

**ATTITUDES OF STUDENTS TOWARDS
INDIVIDUALS WITH HIV/AIDS: AN
INVESTIGATION ON THE UNIVERSITY OF
ZULULAND, KWA-DLANGEZWA CAMPUS**

BY

GUGU NYAWOSE

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A dissertation submitted in partial fulfillment of the requirements for the degree of Master of Arts (Clinical Psychology) in the Department of Psychology University of Zululand.

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JANUARY, 2001

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DECLARATION

I hereby declare that this is my own work and all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

Gugu Nyawose
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GUGU NYAWOSE

JANUARY 2001

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ABSTRACT

The need to carry out research on attitudes towards people with HIV/AIDS stems from a concern about the increasing hostility and prejudice towards people with HIV/AIDS.

The main purpose of this study was to examine the attitudes of tertiary education students towards people with HIV/AIDS. The study also intended to ascertain whether there are any gender difference in attitude of the sample towards individuals with HIV/AIDS.

The questionnaire was administered to 286 students that were attending the University of Zululand. Likert Scale was used to measure the attitudes.

The findings of the study was that the general attitude of students of Zululand University towards people with HIV/AIDS was positive. Another finding was that there were no differences between males and females attitude towards people with HIV/AIDS.

CHAPTER 1

OUTLINE OF THE STUDY

Levels of HIV/AIDS in South Africa are on the increase. Approximately 20 percent of the population is already infected and about 1600 people are infected daily (Business Reporter, 1999). Schlebusch, Bedford, Bosch and du Preez (1991) ably expressed this notion thus: "South Africa is currently experiencing the Epidemic spread of HIV infection and Aids" (p.248). Stephenson (2000) similarly reiterated this idea by noting that it is frightening to learn that in a population of about forty three million people in South Africa more than one tenth of the adult population is HIV infected. Even more worrying, the spread is far more uniform between rural and urban areas than was the case in East African countries, which previously had the highest rates of infection (Stephenson, 2000). Indeed, although South Africa is one of the last countries in Africa to be affected by the HIV/AIDS epidemic (Evian, 1995), it now has the highest HIV infection in the world (Stephenson, 2000).

According to Green-Thompson (1999), the province of KwaZulu-Natal is the most affected. Latest statistics indicated that one in three people in KwaZulu-Natal is infected with HIV/AIDS, (MacGregor, 1999). MacGregor (1999) also, reported that more than 34 percent of pregnant women in KwaZulu-Natal are HIV positive as opposed to 16 percent nationally. At present there are no indications that this trend will change for the better.

Given the lack of an affordable cure and the absence of any cure or vaccination at present, HIV/AIDS threatens the country's social stability, economic prosperity and the survival of the nation. Facts are abundantly clear that a health catastrophe is upon us.

MOTIVATION FOR THE STUDY

The intensity of the problem of HIV/AIDS has been reflected in the striking increase in research work and writings on the topic. Most of the written work dealing with HIV/AIDS has documented that one of the major issues that face individuals with HIV infection and all people with AIDS is the negative attitude of the general public. Numerous writers (Mathews, Kuhn, Metcalf, Joubert & Cameron 1990; Tjaat & Doyle 1993; O'Hare, Williams & Ezoviski 1996), for instance, have confirmed a negative and hostile attitude towards affected individuals.

A culture of silence and fear has also developed around the HIV/AIDS disease. Individuals refrain from disclosing their HIV status because of fear of rejection and isolation from the community. Thus, the present study explored the attitudes of students towards people with HIV/AIDS disease.

STATEMENT OF THE PROBLEM

According to O'Hare et al., (1996), providing students with accurate information about HIV/AIDS has had modest effects on their attitudes, beliefs and behaviour. This suggests that information about HIV/AIDS is essential, but not necessarily enough to initiate and maintain preventive behaviour. Hence researchers face the challenge of ensuring that more scientific information on the subject is produced. It seems reasonable, therefore, that focus be also on changing behaviour that facilitates the spread of HIV/AIDS. Behaviour change cuts across the entire behavioural spectrum including attitudes.

Based on Ajzen and Fishbein's (1980) theory of reasoned action one may argue that individuals are rational beings who use available information systematically to make decisions about their behaviour. This theory maintains that behavioural intention is a product of a person's attitude towards the behaviour, which is determined by personal beliefs about the consequences of behaviour. Then researchers from within the health belief model for instance, Rosenstock, Strecher and Becker (1994) have revealed that people will adopt health promoting behaviours if they believe that they are at risk of contracting the disease and that the disease will have a serious impact on their lives. This model is based on rational decision-making and it fits well with the personal attitude towards behaviour.

Given the seriousness of the disease (HIV/AIDS), particularly in Health Region H, which stretches from the Tugela River to Northern Hlabisa, the present study was undertaken with the aim of changing the attitudes of students towards AIDS and toward people with HIV/AIDS, to a more accepting one and encouraging behaviour that decreases their risk of HIV infection.

OBJECTIVES OF THE STUDY

- The main objective of the study was to assess the attitudes of students at the University of Zululand (Main Campus) towards individuals with HIV/AIDS.
- The study also intended to ascertain whether there are any significant gender differences in the attitudes of the sample towards individuals with HIV/AIDS.

HYPOTHESES

- Prevailing attitudes of students towards people with HIV/AIDS will be negative.
- There will be no significant gender differences in the attitudes of the sample towards HIV/AIDS.

DEFINITION OF TERMS

HIV – Human Immuno-Deficiency Virus

HIV is a virus that destroys the immune system (Greenwood, 1994; Hublely, 1995), most notably the helper T cells that are responsible for the protection of the body against invading foreign bodies (Soicmon & Temoshok, 1987; Edelston, 1988).

This virus which cannot reproduce itself outside the living cell (Hubley, 1995), is present in blood, cervical secretions and semen and to a very small extent in saliva, tears, breast milk and cerebrospinal fluid of the infected person (Kaplan, Sadock & Grebb, 1994).

The HIV virus is slow-acting and may lie dormant for few months to ten or more years. The destruction of the immune system eventually leads to AIDS.

The two major strains of HIV identified to date are HIV-1 and HIV-2. The HIV-1 is mostly prevalent in Western countries while HIV-2 is found mostly in West Africa (Harber, 1998). The latter type is common among the heterosexuals while the HIV-1 type is common in homosexuals and drug users.

AIDS – Acquired Immune Deficiency Syndrome

Aids is an infectious disease that is caused by a virus – HIV (Sarafino, 1994). The virus – HIV destroys the immune system of the affected person. Once the immune system is destroyed and has become weak, the affected person starts to suffer from different kinds of ‘opportunistic’ infections (Edelston, 1988). The estimated period between being infected with HIV and the development of AIDS is about 8 to 11 years (Kaplan et. al., 1994). In South Africa the common opportunistic infection is Tuberculosis (Wilkinson, 1999).

Immune-system

This is the structure of the body that protects it against infections and foreign bodies such as bacteria (Evian, 1995).

Attitudes

Attitudes are the enduring system of affective and evaluative reactions based upon beliefs learned about the characteristics of a social object or class (Shaw & Wright, 1967). Allport defined attitudes as the mental state of readiness, organized through experience, exerting a dynamic influence upon the individual's response to all objects and situations (Tajfel & Fraser, 1987).

Stigma

Alonzo and Reynolds (1995) referred to the concept stigma as representing a construction of deviation from expectations of the wider society. The stigmatized person is isolated, rejected, prejudiced and discriminated by other people (Alonzo & Reynolds, 1995).

AREA OF THE STUDY

This study was conducted at the main campus of Zululand University which is situated at KwaDlangezwa in Zululand. The location of this university is estimated to be 15 Kilometres from

CHAPTER 2

LITERATURE SURVEY

The purpose of this chapter is firstly to answer the question: What do we really know about HIV/AIDS? Some of the available literature on HIV/AIDS will be presented. Then attitudes towards HIV/AIDS victims will be discussed. Finally some theories explaining why people behave in a particular manner with regard to the disease will be outlined.

WHAT WE KNOW ABOUT HIV/AIDS

HIV/AIDS : First Appearance

Exactly when AIDS first appeared is unknown (Evian, 1995). However, recent literature (Hooper, 2000) indicates that the disease might have been around since 1950.

AIDS in Africa

Literature survey (Barnett & Blaike, 1992; Hooper, 2000) show that HIV/AIDS appears to have begun in the countries now known as the Congo, Kwanda and Burundu in the early 1970's. It then spread rapidly throughout Central African nations.

Although in South Africa, the first two cases of AIDS were seen in 1982 (Whiteside, 1990), in Central Africa the magnitude of the existence of the virus became apparent in the latter half of 1986 (Barnett & Blaike, 1992). A similar view is taken by Hooper (2000) who points that Africa's first major Aids epidemic which spread like wildfires across the continent killing hundreds of people every day appeared in 1986. At this time, health workers noticed a rare disease which they termed "slim disease" that caused severe weight loss (Evian, 1995) as shown in Figure 2.1 below.



FIGURE 2.1. One of Africa's earliest AIDS victims.

[Source: Hooper (2000)]

When HIV/AIDS was discovered in Africa, it was more common in heterosexual-oriented people (Evian, 1995).

AIDS in the United States of America

In the United States of America, the first cases of AIDS were identified in early 1981 (Edelston, 1988; Evian, 1995). It now appears, however, that there may have been isolated cases of AIDS before that time.

In the USA, the first discovery was made by a Los Angeles doctor, who found five young men with a rare form of pneumonia. In the same year, it was reported that about 20 men from New York and 6 from San Francisco were having Kaposi's Sarcoma – a form of cancer previously rare in the United States (Jefferies, 1988 cited in Greenwood, 1994).

During its discovery in America, HIV/AIDS was found mostly in young homosexual men (Edelston, 1988; Evian, 1995).

The Discovery Phase

The period between 1981 and 1985 is termed the 'phase of discovery' and it follows the 'silent phase' of the mid 1970's, during which the virus spread unnoticed. During the 'phase of discovery', the

causative virus (HIV) was discovered, statistics on incidence, prevalence and spread of the disease were assembled (Lachman, 1995).

'The true origin of AIDS' : A review of Edward Hooper's theory.

Literature review (Hooper, 2000) reveals that in Africa and Europe signs of Aids were found in the 1970's. Hooper's search for the cause of AIDS took him even further back, to the 1950's – to a time when Africa was used as a testing ground for polio vaccines - when a man called Hillary Koprowski was racing against the clock to be crowned the first person to discover a polio vaccine according to Hooper (2000). Between 1957 and 1960 the vaccine in question, called CHAT, was fed to more than 3000 000 Africans in the countries now known as Congo, Rwanda and Burundu – the very areas now thought by many scientists to be the hearth, or source of AIDS (see Fig 2.2). As indicated by literature (Hooper, 2000) the said vaccine was contaminated with a cell-killing monkey virus, If that virus was SIV (AIDS virus found in Chimpanzees, similar to the human AIDS virus) it was theorised that the vaccination campaign of Third World people should have unwittingly introduced AIDS to Africa.

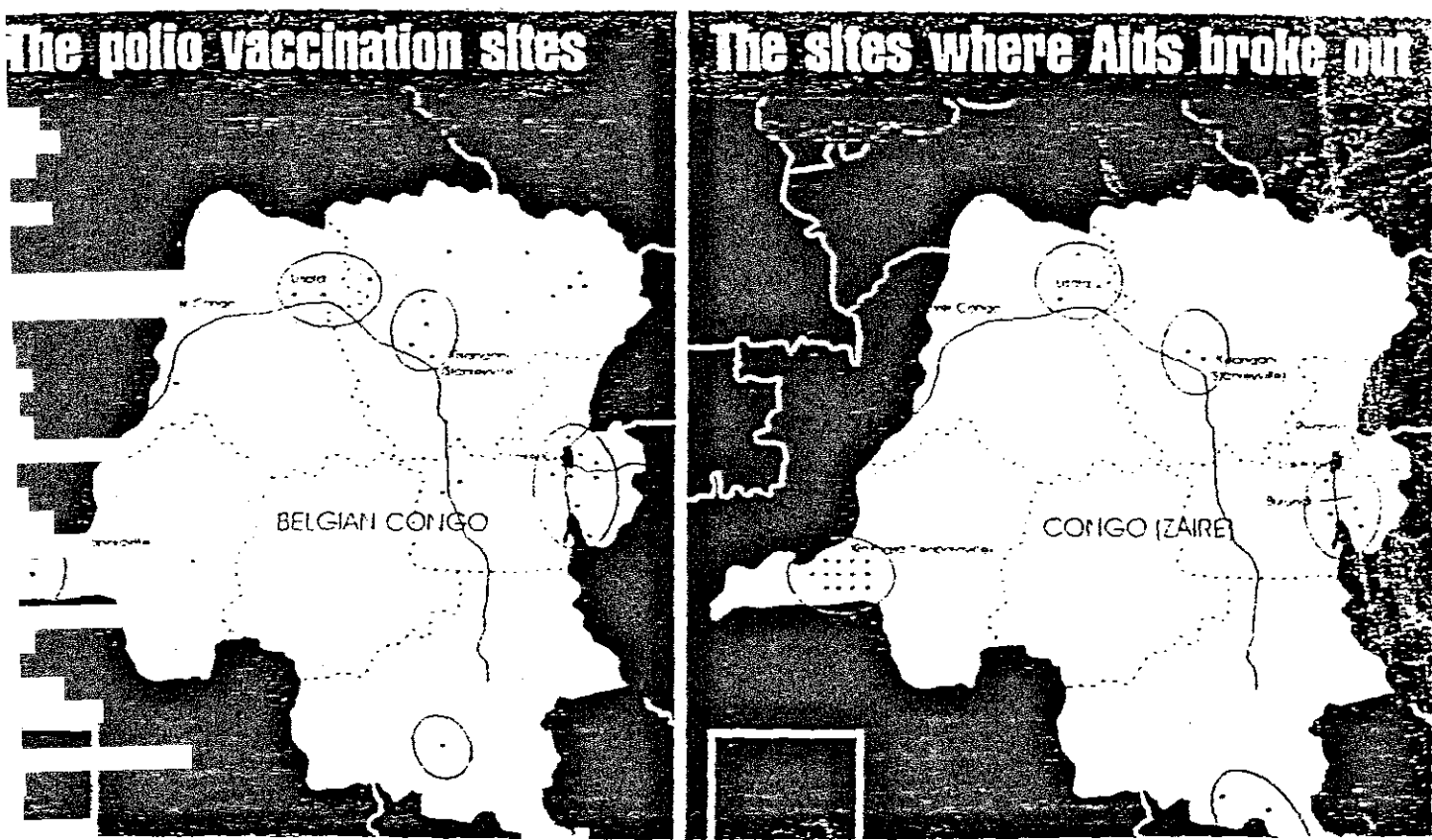


FIG. 2.2 Map of CHAT vaccinations

[Source: Hooper (2000)]

Looking at Figure 2.2. CHAT vaccinations correspond roughly to the regions of highest HIV infection in equatorial Africa. According to Hooper (2000):

- all the early Aids cases were found in the same countries where Koprowski's vaccine was fed

- in those areas where there were no trials, early cases of AIDS could not be found
- Over 87% of all known samples of the AIDS virus from Africa from 1980 or earlier come from towns where the vaccine was fed; 100% come from places within 160 km of the vaccination sites.
- Wherever Koprowki's vaccine was fed, AIDS seemed to follow:

ACKNOWLEDGING HIV/AIDS EXISTENCE

Initially, the majority of people denied HIV/AIDS existence. It took quite sometime for people to accept and take this disease seriously; arguing that it did not exist. Most people demanded to see people with physical symptoms of the disease before they could acknowledge its existence. Unfortunately this took a long time because for this disease, a person can live with the virus for a long period before physical symptoms appear (Stephenson, 2000). Thus the spread of HIV/AIDS continued while people continued to disbelieve and ignore health workers who were talking about its prevention. By the time people started to realise that HIV/AIDS exists, it was already too late and most people were already infected.

THE RECENT DEBATE ON HIV/AIDS

Recently there has been a wide spread debate about whether HIV is really the cause of AIDS. Supporters of the view that HIV is not necessarily the cause of AIDS argue that there are other factors that are responsible for causing AIDS. They argue that poverty could also play a role in bringing about, accelerating and aggravating AIDS. In partly supporting this notion, Hubley (1995) states that in

African countries, the spread of HIV is made rapid by other factors such as poverty, political unrest, refugee problems and the weakening of stable family patterns.

When HIV infection occurs, several years may pass before the person's immune function is impaired—mainly from a reduced number of helper T-cells and symptoms appear (Benjamin & Leskowitz, 1991). Sarafino (1994) explains that during the period before symptoms emerge the virus hides in the person's lymph tissue, multiplying there.

Unlike most epidemics, AIDS does not kill its victim in a short period but it slowly destroys and lowers the immune system (van Aswegen, 1995). Once the immune system is lowered, the affected person then suffers from different diseases called 'opportunistic infections' i.e. AIDS related diseases.

The period between Infection and Diagnosis

Between the time of infection and the AIDS diagnosis, the victim's immune system falters producing a variety of recurrent symptoms such as fever, night sweats, diarrhoea, fatigue and swollen lymph glands (Sarafino, 1994; Hooper, 2000). At this stage, the victim is classified as having AIDS-related Complex (ARC) and may develop AIDS within a few years.

Before developing ARC individuals infected with HIV have no symptoms of the disease. The only way they can tell they are infected is by having a blood test. By the time they are diagnosed with AIDS, their immune system is severely and chronically weakened. From that point on, the disease progresses with repeated bouts of opportunistic diseases, that result from the impairment of the immune system

such as pneumocystis carinii pneumonia, tuberculosis and unusual neoplasm (cancer) etc (Sarafino, 1994; van Aswegen, 1995).

Although most of the opportunistic diseases can be treated successfully with medication, (Sarafino, 1994), evidence has shown that for patients who survive repeated bouts of diseases, the prognosis is still poor and that when the HIV invades the central nervous system AIDS patients develop a brain disorder- a condition called encephalopathy.

MODES OF HIV TRANSMISSION

The HIV virus is mostly transmitted through contact with infected body fluids such as blood, semen, cervical secretions and to a limited extent by saliva, tears, breastmilk and cerebrospinal fluids (Kaplan et al., 1994).

This contact almost always occurs in one of three main ways:

- Sexual activity
- Sharing of contaminated instruments e.g. syringes in drug use
- Birth by an infected mother

Body fluids that are high in concentration of HIV virus are blood and semen from an infected person.

The three most common ways of transmission are sexual contact, infected blood passing directly from the infected person into the body of another person and mother (Nduati & Kial, 1997).

Sexual activity

Sexual contact is the most common method by which the HIV virus is transmitted. High quantities of the HIV virus are found in semen and vaginal fluid of infected people (Evian, 1995). Although male to male transmission had been the most common ways of HIV transmission, the heterosexual transmission now represents a high percentage (Kaplan et al., 1994).

Sharing of Contaminated Instruments

Sharing of contaminated needles and syringes in drug use does transmit the HIV virus. Such transmission is common in developed countries (Whiteside, 1990).

Birth by an Infected Mother

Breastfeeding accounts for 20% of HIV positive babies in South Africa (Macintyre, 1997). The mother can transmit the virus to the child before or during birth and during breastfeeding (Greenblatt & Hessol, 2000).

AIDS STATISTICS

Global Statistics

Since the onset of HIV/AIDS Epidemic in 1981, more than 47 million people have been infected with HIV and many in this figure have died (WHO, 2000). The situation is worse in the sub-Saharan region. UNESCO & UNAIDS (2000) recently reported that more than 95% of the affected people are in the developing countries where poverty, poor health systems and limited resources are making the problem to be worse.

Women are the most affected. According to Monitoring AIDS Pandemic (2000), 55% of all adults living with HIV/AIDS are women. It is estimated that about 600 000 HIV infected infants worldwide are born each year (Wainberg, 1999).

The disease is spreading like 'wildfire' especially in young people. Young women that are in their twenties have the highest rate of HIV infection. It is estimated that of the thirty million persons living with HIV/AIDS around the world, at least one third are young people of 10-24 years age. It is also estimated that every day 7 000 young people are infected world wide (Youth Issues, 1999).

The Picture in Africa

According to Professor Souleymane Mboup in Wotton (1999), about twenty-one million people in Africa are HIV positive and each year an additional four million new cases are reported. In the African continent transmission of HIV virus is mainly through heterosexual contact. The spread of HIV/AIDS among heterosexuals has resulted in devastating implications for the families. It is estimated that more than 80% of all cases of HIV infection in Africa are heterosexually transmitted and up to 10% are from contaminated blood supplies (Green, 1994). In Africa the HIV/AIDS is generally seen as the woman's disease (Wotton, 1999).

The situation in South Africa

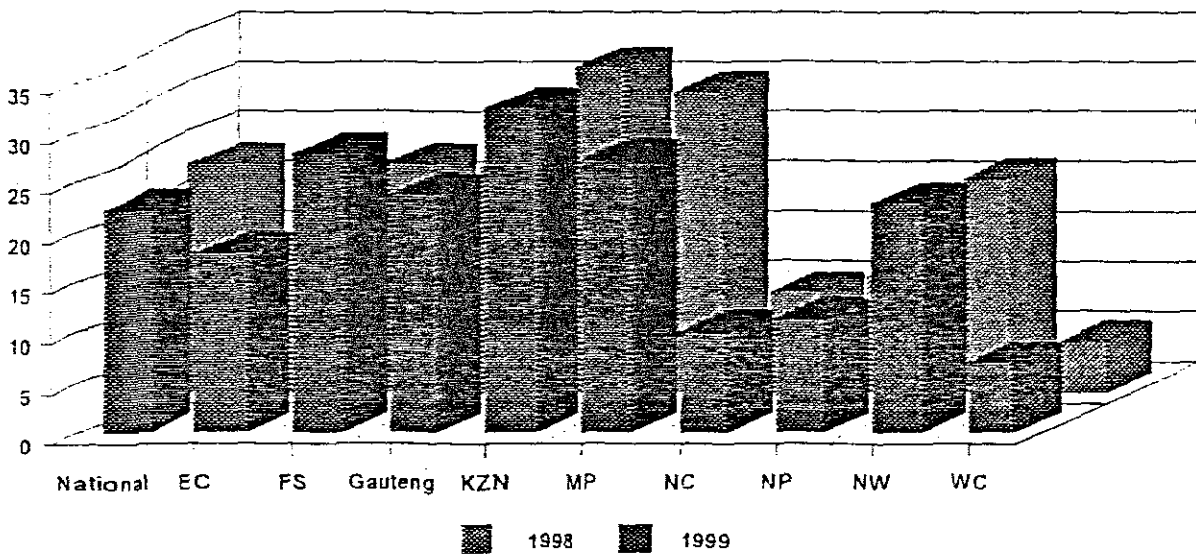
Although South Africa is one of the last countries in Africa to be affected by the HIV/AIDS epidemic it is already having the highest HIV infection rate in the world (Stephenson, 2000). It is estimated that about 3.5 million people in South Africa are infected with HIV infection (Stephenson, 2000). Evidence shows that 20% of the population is already infected with one thousand and six hundred new infections per day (Business Reporter, 1999). It is also estimated that about 60 000 HIV infected infants in South Africa are born each year (Wainberg, 1999). According to Stephenson, 2000), South Africa will have an estimated 800 000 orphans younger than 15 year by year 2005 and as many as 1.95 million by 2010.

The recent seroprevalence done on women attending antenatal clinics has shown some frightening figures with a rise from 17.04% in 1997 and 22.8% in 1998 and this is 33.8% increase (Whiteside, 1999). The results of a seroprevalence survey released by the Department of Health state that the

epidemic is reaching critical levels in the country with KwaZulu-Natal province showing the highest level (Esterhuysen & Doyle, 1993). HIV prevalence nationally and provincially for 1998 and 1999 is presented in percentages below.

Table 2.1

HIV Prevalence Nationally and Provincially in Percentages Comparing 1998 and 1999.



Observations in KwaZulu-Natal

The province of KwaZulu-Natal is the most affected province (Green Thompson, 1999). It is estimated that of the four million people infected in South Africa, half of them live in KwaZulu-Natal. Evidence suggests that by the year 2015, the infected population in KwaZulu-Natal will be six million (Hlongwa, 2000).

The area with a high rate of infection is the North Coast region around Empangeni, Richards Bay and the further North KwaZulu-Natal, region of Hlabisa (Department of Health, 1997 in Harber, 1998). In these areas the high levels of HIV/AIDS are made worse by the factors such as high level of poverty, unemployment and illiteracy.

The level of illiteracy and isolation in some areas is so bad that there are people who are not aware of the function of a condom or who do not even know what a condom is.

Other factors listed by Stephenson (2000) as the problem in controlling HIV/AIDS epidemics in South Africa are the high rates of sexually transmitted diseases, cultural and social resistance to the use of condoms, social norms that accept and encourage multiple sexual partners and low social status of women (Stephenson, 2000).

Validity of HIV/AIDS Statistics

The exact number of people affected by HIV/AIDS is not really known. There are many shortcomings and limitations regarding the validity of the available HIV/AIDS surveillance (Whiteside, 1995).

The HIV/AIDS statistics that is available is mostly obtained from women that are attending antenatal clinics. The problem with this method is that some sectors of the society are excluded because women that are not in their child-bearing age are excluded.

Another problem is that most surveys are done in government hospitals and women who attend private doctors are missed (WHO, 2000).

Pregnant women do not really represent all women in the population. Thus many women are excluded from the available statistics (WHO, 2000).

Hubley (1993) argues that the under reporting of people with HIV/AIDS may also be occurring because of the number of people staying in rural areas who die before coming in contact with the health workers.

Furthermore, the other group of people that could be missed in the available statistics are people that have symptoms but have not yet been diagnosed as having HIV/AIDS. The above arguments make one to be sceptical about the numbers of people with HIV/AIDS that are available. The problem may be worse than what everyone is perceiving it to be.

TREATMENT OF HIV/AIDS

At present there is no available vaccine or treatment to cure HIV/AIDS. An infected person knows that the process of illness is eventually followed by death (Wang & Paterson, 1996).

Presently, people with HIV/AIDS are given antiretroviral treatment. Although these drugs are not a cure for the HIV infection, they are used to slow the progression of HIV infection to AIDS.

However, the high cost of antiretroviral viral drugs and the need for clinical and laboratory services for monitoring its response and its efficacy has restricted the supply of these drugs for people in developing countries (Greenblatt & Hessol, 2000).

According to Barrel (2000), making antiretroviral drugs available to pregnant HIV women could save more than 8000 children's lives.

Traditional healers are also busy trying to find the cure for this deadly disease. Since the antiretroviral drug is not available for the majority of people that are in need of this treatment, traditional healers suggest and support the use of indigenous healing as a solution to this epidemic (Wotton, 1999).

At present, the only method of controlling this epidemic is educating people about HIV spread and prevention.

ATTITUDES TOWARDS PEOPLE WITH HIV/AIDS

A predominant attitude towards people with HIV/AIDS is negative and hostile. This persistent negative societal response plays a critical role in the experiences of individuals with HIV/AIDS as pointed out by O'Hare et. al., (1996). Since HIV/AIDS disease was discovered, affected individuals have been met with hostility, prejudice and stigmatisation (see Highlight 2.1).

HIGHLIGHT 2.1

In December 1999, a woman from KwaMashu was beaten by a mob to death because she publicly declared that she is HIV positive during World AIDS Day Celebration.

[Source: MacGregor (1999) p.1]

The response cited on Highlight 2.1 shows that there is still a long way to go before people with HIV/AIDS can be accepted without any reservations. The hostility depicted here is one of the many examples of the negative attitudes towards people with HIV/AIDS.

In some instances, the discrimination goes to an extent of denying people with HIV/AIDS life insurance's by insurance companies (Aids News, 1999) There are also cases where people with AIDS have been arrested for infecting another person where it is claimed this was done purposely (Green, 1995). Recently there has been a court case where a person was denied employment by a major airline company because of his HIV status (Aids News, 1999).

The resistance in accepting people with HIV/AIDS could be caused by the fact that it took a long time before people admitted that HIV/AIDS disease exists. For many years people denied that there is HIV/AIDS disease. The denial was also helped by the fact that the disease is hidden from view (Stephenson, 2000). The difficulty in accepting that the HIV/AIDS exist shows how difficult it is to even accept people with HIV/AIDS.

THE PSYCHOSOCIAL IMPACT OF AIDS

People are afraid to talk openly about HIV/AIDS because of fear of stigmatization. The extent and serious nature of AIDS stigmatization is not only shown by the society and the media but by people with HIV/AIDS. Many people with AIDS prefer to keep their illness secret for as long as possible (Wang & Patterson, 1996), because of fear of rejection and isolation in the community. This secrecy surrounding having HIV or AIDS can result in social isolation, alienation from family, neighbours and statutory bodies (Hibbard, 1996).

Some of the reasons reported to be the cause of 'non-disclosure' is fear of rejection and being worried about the stigma associated with HIV/AIDS (Simoni, Mason, Marks, Ruiz, Reed & Richardson, 1995). HIV/AIDS victims fear that family members, society and friends will reject them. The common term used in the township when referring to a person suffering from HIV/AIDS disease, is that a person has 'three words'.

'The non-disclosure' may prevent the negative social, personal and material consequences but it may also decrease the opportunities for social support which is an important factor in coping and recovery from physical illnesses (Simoni et. al., 1995).

The social stigma of HIV/AIDS does not only affect the individual affected but it also affects the partner, families and friends of the affected person (Alonzo & Reynolds, 1995) When a person dies of AIDS, the funeral is followed by silence with no one prepared even to mention the cause of death. Sometimes the family members are left confused and in the dark about the illness of the deceased. This sometimes creates tensions within the family, causing the family members to suspect that the family member has been bewitched. It is by accepting that the disease exists and breaking the silence that people can learn to accept people with HIV/AIDS.

People with AIDS have to face the physical consequences of the disease and the problem of being stigmatized and discriminated. Even the disease like leprosy, epilepsy and mental illnesses cannot be compared with the stigma associated with having HIV/AIDS.

Furthermore, people with HIV/AIDS receive less sympathy than those with other terminal diseases (Johnson, 1995). Most studies show that people with AIDS are perceived differently than individuals with other fatal diseases (van Aswegen, 1995). This statement is supported by studies done by Leone and Wingate, (1991); Posson and Jackson (1995). In both studies it was found that people tended to respond more positively towards a person with haemophilia than towards a person with AIDS.

O'Hare et. al., (1996) stated that there is a tendency to treat HIV/AIDS as a moral rather than a medical condition. The person with HIV/AIDS is mostly seen as being responsible for the disease where as those with other diseases are seen as not in control of the disease.

HEALTH PROFESSIONALS PERCEPTIONS

The people that are facing the greatest challenges are the health professionals. Health care workers and other allied care workers are often called to attend to psychological, social and health care needs of those affected by HIV/AIDS.

Most studies show that the attitudes of nurses and other health care workers are often negative and characterized by reluctance to give care to people with AIDS (Kemppainen, Dubbert & McWilliams, 1996). This study was supported by the study by Mbhele (1991), who found that the majority of nurses have negative attitudes towards people with HIV/AIDS.

Mbhele (1991) stated that the majority of health professionals experience feelings of fears of contagion and feelings of homophobia. The frustration is increased by the severity of the symptoms and a lack of ability of medical science to heal or even to alleviate these symptoms.

It is assumed that because health professionals are in contact with information related to HIV/AIDS are knowledgeable about issues related to HIV/AIDS. Even with this knowledge most studies source show that there is still some reluctance from health professionals to work directly with people with AIDS.

In the study that was done by Balogun, Kaplan and Miller (1998), it was found that the professional education appeared to be beneficial in improving the group's knowledge and attitudes towards people with HIV/AIDS but did not affect their willingness to provide services and to work directly with people that are HIV/AIDS. This study was supported by the earlier study by Zagumny and Deckbar (1995), which reported that increasing knowledge about HIV/AIDS has no impact on individual's sympathy towards AIDS patients or willingness to work with them.

Apart from the physical illnesses, people with HIV/AIDS are also at risk of suffering from a variety of psychiatric disorders. One of the reasons for having psychiatric disorders is the dramatic psychosocial consequences of receiving the diagnosis and living with the disease. It is important to know what the attitudes of the mental health professionals are towards people with HIV/AIDS.

The study done by Fliszar and Clopton (1995), showed that psychologists in training tended to have some attitudes that were less positive towards individuals with AIDS than towards people with leukaemia. The less positive attitude towards people with AIDS than towards people with other disease is disturbing. Although the results of this study cannot be taken as the general attitude of all the mental health workers especially psychologists but it does raise some concerns about the quality of emotional care that people with HIV/AIDS are receiving.

The study by Connor and Heaven (1995) found that men have more negative attitudes towards AIDS victims than women. Another study done by Kaplan and van den Worm (1993), contradicted the above study when it found that there were no significant differences between males and females towards people with AIDS.

HIV/AIDS: ISSUES FOR BUSINESS AND EMPLOYERS

The HIV/AIDS epidemic affects everyone, every individual, every family and every business big or small. The existence of HIV/AIDS has become one of the greatest challenges to business development in Africa (Aids Work Place Policy, 2000). The employers are beginning to feel the economic impact of HIV/AIDS epidemics (Stephenson, 2000). The cost to the companies involves HIV-related absenteeism, loss of productivity and the cost of replacing workers lost to AIDS (Aids Work Place Policy, 2000).

It is currently estimated that 11% of the South African work force is infected with HIV and 0.68% are sick with AIDS (Michael, 1999), with many companies losing around 3% of their workers to AIDS each year (Smart, 1999). It is estimated that companies are at risk of losing 20% of their employees through death over the next seven years (Sunday Times Business Times, November 19, 2000).

Life insurance is also hit by a sharp rise in the number of AIDS related deaths (Michael, 1999). A survey that was done by a life insurance company predicted that 18% of the work place would be infected by 2005 (City Press Business, 2000).

People that are needed to fight this epidemics – teachers, health care professionals and government workers – are also dying of AIDS (Stephenson, 2000).

Enlightened companies have recognised that the managing of HIV/AIDS at the work place is a long-term economic investment (Michael, 1999).

SOME REASONS WHY THERE ARE NEGATIVE ATTITUDES TOWARDS PEOPLE WITH HIV/AIDS

The body of literature (Leone & Wingate, 1991; Nicholas & Tredoux, 1994; O'Hare et. al., 1996) investigating the reasons that are thought to be responsible for the negative attitude towards people with HIV/AIDS suggest the following:

- Association of HIV/AIDS with homosexuals and intravenous drug abusers using intravenous materials e.g. needles for injection
- Fear of contracting the disease
- The belief that people with HIV/AIDS are responsible for being infected.

Association with Homosexuals and Drug Users

Personal attitudes towards homosexuals may have an impact on how a person responds to HIV/AIDS positive people. Most studies of health professionals have shown that their level of empathy and caring towards people with HIV/AIDS is negatively affected by the knowledge that the person being treated is homosexual (O'Hare et. al., 1996). In the study by Zagumny and Deckbar (1995), it was shown that more sympathy was given to people who have AIDS whose manner is not known than those known to have got the virus through homosexual behaviour.

The negative attitude towards people with HIV/AIDS can be traced back to how the disease started. When HIV/AIDS was first discovered, it was mostly found in homosexuals and drug addicts (O'Hare et. al., 1996). This has led to a huge stigma around people with HIV/AIDS. When Aids was discovered, it was called gay related immune deficiency syndrome. According to Barnett and Blaike (1992), this name was the beginning of the prejudices associated with HIV/AIDS.

Most people still believe that only homosexuals, drug addicts and promiscuous people have HIV/AIDS. The study conducted by Nicholas and Tredoux (1994) found that 82% of the study sample believed that the majority of gays and lesbians have AIDS. In the same study, the negative attitudes towards homosexuals were very high (Nicholas & Tredoux, 1994).

Several studies have shown that negative attitudes towards those with HIV/AIDS are associated with the preexisting attitudes towards homosexuality (Zagumny & Deckbar, 1995). This is supported by Triplet and Sugarman's study cited in Rozin, Markwith and McCauley (1994), that found that fear of AIDS was attributed to fear of the disease with an unknown cause and to homosexuality.

Internationally, HIV/AIDS is considered to be high among the young male homosexuals and intravenous drug abusers whereas in South Africa it is common in heterosexual people (Schlebusch, et. al., 1991). It is estimated that more than 80% of all cases of HIV infection in Africa have been heterosexually transmitted (Green, 1994). Even in South Africa, where this disease is commonly found among heterosexuals and non intravenous drug abusers, some people continue to associate this disease with homosexuals and intravenous drug abusers.

Most research findings show that fear of AIDS is another way of expressing homophobia (Young, Gallaher, Marriot & Kelly, 1993). HIV/AIDS disease is now found among the heterosexuals but that has not stopped people from associating it with homosexuals and intravenous drug abusers.

Fear of Contamination

The second reason for the negative attitudes towards people with HIV/AIDS that is discussed in most literatures is the lack of knowledge about the spread of HIV/AIDS disease. The study by Armstrong-Esther and Hewitt (1990) that was done with health professional found that the increase in knowledge is related to the change in the attitude towards people with HIV/AIDS and willingness to associate with them. The later study that was done by Zagumny and Deckbar (1995), contradicted Armstrong-Esther and Hewitt (1990) study. In this study the findings were that increasing knowledge about HIV/AIDS does not affect individual's sympathy towards patients with AIDS (Zagumny & Deckbar, 1995).

The lack of knowledge has led most people to fear to associate themselves or to come near a person with HIV/AIDS. There is a wrong assumption that casual contact with a person that is infected can result in contamination. Connor and Heaven (1995), found that the belief that transmission is through social contact was associated with non-sympathetic attitudes. This study also found that the fear of getting the disease may cause people to blame people living with HIV/AIDS and the development of negative attitudes towards them.

Responsibility for the Illness

The HIV/AIDS disease is often associated with immoral ways of living. People believe that people that get HIV/AIDS are homosexuals, drug users and people that are promiscuous. This assumption has made people to have negative attitudes towards people with HIV/AIDS.

The people who contract HIV/AIDS through either homosexual lifestyle or intravenous drugs are seen as being responsible for their illness (Leone & Wingate, 1991). In this study it was found that people felt more positive towards a person with haemophilia because they perceived that this person had no control over contracting AIDS.

This belief that people with HIV/AIDS are responsible for their illness has made people to have negative attitudes towards people with HIV/AIDS, with the results that people with other chronic disease like cancer and heart problems receive more sympathy than people with HIV/AIDS (Johnson, 1995). People believe that people with HIV/AIDS behaviour contribute to whether one gets the disease.

The women sometimes do not have a say in the behaviour of their partners. In South Africa the majority of men work away from their homes and they leave their wives at home. The majority of men that are working away from home become sexually active. During holidays the husband goes back to the wife that have been waiting for months. Unfortunately, most women are financially depended on their husbands and this makes it difficult for them to challenge their behaviour. Most women are uneducated and they are not in contact with health related information.

It is only when people are educated about their rights and until education reaches everyone that the issue of being responsible for being infected can be appropriate.

In the study by van Aswegen (1995), it was reported that 32% of the study group felt that AIDS is the deserved punishment for the 'guilty'. In this study the group identified as being the guilty group were the drug addicts, homosexuals and prostitutes. There is a great need for education of people that it is not only the 'sinners' that get HIV/AIDS and that anyone can get it.

THEORIES

Health belief model

Health belief model appeared in the 1950's as an attempt to understand people's failure to take up preventive and screening programmes (Rutter, Quine & Chesham, 1993). This theory which is a value expectancy theory (Hardy & Conway, 1978) is constructed from three dimensions. The first dimension stipulates that people adopt the health promotion behaviour if they believe that they are at risk of getting the disease. In the second dimension it states that people's behaviour is influenced by how serious the effect on life the disease is perceived to be. If people believe that the disease will have a serious impact on their lives, the chances are high that they will change towards health promotion behaviour (Rutter et. al., 1993). It is also stated that the change in behaviour is influenced by the amount of costs and benefits that will arise from the particular behaviour (Rutter et. al., 1993).

Theory of Reasoned Action

The theory maintains that people are rational beings who make decisions about their behaviour. Unlike the health belief model, the theory of reasoned action is not specific to health. It maintains that behaviour is determined by individual's belief. It proposes that the two sets of beliefs that determine behaviour are personal and normative beliefs (Rutter et. al., 1993).

The behaviour is influenced about what people see as the consequences of their behaviour. The attitude towards behaviour becomes positive when the person perceives the consequences of behaviour to be positive (Rutter et. al., 1993).

The second component of this theory is the normative belief. Normative belief states that the person's behaviour is determined by the individual's perception of what people who are important want them to do (Rutter et. al., 1993).

CHAPTER 3

RESEARCH PROCEDURE

From the existing research literature (Kerlinger, 1973; Cherulnik, 1983; Makunga, 1988; Mason & Bramble, 1989), it is evident that a researcher has numerous possible methods of investigation to select from. Indeed, what is crucial for each researcher is to develop a research design. Author (Makunga, 1988), describes a research design as the logical and systematic planning and directing of a piece of research. In the present study, research was designated to be carried out in two phases.

PHASE 1

In preparing for the main study a pilot study was tried out. For the purpose of this study the definition of pilot study used, is that of Makunga (1988); Mason and Bramble (1989); Huysamen (1994), who define pilot study as a small version of the main study, with a restricted sample of subjects.

Aims of the pilot study

The aim of the pilot study is twofold:

- To examine the research design
- To determine whether the design and the operations will lead to desired information. As Huysamen (1994) puts it, "It ismandatory to test out....questionnaires on a small group of individuals who are representative of the populations for which they are intended" (p.198).

Method

Subjects

Pilot participants were 10 university students (5 males and 5 females) aged 15-30. The selection criterion required that these subjects be none native English-speakers.

Procedure

In the pilot study all details of the major study were undertaken. These included: collecting biographical data, administering the questionnaire, tabulating data and noting findings.

One of the keystone conditions for research is **confidentiality**. After explaining the study's purpose, reading the instructions and ensuring anonymity and confidentiality, participants were requested to complete the questionnaire (see Appendix 1) which was group administered. Participants were requested to carefully read the questionnaire before responding. At the beginning of the examination, participants were comfortably seated.

Data Analysis

Raw data collected by the researcher are not providing any meaning by themselves. In research, the final step is to make sense of the data collected (Makunga, 1988; Neuman, 2000). Results of this procedure are reported in Chapter 4.

The pilot study findings revealed that the research design and the operations would yield desired information.

PHASE II

Aim

To determine the attitudes of people toward HIV/AIDS victims.

Method

Subjects

The sample was 286 students attending the University of Zululand main campus at Empangeni. The research group was technically, a stratified sample as full randomisation was not possible. The stratified sampling technique involved dividing the population into the appropriate strata and then selecting each substrata at random (Reaves, 1992; Harris, 1995).

The population of students who participated in the study is shown below.

TALE 3.1

POPULATIONS OF STUDENTS IN THE STUDY

FACULTIES	DEPARTMENTS	NUMBER OF STUDENTS AND			TOTAL
		YEAR OF STUDY			
		1 ST	2 ND	3 RD	
Science	Chemistry	41	19	04	64
Commerce	Public Admin.	31	43	64	138
Arts	Psychology	24	18	42	84
TOTAL NUMBER OF STUDENTS					= 286

Subjects were told that the investigator was interested in their perceptions of HIV/AIDS. The main motivation for selecting the University of Zululand students is that it is in the province of KwaZulu-Natal that is highly affected by the HIV/AIDS epidemic in South Africa. It is also estimated that about 86.7% of students in this campus are from KwaZulu-Natal (Department of Performance Data, 2000).

Research Design

The survey method was employed in this study. Neuman (2000) explains that the survey is the most widely used data gathering technique. In surveys, researchers usually ask about many things at one time and measure many variables as well as test several hypotheses in a single survey.

Procedure

Written permission to request students to participate in the study was obtained from the authorities of the participating departments. In compliance with the conditions of permission granted, participants completed the questionnaire at the end of a lecture.

The data of the present investigation were collected through group administration of a questionnaire by the researcher. The questionnaire covered the following areas:

1. demographic details
2. student's own perceptions of people affected with HIV/AIDS.

Responses to the questions in the section numbered 2, consisted of choosing the most appropriate answer from a Likert type scale ranging from very negative to very positive. The use of a questionnaire

in this study is of advantage because the researcher gave questionnaires directly to respondents, who read instructions and questions, then record their answers. This type of survey is by far the cheapest, and it can be conducted by a single researcher.

The researcher clarified difficult questions to those who had a problem with understanding some of the questions. Participants were encouraged to be honest in their answers and discussion of questions by participants was discouraged. The importance of anonymity and confidentiality was emphasized (see Appendix 1).

The maximum time taken to fill in the questionnaire was 20 minutes.

Scoring

Data collected was scored and coded by the researcher. All coding was rechecked by the researcher. Information on scoring is reported in Chapter 4.

Data Analysis

To make sense out of data collected by the researcher, frequencies and percentages of responses were tabulated for the total sample. In addition to this, the researcher also used the Chi-Square analysis for the testing of the hypothesis. Findings were also presented using graphs and tables. Results of these findings are given in Chapter 4.

CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

To get a feel for the raw data collected the researcher must analyze it and interpret the results of the analysis. In this chapter, therefore, data collected for this study are presented along with comments about significant findings.

The results are mostly presented in table form. This method of presentation allows the reader to clearly understand the findings of the study.

Pilot Study Results

The average age of the pilot study subjects was 22 years.

The instrument was validated through the use of the method of item analysis. This involved the establishment of discriminative power and difficulty index of an item. As a result of this item analysis, none of the items were discarded.

Main Study Results

All participants in the study were over 18 years of age (see Table 4.1) and they had all been accepted as students at the Main Campus of the University of Zululand. This made the researcher to expect

independent and different responses. Table 4.1 shows that most respondents fell between 18-23 interval age group.

TABLE 4.1

Table 4.1. Age of respondents in years

Age of respondents	18-20	21-23	24-26	27-29	30-32
Number of respondents	102	95	51	25	13

TABLE 4.2

Table 4.2. Attitudes of respondents towards HIV/AIDS

ATTITUDE	FREQUENCY	PERCENTAGE
Very negative	0	0
Negative	6	2
Neutral	0	0
Positive	215	75
Very positive	65	23
TOTAL	286	100

Table 4.2 shows that out of 286 students, 75% (n=215) fell within the positive range and 23% (n=65) fell within very positive range. Therefore a high percentage 98% (n=280) of the sample had positive

attitudes towards people with HIV/AIDS. From this table it can be seen that only a very low percentage (2%, n=6) of the sample had a negative attitude towards people with HIV/AIDS.

The second aim of this study was to ascertain whether there are any significant gender differences in the attitudes of the sample towards people with HIV/AIDS

The number of males and females respondents per faculty is summarized in (Table 4.3).

TABLE 4.3

Table 4.3 Male and female respondents per faculty

Gender	Science	Arts	Commence	Totals
Females	20	66	92	178
Males	44	18	46	108
TOTALS	64	84	138	286

Scores of males and females respondents are cited in (Table 4.4).

Table 4.4

Table 4.4 Attitudes of male and female respondents towards HIV/AIDS

MALE ATTITUDES	FREQUENCY	PERCENTAGE
Very negative	0	0
Negative	4	4
Neutral	0	0
Positive	67	62
Very positive	37	34
TOTAL	108	100

FEMALE ATTITUDES	FREQUENCY	PERCENTAGE
Very negative	0	0
Negative	2	1
Neutral	0	0
Positive	148	83
Very positive	28	16
TOTAL	178	100

Table 4.4 shows that 67 (62%) of male respondents have a positive attitude towards individuals with HIV/AIDS. The table further shows that 37 (34%) of male respondents have a very positive attitude towards people with HIV/AIDS and only 4 (4%) of male respondents have a negative attitude towards people with HIV/AIDS. With regard to females, the table reveals that 148 (83%) respondents have a positive attitude towards people with HIV/AIDS and 28 (16%) of the female respondents have a very positive attitude towards people with HIV/AIDS. Only 2 (1%) of the respondents have a negative attitude towards individuals with HIV/AIDS.

The Chi-Square test was used to determine whether there are any gender differences in the attitudes of the sample. The very negative category and those which are neither negative nor positive were not used because they had zero number of respondents (See Table 4.5).

TABLE 4.5

Gender	Negative	Positive	Very Positive	Total
Females	2	148	28	178
Males	4	67	37	108
Total	6	215	65	286

$$X^2 = 16.24; df = 2; \text{ critical value at } 0.05 = 5.99$$

H_0 : There are no significant differences between males and females in their attitudes towards people with HIV/AIDS

H_1 : There are significant differences between males and females in their attitudes towards people with HIV/AIDS

Observed $X^2 = 16.24$

Df = 2

Critical value at 0.05 level of significance = 5.99

Since $X^2 = 16.24$ and the critical value at 0.05 level of significance is 5.99 which is less than the observed X^2 , we reject the H_0 (null hypothesis) and accept H_1 , alternative hypothesis).

This study therefore confirms that males and females differ in their attitudes towards people with HIV/AIDS.

ANALYSIS OF RESPONSES

The responses that were concerned with the issue of responsibility for the disease and proximity towards people with HIV/AIDS were found to have a higher negative responses.

In item statement number 2, 19% of the sample felt that HIV/AIDS is a punishment for wrong doing and 31% of the sample agreed that people with HIV/AIDS are responsible for their illness with 15% choosing uncertain response.

The majority of the sample (85%) were comfortable with having students with HIV/AIDS in the institution while a substantial number of the respondents agreed that they were uncomfortable with sharing the room with students with HIV/AIDS. This is indicated by 24% of the respondents that agreed that they were bothered with the thought of sharing a room with a student with HIV/AIDS. The issue of intolerance and reluctance to mix with people with HIV/AIDS was also noted. 41% of the sample agreed that it is wise to avoid people HIV/AIDS victims in order to ensure good health.

With regards to the statement that dealt with the existence of HIV/AIDS disease the results were surprising high with 19% of the respondents agreeing that HIV/AIDS is a myth and 25% being uncertain.

Quite a large number of the sample were keen on educating other about HIV/AIDS. This is noted with 90% of the sample that agreed that students should make time to educate their colleagues about HIV/AIDS.

Besides the above statements that showed some negativity, the responses to most statements showed that the respondents' attitudes were positive towards people with HIV/AIDS. In item statement 5, 81% of the respondents agreed that more facts should be available to HIV/AIDS research. It is surprising that 33% of the respondents in item 10 agreed that people with HIV/AIDS are a financial drain to the government.

Although most respondents were positive towards people with HIV/AIDS, about 30% of the respondents held a view that the individuals status is lowered if one contracts HIV/AIDS. Such a view shows that there is some negativity towards people with HIV/AIDS.

CHAPTER 5

In this study the researcher examined the attitudes of tertiary education students towards people with HIV/AIDS. The study also examined gender differences in the attitude towards people with HIV/AIDS.

This study was prompted by the realization that numerous studies show that HIV/AIDS epidemic is on the increase. The research that is looking at people's perception towards people with HIV/AIDS is, therefore, very useful.

The results of this study were derived from the analysis of 20 question responses of 286 students of the University of Zululand, using Likert Scale.

CONCLUSION

The first aim of this study was to look at the attitude of tertiary education students towards people with HIV/AIDS.

This study found that the general attitude of students at the University of Zululand was positive towards people with HIV/AIDS. This study contradicted the study by Nicholas and Tredoux (1994) that found that university students (1st years) had negative attitudes towards people with HIV/AIDS.

There was a marked difference between males and females attitudes towards people with HIV/AIDS. This study found that male and female respondents differed in their attitude towards people with HIV/AIDS. This finding challenges Kaplan and van den Worm's (1993) finding that there is no significant difference between adolescent males and females towards people who have HIV/AIDS.

The results further indicate that although students mostly have positive attitude towards people with HIV/AIDS, they seem to have a high degree of intolerance with regards to close contact with people that have HIV/AIDS.

There were quite a large number of students that were found to believe in exclusiveness of people with HIV/AIDS. These results are consistent with the findings of Connor and Heaven (1995), that people prefer to avoid social contact with people with HIV/AIDS.

Even though quite a high number of students were found to be positive towards people with HIV/AIDS it is surprising that most students felt that people with HIV/AIDS were responsible for their illness. This reflected some moral and judgmental views towards people with HIV/AIDS. The intolerance of people with HIV/AIDS is confirmed as a part of a traditional and politically conservative idea that those with AIDS are responsible for their predicament and God punishes those who sin plays an important role (Johnson, 1995).

In conclusion, it gives hope to see quite a high number of students being positive towards people with HIV/AIDS but the issue that is worrying is the high number of students that are reluctant to mix directly with people with HIV/AIDS. It is likely that the fear of knowledge about the spread of this

disease. The students were, however, found to be positive towards policies that would benefit people with HIV/AIDS.

LIMITATIONS

This study was conducted in one tertiary institution (University of Zululand, KwaDlangezwa Campus), therefore the results cannot be generalized as representing attitudes of all students in tertiary institutions.

The sample size of the current study was small for the population studied. Another obvious limitation of the present study is the exclusion in the sample of people who could have closely associated with an HIV person (e.g. partners affected by HIV from their intimate relationships with their partners). A bigger sample would have probably yielded better results. Therefore generalization is difficult.

Despite the fact that this research is limited in scope, it has provided a basis for much needed similar research at other tertiary institutions.

RECOMMENDATIONS

The results of the present study reinforce the recommendation for incorporating education about HIV/AIDS in the curriculum of tertiary institutions emphasize should be place on educating students about how HIV is transmitted. These can be achieved by having awareness programs to enlighten the students. This will ensure that they are well prepared to work and interact with people with HIV/AIDS

especially those students that are in their final year of study. This is especially important with the final year students because they will soon be exposed to working with people with HIV/AIDS in their working environment.

An attempt should be made to replicate this study and subject the respondents to specific situations (e.g. children affected with HIV/AIDS at birth or through rape), such information will provide clinicians with significant data to plan implement and evaluate intervention targeted at youth.

Having positive attitudes but preferring to keep people with HIV/AIDS won't be of any help to the people that are affected and also to the students themselves.

Most students are likely to encounter people with HIV/AIDS irrespective of a career that they choose and any misinformation may have a disastrous effect on their ability to work with people with HIV/AIDS.

It is also recommended that students should be given a chance to interact with a person with HIV/AIDS. The chance to mix with a person with HIV/AIDS can help the students to be more willing to mix and interact with people with HIV/AIDS.

The present study can only be regarded as exploratory in nature, future exploration looking at the level of students about HIV/AIDS knowledge is recommended.

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APPENDIX A QUESTIONNAIRE

This survey investigates attitudes held by people towards individuals with HIV/AIDS. You are kindly requested to respond to this questionnaire by placing a cross on the answer which you believe is relevant to each question. All data obtained will be treated in a strictly confidential manner.

1. IDENTIFYING PARTICULARS

1. AGE
2. SEX
3. YEAR OF STUDY
4. FACULTY

2. Place a cross on the answer which you believe is relevant for each statement.

3.1 HIV/AIDS is the same as having any other disease.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.2 HIV/AIDS is a punishment for wrong doing.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.3 Students with HIV/AIDS should not be allowed to register at this institution.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.4 Students with HIV/AIDS should share facilities eg. utensils with other students.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.5 More funds should be made available to HIV/AIDS research in South Africa

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.6 People with HIV/AIDS brought it on to themselves.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
----------------	-------	-----------	----------	-------------------

3.7 People with HIV/AIDS should be mixed with other students at the hostel

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
----------------	-------	-----------	----------	-------------------

3.8 People with HIV/AIDS are responsible for their illness

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
----------------	-------	-----------	----------	-------------------

3.9 People with HIV/AIDS should be allowed to improve their lives through education.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.10 People with HIV/AIDS are a financial drain to the government.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.11 HIV/AIDS victims have a role to play in bringing awareness about the disease to the community.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.12 It is wise to avoid HIV/AIDS victims in order to ensure good health.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.13 HIV/AIDS is a myth.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree /
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3.14 Treating HIV/AIDS victims is a waste of time and money.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.15 The thought of sharing a room with a student with AIDS does not bother me.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.16 No one deserves to have a disease like AIDS.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.17 Students should make time to educate their colleagues about HIV/AIDS

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.18 People with HIV/AIDS deserves the best medical treatment.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.19 Educating other students on HIV/AIDS would make me uncomfortable.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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3.20 One's educational status is lowered if one contract HIV/AIDS.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
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APPENDIX B

C/o V.H. Khanyile
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3886

14 August 2000

Head of Department
University of Zululand
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REQUEST FOR PERMISSION TO DO RESEARCH WITH STUDENTS AS THE SAMPLE

Sir/Madam

I am a student at the University of Zululand doing MA in Clinical Psychology. I would like to have permission to do research using students in your department as part of my study sample.

The proposed research is aimed at assessing the attitudes of students towards individuals with HIV/AIDS.

The results of the study will be made available to the University Library. I am hoping that the findings of the study will be of assistance in planning for the future HIV/AIDS educational programmes.

Thank you for giving this matter your attention.

Yours sincerely,

GUGU NYAWOSE