AN INVESTIGATION OF COMMUNICATION STRATEGIES AIMED AT CURBING THE EXTENT OF HIV & AIDS TRANSMISSION
(A Case Study of Uthungulu District Municipality)

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A thesis submitted in fulfilment of the requirement for the Master’s degree in Communication Science

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Ethical Statement by Researcher

I, Gabriel Jabulani Zondi, declare that:

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2. This thesis has not been submitted for any degree or examination at any other university.

3. This thesis does not contain other persons’ data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

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Abstract

An investigation of communication strategies aimed at curbing the extent of HIV & AIDS transmission
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Amidst growing concerns about the impact of Human Immuno Deficiency Virus and Acquired Immunodeficiency Syndrome (HIV & AIDS) on the political, social and economic spheres of our country, comes the responsibility of government to address this pertinent issue, especially through communication within the uThungulu District Municipality Structures.

This research emerges within the context of rising levels of human immuno deficiency virus (HIV) infection amongst young adults, and the escalation of deaths from the acquired immunodeficiency syndrome AIDS. This study critically examines the commonly used theories and models used during HIV & AIDS preventative care communication strategies.

Failure to acknowledge the communication context in campaigns theory has various negative implications. One implication is that the messages are sender-oriented, however there has been sufficient campaigns for grassroots dialogue but the recipients are unable to identify with the message as they are divorced from the context of its production.

Furthermore, because of a lack of engagement by the recipient in the development of messages, retention of knowledge is minimal, and this leads to a lack of acceptance of the message. Clearly, then, there exists a need for the communication strategies, theories and models to be rearticulated so that they are more relevant and may be adapted for application within various cultural contexts.

This study examines the role of communication campaign theory and audience participation as central components during planning, implementation and evaluation phases of HIV & AIDS prevention.
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CHAPTER ONE

ORIENTATION

INTRODUCTION

The Human Immune Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) pandemic is still hindering the economic and social development of South Africans. According to Avert (2014), the HIV & AIDS pandemic is the World’s most problematic disease, with South Africa being the hardest hit with one in seven of the adult population living with HIV & AIDS. The Uthungulu District in KwaZulu-Natal is labelled as the capital of the HIV & AIDS epidemic. The enormity of the impact of HIV & AIDS in communities is destroying the endeavours by government and communities to function effectively.

Green (2008:57) state that unless the countries of the world take the HIV & AIDS Millennium Development Goal seriously, the campaign will be in vain. The other most important Millennium goals will therefore not be reached including a move to end poverty and all kinds of suffering by 2015, let alone achieving universal primary education, promoting gender equality, reducing child and maternal deaths as well as to ensure general environmental stability because the impact of HIV & AIDS permeates every facet of society.

This pandemic is causing a great threat to the sustainable development of the country, owing to loss of the productive men and women at all areas of our economies. This, as well as the decline in the country’s productivity and the re-allocation of limited resources for overall production results in a escalation in the number of child-headed families, orphans and the total destruction of family structures (Kaizer Daily HIV & AIDS Report, 2004:8).

This study explores communication strategies which could benefit the campaign to overcome this pandemic.

BACKGROUND TO THE STUDY

According to the Human Sciences Research Council (HSRC) (2014), South Africa currently has the biggest number of HIV-infected and affected people in Africa and the world, with the KwaZulu-Natal province being the most affected area. By 1998, more than four million people were affected and infected in this Province. The Uthungulu District has the highest replication of HIV and AIDS cases in the whole world (UNAIDS 2007:23).

According to the 2005 South African National HIV Survey, KwaZulu-Natal has the highest number of HIV & AIDS infected individuals. Once again, according to the HSRC (2014),
KwaZulu-Natal still has the highest number of HIV & AIDS infected individuals. This surpasses all other provinces and is followed by Mpumalanga, Eastern and Gauteng. Furthermore, according to the USAID (2006:7) KwaZulu-Natal is listed as South Africa’s highest infected province.

In KwaZulu-Natal, the Uthungulu and Umkhanyakude District Municipalities have the highest percentage of HIV & AIDS prevalence, such that people are now spending more time at funerals than at weddings. This predicament calls for decisive action into the challenges faced by Uthungulu District and its municipalities.

**Literature Survey**

According to Philpott, et al. (2007:197), the research studies, policy development, implementation and observations are indeed worthy of examination when undertaking a comprehensive study of an occurrence. A comprehensive literature study is conducted so that the researcher gains thorough insights into the all the factors which impact on the pandemic.

Young (2001:50) deliberates whether the quality of the communication process in HIV & AIDS is efficient enough to ensure that the main concern of suppressing the epidemic is being feasibly addressed or not. He further questions whether the policies and methods used by the Southern African Development Community (SADC), either at regional level or by member states, are based on evidence and whether they are rooted in viable research. This paves the way to examine obstacles to implement the HIV & AIDS programmes, and to scrutinise ways of bridging the gaps between surveys, policy and implementation.

Whether there is sufficient coordination and distribution of the researched information that is initiated by other academic or research institutions remains a question. Given the region-threatening epidemic, countries must make it a point that resources are not misused by duplication or on research which adds no value. Many studies have revealed the statistics of the pandemic or the need for education but very few have examined the manner in which preventative strategies are communicated. When communication is not adequately addressed, the best messages can lose its value.

HIV & AIDS surveys involve many activities that take into account the basic and clinical science so as to understand, treat HIV infection, and other opportunistic diseases. According to the *Kaiser Daily HIV & AIDS Report* (2004:7), these include:

- Put an end to spread of HIV & AIDS
- Comprehending behaviour which places individuals at risk of getting infected
• Developing way to change such behaviour

Most research methods examine strategies which are aimed at ending the spread of HIV & AIDS. The HIV & AIDS pandemic is complicated and compounded by the unpleasant living conditions that most of the African people live in. The poor economic and social life, in some cases, is aggravated by political agendas in many African countries. Garner, Kale, Dickson, Dans and Salinas (1998:317) maintain that HIV & AIDS research should cover a range of basic science, clinical research, prevention and innovative plans of action that have been agreed by all stakeholders and researchers.

Ekambaran (2004:78) argues that we hope that HIV research might bring about innovations relating to HIV & AIDS prevention and care. It is therefore assumed that on-going awareness on HIV & AIDS on a broader scale would yield good results with regards to peoples’ attitudes, behaviour and conduct. However, he further stresses that HIV & AIDS knowledge may not mean that people will change in behaviour and conduct.

Ekambaran (2004:78) adds that in our understanding and knowledge of some issues relating to HIV & AIDS pandemic may not be enough and therefore there are other research challenges and gaps in this area of research.

Freudenthal (2001:9) disagrees with Ekambaran, and argues that though much is known and that there are research gaps, but that research gaps are not necessarily the barrier to successful HIV & AIDS prevention and intervention programmes. The latter agrees that the knowledge of how to prevent HIV transmission exists, but differ as to whether that research results are seldom used in the implementation of HIV prevention and care programmes.

Again, despite all the behavioural studies, many people have not changed behaviour. (Freudenthal, 2001) identifies the following outstanding research areas:

- The need for research is to focus primarily on the ways in which dominant norms and youth culture place young people’s sexual health at risk, and to also investigate the ways that certain groups of young people resist those norms;

- Research on specific socio-economic areas, especially, an understanding of gender differences in the socialisation of young people into sexuality.

Furthermore, he states that it is imperative to investigate young men and women’s perceptions of sexuality and gender relations;
• It is important to understand how best to hook up with policy-makers, how best to select, train and manage home based carers and youth educators, and addressing gender and cultural factors, and how to scale up programmes;

• Research on media studies for development of innovative approaches for reaching more remote rural areas; and more research on how to make reproductive health services user-friendlier for young people (Freudenthal, 2001).

The relationship between researchers and policy-makers is often assumed and misunderstood, but rarely analysed. Good quality research which is comprehensive and conclusive would influence policy.

The literature review examines all possible literature which would assist in improving communication strategies that could benefit the struggle to overcome the HIV & AIDS pandemic.

**Aim of the Study**

This is a cross-sectional study to determine the improvement of communication strategies which could benefit the struggle to overcome this pandemic in the uThungulu District Municipality, and to ensure that the prevalence of HIV & AIDS is reduced to zero. As part of this project, the researcher examines the effectiveness of communication strategies, outreach programmes and community education which is aimed at improving the lives of people within the community.

**Objectives of the Study**

The objectives are:

• To determine the feasibility of communication strategies designed by the Uthungulu Aids Council, including the Uthungulu District Health Department as well as all six municipalities falling under the Uthungulu District Municipality.

• To determine internal barriers which hinder the dissemination of information by the Uthungulu Aids Council and their complementary organisations.

• To determine the external challenges faced by Uthungulu District and its municipalities with regard to communications and the dissemination of information about HIV & AIDS as well as its prevalence.

• To test the hypothesis that some traditional healers can cure AIDS.

• To determine the impact of the government’s communication strategies in respect of the prevention of HIV & AIDS programmes.
• To critically investigate the impact of culture, literacy, infrastructure and some traditions which assist or hinder the prevention of the spread of HIV & AIDS.

Research Methodology

This research consists of qualitative as well as quantitative components. The qualitative phase reports on the content of the research framework as well as recently published literature on HIV & AIDS prevention strategies. In the quantitative technique, the empirical phase of the study, a representative sample is drawn from Uthungulu District Municipality Management, their community sectors and their community organisations.

Mouton (2001:44) states that the collection of data must be determined by the use of a suitable measuring instrument. He further argues that measuring instruments are also regarded as a questionnaire. According to Mouton, it is reasonably easy to capture quantitative numeric data in a computerised format. The researcher captured the responses on the questionnaires, and the data analysis was compiled by using Moonstats©.

Value of Research

It is envisaged that this research will assist the Department of Communication Science since it will contribute to Communication Science research and improve current teaching material. Research generates new knowledge and leads to new social behavioural change and processes that improve awareness, remove stigma and the new ways of combating HIV & AIDS. Reddy et al. (2003:20) suggest that further research on HIV & AIDS offers the promise that problems facing society today may someday be resolved. This study will also be useful to other researchers who may have an interest in the same or related fields.

Ethical Requirements

This study will adhere to the ethics of research, and the respondents' rights in terms of the following will be ensured:

- Respondents were informed of their right to participate on a voluntary basis.
- Written informed consent was sought from the respondents.
- Confidentiality of respondents is guaranteed and respondents were assured of anonymity.
- Respondents were informed of the purpose of the study.
○ They were given the right not to answer any question which they perceived as sensitive.

**Conclusion**

This chapter provides a description of the background to the study, the objectives of the study as well as the research methodology which underpins the study. The value of the research, as well as, the ethical requirements is dealt with in order to enhance the credibility of the study.

The following chapter examines the origin of communication both as a day-to-day activity and also as a science and an art. Even though it took centuries to put together some of its facets, it has always been improved from time to time, and it continues to thrill us with the 21st century’s discoveries and innovations.
CHAPTER TWO

LITERATURE REVIEW

INTRODUCTION

This chapter provides a brief overview of aspects of communication which can impact on strategies which may influence transmission of HIV & AIDS. The chapter also provides an overview of the AIDS pandemic.

This chapter is divided into three significant parts:

PART 1: Part 1 deals with the spread of HIV & AIDS

PART 2: An overview of HIV & AIDS in India and Britain. The purpose of examining HIV & AIDS in these two countries is to compare how South Africans are managing the pandemic in comparison to other countries. India is a third world country which has similar economic and social dynamics as South Africa. This study examines how Britain manages this pandemic. Britain is a first world country. It is hoped that we could be inspired to extrapolate some practical portions of their strategies for implementation in South Africa.

PART 3: This portion deals with communication issues relating to HIV & AIDS.
PART 1: The spread of HIV & AIDS

An Overview of HIV & AIDS

AIDS is reported have appeared first in the Democratic Republic of the Congo in 1959 (Tiruneh, 2009). Tiruneh (2009) also state that there is a great deal of similarity between the HIV virus and an African monkey virus, although the animal virus does not cause immunosuppression among monkeys. The apparent correlation led to speculation among scientists that African hunters who butchered and ate monkeys might have been exposed to a mutated form of the virus that was infective to humans.

According to Buse (2011), the prevalence of HIV & AIDS has grown dramatically in areas of Africa as a direct result of importation of millions of migrant workers. To maximize the diamond and gold industry output in their country, Africa imported primarily able-bodied men to work in the mines. Strict rules prohibiting even married immigrants from bringing family with them has led to the escalation of HIV & AIDS infection due to indiscriminate sexual activity thought to be compounded by a category of aberrant migrant mentality (Buse 2011).

According to Morison (2001), in 1981, the Centers for Disease Control and Prevention reported unusual clusters of Pneumocystis carinii pneumonia and Kaposi’s sarcoma in gay men in parts of the United States of America, and those were the first cases of Acquired Immune Deficiency Syndrome.

According to the UNAIDS, over 40 million people had been infected by the Human Immuno Deficiency Virus. The UNAIDS report further state that almost all countries in world are affected by the HIV infection (UNAIDS 2004)

The HIV has two main types, HIV 1 and HIV 2 and although HIV 2 is the older version of the virus (Grmek, 1990); it is rarer and causes much fewer infections (Buve et al, 2002).

Morison (2001) states that HIV is mainly transmitted sexually and this is the most common mode of transmission globally. The probability of a person being infected via sexual intercourse depends on the likelihood of unprotected sex with an infected partner. Sexual behaviour patterns and the background prevalence of HIV are important considerations in the prevention of this disease (Merson, Dayton & O’Reilly, 2000).

HIV & AIDS Treatment in SA

Buse (2011), indicates that South Africa receives more than $500 million annually from the President’s Emergency Plan for AIDS Relief (PEPFAR) but is also the only PEPFAR-funded country
that has underwritten most of its own HIV budget for the past 5 years. As the government transitions to independence, it has begun closing many of the specialized HIV-treatment centres created by PEPFAR, moving patients into government-run, community-based health care centres, where long waiting times and medication shortages are common. Some observers worry that this shift will threaten the tremendous success which PEPFAR has enjoyed.

HIV & AIDS in South Africa has always been a controversial subject when compared to any other country. This has been a result of the government’s lack of political will, conflicts within stakeholders, namely; pseudoscience, politicians, HIV & AIDS organisations and scientists.

According to the The National Strategic Plan (NSP 2007-2011), a comprehensive plan to scale-up South Africa's fight against HIV/AIDS, integrating tuberculosis into its efforts against the epidemic for the first time, was announced by President Jacob Zuma on World Aids Day, 1 December 2011. Prevention is at the heart of the new National Strategic Plan (NSP), for HIV, Sexually Transmitted Infections (STIs) and Tuberculosis TB 2012-2016, which aims to reduce new infections by 50% by taking a holistic approach. The plan also promises to do much more in tackling related issues of violence against women.

The National Strategic Plan (NSP), which represents the country's multi-sectorial response to the challenges of HIV, draws on the lessons of the previous NSP of 2007-2011 and guides the development of provincial and sectorial implementation plans.

**Goals & Objectives of the NSP**

The plan brings together five goals and four strategic objectives, which combine to effectively prevent or treat HIV and TB infections.

The five goals are:

- To reduce new infections by at least 50% by using a combination of prevention approaches.
- To ensure that at least 80% of people who are eligible for treatment for HIV are receiving it, with at least 70% being alive and still on treatment after five years.
- To reduce new TB infections and deaths from TB by 50%.
- To ensure an enabling and accessible legal framework that protects and promotes human rights to support implementation of the plan.
- To reduce the self-reported stigma related to HIV and TB by at least 50%.
The NSP has identified four strategic objectives that will help South Africa reach these goals:

- Address the social and structural factors across all sectors that drive these epidemics, influence their impact, and affect the way we care for affected people.
- Prevent new HIV, STIs and TB infections through a combination of biomedical, behavioural, social and structural interventions.
- Sustain health and wellness, primarily by access to quality treatment, care and support services, and to develop programmes that focus on wellness.
- Protect the human rights of people living with HIV, primarily through ending stigma, discrimination, human rights violations and gender inequality.

### Problems Related to HIV & AIDS

Some problems which relate to the management of HIV & AIDS stem from political agendas, from financial glitches, from social woes as well as from incompetent communication officers.

According to Kauffman and Lindauer (2004), the South African government's strategy emphasises HIV & AIDS prevention by promoting public awareness and delivering life skills and HIV & AIDS education. Many AIDS awareness campaigns run by government and Non-Governmental Organisations (NGO) partners such as Love Life and Soul City are bearing fruit. There is now a high level of awareness among the youth on HIV & AIDS (around 90%). However, the pressing challenge is to ensure that this awareness translates into behavioural change. Life skills education, which incorporates HIV & AIDS education, is now a compulsory part of the school curriculum.

The HIV & AIDS problem is grimly affecting both low-income families as well as high profile people. This has led to a decrease in skilled and unskilled workers in different work categories and millions of Rands are lost due to non-performance, which is rooted in HIV & AIDS. However, most countries generate substantial revenue, from companies which produce drugs, for the treatment of HIV & AIDS in high profile patients.

Khomanani is a government-led communication campaign that provides an awareness-raising drive to mobilise individuals and organisations to respond to the challenges of HIV & AIDS, tuberculosis and sexually transmitted infections. Besides a national media campaign, it works through outreach programmes for organisations, towns and villages. Between 2004 and 2006, the government invested R165 million in Khomanani (National Strategic Plan, 2007-2011).
Love-life organization is a nationwide campaign which aims to promote healthy sexual behaviour among adolescents, and reduce the incidence of HIV & AIDS, sexually transmitted diseases and teenage pregnancies. Love Life uses a widespread media campaign targeting adolescents, and offers educational, recreational and sexual health services in under resourced areas (Kauffman and Lindauer, 2004:79).

**TREATMENT**

The South African government's HIV & AIDS response is primarily financed through the national health budget, with an estimated R2.4 billion earmarked for combating the disease in 2007. In February 2007 the National Treasury provided the Department of Health with R5.3 billion to be spent on human resources, HIV & AIDS, hospital revitalisation and tertiary services (Health Systems Trust, 2008).

The first official policy response to the epidemic was in 1992, when the government established the National AIDS Coordinating Committee of South Africa, followed by the creation of the South African National Aids Council in 2000. In March 2007, the government released its National HIV & AIDS and STI Strategic Plan for South Africa 2007 to 2011 (NSP), designed to guide the country's multi-sectorial response to HIV & AIDS.

The plan was adopted by Cabinet in 2007. It aimed to achieve a 50% reduction in new infections by 2011, and provide an appropriate package of treatment, care and support services to at least 80% of people living with HIV and their families by 2011.

The interventions needed to reach the NSP's goals are structured under four key priority areas:

- Prevention
- Treatment, care and support
- Research, monitoring and surveillance
- Human rights and access to justice

The package of care includes:

- Counselling and testing services as an entry point
- Healthy lifestyle interventions, including nutritional support
- Treatment of opportunistic infections
- Anti-retroviral therapy
The plan also includes a monitoring and evaluation component critical in assessing progress and sharing research on the pandemic.

The NSP is an outcome of the National Strategic Plan of 2000-2005, the Operational Plan for Comprehensive HIV & AIDS Care, Management, and Treatment, as well as other HIV & AIDS strategic frameworks developed for government and sectors of civil society in the past five years. It represents the country's multi-sectorial response to the challenge of HIV infection and the wide-ranging impacts of AIDS.

The NSP also forms part of an initiative by the member states of the Africa Region of the World Health Organisation, which committed 2007 to "The Year for Accelerating HIV Prevention". More than 1 060 health professionals have been recruited to support the programme. About 7600 health professionals have been trained in the management, care and treatment of HIV & AIDS.

The NSP is based upon a set of key guiding principles, including:

- Supportive leadership
- Effective communication
- Effective partnerships
- Meaningful involvement of people living with HIV & AIDS
- Promoting social change and cohesion
- Sustainable programmes and funding

The government budget allocated for NGOs involved in the response to AIDS and TB funding has been increased from R56 million in 2006/2007 to R62 million in the 2007/2008 financial year. The funds were made available to eligible organisations providing the following services:

- Prevention interventions, which include voluntary counselling and testing, prevention of mother to child transmission of the virus, youth life skills and high transmission areas interventions.
- Community mobilisation for Aids competence, including home-based care.
- Support for people living with HIV & AIDS.
- Treatment adherence counselling.
Government interventions also place a strong emphasis on promoting abstinence and faithfulness, with a massive condom distribution programme that provides some 300 million free condoms to the public every year.

Cabinet is the highest political authority. However, the responsibility for dealing with on-going HIV & AIDS related matters has been delegated to the Inter-Ministerial Committee (IMC) on AIDS. The South African National Aids Council (SANAC) is the highest national body to provide strategic and political guidance as well as support and monitoring of sector programmes.

SANAC was reconstituted in April 2007, officially bringing together government and civil society in a renewed partnership against HIV & AIDS. The newly-strengthened SANAC operates at three levels through:

- A high level council, meeting twice a year, chaired by South Africa's Deputy President.
- Sector-level coordination, with sectors taking responsibility for their own organisation, strategic plans, programmes, monitoring, and reporting to SANAC.
- Programme-level organisation led by the social cluster of government.

The cluster of government bodies involved in trying to combat HIV & AIDS is called the HIV & AIDS and TB Cluster, which is made up of the directorate for HIV & AIDS and STIs, the Government Aids Action Plan (GAAP), and the Directorate for Tuberculosis.

The Department of Health has also introduced a Healthy Lifestyle Programme that aims to promote healthy lifestyles such as regular physical activity and good nutrition. It discourages use of tobacco, abuse of alcohol, substance abuse and promotes safe sexual behaviour.

The South African government's treatment initiative falls under the Comprehensive HIV & AIDS Care, Management and Treatment Plan to address the challenges posed by HIV & AIDS. South Africa has an extensive anti-retroviral (ARV) treatment programme, with 213 000 patients already on ARV treatment by the end of September 2006, and an estimated 90 000 to 100 000 patients being treated in private and non-government sectors (Norwegian Ministry of Foreign Affairs, 2002).

The country already has the largest number of people on anti-retroviral therapy (ART) in the world, but with an estimated one million people in need of ART, South Africa also has one of the highest unmet needs for ART in the world. But progress has been made. At the end of 2006,
an estimated 287 000 to 363 000 people in the country were receiving ART. This accounts for about 33% of those in need (Mercer et al., 2000).

By 2002, the government had set up 597 testing and counselling sites for HIV as a strategy for prevention and care of HIV. At these sites treatment for opportunistic infections is available for both HIV-positive and HIV-negative patients (Mercer et al., 2008).

The government is working with pharmaceutical companies to lower the costs of drugs to treat these infections. In December 2000, an agreement was signed with pharmaceutical company Pfizer to provide Fluconazole (Diflucan) to public hospitals and clinics for two years. Funding was provided for the training of healthcare workers in diagnosing and managing oral thrush and cryptococcal meningitis (National Strategic Plan, 2001-2005).

In the belief that anti-retroviral treatment can cause harm if not administered correctly, or if health services are inadequate, the government will intensify its campaign to make sure that patients infected with HIV, TB, thrush and meningitis follow the correct treatment advice.

The government continues to lobby drug companies to lower the cost of anti-retroviral and investigate the production of generic equivalents. In the knowledge that poverty increases vulnerability to illness, it will also work towards poverty alleviation and provision of nutrition for those lacking it; as well as encourage investigation into alternative treatments, particularly those that boost the body's immune system.

Prevention of Mother-to-Child transmission

In September 2001, the South African government initiated a national programme to prevent mother-to-child transmission of HIV. In 2005, Prevention of Mother-to-Child transmission programme (PMTCT) services were available at over 3 000 health sites nationwide, making the programme one of the largest PMTCT programmes in the world. More than 80% of government clinics are currently providing a PMTCT programme, and the target is to have these services available in all clinics by December 2007 (NSP, 2007-2011).

Post-natal transmission of HIV from mother to child through breast milk remains a key challenge despite the availability of replacement feeds as part of the national Perinatal and Maternal Morbidity and Mortality Rate programme (NSP, 2007-2011).

The percentage of HIV-positive pregnant women who received anti-retroviral treatment to reduce the possibility of transmitting HIV to their infants increased from 22% to 30% between 2004 and 2005. At least 580 880 pregnant women accessed the PMTCT services during the calendar year 2006, and of these, 74 052 ante-natal clients received Nevirapine prophylaxis. In
the same period, a total of 19 758 babies born to mothers living with HIV were tested for HIV infection. 16 288 babies tested HIV-negative, while 3 470 babies tested HIV-positive, (Health Protection Agency 2010).

According to figures released in 2005, women are disproportionately affected by AIDS, accounting for some 55% of HIV-positive people. Many of those with HIV & AIDS depend on home-based care, placing a further burden on women, and often resulting in child-headed households (Steinberg 2007).

Maternal deaths are on the increase, mostly fuelled by the HIV epidemic, and for many HIV-infected women, decision-making in regard to pregnancy and childbirth is hampered by a lack of information on contraception, interactions between ART, drugs for treatment of opportunistic infections and lack of knowledge about their HIV status when they become pregnant (Steinberg 2007).

An outcome of the NSP has been the introduction of dual therapy to reduce mother-to-child-transmission of HIV. The move from a single dose of nevirapine to dual therapy (nevirapine and AZT) was based on the recommendations of the National Essential Drugs Committee and the Medical Research Council (MRC) (NSP, 2007-2011).

There has been a reversal in the prevalence of syphilis among pregnant women in the past five years, and this has been attributed to the introduction of syndrome executive summary management of sexually transmitted infections (STIs) in 1995, as well as the introduction of the primary health care system (NSP, 2007-2011).

The incidence of violence against women in South Africa is high, and contributes to the spread of HIV. The government is endeavouring to provide anti-retroviral treatment to survivors of sexual assault and those with needle-stick injuries, as well as counselling and testing for HIV, STIs and pregnancy.

**Care and Support of Families**

Families affected by the epidemic are being helped with foster care grants, assistance to child-headed households, food parcels and other interventions. The government budget for home-based and community-based care for people suffering with AIDS in 2004/5 was R138-million (GCIS, 2008).

Berlatsky (2012:103) states that the government promotes voluntarism as an answer to the demand for home-based caregivers to cope with the rising number of people infected with HIV, and because hospitals cannot cope with the number of people needing care.
Berlatsky further argues that most care programmes rely on unemployed volunteers from affected communities, who are usually female and unsalaried or, in a few cases, paid a small stipend. But this approach has drawn criticism from the Health Economic and AIDS Research Division (HEARD) of the University of KwaZulu-Natal, which recommends that the Department of Health review primary health care models and refine volunteer-based programmes, provide stipends and assist caregivers to ultimately obtain formal employment (NSP, 2007-2011).

**Innovation in health care Practices**

In the on-going fight against the spread of the human immuno-deficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS), African mothers and babies constitute an endangered breed. A statement released at the end of a meeting of world leaders at the United Nations (UN) headquarters in New York in 2010 July identified yet again sub-Saharan Africa as the most ravaged region, owing to poverty that has become a major hindrance to effective and sustained medical treatment.

Within Africa and elsewhere, HIV is widely regarded as a major illness that accounts for the deaths of a large number of mothers. Children are not left out, too. The British Broadcasting Corporation (BBC) cites a UN report which indicated that a child is born with HIV nearly every minute, almost all of them in sub-Saharan Africa. In fact, in 2009 alone, approximately 370 000 babies were tainted at birth with HIV, and most of them were from Africa (UN Special Programs, 2011).

In the light of these dreadful scenarios, two key concerns require urgent attention. First, there must be significant reduction in mother-to-child transmission of the virus. Second, there must be considerable reductions in AIDS-related maternal deaths. It is important to focus on the health care needs of mothers and babies because research shows they are the people most at risk of being infected with the HIV, or in danger of dying from AIDS. As we enter the second decade of the twenty-first century, humanity must not allow this health monster to consume the lives of mothers and babies.

In his address at the UN meeting, Ban Ki-Moon sounded more optimistic than current statistics suggest. He said that they were to ensure that all children are born healthy and free of disease. he stressed his intentions to ensure that their mothers would live to see them grow. (UN Special Programs, 2011). If the UN could achieve this, it would be one of the most phenomenal achievements of our lifetime. However, in Africa, as in other developing regions, there is no basis to rejoice yet. The HIV is still spreading fast. The mother-to-child transmission rate is still
unacceptably high and AIDS-related maternal deaths are still rising. Additionally, many governments in Africa are not channelling much-required funds to the purchase of anti-retroviral drugs to improve the healthcare needs of HIV & AIDS patients. (UN Special Programs, 2011).

**Opportunistic Malaria and Tuberculosis**

Berlatsky (2012:103), in his article “Global Fight against HIV & AIDS, Malaria and Tuberculosis”, states that a high burden of malaria, tuberculosis and HIV infection contributes to national and individual poverty. Berlatsky (2012:103), further states that he reviewed a broad range of evidence detailing factors at individual, household and community levels that influence vulnerability to malaria, tuberculosis and HIV infection, and used that evidence to identify strategies that could improve resilience to these diseases.

The first part of the review explores the concept of vulnerability to infectious diseases and examines how age, sex, and genetics could influence the biological response to malaria, tuberculosis and HIV infection. Berlatsky (2012:103) also highlights factors that influence processes such as poverty, livelihoods, gender discrepancies and knowledge acquisition, and provides examples of how approaches to altering these processes may have a simultaneous effect on all three diseases.

He further states that apart from the human suffering caused by these three diseases, HIV & AIDS in particular has the potential to retard the socio-economic development of individual societies because of the associated high adult mortality in some countries, especially in sub-Saharan Africa. Despite the progress made in the response to HIV & AIDS during the last decade, the HIV pandemic remains one of the most serious challenges to global health, and will probably continue to be one of the leading causes of death and disability in the world for the several decades. Since the initial description of HIV as the causative agent of AIDS, more than 60 million people have been infected with the virus, and more than 25 million people have died (Berlatsky (2012:103).

Berlatsky also states that a potentially harmful debate has opened up about whether disease-specific programmes help or hinder health systems. A commitment to achieve universal access to HIV & AIDS prevention, treatment, care and support must be coupled with determination to address health system weaknesses, ensuring both approaches are mutually reinforcing.

TB is the second most common infectious cause of death worldwide, especially in Asia and sub-Saharan Africa. Globally, 9.2 million new cases and 1.7 million TB-associated deaths occurred in 2006. The majority of these cases occurred in Asia, but the highest death rate has been observed in Africa, where the prevalence of HIV infection is at its highest. According to WHO,
approximately 700 000 cases and 200 000 deaths related to TB occurred in the HIV positive population worldwide in 2006 (WHO, 2006).

Malaria is endemic in 109 countries, and continues to cause between 189 and 327 million clinical episodes of illness each year, with at least 881,000 associated deaths. Around 60% of these cases and more than 91% of deaths occur in sub-Saharan Africa, where malaria is the leading cause of morbidity and mortality in children younger than five years and pregnant women. Constituting 10% of the overall disease burden, malaria places a substantial strain on health services, and costs Africa about $12 billion in lost production each year. Furthermore, malaria consumes around one fourth of household incomes in most African endemic countries, reducing access to preventive interventions and lifesaving services (WHO, 2006).

However, common themes extending to HIV, TB and malaria are the need to adopt interventions according to local epidemiology, and to invest in strategic information, particularly weak for malaria. Another common element to these three public health problems is the urgent need to strengthen laboratory capacity to expand access to diagnosis and adequate management of HIV, TB and malaria.

Berlatsky (2012:103) says that although the increased funding availability provides an opportunity for laboratory strengthening, unless efforts are made to simplify, standardise and coordinate this process to support a public health approach in a comprehensive manner, there is a real risk that this investment in laboratory strengthening will not lead to efficient, effective and sustainable services that strengthen national health services.

The World Health Organization, as the UN agency responsible for global public health, is committed to supporting the strengthening of laboratories in support of national health responses (UNAIDS, 2007).

**Drugs & HIV & AIDS**

Alcoholics are more prone to contact HIV. Likewise, people with HIV will presumably abuse alcohol at some time during their lives. Alcohol use is associated with high-risk sexual behaviour and drug use by injection, two major modes of HIV transmission. Concerns about HIV have increased as recent trends suggest a resurgence of the epidemic among men who have sex with men, as well as dramatic increases in the proportion of cases transmitted heterosexually.

HIV is most commonly transmitted by sexual contact and the sharing of contaminated needles by injection drug users. By the end of 2000, an estimated 900 000 Americans were living with
HIV. Approximately 40,000 new cases of active AIDS cases are diagnosed annually (UNAIDS: 2004).

Recently, however, the proportion of HIV cases acquired through heterosexual contact has increased, and almost equals the proportion of cases attributable to injection drug use. The proportion of all AIDS cases reported among women has tripled since the mid-1980s, primarily as a result of heterosexual exposure and secondarily through injection drug use. Minority groups are the most heavily affected by HIV associated with drug injection, and Blacks and Hispanics now account for an estimated 70% of all new AIDS cases (NSP, 2007-2011).

Alcoholics are more likely to engage in behaviour that places them at risk of contracting HIV. For example, rates of injection drug use are high among alcoholics in treatment, and increasing levels of alcohol ingestion are associated with greater injection drug–related risk behaviour, including needle sharing. A history of heavy alcohol use has been correlated with a lifetime tendency toward high-risk sexual behaviour, including multiple sex partners, unprotected intercourse, sex with high-risk partners (e.g. injection drug users, prostitutes), and the exchange of sex for money or drugs (NSP, 2007-2011).

Alcohol increases susceptibility to some infections that can occur as complications of AIDS. Infections associated with both alcohol and AIDS include tuberculosis; pneumonia caused by the bacterium *Streptococcus pneumoniae*; and the viral disease hepatitis C, a leading cause of death among people with HIV. Alcohol may also increase the severity of AIDS-related brain damage, which is characterised in its severest form by profound dementia and a high death rate.

Berlatsky (2012:105) states that the progression of HIV and the development of AIDS-associated infections may be controlled by highly active anti-retroviral therapy (HAART), a combination of powerful antiviral medications. Despite markedly increased survival rates, HAART is associated with several disadvantages, including the emergence of medication-resistant HIV strains, and the occurrence of adverse interactions with other medications, some of which are prescribed for AIDS-related infections.

Berlatsky (2012:109) further states that many patients fail to comply with the complex medication regimen. His studies have associated heavy alcohol use with decreased medication compliance as well as with poorer response to HIV therapy in general. The outcome of HIV therapy improved significantly among alcoholics who stopped drinking.
PART 2: An overview of HIV & AIDS in Britain and India

The purpose of examining HIV & AIDS in these two countries is to compare how South Africans are managing the pandemic in comparison to other countries. India is a third world country which has similar economic and social dynamics as South Africa. This study examines Britain to compare how a first world country manages the pandemic compared to South Africans.

INDIA

According to Mitra and Sarkar (2011), India has the third highest percentage of people infected with HIV & AIDS in South Asia, following Thailand and Cambodia. The first case of AIDS was first reported in 1986. Godbole (2005) states that the HIV infection has been reported in 28 states, as well as, in seven union territories. The National AIDS Control Organization (NACO) estimated the total number of people living with HIV & AIDS in 2006 to be about 2.47 million (Mitra & Sarkar, 2011).

Poku (2007:5) also agrees with Mitra and Sarkar (2011) by stating that India has among the highest number of persons living with HIV & AIDS in the world today, although the overall prevalence remains low. Some states experience a generalised epidemic with the virus transmitted from high-risk groups into the general population. A major challenge is to strengthen and decentralise the programme to the state and district levels to enhance commitment, coverage and effectiveness.

The first cases of HIV were reported in Chennai in Tamil Nadu where several female sex workers tested positive Mitra and Sarkar (ibid). Generally, the infection spreads through risky sexual behaviour, use of drug and blood transfusions (Gisselquist and Correa, 2006).

India has been using statistics drawn clinics and hospitals, where high risk groups (sex workers, intravenous users, men who have sex with men with sexually transmitted diseases (STDs) are tested for HIV and low risk groups are mostly tested in the antenatal clinics.

India has major social, economic, cultural and behavioural issues that are contributing to the spread of HIV & AIDS. This is coupled with unequal and low status of women. There is a high level of disparities in literacy, educational attainment, labour force participation and lack of exposure to the media (Mitra and Sarkar, 2011). Bachani and Sogarwal (2010), further add that the primary drivers of the pandemic in India practice unprotected paid sex, unprotected sex between men and injecting drugs use.
According to Bachani and Sogarwal (2010), The National AIDS Control Programme (NACP) aimed to contain the spread of HIV in India by building all-encompassing response reaching out to diverse populations. A national strategy was developed and based on a four-pronged strategy:

- Prevention of infections through saturation of coverage of high risk groups with targeted interventions and scaled up interventions in the general population.
- Providing care and support to people living with HIV & AIDS.
- Reviving infrastructure, systems and human resources in prevention, care, support and treatment programmes at a local, district, state and national levels.
- Lastly, enhancing the National Strategic Information Management System (SIMS).

The UNAIDS also states in its annual report that there are more than 5.1 million individuals infected with HIV in this country of over a billion people (UNAIDS, 2003). The total number of AIDS cases in 2002 was estimated to be about 550,000. Seven states – Andhra Pradesh, Goa, Karnataka, Maharashtra, Manipur, Mizoram and Nagaland – already have generalised epidemics, as indicated by a one per cent or higher prevalence rate among pregnant women in prenatal clinics. These seven states represent 22 per cent of the population (Poku, 2005:7).

Several factors, as indicated above, put India in danger of experiencing a rapid spread of the disease if effective prevention and control measures are not scaled up and expanded throughout the country. These risk factors include:

**Unsafe Sex and Low Condom Use**

In India, sexual transmission is responsible for 84 percent of reported AIDS cases. HIV prevalence rates are highest among sex workers and their clients, injecting drug users, and men who have sex with men (many of whom are married). When surveyed, 70 per cent of commercial sex workers in India reported that their main reason for not using of condoms was because their customers objected (Poku, 2005:7).

**Migration and Mobility**

Migration for work for extended periods of time takes migrants away from the social environment provided by their families and community. This can place them outside the usual normative constraints and thus they are more likely to engage in risky behaviour. Concerted efforts are needed to address the vulnerabilities of the large migrant population (UNAIDS, 2004).
Injecting Drug Use (IDU)

Studies indicate that many drug users are switching from inhaling to injecting drugs. This phenomenon is more localised in the north-eastern states of India, and injecting drug users show sharp increases in HIV prevalence. Forty-one per cent of IDUs in a national survey reported injecting with used needles or syringes. Of those who cleaned their needles and syringes, only three per cent used an effective method such as alcohol, bleach, or boiling water. Appropriate strategies are also needed to address the double impact of drug use and unsafe sexual practices (UNAIDS, 2004).

Low Status of Women

Infection rates have been on the increase among women and infants in some states. As in many other countries, unequal power relations and the low status of women, as expressed by limited access to human, financial, and economic assets, weakens the ability of women to protect themselves and negotiate safer sex, thereby increasing vulnerability (UNAIDS, 2004).

Widespread Stigma

Stigmatising people infected with HIV & AIDS is widespread. The misconception that AIDS only affects men who have sex with men, sex workers, and injecting drug users strengthens and perpetuates existing discrimination. The most affected groups, often marginalised, have little or no access to legal protection of their basic human rights. Addressing the issue of human rights violations and creating an enabling environment that increases knowledge and encourages behaviour change are thus extremely important to the fight against AIDS (UNAIDS, 2006).

How India managed to overcome its HIV & AIDS epidemic

HIV & AIDS epidemic is mainly concentrated in the high-risk population, for example, the men having sex with men, injecting drug users, female sex workers and clients of sex workers. According to Bachani and Sogarwal (2010), the intervention strategy included four elements:

- Treatment for sexually transmitted infections,
- Monitoring access to and usage of condoms,
- Behaviour change, and
- Ownership building and creating an enabling environment.

The Management of STIs

The management and control of Sexually Transmitted Infections (STIs) through early treatment provided a window of opportunity for prevention of new HIV infections and it became the most effective way of preventing HIV transmission (Bachani and Sogarwal 2010).
Indian Policy Initiatives

Bachani and Sogarwal (2010), states that India was able to learn lessons globally as well inside the country that National responses should not wait for HIV & AIDS cases to soar. Policies should not wait at a time when crucial prevention and care information and services were needed. HIV is particularly fuelled by the situations of injustice and poverty and its impact is felt beyond health sectors. Multi-sectorial strategies were designed in the context of the overall development strategy to ensure its sustainability and effectiveness.

Therefore, a substantial component of AIDS prevention and care relies on strong public health infrastructure in order to mount a more effective health sector response to AIDS. That includes early diagnosis and treatment of sexually transmitted infections using the syndromic approach, blood transfusion safety, epidemiological surveillance and research and a continuum of HIV & AIDS care linking health institutions, community and home Bachani and Sogarwal (ibid).

In India the HIV & AIDS initial cases were reported among commercial sex workers in Mumbai and Chennai and injecting drug users in the north-eastern State of Manipur. The infection has since then spread rapidly in the areas adjoining these epicentres and by 1996 Maharashtra, Tamil Nadu and Manipur together accounted for 77 per cent of the total AIDS cases with Maharashtra reporting almost half the number of cases in the country Bachani and Sogarwal (ibid).

Even though the officially reported cases of HIV infections and full-blown AIDS cases are in the thousands only, it was realised that there is a wide gap between the reported and estimated figures because of the absence of epidemiological data in major parts of the country. The latest estimate for the HIV & AIDS infected adult population in the country is 10.5 million in 2012. The overall prevalence in the country is still, however, very low, a rate much lower than many other countries in the Asia region. (Berlatsky 2012)

About 85% of the infections occur from the sexual route (both heterosexual and homosexual), about 4 per cent through blood transfusion and another 8% through injecting drug use. About 89% of the reported cases are occurring in sexually active and economically productive age group of 18-49 years. One in every four reported cases of infection is a woman. The contributing factors for such rapid spread of the epidemic across the country today are labour migration and mobility in search of employment from economically backward to more advanced regions, low literacy levels leading to low awareness among the potential high risk groups, gender disparity, sexually transmitted infections and reproductive tract infections - both among men and women. (UNAIDS 2013)
The social stigma attached to sexually transmitted infections also holds good for HIV & AIDS, even in a much more serious manner. The effects of stigma are devastating. Discrimination against People Living with HIV & AIDS denies them access to treatment, services and support and hinders effective responses. It creates a climate in which decisive action from the government may be side stepped (UNAIDS 2013).

There have been cases of refusal of treatment and other services to AIDS patients in hospitals and nursing homes both in Government and private sectors. This has compounded the misery of the AIDS patients. More often it is mistaken to be a contagious disease and patients are isolated in the wards creating a scare among the general patients. In the workplace there are cases of discrimination leading, on some occasions, to loss of employment. (UNSP, 2011)

The active part played by some non-Governmental organisations in bringing out public interest litigations against such cases of discrimination and the judicial pronouncements by courts in support of the rights of such people has partly helped in alleviating the misery of the affected persons. People Living with HIV & AIDS have provided the best response to the stigma and the denial that shroud the epidemic (UNSP, 2011).

They bring faces and voices to the realities. Only clear and candid information about how HIV is and is not transmitted will alleviate unnecessary fear and discrimination. Efforts need to be made to train all medical and Para-medical health care workers to create a congenial environment where HIV & AIDS patients are admitted and treated without any fear and scare. The treatment options are still in the initial trial stage and are prohibitively expensive. (USAID 2006)

Giselquist and Correa (2006) states that while there is no vaccine in sight, multi-drug anti-retroviral therapy, popularly known as ‘cocktail therapy’, is not a cure to the disease and may help only in prolonging the life of the patient. Standardisation of treatment regimens for these drugs is still evolving and there are fears of patients developing drug resistance and side effects if the therapy is not administered under proper medical supervision. There are instances of quacks taking advantage of the situation and promising cures and defrauding unsuspecting people who are infected with the virus of large sums of money.

Transmission of the disease through blood, though limited to 4% of the cases down from 8% in 1992, is also a serious issue as unsuspecting population can get infected through this route if safe blood is not ensured. Existence of a large number of small and medium blood banks, many of them in the private sector, also compounds the problem. The Supreme Court directive of May, 1996 has helped in phasing out unlicensed blood banks by May, 1997 and professional blood donors by December, 1997. Mandatory testing of blood for HIV along with Syphilis, Malaria
Hepatitis B and C has helped in checking transmission of HIV virus through blood transfusion (Gisselquist and Correa: 2006).

Transmission among injecting drug users is also one of the major causes for the spread of HIV & AIDS in the country. Even though the cases are more prevalent in the north-eastern States, incidence of HIV through injecting drug use is evident from many parts of the country, specially the urban areas (Gisselquist and Correa: 2006).

Bachani and Sogarwal (2010) states that harm reduction programmes which involve exchange of syringes and needles, coupled with peer education, community outreach, access to health services and a range of treatment modalities from abstinence to oral drug substitution have been adopted by other countries to effectively reduce transmission of HIV through injecting drug use. In India the harm-reduction approach is yet to find wider acceptability because of ethical and moral considerations.

Although transmission of HIV through use of needles, razors and other cutting instruments in beauty parlours, hair-cutting saloons and dental clinics is insignificant, lack of hygienic practices in majority of these establishments also poses a health risk to the unsuspecting general population who visit these places every day. There is an urgent need to bring these establishments to acceptable standards of hygiene to minimise and almost eliminate the chances of HIV transmission through the use of needles and sharp cutting instruments Bachani and Sogarwal (2010).

With a high prevalence of TB infection in India the problem of HIV/TB co-infection also poses a major challenge. Nearly 60% of the AIDS cases are reported to be opportunistic TB infection cases. Treatment of TB among the HIV-infected persons is a new challenge to the National TB Control Programme which has now adopted Directly Observed Treatment Short-course (DOTS) strategy for control of TB infection. Some of the drugs which are recommended for TB treatment pose complications in cases of HIV-infected persons and had to be withdrawn in areas of high HIV prevalence Bachani and Sogarwal (2010).

At the same time looking for HIV among TB infected persons will also cause the problem of scaring away a large number of TB infected cases in the country from seeking treatment under the DOTS strategy. There is no risk of any TB patient getting infected with HIV unless he or she practises high risk behaviour or gets infected from transfusion of HIV-infected blood (Buse 2011).

HIV & AIDS is not a disease which spreads randomly, and is transmitted as a consequence of a specific behavioural pattern and has strong socio-economic implications. It not only costs huge
sums of money in terms of controlling the opportunistic infections such as TB, Pneumonia and cryptococcal meningitis, but seriously affects individuals in their prime productive years causing serious economic loss to them and their families (Buse 2011).

**Economic Impact**

Buse (2011) indicate that the effect of the epidemic is normally transferred from households to households; as well as, across societies. In Cote d'Ivoire, urban households that have lost at least one family member to AIDS have seen their income drop by 52-67%, while their expenditure soared four fold. To cope up, they have to cut their food consumption by about 41%. Rural households facing similar predicaments in Thailand are seeing their agricultural outputs shrinking by half. In 15% of the cases, children are removed from schools to take care of family members who are ill and to regain lost income.

Buse (2011) further states that while addressing the problem of HIV & AIDS among the economically productive and sexually active sections of the population, specific emphasis needs to be given not only to high risk groups like commercial sex workers and injecting drug users, but also to specific groups in the general population like students, youth, migrant workers in urban and rural areas, women and children. Migration of economically productive sections of the population from rural to urban areas in search of employment is a common phenomenon all over the country.

Most of the migrant labour is in the unorganised sector, is highly mobile and live in unhygienic conditions in urban slums. Long working hours, relative isolation from the family and geographical social mobility may foster casual sexual relationships and make them highly vulnerable to STDs and/or HIV & AIDS. All these aspects provide an unusual challenge of the spread of HIV infection through various routes which comes with its long period of invisibility and subsequent manifestation through opportunistic infections (Buse 2011).

In India with a large population and population density, low literacy levels and consequent low levels of awareness, HIV & AIDS is one of the most challenging public health problems ever faced by the country (Buse 2011).

**Response**

Bharat, Aggleton and Tyrer (2001) states that soon after reporting of the first HIV & AIDS case in the country, the Government recognised the seriousness of the problem and took a series of important measures to tackle the epidemic. A high-powered National AIDS Committee was constituted in 1986 itself and a National AIDS Control Programme was launched a year later. In the initial years the programme focussed on generation of public awareness through mass
communication programmes, introduction of blood screening for transfusion purposes and conducting surveillance activities in the epicentres of the epidemic. In 1992 the Government formulated a multi-sectoral strategy for the prevention and control of AIDS in India. It is implemented through the National AIDS Control Organisation at the national level and State AIDS Cells at the State/UT levels. The programme concentrated on the following areas which conform to the global AIDS prevention and control strategy:

- Programme Management
- Surveillance and research
- Information, Education and Communication including social mobilisation through Non-Governmental Organisations (NGOs)
- Control of Sexually Transmitted Diseases
- Condom Programming
- Blood Safety; and
- Reduction of impact.

Eight years into the programme, the Government can look back with a measure of satisfaction for its success in important areas like generation of awareness about HIV & AIDS among the urban and rural population of the country. Awareness levels which were almost insignificant at the beginning of the epidemic have substantially increased in urban areas even though the level of awareness in rural areas continues to remain low (Bharat et al, 2001).

Some very successful intervention programmes among the high risk groups like commercial sex workers in the Sonagachi area of Calcutta, men having sex with men in Chennai and injecting drug users in Manipur were carried out through the dedicated involvement of non-Governmental organisations. Emphasis has been laid on control of STDs by strengthening STD clinics at the district level by early diagnosis and proper management of STDs (Bharat et al, 2001).

Gisselquist and Correa (2006) agree that the availability of good quality condoms, through social marketing, has made a significant decrease in the transmission of sexually transmitted diseases in the last three years. Several important actions have been taken to ensure blood safety by modernisation and strengthening of blood banks, introduction of the licensing system for blood banks and gradual phasing out of professional blood donors. The introduction of component separation facilities has also helped in proper clinical use of blood for transfusion. The
percentage of infections occurring through blood transfusion has reduced from 8% in 1994 to 3-4% in 2001.

HIV & AIDS is not merely a public health challenge; it is also a political and social challenge. Behaviour change will not occur without a significant change in the social and political environment. Unequal gender and power relations, taboos in frank and open communication about sexual health and stigma and discrimination are particularly significant obstacles to an effective response (Gisselquist and Correa: 2006)

The economic impact of the AIDS epidemic needs to be acknowledged. The largest economic cost of a death due to HIV & AIDS is usually lost income as those who die from AIDS are generally younger and in their most productive years.

Gisselquist and Correa (2006) is of the view that there are still many gaps left in the programme and many lessons have been learnt. The inexorable spread of the disease from the initial epicentres to the rest of the country underscores the immediate need to have a paradigm shift in the response against HIV & AIDS at all levels making it imperative to formulate a comprehensive national policy on HIV & AIDS in order to cope effectively with the changed nature of the HIV & AIDS problem. The entire programme of prevention and control of HIV & AIDS needs to adopt a more holistic approach looking at AIDS as a developmental problem and not as a mere public health issue.

Objectives and goals

The general objective of the policy is to prevent the epidemic from spreading further and to reduce the impact of the epidemic not only upon the infected persons but upon the health and socio-economic status of the general population at all levels. The policy envisages effective containment of the infection levels of HIV & AIDS in the general population in order to achieve zero-level of new infections by 2007. The specific objectives of the policy are:

- To reiterate strongly the Government’s firm commitment to prevent the spread of HIV infection and reduce personal and social impact.
- To generate a feeling of ownership among all the participants both at the Government and non-Government levels, like the Central Ministries and agencies of the Government of India, State Governments, city corporations, industrial undertakings in public and private sectors, panchayat institutions and local bodies to make it a truly national effort.
o To create an enabling socio-economic environment for the prevention of HIV & AIDS, to provide care and support to people living with HIV & AIDS and to ensure protection/promotion of their human rights including right to access health care system, right to education, employment and privacy and to mobilise support of a large number of NGOs/ Community Based Organisations (CBOs) for an enlarged community initiative for prevention and alleviation of the HIV & AIDS problem.

o To decentralise HIV & AIDS control programme to the field level with adequate financial and administrative delegation of responsibilities.

o To strengthen programme management capabilities at the State Governments, municipal corporations, panchayat institutions and leading NGOs participating in the programme.

o To bring in horizontal integration at the implementation level with other national programmes like Reproductive and Child Health, TB Control, Integrated Child Development Scheme and with the primary health care system.

o To prevent women, children and other socially weak groups from becoming vulnerable to HIV infection by improving health education, legal status and economic prospects.

o To provide adequate and equitable provision of health care to the HIV-infected people and to draw attention to the compelling public health rationale for overcoming stigmatisation, discrimination and seclusion in society.

o To constantly interact with international and bilateral agencies for support and cooperation in the field of research in vaccines, drugs, emerging systems of health care and other financial and managerial inputs.

o To ensure availability of adequate and safe blood and blood products for the general population through promotion of voluntary blood donation in the country.

o To promote better understanding of HIV infection among people, especially students, youth and other sexually active sections to generate greater awareness about the nature of its transmission and to adopt safe behavioural practices for prevention.
Strategy

The national AIDS control policy principally aims at the following strategy for prevention and control of the disease:

1. Prevention of further spread of the disease by:
   - Making the people aware of its implications and providing them with the necessary tools for protecting themselves.
   - Controlling STDs among vulnerable sections together with promotion of condom use as a preventive measure
   - Ensuring availability of safe blood and blood products; and
   - Reinforcing the traditional Indian moral values among youth and other impressionable groups of the population.

2. Creating an enabling socio-economic environment so that all sections of the population can protect themselves from the infection, and families and communities can provide care and support to people living with HIV & AIDS.

3. Improving services for the care of people living with AIDS in times of sickness both in hospitals and at homes through community healthcare.

4. NGO’s and private sector have an equally critical role to play in an effective response. The challenge is to identify appropriate, locally relevant interventions and experienced community based organisations to work with poor and marginalised populations who are particularly vulnerable to HIV infections. HIV & AIDS control programmes, however well planned and designed at the central level, remain ineffective unless they reach out where people live, work, study and access health and other welfare services including information services.

Ideas from India

Berlatsky (2012) states that India began conducting tests for HIV & AIDS at sentinel sites, with 55 clinics and hospitals, and later extended the sites to 455 in 2003, by which time South Africa had been arguing on whether to start administering anti-retroviral therapy or not. This is the time where even the then State President Thabo Mbeki and his Health Minister Manto Shabalala Msimang were at their worst state of denial. Just as in India, with the exit of Thabo Mbeki, the rolling out of the ARTs started (The Lancet, 2009). The sites include antenatal clinics, STD clinics, injecting drug user's clinics, female sex worker's clinics, and a few sites for testing the disease among men having sex with men. The vast majority of poor women dwelling in rural areas also started accessing the ARTs.
Gender inequality in the spread of HIV/AIDS in the high prevalence states

According to Berlatsky, in India, the major social, economic, cultural, and behavioural issues contributed to the rapid spread of HIV & AIDS. The Government, therefore, focused on gender disparities in literacy, educational attainment, labour force participation, and exposure to media as contributing factors to the low status of women in some of the high prevalence states (ibid). Additionally, patriarchal social and cultural norms, gender differences in awareness of the disease, discrimination, and social stigma were significant obstacles in deterring the spread of the virus among women in the six high prevalence states in India (ibid). South Africa, with a lot of NGOs that took the issue of HIV & AIDS seriously, were able to deal with issues of culture, including issues of polygamy, and the consequences thereof.

Chatterjee and Hosain (2006) states that the lack of education, financial independence, exposure to mass media, and autonomy often leave women in many parts of the country unaware of the dangers of HIV & AIDS. Chatterjee and Hosain (2006) further states that women also face social and cultural stigma that points the blame of contracting HIV & AIDS on them when actually it is the men who are responsible for transmitting the virus to the women. In India, a high percentage of married women who are monogamous contract the disease from their husbands who have multiple sexual partners. Patriarchal norms and the lack of economic or social leverage on the part of women lead to domestic and sexual domination and even violence, especially in rural areas (ibid).

A strong campaign on HIV & AIDS was launched in the late 90's until very recently, and South Africans were able to access AIDS education in all media, including radio and television.

Literacy, educational attainment, and employment status of women

Godbole and Mehendale (2005), is of the view that literacy and education are important tools for gender empowerment. While access to education, in general, enables women to find employment and enjoy better economic status, the autonomy attainable through greater economic independence also makes them less vulnerable to domestic violence and abuse (ibid).

According to Godbole and Mehendale (2005) the labour force participation rates for women in each of the six states are lower than that of men. Besides, unequal distribution in the method of payment made to male and female labourers are likely to lead to lack of economic independence and autonomy for women (ibid). South Africa opened its door for learning to everyone, young and old, and the conditions of employment and employment equity changed the status of all our women across the board.
Exposure to media

National Aids Control Organization (NACO 2006) explains that exposure to any kind of media enables the general population to understand and be aware of the prevalence of HIV/AIDS, the way the virus is contracted, and possible methods of prevention and treatment of the disease. NACO (2006) further states that given the lack of literacy, especially among women in rural areas, the role of media becomes crucial in the effective prevention and containment of the disease. Complete lack of exposure to any form of media is more prevalent among women than men in the six hard hit states. In rural India, watching television at least once a week is the most common method of exposure for women and men, although men have greater exposure to a variety of media, including listening to the radio or reading a newspaper at least once a week (NACO 2007).

Access to all forms of media to South Africans has never been restricted, except for those that reside in deep rural areas that have minimum or no network at all.

Patriarchy, social and cultural norms

Gisselquist and Correa (2006) state that while attainment of human capital and achieving economic independence are the most obvious hurdles towards achieving gender equality, social norms, and the cultural climate in these states are glaring indications of the subservient treatment meted out to women in society, households, and sexual contracts. Until gender equality is achieved in all the above spheres, women will remain subject to physical, economic, and sexual exploitation by men (ibid).

Women often submit to having sex with their infected husbands for fear of physical violence (Godbole and Mehendale, 2005). Less than ten percent of men believe that the husband should refuse financial support or use force to have sex with the wife or have sex with another woman when the wife refuses to have sex with the husband (ibid).

Infected wives, in many cases, unknowingly transmit the virus to their children, especially in rural areas where awareness among women is low. Patriarchal and cultural norms also prevent wives from questioning their husbands about their sexual fidelity (Chatterjee and Hosain, 2006).

Social stigma and discrimination against women

According to Chatterjee and Hosain (2006), Social stigma and ignorance about the disease pose huge obstacles in the containment of HIV/AIDS in India. Stigma can be a form of social control used to devalue and reject the less powerful people in society. HIV/AIDS is often ignorantly
constructed as a punishment for perverse sexual behaviour and lack of moral values. The infected patients are often shunned by their relatives, friends, and health workers (ibid).

Women in India face the brunt of stigmatisation associated with the spread of the disease. Female sex workers are looked down upon by society, and their rights and welfare are seldom discussed in the context of public policy.

In India, wives who have been infected by their husbands are often blamed for failing to fulfil the husband sexually and are abandoned by the family (Bharat and Aggleton, 1999). This is especially true for the poor and marginalised women who have low social and economic status. On the other hand, married men can pursue non-regular partners for sex and are not subject to this kind of stigmatisation by their family and friends. The unequal treatment of HIV positive men and women in India is a reflection of societal values where they are subject to different standards of sexuality (Godbole and Mehendale, 2005).

Godbole and Mehendale (2005) further state this kind of stigmatisation against women is rooted in history, social norms, class, and caste stratification, and culture. The level of stigma and discrimination faced by women varies across different communities in India and is inversely related to high gender development indices. Even in South Africa, in the context of public health, this kind of stigmatisation is a huge deterrent in the attempt to curb the spread of the HIV & AIDS virus among the general population in India. Additionally, ignorance about the availability of centres where men and women can go and get themselves tested is adding to this burden.

**Social status of women**

In India, as much as it is in rural South Africa, polygamy is still practiced and women are sometimes forced to suffer abuse for fear of their husbands taking another wife. This is perhaps indicative of the fact that social norms and patriarchal practices dominate other variables when it comes to the treatment of women who are vulnerable to the disease and are at risk of spreading HIV & AIDS to their children unknowingly.

India provides a glaring example of the need for gender-sensitive policy aimed towards the prevention and control of the HIV & AIDS epidemic. Policies need to focus on the allotment of more resources and development of specific devices (e.g. female condoms and virucide) that empower women and would allow them to gain control over their vulnerability to acquire diseases. What needs special attention goes beyond the usual gender perspective that emphasises gaps in human capital and economic empowerment. Women need to gain stronger footing in
domestic negotiations and life skills that help them practice safer sex through greater awareness and access to more resources.

Generally, South Africa has a smaller population compared to India; however, most of the social issues relating to the spread of AIDS are nearly the same. The efforts to prevent AIDS by the governments of India and South Africa are more or less the same.

**Britain**

**The spread of HIV & AIDS in Britain**

Although AIDS gets less attention from the media in the UK than it did during the early history of the United Kingdom the AIDS epidemic is far from a problem of the past. In fact, the epidemic has expanded, with the annual number of new HIV diagnoses more than doubling between 1999 and 2003, and peaking in 2005 at almost 8 000 diagnoses. Annual diagnoses have slightly declined since then with 6 660 people diagnosed HIV-positive in 2010 (BHIVA, 2006).

The United Kingdom AIDS statistics show that of the 91 500 people living with HIV in the UK at the end of 2010, approximately 24 per cent were unaware of their infection (British HIV Association (BHIVA) (2006).

Relatively low numbers of people in the UK have died from AIDS in recent years thanks to the availability of HAART (Highly Active Anti-retroviral Therapy), which dramatically increases the life expectancy of people living with HIV. In 2010, around 529 HIV-infected persons died, compared to 1 723 in 1995, when anti-retroviral treatment for HIV was not widely available. The majority of AIDS-related deaths in 2010 occurred because people were diagnosed late and therefore did not start treatment early enough. In 2010, an estimated 50% (3 300) of adults were diagnosed at a late stage of infection (DID, 2010).

Since 1996 the life expectancy of people living with HIV in the UK, on anti-retroviral treatment, has increased by 15 years. Until recently, an average person living with HIV, aged 20, was expected to live an additional 30 years. However, a recent study indicates that an average person living with HIV, aged 20, is now expected to live an additional 46 years. This is still about 13 years less than the general UK population. Improvements to anti-retroviral treatment were cited as the main reason for the increase (DID, 2010).

According to the Health Protection Agency (2010), this estimation of life expectancy does vary depending on certain factors, such as sex, CD4 count and lifestyle. For example, women living with HIV in the UK have a slightly higher life expectancy than men. Also, if a person’s CD4 count is low when they begin anti-retroviral treatment; their life expectancy is expected to be
significantly lower, at least 10 years less, than if they had started treatment at the recommended CD4 count of between 200-350 cells/mm³. Factors such as smoking, alcohol and drug use, and the existence of co-morbidities can also affect life expectancy, but were not measured in the study (Health Protection Agency, 2010).

Infections acquired through heterosexual sex account for the largest number of HIV diagnoses in the UK. The majority of people who acquired HIV heterosexually were infected overseas, but only became aware of their status after being tested in the UK according to Health Protection Agency (2010). However, this majority appears to be diminishing; The number of new HIV diagnoses among people infected overseas has decreased since 2004, whilst diagnoses among people who most likely were infected heterosexually within the United Kingdom have recently risen dramatically, from 320 in 2001 to 1 090 in 2010 (ICE, 2011).

By 2010, people who were infected within the UK accounted for a third of all heterosexuals newly diagnosed that year. Recently, new infections among gay men (and other men who have sex with men) have also risen, reaching an all-time high and accounting for 45% of new infections in 2010.

Despite the rising numbers of new HIV infections in the UK, public knowledge of HIV & AIDS appears to have declined. In 2000, 91% of people in the UK knew that HIV was transmitted through unprotected heterosexual sex; by 2010 this figure had fallen to 80%.

Many United Kingdom HIV & AIDS organisations have called for improved sexual health services. The Terrence Higgins Trust, for example, released a 2007 report stating that sexual health services in England remain woefully under prioritised and underfunded. It claims that despite the government's promise of an extra £300 million for sexual health services across the United Kingdom to modernise clinics and reduce waiting times, many GUM (genito-urinary medicine) clinics remain cramped, out of date and understaffed (Sigma Research, 2010).

In 2011 a report by the House of Lords Select Committee into HIV & AIDS in the UK noted that despite a growing epidemic and increasing numbers of people on treatment, awareness of HIV & AIDS in Britain has fallen below the public radar. More resources directed towards HIV prevention, including wider access to HIV testing, were identified as key measures needed to reduce new HIV infections in the UK and effectively deal with the epidemic (Sigma Research (2010).

Funding cuts announced by the government in 2010 will probably affect services for HIV & AIDS in the UK. In June 2010 it was announced that £28 million allocated for HIV & AIDS support services in the country would no longer be protected, a decision with probable knock-on
effects for counselling, peer support, staff training and care services for people living with HIV in the UK (National Aids Trust, 2011).

According to National Aids Trust (2011), Charities such as the Terrence Higgins Trust and the National AIDS Trust have expressed concern that such cuts will affect local HIV organisations who rely on such funding to provide specialist social care support to HIV-positive people who are not necessarily catered for by mainstream services. However, there is a broad geographical distribution of services, with more than 80% of people with a diagnosed HIV infection living within five kilometres of an HIV service.

Management of AIDS in the United Kingdom

HIV remains one of the most serious public health challenges facing Britain. There are now over 70,000 people infected with HIV in the UK, with one in three of this number undiagnosed. The numbers living with diagnosed HIV have trebled in the last ten years. New diagnoses currently exceed 7,000 a year – there were 7 662 new HIV diagnoses in 2005, the last year for which we have complete data, compared with 2 665 in 1995. According to the UNAIDS Report 2013, the number of people living with HIV was 130 000, made up of adults aged 15-49 and a prevalence rate 0.3%. The number of women aged 15 and up living with HIV was 38 000 and none of the children aged 0-4 was living with HIV. There were no deaths due to AIDS and also no orphans due to AIDS aged between 0 and 17 (BHIVA 2013, UNAIDS 2013).

The highest ever number of HIV diagnoses among gay and bisexual men of 2 500 was recorded in 2005. Overall HIV prevalence remains low at 0.1%, but the epidemic is concentrated in two often marginalised communities – gay and bisexual men and Africans – and prevalence within these communities is much higher. Prevalence amongst gay and bisexual men between the ages of 15 and 44 is estimated nationally at 5.2% (diagnosed and undiagnosed) – disaggregated as 8.4% in London and 3.6% in the rest of England and Wales. There are also very high numbers of gay and bisexual men living with diagnosed HIV in Brighton and Manchester. Prevalence of diagnosed HIV infection is estimated to be 3.6% amongst black Africans (BHIVA 2013, UNAIDS 2013).

While for most people living with HIV in the UK, the advent of anti-retroviral therapy has radically transformed the implications of the disease, allowing them to live full and productive lives, there continues to be between 500 and 600 HIV-related deaths every year, often related to late diagnosis. Moreover, HIV infection unfortunately brings with it for many the experience of stigma and discrimination (BHIVA 2013, UNAIDS 2013).
The significant increase in HIV prevalence has a number of causes. These include the fact that people with HIV are living longer as a result of effective treatment, and recent migration to the UK of people living with HIV (usually undiagnosed), both heterosexual from high prevalence countries and also men who have sex with men (MSM), often from the EU (BHIVA 2006).

But prevalence is also a result of ongoing transmission of HIV within the UK. There are continuing significant levels of risk-taking behaviour amongst gay and bisexual men and some evidence of increased incidence amongst gay men aged over 34 in London. Aggregated statistics also disguise particular problems in sub-groups — for example, there is a much greater vulnerability to HIV infection amongst migrant and black and minority ethnic gay men (ICE, 2011).

Incidence might still be relatively low compared with some countries but this should not blind us to the disproportionate burden of physical and mental ill-health caused by HIV infection in particular communities, nor of the danger of incidence increasing if we fail to increase our efforts in HIV prevention. With numbers with HIV three times what they were ten years ago, with significantly larger gay and black African communities, and with evidence of increased risk-taking behaviour amongst gay men, the need to invest in effective HIV prevention services is greater now than it has ever been previously (ICE, 2011).

The National AIDS Trust has as one of its priorities ‘securing political will, commitment and resources for HIV prevention based on need ...‘. The commissioning process within the NHS is central to the effective support and resourcing of HIV prevention. There are some national HIV prevention programmes funded centrally by the Department of Health — in particular the CHAPS partnership, managed by the Terrence Higgins Trust, which works on HIV prevention amongst men who have sex with men (MSM), and the National African HIV Prevention programme (NAHIP) which is managed from within the African HIV Policy Network (AHPN). But these funds only provide additional and complementary support for local work and cannot substitute for targeted and effective local commissioning of HIV prevention activities, based on local need. PCTs receive funding from the Department of Health for HIV prevention as part of their overall resource allocation.

The National AIDS Trust (NAT) decided to undertake a survey of the commissioning of HIV prevention activities in England. This was in the context of increasing levels of concern as to whether HIV prevention was being commissioned adequately in terms of resources, or effectively in terms of need. Recent reports underline concerns over current commissioning practice. For example, Terrence Higgins Trust’s (THT) report ‘Disturbing Symptoms 5’ describes a ‘loss of expertise in local sexual health service planning’ and ‘a continuing disconnect
between national strategy and local action on sexual health’. Commenting on the THT survey findings, the report states, ‘Despite the increasing importance of well-informed commissioning, more than two in five responding PCTs could not say that a local sexual health needs assessment had taken place in the last three years’.

At about the same time as NAT’s survey of HIV prevention commissioning, a survey was also carried out for the AIDS Funders Forum on the commissioning of HIV social care, support and information services across the UK. The report comments, ‘NHS HIV commissioners occupy a range of job roles, have a range of backgrounds and skills and are rarely HIV specialists. Many have multiple other priorities and roles, few have received any formal training and many receive no ongoing support. Expertise in service development is not a common skill among commissioners’. The report goes on to state that many NHS commissioners believe their role is to save money and monitor and remove existing contracts rather than commission new services.

An important recent report from the Healthcare Commission, ‘Performing better?’, has also identified real concerns on the use of data to inform the provision of sexual health services at both national and local levels. For example, PCTs did not always have the information they required to allow them to target their programmes to help those most in need. In relation to PCTs, the report recommends that they should focus on reducing inequalities in sexual health commissioning services in line with national standards, assessing local needs and evidence of good practice.

There is a disturbing mismatch between the problems in commissioning apparent from such research, and the ambitions for commissioning found in Government policy documents. These ambitions are communicated most recently in the consultation document and White Paper ‘Commissioning framework for health and well-being’ which sets out an important agenda to achieve:

- A shift towards services that are personal, sensitive to individual needs and that maintain independence and dignity
- A strategic reorientation towards promoting health and well-being, investing now to reduce future ill health costs
- A stronger focus on commissioning the services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities. NAT’s survey of HIV commissioning took place during the reconfiguration of PCTs
in the latter half of 2006, as did the work relating to the reports cited above from THT and the AIDS Funders Forum/Sigma Research.

Even though the NHS was in a state of flux in 2006, the continuing rate of change within the NHS has meant it is hard to find a ‘stable period’ in which to carry out such a survey, but in any event, the merging of most PCTs into larger units (from 303 PCTs to 152) should not have necessarily meant the loss of expertise. Furthermore, this was an opportunity to get some sort of baseline data on HIV prevention commissioning pre-reconfiguration against which future progress in the newly established PCTs could be measured.

**Overcoming Obstacles**

Since the highest ever number of HIV diagnoses amongst gay and bisexual men of 2,500 was recorded in 2005, Britain’s overall HIV prevalence remains low at 0.1%, but the epidemic is concentrated in two often marginalised communities – gay and bisexual men and Africans – and prevalence within these communities is much higher. Prevalence amongst gay and bisexual men between the ages of 15 and 44 is estimated nationally at 5.2% (diagnosed and undiagnosed) – disaggregated as 8.4% in London and 3.6% in the rest of England and Wales. There are also very high numbers of gay and bisexual men living with diagnosed HIV in Brighton and Manchester. Prevalence of diagnosed HIV infection is estimated to be 3.6% amongst black Africans.

The biggest HIV/AIDS NGOs, CHAPS partnership, managed by the Terrence Higgins Trust, which works on HIV prevention amongst men who have sex with men (MSM), and the National African HIV Prevention programme (NAHIP) which is managed from within the African HIV Policy Network (AHPN) worked with most people living with HIV in the UK and the advent of anti-retroviral therapy has radically transformed the implications of the disease, allowing them to live full and productive lives.

**Ideas from the United Kingdom**

South Africa took very long to realize that people with HIV & AIDS in the developed world are living longer and healthier lives following the introduction of the Highly Active Anti-retroviral Therapy. In the United Kingdom, the medical management of stable HIV infection could eventually fit into the more normal pattern of chronic disease management (King, 1988).

What South Africa can learn from Britain’s programme on HIV/AIDS is that National organisations such a National Progressive Primary Health Care Network (NPPCN), South African National NGOs Coalition (SANGOCO) and Treatment Action Campaign (TAC), to mention a few must not be marginalised, but be an active part of the Government’s effort to combat HIV/AIDS.
Business Unity South Africa (BUSA) has always been taking HIV & AIDS issues seriously, ensuring that health and welfare of all workers is taken care of. Policies and programmes developed responses to the impact of the epidemic on the development process, bearing in mind the demographic changes which result from AIDS-related sickness and death. For example, traditional agricultural extension programmes train men or women farmers of reproductive age. In the era of HIV & AIDS, these programmes have gone out of their way to encourage participation of the very young and the very old, and respond to their needs. That necessitates the development of new methods of agriculture, as well as new methods of community outreach.

In Britain, as well as in South Africa, development organisations including NGO’s looked at the impact of HIV & AIDS on their own sustainability and survival. Addressing staff problems in terms of sickness, absenteeism, high cost of treatment, and low production became the order of the day, and the impact of stigma and ostracism on staff, which is worse for women.
PART 3: Communication issues relating to HIV & AIDS

COMMUNICATION

Zaaiman (2009:244) states that the term communication has been derived from the Latin word *communis* which means common. Therefore, to communicate means to make known. The process of making common or known is carried out through exchange of thoughts, ideas or the like. The exchange of thoughts and ideas can occur through gestures, signs, signals, speech or writing.

People are said to be in communication when they discuss some matter, or when they talk on the telephone, or when they exchange information through letters and other communication devices. Communication basically is the sharing of information, whether it is written or verbal (Zaaiman, 2009:245).

MASS COMMUNICATION

Issues of HIV & AIDS require broadcasts using mass communication strategies. Personnel who are involved in broadcasting education or information about HIV & AIDS need to understand the dynamics of mass communication to be able to successfully communicate messages of this type.

According to Hanson (2011:9), mass communication is the pinnacle of the communication pyramid, a society-wide communication process in which an individual or institution uses technology to send messages to a large mixed audience, most of whose members are not known to the sender. The news, speeches, newspaper reports and magazines are forms of communication. Hanson further states that traditionally, mass communication has allowed only limited opportunities for feedback because the channels of communication are largely one way, but with the rise of interactive communication networks, the opportunities for feedback are growing rapidly.

Also, mass communication occurs when a small number of people send messages to a large, anonymous and usually heterogeneous audience through the use of specialised communication media.

A simple definition of mass communication is that it is a public communication transmitted electronically or mechanically. In this way messages are transmitted or sent to large numbers, perhaps millions or billions of people across the world.

However, according to Poku, (2005:7), the term mass communication was coined in the 1920s, with the evolution of nation-wide radio networks, newspapers and magazines which were
circulated among the general public. The dissemination of information to a wide range of people remains the main function of mass communication. Mass communication technically refers to the process of transferring or transmitting a message to a large group of people. Typically, this requires the use of some form of media such as newspapers, television, or the Internet.

Poku, (2005:6) further states that another definition of the term, and perhaps the most common one, refers to an academic study of how messages are distributed to larger groups of audience simultaneously.

**Mass Audiences**

The receivers of mass communication messages, according to Hanson (2011:16), have traditionally been seen as an anonymous audience. This means that the sender does not personally know all, or even most, of the people receiving the message.

Vivian (1997:371) states that the size and diversity of a mass audience add complexity to mass communication. Mass communicators are never sure exactly of the size of audiences, let alone of the effect of their messages. Nagasvare and Krishnasamy (2011:67) state that the modern revolution enables everybody to become a journalist at little cost and with global reach. Nothing like this has ever been possible before. Fast-developing and innovative technology is fuelling the mass communication revolution. Digital broadcasting and the internet are doing away with the limitations of the analogue world, and therefore weakening the grip of government-owned mass media platforms.

Nagasvare and Krishnasamy (2011:67) further state that the new mass communication is a cyber-culture with modern computer technology, digital data controlled by software and the latest fast-developing communication technology. Most technologies described as new media are digital, and often have characteristics of being networkable, dense, compressible, interactive and impartial (Nagasvare and Krishnasamy, 2011).

**Conclusion**

This chapter outlined how the HIV & AIDS epidemic has affected India and United Kingdom. The primary purpose of examining the spread of the epidemic in these regions was to gain insight into various methods which are used to contain the disease. The idea is to examine whether we, as South Africans, can learn to improve our strategy in the fight against this epidemic.
CHAPTER THREE

A CONCEPTUAL MODEL FOR HIV & AIDS COMMUNICATION

INTRODUCTION

In this chapter the researcher discusses the Shannon and Weaver theory as well as the ‘Uses and Gratification’ theory. The Shannon and Weaver model of communication is cited in many areas of this chapter since it is used to conceptualise a communication model as a strategy to curb HIV & AIDS transmission. This is significant to the study since ideal solutions for communication are presented to local government as a communication strategy to overcome the problem of HIV & AIDS transmission. By using these two theories the researcher will create an ideal solution (a model) by taking into account current problems. It is impossible for the organisation to perform a successful activity without examining challenges. The role of communication is to prepare the community for public engagements.

A MODEL

According to Mortensen (2005), a model is a systematic representation of an object or event in idealised and abstract form. Models are somewhat arbitrary by their nature. The act of abstracting eliminates certain details to focus on essential factors. The key to the usefulness of a model is the degree to which it conforms in point-by-point correspondence, to the underlying determinants of communicative behaviour.

Communication models are merely pictures; and are even distorting pictures, because they stop or freeze an essentially dynamic interactive or trans-active process into a static picture. Models are metaphors. They allow us to see one thing in terms of another (Mortensen 2005).

THE ADVANTAGES OF MODELS

- They should allow us to ask questions.

A good model is useful and also provides both general perspective and particular vantage points from which to ask questions and to interpret the raw stuff of observation. The more complex the subject matter, the more amorphous and elusive the natural boundaries, the greater are the potential rewards of model building.

- They should clarify complexity.
Models also clarify the structure of complex events. They do this, as Chapanis (1961) notes, by reducing complexity to simpler, more familiar terms; thus the aim of a model is not to ignore complexity or to explain it away, but rather to give it order and coherence.

- According to Mortensen, they should lead us to new discoveries.

Models should be able to draw our attention far beyond what they are intended to. It should lead us to new discoveries that we never anticipated, such that innovations can be applied and developed for future use and generations.

**Limitations of Models**

According to Wilson (2010), there is no denying that much of the work in designing communication models illustrates the oft-repeated charge that anything in human affairs which can be modelled is by definition too superficial to be given serious consideration. Duhem (1954:46) states that there is no value in models at all, as he feels that we can guard against the risks of oversimplification by recognising the fundamental distinction between simplification and oversimplification. By definition, and of necessity, models simplify. So do all comparisons. Kaplan (1964:73) states that science always simplifies; its aim is not to reproduce the reality in all its complexity, but only to formulate what is essential for understanding, prediction, or control. That a model is simpler than the subject matter being inquired into is as much a virtue as a fault, and is, in any case, inevitable.

Insofar as a model ignores crucial variables and recurrent relationships, it is open to the charge of oversimplification. If the essential attributes or particulars of the event are included, the model is to be credited with the virtue of parsimony, which insists – where everything is equal – that the simpler of the two interpretations is superior.

Simplification, after all, is inherent in the act of abstracting. For example, an ordinary orange has a vast number of potential attributes; it is necessary to consider only a few when one decides to eat an orange, but many more must be taken into account when one wants to capture the essence of an orange in a prize-winning photograph (Kaplan (1964:73)).

Mortensen (2005:292) states that critics also charge that models are readily confused with reality. The problem typically begins with an initial exploration of some unknown territory. Then the model begins to function as a substitute for the event: in short, the map is taken literally. And what is worse, another form of ambiguity is substituted for the uncertainty the map was designed to minimise.
Shannon and Weaver

Claude Shannon, an engineer for the Bell Telephone Company, designed the most influential of all early communication models. He introduced a mechanism in the receiver which corrected the differences between the transmitted and received signal. This monitoring or correcting mechanism was the forerunner of the now widely used concept of feedback (Hartley & Bruckmann, 2002:22).

In summary, Shannon and Weaver indicate that when a message is sent from the sender to the receiver, the message is likely to be distorted. This is what they refer to as the “noise”, or disturbance. The theory is very valuable today when we try to understand why a communicated message does not reach its destination, or is not understood in its intended context (Quintanilla & Wahl, 2011).

Feedback about the message is important to determine whether the message has been received and understood in its correct context. In the quest to address issues relating to noise reduction and receipt of the message, it is important that the governing structures also take cognizance of the quality of the channel of the message.

According to Duck (2007:86), the concepts of this model are important in communication research. It prompts us to examine the following issues in communication:

- Entropy – the measure of uncertainty in a system.
- Redundancy – the degree to which information is not unique in the system.
- Noise – the measure of information not related to the message.
- Channel capacity – the measure of the maximum amount of information a channel can carry.

These concepts would later be used to address the communication gaps within municipalities.

Noise

Noise is anything that can try to distract the message. Noise can be physical distractions: for example, when a councillor is addressing people in a meeting and people are unwilling to concentrate because they harbour negative feelings about the speaker, this hinders their listening skills.
Uses and Gratification Theory

Uses and gratification theory suggests that media users play an active role in choosing and using the media. Van der Velde, Jansen and Anderson (2004:45) believe that users take an active part in the communication process, and are goal-oriented in their media use. These theorists say that media users seek out a media source that best fulfils their needs. Uses and gratification assume that the users have alternative choices to satisfy their needs. Uses and gratifications theory takes a more humanistic approach to looking at media use. According to the theory, media consumers have a free will to decide how they will use the media and how they will affect them.

According to Quintanilla and Wahl (2011:13), uses and gratifications theory consists of several elements. One element is that the audience is viewed as active and not passive. Local government should consider community members as business partners and stakeholders. This means that community members are the decision-makers in whatever medium of communication they want to use. Not only are they decision-makers, they are purposeful and intentional in their selection of media; for example, the community will prefer and be more comfortable with one medium over another.

The second element suggests that the link between the effects of media on a person is limited since it is their choice regarding which medium they use. This simply means that there can be a link between the medium chosen and the need that is being fulfilled, such as in using a loud addresser or distributing pamphlets to notify community members about a ward meeting.
The third element is the media battle with other outlets and sources that could meet a person’s need. These could be more traditional sources such as television and radio.

The fourth element of the theory is that people are able to identify and support their own interest and motives in a verbal way. If the community is not happy or not satisfied they will be able to show that and audibly express it. The expression of this could lead to changes in the medium that would calm the unpleased community.

The last element is cultural significance, which can be postponed while audiences explore their orientation to the subject. This illustrates the power of the audience by being able to suspend cultural significance until the audience forms an opinion about it (Hartley and Bruckmann, 2002:37).

Quintanilla and Wahl (2011:17) state that uses and gratification theory is an ideal solution to the problem that gives a framework and a starting point from which the real situation can be examined. This will assist to provide a more realistic solution to the problem. Shannon & and Weaver’s communication model helps to understand a communication problem which exists within local government, and probes to identify distractors of communication which hinders effective communication. According to the literature, possible problems in communication could arise from the following:

- Ineffective communication channels.
- Communication barriers.
- Geographical location differences between the municipality and the community.

Finally, from a theoretical perspective the following would be an “ideal” solution to the problem:

- Trained staff that will handle community matters.
- The use of effective communicating channels.
- Transparency, faithfulness and trust from both the municipality and community.

**A Conceptual Model**

When examining the Shannon and Weaver model of communication as well as the uses & and gratification theory, we realise that the following key elements must form the focal points of the communication model which is aimed at curbing HIV & AIDS:
- **Noise** (or interference to the message): the communication strategy must identify the factors which distort (hinder) the message. For example, incorrect language use in posters, banners and other advertisements.

- **Feedback**: messages sent must be monitored to check whether they have the desired impact.

- **Usefulness of the message**: what is packed in the message which will gain the people’s interest?

- **Gratification**: the receiver of the message must at least assume that he/she will benefit from the message.

The communication strategy which the municipality needs to use must be based on the following principles:

The municipality must identify needs, challenges and culture before attempting to design a communication strategy.

Communication is the primary interface which makes any organisation successful. It includes conducive communicating between the organisation and its publics. It ensures that structured messages are tested and meet their target audience. It ensures success of marketing and advertising initiatives. It directs marketing and advertising methods.

**The design of the message**

- The design must have the core message, which provides the foundation for any marketing programme or branding strategy, and is unique in its systematic approach.

- The design sugar-coats the core message, a user-friendly message that will enhance the attention of the user.

- The message must be practical, workable and easily identified with.

- It must be achievable.

- It must be compiled by communication strategists, not secretaries.

According to Hanan (2001:133), the usefulness of the contents has the following advantages.

- It motivates people to bring change in their existing behaviour regarding the adoption of new ideas, practices or methods.

- It also boosts the knowledge and retention ability of the audience.
Therefore, to sum up, the above-mentioned factors have great importance in an effective message construction for communication campaigns in general and health-related communication campaigns in particular. uThungulu District Municipality must include popular slogans, short messages that will lead to a specific behaviour defined by a combination of four components: action, target, context and time, e.g., implementing a sexual HIV risk-reduction strategy. The message must raise awareness and the knowledge of health risk so that people will know that they can change their behaviour.

**Creating a gratifying message**

- This is actually marketing and advertising.
- It must be created by advertising specialists, not secretaries.
- How is the message sugar-coated to appeal to the target audience?
- What good will the receivers gain?

Gratification is the positive emotional response which can be expressed, in other words, as happiness in the fulfilment of a desire. Thus, the definition shows the term gratification to have two meanings: first, it means the state of being gratified; and having great satisfaction. Secondly, the term means the act or an instance of satisfying.

The end user of the message must be gratified, which is the most difficult issue. However, the uThungulu District Municipality must endeavour to find channels and messages that will in the end, gratify the users.

Blessing and Higson-Smith (2000) have advanced four areas of gratifications in which people used media texts and broadcasts to gain their gratification needs. These include:

**Personal Identity:** This is when people (audiences) create part of their own identity from things they find attractive in people from the media.

**Surveillance:** The audience can gain understanding of many things around the world by consuming a media text; for example, print and broadcast news.

The media are used to focus on information in which the audiences try to find out relevant events and conditions in immediate surroundings; seeking advice on practical matters or opinion and decision choices; satisfying curiosity and general interests; enhancing learning and self-education; and gaining a sense of security through knowledge. Therefore, usage and gratification theory, as Blessing and Higson-Smith had have argued, is concerned with how people use media to satisfy their needs in relation to Abraham Maslow’s hierarchy of needs. In
short, people are proactive and seek media that satisfy their needs. This scenario, therefore, compels different media to compete to satisfy individual needs with two important goals: first, to create popularity among society at different levels (local wards and municipalities). Secondly, the media compete for the audience for purely commercial reasons. The more popular the medium, the more advertisers would like to use it.

**Select a suitable medium**

Choice of medium must be based on what is available to all members of the community – not a select few. The uThungulu District Municipality has the following media available to it: Shine FM, situated in Richards Bay; iNdonsakusa Community Radio; Zululand FM; 1KZN TV; uMlozi; Bay Watch; Eshowe (Western Watch) and Northern Watch.

**Feedback**

- Feedback must be analysed by communication specialists – not secretaries or any unqualified personnel.
- It is the most important aspect of communication planning.
- Feedback allows us to gauge the success of an endeavour, thus enabling us to identify areas requiring significant improvement.
- It evaluates the sender's task and establishes the receiver's value, so that both can realise the importance of communication contents.
- Gaps in messages can be easily identified and corrected.

**Monitoring and Evaluation**

Monitoring is a continuous process that starts from planning and ends up at the evaluation stage. It refers to the periodic examination of the status or value of project/campaign indicators. Depending on the campaign, monitoring may occur every few days, weeks or months.

Gauging effectiveness, providing feedback, and assessing usefulness and impact should be planned at the start and continued throughout the life of the communication programme, validating the programme, validating facts from research and maintaining a balance between that which is needed and that which is provided. Successful campaigns have established independent evaluation and feedback mechanisms that guide not only the process of creating communication strategy, but are also incorporated in all stages.

**Integration and Linkage between Programmes and Social Services**

Health resources are most effective when linked to other activities and backed up by relevant services. For example, a counselling service for teens must be established to provide a
confidential telephone-based service with which the target can consult on matters relating to abstinence and condom use.

Build on Existing Relationships and Practices
It is also important to make use of the communication practices and channels already in use. The uThungulu District municipality has structures of the Department of Health, uThungulu District office, many NGOs that are hands on, and many other stakeholders are great resources to take advantage of.

Sustainability and Expansion
Find creative and innovative ways to repackage messages and communication strategies that have been exemplary in performance.

Conclusion
In this chapter the researcher has investigated Shannon and Weaver’s communication models, but has also explored authors that came up with different models, including the mathematical model which was always compared with general communication models.

The next chapter describes the research methodology applied in the study, including the data collection method, the data collection instruments, the research population and the method of sampling used. The research methodology outlines and explains the relationship between the research problem, the data collecting instruments and the analysis of the research.
CHAPTER FOUR

RESEARCH METHODOLOGY

INTRODUCTION

This chapter describes the research methodology applied in the study, including the data collection method, the data collection instruments, the research population and the method of sampling used. The research methodology outlines and explains the relationship between the research problem, the data collecting instruments and the analysis of the research. Young (2001) states that the aim of methodology is to help the researcher understand the processes and products of scientific inquiry. This can be done through different data collecting techniques or strategies that are available, and making meaning out of the collected data.

RESEARCH OBJECTIVES

The objectives are:

- To determine the feasibility of communication strategies designed by the Uthungulu AIDS Council, including the Uthungulu District Health Department and all six municipalities falling under Uthungulu District Municipality,
- To determine internal barriers which hinder the dissemination of information by the Uthungulu AIDS Council and their complementary organisations,
- To determine the external challenges faced by the Uthungulu District and its municipalities with regard to communications and the dissemination of information about HIV & AIDS and prevalence,
- To test the hypothesis that some traditional healers can cure AIDS,
- To determine the impact of the government’s communication strategies in respect of the prevention of HIV & AIDS programmes, and
- To critically investigate the impact of culture, literacy, infrastructure and some traditions which assist or hinder the prevention of the spread of HIV & AIDS.

ETHICAL REQUIREMENTS

This study will adhere to the ethics of research, and the respondents' rights in terms of the following will be ensured:
Respondents will be informed of their right to participate on a voluntary basis.

Written informed consent will be sought from the respondents.

Confidentiality will be guaranteed at all times.

Respondents will be informed of the purpose of the study as a requirement for the researcher to carry out a research project to fulfil his doctoral degree requirements in Communication Science.

Respondents will be assured of anonymity.

**The research method**

Tashakkori and Teddlie (2003) describe the research methods as ways, techniques or tools for generating thoughtful, accurate and ethical data about a programme, and also ways, techniques or strategies for manipulating the collected data. Cohen et al. (2000) agree with Tashakkori and Teddlie, but further note that methods are to be used as a basis for interference and interpretation, explanation and prediction. The research entails a quantitative pilot study. Cohen et al. (2000) mention that quantitative research is the systematic scientific investigation of quantitative properties and phenomena and their relationships.

The second factor is the shift concerning the nature of the entities that are being studied and their mode of action and relating with marketing strategies in rural areas. According to Cohen et al. (2000) it is wise to consider conceiving of human beings as people and their mode of action as that of social beings. This chapter conceptualises a model for enhancing culture of HIV and AIDS in a rural context by examining Shannon and Weaver’s model of communication in conjunction with the technological usage.

**Acceptance Model**

Williamson (2004) notes how a pilot study or feasibility study can be used in a small experiment designed to test logistics and gather information before a larger study in order to improve the latter’s quality and efficiency. This research entails only six local municipalities within the uThungulu District, KwaZulu-Natal. The results of this study may provide input for a future study incorporating a larger sample of local municipalities at uThungulu.

In order to gauge the responses from the community of the uThungulu district as well as the municipality workers and administrative staff members, two separate questionnaires were drawn up.
**Sampling**

Wilson (2010:191) state that the basic idea of sampling is that by selecting some of the elements in a population, we may draw conclusions about the entire population. A population element, therefore, is the subject on which the measurement is being taken. It is the unit of study. Wilson (2010:191) simplifies it further when he states that taking a subset from a chosen sampling frame or entire population is called sampling.

Hair *et al.* (2007:170), also state, in accord with others, that a sample is a relatively small subset of the population. It is drawn using either probability or non-probability procedures. Whether a probability or non-probability approach is used, careful consideration of sampling design issues is necessary in selecting the sample.

**Sampling Process**

Representative samples are generally obtained by following a set of well-defined procedures. These include the following steps:

- Defining the target population
- Choosing the sampling frame
- Selecting the sampling method
- Determining the sample size
- Implementing the sample plan

**Target Population**

According to Hair *et al.* (2007:173), the research objectives and scope of the study are critical in defining the target population. The target population is the complete group of objects or elements relevant to the research project. They are relevant because they possess the information the research project is designed to collect. Other practical factors may influence the definition of the target population. These may also include knowledge of topic of interest, access to elements, availability of elements and time frames.

Hair *et al.* (2007:173) state that the elements or objects available for selection during the sampling process are called sampling units. Sampling units can therefore be people, households, businesses or any logical unit relevant to the study’s objective. When the sampling plan is executed, sampling units are drawn from the target population to use in making estimates of population characteristics.
Sampling Frame

According to Wilson (2010:191), a sampling frame is a list of the actual cases from which the sample is drawn. The sampling frame is a representative of the population. Velde, Jansen and Anderson (2004:60) state that a sampling frame is a type of record in which research units and/or their attributes are registered; for example, the research units registered in the citizen registry of the municipality, or an address list from the personnel department of the organisation.

Once a sampling frame has been established, the following stage is to consider the sampling and the sampling techniques.

Sample Choice

Hair et al. (2007:173) state that the sampling frame provides a working definition of the target population. A sampling frame is therefore a comprehensive list of the elements from which the sample is drawn, and is as complete a list as possible of all the elements in the population from which the sample is drawn. It is also an accurate, complete listing of all the elements in the population targeted by the research, and is often flawed in a number of ways:

- It may not be up to date.
- It may include elements that do not belong to the target population.
- It may not include elements that do belong to the target population.
- It may have been compiled from multiple lists and contain duplicate elements as a result of the manner in which the list was constructed.

Sampling Method

Saunders, Lewis and Thornhill (2009:213) state that there are two types of sampling:

- Probability or representative sampling
- Non-probability or judgemental sampling.

Traditional sampling methods can be divided into two broad categories: probability and non-probability. Probability methods are based on the premise that each element of the target population has a known, but not necessarily equal probability of being selected in a sample. In probability sampling, sampling elements are selected randomly, and the probability of being selected is determined ahead of time by the researcher.

In non-probability sampling, the inclusion or exclusion of elements in a sample is left to the discretion of the researcher.
QUANTITATIVE / QUALITATIVE RESEARCH METHODS

Quantitative Data
Saunders, Lewis and Thornhill (2009:414) point out that quantitative data refer to all data, and can be a product of all research strategies. They can range from a simple count, such as the frequency occurrences, to more complex data such as test scores, prices or rental costs. Quantitative data collection involves gathering numerical data using structured questionnaires or observation guides to collect primary data from individuals (Hair et al. 2007:203). The data range from beliefs, opinions, attitudes, behaviour and lifestyles to general background information on such matters as gender, age, education and income, as well as company characteristics like revenue and number of employees (Hair et al., 2007:204).

Qualitative Data
According to Wilson (2010:253), qualitative data refers to all non-numeric data or data that have not been quantified, and can be a product of all research strategies. Qualitative data are associated with such concepts, and are characterised by their richness and fullness based on one’s opportunity to explore a subject in as real a manner as is possible (Saunders et al., 2009:482).

Advantages of Questionnaires
According to Gratton and Jones (2010:126), the benefits of using a questionnaire as a data collection tool are as follows:

○ It is practical.

○ Large amounts of information can be collected from a large number of respondents in a short time and in a cost-effective way.

○ It can be carried out by the researcher or by any number of respondents with limited effect on its validity and reliability.

○ The results of the questionnaires are quickly and easily quantified by either a researcher or through the use of a software package.

○ A questionnaire can be analysed more scientifically and objectively than other forms of research.

○ When data have been quantified, it they can be used to compare and contrast other research, and may be used to measure change.

○ Positivists believe that quantitative data can be used to create new theories and/or test existing hypotheses.
Sampling Types
The primary data collection procedure was a self-administered questionnaire. Letters requesting permission to conduct research were sent to the uThungulu District.

Questionnaires
Two separate questionnaires, which were self-administered, were developed to collect the primary data needed for this research. One was given to the uThungulu District Municipality workers and the other to the general public – the community. They were structured questionnaires composed of closed-ended questions, biographical and rating-scale types of question. A copy of the questionnaire can be found in Appendix A.

The External Public’s questionnaire
The external public’s questionnaire was arranged in the following format.

A- Personal information
The questions focused on the personal information such as area of location, gender, age, race, ethnic group, and qualification(s).

B- General Information
The questions focused on the attitudes of the respondents towards other people, their involvement in community service, and how an individual relates to other people.

C- Perception
The questions focused on the sources of HIV & AIDS information, all that the respondents already knew about HIV & AIDS, and what they perceived the role of the District Municipality to be.

The Internal Public’s Questionnaire

A- Personal information
The questions focused on the personal information such as area of location, gender, age, race, ethnic group, and qualification(s).

B- General Information
The questions focused on the attitudes of the respondents towards other people, their involvement in community service, and how an individual relates to other people.
C. Perception

The questions focused on the sources of HIV & AIDS information, all that the respondents already knew about HIV & AIDS and what they perceived the role of the District Municipality to be.

The research Population

Williamson (2004) notes a convenience sample as used in exploratory research where a researcher is interested in getting an inexpensive approximation of the truth. As the name implies, the sample is selected because it is convenient. Schools constitute a convenience sample.

Pedhazur and Pedhazur (1991) state that stratified random sample is used where the population embraces a number of distinct categories; the frame can be organised by these categories into separate strata. Each stratum is then sampled as an independent sub-population, out of which individual elements can be randomly selected. Using a stratified random sampling technique enables a researcher to draw inferences about specific sub-groups that may be lost in a more generalised random sample.

Using it can lead to more efficient statistical estimates. Each stratum is treated as an independent population, and different sampling approaches can be applied to different strata, potentially enabling researchers to use the approach best suited for each identified sub-group within the population.

This study uses a multistage approach to stratified random sampling as previously done by Cronje (2006). The first basis for stratification was across the six municipalities within the uThungulu District Municipality.

Conclusion

This chapter outlines the research methodology which lays a foundation upon which this study has been based. The value of research and the ethical requirements have also been dealt with to enhance the credibility of the study.

The following chapter presents and outlines the findings of the research as presented in graphs and charts. The analysis of the data is also presented under each chart.
CHAPTER FIVE

DATA ANALYSIS

INTRODUCTION

In general, once the data is collected, the purpose is to analyse the data in order to obtain useable and useful information. According to Blessing and Higson-Smith (2000:137), once data collection and checking has been completed, the researcher should begin the process of analysing the data.

This chapter deals with the presentation of analysed data and the results in respect of the research questions.

ANALYSIS OF DATA

This study was conducted in six local municipalities under the uThungulu District Municipality. Six hundred and fifty-eight questionnaires were retrieved. Of these, six hundred questionnaires were randomly chosen and analysed using Moonstat’s statistical analysis programme. The remaining questionnaires were used to replace spoilt questionnaires when necessary. The following constitutes the analysis of the appropriate questions:

The pie chart below indicates the number of respondents in the uThungulu District Municipality, and is divided into six municipalities as indicated below.

Figure 2: Pie diagram representing respondents from the municipalities constituting uThungulu District.

uThungulu District Municipality (DC 28) consists of six local municipalities: uMfolozi Municipality, previously known as uMbonambi (KZ 281), uMhlathuze Municipality (KZ 282),
Ntambanana Municipality (KZ 283), uMlalazi Municipality (KZ 284), uMthonjaneni Municipality (KZ 285) and Nkandla Municipality (KZ 286).

Each of the slices of the pie chart represents each of the municipalities and is indicated by the Municipal Codes - KZs. The majority of the participants in the survey were from the uMhlathuze Municipality, because this municipality has 30 wards, which make it one of the largest municipalities on the North Coast of KwaZulu-Natal.

The Inkandla Municipality (KZ 286) has the least number of participants, which may have been because it is one of the smaller municipalities, and is not easily accessible, since it is predominantly a mountainous sub-region.

![Figure 3: The gender of respondents.](image)

The chart indicates that 68.89% females were willing to participate in the survey (this may have been because of their availability and willingness to participate), and only 29.95% represented the male population, and only 1.16% who could not state whether they were male or female.
The graph shows the majority of participants in this research were Africans at 86.86%, followed by Indians at 9%, Whites at 2.16%, and Coloureds at 1.33%.

The pie chart above indicates the age range of the participants in the survey. 26.67% of the participants were between the ages of 18-20, 30-39 years at 7.67%, 40-49 years at 4.67% and only 0.67 were 50 years and older.
The reason for the high participation of the younger age group was mainly due to their accessibility during this survey. The low participation of respondents aged 40 or older was attributed to their unavailability during this survey.

![Figure 6: The distribution in working experience.](image)

The pie chart diagram represents the working experience of the people that participated in the survey for both internal and external subjects. Those who were between three and fewer years of experience were 52%, 4-9 years at 17%, 10-19 years were 9%; 20-29 years of experience were 4%; 30-39 years at 1% while 40 years of experience and over were at 17%.
51% of the respondents had completed high school, 20.17% did not complete high school, 14% were university undergraduate students, 3.5% graduates and postgraduates were about 1.67%. About 10% were presumed illiterate, and unable to use the written communication. It is even worse if the communication is in a foreign language; hence most illiterate people are hard hit by HIV & AIDS.

Figure 7: The qualification/literacy distribution
General information

Figure 8: The frequency distribution on whether they could open their homes to the homeless or not.

The above chart shows that 52% of the respondents were willing to open their homes to accommodate the homeless and the needy who were either infected or affected by HIV & AIDS, while 33% was not sure, and 12% saying said they could not open up.

Figure 9: The respondents’ response on whether or not they are involved in the uThungulu home-based care activities.
The respondents were asked if they could visit the infected and render home-based care service, under the topic “Community Involvement”. 47% of the respondents stated that they could do so, 23% of the respondents were not willing, and only about 30% of the respondents stated that they would visit the infected and render the service.

![Bar chart](image_url)

**Figure 10: The respondents’ responses on whether the participants would run errands for elderly neighbours without payment or not.**

The respondents’ reflection of their feelings as per the above chart indicates that 40% of the respondents were not willing to help the elderly people including neighbours, 43% would only help sometimes, and 16% clearly understood voluntary work, and were willing to help without expecting anything.
A little more than half of the respondents were willing to visit people in a hospital or neighbours who are ill. 26% stated that they would never visit sick people, and only 23% said that the sick must be visited regularly.

The above chart indicates the respondents’ feelings about helping sick or palliative people with duties at home without payment. 24% indicated that they would never help anyone, 32% stated that they would help sometimes, and 44% stated that they would always help.
Only 46% of the respondents seemed to be willing to help at home without payment, 18% were not even willing to help the parents and/or guardians, and 36% of the respondents would only help sometimes.

Figure 14: A distribution on how well respondents and their parent/s or guardian/s get along with one another
66% of the respondents have a very good relationship with their parents or guardians, 19% considered that there was still room for the relationship to improve, and only 15% were not getting along very well with their parents.

Only 32% of the respondents felt that their co-workers/neighbours were happy with their voluntary community work, 27% were very happy, 41% did not comment and 0.17% respondents were not sure.
This above chart shows that 39% of the respondents got information about HIV & AIDS from parents, while 2% did not get it from either parents or guardians. 46% was not sure while 13% of the respondents were undecided.

About 61% of the respondents were getting information from their brothers or and/or sisters, 38% were not doing so and only 1% was not sure.
Figure 18: The frequency distribution of respondents on whether they got AIDS information from their friend(s) or not.

For those respondents who prefer to share social issues with friends, the above chart shows that 63% of the respondents got information about AIDS from their friends, and 37% stated that they did not share AIDS-related issues with their friends.

Figure 19: The distribution of responses on whether or not respondents got information about AIDS from AIDS volunteers during community/staff meetings.

71% of the respondents were getting information about AIDS from AIDS volunteers during community or staff meetings, while 28% were not. This basically means that the communities
like to attend events organised by the AIDS volunteers, and that the AIDS volunteers’ efforts are much more effective.

![Bar chart showing responses](chart1)

**Figure 20:** The responses on whether respondents get information about AIDS from their doctor or primary health care workers

The respondents were asked if they got information about AIDS from their doctors and/or primary health care workers. More than 76% said yes, and just above 23% of the respondents were not getting information in that way.

![Pie chart showing distribution](chart2)

**Figure 21:** The distribution of respondents on whether or not they get information about AIDS from their religious leaders in their community

The researcher also learnt that 60% of the respondents were getting HIV & AIDS information and 40% of the respondents were not getting information from their religious leaders. This means the religious leaders of the uThungulu District Municipality are very active in
communicating AIDS issues with their communities, or the communities are still trusting and relying on the information as given by the religious leaders from time to time.

![Bar chart showing information about AIDS](image)

**Figure 22: Information about AIDS**

The above chart shows that 81% of the respondents got their information from newspapers and/or magazines, while 18% said no. The uThungulu District Municipality population is therefore mostly a reading community.
89% of the respondents got information about AIDS by listening to the radio, and only 10% were either not keen to listen to the radio, or they did not have it. It could also mean that even when they listened to the radio, they did not pay attention when the information about AIDS was aired.

Figure 23: The distribution of respondents getting or not getting the information from radio broadcasts

Figure 24: Information from radio
Television seem to be one of the favourite media in the region, because according to the above chart, 88% of the respondents got information about AIDS from the television programmes, and only 11% were not keen to watch these programmes, or they probably did not have access to television at all.

Figure 25: The distribution of respondents either getting or not getting information from library books.

The people in the region are getting more and more literate. The respondents scored just over 75% saying they used library books to get information about AIDS, and only 24% are either illiterate, or they just could not access libraries. It could also mean that they were just too lazy to read books.

Figure 26: The distribution of respondents on whether or not they were getting the information from other sources.
The above chart shows how the respondents responded to the question. Fifty-eight per cent (58%) said they got the information from other sources even though they were unable to name them, and just over 41% stated that there were no other sources of information. Only 1% did not respond.

Figure 27: The distribution of respondents on whether HIV is a virus that causes AIDS or not

The respondents were asked if they knew if HIV is a virus that causes AIDS. 86% indicated that knew it, 10% did not know, and 4% stated that HIV is not a virus that causes AIDS.

Figure 28: The response of the participants on whether or not AIDS can kill a person who gets infected with it
The chart above indicates that more than 80% of the respondents said that AIDS can kill a person who gets infected with it, while 11.5% did not know, and only 8% said no.

![Pie chart for UNPROSEX](image)

**Figure 29:** The frequency distribution of respondents’ thinking about whether they could get AIDS by having unprotected sex with a person that had the disease

More than 86% of the respondents reaffirmed their knowledge of HIV & AIDS by saying yes, only 6% said no, and about 8% were not sure.

![Bar chart for BLOODTRANS](image)

**Figure 30:** The distribution of respondents’ thinking about whether they could get AIDS by having unprotected sex with a person that had the disease.

The respondents were much more aware of this: 71% of the respondents said yes, 17% did not know, and 13% said no.
On this there was a very serious problem of ignorance. Only 44% of the respondents said no, about 37% said yes, and those that did not know were about 19%. This means that most respondents were uninformed on this issue.

On the above question, 19% of the respondents did not know, 25% said no, and the majority said yes.
54% of the respondents said no, 11% did not know, and 35% said yes.

The majority of the respondents (about 65%) said no, one cannot get AIDS if one has eaten or touched meat, if the meat is assumed to have been contaminated by the virus. 17% was were not
sure, and almost 19% said yes. This is worrying, because it means that a lot of education on HIV & AIDS must be done.

54% of the respondents said it is impossible, 31% were not sure, and 16% thought AIDS can be transmitted through fruit.

Figure 35: The distribution of respondents' feelings on whether one can get AIDS if one eats fruit that has been contaminated with the disease.

Figure 36: The distribution of respondents' feelings on whether a man can be cured of AIDS if he sleeps with a virgin or an old woman.
76.09% of the respondents indicated that that is a myth. 12.71% of the respondents did not know, and 11.20% said yes. This implies that we still need to do more in terms of HIV & AIDS education.

![Diagram](attachment:image.png)

Figure 37: The distribution of respondents’ on whether they agree or not that the management communicates HIV & AIDS issues with the community.

100% of the respondents considered that the management is communicating HIV & AIDS issues with the community.

![Diagram](attachment:image.png)

Figure 38: The distribution of people affirming that their co-workers participated in communicating HIV & AIDS issues or not.
Where co-workers were assessed on how they participate in communicating HIV & AIDS issues, 37% of the respondents thought that their co-workers are were participating well, 34% said no, and the remaining 21% were not sure.

![Figure 39: The distribution of respondents' knowledge on whether the general community participate in HIV & AIDS issues or not](image)

The above chart indicates the communities’ (external public’s) participation in the HIV & AIDS related issues and/or programmes. 46% of the respondents agreed that the community of uThungulu District Municipality does participate in such programmes, 30% of the participants said no, and the rest did not know.
The above pie chart shows that the majority of respondents agreed that the current programmes which the uThungulu District has are effective, 30% did not know, and only 23% said no. The current HIV & AIDS programmes at uThungulu District Municipality are not effective.

When the participants were asked if they often get information regarding about HIV & AIDS, 58% of the respondents answered yes, 22% said no, and about 20.5% did not know.
47% of the respondents said they did have HIV & AIDS-related activities currently underway, 25% said they did not have any, and 28% did not know. This basically means that even the industries around uThungulu District Municipality have been affected by HIV & AIDS, and are doing what they can to deal with the pandemic. That not only helps sustain the economy and the well-being of the workers in their industries, but also helps spread the message of hope, prevention and care.
47% of the respondents felt that the councillors and the community understand the issues of HIV & AIDS, 35% did not want to comment much on this, and 18% thought that neither the councillors nor the community understand the issues of HIV & AIDS.

![Figure 44: The distribution of respondents' knowledge on whether management and workers participate in various programmes concerning HIV & AIDS or not](image)

It is very clear that most many of the uThungulu District Municipality staff participates in various programmes concerning HIV & AIDS. However, 36% of the respondents said that they did not know whether they did, and 22% say said staff did not participate.
Figure 45 shows that 41.4% of the respondents indicated yes to the above question, 36% said they did not know, and 21.86% said the management does not show any interest in implementing the HIV & AIDS related programmes. The remaining fraction did not want to comment.

About 46% of the respondents indicated that the management was indeed conversant with the problem, 25% were not sure, and about 28% said the management does not know anything about HIV & AIDS. 17% had no comment.
Figure 47: The distribution of respondents’ thinking about the effectiveness of the uThungulu’s UDM’s proper channels for communicating HIV & AIDS messages.

Just over 37% of the respondents agreed that the Municipality’s channels of communication were effective, 38% did not know, and 24% did not agree. Less than 1% of the total number of participants did not comment.

Figure 48: The distribution of respondents’ thinking about the effectiveness of the uThungulu's communication strategies to curb the spread of HIV & AIDS

34% of the respondents agreed that uThungulu District is indeed very effective, 44.98%, indicated that a larger number of the respondents considered that the communication strategies
aimed at curbing the spread of HIV & AIDS are sometimes effective; 15% felt that these strategies are basically not effective, and 6% considered that they were definitely not working.

**Conclusion**

The purpose of this chapter has been to present an analysis and interpretation of the data. Data has been presented graphically by extensive use of bar and pie charts. The kind of data dictated which type of graphical presentation was used. The Moonstats statistical analysis programme was used, and then copied into Microsoft word, which was used in typing this dissertation. The next chapter presents the summary, recommendations and conclusion of the study.
CHAPTER SIX

DEDUCTIONS AND RECOMMENDATIONS

INTRODUCTION

The previous chapter provided a presentation, analysis and interpretation of statistical data collected from respondents. It also scientifically summarised the overall outlook of residents about communication strategies which would promote behaviour change with the view to reducing HIV & AIDS infections within their community.

The main objective of this study was to investigate communication strategies aimed at curbing the extent of HIV & AIDS transmission. This was accomplished by presenting a detailed literature survey which explored information relating communication strategies aimed at curbing the extent of HIV & AIDS transmission. This chapter identifies the challenges revealed from the quantitative survey which communities are faced with in terms of receiving adequate and reliable communication with regard to curbing the extent of HIV & AIDS transmission. This chapter is important because not only does it provide deductions but also attempts to solve the communication problems which were identified in the objectives from the previous chapter.

OBSERVATIONS

This section gives a summary of what was discovered in the previous chapter. Respondents from six uThungulu District Municipality participated in the survey.

About half of the respondents completed their grade 12 education. A small percentage of matriculants, from these communities, enrolled at university.

Almost half of the respondents indicated that they are not knowledgeable about HIV & AIDS prevention. They either do not understand communication about this subject or the communication has not reached them. Respondents indicated that they have little knowledge about the disease or control mechanism. However, these respondents visit and support family and friends who are infected. Although respondents know when family and friends have contracted the disease, they are unable to identify the symptoms at the onset.

Religious leaders and traditional healers offer the majority of information relating to HIV & AIDS transmission; however respondents claim that the information is minimal or distorted (according to the leaders’ viewpoint). Religious leaders normally categorise the disease as a demonic attack.

Respondents indicated that information about HIV & AIDS are provided by programs which are hosted on national televisions, local radio stations, national and local newspapers are helpful to the
community, however, most of it is not comprehensive and easy to comprehend especially because of the literacy level of these communities. For example, most respondents did not know that they can get HIV & AIDS through blood transfusion.

The uThungulu District Municipality lacked realistic objectives in terms of communicating HIV & AIDS messages to their specific communities. Noting that South Africa has a very heterogeneous population, objectives should be realistic, measurable and specific to a particular community. Messages need to be engineered differently for different communities. A generic formula cannot be used to communicate a message to the entire South African population using a singular method. There should also be a clear timeframe for achieving success through these messages.

The community engagement communication programme which these municipalities implemented failed to get the support of traditional leaders. There are strong indications that the programme was not discussed with the local leaders at the onset, hence the defiance from the local leaders as it seemed to have been imposed on them.

Campaign resources are more likely to be effective if the target audience participates in the planning, implementation, monitoring and evaluation of campaign communication strategies.

**Recommendations**

The recommendations are based on the reflections from the quantitative study as well as directives from the conceptual model which was proposed in chapter 8.

The researcher proposes changes to be made to current and previous programs to improve the efficiency of its delivery and consumption:

- Audience participation as a necessary event in the planning, design, and production phases of the campaign;
- Using culturally relevant theories to guide internal processes;
- Outlining clear process and outcome objectives and management plans;
- Repackaging successful messages.

For every successful message and for every successful campaign the following must take place:

**The Messenger**

The team or person who designs the messages for the municipality is the messenger. The messenger must be a communication specialist. This means that the municipality must hire competent (and appropriately qualified) communication specialists. The municipality must put effective training programmes in place to ensure that the communication and marketing specialists
are kept up to date with new innovation in communications and marketing. Strategies must be in place to eradicate nepotism and bribery in hiring the correct personnel.

**The Message**

The message about HIV & AIDS education is referred to as the message in this context. These messages are just as important, or even more important, as messages designed for Mercedes Benz or BMW commercials. Commercials for luxury products get better professional marketing and advertising attention than life-saving campaigns. With this in mind, the messages which relate to life and death require similar or more attention to detail. Good marketing can be very effective in changing behaviour patterns. Messages designed by the communication specialist in conjunction with the marketing and advertising specialist must work together in creating and sustaining healthier behaviour patterns. For example, if Nike can encourage people to wear their shoes, marketing and advertising specialists can make people embrace healthy lifestyles.

**Encoding**

The message which needs to be transmitted to the community must be encoded in a format which takes into account the cultural make-up of the members of the society. The message must be moulded in a language which is familiar to society and which can be easily understood with minimum interpretation. This would minimise the probability of the message being misconstrued or distorted.

Caution must be exercised in ensuring that the message is effectively displayed and distributed in order to ensure that the majority or all the members of a community receive the message. Area tick-sheets would work well in ensuring that all areas of a particular municipality are covered. It is strange that voter billboards are posted in some of the most remote areas of the country, yet health education advertisements are only posted in and around clinics. Local governments could take a cue from political advertisements when creating healthcare advertisements. Marketing and advertising by local government must be upgraded to meet marketing and advertising standards of the corporate and political arena.

It is important that the message, which is intended to change the behaviour of people, be designed such that it has an appeal to the target population. The target audience must find value in the message – this can only be achieved when trained communication specialists are used to design the message so that the target population is motivated to read and accept the message. People must find or assume that they find gratification in the message.

Without well thought-out plans of action, campaigns are forced to rely on things falling into place. This can turn into a perilous situation that can lead to a waste in money, time and effort when
plans do not actualise. Campaign resources are more likely to be more effective if the target audience participates in the planning, implementation, monitoring and evaluation of campaign communication strategies.

Feedback

Steps must be in place to receive feedback about a message which is sent. The feedback can be positive or negative. Feedback is used to measure the success or failure of the message. This would assist the marketing and advertising teams to determine whether they need to alter their strategy or improve the current one.

In keeping with Lagarde’s (2003:47) opinion, messages should be designed and pre-tested with a range of audiences, including those who may be offended and or a victim of potential stigmatisation, to anticipate potential concerns, prevent a backlash against insensitive material as well as develop appropriate responses to such concerns. Assumptions, whether or not influenced by past experience, should never inform the design, production and evaluation stages of a campaign, or its choice of communication strategy.

Campaigns should be designed and implemented by building on best practices in health communications and social marketing, as well as the success factors in recent campaigns, such as pre-testing and evaluation, multiple channels including Web-based communications, quality materials, use of testimonials, partnerships, as well as local and networking outreach strategies. Sound management plans should be in place to guide development.

Campaign implementation processes and management plans and schedules should allow for enough time to mobilise resources, human and otherwise, as well as enough time to test and deliver materials properly.

Effective monitoring and evaluation

Gauging effectiveness, providing feedback, assessing usefulness and impact should be planned at the start and continued throughout the life of the communication programme. It is especially important to validate facts from research and to maintain a balance between that which is needed and that which is provided.

Personal opinions or informal investigations about the appropriateness of message design and impact of message delivery do not constitute reliable and valid measurement. Successful campaigns have established independent evaluation and feedback mechanisms that guide the process of creating effective communication strategies.
Sustainability and expansion

Ad hoc, unconnected messages that lack continuity are less effective than sustained activities that help keep issues on the agenda and fresh in people’s minds. uThungulu District Municipality must support three intervention strategies that work together to create conditions conducive to helping adolescents adopt beliefs, attitudes and behaviours that reduce their risk of becoming infected with HIV. These three strategies include advocacy, behaviour change communication and education.

Advocacy is used to remove environmental constraints and create a supportive politico-administrative, organisational and socio-cultural environment for effective program implementation. Adolescent health programming must take place in a supportive environment. Traditional parental rights and responsibilities often conflict with the pressures of a fast-changing society and the obligations of government. Religious and other social barriers can increase a widespread reluctance to accept the fact that adolescents indulge in sexual activities.

One cannot simply impose views and standards on a national government or local community without respect to their cultural and religious values and traditions. It is therefore important to find a rationale for behaviour change from within existing norms and legislation. For instance, working together with religious leaders to reinterpret religious conventions in ways that do not deny reproductive rights is a way to recognise and build upon people’s existing beliefs.

uThungulu District Municipality is advised to develop a comprehensive communication plan to strategically guide its people about HIV prevention. Its framework for strategic communication should embrace three core areas:

- Marketing and advertising to stimulate a need for the use of both male and female condoms with the aim of preventing HIV and other sexually transmitted infections;
- Marketing and advertising aimed at generating gratification within individuals who participate in safe sex.
- Marketing and advertising which embraces HIV & AIDS prevention and aims at reaching the relevant target population.

The communication strategy

The communication strategy necessitates the selection of primary and secondary audiences so that messages and approaches can be tailored to their specific characteristics. There are several effective methods to choose from in doing this:
o Review the communication options available to address the HIV situation among adolescents and adults.

o Assess the benefits and lessons learned about the most commonly employed HIV prevention tactics;

o Review additional considerations influencing strategy design, such as audience media habits and media channel selection.

Conclusion

This chapter provides a summary of the observations made during the quantitative study. Thereafter, recommendations are offered to improve communication strategies aimed at curbing the extent of HIV and Aids transmission.

The next few pages contain a bibliography of the sources cited in the entire study.
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