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**THE IDENTIFICATION OF  
COMMUNITY NEEDS FOR AIDS  
HEALTH EDUCATION**

by

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Dissertation  
Submitted in fulfilment of the requirements  
for the degree

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*in the Faculty of Health Sciences  
of the University of the Free State*

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**Co-study leader: Mrs L Visser**

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*This study is dedicated to my parents, who  
nurtured and gave me a sound foundation  
on which to build my entire life.*

## DECLARATION

I, **Sylvia Rejoice Olebile Khokho** declare that the dissertation hereby submitted by me for the Masters Societatis Scientiae (nursing) degree at the University of the Free State is my own independent work and has not previously been submitted by me at another university/faculty. I furthermore cede copyright of the dissertation in favour of the University of the Free State.

  
**S.R.O. KHOKHO**

November 1997

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## SUMMARY

AIDS is a fatal disease which mostly affects the economically productive age-group (25-50 years). It therefore adversely affects the economy of the country. It is also expensive to treat as it affects the immune system of the body, thereby rendering the person critically ill and requiring intense and expensive nursing and medical care.

AIDS is also seen as a disease of attitude and behaviour, as it is closely associated with sexual behaviour, where a person has more than one sexual partner. This practice, in the form of polygamy (as seen today) and concubinage, is still accepted as normal cultural practice in most black communities in spite of the effect of social change on many tribal customs.

There is a drastic increase in the number of persons infected with AIDS in spite of existing efforts to combat the disease. This increase is not specific to a particular racial group, country, community or town. It is a worldwide problem. However, most new cases of AIDS are found among the black population.

Health education seems to be the only strategy available as a measure for controlling the spread of AIDS in the absence of a cure. There is therefore a



definite need to investigate the requirements for the development of a health education program for the control of AIDS.

The aim of this study was to identify the needs of the community for AIDS health education. This entailed eliciting their perceptions of AIDS, establishing their preference regarding the AIDS educator, identifying topics/aspects to be addressed in the educational program, as well as establishing principles with which ethnic-specific health educational programs should comply to be acceptable to communities.

Interviews were conducted with clients visiting health services in Mangaung. Trained fieldworkers were used to help with the implementation of the structured interview schedule. The data were analysed and the findings were compared and discussed in terms of the literature review. Reliability of the data collection instrument was ensured by training fieldworkers to ask questions correctly. The conduction of a pilot study to identify possible problems and address these before the major study helped to ensure reliability. For the purpose of validity, the interview schedule was submitted to experts in research. This ensured face validity. Content validity was ensured by submitting the measuring instrument to a domain expert. It was also handed to an expert working at the AIDS Training, Information and Counselling Centre (ATICC) for evaluation. These experts were

asked to evaluate the interview schedule in terms of whether the questions were correctly and objectively worded and whether they matched the objectives of the study. Conclusions and recommendations were made and guidelines, based on findings, were set for the development of a health education program for the control of AIDS.

## OPSOMMING

VIGS is 'n terminale siekte wat hoofsaaklik die ekonomies produktiewe ouderdomsgroep (25-50 jaar) affekteer. Dit het dus 'n negatiewe invloed op die ekonomie van die land. Dit is ook duur om te behandel aangesien dit die immuunsisteem van die liggaam aantast. Lyers word kritiek siek en benodig intensiewe en duur verpleegkundige en mediese sorg.

VIGS word ook as 'n siekte van houding en gedrag beskou, aangesien dit met seksuele gedrag in gevalle waar 'n persoon meer as een seksmaat het, verbind word. Ten spyte van die effek van sosiale verandering op vele stamgebruike word hierdie praktyk, in die vorm van veelwywery en konkubinaat, steeds as normale kulturele praktyk in die meeste swart gemeenskappe aanvaar.

Ten spyte van die huidige pogings om die siekte te bekamp is daar 'n drastiese toename in die aantal persone wat met VIGS besmet is. Die toename is nie tot 'n spesifieke bevolkingsgroep, land, gemeenskap of dorp beperk nie. Dit is 'n wêreldwye probleem. Daar is egter bevind dat die meeste nuwe gevalle van VIGS onder die swart bevolking voorkom.

In die afwesigheid van 'n geneesmiddel wil dit voorkom of gesondheidsvoorligting die enigste beskikbare strategie is om die verspreiding van VIGS te bekamp. Daar is dus 'n besliste nood aan navorsing insake die behoefte aan die ontwikkeling van 'n gesondheidsvoorligtingsprogram vir die beheer van VIGS.

Die doel van hierdie studie was om die behoeftes van die gemeenskap van Mangaung aan VIGS voorligting te identifiseer. Dit het behels dat hul persepsies van VIGS en hul voorkeur ten opsigte van voorligters vasgestel moes word. Onderwerpe/aspekte wat in die voorligtingsprogram aangespreek moes word, asook beginsels waaraan 'n etnies-spesifieke gesondheidsvoorligtingsprogram moet voldoen om vir die gemeenskap aanvaarbaar te wees, moes ook nagevors word.

Onderhoude is gevoer met kliënte wat die gesondheidsdienste in Mangaung besoek het. Opgeleide assistente is gebruik om met die administrasie van die gestruktureerde onderhoudskedule te help. Die data is ontleed en die bevindinge is met 'n literatuurstudie vergelyk en bespreek. Die betroubaarheid van die dataversamelingsinstrument is verseker deur assistente op te lei om die vrae korrek te stel. Die loodsstudie om moontlike probleme te identifiseer en aan te spreek voordat die hoofstudie aangepak is, het gehelp om betroubaarheid te verseker. Die onderhoudskedule is aan navorsingskundiges voorgelê om gesigsgeldigheid te

verseker. Inhoudsgeldigheid is verseker deur die meetinstrument aan die studieleier, wat 'n kundige op die gebied van VIGS is, voor te lê. 'n Domeinkundige wat by die VIGS Opleiding, - Inligtings en Beradingsentrum werk is ook gevra om die instrument te evalueer. Die kundiges is gevra om die instrument te beoordeel in terme van die korrektheid en objektiwiteit van die vrae en of dit aan die doelwitte van die studie voldoen. Gevolgtrekkings en aanbevelings is gemaak en riglyne, op die bevindinge gebaseer, is vir die ontwikkeling van 'n gesondheidsvoorligtingsprogram vir die beheer van VIGS gestel.

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# **CHAPTER 1**

## ***Statement of the problem, purpose of the study and method of investigation***

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### **1.1 INTRODUCTION**

In 1994 there were 550,000 South Africans infected with the Human Immune Deficiency Virus (HIV) (Express, 1994:26). According to the Express (1994:26), there is a daily increase of about 550 new cases of HIV infection. That implies that there will be more than 750,000 HIV positive cases in South Africa at the end of 1997. According to the seventh national HIV survey of women attending antenatal clinics of the public health services in South Africa conducted during October/November 1996, levels of HIV infection have increased in seven of the nine provinces from what it was in 1995. Exceptions are Western Cape and Mpumalanga, where estimates were lower than in 1995. The survey further showed that the Free State had the third highest HIV infection level after North West and KwaZulu-Natal (AIDS Scan, 1997:5).

Infection with the HIV leads to Acquired Immune Deficiency Syndrome (AIDS) which is described as a fatal disease (SANA, 1989:1). It is associated with the environment and not inherited; it affects the immune system of the body, rendering it incomplete or lacking.

Goddard (1989:17) defines AIDS as a deadly, avoidable viral disease of human beings. The causative virus, the HIV is transmitted through contact with the genital fluid, blood and blood products, other body fluids and through the placenta to the unborn foetus.

Claxton and Harrison (1991:13) state that the HIV is a member of the lentivirus sub-family of the retroviruses. Retroviruses derive their name from the fact that their genome consists of RNA. This class also contains all cancer viruses. Unlike cancer viruses, lentiviruses have been found to be infectious and to attack mainly the central nervous system. Only a few human diseases, such as AIDS, are associated with lentiviruses (Cremers, 1993:36-37).

According to Goddard (1989:18-19) the characteristics of the HIV make it difficult, if not impossible, to produce a vaccine for this fatal disease. Examples of these viral characteristics are:

- The continuous mutation of the virus.
- The fact that it is species specific. This means that *"no laboratory animal has the same specifications as the human body"*.

## **1.2 STATEMENT OF THE PROBLEM**

There is a drastic increase in the number of persons infected with AIDS in spite of existing educational programs to combat the disease. Statistics at AIDS centres,



hospitals and clinics, the mass media and literature bear witness to this. Increase in the rate of HIV infection is a worldwide problem. According to Whiteside (1993:1), however, most new cases of AIDS are among the black population. This has prompted the researcher to undertake this study, to investigate the reasons for this increase. According to previous research, a number of reasons for the increase have been identified. These will be discussed in the pages that follow.

The researcher decided to use the community of Mangaung as subjects in her study. This is by no means meant to imply that this community has the highest rate of HIV infections or of AIDS cases. It was chosen merely for practical purposes and for reasons of feasibility. The researcher lives in Mangaung, she knows and understands the culture of the community and undertook her basic nurse training as a member of this community. She has also worked there as a community health nurse. The researcher therefore believes that she will be accepted and understood by the community, and is also in a position to understand them. Findings from this research will be used in constructing an ethnic-specific health education program for the combating of AIDS for any community with the same characteristics.

## **1.2.1 Motivation of the problem statement**

### **1.2.1.1 *Extent of AIDS in black communities***

AIDS is said to be one of the most severe public health problems, especially among Africans. It is also seen as a "*disease of attitudes and behaviour*"

(Shikhibane, 1993:1). It is closely associated with sexual behaviour, where a person has more than one sexual partner. This practice, in the form of polygamy (as seen today) and concubinage is still accepted as a normal cultural practice in black communities, in spite of the effect of modern life on many tribal customs. This makes it difficult to stigmatize promiscuity as a reason for the spread of AIDS (Mokhobo, 1989(a):18).

Other cultural practices and traditional beliefs of black communities that may hamper the acceptance of AIDS education programmes may be listed as follows:

- The attitude of black males in particular, is that condoms are a white conspiracy aimed at limiting black population growth and lessening their political power (Zazayokwe, 1990:9).
- Males believe that contraception by condom may expose them to being bewitched as their <sup>semen</sup> is collected in a "tube". *semen will be stereotyped to be controlled by whites*
- Sexual promiscuity, whether called prostitution or concubinage is not likely to endure a stigma of disapproval in an African society. Any strategy should therefore rather emphasize safe sex.
- Sexual excesses, when practised by males are seen as prestigious. They also reinforce the traditional attitude of male supremacy and male sexual prowess (Mokhobo, 1989(a):18).

- AIDS is a sexually transmitted infection. These infections are perceived by a lay person as those affecting the sexual organs. AIDS can therefore not be accepted as a sexually transmitted infection as it cannot be linked to sexual activity. This is because it does not affect any specific organs (Mokhobo, 1989(a):20).
- The researcher has observed that in black communities, especially those in rural areas, a couple is separated for some time after the birth of the child so that the *"milk is not contaminated through sexual intercourse"*. This practice, although it may have certain advantages like allowing healing of the episiotomy as well as allowing uterine involution; may have certain disadvantages. The male, who is not suffering any physical postpartum effects, may seek sexual satisfaction from other women. This may expose him to infection with the HIV, as he may not be aware of the sexual behaviour of these new partners.

According to Mokhobo (1989(a):20) blacks have lost their traditional sexual taboos, where they were expected to have only one sexual partner. The following factors may be seen as reasons for the breakdown of these taboos:

- **Urbanization**

This has broken down many black families, as husbands had to move from rural areas to urban areas, for better employment opportunities. Wives and children had

to be left behind, as there were no homes in urban areas. Hostel accommodation was sometimes provided but catered only for males. Soon the man would feel lonely and resort to another woman for sexual satisfaction. This led to many sexual partners or concubinage which could expose him to infection with the HIV.

- **Poverty**

Due to poverty some women may yield to sexual advances by many males for economical gain. Some do this so that the men would provide them with accommodation. Employment opportunities are few, especially for rural black females who are basically uneducated. This practice leads to prostitution, which predisposes them to sexually transmitted diseases, including AIDS.

According to Evian (1993:230) these women often resort to "*selling sex as a way to earn much-needed money*". This happens around desperate circumstances where the woman has no chance to gain information on the sexual behaviour of these partners or to suggest protection with a condom. Should the man disagree with her about protection, it could lead to her losing the money if she insists.

Women are said to face economic and social disadvantages. Their economic dependence is perpetuated by the fact that they are less likely to be educated, have skills or stable employment (Basset, 1993:8-9). This situation has, however, changed dramatically.

- **The migrant labour system**

As in urbanization, this can lead to the disintegration of healthy family relationships. The male has to migrate from place to place in search of employment. In this situation it becomes impossible for him to take his family along until he settles somewhere after securing employment. He may also have to leave his family behind during the first few days after transfer until proper arrangements have been made for their accommodation. This separation from his partner may tempt the man to have sexual partners in the places he reaches without her. This once more results in promiscuity, which predisposes to infection with the HIV (Mokhobo, 1989(a):18; Evian, 1993:229).

According to Bassett (1993:8) half of the black South African working force are migrant labourers. These men live in single sex hostels or compounds near their places of work while their wives and children live on their own in the country. Very few places of residence have been built for these labourers near their places of employment. This situation, however, improved slightly when the Group Areas Act was repealed. This Act defined the areas in which people could live, provided for influx control and resulted in insufficient land being zoned for the future development of black townships.

- **Travelling**

Many black men are employed as long distance truck drivers. According to Fleming (1993:18) heterosexually acquired HIV infection was recognised in migrant labourers travelling from Malawi and Zambia to South Africa in 1985.

Whiteside (1994:4) noted that the number of AIDS cases increased dramatically in Botswana when numerous trucks started travelling through this country on their way from South African ports to Zambia, Zaire, Malawi and Angola or from Namibia to Zimbabwe. Female traders also travel regularly from Zambia and Zimbabwe to buy goods in Francistown, a city in Botswana. These women are found to be vulnerable to sexual exploitation while travelling. This massive movement of people to, from and through Botswana has created the *"perfect situation for the rapid spread of the HIV"* (Basset, 1993:8).

AIDS is also said to spread rapidly in cities that are traversed by busy roads. Large cities that are traffic crossroads, such as Kampala in Uganda, have a very high incidence of HIV infection. The incidence of HIV infection in Africa is said to double every eight to nine months (Cremers, 1993:38-39). Travelling by air, which is even faster, is seen by the researcher to aggravate the situation. This is because in an aircraft, a person with AIDS will reach his destination faster, and so will the AIDS virus in his body.

- **Level of education**

Black communities, especially in rural areas, are said to be semiliterate or literate only in their mother tongue (Hyde, 1992:26). This may be because in earlier times education was not a priority in the mind of black South Africans. Perhaps most black families could not afford to educate their children enough to be able to compete favourably with other racial groups. Even those that could afford it were subjected to sub-standard education in accordance with apartheid policies on education.

Because of this shortcoming many blacks reject educational programmes, including those on AIDS. This is either because they are constructed in English or Afrikaans or because they fail to comprehend the underlying principles. Although some of these programmes may be translated or read to them, most of them are constructed by educated white people who may be unaware of the beliefs, attitudes, customs and needs of black communities (Shikhibane, 1993:1). These programmes are therefore in his opinion *"targeted towards middle class and educated white people, leaving blacks aside"*. In the opinion of the researcher, this is, however, changing as witnessed by the many attempts by various black authors to focus on black communities in their efforts to give education and counselling on AIDS.

However, in spite of this, Whiteside (1993:1) states that most new cases of AIDS among the black population are due to apartheid and the social, economical and political milieu many black people were forced to live in.

The apartheid regime is responsible for the fact that many blacks could not get an education that was enough to civilize them and help them alter their traditional beliefs. Amongst these beliefs and cultural practices are those that predispose them to AIDS, such as concubinage. The economic environment many blacks find themselves in, is that of poverty. This also forces many of their women to resort to prostitution for financial gain. The political system has pushed many black communities into poverty due to poor allocation of resources such as money and employment opportunities. This has also resulted in the social milieu of strikes and unrest which makes them even poorer as some lose their belongings and others lose their employment ( Whiteside, 1993 : 1-2 ).

Even where attempts are made by health educators and health professionals to educate black communities about AIDS, sometimes one finds that their efforts are frustrated by the barriers to education that are inherent in such communities.

#### **1.2.1.2.     *Barriers to education on Acquired Immune Deficiency Syndrome***

In her work as AIDS counsellor, Zazayokwe (1990:8) encountered the following obstacles, which hamper AIDS education in black communities:



## - **Projection**

There is a tendency to blame AIDS on others and completely dissociate oneself from this disease. For example people see AIDS as a disease of intravenous drug users and prostitutes. It is also thought to be a gay disease or a disease of migrant workers. Some perceive it as God's punishment for homosexuality and promiscuity. People who do not engage in high-risk behaviour therefore fail to see how they can be infected with the HIV.

It is important to stress in educational programmes that AIDS is not prejudiced against any particular group. Any sexually active person can be infected. The risk is even greater when one has more than one sexual partner.

## - **Language**

This may result in a serious communication barrier in AIDS education. Elementary concepts used in describing the disease, such as virus, condom and immunity do not exist in any black language. Relevant analogies and visual aids are used to overcome this hurdle. For example, the immune system is likened to soldiers that protect the body against invaders such as the HIV. The word germ is used instead of virus. Several concepts are used to describe the condom as French letter, or "*kgotlopo*".

- **Culture**

Black culture associates wisdom with an increase in age. It may not be culturally acceptable, therefore, for a young nurse to educate adults on AIDS. Females are also viewed as perpetual minors and may also not be acceptable as AIDS educators, especially to male audiences.

For one to earn credibility before a group, it may perhaps be necessary to wear nurses' uniform. This may help in overcoming discrimination against age and sex (Zazayokwe, 1990:8). The acceptance of this, however, depends upon the group being addressed. Some groups may reject a nurse in uniform as an educator. In this instance casual dress may be recommended.

- **The sickness concept**

Van Dyk (1992:250) states that traditional blacks fail to see AIDS as a disease caused by a virus. They believe that illness is brought on a person due to being bewitched or that angry ancestors have let evil spirits loose in order to spread AIDS.

Zazayokwe (1990:8) feels that teaching aids must be used to explain this concept to black people. Mokhobo (1989(a):18) indicated that it could be difficult for some people to perceive AIDS as a disease of sexual organs due to the fact that it attacks the body in general and not the sex organs specifically.

## - **Educational background**

Most lay people lack the education to help them understand the anatomy of the female sexual organs. This has a negative influence on their acceptance of the condom. For example, according to Zazayokwe (1990:9) some state that they may suffocate and die if the condom accidentally slips off during sexual intercourse. They believe that it may stray to the lungs.

Visual aids depicting the female reproductive organs may be useful in dispelling this misconception.

## - **Traditional healers**

According to Shikhibane (1993:23) there is always a cure by inyangas or sangomas for every disease in black society. AIDS is no exception to this rule. In fact Lachman (1991:297-298) states that black AIDS patients often come very late for medical attention because they believe in treatment by "*non-scientific*" traditional healers.

Zazayokwe (1990:9) sees this as a disparity between indigenous and Western healing. She also views it as a major barrier in education on AIDS. This is because traditional healers often use razor blades to administer drugs through an incision. This is a very direct way through which the HIV can be introduced into the body, and it becomes worse as traditional healers use the same blade until it gets lost or breaks. This obstacle can be overcome by hosting seminars to educate sangomas.

- **Polygamy**

Preaching monogamy to blacks may be a waste of time as the black culture still allows polygamy and concubinage (Basset, 1993:8; Mokhobo, 1989(a):22).

To overcome this, one may have to stress loyalty between husband and his more than one wives to promote prevention of infection outside marriage. This can of course only be successful if all wives and their husband are free from infection with the HIV in the first place (Burnard, 1992:50).

- **Media coverage**

Evian (1993:231) notes that the media comprise the most accessible source of information to the general public. Many people, especially teenagers, are influenced by the mass media. Magazines and movies often portray sexy pictures and advertisements that promote sex. To be accepted and respected by their friends teenagers feel that they have to act according to these advertisements. They also find it difficult to negotiate safer sex with their partners, lest they leave them for someone else.

This obstacle, according to Shikhibane (1993:21) is a difficult one as people often cling to what they have seen on television, heard over the radio or read in newspapers prior to getting factual information.

Health education programmes must therefore emphasize facts so that people are able to critically evaluate what they are told in the media.

- **Sex as taboo subject**

Some people find it difficult to talk openly about sex. They may therefore fail to discuss ways in which they may engage in sex more safely or how to avoid sexual intercourse if and when they are not ready for it (Evian, 1993:231).

To overcome this obstacle, people must be encouraged to be more open on the topic of sexual intercourse. They will have to talk to their partners about their fears as well as about how to enjoy sex in a safer manner (Burnard, 1992:67).

- **Animation pictures**

According to the "AIDS Scan" (1991:40) this is one of a variety of new and innovative methods of transmitting information on AIDS to communities. The method draws aspects of puppetry and street theatre together and uses this in an entertaining and educational show. This method is usually used at a venue that can accommodate many people as it often attracts large numbers of people.

The researcher is of the opinion that this method must, however, be used with care as it can be an obstacle to education on AIDS if used carelessly. It is open to many interpretations or rejection by some communities who may not associate the puppets or pictures with their situation, for example, where a big animation

mosquito is used to show how AIDS can destroy life. Communities with the normal type of mosquito may feel that it means that their type can never cause AIDS. They are therefore, in their opinion, immune from infection with the HIV or AIDS. However the researcher does not imply that mosquitoes cause AIDS. Animation pictures therefore must be evaluated for effect and interpreted to viewers to prevent misconceptions.

It is against this scenario that the researcher feels that black communities, in spite of existing AIDS education programmes, still lack enough information on AIDS. It seems that they do not really benefit from existing programmes, or that they do not accept them. The researcher therefore feels that there is a need to devise a strategy that may be used in constructing a health education program that is suitable for, and therefore acceptable to black communities in the control of AIDS. Perhaps one will not necessarily give information but rather augment whatever knowledge they have. To be able to accomplish this the researcher feels that it is imperative that one assesses their actual knowledge, attitudes and needs with regard to AIDS. This will help in devising a strategy that may be used in constructing a health education program for combating AIDS that is acceptable to them.

In conclusion, it is due to economic factors, illiteracy and poverty that educational programmes on AIDS are either not accessible to or are not directed at appropriate target groups.

### **1.3 AIM OF THIS STUDY**

The aim of the study was to identify the needs of the community of Mangaung with regard to the development of a health education program for the prevention of AIDS.

### **1.4 PURPOSE OF THE STUDY**

In view of the stated problem, the purpose of this study is to:

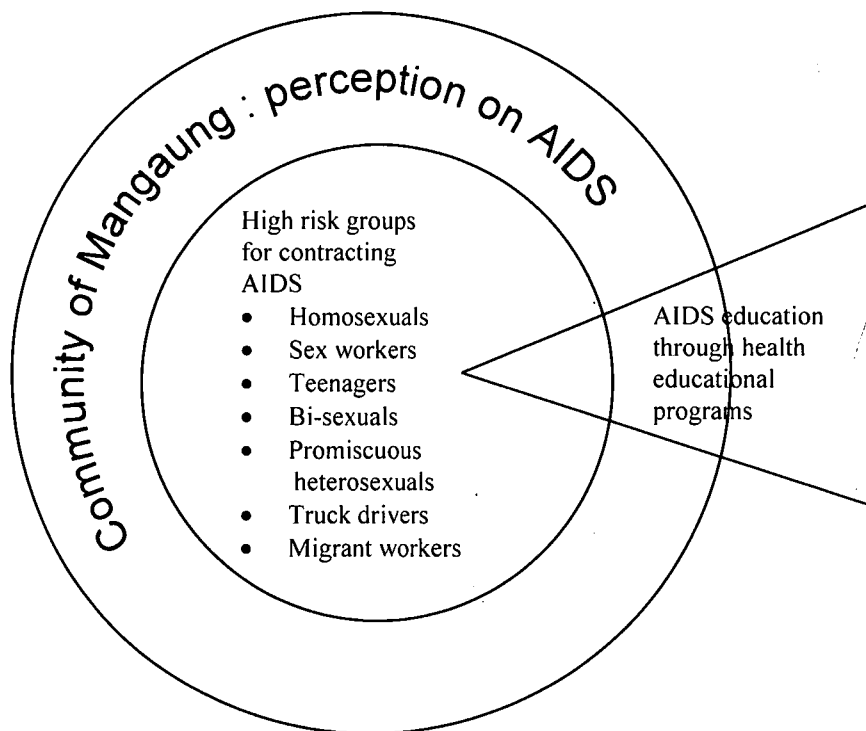
- assess the knowledge of the community of Mangaung on AIDS;
- establish their preference regarding who should be responsible for AIDS education;
- identify aspects that in the opinion of the community may influence avoidance of risky sexual behaviour.

### **1.5 JUSTIFICATION OF THE STUDY**

The rate of AIDS in communities is increasing drastically in spite of efforts to try and combat it. Health education is the only strategy that can be employed in the control of this deadly disease due to a lack of a vaccine or a cure for AIDS.

It is therefore imperative to investigate whether or not a strategic AIDS education program is, in fact, in use. If there is, then why is it not effective in reducing the rate at which people are being infected with the HIV?

## 1.6 CONCEPTUAL FRAMEWORK



This framework consists of two circles. The outer circle indicates the community of Mangaung, which is the population in this study. The community has some perceptions of AIDS and infection with the HIV.

The inner circle represents some high risk groups for contracting AIDS that are found within the population such as homosexuals, sex workers, teenagers, truck drivers, migrant workers and promiscuous heterosexuals. These groups are found to be at risk due to various factors such as their life style or socio-economic factors like poverty and a lack of education.



The triangle represents AIDS education through health educational programs. People outside Mangaung such as the National Department of Health give such education to a great extent. Some educators that reside in the Free State but not necessarily in Mangaung also give a great part of education on AIDS.

Professionals and lay educators in Mangaung are also involved in the dissemination of health education on AIDS. The professional group includes doctors, nurses, teachers and social workers that contribute to education on AIDS. In some workplaces peer educators also engage in AIDS preventive education.

The triangle also shows that some education on AIDS is given by groups at risk of contracting AIDS such as sex workers, some teenagers, some promiscuous heterosexuals and some AIDS sufferers residing in Mangaung.

## **1.7 OPERATIONAL DEFINITIONS OF A FEW IMPORTANT CONCEPTS CONCERNING AIDS EDUCATION**

The following definitions were formulated and utilized for the purpose of this study. This was necessary to avoid confusing the reader with a jungle of semantics. It is important to clarify the context in which each concept is used in the study.

### **1.7.1 Community**

The World Health Organization has defined a community as a social group sharing the same geographical boundaries and/or common values and interests.

Community members are said to create norms, values and social institutions for themselves. They also know each other and interact with one another (Clemens-Stone, Eigsti & McGuire, 1991:72-73).

Popenoe (1983:88) views a community as a relatively small cluster of people, focused on individual homes and places of work, and based on daily patterns of interaction. In this study, community must be understood to refer to people who are residing in Mangaung and are of the same racial group.

### **1.7.2 Acquired Immune Deficiency Syndrome**

The definition currently in use at the Centre for Disease Control (CDC), in Atlanta, Georgia is that AIDS is "*an alteration in the body's cellular immune system of a previously healthy patient*". The interference with the immune system makes a person susceptible to opportunistic diseases and some cancers, such as Kaposi's sarcoma (Wells, 1986:8).

The SANA (1989:1) sees it as a deadly disease caused by the HIV. It is acquired in that it is not inherited or genetic but associated with the environment. Immune refers to the fact that it affects the body's natural resistance rendering it either lacking or deficient. It is a syndrome as it is characterized by a group of particular signs and symptoms that occur together and characterize a condition.

Consequently, AIDS is, for the purpose of this study, defined as a syndrome of opportunistic diseases and certain cancers, which occur in people with acquired immune deficiency following infection with the HIV. This definition is a combination of definitions by various authors cited in this text and will be used in this study to refer to the disease.

### **1.7.3 The Human Immune Deficiency Virus**

An international abbreviation for the Human Immune Deficiency Virus is HIV (Basson, 1992:1). The virus is a member of the retroviruses (Shikhibane, 1993:4). HIV is a causative virus for AIDS.

### **1.7.4 High risk groups**

This concept refers to groups of people who, by virtue of a particular behaviour or factor are more prone or exposed to a particular situation. In this study high risk groups will be used to refer to people who, because of engaging in risky behaviour such as unprotected sexual intercourse and the sharing of intravenous injection needles are at risk of contracting AIDS or being infected with the HIV.

### **1.7.5 Health Education**

Health education refers to the dissemination of health information or knowledge to communities or individuals with the aim of motivating them to participate actively in the improving of their health status. A community has benefited from health education programs when the people actively and voluntarily participate in health

promotive and ill health preventive actions. An important objective of health is self-care by the population.

In this study, health education on AIDS will be effective if it has succeeded in making the community ready and willing to absorb education or advice to change risky attitudes and sexual practices and adopt AIDS preventive behaviour.

## **1.8 METHOD OF INVESTIGATION**

An empirical investigation will be undertaken by using a self-designed structured interview schedule as a measuring instrument. Items of this instrument will be well founded in the literature review. Through a literature view, the researcher aims to describe the extent of AIDS in South Africa. This will be followed by a discussion of the principles with which any ethnic-specific health education program should comply to be acceptable to the target group. Factors that may hamper AIDS education in communities will then be presented to complete the literature view.

The health services in Mangaung will be used to elicit information from community members. Various residences in Mangaung will also be visited to obtain information. The researcher intends training a few assistants to help her with the administration of the measuring instrument.

The empirical investigation will lead to the establishment of a nursing health education program to be used in the prevention of AIDS. The interview schedule

to be used will be given to experts on the subject of AIDS and on educational programs for evaluation to ensure validity and reliability.

The community of Mangaung will be used as the population from which a sample will be drawn. Random selection of subjects and households will be used, where each individual stands an equal chance of being selected. A sample of 200 respondents will be selected from the population.

Descriptive statistics will be used in data-analysis.

## **1.9 MODUS OPERANDI**

**Chapter 1** This chapter is devoted to the statement of the problem, the purpose of the study and a brief description of the research methodology as well as operational definitions and further course of study.

**Chapter 2** This chapter deals with the prevention of AIDS with special emphasis on the establishment of a nursing health education program for the control of AIDS.

**Chapter 3** The influence of AIDS knowledge on the behaviour of people is presented in this chapter. Special emphasis is laid on the application of the health belief model.

**Chapter 4** This chapter covers the empirical investigation, the research methodology as well as statistical manipulations.

**Chapter 5** Research findings as well as interpretations thereof are described in this chapter.

**Chapter 6** The chapter reflects on the entire study in terms of its findings and conclusions. Based on this, recommendations will be made and guidelines set for the development of the health education program for the control of AIDS.

## **1.10 SUMMARY**

In this chapter, an overview of the study was given, which includes a statement of the problem, purpose of the study, method of investigation, operational definitions and modus operandi.

In the next chapter, prevention of AIDS through health education programs as well as its epidemiology will be dealt with.

## **CHAPTER 2**

# ***Prevention of Acquired Immune Deficiency Syndrome***

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### **2.1 INTRODUCTION**

According to Goddard (1989:18) the characteristics of the HIV make it difficult if not impossible to produce a vaccine for this fatal disease. Examples of these viral characteristics have been outlined earlier in this text. The only major strategy of prevention is therefore by means of a health education program. This education must be aimed at the *“alteration of human behaviour, bearing in mind the rights of the individual and the protection of society”* (Lachman, 1990:93).

Macklin (1989:166) states that education is presently the only *“vaccine”* that we have against AIDS. Yet, this strategy presents many problems. This is because AIDS education must deal with sensitive sexuality issues, with which society has not dealt. Presently many people in fact still query the advertising of condoms on radio and television.

### **2.2 EPIDEMIOLOGY OF AIDS**

The medical profession was first alerted to AIDS by the appearance of Karposi's sarcoma. In 1981, six unusual cases of pneumonia were reported from Los Angeles.

From this year, the United States of America started reporting AIDS cases. However, by 1987, the disease had become pandemic, with 142 countries now reporting cases to the WHO (Goddard, 1989:17). In 1982, the first AIDS patient was diagnosed in South Africa. This was a white homosexual male (Basson, 1992:2).

Sher, as quoted by Goddard (1989:17) states that to date AIDS is still underreported. Only actual AIDS cases are reported, leaving out many cases that are infected with the virus but not showing any signs of the disease. It is this "*asymptomatic carrier*" who is of great danger to others (Goddard, 1989:17).

Fleming (1993:18) outlines the following unique features of the epidemic of AIDS in Southern Africa:

- There have been two separate epidemics - one in the male homosexual community, who are predominantly white, the second in the heterosexual population with the majority cases being among blacks.
- Eastern and central countries in Southern Africa had no warning. Seroprevalence was already high when serological tests were introduced for the first time in 1985.
- South Africa had a warning seven years ago when seroprevalence was still extremely low. Southward spread of HIV infection was, however, inevitable.



- Responses to the AIDS epidemic have shown the mistrust and hatred that divide a society in which apartheid disappears in law only. This means that it is evident in South Africa that there is mistrust between racial groups. Blacks are suspicious of whites when these try to educate them on the prevention of AIDS. They feel that there is still evidence of hatred and whites could be using AIDS education programs to reduce their numbers so as to defeat them. Cameron (1993:6-7) noted that as recently as 1993, persons with HIV and AIDS were discriminated against by denying them access to adequate resources. This abuse of human rights is happening increasingly in both the public and the private sector. It is proliferating and takes various forms, for example pre-employment HIV testing for the purpose of denial of employment, exclusionary and unjust discrimination in insurance as well as discriminatory denial of fair and adequate health care of persons with HIV or AIDS (Mokhobo, 1991:6-7). The researcher has, however, noticed an improvement since the inauguration of the new South African Government.
- The economic impact of AIDS is not only felt in South Africa, but beyond its borders. This is because it attacks mostly the labour force, that is people of ages 25 to 50 years. As it is expensive to control, it strains the economy of the country, as the state has to spend more money on its control.

Figures in South Africa by March 1991 showed an HIV infection rate of 1,61% for Kwazulu/Natal; 10,55% for the Free State and the Transvaal and 0,16% for the Cape

(Cremers, 1993:39). These statistics might have changed dramatically today as shown by the latest statistics on the number of AIDS cases in South Africa. These show the rate of reported cases in December 1994 as 990 for Kwazulu/Natal; 331 in the Free State; 435 for the Transvaal and 225 for the Cape Province (Department of Health, 1994:287).

There are many reasons why AIDS has become an epidemic: many youths and many traditionally monogamous communities have adopted promiscuity as a way of life. This has consequently become acceptable in many societies (Cremers, 1993:38; Mokhobo, 1989(b):20).

For a diagnosis of AIDS to be made, the following criteria must be met:

- Laboratory evidence of HIV namely antigen and antibody detection.
- Virus isolation through culture.
- Cellular immune deficiency.
- Clinical evidence of opportunistic disease infections or certain cancers; HIV wasting syndrome or a combination of any of these (Goddard, 1989:17; SANA, 1989:2).

## **2.3 PREVENTION OF ACQUIRED IMMUNE DEFICIENCY SYNDROME THROUGH HEALTH EDUCATION PROGRAMS**

According to Mokhobo (1991:7) it is imperative that an AIDS steering committee be established, on which a wide range of interested parties should be represented e.g. management, workers, the media, personnel, public relations, communication and safety representatives. Nationally, National AIDS Counselling Organization of South Africa (NACOSA) exists as such a committee and it was established in 1992. Small groups also exist in the Free State to combat the spread of AIDS. These are, however, not yet effective as they are in their formative phases, e.g. the AIDS Initiative Committee. A need for the co-ordination of these committees exists. It is impossible to educate people effectively about AIDS if they do not, at a personal level believe that what they are taught is the responsible route to take. The first step in the prevention of AIDS, according to Mokhobo (1991:7) is the raising of awareness through health education programs.

According to Shikibane (1993:17) communities must make the prevention and control of HIV infection an international public health priority, which requires the full commitment of political, financial and professional resources of every country. Evian (1993:236) recommends that this health education must cover aspects such as the cause of AIDS, the modes of transmission, the lack of a preventive vaccine or a cure, as well as the specific ways in which individuals can protect themselves from being infected now or in the future.

### 2.3.1 Safer sex behaviour

The only behaviour that may be said to be safe as far as being completely protected from contracting AIDS would be total abstinence from sexual intercourse. As this is not always feasible, one can only talk of safer sex, which will only offer some protection and not total protection against the AIDS virus (Akande, 1994:301). Although it is important for groups at risk to be given enough knowledge about the epidemiological risks of AIDS, Ahia (1991:51) notes that knowledge alone does not significantly influence compliance with safer sex guidelines. In applying Pender's health belief model, Ahia was able to conclude that awareness of the epidemiology of AIDS is a "necessary starting point but not sufficient for compliance to safer sex guidelines".

This means that health education programs must not only give information on safer sex practices, but must also evaluate the group or individual's perceived severity and perceived consequences of the particular health problem (Mayes *et al.*, 1992:511). These techniques will be explained in the education program and communities will be motivated to adopt them.

Before 1980, the term safer sex referred to precautions taken to prevent unwanted pregnancies. Since the appearance of HIV, it is however, commonly used in reference to measures taken to prevent the contraction or transmission of HIV

(Dilorio, C., Adame, Carlone, Lehr, and Parsons, 1992:203). The following safer sex practices are described by Dilorio *et al.* (1992:204):

### ***2.3.1.1 Assertiveness and interpersonal skills in negotiating protection during sexual intercourse***

The epidemiology of HIV infection indicates that people who have taken part in particular activities, or who still do, are at a much higher risk than others (Adler & Johnson, 1988:51). Homosexual and bisexual men are referred to by Burnard (1992:62-63) as the "*closeted heterosexually-married, homosexually-active men*" that constitute a very difficult population to reach. This is because some of them live in a heterosexual relationship and hide their homosexual behaviour from their partners. Their partners are therefore not in a position to negotiate protection and this puts them at risk of infection. Akande (1994:287) notes that some homosexual adolescents engaged in activities, which placed them at risk of HIV infection due to a lack of assertiveness. Their peers therefore impose unsafe sexual activities on them. A need for social assertiveness in AIDS preventive behaviour is therefore identified.

### ***2.3.1.2 Avoidance of those persons at risk***

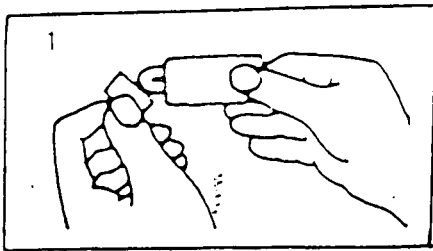
This is a practice that will reduce the risk of exposure to infection with HIV if the person knows groups of people that may be at risk and therefore avoids sexual contact with them. Intravenous drug users form a group that is at high risk due to the

fact that they sometimes share needles without knowing the HIV status of one another (Burnard, 1992:58-59). Slonim-Nevo, Auslander, Munro and Ozawa (1994:68) note that it is not only the drug user who is at risk, but also his or her sexual partner. Moreover, the sexual partner may not know about their partners' drug use behaviour, or may not be willing to be associated with drug users and therefore deny the possibility that their partner is one.

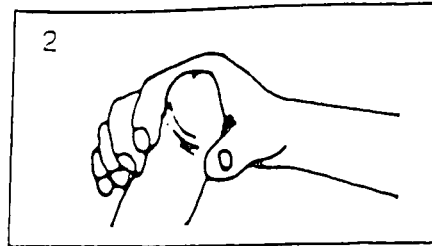
Haemophiliacs constitute another group with whom sexual intercourse should be avoided as a protective mechanism. They are at a particularly high risk for HIV infection and AIDS due to their exposure through transfusion with contaminated blood products. That risk has however, been reduced considerably through improved donor screening as well as the use of improved methods for inactivating the AIDS virus in clotting factor concentrates, such as heat. Research shows a gradual increase in the percentage of female sex partners of haemophiliacs becoming HIV positive. (Mayes *et al.*, 1992:505).

### ***2.3.1.3 The use of condoms***

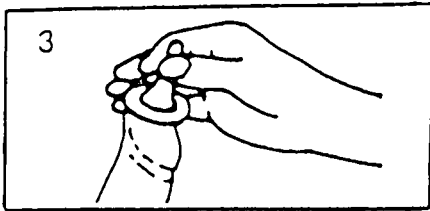
When used correctly, condoms may be seen as a very effective safer sex technique in reducing the risk of sexual transmission of the HIV. Widespread public health efforts are today being directed at condom promotion. Because teenagers are at high risk for HIV infection through exploratory unprotected sex, sometimes with multiple partners, they must be a key target for condom promotion campaigns (Sankar & Karim, 1991:22).



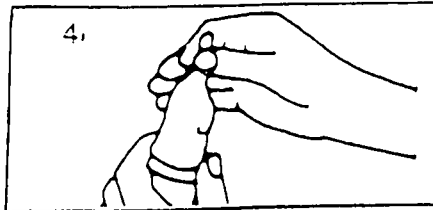
- Use a NEW condom every time you have sex.
- Open packet carefully.
- Prevent breaking condom with nails.



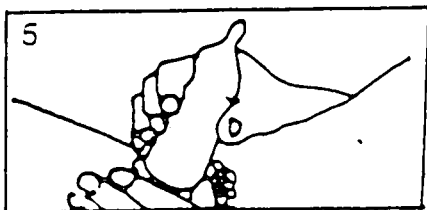
- Pull back loose skin of the erect/hard penis



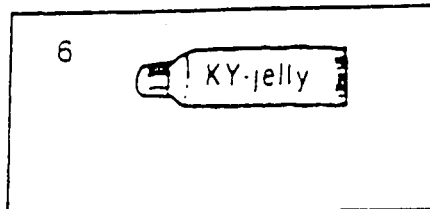
- Put condom over tip of erect penis.
- Squeeze air out to facilitate semen collecting in tip. Avoid spilling



- Keep holding tip of condom and unroll with other hand.

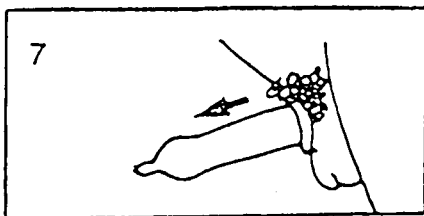


- Unroll condom all the way down to base of penis.

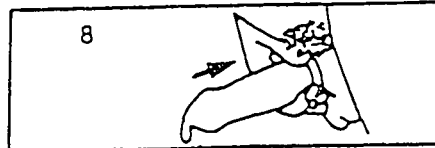


If lubricant is required:

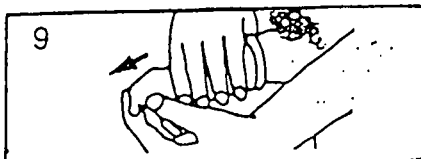
- Don't use oil-based lubricants like greasy ointment, hand cream or cooking oil. It weakens condom, which then breaks easily.
- Use only water-based lubricants, like KY-jelly.



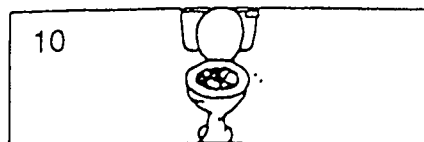
- Always put condom on before contact with private parts or before having sex, to protect you and you partner from AIDS and other sexually transmitted diseases.



- After the man comes (ejaculates) he should hold onto condom while withdrawing penis from partner's vagina.
- Be careful not to let semen (seed) spill from the condom.



- Remove the condom.



- Wrap the condom in paper and flush down toilet.
- Use each condom ONCE only.

FIGURE 2.1: How to use a condom (rubber) to protect you and your partner (Department of Health and Welfare, 1994:9)

In a study conducted among teenagers in black schools in Durban (Sankar & Karim, 1991:22) two very crucial facts came to light:

- There was a low level of condom use in spite of its ability to offer some protection from infection.
- Misconceptions, lack of knowledge and skill in using them were cited as some impediments to their use. The facts above emphasize further the need for intense education not only to motivate people to use condoms, but to teach them how to use this device.

Posters, which give a step by step demonstration of how to use a condom (rubber) to protect you and your partner may be used (see Figure 2.1).

In conclusion, there is a need for awareness and caution as well as general messages of safe sex and condom use to be advocated as fundamental sexual practice for heterosexuals and homosexuals alike. This campaign should be continued even in the absence of an epidemic (McGavock, 1994:20).

#### ***2.3.1.4 Avoidance of contact with body fluids***

Human Immune Deficiency Virus transmission depends largely on the transfer of HIV infected cells through contact with body fluids such as seminal fluid, vaginal and cervical secretions. It also follows that purulent discharges and ulcerative



lesions associated with sexually transmitted infections increase both infectivity and receptivity. Human Immune Deficiency Virus may also bypass the white cell, by transfer from spermatozoa to genital and oral mucosal Langerhans cells expressing the CD4 antigen (Van Ammers, 1990:304).

Blood and blood products constitute another body fluid with which contact should be avoided. Strict regulations in South Africa therefore regulate blood donation for purposes of transfusion and the operation of a blood transfusion service (Strauss, 1991:16).

People with more than one sex partner must therefore be encouraged to use condoms during sexual intercourse to avoid contact with seminal, vaginal and cervical secretions. Avoidance of contact with blood and blood products possibly infected with HIV is done through routine testing of blood donated for transfusion for the presence of the HIV (Burnard, 1992:64-63). However, the risk of HIV infection along this avenue can never be completely eliminated. For South Africa the risk ranges between one in 150,000 to one in 1,5 million. A few isolated cases of HIV infection via this route have occurred in South Africa (Strauss, 1991:16-17).

#### ***2.3.1.5 Avoidance of alcohol and drugs before or during sexual intercourse***

The use of alcohol and drugs before or during intercourse is seen to take away one's judgement and may therefore make individuals ignore the need for taking protective measures for example like using the condom. Even assertive individuals, who would

normally negotiate protection, may neglect this due to the influence of alcohol and drugs (Rip, 1994:66). The need to avoid alcohol and other drugs prior to sexual intercourse is also identified by Lachman (1991:182) as a safer sexual practice.

Other safer techniques are outlined by Burnard (1992:51-52) as flirting, fantasy, hugging, body rubbing, dry kissing, massage, showering together, mutual masturbation with "*on me and not in me*" orgasms.

### **2.3.2 Modes of transmission**

The most known modes of transmission of the HIV may be outlined as follows:

#### **2.3.2.1 Paediatric (*mother to child*)**

Human Immune Deficiency Virus can be transmitted from an infected woman to her foetus in utero or during birth (Macklin, 1989:166; Adler, & Johnson, 1988:51). A particular concern is whether a baby can contract HIV from breast milk as the milk of an infected mother has been found to contain small amounts of the virus. The risk for this mode of transmission is so small that it is outweighed by the risk of gastrointestinal infection involved in refusing the mother to breast feed and encouraging her to bottle-feed. Because South Africa is still a developing country, it is not wise to discourage breast feeding as mothers may not be able to afford artificial feeding. The World Health Organization therefore advises mothers to breast feed their babies whether or not they are infected with HIV. Van Ammers (1990:304-305) also notes

that transmission of HIV may only take place in the presence of large amounts of extracellular virus.

The risk of vertical HIV transmission (from mother through the placenta to the foetus) appears to be very small, although most deliveries involve the passage of a foetus through an environment with copious amounts of maternal body fluids, including cervical and vaginal secretions, urine and blood (Van Ammers, 1990:304).

### ***2.3.2.2 Through blood products***

Transmission through blood and blood products was very common between 1979 and 1985, when the concept AIDS was relatively new and people had not yet developed screening tests for HIV (Burnard, 1992:64). Mayes *et al.* (1992:505) however, note a decrease in this type of transmission after the introduction of scientific donor screening and testing methods.

Before any patient can be transfused with blood, it is imperative that the patient be informed of the risk, however, slight, that he may be exposed to HIV infection. This is because no matter how strict the screening, the risk cannot be completely ruled out (Strauss, 1991:17-18).

The Department of Education and Training (1993:44) noted that pupils could be infected through injuries where nose bleeding occurs from an infected pupil and his friends offer help. One of them might have an open wound through which

contaminated blood may enter his body. This may also occur during accidental injuries in sporting activities such as boxing and athletics (Shikibane, 1993:9-10).

### *2.3.2.3 Unsafe or unprotected heterosexual intercourse*

The heterosexual route is gradually becoming the most common mode of transmission, contrary to the general belief that AIDS is a disease of the gay community. This fallacy still continues in spite of the fact that as far back as the end of 1990, the WHO reported that already 60% of all those with full blown AIDS around the world came from the heterosexual population (Kuykendall, 1992:26). Zuma (1995:4) notes that it is the heterosexual nature of AIDS that is responsible for the number of affected children.

The HIV epidemic in Southern Africa is seen to have several components, of which heterosexual transmission and transfer from mother to child predominate. This mode of transmission falls into four categories:

- A female to male ratio, which frequently exceeds 1:1.
- The highest HIV seroprevalence rates occur in age groups that may be regarded as particularly sexually active, if not promiscuous.
- The most significant category is the association of HIV with sexually transmitted infections, notably those characterized by ulcerative lesions.

- The last category comprises women at antenatal and delivery services, an increasing number of whom are seropositive (Van Ammers, 1990:303-304).

#### *2.3.2.4 Homo-/bisexual activities*

Many people take it that AIDS can only be transmitted between homosexuals/bisexuals. This fallacy seems to be substantiated by the fact that in the United Kingdom, the majority of individuals diagnosed with full blown AIDS still come from these groups (Kuykendall, 1992:26). Because of these facts, many people fail to take precautionary measures for instance using safer sex techniques. Some are even promiscuous with the hope that they will not be infected as they do not engage in homo/bisexual behaviour. This leads to pregnancies where children are not only infected with HIV but some will be orphaned early in life due to their parents dying from AIDS (Macklin, 1989:166).

Because children constitute the adults of the future, it is important that they be protected by preventing the spread of AIDS to them as far as possible. The rate of heterosexual as well as bisexual spread in particular, must be controlled as it increases the rate of transmission from mother to child (Heinmann, 1994:11).

### **2.3.3 Myths surrounding the transmission of Human Immune Deficiency Virus**

The existence of such myths is noted by Keeling (1993:263-264). Many fallacies also exist, not only surrounding how AIDS can be transmitted, but also concerning who may be infected with the virus (Kuykendall, 1992:26-27).

Human Immune Deficiency Virus is not transmitted through droplet infection, nor by any ordinary residential, academic, social, recreational or occupational contact (Shikhibane, 1993:11). The basic mechanisms and underlying process of transmission of HIV are the same in all cultures and countries (Keeling, 1993:263).

Cowan & Johnson (1993:34) indicated that household studies have proved that AIDS is not spread by sharing fomites such as eating utensils and glasses, toilet seats, door handles, clothes and telephones. Neither will swimming pools, steam rooms and shared bathrooms cause the transmission of AIDS. However, if any fomites such as toothbrushes lead to bleeding, they should not be shared as they may bring blood into contact with the delicate mucosal lining of the mouth (Department of Health, 1994:9).

### **2.3.4 Prevention strategies**

Prevention of AIDS should target the three major modes of spread. These are sexual contact, transmission through blood and intravenous transmission. Sexual contact,

which accounts for more than 80% of cases can be reduced through condom promotion and supply. Accessible and affordable treatment of sexually transmitted infections is another strategy that may be employed to control sexual transmission of HIV. This is because there is a definite link between sexually transmitted infections, and AIDS is a sexually transmitted infection. The presence of any other sexually transmitted infection irritates and corrodes the genital mucosa thereby rendering it vulnerable to invasion by HIV (AIDS Bulletin, 1991:8). There is also a need for intense health education to promote a change in risky behaviour and attitude (Steinberg, 1993:4).

Promoting public awareness of AIDS and motivating people to use safer sex techniques may be employed as strategies to prevent this type of spread. There is also a need to develop a cultural environment that supports behaviour change in communities.

The second mode of transmission to be focused on is transmission through blood. This method of transmission should be controlled by emphasizing strategies for providing safe blood for transfusion. Because skin piercing also brings the instrument into contact with blood vessels and tissues, all skin piercing instruments, for example injection needles and razor blades used by health professionals and by traditional healers, must be cleaned by sterilization or boiling for ten minutes. These strategies should not only apply in medical settings, but also in community settings such as clinics and services rendered by traditional healers (AIDS Bulletin, 1991:8).

This is because most black AIDS sufferers and HIV positive individuals prefer the services of sangomas and traditional healers as part of their cultural heritage and because they are told that there is as yet no real medical cure for AIDS (Green, Zokwe & Dupree, 1995:503-504).

The use of intravenous drugs has been identified as a third major mode of HIV transmission (AIDS Bulletin, 1991:8). Although this practice was, in the past, not very common among blacks in Mangaung, it is gradually becoming common and will soon overtake transmission by blood and become the second major mode of HIV transmission. This may be caused by the social change, where the use of drugs by teenagers in particular, is fashionable. This practice may be curbed through intense health education on the prevention of the indiscriminate use of intravenous drugs. Syringes and needles may also be made freely available to those already using them whilst they are being rehabilitated. This will prevent the exchange of used needles between intravenous drug users (Rip, 1994:72).

The Government must also act on the socio-economic issues that promote the spread of AIDS, for example the migrant labour system, poverty and illiteracy (Mayes *et al.*, 1992:504). In a study on the effectiveness of an AIDS education program, Nyamathi and Flaskerud (1989:402) noted that the promotion of safer sex practices is a strategy of utmost importance as it targets the most common mode of transmission, which is sexual spread (AIDS Bulletin, 1991:8-9).



## **2.4 ESTABLISHMENT OF AN ACQUIRED IMMUNE DEFICIENCY SYNDROME HEALTH EDUCATION PROGRAM**

The planning of an AIDS education program may be regarded as the most important aspect of the prevention of the disease. Nyamathi & Flaskerud (1989:397-400) realized that the results of a pretest conducted before using an AIDS education program changed dramatically after implementing the program. There was an obvious change in knowledge, attitudes and behaviours. The health education program must however, bridge the gap between information and education by motivating individuals to take the information and also apply it (Akande, 1994:28). This is because it is clear that education alone is not enough to change risky behaviour. It must be combined with the motivation of individuals towards maintaining an illness-free state through preventive efforts (Pender, 1982:41).

Planning the education program involves consideration of the various aspects that need to be combined in order to achieve the objective, for example revising and changing the curriculum according to needs and evaluating the program regularly for effectiveness (Green *et al.*, 1995:512). A properly planned health education program should provide the weight to reduce the spread of the disease and result in behavioural change.

### **2.4.1 Goals and objectives of the health education program**

Goals and objectives are important in guiding the course of the program in order that the ultimate intention may be kept in mind. The setting of goals and objectives must be a joint effort between all role players. In the case of AIDS, various bodies and the government decided to organize a national convention in 1992, National AIDS Counselling Organization of South Africa (NACOSA). It was at this conference that a framework for a National AIDS strategy was developed (Whiteside, 1993:6). The objectives of education programs on AIDS in South Africa should be based on this national strategy adopted by the government. Such a program will be developed for the community of Mangaung as none exists.

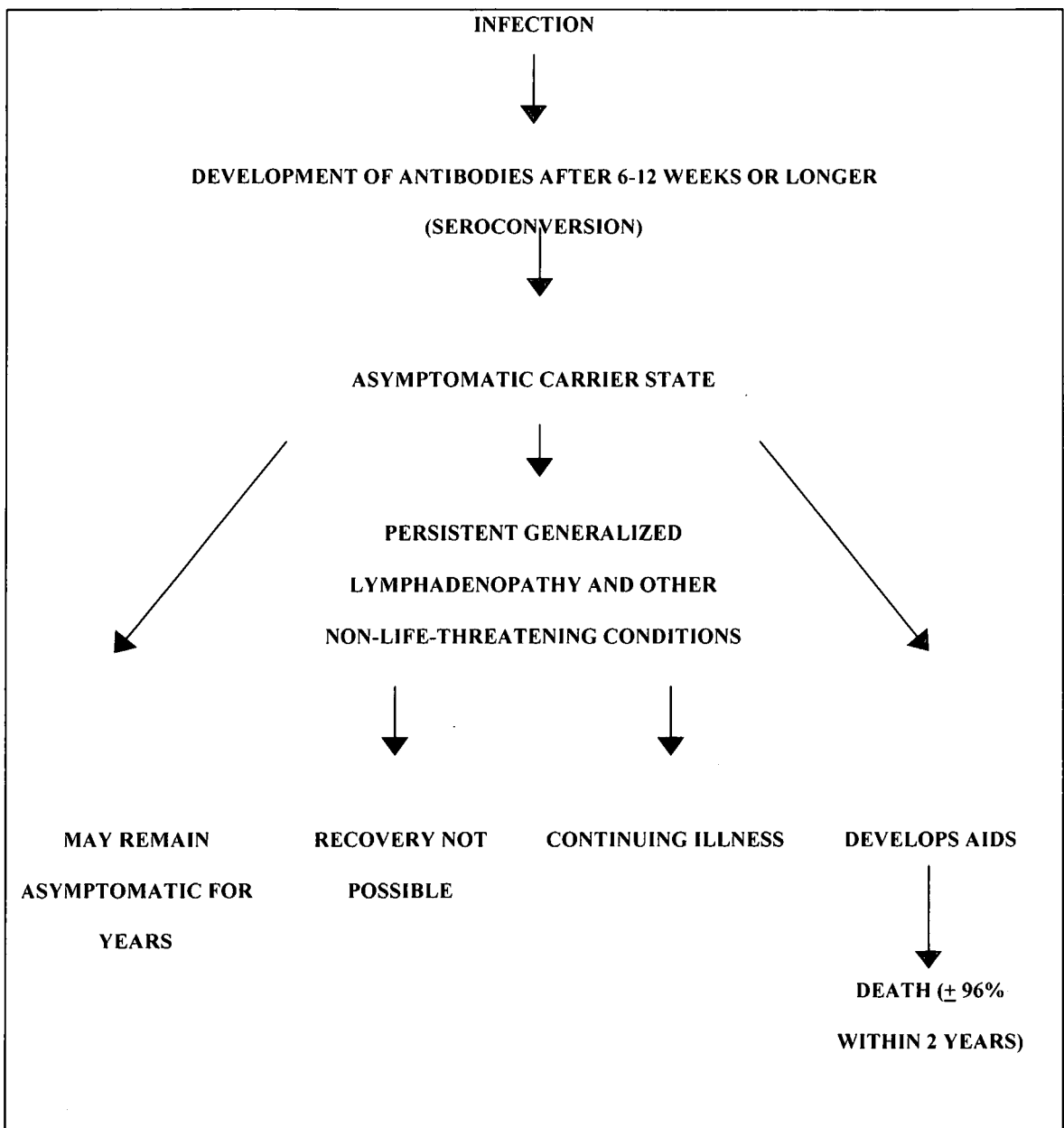
Sepulveda, Fineberg and Mann (1992:156) summarise the goal of such an education program as being to modify the behaviour of high-risk groups and their partners in ways that will result in the reduction of the sexual transmission of AIDS. The objectives of the program can be described as follows:

- To inform the population, particularly those at risk, about AIDS. Special emphasis should be put on the fact that it is a sexually transmitted disease (Burnard, 1992:57). Teaching aids depicting the male and female reproductive systems as well as the gastro-intestinal tract may be used to explain the aetiology of AIDS and the fact that if it was caused by something taken orally, it would not reach the reproductive organs directly (Zazayokwe, 1990:8).

Populations must also be informed about symptoms to look out for that may make them suspect that they may be suffering from AIDS. The Department of Health and Welfare (1994:9) lists the following as possible symptoms of AIDS:

- Inexplicable weight loss. This may be due to the anorexia and diarrhoea that accompany the disease. Weight loss of over 10% of body weight is an important warning;
- Swollen glands in the neck, armpits or groin as the infection invades the immune system.
- Long-lasting spread and severe herpes simplex;
- Skin rash in any part of the body;
- Persistent diarrhoea, lasting over one month;
- Chronic fatigue due to anorexia and weight loss;
- Mental disorders such as loss of memory and intellectual capability; and
- Persistent, dry cough (Allan, 1992:46).

Once the immune system is exhausted and the body rendered unable to protect itself against diseases, “full-blown” AIDS develops and the HIV infected person contracts the so-called “*opportunistic diseases*”. These diseases include pneumonia, tuberculosis and certain rare cancers, for instance Karposi’s sarcoma. These disorders prove fatal in most cases as the body is left with no defence against them (Goddard, 1989:17-18). The natural history of the disease is outlined in Figure 2.2.



**FIGURE 2.2: Natural history of HIV infection** (Goddard, 1989:20)

According to Figure 2.2 the development of antibodies only starts six to twelve weeks after infection with the HIV. After this the person becomes an asymptomatic carrier. It is during this period that the most spread of the HIV occurs. The person may remain asymptomatic for years or may develop

persistent generalized lymphadenopathy and other non-life-threatening conditions. Should lymphadenopathy occur, continuing illness occurs and recovery is not possible. The person will then develop AIDS and death usually occurs within two years in approximately 96% of the cases.

Populations at risk also need to be informed of the fact that there is at present no cure for, or a vaccine against AIDS. Education and a change in sexual life-style are the only ways to prevent the continuing spread of AIDS. Monogamy should replace promiscuity and a condom is mandatory when having sexual intercourse with a partner whose sexual practices and HIV status are not known (Bülbring, 1991:18-19; Akande, 1994:285). In conclusion, the Department of Health and Welfare (1994:9) emphasises the fact that "*the safest way is still a lifelong, mutually faithful relationship between two people*". However, it has been proved by various research studies that this is not always feasible, it is important to inform the general public of other safer sex techniques outlined earlier in this chapter (Lachman, 1991:182).

- To motivate and support behavioural change in high-risk groups to reduce the risk of infection. In her application of the Health Belief model to diabetes mellitus, Hurley (1992:44) noted that "*fundamental beliefs are strong motivators of human behaviour*". Pender (1982:41-42) supports this by stating that an individual's beliefs must be accurately assessed and these must be used to guide any educational intervention. The results of a study by Ahia (1991:51) showed

that perceived severity and perceived consequences of a health problem would influence compliance with health protecting behaviour. Research evidence suggests that education directed towards the provision or enhancement of the ability to alter social and interpersonal behaviour associated with HIV transmission probably would be more effective than information alone. This is because the provision or enhancement of this ability would provide individuals with the social skills necessary to put their knowledge into practice (Akande, 1994:287).

The Health Belief Model, which has been applied to HIV related behaviour predicts that individuals will adopt HIV preventive measures if they have information about AIDS, if they believe that they are susceptible to HIV infection, that preventive steps are effective against HIV infection and if they have sufficient self-efficacy to change their behaviour. The Health Belief Model further predicts that people will adopt such preventive measures if they believe that they experience few barriers to action, that they have access to health care/advice and perceive concerted social support for behavioural change (Dublely, Lavelle, Msimanga and Wilson, 1991:196). This model has been applied in many countries for example America and Zimbabwe. It can also be used in South Africa to predict HIV preventive behaviour among different groups for example adolescents, homosexuals and adults, as it has in other countries.

Besides the need to assess the individual's needs and his perceived severity of the health problem as well as how he perceives the consequences of the problem, a study conducted using the Health Belief Model in adults in Zimbabwe also suggests that perceived social support for behaviour change is the major predictor of HIV related behavioural risk reduction (Dublely *et al.*, 1991:201). This discovery has definite implications for policy. Policy-makers in South Africa must therefore adopt a participative, community-based approach if they wish to change social norms. Various government departments must therefore co-ordinate and evaluate projects by communities for the control of AIDS (Venter, 1991:39).

- To teach groups at risk how to obtain, store, use and dispose of condoms correctly. A study by Mayes *et al.* (1992:504) showed that women at risk of infection with HIV did not use condoms because they found them unpleasant or an unwanted reminder of AIDS. Some felt obliged to share their partner's fate or were willing to sacrifice and to communicate a lack of rejection to their infected partners. Zazayokwe (1990:9) notes that some blacks may not be able to afford to buy condoms. She therefore suggests that they be advised on where to obtain them free for example at family planning clinics. Groups at risk must also be motivated to use condoms correctly and consistently (Department of Health and Welfare, 1994:8). Some people are shy to ask for condoms. Self-service systems should therefore be instituted at public places such as clinics, hotels and

factories. They should not be stored in hot places and should not be used after the date of expiry.

- To teach high risk groups how to recognise common symptoms of sexually transmitted infections and to understand the importance of obtaining prompt treatment. The inter-relationship between AIDS and sexually transmitted infections is poorly understood by clients attending sexually transmitted infection clinics. This was shown by a study of this group conducted in the Western Cape in August/September 1993 by Steinberg (1993:4). This is probably one reason why individuals with sexually transmitted diseases have a poor perception of their HIV infection risk.

The presence of sexually transmitted infections promotes the transmission of HIV. This is because sexually transmitted diseases irritate, corrode and break the mucosal lining of the reproductive organs thereby making them vulnerable to the HIV. The AIDS Bulletin (1991:8) therefore suggests that an effective preventive strategy for AIDS is the effective and accessible treatment of sexually transmitted diseases combined with education that promotes behaviour change. Sepulveda *et al.* (1992:161) agree with these facts by stating that sexually transmitted disease services need to be strengthened as these infections constitute a co-factor of transmission for individuals at high risk of HIV infection. In Nigeria, one strategy used to evaluate the incidence of HIV includes baseline and follow-up examinations of a sample of women for evidence of gonorrhoea, syphilis and genital ulcers.



Where the service is based at a clinic, it is also evaluated through monitoring sexually transmitted disease statistics on the number of clients seen, tests provided, condoms distributed and women counselled (Sepulveda *et al.*, 1992:162).

South Africans are accused of unnecessarily looking beyond the region for information and research for example when they looked at the situation in Tanzania to establish whether there is a causal relationship between AIDS and sexually transmitted diseases.

The findings of a research study conducted on heterosexual attendees at a sexually transmitted diseases clinic in Durban proved that genital ulcerative disease and cervical inflammation secondary to sexually transmitted diseases facilitate HIV transmission. The study also notes that the highest seroprevalence rates were in women aged 15-19 years. This has direct relevance for actions aimed at curbing the spread of HIV and this is that "*sexually transmitted diseases must be targeted*" (O'Farrel, Windsor & Becker, 1991:17-20).

#### **2.4.2 Target group**

Identification of the target population is, according to the "*PROJECT HOPE*" and the "*National AIDS prevention and control programme*" of Swaziland (1992:35) a very important step in the planning of any specific program. This will ensure acceptance of the program as it will be used for people who really need it. It will



also be cost-effective as it will be a necessary undertaking and will be more easily accepted as it will be addressing felt needs of the audience. Target populations must therefore not only be accurately diagnosed, but they must be involved in the development of the education program for it to be acceptable to them (AIDS Bulletin, 1991:8). Certain criteria with regard to the target audience should be borne in mind. These include:

- Demographic indicators such as the age of the group and their income. Different age groups will require different approaches and strategies. For example adolescents want independence and control of their lives; they rebel to gain independence and they are at the same time desperate for peer support and approval (Kuykendall, 1992:26). For this age group it would perhaps be best to use the peer health educator strategy. This strategy has been used with success in Ghana, Cameroon, Mali and Burkina Faso (Sepulveda *et al.*, 1992:157).

The income of the target group is important as it may influence the type of health education given. Poor people may not be able to afford to buy condoms from chemists. They must therefore be educated on how to obtain them free from clinics (Department of Health and Welfare, 1994:8-9).

Some barriers to AIDS prevention are seen by Slonim-Nevo *et al.* (1994:68-69) to be related to the lack of financial resources. For example, women who receive no prenatal care mainly because of a lack of health insurance, were more likely

to report engaging in unsafe activities. This may be due to economic dependence on the partner as they are not working.

- Literacy level, cultural practices, language, religion and sexual orientation. Some religions are against the use of any strategy to prevent pregnancy, as it was God's instruction that people must multiply. The language to be used in any education program depends on the literacy level of the target group. Any educational endeavour that is against the cultural beliefs of the audience is doomed to possible rejection and failure (AIDS Bulletin, 1991:8).
- Organizations that the group belongs to, for instance schools, church groups or prisons. AIDS education may be built into school curricula. Health education addresses may be given during church meetings or prison officials may be requested to allow educators to give such education to both officials and inmates.
- Risk-prone individuals in the group for example people with multiple sexual partners and people who practice unsafe sex.
- Needs of the group as well as their specific behaviour that needs to be influenced.

The success of any strategy or program depends on the accurate diagnosis of the target population as well as its involvement from the planning stage throughout

the implementation and evaluation of the program (Sepulveda *et al.*, ;1992:157).

Groups to be targeted in preventive education on AIDS and HIV infection are:

#### **2.4.2.1 The youth**

These are recognised as a “*priority target group for AIDS prevention programs*” (Steinberg, 1993:4). Akande (1994:287) notes the need for African youths of both sexes to see themselves as vulnerable to infection with the AIDS virus like any other person. This is because many adolescents think that they can not become infected because they are neither intravenous drug users nor homosexual/bisexual individuals.

There is therefore a need for the youth to be motivated to practice safer sex even before they become sexually active. Because there are approximately 48 million children and teenagers in South African schools. Perhaps there is an urgent need to concentrate health education efforts on AIDS in schools so as to reach the majority of the youth. Because adolescents, who constitute the youth, engage in experimentation with things like drugs and sex, they need educators that recognise that speaking about condoms will not cause people to become sexually active (they already are). They also need educators that recognise that condom usage will not encourage promiscuity - rather what it encourages is personal responsibility and responsibility and care towards another individual (Brown, Spirito, Reynolds, and Hemstreet, 1992:467-468). A need therefore exists to support the youth to take

knowledgeable decisions that will help them through the present crisis of being infected with AIDS (Jemmot & Jemmot, 1992:273). Education in schools, like anywhere else is seen by Pender (1982:42) as having the potential to promote health and prevent AIDS by producing a change in knowledge, attitude and behaviour. This can be achieved by instilling safer sex techniques in the youth even before they indulge in sexual intercourse. AIDS education can therefore be included in school curricula.

This, however, presents a conflict between conservative sexual values and educational necessity that faces many public institutions and private individuals. Some parents feel that their children should not be exposed to sex education in any form as it will "*corrupt their minds before time*" (Macklin, 1989:169). Moralists, who are obsessed with the belief that sex education only increases practising sex, have also captured the Education Department. According to Fleming (1993:19), sex education in the Government schools in South Africa was rejected because it was still "*widely believed that ignorance protects innocence*". In the past three years conception, abortion and AIDS/HIV education has been removed from the secondary science curriculum and parents have the right to remove their children from sex education programs. This means that sex education can no longer be a cross-curriculum subject given wherever it is appropriate (Dean, 1994:1149). These developments occurred despite the fact that the National Survey of Sexual Attitudes found that children who received sex education in schools experienced first

intercourse later than those who picked up this information from friends (Lundgren, Pedersen & Clumeck, 1994:1068). Cranford, Turtle and Kippax (1990:128) noted the necessity to reach teenagers before they are faced with decisions regarding sexual intercourse. It has also been admitted that classroom instruction must be broad enough to include the development of skills in decision-making aimed at risk reduction.

Presently, however, the situation is said to have slightly improved with this topic being handled by experts in communicating with young people such as specially trained teachers and counsellors. The education is also suitable to the age group, for example teenagers may be taught through puppet shows whilst pre-scholars are taught AIDS songs and taught through story telling rather than being given bare facts on sexual issues (Lustig, 1994:162-163).

It has however, come to the notice of the researcher that this conflict is gradually being resolved as more and more parents are involved in curriculum development through school committees and parent-teacher associations.

The youth can also be found in youth centres and social clubs. Any other community areas where the youth congregate need to be targeted.

#### *2.4.2.2 Clients attending sexually transmitted infection clinics*

Because of the fact that AIDS is also a sexually transmitted infection, clients at such clinics constitute a high-risk group that needs to be targeted with preventive strategies. This need is identified by Sepulveda *et al.* (1992:158) when they state that service providers at such clinics must educate their clients regarding their HIV infection risk when they visit the clinic. Macklin (1989:174-175) notes that HIV infection is common mostly among individuals with a high number of sexual contacts, typical of the pattern seen in any sexually transmitted infection epidemic. This reinforced the idea that AIDS is associated with promiscuous behaviour. Because the largest proportion of cases of AIDS and HIV infection is among the homosexual community, this encourages the belief that homosexuals are promiscuous and that AIDS is a disease of homosexuals. It is unfortunate that these facts increase the tendency of heterosexuals to disregard their risk of contracting AIDS (McGavock, 1994:20).

Sexually transmitted infection management is important for reducing the risk of HIV transmission and reducing worker illness in general (Roberts, 1995:7). The "*PROJECT HOPE*" (1992:5) notes a probability that the presence of some sexually transmitted infections facilitates the transmission of HIV. A strong association between HIV infection and the presence of sexually transmitted infections is also noted.

### 2.4.2.3 Women

Steinberg (1994:4) identifies this group as a third priority group for AIDS intervention. Statistics show that women become infected at a significantly younger age than men.

In a survey of peri-urban women in the Western Cape, about 60% reported a diagnosis of pelvic inflammatory disease, a late complication of genital tract infection. This suggests that women tolerate earlier symptoms of sexually transmitted infections. This may predispose them to infection with HIV.

A large percentage of women in a study conducted by Mayes *et al.* (1992:504) on women partners of HIV infected haemophiliacs also reported difficulties in negotiating safer sexual practices such as the use of condoms.

Aggleton., Homans, Mojsa, and Watson, (1989:75) point out that the assumption in much health education literature is that the negotiation of safer sex takes place between equals; this is rarely the case in sexual relationships. In particular, female partners of bisexual men are at a marked disadvantage in such negotiations. This may be due both to their subordinate position in gender relations generally, and perhaps also to their partner's lack of openness about his bisexual activities and therefore his partner's possible risk of infection with HIV. This is because as Kuykendall (1992:26) states, most AIDS cases come from bisexual and homosexual men.



According to the editorial comments in the AIDS Bulletin (1995:9), poor socio-economic conditions, unequal gender relations and a lack of access to health care and education all increase the vulnerability of women to AIDS infection. The autonomy of women and their regard for their human rights should therefore be enforced by legislation.

#### **2.4.2.4 Sex workers**

This is another group of people identified by Basset (1993:8-9) as a high-risk group. This author notes that it is not too difficult to reach the visible sex worker in bars or night -clubs. The major difficulty is reaching the so-called "*submerged part of the iceberg*" - women who have multiple partners, but who do not consider themselves sex workers. Clients of sex workers and their spouses therefore also constitute a high risk group, particularly as Hambridge (1993:2) states that clients of sex workers sometimes refuse to use condoms. They feel they need to "*enjoy fully*" what they have paid for.

Whiteside (1994:12) states that the best strategy is to encourage sex workers to find another line of work; or if they insist on prostitution, then strict use of condoms with spermicides and other safer sex practices, wherever practical, would be the most effective strategy. Although this may not be practical, it is, however, worth trying, as AIDS is a deadly disease.

#### **2.4.2.5 Lesbians**

Initially, lesbians were known to use methods such as flirting, body rubbing, dry kissing, massage and mutual masturbation to obtain sexual satisfaction. These are seen by Burnard (1992:51-52) to be safer sex techniques. Lesbians will therefore not be at high risk of contracting AIDS if they adhere strictly to the above practices. This will be the case on condition that before they became lesbians they, like all other groups, had not engage in any risky behaviours, for instance using intravenous drugs, receiving blood transfusion or blood products between 1979 and 1985, or have had unsafe sexual contact with individuals in risk groups (Burnard, 1992:64). It has however, been noted by the researcher that with the present social change, lesbians have also been observed to engage in risky sexual behaviours such as oral sex. This may also include them under groups at risk of HIV infection and therefore a target group for preventive health education on AIDS.

#### **2.4.2.6 Bisexual and homosexual men**

Because most AIDS cases in the United Kingdom come from this group, Kuykendall (1992:26) states that this group needs to be targeted with preventive education on AIDS. Although research has proved that it is equally found among heterosexual groups today (Van Ammers, 1990:303); homosexual and bisexual men still constitute a target group. Female partners of bisexual men are at particular risk as some are not aware of the bisexual behaviour of their partners.

#### **2.4.2.7 Prisoners**

This is another group at risk that must be targeted. This is due to the high rate of drug use, some consensual homosexual behaviour and the potential for criminal assault or rape in prison. Burnard (1992:65) suggests that education programs for inmates must take into account the diversity of racial and ethnic persons in the penal system as well as the need to adapt to the cultural beliefs and languages of the represented population.

A warning to South African prison authorities was sounded in the newspapers in 1993 that AIDS is currently the single greatest cause of death in prisons. In 1982 five prisoners died of AIDS, compared with 213 AIDS deaths in the first ten months of 1992 (Whiteside, 1994:12). This implies that the rate of AIDS in prisons is very high due to the reasons cited in the preceding paragraph. There is therefore a need for preventive health education in prisons.

#### **2.4.2.8 Families and partners of persons with HIV infection**

Roberts (1995:6) notes that AIDS and HIV infection cause serious emotional disruptions in family relations. Families, lovers and partners of persons with HIV as well as members of their households therefore need education on the prevention of self-infection. This education must present clearly the fact that causal contact, in the form of sharing food and fomites, bathrooms, telephones and other common household contact will not cause the spread of HIV (Cowan *et al.* 1993:34).

The emotional and physical cost to a family of looking after a person with AIDS is high, but so are the rewards. It is rewarding to look back and say, "*although I could not share the pain, I could, on another level, share the experience*" (Turton, 1992:31). Families and partners therefore need to be supported by the entire health team in their rendering of care and support to the person with HIV/AIDS. They must however, be educated on how to avoid contact with body fluids and secretions through the use of gloves when handling body fluids from the patient as well as using condoms correctly and consistently during sexual intercourse (Department of Health and Welfare, 1994:8-9).

#### ***2.4.2.9 Persons with HIV infection***

Persons infected with HIV need to be educated on the avoidance of any activities that might expose them to further HIV infection or which could transmit HIV to others. Because their immune system is already lacking due to infection with HIV these people need education on the prevention of further infections and therefore on the use of safer sex techniques (Department of Health and Welfare, 1994:9). Further HIV infection may destroy the immune system more and render the person prone to full-blown AIDS.

Persons infected with the HIV should not donate blood, semen or body organs. They should not share needles for intravenous drugs or participate in unsafe sexual practices.

### **2.4.3 Acquired Immune Deficiency Syndrome (AIDS) education at the workplace**

The AIDS education program to be developed will not only be used in the workplace. It is however, important for the workplace to be mentioned specifically as many adults, particularly in their reproductive ages are found to congregate at their place of work (Van Wyk, 1991:5). There is a need for everyone to be educated about AIDS. Top managers in particular need this education, as they have to make policies and take decisions on facts against which AIDS issues should be judged (Mokhobo, 1991:6-7).

Roberts (1995:6) notes the effect of HIV and AIDS on the economy of the country and that it occurs in the following significant ways:

- AIDS causes illness, disability and death to employees resulting in severe economic disruptions.
- It increases the cost of running a business in terms of health care, death benefits, pensions, recruitment and training.

- AIDS leads to decreased productivity as workers are absent due to illness or away from work, nursing sick relatives. Sometimes it is the experienced workers with valuable training that are affected.
- As more people become ill and die of AIDS, there are fewer people with enough money to buy products and services.

Evian (1993:234) supports the need for education on AIDS in the workplace by stating that there is a need for this in many different areas such as schools, health services, the workplace and religious organizations.

The risk for health workers to be infected with HIV also exists. This necessitates intense education in health services to all health workers. Educational endeavours must focus on a wide spectrum of issues relating to the handling of individuals infected with HIV or suffering from AIDS (Cremers, 1993:39). This is because many health workers fail to protect themselves, for example by wearing gloves and avoiding needle pricks when dealing with such persons.

The number and percentage of deaths as a result of pneumonia and influenza among persons 25 to 44 years of age has more than doubled during the 1980's in cities with a high prevalence of AIDS. These diseases are seen to be either complications of AIDS or opportunistic diseases associated with this condition (Lachman, 1990:147).

Because persons aged 25 to 44 years are adults, they can be found at their places of work. This increases the need for an AIDS education program in the workplace.

- A company education program on AIDS has to be designed taking certain points into account, and avoiding certain pitfalls, for it to be relevant and acceptable. Snyman (1993:7) suggests the following as the two aims of such a program:
  - Community health oriented approach that is to prevent AIDS through education. This approach will be adopted in the proposed AIDS education program.
  - To promote the acceptance of HIV infected persons by co-workers. Failure to achieve this could result in pressure from employees that the infected person be dismissed. This unfair labour practice could lead to industrial court action.
- According to Snyman (1993:7) the content of such a program should include medical facts about AIDS/HIV, including the mode of transmission of the virus as well as myths and fears concerning the disease and how it is **not** transmitted. The company stance or policy on HIV - related diseases should also be highlighted in this program, as well as the assessment of employee and management knowledge, attitudes and behaviour regarding HIV related diseases.

Hyde (1992:26-27) identifies the following as difficulties that may be encountered when planning AIDS education programs in the work environment:

- The co-ordinator of the program is confronted with a number of videos and posters and is not sure which are effective.
- Shortage of suitable personnel within the company to conduct AIDS education.
- Venues for training as well as audio-visual aids are often limited or situated far from employee groups.
- A large percentage of the workforce is semiliterate or literate only in their mother tongue. These people not only lack skills in reading, but most of the time also have underdeveloped cognitive and perceptual abilities. This group therefore needs specially designed teaching material.
- The program co-ordinator may lack confidence in the effectiveness of the program. This is because changing people's sexual behaviour is a long-term process.
- There may be resistance from, or a lack of support for the program by management and trade unions. To address this hurdle Roberts (1995:6) feels that company managers should be motivated to accept the problem of AIDS as a "*national problem at every employer's doorstep*". This is therefore a management, union and worker problem (Mason, 1995:4-5).



- Condoms may be supplied freely to employees but for some reason they are not in demand.

In conclusion, an AIDS education program for the workplace must be tailor-made to be suitable to the company schedule, workforce and resources (Hyde, 1992:27). It must be evaluated regularly, be cost-effective, credible and must reflect ongoing commitment (Snyman, 1993:7). Finally the program should be reviewed regularly for relevance. A recommendation is that it be reviewed every two years for updating to keep pace with current knowledge and public opinion (Snyman, 1993:8; Mason, 1995:4). Two years seem reasonably long enough for the effect of the education to be visible.

#### **2.4.4 Resources for the development and implementation of the health education program**

Resources needed to strengthen or support the AIDS prevention program need to be investigated and utilized to ensure maximum success of such a program (“PROJECT HOPE”, 1992:19). Such resources may be role players in the community, for example schools and churches, administrators, teachers, parents and pupils.

Information on AIDS must come from credible sources and must be reinforced by social and reference groups. Teaching aids must be sufficient and relevant. The media are very important resources if used in communities that understand the

message that is that can read or understand the language used on the radio or on television.

Personal networks such as well-trained clinic and hospital staff as well as counsellors for instance social workers, are important resources (Sepulveda *et al.*, 1992:179). These resources need to be assessed, developed or strengthened and maintained throughout to make sure that the education program does not collapse midway. The Government, as an important resource, has input in the prevention of AIDS. Hambridge (1993:1-2) states that since the NACOSA conference in 1992, commissions have been set up on relevant issues including care, counselling, education and ethics. Regional committees are in place and regional conferences have been held in order to develop a national strategy. More recently, financial support has been obtained through allocation of money from the health budget to employ full-time staff and finance local and regional AIDS initiatives.

#### **2.4.5 Deciding on a strategy for undertaking the health education**

After identification of the target group, the next step is the decision on which methods to use to have an effective impact. According to Adler *et al.* (1988:54) whatever method is chosen, evaluation of its effectiveness must be undertaken through population studies of knowledge about AIDS, social studies of sexual and drug using behaviour as well as seroprevalence studies in different groups at risk.

This evaluation of health education strategies must be a co-ordinated national and international effort done through surveillance and research.

The STOPAIDS project in Nigeria (Nwashili, 1991:75-76) decided on the strategy of training members of the target populations to spread information on AIDS, to facilitate the development of appropriate and accessible health services as well as encouraging feedback from the target population about their health concerns and needs. Members of the target group will therefore be used to disseminate information to their fellow community members. This will however, be done with the greatest caution, as the peer health educator will need to be thoroughly prepared and strictly supervised.

The peer health educator strategy is described by Sepulveda *et al.* (1992:157) as featuring the identification and recruitment of natural leaders of the high-risk group to be health educators and condom distributors to their peers. The criteria for selection as a peer health educator include acceptance by group members, being an opinion leader in the target group, and exhibiting a concern for one's peers as well as a willingness to be trained and to work with the program.

The effectiveness of peer health educators can be enhanced by other health education techniques. Supportive interventions such as periodic community meetings led by peer health educators, where dramatic presentations, condom demonstrations and educational lectures should be used wherever possible to sustain

the program. On-site AIDS education and condom distribution programs in places where sex workers and clients are present, such as bars, night clubs and hotels are other strategies that may be employed to enhance the effectiveness of the peer health educator strategy (Hyde, 1992:39-40).

Mokhobo (1991:7-8) notes that many educators on AIDS use instructional materials such as curriculum guides, video cassettes, pamphlets and films to generate learner interest and involvement. Posters, songs, media announcements and magic shows may also be strategies of choice. These however, cannot replace the AIDS educator but must only be used to emphasise facts given by the educator (Hyde, 1992:40).

The "PROJECT HOPE" (1992:20) divides channels of communication that could be utilized in AIDS education as follows:

#### ***2.4.5.1 Non-personal methods and media***

- Pamphlets;
- Posters;
- Advertisements;
- Television and radio-programs such as phone-ins and dramatisation; and
- Audio-visual material for example videos and rural television.

#### ***2.4.5.2 Interpersonal methods***

- Seminars;

- Shows and exhibitions;
- Group work with specific target groups; and
- Liaison activities.

The use of non-personal methods and media of communication alone are said not to be effective in establishing a change in behaviour. These are valuable tools in disseminating knowledge, but should be used together with interpersonal methods of education to attain and maintain changes in behaviour practices (Department of National Health and Population Development, 1991:21). Diffusion theorists also agree with these facts by stating that interpersonal communication is most effective in modifying behaviour (Hyde, 1992:39).

Because of the above facts, the researcher intends using mostly interpersonal methods of communication such as seminars, group work as well as shows and exhibitions in her education program. Non-personal methods and media will be used with discretion to augment the interpersonal strategies. For example, during a seminar on AIDS, posters and pamphlets will be used either to explain or to emphasize facts.

Sepulveda *et al.* (1992:157) state that strategies and channels of communication must be chosen according to the nature of the high-risk group being addressed. This means that for educated groups living in urban areas, magazines and newspapers might be appropriate, while radio programs may be relevant in remote rural areas on

condition that they have radios in their homes. Rural people may not only be unable to read newspapers, but they may also not be supplied with newspapers.

Another strategy being used with success in Kenya, Zimbabwe and Cameroon to disseminate information on AIDS, is "*the client outreach strategy*". This strategy may be adapted for local use (Sepulveda *et al.*, 1992:157-158). In this strategy, sexually transmitted diseases clinic staff and staff at other community-based services are used to give education on AIDS and HIV, to go out and do follow-up visits as well as engage in counselling. Nurses at the local clinics and family planning motivators are already engaged in using this client outreach strategy, although they are not specifically focused on AIDS patients but rather on all categories of clients. More emphasis could be placed on AIDS patients to reduce rates and offer support to clients and families (Turton, 1992:39).

The prevention of AIDS is the responsibility of everybody. The government, employers, educators, insurance companies, families, friends, health care providers and the clients and patients themselves. Hambridge (1993:2) identifies the stultification of AIDS awareness, education and prevention programs as being the result of more pressing political issues which require an urgent solution if we are to win the battle against AIDS. Political issues such as the preference for training the army over health issues belonged to the previous Government and could have stultified AIDS prevention programs. These issues have been addressed in the

present Government as more money has now been allocated to the control of AIDS (Hambridge, 1993:1-2).

#### **2.4.6 Principles underlying the health education program for the prevention of Acquired Immune Deficiency Syndrome (AIDS)**

Burnard (1992:40) presents the following principles that should underlie any AIDS education program for it to be effective:

- The program should be implemented immediately for everyone. The entire population has a right to AIDS education. Although this is suggested in the literature, it might not be feasible in South Africa due to limited resources and the extent of the AIDS problem.
- AIDS education should be adapted so that it is culturally appropriate to the audience.
- The program should be designed and implemented by professionals who are trained in sexuality education, education on substance abuse, small group and community process, racial and ethnic variations as well as family and individual dynamics.

- AIDS education should include factual information and give opportunities for discussion and for individuals to ask questions and explore their attitudes and emotional reactions.
- The program should emphasize risk behaviours that lead to the spread of HIV.
- In public schools AIDS education programs should be part of a comprehensive health program.
- All programs should include a component that addresses the relationships among behaviours, values and social responsibility.
- Evaluation should be an integral component of all AIDS education programs.

## **2.5 SUMMARY**

In this chapter, the prevention of AIDS through health education programs was presented. The next chapter will focus on the influence of AIDS knowledge on the behaviour of people. Special emphasis will be placed on the application of the Health Belief Model. Psychosocial effects of AIDS and HIV infection will also be presented in this chapter.



## **CHAPTER 3**

# ***The influence of Acquired Immune Deficiency Syndrome knowledge on the behaviour of people***

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### **3.1 INTRODUCTION**

Due to the fact that the Health Belief Model (HBM) was used in the past to change the behaviour of people it has been found relevant in this study as the major aim of this study is also to change attitudes and behaviour. The Health Belief Model is a framework for understanding the psychological readiness of individuals to undertake health action. Personal beliefs of perceived susceptibility to, and seriousness of the health condition as well as perceived benefits of action when weighed against barriers to action, are considered the major dimensions of the Health Belief Model (Hurley, 1992:45). This model is adapted and used as a theoretical framework for this study.

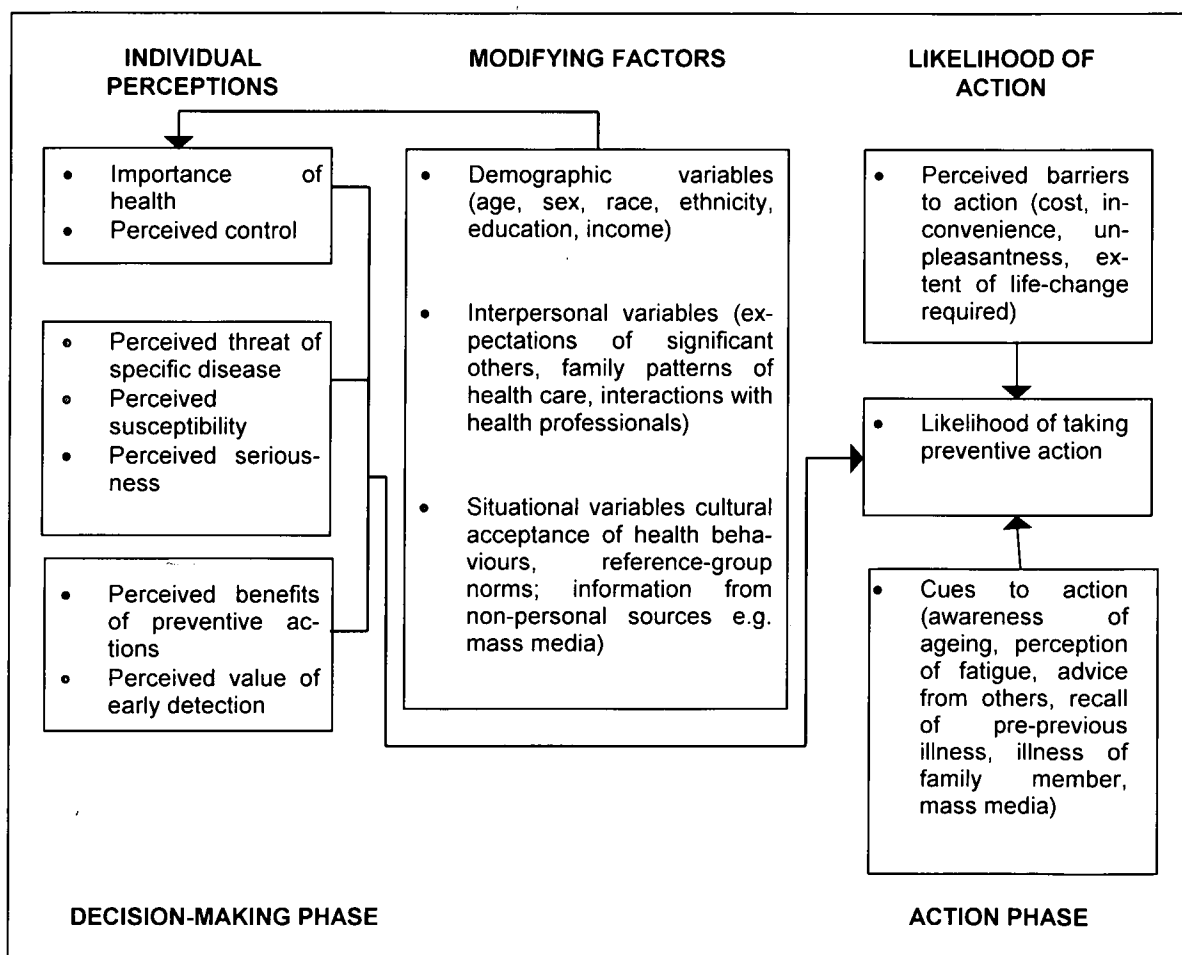
The model was developed in the early fifties by a group of social psychologists, namely Rosenstock, Hochbaum and Kegeles (Basson, 1992:35). Pender (1987:43) adapted the model and used it to explain health protective behaviour. According to the Health Belief Model, it is the perception of reality, rather than reality itself that determines human behaviour (Hurley, 1992:45). This means that individuals need to be helped to understand the risk involved in a condition for them to adhere to

preventive measures. This can be done by giving them more knowledge about the risk entailed in a particular disease. Ahia (1992:51), however, notes that knowledge (awareness) about the epidemiology of AIDS is a necessary starting point, but it is not sufficient for compliance to safer sex techniques. AIDS education programs should therefore be concerned not only with the cognitive aspects of AIDS, but should incorporate behavioural mores and skills necessary for AIDS risk reduction.

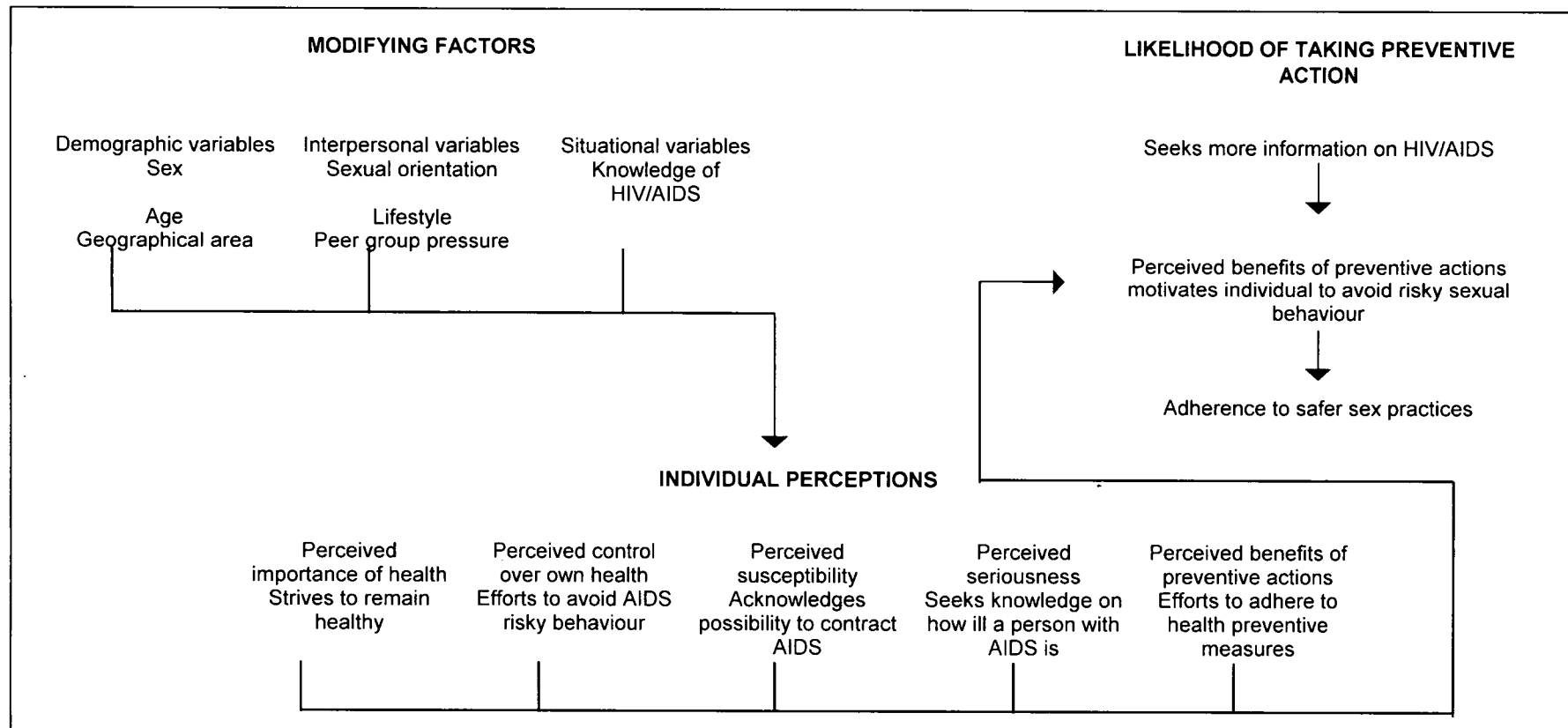
### **3.1.1 Motivation for the use of the Health Belief Model in this study**

According to this model, there are three factors that greatly influence individual compliance with recommended preventive health measures. These factors include: risk appraisal, perceived outcome expectancy and self-efficacy (Ahia, 1991:49-51). Risk appraisal refers to an individual's evaluation of the seriousness or consequences of a particular health problem such as AIDS. This has a positive correlation to compliance with safer sex techniques. It therefore follows that if an individual is given more knowledge as to the risk entailed in a particular condition, this may enhance his chances of compliance with recommended health preventive behaviours. Perceived outcome expectancy explains the ratio of the perceived benefit of preventive health measures to its cost (monetary, time and emotional). If the costs associated with preventive health measures exceed the benefits, a barrier to compliance to such preventive health measures arises (Ahia, 1991:50). Self-efficacy emphasizes the importance of self-assessment of one's capability and motivation in carrying out the recommended preventive health measures.

The Health Belief Model focuses on specific disease preventive behaviour for a particular health problem. It is therefore disease specific and not action specific (Basson, 1992:35). The model presented in Figures 3.1 shows modifications of the Health Belief Model as proposed by Pender to make it usable in the prevention of illhealth. Figure 3.2 shows how the Health Belief Model as modified by Pender was further modified to make it suitable for this study.



**FIGURE 3.1:** Pender's proposed modifications of the Health Belief Model (Pender, 1982:55).



**FIGURE 3.2: The Health Belief Model as modified for this study**

Both models consist of three components, namely: individual perceptions, modifying factors and variables affecting likelihood of action towards change in behaviour. Additional factors in the Health Belief Model that can trigger compliance to preventive health measures in a positive direction include demographic factors such as age and gender; psychosocial factors for example peer group pressure and structural factors like previous contact with the disease. Cues to action (events, communication) are also considered influential (Pender, 1982:51-53).

Although AIDS knowledge definitely has, to some extent, a positive influence on the behaviour of individuals, a study by Jadack, Hyde and Keller (1995:314) has shown that despite increased knowledge about HIV and AIDS, knowledge has not been strongly linked with safer sexual behaviours. This has prompted experts to call for new innovative ways in which to rephrase messages about AIDS or additional factors to be considered in order to change the risky sexual behaviour of individuals.

### **3.2 SEXUAL BEHAVIOUR**

According to the Health Belief Model, the following factors are important if risky sexual behaviour of individuals is to be changed as an AIDS preventive measure:

- Individual perceptions
- Modifying factors

- Likelihood of action (see Figure 3.1)

If perceptions are right, then there will be a likelihood that action will be taken in the form of adopting and adhering to health protective measures. Although all three factors stated above are important, for the purpose of this study, more emphasis will be laid on the assessment and consideration of modifying factors. This is because if modifying factors are known, and these are considered when giving AIDS information to people, there will be an increase in the likelihood of action being taken. Modifying factors therefore influence individual perceptions, which are factors to be considered in changing risky behaviour and these in turn influence the likelihood of action (see Figure 3.2). Among the modifying factors is knowledge of AIDS. This further shows that AIDS knowledge has an influence on the behaviour of people.

### **3.2.1 Modifying factors**

These factors directly influence a person's perceptions of:

- The importance of health
- Control over his own health
- Susceptibility to disease
- Seriousness of the disease
- Benefits of taking preventive action (see Figure 3.2).

A person's perceptions will in turn influence his motivation to take protective measures. This means that if a person views the disease as having untoward effects on him, he will undertake to change his risky behaviour to avoid being infected by the disease (Basson, 1992:37).

Modifying factors are divided into the following three categories:

- demographic variables
- interpersonal variables and
- situational variables (see Figure 3.2).

### ***3.2.1.1 Demographic factors***

Aspects such as age, sex and level of education are demographic factors that influence the behaviour of people (Pender, 1982:51).

#### **- Sex**

Statistics show that only three million of the eight million HIV infected persons in the world are women. Women play a leading role in the spread of health information as well as in the care of the sick (Basson, 1992:39). This group is more relevant to the Health Belief Model as they could be educated on the prevention of AIDS and they will be more willing to undertake health preventive measures and therefore help in the control of AIDS. As compared to men, women are more inclined to change risky behaviour and adopt health preventive measures (Pender, 1982:51).

The need to focus more on women with health preventive behaviour for AIDS is increased by the fact that various studies show that women are gradually overtaking men in contracting AIDS (AIDS Bulletin, 1991:8). Various reasons can be cited for this. In a census conducted in Zambia in 1990 it was evident, as in many countries in sub-Saharan Africa, that the transmission of HIV is predominantly heterosexual, typically with women being infected at an earlier age than men. The majority of those infected are in the reproductive and economically productive age group, poor socio-economic conditions, unequal gender relations and lack of access to health care and education also increase the vulnerability of women to HIV infection. Another contributing factor to the increasing susceptibility of women to HIV infection is the silent nature of many sexually transmitted infections, which act as co-factors for HIV transmission (Steinberg, 1994:4).

Men on the other hand, are not always willing to change their risky sexual behaviour even when they have been given factual knowledge about AIDS (Pender, 1982:51). In fact men are found to be partly responsible for the increasing rate of HIV infection in women. This is because culture tends to protect them and permit them to engage in sexual excesses, which, when practised by males are seen as prestigious. They are also seen to reinforce the traditional attitude of male supremacy and male sexual prowess (Mokhobo, 1989(a):18).



Hambridge (1993:2) also sees men who use the services of sex workers as exposing their spouses to HIV infection; particularly as they are said to refuse to use condoms. Female partners of homosexual and bisexual men are also at particular risk. This is because some of these men live in a heterosexual context and hide their bisexual activities from public view. Their spouses, unaware of this, are therefore at risk (Aggleton *et al.*, 1989:77). Some men who travel from place to place as part of their employment, such as long distance truck drivers, are promiscuous in the sense that they either take a different woman along on every trip or they have a sexual partner at each place they visit. A study conducted in 1993 on truck drivers showed that sex workers operate on these long-distance routes and that many drivers engage in high risk sexual activities (De la Rey, 1993:9-15). In a study by Jadack *et al.* (1995:313-314) men reported more permissiveness than women in their sexual relations. They also had more sexual partners. Women were seen to be more motivated to initiate safer sex behaviour than men.

Therefore it is clear that sex plays a definite role in the transmission of HIV. Infection occurs in both sexes but as women tend to be more ready to undertake health-protecting behaviour, this can reduce the rate among women faster than it can among men. Both sexes must therefore be motivated to adopt health protective measures.

- **Age**

Age has a definite influence on the adoption of health protective behaviour (Pender, 1982:52). Universally, adolescents have been identified as a group at high risk for HIV infection. In South Africa and the United States of America, for example, persons of 20-29 years of age account for a significant proportion (24,5% and 20% respectively) of all known AIDS cases. Given the median latency period of 8-10 years between HIV infection and the development of AIDS, many of the young adults must have contracted the infection during their teenage years (Richter & Swart-Kruger, 1995:31). Recent reports have indicated that an estimated 2:1,000 tertiary institution students are infected with HIV. Because approximately 70% of tertiary institution students are sexually active and have more than one sexual partner per year, increasing numbers of college students are at risk for HIV infection (Jadack *et al.*, 1993:313).

In a study on street-children conducted in 1993 in South Africa, it was found that most boys perceived AIDS as a "*foreign*" disease "*imposed*" on black people in South Africa. Nearly half of the boys felt that it was a ploy by the white government to wipe out the black population or to stop blacks from having babies. Their perception of individuals at risk was moralistic in that they associated it with homosexuals, sexworkers, people who are promiscuous and lower class people like hobos and criminals. They were therefore not prepared to take any initiative to protect themselves against AIDS nor to use condoms. They stated that condoms

were "smelly", were good as balloons only and that they "wasted sperms". However, 93% of these boys accepted that condoms are an effective means of prevention (Richter *et al.*, 1995:33). This showed that AIDS knowledge alone will not necessarily mean that people will adopt health protecting behaviours.

A study conducted in township schools in Cape Town in 1991 also revealed the need for AIDS education in both high school and junior school students. Three quarters of a sample of 1,000 students reported that they had sexual intercourse. Most students had heard of AIDS, and the majority of these knew that it was infectious. They were, however, not doing anything to protect themselves although they knew condoms could protect them from infection. Students did not acknowledge that AIDS could affect them directly, and attributed the problem to sexworkers and promiscuous individuals (AIDS Scan, 1991:40). This shows that although the youth are sexually active and sometimes even promiscuous, they are not really well informed about AIDS. This further emphasizes the fact that information alone will not induce a change in behaviour.

The above facts show that teenagers are sexually active, that they are not easy to convince to change risky sexual behaviour and that they do not attach much importance to health protective measures. This is because teenagers are at high risk for HIV infection through exploratory unprotected sexual relations with multiple partners and their high rate of sexually transmitted infections (Sankar *et al.*, 1991:22). Basson (1992:42), however, feels that teenagers can be helped

through the Health Belief Model to change their behaviour patterns and thereby avoid exposure to infection with the HIV. To support this, a study conducted in Durban high schools in 1990 showed that when teenagers are exposed to AIDS information before they are faced with decisions regarding sexual intercourse they do start off with safer sexual practices (Cranford, Turtle & Kippax, 1990:123). Classroom teaching must therefore be broad enough to include the development of skills in decision-making aimed at risk reduction.

A survey was undertaken in a high school in Gauteng in 1995. The findings endorse those of similar surveys done elsewhere in the world, which show that school children are at high risk of contracting HIV. The survey findings further recommended that AIDS education should be started at primary school level, that peer groups should be used to develop health messages and that more emphasis should be laid on skills and social norms rather than on the improvement of knowledge only (Van Aswegen, 1995:307). This study further emphasized the empowerment of young people to practice safer sex, acceptance of the fact that sexual activity is especially difficult to change, that information alone is insufficient to promote meaningful changes and that access to contraceptives does not hasten sexual activity (Van Aswegen, 1995:307:318).

According to Dubley, *et al.* (1991:196-197) the Health Belief Model has predicted HIV preventive behaviour among homosexuals, adults and adolescents. It predicts that individuals will adopt HIV preventive measures if they have information about

AIDS, believe that they are susceptible to HIV infection, that they have sufficient self-efficacy to change their behaviour, experience few barriers to action, have access to health care/advice and also perceive concerted social support for behaviour change. The association of the six elements of this model to three indices of HIV related behavioural risk reduction namely: reduced number of sexual partners, increased consistency of condom use (among males only) and reduced contact with sex workers, was examined by a self-report inventory among 202 men and 100 women in Bulawayo, Zimbabwe in 1996. Social support for behaviour change, followed by accessibility of health care/advice were identified as the most consistent predictors of risk reduction across sex and age-group outcome measures (Dublely *et al.*, 1991:196). It is therefore concluded that AIDS campaigns must foster the perception that there is concerted normative support for HIV-related behaviour change and that community and small group, face-to-face AIDS education rather than mass media campaigns must be utilized.

The demands of the AIDS epidemic also challenge the conservative approaches of many parents and educational decision-makers, who feel that AIDS and sexuality education must not be included in the school curriculum. Social and moral values vary with time and generation. This creates a gap between the ideals of the old and the behaviour of the young. Established decision-makers must be convinced that the AIDS epidemic demands a bold attack, which is based on objective new strategies (Sankar & Karim, 1991:24). Emphasis on the incidence of AIDS among

the youth does not mean that it is only the youth that are prone to infection with the HIV. Van Wyk (1991:5) notes the importance of targeting the workplace with AIDS preventive endeavours. This is because many adults, particularly in their reproductive ages, congregate in the workplace. This group is particularly prone to HIV infection as it is in the child-bearing period (Snyman, 1993:7-8).

- **Geographical area**

The third demographic factor of interest in the motivation of individuals to adopt AIDS preventive behaviour is geographical area (see Figure 3.2). Statistics show that countries that are struck by the AIDS pandemic are those in the central, eastern and southern areas of the African continent, including Zimbabwe, Botswana and Zambia (Hambridge, 1995:3). When one considers that South Africa is also situated in the southern part of Africa, one can accept that the same geographical problems exist in South Africa as found in the rest of Africa (Basson, 1992:43). This fact is also confirmed in the literature, where it is stated that it is highly probable that Botswana's experience of reaching very high levels of HIV may be repeated in South Africa and other countries of the region. South Africa also has a number of special factors that it is believed, will increase the vulnerability of its population to the rapid spread of HIV (Whiteside, 1993:1). These factors include:

- **Massive cross-border and internal migration of men.** Many black men are migrant labourers. These men live in single sex hostels or compounds near their

places of work while their spouses and children live on their own in the country (Basset, 1993:8). This tempts the men to have extra-marital affairs to satisfy their sexual needs. This promiscuous behaviour is a risk practice exposing them to infection with HIV.

- **Significant numbers of internal and external refugees.** Some of them come already HIV positive from their countries or areas of origin. Squatter areas have erupted due to this practice and this provides the "*perfect situation*" for the transmission of AIDS (Winbury, 1994:3).
- **Conflict and civil war which creates feelings of anomy.** Anomic people do not easily adhere to health protective behaviour as they are not really motivated or controlled by social norms (Rip, 1994:78). The present unrest situations in South Africa may create feelings of anomy.
- **Militarisation with the SADF, paramilitary forces, homeland armies and the liberation movements.** With the new government in place, armies are being integrated into one and liberation movements have become uncommon. The large number of military camps in the previous order could increase the spread of AIDS due to absence from family.
- **Poverty and rapid urbanization.** Evian (1993:230) notes that due to poverty, some women may yield to sexual advances by many men for economic gain. Employment opportunities are few, especially for rural black women who are

basically uneducated. Some women even resort to "*selling sex*" as a way of earning much-needed money. Urbanization has also broken down many families, as husbands have to move to urban areas in pursuit of employment. This exposes them to infection with the HIV due the concubinage system occurring in many urban areas.

- **The high rates of sexually transmitted infections, which are co-factors in the causation of AIDS.** This is because these infections, as stated earlier in this study, corrode the mucosal lining of the genital tract making it more vulnerable to HIV infection.
  
- **The low status of women.** It was due to the fact that women were economically and socially disadvantaged as they were less likely to be educated, to have skills or stable employment due to their traditional role of having to stay at home and look after children. They were therefore economically dependent, initially on their parents and later on their husbands (Basset, 1993:8). Today, many compete equally with males in education and in the open labour market. The new government has also started to address the inequities of the past by employing women, who qualify, in top positions.

In South Africa, the incidence of HIV infection and AIDS seems to be higher in urban areas than in rural areas. This may be due to urbanization, which as stated earlier in this text, breaks up many families. Urbanized men find more permissive



norms and availability of sex-worker services in urban areas. These predispose them to HIV infection (Basson, 1992:43). Although AIDS is more prevalent in urban areas, it can spread to rural areas as urban workers visit their spouses from time to time in the rural areas. Wives may also visit their husbands if accommodation facilities permit, for example if the husband has moved out of a single sex hostel and rented a house in the township (Cremers, 1993:38-39).

It would appear thus that the permissive attitude in cities, the lack of knowledge of AIDS due to overcrowding in health centres as well as the availability of sex workers, are contributory factors to the high incidence of AIDS in these areas. Application of the Health Belief Model in urban areas may help to motivate people there to change their risky sexual behaviours and adopt health protective practices. This will reduce the rate of HIV infection and AIDS.

### ***3.2.1.2 Interpersonal variables***

#### **- Sexual orientation**

The sexual orientation of individuals is an important factor that will influence their willingness to adopt safer sexual practices. This should therefore be borne in mind when attempting to motivate people to change their AIDS risky behaviour.

Internationally, people tend to view AIDS as a phenomenon that originates from, and spreads between groups other than those with which they identify. AIDS is therefore a “not me,” “not my group” illness even for many South Africans.

White South Africans believe that bestiality and promiscuity are some of the factors that contribute to the high incidence of AIDS among blacks. Black South Africans on the other hand believe that homosexuality and promiscuity contribute to the white AIDS problem (Joffe, 1993:6). Whilst there are signs that people are beginning to listen to the call for safer sex, there is also evidence that people still associate AIDS with being homosexual (Burnard, 1992:3-4).

The association of AIDS with homosexuality could have its origin in the fact that AIDS was first diagnosed in South Africa in 1982 in white male homosexuals (Fleming, 1993:18), as well as in the fact that the largest proportion of cases of AIDS and HIV infection was found among the homosexual community (Sepulveda *et al.*, 1992:158).

The epidemiology of AIDS indicates that people who have taken part in certain activities or still do, for example homosexual and bisexual men, are at a much higher risk than others of contracting AIDS (Adler, *et al.*, 1988:51). Burnard (1992:62-63) refers to the bi-sexually-married, homosexually active men as a very difficult population at risk to reach. This is because some of them live in a heterosexual relationship and conceal their bisexual behaviour from public view. It is therefore very difficult to motivate this group towards safer sexual activities. According to Akande (1994:287) even some adolescents are homosexual. This may be due to peer pressure or their lack of assertiveness. In the United States of America and Great Britain, voluntary groups involved in AIDS education

campaigns targeted homosexual men. Following these educational efforts, evidence is accumulating that substantial changes in sexual behaviour, a reduction in the incidence of new HIV infections, and a reduction in the incidence of gonorrhoea have occurred in homosexual men. This has also led to a general decrease in the incidence of AIDS statistics (Adler, *et al.*, 1988:51).

The above facts support the view that sexual orientation or practices should be considered in motivating people to adopt healthy sexual practices. This therefore supports the use of the Health Belief Model in the control of AIDS.

The fact that AIDS is generally associated with the homosexual community does not mean that heterosexual individuals are immune to AIDS. Any person who participates in risky sexual behaviour is exposed to HIV infection. In fact, the heterosexual spread of AIDS is gradually overtaking other modes of transmission, contrary to the general belief that AIDS is a disease of the gay (Zuma, 1995:4). To support this fact, Fleming (1993:18) states that heterosexually - acquired HIV was recognised in migrant labourers from Malawi and Zambia in 1985. Seroprevalence, however, remained low in indigenous South Africans, even those with high-risk behaviours until 1987. From early 1988, the epidemic expanded in the black heterosexual population. The World Health Organization estimates that worldwide, 80% of all HIV infections are acquired due to sex between men and women. In 1993, in sub-Saharan Africa alone, about seven million people whose only risk activity for HIV is heterosexual sex, were estimated to be HIV positive

(McGavock, 1994:17). The Communicable Disease Surveillance Centre (CDSC) reported that in 1992, 14% of all AIDS cases and 29% of all HIV infections were acquired through heterosexual sex, while only 2% of all AIDS cases were acquired in this way in 1986. Similar increases have been recorded in the United States of America, southern Europe and Scotland (McGavock, 1994:17). These facts support the belief that AIDS and HIV-infection can and does occur within the heterosexual community as well.

Therefore, the application of the Health Belief Model in changing risky sexual behaviours focuses on homosexual men as they are more motivated to adopt healthy sexual practices when given information on AIDS and its transmission. The heterosexual group should, however, not be left out. Van Ammers (1990:303) supports this by stating that the HIV epidemic in Southern Africa has several components, of which heterosexual transmission and transfer from mother to child predominate. The typical pattern of "*Western AIDS*" on the other hand has to date been that of homosexual transmission and intravenous drug abuse.

#### - **Lifestyle**

The relationship between lifestyle and disease preventive behaviour will be presented in this part of the study (see Figure 3.2). This relationship is presented by Schutte (1993:1) when he states that factors such as poverty, level of education, cultural beliefs, traditional practices, drug abuse, movement from rural to urban areas as well as the breakdown of normal social behaviour constitute a person's

lifestyle. He further states that these factors, together with a "*virus as insidious as HIV*" have posed difficulties in the control of AIDS as they influence the person's readiness to adopt a healthy lifestyle and thereby prevent disease.

The Government of the day and progressive organizations evident in the previous government characterised AIDS as a socio-economic disease, the spread of which has been exacerbated by the apartheid system. The epidemic has taken a peripheral seat while issues such as adequate housing, employment creation, access to health care facilities and education are believed to enjoy first priority (Whiteside, 1993:1).

Because black communities, especially in rural areas, are either semiliterate or literate only in their mother tongue, most of them tend to reject educational programs including those on AIDS (Hyde, 1992:26). This makes it difficult, if not impossible to influence their behaviour or alter their risky sexual behaviour through education on AIDS.

The apartheid regime is seen by Whiteside (1993:1) to be responsible for the fact that many blacks could not obtain sufficient education to civilize them and help them alter their traditional beliefs and cultural practices. Among these beliefs and practices are those like concubinage that predispose them to HIV infection. This practice constitutes promiscuity but is not likely to endure a stigma of disapproval in the African society. This is because, according to Mokhobo (1989(a):18), it is

till accepted as a normal cultural practice in black communities and is, therefore, part of the lifestyle of a black man. This lifestyle, however, excludes health protective behaviour associated with the prevention of HIV infection.

The economic environment many blacks find themselves in is one of poverty. The cause of this is multifactorial. A poor education as described above leads to lack of employment. Another factor is the inaccessibility of health care facilities and, therefore, the lack of exposure to health information including that on AIDS (De la Rey, *et al.* 1993:9-13). The inability of some blacks to reach health facilities forces them to resort to their initial lifestyle, that is that of using the services of traditional healers in the place of western medical care. Traditional healers often spread HIV through making incisions with unsterile razor blades (Shikhibane, 1993:2). This style of living is so deeply inculcated in the culture of some blacks that it is very difficult to change.

Intravenous drug abuse is another practice forming the lifestyle of certain individuals. These people sometimes share needles without knowing the HIV status of each other (Burnard, 1992:58-59). The euphoric effect of these drugs produces addiction in users, making them very difficult to convince that the lifestyle they are leading puts them at risk of infection with the HIV.

In Zimbabwe, contemporary sexual culture has been shaped largely by the twin legacies of traditional patriarchal values and colonial labour relations, which

entrenched the migrant labour system. This meant that African men had to be separated from their wives as "*a way of life*". This practice had its problems, which included both spouses being at risk for infection with HIV, (Basset, 1993:8-9). Long distance truck drivers also spend many nights away from home as part of their lifestyle. When considering that these drivers are highly mobile and they come from all parts of South Africa one can comprehend the rate at which they transmit the HIV, not only between people but also from place to place (De la Rey *et al.*, 1993:9-15).

This shows the need to assess and understand the lifestyle of individuals before motivating them to alter their risky sexual behaviours is emphasized. Therefore it is important to apply the Health Belief Model in attempting to encourage health-protecting behaviour.

- **Peer group pressure**

Ahia (1991:50) identifies peer group pressure as one of the psychosocial factors that are believed to influence compliance with safer sex guidelines according to the Health Belief Model. According to Basson (1992:48) this factor can trigger compliance either positively or negatively. In the case of teenagers, peer group pressure often encourages them to be sexually active.

Some adolescents engage in activities such as homosexuality that place them at risk of HIV infection, due to a lack of assertiveness on their part. Their peers

therefore coerce them into unsafe sexual activities (Akande, 1994:287). A need for social assertiveness in AIDS-preventive behaviour is, therefore, identified. In 1993 a study was conducted on street children and young people in non-governmental organizations in South Africa that provide shelter, food and other services for these children. The results of this study revealed that the majority of boys engaged in sexual activities that could put them at risk for HIV infection in order to get money and to be accepted by the group as "*contributing to the budget of the group*". All the groups agreed that the best way to get money was through "*selling sex*" to both men and women and that unprotected penetrative oral, anal or vaginal sex was usually required by their customers for amounts varying from R10 to R200 per day (Richter & Swart-Kruger, 1995:34). Their peer group expected them to oblige otherwise they would be sanctioned and assaulted.

Drug and alcohol abuse is also common among street children. This is another practice where street youth are pressurized by their peers to oblige. Compliance is for purposes of enlisting powerful others in exchange for protection, accommodation or any other services or goods. Intoxication interacts with high risk sexual behaviour by, on the one hand, making street children more vulnerable to rape when "*high*" and, on the other hand by rendering their sexual behaviour less discriminating through easing their inhibitions (Richter & Swart-Kruger, 1995:34-35). Youth that come from inner cities are, according to Cunningham, Stiffmann, Dore, and Earls (1994:233-234) under tremendous pressure, not only in



from their peers but also from the more permissive environment in cities to engage drug and alcohol abuse, to initiate sexual activity early, to have multiple and/or risky partners and are often unreliable users of contraception. Their mental health and behavioural problems may also increase their risk of infection with HIV. For example, the disinhibitory effects of alcohol and drugs may complicate the use of contraception as well as the choice of a sexual partner. This is because they have behavioural problems as they are rebellious to adult authority, they explore their sexuality and they experiment with drugs. This makes their mental health very unstable and unpredictable (Jones, 1991:592).

Diffusion theorists would, according to Hyde (1992:39), agree that interpersonal communication is most effective in modifying human behaviour. The peer educator could be used as a role model to his peers for desired behaviour change. If this educator is properly chosen, specially trained and motivated not only to conduct an education program aimed at his group mates, but also to display acceptable health protective and AIDS preventive behaviour, then the objective of reducing risky behaviours would be attained. Peer educators have been used with success internationally, particularly amongst sex workers, truck drivers, youths, airline cabin crew and the gay community (Hyde, 1992:39). In a study on African teenagers conducted by Sankar & Karim (1991:22-24); it was discovered that there were complex intermediate variables between AIDS awareness and behavioural change. This was because many teenagers were aware that AIDS is mainly a

sexually transmitted infection, they knew that condoms would protect them from contracting AIDS and were aware of safer sex techniques. In spite of their awareness the teenagers did not change their risky sexual practices. To overcome this, the researchers trained some of these teenagers and used them to influence the behaviour of their peers. This improved the situation slightly although the results were not 100% positive (Sankar & Karim, 1991:22-24).

It is clear that adolescents are at a particularly high risk for contracting sexually transmitted infections including AIDS. This is because they engage in risk-taking behaviours such as drug and alcohol abuse and reckless sexual activity. They are under extreme pressure from their peers, some adults, and the social environment to involve themselves in such behaviours. Their mental status is still immature; they have behaviour problems and lack the assertiveness to resist this pressure. Jones (1991:592) has recommended that parents, educators, community leaders and all adults teach young people to protect themselves and others against exposure to the HIV and that this education starts in early elementary school and at home. It will then perhaps influence pre-adolescents before they are confronted with having to take decisions on sexual issues and the use of drugs.

### 3.2.1.3 *Situational variables*

#### - **Knowledge of AIDS**

- In the absence of a cure or vaccine for AIDS, as well as the fact that it is neither practical nor morally acceptable to isolate the infected person as a means of avoiding contamination, the world-wide response to the AIDS pandemic has been to use education to prevent infection and lessen the stigma. Such education needs to convey ideas that may increase knowledge and change attitudes and practices (Eagle & Brouard, 1995:21-22). The impact of AIDS education has also been the subject of considerable research. Results have varied depending on the duration of the program, the nature of the education, the style of presentation and the target group (Dublely, *et al.*, 1991:196-197). Information on AIDS should, therefore, be factual, relevant to the target group in that the method of presentation should be suitable. For example pre-scholars and primary scholars could be shown magic shows which are later interpreted at their level of understanding. AIDS information must be started at home and at primary school level, as it is more difficult to dispel myths and risky behaviours than it is to teach facts and instil healthy practices to an "*innocent*" mind (Jones, 1991:592).

It is unfortunate that increased knowledge cannot be linked to safer sexual behaviours (Jadack *et al.*, 1995:314). Various research findings support this notion. For example a study by Ahia (1991:50-51) revealed that knowledge alone is not sufficient to make people assume preventive behaviour against HIV infection. Awareness about the epidemiology of AIDS was, therefore, seen as just a "*necessary starting point but not sufficient for compliance to safer sex guidelines*". Van Aswegen (1995:308) also observed in a sample of undergraduates, an improvement of knowledge over time, but a stability in moral reactions. This discovery was not surprising as AIDS is said to be interpreted within the personal framework of religious beliefs, political persuasions, sexual experience and identity. All these are dimensions of individual personality that help a person to interpret AIDS and comprehend the risk involved in this condition. It is against this background, and not on knowledge alone that a person will be prepared to institute a change in risky sexual behaviours.

Basson (1992:50) recommends that the gap between information and training needs to be bridged if individuals are to be motivated to apply the information that they receive. This means that people must not only be given information on AIDS, but should be helped with the acquisition of social skills that will motivate them to abandon risky sexual behaviours. A study by Jemmot, *et al.* (1992:276-277) on the condom-use intentions among sexually active black adolescent women supports the fact of bridging the gap between information and training so as to motivate the

adoption of safer sex practices. After being given information on the cause, transmission and prevention of AIDS, the intentions of these women to use condoms did not increase. It was only after they had been trained in the use of the condom to protect themselves and their partner (see Figure 2.1) as well as other safer-sexual practices (outlined earlier in this study) that the women felt more motivated to put their knowledge into practice. They were more motivated to abandon their risky sexual practices and adopt AIDS preventive behaviours (Jemmot & Jemmot, 1992:277).

Sometimes the reason why people do not change their behaviour after being educated about AIDS is moral obligations, a lack of assertiveness or other reasons and not necessarily insufficient information to evoke a change.

The fact that knowledge does not always bring about a change in attitude was also proved in a study conducted in 1993 on nurses and psychologist in South Africa. This study revealed that nurses had the most knowledge of AIDS, but had the least positive attitudes. These were not attitudes of sexual behaviour but of contact with persons with AIDS. The implications of this study for training courses and health education were that more emphasis should be laid on the fact that AIDS cannot be transmitted through casual contact. There is, however, a need to take strict protective measures when handling the blood and body secretions of patients and infected people (Robbins, Cooper & Bender, 1992:198).

### **3.3 PSYCHOSOCIAL EFFECTS OF INFECTION WITH HUMAN IMMUNE DEFICIENCY VIRUS AND SUFFERING FROM ACQUIRED IMMUNE DEFICIENCY SYNDROME.**

The number of people infected with AIDS increases every day in South Africa (Basson, 1992:4). Times of the AIDS epidemic are said to be times of psychosocial tensions. This is worsened by the fact that relevant authorities in South Africa are very slow in awakening to the scope of the problem. The major psychological problem for the patient is the feeling of being unwanted, uncared for and deserted by everybody (Lachman, 1991:292).

Because of the moral judgements about the acquisition of the disease, which are said by Lachman (1991:293) to be inappropriate and unkind, communities experience fear and hysteria. These also create their own problems such as denial, rejection and discrimination against the person with AIDS (Evian, 1993:235). The feelings of fear are not only experienced by infected people, but by friends and families as well. It is therefore important that families and friends of the AIDS patient be given psychological support. They must be helped to learn that their fears or beliefs are normal and common. Their feelings of ambivalence should be handled as normal and natural. They must therefore be helped to cope with them (Burnard, 1992:67).

The question of confidentiality in dealing with people infected with the HIV seems to clash with the extended family support system, where everybody knows more or less about everybody else's problems. The AIDS patient may interpret this disclosure as a lack of confidentiality on the part of the health professional. This may lead to mistrust between patients and their caregivers. It is therefore best to leave disclosure to the discretion of the individual (Mokhobo, 1991:7).

Among the psychosocial issues that face people who are HIV positive or who have AIDS is the fact that many of them, especially gay people, still see themselves as being punished for their behaviour. Many of these people present with social disruption, withdrawal as the person struggles with acceptance of the diagnosis (Burnard, 1992:7-8).

Psychiatric problems such as major mood disturbances, psychosis, acute anxiety, panic attacks, acute confusion, severe depression and dementia are also observed in many people infected with the HIV (Youle, Clabour, Wade & Farthing, 1988:91). Counselling should therefore focus on psychological and psychiatric problems, and should be started before HIV antibody testing as a primary preventive measure (Allan, 1992:46).

Although very small, the risk of transmission of HIV by aerosols (small droplets in the air, which may carry the virus) exists (Cremers, 1993:39). The author also notes that in the past seven years two technicians who worked under biohazard

conditions with extremely high concentrations of HIV have been tested HIV positive. This makes every health worker who works with HIV infected persons or blood and blood products to suffer "*bouts of paranoia*" called the fear of AIDS. The only remedy therefore, is to keep a cool head, to bear the facts of HIV transmission in mind and in extreme cases to request an HIV test (Cremers, 1993:39).

### **3.4 THE AIDS EDUCATOR**

According to Macklin (1989:166) the importance and role of education in the prevention of AIDS is no longer debatable. The lack of a cure or a vaccination against this deadly disease makes it imperative to use education to change the behaviour and attitudes of persons at risk. To be effective, however, the AIDS health education program must be acceptable to target communities. This means that these communities must be involved in the designing and implementation of such a health education program. Their opinion must also be sought regarding who should give them the health education on the prevention of AIDS.

Burnard (1992:40) feels that the AIDS educator must be a health professional who is trained in sexuality education, substance abuse education, small group and community process, racial and ethnic variations as well as individual and family dynamics.



Prevention cannot, however, be limited to health service settings. It will need to include community work in all public places like pubs, clubs and schools (Adler, *et al.* 1988:54). This means that community health workers and teachers may also be used to give education on AIDS.

Hyde (1992:26) feels that the human educator is the best. He can never be replaced by videos or posters. This author therefore suggests that companies should select from among their employees members to be trained to give education on AIDS at work. They should be given proper training and skills, as they have to teach heterogeneous audiences consisting of literate, semiliterate and illiterate individuals.

The peer educator is likely to understand his peers, to be accepted and to have empathy with them. He can also be used to extend the program to the families of the employees.

Basic requirements of the peer educator according to Hyde (1992:4) depend on the audience, available resources and on his capabilities. These may be generally listed as follows:

- Knowledge of the language of his audience;
- Educator kit (condoms, gloves, needles, syringes and posters);
- Audio-visual material;
- A quiet, attractive, comfortable and private venue;

- Support and supervision by management; and
- Prearranged scheduling with the supervisor.

### **3.5 SUMMARY**

Although it is evident that knowledge alone will not bring about a change in behaviour of AIDS, education remains the beginning of any AIDS preventive campaign. It is, however, important first to evaluate the extent of knowledge that communities already possess, to assess other modifying factors so as to change the perceptions of individuals to those that are relevant to actions aimed at changing risky sexual behaviours and taking preventive action against the spread of AIDS and HIV (see Figure 3.2).

To be able to motivate people to change risky sexual behaviours and adopt health-protecting behaviour the application of the Health Belief Model is found most suitable. This model has, however, been modified to make it suitable for this study. Guidelines for the development of a health education program on AIDS and infection with the HIV will therefore be well founded in the various aspects of the Health Belief Model.

The influence of AIDS knowledge on the behaviour of people was presented in this chapter. The next chapter will deal with the research methodology, where the research design, research techniques, ethical considerations as well as application of the interview schedule will be discussed.

# **CHAPTER 4**

## ***Research Methodology***

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### **4.1 INTRODUCTION**

The incidence of AIDS in black communities is increasing drastically in spite of attempts to curb it. The lack of a cure or a vaccine against this deadly disease makes health education to be the only method of attack against HIV infection and AIDS. Information on AIDS is disseminated by various strategies such as the mass media. This method however, does not succeed in reducing the rate of HIV infection and AIDS. The above scenario necessitates an investigation to find out why health education is failing to bring about a reduction in AIDS statistics.

### **4.2 METHODOLOGY**

#### **4.2.1 The research design**

A cross-section descriptive survey design was used in this descriptive empirical study. After an intensive literature review, principles with which any ethnic-specific AIDS education program should comply were identified. According to Burns and Grove (1993:193) a descriptive design may be used to identify problems with current practice. This design was therefore chosen in an attempt to identify problems in the current manner

of giving health education, which makes it ineffective in reducing the incidence of AIDS. The findings were presented in a descriptive analytic narrative format.

Descriptive studies, according to Polit and Hungler(1983:17-18) can be of considerable value to the nursing profession. This is because such studies enable the researcher to observe, describe and perhaps classify. Many phenomena in nursing, including the occurrence of major diseases such as AIDS require this type of investigation.

#### **4.2.2 The Interview Schedule**

A self-designed interview schedule was used as a research instrument. Various themes of the measuring instrument were well founded in the literature review under discussion. Burns and Grove (1993:366) recommend the use of close-ended questions in interview schedules. Such questions do not require the respondent to discuss issues or to elaborate at length. Close-ended questions were therefore asked in this study. These called for mere indications on a statement or a question.

#### **4.2.3 Research Techniques**

##### ***4.2.3.1. Literature Study***

An intense study of relevant literature was undertaken on the following aspects:

- Factual information on AIDS, the extent of AIDS in black communities, the epidemiology of AIDS, prevention as well as barriers to education on this fatal disease.

- Psychosocial effects of HIV infection and AIDS.
- Motivation of health-protective behaviour through the use of the Health Belief Model.

#### **4.2.4 Population and Sampling**

##### **4.2.4.1 *Population***

The population consists of members of the black community residing in Mangaung.

##### **4.2.4.2 *Sampling***

For the purpose of this investigation four clinics in Mangaung in the Free State Province were visited for data collection. The clinics were chosen at random by picking clinic names from a hat. A sample of 200 subjects was selected. Permission was obtained from the Regional Director as well as from the Medical Officer of Health to conduct the study in the various clinics (see Annexures B and C).

The non-probability sampling method was used, where every client visiting the clinic on days on which the research was conducted stood an equal chance of being selected as a respondent. The sample was also handpicked at random. Every third client entering the clinic was selected as a respondent. All categories of age, sex, ethnic group and occupational class happened to be included in the sample. This method of sampling also ensured that the respondents could comprehend the importance of the investigation without involving only the highly educated people.

#### **4.2.5 Ethical Considerations**

Attached to the interview schedule was a letter explaining the purpose of the data being collected, that is that the data was solely for research purposes (see Annexure A). Respondents were also assured that all information would be treated as confidential and that their name and that of their institution would not appear anywhere on the interview schedule. This was to guarantee anonymity and confidentiality. The interview schedule was completed voluntarily. Respondents voluntarily gave informed consent and were made aware of their rights.

Privacy was ensured in order that the respondents could think and respond without any interference. The worth and dignity of the respondents were ensured and maintained at all times, by the manner in which they were addressed and listened to.

Informed consent to participate in the study was obtained from the respondents and from the research assistants. It was also indicated that their participation was voluntary and that they were therefore free to withdraw at any stage during the course of the study, should they wish to do so.

Participants will be informed of the research outcomes, if they so wish.

Respondents would be supported by being referred to appropriate services whenever this became necessary.

#### **4.2.6 Composition of the Structured Interview Schedule**

Burns and Grove (1993:365-367) state that, an interview schedule has been referred to by some authors as the lazy man's way of gaining information. However, the careful preparation of a good interview schedule requires a great deal of time, ingenuity and sophistication on the part of the researcher. Unless the researcher knows what he wants, he is not likely to ask relevant questions or to phrase them correctly.

The interview schedule should be constructed in such a way that it reflects scholarship, questions should be kept as brief as possible and should be phrased as simply as possible (Burns and Grove, 1993:367). This would minimise the amount of time the respondent would take to answer the questions. According to Shikhibane, (1993:42-43) questions should be phrased in such a way that they can be understood by every respondent. Questions should also enable the researcher to elicit unambiguous answers and to avoid bias or prejudice. Questions should not mislead due to unstated assumptions; therefore alternatives to items should be exhaustive. The researcher should try by all means to avoid questions that may elicit reactions, embarrassment, suspicion or even hostility in the respondent. Finally, the interview schedule should have an attractive appearance with neatly arranged questions whose responses can be easily tabulated.

For the purpose of this investigation, a self-designed, structured, closed form interview schedule was developed. In Sections A, B and C a list of alternative answers was given to each question from which respondents were to choose one answer. In Sections D and E,

however, the respondents were requested to indicate on a five-point scale the extent to which they agreed with a specific statement.

#### **4.2.7 Aspects addressed in each section of the structured interview schedule**

The interview schedule was composed of sections A to E. Section A consisted of the respondent's biographical information in the form of age, sex, occupation, home language and highest qualification. In Section B respondents answered questions relating to their source of existing knowledge of AIDS. They were asked to state whether the hospital, the clinic, the mass media or the AIDS information and counselling centre gave them the most knowledge on AIDS. They were also asked for their preference regarding an AIDS health educator. In Section C respondents answered questions concerning their knowledge of various aspects of AIDS. These included questions about the other name for AIDS, the possibility of contracting AIDS by failing to stick to one uninfected partner and about whether there was a cure for AIDS. Other questions dealt with whether or not respondents believed that AIDS was a gay disease only, whether correct condom use would prevent AIDS and which categories of people may be affected by AIDS. In Section D respondents were expected to give their opinion about the inclusion of factual information on AIDS in the AIDS education program. This information addressed the psychosocial effects of HIV infection and AIDS. These aspects were regarded as fit to be included in the education program because the researcher felt that if people are educated regarding these aspects and they understand them, they might be motivated to abandon risky sexual behaviour and adopt AIDS preventive behaviour.



Section E contained questions about motivation to avoid risky sexual behaviour and adopt AIDS preventive behaviour. In this case too, respondents were expected to indicate whether or not they agreed that certain factors should be included in the health education program for the assessment of persons being given health education. These factors would be used to evaluate whether the person would readily accept the education or would be resistant to adopting AIDS preventive behaviour. They included demographic factors such as age and sex, geographical factors such as whether the person lives in a rural or urban area, as well as sexual orientation. Socio-economic factors such as poverty, level of education, cultural and traditional beliefs and practices were also used in the assessment that the abuse of alcohol and drugs, the ability to resist group pressure (assertiveness) as well as the possession of sufficient and relevant knowledge of AIDS were also factors that should be used to assess a person's readiness to change risky sexual practices. Finally, respondents were expected to indicate whether or not they agree that teenagers and their risky sexual behaviour constitute an important risk to the future spread of AIDS.

#### **4.2.8 Pilot Study**

A pilot study was conducted using 20 subjects chosen from the same population as that of the major study. These participants were not chosen as respondents for the major study. Through the pilot run, some problems such as ambiguity and a lack of clarity in some questions were identified. These were rectified by re-phrasing or further clarification.

The pilot study was undertaken to test the feasibility of the study, as well as to identify any problems that might arise during the application of the measuring instrument. Polit and

Hungler (1983:15-18) recommend a pilot study as a means of assessing the feasibility of a study. It is also seen as a trial run or a means of perfecting and refining the technique of interviewing and identifying problems before the major study.

#### **4.2.9 Application of the Interview Schedule**

The researcher consulted the professional nurses in charge of the clinics concerned personally to obtain their permission to conduct the research in their health services. The written permission of the responsible authorities was shown to them. Suitable dates for conducting the research were then arranged. The researcher could utilise any clinic day as clients all stood an equal chance of being subjects.

Interview schedules were taken to the clinics personally by the researcher. One professional nurse at each clinic was trained to assist with the implementation of the questionnaire. The researcher conducted a few interviews at each clinic to serve as an example for the research assistant. As the fieldworkers were professional nurses, they were in a better position to understand the questions as they were familiar with the subject. The fieldworkers were trained in methods of conducting interviews in an unbiased manner. They were also encouraged to create a permissive, quiet and private atmosphere where the subject could be encouraged to respond to sensitive topics with ease (Burns and Grove, 1993:366).

The researcher herself trained the fieldworkers. As a way of evaluating the training, fieldworkers were asked to do one interview under the supervision of the researcher.

Interviews for the pilot study were all conducted by the researcher herself. The evaluation demonstrated that fieldworkers understood the questions and would therefore be able to ask them appropriately.

Probing may be used by the interviewer to obtain more information on a specific aspect. The question may also be repeated for clarity. Some questions may be explained further. Probes should however be neutral to avoid biasing the subject's responses. These should also be undertaken within reasonable guidelines to prevent the subject from feeling that he is being "cross-examined" on a topic (Burns and Grove, 1993:366-367). To ensure neutrality, questions were explained to the subject, informed consent was obtained and subjects encouraged to relax. This ensured that subjects did not feel victimized.

#### **4.2.10 Collection of data**

Data were recorded during the interview. Because the data collection instrument was an interview schedule with close-ended questions, every answer was ticked immediately. This ensured that there were no misconceptions.

Descriptive statistics were used in data analysis. Data was presented in table form, from which conclusions were drawn.

#### **4.2.10.1 Reliability**

Reliability refers to precision, or the degree of consistency, in terms of which the measuring instrument produces the same results every time it is used (Burns and Grove, 1993:348).

In this study, this construct was demonstrated by:

- literature review by which the views of authors and researchers who had conducted similar studies were discussed to establish commonalities as well as to compare findings;
- external control by means of two accomplished researchers.
- training research assistants to make sure that they ask questions correctly,
- conducting a pilot study or a trial run of the study. This provided the researcher with an opportunity to identify and address problems in the measuring instrument before implementing the major study;
- as part of evaluating the effectiveness of their training, research assistants were selected as subjects for the pilot study. This made them even more familiar with the questions.

#### **4.2.10.2     *Validity***

Validity or the “truth value” is concerned with the accuracy and trustworthiness of scientific findings. Validity is comparable to accuracy, in which evidence of content-related validity addresses the extent to which an instrument measures the domain defined in the study (Burns and Grove, 1993:347-348). In this study, the interview will be termed trustworthy if it reflects the needs of the community as far as health education on AIDS is concerned.

Error is identified as one of the key factors affecting validity. Major sources of error are seen as the researcher, the respondents, the situation or social context as well as methods of collecting data and data analysis (Brink, 1993:36).

The interview schedule was submitted to experts in research before its administration. This ensured the face validity of the measuring instrument.

For the purpose of content validity the interview schedule was submitted to the supervisor who is an expert on the subject of AIDS. It was also submitted to a professional nurse in charge of the AIDS Training Information and Counselling Centre, who is also an expert on AIDS. The experts were asked to evaluate whether the questions were phrased correctly and objectively, and whether they met the objectives of the study.

### **4.3. SUMMARY**

This chapter sums up the research methodology. The research design, methods and techniques of data collection and analysis were discussed. In the following chapter, the research findings as well as their interpretations will be described. These findings will contribute towards the setting of guidelines for the development of a health education program for the control of AIDS.

# CHAPTER 5

## *Data analysis and interpretation*

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### 5.1 INTRODUCTION

The aim of the study was to identify the needs of the community of Mangaung with regard to the development of a health education program for the control of AIDS. Based on this aim, collected data will be analyzed and interpreted in this chapter.

### 5.2. BIOGRAPHICAL INFORMATION

#### 5.2.1 Distribution according to age

*Table 5.1: Frequency distribution according to age.*

AGE IN YEARS	FREQUENCY	%
1. Younger than 16 years	1	0.5
2. 16-20 years	16	8.0
3. 21-25 years	30	15.0
4. 26-30 years	26	13.0
5. 31-35 years	28	14.0
6. 36-40 years	36	18.0
7. 41-45 years	17	8.5
8. 46-50 years	16	8.0
9. 51-55 years	10	5.0
10. 56-60 years	10	5.0
11. 61-65 years	5	2.5
12. Older than 60 years	5	2.5
<b>Total</b>	<b>200</b>	<b>100</b>

In Margaung health services are utilized by all age groups, especially the economically productive ones between 26 and 60 years. This age group constituted a large percentage of the sample (71,5%). This situation provides health educators with a good opportunity of giving education to a large proportion of the community. It is documented clearly in the literature that AIDS affects the economy of the country as it occurs at the time when people should be employed and contributing to the economy (see Chapter 2, section 2.2).

The age group 16-25 years is also well represented in the sample (see Table 5.1). Twenty-three per cent of the respondents fell in this age category. This is the age group in which most people become sexually active. It is also stated in the literature that because of the median latency period of 8-10 years between HIV infection and the development of AIDS, many of the people who show signs of the disease must have contracted it during their youth (Richter, *et al.* 1995:31). The fact that this age-category presents itself at the health services also provides the health educator with a good chance of disseminating AIDS knowledge to an appropriate target group.

### 5.2.2 Distribution according to sex

*Table 5.2: Frequency distribution according to sex.*

<i>SEX</i>	<i>FREQUENCY</i>	<i>%</i>
1. Male	82	41.0
2. Female	118	59.0
<b>Total</b>	200	100



Table 5.2 shows that there were more females (59%) than males (41%) visiting the clinics.

Men tend to visit health services to a lesser degree than females (see Table 5.2). This is the case in most communities as the researcher has also found. One reason may be because men generally take a long time before seeking medical attention when they are not well. This may lead to complications, and is probably one of the reasons why they have a shorter life span than women. Another reason for fewer men to visit the clinic, may be the fact that men are taught from childhood to be strong and to endure pain. Society instills into their minds the idea that visiting health services means they are weak, and that such a practice is expected of women.

This situation, although not very grave, as the gap between the two percentages is not very wide, may pose problems for the health educator on AIDS. Men are identified in the literature as a group on whom AIDS preventive endeavours need to be focused. This is because men constitute a group more prone to contracting AIDS as they have difficulty in agreeing to use condoms. Any strategy used with men should therefore rather emphasize a change in attitude and promote other safe sex practices (see Chapter 1, section 1.2.1). Men are also said to be protected by societal norms. Sexual excesses, when practiced by men are seen as prestigious. This protection also reinforces the traditional attitude of male supremacy and male sexual prowess (Mokhobo, 1989(a):18).

Health educators are therefore not only faced with the challenge of educating men, but also of ensuring that they reach them wherever they are if they want to achieve results with their AIDS preventive efforts. It is suggested in the literature (Van Wyk, 1991:5-8) that this can be accomplished through the development of an AIDS education program for the workplace, where most men congregate (see Chapter 2, section 2.4.4).

### 5.2.3 Distribution according to occupation

**Table 5.3:** *Frequency distribution according to occupation.*

OCCUPATION	FREQUENCY	%
1. Medical	27	13.5
2. Teaching	14	7.0
3. Labourers	33	16.5
4. Unemployed	57	28.5
5. Student	40	20.0
6. Home executive	8	4.0
7. Administrative	17	8.5
8. Security/Safety	4	2.0
<b>Total</b>	<b>200</b>	<b>100</b>

Table 5.3 indicates that 52.5 % of the respondents were not earning a salary. This includes the home executive (4%), the unemployed (28,5%) and students (20%).

The reason why most of the respondents were either not gainfully employed (52,5%) or were labourers (16.5%) could be attributed to the fact that the study was conducted just after the introduction of free health services in the country. The

introduction of free health services has resulted in longer queues at clinics due to staff shortages and in some cases abuse of health services. People who can afford private health care have therefore decided not to visit clinics, as they do not want to stand in long queues. Those who do not mind the long waiting time, however, still make use of clinics as represented by the 31% of employed categories in the sample.

According to the researcher's observation, most people in Mangaung that are unemployed or labourers are minimally educated. According to Hyde (1992:26), this group tends to reject educational programs either because they are constructed in English or Afrikaans or because, due to their lack of education, they fail to comprehend the underlying principles (see Chapter 1, section 1.2.1). This provides the health educator with a good opportunity to educate this group on the prevention of AIDS as they are quite a lot (49%) at clinics. It is also stated that unemployed people sometimes engage in sexual intercourse out of boredom. If this is the case, they are just the correct target group for the health educator in the health service. Because students are still learning they have an open mind. They are also the right target group for the health educator.

#### 5.2.4 Distribution according to home language

*Table 5.4: Frequency distribution according to home language*

HOME LANGUAGE	FREQUENCY	%
1. S. Sotho	92	46.0
2. Tswana	54	27.0
3. Xhosa	42	21.0
4. Zulu	12	6.0
<b>Total</b>	200	100

Table 5.4 indicates that most (46 %) of the respondents were Sotho speaking, while 27 % were Tswana speaking.

The probable reason why most respondents (94%) in this study were South Sothos, Tswanas and Xhosas can be ascribed to the fact that Mangaung is a home for these three ethnic groups. Burnard (1992:40) feels that the AIDS educator must be a health professional who is trained in sexuality education, substance abuse education, small group and community process, racial and ethnic variations as well as individual and family dynamics (see Chapter 3, section 3.4). If the situation of appointing a local person as a health educator could be acceptable to the community of Mangaung, then the health educator would probably be a person able to speak one or all the languages spoken in Mangaung. This would make the task so much easier and would also help her/him to be acceptable to the community.

### 5.2.5 Distribution according to highest qualification obtained

*Table 5.5: Frequency distribution according to highest qualification obtained.*

QUALIFICATION	FREQUENCY	%
1. Grade 4 or lower	20	10.0
2. Grade 5 to 8	39	19.5
3. Grade 9 to 10	35	17.5
4. Grade 11 to 12	60	30.0
5. Diploma.	26	13.0
6. Degree	20	10.0
<b>Total</b>	<b>200</b>	<b>100</b>

Table 5.5 indicates that very few people in the research (23 %) had either a diploma or a degree as their highest qualification. Most of the respondents (77%) did not have any tertiary education.

The reason why only 23% of the respondents had tertiary education, with the majority (77%) having standard 10 or below as their highest academic achievement, might be because in general, the community of Mangaung is according to the researcher's opinion, not highly educated. Another reason may be that the study was conducted during the day, when educated people may have been at work.

This might pose a problem for the health educator as it is more difficult to give health education to people with a low level of education than it is to educate a generally educated audience (see Chapter 1). However, according to the researcher's personal experience, it is sometimes difficult to change the perceptions of educated people as they have already internalized certain principles. The fact that the community of Mangaung may be generally not highly educated might therefore be just the relevant situation to educate them on the prevention of AIDS, and try and change their attitude and behaviour.

## 5.2.6 Existing Acquired Immune Deficiency Syndrome (AIDS)

### knowledge

**Table 5.6: Frequency distribution indicating how respondents see their present knowledge of AIDS.**

KNOWLEDGE OF AIDS	FREQUENCY	%
1. Very good	14	7.0
2. Good	57	28.5
3. Average	69	34.5
4. Limited	37	18.5
5. Very limited	23	11.5
<b>Total</b>	200	100

According to this table 70 % of the respondents indicated that they have knowledge of AIDS whilst 30 % was according to them, limited. Perhaps the reason for this fairly high percentage is that about 13.5 % of the respondents worked in the medical field (see Table 5.3), and some of the students had some medical knowledge, as they were student nurses. This was evident as the data collection instrument was an interview schedule.

It is surprising that the incidence of AIDS is so high and continues to rise in spite of the fact that such a high percentage of respondents were knowledgeable about the disease. A possible reason for this state of affairs may be, as shown in the literature, that knowledge alone will not bring about a change in behaviour.

Another possibility is that communities may view themselves as having knowledge of AIDS, whereas their knowledge consists only of superficial facts provided in the mass media. Most of the respondents (53%) in this study learnt about AIDS from the mass media (see Table 5.7). As stated by Evian (1994:231), the mass media comprise the most accessible source of information to the general public, and have a great influence on many people, especially teenagers. The same mass media however often publish sexy pictures and advertisements that promote sex. According to Shikhibane (1993:21) people often cling to what they have seen on television, heard over the radio or read in newspapers prior to getting factual information (see Chapter 1, section 1.2.1). Health educators must therefore emphasize facts so that people are able to critically evaluate what they get from the media.

Whether the mass media contributed to an in-depth knowledge of AIDS or not is an open question and cannot be explained by this investigation. It is, however, possible that they merely contributed to an awareness of AIDS owing to the all-embracing prominence this subject received from the mass media.

### **5.2.7 Places where respondents learnt about Acquired Immune Deficiency Syndrome (AIDS)**

Table 5.7 shows that hospitals and clinics provided AIDS knowledge to 18.5 % of the respondents respectively.

**Table 5.7: Frequency distribution of places where respondents learnt about Acquired Immune Deficiency Syndrome**

PLACE	FREQUENCY	%
1. Hospital	37	18.5
2. Clinic	37	18.5
3. Mass media	106	53.0
4. AIDS training centre	6	3.0
5. Friends	6	3.0
6. Church	0	0
7. School	7	3.5
8. Any other ( specify)	1	0.5
<b>Total</b>	<b>200</b>	<b>100</b>

The fact that 37% of the respondents received information about AIDS from clinics and hospitals combined is understandable, as health services are places where information on health issues should be disseminated. A challenge to professionals dealing with health education is perhaps that they must make sure that the information disseminated through the mass media is factual and in-depth information and not merely awareness of AIDS. This can be accomplished by buying time slots from the media such as radio and television, in which professionals themselves disseminate information. The Free State Department of Health is already utilizing this strategy. More emphasis should be placed on the control of AIDS, particularly as the Free State, according to Cremers (1993:39), had one of the highest HIV infection rates in the country in 1993 (see Chapter 1, section 2.2).



Presently, the Free State has the third highest HIV infection rate of 17,49% after the North West (25,13%) and KwaZulu-Natal (19,90%). The rate in the North West is however said to be a possible over estimate of the true situation. This is because of a lack of existence of good historical data of the epidemic in this province, unlike in all other provinces (AIDS, Scan, 1997:5).

### 5.2.8 Preference for an educator on Acquired Immune Deficiency Syndrome (AIDS)

*Table 5.8: Frequency distribution of preference for an AIDS educator.*

PREFERENCE	FREQUENCY	%
1. Nurses	112	56.0
2. Social worker	4	2.0
3. Doctors	38	19.0
4. AIDS sufferers	38	19.0
5. Traditional healers (sangoma)	0	0
6. Peer educators such as trained co-worker	8	4.0
<b>Total</b>	200	100

Most respondents in the research group (75%) preferred to receive information on AIDS from nurses and medical doctors. This preference may be influenced by the fact that AIDS is a disease. Respondents may therefore presume that medical doctors and nurses have first hand information about the disorder. The fact that none of the respondents give preference to traditional healers on this issue must be viewed in the

light of the specific nature of AIDS as a disease. This does not mean that the research group necessarily rejects traditional healers for other purposes. In fact it has been clearly documented in the literature that black AIDS patients often seek medical attention at a very late stage because they believe in treatment by traditional healers (Lachman, 1991:297-298). The zero percentage could possibly indicate that people are aware that there is no cure as yet for AIDS as shown by the fact that 87,5% of the respondents believed this to be the case (see Table 5.9). The reason for this percentage could not be established through this study.

The fact that social workers were preferred by such a small percentage (2%) is worrying, because AIDS, being a condition complicated by psycho-social factors (see Chapter 3, section 3.3), the social worker would be a very suitable person as an educator and counselor. Perhaps respondents are aware of the distinction between health education and counselling and therefore wish to have the two separated. However, with a multi-disciplinary approach that is being adopted in health care, social workers will always be part of the health team and provide the counseling that is so crucial in the education and care of patients with AIDS and those infected with the HIV.

Persons suffering from AIDS are increasingly being utilized in the dissemination of information about AIDS. As this is a highly emotional subject that requires the AIDS sufferer to be well prepared and highly motivated, it should be used with great caution. The researcher has personally observed this approach being employed in

television programs and at the local AIDS Training, Information and Counseling Centre (ATICC). The fact that 19% of the respondents also prefer this approach could be because they have observed it in use and liked it, or that they believe that the AIDS sufferer will be giving them first hand information obtained through personal experience. The fact that experience is the best teacher has been widely documented in the literature.

Hyde (1992:39), however, suggests that for economic reasons a peer educator could be used to give health education on AIDS in the workplace. This is an employee who is specially trained to conduct health education activities aimed at his fellow employees. This strategy has apparently been widely used with success (see Chapter 3, section 3.4). It is, however, unfortunate that in Mangaung, AIDS education by a peer educator does not seem to be popular as reflected by the very small percentage of respondents (4%) who preferred this approach (see Table 5.8).

### **5.2.9 Knowledge on different aspects of Acquired Immune Deficiency Syndrome (AIDS)**

Table 5.9 shows that 91% of the respondents are aware that AIDS is transmitted mainly through sexual contact. However, 55% of the respondents wrongly believed that HIV is the other name for AIDS and not its causative virus.

**Table 5.9: Frequency distribution in respect of respondents' general knowledge on AIDS.**

	<i>YES</i>		<i>NO</i>	
	<i>Frequency</i>	<i>%</i>	<i>Frequency</i>	<i>%</i>
Is AIDS mainly a sexually transmitted disease?	182	91	18	9
Is HIV the other name for AIDS?	111	55	89	44.5
Is the possibility of contracting AIDS less when one sticks to one uninfected sexual partner?	191	95.5	9	4.5
Is there a cure for AIDS?	25	12.5	175	97.5
Does AIDS only affect gay people?	17	8.5	183	91.5
Can children be affected by AIDS?	180	90	20	10
Is it possible for heterosexual people to contract AIDS?	194	97	6	3
Does correct condom use prevent AIDS?	184	92	16	8

Almost all the respondents (95.5%) were aware that sticking to one uninfected sexual partner would reduce the risk of contracting AIDS. The vast majority (87,5%) respondents knew that there is no cure for AIDS. Ninety per cent of the respondents were aware that AIDS could affect children, while most (91,5%) were aware that AIDS does not only affect gay people. Almost all the respondents (97%) knew that AIDS could also affect heterosexual people. Finally this table shows that 92% of the respondents were aware of the fact that correct condom use does prevent AIDS.

The conclusion from the above information is that the community has enough knowledge on HIV infection and AIDS. The rate of infection of HIV however continues to escalate. This shows that knowledge alone will not bring about a change

in behaviour. There is therefore a need to provide education on how to change risky sexual behaviour.

It is shocking to discover that in spite of the fact that such a high percentage (91%) of the respondents knew that AIDS is mainly a sexually transmitted disease and that correct condom use prevents it (92%), there are still so many problems experienced with the use of condoms during sexual intercourse. In some instances it is not only the men who resist using them as stated in the literature study (see Chapter 1, section 1.2.1.1), some women at risk of infection with HIV also refuse to use condoms and state that they find them unpleasant or an unwanted reminder of AIDS (Mayes *et al.* 1992:504). Even when they are aware that their partners may be infected with the HIV, some women are said to feel obliged to share in the plight of their partner, or are willing to sacrifice rather than communicate a lack of rejection to their infected partners (see Chapter 2, section 2.4.2).

The fact that 55% of the respondents wrongly believed that HIV was the other name for AIDS rather than being the causative virus may be due to the fact that there is a general lack of knowledge of the difference between these two concepts. Some people, even in the medical profession, still cannot make a proper distinction between them. It is important to clarify the misconception through health education as the confusion may influence the effect of education concerning the avoidance of exposure to infection with the HIV through contact with the blood and genital secretions of infected people.

Although the percentage of people who believe that there is a cure for AIDS is small (12,5%), it is a cause for concern as these few people may, in the absence of factual information on this aspect, disseminate this fallacy, thereby negating the effect of health education. Keeling (1993: 263-264) and Kuykendall (1992: 26-27) support the fact that myths and fallacies may negate the effect of health education (see Chapter 2, section 2.3.4).

Although quite small (8,5%), the percentage that believed that AIDS affects only gay people this is a cause for concern because this fallacy may encourage heterosexual people to be promiscuous hoping that they will not contract AIDS. This would be a very dangerous practice, as the transmission of AIDS through heterosexual intercourse will also cause transmission to children conceived through such contact. Heterosexual transmission is identified in the literature as accounting for 80% of AIDS cases (see Chapter 2, section 2.3.5).

It was comforting to note that such a high percentage (90%) of the respondents knew that AIDS could affect children. Whether they knew how transmission to children occurs is beyond the scope of this research. It is however, clear from the literature that children are mostly infected through the vertical HIV transmission route (from the mother through the placenta to the foetus), or by passing through the birth canal if the mother is infected (see Chapter 2, 2.3.3). However, Van Ammers (1990:304) believes that the risk of the infection of the children through the vertical HIV transmission is quiet small. Perhaps, this percentage of respondents is worried by the

emerging trend these days of children being infected through sexual abuse by HIV positive men. The myth that raping a child will rid the rapist of the HIV positive status and render him negative demands particular attention in the health education program.

Finally, in the light of the extent of promiscuity in communities it was shocking to see that almost all the respondents (95,5%) are aware that the possibility of contracting AIDS is lesser when one sticks to one uninfected sexual partner. This is in agreement with the literature that knowledge alone will not necessarily bring about a change in behaviour. Perhaps this is because in the African society, sexual promiscuity, whether called concubinage or prostitution is not likely to endure any stigma of disapproval as it is part of accepted cultural practices and traditional beliefs (see Chapter 1, section 1.2.1). It is therefore important that the education program on AIDS also focuses on efforts to help people change such risky sexual practices.

#### **5.2.10 Knowledge of the transmission of Acquired Immune Deficiency Syndrome (AIDS)**

Table 5.10 shows that 99% of the respondents agree that HIV is mostly transmitted through sexual contact; while 75.5% agree that it can be transmitted through breast feeding.

**Table 5.10: Frequency distribution based on the respondents' knowledge of the transmission of AIDS.**

	<i>YES</i>		<i>NO</i>	
	<i>Frequency</i>	<i>%</i>	<i>Frequency</i>	<i>%</i>
Is it true that HIV is mostly transmitted through sexual contact?	198	99	2	1
Can HIV be transmitted through breast-feeding?	151	75.5	49	24.5

The fact that most of the respondents were aware that HIV is transmitted through blood (94%); that it is also transmitted through contact with genital secretions (97%); that most transmission occurs through sexual contact (99%) and that transmission of HIV can also occur through breast feeding (75,5%) does not necessarily mean that they will avoid exposing themselves to infection with the HIV. It has been clearly documented in the literature that knowledge alone will not bring about a change in risky sexual practices. Efforts must be made to change the attitude of people so as to bring about the replacement of risky sexual practices with health protective behaviour.

In view of the shocking rate at which the incidence of intravenous drug abuse is increasing in Mangaung as documented in the literature (see Chapter 2, section 2.3.5); it is surprising that such a high percentage (94%) of the respondents were aware of the fact that this practice can expose them to contracting AIDS. The fact that HIV is transmissible through the intravenous route is supported by the literature (AIDS Bulletin, 1991:8).



As stated earlier in this chapter, it is surprising that with so many respondents aware of the fact that contact with the genital secretions of an infected person through unprotected sexual contact, people still engage in risky sexual practices such as unprotected sexual intercourse. It is therefore true that knowledge about AIDS alone will not change behaviour.

The results of this study are in contrast with findings reported in the literature that people believe that the risk of transmission of HIV through breast-feeding is very small. This is indicated by the 24,5 % of the respondents who stated the opposite.

Table 5.10 therefore shows that the community is generally aware that AIDS is mostly transmitted through sexual contact.

### **5.2.11 Knowledge of high risk behaviour as far as Acquired Immune Deficiency Syndrome is concerned (AIDS)**

Table 5.11 indicates a good knowledge among respondents as far as high-risk behaviour in relation to AIDS is concerned. According to this table, 88,5% of the respondents were aware that HIV is transmitted from person to person. Almost all the respondents (99,5%) knew that people with more than one sexual partner engage

in high risk behaviour and that even those who do not engage in such behaviour are at risk if their sexual partners engage in risky sexual behaviour (98.5%). Generally, the respondents were aware that a person can contract AIDS through anal (92%), vaginal (99%) and oral sexual intercourse (88,5%). The apparent high level of knowledge on the modes of transmission of HIV may be attributed to the all-embracing information campaign of the past few years.

It is, however, evident that the efforts of the various sectors such as health, social welfare, education, as well as the priority given to the subject of AIDS in the mass media have provided people with knowledge but have not succeeded in changing their risky sexual behaviours. This is evident from the fact that the literature as well as personal observation by the researcher still provides evidence of risky sexual practices. These includes practices such as extra-marital relationships, polygamous marriages, intravenous drug abuse where many people use the same needle, skin piercing by traditional healers using one blade over and over again, as well as homosexual activities, where partners use the anal and the oral routes for sexual intercourse (Chapters 1 and 2).

**Table 5.11: Frequency distribution based on the respondents' knowledge of high-risk behaviour as far as AIDS is concerned**

	<i>YES</i>		<i>NO</i>	
	<i>Frequency</i>	<i>%</i>	<i>Frequency</i>	<i>%</i>
Does transmission of HIV occur from person to person?	177	88.5	23	11.5
Is the risk of infection with AIDS based on exposure to HIV?	187	93.5	13	6.5
Do people that have more than one sexual partner engage in high-risk behaviour?	199	99.5	1	.5
Are people whose sexual partners engage in risky behavior also exposed to HIV infection even if they themselves do not engage in high-risk behaviour?	197	98.5	3	1.5
Can a person contract AIDS through anal sex?	184	92	16	8
Is it possible to contract AIDS through vaginal sex?	198	99	2	1
Is HIV transmissible through oral sex?	177	88.5	23	11.5

### **5.2.12 Psycho-social effects of infection with Human Immune Deficiency Virus (HIV) and contracting Acquired Immune Deficiency Syndrome (AIDS)**

From table 5.12 it is clear that 95% of the respondents agreed that it is important that the fact that fatigue and weakness associated with AIDS can adversely affect the performance of daily activities, should be included in AIDS education programs.

This is in agreement with sources in the literature, which state that although the emotional and physical cost of caring for a family member with AIDS is high, so are the rewards. Turton (1992:31) states that it is satisfying for the family to look back and say that although they could not share in the pain, they shared in the experience of the family member who was suffering (see Chapter 2, section 2.4.3).

**Table 5.12: Frequency distribution in respect of the need to include the psychological effects of AIDS and HIV infection in educational programs on AIDS.**

	Definitely agree		Agree		Uncertain		Disagree		Definitely Disagree	
	n	%	n	%	n	%	n	%	n	%
Fatigue and weakness can affect the performance of daily activities.	79	39.5	111	55.5	6	3	3	1.5	1	.5
The AIDS patient feels unwanted and uncared for.	82	41.0	110	55.0	6	3	2	1	0	
Emotional disturbances, social disruption and withdrawal are often experienced by the patient.	76	38	118	59	4	2	2	1	0	
The person's self-image and emotional balance is affected by AIDS.	80	40	113	56.6	5	2.5	2	1	0	
The patients fears acute illness	136	68.0	58	29.0	5	2.5	1	.5	0	
A fear of death exists in AIDS patient.	148	74.0	38	19.0	4	2	6	3	4	2
The AIDS patient experiences a loss of concentration.	69	34.5	98	49.0	28	0	5	2.5	0	
There is a fear of being isolated by society.	82	31	113	56.6	4	2	1	.5	0	
Stigmatization of the person with AIDS leads to social isolation	69	34.5	124	62	4	2	1	.5	0	

This table also shows that 73.5% of respondents agreed that there is a need to include the fact that AIDS patients experience a loss of concentration. This

information is important as a lack of concentration may pose problems for the health educator, who may have to structure the teaching to accommodate the patient's lack of concentration.

Employers must also be involved, as a lack of concentration will also affect productivity at work. The fact that 96,5% of the research group agreed that the education must also focus on the fact that AIDS patients experience problems with their self-image and emotional balance, will provide family members and friends with the patience to encourage the patient to care for himself as before. This information will also provide them with the ability to understand why the patient has lost his self-image.

Finally, 96.5% respondents agreed that the community must be made aware of the fact that stigmatization of the person with AIDS leads to social isolation. It is surprising to see such a large percentage of awareness as it is obvious from the literature that AIDS sufferers are often stigmatized and isolated due to the fact that they feel that they might be infected through casual contact and the sharing of fomites as well as through residential, academic, social, recreational or occupational contact (Shikhibane, 1993:11). Fomites such as shared tooth brushes may, however, cause contact with blood and thereby cause HIV transmission as they lead to bleeding from the gums (Department of Health, 1994:9). The sharing of tooth brushes between family members still occurs in some families either due to poverty or due to a lack of health information (see Chapter 2, section 2.3.4).

The agreement by the research group that communities should be educated about the effect of psychosocial factors on the AIDS patient is supported in the literature. It has also been clearly documented that such education is necessary to improve the care given by health professionals as well as the support by friends, relatives and the community at large (Lachman, 1991:292-293; Evian, 1993:235).

### 5.2.13 Motivation of persons to avoid risky sexual behaviour and adopt Acquired Immune Deficiency Syndrome (AIDS) preventive behaviour.

**Table 5.13: Frequency distribution in respect of demographic factors to be taken into consideration in assessing a person's resistance to or acceptance of a change in risky sexual behaviour**

	Definitely agree		Agree		Uncertain		Disagree		Definitely Disagree	
	n	%	n	%	n	%	n	%	n	%
Age is an important factor in AIDS preventive health education	99	49.5	64	32	18	9.0	16	8.0	3	1.5
A person's sex may influence his/her acceptance of AIDS preventive health education	92	46.0	62	31.0	20	10.0	21	10.5	5	2.5

Table 5.13 indicates that 81.5% of the respondents agreed that age is an important factor in health education about AIDS and should therefore be taken into

consideration when assessing whether or not a person will be willing to accept advice to change risky sexual practices or not.

Seventy-seven per cent of the respondents agreed that the sex of an individual might influence his/her acceptance of AIDS preventive health education. Some people may be resistant due to the fact that they are of a particular sex.

The need to consider sex as a factor in assessing people is also supported in the literature (Mokhobo, 1989(a):18-19). Men in general, and black men in particular, are said to be difficult to educate regarding the prevention of AIDS. They are sometimes resistant to condom use and are promiscuous most of the time. They are protected by society as sexual excesses are said to show male prowess when practiced by men. This fact has been stated earlier in this chapter.

The fact that as many as 81,5% of the research group viewed age as an important factor to be considered in assessing whether or not a person will accept advice to change risky sexual practices; that most respondents (77%) agree that a person's sex may influence his/her acceptance of AIDS preventive health education is also supported by the literature (Richter & Swart-Kruger, 1955:31). It is clearly documented that adolescents are more prone to infection with the HIV as they experiment with risky sexual encounters, they abuse drugs and alcohol which affects their reasoning ability and they are under tremendous pressure from their peers, some adults and society in general succumb to peer pressure. Their mental state is

not yet stable enough to withstand this pressure and they are also said to lack assertive skills (see Chapter 3, section 3.2.1.1).

### 5.2.14 The influence of geographic factors on an individual's willingness to accept health education on Acquired Immune Deficiency Syndrome (AIDS)

**Table 5.14: Frequency distribution in respect of the influence of geographic factors on an individual's willingness to accept health education on AIDS**

	Definitely Agree		Agree		Uncertain		Disagree		Definitely Disagree	
	n	%	n	%	n	%	n	%	n	%
A person's geographical area may influence his/her acceptance of health education on AIDS.	44	22	83	41.5	55	27.5	15	7.5	3	1.5

Table 5.14 indicates that 63.5% of the respondents agreed that geographical area may influence one's acceptance of health education about AIDS and must therefore be considered when developing AIDS health education programs for communities.

The fact that 63,5% of the respondents agreed that the geographical area may influence an individuals acceptance of health education about AIDS does not mean that people from some geographical areas must be prejudiced when giving health education to communities. It does mean that this is an important factor and it should be considered when assessing whether or not a particular person will accept health education with ease. Research has found that societal norms in urban areas are more



permissive than those in rural areas. This may make it more difficult for people coming from urban areas to abandon risky and permissive sexual practices and adopt AIDS preventive practices (see Chapter 3, section 3.2.1.1).

### 5.2.15 The influence of a person's sexual orientation on his/her willingness to abandon risky sexual behaviour

**Table 5.15: Frequency distribution in respect of the influence of a person's sexual orientation on his/her willingness to abandon risky sexual behaviour.**

	Definitely Agree		Agree		Uncertain		Disagree		Definitely Disagree	
	n	%	n	%	n	%	n	%	n	%
Homosexuality is an important factor to be borne in mind in evaluating the person's willingness to abandon risky sexual behavior	111	55.5	49	24.5	24	12	14	7	2	1
Heterosexuality will influence a person's acceptance of preventive health education on AIDS	108	54	57	28.5	20	10	12	6	3	1.5

According to the table above, 80% of the respondents agreed that homosexuality is an important factor to be borne in mind in assessing a person's resistance to or acceptance of health education regarding changes to risky sexual behavior. Eighty-two point five per cent of respondents agreed that heterosexuality is an important factor as it may also influence acceptance of motivation to abandon risky sexual practices.

The fact that there was general agreement that sexual orientation may influence a person's willingness to abandon risky practices is in agreement with literature in this regard (Kuykendall, 1992:26). The link between homosexuality and exposure to HIV infection and AIDS has been widely documented. Because homosexuals are not able to satisfy the sexual urge through the heterosexual route, they tend to resort to the anal and oral routes. This makes them more prone to infection as the oral and anal mucosa is delicate and breaks easily. Homosexuality, just like heterosexuality is a way of life. It is so ingrained in a person's life that it is almost impossible to change even if the individual has been made aware of the danger of contracting AIDS associated with this practice (see Chapter 2, section 2.4.2).

According to McGavock (1994:20), the fact that people associate AIDS with homosexual activities may make heterosexual people ignore advice to adopt AIDS protective behaviours and end up contracting AIDS.

#### **5.2.16 The influence of socio-economic factors on an individual's acceptance of health education on Acquired Immune Deficiency Syndrome (AIDS)**

From table 5.16 it is clear that 81.5% of the respondents agreed that assertiveness (ability to resist group pressure) would help a person to avoid risky sexual practices. Almost all (96 %) of the respondents agreed that sufficient and relevant AIDS knowledge will help motivate people to accept preventive health education on AIDS.

Finally, it is clear from this table that most (90.5%) of the respondents agreed to the fact that due to their risky sexual behaviour, teenagers constitute an important risk factor as far as the future spread of AIDS is concerned.

**Table 5.16: Frequency distribution in respect of the influence of socio-economic factors on individual's acceptance of health education on AIDS.**

	Definitely agree		Agree		Uncertain		Disagree		Definitely Disagree	
	n	%	n	%	n	%	n	%	N	%
Poverty may influence a person's acceptance of health education on AIDS	23	11.5	83	41.5	62	31	24	12	8	4
A person's level of education will influence his acceptance of AIDS preventive health education	102	51	65	32.5	17	8.5	15	7.5	1	.5
Cultural beliefs may influence acceptance of AIDS preventive health education	49	24.5	97	48.5	36	18	15	7.5	3	1.5
Traditional practices may affect acceptance of health education on AIDS	48	25	97	48.5	43	21.5	11	5.5	1	.5
The abuse of alcohol may affect acceptance of health education on AIDS	136	68	35	17.5	17	8.5	11	5.5	1	.5
The abuse of drugs will influence a person's willingness to abandon risky sexual practices	135	67.5	41	20.5	13	6.5	6		2	1
Assertiveness will help a person to avoid risky sexual practices	129	64.5	34	17	27	13	9	4.5	1	.5
Sufficient and relevant AIDS knowledge will help in motivating a person to accept preventive health education on AIDS	156	78	36	18	6	3	1	.5	1	.5
Teenagers and their risky sexual behaviour constitute an important risk as far as the future spread of AIDS is concerned	147	73.5	34	17	9	4.5	6	3	4	2

From table 5.16 it is clear that 53% of the respondents agree that poverty may influence a person's acceptance of health education on AIDS. Eighty-five per cent of the respondents agreed that a person's level of education would influence his/her acceptance of AIDS preventive health education. The abuse of alcohol was seen by 85.5% of the respondents as an important aspect to be considered in assessing a person's readiness to abandon risky sexual behavior and accept AIDS preventive education. Most (89%) of the respondents agreed that the abuse of drugs will influence a person's willingness to abandon risky sexual practices. Cultural beliefs and traditional practices were seen by 73% and 73,5% of the respondents respectively as crucial to the assessment of a person's willingness to accept preventive AIDS health education.

In view of the high percentage of respondents who agreed that these factors will affect the impact of AIDS preventive health education, it is clear that the community desires that these factors be included in health education programs for the prevention of AIDS and transmission of HIV.

The fact that a large percentage of the respondents (53%) agreed that poverty may influence a person's acceptance of health education on AIDS tallies with research findings as these show that some women resort to becoming sex workers for financial gain. Some agree to sexual intercourse with men in the hope that these men will provide them with accommodation and financial support (see Chapter 1, section 1.2.1).

Level of education is also viewed as having an influence on one's acceptance of health education about AIDS (83,5%). This fact is supported in the literature by the finding that a lack of education is cited as one of the barriers that hamper AIDS education in black communities (Zazayokwe, 1990:9). Poor education is associated with the inability to comprehend principles of prevention. There is also a definite link between lack of education and poverty, as poorly educated people find it difficult to get employment. Poverty has been cited above as increasing a person's risk of contracting AIDS.

The fact that 85,5% and 89% of the respondents respectively agreed that the use of alcohol and drugs are important aspects to be considered in assessing a person's readiness to abandon risky sexual behavior and accept AIDS preventive education may be attributed to the fact that alcohol and drugs have been found to lessen inhibitions. This therefore lessens the ability to negotiate protection with a condom or to make a responsible decision whether or not to go ahead with sexual intercourse.

Most respondents (73% and 73,5% respectively), felt that cultural beliefs and traditional practices are also important in the assessment of people since traditional practices such as concubinage and polygamy (as seen today) are documented as still acceptable in the black culture. These beliefs and practices can predispose people to infection with the HIV if the partners in a polygamous relationship are not honest and have other sexual contacts outside the marriage. This may also be the case if the

sexual partners were not free from infection before entering the polygamous marriage (see Chapter 1, section 1.2.1).

Assertiveness was seen by the majority of the respondents (81,5%) to help a person avoid risky sexual practices. This may be necessary where the peer group or societal norms force individuals to conform. It has been stated earlier in this text that adolescents are particularly at risk as they lack the assertiveness to resist group pressure (see Chapter 2, section 2.3.2). This fact is also supported by the view of 90,5% of the respondents in this study who agreed that due to their risky sexual behaviour, teenagers constitute an important risk factor as far as the future spread of AIDS is concerned.

The fact that almost all the respondents (96%) felt that sufficient and relevant AIDS knowledge will help in motivating a person to accept preventive health education on AIDS does not mean that knowledge alone will bring about a change in behaviour. It has been widely documented in the literature that giving relevant and sufficient AIDS knowledge is a starting point to a change in risky sexual practices. It should be followed by definite motivational strategies for changing attitudes and behaviour. As stated earlier in this text the identification and implementation of such strategies, is beyond the scope of this study.

## **5.4 SUMMARY**

Data analysis and the interpretation of results were discussed in this chapter. Conclusions, recommendations and guidelines for the development of a health education program aimed at the control of AIDS will be dealt with in the next chapter.

## **CHAPTER 6**

### ***Recommendations and guidelines for the Development of a Health Education Program***

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#### **6.1 INTRODUCTION**

In this chapter, recommendations based on the findings of the study are drawn. These will serve as guidelines for the development of the health education program for the control of AIDS.

#### **6.2 THE HEALTH EDUCATION PROGRAM**

There is a drastic increase in the number of persons infected with AIDS in spite of existing efforts to combat this disease. This is a worldwide problem, with most new cases among the black population. A number of reasons for this increase have been identified as outlined in chapter one. A need therefore exists for the identification of the needs of the black community as far as AIDS education is concerned. This would help in the development of a health education program that will be acceptable to them, with their full participation and that will help them in changing risky sexual practices and adopt AIDS preventive behaviour.



Although it is evident that knowledge alone will not bring about a change in behaviour, AIDS education remains a good starting point for any preventive campaign on AIDS. It is however important first to evaluate the extent of knowledge possessed by communities, to assess other modifying factors in the changing of perceptions of individuals to those that are relevant to actions aimed at changing risky sexual behaviour and taking preventive action against the spread of AIDS. There is also a great need for the community to be supported towards a change in behaviour. This will promote ownership of the program by the community as well as the development of a program that is acceptable to such a community.

According to the Health Belief Model, the likelihood of taking preventive action starts with the person seeking more information on the particular condition (see Figure 3.2). The process then proceeds towards a situation where perceived benefits of preventive action will motivate individuals to avoid risky sexual behaviour. Seeing that the results of this study show that the community is knowledgeable on AIDS, it is therefore recommended that the program should rather focus on informing them on the benefits that they will get from adopting AIDS preventive actions. These will be highlighted as safe sexual practices as outlined in chapter one. The Health Belief Model further stipulates that it is only when people perceive such benefits that they will adhere to safe sex practices.

The Health Belief Model therefore suggests that individuals be assisted with self-assessment of their capabilities and motivation in carrying out the recommended preventive health measures. It is also clear from the findings of this study that the community agrees that individuals should be assessed as far as their motivation to accept the adoption of health protective behaviour (see Table 5.13). To be able to motivate people to abandon risky sexual practices and adopt health-protecting behaviour, the application of the Health Belief Model was therefore found most suitable. This model has, however been modified to make it suitable for this study (see Figure 3.1).

#### **6.2.1 Content of the health education program**

According to the results of this study, the community expresses a need to be educated on the effects of the psycho-social factors associated with HIV infection and AIDS on the person (see Table 5.12). This, they feel will help them to be able to understand the person better and be able to support him. If people are helped to see how a person with AIDS suffers from the various effects of this disease, they may be motivated to abandon risky sexual practices so that they themselves do not suffer the same way.

The community also feels that demographic factors, geographical factors, a person's sexual orientation, as well as socio-economic factors need to be considered when assessing whether a person would accept or resist motivation to

abandon risky sexual behaviour and adopt AIDS preventive behaviour (see Tables 5.13, 5.14, 5.15 and 5.16). It is therefore recommended that the above factors be included in the health education program as suggested by the findings of this study.

The health education program should also include a component that addresses the relationship between behaviours, values and social responsibility. This can be accomplished by considering factors such as sexual orientation, psycho-social effects as well as socio-economic factors when assessing the person for acceptance of health education on AIDS.

It is evident from the literature study that the HIV is mostly transmitted through unsafe sexual contact, blood and through the intravenous route (AIDS Bulletin, 1991: 8-9). The health education program should therefore focus on the control of HIV transmission. Prevention strategies should target these three major modes of transmission. Sexual transmission, which accounts for more than 80% of cases might be reduced through correct condom promotion and supply, as well as motivation to change risky sexual behaviour. It is therefore advisable if problems associated with the use of condoms such as resistance by some people as well as the fact that some people are shy to ask for condoms can be addressed so as to strengthen this prevention strategy. It is suggested in the literature that condom-dispensing machines be placed at public places such as garages and hotels. As far as possible condoms should be supplied free of charge (Department of Health and Welfare, 1994:8).

The link between AIDS and other sexually transmitted infections has been clearly documented in the literature (Steinberg, 1993:4). The treatment of other sexually transmitted infections will therefore also help with the control of the sexual transmission of AIDS.

It is clear from the literature that there is no evidence of the transmission of HIV through contact with saliva, sharing of fomites such as eating utensils, touching, massage and other intimate behaviours that involve no contact with genital fluids (Cowan & Johnson, 1993:34). Findings of this investigation however show that most community members are knowledgeable on this aspect (see Table 5.10). It is however also stated in the literature that if fomites cause bleeding such as toothbrushes do, they may bring blood into contact with the delicate mucosal lining of the mouth. This may increase the risk of HIV transmission, as transmission through blood is one of the major modes of transmission (Department of Health, 1994: 9). The health education program should therefore also focus on the clearing of the myth that AIDS can be contracted through casual contact. Although it was a very small percentage of the community that had this believe (see Table 5. 10), this may hamper health education on AIDS as it may lead to the social isolation of the person with AIDS.

From the literature study, it is clear that the transmission of HIV may occur from infected mothers to their infants in utero through the trans-placental passage of the virus during labour and delivery. This will occur through exposure to the infected

maternal blood and vaginal secretions, or post-natally through breast-feeding. The risk of transmission of the HIV through breast feeding is however found to be so small that it is outweighed by the risk of gastro-intestinal infection involved in refusing the mother to breast feed and encouraging bottle feeding (Van Ammers, 1990:304). Findings of this research show that most community members (75,5%) are aware that AIDS can be transmitted through breast-feeding (see Table 5.10). The recommendation is therefore that the education program should focus on encouraging breast-feeding when artificial feeding is not affordable. Seeing that South Africa is still a developing country, it is not wise to discourage breast-feeding, as mothers may not be able to afford artificial feeding. The program should also address the fact that some community members think that HIV cannot be transmitted through breast-feeding (see Table 5.10).

### **6.2.2 Target group for health education**

In this study, the community of Mangaung constitutes the clientele receiving the health education on AIDS. This group should therefore be thoroughly assessed as far as their needs for health education as well as the existence of groups at risk within the community. This will help in tailoring the type of education according to identified needs and categories found in the community. The recommendation from this study is therefore that the development of the health education program for each community be preceded by a thorough assessment of the needs of such a

community as far as their needs for such health education. In this study, such needs have been identified and outlined earlier in this chapter.

Social issues such as teenage, promiscuity among heterosexuals, the abuse of drugs, the migrant labour system, poverty, illiteracy, travelling, homo/bi-sexuality and sex worker activities have been identified as factors that predispose individuals to AIDS. These are very crucial in the giving of health education on AIDS as they may constitute high-risk behaviour. This fact has been confirmed by a number of authors on this issue (see Chapter 1, section 1.2.1.1). The empirical investigation shows that the community requires that these factors must be borne in mind when giving them health education (see Tables 5.15 and 5.16). It is therefore recommended that these be included in the program and be utilized in assessing whether people will accept the health education or not.

Universally, it is evident in literature that adolescents have been found to be at a particular risk for contracting AIDS (Sankar & Karim, 1991: 24). They therefore constitute an important group as far as the future spread of AIDS is concerned. Findings of this study have also confirmed this fact (see Table 5.16). This is because adolescents engage in risk-taking behaviours such as drug as well as alcohol abuse and reckless sexual activities. They are also under extreme pressure from their peers, some adults and the social environment to involve themselves in such behaviour. Their mental state is still immature; they have behaviour problems and therefore lack the assertiveness to resist this pressure. It is therefore suggested

in the literature that adults and community leaders must teach young people to protect themselves and others against exposure to the HIV; and also that this education should start in early elementary school and at home (Jones, 1991: 592). The recommendation from this study is that such educational efforts be supported through giving special attention to the needs of the adolescents in the development and implementation of the health education program on AIDS.

Another group that needs special attention in AIDS health education is men. It is evident from this investigation that professionals are not able to reach men at the health services as very few men visit such services (see Table 5.2). Besides being protected by societal norms when they practice sexual excesses, it has been documented clearly in the literature that men have a difficulty in agreeing to use condoms during sexual intercourse (see Chapter 1, section 1.2.1.1). Any strategy used with men should therefore rather emphasize a change in attitude and promote other safe sex practices.

It is therefore recommended that health education be given wherever the client is. In public schools AIDS education should be part of a comprehensive program. This will help in the targeting of the youth as a group at risk of infection with the HIV. The youth constitute an important group in the future spread of AIDS. Most people dying of AIDS during adulthood were infected during their youth. This is because of the long latency period of HIV infection, which lasts from 8-10 years.

### 6.3 HEALTH EDUCATORS

The prevention of AIDS is not the responsibility of the health sector alone. The government, employers, educators, the private sector, families and friends of the HIV positive person, as well as the AIDS sufferer have a role to play. All these role players must be involved as consultants in the development and implementation of the health education program.

According to Burnard (1992:40), the program should be designed and implemented by professionals who are trained in sexuality education, education on substance abuse, small group and community process, racial and ethnic variations as well as family and individual dynamics. It is clear from this study that nurses, doctors and social workers are preferred by the community as health educators on AIDS (see Table 5.8). The above mentioned aspects are included in the basic curricula for the preparation of these professionals. Where these aspects are not addressed by existing curricula, such gaps in training of health professionals must be filled through in-service and continuing education.

Where peer educators or AIDS sufferers are utilized in the giving of health education on AIDS as preferred by some community members (see Table 5.8), it is recommended that these be thoroughly trained on the aspects mentioned above.



#### **6.4 METHODS OF HEALTH EDUCATION**

The program should be implemented in such a way that it reaches everyone. The entire population has a right to AIDS education. It is however evident that in some parts of the country it might be that some people do not receive this education. Cultural practices, age, sex, sexual orientation, geographical area, and any other factor that brings a difference in target audiences must however be borne in mind when undertaking the health education.

Based on the findings of this study it is recommended that the health education program should be implemented in such a way that it reaches all categories of the community. Groups that do not visit health services should be targeted wherever they are through outreach programs such as AIDS education at the workplace, at schools and at home during home visits.

The AIDS education should be adapted so that it is culturally acceptable to the audience. This can be accomplished through involvement of the target community throughout the development and implementation of the health education program. Developers and implementers of the health education program should preferably come from the community itself so that they can be in a better position to understand the culture and language of the community receiving the health education.

Health education on the prevention of AIDS should not be done in a haphazard manner. The needs of the community as far as the development of the health education program for the prevention of AIDS, as identified in this study, must be taken into consideration in the development and implementation of the program. In undertaking the health education, barriers to such education in black communities as presented in chapter one of this study should be borne in mind.

The education should include factual information and give opportunities for discussion and for individuals to ask questions and to explore their attitudes and emotional reactions (Hurley, 1992:45). To address this, AIDS education can be given using both the formal and the informal methods of instruction. Group and individual sessions will provide a valuable opportunity for individuals to ask questions and for catharsis.

## **6.5 MONITORING AND EVALUATION**

Monitoring and evaluation of the effect of the education on the community's behaviour and therefore on the prevalence of AIDS should be an integral component of the health education program. This will ensure flexibility in the implementation of the program. The recommendation here is that the educational program must be monitored regularly to check whether objectives of the health education are being met. Evaluation of the program should be done regularly with the aim of alteration of the program to ensure relevance whenever community

needs change. During evaluation of the program, special attention should be given to assessing whether it is succeeding in changing attitudes and risky sexual behaviours of target communities.

## **6.6 RECOMMENDATIONS FOR FURTHER RESEARCH**

From this investigation, the following recommendation for further research is made:

- That further research be undertaken on strategies necessary, over and above the giving of knowledge, to bring about a change in the attitudes and behaviour of communities as far as AIDS is concerned. These strategies will, as stipulated in the Health Belief Model, include factors that influence compliance with recommended preventive health measures such as risk appraisal, perceived outcome expectancy and self-efficacy (Ahia, 1991:49-51). It is evident from this study that the community does have knowledge on AIDS, but the rate of infection however still continues to escalate.
- That further research be undertaken to investigate the reason why only two percent respondents prefer social workers as educators on AIDS. This is crucial as AIDS is a psychosocial condition, and therefore requires the expertise of social workers.

## 6.7 SUMMARY

In this chapter, guidelines were set for the development of the health education program for the control of AIDS. The Health Belief Model was proposed as the model to be followed. An area for further research was identified as the development of strategies for effecting a change in the attitudes and behaviour of communities as far as AIDS is concerned.

Finally, the aim of this study, which was to identify the needs of the community for health education on AIDS, was reached. This study showed that the community of Mangaung has knowledge on most aspects of AIDS. This knowledge will therefore only be augmented through health education. Furthermore the community stated a need to be educated on psycho-social effects of HIV infection and AIDS. This will help them abandon risky sexual practices, as they will understand how the person suffers.

This study has shown a great need to go beyond the giving of knowledge by also assisting communities to change their attitudes and behaviour with regard to AIDS. This will be attained through making them perceive the benefits of preventive actions as far as AIDS is concerned. This will, as stated in the Health Belief Model, motivate them to avoid risky sexual behaviour and adhere to safer sex practices (see Figure 3.2).

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# *ANNEXURE A*

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An interview schedule to elicit information on the aspects to be addressed in a health educational program for the control of AIDS.

To the respondent

Kindly answer all the questions directed to you by the interviewer. The information is required solely for research purposes and will be treated as confidential. Your name or that of your institution will not appear anywhere on the documents.

# SECTION A

FOR OFFICE USE

## Biographical information

--	--	--	--

 1-4

1. Age

Younger than 16 years	1
16-20 years	2
21-25 years	3
26-30 years	4
31-35 years	5
36-40 years	6
41-45 years	7
46-50 years	8
51-55 years	9
56-60 years	10
61-65 years	11
Older than 65 years	12

--	--

 5-6

2. Sex

Male	1
Female	2

--

 7

FOR OFFICE USE

3. Occupation

	1
--	---

		8-9
--	--	-----

4. Home language:

	1
--	---

	10
--	----

5. Highest qualification:

Grade 4 or lower	1
Grade 5 to 8	2
Grade 9 to 10	3
Grade 11 to 12	4
Diploma	5
Degree	6

	11
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## SECTION B: Source of existing AIDS

FOR OFFICE USE

### knowledge

6. How do you see your present knowledge about AIDS?

Very good	1
Good	2
Average	3
Limited	4
Very limited	5

12

7. Where did you learn about AIDS? (Choose only one)

Hospital	1
Clinic	2
Mass media	3
AIDS Training, Information and Counselling Centre	4
Friends	5
Church	6
School	7
Any other (specify)	
	8

13

8. From whom would you prefer to receive education on AIDS? (Mark your first choice only.)

Nurses	1
Social workers	2
Doctors	3
AIDS sufferers	4
Traditional healers like sangomas	5
Peer educators like a trained co-workers	6

14

**SECTION C: Knowledge on different aspects of AIDS**

FOR OFFICE USE

9. Is AIDS mainly a sexually transmitted disease?

Yes	1
No	2

15

10. Is HIV the other name for AIDS?

Yes	1
No	2

16

11. Is the possibility of contracting AIDS lesser when one sticks to one uninfected sexual partner?

Yes	1
No	2

17

12. Is there a cure for AIDS?

Yes	1
No	2

18

13. Does AIDS only affect gay people?

Yes	1
No	2

19

14. Can children be affected by AIDS?

Yes	1
No	2

20



15. Is it possible for heterosexual people to contract AIDS?

Yes	1
No	2

 21

16. Does correct condom use prevent AIDS?

Yes	1
No	2

 22

### Knowledge on the transmission of AIDS?

17. Is HIV transmitted through blood?

Yes	1
No	2

 23

18. Is HIV transmitted through contact with genital secretions of an infected person?

Yes	1
No	2

 24

19. Is it true that HIV is mostly transmitted through sexual contact?

Yes	1
No	2

 25

20. Can HIV be transmitted through breastfeeding?

Yes	1
No	2

26

FOR OFFICE USE

### Knowledge on high risk behaviour patterns

21. Does transmission of HIV occur from person to person?

Yes	1
No	2

27

22. Is the risk of infection with AIDS based on exposure the HIV?

Yes	1
No	2

28

23. Do people that have more than one sexual partner engage in high risk behaviour?

Yes	1
No	2

29

24. Are people whose sexual partners engage in risky behaviour also exposed to HIV infection even if they themselves do not engage in high risk behaviour?

Yes	1
No	2

30

25. Can a person contract AIDS through anal sex?

Yes	1
No	2

31

FOR OFFICE USE

26. Is it possible to contract AIDS through vaginal sex?

Yes	1
No	2

32

27. Is HIV transmissible through oral sex?

Yes	1
No	2

33

**SECTION D: Psychological effects of HIV infection and AIDS**

FOR OFFICE USE

If individuals are educated on and they understand the negative psychological effects of AIDS/HIV, they might be motivated to abandon risky sexual behaviour and adopt AIDS preventive behaviour. Indicate the response that best describes your opinion as to whether these facts should be included in the health educational program or not.

28. Fatigue and weakness due to AIDS can adversely affect the performance of daily activities.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

34

29. The AIDS patient experiences a feeling of being unwanted, uncared for and deserted by everybody.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

35

30. Emotional disturbances such as major mood disturbances and social disruption and withdrawal are often seen on AIDS patients.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

36

31. The person's self-image and emotional balance is affected by AIDS.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

37

32. There is a fear of acute illness by the AIDS patient.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

38

33. A fear of death exists in the AIDS patient.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

39

34. The AIDS patient experiences a loss of concentration.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

40

35. There is a fear of being isolated by the society on the AIDS patient.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

41

36. Stigmatization of the person with AIDS leads to social isolation.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

42

**SECTION E: Motivation of persons to avoid risky sexual behaviour and adopt AIDS-preventive behaviour**

FOR OFFICE USE

The following factors should be taken into consideration in evaluating the person's resistance to or acceptance of a change in risky sexual behaviour. Indicate your opinion as to whether you agree or do not agree that the following factors should be included in the health educational program for assessment of the person being given health education on AIDS. Only circle the response that best describes your opinion.

**Demographic factors**

37. Age is an important factor in AIDS preventive health education.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

43



38. A person's sex may influence his/her acceptance of AIDS preventive health education.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 44

### Geographical factors

39. A person's geographical area (urban and rural) may influence his/her acceptance of health education on AIDS.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 45

**Sexual orientation**

40. Homosexuality is an important factor to be borne in mind in evaluating the person's resistance to or acceptance of education to change risky sexual behaviour.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 46

41. Heterosexuality will influence a person's acceptance of preventive health education on AIDS.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 47

**Socio-economic factors**

42. Poverty may influence a person's acceptance of health education on AIDS.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 48

43. A person's level of education will influence his acceptance of AIDS preventive health education.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 49

44. Cultural beliefs may influence acceptance of AIDS preventive health education.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 50

45. Traditional practices may affect acceptance of health education on AIDS.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 51

46. The abuse of alcohol will influence a person's readiness to abandon risky sexual practices.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 52

47. The abuse of drugs will influence a person's willingness to abandon risky sexual practices..

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 53

48. Assertiveness (ability to resist group pressure) will help a person to avoid risky sexual practices.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 54

49. Sufficient and relevant AIDS knowledge will help in motivating a person to accept preventive health education on AIDS.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 55

50. Teenagers and their risky sexual behaviour constitute an important risk factor as far as the future spread of AIDS is concerned.

Definitely agree	1
Agree	2
Uncertain	3
Disagree	4
Definitely disagree	5

 56

## *ANNEXURE B*

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P. O. Box 23072  
Kagisanong.  
9309.  
18. 11. 1996.

The Director,  
District Health Services.  
Region A.  
BLOEMFONTEIN.  
9300.

### **Request to implement Research**

Dear Mr. Shuping,

I am presently undertaking a study on AIDS with the University of Free State as partial fulfilment of the requirements for the M.Soc.Science Degree. The topic I have chosen is: **The identification of community needs for AIDS health education.** I am hereby requesting your permission as a Regional Director to implement this study in the clinics in Mangaung.

This entails interviewing a total of two hundred (200) clients divided equally between the clinics. Direct implications for personnel are minimal as the researcher will be conducting the interviews herself with the help of a few trained assistants. Actual dates for this implementation cannot be finalised pending your response. The data collection instrument has been finalised and is ready for administration. A copy thereof is enclosed herewith for your records if needed.

Hoping for your favourable response, I remain.

Yours faithfully,

S.R.O. KHOKHO (Mrs).

# ANNEXURE C

FREE STATE PROVINCE • VRYSTAAT PROVINSIE • PROFENSE YA FOREISTATA

## DEPARTMENT OF HEALTH DEPARTEMENT VAN GESONDHEID LEFAPHA LA BOPHELO BO BOTLE

MRS S.R.O. KHOHKO  
P.O. Box 23072  
KAGISANONG  
9309

Reference:  
Verwysing:  
Tshupo:  
Enquiries: Mr S Shuping  
Navrae: Director  
Dipatlisiso: District Health Services  
Office: Room 517  
Kantoor: Lebohang Building  
Ofisi: Bloemfontein  
☒ P O Box 517  
Bloemfontein  
9300  
☎ 051-4054320  
Fax/Faks 051-4480580

### RE: REQUEST TO IMPLEMENT RESEARCH:

Thank you for your request and good luck with your important study work.


District Health Services would like to support the work which you are doing and as such see no reason why your research work cannot be implemented around the clinics in Bloemfontein.

As you know, rendering of PHC around Bloemfontein is under the direct control of the Local Authority. Dr Ann Hiemstra is the Medical Officer of Health for these clinics. I would suggest you contact her for her assistance and support. Knowing Dr Hiemstra, I am sure she should be able to assist you with your request.

Once more good luck.

Kind regards

Yours sincerely

  
HEAD: HEALTH

DATE: 9/10/06  
.....  
RESEARCH



BLOEMFONTEIN  
New Nation • New Capital

# ANNEXURE D

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P.O. Box 23072  
Kagisanong  
9309  
27 January 1997

Medical Officer of Health  
Bloemfontein Municipality  
BLOEMFONTEIN  
9300

## Request to implement Research

Dear Dr. A. Hiemstra

I am presently undertaking a study on AIDS with the University of Free State as partial fulfilment of the requirements for the M.Soc.Science Degree. The topic I have chosen is: **The identification of community needs for AIDS health education.** I am hereby requesting your permission as the Medical Officer of Health to implement this study in your service.

This entails interviewing a total of fifty (50) clients at 3 clinics in Mangaung, namely: Batho, Mmabana, Thusong clinics. Provincial support in this matter was sought and obtained. Direct implications for personnel are minimal as the researcher will be conducting the interviews herself with the help of a few trained assistants. Actual dates for this implementation cannot be finalised pending your response. The data collection instrument has been finalised and is ready for administration. A copy thereof is enclosed herewith for your perusal if needed.

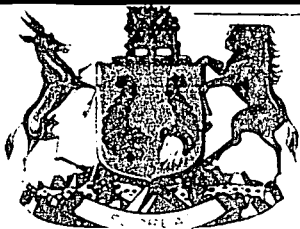
Hoping for your urgent response, I remain.

Yours faithfully,

S.R.O. KHOKHO (MRS.)

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ANNEKURE E

**Die Stad Bloemfontein**  
City of

GEREGTELIKE HOOFSTAD VAN SUID-AFRIKA  
JUDICIAL CAPITAL OF SOUTH AFRICA

HOOFSTAD VAN DIE VRYSTAAT  
CAPITAL CITY OF THE FREE STATE

Posbus/ P.O.Box	Faks/ Fax	Tel	Ons verw/ Our ref	U verw/ Your ref
3704	(051) 4058310	(051) 4058329	Ms M Reid/lvj	

3 February 1997

Mrs S R O Khokho  
P O Box 23072  
KAGISANONG  
9309

Ms Khokho

**REQUEST TO IMPLEMENT RESEARCH**

Your request to undertake a research study on Aids at Batho-, Mmabana-Phahameng- and Thusong clinics has been granted. Your study can be conducted during February 1997. We would appreciate it if you could supply us with the results of your research.

Best wishes with your studies.

Yours sincerely

*Almontra*

MEDICAL OFFICER OF HEALTH

# ANNEXURE F

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P.O. Box 23072  
Kagisanong  
9309  
22 January 1997

The Director: MUCPP  
P.O. Box 23160  
Kagisanong  
9309

Request to implement Research

Dear Prof. S.J. Wessels

I am presently undertaking a study on AIDS with the University of Free State as partial fulfilment of the requirements for the M.Soc.Science Degree. The topic I have chosen is: **The identification of community needs for AIDS health education.** I am hereby requesting your permission as a Director to implement this study in your service.

This entails interviewing a total of fifty (50) clients. Direct implications for personnel are minimal as the researcher will be conducting the interviews herself with the help of a few trained assistants. Actual dates for this implementation cannot be finalised pending your response. The data collection instrument has been finalised and is ready for administration. A copy thereof is enclosed herewith for your perusal if needed.

Hoping for your favourable response, I remain.

Yours faithfully,

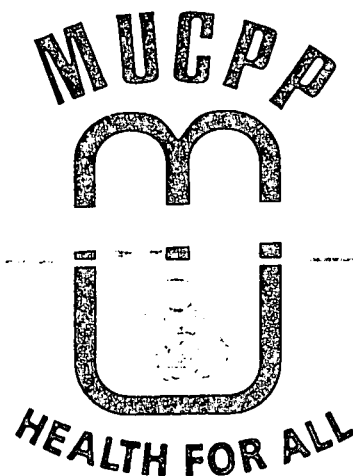
S.R.O. KHOKHO (MRS).

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angaung - University OFS  
Community Partnership  
Programme

ANNEXURE 1 G



9 April 1997

Mrs S R O Khokho  
P O Box 23072  
KAGISANONG  
9309

Dear Mrs Khokho

Your request received on 22 January to do research for your M. Soc. Science Degree has been accepted by the Management Committee of MUCPP. We however need more detail on the research you wish to implement. Would you be so kind as to contact Mrs Sophy Machedi or Mrs Noshipo Tsubane in this regard.

We wish you everything of the best with your studies.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Basie Wessels', written over a horizontal line.

PROF BASIE WESSELS  
DIRECTOR : MUCPP

Contact Persons: Prof. S.J. Wessels, J. Mokoka  
P.O. Box 23160, KAGISANONG, 9323  
Tele: (051) 4352902/4352903 Fax: (051) 4352841  
Site: 19057 Singozo Street, Rocklands.