VULNERABILITY TO HIV AMONGST AFRICAN PEOPLE IN RURAL AREAS: THE THUSANO PROJECT

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SUMMARY

Title: Vulnerability to HIV amongst African people in rural areas: The Thusano project.

Key words: Vulnerable, HIV, African, rural area, Thusano project.

Research has outlined numerous factors that impact on HIV risk behaviours of African people. These include a history of sexually transmitted diseases, number of sexually transmitted diseases, number of sexual partners, the perceived behaviour of peer groups and perceived vulnerability to HIV. Little is known regarding the factors that promote perceptions of vulnerability to HIV and the role this constraint plays in the maintenance of AIDS risk-reduction practices among African people in rural areas.

This research paper gives an overview of the vulnerability to HIV among African people in a rural area. The information has been collected in the Kuruman district. The multi-disciplinary survey was undertaken with one of the objectives to investigate the vulnerability to HIV amongst African people in a rural area.

The aim was achieved by means of a study of the relevant literature and through empirical research. The available literature on the subject was consulted to determine whether any research has been conducted in this field. The empirical research was conducted to confirm previous research findings.

In this study the survey method was used as a systematic fact gathering procedure. Data was gathered by means of an interview schedule. The researcher administrated the schedules by conduction personal interviews with respondents. In this research, which forms part of the Thusano project, the focus was on the vulnerability to HIV/AIDS of people living in a rural area in the Kuruman district. The Thusano project forms part of a multi-disciplinary research project of the Potchefstroom Campus of the North-West University, entitled the Social-motor Empowerment of Families in Impoverished Circumstances under the Leadership of Professor

A.E. Pienaar of the School of Biokinetics, Recreation and Sport Science. "Thusano" means to help each other and this is a Nelson Mandela funded project which has to address the needs of families in impoverished circumstances living in seven communities in the Kuruman district. The project is driven by the social worker, Ms Tineke Uys, and field workers. An early childhood programme aiming at school readiness has been implemented by them. However, many other needs are identified by the social worker which they are not able to address properly, such as HIV prevention and counselling, family violence, identification of motor delays and other health related problems. The research was conducted in seven communities of the Kuruman district with regard to 50 respondents from different households.

The findings of this research reflect that there definitely are factors such as practising unsafe sex, poverty, poor education and over-crowded households that play an important role in the people's vulnerability to HIV/AIDS in the seven communities of the Kuruman district.

OPSOMMING

TITEL: Kwetsbaarheid ten opsigte van MIV tussen Afrikane in plattelandse gebiede: Die Thusano projek.

Sleutel terme: Kwetsbaar, MIV, Afrikaan, platteland, Thusano.

Navorsing het 'n hele aantal faktore begrens wat 'n uitwerking op MIV-risikogedrag van Afrikane het. Dit sluit in 'n geskiedenis van seksueel oordraagbare siektes, die aantal seksueel oordraagbare siektes, die aantal seksmaats, die waargenome gedrag van portuurgroepe en waargenome kwetsbaarheid vir MIV. Min is bekend rakende die faktore wat insig in die kwetsbaarheid vir MIV bevorder en die rol wat hierdie beperking in die uitoefening van VIGS risikobeperkende praktyke onder Afrikane in plattelandse gebiede speel.

Hierdie navorsingsverslag gee 'n oorsig van die kwetsbaarheid vir MIV onder Afrikane in 'n plattelandse gebied. Die inligting is in die Kuruman-distrik ingesamel. Die multidissiplinêre opname is onderneem met een van die doelwitte om die kwetsbaarheid vir MIV onder Afrikane in 'n plattelandse gebied te ondersoek.

Die doel is bereik deur middel van 'n studie van die toepaslike literatuur en deur empiriese navorsing. Die beskikbare literatuur oor die onderwerp is geraadpleeg om te bepaal of enige navorsing al op hierdie gebied gedoen is. Die empiriese navorsing is uitgevoer om vorige navorsingsbevindinge te bevestig.

In hierdie studie is die opnamemetode benut as 'n sistematiese feite-insamelingsprosedure. Data is aan die hand van 'n onderhoudskedule ingesamel. Die navorser het hierdie skedule aangewend deur persoonlike onderhoude met respondente te voer. In hierdie navorsing, wat deel uitmaak van die Thusano-projek, was die fokus op die kwetsbaarheid vir MIV van mense wat in plattelandse gebied in die Kuruman-distrik woonagtig is. Die Thusano-projek maak deel uit van 'n multidissiplinêre navorsingsprojek van die Potchefstroomkampus van die Noordwes-

Universiteit, getitel die Sosio-motoriese Bemagtiging van Gesinne in Armoedige Omstandighede onder leiding van professor A.E. Pienaar van die Skool vir Biokinetika, Rekreasie en Sportwetenskap. "Thusano" beteken om mekaar te help en dit is 'n Nelson Mandela-befondsde projek met die doel om die behoeftes van gesinne wat in die Kuruman-distrik in armoedige omstandighede lewe, reg te stel. Die projek word deur die maatskaplike werker, me Tineke Uys, en veldwerkers gelei. 'n Vroeëkinderjare-program wat op skoolgereedheid gemik is, is deur hulle in werking gestel. Talle ander behoeftes is egter ook deur die maatskaplike werker geïdentifiseer wat hulle nie na behore kan hanteer nie, soos MIV-voorkoming en –voorligting, gesinsgeweld, die identifisering van motoriese agterstande en ander gesondheid verwante probleme. Die navorsing is in sewe gemeenskappe van die Kuruman-distrik uitgevoer ten opsigte van 50 respondente uit verskillende huishoudings.

Die bevindinge van hierdie navorsing weerspieël dat daar beslis faktore soos die beoefening van onveilige seks, armoede, gebrekkige opvoeding en oorvol huise voorkom wat 'n belangrike rol speel in die kwetsbaarheid vir MIV/VIGS van die mense in die sewe gemeenskappe van die Kuruman-distrik.

FOREWORD

The article format has been chosen in accordance with Regulation A.11.2.5 for the degree MA (SW). The article will comply with the requirements of one of the journals in social work entitled, *Social Work / Maatskaplike Werk.* **This article comprises 10% of the total mark of the course.**

INSTRUCTIONS TO THE AUTHORS

SOCIAL WORK/MAATSKAPLIKE WERK

The Journal publishes articles, short communications, book reviews and commentary on articles already published from any field of Social Work. Contributions may be written in English or Afrikaans. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee. All refereeing is strictly confidential. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice. Commentary on articles already published in the Journal must be submitted with appropriate captions, the name(s) and address(es) of the author(s) preferably not exceeding 5 pages. The whole manuscript plus one clear copy as well as a diskette, with all the text, preferably in MS Word (Word or Word Perfect) or ACSII must be submitted. Manuscripts must be typed, double spaced on one side of A4 paper only. Use the Harvard system for references. Short references in the text: When word-for-word quotations, facts or arguments from other sources are cited, the surname(s) of the authors(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "..." (Berger, 1976:12). More details about sources referred to in the text should appear at the end of the manuscript under the caption "References". The sources must be arranged alphabetically according to the surnames of the authors.

SECTION A

ARTICLE 1

VULNERABILITY TO HIV AMONGST AFRICAN PEOPLE IN RURAL AREAS: THE THUSANO PROJECT

Seyama KDV and Roux, AA (Ms Seyama is a student and Dr Roux a senior lecturer in the School of Psychosocial Behavioural Sciences: Social Work Division, Potchefstroom Campus of the North-West University)

OPSOMMING

Suid Afrika het die grootste aantal persone in die wêreld wat met die MI-virus geïnfekteer is. Persone in die ouderdomsgroep 25-49 jaar is dié wat die meeste geraak word. Volgens statistieke is die hoogste infekteringsyfers onder Afrikane in Suid Afrika. Verskeie faktore maak hierdie persone meer kwetsbaar vir infektering met die MI-virus. Faktore wat 'n rol mag speel is dié soos ontoereikende kennis oor die siektetoestand, armoede, wanvoeding, oorbewoning en seksuele omgang met meer as een maat.

Dit is 'n multidissiplinêre ondersoek hierdie, getitel die THUSANO-PROJEK, met een van die doelwitte om die kwesbaarheid vir MIV van Afrikane in 'n plattelandse gebied te bepaal.

PROBLEM STATEMENT

HIV/AIDS is one of the largest public health hazards or threats facing the world (Stine, 1993:11). HIV/AIDS affected everyone and every sector of society (Buthelezi, 2003:1). According to Nortje and Associates (2000:3), HIV/AIDS "is not an issue that only concerns government or the medical fraternity, or something that happens 'somewhere" or "to other people". It directly affects your business/organization — today and in the future". According to Abdool Karim (2005:31), more than two decades have passed since the first case of HIV/AIDS was described. In this relatively short period the number of people infected

increased from a mere handful of cases in 1980 to approximately 40 million by the end of 2003. More than 20 million people have already died of AIDS. The HIV/AIDS pandemic is the principal challenge facing South Africa and will have an enormous impact on children and teenagers. According to statistics, the AIDS pandemic will be beyond control by the year 2006, as is already evident (Le Roux, 2000:15). HIV/AIDS extends to all age groups, geographic areas and race groups (Shisana & Simbayi, 2002:5). According to Strydom (2002:346), South Africa has the largest number of people living with HIV/AIDS. Recent statistics of the Department of Social Development (Brümmer, 2004:6; SA, 2001:6) show that South Africa has the second fastest growing epidemic in the world with nearly 5 million to 5,3 million people (Abdool Karim, 2005:31). Although all races are at risk of HIV infection, there is substantial variation in prevalence among different groups. The HIV prevalence among adult Indians in South Africa, according to Shisana and Simbayi (2002:8), is 1.8%, Whites 6.2%, Coloureds 6.6% and Africans 18.4%.

According to Strydom (2002:2), the effects of AIDS on the people of South Africa may be seen in different areas and the highest mortality rate may be seen in childhood and early adulthood. According to Strydom (2002:351), late adolescents and young adults are the groups with the highest HIV prevalence rates in South Africa. They are exceptionally vulnerable. The statistics according to Shisana and Simbayi (2002:7) indicate that the highest HIV prevalence was in the age group 25-29 (28%). The estimated HIV prevalence among the age group 2-14 years was 6%, age group 14-19 years was also 6% and age group 20-24 years was 13%. Data from the study of Shisana and Simbayi (2002:5) shows that Free State (14,9%) Gauteng (14,7%), and Mpumalanga (14,1%) have the highest prevalence rates. Shisana and Simbayi (2002:6) point out that there is evidence of a higher vulnerability to HIV among people living in urban informal settlements (28,4%) and urban formal settlements (15,8%), compared to those living in tribal areas (12,4%) and farms (11,3%). The situation in

South Africa, compared to other countries in the world, paints a bleak picture (Roux, 2002: 48).

HIV/AIDS tends to attack disadvantaged and poor communities sooner and more severely than in other communities. Research has outlined numerous factors that impact on HIV risk behaviours of African rural people (Evian, 2000:21-22; Roux, 2002:53-57). These factors include the history of sexually transmitted diseases, number of sexual partners, the perceived behaviour of friends and peer groups and perceived vulnerability to AIDS (Kelly & Lawrence, 1998; Romer, 1994). Little is known regarding perceptions of vulnerability to HIV and the role this constraint plays in the maintenance of AIDS risk-reduction practices among African rural people (Van Dyk, 2001:135). The link between poverty and HIV/AIDS, according to Defilippi (2004:161), is undisputed. This trend is linked to a number of social factors that contribute to HIV infection including lack of access to health and social services, poverty, labour migration, rapid urbanisation, unemployment, poor education, illiteracy, an inferior social position of women, diversities in language, culture, crime, violence, sex work, overcrowding, political instability and war (Evian, 2000:21; Roux, 2002:55). Girls and women are more vulnerable due to the high prevalence of rape and sexual harassment, by which they are subjected to sexual assaults that expose them to HIV, other STD's and pregnancy (Soul City, 2002:3).

The contexts within which people live dramatically influence their vulnerability to HIV infection and their ability to cope with AIDS. Rural areas are mainly affected by the HIV/AIDS pandemic (Ferreira, 2002: 4). Over and above the lack of access to basic resources, however, there are also disparities in terms of access to information, and rural communities are often at a greater disadvantage because of the lack of understanding of their communication systems. In research done by Schenk (2002:17), she mentioned that people living in rural areas "... are the poorest of the poor and the 'unseen' and 'voiceless' people".

Vulnerable families care for vulnerable children and one consequence of this loss of income and support is that the affected poor sink even deeper into the mire of poverty and neglect (SA, 2001:7).

According to Modise (2005:2), the HIV/AIDS pandemic calls for a multi-disciplinary approach in working with both the infected and affected. These aspects include the emotional, financial and social aspects demanding the involvement of professionals such as social workers to provide care for the infected. It is therefore important to know what circumstances in a rural area such as the Kuruman district led to the vulnerability of people to HIV infection.

In this research, the focus will be on vulnerability to HIV/AIDS of people living in a rural area in the Kuruman district, which is being addressed by the Thusano project. The Thusano project is part of a multi-disciplinary research project entitled the Social-motor empowerment of families in impoverished circumstances under the leadership of Professor A.E. Pienaar of the School of Biokinetics, Recreation and Sport Science. "Thusano" means to help each other and this is a Nelson Mandela funded project, which has to address the needs of families from impoverished circumstances living in seven communities in the Kuruman district. The project is driven by the social worker, Ms Tineke Uys, and field workers. An early childhood programme aiming at school readiness was implemented by them. However, many other needs were identified by the social worker which they are not able to address properly, such as HIV prevention and counselling, family violence, identification of motor delays and other health related problems. The main aim of this multi-disciplinary research is to analyse, develop and evaluate models of suitable, appropriate intervention programmes to improve the social circumstances, physical health and well being of children and their families in the Thusano project.

The following question developed from the information provided:

What circumstances in a rural area, such as the Kuruman district, make African people vulnerable to HIV/AIDS?

AIM AND ONJECTIVE OF THE RESEARCH

The aim of the research is to determine the vulnerability to HIV amongst African people in a rural area.

The objective of the research was:

- To investigate the circumstances in a rural area that intensify the vulnerability of African people towards HIV/AIDS.

CENTRAL THEORETICAL ARGUMENT

African people in a rural area are vulnerable to HIV/AIDS due to a lack of access to health and social services.

RESEARCH METHODOLOGY

The methods used for investigation were a literature study and empirical research.

Literature Study

The central focus of this study was on the vulnerability to HIV/AIDS amongst African people in a rural area. This was used to substantiate the role of counsellors during counselling intervention in an attempt to reduce vulnerability and risk behaviour. Data which was utilized for the systematic library search was a repertoire of South African Journals, Social Work Abstracts and Social Sciences Indexes. There were a number of journals and books on HIV/AIDS, but little is known regarding perceptions of vulnerability to HIV and the role this constraint plays in the maintenance of AIDS risk-reduction practices among African rural people.

EMPIRICAL RESEARCH

Research Design

An exploratory design was used (Strydom, 2000:77). According to Bless and Higson-Smith (2000:154), the purpose of the exploratory research is to explore certain phenomenon with the primary aim of formulating more specific research questions relating to that phenomenon.

Participants

The participants were 50 African women from different families living in the Kuruman-district. This group was chosen because they were part of the Thusano project, run by the social worker from Kuruman. A non-probability sampling technique was used and specifically the convenience sample (Grinnell, 1993:162; Strydom, 2000:69). Participants were selected by the leader of the Thusano Project (social worker) in conjunction with members of the research team from the Potchefstroom Campus of the North-West University. The respondents voluntarily took part in the research and a contract was drawn up beforehand to meet the requirements of both parties. The areas were rural. In all the families the husbands were absent due to either their work in different areas or because the women were single parents. The women who took part in the Thusano project were from the following areas:

Batlharos: 12 households;

Ncweng: 4 households;

Maruping: 4 households;

Seodin: 13 households;

Wrenchville: 5 households;

Groenwater: 6 households;

Skeyfontein: 6 households.

The participants took part voluntarily. Time was finalised with them and a contract was signed. They provided information about their households.

Measuring Instrument

Data was obtained by means of personal interviews in accordance with a schedule (Rubin & Babbie, 2001:406-408). For purposes of this research the structured schedule was used to measure the vulnerability of African people to HIV and related matters in the Kuruman district (see Annexture 1). The focus was on the following aspects:

- total number of people living in households of the respondents;
- average income of households of respondents;
- education level of the family members of respondents;
- living conditions of respondents;
- general health of respondents and their households ;
- habits and lifestyle of respondents and their households.

The schedule was approved by the Department of Statistical Consultation Services of the Potchefstroom Campus of North-West University.

Procedures

The social worker of Kuruman selected the group of respondents. They all formed part of the Thusano project. The survey procedure was used with the help of quantitative questions. Schedules were completed by the researcher during personal interviews.

Ethical aspects

Ethics, according to Strydom (2005:63), is "a set of moral principles which are suggested by an individual or group, are subsequently widely accepted and which offer rules and behavioural expectations concerning the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students". The project was approved by the Ethics Committee of the Potchefstroom Campus of North-West University, **number 04M11**. The questionnaire ensured that the information provided remains confidential. It also ensured that the findings do not impact negatively on the respondents. The completion of the questionnaire was done anonymously and the respondents' identities were not disclosed. The purpose of the research was explained to the participants and they were assured safety and confidentiality. Consent to participate in the study was obtained from the participants by means of a consent form.

Data Analysis

Data was quantitatively analyzed in terms of categories by hand. It was transformed into statistically accessible forms by counting procedure (McKendrick, 1990:275).

TERMINOLOGY

To reduce the different interpretations of the same term, it is necessary to define a few key terms used in the research study.

HIV

HIV stands for the Human Immune Deficiency Virus (Strydom, 2002:19, Whiteside & Sunter, 2000:2). The HI virus attacks the CD4 and T4 cells which control and support our immune system (Buthelezi, 2003:19). The CD4 cell count is the best indicator or predictor for the risk of developing opportunistic diseases or infections and its likely severity.

AIDS

Aids stands for Acquired Immunodeficiency Syndrome (Strydom, 2002:18)

Acronym given in Whiteside and Sunter (2000:1):

"A" stands for Acquired – in order to be infected the person has to do something or have something done to them which exposes them to the virus.

"I" and "D" stand for Immunodeficiency. This virus attacks the immune system and incapacitates it to fight infections. Thus the immune system becomes Deficient.

"S" stands for Syndrome. AIDS presents itself as a number of diseases that come about as the immune system fails. People do not die of AIDS, but of opportunistic disease and infections which attack the body when immunity is low (Buthelezi, 2003:19).

Vulnerable

The word vulnerable, according to the Word Power Dictionary (2001:1100), means to be "exposed to the chance of being attacked or harmed, either physically or emotionally". According to Roberts and Green (2002:849), vulnerable clients are "people who have sought assistance with a problem or issue whose disabilities and impediments are serious and long term and make it difficult for them to meet ordinary personal and social requirements or to fulfil activities of daily living". It is a latent variable that refers to an individual's belief of their likelihood of contracting HIV when not using a condom. Rosella & Albrecht (1993: 196-208) and Nickeus (1990:20) stated that perceived vulnerability to AIDS is convincingly related to an increase in behaviour associated with health promotion. Perceived vulnerability is best understood as a personality trait that is affiliated with some personal experience.

African

According to Labuschagne and Eksteen (1993:24) and the Word Power Dictionary (2001:15), the word African means a person from Africa. It especially is a black person and a person of black African descent (Word of Power Dictionary, 2001:15-16).

Rural

The word rural is described by the Word Power Dictionary (2001:855) as "relating to or characteristic of the countryside rather than the town". The Kuruman district, namely the areas of Batlharos, Ncweng, Maruping, Seodin, Wrenchville, Groenwater and Skeyfontein measure up to the description of a rural area

PROFILE OF PARTICIPANTS

Of the 50 respondents, 45 (90%) were Tswana-speaking, 4 (8%) Afrikaans-speaking and 1 (2%) Xhosa-speaking.

Gender and age of households

All 50 (100%) of the respondents were women. To a question as to what the sex of the household head is, the outcome was that 17 (34%) were men and 33 (66%) women. Table 1 illustrates the different age groups of the respondents' households.

Table 1: Age of people living in household

Age	Male	Female	fr	%
Under 1 year	7	4	11	3.56
1-5 years	25	20	45	14.56
5-12 years	20	31	51	16.50
12-18 years	23	21	44	14.24
18-30 years	21	40	61	19.74

31-45 years	22	29	51	16.50
46-60 years	7	18	25	8.91
61 years and older	6	15	21	6.80
N	131	178	309	100

The age group that is most affected by HIV, according to Roux (2002: 73) and Whiteside and Sunter (2000:32), is that between 15 and 45 years of age. If the age of the respondents is taken into consideration, it is evident that 156 (50,49%) of the people in these communities are in the age group that is vulnerable to be infected and affected by the HI virus. According to Gouws and Abdool Karim (2005:61),"the shape of the antenatal HIV age prevalence curves, fitted to a log-normal function, has remained much the same over a period of nine years, with peak prevalence occurring at around 24 years". In this research, 61 (19,74%) of the population in these communities were in the age group 18-30 years.

Education level

To a question concerning the highest level of education of people that could have attended school, the following data was supplied: 43 (13,92%) of the 309 people living in the households never attend school; 80 (25,89%) of the people in these households only had a pres-school education; 15 (4,85%) attended grade 2; 10 (3,24%) grade 3; 14 (4,53%) grade 4; 14 (4,53%) grade 5; 14 (4,53%) grade 6; 25(8,09%) grade 7; 25 (8,09%) grade 8; 22 (7,12%) grade 9; 12 (3,88%) grade 10; 14 (4,53%) grade 11 and 21 (6,79%) grade 12. On average, most of the people 215 (69,58%) in these communities have no to lower than grade 8 education. Basically, most people (69,58%) fall in education levels below grade 8. This does go beyond basic educational level and makes them vulnerable to HIV because poor education and low literacy levels, according to Evian (2000:21), "help to keep people ignorant of the ways and means to avoid diseases like AIDS". According to Soul City (2002:7), many

people who cannot read or write manage their lives very well but may not be able to obtain the information they need to protect themselves against HIV/AIDS. In these households, 94 (30,42%) were educated higher than grade 7 and are expected not to have a problem reading literature on HIV/AIDS. This situation tends to make these people less vulnerable to HIV.

The respondents' knowledge of HIV/AIDS was tested. A question asked on how people protect themselves from HIV infection. Table 2 illustrates their knowledge concerning some of the information on HIV/AIDS.

Table 2: Protection from HIV/AIDS

Statement	Yes fr	%	No fr	%	Don't know fr	%	N	%
Having a good diet	2	4	5	10	43	86	50	100
Staying with one partner	34	68	0	0	16	32	50	100
Avoiding using public toilets	35	70	0	0	15	30	50	100
Using condoms during sexual intercourse	35	70	0	0	15	30	50	100
Avoiding touching someone with HIV/AIDS	6	12	0	0	44	88	50	100
Avoiding sharing razor blades	1	2	0	0	49	98	50	100

Generally, HIV is spread in three ways says Evian (2000:13), namely via sexual intercourse, when HIV-infected blood is passed directly into the body and from mother to child during pregnancy, childbirth and via breast feeding. HIV can never spread by behaviour such as touching, couching, kissing, hugging and using a public toilet (Roux, 2002:202). From the data in Table 5 it is obvious that the respondents' knowledge of HIV is limited. Although they have free access to the clinic, and 40 (80%) respondents get their information on

HIV/AIDS from the clinic and 29 (58%) from the TV or radio, they somehow do not get enough information on HIV/AIDS or do not listen to what they are told or do not understand the information they are given. This correlates with research done by Roux (2002) as well as Sito (2005). According to Soul City (2002:7), staff at busy and overcrowded clinics may not have the time to give their patients information about HIV/AIDS. These patients may not be able to receive information from anywhere else. The lack of knowledge regarding HIV/AIDS in these communities causes a vulnerability to be infected by the HI-virus.

A question was asked as to whom the respondents prefer to get correct information on HIV/AIDS from. Thirty (60%) preferred from the nurse at the clinic, 9 (18%) from a professional person such as the social worker or counsellor, 3 (6%) from the doctor, 1 (2%) from the hospital, 1 (2%) from the reverend and only 1 (%) from a parent. Five did not answer the question. It is evident that these people are very sensitive about HIV/AIDS. They would rather get the information from the clinic and professionals than from their families and the church. In research done by Roux (2002), HIV/AIDS patients also preferred help from professionals and the clinic.

Living conditions

Socio-Economic Situation

Drower (2005:102) points out that the impact of HIV/AIDS is "seen at the level of the family where poverty and the number of child-headed households increase with the illness and death of the breadwinner; at the level of the community, where traditional community support structures and coping mechanisms are laced under severe strain ...". Poverty, according to Soul City (2002:6), means that people often have to leave home to find work in other places. In such situations these people look for new friends and sometimes new sexual partners.

The majority of households in this study were in the low-income categories, having less than R1 000 per month. The average total income of the 50 households, was R621,20 per month. The average number of people living in a household is 6,18 people. According to this data these households definitely suffer to survive economically. The poverty of the people in these communities made them more vulnerable to HIV. Although poverty, according to Soul City (2002:6), "may make people more vulnerable to HIV and AIDS, poverty does not cause the disease". A lack of sufficient money sometimes leads to situations such as prostitution, because women want to earn more money to care for the family (Evian, 2000:21). Deflippi (2004:163) says that "sex is often the only means by which a poverty-stricken woman can procure money and food". Alcoholism, which in most cases is found in poor communities, leads people to forget about their problems (Evian, 2000:21). Most of the time the low income per household causes malnutrition, which makes people vulnerable to infections (Roux, 2002:209-217). Defilippi (2004:162) points out that "the link between poverty and AIDS is undisputed. The malnutrition associated with poverty implies a compromised immune status and exposes people to infections such as TB and AIDS. They could, in fact, be described as already having an inherited immune deficiency syndrome". To a question as to whether people in the community go hungry and belong to a feeding scheme, 28 (54%) answered sometimes, 2 (4%) answered seldom and 20 (40%) never. Twenty six (54%) of the households in this research belong to a feeding scheme. This is an indication that poverty does exist in these communities.

A question was asked about what the respondent and the other people in the household ate the previous day. The answers received to this question were the following:

Breakfast

Most of the respondents, namely 44 (88%), answered porridge and 5 (10%) had bread for breakfast. One (2%) household had nothing for breakfast.

Lunch

The meals in the afternoon consisted of the following: porridge and bread 3 (6%); meat 7 (14%); bread 12 (24%); cabbage 4 (8%); scrap 6 (12%); samp 1 (2%); rice 5 (10%); "vetkoek" 1 (2%); soup 6 (12%); tinned fish 2 (4%); liver 1 (2%) and 3 answered "nothing". Only one household had a combination of two of the above mentioned meals.

Dinner

The meals at dinner time consisted of the following: tinned fish 1(2%); meat 6 (12%); porridge 21 (42%); potatoes 1 (2%); rice 2 (4%); dumplings 4 (8%); bread 5 (10%); "vetkoek" 3 (6%); scrap 4 (8%); vegetables 1 (2%); spaghetti 1 (2%); soup 3 (6%); cabbage 4 (8%); bones 1 (2%) and liver 1 (2%). Nine (18%) of the respondents had nothing for dinner the previous night.

Fields-Gardner *et al.* (1997:39) mention that a man needs 16 calories for each pound weight as a balanced diet and ladies 13 calories for each pound weight. For a person who needs 1,200 calories per day, the diet has to consist of four portions grain, four portions fruit, three portions vegetables, two portions dairy products and two portions protein (Roux, 2002:210-211). With the above information, it is evident that the diets of households in these communities are not suitable for the needs of a healthy person. The diets of these households make them vulnerable to HIV because they do not eat a balanced diet daily.

They were asked whether they have a food garden. The responses were that only 8 (16%) of the households do have a food garden, whilst 42 (84%) do not. Table 3 illustrates the reasons why they do not have a food garden.

Table 3: Reasons for no food garden

Reason	Fr	%
No fence	4	9,52
No tenant	1	2,38
No money to buy seeds	4	9,52
No time	1	2,38
Shortage of water	17	40,47
Not suitable ground	2	4,76
Too lazy	1	2,38
Just move into house	1	2,38
Not my home	1	2,38
No reason	10	23,80
N	**42**	**100**

From this data it is evident that people do not have food gardens and this situation does not help these people to improve their living standard and especially their diet. If they can start growing their own food gardens, it will improve their living standard and their diet.

In this research, 11 (22%) of the 50 respondents were the head of the household with an average income of R528.00 per month. In female-headed households, women are considered the legal and customary head (Kennedy & Peters, 1992:1077). Women live either alone or with relatives. There is no senior man in the household. This confirms what Evans (1992: 12) calls "female headship by household composition". Women are called heads of household and also make decisions either alone or including other household members. Inter-generation dynamics also determine the measure of power the female head can exercise and how power is distributed in the household. An older woman may have enough power over grandchildren who interfere with her interests of resource allocation. This figure corresponds

with national figures, according to a document presented at the Fourth World Conference on Women in Business [1995], that at least 35% of the households are female headed.

In this research, women who have no partners are supported by their male relatives. The head is then a brother, nephew or uncle. One interviewee stated: "I don't get any money from my brother, he just sends his son to bring me food." This illustrates that the interviewee is economically totally dependent on the brother.

Apart from power relations between the genders, the general situation in households is shaped by inter-generation and other intra-household dynamics. Although gender relations are crucial to the balance and survival of households, it became clear during the research process that other dynamics are often more important, depending on the organisation of the specific household. It is obvious that gender relations and authority and power relations within families and households are changing.

Interviewees were asked what sources of income the household has. The following answers were received:

Child grant (41)

Adult grant (42)

Old age pension (9)

Other resources (33)

In most female headed households, the interviewee will be doing piece jobs. This ranges from doing washing two or three days per week for R10-R15 per washing load. This result demonstrates that people manage to engage in various activities and find niches that enable them to adapt to situations of limited resources. The maintenance grant of those households that receive it, in most cases is below R500, which means that the pension is the only source of income.

Health and access to health care services

Ntuli (2001) points out that, among significant events that affected the health systems during 2001, are the process of decentralization of health care services, heightened attention to proper corporate governance, especially with regard to financial reporting, and the profound impact of HIV/AIDS. The respondents were requested to rate their general health condition. Seven (14%) respondents' health condition, according to them, was good, 7 (14%) were average and 36 (72%) answered poor. The respondents indicated that in 26 (52%) of the households, people were ill in the course of the past six months and in 24 (48%) no people were ill in the households. Of these ill persons, there was only 1 (2%) of the households where there was a terminally ill person. In 4 (8%) of the households, people died during the last six months. Table 4 illustrates the chronic and other illnesses these people suffer from.

Table 4: Illnesses

Chronic and other illness	fr	%
High blood pressure	3	11,11
Stroke	4	14,82
Diabetes	1	3,70
Asthma	2	7,41
Lung infections	16	59,26
Sexual transmitted disease	1	3,70
N	27	100

Viewing these data, it is possible to note that some of these people may be HIV positive because the "presence of any serious opportunistic infection is a sign that the body is not coping immunologically" (Evian, 2000:32). According to Evian (2000:123), respiratory infections are common in advanced HIV disease. Having a sexually transmitted disease

assists in the transmission of the HI virus into the body, says Evian (2000:4). To a question as to whether anyone in the household is covered by a medical scheme, 4(8%) answered "yes" and 46 (92%) "no". The data on the health condition of the respondents indicate that these people are vulnerable to HIV.

The 50 respondents were asked how far they stayed from the nearest clinic. The average distance was 4,23 kilometres. Their modes of transport are the following: walk 32 (64%); hike 15 (30%), own car 1 (2%), taxi 1 (2%) and bus 1 (2%).

From this data it is clear that people in these communities mostly have easy access to clinics for medical services, which should make them less vulnerable to HIV. According to Modise (2005:22) primary care physicians provide the majority of care in rural areas. To a question as to where they receive their information on HIV/AIDS, 40 (80%) said from the clinic sister or doctor. Forty-seven (94%) do trust the information they received and 30 (60%) said that they would prefer to receive the information from the clinic sister. These data confirm the Government's approach to HIV/AIDS when they reported the following in the White Paper for Social Welfare (SA, 1997:90): "Appropriate and innovative ... social services will be promoted in partnership between Government, civil society and the private sector". It is obvious that the clinic plays an important role in these communities in helping people to cope with the HIV/AIDS pandemic.

Housing facilities

To a question concerning the type of house the respondents lived in, information described in Table 5 was given.

Table 5: Housing

Type of house	fr	%
Traditional hut	12	24
Mokuku	15	30
Brick house	23	46
N	**50**	**100**

Although most of the respondents, namely 23 (46%), lived in brick houses, 27 (46%) have to use public taps and 10 (20%) tankers. Only 1 (2%) of these respondents received piped water in their yards. Four (8%) of the respondents even use rivers and springs to obtain water.

To a question concerning the type of toilet facilities the respondents use, 33 (66%) of the households answered that they use pit latrines as a toilet facility, 7 (14%) a bucket latrine, 4 (8%) have no facilities and use the bush or veld, 1(8%) use facilities of the neighbour and only 5 (10%) have a flush toilet. This data indicates poor hygienic conditions. Most of these respondents are poor or average and cannot afford disinfectant to keep the toilets clean. These circumstances make them exceptionally vulnerable to HIV because, according to Roux (2002:213-217), good hygiene is important to prevent infections and to care for the HIV/AIDS-infected person.

There was an indication that, on average, 3,34 rooms are occupied per household. Table 6 illustrates the number of rooms used for sleeping.

Table 6: Rooms for sleeping

Amount of rooms	fr	%
One room	17	34
Two rooms	19	38
Three rooms	11	22
Four rooms	3	6
N	**50**	**50**

If the fact is taken into consideration that an average of 6,18 persons who participated in this research live in the households, and 34% of these people have only one bedroom and 38% two bedrooms, it is obvious that most (72%) of these 6,18 people share one or two bedrooms and do indeed live in poor conditions. Over-crowded living conditions are not only bad for the health situations of the HIV/AIDS-infected person, but also for the other residents (Kotze *et al.*, 2001:77-78). According to Evian (2000:22), poverty creates the conditions and environment which contribute to the spread of HIV such as overcrowding, poor recreation options and poor access to health care. A lack of services directly impacts on the health of people and their ability to generate livelihoods.

A question was asked as to what the household uses for cooking and heating. More than one answer was given that includes the following: 23 (34,33%) use electricity, 21 (31,34%) paraffin, 20 (29,85%) wood, 2 (2,99%) gas and one (1,49%) candles. From this data it is evident that 34,33% of the respondents have access to electricity, which is an advantage, because they are mainly living in a rural area. What must be taken into consideration is the fact that 65,67% does not use electricity for cooking or heating. However, a disadvantage exists in some rural areas due to the inequities of the allocation of resources.

HABITS AND LIFESTYLE OF RESPONDENTS

Condom use

The lifestyle of a person plays a very important role in the vulnerability of people to HIV infection. Abdool Karim (2005:40) maintains: "Success is being achieved in some prevention interventions, leading to a reduction in sexual risk behaviour". In this study the respondents were asked whether they used a condom the last time they had sex. Only 11 (22%) answered "yes" and 39 (78%) "no". Forty eight (96%) indicated that they know where to get a condom and know what a condom is. To another question as to whether they use a condom, 19 (38%) answered "yes" and 31 (62%) "no". Table 7 illustrates the reasons why the respondents do not use a condom.

Table 7: Use of condom

Reasons	**f**	**%**
Is trust between us	12	24
Don't like it	5	10
Boyfriend doesn't like it	4	8
Too old	3	6
Don't sleep with men	4	8
No reason	3	6
No answer	19	38
N	**50**	**100**

The respondents' reactions to this question were not good. They do not like answering personal questions about HIV/AIDS. Most of the respondents (24%) gave as reason why they do not use a condom, that there is trust between them. This situation makes them vulnerable

to HIV, especially because only 12 (24%) know their HIV status, whilst 38 (76%) had never been tested for HIV.

Use of alcohol

To a question whether any of the household drink alcohol, 24 (48%) of the respondents answered "yes" and 26 (52%) "no". The average number of bottles that is drunk during one week per household is 2,17. When asked where the persons in the household drink their alcohol, 18 (75%) answered at home and 6 (25%) at the shebeen. If these answers are correct, the alcohol use in these communities is not a real problem. Poor adherence is the major cause, according to Wood (2005:514), "to achieve viral suppression with existing antiretroviral regiments". Wood (2005:515) further points out that alcoholism and drug dependency negatively impact on adherence". Alcoholism, according to Evian (2000:22), creates the environment which contributes to the vulnerability to and spread of HIV.

Exercise/sport

According to the Department of Social Development (SA, 2001:4), one finds that communities with a high prevalence of HIV/AIDS are already disadvantaged and experience a high level of poverty, poor infrastructure and limited access to services. The question was asked whether anyone in the household participates in sport activities. Nine (18%) of the respondents answered "yes" and 41 (82%) "no". The activities they participated in were netball 3 (33,33%), soccer 3 (33,33%) and volleyball 3 (33,33%). The reason why only nine people participated in sport could possibly be because there are not many facilities in these communities. To do exercise and take part in sport activities is important and in this regard Detroyer (2000:37) said the following: "In the past, exercise has been overlooked as a therapy to treat complications associated with HIV/AIDS because of the fear that it might decrease immunity ...". However, according to Roux (2002:218-219), Fields-Gardiner *et al.*(1997:37)

and Watson (1994:181), exercise is important in the treatment of HIV-infected people. Detroyer (2000:37) is of opinion that exercise can strengthen the immune functions and relieve many of the complications associated with this debilitating disease". The disuse of muscle, says Watson (1994:82), "inevitably results in atrophy of the muscle and this may be a factor in the muscle wasting found with AIDS patients". If one looks at the health conditions of the households in this research and the fact that only 12 (24%) of the respondents had undergone a HIV/AIDS test, there is the possibility that respondents or other people in the households may be HIV positive.

CONCLUSIONS

To address the vulnerability of the people in the communities of rural areas such as the Kuruman district, education programmes had to be launched in these communities. In research done by Modise (2005:80) in a rural community, she stated the following: "The government and its counterparts such as NGOs, CBOs and FBOs are faced with a responsibility of transmitting proper education to the communities and promoting the spirit of *Ubuntu*". According to Modise (2005:80), role players need to continue with the community awareness campaigns that are aimed at educating people on taking joint efforts in the fight against HIV/AIDS. Steinberg (2002), in his report on how households cope with the impact of the HIV/AIDS epidemic, indicated that no sector of the population is unaffected by the HIV epidemic, but it is the poorest South Africans who are most vulnerable to HIV/AIDS and for whom the consequences are inevitably most severe.

In this research definite factors such as practising unsafe sex, poverty, poor education and over-crowded households were evident which play an important role in people's vulnerability to HIV/AIDS in the seven communities of the Kuruman District. With rapid social, demographic and economic changes presently taking place in South Africa and the poverty gap widening, it must be taken into account that large numbers of impoverished people live

precariously on the margins of subsistence. Household income for the majority of households in these communities are less than R1 000 (one thousand rand) per month. The poverty of these people made them more vulnerable to HIV/AIDS because in certain instances it leads to situations such as prostitution and alcoholism.

There are strong indications that the young adults and elders in this study have good access to accurate HIV/AIDS information and they have had exposure to HIV/AIDS media from a range of different sources. Although they have access to information, there are still people in this community that do not know much about HIV/AIDS. In sites with high levels of technology such as television, radio, cell phones and electricity, there is evidence of mobilisation around HIV/AIDS and strong signs of responding actively in order to reduce HIV infection risk. A need for information exists in rural areas and poor communities where there is low media penetration. They are dependent on experts such as social workers and medical staff.

The data on sexual knowledge and their neglect to use of condoms is very disturbing. There is little condom use, although condoms are very easily accessible. A great concern is that in most sites, the respondents have heard of sexually transmitted diseases, but there are notably high levels of early adolescent sex in rural areas without the use of condoms. A conclusion can be drawn from the data relating to condom use that sexual intercourse in relationships that are socially constructed as "trusting" is reported as being "unprotected", suggesting that the ways that "trust" is construed mitigates against condom use.

If one looks at the data concerning the respondents' health, it is possible that some of the members of the households may be HIV positive. A positive aspect is the fact that they have easy access to the clinics. The clinics play an important role in helping these people cope with HIV/AIDS.

The housing conditions of the respondents are not good. If the fact that an average of 6,18 persons live in the households and 34% of these people have only one bedroom is taken into consideration, one must admit that the over-crowded living conditions make these members of the households exceptionally vulnerable to HIV.

RECOMMENDATIONS

- Condom promotion should focus on establishing patterns of more consistent condom use and maintenance of condom use as a social norm.
- Education programmes had to be launched in rural areas to address the vulnerability of people towards HIV/AIDS. Role players like the government and NGOs need to continue with the community awareness campaigns at educating people in the fight against HIV/AIDS.
- Having to share a small house with many members, having little income or no income, little food and little education or being illiterate, contributes to upholding existent safe measures against HIV/AIDS. There needs to be a shift in the apportionment of resources in rural areas.
- All stakeholders need to intensify their approach aimed at addressing poverty in especially rural areas.
- A programme needs to be developed which can be used in planning and evaluation. This will need to include indicators of behavioural change and also indicators which access dimensions of developmental process towards change. This includes indicators relating to the capacities of the health services to provide appropriate services and indicators relating to the development of communities in all areas (health, sanitation, education, habits, lifestyles and household) which impact directly on community responses to HIV/AIDS.

- Social workers must play an important role in empowering these communities through group work en community development. Social development and empowerment are more appropriate than individual thought processes.

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ANNEXURE 1

Number			

DEMOGRAPHIC AND HEALTH SURVEY: THUSANO PROJECT

IDENTIFICATION			
Date of interview			
Relation to household if respondent not household head			
Household:	Ward/Area/Town		
	Name /sex of household head		
	Age of household head		
	Total living in household		
	Income of **household head**		
	Total income in household		
		Male	**Female**
	Total adults 18 – 30		
	Total adults 31 – 45		
	Total adults 46 – 60		
	Total adults 61 years and over		
	Children under 1 year		
	Children 1 – 5 years		
	Children 5 – 12 years		
	Children 12 – 18 years		

LANGUAGE	
Home language of respondent	
Translator used	
Can you read and understand a letter or newspaper in	Easily

your home language easily, with difficulty, or not at all? Mark the answer.	With difficulty
	Not at all

NEAREST CLINIC		
NAME OF CLINIC	WALK (How far?)	Mode of TRANSPORT (Taxi/Own car/Other)

HOUSEHOLD SCHEDULE (Now we would like some information about the people who usually live in your household or who are staying with you now)

No	USUAL RESIDENTS AND VISITORS	RELATION-SHIP TO HEAD OF HOUSE-HOLD	RESIDENCE				SEX		AGE	WORK				GRANTS/PENSION	
	Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household	What is the relationship of **(NAME)** to the head of the household?	Does **(NAME)** normally live here?		**Who is the *breadwinner* in your home?**		Is **(NAME)** a male or a female?		How old is **(NAME)**?	Did **(NAME)** work for any pay during the last week?		*Does* **(NAME)** *have* a permanent work? If yes, is the salary less than R500/R1000/ R1500/R2000/ *R2500or more than* R2500?		Does **(NAME)** receive a child maintenance grant, disability grant or a pension from the government?	
			Yes	No	Yes	No	Male	Female		Yes	No	Yes	No	Yes	No
1															
2															
3															
4															
5															
6															
7															
8															

NO	USUAL RESIDENTS	EDUCATION							
	Write the name if it is necessary (when the question applies to the name)	Has **(NAME)** ever been to school?		IF ATTENDED SCHOOL (Also applicable for pre-school facilities)					
				What is the highest level of school **(NAME)** completed?	Is **(NAME)** still in school? Applicable to all persons that are still in school (also pre-school). If the answer is NO with a child, give reason		What is the name of the school **(NAME)** attends (also pre-school)?	What is the distance that **(NAME)** must travel to school (also pre-school)?	What type of transport does **(NAME)** use to get to school (also pre-school)?
		Yes	No		Yes	No			
1									
2									
3									
4									
5									
6									
7									
8									

GENERAL QUESTIONS ON HOUSEHOLD	
What type of house do you live in: Traditional hut=12; Mokuku=14; Brick house= 23; Other(shack)=1 N=50	
What is the source of drinking water for members of your household?	
Piped water (tap) in dwelling	
Piped water in yard	
Public tap	
Water carrier/tanker	
Borehole/well	
Dam/River/Stream/Spring	
Rain-water tank	
Other / Remarks Van Bure/ From Neighbours	
How long does it take you to get the water and come back?	
What kind of toilet facility does your household have?	
Flush toilet (own)	
Flush toilet (share)	
Bucket latrine	
Pit latrine	
No facility/Bush/Veld	
Other / Remarks (Neighbours)	
What does your household use for cooking and heating? Record all mentioned.	
Electricity	
Gas	
Paraffin	
Wood	
Coal	
Animal dung	
Other / Remarks (Candles)	
What is the main material of the floor? Record observation.	
Earth/Sand/Dung	
Bare wood planks	
Cement	
Vinyl	
Carpet	

Ceramic tiles	
Other / Remarks	

What is the main material in the walls? Record observation.

Plastic/Cardboard	
Mud	
Cement and mud	
Corrugated iron/Zinc	
Prefab	
Bare brick/Cement block	
Plaster/Finished	
Other / Remarks	

How many rooms are in your household?	
How many rooms in your household are used for sleeping?	

GENERAL QUESTIONS ON HOUSEHOLD (CONTINUE)

Do you or someone in the household belong to a feeding scheme?	Yes	No
How many of the people in this household belong to a feeding scheme.		

Do you have a food garden? If answer is NO, ask reason.

Would you say that the people here often, sometimes, seldom or never go hungry? Mark the answer.	Often	Sometimes	Seldom	Never

What did you and the others in this household eat yesterday? Probe for answer. Write down what the person tells you.

Morning

.....

Afternoon .....

Night... .....

Other.....

Does your household have one or more of the following:

Electricity	Yes	No
Radio	Yes	No
Television	Yes	No
Telephone (land phone)	Yes	No
Cell phone	Yes	No
Refrigerator	Yes	No
Washing machine	Yes	No
Personal computer	Yes	No

Does any member of your household own one or more of the following:		
Car	Yes	No
Motorcycle	Yes	No
Bicycle	Yes	No
Donkey/Horse	Yes	No
Sheep/Cattle	**Yes**	**No**

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GENERAL HEALTH INFORMATION OF THE HOUSEHOLD MEMBERS

USUAL RESIDENTS Write the name if it is necessary (when the question applies to the name)		GENERAL HEALTH			*Is anyone in the household covered by a Medical Aid/Medical Benefit Scheme?* *(Any scheme that helps you pay for health drug service)*		Has any person **(NAME)** in the household been ill/sick the past 6 months? If YES, specify illness of **(NAME)** (Probe for the reason why the person is bedridden, if so)			Is any person in the household terminally ill? If YES, specify who **(NAME)** is taking care of the terminally ill person			Do you have support from the community? If answer is YES, specify the type of support **(NAME)** receives from the community		
No	**Name**	*Good*	*Ave-rage*	*Poor*	*Yes*	*No*	*Yes*	*No*	*Illness*	*Yes*	*No*	*Illness*	*Yes*	*No*	*Illness*
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															

CHRONIC AND OTHER DISEASES

Has any person in the household been ill/sick the past 6 months? Is the *illness* one of the *following*? If YES, ask the *name* of the person and let the respondent explain the illness. If other disease than listed, specify	ILLNESS	NAME of PERSON with illness
	High Blood Pressure	
	Stroke	
	Diabetes/Blood sugar	
	Asthma	
	Cancer	
	Lung infections e.g. TB, Flu, Bronchitis	
	Sexually transmitted disease (discharge, sores on penis/vagina, HIV/AIDS)	
	Other	

OTHER HEALTH INFORMATION		
Has anyone in the household died in the past 6 months?		
How many people died in your household in the past 6 months?	..... people died	
What was the cause of the death? Specify for each one of the members that died.		

SPIRITUAL NEEDS		
Do you belong to a church? Yes		
If 'yes', what is the name of your church?		
Do you believe that a person has spiritual needs? Specify why you say YES/NO	Yes	No
Where do you go for spiritual help?		

HABITS AND LIFESTYLES

Now we would like to ask questions about the household's diet and some other habits of persons in the household that you could observe.

Do you think there is someone in the household that is overweight/underweight? If the answer is YES, give the name of the person and indicate whether he/she is over-/underweight. Probe for answer and observe.	NAME OF PERSON	OVER WEIGHT	UNDER WEIGHT

Have you or the other members of the household smoked or used some of the following?	TYPE	AMOUNT
	Cigarettes	
	Tobacco/Pipe	
	Snuff	
	Chewing tobacco	
	Dagga	

Does any person in the household drink alcohol? Also homemade beer.	Yes	No

If the answer is YES, probe for the average that is drunk during one week. Ask whether it is one bottle/day? Or is it more than one bottle/day.	.....bottles/week	
Where do the persons in the household drink their alcohol? Specify		
Do you or anyone else in the household do exercises?	Yes	No
If the answer is YES, ask what exercises they do. Specify.		
Do you participate in any sport activities? Yes No		
If yes, in which of the following? Netball, Hockey, Rugby, Soccer, Cricket, Tennis, Volleyball, other		
If you had a choice, in which of the following sports activities would you participate? Netball, Hockey, Rugby, Soccer, Cricket, Tennis, Volleyball; Jogging; Athletics		
Now we are going to ask you questions on some social behaviour. Please remember that this information will be kept strictly confidential and that this is only to test your knowledge.		
Do you have a boyfriend/girlfriend	Yes	No
Do you only sleep with one partner?	Yes	No
Have you ever heard of sexually transmitted diseases?	Yes	No
Have you ever heard about the disease called HIV/Aids?	Yes	No
Do you know what a condom is?	Yes	No
The last time you had sex; did you use a condom?	Yes	No
In the past 12 months; with how many different men/women did you had sex?	.....Men/Women	
Do you know where you can get a condom? Specify.	Yes	No
Do you use a condom?	Yes	No
If the answer is NO, ask why the person does not use a condom. RECORD ALL MENTIONED		

Have you ever had an HIV/Aids test done?			
Do you know where to go for a HIV test?			
How can people protect themselves from HIV/Aids?			
Having a good diet			
Staying with one faithful partner			
Avoiding public toilets			

Using condoms during sexual intercourse			
Avoiding touching someone with HIV/Aids			
Avoid sharing razor blades			
Whom do you get information on HIV/Aids from?			
Do you trust the information that you get? If the answer is NO/YES, specify. They are reliable. Professionals gave information. Did not answer.	Yes	No	
From whom would you prefer to get correct information on HIV/Aids? The person can mention more than one. Write down all the person mentioned			
How would you prefer to obtain information on HIV/Aids? (They can mention more than one)	Personally (mouth to mouth)		
	Read about it		
	See on TV or in magazine		
	Listen on the radio Other (specify)		
Do you know any organisation/NGO, etc. that provides information/lectures on HIV/Aids? If YES, ask for the names.	Yes	No	

Thank you for taking part in this survey. If you have any questions, we are willing to answer them now if it is possible.

How do you feel about this visit?

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INTERVIEWERS OBSERVATIONS

Comments about the Respondent/s:.....

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Comments on Specific questions:.....

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Any other comments:.....

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Compiled by Mada Watson (Senior Lecturer: PU for CHE) and recommendations from the Potchefstroom Wellness Forum, Cornelia Wessels and Adrie Roux..

GENERAL HEALTH INFORMATION ON THE HOUSEHOLD MEMBERS