

**AN INVESTIGATION INTO THE KNOWLEDE AND ATTITUDES OF THE
SOMERVILLE COMMUNITY TOWARDS HIV/AIDS**

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Philosophy (HIV/AIDS Management) at Stellenbosch University



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DECLARATION

I, the undersigned hereby, declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part submitted it at any university for a degree.

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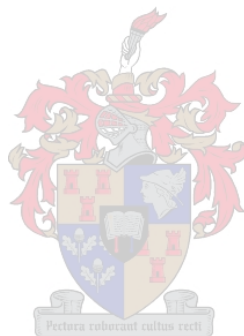
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ABSTRACT

This research was conducted during 2005 in the Somerville Community in the Qumbu District of the Eastern Cape. The aim of the research was to investigate the attitudes of the community towards people living with HIV/AIDS and also the knowledge of the community about the HIV/AIDS.

Data was collected using focus group discussions with 50 members from the Somerville community. Results showed that the community members did not have adequate knowledge around HIV/AIDS and they had negative attitudes towards those who are HIV positive.



OPSOMMING

Die navorsing het in 2005 in die Somerville Gemeenskap in die Qumbu Distrik van die Oos-Kaap plaasgevind. Die doel van die navorsing was om lede van die gemeenskap se kennis rondom MIV/VIGS en hul houdings teenoor mense wat lewe met MIV/VIGS te ondersoek.

Data is deur middel van fokusgroepe ingesamel onder 50 lede van die Somerville gemeenskap. Resultate toon dat die gemeenskapslede nie oor voldoende kennis rakende MIV/VIGS beskik nie en dat hul negatiewe houdings toon teenoor die wie MIV positief is.



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1. INTRODUCTION

HIV/AIDS raises many peculiar and special problems for people. It targets and seriously affects the most physically active in society and those on whom others usually depend. It is a disease with an extra-ordinary symptomatic period and one, which raises many uncertainties and potential fears. For many, it is often prejudice, discrimination, stigma and rejection, which is more difficult to deal with than the disease itself. Economic costs are growing as HIV causes premature disability and death. Ninety five percent of those affected are between the ages of 16 and 59, often resulting in disrupted families and loss of creative and economic productivity at a period of life when growth is a norm. The direct of cost of health care for HIV alone is staggering. It is of great concern when added to a health care system that is already unable to meet the needs of many people (Stanhope and Lancaster, 1992:46).

2. BACKGROUND

It is now widely recognized that marginalization, discrimination, alienation and other impediments to the development of one's full potential are factors that contribute to increased vulnerability to Human Immunodeficiency Virus (HIV) infection. Nowhere is this more starkly demonstrated than in South Africa. Black people, particularly black women, are the hardest hit by this epidemic. The power imbalances between men and women and the different perceptions regarding gender roles are recognized as the crucial contributing factors to women's excess vulnerability. (Karim, 1998:184).

Although current HIV data are patchy and incomplete, the data from the annual antenatal surveys that have been conducted since 1990 in the public health sector facilities provide a reasonable indication of temporal trends of Human Immunodeficiency Virus epidemic in South Africa. These surveys demonstrate a twenty-one-fold-rise in HIV/AIDS infection within eight years, from one percent in 1990 to 16 percent in 1997, and a continued increase in the following years. (Department of Health Statistics, 1997).

Based on these surveys it is now estimated that about five to six million South Africans are infected with HIV/AIDS. This is equivalent to almost 12 percent of all adults in the total population. While the HIV epidemic is more advanced in some provinces such as Kwazulu-

Natal, Mpumalanga and Gauteng, it is well established in all provinces. Kwazulu-Natal is the hardest hit by the epidemic (Karim, 1998:17).

3. STATEMENT OF THE PROBLEM

It is postulated that attitudes of communities are negative towards people living with HIV/AIDS. The latter are neglected and isolated by their families, their co-workers and by the community at large.

4. OBJECTIVES

- To investigate the attitudes of the community towards people living with HIV/AIDS.
- To investigate the knowledge of the community about the HIV/AIDS.

5. DEFINITIONS OF TERMS

5.1 Human Immune-deficiency Virus (HIV)

This is the virus that infects the cells and remains latent of several years or months, causing no symptomatic illness. Although it is caused or spread through a number of ways, sexual intercourse with a person who is already infected is a common mode of transmission. The incubation period is from several months to many years, and it can take 11 years or longer for the symptoms to develop. During this period of latency, the infected person carries and is able to transmit the virus to others (Stanhope & Lancaster, 1992:334)

5.2 The Acquired Immune Deficiency Syndrome (AIDS)

AIDS is the last step on the long continuum of Human Immunodeficiency Virus. It is characterized by encephalopathy, wasting syndrome or certain diseases caused by immune deficiency in a person such as pneumonia, tuberculosis, and secondary cancers. These are called opportunistic diseases (Stanhope & Lancaster 1992:335).

5.3 Family

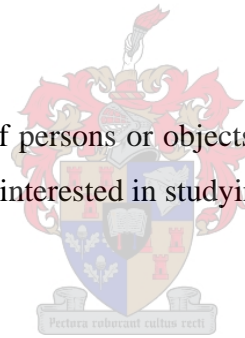
The term is used to refer to the person or people with the main responsibility for caring for a person with Acquired Immune Deficiency Syndrome in the home. The person providing such care may be a blood relative, a relative by marriage, for example a spouse, a friend, a neighbour, or some other person (Harton *et al*, 1991:6).

5.4 Focus Group Interviews

5-15 people whose opinions and experiences are requested simultaneously. It is often useful to allow participants to share their thoughts with each other. In this way they spark off new ideas and consider a range of views before answering the researcher's questions. One disadvantage is that some people are uncomfortable talking in groups. Focus groups are particularly useful in participatory and action research where members of the communities are equal participants in the planning and implementation of research and where the topic of research is a practical community concern (Brink, 1996:159).

5.5 Population

A population is the entire group of persons or objects that is of interest to the researcher or that meets the criteria the researcher is interested in studying (Brink, 1996:132).



5.6 Sample

A sample is a part or fraction of a whole, or a subset of a larger set, selected by the researcher to participate in a research project. A sample consists of selected groups of elements or units from a defined population of not less than 5000 (Brink, 1996:133)

5.7 Sampling

Sampling refers to the process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that present the population of interest (Polit Hungler, 1995:18).

5.8 Data Analysis

Data analysis entails categorizing, ordering, manipulating and summarizing the data and describing them in meaningful terms (Brink 1996:178).

6. RESEARCH METHODOLOGY

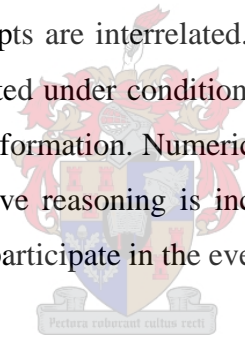
6.1 Qualitative research design

Qualitative research focuses on qualitative aspects such as meaning, experience from the viewpoint of the research subjects and in the context in which the action takes place. The four most frequently used approaches of conducting qualitative research are

- phenomenology;
- ethnography;
- grounded theory; and
- the philosophical approach (Brink, 1996:119)

6.2 Quantitative research design

Quantitative research focuses on a relatively small number of concepts. It begins with pre-conceived ideas about how concepts are interrelated. It uses structured procedures and formal instruments. Information is collected under conditions of control, and objectivity is emphasized in the collection and analysis of information. Numeric information is analysed through statistical procedures, and a logical deductive reasoning is incorporated. The investigator collects data from a real distance and does not participate in the events. (Brink, 1996:108-111).



7. LITERATURE REVIEW OF HIV/AIDS IN SOUTH AFRICA

HIV/AIDS places enormous stress on infected individuals and their families who are confronted with the demands of caring for the seriously ill and with the trauma of death. In addition, they face the economic burdens of health care and funeral costs, and less income when breadwinners become ill. All of these factors are aggravated by the stigma associated with AIDS. This means that people can be victims of prejudice at work, in their community and at home, and invariably lack the support mechanisms, which are available for most other fatal diseases. The death of an adult can have a dramatic impact on family structure and function. Children, the elderly or single parents may be left to run households, with severe implications for those concerned.

Some community members have the attitude that HIV/AIDS is only a problem for prostitutes and loose men who live in the city. They do not see it as a problem in rural areas. Some of the

statements made by the communities indicate lack of knowledge about this disease, as quoted by Gordon et al (1990) “in a war you hear that so and so died. He was a victim. Where are the AIDS victims? We want to know how they are feeling”.

Some are not convinced that they can become infected with HIV/AIDS through sex with an infected person, be it male or female. There is a belief that the disease can come through the air or in water. Some say it is punishment from God for wrongdoing. If they can behave properly they will not get HIV/AIDS (Gordon et al, 1990:90).

Many people in the community do not believe that HIV/AIDS is real. They think it is a story to force people to use condoms or to stop having sex. Thousands of people have already died of AIDS and it is possible that millions of them are living with HIV/AIDS but unaware of it. Some people think that its homosexuals who contract AIDS. In South Africa some people say that AIDS is only a disease of white people. Some traditional healers like “Sangomas” claim they have a cure for AIDS (UNAIDS, 1997)

In a study conducted on perceptions and knowledge among family members, Govender et al (1992:66) discovered that various misconceptions existed. Sixty four percent cited toilets seats, 47 percent sharing of utensils and 70,1 percent donating blood as means by which HIV/AIDS could be acquired. Only 47,1 percent and 34,2 percent respectively believed that the contraceptive pill and intra-uterine contraceptive device did not protect against HIV infection. Eighty six percent of the women were sexually active and 8 percent admitted to currently having more than one sexual partner. None used condoms and generally feelings regarding condom use were negative. Most believed HIV/AIDS patients should not be allowed to stay in the community, and that AIDS patients should be hospitalized; 68 percent said they should be kept in isolation wards.

A descriptive survey was conducted on the attitudes of medical staff to caring for HIV infected children in three teaching hospitals in Cape Town, South Africa. The study was designed to determine whether the knowledge of a patient’s HIV positive status affects the doctor’s attitudes and management to determine the doctor’s competence with regard to management of pediatrics AIDS and to identify major concerns in the management of pediatrics patients with HIV infection. The sample consisted of 81 percent of registration and medical officers employed at hospitals during the period July/August 1996.

The study highlighted that doctors working in a situation where the epidemic recently emerged, perceived themselves as being inadequate with regard to management of HIV infection in children. There are indications that doctors may be influencing HIV positive status of children when making decisions regarding this medical management. One of the major concerns with regard to the management of patients with HIV expressed by doctors was the lack of management and policy guidelines (Fransman et al, 1996)

It appears that, at times, physicians manifested harsh attitude judgments towards patients with AIDS and were less willing to interact with patients with AIDS than patients with other illnesses. An evaluation of 119 medical students revealed that they also held negative and prejudiced attitudes towards both AIDS and homosexual patients. (Scott et al, 1993:12).

Women often do not have much power in their marriages and relationships. It is often very difficult for them to talk to their partners or to be able to say they must have safer sex. As a result of cultural, social and economic pressures, women are often more reluctant to talk about HIV/AIDS. Susceptibility is increased by factors ranging from rape, pressures on teenage women to have relationships with older men, and economic dependence on men.

Biological factors also put women at higher risk of infection. Women and girls tend to bear the main burden of caring for the sick family members, while they themselves are infected (Scott et al, 1993:11).

The HIV epidemic will produce large numbers of orphans. King (1995:14) estimated that in 2005 there would be nearly a million children under the age of 15 who would have lost their mothers to AIDS. Care of orphans will become one of the greatest challenges facing the country. Extended family structures often care for many orphans. However, many South Africans no longer have strong extended families and experience shows that even strong families can become overloaded.

King further stresses that orphans have severe stress, even if they do not have AIDS. Many orphans will end up in the streets. They will have to deal with the trauma of losing parents, and the stigma surrounding HIV/AIDS. Orphans have less access to food or education than non-orphans and face worsened poverty as the number of dependents increases in households, which

take them in. Some studies have shown that death rates among AIDS orphans are 2,5 to 3,5 times higher than for non-orphans (King et al, 1995:14-15).

In the Living Issue (2000) a true story of an HIV/AIDS victim is given. It states that the homecoming of she who is HIV positive is joyous for all in the household. Soon enough she is nested in the love of women. They were delighted to see her laugh again. Her family understands the seriousness of her condition. Every effort must be made to keep her well through proper diet and rest. They understand that she must travel to hospitals as soon as the diarrhea appears again.

A survey done by Hope Worldwide, a non-governmental community based support group for the people with AIDS, has established that about 200 000 people in Soweto are living with HIV/AIDS and are dependant on public health facilities for medical care. While 80 percent expressed emotional needs such as coping with fear and depression during the survey, 40 percent expressed the need for additional food and 53 percent had multiple children to support. Hope Worldwide sponsored by Old Mutual has started a Home Care Training program based on the training programs of the Witwatersrand Hospice and St Johns Ambulance Service. Fifteen home care workers have been trained. Hope Worldwide plans to extend the program to Ivory Park and Alexandra (Health and Hygiene, 1998).



In South Africa, during 1997 special events and prayers were held throughout the country, including puppets against AIDS performing at bus and taxi ranks in the Eastern Cape and a number of youth workshops. The challenge to all South Africans was to significantly change their attitudes and behaviour. Three areas that deserve attention are

- policy on disclosure of HIV status;
- resources for prevention of spread of HIV/AIDS from mother to child; and
- treatment of those infected with HIV to reduce progression to full-blown AIDS, (Health and Hygiene, 1997: 20).

Large numbers of schoolgirls have a “superficial” knowledge about AIDS. A mixture of appropriate and inappropriate information characterizes this knowledge. Lack of in-depth facts about the disease is attributed to their main sources of information – peers who are not experts.

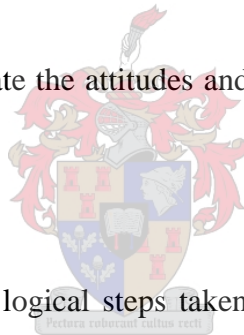
Parents were found playing a limited role in conveying sexual knowledge. It is an essential fact that if children do not receive information about sexuality from their interpersonal source of communication it may undermine the perceived importance of the disease. (HST Update, 1997:20)

A descriptive study conducted in 12 high schools in the North West Province revealed that the majority of respondents did not perceive themselves to be at risk of contracting the virus. This finding suggests that communities need to be warned about their vulnerability to infection. It should be noted that while communities believe in condom use, few actually use them. Thus it can be concluded that it is not enough to merely provide information on AIDS, but also to focus on the importance of self-value and ability to be assertive, (HST Update, 1997:20).

8. PROFILE OF STUDY

8.1 Planning of a survey

A survey was planned to investigate the attitudes and knowledge of the Somerville Community about HIV/AIDS.



8.2 Research methodology

The research design is the set of logical steps taken by the researcher to answer the research question. It flows directly from the particular research question or hypothesis and the specific purpose of the study. Also, it forms the blueprint pattern or recipe for the study and determines the methods used by the researcher to obtain subjects, collect data, analyze the data and interpret the results. In this study a qualitative assessment method has been used to evaluate the attitude of the community members towards people infected with HIV/AIDS.

8.3 Area of study

The study was carried out in Qumbu District in the Eastern Cape Province, on the Somerville community of about 300 members.

8.4 Method and procedure

A descriptive qualitative study was conducted. Data were collected using focus group discussions with the members of the community of all sexes, in the age-group 15 to 50 years.

8.5 Data collection

Data were collected using focus group discussions, diaries and a tape recorder. A certain number of specific questions were used. The researcher used the community centre for collecting data. Some preferred to express themselves in Xhosa, and others in English.

8.6 Sample

The sample consisted of 50 employees from Sommerville Location. There were ten adult females and ten adult males. Of the ten adult females, six were educated and four illiterate. Five adult males were educated and five illiterate.

8.7 Ethical considerations

Permission was obtained from the community member in charge of this location before the study began since his help in engaging the involvement of the community members was of crucial importance. Informed consent was requested from the respondents. Letters explaining the study and requesting the respondent's participation were hand-delivered to the community by the researcher. Participants were assured of confidentiality. None of them refused to participate. Guaranteeing anonymity ensured Confidentiality/privacy. It was explained to the respondents what was going to happen to the result and that the researcher would return to give respondents the results. Participants were encouraged to answer questions and express themselves freely. Adult males were seen separately from adult females. The youth groups were mixed.

9. DISCUSSION OF RESULTS

9.1 Introduction

Results are presented in the form of the following themes:

- Knowledge (cause, transmission, condom use).
- Attitude (negative attitude, the need for guidance, HIV/AIDS due to promiscuity).
- Acceptance.
- Confidentiality.
- Sex and age affected.
- Living with HIV/AIDS.

9.2 Knowledge of HIV/AIDS

Participants had a clear knowledge of the meaning of HIV/AIDS, its cause, transmission and condom use. People in this community define HIV/AIDS as Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome. The cause is a virus, the Human Immunodeficiency Virus that, according to the participants, causes premature disability and deafness.

Although the respondents seem to understand the term HIV/AIDS, and that it is a disease which is spread through having sex with an already infected person with the disease and through contaminated blood, they did not mention the prenatal transmission through an infected mother to her fetus during pregnancy or delivery or to an infant during breastfeeding.

Participants seem to have a problem in using condoms as 80 percent of them say they are left inside the vagina during sexual intercourse. They do not know how safe females are from HIV infection as the condoms are left inside. This happens because the condoms are of poor quality. Only 20 percent of the participants seem to be aware that the use of condoms can prevent the exchange of body fluids during sexual activity. If used correctly and consistently condoms can prevent both pregnancy and sexually transmitted diseases. Although the failure rate of condoms has been estimated up to 10 percent, most people agreed that condom use should be encouraged. The failure is related to incorrect use rather than condom failure. It is important to stress that when a sexual encounter takes place, each partner is exposed to all the micro-organisms of all people that the other partners have been intimate with. Safe use of condoms is therefore of importance in the education of communities.

9.3 Attitudes towards those living with HIV/AIDS

Seventy seven percent of the youth say they distance themselves once they know that someone is HIV positive. Thirteen percent say they distance themselves because they do not know what are they supposed to do with the sick persons who are facing death. Although they know that everybody is going to die, but with AIDS it is a different topic.

Seventy percent of the youth say it is necessary to accept that one is HIV positive. Three percent are prepared to support people with HIV/AIDS as long as they can be taught how to handle these people, especially when they are very ill. They say they are prepared to form support groups and educate people on HIV/AIDS as long as they can be guided.

Adult males who are educated say that they need guidance so that they are able to support their children. The illiterate participants, both males and females, say these people must be kept in hospitals, as they cannot afford staying with them in their homes. Both adult males still believe that this disease is the payment for bad behaviour whether you are young or old. They believe that having one partner cannot lead to people having HIV/AIDS.

9.4 Acceptance

Participants accept HIV/AIDS people as community members in their location. “We accept these people as members of our community even though they are HIV positive.”

9.5 Confidentiality

Participants were fully assured that confidentiality was necessary to prevent rejection of clients with HIV/AIDS. “It is necessary for this disease to be kept confidential because it becomes very easy for those people to be provoked by others, only to be reminded that they are HIV positive.”

They are perceived to have disgraced their location. Youth blame parents for hiding the diagnosis when the child has been diagnosed as being HIV positive. When children with HIV/AIDS die parents say their child has been suffering from “idliso”, headache and all sorts of other diseases, but not HIV/AIDS. That is why parents prefer that their children be hospitalized. Half of the youth feel that is better for this disease not to be kept confidential so as to be able to stay away from the infected person, be it your brother or sister.

In community health care relationships, confidentiality of information is maintained for several reasons. First, if health care professionals did not follow a rule of confidentiality, clients might not seek help when they need it. They would reveal necessary information relating to their illness that would facilitate treatment. For example, family planning clients might not reveal information relating to their productive history that would facilitate appropriate and safe nursing care and follow up treatment.

The subject of confidentiality is one of the issues that the public demands and from which it also derives benefits. A person may confide in a doctor or a nurse, confident that the information will not be made public. The concept of confidentiality allows for the flow of important information to occur, which in turn allows for the advancement of treatment of the person. The person

him/herself chooses a doctor whom she/he can trust. The important issue of confidentiality however throws the medical community into many conflicts in which the person is liable to become adversely affected by the divulging of his/her secrets. Other people might lose faith. People would avoid treatment and thus risk to society would increase. The delicate balance between societal and individual rights would become disrupted. To ensure that patients appear even for treatment, it is imperative to preserve the rights of privacy, freedom, employment, medical treatment, and protection under the law, education and other basic needs. Any violation of these creates discrimination.

9.6 Sex and age affected

In the opinion of the male participants females are commonly infected with HIV/AIDS. They claim that many females, especially younger ones, get drunk and when they are drunk they allow men who to take advantage of them. Some say many females are raped on a regular basis, and are hence the victims of HIV/AIDS. Only 50 percent of the group (both males and females) stated that all sexes and age become infected with HIV/AIDS. They say rapists rape even two-year-old babies, whether male or female. This is possibly the consequence of a myth that claims that when an HIV positive male rapes a child this disease becomes cured.

This means that two-year-old babies born without HIV/AIDS easily become victims. Some state that males are not easily infected “because they expel the disease to females during sexual intercourse.”

Regarding the gender distribution of AIDS in South Africa, the statistics show that by far the majority of cases occur among males. 85 percent of the 326 diagnosed cases were males, only 14,percent were females. Just in the pattern of total cases, the greatest quantity is concentrated on males in the 30-39 year age-category, while most cases among females occur in the 20-29 age-category. A majority of the adolescent and child cases are also males. This is partly the result of hemophilia, which is a risk factor afflicting mostly males. Since homophiles are treated with blood products, the latter should be screened.

The other group of reported AIDS is in the age group of 30 to 39 years. 88 percent of all AIDS cases are between the ages 20-49 years of age. Because the incubation period is so long, the infection is likely to have occurred during the adolescence and young adulthood.

9.7 Living with HIV/AIDS

Only 20 percent of the youth - both males and females - are prepared to live with HIV/AIDS. They are also willing to teach others about the disease, and they are prepared to form support groups.

Three percent of the group questioned the motives of those who are prepared to support those people living with HIV/AIDS; this could imply that they themselves are HIV positive. Adults see the words “living with HIV/AIDS” as a disgrace. They question how one can live with a disease he /she does not know him/herself. What about the stigma attached to the disease? Some say the moment you talk about this disease people will assume that you are suffering from it. Nurses can talk about the disease, because they know what to do once they catch this disease.

Fifty percent of the group reported stress resulting from conflicting demands from home and work, resulting in poor marital relations and deteriorating parent-child relationships, as employees still do not accept those suffering from HIV/AIDS in their work places. Respondents report that many infections that come with HIV/AIDS can be treated and many more symptoms can be dealt with using simple medicines and proper care. If someone lives with HIV/AIDS there are certain things one needs to do such as: keeping strong by eating good diet; including food that is rich in protein, vitamins and carbohydrates, staying as active as possible, exercising to prevent depression and anxiety, resting when feeling tired and get enough sleep and continue to work if possible. Also to stay occupied with meaningful activities, talk to someone about someone’s diagnosis and the illness, meeting as often with one’s friends and family. Seeking medical attention for health problems and following the advices someone is given. This includes taking steps to prevent other infections. If one is caring for children or infants with HIV/AIDS one should make sure that they get immunization for other diseases, to avoid other infections including further exposure to HIV/AIDS. Each infection one gets weakens one’s immune system, further making him susceptible to subsequent infections, which makes his immune system weaker. Using un-prescribed medicines can have side effects that may be particularly harmful if someone has AIDS. Friends can also do a lot to help one keep active and positive. Therefore, friends should not be shut out of the life of one living with HIV/AIDS.

10. RECOMMENDATIONS

10.1 Education and condom use

The community still needs extensive education on the use of condoms since they say that condoms are left inside the vagina during sexual intercourse. The department should send educators to make workshops in the community on the proper use of condoms and how to know when they are expired.

10.2 Guidance and formation of support groups

These people need education on the fact that HIV/AIDS does not infect people through sharing of utensils or staying close to an infected person or hugging. These people still lack knowledge on how to form support groups. The department should be asked to send educators to conduct workshops with this community so that they can be able to form support groups and educate others on HIV/AIDS.

10.3 Counselling of community members

Counselling of family members is important so that they do not conceal the fact that someone close to them has died of AIDS-related complications.

10.4 Education on how to live positively

In order to keep strong, people living with HIV/AIDS must be educated on eating a good diet (including food rich in protein, vitamins and carbohydrates), staying as active as possible (exercise helps prevent depression and anxiety), and talk to someone about their diagnosis and illness.

10.5 Volunteer work

People living with HIV/AIDS must be encouraged to volunteer themselves and be educated about HIV/AIDS. It is through volunteer work that these people will learn how to care for the people with HIV/AIDS in their homes. This enlightens them on how to teach others.

Integration of life education as an introductory programme in primary schools has to be followed up by school-based prevention programmes in middle and high schools. This may prove to be an acceptable approach for an ongoing educational program that equips young people with skills necessary for prevention of health and social problems and to be able to make informed decisions and to negotiate safe sex.

The involvement of young people in the planning stages of the above programmes, will give them the opportunity to identify their own needs and priorities.

Lastly, the involvement of people living openly with HIV/AIDS could be of great assistance, for they will tell the community about what they themselves have actually experienced.

11. CONCLUSION

HIV/AIDS is here to stay; therefore it is important that everyone in the community be educated on HIV/AIDS. All the people must be taught on how to take care of themselves, as well as their beloved ones and families when contracted this disease.

Also, as there is no cure for AIDS, prevention is the best defense. Therefore, taking this into account, emphasis is placed on changing personal behavior as well as increasing public awareness. Everybody should be able to protect and promote his/her own and others' health.



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