IMPACT OF HIV/AIDS ON RURUAL COMMUNITY OF KWA-MTHETHWA AREA IN KWAZULU-NATAL

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DECLARATION

I, Miss Simangele M Sibaya, hereby declare that Impact of HIV/AIDS on rural community of Kwa–Mthethwa area in KwaZulu-Natal is my own work, and that all the sources that I have used or quoted, have been indicated and acknowledged by means of complete references.

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Ms Simangele M. Sibaya

DEDICATION

This work is dedicated to my parents, Prof PT Sibaya, Dr DC Sibaya and my brothers and sisters.

SUMMARY

A study of impact of HIV/AIDS on rural community involves a whole range of factors. This investigation focused on youth's level of knowledge of HIV/AIDS, youth's informants and youth's attitudes towards HIV/AIDS sufferers.

Literature review was conducted. This has revealed that the attitude within the community feeds on a plethora of explanations for caring of AIDS sufferers. Much research has focused on poverty. Most research recognize the importance of support groups and champion this idea to many communities.

An empirical investigation was conducted. The findings reveal that many adolescents/youth understand a lot about HIV/AIDS. Furthermore youth is receptive to a wide spectrum of credible sources of information. The attitude of the community is generally positive towards HIV/AIDS sufferers.

The dissertation concludes with recommendations for further research in this field.

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CHAPTER ONE

AN ORIENTATION BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Since the emergence of the epidemic in the 1980s, Acquired Immune-deficiency Syndrome (AIDS) has become an increasingly serious health threat and the most feared disease world - wide. As there is no known vaccine for AIDS, predictions of its consequences with respect to human suffering, population growth and monetary implications have received tremendous attention. Futile attempts have been made to play down the extent of menace by comparison with mortality figures of other major infections and non- – infection diseases. However, this procedure ignores the compendium of features that collectively make AIDS a dreadful disease.

Regardless of the fact that the dread of AIDS has caused world – wide panic, research has shown that most people have been reluctant to adopt safer sexual practices in order to eliminate the likelihood of being infected with AIDS virus. Most people still deny that anyone, irrespective of race, colour, age or gender has the potential of contracting the virus, which leads to AIDS. In recent years it has become commonly known that young people, specifically between the age 15 – 29, are a high – risk group for contracting HIV infection because of the high incidence of unprotected coitus among this group. It was evident that young people were aware of the HIV, which leads to AIDS, its mode of transmission, possible risk reduction behaviour and safer sexual practices, particularly condom use.

However, young people are targeted with more factual information regarding HIV infection and AIDS. Furthermore, past research on intervention to change premarital sexual behaviour, smoking, drinking as well as unsafe sexual practices suggest that knowledge per se neither encourages positive attitudes nor appropriate behaviour. Therefore, many variables, including one's attitudes, knowledge, values, beliefs, cultural norms and the influence of significant other (family, friends, peers) play an active role in determining whether or not socially acceptable sexual behaviour is practiced.

According to Sandlers and Myers (1996: 3), AIDS is an issue, which concerns are likely to remain so for many years to come. However, a great deal of progress has been made in understanding the nature of the disease and how we reduce the risk of exposure to the virus which causes it. Sandlers and Myers (1996:4) maintain that initial reports about AIDS in the media were often misleading or false, causing panic and prejudice. Education measures have helped to counteract this and make sure people are correctly informed about the HIV/AIDS epidemic. Many governments are funding research focusing on a cure for AIDS and a vaccine to prevent the spread of the virus.

We know that AIDS comes from a virus, a microscopic organism that causes disease. The AIDS virus is called HIV. Almost everybody who is infected with HIV develops AIDS and dies. Medicines have been discovered that can help people who have AIDS and prolong their lives. AIDS passes from one person to another, mostly through certain kind of risky behaviour. Preteens and teens can have the disease just as adults can (Mc Guire, 1998:5). There

are countless courageous stories about the people affected by the disease, and the relationships, which have been deepened and enriched through caring, understanding and compassion. The enthusiasm of many people throughout the world in their efforts to overcome this disease is enlightening and exciting.

1.2 MOTIVATION FOR THE STUDY

- The researcher often seeks to describe and analyze the behaviour of the family and their values in an effort to understand the HIV/AIDS victims.
- The researcher faces the challenge to offer life skills to young people, parents, learners and educators to take responsibility for shaping their lives, environment and the community.
- The researcher wanted to fight against the epidemic since she had lost some beloved ones.
- The researcher is interested in the investigation of HIV/AIDS since she wants to be more educated about the epidemic.

The significance and value of the present can serve as grounds for motivation:

- The study will throw light on the experiences and coping strategies of members of the community who are living with AIDS/HIV sufferers.
- The study will throw light on solutions for this epidemic.
- This study will provide information on HIV/AIDS prevention strategies.

1.3 STATEMENT OF THE PROBLEM

Despite the methodological sophistication level of the study, the country as a whole has experienced eruption of the HIV/AIDS epidemic, especially in rural areas. In South Africa there are insufficient funds to support those living with the epidemic compared to other developed countries. There are disruptions of life in rural communities, which includes the following;

- Rural communities are often at great disadvantage because of lack of understanding of their cultural norms and values.
- The social and family disruption as a consequence of apartheid and migrant labour.
- Low status of women in society and relationships making it difficult for them to protect themselves in sexual relationships.
- Lack of facilitators for workshops, for example, gender and sexuality education workshops.
- No social services organization for the community.
- No communal resource centers for members of the community to voice their grievances.
- High poverty and low educational level resulting in commercial sex work.

Furthermore, no workshops have been conducted in the rural community on the influence of a combination of practical and theoretical lessons, on HIV/AIDS and Sexual Transmitted Diseases (STD'S).

1.4 RESEARCH QUESTIONS

The present study attempts to find answers to the following questions:

1.4.1 What is the level of knowledge about HIV/AIDS among youth?

1.4.2 Who informs youth about HIV/AIDS?

1.4.3 Who are the preferred informants about HIV/AIDS?

1.4.4 What is the nature of attitudes of community members towards HIV/AIDS sufferers?

1.5 AIMS OF THE STUDY

Since the nature of the aim of the study is purely exploratory and hypothesis will not be formulated. This aim includes the following objectives;

1.5.1 To determine youth's level of knowledge of HIV/AIDS.

1.5.2 To identify youth informants about HIV/AIDS.

1.5.3 To identify information mongers on HIV/AIDS as preferred by youth.

1.5.4 To find out about nature of attitudes of community members towards HIV/AIDS sufferers.

1.6 RESEARCH METHODOLOGY

Methodology as explained by Bailey (1997:33) is the philosophy of the research process. Included in this philosophy are the assumptions and values that serve as the rationale for the research and criteria the research uses for interpreting data and reaching conclusion. This subsection focuses on

research design, population and sample, research instrument procedure for data collection, data analysis and interpretation.

1.6.1 Research design

This is a descriptive study. We do not manipulate the independent variable in descriptive studies. The study examines the present status of the event. This descriptive study will take the form of a field study/field experiment. The subjects/participants will be studied under their natural settings or conditions.

1.6.2 Research instrument

The techniques for data collection will be interview schedules and questionnaire. The nature of the instrument will depend on the nature of research questions the study attempts to unravel. A wide range of scoring and data analysis procedures will be used.

1.6.3 Population and sampling design

A combination of cluster and accidental/incidental sampling designs will be used. This study will be carried out in KwaZulu-Natal provinces. A cluster sampling design will be used. This sampling design presupposes that the area under study is divided into regions or districts. Each region is heterogeneous but the regions are homogeneous. By selecting one region randomly , the researcher is

able to capture the characteristics of other regions. This study will provide information on HIV/AIDS prevention strategies.

The participants will be selected on the basis of this willingness to participate in the study i.e. accidental/incidental sampling design. The issues of confidentiality and informed consent will be observed.

1.7 PROCEDURE FOR DATA COLLECTION

When collecting data all participants who were included in a sample, were visited in their respective homes and in their respective school. The researcher had first introduced herself, explained the purpose of a visit, and then requested for permission to include them in a sample. Such permission was sought from patients and or relevant family members as well as learners from high schools. Once, given a permission, a series of questions were asked from respondents using their home language (i.e. Zulu).

1.8 DEFINITION OF TERMS

1.8.1 AIDS

AIDS is a group of different diseases resulting from a breakdown in the body's immune (defense) system. The acronym AIDS stands for:

A - Acquired = *it passes from person to person, it is not inherited.*

I - Immune = to do with the body's defense against disease

D - Deficiency = not working properly, a breakdown

S - Syndrome = a collection of different diseases/symptoms

1.8.2 HIV

H = Human

I = Immune – deficiency which causes the body's protective system against disease to stop working properly

V = is a small virus or germ, which is found in the body fluids (blood, semen, vaginal fluids, and saliva). It is sometimes also called the AIDS virus or the virus that causes AIDS. Other examples of viruses are those that cause measles, polio and flu.

1.8.3 The virus

It is a microscopic organism that enters the bloodstream and causes disease. The virus replicates by using an enzyme called reverse transcriptase to convert its RNA (the form in which it stores its genetic material) into DNA. (Website: www.tac.org.za, page 10).

1.8.4 Sexually transmitted infections/disease

It is a disease cause by germs that are passed from one person to another during sexual intercourse (AIDS helpline, pamphlets September 2003).

1.8.5 AZT

This acronym stands for : Azidothymidine. It is a drug that reduces the rate of deaths among people with AIDS (McGuire, 1998:36). It

provided exposure prophylaxis protection to the infant and also reduced the material viral load (website: www.tac.org.za).

1.8.6 Condom

It is a latex covering for penis that traps semen and prevents it from entering another person's body (Internet: AIDS Foundation of SA).

1.8.7 Epidemic/Pandemic

It is kind of a disease that is occurring all over the country for example cholera, cancer as well as AIDS itself (Paperback Thesarus: 1990: 209).

1.8.8 AIDS Orphans

The Tanzanian definition refers to an orphan as a child who has lost one or both parents. Some African definition studies focus on the death of the mother as the primary caregiver for the children. In Western countries an orphan is usually a child who has lost both parents (Karlenza, October 1998:4)

The operational definition of an orphan, therefore, is any person under the age of eighteen (18) years, who has lost one or both parents due to AIDS related diseases.

1.8.9 Patient

A patient is a person who is receiving medical treatment especially in a hospital or as an out-patient from a physician (Hereby 1995: 849). The researcher's operational definition of patient refers to any person who is no longer fit for work and has been placed in, a home based care programme, after having been tested and confirmed to be suffering from AIDS related diseases.

1.8.10 Youth

The term youth is used in this study to refer to high school learners.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Literature Review is the study of all relevant documents which have bearing on the problem under investigation. It helps to provide guidelines to the research, acquaints the researcher with the phenomenon under scrutiny, and also helps to prevent the duplication of the researchers work (Uys & Basson 1996: 17). In reviewing literature in this study, the focus will be on the exposition of relevant concepts, theoretical approach, how HIV/AIDS affects the body, the phases of HIV/AIDS, its impact on the sufferers and their families, children, extended families, and on the community and the country's economy, the state and non-governmental organizations (NGO's), the origins and objectives of HIV/AIDS, as well as the summary of the chapter.

2.2 HOW DOES HIV/AIDS AFFECT THE BODY?

The human body has a defense system, which protects it against disease and infection. This defense system is called the immune system. HIV destroys this defense system and leaves the body unprotected against many infections and diseases, which can eventually kill a person.

HIV is a sexually transmitted disease, and transmission of the virus can happen when having unprotected sexual intercourse with an infected person;

that is when bodily fluids are exchanged during sexual contact, vaginal, anal or oral sex.

HIV is most easily transmitted by direct introduction into the blood stream, from infusion of infected blood or blood products, i.e. from sharing needles or blades with someone who is infected.

A woman who is HIV infected can become pregnant just like any other woman. Once pregnant, she may be at risk of developing AIDS much faster than if she does not fall pregnant. There is also a strong chance of her passing the virus on to her baby.

Transmission of the virus from mother to child may occur:

- during pregnancy because the unborn child can only get food from the umbilical cord.
- during the birth process because neonate protection depends on nurses/Doctors.
- from breast – milk feeding because the nurses usually advise the mother for not giving a child breast milk for six months after birth if the mother is being diagnose positive.

2.3 REVIEW OF THE RELEVANT STUDIES IN THE FIELD OF INVESTIGATION

In Africa, in public health and academic circles in the United States and Europe, it has become popular to blame the AIDS pandemic to developing

countries on poverty, particularly extreme poverty and its associated ills of malnutrition, depleted immune system, and lack of affordable health care. Certainly it cannot be denied that poverty exacerbated corruption, social upheaval, racism and harshly unequal distribution of wealth has contributed to the spread of AIDS and other diseases in Africa and elsewhere. It is recommended that an all out war against poverty is urgently needed to relieve much of humanity's misery?

According to Whiteside and Sunter (2000: 47), the first two cases of AIDS were identified in South Africa in 1982. The epidemic was primarily located among White homosexual. Nonetheless, as number of case rose, so the disease began spreading among other groups. In July 1991, the number of homosexual epidemic had been completely overshadowed by the heterosexual epidemic.

Whiteside and Sunter (2000: 47) maintain that since 1991 there have been more heterosexuals infected than homosexuals and the disease has spread among all race groups. As we would expect, in terms of absolute numbers, there are many more black people groups in South Africa. Furthermore, Whiteside and Sunter (2000:10) indicate that HIV/AIDS is not a very strong virus. HIV is hard to transmit. In order for a person to be infected, the virus has to enter the body in sufficient quantities. It must pass through an entry point in the skin or mucous membrane into the bloodstream. This might be during sex, with infected sperm or vaginal. Fluids are passed from one person to another. Sharing needles for injection drugs is highly risk as tiny amount of blood can be trapped in the end of the needles. Pregnant women who are HIV positive can also pass the virus to their unborn child and

through breastfeeding. Other modes of transmission involving blood include bodily contact involving open wounds. It is not carried in waste products such as sweat or urine.

According to Berer (1993:5), HIV is not the first virus in the world, or the first sexually transmitted disease, or the first potential fatal one. AIDS became a leading cause of death among women of reproductive age in many parts of the world by the second half of the 1980's. Yet, it was only 1 December 1990 that World AIDS Day called the whole world's attention to the extent of a problem women living with and dying from HIV/AIDS. HIV does not recognize gender, race, class or national boarders everyone is potentially vulnerable. Any one of us may be at risk or already have HIV. Given the extent of this epidemic worldwide, we should not imagine that we are divided into those who have HIV/AIDS and those who do not. This virus and its defeat belong to all of us. We can only act once we recognized that all of us are living with HIV and AIDS.

According to Berer (1993:7) most people with HIV have no idea when they became infected. Many get no sign whatsoever. Some get symptoms that last for a few days or weeks after infection. The most commonly reported are fever, swollen glands, sore throat, skin rash and aches. These almost always disappear, though swollen glands might persist. The HIV test that is currently used measures antibodies to HIV in the blood, which indicate the presence of HIV infection. It takes from 2-6 months and sometimes longer, for the blood to produce enough antibodies to HIV for a blood test to detect them. This is called the "window period". A person with HIV can transmit it to others during this period, even though an antibody test may be negative.

HIV travels to other parts of the body. HIV has been isolated in cells in the gastric intestinal tract, kidney, lungs, eyes, heart, joints, liver, skin and thymus. HIV does not necessarily enter all possible tissues. This may explain why some people get certain HIV related illness and others get different ones, and why women and men do not always get the same ones. Although, HIV has sometimes been isolated in very low quantities in other body fluids, only blood, sperm/semen and vaginal mucus are considered generally infectious in everyone who has HIV.

Some people have had HIV for more than twelve years with no signs of illness. Their bodies may have developed effective self-protective factors, and they may never become ill. The majority of people with HIV do get HIV– related illness, and their health can decline quickly. Unfortunately all the sings suggest that the longer a person is infected, even if they feel well, the more likely they are to lose immune function, become seriously ill and die.

Once someone learns that they have HIV, they can take steps to protect themselves and others from repeated exposure, seek early treatment for any illness, and take other steps that help to prolong life and health. Other studies have shown that cigarette smoking, poor diet, stress and severe depression all have an adverse effect on the health of people with HIV. Learning of their HIV infection has often been a catalyst for people to make positive changes. Research indicates that living with HIV is not necessarily an early death sentence, and certainly not an immediate one. People with HIV are living full lives, often for many years if the resources to help them are there when needed (Berer, 1993:10).

There are gender differences in the manifestations of many diseases, for example with sexually transmitted diseases such as gonorrhea and Chlamydia. There is also evidence that certain HIV related illnesses can appear earlier or later, or with different frequency and severity in HIV positive women than in HIV positive men. Yet more is known about regional differences with HIV/AIDS than those relating are to gender. HIV positive women in developed countries have been calling for more gender specific research on HIV/AIDS in women since the mid – 1980s. The scientific community has been slow to respond. These inadequacies were acknowledged in a meeting on research priorities relating to women and HIV/AIDS at the WHO Global Programme on AIDS (GPA) in November 1990. Now, greater awareness within the scientific community along with pressure from outside is needed to ensure that the research is undertaken (Berer, 1993: 15).

According to Berer (1993: 17), medical professionals may interpret symptoms in women differently from men. For example many early symptoms of HIV infection may be attributed to depression and/or stress or overwork. Women themselves may not view their own symptoms. Often, mothers who are obviously ill go to a clinic only when their own children are ill, and may not expect attention for themselves. The minor signs of HIV infection are;

- Unexplained enlarged or swollen lymph glands in the neck, armpit or groin for more than three months felt as painless lumps (generalized lymphoid no patchy).
- Chronic or severe tiredness, lack of energy and general weakness.

- Unexplained weight loss of more than 10% of body weight. Women generally have more body fat than men, so weight loss may be ignored or misinterpreted as something desirable in women in some cultures does.
- Unexplained fever lasting more than one month, chills and night sweats.
- Itchy skin or skin rash
- Infections of the skin – fungal, bacterial or parasitic
- Muscle and joint pains
- A viral infection of the tongue which appears as white marks. This may come and go and is not thought to be infectious. It is very rare except with HIV
- Loss appetite, nausea and vomiting
- Shingles (herpes zoster virus) Shingles is a recurrence of childhood chicken – pox and is very infectious. It used to be seen mainly in elderly people and sometimes in those with other illness that cause immune deficiency.

Many people in developing countries go to traditional healers first if they feel ill. Reliable practitioners of traditional medicine do not claim to be able to cure AIDS or prevent HIV related illness, but they do help people come to terms with illness by giving spiritual comfort. In many African cultures, illness is blamed on disharmony among ancestral spirits. Rituals that appease those spirits may not cure the illness, but will satisfy patients and their families that the correct measures have been taken, allowing acceptance and support for the patient by the family. Traditional healers can give health and hygiene education, recommends condom use, and gives preparations that may help someone to feel better psychologically. They can also encourage anyone with symptoms of HIV infection to see a doctor. Cooperation

between traditional healers and health services will be of great benefit to the people with HIV (Berer 1993: 29).

2.4 AIDS AND EDUCATION

2.4.1 What about children with HIV/AIDS attending school?

According to Greathead (1998: 195), there are no known cases of HIV being transmitted in the normal educational setting. However, the increase in the spread of the HIV virus means that infected learners will increase from part of the school population. More and more children born with HIV will with better medical care, reach school – going age and attend primary schools. Indications are that more young people are sexually active and this means that an increasing number of learners attending secondary school might be infected with the HIV virus. Intravenous drug use may also become a more important source of HIV transmission among learners. In accordance with the new South African constitution each person is guaranteed individual's right, not to be unfairly discriminated against, the right to freedom of access to information and the right to privacy. The South African law commission has drawn up the national policy on HIV/AIDS in schools.

2.4.2 Epidemiology of HIV/AIDS in Africa

According to Miller and Rockwell (1988:31), epidemiology information needed to identify and contain an infectious disease was

rarely used until the 19th century when John Snow plotted the cholera epidemic in London. By the 20th century the understanding of the epidemiology of small pox and other infectious diseases helped lead to their containment or eradication. Now the emergence of AIDS poses a new epidemiological challenge that is particularly acute in Africa. Containing the HIV virus, which causes AIDS, will depend in part on an accurate understanding of its distribution among various populations. The present data are so fragmentary that a comprehensive epidemiological description is not yet possible.

Miller also emphasized that the total extent of the understanding of AIDS cases is known but will presumably decrease with time as the medical establishment in every country focus on this epidemic. However if the process of reporting AIDS improves greatly, incidence estimates will reflect the present medical situation in a country. The long average incubation period between initial HIV infection and the development of AIDS means that the patterns of HIV infection in a population, provide a window on the future of the epidemic. It is also indicated by the scientists that comparisons of the estimated seroprevelence of HIV by gender and age in urban and rural communities, and for different high and low risk groups among these communities show discrepancies as large as those between reported AIDS cases and estimated HIV seroprevalence.

2.4.3 HIV prevalence by age and gender

Like most pathogens, HIV does not infect everyone equally, in most industrial countries AIDS is a predominantly a male disease. In Africa, however, HIV has infected men and women almost equally. In some age groups, women in fact have a higher estimated seroprevalence rate than men. The virus impact is differentiated much more by age than by sex. This age and sex pattern of infection is very different from that found in Europe and the United States. In the United States, 93% of the AIDS cases have been men. The age pattern among adult US men is similar to the distribution among men in Africa. But the rate of infection among infants is much higher in Africa than in the United States (1988: 37).

2.4.4 Comparisons of urban and rural estimates of HIV seroprevalance

According to Miller (1988: 37), these are the areas that have been studied first by researchers because they are most accessible to the large urban hospitals that have the facilities and the staff to perform the tests. But most African countries have only a small proportion of their populations living in urban areas. Therefore, we know that the results of these surveys are not representative of the general population in the countries. Fortunately, a survey that has been done in rural area shows a much lower HIV seroprevalence than in the urban areas. For instance, the HIV seroprevalence rates for similar kinds of people who live only 15 kilometers away from each other can be dramatically different. In a study of rural Zaire, the seroprevalence

rate in 1986 was similar to the rate in 1976. This reinforces the observation that the rapid increases in seroprevalence rates are urban phenomena. Unfortunately, the urban areas in Africa are the fastest growing areas in the world (Miller, 1988: 37 – 40).

On the other hand, Zaire moved faster than any other African country to open its doors to research on AIDS, including the testing of vaccines on its citizens. In other East and Central African countries responses to AIDS cases moved more slowly. Tanzania first case of AIDS was identified in 1983. But it was not until 1985 that education programs were launched. Kenya's first case was identified in 1985. It was not until July 1986 that the Kenyan Red Cross began to distribute leaflets, posters, and booklets in English and Swahili. There are other measures besides public education that are essential to checking the spread of AIDS.

2.5 THE IMPACT OF HIV/AIDS ON THE PATIENT AND FAMILY

Being ill, especially if it means being confined to bed, inevitably leads to some restrictions of the personal freedom and increased dependence on others. Unlike in the hospital where there are full time professional staffs, at home, it is the family which shoulders most of the burden of patient's dependence. For the patient's family, even a short illness can create problems, especially if the patient is the mother of the family (Clark & Hiller 1980: 65). When the illness is prolonged or chronic, the effects on both the patient and his/her family may be considerable. The patient dependence may

alter relationships within the family. For example, a marriage, relationship built on shared responsibilities and traditional husband and wife roles are distorted when illness prevents the husband from performing his role as a breadwinner, or the wife from carrying out the domestic tasks which are an important part of motherhood. This includes the physical discomforts of his illness, where the patient may have to cope with feelings of inferiority and loss of self esteem (Clark & Hiller 1980: 06).

The degree of stigma attached to HIV infections means that not only the infected individuals, but their families too, face the threat of social rejection. Regardless of whether the family opts for disclosure or secrecy, the result is social alienation at a time. When social support is maximally required, disclosure or discovery of an HIV positive status can, and often does, result in the loss of employment, housing and even schooling and child care. Lack of disclosure, on the other hand, removes any potential for community support and result in strong fears of discovering. In many cares, the fear that the secret of HIV infection in the household will be discovered, becomes an overriding pre – occupation (Stein, 1988:40).

In the study that was conducted in Uganda, many women deserted their sick husbands. Some were forced to have deserted the homestead immediately after the husband death and often went to the roadside location where they could survive through petty trade or find work as labourers. The general economic insecurity of women leads many to seek patronage and support from one or more men, thus spreading the infection further, if she has been infected by a deceased partner (Barnett & Blaike 1992: 113).

2.6 THE IMPACT OF HIV/AIDS ON CHILDREN

Traditionally, wives, grandmother and adult members of the family provide care to the terminally ill. Women are also responsible for parenting, and as they become ill and or taken on the additional burden of terminal care giving, childcare inevitably diminishes. In fact, the parent – child relationship of care is often inverted by AIDS. This is especially true in single parent households or when one parent already died of AIDS. The reports of children in Africa caring for sick parents with AIDS are common. In Uganda child cares are so common in such that an outreach program has been initiated, to provide children with information on basic nursing (Stein, 1998: 42).

In addition to the need for social care, the psychological and emotional needs of AIDS orphans cannot be overlooked. The trauma of seeing the effects of HIV infection, of a parent and of being orphaned, can be expected to result in psychological morbidity and antisocial behaviour. The bereavement process is often hampered by secrecy, as children may be excluded from discussion and prevented from talking to others about the nature of parent's death (Stein, 1998: 42). The belief that children should not be part of the bereavement discussion, and often leaves them with serious emotional scars, due to lack of ventilation.

The study that was conducted in Uganda revealed that six months after their last parent had died of AIDS, 67 % of orphans in that country were naked, malnourished and had no home. Children in this position would then resort

to the easiest ways of making money, namely prostitution, crime and thus becoming more vulnerable to HIV infection (Barnett & Blaike, 1992:05).

Buganda is a traditional society in Uganda in which the extended family will always pick up the pieces when disaster strikes. Such indigenous mechanisms for managing orphans within the Kinship and household system have now reached, or are reaching their absorptive capacity. All this is due to the economic climate e.g. people feel that they can barely feed, clothes and send their children to school, let alone assume additional responsibilities for orphans. Even the wealthy ones, now feel they are unable to produce for any more dependants in their households. Another reason for this is the fear of being infected with AIDS, which still requires more public education, on the mode of disease spread (Barnett & Baikie, 1992: 112).

In Kwa-Mthethwa area the situation is even worse since the majority of families survive on grants, and therefore unable to meet the needs of their own children adequately, let alone those of the AIDS orphans. This calls for an inter-sectoral, interdisciplinary and interdepartmental approach in trying to deal with the situation.

The Community of Kwa-Mthethwa is one of the communities whereby indigenous community support system, still plays an important role. For instance, if a woman is known to be terminally ill, other women in the community may help with house chores etc. Sometimes they come together and allocate duties amongst each other. Such duties usually include; cleaning the house, cooking and other things. These indigenous community support

systems are gradually losing their coordination, because of the number of affected families.

The experience from other African countries has shown that, it is unrealistic to expect extended family members to provide the socio- economic support required. Households reach a threshold at which external support is required. In South Africa community based support programmes which provide assistance to affected families are not sufficient (Stein, 1998:42). In addition to this HIV/AIDS usually affects younger people who are at their productive age category, and who are breadwinners in their families. When these people become seriously ill and die of AIDS, the economies of the country become affected.

According to Unicef latest report, Uganda has nearly two million orphans. The report, entitled Africa's Generation of orphans, carried out in 46 sub-Saharan states, says 1,731,000 Uganda children are orphans, of which 1, 144, 000 have lost their fathers, 902,000 their mothers and 315,000 both parents. Furthermore the report indicates that 42% of them were orphaned by HIV/AIDS. The report maintains that 11 million children under the age of 15 live in Sub-Saharan Africa. It urges governments and donors to address poverty and deprivation. The responsibility of caring for orphans is a major factor in pushing many extended families beyond their ability to cope.

It is estimated that AIDS killed 40% of children who died in South Africa in 2000. Most of them died before they reached their first birthday. Results from a new Medical Research Council (MRC) survey that looked at all causes of death in the country, showed AIDS was the leading cause of death

among children up to no age of four years. The survey was partly funded by the United Nations Children's Fund. MRC research unit head Debbie Bradshaw said "Although the percentage of deaths is higher in the one to four age group, the largest number of deaths occur in the under one-year group. The high death rate was mainly attributed to the number of babies who had acquired AIDS through mother - child transmission of HIV. We looked at data that covered a range of sources, including malnutrition and domestic hygiene.

Our concern was the rate at which HIV/AIDS was being transferred from mother to child. The infection figure maybe down now, since the introduction of a programme to deal with this problem. The research found many of the leading causes of death among children aged one to four were associates with poor socio-economic conditions. Among children aged five to 14, "external" causes like traffic accidents and drowning were more prevalent. This is particularly noticeable among boys, who die in greater numbers than girls. The MRC had identified three areas needing attention, namely the prevention of mother to child transmission of HIV/AIDS, environment and development initiatives dealing with poverty, and high incidence of road accidents and violence. Many deaths can be prevented. Reducing poverty, meeting basic needs and adopting a comprehensive primary health care approach care with renewed vigor must be high on the agenda.

The loss of adults in their professional prime years has hit the teaching, nursing and law enforcement fields in Swaziland, while AIDS is also killing off agricultural workers and contributing to declining harvests in a country

hit regularly by famine. AIDS is creating 35 000 new orphans a year from children who have lost both parents to the disease. The National Emergency Committee on HIV/AIDS predicts that by 2010 about one sixth of the population will be AIDS orphans under 15 years of age. Anti-retroviral (ARV) drugs, the only medicines proven to slow the progress of the disease, are hard to come by in the country. ARV has been accepted the world over, but the health minister blocked them.

The full scale of the devastation wreaked on Africa by the AIDS epidemic was revealed in the World Health Organization's annual report. Life expectancy in some African countries has fallen by 20 years in the past decade, mainly due to the HIV/AIDS crisis. Child and adult mortality rates in more than a dozen sub- Saharan countries have increased in the past 10 years, even as life expectancy in developed countries is improving. The WHO report uses a simple comparison to highlight the issue, a girl born in Britain today can expect to live to 80.6 years. A girl born in Sierra Leone is unlikely to make it past her 36th birthday. Jong- Wook Lee, director general of the WHO, said, these global health gaps are unacceptable. A world marked by such inequities is in very serious trouble. Fourteen countries are now having higher child mortality rates than they did in 1990. Average life expectancy in Zambia, Zimbabwe and Angola is now under 40 years, a trend which the WHO calls a major public health concern.

Life expectancy has fallen by 20 years in Botswana, Lesotho, Swaziland and countries where up to a third of the population is now HIV positive. The life expectancy of Russians has also fallen over the past 10 years, as their country's health system has collapsed and the AIDS epidemic hit millions of

people. A boy born in Russia today can expect to live for just 58 years. One in three people in developing countries now dies before the age of 60, adding to economic deprivation, as a generation has been in effect wiped out by AIDS. Only 5% of people in the developing world who need life saving antiretroviral drugs for HIV receive them, according to the report. In Africa, 5 000 adults and 1 000 children die every day as a result of HIV and AIDS while around 30 million people on the continent are infected with the virus. AIDS is now the leading cause of death in adults aged 15 to 59. More than a third of children in Africa are at higher risk of dying before they reach adulthood than 10 years ago.

An estimated 15, 7 % of workers employed in the public and private health sectors in 2002 were infected with HIV and AIDS. This startling finding is revealed in a national survey carried out by the Human Sciences Research Council (HSRC), in conjunction with the Medical Research Council (MRC) and the National School of Public Health (NSPH) at Medunsa. Another disturbing finding of the study into the HIV and AIDS prevalence in South Africa's health sector was that more than 60% of all children admitted to a tertiary level academic hospital in Durban were HIV positive. The majority of these children were younger than 12 months. The HIV and AIDS prevalence among health workers and children is set to have a substantial impact on the national health care system's capacity to deal with the pandemic.

The report was published and handed to the department of health in mid 2003. The findings of this survey have not officially been made public. A source claims that the department requested that the report be retracted due

to the gravity of the HSRC's findings. The outcome of the HSRC study revealed that the impact of HIV and AIDS on health workers cannot be isolated from other human resource challenges currently confronting the health system. These include the shortage of medical practitioners, professional nurses and the inequitable distribution of professional health skills across the country. The HSRC interviewed 2 000 professional and non – professional health workers treating patients at public and private health facilities, as well as 2 000 patients in all nine provinces. Anonymous HIV testing was conducted on health workers employed at public and private health facilities and patients in the Free State, Mpumalanga, KwaZulu-Natal and North West provinces.

Results have shown that an estimated 16.3% of all public sector health workers in the four provinces are HIV positive. In the four provinces, it was found that 28% of patients admitted to both public and private health care facilities were HIV- positive. Specimens obtained for the testing of HIV antibodies were examined at three different laboratories. During the period 1997 to 2001, HIV and AIDS related illnesses are believed to have caused 5.6% of deaths among South African health workers.

The HSRC report has also found that if death due to TB, associated with AIDS is included, an estimated 13% of health workers died from HIV and AIDS during that period. Tuberculosis is an opportunistic infection related to HIV. Figures have shown that the increase in patient admissions in rural hospitals is related to HIV and AIDS patients infected with TB. Since priority health care is given to HIV positive patients, this could mean that HIV negative patients may be crowded out of the national health care

system. The HSRC has recommended to the department of health that efforts to improve services for treating TB patients be stepped up. Pretoria News has been trying for days to get the department's response without success.

Although dominated by the rise of HIV/AIDS, classic infectious diseases such as diarrhea, respiratory infections and malnutrition are still important causes of mortality and road traffic accidents and violence, including homicide and suicide, are another group of high mortality conditions that will require dedicated interventions. Bradshaw said the leading causes of death among children aged one and four in 2000 were associated with poor socio-economic conditions. Many of these deaths can be prevented.

This is particularly noticeable among boys, who die in greater numbers than girls. In recent years mortality among young adults, and in particular young women, has increased morbidity, mortality and orphan hood. One important benefits of proving anti-retroviral drugs to those living with HIV/AIDS is that their lives will be extended. This will in turn lead to a significant decline in the number of orphans. The study was partially funded by Unicef South Africa (United Nations Children's Fund) to focus on the burden of disease among children, particularly those under the age of five years. The study highlighted that without an intervention to extend the lives of people living with AIDS, the total premature mortality burden could be expected to double by 2010.

The report is based on interviews done between April and mid September, 2003 with 8, 561 households in Kenya's eight provinces. For the HIV statistics, male and female members of half of the 8,561 households were

asked whether they were willing to be tested and 70% of them agreed. Dr Kevin DeCock, the local director of the US Centers for Disease Control and Prevention. The number of HIV infected people in Kenya is lower than previously estimated. This is based on better more accurate measurements.

Blomfield cites the preliminary report of the recent Kenya Demographic and Health Survey, which reveals an apparently lower HIV prevalence among Kenyans of 6.7% prevalence of 8.7% among women, which is in the same range as the 9.4% prevalence estimated by UNAIDS and WHO. It also found an HIV prevalence of 4.5% among men, significantly lower than expected. This ratio of HIV infection levels between women and men is larger than any seen for the general population anywhere else in the world. This suggests a strong possibility that the results for men may have been biased by absence from the household or refusal to participate. Infact, 30% of people refused testing in the Kenya survey.

It is important to note that UNAIDS/WHO estimates are based on all available data, including surveys of pregnant women and household surveys, such as the Kenya one. UNAIDS views both as complementary and useful in helping to estimate the number of people living with HIV in a country. As the epidemic unfolds it is critical to base decisions on the best possible estimates of levels and trends and there must be a wise balance between evidence for action itself. Millions of people are in need of life prolonging treatment and hundreds of millions are at risk of HIV.

2.7 IMPACT OF HIV/AIDS AND MENTAL HEALTH CONCEQUENCIES

The most systematic and ongoing measure of HIV discovery in South Africa, is antenal surveillance conducted in clinics by the Department of Health. KwaZulu-Natal recorded the highest HIV prevalence (33,5%) followed by Gauteng and Mpumalanga (29,2%). It has also been found that HIV infection peaks at younger age in women than in men (Shisane & Simbayi, 2002; Taylor, Dlamini, Kagoro, Jinabhai & de Vries, 2003; Freeman, 2004).

Research points out that there are a number of mental health problems linked to HIV/AIDS. Dementia seems to be a late manifestation of HIV disease. This occurs especially to the patients who have not been taking anti-retroviral treatment (Freeman, 2004).

Cognitive impairments is usually found in aids patients. Struthers (2002) further reports that there is an increase in neuropsychological deficits that coincide with the progression of the disease.

About 43% to 65% of late-stage HIV patients are reported to have delirium. This disorder seems to occur due to infection and multi medications which the patients take. This may also be caused by substance abuse prior to the illness.

Freeman (2004 : 147) further asserts that HIV positive people have a major depression ranging between 4% and18% as against HIV – negative people,

which is between 4% and 9%. Manic episodes have been found to be a late event in AIDS patients. This disorder can also be the result of anti-retroviral medication.

The rates of 30% to 40% of individuals with HIV/AIDS have been found to have four times higher than figures for the general population with out the disease. The most common of these disorders are anti-social and borderline personality disorders.

Psychological impact of HIV/AIDS among family members of HIV/AIDS infected people, is enormous among care givers. This type of work expose them to additional stress. One reason may be that they may be feeling anxious about their HIV status. It is also reported that HIV women partners and children, before looking after themselves. Poor women spend the little money they have on essentials such as food for their children rather than on medication for themselves. This may hasten their death and have longer-term detrimental effects to their children (Goosen & Klugman, 1996; Walker, 2002).

AIDS sufferers who are breadwinners are faced with the trauma of dying and leave behind dependent children, as HIV- infected patients are usually young people. This becomes a big problem to the sufferer if there is no clear plan as to what may happen to children.

Freeman (2004 : 149) enumerates four conditions that are stressfull to the families of an HIV – infected people. Firstly, the knowledge that one's life is going to be terminated very soon is painful. This is worse if a person is in

the prime of his or her life. This tragedy tends to be greater than if a person has lived a long and fullfilled life.

Secondly, the AIDS stigma puts and added stress on those close to he infected person. In addition the family members will suffer psychological distress if they themselves hold stimatising attitudes towards people with HIV/AIDS. This can result in cognitive and emotional dissonance, with feelings of anger and resentment mixed with love and compassion. Freeman (2004) further points out that such dissonance may or may not become resolved with time.

Thirdly, as the HIV-positive person becomes ill, family responsibilities are forced to shift. Other family members may be forced to take responsibility for tasks such as income generation, cooking, cleaning, caring for children. Such forced shifts put additional strains on individuals and on relationships between family members.

Fourthly, caring for a deteriorating person is psychologically stressful and emotionally exhausting, especially if there is no respite. If there is more than one family member who is ill, which is not unusual with the HIV pandemic, all the above mentioned issues become more complex and the resultant psychological impact is seriously exacerbated.

Studies reveal a number of stressors which impact on the mental health of orphaned children. These include economic deprivation, disrupted schooling, stigma, social isolation and lack of adequate care and control. These stressors result in depression, hopelessness, suicidal ideation,

loneliness, anger, confusion, anxiety and fear of being along (Karus & Raveis, 1996; Worden, 1996; Wild, 2001).

Orphans of HIV/AIDS people are placed in homes others in institutions where their needs for shelter and food are more or less met but where emotional bonding, attachment are relatively poorly seen. In rural places these orphans go to towns and become street children, some head homes and others become vagrants. These orphans end up indulging in risky behaviour, like risky sexual behaviour, substance abuse and violence. Such conditions usually make these children to turn to crime.

The youths' level of knowledge of HIV/AIDS research shows that youths around the world understand how HIV is transmitted, and the unsafe nature of sexual practices. This however does not mean that the youth is taking precautionary measures towards HIV/AIDS, like practising safe sex. Youths know that condoms prevent transmission of the HIV virus. This however, does not mean that there is an increase in the use of condoms (Williams, 1991; Kelly, 1999).

Although South African have adequate knowledge about HIV/AIDS, research shows that there is sizeable minority of South Africans with misconceptions and myths about HIV/AIDS. Some common myths and misconceptions are : sharing a meal with someone with AIDS results in AIDS transmission and that AIDS is transmitted by mosquitoes (Du Plessis, Meyer-Weitz & Steyn, 1993; Peltzer, 2003).

Studies reveal that knowledge about HIV/AIDS may not be the main factor to practise safe sex so as to avoid HIV (Campbell & Foulis, 2002 : 313; Akande, 2001 : 249). There are other threshold conditions to be fullfilled, namely having a condom available, to reach an agreement with a partner to use a condom. This is however a critical issue of communication with the sexual partner, which is not an easy task with South African youths, who are brought up in cultures where discussion of sexual matters is taboo. This means that knowledge about HIV/AIDS does not predict precautionary behaviour or changes in individuals' behaviour.

There is a need, especially in South Africa for relevant training that will empower the youth with culture-relevant approaches. Such approaches will lead to behavioural changes in youths and be able to correctly gauge their level of risk and be able to reduce the risk that may lead to contracting HIV (Kelly, 1999; Peltzer, 2003).

Akande (2001 : 252) further emphasize that helping professionals like educators, medical doctors, psychologists and other behaviorual scientists should in their intervention provide the youth with behavioural skills needed for healthier behaviours so as to reduce the spread of pandemic among youths.

Informants about HIV/AIDS pandemic has led to creating strategies to reduce HIV transmission. One of the approaches is targeting peer groups to be informants about HIV/AIDS diseases. Peer education is based on the assumption that peers are the most important influence on young people's sexual behaviour. This is due to the fact that young people are more likely to

understand and trust one another than adults, and are united by common cultural interest like music (Campbel & Foulis, 2003 :314).

Government departments have used media as an agent in behaviour change. Government has done this by facilitating various HIV related media campaigns, like Soul City and Lovelife (Leclere-Madlala, 2002). Even in these campaigns, emphasis is being placed on promoting youth participation, in the light of the insight that behaviour change is most likely to take place in collective peer context.

Educators are expected to take a leading role in teaching learners about sex education, which is incorporated in life skills curriculum.

Health service professionals and counsellors in sex education help teachers in school based sex education as they are specialists in this field of sex education (Monk, 1998).

Studies show that parents can also be active participants in their children's education about HIV/AIDS. In this case parents can exercise their influence over sex education, they are therefore, not passive recipients of services. They, therefore, help in disseminating information which is potentially life saving (Quicke, 1988; Bell, 1993; Baron, 1996; Monk, 1998).

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

Research design is the plan and structure of investigation so conceived as to obtain answers to research questions. This plan is the overall scheme or programme of the research. It includes an outline of what the investigator will do from writing the hypotheses and their operational implications to the final analysis of data. A structure is a paradigm or model of the relations among the variables of a study. A research design expresses both the structure of the research problem and the plan of investigation used to obtain empirical evidence in the relations to the problem. A paradigm is a model, an example. Diagrams, graphs and verbal outlines are paradigms.

Research design has two basic purposes namely, to provide answers to research questions and to control variances. Design helps investigators obtain answers to questions of research and also help them to control the experimental, extraneous, and error variances of the particular research problem under study. Without strong stress on the research questions and on the use of design to help provide answers to these questions, the study of design can degenerate into an interesting, but sterile, technical exercise.

Research designs are invented to enable researchers to answer research questions as vividly, objectively, accurately and economically as possible. Research plans are deliberately and specifically conceived and executed to bring empirical evidence to bear on the research problems.

The presented study shall use the field experimental design. This is a descriptive study. We do not manipulate the independent variable in descriptive studies. The study examines the present status of the event. This descriptive study will take the form of a field study or field experiment. The subjects/participants will be studied under their natural settings or conditions.

3.2 SAMPLING DESIGN

It would be appropriate to draw our conclusions from the whole population but it is not always possible, and samples are employed. A major aim of science is to provide sound propositions about people in general or about specific groups of people. Rarely however, does a researcher actually study or observe all people/objects/things/events she/he is interested in. A researcher tries to understand a segment of the world, a **population** on the basis of observing a smaller segment, a **sample**. A popular is thus the total collection of people, things, or events under consideration; it is whatever group the investigator wishes to make inferences about. The cost involved in a complete survey or census of the population is so high that samples are often preferred. A sample is a subset of a population. Samples can be any

size and can be selected in a number of different ways. The question arises: From a limited number of observations, called a sample, can we not make meaningful deductions concerning the properties of a population? Or to put the same question differently. What constitutes an appropriate sample? The answer is if the sample complies with specified requirements of representation of the population then the properties of the population can be estimated within certain bounds with a certain confidence.

The present study will be carried out in KwaZulu-Natal provinces. A cluster sampling design will be used. This sampling design presupposes that the area under study is divided into regions or districts. Each region is heterogeneous but the regions are homogeneous. By selecting one region randomly, the researcher is able to capture the characteristics of other regions. This study will provide information on HIV/AIDS prevention strategies.

The participants will be selected on the basis of their willingness to participate in the study. the issues of confidentiality and informed consent will be observed.

For the present study, the researcher selected twenty (20) families from KwaMthethwa Community and twenty learners from two different high schools. The key issue was that participants should be or have been living with HIV/AIDS sufferer. The sampling design combined both cluster sampling of regions or district and also

accidental or incidental sample as far as the selection of participants was concerned.

3.3 RESEARCH INSTRUMENT

The present study will make use of interview schedule and questionnaire. Interviews are tools of scientific research. The interview is a face to face interpersonal role situation in which one person, the interviewer, asks a person being interviewed, the interviewee, question designed to obtain answers pertinent to the research problem. There are two broad types of interviews; structured and unstructured or standardized and unstandardized. Standardized interviews are interview schedules that have been carefully prepared, the questions, their sequence and wording are fixed and relatively little liberty allowed for the interviewer. It is therefore a closed situation. The unstructured/nonstandardized interviews are ore flexible, open and no schedule is used.

The use of a questionnaire as a data-collection technique whereby a document containing either questions or statements is used to obtain information from a respondent who records answers thereon. As with interviews, questionnaires may, involve face-to-face interaction (that is, administering the questionnaire in a group setting such as a classroom) or may lack this aspect (that is, administering the questionnaire by mail) the noticeable difference between questionnaires and interviews is that in the latter, a researcher asks the question, while in questionnaires a respondent reads the question.

The questionnaire is divided into four (4) sections:

- Section A - Deals with the personal details of the respondents

- Section B - Deals with the multiple choices whereby a respondent is obliged to choose the appropriate answers by making a cross in the appropriate answer.

- Section C - Is where the respondents have to respond by explaining in detail.

- Section D - Is where the respondents have to indicate whether they agree, disagree or cannot say with regard to each statement.

The techniques for data collection will be interview schedules and questionnaire. The nature of the instrument will depend on the nature of research questions the study attempts to unravel. A wide range of scoring and data analysis procedures will be used.

3.4 PROCEDURE FOR DATA COLLECTION

To comply with ethical code for research with human participants, informed consent was obtained from the subjects. When collecting data all participants who were included in a sample, were visited in their respective homes and in their respective schools. The researcher

first introduced herself, explained the purpose of a visit, and then requested for permission to include them in a sample. Such permission was sought from patients and/or relevant family members as well as learners from high schools. Once, given a permission, a series of questions were asked from respondents using their home language (that is, Zulu).

CHAPTER 4

4.0 DATA ANALYSIS AND INTEPRETATION

4.1 ANALYSIS OF DATA

The main aim of the study was to determine level of knowledge of HIV/AIDS among youth and their informants about HIV/AIDS and attitudes of the community towards HIV/AIDS sufferers. This chapter deals with analysis of data.

TABLE 4.1 : DISTRIBUTION OF RESPONDENTS ACCORDING TO GENDER (N=40)

GENDER	NUMBER OF RESPONDENTS	PERCENTAGE
Males	19	47.5
Females	21	52.5
TOTAL	**40**	**100**

Table 4.1 indicates that 52.5% of the respondents were females. This is because of the fact that females generally form the majority of the total population and the system of selecting the respondents randomly was applied. Males do not often participate in projects. In addition, to this, the cultural factors or their socialization process patterning, the feeling of dominance and independence on males are the main reasons for their lack of motivation to in community projects.

TABLE 4.2: DISTRIBUTION OF RESPONDENTS ACCORDING TO AGE (N= 40)

AGE IN YEARS	NUMBER OF RESPONDENTS	PERCENTAGE
15-20	8	20
23-28	10	25
29-34	10	25
35-40	12	30
TOTAL	**40**	**100**

Table 4.2 indicates age range of the respondents as 15 – 40 years. The majority (30%) of respondents are adults. This is because of the stigma that is attached to the people who received information about HIV/AIDS in rural communities. Another reason for having more adults (30%) who are exposed on the HIV/AIDS programmes is because one gets older one acquires a number of responsibilities. It also indicates the age distribution. Another 20% of the respondents (adolescents) get information about HIV/AIDS in schools since they have a period for sexuality education and 50 % are young adults, who are between 23-34 age range. This group received information on the media and other sources.

TABLE 4.3: DISTRIBUTION OF RESPONDENTS ACCORDING TO DEMOGRAPHIC FEATURES (N= 40)

DEMOGRAPHIC	NO. OF RESPONDENTS	PERCENTAGE
Learners	20	50
Parents	12	30
Community members	8	20
TOTAL	**40**	**100**

Table 4.3 indicates the demographic features of the respondents. Thirty percent were parents or adults who were never married but living with their children. Such families are well known in the community, and they receive the same recognition as formally married families. Followed by 20% who are other community members and they also participated in HIV/AIDS programmes. The majority of the respondents were learners (50%) who are also exposed on HIV/AIDS programmes.

TABLE 4.4: DISTRIBUTION OF RESPONDENTS ACCORDING TO THE LEVEL OF EDUCATION (N= 40)

SCHOOL GRADES	NO. OF RESPONDENTS	PERCENTAGE
No Schooling	20	50%
Grade 1 –7	8	5
Grade 8-10	6	25
Grade 11- 12	4	20
TOTAL	**40**	**100**

Table 4.4 shows the respondents' level of education. About 50% of respondents were parents who never attended school, but they are good source of care and understand about HV/AIDS epidemic because they encourage youth to preserve their virginity and helping physical challenged people as well as orphanage children by giving information about HIV/AIDS. This table also illustrates that learners from grade 1 to grade 12, constitute 50% of the sample. Out of this 50% of respondents, 5% are in grades1-7, then 25% of respondents are in grades 8-10, and followed by 20% who are in grades 11-12.

4.2 DATA ANALYSES ACCORDING TO THE AIMS OF THE STUDY

TABLE 4.5 : DISTRIBUTION OF RESPONDENTS ACCORDING TO THE LEVEL OF KNOWLEDGE OF HIV/AIDS (N = 40)

RESPONSE	NO. OF RESPONDENTS	PERCENTAGE
YES	32	80
NO	8	20
TOTAL	40	100

Table 4.5 shows that the majority (80%) of the respondents understand the concept HIV/AIDS and only 20% showed lack of knowledge. This indicates that the respondents are exposed to various sources of information such as the awareness campaigns in the community. The way in which community is bombarded with information might result in fewer members who will remain ignorant about HIV/AIDS. It is therefore, necessary that youth

educators or HIV/AIDS counsellors should establish how many community members would need the information about HIV/AIDS education.

TABLE 4.6: DISTRIBUTION OF RESPONDENTS ACCORDING TO INFORMANTS ABOUT HIV/AIDS (N= 40)

RESPONSE	NO. OF RESPONDENTS	PERCENTAGE
YES	33	82.5
NO	7	17.5
TOTAL	40	100

Table 4.6 shows that the majority (82.5%) of the respondents understand the term HIV/AIDS and only 17.5% showed lack of information. This indicates that the respondents got information from various sources such as media, educators from schools, pamphlets, posters, textbooks, clinics and hospitals. There are fewer respondents who did not get the information through these sources due to the fact that they are illiterate. It implies that AIDS programmes need to be planned at the level at which all members of the community should benefit. As the lack of understanding and ability to read make the community members to be vulnerable this virus or diseases.

TABLE 4.7 : DISTRIBUTION OF RESPONDENTS ACCORDING TO INFORMATION MONGERS ON HIV/AIDS AS PREFERRED BY YOUTH (N= 40)

INFORMATION MONGERS	NO. OF RESPONDENTS	PERCENTAGE
Peers and educators	21	52.5
***Other sources**	19	47.5
TOTAL	**40**	**100**

* **media, parents, hospitals etc.**

Table 4.7 illustrates that 52.5% of respondents prefer to be informed by their peers and educators at school. Forty-seven and half percent of respondents prefer to get information from other sources (media, parents, AIDS counsellors, hospitals and etc). It is disturbing to note that parents and AIDS counsellors were chosen as the last sources for information about HIV/ AIDS.

TABLE 4.8 DISTRIBUTION OF RESPONDENTS ACCORDING TO THE NATURE OF ATTITUDES OF COMMUNITY MEMBERS TOWARDS HIV/AIDS SUFFERERS (N=40)

	Attitude			
Gender	**Negative**	**%**	**Positive**	**%**
Males	8	44.4	10	55.6
Females	4	18.2	18	81.8

Table 4.8 illustrates that male and female respondents do not differ in their attitudes towards HIV/ AIDS sufferers. About 81.8% female respondents have a positive attitudes and 55.6% male respondents have a positive attitudes towards HIV/AIDS sufferers. This table further shows that 44.4% male respondents were negative and only 18.8 % of female respondents were negatively disposed towards HIV/AIDS sufferers.

4.3 DISCUSSION OF FINDINGS

4.3.1 *Findings with regard to the level of knowledge about HIV/AIDS among youth*

The majority (80%) of the respondents understand the concept HIV/AIDS and only 20% showed lack of knowledge. Although the majority of peers do have knowledge, it is insufficient. The reasons are probably that the available sources of information and social support system are not available within rural areas. It is suggested that the educators together with HIV/AIDS Counselors be encouraged to establish support groups. This should be done so that HIV/AIDS sufferers can feel free to express their problems in a very supportive way where only AIDS patients would take part.

This may be a good platform for sharing ideas and teaching each other certain skills, especially problem solving skills. An assessment of HIV/AIDS infected and affected programme has never taken place within Kwa- Mthethwa area, and therefore, extensive studies are also highly recommended, that would not only focus on the patient per se,

but it would instead include patient relatives and the infected people as well.

4.3.2 Findings with regard to the youth information mongers about HIV/AIDS

These findings reveal that 100% of young people from grade 1 to grade 12, are informed about HIV/AIDS. In response to the question "I feel happy when reading about HIV/AIDS from magazines" the respondents (20%) reported to be happy when reading information from magazines and watching television. Only 10% of respondents get information from other sources such as awareness campaigns, Soul City and other media. Parents and teachers were identified by youth (5%) as third and the least source of HIV/AIDS information. Most of the respondents (70%) receive information from other peers.

4.3.3 Findings with regard to the youth preferred informants about HIV/AIDS

The findings show that 70% of learners prefer other peers as the first source of information. The second choice of their preference (15%) is the media such as magazine and watching television. It has been discovered that when children grow older, they changed their preference. When learners are still young, many of their questions are directed to their parents and answered positively, but when they reach adolescence stage they search knowledge from peers. The results show that fewer learners (5%) prefer to get information from parents.

Therefore, it is disturbing to note that parents and teachers were chosen as the last sources for information about HIV/AIDS. Generally, parents and teachers are good sources of care and understand about HV/AIDS epidemic. They are the ones who encourage the youth to preserve their virginity and helping physical challenged people as well as orphanage children by giving information about HIV/AIDS. In spite of this, learners prefer other peers as a first source of information.

4.3.4 Findings with regard to the nature of learners' attitudes towards HIV/AIDS sufferers

The findings show that majority of community members (65%) has positive attitudes towards HIV/AIDS sufferers and 35% of respondents have negative attitudes. This implies that the majority of the respondents are comfortable with having HIV/AIDS sufferers within the community. While a substantial number of respondents agree that they were uncomfortable of sharing items with HIV/AIDS sufferers. Therefore, the issue of intolerance and reluctance to mix with people who are HIV positive are also noted. It is also indicated that that male and female respondents do not differ in their attitudes towards HIV/AIDS sufferers. About 81.8% female respondents have positive attitudes and 55.6% male respondents have positive attitudes towards HIV/AIDS suffers. This means that gender does not influence attitudes towards HIV/AIDS sufferers differently.

All in all, it is revealed that 100% of respondents have knowledge about HIV/AIDS but the knowledge is not enough, as the sources of information are not effective. Many people still die of this disease and there is a high percentage of people who are both infected and affected. There is high percentage of young people who are HIV positive in this community. The reason is that they are misled by their peers and have myth about the cure of this disease. Although most members have positive attitudes towards HIV/AIDS victims, counsellors in rural community are not playing their role at all. Secondly people who are the victims of HIV/AIDS do not receive emotional support such as love, acceptance and caring. They don't have support groups with whom to share their feelings.

4.4 SUMMARY

The results were presented and discussed in this chapter. The next chapter presents summary, conclusion and recommendations.

CHAPTER FIVE

5.0 SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

5.1 SUMMARY

5.1.1 The problem

In this study the problem investigated was youth's information level about HIV/AIDS and the nature of attitudes of community members towards HIV/AIDS sufferers.

5.1.2 The aims of study

The aim of study was to achieve the following objectives:

(i) To determine youth's level of knowledge of HIV/AIDS.

(ii) To identify youth informants about HIV/AIDS.

(iii) To identify information mongers on HIV/AIDS as preferred by youth.

(iv) To find out about nature of attitudes of community members towards HIV/AIDS sufferers.

5.1.3 Methodology

Chapter one consists of motivation for the investigation in this field, statement of the problem, aims of study, research design, sampling

design, research instrument and procedures for carrying out empirical investigation.

Chapter two provides a theoretical background to the study.

Chapter three details research methodology used in this study.

Chapter four is concerned with presentation and analysis of data.

Chapter five concludes the research report/dissertation and makes recommendations.

5.1.4 Results and findings

The following results were obtained:

This study has answered the research questions raised in chapter one. The study reveals that the majority (80%) of respondents understand a lot about HIV/AIDS.

This study reveals that the respondents prefer a wide variety of sources of information about HIV/AIDS. Most of the respondents (70%) receive information from their peers.

Generally speaking, youth is exposed to a wide spectrum of sources about the epindemic. These sources are credible for the youth.

Youth's attitudes towards HIV/AIDS sufferers in the community are positive. Both male and female respondents are characterized by positive attitudes.

5.2 LIMITATIONS

One limitation of this study is that its sample was relatively small. Generalization can only be made with cautions. It is difficult to get a large sample on HIV/AIDS sufferers. People are reluctant to discuss matters of this disease.

The instrument used in this study was not standardized.

No rigorous statistical tools were used to analyze data. Inferences are drawn on percentage distribution.

5.3 RECOMMENDATIONS

This study has opened avenues for further research.

i) It is desirable to investigate attitudes of community members (other than youth) towards HIV/AIDS sufferers.
ii) There is a need to conduct a survey using larger sample.
iii) An investigation into the actual and desired role functions of family members in caring for HIV/AIDS sufferers, is necessary.
iv) An examination of some basis of HIV/AIDS sufferers content/discontent with home based care, must be carried.

v) The feasibility study psychoeducation models in AIDS prevention, should be undertaken.

vi) As a matter of highest priority we need to examine availability of health related services in the rural areas of KwaZulu-Natal.

vii) On the whole, it appears that the central problem areas requiring further research are that of prevention, diagnosis and intervention strategies with patients who manifest HIV/AIDS.

5.4 CONCLUSION

Although this study was exploratory, there is a need to take its findings seriously. HIV/AIDS is a menace to society. Unless it is curbed it will mow down many of our citizens. Let us combine our available resources to wear down the scourge of AIDS.

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ANNEXURE A

LETTER TO THE CHANCELLOR

UNIVERSITY OF ZULULAND
PRIVATE BAG X 1001
KWA-DLANGEZWA
3886

The Chancellor

Dear Sir / Madam

REQUEST FO PERMISSION TO DO A RESEARCH

I am a Masters at the University of Zululand. I am currently engaged in a research project concerning the impact of HIV/AIDS in the community as part of my dissertation in the Department of Sociology.

My basic concern is to investigate the impact of HIV/AIDS in schools. I would greatly appreciate your assistance by allowing me access to your learners. This research will add to the already existing knowledge of the impact HIV/AIDS in the community.

Your contribution is of utmost importance and will be highly appreciated.

Thanking you in anticipation.

Yours sincerely

_____

S.M SIBAYA (MISS)

ANNEXURE B

LETTER TO THE PRINCIPALS

UNIVERSITY OF ZULULAND
PRIVATE BAG X 1001
KWA-DLANGEZWA
3886

10 February 2003

The Principal
_____

_____

_____

Dear Sir / Madam

REQUEST FO PERMISSION TO DO A RESEARCH

I am a Masters at the University of Zululand. I am currently engaged in a research project concerning the impact of HIV/AIDS in the community, especially among the youth as part of my dissertation in the Department of Sociology.

My basic concern is to investigate the impact of HIV/AIDS in schools. I would greatly appreciate your assistance by allowing me access to your learners. This research will add to the already existing knowledge of the impact HIV/AIDS in the community.

Your contribution is of utmost importance and will be highly appreciated.

Thanking you in anticipation.
Yours sincerely

_____

S.M SIBAYA (MISS)

ANNEXURE C

QUESTIONNAIRE FOR LEARNERS AND COMMUNITY MEMBERS

THE IMPACT OF HIV/AIDS ON RURAL COMMUNITY OF KWA-MTHETHWA AREA IN KWAZULU-NATAL

QUESTIONNAIRE FOR LEARNERS AND COMMUNITY MEMBERS

The questionnaire consists of 4 sections.

SECTION A

This is a study of the impact of HIV/AIDS on the community.

You are requested to fill in your personal information by making a cross (X) in the appropriate space provided with information applicable to you.

GENDER

Male		Female	

AGE

15 –20 years	
21 –26 years	
27 – 32 years	
33 years +	

DEMOGRAPHIC FEATURE

Learners	
Parents	
Other community members	

LEVEL OF EDUCATION

No schooling	
Grade 1 –7	
Grade 8 –10	
Grade 11 –12	

SECTION B

This section covers the information and knowledge that you have about HIV/AIDS.

Please indicate your agreement by placing a cross (X) in the provided box.

Key: YES means Agree

NO means Disagree

	QUESTIONS	YES	NO
1	Do you get appropriate information about HIV/AIDS		
2	I feel that it is wrong for teen of my age to be taught me about HIV/AIDS		
3.	You can use condoms to prevent HIV/AIDS		
4.	A person can get HIV/AIDS having sexual intercourse without using a Condom with a person who is infected.		
5.	You can get HIV/AIDS if another persons blood semen, virginal fluids, tears saliva touches your skin.		
6.	One can be cured of HIV/AIDS if you have sexual intercourse with a Virgin.		
7.	HIV/AIDS come from a virus, microorganism that causes diseases.		
8.	High poverty and low educational level precipitate HIV/AIDS.		
9.	Peer counselor and other sources of information are not effective in the community.		
10.	I don't prefer to get the information about HIV/AIDS from my parents at home.		
11.	Lack of facilitators for workshops lead to HIV/AIDS		
12.	I prefer to get the information about HIV/AIDS from my educators at School.		
13.	Educator at school informs me on HIV/AIDS.		
14.	Watching TV and reading magazines help me to acquire knowledge about HIV AIDS		
15.	Peer educators and HIV/ AIDS counsellor do inform about HIV/AIDS		
16.	I receive information about HIV/AIDS through VCT in the hospital.		
17.	There is AIDS awareness campaign in my community		

18.	I prefer to get the information about HIV/AIDS through other sources such as reading magazines, TV and newspaper		
19.	I prefer to get the information about HIV/AIDS from my friends		
20.	I prefer to get the information about HIV/AIDS from my parents at home		

SECTION C

In this section there are different statements about attitudes of community members towards HIV/AIDS sufferers. Circle the response, which most closely represents your attitudes towards each statement. Answer all statements.

NOTE THE FOLLOWING ABBREVIATIONS:

SA means Strongly Agree.
A means Agree.
NS means Not Sure.
D means Disagree.
SD means Strongly Disagree.

STATEMENT	SA	A	NS	D	SD
1. People who are both affected and infected by HIV/AIDS should be rejected in community.	SA	A	NS	D	SD
2. People living with HIV/AIDS are always to be seen as shameful.	SA	A	NS	D	SD
3. I feel that parents are not doing enough at home regarding sex education.	SA	A	NS	D	SD
4. Mixing learners who are HIV/AIDS sufferers and normal learners in our school is unacceptable.	SA	A	NS	D	SD
5. I feel that helping people who are infected by HIV /AIDS is a waste of time.	SA	A	NS	D	SD
6. I support the idea of bringing out the best and supporting people who are HIV/AIDS sufferers.	SA	A	NS	D	SD
7. HIV/AIDS sufferers are acceptable to me to stay in the community and they should not be stigmatized.	SA	A	NS	D	SD

8. I don't feel comfortable when sharing items with people who are HIV positive.	**SA**	**A**	**NS**	**D**	**SD**
9. I have nothing against HIV / AIDS sufferers in the community.	**SA**	**A**	**NS**	**D**	**SD**
10. I have a problem to live with HIV / AIDS sufferers in the community.	**SA**	**A**	**NS**	**D**	**SD**

SECTION D

Is there any thing you would like to report about HIV/AIDS

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_____

_____

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