/AIDS patients should not be discriminated against. In addition 17.1% said offering of appropriate counselling services could be the major weapon to safeguard the health of other patients and health personnel.

2.2 When asked whether HIV/AIDS patients are managed differently in hospitals, the following were the responses of hospital staff members.

TABLE NO. 14(b)

Hospital policy with regard to the managing of HIV/AIDS patients.

Response	Number of respondents	Percentage
Not managed differently	1	5.0
Managed differently	15	75.0
Uncertain	4	20.0
Total	20	100

The above table shows that 95.0% including the 20.0% uncertainties responded that hospital policy does not advocate different handling of HIV/AIDS patients. This is a clear indication that hospitals apparently have not promulgated a separate policy for HIV/AIDS patients and that all patients, whatever their illness are treated equally.

However, it is accepted that health staff are well informed of possible dangers regarding these patients.

2.3 In the following table the awareness/unawareness, including knowledge of the disease regarding the risk of being infected by HIV/AIDS infected patients, in hospital wards was investigated.

TABLE NO. 15

The awareness/unawareness of the danger of being infected by other patients.

Response	Number of respondents	Percentage
Aware	5	25.0
Unaware	15	75.0
Total	20	100

It is apparent from this table that the majority (75.0%) of the respondents said patients were unaware of the danger of being infected by other patients.

2.4 The responses below provide details regarding health workers' reaction towards patients with HIV/AIDS.

TABLE NO. 16

Threat of nursing/dealing with HIV/AIDS patients.

Response	Number of respondents	Percentage
Comfortable	9	45.0
Uncomfortable	11	55.0
Total	20	100

According to the above table more than half of the workers (55.0%) stated that they feel uncomfortable realizing that they knowingly or unknowingly need to nurse HIV/AIDS patients. This gives an indication that a large proportion of nursing staff do have negative attitudes towards patients with HIV/AIDS. Contrary to the above mentioned figure 45.0% of the respondents stated that they feel comfortable dealing with patients living with HIV/AIDS. The reasons for being comfortable in nursing HIV/AIDS patients are firstly, that they know what precautionary measures to take to safeguard themselves and secondly, they have no other choice as this function is part and parcel of their task.

2.5 Similar to the afore-mentioned question respondents were asked whether they feel comfortable or uncomfortable when working in close quarters with HIV/AIDS infected colleagues, they responded in the following manner.

TABLE NO. 17

The attitude of health workers when working in close quarters with (possible) HIV/AIDS infected colleagues.

Response	Number of respondents	Percentage
Feel comfortable	15	75.0
Feel uncomfortable	5	25.0
Total	20	100

The majority of the respondents (75.0%) are of the opinion that working in close quarters with an HIV/AIDS colleague will not concern them. According to data collected one can accept that the majority of health workers, because of their knowledge of the disease, either are free of HIV/AIDS or they know how to deal with this disease. However, 25.0% of the health workers indicated that they would feel uncomfortable which is an indication of discrimination based on fear of contracting the disease.

2.6 The table below states that choices of health workers are prepared to nurse HIV/AIDS patients.

TABLE NO. 18

Choice with regard to HIV/AIDS patients.

Response	Number of respondents	Percentage
Not to attend	-	-
Attend	15	75.0
Compelled to attend	5	25.0
Total	20	100

100%

According to the health workers point of view they are either prepared or compelled to attend to every ill person whether it be a patient with HIV/AIDS or not. This response corresponds with previous information which indicated that if health work is your professional choice, you are either prepared or compelled to attend to all the patients alike.

2.7 Asked on how patients may react when placed in the same ward with HIV/AIDS infected patients, health workers were of the following opinion.

TABLE NO. 19

The possible reactions of patients according to health workers if placed in the same ward with HIV/AIDS patients.

Response	Number of respondents	Percentage
Would not accept care in the same ward/would feel uncomfortable	2	10.0
Would think that staff members are irresponsible and not caring	5	25.0
Develop an attitude towards that patient	3	15.0
Feel anxious due to lack of knowledge	2	10.0
Will isolate him/herself	2	10.0
HIV/AIDS reactions will develop on how knowledgeable the patient is about HIV/AIDS	2	10.0
Confidentiality	4	20
Total	20	100

The majority of the respondents mentioned that patients may react unfavourably if they are aware that they have been placed in the same ward together with HIV/AIDS patients. Included in the possible unfavourable reactions of patients are that they may feel that hospital staff are irresponsible placing them in the same ward with infected patients (25.0%), that they may react heavily against such a fellow patient (15.0%) and may feel anxious (10.0%). These and the other remarks indicate that

although hospital staff are to a great extent compelled to deal/nurse HIV/AIDS patients, ordinary patients admitted to hospitals may feel uneasy to share the same ward with HIV/AIDS patients. This attitude may be the result of discrimination or mere fear that they may contract the disease as well.

2.8 The following question which is very similar to the previous question was asked to find out how patients may react towards HIV/AIDS infected nursing sisters.

TABLE NO. 20

The patients reactions towards an HIV infected nursing sister.

Response	Number of respondents	Percentage
Confidentiality	4	20.0
Depends on the knowledge of patients about HIV/AIDS	4	20.0
Patients will be anxious, uncomfortable and will react negatively	10	50.0
Asked orf discharge	1	5.0
Refuse treatment	1	5.0
Total	20	100

60%

Data collected from the above table is reasonably similar to the information collected from the previous table, whereby a great number of the respondents (60.0%) said that

patients will feel anxious and uncomfortable when they realize that the nursing sister in charge is HIV/AIDS infected.

2.9 To the question, should health workers continue working irrespective of HIV/AIDS status, the following answers were given.

TABLE NO. 21

Continuing nursing duties after being diagnosed HIV positive.

Response	Number of respondents	Percentage
Permissible	16	80.0
Not permissible	1	5.0
Uncertain	3	15.0
Total	20	100

From the above table it is apparent that the vast majority (80.0%) of the respondents believe that they will be retained by hospitals even if they are HIV positively diagnosed.

2.10 All hospital staff are supposed to take the necessary precautionary measures to safeguard themselves against possible infection. The question was put to them to determine their feelings despite the precautionary measures.

TABLE NO. 22

Feelings of health personnel despite precautionary measures.

Response	Number of respondents	Percentage
The notion should be that every patient may be potentially HIV positive	8	40.0
Despite precautionary measures they still feel unsafe, uncomfortable & at risk	12	60.0
Total	20	100

The above table is a clear indication that health staff are continuously aware of the fact that the patients they are dealing with on a daily basis may be HIV positive. In other words there is the potential threat of being infected by them. This attitude urges them to be more cautious in the execution of their duties. However, 60 % of the health workers unconditionally exclaimed that they still feel uncomfortable knowing that they may be dealing with HIV positive patients.

2.11 All patients despite their illness are managed similarly. Hospital staff are aware of the risks involved with certain communicable diseases such as AIDS. For this reason certain precautionary measures as mentioned in the table below are imperative.

TABLE NO. 23

Precautionary measures.

Response	Number of respondents	Percentage
Educating patients	8	40.0
Offering appropriate counselling	8	40.0
Wearing gloves	4	20.0
Total	20	100

Three matters clearly emerge from the above table: firstly, all patients in hospitals need to be educated on measures to curb the possible spreading of the disease to fellow patients and health personnel. As many people may not be aware of their HIV/AIDS status or may not be prepared to disclose this knowledge, all patients, excluding AIDS patients per sè, are considered to be at risk and therefore they need precautionary education. Secondly, known HIV/AIDS cases need counselling as a tertiary preventive measure and thirdly, health workers as a precautionary measure should wear gloves where necessary in cases where transmission of the disease is possible.

2.12 Health workers like-wise do take precautionary measures to safeguard themselves from being infected with HIV/AIDS. Therefore the following table listed various measures that health workers make use of to safeguard themselves.

TABLE NO. 24

Precautionary measures that are taken by health staff to safeguard themselves from possibly being infected in the workplace.

Response	Number of respondents	Percentage
In-service training, awareness campaigns & workshops	5	16.6
Wearing gloves and gowns	16	53.3
Infected objects for example, needles should be properly discarded	4	13.3
Treat all patients as potentially HIV positive	4	13.3
No precautions taken	1	3.3
Total	30	99.8

According to the above table only a small percentage (3.3%) of the respondents mentioned that no precautionary measures are taken to safeguard themselves against AIDS. Being health workers one would expect that, apart from being made aware of precautionary measures on a regular basis, all possible measures will be taken to protect themselves from being infected.

3. KNOWLEDGE AND ATTITUDE OF EMPLOYERS

The following is an indication of data collected from employers/businesses concerning their policies; knowledge and attitudes concerning HIV/AIDS infected

employers.

3.1 Initially it was necessary to determine whether employers have an accepted policy with regard to HIV/AIDS.

TABLE NO. 25

Workplace policy with regard to the employment of HIV/AIDS persons.

Response	Number of respondents	Percentage
They should be employed	10	50.0
They should not be employed	4	20.0
Uncertain	6	30.0
Total	20	100

Workplace policy with regard to existing employers with HIV/AIDS.

Response	Number of respondents	Percentage
They must be fired	10	50.0
They should remain	8	40.0
Uncertain	2	10.0
Total	20	100

The above tables reveal that there is no laid down policy with regard to HIV/AIDS in the workplaces selected for this research. The majority of the respondents (50.0%) were of the opinion that people should be employed irrespective of their HIV/AIDS

status. They mentioned that employees with HIV/AIDS are similar to other employees suffering from other ailments. However, 50% of the respondents indicated that people with HIV/AIDS must be fired. Reasons for this drastic action are amongst others that they may be a risk factor in the workplace and possible absenteeism. According to the responses it is obvious that half of the employing bodies indicated that they are not in favour of employing or retaining HIV/AIDS persons in their workplace.

3.2 Following the previous question, respondents were asked whether a HIV test is a prerequisite for employment of a person.

The majority of the respondents mentioned that the HIV status of a person should not determine whether a person must be employed or not. A HIV test is therefore not at present a pre-requisite.

3.3 The following question was asked to discover how the respondents felt knowing that there are 1600 new cases of HIV/AIDS per day in South Africa.

TABLE NO. 26

Attitude concerning the rapid increase of HIV/AIDS.

Response	Number of respondents	Percentage
Feel comfortable	12	60.0
Feel uncomfortable	8	40.0
Total	20	100

Most people do not fully realize the pandemic proportions of this deadly disease and

although they may be aware of the rapid increase, it is not practically visible to them. As mentioned previously a great number of great employers will not employ a person with HIV/AIDS or will even dismiss a person with HIV/AIDS. This action will however only be taken if the employer is aware of such cases. However, HIV/AIDS is not visible until an advanced stage and therefore people in general are not bothered with its existence or increase.

3.4 The following responses summarize the management's attitude about working alongside or in close proximity with a person living with HIV/AIDS.

TABLE NO. 27

Attitude in working alongside or in close proximity with an HIV/AIDS infected person.

Response	Number of respondents	Percentage
Prepared to work alongside an HIV/AIDS person	12	60.0
Not prepared to work alongside an HIV/AIDS person	8	40.0
Total	20	100

According to the above table the majority of the respondents (60.0%) indicated that they will not mind working alongside or in close proximity with a colleague with HIV/AIDS. This indicates that employers do have a positive attitude or empathy towards fellow workers.

3.5 Employers were asked how they think employees will react if they know that there is a person infected with HIV/AIDS in their midst.

TABLE NO. 28

The attitude of employees towards co-workers with HIV/AIDS.

Response	Number of respondents	Percentage
React favourably	6	30.0
React unfavourably	12	60.0
Uncertain	2	10.0
Total	20	100

From the above table it is clear that the majority of the respondents (60.0%) are of the opinion that employees would most probably react unfavourably towards co-workers with HIV/AIDS.

3.6 Respondents were asked what their reaction would be in the event of an employee complaining that he feels uneasy working with a known HIV/AIDS infected person. The majority of the employers mentioned that through the aid of workshops, seminars and awareness campaigns most of their employees are well-informed and aware of HIV/AIDS. However, if an employee should appeal to management about being unsettled while working alongside a person with HIV/AIDS, they will make him/her aware that HIV/AIDS is not contracted through casual contact and should not disturb him/her at all.

3.7 Following the previous question employers were asked what precautionary measures they should take to ensure the safety of their employees against HIV/AIDS.

The majority of the respondents indicated that the following precautionary measures are adopted at their workplaces: monthly awareness meetings on HIV/AIDS, video cassettes are shown on HIV/AIDS, distribution of leaflets, brochures and pamphlets of HIV/AIDS and holding of regular seminars and workshops on HIV/AIDS. These actions by employers prove that they are aware of the disease and apparently do their utmost to make employees aware of the dangers of the disease and what they should do to safeguard themselves against contracting HIV/AIDS.

4. KNOWLEDGE AND ATTITUDE OF SCHOOLS

As an important section of the community, school principals were asked about their policies, knowledge and attitudes towards HIV/AIDS.

4.1 To determine the policy of schools the table below enunciates the different views of educators regarding the Department of Education's policy towards HIV/AIDS.

TABLE NO. 29

The Department of Education's policy with regard to HIV/AIDS.

Response	Number of respondents	Percentage
Acceptance	25	89.2
Rejection	-	-
Uncertain	3	10.7
Total	28	99.9

At present it would seem that the Department of Education does not have a specific policy with regard to AIDS. Data collected manifest that schools have a positive

attitude towards learners and educators with HIV/AIDS. This is supported by the above table, where 89.2% of the educators said that they will not discriminate against learners with HIV/AIDS and that they will unconditionally accept them in their schools.

4.2 The following information provides the school's policy with regard to the employment of staff members bearing in mind the possibility of applicants being HIV positive. All the principals mentioned that there is no laid policy with regard to the employment of HIV/AIDS infected teachers. Their response was that they will accept/employ HIV infected teachers. The fact is however that in the majority of cases they will not know whether applicants are HIV positive or not.

4.3 The following table summarizes the schools" opinions about the admittance of learners who may be HIV positive.

TABLE NO. 30

Admittance of HIV infected learners.

Response	Number of respondents	Percentage
Will be accepted/admitted	27	96.4
Will not be accepted/admitted	1	3.5
Total	28	99.9

From the above table it is obvious that the majority of the educators (96.4%) indicated that they will accept or have a positive attitude towards learners with HIV/AIDS in their schools. They mentioned that learners with HIV/AIDS are

similar to other children suffering from other ailments and they are therefore entitled to enjoy their human rights, namely the right to education. They further mentioned that they should not be discriminated against and they should be treated with respect. The respondents also mentioned that these children are protected by the Constitution.

4.4 The question arose that if a school should find that a learner is HIV/AIDS infected, will they retain the child in the school. Considering the response in table 4.1 it was not surprising to find a 100% retainment response in this regard. The educators also mentioned that the HIV status of a child cannot be used as a basis for excluding him/her from school unless his/her health has deteriorated and that it is not advisable for his/her sake to be in the school or if his/her personal behaviour may be a threat to other children in the school.

4.5 Parents, as one of the stakeholders in the educational system, also have a say in the admittance and or retainment of children with HIV/AIDS in schools. In the following table school principals were asked what they perceived parents' reaction would be in this regard.

TABLE NO. 31

Parents reactions toward HIV/AIDS infected learners (as seen through the principals'eyes)

Response	Number of respondents	Percentage
Unfavourable reactions	20	71.4
Favourable reaction	8	28.6
Total	28	100

Although the previous information indicated that principals will accept HIV/AIDS learners in their school, they are also aware that parents may not similarly react. Therefore 71.4% responded that parents may not accept such a situation. This again is an indication that parents may discriminate on the ground that they fear contamination of their own children.

4.6 As a follow up question to the previous table educators were asked what their own attitude would be if their children were HIV positive or if their children were in school with HIV positive children.

The information revealed that principals in this regard were faced with two issues: firstly, they mentioned in 4.1 and 4.2 that they are prepared or compelled to accept all children irrespective of their HIV/AIDS condition which expectedly also included their own children. Secondly as parents they would not like their children to be discriminated against which further supports their response of acceptance.

4.7 The following table is an indication of how principals will react towards teachers who may be HIV positive.

TABLE NO. 32

The reaction of principals towards HIV positive teachers.

Response	Number of respondents	Percentage	
Accept them	13	46.4	
Give them moral support	9	32.1	78.5%
Refer them for appropriate counselling	6	21.4	
Reject them	-	-	
Total	28	99.9	

Reflected in the above table 78.5% of the principals were of the opinion that HIV positive teachers should be accepted as they are and that they should be given moral support. This is a clear indication of non-discrimination.

4.8 Precautionary measures in schools are reflected in the following table.

TABLE NO. 33

Precautionary measures against HIV/AIDS in schools.

Response	Number of respondents	Percentage
Precautionary measures are taken	21	75.0
Precautionary measures are not taken	7	25.0
Total	28	100

Although the majority of principals (75.0%) said that precautionary measures are taken in their schools, these measures were not clearly elaborated on. The fact remains that the majority of schools are aware and prepared to deal with the possible spread of the virus.

4.9 To the question, what kind of precautionary measure are adopted by the schools to safeguard children against HIV/AIDS infection, the following were their responses.

TABLE NO. 34

Measures adopted by schools to safeguard learners against HIV/AIDS.

Response	Number of respondents	Percentage
Workshops, awareness campaigns, seminars & lectures	14	66.6
Distribution of condoms	7	33.3
Total	21	100

Looking at the above table it is clear that learners need to be made aware of the dangers of HIV/AIDS infection and therefore schools deliberately have to inform children about HIV/AIDS. The question of condoms is a most debatable issue. 37.5% of principals mentioned that they advocate the use of condoms even though learners may see this is a form of approval to perform sexual acts. However, data revealed that the majority of principals are totally against the advocating of condoms for school children.

CONCLUSION

To date there is no laid down or definite policy with regard to HIV/AIDS in the three institutions namely hospitals, business and schools. It seems as if the Constitution is regarded the only ruling instrument when coming to the issue of HIV/AIDS in these institutions. The Constitution emphasises that all people should not be discriminated against. The evidence indicates, however that people living with HIV/AIDS are accepted by the community at large including the afore-mentioned institutions. Though a certain percentage of the respondents discriminate against HIV/AIDS people, their discrimination is visibly based on fear. Furthermore, evidence indicates that discrimination will continue to exist even if there is/there may be a specific policy regarding HIV/AIDS infected people.

The issue of precautionary measures was also entertained, and it was clear that all the three institutions not excluding the community at large make use of precautionary measures to help prevent the spread of AIDS. The following were stated as the measures to prevent the spread of AIDS namely, wearing of gloves and gowns where necessary, workshops, educational campaigns and seminars on HIV/AIDS and finally advocating the use of condoms.

Information gathered revealed that it is important for infected people not to be discriminated against and that it is also necessary to create conditions for their acceptance in every sphere of life, that is in hospitals, businesses, schools and in the community. To achieve this objective, community participation remains an absolute pre-requisite.

CHAPTER SIX

6. MAIN FINDINGS AND RECOMMENDATIONS

This chapter focuses on the main findings and recommendations of the study. The main findings serve as the main summary of the research study, whereby all important facts are pointed out clearly. Based on the main findings the researcher was in a better position to formulate her recommendations. In an effort to test the attitude of the community towards people living with HIV/AIDS, the researcher questioned respondents from the community at large, hospital staff, employers and schools. The results of this survey can be summarized as follows:

6.1 THE EXTENT OF AIDS EPIDEMIC

It was pointed out that the first cases of AIDS were identified in South Africa in 1982 in homosexual men. At that stage, the epidemic resembled the Type I epidemic found in Western countries where the majority of infections were amongst homosexuals and bisexual men with a few cases being attributed to intravenous drug use and blood transfusions. Within a short time however, the epidemic began to reflect Type II epidemic found in developing African countries with the majority of infections occurring as a result of heterosexual transmission associated with increasing numbers of paediatric infections (Monogram for Dept of Health, April, 1999).

In particular there has been a dramatic rise of people living with HIV/AIDS in the North West Province since the beginning of the epidemic in the 1980's. Statistics from the 1988 surveillance on pregnant women showed that the North West province had moved from position four of all provinces in South Africa, to position one with regard to the prevalence of HIV. By 1998 more

than 36 percent of AIDS cases were reported in the North West Province (Monogram for Dept of Health, April, 1999). The latter figure reveal an alarming high predicted prevalence of AIDS in the North West Province with serious implications for the future such as the massive loss of people.

6.2 TRANSMISSION

Based on available data, scientists have concluded that throughout the world HIV is mainly transmitted through sexual contact. For HIV to be transmitted infected body fluids must enter the bloodstream of an uninfected person. The relevant infectious body fluids are semen, blood, vaginal secretions and breast milk. The virus can enter the body through the lining of the vagina, vulva, penis, rectum or mouth during sexual acts. Furthermore HIV can be transmitted through blood as well as from an infected mother to her child. The above mentioned modes of transmission are the well-known modes of transmission throughout the world an no other evidence has emerged to suggest different mods of HIV transmission.

6.3 SIGNS AND SYMPTOMS OF AIDS

AIDS is composed of many different diseases, and its signs and symptoms vary with the type and severity of the disease process. Many of the symptoms of AIDS are similar to those that occur in common illnesses such as colds, bronchitis and stomach flu. However with AIDS, these symptoms are usually more severe and last for a longer period of time. Generally speaking, the following are some of the common signs and symptoms of AIDS, namely, persistent fever or night sweats, severe fatigue, thrush (Candida), persistent diarrhoea, skin rashes and spots.

6.4 PREVIOUS RESEARCH STUDIES REGARDING AIDS

The current study found that limited studies on AIDS were carried out locally in South Africa. Some of these studies merely examined the knowledge and attitudes of health care professionals regarding AIDS (Eagle & Bedford, 1992). Further studies mainly concentrated on students knowledge and attitudes and practises concerning the disease. In this regard Basson et al. (1990) and Perkel et al. (1990) amongst others found that black high school students in the Cape Town area were relatively ignorant with regard to AIDS. Studies which utilized mostly white and coloured students from the Universities of Free State and Western Cape as well as white medical professionals in the Johannesburg area and the University of Natal Medical school in Durban found that their participants were mostly well-informed on the main facts about AIDS (Eagle et al., 1992; Schlebush et al., 1991).

However, according to Lachman (1991:183) whatever the level of knowledge, it is imperative that sex education should be available to both males and females at an early stage and should preferably start at primary school level.

In this regard recent studies (Diclemente, 1992:6; Mogotsi, 1994:62; Kaya and Kau, 1993:10) found that the majority of adolescents were knowledgable of the disease but have many misconceptions which make them highly vulnerable. Despite the knowledge held by students it was found that few changed their unsafe sexual practises. These findings suggest that there is a need for further research to investigate how AIDS knowledge can be translated into effective self-protection action against HIV infection.

6.5 KNOWLEDGE AND ATTITUDES TOWARDS AIDS

It was found that attitudes of people towards AIDS patients may be influenced by the way people perceive the disease. Gilman (1988) as mentioned by Lesley (1992:42) states that people 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 than themselves or their group. People especially the youth have a tendency to project AIDS away from themselves.

Denial also has an effect regarding change of attitudes. According to Silgerson and Peterson (1990:123) most human beings are still faced with a "denial syndrome" of saying "I have no chance of becoming infected". This therefore makes it difficult for people to change their attitudes.

Mwale and Burnard (1992:72) in their study on rural women and AIDS found that women have knowledge that promiscuous behaviour is the quickest mode of HIV transmission. Furthermore, they indicated that sticking to one partner and using condoms are the most effective ways to prevent the AIDS spread. It is clear from the above observation that many women know how and what should be done to prevent AIDS. However, experts are of the opinion that no matter how accurate the information is people may have about AIDS, it has not led to long term behaviour changes (The Star, 11 July 1991). A major problem in the spreading of the disease is that a great number of people are not aware that they are infected. The reason why people are reluctant to know about their health status is that there is no cure for AIDS. According to Evian (1993:73) many people are of the opinion that there is little to be gained in undergoing the AIDS test because there is no effective treatment for those who discover that they are antibody positive.

AIDS is everyone's issue. As a result, it requires a response rooted in a commitment to challenge all our attitudes, assumptions, fears, prejudices and traditional approaches on every related issue to come up with truly new solutions which are in everyone's interest (Herbst, 1991:83). HIV/AIDS patients need support from their families, friends, colleagues and different organisations. This will help the afflicted person to reduce anxiety, alleviate depression, lessen self-destructive impulses and help people to cope with mental and physical stress associated with the need of living with others.

6.5.1 KNOWLEDGE & ATTITUDES OF THE COMMUNITY TOWARDS PEOPLE LIVING WITH HIV/AIDS

The findings suggest that the past history has affected the South African community to an extent where AIDS was identified as a potential instrument used by the previous government to scare the black community with the purpose to decrease fertility and keep the population in balance (AIDS & Your Response, 1992:143). To the broader community this was an accepted message to use AIDS as a political tool by government to continue its undemocratic running of the country without the majority having a democratic right to the high echelons of the government. For this reason massive campaigns against AIDS are needed for the various communities to change their attitudes towards the disease away from political issues.

Similarly, misinformation about the basic facts of AIDS is responsible for attitudes of prejudice, fear and aggression against people with HIV/AIDS and their relatives. Despite many efforts to educate people about HIV/AIDS, the myths do not die out. These myths were shown in

Drum (1997:21) that some men believe keeping a condom under the pillow during sex or that if you do not breath deeply while making love will keep AIDS away.

According to Leclerc-Madlala (Sunday Times, 4 April 1999) more young girls are being raped by men who believe that this will "cleanse" them of the disease. Leclerc-Madlala continues to state that "according to 19th century beliefs, sex with a child was thought to provide a cure for syphilis ... quack doctors kept special brothels in Liverpool since 1827 to provide for this cure". This myth still exists that sex with a virgin is a cure for AIDS. The existence of this myth was found by researchers in KwaZulu-Natal, Zambia, Zimbabwe and Nigeria. It is further indicated that this myth is more prevalent than local authorities in South Africa and AIDS educators are prepared to acknowledge. These myths may also be a significant factor in the reported rapid rise in the past years of sexual abuse and HIV infection among young girls (Anderson, 1999).

The findings suggest that it has become necessary to do research on the knowledge and attitudes of the community towards people living with HIV/AIDS as this disease is affecting people at an alarming rate. The diagnosis of AIDS itself is a catastrophic trauma. The manner in which AIDS patients are being discriminated against especially in hospitals, workplaces, schools and the community at large, also has an impact on their increase in stress level and low immune functioning. The increasing number of people infected by AIDS, their reluctance to

share their HIV positive status is a warning signal that people need to change their attitudes towards people living with HIV/AIDS.

Finally, all members of the communities, in the educational institutions, in the workplace, in schools, in the media, in financial institutions, hospitals, places of worship and recreation must work together to eradicate the discrimination that denies support and dignity to those who are living with HIV/AIDS. It is a reality and spreading at a rapid pace. The community can only win against HIV/AIDS if it comes together to save the nation.

6.5.2 KNOWLEDGE & ATTITUDES OF THE HOSPITALS TOWARDS PEOPLE LIVING WITH HIV/AIDS

The study revealed that in the absence of a specific hospital policy regarding HIV/AIDS patients, HIV/AIDS patients should be treated the same as any other patients in hospitals. Therefore health workers are bound to the same policy which govern all hospital patients and like wise patients are bound by the same policy. The responses stated that the emphasis in hospitals concerning HIV/AIDS patients are placed in confidentiality. It was also noted that offering of appropriate counselling services could be the major weapon to safeguard the health of other patients and health personnel.

According to the health worker's point of view they are either prepared or compelled to attend to every ill person whether it be a patient with HIV/AIDS or not. This response emphasises that health work is a

professional choice and therefore a health care professional should either be prepared or is compelled to attend to all the patients alike.

Data clearly revealed that health staff are continuously aware of the fact that the patients they are dealing with on a daily basis may be HIV positive. In other words the potential threat of being infected by them. This attitude urges them to be more cautious in the execution of their duties. However, 60% of the health workers unconditionally exclaimed that they still feel uncomfortable knowing that they may be dealing with HIV positive patients.

The study further demonstrated that fear and concern about acquiring HIV infection is widespread among health workers. Knowledge about occupational transmission and inactivation of the virus is also limited (Sibbad & Freeling, 1988). Fear of occupational infection is often associated to overestimating the risk of casual transmission of HIV, and ignorance about infection control measures. There appear to be some health care professionals whose perceptions of personal risk associated with providing care to AIDS patients have led to attempts to refuse or avoid giving care. Such perceptions create fear in health care providers and give them a false impression that their archons are ethically justifiable to refuse providing care. Blumefield & colleagues (1987:132), for example, reported a high percentage of nurses they surveyed who said that they would seek a transfer from their assigned unit if they were required to work with AIDS patients on a regular basis.

In addition to the above mentioned statement, the advent of AIDS is accompanied by uneasiness, anxiety and even panic among health care professionals. In many instances these reactions persist, despite an abundance of literature supporting the low probability of infection. Because of significant fear of contamination, patients are regarded with suspicion and the social stigma attached to AIDS leaves patients vulnerable to moral condemnation (Nursing Republic of South Africa, 1990:2). What form it takes, AIDS discrimination will be redressing for those who have HIV related illnesses or are antibody positive.

There is strong evidence indicating that by genuinely listening to and acknowledging the patient's fears and concerns, the nurse can provide support to an individual who is probably feeling hopeless, powerless, confused and frightened. Sometimes just being there for the patient is helpful, allowing them time or providing physical contact, comfort and even distraction through music or reading.

This study on health worker's knowledge and attitudes towards people living with HIV/AIDS, point to a need for continuing staff training and education, both for their own and the patient's benefit. Exposure to professional acquaintances with HIV positive people promote better attitudes towards their care and a more realistic assessment of the risk of HIV transmission in the hospitals.

6.5.3 KNOWLEDGE & ATTITUDES OF THE EMPLOYERS TOWARDS PEOPLE LIVING WITH HIV/AIDS

It was noted that there is no laid down policy with regard to HIV/AIDS in the workplaces selected for this research study. Despite this a great number of respondents (employers) were of the opinion that people should be employed or retained in their employment irrespective of their HIV/AIDS status. They mentioned that employees with HIV/AIDS are similar to other employees suffering from other ailments. However, 50% of the respondents indicated that people living with HIV/AIDS must be fired. Reasons for this drastic action are amongst others that they may be a risk factor in the workplace and possible absenteeism. According to the responses it is obvious that half of the employing bodies indicated that they are not in favour of employing or retaining HIV/AIDS persons in their workplace.

The current study found that, to understand the underlying dimensions of ethical issues regarding AIDS at the workplace, one must bear in mind the myths and misunderstanding that form the basis for many assumptions about the virus. In spite of documented evidence to the contrary, many individuals, including public and private managers, believe that AIDS can be contracted by casual, nonsexual contact. This is simply not the case as there has been no documented proof of infection resulting from such casual contact. In fact, studies of family members and loved ones caring for AIDS patients have shown no cases of infection due to this type of contact.

Available data dictate that South African managers need to be aware of the potential impact of AIDS on their organisations, their employees and productivity. The way in which managers address AIDS in the workplace will determine whether companies can survive the first decade of the 21st century (Iclinic, August 1999:29). South African statistics show that the workforce is likely to be 20% HIV positive by this year 2000. There will also be 580 000 new cases a year and a life expectancy of just 38 by 2010. There are 2.2 million AIDS orphans in South Africa alone which predicts a very high potential for the next generation. Accoridng to Iclinic (August, 1999:29) South Africa could lose about 20% of its workforce within the next six or seven years. Many companies are already losing 3% of their workforce annually to the disease.

Indeed, AIDS is an employment issue and cannot be ignored until there is an incidence of AIDS in the organisation. Besides the legal, ethical and economic considerations, employers need to recognise that they are going to have to deal with prejudice, ignorance, discrimination and fear. It is therefore important to be proactive and to formulate a policy on AIDS prior to being confronted with the problem of an employee who has been exposed to HIV/AIDS (Community Health in South Africa, 1990:29).

The study emphasizes that it is equally important that all employees are reached and that implications of the infection are clearly outlined. It is of paramount importance that the employee representatives and their organisations (Unions and shop stewards) are informed of the

potential risk and danger to their constituencies and that they be integrally involved in all initiatives and steps to convince employee representatives of the issues and to enlist their commitment and support to contain the epidemic. Failure to do so will most definitely result in the epidemic following its predicted course with little hope of reducing the future size of the epidemic.

6.5.4 KNOWLEDGE & ATTITUDES OF SCHOOLS TOWARDS PEOPLE LIVING WITH HIV/AIDS

In regard to learners, recent studies in South Africa show that the youth are sexually active from an early age (on average at 7-14 years) and in most cases have multiple partners. The youth therefore have an increased risk of exposure to HIV infection. This is an important factor when considering suitable measures for prevention of HIV infection in South Africa. However data from a variety of high school sex education classes offered across the country, indicate that teenagers are learning the essential facts about HIV/AIDS but are not practising what they learn (Stine, 1993:351). They do not do what they know. Risky sexual behaviour is widespread among teenagers and has resulted in high rates of STD's and HIV infection.

A recent survey run by People Magazine indicated that 90% of high school students and 99% of college students knew that HIV is mainly spread through the heterosexual population. However the majority of these learners stated that they continued to practice unsafe sex. Combined data from surveys performed in 1988-1989 indicated that among sexually active teenagers, only 25% used a condom (Stine,

1993:358). If HIV becomes widespread among today's teenagers , there is a real danger of losing tomorrow's adults.

Concerning the reaction of schools towards HIV/AIDS, it would seem that the Department of Education does not have a specific policy with regard to HIV/AIDS. Data collected manifest that schools have a positive attitude towards learners and educators with HIV/AIDS. This is supported by 89.2% of the educators who said that they will not discriminate against learners with HIV/AIDS and that they will unconditionally accept them in their schools.

Looking at the information gathered it is clear that learners need to be made aware of the dangers of HIV/AIDS infection and therefore schools deliberately have to inform learners about HIV/AIDS. The question of condom advocacy was the most debatable issue. 35.7% of the principals mentioned that they advocate the use of condoms even though learners may see this as a form of approval to perform sexual acts. However, data revealed that the majority of principals are totally against the advocating of condoms for school children/learners.

In conclusion, the results of this study indicated that commitment is urgently needed in the educational institutions to start addressing the issue of HIV/AIDS in the primary and secondary schools, in the teacher training colleges and at tertiary education level. It is important that AIDS education in schools be aimed particularly at learners younger than the age group likely to have risk behaviours. If many students leave school before this age it may be appropriate to target even

younger learners. All older students also need to be targeted (AIDS Prevention Through Health Promotion, 1991:70).

6.6 MEASURE TO COMBAT HIV/AIDS

The study found that, in challenging discrimination against HIV/AIDS patients, there should be a representative for people living with HIV/AIDS who will present their concerns at national, provincial and community levels. AIDS representatives should ensure that there is recognition of the fundamental human rights, that is, at schools, workplaces, hospitals and within the community at large and that these rights should be encouraged and be practised by all.

Discrimination against people living with HIV/AIDS could also be challenged through workshops on AIDS. Peer educational model could be used where people living with HIV/AIDS may share their experiences with their communities, thereby contributing to the prevention of the virus. This model may be the most innovative, energetic and successful method of educating people about AIDS as well as changing people's attitudes towards people living with HIV/AIDS.

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. According to Gordon and Klouda (1988:106) people with AIDS need a friend with whom they can share the grief, fears and joys.

With regard to precautionary measures, the majority of the employers indicated that the following measures are adopted at their workplaces: namely, monthly awareness meetings on HIV/AIDS, distribution of leaflets, brochures and pamphlets on HIV/AIDS

among the employees and holding of regular seminars and workshops on HIV/AIDS. These actions by employers prove that they are aware of the existance of the disease and apparently do their utmost to make employees aware of the dangers of the disease and what they should do to safeguard themselves against contracting HIV/AIDS.

A small percentage of health professionals mentioned that no precautionary measures are taken to safeguard themselves against AIDS. They further mentioned taht being health workers one would expect that apart from being made aware of precautionary measures on a regular basis, all possible measures will be taken to protect themselves from being infected.

Although the majority of principals said that precautionary measures are taken in their schools, these measures were not clearly stated. The fact remains that the majority of schools are aware and prepared to deal with the possible spread of the virus.

Given the statistics and the particularly strong impact of this disease, HIV/AIDS awareness programmes need to be ongoing and sustained. It needs to be properly targeted and carried out by experts in appropriate languages. Persons affected by or believed to be affected by HIV/AIDS should be protected from stigmatisation and discrimination by co-workers, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.

Social workers are therefore needed to translate health knowledge into effective self protection against HIV infection. This goal is based on the premise that AIDS is completely preventable with adequate information and the adoption of appropriate and

acceptable behaviours. Unfortunately, most studies have indicated that there is still a great deal of ignorance surrounding AIDS. With this lack of knowledge it becomes imperative that social workers be involved in AIDS programmes and education. Information gathered revealed that it is important for infected people not to be discriminated against and that it is also necessary to create conditions for their acceptance in every sphere of life, that is in hospitals, businesses, schools and in the community at large. To achieve this objective, community participation remains an absolute pre-requisite.

6.7 RECOMMENDATIONS

HIV/AIDS represents a major public health and social problem in South Africa. The spread of HIV has occurred through the exchange of body fluids between individuals, specifically blood products, vaginal fluids, semen and breast milk. The virus cannot be spread by casual person to person contact. Because of the stigmatisation of the disease and its initial appearance with segments of the population that have traditionally been discriminated against, there is an erosion of basic human and civil rights of all people with HIV/AIDS infection and even those presumed to be carrying this virus. Advocacy HIV/AIDS related discrimination.

Based on the researcher's main findings, the following recommendations are made: Even though from the research findings it is indicated that the community most probably have some knowledge about AIDS, it should not be assumed that all people know enough about this disease, especially people at grass roots level. There is still a need for the community to be enlightened about the contributing factors to HIV/AIDS and therefore educational campaigns should be intensified so as to champion this mission. It is equally important that all community members are reached and that implications of the infection are clearly outlined. Failure to do so will almost surely

result in the epidemic following its predicted course with little hope for reducing the future size of the epidemic.

In addition to the above mentioned recommendations, the government should avail more resources in the form of manpower, financial resources and communication resources to help bring HIV/AIDS information to the community especially in areas or groups where HIV/AIDS has been found to be more prevalent. Communities should also be empowered and encouraged to form community based organizations and non-governmental organizations that will champion the rights of HIV/AIDS patients and give them support. This will show most people that HIV positive patients are also worth living normal lives.

Education about HIV/AIDS should also be conducted in the workplaces where resourceful people or speakers from a local AIDS organization will conduct educational presentations to the employees. A series of presentations and/or workshops are recommended to convey the current state of the epidemic to companies and its employees. It is equally important that all employees are reached and that the implications of the infection are clearly outlined. HIV/AIDS have to be integrated into existing workplace policies. There must be equal opportunities for all employees, for example, sick leave granted to infected employees should not allow discrimination in the workplace and institutions. Policy should include equal treatment in the same manner as any other progressive/debilitating illness. Furthermore, large companies should introduce programmes like Employee Assistance Programmes (E.A.P) to assist employees and their families with personal issues and how to cope living and working with an HIV positive person.

Educational campaigns should try by all means to target children while still in their formative years (Ratefane, 1999, Life skills Annual General Meeting). Messages and educational programmes need to be used to communicate about HIV/AIDS. The youth, as the most exposed people to this disease should be involved in a fight against AIDS contrary to them being used as tokens. They should be engaged as active participants in decision making.

Therefore life skills involve personally responsible choices. When people are being personally responsible they are in the process of making choices that maximize their happiness and fulfilment. Personal responsibility is a positive concept wherein people are responsible for their well-being and for making their own choices within the givers of their existence.

Life skills are the component skills through which people assume rather than avoid personal responsibility for their lives. Life skills are self-helping skills that enable people to help themselves. As such they empower people to internalize a repertoire of life skills according to their developmental tasks and specific problems of living rather than disempower or weaken people. Skills therefore enable people to care for themselves in a supportive environment and is concerned with independence in self care, understanding the environment and living with others.

It is also recommended that if a family member becomes infected, the whole family should be counselled on how to handle the situation and the infected person must join groups where HIV/AIDS infected people are involved, so that he/she must not feel rejected or unwanted. In this case, groupwork as a method of social work can be implemented to people living with HIV/AIDS to help them meet their personal needs. When people living with HIV/AIDS meet together they are likely to give each other

advice and support so as to cope more effectively with daily demands. They also realise that they are not alone with their problems.

The usage of condoms as prevention strategy should be encouraged at all costs. Condoms should also be availed in all public places, that is, pubs, schools, universities, government complexes, toilets, airports and all other places where people meet. Local, provincial and national public office bearers should give out condoms at every public rally they address.

Churches as the pillars of community morals, should also spearhead the campaigns to teach their congregations about the importance of nurturing HIV/AIDS patients. Priests and other church leaders must lead the campaigns by preaching about the ways to prevent the disease from further spreading.

Social workers should participate with other groups to lobby actively at the local, provincial and state levels on behalf of people with HIV infection to improve their quality of life and to protect their civil liberties. They should also advocate for increased funding for appropriate education, prevention interventions, treatment, services and research.

Future research efforts need to be more specific. The researcher is of the opinion that community members should also be asked to explain which aspects of HIV/AIDS they know, agree/disagree with and to provide reasons for their answers. This will help to find out how knowledgeable people are about HIV/AIDS issues. Furthermore, carefully structured research in particularly this area (the knowledge and attitudes of the community towards people living with HIV/AIDS) is needed to contribute to improved understanding. A survey on a much broader scale involving attitudes is therefore

recommended as the community will be faced with an increasing number of infected persons in their midst.

The most important and compelling conclusion is that the HIV epidemic has the potential, over the medium term, to block sustained human development. The unfair discrimination and human rights violation of infected and affected people requires urgent attention. The objective of sustainable human development is that all citizens should participate in and benefit from economic and social development. The degree to which this objective is achieved in South Africa will determine our ability to respond effectively to the HIV epidemic.

6.8 BIBLIOGRAPHY

1. A **Resource manual,** May 1997.
2. Aggleton P, Davies P, and Hart G, 1995 : AIDS. **Safety, Sexuality and Risk.**
3. Aggleton, P, Davies P and Hart G, 1994: **Social Aspects of AIDS - AIDS Foundations for the future**. Burgess Science Press, Great Britain.
4. Aggleton, P, Davies P and Hart G, 1995: Aids – **Safety, Sexuality and Risk.** Burgess Science Press, Great Britain.
5. **AIDS Analysis Africa**, 1993-1995 Vol. 4-6 No 1-6
6. **AIDS Analysis Africa,** April 1994 Vol. 4 No 6
7. **AIDS Analysis,** June/July Vol. 8 No 1
8. AIDS and Your Response, 1992: **The Institute of World concerns University of South Africa and Conference Planners**, United Kingdom.
9. **AIDS Bulletin,** August 1992 Vol. 1 No 1
10. AIDS Prevention Through Health Promotion, 1991 - **Facing Sensitive Issues.** Published by WHO. The Royal Tropical Institute, Amsterdam.
11. **American Journal of Nursing**, February 1986.
12. Anderson et al. 1991: AIDS. Abstract of Psychological and Behavioural literature 1983-1991 (3rd ed) Washington, D.C.: **American Manuscript**. Psychological Association.
13. Anderson W.W. **The causes of child sexual Abuse**. Unpublished manuscript.
14. Ashmore D, 1975: "**Societal and Individual Orientations Toward Prevention**". In A Milunsky. **The Prevention of Genetic Diseases and Mental Retardation**.
15. Babbie A, 1992: **The Practice of Social Research**. Wodsworth Publication Co., California.
16. Babbie E.R, 1973: **Survey Research Methods**. Wadsworth Publishing, USA.
17. Bailey K.D, 1987: **Methods of Social Research**. The Free Press, London.
18. Bandura, A, 1983: Self-efficacy. Mechanism in Human Agency. **American Psychologist.**

19. Banyard P and Hayes N, 1994: **Psychology - Theory and Application**. Published by Chapman & Hall, London.

20. Barnett, T & Blaikie , P . 1992. **AIDS in Africa: Its present and future impact**, 1st edition. Belhaven Press, London

21. Behr L, 1988: **Empirical Research Methods for Human sciences.** Butterworth Publishers (Pty) Ltd, Durban.

22. Berer M, 1993: **Women and AIDS.** An international resource Book. Pandora Press, London.

23. Blendon, R. 1992: **Public Opinion on AIDS**. Jama Publishers, USA.

24. Blumefield and colleagues, 1978.

25. Bracht. N, 1978: **Social Work in Health Care**. A Guide to Professional Practice: Haworth Press, New York.

26. Breytenbach H.J, Basson A.F, & Van Deventer, A 1990. **Bewyssyn van en gesinheid teen Vigs by studente van die UOVS**. Community Health in South Africa.

27. Bush C, 1988. **Nursing Research**. Reston Publishing Co. Inc., Virginia.

28. Caputo L, 1985 : Dual Diagnosis. AIDS and Addiction. **Journal of the National Social Workers** Vol. 30 No. 4.

52. Chapter of NASW Recommendations, May 1993 **"Social Work Practice for people affected by HIV infection"** New York.

29. Chipfakacha, V, 1987: **HIV/AIDS and sexually-transmitted diseases** – unpublished manusript.

30. **Community Health in South Africa**, March 1990. Vo. 5 No 1.

31. Cross C.P, 1994: **Interviewing and communication in social work**. Routledge and Kegen Paul, London.

32. Cross S and Whiteside A, 1993: **Facing up to AIDS**. The socio-economic Impact in South Africa. St Martin Press.

33. Dan A.J, 1994 : **Reframing women's Health**. Multidisciplinary Research and Practice. Sage Publications, USA.

34. Denning J.V, 1992 : AIDS. **The Real Truth about the Acquired Immune Deficiency Syndrome.**

35. Dhoopers, 1988 : **Social Work Practitioners Attitudes Towards AIDS**. Journal of Applied Social Sciences Vol. 12 No 361.

36. Diclemente R, 1992 : **Adolescents and AIDS. Sage Publications Inc.**, USA.

37. **Drum Magazine**, 1997.

38. Eagle G, & Bedford R, 1992 : AIDS: **Knowledge and attitudes of a group of South African health Professionals**. South African Journal of Psychology Vol. 22 No 1.

39. Eskander G.S, Jahan M.S. and Carter R.A, 1990 : AIDS. Knowledge and attitudes among different ethnic groups. **Journal of the National Medical Association.** Vol. 82. No4.

40. Evian, 1995 : **Primary care**. Jacana Education Publishers, Johannesburg.

41. Fishbein and Ajzen, 1975: **Belief, Attitude, Intention and Behaviour**. Massachusetts, Addison-Wesley

42. Goettsch D.L, 1993 : **Occupational Safety and Health** (2nd ed) Prentice Hall Inc., United States of America.

43. Golden R.M, 1984 **: Longman Dictionary of Psychology and Psychiatry**.

44. Gong V, 1985 : **Understanding AIDS. A comprehensive Guide**. Cambridge University Press, USA.

45. Gordon G. And Klouda T, 1989 : **A crisis. AIDS and family planning work.** Macmillan Publishers Ltd, Hong Kong.

46. Gottlieb, N.H, Vacalis , D.T. Palmer, D.R & Conlon , R. T . 1989. **AIDS-related knowledge, attitudes, behaviours and intentions among Texas College students.** Special issues AIDS. Health Education Research. Vol. 2 , No. 8

47. Green J. And Miller D, 1986 : AIDS. **The story of a Disease.** Grafton Books, London.

48. Grinell R, 1988 : **Social Work Research and Evaluation**. Liveburgy Publishers Illinois F.E, Britain.

49. Hayes N, 1994 : **Foundations of Psychology. An Introductory Text**. Clays Ltd, St IVESPCC, Great Britain.

50. **Health and Medical Information Booklet**, 1999. American Embassy, Pretoria.

51. Herek G.M and Glunt E.K, 1988 : **An Epidemic of Stigma. Public Reactions to AIDS.**

52. **HIV/AIDS and Human Development**, 1988. South Africa.

53. **HIV/AIDS and The Law**, 1997 : Published by the AIDS Law Project and Lawyers for Human Rights.

54. Hubley J, 1990 : **The AIDS Handbook**. Macmillan Publishers. Ltd, Hong Kong.

55. Iclinic, 29 August 1999 : AIDS : **Exponential workforce wipe-out, end to Africa Renaissance dream.**

56. **Journal of American Medical Association**, 1997.

57. **Journal of Community Health in South Africa**, March 1990.

58. **Journal of Comprehensive Health,** January/March 1996 Vol. 7 No 1

59. Kaya O, and Kau M, 1993 : Knowledge, Attitudes and Practice in regard to AIDS. Social Science Students at the University of Bophuthatswana. **In curationis**, 1994 Vol.17 No 2.

60. Kiple K.F, 1993 : **The Cambridge world History of human Disease,** Cambridge University Press, New York.

61. Klouda, 1989. **A crisis: AIDS and family planning work**. Macmillan Publishers Ltd.

62. Krebs, D & Schmidt, P. (Eds). 1993: **New Directors in Attitude Measurement**. Walter de Gruyter & Co., Berlin.

63. Lachman S.J, 1991 : **The Challenge. AIDS in the 1990's**. Lennon Limited, South Africa.

64. Lesley M, 1992 : Women, AIDS, Power and Heterosexual Negotiation. **A Journal about women** Vol. 5.

65. Lippa, R.A, 1994 : **Introduction to Psychology** (2nd ed) Wadsworth, Inc., Belmont, California.

66. Liskin L, Church C.A, Piotrow P.T and Harris, J.A. 1989 : **Population Reports. AIDS Education - a beginning. Issues in World Health.**

67. Little M, 1979. **Sexually Transmitted Diseases**. Chelsea House Publishers, New York Philladelphia.

68. Lo-Bion-doowood and Herber, 1990 : **Nursing Research**. The C.V. Mosby Co., USA.

69. Maforah F, 1991 : **An investigation into the knowledge and attitudes of the community with regard to the Prevention of Genetic Diseases and Mental Retardation**. Unpublished Manuscript.

70. Mallman M, Cliff R.A and Hagget P, 1992 : **Atlas of AIDS**. Blackwell Publishers, Cambridge - USA.

71. Mann, J, 1988 : **Prevention and control of AIDS**. Summit of Ministers of Health Programs. Pergamon Press, Oxford.

72. Mann, M, Piot. P, Ngugi E.N, Colebunders R, and Wabitsch R, 1992 : **AIDS in Africa**. A Manual for Physicians. World Health Organisation, England.

73. Maslow, A, 1969 : **Toward a Psychology of Being**. Van Nostrand, New York.

74. Matshego, 1991 : **The Role of the Prison Social Worker with Special Reference to the Implementation of a problem-solving treatment programme for Juvenile Delinquents at Odi District Prison in Bophuthatswana**. Unpublished Manuscript.

75. Matthews C, Kuhn C, Metcalf C.A, Jourbet G, and Cameron N.A, 1990 : Knowledge, Attitudes and beliefs about AIDS in Township school students in Cape Town. **South African Medical Journal**.

76. McKendrick B.W, 1990 : **Introduction to Social Work in South Africa**. Haum Tertiary, Pretoria.

77. Metropolitan Life, 30 September 1999 : **AIDS Pandemic seen worsening next century.**

78. Miller et al. 1986 : **The Management of AIDS Patients**. Macmillan Press, London.

79. Miller N. And Rockwell R.C, 1988 : AIDS in Africa. The social and Political Impact. Studies in Africa. **Health and Medicine** Vol. 10. The Edwin Melta Press, Lewiston/Queenstown.

80. Mitchel G, 1979 : **A New Dictionary of Social Science**. Routledge and Kegan, Britain.

81. Mogotsi M.M, 1996 : **An Investigation into the knowledge and Attitudes of female scholars in regard to sexual practices and AIDS**. Unpublished Manuscript.

82. **Monogram for the Department of Health**, April 1999.

83. Motang R 1992 : Social Work Needs to Address AIDS. **Social Work Practice** Vol. 2 No. 90.

84. Mouli C, 1992 : **All Against AIDS**. G. And A Williams Publishers, London.

85. Muma R and Lyons B.A, Borucki M.J. and Pollard R.B, 1994 : **HIV Manual for Health care professionals**. Appleton and Lange, United States of America.

86. Mwale G, and Burnard P, 1992 : **Women and AIDS in Rural Africa**. Avebury Publishers, Britain.

87. **Nursing Education**, January 1999 Vol. 38 No. 1 Aslack Incorporated Publication.

88. **Nursing Republic of South Africa**, August 1990 Vol. 4 No. 8

89. Oskamp, S, 1977. **Attitudes and opinions**. New York, Prentice Hall

90. **Oxford Reference Dictionary**, 1986 : Oxford University Press, Britain.

91. **Oxford Study Dictionary**, 1991 : Oxford University Press, Great Britain.

92. Panos, 1989 : **The Hidden cost of AIDS. The challenge of HIV to Development**. The Panos Publications Ltd., London.

93. Piane, 1988 : AIDS. **Psychiatric and Psycho-social perspectives**. Croom Helem, New York.

94. Polansky L, 1976 : **Social Work Research**. The University of Chicago Press, USA.

95. Pollak et al., 1992 : **AIDS. A problem for sociological Research**. Sage Publications Ltd., London.

96. Pratt J, 1988 : **AIDS. A Strategy for Nursing Care**. Edward Arnold, London.

97. Pratt R, 1992 : **AIDS. A Strategy of Nursing care** (3rd ed) Britain Library cataloguing in Publication Data, Great Britain.

98. **Psychology Medicine of HIV infection**, 1995.

99. **Public Health Nursing**, August 1998.

100. **Public Health Nursing**, February 1998.

101. **Public Health Nursing**, February 1998.

102. Ratefane T, 1999: **Life Skills Annual General Meeting**.

103. Reid W, 1984: **Research in social work**. Columbia University Press, New York.

104. Richardson, P, 1989: **Women and the AIDS crisis**. Unwin Hyman Ltd., London.

105. Rokeach M, 1973. **The nature of human values**. New York. The Free Press

106. Ross , M, W. 1989. **Distribution of knowledge of AIDS**. A National Study. Social Science and Medicine

107. Rubin A and Babbie, 1993: **Research Methods for social work** (2nd ed) Wadsworth Inc., California.

108. Sapire E, 1990: AIDS. Are teenagers at risk. **Medical Sex Journal** Vol. 1 No.2

109. Schoub B, 1984 : **AIDS and HIV in Perspective**. Cambridge University Press, Great Britain.

110. Schrunik E and Schrunik W.J, 1990. **Lay Perceptions of a group of gay men**. Human Science Research Council, RSA.

111. Silgerson P and Peterson F, 1990 : AIDS. **What should we Do?** Milbook Publishers, London.

112. Simbayi L, 1993: **A Survey of knowledge**, **Attitude and Practice of college of education students in Bophuthatswana Regarding AIDS and condom use.** Unpublished Manuscript.

113. Sineloff P, 1982: **Experience and outcomes in AIDS**. Social Press, California.

114. Skidmore R.A. & Thackery M.G. 1988: **Introduction to social work** (4th edition).

115. **Social work Abstract**, December 1997 Vol. 33 No.4

116. **Social work Practice** Vol. 2 No 92

117. Stine G.I, 1993: **Acquired Immune Deficiency Syndrome**. Prentice Hall, New Jersey.

118. Suchman, A: Preventive Health Behaviour. A model for Research on community health campaigns, **Journal of health and social behaviour**, Vol. 8 No. 3

119. **Sunday Times Newspaper**, 14 November 1999

120. **Sunday Times Newspaper**, Business Times, 4 April 1999

121. Temoshok, Sweet and Zich, 1990. The three city comparison of the public's knowledge and attitudes about AIDS. **Psychology & Health**, Vol. 1 No. 1

122. **The Concise Oxford Dictionary**. 1983: The Oxford University Press. Great Britain

123. **The Star Newspaper**, 11 July 1991

124. Thomas, S. B , Gilliam, A. G & Iwery, C. G. 1988. Knowledge about AIDS and reported risk behaviours among black college students. **Journal of American College Health**. Vol. 38 , No. 2

125. Timms, R and Paul K, 1982 : **Dictionary of social welfare**, London - Boston.

126. Tyson, G. A. 1987. **Introduction to Psychology: A South African perspective**. Westro Reproductions, Johannesburg

127. **Universal Dictionary**, 1988: Readers Digest (5th ed). The Readers Digest Association.

128. Van Rensburg, H.C.J ; Fouke A ; Pretorious , E . 1994. **Health Care in South Africa – Structure and Dynamics**. Kohler Carton and Print, Natal

129. Weisberg H, Kronsnick J and Bowen B, 1996: **An Introduction to survey Research**. Polling and Data Analysis (3rd ed). Sage Publications Inc., California.

130. Whiteside A, 1988: **Implications of AIDS for Demography and Policy in Southern Africa**. University of Natal Press, Durban.

131. Whiteside, 1990. **Facing up to AIDS. The socio-economic impact in South Africa**. Macmillan Press Ltd.

132. Williams, G, 1992. **From fear to hope. AIDS care and prevention at Chikankata Hospital**, Zambia Actionaid, London

133. Wolman B.B, 1982 : **Dictionary of Behavioural Science** (2nd ed), New York.

134. **World AIDS**, July 1999 No. 10

135. **You Magazine**, 1997

136. Zazayokwe M, 1990 : **Some Barriers to Education About AIDS in the Black community**. Social Work Practice Vol. 2 No. 90.

ADDENDUM

A QUESTIONNAIRE

FOR

THE COMMUNITY INCLUDING HOSPITALS, BUSINESS AND SCHOOLS

TITLE : INVESTIGATION INTO THE KNOWLEDGE AND ATTITUDES OF THE COMMUNITY TOWARDS PEOPLE LIVING WITH HIV/AIDS

RESEARCHER: LORNAH REFILWE MPHO RAKOMA
DEPARTMENT OF SOCIAL WORK
UNIVERSITY OF THE NORTH WEST

THE RESEARCHER WOULD LIKE TO REQUEST YOUR ASSISTANCE IN A RESEARCH STUDY DESIGNED TO INVESTIGATE THE KNOWLEDGE & ATTITUDE OF THE COMMUNITY TOWARDS PEOLE LIVING WITH HIV/AIDS.

YOUR PERSONAL IDENTIFICATION (ADDRESS, SIGNATURE ETC.) DOES NOT APPEAR ANYWHERE ON THE QUESTIONNAIRE. THIS MEANS THAT YOU REMAIN ANONYMOUS. PLEASE NOTE THAT ALL THE INFORMATION YOU PROVIDE BY ANSWERING THE QUESTIONS WILL BE TREATED AS HIGHLY CONFIDENTIAL.

GENERAL INSTRUCTIONS

PLEASE ANSWER ALL QUESTIONS COMPLETELY AND HONESTLY. REMEMBER, YOU REMAIN ANONYMOUS! MARK THE APPROPRIATE ANSWER WITH A CROSS (X) OR WRITE YOUR RESPONSE ON THE GIVEN SPACE.

ADDENDUM

QUESTIONNAIRE TO THE COMMUNITY

Demographic information

1. Sex

Male	
Female	

2. Age

25-35	
36-45	
46-53	
56 and above	

3. Educational status

None	
Standard 1-5	
Standard 6-10	
Tertiary Education (College, Technikon and universities	
Professional (Teacher, nurse, lawyer etc)	

4. Occupation

Administrator	
Artisan	
Unskilled	
Pensioner	
Housewife	
Unemployed	

Other (specify) _____

Questions regarding AIDS

5. Can you identify a person who is HIV infected?

Yes	
No	

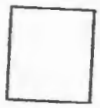
6. If yes how?

_____

_____

7. As a parent/guardian will you allow your daughter or son to go out with a person with HIV?

Yes	

No 

8. If yes, are you not afraid that your daughter or son can be infected:

_____

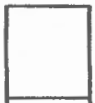
_____

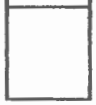
9. If no, why not?

_____

_____

10. As one is not aware of the fact that a stranger may be infected with HIV, would the possibility refrain you from assisting an injured person?

Yes 

No 

11. If Yes, what would you do?

_____

_____

12. If No, why not?

_____

_____

ATTITUDE QUESTIONS

Attitude	Agree	Disagree	Uncertain
13. When people discover that they have AIDS they purposefully spread the disease			
14. AIDS should be declared a notifiable disease			
15. People think that people with AIDS are themselves responsible for what happened to them			
16. People who are HIV infected should be marked so that people will recognise them			
17. It is scaring to realize that there are so many people you daily come into contact with who may be HIV infected			

KNOWLEDGE ABOUT AIDS

18. What are the symptoms of AIDS?

Loss of body weight	☐
Diarrhoea	☐
Swollen glands and neck	☐
Vomiting	☐

Other (specify) _____

19. How is AIDS spread?

Sexual acts	☐
Blood transfusion	☐
Using same needles for drugs	☐
Breast feeding	☐

Other (specify) _____

20. How would you react if you were told that you have HIV/AIDS?

Commit suicide	☐
Deny it	☐
Isolate myself from other people	☐

Other (specify) _____

21. What can be done to prevent the spread of AIDS?

Regular blood tests	
Usage of condoms	
HIV mothers should be sterilised	
AIDS should be a notifiable disease	
Educational campaigns	
Isolation of AIDS patients	

PLEASE GIVE AN EXPLANATION TO THE FOLLOWING QUESTIONS.

22. Would you share your bathroom with a person living with AIDS?

_____

_____

_____

_____

23. Would you accept a boarder in your house if you know that he/she is HIV infected?

_____

_____

_____

_____

24. If any of your close family members becomes HIV infected, would you allow him or her to remain in your household?

_____

_____

_____

_____

25. If you find that one teacher, where your child is attending is HIV positive and already showing positive signs of AIDS, what would be your reaction?

_____

_____

_____

26. What would you do if you find that a person living with AIDS has given you first Aid by breathing through your nostrils?

_____

_____

_____

27. Further comments

_____

_____

_____

ADDENDUM

Dr. Vitalis Goodwell Chipfakacha
STD/HIV/AIDS and Health Promotion
Department of Health
Private Bag X2068
Mmabatho
Tel: 018 3875 227/0825784046
Fax: 018 3875 332

Thusong Hospital
Bophelong Hospital
Victoria Hospital

RESEARCH: ATTITUDES OF THE COMMUNITY TOWARDS PEOPLE LIVING WITH HIV

My office would appreciate your helping Ms Lornah Refilwe Mpho Rakoma in her research on the Attitudes of the Community towards people living with HIV.

As hospital employees are part of the community she would like to hear their opinion using a questionnaire survey.

She needs only 7 questionnaire answered by sisters in charge of wards and hospital Matrons.

This study is of great importance to us as well.

Thanking in advance

V.G. Chipfakacha

cc. Mr V. Panday : Director Hospital Services

ADDENDUM

QUESTIONNAIRE TO HOSPITALS

Behavioural questions regarding AIDS.

1. What is the hospital policy with regard to AIDS/HIV patients?

_____

_____

_____

2. Does the fact that you know that a certain percentage of your patients are HIV/AIDS infected make you feel uncomfortable?

Yes ☐

No ☐

Please motivate your answer

_____

3. According to your experience, are patients in hospitals aware of the danger of being infected by other patients?

Know ☐

Don't know ☐

Please motivate your answer

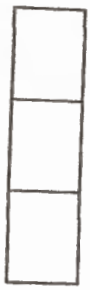
_____

4. According to hospital policy are HIV/AIDS patients handled differently?

Yes

No

Uncertain



Please motivate your answer

_____

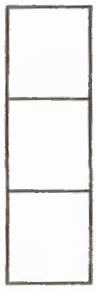
_____

5. Is it permissible that staff of the hospital can continue his or her job after being diagnosed HIV positive?

Yes

No

Uncertain



Please motivate your answer

_____

_____

6. If yes, what precautions are taken, that she or he does not transmit the disease further?

_____

_____

7. Would you mind working in close quarters with an HIV/AIDS colleague?

Yes ☐

No ☐

8. If you had a choice whether to attend to an HIV patient or not, what would have been your choice?

Not to attend ☐

Attend ☐

Compelled to attend ☐

Please motivate your answer

9. What precautions are being made by this hospital to safeguard their staff from being infected?

10. According to your opinion how will a patient react if she or he is placed in the same ward with an HIV/AIDS infected patient?

11. People are not compelled to undergo AIDS tests, how does this affect the staff not knowing whether a patient is HIV/AIDS infected or not?

12. According to your opinion how will the patient react if she or he finds out that the nursing sister who is in charge of him/her is HIV/AIDS infected?

13. Further remarks

ADDENDUM

31 May 1999

AIDS SURVEY
TO WHOM IT MAY CONCERN

Knowledge and attitudes of the community towards people living with AIDS

The Minister of Health recently mentioned that we in this country experience an added number of 1500-2000 new cases of HIV daily. The result of this rapid increase is that we will on a daily basis come into contact with more and more AIDS patients.

The question arose what will be the attitude of the general community be towards AIDS patients. For this reason the Department of Social Work at the University of North West decided to undertake research to determine the knowledge and attitudes of the community in general towards AIDS patients. It will therefore, be appreciated if you can assist Ms Lornah Rakoma in gaining information regarding this research project.

We appreciate your co-operation.

Your sincerely

_____

Prof W W Anderson
Department of Social Work

ADDENDUM

QUESTIONNAIRE TO EMPLOYERS

Knowledge about AIDS

1. What is the general policy at your work-place with regard to HIV/AIDS with special reference to employees and those who are about to be employed?

_____

_____

_____

2. Are there any measures taken at your workplace/company to properly inform employees of the existence, spread and precautions with regard to HIV/AIDS?

Yes ☐

No ☐

3. If Yes, what are the measures?

_____

_____

_____

4. Would you as part of management be prepared to work alongside, in close proximity with a person living with AIDS?

Yes ☐

No ☐

Please motivate your answer

_____

_____

5. Are there any AIDS tests expected before employing a person?

Yes

No

Motivate your answer

_____

_____

6. We know that HIV/AIDS affects 1500 people per day in South Africa. Does this make you feel uncomfortable?

Yes

No

Please motivate your answer

_____

_____

7. What will the attitude of other employees be according to your experience/opinion, if they should know that there is a person living with AIDS in their midst?

_____

_____

_____

8. If employees are aware of such a situation and should appeal to you, what will management do, or how will they react to that?

_____

_____

_____

9. Further remarks

_____

_____

_____

QUESTIONNAIRE TO SCHOOLS

Demographic information

1. Sex

   Male

   Female

2. What is the Department of Education's policy with regard to AIDS?

   _____

   _____

   _____

3. As the principal will you accept a child in your school if you know that she/he is infected with AIDS?

   Yes

   No

   Uncertain

   Please motivate your answer

   _____

   _____

   _____

4. If it is found that one of the children in your school is HIV infected, would you retain him or her or ask him or her to leave the school?

Motivate you answer

_____

_____

_____

5. According to your experience/opinion would parents react if they should be aware of an HIV/AIDS child/pupil in the school?

Motivate you answer

_____

_____

_____

6. If you, yourself had children in a school where you know that there are children with HIV/AIDS, what would be your attitude in this regard?

_____

_____

_____

7. Children play and blood may be mixed, what precautions are taken at your school to possibly prevent AIDS?

_____

_____

_____

8. What measures has your school adopted to safeguard children against HIV infection?

_____

_____

_____

9. If you find that some of your teachers are HIV positive what will be your reaction?

_____

_____

_____

10. Is there any policy which requires the HIV status of your staff before employment? Please motivate your answer

_____

_____

—

11. Are there any measures taken at your school to properly inform staff members of the existence, spread and precautions with regard to AIDS?

Yes	
No	
Uncertain	

12. If Yes, what are the programmes?

_____

_____

13. Further remarks

_____

_____