

**IMPACT OF WORK-BASED HIV/AIDS INTERVENTIONS ON
KNOWLEDGE, ATTITUDES AND PERCEPTIONS OF WORKERS IN A LOCAL
MUNICIPALITY**

Moipone Maureen Motsukunyane

Assignment presented in partial fulfilment of the requirements of the degree of Master of
Philosophy (HIV/AIDS Management) at the University of Stellenbosch



Supervisor: Dr Thozamile Qubuda

December 2009

Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

25 November 2009

ABSTRACT

INTRODUCTION

It is without a doubt that in the workplace, HIV/AIDS presents various challenges for both management and employees. Prevention programs that are in place have failed to have the desired effects mainly because they have not sought to challenge the attitudes and perceptions of those people they are targeting.

RESEARCH METHODOLOGY

The research study is designed to be qualitative in nature and a questionnaire was developed for this purpose. The researcher used semi-structured personal interviews to collect the data. Once all data was collected, open coding was used in order to categorise data that has been collected. Data was then analysed according to the categories identified in the coding process.

MAJOR FINDINGS

There were several key findings of the study and they can be summarised as follows:

- Knowledge about HIV/AIDS did not necessarily mean that those who are exposed information will make appropriate behaviour modification.
- There seems to be confusion about whether or not HIV is curable. There is a perception amongst the majority of the participants that HIV is curable by traditional doctors and there was also a group of participants who believe that HIV is not curable.
- Condom use is very rarely an individual choice; it is based on many factors such as social pressures, socially constructed sexual identities, and sexual power relations and to some extent cultural influences.
- There is still stigma and discrimination following those who are infected with HIV/AIDS since the disease became public two decades ago.
- Lastly, offering training in the workplace is one area that is lacking and this is one of the things that the participants alluded to.

OPSOMMING

INLEIDING

Dit is sonder twyfel dat MIV/VIGS verskeie uitdagings bied vir beide werkgewers en werknemers. Voorkomingsprogramme het nie geslaag om die verwagte resultate te behaal nie, hoofsaaklik omdat hierdie programme nie fokus op die houdings en persepsies van die persone wat geteiken word nie.

NAVORSINGSBEVINDINGS

Die empiriese studie is ontwerp om kwalitatief van aard te wees en 'n vraelys is vir die doel ontwikkel. Die navorser het semi-gestruktureerde persoonlike onderhouds gebruik om die data te dokumenteer. Nadat die data ingesamel is, is dit gekodifiseer asook gekategoriseer. Die data is gevolglik ontleed na gelang die kategorieë wat gebruik is in die kodifiseringsproses.

BELANGRIKSTE BEVINDINGS

Daar is sekere kern-bevindings wat soos volg opgesom kan word:

- Kennis rakende MIV/VIGS beteken nie dat die persone wat blootgestel is daaraan die regte gedrag aangeleer het nie
- Dit blyk dat daar verwarring heers of MIV genees kan word. Daar bestaan 'n persepsie onder die meerderheid van die respondente dat MIV genees kan word deur tradisionele genesers en daar was ook 'n groep respondente wat glo dat MIV nie genees kan word nie.
- Kondoom-gebruik is bykans nooit 'n individuele keuse nie; dit is gebaseer op verskeie faktore soos byvoorbeeld sosiale druk, sosiaal-gestruktureerde seksuele identiteite, seksuele mag-verhoudings en tot 'n sekere mate kulturele invloede.
- Stigmatisering en diskriminasië ontstaan teenoor die persone wat besmet is met die MIV/VIGS-virus sedert dit openbaar gemaak is twee dekades gelede.
- Laastens, deur opleiding in die werksplek aan te bied is die een gebied wat as 'n leemte uitgewys is deur die respondente.

ACKNOWLEDGEMENT

This work has been made possible by GOD; to whom I owe my being, I am because HE is. Truly, HIS mercy endures forever. I am deeply thankful to GOD for each opportunity and blessing I have had. The following people are worth mentioning:

- Dr Thomazile Qubuda, my supervisor, for his guidance.
- Emfuleni Local Municipality management for granting permission to do the research.
- My husband and children never gave up supporting and believing in me.

To all the respondents, my sincere thanks and may you be as caring and helpful to others as you've been to me.

GOD BLESS!!!

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION AND PROBLEM STATEMENT

1.1	Introduction	12
1.2	Motivation for the study	14
1.3	Research problem	17
1.4	Goals and objectives	18
1.4.1	Specific objectives	18
1.5	Theoretical background	19
1.6	School of thought	20
1.7	Research method	20
1.7.1	Data collection	20
1.7.2	Data analysis & interpretation	21
1.8	Deployment of contents	21
1.9	Conclusion	22

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1	Introduction	23
2.2	Understanding HIV/AIDS	23
2.2.1	What is HIV?	24
2.2.2	Origins of HIV	25
2.2.3	Modes of transmission	25
2.3	AIDS in the world: Dimensions of the epidemic	26
2.3.1	Asia and the Pacific	28
2.4	AIDS in Africa: A continent in crisis	29
2.4.1	North and West Africa	30
2.4.2	AIDS in sub-Saharan Africa	31
2.4.3	Uganda: A success story in Africa	35
2.5	The social epidemiology of AIDS	37
2.5.1	Personal/Individual determinants	37

2.5.1.1 High risk behaviour	38
2.5.2 Social factors	38
2.5.2.1 Poverty	39
2.5.2.2 Access to health care	40
2.6 Conclusion	41

CHAPTER 3

THE SOUTH AFRICAN EPIDEMIC

3.1 Introduction	43
3.2 Government's response to HIV/AIDS	43
3.3 The current state of the epidemic	44
3.4 Social responses to HIV/AIDS	50
3.4.1 Race	50
3.4.2 Poverty	52
3.4.3 Level of education	52
3.5 Factors affecting condom use	52
3.6 Migrant labour and HIV transmission	54
3.7 Economic impact of HIV/AIDS	56
3.8 HIV/AIDS in the workplace	58
3.8.1 Prevention programmes in the workplace	62
3.9 Local government in SA	63
3.9.1 HIV prevention programmes in local government	64
3.10 Conclusion	65

CHAPTER 4
RESEARCH METHOD

4.1	Introduction	67
4.2	School of thought	67
4.3	Research methodology	67
4.4	Data collection	68
4.4.1	Population, sampling frame and sample	68
4.4.2	Questionnaire	69
4.5	Interviewing	70
4.5.1	Administration of interviews	71
4.6	Analysis of data	71
4.6.1	Open coding	72
4.7	Conclusion	72

CHAPTER 5
FINDINGS OF THE STUDY

5.1	Introduction	73
5.2	Biographical information	73
5.3	Knowledge, attitudes and practices in AIDS	74
5.3.1	Level of awareness about HIV	74
5.3.1.1	Modes of HIV transmission	78
5.3.1.2	Extent to which participants believe that AIDS exists	79
5.3.1.3	Participants' beliefs on whether HIV/AIDS can be cured	81
5.3.2	Importance attached to condom use	82
5.3.3	Participants' attitudes regarding working with people who are infected with HIV	84
5.3.4	Participants' perceptions regarding HIV training	85
5.4	Conclusion	86

CHAPTER 6

INTERPRETATION OF THE FINDINGS

6.1	Introduction	87
6.2	Knowledge about AIDS	87
6.3	HIV prevention & sexual behaviour	89
6.4	Insight regarding those who are infected with HIV/AIDS	91
6.5	Conclusion	92

CHAPTER 7

OVERVIEW AND RECOMMENDATIONS

7.1	Overview	94
7.2	Recommendations	95
7.2.1	HIV prevention programmes	95
7.3	Limitations of the study	96
7.4	Conclusion	96

BIBLIOGRAPHY	97
---------------------	----

ANNEXURES

Annexure 1: Requisition to conduct research study.	101
Annexure 2: Covering letter.	102
Annexure 3: Questionnaire.	103

LIST OF ABBREVIATIONS

AFSA	AIDS Foundation South Africa
AIDS	Acquired Immuno Deficiency Syndrome
ARV	Antiretroviral treatment
BER	Bureau for Economic Research
BMR	Bureau of Market Research
CSW	Commercial Sex Worker
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
PLWHA	People Living with HIV/AIDS
Stats SA	Statistics South Africa
SwaNASO	Swaziland Network of AIDS Service Organisations
UNAIDS	United Nations AIDS
UNESCO	United Nations Educational, Scientific & Cultural Organisation
USAID	United States Agency for International Development
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION AND PROBLEM STATEMENT

1.1 Introduction

The first case of AIDS was documented over 20 years ago and more than 15 years ago, HIV was identified as a causative agent for AIDS. Since then, the epidemic has spread through out the world but at a very uneven pace. It is estimated that over 60 million people worldwide have lived with HIV/AIDS over the last 15 years and over 20 million of these have died (Shisana & Simbayi, 2002). At the beginning of 2003, the infection rate in the world stood at 43 million and 25 million of these cases were in sub-Saharan Africa (World Health Organisation, 2004). Despite advances made in terms of providing information about HIV prevention, the disease continues to spread. Globally, sub-Saharan Africa has been the hardest hit region; with the Southern African Development Community (SADC) being home to over 24 million AIDS sufferers (UNAIDS report, 2004). South Africa, has earned itself the unfortunate reputation of being the one country in the world with the highest number of people living with HIV/AIDS (HSRC, 2005). As is stands, over 5 million South Africans are HIV positive and 1 million die every year due to AIDS (Statistics South Africa, 2006). It is without a doubt, HIV is today the biggest threat to South Africa's development and economic growth.

South Africa still has the largest HIV epidemic in the world, with an estimated 5, 7 million people living with HIV in 2008. This is according to the Joint United Nations Programme on HIV/AIDS (UNAIDS) 2008 Report on the Global AIDS Epidemic. According to the report almost 33 million are currently living with HIV/AIDS worldwide, with 7 500 new infections every day and 25 million people having died of HIV-related causes since the epidemic broke out. The report showed slight decline in infections worldwide and that means the world is making some real progress in its response to AIDS.

The report confirmed that HIV data from antenatal clinics in South Africa showed that the country's epidemic might be stabilizing but added there was no evidence yet of major changes in behaviour. (UNAIDS) 2008. Report on Global AIDS Epidemic.

So far, HIV has been treated as a medical problem that can be managed through medical intervention, neglecting the social aspect of the disease. Shisana argues that if this were truly the case, there would be no discrepancies in the infection statistics around the globe (2000). The World Health Organisation (WHO) revealed that in 2002, Australia and New Zealand combined had an infection rate of only 15 000, compared to the 28,5 million in Sub-Saharan Africa (WHO report, 2003). This means that the sub-Saharan region is home to over 70% of those infected with the virus, while representing only 10% of the world's population. One of the most populated regions in the world, Asia had an infection rate of 2.5 million in 2003, out of a population of more than 1.5 billion. This indicates that sub-Saharan Africa indeed has a serious problem. Research has suggested that factors that influence the rate of infection vary, one of them being the level of education and literacy in a region. In light of this information, Sub-Saharan Africa could then be said to be at a disadvantage as over one third of the population is illiterate (WHO, 2004).

HIV is a global epidemic that respects no cultural, economic, social and religious boundaries, each and every part of the globe has felt its impact. It has been reported by WHO that in 2003 almost five million people became newly infected with HIV, the greatest number in any one-year since the beginning of the epidemic. Globally, the number of people living with HIV continues to grow - from 35 million in 2001 to 38 million in 2003. In 2003, AIDS killed almost three million people while over 20 million have died since the first cases of AIDS were identified in 1981. This 20 million accounts for about 5% of the world's population (WHO, 2004).

In 1998 when UNAIDS issued a map showing global infections, it was evident that there is no place in earth untouched (Whitehead and Sunter, 2000). The majority of people living with HIV, 95% of the global total, live in the developing world (UNAIDS 2003). According to Whitehead and Sunter (2000), this proportion is set to grow even further as infections rates continue to rise due to the following factors:

- poverty
- lack of education
- inequality

Authors such as Shisana (2000), Whitehead and Sunter (2000) and Crewe (2002) have argued that while HIV can be medically defined and treated; the solution in curbing its spread lies in behaviour modification instead of medical treatment and intervention. Shisana argues that “HIV is a behavioural problem that can be solved through change of attitude, perceptions and consequently the behaviour of individual members of society”. Globally, there has never been an epidemic that matches the devastating effects that HIV has. HIV infection rates have spiraled out of control in sub-Saharan Africa and the ripple effects will undoubtedly still be felt in the years to come.

1.2 Motivation for the study

In various research studies around South Africa, it has been confirmed that the level of education and socio-economic conditions very much contribute to one’s susceptibility to HIV infection (Maharaj, 2001). This claim is justified by the fact that the most infected groups in society are those with very little education, who do not have formal skills, who occupy the so called “lower levels” of the economic hierarchy and who are in some way or another linked to the migrant labour system (Shisana, 2004; Dladla et al, 2001 and Maharaj, 2001). This would mean that within the South African social landscape, the people that are most susceptible to contracting HIV are people with little formal education, who have no skills and are migrant labourers. There is a strong correlation between HIV transmission and mobility; in many cases, most unskilled and semi-skilled male workers are migrant labourers who leave their families in the rural areas to come work in the city (Department of Labour, 2003 and Barker, 2002). This results in most male workers having dual relationships, a girlfriend in the city and a wife back home. This pattern of relationships has inevitably led to the high levels of HIV infection among those workers that are either unskilled or semi-skilled (Dladla et al, 2003).

Within the Sedibeng region, Emfuleni Local Municipality is the biggest employer of unskilled and semiskilled workers and the majority of these workers are migrant labourers (Emfuleni Local Municipality. HIV/AIDS Policy, 2006). In essence, this would mean that the majority of the workers within the local municipality are most likely to contract HIV. This risk is further exacerbated by the fact that those who are migrant labourers are away from their families, they live in single sex hostels and their lifestyle is that of sexual irresponsibility. The Local Municipality is thus faced with a potential time bomb where the people who are most crucial to their mandate of service delivery are at

a very high risk of contracting HIV. In order to avert this potential disaster, one would need to educate workers of the dangers of HIV, educate them about ways to avoid being infected and also give them the necessary information that would enable them to make responsible sexual choices.

Local government plays a crucial role in the South African democratic landscape. It is the one level of government that is closest to the people, it has its pulse on what is happening on the local scene and it is the first port of call for service delivery. Service delivery is in turn dependent on a healthy and productive workforce, in order to deliver on the promise of services to the communities that it services; the Local Municipality thus needs to ensure that its workers are indeed informed about HIV/AIDS. Ultimately, in order for this information to be useful, it has to take into account people's beliefs and attitudes are said to be the main determinants of behaviour in terms of taking preventative measures where HIV is concerned. This knowledge would then have to be translated into behaviour modification where needed and making responsible sexual choices that reduce the chances of contracting HIV.

Very little research has been done within the local government sector to ascertain the level of HIV awareness among employees. As a result, most local governments around the country have under-estimated the crisis that they are dealing with when it comes to HIV. The South African Local Government Association has made it clear that there is a war against HIV and it is a war that employers need to win in order to deliver services to different communities. In its mission statement on HIV/AIDS, Emfuleni Local Municipality has declared that it acknowledges the existence of HIV and it will do anything that needs to be done in order to educate its employees regarding the virus. As a result, the municipality has a unit that is dedicated to HIV prevention campaigns and supporting those who are already living with the virus. For the purposes of this study, the researcher has chosen the Emfuleni Local Municipality as the population for conducting research. The focus fell solely on those workers who are in semi-skilled and unskilled positions.

Municipalities in South Africa are one of the major employers of unskilled and semi-skilled labour. They provide the most basic of services and efficient service delivery to communities has been a priority for municipalities. Given the increasing number of

infections in the unskilled and semi-skilled sectors of the population, service delivery has been somehow hampered by the incidences of high absenteeism due to prolonged diseases as a result of HIV infection (South African Local Government Association, 2004). Despite efforts made by SALGA to promote HIV education in the workplace, more and more municipal employees are getting infected with the virus. The researcher believes the municipality is ideal for research as there have not been many researched cases in the local government sector, particularly on HIV/AIDS. There are also a number of reasons why the researcher has chosen to focus on the local municipality.

Firstly, according to the statistics released by the municipality; about 60% of the workforce is the semi-skilled and unskilled and over 50% of them in these ranks are migrant labourers (Emfuleni Local Municipality, 2006). Pertinent literature and research concerning the sociology of HIV infection in South Africa suggests that the migrant labour system has been one of the major contributing factors towards the spread of HIV in South African urban and rural areas (Barker, 2002). It is therefore the aim of the researcher to find out more about the attitudes and behaviour of these employees. In examining attitudes, it is also the aim of the researcher to investigate the attitudes of employees towards their HIV infected colleagues.

Secondly, these semi-skilled and unskilled workers are highly traditional and hold on strongly to their beliefs; as a result, these workers have been very weary of taking the western explanation of HIV very seriously. In light of the HIV prevention programs aimed at these workers, it would be interesting to examine the influence that these programs have in changing people's perceptions towards HIV.

Thirdly, research has indicated that sectors of the population with low literacy rates are the most affected by the virus as they have little or no knowledge and understanding about the disease. This makes the municipality an ideal ground for testing out this theory as the majority of the labourers have little or no formal school education.

Lastly, the researcher has chosen the municipality because very little is known about attitudes and perceptions that influence employees in terms of how they respond to the virus.

1.3 Research problem

It is beyond a doubt that there has been a significant effort made to educate people about the dangers and prevention of HIV. South Africa has particular case in the sense that the disease is spreading because people are still holding on to their traditional perceptions that in turn inform their attitudes and behaviours.

HIV prevention programs that are currently in place here in South Africa have been gravely criticised for taking a blanket approach when it comes to disseminating information on the virus. Very few if any of the prevention programs in place take into account the audience that the information is directed at. A crucial criticism by Natrass (2004) is that HIV prevention programs in South Africa fail because they have not begun to understand the social demography, the economic inequality and the politics that surround the epidemic. In order for any information to have the intended effect, those who deliver the information should do it in such a way that the intended audience can identify with what is being said. It is also imperative if the information being broadcast seeks to change behaviour; then people's attitudes, perceptions and responses should be taken into account.

The reasons for the spread of HIV in South Africa are many but the most crucial one relates to the way in which people respond to the epidemic; based on their knowledge, attitudes and perceptions that they have towards HIV.

It is very hard to change people's perceptions even when those perceptions lead to behaviour that puts one's life at risk where HIV/AIDS is concerned. It has been argued by writers such as Crewe (2002), Shisana (2002) and Maharaj (2001) that it is very hard to change people's perceptions when it comes to HIV/AIDS, especially if those people have very little education.

There seems to be a reciprocal understanding that people with high levels of education lead healthier and much more productive lives. They have access to information; they are exposed to different view points and as such, are able to absorb new information and transform it into knowledge with ease. For this sector of the population, HIV prevention programs are useful sources of information. The opposite applies to those who are illiterate or semi-literate. Absorbing new information and translating it into knowledge is never an easy task and is often met with skepticism. This has been

precisely the case when it comes to information about HIV/AIDS. It has been established that those with limited education still believe AIDS was spread deliberately by the apartheid forces to decrease the African population, others believe that AIDS can be cured by the use of traditional medicine and there still is a large number of people who believe that HIV does not exist at all (Shisana, 2004). When examining sexual behaviour, it is imperative to marry beliefs and attitudes because to a large extent, perceptions held by people towards HIV have ultimately inform their attitudes towards sexual behaviour.

Recent reports in the financial publications have indicated that South Africa in particular is losing millions of rand in productivity every year due to employees who are constantly sick as a result of HIV related diseases (Moodley, 2006). In light of the increasing infections each year, this situation is not about to get better. This is one of the primary reasons why there should be a focus on employees, especially in the blue-collar segment of the economy, in order to ascertain training needs that will be crucial in curbing the spread of the virus.

1.4 Goals and objectives

The primary aim of the research is to investigate the knowledge, perceptions, attitudes and behaviours of employees in the local municipality.

1.4.1 Specific objectives

The primary objective of this study is to examine the attitudes, perceptions and behaviours of unskilled and semi-skilled workers within the local municipality. Specific objectives of the study are:

- To investigate the extent to which traditional belief systems inform attitudes, perceptions, and behaviours of the employees towards HIV/AIDS.
- To explore how people's attitudes and perceptions regarding the virus and how these perceptions influence their behaviour.
- To investigate to what extent is the HIV awareness programs run by the municipality effective. The municipality has a dedicated team of health workers responsible for educating municipal employees on all aspects of the virus (Emfuleni Local Municipality, 2004). It is therefore the aim of the researcher to

investigate whether training provided to labourers has managed to educate them about the virus vis-à-vis their change in sexual behaviour.

- To assist the municipality in identifying training needs of its workers when it comes to HIV education and to make recommendations based on the outcomes of the study.

1.5 Theoretical background

Behaviour is often thought to be an individual act that is done in isolation and that there is always an explanation behind such actions. When it comes to HIV/AIDS, it has always been assumed that risky behaviour is intentional and that people engage in such behaviour knowingly. According to the theory of reasoned action, intention to do a particular behaviour and the motivating factors behind this intention are able to better explain human behaviour. The theoretical framework in this research will be based on the theory of reasoned action and its application to AIDS preventative behaviour. The theory of reasoned action is a theory that attempts to explain behaviour in terms of the intention to do a particular behaviour, the factors motivating factors behind the intention and also the behaviour that results (Terry, Gallois & McCamish, 1993). For the purposes of this research project, an attempt will be made to understand the knowledge, attitudes and perceptions that workers have when it comes to HIV/AIDS. It is therefore fitting to use a theory that examines attitudes and intentions in understanding behaviour. The use of this theory has also been motivated by the realisation that knowledge of the determinants of behaviour has implications for the general understanding sexual behaviour as well as the development of intervention programs to encourage people to engage in safe sexual practices. Overall, understanding determinants of behaviour is significant for the successful implementation of prevention programs.

The theory of reasoned action has been widely used in studies that attempt that attempt to understand human behaviour particularly in AIDS preventative behaviour. Like any other theory, the theory of reasoned action has its own shortcomings but it does nonetheless provide a framework within which human behaviour can be understood and interpreted.

1.6 School of thought

In social research, theories challenge our understanding of the social world and the systematic gathering of data is extremely crucial to this practice. There are different schools of thought that one can approach research from; for the purposes of this study, the researcher will approach the research from the subjective school of thought. Subjectivity as a school of thought focuses on the meanings that people give to their environment, as a researcher within the school of thought the central interest is focused on people's understandings of their social environment (May, 1997). It is from this approach that the researcher will attempt to understand how people give meaning to their behaviour and perceptions towards the virus. In understanding the meaning attached to behaviour and perceptions, the researcher can then begin to understand the role that knowledge and the social environment play in shaping people's responses to the epidemic.

1.7 Research design and methodology

The study was qualitative so as to fully understand the perceptions held by the workers, one needs to conduct an exploratory study that will seek to explicate the research question at hand. In this study, the researcher has chosen to make use of a questionnaire that has been designed specifically for the purposes of this study. The advantage of using a questionnaire in this study is that the researcher will be able to measure the attitudes and behaviours of the workers through the formulated questions. The participants were asked a set of standard questions; this ensured that there is standardisation in the study. Another advantage of this research design was its ability to provide understanding of the workers knowledge, attitudes and perceptions towards HIV and how their responses towards the epidemic have been shaped.

1.7.1 Data collection

Data was collected through interviews where a questionnaire was used as guiding tool. Participants had the liberty to express their opinions about HIV and their responses were not necessarily limited to the questions contained in the questionnaire. For the purposes of this study, that data is presented in the form of text and all the data gathered will be useful in understanding the responses given.

1.7.2 Data analysis and interpretation

In analysing data, the information was organised into categories based on the recurrent themes and concepts in order to formulate a clear picture of the workers attitudes and knowledge with regard to HIV/AIDS. In other words, the researcher used the process of coding in analysing data. Coding refers to a process where responses obtained are studied, analysed and then put into similar categories (Neuman, 2000). This process requires an understanding of what is being said in order to have appropriate categories that are truly representative of what was said.

Firstly, open coding will be used; this is a process where the mass data obtained from the responses were be condensed into categories. Following open coding, the researcher then used axial coding where different cases that illustrate themes were clearly identified. The advantage of using a two stage coding process is to enable the researcher to formulate a story that connects and integrates all categories that have been identified (Babbie, 2002).

Data interpretation was in line with the theoretical framework as outlined in chapter two of the study. The theory of reasoned action was used as the main theory against which the study is to be understood. The aim of using theory is to better understand how behaviour is influenced by the environment, intention and the approval from others.

1.8 Deployment of contents

- Chapter 2 provides an overview of existing literature, with the aim of elucidating some of the more complex issues concerning the sociology of HIV transmission. This chapter will outline some of the theoretical discussions that have attempted to analyse the gravity of the epidemic. Different countries will be looked at, with the intention of drawing comparisons where prevention campaigns are concerned.
- Chapter 3 chapter addresses the epidemic in South Africa. The state of the epidemic will be examined, the economic and broader impact of HIV/AIDS on government will be closely looked at and lastly a model for understanding behavioural determinants when it comes to HIV/AIDS will be used to understand employees' attitudes and responses to HIV.

- Chapter 4. A discussion on the methodology used to carry out the study is carried. Various operationalisation steps are discussed; these include sampling, questionnaire administration, and data analysis.
- Chapter 5. The findings of the study are dealt with.
- Chapter 6. Provides an analysis and interpretation of the findings. This analysis of findings is in line with the theory and model of behavioural determinants as discussed in chapter 2
- Chapter 7. The concluding chapter offers an overview of the study, outlines the limitations of the study and puts forward recommendations that can be used by the municipality for future policy planning and prevention programs.

1.9 Conclusion

HIV/AIDS has had devastating effects in the world. No part of the world has been left untouched and the epidemic is still continuing to destroy lives. The world has been waging a battle that has up to now, proven to be difficult to win. Resources have been directed at fighting the spread of the epidemic and the world is yet to see their positive effects. For the past two decades, the world has been faced with a calamity so titanic; it has shaken the very foundations of human stability and social security. In order for the battle against HIV to be won, each possible effort should be directed towards curbing the rapid spread of the pandemic.

In this chapter, the researcher has tried to introduce the study by identifying the reasons that indeed warrant an investigation into the knowledge, attitudes and perceptions of workers where HIV/AIDS is concerned. The researcher has also identified the school of thought within which the study will be located in order to gain a clear understanding of the meaning the workers attach to their attitudes than in turn inform their responses. Research methodology and design to be followed have been explained; data collection processes to be followed in data analysis and interpretation have also been explained.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

It goes without saying that each part of the world has been adversely affected by the HIV epidemic, how the world has responded has left much to be desired. HIV has ceased to be a biological disease; it has instead become a disease of society. The researcher will provide an overview of the major issues surrounding the HIV epidemic, an explanation of the virus will be provided and a theoretical framework will also be dealt with. In essence, treating HIV should be examined holistically and all the important factors should be taken into account. In an attempt to understand HIV, this chapter will also deal with some of the factors that act as impediments and that render prevention programs ineffective.

2.2 What is HIV/AIDS?

HIV stands for Human Immunodeficiency Virus; this is a slow acting virus that enters the body mainly through blood and body fluids. The HI Virus is an incredibly small organism; it is roughly one ten-thousandth of a millimeter in length, it cannot be seen with the naked eye but is powerful enough to destroy lives (Barnett & Whiteside, 2002). In order for the virus to live, it has to enter the body and attach itself to host cells; the virus then multiplies in the body by attacking a particular set of cells in the human immune system. HIV attacks a group of cells known as CD4 cells; the virus specifically attacks the CD4 positive T cells which organise the body's overall immune response to foreign bodies and infections (Shisana, 2006). When a person becomes infected, the virus enters the body and attaches itself to the T cells; the virus then gets a chance to multiply in the body in the body through attacking immune cells called microphages. These microphages are cells that engulf foreign invaders and ensure that the body's immune system will recognise them in the future. Once the virus has penetrated the wall of the CD4 cell it is safe from the immune system because it copies the cell's DNA and therefore cannot be identified and destroyed by the body's defense mechanisms (AFSA, 2006).

During the time when a person is infected with HIV there begins a battle between the body's immune system and the virus. Initially, the body is able to fight the virus but after some time the virus mutates, it also multiplies at a very fast rate and the viral load becomes too much for the immune system to handle. The body then goes through different stages where the immune system is weakened immensely and in the end breaks down. When this time comes, one develops AIDS, which stands for Acquired Immuno Deficiency Syndrome; AIDS is the end stage consequence of HIV infection. One thing that needs to be noted about AIDS is that it manifests itself through a group of symptoms that combine to demonstrate a particular condition or disease. A formal diagnosis of AIDS is usually made after an individual with HIV infection begins to present a group of symptoms or when there is a development of a number of life threatening opportunistic diseases such as Kaposi's sarcoma, lymphoma's, cryptococcal meningitis and pneumocystic carinni pneumonia (Mngomezulu, 2002).

2.2.1 Origin of HIV

There is an African proverb which says when a snake enters a house, one has to kill the snake first and then ask where the snake came from (Nyembezi, 1954). If one was to liken HIV to a poisonous snake, then one would have seen it appropriate for the world to kill the snake and then proceed to ask where it came from. The problem however is that HIV is unlike any other snake; HIV is indeed a different kind of snake and the world needs to understand its origins in order to successfully kill it.

Over the past three decades, there has been an extensive debate about where HIV comes from and how it came to infect humans. Scientists believe that HIV began after an ape and monkey version of the virus known as simian immunodeficiency virus (SIV) crossed barriers from chimpanzees to humans (Mngomezulu, 2002). Recently, there have been reports that the origin of SIV has been traced to chimpanzee colonies in the remote parts of Cameroon (Mail and Guardian, 2006). The spread of disease from animals to humans has not been unique to HIV; the problem with HIV is that it has managed to spread rapidly amongst humans because it has proper "receptors" within the human body. The question of when and how HIV entered human population has been a source of great debate and this debate has not done any good in terms of putting people at ease. The speed with which the HIV replicates in the body has made it impossible to control and at present, there is still no clear answer about how HIV came

to be a human virus. Presently, all that is known is that the virus entered the blood of humans at some point and then spread through sexual contact from person to person.

There are various hypotheses that have been put forward as to how the virus came into contact with human blood. It has been assumed that the virus crossed over to humans through the consumption of bush meat by some tribes in North Africa; another supposition is that SIV crossed the species barrier through ritualistic behaviour and it has also been said that SIV might have crossed over to humans through contaminated needles in rural clinics (Barnett & Whiteside, 2002). The above scenarios are not difficult to imagine and at times, have managed to be the most widely discussed methods of through which the virus crossed the species barrier.

There is still no clear answer of how HIV entered the human species; however the state of the pandemic dictates that the world should direct all possible resources towards mitigating the impact of the epidemic. The time has now come for the world to kill the snake and ask questions later.

2.2.2 Modes of HIV transmission

HIV is a virus can only be transmitted through the exchange of contaminated body fluids and for a person to be infected the virus has to enter the body in sufficient quantities. As thus, it is highly unlikely that the virus can be transmitted through saliva. The virus can also pass through an entry point in the skin or mucous membranes into the blood stream. Unlike viruses such as cold and influenza, HIV is a very delicate virus that dies if it exposed to air (AFSA, 2006). The main modes of transmission are:

- Unsafe sex
- Transmission from infected mother to child
- Use of infected blood or blood products
- Intravenous drug use with contaminated needles
- Other modes of transmission involving blood such as open wounds

(Source: Department of Health, 2006)

The most common mode of transmission has been unsafe sex, during the early stages of the epidemic the primary mode of transmission was through homosexual intercourse but in recent times, both homosexual and heterosexual intercourse are responsible.

The mode in which HIV is transmitted has been one of the enabling factors towards the spread of the epidemic. Shisana (2004), Crewe (2002) and Crothers (2001) argue that if sexual body fluids were not the carriers of the virus, the infection rates would be much lower than they are today. It remains to be seen whether the future developments of vaccines will be able to bring the virus under control.

In the following sections of this chapter, the researcher will attempt to paint a clear picture that will elucidate some of the pressing issues around HIV/AIDS and the researcher will also show the effect the HIV pandemic has had around the world. As the grip of epidemic has not been the same in countries of the world; an attempt will be made to investigate the factors behind this discrepancy. Socio-economic factors that arise from the epidemic will also be discussed; such a discussion is an endeavor to demonstrate that the world cannot talk about issues of economic growth, social equality and development without addressing the epidemic. It is also an attempt to show that the diffusion path of HIV has put Africa at a disadvantage because it is the one continent that has felt the devastating effects of AIDS more than any other continent in the world.

2.3 AIDS in the World: Dimensions of the Epidemic

The people of Africa are watching helplessly as more sons and daughters die everyday because of AIDS. Across the continent, there are now over 25 million people living with HIV/AIDS, health care systems are rapidly becoming AIDS care systems and close to ten million orphans are looking for a home (WHO, 2004). In Southern African countries, 20 percent of the adult population is infected and in less than a decade life expectancy has dropped from well over 60 to less than 45 years. In addition, the pandemic has been gradually extending throughout Asia, from Thailand to China and to India. In the Ukraine, Russia and the rest of Europe, the pandemic is now expanding at an exponential rate due to the social conditions ideal for the spread of the virus, such as high levels of intravenous drug use, political and social instability; collapse of financial systems and continuing wars (WHO, 2004).

In some countries, prevention programs have achieved considerable success, but for the most part across the world, the response to the pandemic has been delayed, inappropriate or insufficient. The response of the international community has been, at

best, indifferent and at worst disgraceful. The world still has no real idea what promotes and secures behaviour change, how to turn skeptical populations into believing ones, how to address the needs of young people.

Table1: Regional statistics of HIV infections.

Country	Adult prevalence rate (%)	Adults living with HIV/AIDS	Adult and child deaths
Sub-Saharan Africa			
2005	6.1	24.5 million	2.0 million
2003	6.2	23.5 million	1.9 million
North Africa			
2005	0.2	440 000	37 000
2003	0.2	380 000	34 000
Asia			
2005	0.4	8.3 million	600 000
2003	0.4	7.6 million	500 000
Oceania			
2005	0.3	78 000	3 400
2003	0.3	66 000	2 300
Latin America			
2005	0.5	1.6 million	59 000
2003	0.5	1.4 million	51 000
Caribbean			
2005	1.6	330 000	27 000
2003	1.5	310 000	28 000
North America & Western Europe			
2005	0.5	2.0 million	30 000
2003	0.5	1.8 million	30 000

Source: UNAIDS epidemic update, 2006.

The previous table is an illustration of the different infection patterns of the epidemic. The overwhelming number of people, 95% to be exact, living with HIV are in the developing world (UNAIDS, 2006). The most conspicuous and disturbing observation about the table above is that Sub-Saharan Africa is the region with the most infections, with over 30 million people being infected with the HI Virus. This proportion is set to grow even further as infection rates continue to rise in Sub-Saharan African countries, where there are several factors that fuel the spread of the virus (Barker, 2002). These factors are:

- Poverty
- Under-developed infrastructure
- Poor health systems
- Lack of education
- Social and sexual inequality
- Limited resources for prevention

According to UNAIDS, the epidemic is under control in industrialised countries largely due to the fact that enabling factors that have contributed to the spread of the virus in the developing world are largely absent. The number of new cases of HIV and AIDS related deaths has fallen significantly because of the availability of antiretroviral therapy for most of those diagnosed (Barnett & Whiteside, 2002). In the United States, AIDS related deaths have declined by over 54% from 1998 to 2003 while in Western Europe the figure stood at 42% during the same period (UNAIDS, 2004). In developing countries, however, there is a varied depiction of the epidemic with some countries making progress and some still digging themselves further in the trenches in terms of increasing infection rates. In the subsequent sections in this chapter, the researcher will take an in-depth look at various regions around the world in order to examine where they stand in respect of the epidemic.

2.3.1 Latin America and the Caribbean

As in other developing countries, the epidemics in Latin America and the Caribbean are well established. Several Caribbean island states have worse epidemics than any other country outside sub-Saharan Africa (Barnett & Whiteside, 2002). The countries with the

highest HIV rates in the region are found in the Caribbean, according to figures released by the WHO, over 7% of pregnant women in Guyana tested HIV positive (2004).

Brazil is experiencing a major heterosexual epidemic but there are very high rates of infection among injecting drug users and those with homosexual relations. In Mexico, Argentina and Columbia, HIV infection is confined largely to these groups. HIV/AIDS has now become a leading cause of death in some Latin American countries with Haiti remaining the worst affected, with an estimated national adult HIV prevalence of over 6% (UNAIDS, 2006). These prevalence rates do not necessarily mean that the whole region is in a state of emergency, they do mean however that there is an increase in HIV infection rates and this should be addressed accordingly.

Despite many constraints, the region has made admirable progress in provision of treatment and care, with Brazil continuing to show the way. Though now guaranteed in many countries, access to antiretroviral treatment is still unequal across the region, due largely to drug price discrepancies (Barnett & Whiteside, 2002). Prevention programs among injecting drug users have contributed to a substantial decline in HIV prevalence in this population in several large metropolitan areas. In addition, a national survey has shown increasing condom use amongst the general population, from 42% in 1999 to 65% in 2000; a sign that sustained education and prevention efforts are bearing fruit (UNAIDS, 2005).

2.4 AIDS in Africa: A Continent in Crisis

AIDS has been called in many circles an African epidemic. In understanding the extent to which the pandemic has gripped Africa, one needs to understand that the threat of the AIDS epidemic lies not only in its effects on the population; reduced life expectancy and the growing number of AIDS orphans but it also lies just as significantly in how the rest of the world feels able to talk and describe Africa now (Jackson, 2002). Throughout the world, AIDS is seen as an African epidemic and the continent is seen as the Africa of AIDS.

AIDS has been difficult to curb in Africa because of the social misrepresentations of the disease in the continent (Treichler, 1999). There has been a failure to address race, as a result, Africans are seen in very simplistic ways. The typical view of an African is someone who is black, poor and a peasant who survives against all odds. This

simplistic account of Africans has led to the additional racism of directed against people who are defined in other ways –as white, as Asian and as mixed race – and as not being African. The problem with this simplistic analysis has led to a situation where the more affluent members of African society are assumed immune from the clutches of the epidemic. In many circles, in Africa and the world, AIDS is thought to be a poor man's disease that cannot transcend social boundaries (Crewe, 2002). Challenging the HIV/AIDS related racism in all its forms requires the world to address HIV/AIDS in all its manifestations as there two are integrally connected. Racism is deeply ingrained in all societies and HIV/AIDS has shown that it has the ability and potential to feed into such racism. Unless such racism is challenged, Africa and the rest of the world will continue to build AIDS strategies in response to these views and accusations, rather than to the pressing needs of the epidemic and social change (Crewe, 2002).

If AIDS is a disease for the whole of Africa, one would assume that the African continent is experiencing the impact of the epidemic in equal proportions. This view, however, is not a proper representation of reality. The epidemic has affected Africa in very different patterns, with some regions being more affected than others. While North Africa is relatively AIDS free, sub-Saharan Africa is currently the epicentre of HIV and AIDS (Whiteside and Sunter, 2000).

2.4.1 North and West Africa

North Africa has been fortunate enough not to experience the full might of the virus. The WHO reports that in the last ten years there has been a steady increase in the infection rates of North African countries even though they have not reached epic proportions. Countries such as Morocco, Libya and Egypt have all reported an increase in infection rates from the year 2002 to 2004, suggesting that there is an urgent need to curb the epidemic while in its infancy. The one advantage that North and West African countries have is that the prevalence rates in the region are less than 5%, making the region one of the least infected in the world.

Other African countries such as Algeria and Tunisia have reported that prevention campaigns have been successful in so far as promoting condom use and encouraging single sex partners. (Barnett & Whiteside, 2002). Nigeria, Africa's most populated country has also not experienced the full might of the virus. While there are poor

economic conditions and poverty, the spread of the virus has been curtailed. Coherent government programs and policies have led to the controlled spread of the virus. One would therefore conclude that while AIDS is predominant in Africa, not all regions in Africa are impacted in the same way.

2.4.2 AIDS in Sub-Saharan Africa

While North Africa is relatively AIDS free, in Sub-Saharan Africa the picture is different. At the end of 2004, the WHO estimated that over 25million people in sub-Saharan Africa have either HIV or AIDS. This means that 70% of the world’s infections are found in an area with only 10% of the world’s population (Shisana, 2004). These figures do not make for very optimistic reading and more interestingly; population based surveys that have been conducted in the region suggest that infection levels in men are lower than in women (Barnett & Whiteside, 2002; Shisana & Simbayi, 2000).

Table 2: Comparative HIV prevalence rates in selected sub-Saharan African countries.

Country	HIV prevalence in antenatal clinics (%)	Population based survey (%)	2003 prevalence rate (%)	HIV 2005 Prevalence rate (%)
Botswana		25.2		24.1
Burkina Faso	38.5	1.8	38.0	2.1
Burundi	2.5	3.6	4.2	3.3
Cameroon	4.8	5.5	6.0	5.5
Lesotho	7.3	23.5	7.0	23.2
South Africa	28.4	16.2	29.3	18.8
Uganda	29.5	7.1	20.9	6.7
	6.2		4.1	

Source: UNAIDS epidemic update 2006.

The table above is a representation of the infection rates of some of the sub-Saharan countries that are affected by the virus, though in different proportions. Zambia is one of the most infected countries while Mali paints a different picture. Although not represented in the table, Zimbabwe and Swaziland respectively are said to be amongst the countries with the highest prevalence rates in the world, while South Africa is said to be the one country with the highest incidence rate. (BER, 2006). Epidemiologically, the incidence rate refers to the number of infections per specified unit of a population while the prevalence rate would refer to a percentage of the population which exhibits the disease at a particular time (Shisana 2003).

On average, the 15 studies conducted in both rural and urban areas in nine different countries suggest that between 12 and 13 African women are infected for every 10 men (Whiteside and Sunter, 2000). UNAIDS/WHO estimate that at the end of 2004 13,2 million women and 11,1million men aged 15-49 were living with HIV in sub-Saharan Africa. This implies a future skewing of the demography of many African countries with men outnumbering women. The change in demographics will lead to decreasing population growth in most sub-Saharan African countries and inevitably, there will be economic implications. According to Quattek (2003), South Africa, Swaziland and Botswana will enjoy a reduction in the Growth Domestic Product (GDP) which will consequently lead to reduced expenditure. It is evident therefore, that increasing rate of infections amongst women will have far-reaching effects than originally envisaged.

Three countries in sub-Saharan Africa will be discussed in greater detail. These are Swaziland, Botswana and Uganda. This is to show how the responses to the epidemic in the region have differed, it is also to show that combating the fight against HIV is not easy and there is no one formula that can be said to be a panacea for all the epidemic ills. However, there are fundamental elements that are necessary for any progress to be made. Uganda will be used as an example to illustrate this point.

Swaziland is one of the smallest countries in Africa but according to reports issued by the Swaziland Network of AIDS Service Organisations (SwaNASO); Swaziland is one of the worst hit countries in the world (Jackson, 2002). Swaziland ranks in the top four countries to be worst hit by the epidemic, alongside South Africa, Botswana and Zimbabwe. In 2005, national prevalence rates at antenatal clinics in Swaziland stood at 23% and it is estimated by UNAIDS that by 2010 AIDS will increase the crude death

rate in Swaziland by more than 200%. The last national prevalence rate done by UNAIDS found that in 1998, over 31% of women in antenatal clinics were HIV positive (1999). The epidemic has also had devastating effects, in 2000 there were over 25 000 AIDS orphans in Swaziland and this figure is expected to double by 2010 (UNAIDS, 2000). Migrant labour has been a contributing factor to the rising infection rate in Swaziland, remittances from Swazi workers in South African mines increase domestically-earned income by as much as 20%. Swaziland is in a very difficult position because no national resources have been committed to fighting the HIV pandemic. There have been no coherent plans that integrate, education, policies and actions plans. Political leadership in HIV/AIDS ravaged countries is one of the pre-requisites for successfully winning the battle against the epidemic, in Swaziland there has been no visible commitment and as such, there has been no progress in advancing the fight against the epidemic. The King has declared AIDS a national crisis but nothing much has been done by relevant ministries to address the scourge of the epidemic. Unless there is a clear commitment from government, Swaziland will struggle to secure the external financial and technical assistance it so desperately needs (UNAIDS, 2000).

Education, knowledge and behaviour modification are crucial tools in combating the epidemic. It is necessary therefore that if education is to be successful there should be as much talking as possible in order for people to know what should be done in fighting the disease (USAID, 2002). There have been several attempts made to ensure that the scourge of the epidemic is brought under control, people in Swaziland are trying everything not be infected. Recent research reports jointly issued by the South African Department of Health and its French counterpart revealed that circumcision can be instrumental in reducing the risk of contracting HIV. Since this announcement, Swaziland has experienced an increase of over 100% in circumcisions in hospitals. Circumcision has been banned in Swaziland for decades but now the practice is gaining popularity again because of decreasing the risk of contracting HIV (Harrison, 2006).

The workforce in Swaziland has also been adversely affected by the epidemic, the denial of the extent of the AIDS epidemic in the small country has meant that organisations have taken long to respond. While there are no reliable statistics to refer to in terms of the total number of workers living with HIV/AIDS, company executives have conceded that there has been an increase in the number of deaths and also an

increase in absenteeism. The Swazi workforce is currently a ticking time bomb because companies and organisations have no idea of the real situation and have not, as a result, made any contingency plans to deal with the epidemic that is set to disrupt the labour market. Foreign investors have indicated that they are in no way interested in investing in Swaziland because they have been reluctant to train workers who will fall ill in a year or two (Harrison, 2006).

In Botswana, the story is not that much different although the two countries have totally different HIV prevention strategies. In 2005 the national prevalence rate of HIV infected persons in Botswana stood at 38,5%, making Swaziland and Botswana first and second in the world respectively in terms of the highest prevalence rates (UNAIDS, 2006:35). In response to the AIDS epidemic, the Botswana government has dedicated over 3 billion pula to deal with the pandemic (UNESCO 2006). This includes making freely available ARV's to those who are infected while intensively driving education programs to reach even the most rural of areas and supplying free condoms in public places. So far, this approach has not yielded any positive results. UNESCO reported that infection rates in Botswana are still on the increase despite government's efforts to reduce the spread of the epidemic (2006). The town of Lobatse is one of the hardest hit in Botswana, at the beginning of 2004 over 40% of pregnant women in antenatal clinics were HIV positive, one would therefore assume that this translates into meaning that in Lobatse 40% or more adults are also HIV positive (UNAIDS, 2005).

In Swaziland, the approach has been different. The ruling monarchy has not taken a firm stance in dealing with the epidemic. In a country where over 40% of its population lives in absolute poverty, HIV has not been a priority (Whiteside & Sunter 2002). SwaNASO reports that there is very little education focusing on ways to prevent the epidemic, there is still discrimination towards those who are openly living with the virus, and as such, there is little exposure to the virus as those who are infected shy away from the public domain. The situation in Swaziland is not getting any better, it was reported that in between 2003 and 2005 the rate of infection went up by 4% (UNAIDS, 2006). This would indicate that the infection rates are on the increase instead of declining. Different stages of the epidemic around the world have shown that what is most important in combating HIV/AIDS is to have a political system that is conducive to

the success of prevention programs. In a country like Swaziland, this crucial feature in fighting the virus has been absent.

2.4.3 Uganda: A Success Story in Africa

The battle against the HIV pandemic has been a very difficult one to win. The one country in Africa that has made considerable progress in ensuring that war can be won is Uganda. The country has managed to consistently reduce the levels of infection in the past five years (UNAIDS, 2006). One of the reasons for the consistent decline in infection rates in Uganda has been the increase in condom use. According to the United Nations, the rate of condom use in Uganda is one of the highest in Africa and the world.

Uganda was also one of the first countries in the world to conduct antiretroviral trials on HIV/AIDS sufferers and it was also one of the first countries to make anti-retroviral therapy available to its infected citizens (Jackson, 2002). While Uganda has had success through antiretroviral therapy, it has also focused strongly on behavioural change through education.

In the beginning, much of the Ugandan focus was on condom use, as time went on however, the Ugandan health officials combined condom use with behavioural change that was consistent with social networks in the country (Kelly, 2002). A vital key to the success of any prevention program is the way in which such a program is communicated to the intended target group, in order for any prevention programs to be effective, communication has to take into cognisance the social networks and communication patterns that govern people's behaviours. As a health worker in Uganda pointed out, much of the behaviour that people have is shaped by social networks that people are part of and as such, behavioural change education needs to challenge these networks if it is to be effective (UNESCO, 2006).

Uganda has had the most successful AIDS prevention campaigns because the country has managed to link AIDS programs to social networks which may be associated with population behaviour changes and HIV prevalence declines. The communication of AIDS prevention programs moved from the formal to the personal. Rather than communication being through formal channels such as the media and health workers,

communication moved to the personal where friends, the community and the workplace focused on creating personal social networks. The significance of this approach is that AIDS prevention programs focused on creating a system where HIV prevention & transmission was no longer treated as just being a medical issue but it was treated as a disease that was dependent on social networks in order for it to spread.

Another reason why Uganda has been so successful in fighting the virus is that sex education became an integral part of the school curriculum very early on, exposing young people to the dangers of the epidemic at a young age. Uganda has experienced dramatic declines in the infection rates of young people with secondary school education and it was found that in Uganda a girl who has dropped out of school is 3 times more likely to be HIV infected than an age mate that stayed in school. Research further showed that girls who remain in school longer are more likely to require male partners to use condoms; this contributes to the reduction of HIV transmission (Kelly, 2002:4). This approach has since paid dividends as the WHO reports that Uganda is one of the few countries in the world where the prevalence rate of people younger than 49 is indeed very low (2006). It therefore seems that if other African countries wish to turn the tide against the HIV/AIDS epidemic, there are a few lessons from Uganda:

Firstly, in order to curb the epidemic fully Uganda has shown that there needs to be a nexus between education and social networks that govern and inform people's behaviours.

Secondly, HIV/AIDS can never be fully treated as medical problem that can be solved only through the provision of antiretroviral treatment; instead it should be seen as a behavioural and a bio-medical problem that needs a combination of solutions from the two fields in order to be overcome.

Thirdly, the establishment of unique communication networks has addressed the social aspect of HIV prevention and transmission by creating personal networks that create an awareness around HIV as a social disease

Lastly, Uganda has been successful because of co-operation between religious leaders, government officials, the medical fraternity, the private sector, civic organisations and

non-governmental organisations. It is thus clear that the success that Uganda has enjoyed in terms of reducing HIV infections can be attributed to treating HIV as a social and medical problem. (Jackson, 2002).

2.5 The Social Epidemiology of HIV/AIDS

Social epidemiology is defined as “the study of the distribution of health outcomes and their social determinants” (Berkman 2000). In the case of HIV/AIDS, social epidemiology would thus pertain to the study of social determinants that have led to the transmission and the progression of the epidemic. These social determinants become aspects of and conduits by which social conditions affect health. In understanding HIV, social epidemiology is essential in that “it offers an examination of how persons become exposed to risk or protective factors and under what social conditions individual risk factors are related to the disease” (Poundstone,2004). Social factors thus become critical in understanding the dependent nature of disease transmission; this would mean that in understanding the diffusion path of HIV one also needs to understand how one outcome is dependent on results and exposures in others. Determinants of HIV transmission can be separated into three interdependent levels, namely the individual or personal, the social and the structural. All these three levels form a network that can be used to understand the spread of HIV around the world, why the diffusion path has been varied in different regions and also help us to understand HIV transmission dynamics.

2.5.1 Personal/ Individual determinants

When it comes to HIV/AIDS, personal determinants go a long way in determining the rapid or slow spread of the epidemic. Personal determinants refer to factors where the individual is directly responsible for personal behaviour. Personal determinants would thus refer to instances such as high risk behaviour, attitudes and responses to the virus. The global epidemic is characterised by a combination of personal and socio-economic factors, in African countries individual ignorance and economic factors have propelled the epidemic. In Western countries, individual freedom of choice and good economic conditions have meant that people are choosing to be careful and heed advice when it comes to HIV (Poundstone 2004).

2.5.1.1 High risk behaviour

It is without a doubt that the epidemic in the west has taken a less devastating form as compared to the epidemic that has gripped the African continent. Logic would dictate that one should first assess the factors that have contributed to this drastic spread of the epidemic in Africa and then seek to find solutions that will curtail the spread of HIV/AIDS. When one speaks of high risk behaviour where HIV/AIDS is concerned, one speaks about behaviour that increases a person's chances of contracting the HIVirus. Such behaviour would entail intravenous drug use, having multiple sexual partners without the use of condoms and the use of commercial sex workers without protection. When one speaks of an HIV positive person, a typical image that comes to mind is a young African man sitting outside in the sun, taking stock of his life and counting his days while waiting for his turn to die. While this African man is taking stock of his life; memories of many girlfriends with whom he had unprotected sex come to mind. As he tries to think back he constantly asks himself from whom did he contract the disease, after many deliberations he has no assured answer but only speculations he has no way of confirming.

Unfortunately, the above scenario has become nothing but a reality for many families in Africa, most especially in sub-Saharan Africa. In the absence of any cure or vaccine and with the little enthusiasm shown towards condom use, behaviour modification is the only solution to curbing the spread of HIV. All countries in the sub-Saharan region have prevention programs that highlight the danger of HIV, ways in which the virus is transmitted and ways that one can protect him/herself against the virus. Such programs have hinged on behaviour modification and so far, not many countries can claim that this approach is working. High risk behaviour is as prevalent now as it was with the advent of HIV.

2.5.2 Social factors

Crucially important in the study of the social epidemiology of HIV/AIDS are the social factors that very much contribute to the spread of the epidemic. When speaking of social factors, one speaks of the cultural context, the social networks, neighbourhood effects and social capital (Poundstone, 2004).

In understanding HIV transmission, one would need to understand the culture of each society and study how that culture contributes to the state of the epidemic. Global cultures are different, they pay attention to different things and they encourage different behaviours. The culture of polygamy in many African, Asian and South American countries encourages men to have more than one sexual partner. Initially, polygamy was meant to give a man an allowance of having more than one wife but in recent times polygamy has been interpreted to mean the allowance of more than one sexual partner. This has led to a situation where men are encouraged to have more than one sexual partner because it is a practice that is condoned by society as it is culturally acceptable. Multiple sexual partners have then meant that the risk of contracting HIV is increased. Western cultures do not necessarily openly promote polygamy; instead the principle of sexual exclusiveness is promoted between partners.

Socially, AIDS is a disease of stigma and shame; those who infected with the disease are treated as outcasts that deserve no place in the communities. In African countries this scenario is made worse by the misperception equating HIV with promiscuity. The HIV epidemic has affected countries in totally different ways, perhaps the most visible impact that HIV has is on the economic systems of those countries. African countries in particular, have felt the devastating economic effects of the HIV pandemic. In the past ten years, AIDS has subtracted years of achievements in socio-economic development in Africa. The pandemic has undermined countries' efforts to reduce poverty and enhance living standards. More than anything, the HIV pandemic has ensured that Growth and development have been severely hampered by the AIDS epidemic and there is still a momentous task ahead to mitigate the effects of the pandemic. Ravaging wars, poverty and underdevelopment contribute negatively towards the success of Africa.

2.5.2.1 Poverty

AIDS affects people of all income and education levels; yet the poor are more vulnerable to its consequences. The poor are less likely to recover from the shock that the loss of a productive adult and the loss of economic resources cause to the household. In Africa, the circle of poverty perpetuates the spread of the epidemic in the sense that in poverty-stricken homes, economically beneficial relationships are most likely to be pursued at the cost of unprotected sex. According to AIDS Foundation South

Africa (AFSA) poverty creates a risk environment that contributes to the transmission of HIV because it is linked to limited productive assets and gender inequality in access to resources (2006). In turn, rural poverty is exacerbated. The impact of the HIV/AIDS epidemic is proving to be most catastrophic at household level. Increasing levels of HIV/AIDS morbidity and mortality pose a serious threat to food security and nutrition in households. Families lose income earners, household expenditure is redirected to cover non-food items such as medical costs and funerals, children are taken out of school for lack of fees or to care for sick relatives, workers have to take time off to provide terminal care, resources may have to be shared with more dependents, and productive assets are sold off (BER, 2006).

The lack of social security and high levels of unemployment in South Africa mean that poor households and communities slip further and further into poverty and deprivation. Invariably the burden of coping falls on women, particularly girls and grandmothers. Much of this deepening poverty is invisible to donors and policy makers. Local organisations find themselves overwhelmed with requests for support at the same time as they lose staff and volunteers to the epidemic.

2.5.2.2 Access to health services

People in developing countries do not have access to health services like people in the west. Advances in health care for those who are HIV positive has meant increased life expectancy for many and yet for those in developing countries getting treatment has been an uphill battle. Anti-retroviral treatment has been proven to prolong the lives of those who infected with HIV and also improve their quality of life. There has been very little progress by developing countries to provide ARV treatment for those who are infected with HIV. There has also been a fair amount of reluctance by developing countries to commit themselves to providing such treatment. This reluctance can be attributed to a number of reasons. Firstly, there has been a contention by a number of governments, South Africa included, that ARV's are not fit for public consumption. There is a debate in the world of science regarding the safety of ARV for the masses. Dissidents argue that anti retroviral treatment is not safe because it compromises the immune system. The contention that ARV's are not safe has seen many a government being taken to court, in many countries the fight is still on (UNAIDS, 2006:45).

Secondly, affordability is also an issue that has affected of roll out ARV's in developing countries. ARV treatment is expensive and many governments in the south cannot afford an extensive roll-out for all those who are infected. The prevention of mother child transmission is in three phases. The first phase is where the pregnant mother must be given anti retroviral treatment that will minimize the chances of the unborn child being infected with HIV virus. The second phase is to ensure that the risk of the virus being transmitted through body fluids is minimized, hence the cesarean birth is recommended for HIV positive mothers. The third phase is to make sure that the new born does not contract HIV as carried in the mother's milk. The provision of ARV treatment for mothers who are infected and have new born infants requires that these mothers also be given infant formula so as not to infect their babies through breast milk. In the long run, providing ARV treatment as well as formula will prove to be a costly exercise hence the option by many governments not to provide treatment (USAID, 2005).

Many African countries are faced with many challenges such as unstable political environments, slow economic growth and social disorganisation. Providing HIV treatment is tantamount to ignoring other important areas of governance that need urgent attention. African countries have shown to be unable to cope with the HIV pandemic. It has posed many challenges that many of these countries have been unable to deal with. In light of these challenges, most African governments have very little incentive why they should make ARV treatment a national priority. With the exception of countries like Uganda, South Africa, Botswana and Namibia, ARV treatment is still something that other African countries have not paid much attention to (UNAIDS, 2006).

2.6 Conclusion

The worldwide HIV epidemic has unquestionably presented a massive challenge for the global community. The response to the pandemic has been questionable at times, especially from those countries that are the hardest by the epidemic. While there is consensus in the global economy regarding the exigent effects of the pandemic on developing economies, the same consensus is lacking in dealing with these effects. This chapter has provided a summary of the state of the epidemic globally, it has dealt with the broad themes that arise from the epidemic and the devastating effects it has

had on every corner of the globe. What is evident from the discussion above is that HIV has left no place in the world untouched, each continent has felt its scathing effects even though they have been discriminatory in some regards and those effects will continue to reverberate for years to come. Africa in particular is feeling the effects of the epidemic more than any other continent and Africa's development has been hampered severely by the rapid spread of the epidemic. Uganda, however, has demonstrated that the tide against HIV can be turned, provided a multifaceted approach is adopted.

CHAPTER 3

THE SOUTH AFRICAN EPIDEMIC

3.1 Introduction

The world has been presented with the unique challenge of curbing the spread of HIV/AIDS; this challenge is even greater in South Africa because of barriers affecting the success of prevention campaigns. The destructive impact of AIDS has been enormous in South Africa; it has most certainly affected the national and household economies while wreaking havoc in the workplace. In the 1990's, South Africa was the only country in the world which had to contend with the exponential rise in HIV prevalence rates in the context of a changing political dispensation (Crewe, 2002). The failure of the apartheid government to address HIV prevalence whilst still in its infancy meant that the present government led by the African National Congress (ANC) inherited an already catastrophic pandemic that had become very difficult to control (Treichler, 1999). The development of the National AIDS Plan by the Department of Health in 1994 was an attempt to address the scourge of AIDS with the hope of controlling the spread of the infections.

3.2 Government's responses to HIV/AIDS

Crucial to the success of any HIV prevention program is the unconditional political support from the highest office in the land and the ministry of health. Thabo Mbeki has been gravely criticised for his responses to the AIDS epidemic. At best, the response by the government has been indifferent and at worst it has been disgraceful. The history of HIV/AIDS in South Africa is complex and has been characterised by lack of political leadership, incoherent strategies, no proper policies and inadequate provision of treatment for those who are infected.

In 2001, Mbeki questioned the link between HIV and AIDS. The argument that was put forth by the then president together with his dissident advisers was that a virus cannot cause a syndrome and that there had to be other ways for the body to acquire AIDS. This view did nothing to help the cause of reducing infection rates but it managed to confuse the majority of the South African population that was already confused about HIV and AIDS; the further insistence by the president that there had to be a causal link

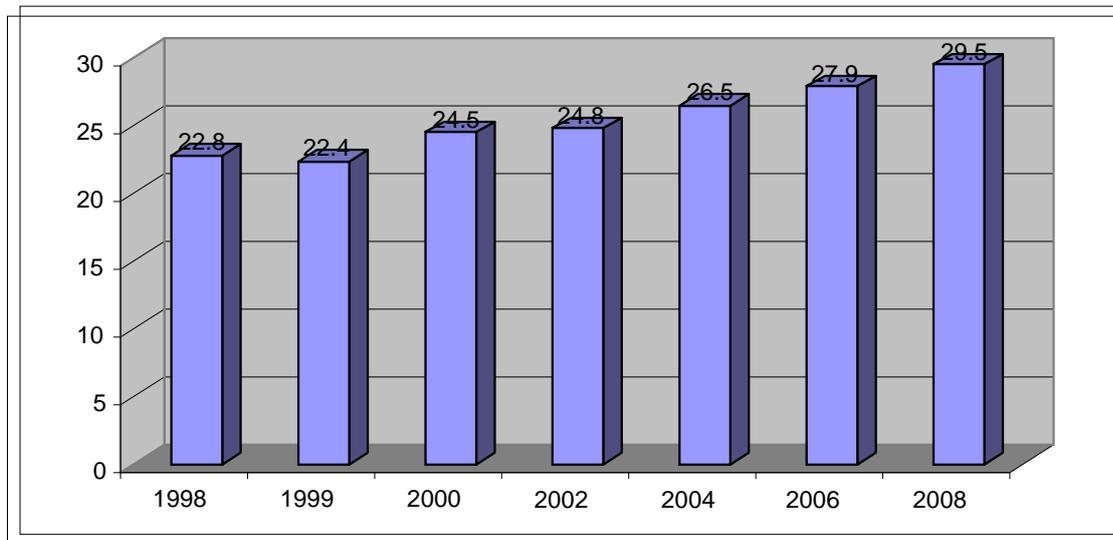
between poverty and AIDS fed into the many doubts that people already had. Poverty has not been scientifically proven to have a direct causal link with AIDS and HIV transmission, rather it can be said that the cycle of poverty does to some extent perpetuate the spread of HIV (AFSA, 2006).

The lack of political leadership in South Africa has done irreparable damage in terms of providing solutions. According to the World Bank, in order for political programs to be effective they have to get support from the national government. South Africa has three tiers of government; national, provincial and local government (World Bank, 2003: xvii). Provincial and local structures of government are dependent on the national government for HIV/AIDS strategies. The national Ministry of Health under the leadership of the minister did not implemented coherent strategies regarding the prevention, treatment and management of HIV/AIDS in South Africa. The National AIDS Plan has not been effective in that it has failed in achieving its primary goal: reducing the number of new infections. For the past ten years, the infection rate in South Africa has been on the increase and it is only from 2006 that the infection rates showed some stability.

3.3 The current state of the epidemic

The South African government, business and communities face the significant challenge of trying to curb the spread of the virus while bringing about behavioural change. As mentioned before, behaviour modification is never dependent on the information provided, but rather on how that information is received by the intended target groups. There have been different campaigns that have been aimed at different target groups but none of those have been effective as the HIV infection rate is still on the increase. According to the Rehle and Simbayi (2003), infection rates in South Africa will continue to be on the increase unless there is a drastic change in behaviour.

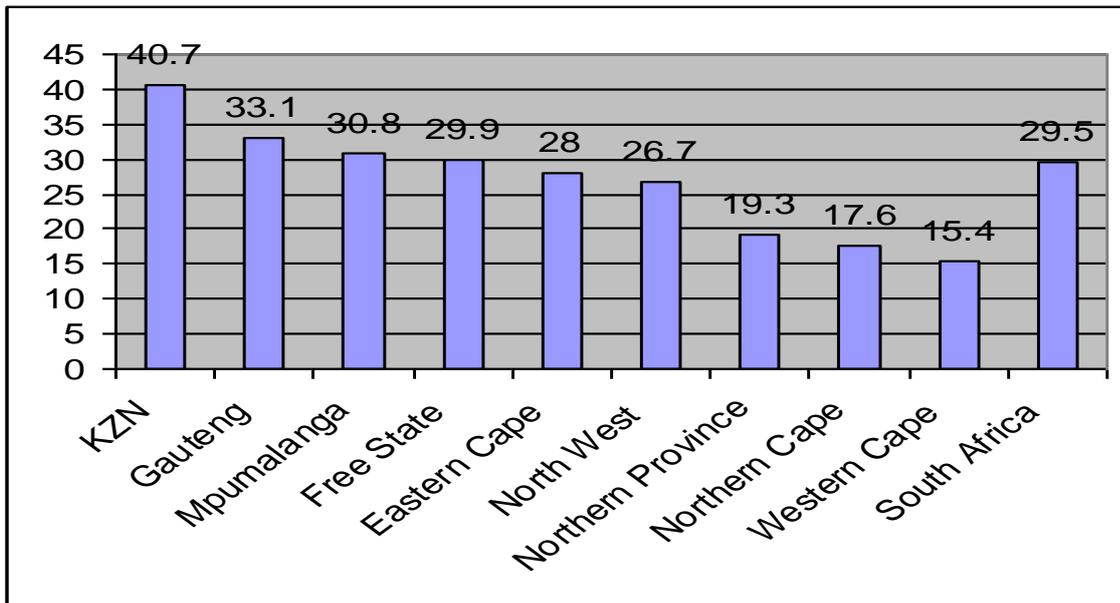
Figure 2: HIV prevalence among pregnant women in South African antenatal clinics.



Source: Department of Health, 2008.

HIV infection and prevalence rates in South Africa are mainly obtained from antenatal clinics and from these statistics conclusions are made regarding the state of the pandemic. The graphic representation of the epidemic in South Africa indicates that the country is faced with more challenges than initially envisaged. According to the table above, there has been a steady increase in HIV infections; statistics released in 2006 indicate that just over 5 million people out of a total of 46 million South Africans were HIV positive, this is about 11% of the total population. The HIV prevalence rate of pregnant women stands at just over 35% and this figure is not about to decrease any time soon. Presently, India is the one country that the highest number of people living with HIV, with South Africa following closely (UNAIDS 2008).

Figure 3: HIV prevalence rates by province.



Source: Department of Health, 2008.

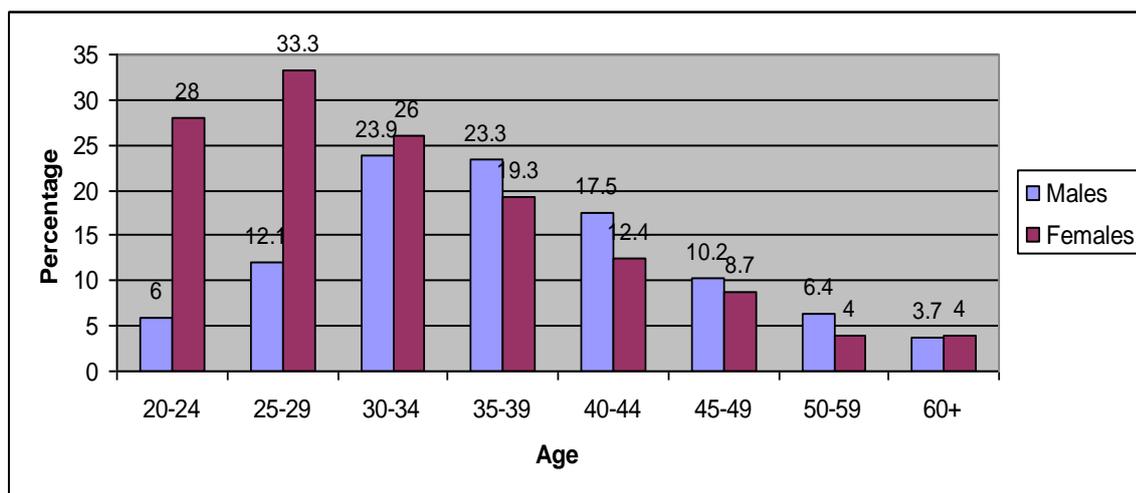
In South Africa, KwaZulu-Natal is the epicenter of the HIV pandemic. It has been recently reported that the prevalence rate varies from 38% to 50% depending on areas within the province. In areas of the south coast, prevalence was found to be as high as 70% and there is no indication that this number will decrease in the near future (Medical Research Council, 2008). Gauteng is second with the prevalence rates and it is closely followed by Mpumalanga, the Free State and the Eastern Cape. The Northern Province, Northern Cape and Western Cape are the only three provinces to have a prevalence rate under 29%.

Demographically, prevalence is higher amongst women than men between the ages of 15-34 while the prevalence rate is slightly higher for men in the older age categories (Shisana et al, 2005). The mortality rates due to the virus are on the increase; statistics indicate that in the past ten years over 1.2 million South Africans have died of AIDS related illnesses and it is projected that by 2015 over 5 million South Africans would have died because of AIDS. It is further stated that the cumulative number of AIDS deaths is expected to rise to a total of 9.31 million by 2020. In the next ten years, the number of people who are AIDS sick will stand at just over 700 000 and the country will have a population growth rate of just 0.3% compared to the current rate of

over 4%. Projections done by the HSRC show that the total population of South Africa is expected to be 28% smaller that it would be in a no-AIDS scenario. Life expectancy will also be severely affected by the AIDS epidemic, it is expected that life expectancy at birth will hit a low of 45.6 years in the period of 2005-2015 which is 22 years less than it would have been in the absence of AIDS (Shisana, 2003).

In the South African population, there is a discrepancy in the infection patterns. Statistics released by the HSRC have indicated that between the ages of 20-34 there are more females infected than there are males. The position of women in society puts them at a disadvantage because in most cases women are financially dependent on men and as such, are in a position to demand the use of protection.

Figure 4: HIV prevalence by gender.



Source: Human Sciences Research Council, 2006.

The graph above presents HIV distribution by gender. Between the ages of twenty to thirty HIV is most prevalent in women. Women who are between the ages of 25-29 are the most infected because they form part of an age group that comprises a large share of the population (BER, 2006).

Racially, Africans have a higher prevalence rate than any other race group. The racial distribution is highly skewed; the prevalence rate of Africans is 13.75% while the prevalence rate for the other race groups stands between 2.5% and 3%. There is a strong correlation between social class, race and HIV infection. Africans are

predominantly middle class and they are more at risk of contracting HIV than any other race group in South Africa. In most cases, race is confounded with social class and any discrepancies in the prevalence rate should be interpreted with this fact in mind.

The seriousness of AIDS in South Africa is undoubtedly understood, there are prevention programs aimed at raising awareness in the general population and there is a growing awareness in government concerning the need to provide health care intervention for the infected (Barnett & Whiteside, 2002). Despite all these concerted efforts, the South African epidemic still continues to defy description. Crewe, 2002 argues that, as the epidemic continues to grow this growth has been characterised by three features:

- The rapid and unchecked growth of the epidemic,
- The lack of coherent policy documents on crucial issues
- The failure of public prevention programs to have an impact

The observation made is that South Africans are largely an AIDS aware population but one that has not seen the necessity to turn this awareness into personal behaviour modification. According to Campbell, knowledge and observation in South Africa have not translated into action; hence the lack of anticipated behavioural changes (2003:44). This is the main problem in South Africa; awareness programs have been successful only in so far as making aware the general population about HIV but this awareness has not been translated into appropriate behaviour modification and consequently, prevention.

Perhaps the reason for this lack of behaviour modification has been the way in which information is transmitted and in turn, received. As Barnett & Whiteside (2002) point out, communication is never easy because the reception and absorption of information provided depends on a lot of factors. In order for information to be properly received by the intended group, the following are required:

- The appropriate medium
- The ability of the target audience to access it
- The conceptual framework to understand it and translate it into action

- Legitimacy and a framework for it to be processed.

(Source: Barnett & Whiteside, 2002)

Possibly, one could say that some of these elements have been missing from the South African communications network as information has not been well received as was envisaged. Differences between observation and information play a very crucial role in explaining the epidemic profile here in South Africa. We live in a country that has high levels of poverty; poor people in any society have constrained decision horizons and little scientific ideas about the disease. The knowledge and experience of HIV/AIDS is related to their own cultural-conceptual frameworks and to their material circumstances (Campbell, 1997). Much of the prevention campaigns have been through the mass media such as television, newspapers, and recently, billboards. There is a problem with such campaigns because television or newspaper advertisements cannot reach populations who cannot read and such advertisements cannot reach those who do not have access to electricity and as such they are automatically deprived of the information they are intended to be getting.

Furthermore, the reason why prevention programs have not had the desired effect is that the explanation of HIV/AIDS has been received with very little understanding because such a complex disease cannot be simply explained in terms of germ theory in cultures where this concept has no meaning (Campbell, 2003). HIV has been presented as a foreign concept to much of the South African population; no attempt has been made to explain the disease in a manner that has been easy to understand to each and every person that is at risk of contracting the virus (Barnett & Whiteside, 2002).

The foremost question asked in many circles is that if people know about the dangers of the epidemic, why hasn't this knowledge been translated into appropriate behaviour change in order to decrease the spread of the epidemic? Dealing with HIV/AIDS in South Africa raises all kinds of social, racial, and cultural issues that have not been dealt with. These are issues such as the sexual behaviour and sexualities of men, the sexualities of women, patriarchal behaviour and domestic violence, the sexualities of young people and their perceptions of the future (Crewe, 2002). Prevention programs

led by both government and the private sector have so far failed to develop multi-faceted approaches that will tackle the pandemic successfully. Such programs should in fact not only attempt to provide information about the virus, they need to take into cognisance the social communication networks that influence how information is received and they indeed should also be challenging the mindsets and stereotypes that people have towards HIV/AIDS. Behaviour is never isolated, it is shaped by certain social repertoires and those repertoires go a long way in shaping how people receive and absorb information. Attitudes that also arise from these social repertoires have very much contributed to the responses that people have towards the virus. Education has played a major role in terms of informing people about the medical aspects of HIV, what is now needed is an approach that will challenge the beliefs, attitudes and perceptions that people have towards the virus. HIV has long ceased to become a medical problem; instead it has become a social and economic problem that threatens to shake South African foundations to their core (Crewe, 2002).

3.4 Social responses to HIV/AIDS in South Africa

One way of fully understanding why the South African pandemic has increased so rapidly in the past decade is to understand the social responses around the spread of HIV/AIDS. In understanding these responses, one needs to firstly intricately examine the high levels of racism that surround this epidemic and the impact this racism has had on the ability of South Africa to deal with it (Crewe, 2002). Secondly, one ought to examine poverty and the role that it has played in the spread of the epidemic. Thirdly, one should carefully examine the socio-economic status of the country, more specifically the migrant labour system that has been one of the enablers of the HIV/AIDS pandemic and its spread through South Africa and indeed Southern Africa.

3.4.1 Race

The social distributions of HIV infection are complex and at times require a nuance understanding of the social processes themselves. On top of the list of these social distributions is race. HIV/AIDS is seen as a disease given to blacks by whites, while in the white community it is viewed as a black disease spread amongst the white community by black prostitutes (Crothers, 2001). The fact that black South Africans are victims to a degree that totally outnumbers that of other groups has done nothing to ease the confusion around the disease (Shisana, 2004). Perhaps more puzzling in the

whole analysis of HIV is that as a disease HIV has infected a specific social and racial group the most.

Research conducted under the auspices of the HSRC and the Nelson Mandela Foundation has found that of the African people infected with HIV, over 90% of them have been infected through penetrative sex. There has been a considerable amount of literature on sexual behaviour, with many reports indicating that South Africans generally, (predominantly people in the African sector of the population), adopt a nonchalant attitude when it comes to preventative behaviour (Crothers, 2001). Amongst other findings, levels of Sexually Transmitted Infections (STI's) are higher in urban areas, amongst African men and amongst those who are less educated. There have been consistent findings that indicate that condom use decreases with age, amongst those in non-urban areas, amongst low-educated people and amongst Africans. Amongst the African population it was found that mutual faithful monogamy was uncommon, as most had multiple sexual partners, condom use was rare and greatly influenced by notions of trust and love (Barnett & Whiteside, 2002).

Understanding sexual behaviour requires not only understanding of choice but also understanding sexual culture and lifestyles. Sexual culture refers to the "beliefs, expectations and rules for sexual conduct" (Crothers, 2001). These beliefs tend to govern the sorts of activity that are defined as legitimate; the danger being that such beliefs are not open to individual scrutiny because such beliefs are dictated by age, race and social standing. African culture and belief has been said to be a facilitating factor in the spread of the virus. African culture and belief dictates that a man should have multiple sexual partners in order to prove virility and sexual prowess, in the process preventative measures are not encouraged. It is because of these beliefs that HIV/AIDS has continued to spread amongst the African population; individual sexual behaviour has been largely dictated by the cultural beliefs held by general society. The diffusion path of HIV infection in South Africa can thus be said to be along racial lines because of cultural beliefs and ideas that have dictated how individuals within the African population group behave.

3.4.2 Poverty

Socially, HIV/AIDS is thought to be a disease of poverty, supporting the view that there is an inverse relationship between class and HIV infection. In reality however, the issue is not as simple. Belonging to the upper class in society does not necessarily preclude one from HIV infection. Sexual behaviour is dictated by, amongst other things, access to economic resources. Having more economic resources gives those with some social standing a greater opportunity to indulge in sexual activity with whomever the individual chooses something of a luxury to those who are poor. South Africa is plagued by high levels of unemployment and as such, people will do anything to find themselves in improved economic conditions. In most cases, men who have access to economic resources enjoy greater access to sex and as such, can make demands when it comes to using protection (Crothers, 2001). The general perception held is that high levels of education mean belonging to the upper class in society, which in turn translates into lower risks in terms of HIV infection. As people have increasingly engaged in risky behaviour because of poor judgment, infection rates have been on the increase.

While poverty as a social factor contributes to the spread of HIV in South Africa, there is yet to be scientific evidence that suggests that poverty causes AIDS.

3.4.3 Level of education

Generally, people believe that educated people make informed choices when it comes to sexual behaviour. In studies conducted by the HSRC, it has been shown that there is a definite link between the level of education and risk of contracting HIV. For many people with little education, HIV has been explained in a manner that is often too abstract to comprehend. The result of that have been a general lack of understanding of HIV and the consequent lack of behaviour change.

3.5 Factors affecting condom use

Much of the preventative campaigns around HIV in South Africa have hinged on condom use as being the most useful tool against fighting HIV transmission. Condoms have been around for a very long time; in the past they were primarily used as a method of contraception and with the advent of HIV/AIDS their use shifted toward being used for the prevention of sexually transmitted diseases. Generally, condoms evoke feelings of suspicion amongst both males and females; this suspicion is largely due to the way in

which condoms were first presented to the general public. The majority of males regard condoms as fuelling promiscuity and the rationale behind this thinking is this: if a female partner asks to use a condom it is because that partner is having an extra marital affair and the insistence on the use of condoms is to make sure that both partners are safe. People in the rural areas are informed mainly by their traditional beliefs and social constructions of gender roles, these beliefs inexorably shape their behaviours and attitudes towards condoms. In many communities; condoms are associated with illicit sex and promiscuity and as such women's requests to use them are highly emotive. This is one of the primary reasons why there is low condom use in South Africa, despite the knowledge that condoms are highly effective in preventing HIV from one partner to another.

According to the theory of reasoned action, human beings go through certain thought processes before they reach a particular decision. In sexual matters, it can also be said that individuals go through certain processes before they reach a particular decision. The theory of reasoned action can be used to understand condom use, in applying this theory one would need to understand the motivation behind the use or non-use of condoms through various thought processes. In a study done by Maharaj in KwaZulu-Natal, it was found that condoms are only considered when the partner is not known or when the relationship is still new (2001).

In most of the studies such as that done by Maharaj (2001), there also seems to be an inconsistency between people's attitudes towards condoms and their use. The above studies reported that participants who reported that they have faith in condoms did not necessarily use them in their lives. This would then indicate that positive attitudes towards condoms do not necessarily indicate the intention to use them.

Condom use in relationships is based on power relations and power games. In most instances, the power scales are tipped in favour of the male in the relationship. This is due to the fact that in most societies, especially African societies, the male is seen to be the only party fit to make decision on any matters relating to sexual behaviour. The position of women in society and their lack of economic power has necessitated that condom use be at the discretion of the sexual partner and in the process putting the woman at risk.

One of the factors that have facilitated the spread of HIV in South Africa is economic inequality; in understanding this inequality, one would first need to understand that the position of women in sexual matters is dependent on economic freedom. In so long as women lack the economic power to bargain for the use of condoms in relationships, then HIV/AIDS will continue to spread.

There has been a pervasive misconception amongst blacks that condoms are for single, young people who are not in committed relationships, this misconception has continued to inform people's behaviour as the study found that even when a married man has extra-marital affairs he does not consider it fit to use a condom with his wife. This attitude towards condoms can also be attributed to the level of risk attached to promiscuity. Many married men still see themselves as being not being at risk of contracting the virus even though they are engaging in unsafe sexual practices with multiple partners. Prevention programs that have been initiated by government, communities and the private sector have very much advocated the use of condoms as the main tool against which the fight on HIV transmission can be won.

3.6 Migrant labour and HIV transmission

Migration between settlements has been an instrumental factor in spreading the disease. In light of poor infrastructural and economic development in rural areas, migrant labour has become a way of life for thousands of working men in South Africa in rural areas with almost 60% of those employed being migrant labourers (Shell, 2000).

Migrant miners and truck drivers have been researched extensively in the South African context and as such inform most of the literature written on migrant workers and the sociology of HIV transmission. As such, research studies from the mining sector will be used to illustrate the various factors that influence high rates of HIV/AIDS amongst migrant labourers. The local government sector is mainly made up of migrant labourers from the most rural of places in South Africa; their beliefs, perceptions, attitudes and social identities can be said to be similar to those of migrants in the mining sector. It is for the reason that the researcher has chosen to examine research done on migrants in the mining sector as a backdrop against which this study can be understood.

Dladla et al attempted to understand the sexual behaviours and different types of relationships female partners of migrants have and how they behave in each relationship in terms of communication and condom use (2001). Researchers found that women recognised that sexual partnerships with migrant workers put them at high risk of HIV infection and this risk is attributed to their partner's behaviour. Conventionally, it has always been thought that it is only men who have extra-marital sexual partners and not the women. HIV transmission can never be fully understood without taking into cognisance the social networks and social pressures that shape and dictate people's behaviour, attitudes and perceptions towards the virus.

In 1997, Campbell conducted a study on migrant labour and HIV infection seeking to understand the factors that have made migrant labourers to be one of the most highly HIV infected social groups within society. Of particular significance to the study is the life situation of migrant workers in a range of contexts which render them particularly vulnerable to HIV. Levels of HIV infection are high among migrant labourers, with heterosexual sex being the main form of transmission (Campbell, 1997). There are various reasons why migrant labourers are the one group that is highly susceptible to HIV infection, one of those reasons being that sexual behaviour is inextricably linked with the norms typical of the social group with which people identify themselves, these norms often shape the boundaries of permissible behaviour and define the limits of deviance (Campbell & Williams, 2001).

Often, explanations of why people engage in high-risk behaviours involve an understanding of their social identities and also an understanding of the social conditions within which such identities are constructed. As such, condom use or non use can never be understood without taking into account the context in which men see their virility as compromised by using condoms and women are reluctant to insist on their use. Within social settings that do not support the use of condoms, telling people to use them will have very little effect because social contexts that act as barriers to condom use will still be standing and preaching the use of condoms "will be ignoring the broader social context of masculine and feminine identities which make the negotiation of condom use very difficult and complex" (Campbell, 1999).

Part of the problem with existing educational programs on HIV prevention has been that most of them have not taken into account the beliefs and attitudes that people have

towards the virus and by so doing, ignoring the important behavioural determinants that dictate how people respond to the virus. An issue of concern in gold mines is that a particular set of living conditions make unprotected sex with multiple partners a compelling behavioural option for migrants; these conditions being both physical and the emotional (Campbell & Williams, 2001). Physically, mine compounds are not hygienic; in most cases they are overcrowded with very little room for personal space and emotionally there is very little that miners can do to fulfill their intimacy needs (Campbell, 1997).

3.7 The economic impact of HIV/AIDS in South Africa

Research has indicated that of all the AIDS related deaths in South Africa, 70% of those deaths are of people in the age group of 24-45 (Shisana 2004). This means that the most economically active group in the population is the hardest hit, this has implications for the economy, the state and privately owned organisations. AIDS related deaths will without a doubt affect the economic growth of the country. There are several channels through which the AIDS epidemic can potentially influence economic growth:

- AIDS decreases life expectancy and hence the incentive to invest
- The AIDS epidemic creates a huge number of orphans. In all likelihood human capital accumulation by orphans faces more obstacles than if parents were present
- Potentially large medical costs associated with treatment of AIDS patients can divert public resources from productivity enhancing public expenditures such as education or infrastructure developments
- Firms might be reluctant to hire and invest in training of workers if there is a high likelihood of workers dying because of AIDS

The elements mentioned above are by no means exhaustive but they are aimed at highlighting some of the major repercussions that countries will experience as a result of the growing AIDS epidemic. As a developing country, South Africa is not immune from these effects. According to Barker, in the next 5 years there will be an increase in lost productivity and production costs because there has been a steady increase in absenteeism as a result of AIDS. Of the adults who AIDS will affect, over 90% will be between the key productive ages of 20-50years. Although AIDS will lead to large

losses of labour, a high proportion will be semi-skilled or unskilled workers that can be replaced. Highly skilled workers will be affected to a greater degree than less skilled workers or unemployed persons as they command the higher salaries that enable them to purchase sex and they are also more mobile. Production costs will also be increased because of the higher costs of group life insurance, pensions and medical aids (Barker, 2002).

There are also macroeconomic effects; the consequences of AIDS over the medium term have not been as devastating, although they may pose serious threats to ongoing economic growth if the infection rates continue to be on the increase. Regarding the long-term effects, it has been estimated that the GDP growth rate in sub-Saharan Africa between 1995 & 2025 could be cut by 1.47 percentage points, largely due to the costs of diverting savings into treating AIDS patients (Barker, 2002). In South Africa, Quattek estimates that there could be a decline of about 4, 7% in the real gross domestic growth due to increasing infections (2004). This will result in lowered disposable household incomes and as such, decreases expenditure. In a research report compiled by the Bureau of Market Research in 2004, it was indicated that there will a decline in total final consumption expenditure on durable goods by 2015 due to HIV/AIDS (BMR, 2004).

The insurance industry is said to be the one industry that will feel the effects of the epidemic. Insurers are increasingly exposed to increasing liabilities on existing policies and as such, insurers are forced to increase premiums, this invariably has an adverse effect on the economy as it means less disposable income to insurance holders and consequently less expenditure (Barker, 2002). It is estimated that with the labour force continuing to grow, job creation will become an imperative in this country. AIDS will result in an increase in mortality in the 25-40 year age group and this will negatively affect the dependency ratio as a large number of orphans and elderly will lose their adult children and thus their support structure (Barker, 2002). Poverty will also have a significant impact on communities. Many households will face financial difficulty as income earners fall ill and die and household incomes are diverted for care of HIV/AIDS infected persons.

According to the Bureau for Economic Research, the economic impact of HIV will be monumental. Projections into the next 10 years indicate that the economy will shrink

and there will be much pressure placed on fiscal spending as there will be a high dependency on social grants by those who are infected and affected (BER, 2006).

With government expenditure on the increase due to the devastating effects of the epidemic, the healthcare industry will also be severely affected by the epidemic. The impact of AIDS on health services will be profound and may well be devastating (Barker, 2002). The recent introduction of ARV treatment in public health care has meant that the health department should now be awarded a greater share of the budget in order to sustain rollout programs that have already started. This has, however, had a negative impact on the economy as it has meant that government now has to reduce the budget for other departments that are crucial in facilitating the economic growth of the country. The rise in AIDS patients who require hospital care has meant that the majority of public hospitals are clogged up with AIDS patients, thus reducing effective health care for the public.

The above section has tried to highlight that the HIV/AIDS has far more reaching effects than ever envisaged. While the economy is said to be growing at a uniform rate in the past five years, AIDS mortality rates will undoubtedly have an adverse effect on this trend in the near future. The one conclusion that can be reached is that AIDS will not only plunder South Africa into economic quandary but it will also result in the attrition of basic needs, due to channeling resources to controlling its spread.

3.8 HIV/AIDS in the workplace

In the workplace, HIV/AIDS raises many very serious issues. One of those issues is the way in which HIV positive workers are viewed and treated by their colleagues. Traditional perceptions and belief systems have very much informed people's attitudes still continue to shape their responses towards people who are living with HIV/AIDS (PWLHA). Another issue of concern is how employers respond to their employees who are infected with the virus. Over the past ten years, organizations have incurred major costs due to HIV/AIDS impacts on employees. In addition, the HIV/AIDS epidemic has brought on profound social and economic effects which will impact on the organisations. How HIV/AIDS is viewed in the workplace can be looked at from the employers and employees viewpoints, in some areas their needs overlap and in others they diverge. A case in point would be employees' need for medical care, sick leave benefits, death in

service and pension benefits while employers will be concerned about decreased productivity, increased medical costs and the need to limit expenditure. As a result of this, organisations and employees are faced with serious risks because of the increased impact of the epidemic within the workplace. Employers are faced with a particularly hard challenge because HIV/AIDS does not only cause illness, disability and death for employees and severe economic and emotional disruption for their families – it also increases the cost of doing business. (UNAIDS, 1998a) For employers and managers in sectors with high HIV/AIDS prevalence, the following risks can be expected:

- Increased absenteeism due to ill health, looking after relatives and attending funerals
- Increased deaths among the workforce at all levels
- Escalating costs of occupational benefits such as sick leave and compassionate leave, life assurance and health care
- Higher costs of recruitment, training and retraining as a result of reduced investment in human resources
- Higher staff turnover, loss of skills, experience and institutional memory
- Lowered morale, reduced efficiency and output
- Increased strain on personnel staff

(Source: Barker, 2002)

The economic impact of HIV/AIDS on organisations is titanic, it is estimated that in the next ten years HIV/AIDS will be the single biggest challenge facing organisations in South Africa. Apart from the anticipated direct costs to be incurred by organisations, there are also indirect costs that will heavily burden organisations. Indirect costs such as absenteeism, morbidity on the job and drainage of management resources will also have an adverse effect on how organisations function.

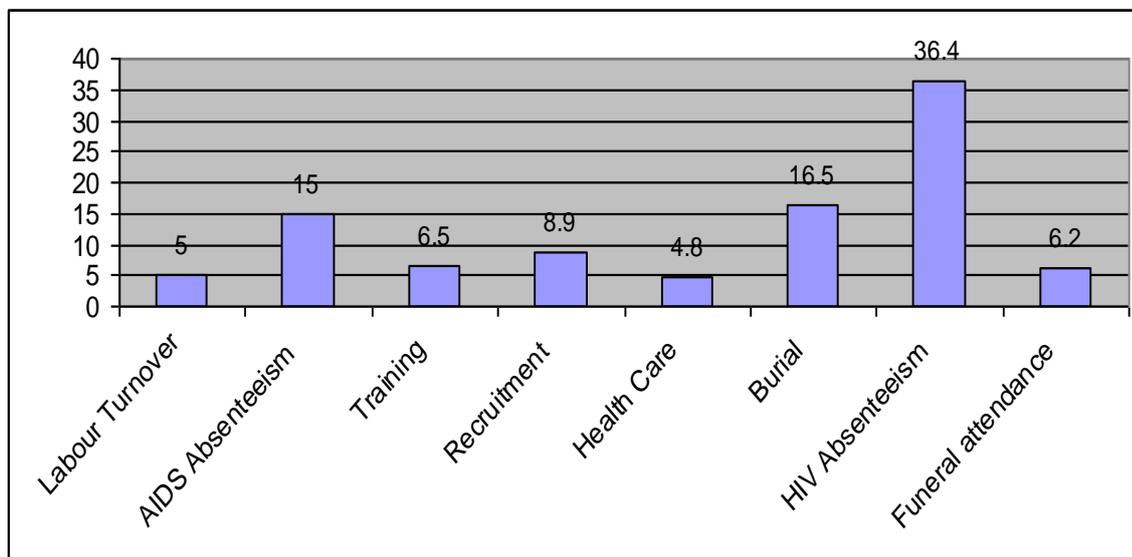
According to a report in the Business Report, South African companies are reaching into their pockets to invest in HIV and Aids treatment programs for staff as the high costs of ignoring the epidemic start to be felt. Absenteeism costs directly related to HIV and AIDS are between R1.8 billion and R2.2 billion annually. Employers have been reluctant to accept responsibility for HIV positive employees and now they are feeling the effects of carrying these workers. South Africa lost up to R12 billion a year

due to absenteeism, with between R1.8 billion and R2.2 billion being directly attributed to Aids, it has been estimated (Moodley, 2007).

Legislation in South Africa prohibits any employer from dismissing an employee on any grounds that are related to his/her HIV status. This has resulted in employers having to carry the burden of treatment for such employees. A study conducted by 2005 has found that companies in South Africa are increasingly feeling the pinch due to increased absenteeism and high staff turnover as the pandemic is gaining impetus in most companies. Anglo-American happens to be one of the biggest employers in South Africa and is at the moment faced with a crisis of having over 145 000 HIV positive employees on board with 9 000 of them needing treatment urgently (Moodley, 2007).

Barnett & Whiteside state that there are various direct and indirect costs of HIV/AIDS in the workplace and direct labour costs that are attributable to HIV/AIDS.

Figure 5: Distribution of increased labour costs due to HIV/AIDS



Source: Stats SA, 2007

The table above illustrates the increased labour costs that organisations will incur as a result of the epidemic. Absenteeism due to HIV/AIDS is the main cost that

organisations will have to deal with, as there have been an increasing number of employees being infected with the virus. Costs emanating from factors such as funeral attendance and burials should not be incurred by organisations but in reality they are and they also contribute to decreasing productivity levels due to shortage of staff. Within the workplace, increasing levels of HIV infection and AIDS gradually impact on the security and sustainability of employment from both the perspective of the employer and employee. Employees however, remain the most adversely affected by the problems AIDS creates directly for management and employers. As the business becomes less productive and as the business environment deteriorates, jobs are lost and employee security decreases. While employers are faced mainly with economic and social responsibility challenges, employees are faced with a daunting challenge of having to deal with the virus on daily basis. Individual employees face many potential difficulties at work if they have HIV/AIDS. These are:

- Loss of confidentiality
- Discrimination, including possible non-recruitment, lack of access to training or promotion, demotion and being fired
- Stigma, isolation or rejection by colleagues and workmates
- Difficulty in changing jobs
- Increasing difficulty managing a job as health declines, increased absenteeism and non-reliability, reduced probability
- Loss of occupational benefits, including access to life insurance, pension and death benefits
- Loss of medical aid if sickness leads to ill health retirement

Loss of income just as health costs escalate, risks of family impoverishment to meet medical costs. (Dept of labour, 2006)

A thorny issue in both labour and business circles has been the issue of disclosure by those who are HIV positive. Thus, a major challenge for employees living with the virus has been to deal with colleagues that are not fully informed about the virus and as such are discriminatory against them. Since the employer has a duty to protect employees in service, one would assert therefore that employers have a duty to ensure that these employees in their service are not stigmatised within the workplace and they receive all

the necessary support. This however, has not been the case since many employers have no idea on how to formulate to this effect. So far, employers have concentrated on offering training and information about preventing the transmission of the virus.

3.8.1 HIV prevention programs in the workplace

A worrying factor that has been a consistent issue in business circles is the extent to which corporate organisations have taken ownership of HIV prevention programs in the workplace. More worrying is the fact that many organisations have no information about the infection rates among workers. In a study done by Sanlam in 2002, as much as 75% of the organisations surveyed admitted to keeping no records about HIV infected employees, this was due to ignorance rather than the consideration of employee confidentiality (Dickinson, 2004). This in turn meant that these organisations had no coherent HIV/AIDS policies and prevention programs in place that could address the problems encountered by those who are infected within the organisation. All in all, corporate organisations have offered a very slow response in dealing with the epidemic within the workforce. Dickinson (2004) asserts that if employers were indeed concerned about their employees' well being, such employers would take ownership of controlling HIV/AIDS within the workplace.

Of those organisations that have initiated prevention programs, they have done very little up to so far in understanding the intricacies of designing effective prevention programs that will lead to the desired results of behavior modification. It has been argued throughout this chapter that no prevention program can ever be successful if it does not take into cognisance the social networks that inform and shape people's attitudes and responses to the virus. While there have been attempts to provide employees with training and information in so far as HIV transmission is concerned, there have been very few programs that have sought to challenge and modify how people view and feel about the virus.

Recently, there has been a rapid shift from the view that was held by employers that HIV/AIDS is none of their responsibility. Having a productive business relies on stable and sustainable productivity that can only be achieved through a healthy workforce

In sectors such as mining, the military and education; the focus has been on promoting the use of condoms as a preventative measure without encouraging behaviour change.

Condom use is in itself dependent on social identities and networks that govern how people behave, without challenging these networks such preventative measures yield very little success. Prevention programs that have gone down this route have been criticised by the likes of Shisana (2002), Crewe (2002) and Crothers (2001) for not addressing the most important aspect of HIV prevention and transmission, which is behaviour. In an evaluation of prevention programs in the mining sector it was found that most of the programs were failing because of not taking into cognisance the social identities that dictate sexual behaviour. Campbell (2003) found asserted that in order to successfully inform people HIV/AIDS within the workplace, the social networks within which these workers exist should be given preference. It therefore can be said that prevention programs aimed at giving employees information and training regarding the virus should not only dwell on the medical aspects but rather on behaviour modification.

3.9 Local government in South Africa

Governance in South Africa is made up of three distinctive yet interdependent and interrelated spheres of government on national, provincial and local level. The most important sphere of government is local government as it is the sphere closest to the people and can thus be said to be the most effective means to fight HIV/AIDS. In the different spheres of government, municipalities can be said to be the most important components as they are tasked with the responsibility of delivering basic services to the communities they serve. Increasingly, municipalities have been mandated to play a more central and development role in the fight against HIV. As the level closest to communities, they are responsible for ensuring a good quality of life for citizens and for promoting sustainable development. In order to fulfill this mandate, municipalities need a healthy and productive workforce.

The economic impact of HIV/AIDS on municipalities will be huge, there are issues of service delivery to be taken in to account, there will be ramifications because of the loss of skilled labour and there will be the challenge of fulfilling the mandate that local governments have been given. The important role that local governments have to play in reducing the rate of HIV/AIDS in the workplace and in the community has been met with little enthusiasm since there have no sustainable HIV/AIDS programs within the local government sector.

3.9.1. HIV prevention programs in local government

The researcher has decided to focus on a municipality for this study because HIV/AIDS will affect each and every municipality in South Africa one way or another. It has been pointed that HIV/AIDS presents a scenario where local municipalities will be faced with a multitude of problems due to the loss of staff, due to the growing number of HIV infections within the public sector. In a study done by the HSRC, it was found that HIV/AIDS was on the increase in most sections of the public sector and this will invariably present a problem as there will be a drastic loss of labour, this will place added pressure on already stretched resources. This increase in HIV infections will further undermine the capacity of local governments to carry out their core functions of local service delivery. In recent years, municipalities have been expected to assume greater responsibility for mounting a range of AIDS prevention programs, both for employees and communities. Municipalities are increasingly expected to perform a more central role in responding to the HIV/AIDS epidemic. Although local responses to HIV/AIDS have been highlighted as an important component in the fight against the disease, little has thus been done to understand the challenges local governments face in dealing with HIV/AIDS.

Municipalities also fall under the public sector, which in the past decade has experienced problems in terms of increasing HIV infection rates in the workforce. The growing number of infections at the disease will escalate the socio economic and health needs while at the same time undermining municipalities' capacity to provide such needs

It is very unfortunate that research in the local government sector with regards to HIV/AIDS has not been forthcoming. Local government plays a very pivotal role in South Africa as it is the first port of call for many of the service delivery issues. Much of the service delivery problems that municipalities have been facing have been due to lack of resources, be it human or financial although the latter has been treated as the main reason behind service delivery back logs. In the preceding sections, it has been discussed that one of the effects of HIV/AIDS will be reduced productivity both in the private and public sectors; it appears that the public sector has felt the most devastating effects. According to the World Bank (2003) there is an imperative need for local

government to respond to swiftly to the HIV/AIDS epidemic. The World Bank suggests that an effective local government response to HIV should have the following elements:

- It should be consistent in what it does with National AIDS Policy
- It should be informed by an understanding of local realities, norms and trends
- The response should be multisectoral, recognising that the impact of HIV/AIDS and the response require a multi-pronged approach
- It should be comprehensive in assessing how best to deal with prevention, treatment/care and impact mitigation
- The response should be committed to address issues related to stigma and discrimination as well as the gender dimensions of the epidemic. (Source: World Bank, 2003)

There has been a problem in South Africa in terms of designing local government responses to AIDS; most municipalities do not have programs for dealing with HIV in the workplace. This can be attributed to the lack of financial resources as the focus has been on service delivery rather than HIV educational programs. The World Bank further attributes this failure to the fact that local governments are not receiving sufficient support in dealing with the pandemic (World Bank, 2003). Most of the municipalities who did have HIV/AIDS programs focused on prevention rather on mitigating the impact of the epidemic and providing support for those infected. The reason behind this was lack of funding and the lack of human resources that could drive such projects. The study revealed that HIV pandemic raises serious issues around the provision of human and capital resources for the fight against HIV/AIDS in municipalities. Much of the research that has been done in the public sector has not focused on local governments and yet they fill a very important role in the provision of basic services to the community. One of the greatest challenges that have to be dealt with at local government level is the balancing of the greater need for service delivery with an equally important responsibility towards employees.

3.10 Conclusion

South Africa is faced with the task of reducing HIV infection rates across the population. This challenge has proven to be a difficult one because each year, infection rates are on the increase. Successfully dealing with the HIV pandemic has been a very intricate

process in this country, more so because there has been no clear strategies and commitment from government regarding the provision of treatment for those who are already infected. Prevention programs have so far been the main form of fighting the pandemic; in light of the recent statistics, this approach has not produced the desired results. This chapter has dealt with the broad themes that arise from the epidemic and the devastating effects it has. The general state of the epidemic as it stands now in the country was discussed; the social systems that govern and inform people's behaviour were also discussed in greater detail. A section on the economic impact of the epidemic was included in order to highlight the far-reaching effects that the epidemic will have for South Africa. Several case studies have been included, these were meant to be a backdrop against which this study can be understood and as such put into context. Lastly, HIV in the workplace was discussed in an attempt to expound some of the issues that have risen as the epidemic continues to spread and having adverse effects on employers and employees.

CHAPTER 4

RESEARCH METHOD

4.1 Introduction

This study is qualitative in nature, it is meant to paint a clear picture of what labourers think about HIV; the study is intended to give a clear understanding of their knowledge, perceptions and attitudes towards the virus. In this chapter, a broad overview of how the study was carried out will be provided; the school of thought within which the study was conducted, research methodology used, data collection processes and the advantages of qualitative research.

4.2 School of thought

There are different schools of thought that point the researcher towards a particular direction; each of those schools of thought has its own philosophic underpinnings and points of reference. Positivism, for example, is based on the postulate of cause and effect. It assumes that human behaviour is a direct consequence of the environment and that human beings play no conscious role in their own behaviour. Subjectivity, however assumes that human beings are fully conscious of their actions and they give meaning to their environments instead of being unquestionably influenced by them. Within the subjective school of thought, it is assumed that human beings are very much aware of their environment and the decisions that they make. Subjectivity also attempts to understand the thought processes of those being research in order to understand the motivations for their behaviour.

For this particular study, subjectivity has been chosen as the preferred school of thought.

4.3 Research methodology

The study is concerned with investigating the attitudes, perceptions and behaviours of Effluent Local Municipality employees. Since the study will be located within a subjective perspective, the study will be qualitative in nature in an attempt to thoroughly understand what informs the labourer's attitudes and perceptions regarding the HIV. Qualitative research methods are data enhancers in the sense that they allow for key aspects of the cases to be seen clearly. Furthermore, qualitative studies yield in depth

and holistic insight into a phenomenon because the process of data collection is intensive and creates a mental picture of what is being studied. In qualitative research, the researcher is able to share in the understandings and perceptions of others as well as understand how people give meaning to their daily lives Larry B.Christensen (2007).It has been established that responses to HIV/AIDS are at most times determined by the social environment and are seldom based on logic or rational thinking. The aim of the researcher is therefore to get a very vivid picture of how these labourers' attitudes, perceptions and social constructions of the virus inform their behaviours, more particularly sexual behaviour.

Much of the studies that have been done in an attempt to understand the diffusion path of HIV transmission have relied of the Knowledge, Attitudes, Beliefs and Perceptions (KABP's) that people have with regards to the virus. This study will also follow the same route. Campbell & Williams (2001) conducted a study on mine workers using the KAP model; Maharaj (2002) also used the same model when he did a study in KwaZulu-Natal regarding the use of condoms. In both these studies, and many others, it was found that people's attitudes and perceptions are not only influenced by the level of knowledge they have but rather by their traditional belief systems and social settings. This study also aims to understand the relationship between the knowledge that people have and how this knowledge influences the way in which they respond to HIV/AIDS.

As mentioned in the literature review, very limited research has been done in local municipalities regarding the attitudes and perceptions of labourers on HIV and AIDS. As a result, this will be an exploratory study.

4.4 Data collection

This section will deal with the collection of primary data from the chosen sample.

4.4.1 Population, sampling frame and sample

The municipality is one of the biggest employers of unskilled labour in the region. As such there are various classification categories of workers within the municipality. The aim of this research is to examine the knowledge, perceptions and attitudes of those workers who are said to be in high risk categories. These categories are those people

with little education, who are migrant labourers and have very little formal skills. For the purposes of this research, the study population was thus seen to be fit to comprise of workers within the unskilled and semi-skilled levels of employment within the municipality. The population for this study will thus consist of employees who are classified as level 18/19 in the local municipality. These levels comprise manual labourers in the municipality.

The municipality has different departments in which semi-skilled workers are employed. In total, there are 1500 employees that are in the lower strata of the municipal hierarchy. In choosing the sample for the study, the researcher had to depend on those employees who were prepared to answer questions and who did not feel ashamed of voicing their opinions. Talking about AIDS elicits feelings of shame for some people; it is understandable therefore that there were some individuals who did not feel comfortable about talking HIV and AIDS openly, the researcher therefore had to rely on available subjects; the sampling method was therefore a convenient sample. A total of 110 participants formed part of the study and they were the sources of primary data.

4.4.2 Questionnaire

Keeping in line with the subjective school of thought and qualitative research, a questionnaire was used as the primary research tool. There are several factors that motivated the researcher to use questionnaires as primary tools for data collection. Firstly, a questionnaire has been proven as the best means to collect information where the data collected still needs to be classified and analysed. Larry B.Christensen (2007). Secondly, questionnaires allow for interaction between the researcher and the participants. This interaction allows for better understanding of those who are providing the data and it also allows for the researcher to probe deeper. This research tool has proven to be advantageous for the researcher because interviews allow the participants to voice their opinions freely without feeling constrained. In situations where a deeper understanding of attitudes is needed, in-depth structured interviews are the best tool.

For the purposes of this study, a questionnaire with a combination of close ended and open questions was used and this enabled the researcher to get standard information while also paying attention to the opinions and views that will be expressed in order to get the necessary data. Larry B.Christensen (2007) argued that having these two

types of questions allows the researcher to have uniformity in the study while gaining in depth knowledge about the opinions held by the participants.

The questionnaire comprised of three sections, these were:

- Section A consisted of biographical information. This pertains to the socio-economic elements of the workers such as age, marital status, and level of education and place of current residence.
- Questions relating to the knowledge, attitudes and practices on HIV/AIDS were in Section B. The questions dealt with level of knowledge regarding the HIV/AIDS, belief systems and sexual behaviours.
- The last section of the questionnaire dealt with training levels regarding HIV/AIDS. The primary aim of this section was to see to what extent is the training provided by the local municipality in terms of changing already existing perceptions of the virus.

4.5 Interviewing

The study used semi-standardised questionnaires to conduct interviews with the participants. The researcher on a one-on-one basis administered the questionnaires with the participants, the primary aim being to collect qualitative data. In depth interviews were particularly relevant for this study as the aim was to explore, rather than calculate responses. The primary aim of the study was to determine the knowledge, attitudes and perceptions of workers regarding HIV, and the best way to gain a deeper understanding was to use interviews where participants could in fact voice their opinions freely.

One of the major problems in the study was the willingness to talk openly about HIV/AIDS. Initially, many of the participants were sceptical of discussing their views and opinions about HIV as they didn't feel comfortable. As time went on however, the participants felt quite comfortable in sharing their opinions, their level of knowledge and their practices regarding HIV. In most societies, especially black societies, HIV/AIDS is still a very difficult topic to discuss more especially when the discussion centers on one's views and attitudes regarding the subject matter. Perhaps one can attribute this difficulty to the fact that in general sexual matters are regarded as taboo and they are

never discussed in the open. They are only discussed in reaction to some thing that has happened or as a response to a comment. It can be said that maybe people do not talk freely about HIV/AIDS because of the fear of being judged or ridiculed, whatever the case maybe, there is not enough talk when it comes to HIV/AIDS.

4.5.1 Administration of interviews

The interviews were done on a one to one basis; this was to ensure confidentiality and to give the participants the freedom to express themselves without feeling inhibited as would be the case if there are other people in a room. As much as possible, the participants were put at ease and assured that their views are confidential and they will not be judged based on their views. The interviews themselves prompted the participants to think about issues around HIV/AIDS, their attitude towards the virus and how their perceptions shaped their response to the epidemic. At times, responding to questions relating to HIV requires one to think about socially acceptable responses and whether to be honest or give a response that sounds responsible. The researcher encouraged participants to voice their own opinions and not feel pressured to give socially responsible answers. Time constraints necessitated that interviews be conducted during lunch breaks as this was the only time that most of the participants were available for the whole interview. Semi-standardised questionnaires were used for this study and this enabled the researcher to have the freedom to probe further in order to clearly the participants.

4.6 Analysis of data

The data was gathered in the form of text, this data was then organised into categories based on specific themes identified and those themes were able to illustrate how the participants' knowledge, attitudes and perceptions regarding HIV/AIDS. This process of organising data into categories that can be easily managed is called coding (Babbie and Mouton). Coding in qualitative research is very much based on grounded theory; this refers to "the discovery of regularities as the identification of categories of elements and the establishment of their connections" (Babbie and Mouton). In this study, coding was the procedure adopted for data analysis.

4.6.1 Open coding

Raw data does not make much sense if it is not organised into categories that have meaning. Coding is important in the data analysis process as it allows specific categories that have meaning to be created and allow for data to be organised more effectively. In the coding process, the data was organised into categories that where themes were identified using certain segments of texts. This process is known as open coding (Babbie & Mouton). The data was transcribed and then responses with similar themes were grouped together according to the themes identified. During this stage of coding, themes are created according to the range of responses that are drawn from the initial research questions and the vocabulary used by the participants. Coding can be a complex process as it requires the proper understanding of what is being said and categorizes all the data without losing the original meaning. The advantage of coding data is that one is able to compress mass data into categories that are easy to manage and work with. Once categories have been formed, it becomes easier to manipulate data.

4.7 Conclusion

This chapter served as a broad overview of how the study was carried out. Research methodology provides a scientific basis for any qualitative study and gives studies credibility. In any research study having a scientific method of finding information provides the study with a degree of validity and reliability. In this section of the research, philosophic influences were discussed, the methodology used has also been discussed at length and the researcher has attempted to show how the coding was done. In the next chapter, the findings of the study will be discussed, in along with the themes that have been identified and presented in this chapter.

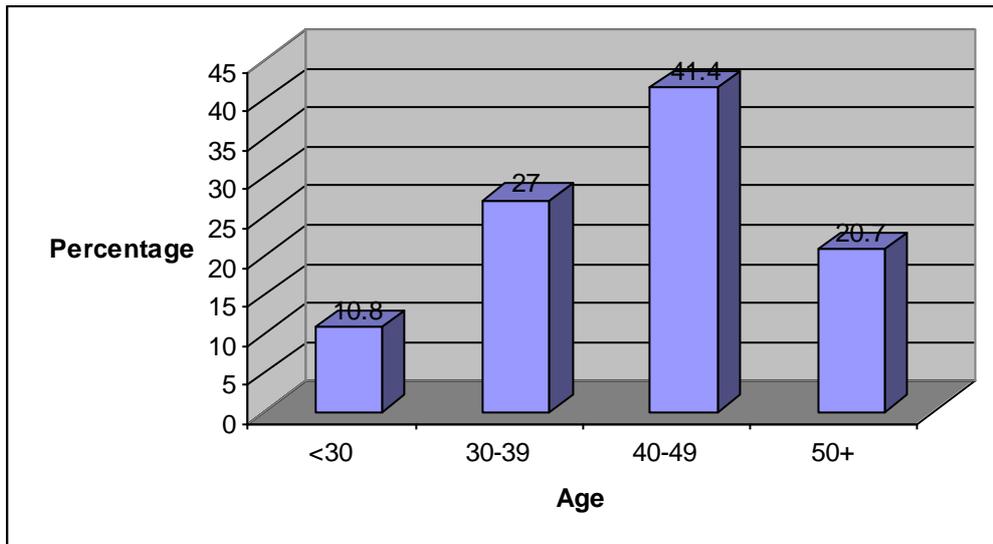
CHAPTER 5

FINDINGS OF THE STUDY

5.1 Introduction

This chapter will then deal with the findings obtained from the interviews that were conducted. The raw data was obtained from the participants and was then analysed using coding process. The process of coding allowed the researcher to compress large volumes of data into manageable categories that can be easily manipulated to get a more structured meaning from the responses. In this chapter, the findings will be presented as they are from the participants and they will be presented under the different themes that were identified in the coding process. The responses from the participants will be indented and in italics.

5.2 Biographical information: Municipality Employees



There were a total of one hundred and eleven participants in the study and as per intention, all the participants were male. Of these participants, 10.8% were below the age of thirty; 27% of the participants who between the ages of thirty to thirty-nine, a further 41.4% were between the age of forty and forty-nine and 20.7% of the participants were over the age of fifty. In terms of language, only 1.8% of the participants spoke Tswana as a mother tongue, 44.4% indicated that Sotho is a mother tongue, 30.6% spoke Xhosa and 23.4% spoke Zulu as a first language. In the sample, 39.6% of the participants lived in a hostel, 32.4% lived in their own house and there were 26.1% of the participants were renting their place of residence.

There is a trend for municipal workers to work for the same employer for a long time and in this study 35.1% of the participants had worked for the municipality for more than twenty years. About 15.3% had worked for more than fifteen but less than twenty years, 37.8% had workers for more than five years but less than fifteen years and 11.7% of the participants had worked for municipality for less than five years.

5.3 SECTION B: Knowledge, Attitudes, Practices on AIDS

This section of the questionnaire attempted to gather the participant's knowledge, attitudes, and practices on AIDS. Five broad themes were identified in this section, these are:

- The level of awareness of HIV/AIDS
- Importance attached to condom use
- Respondent's attitudes about working with people who are infected with HIV
- Risk behaviour
- Perceptions regarding training about HIV/AIDS

5.3.1 Level of awareness of AIDS

The first broad theme identified in the questionnaire was the level of awareness that participants have about HIV/AIDS. The first question that was posed to the participants is whether they knew about AIDS. All of the participants said that they did know about AIDS even though their degrees of knowledge differed. The degree to which they knew about AIDS depended on where they had first heard about the disease and as such, the level of awareness regarding AIDS varied. There were some participants who had

negligible knowledge about the disease, mainly because they thought it will not affect them in any way while others had considerable knowledge since they had been personally affected by the disease. Largely, the respondent's perceptions about HIV/AIDS attitudes determined their perceptions and consequently, responses to the disease. Participants who had personal experiences with the disease had different attitudes than those participants who did not have any personal exposure to the disease.

Participants were asked how they know about AIDS, in answering this question many of the participants referred to the media, word of mouth and even health workers as their initial sources of information. In the study, 36.9% of the participants had heard about AIDS through the media; these participants said that AIDS is all over the place and it is the one topic that has constantly dominated news headlines in recent years.

A response from one respondent:

“AIDS is all over the news, it is dominating every aspect of our lives and people talk about it as if it is going the end world”

Another respondent who has also heard about AIDS from the media had this to say:

“I have heard about AIDS from various sources, I've heard about it from the news, in various newspapers and magazines. It's a very hard topic to miss”

There has been considerable attention given to AIDS by the media, in South Africa and across the globe. The way in which AIDS has been portrayed has in fact petrified and at the same time baffled a lot of people because the message that has been sent to the general population is that AIDS is nothing but a disease that kills. This would mean that the minute a person contracts HIV then that person has received a death sentence. There has not been considerable attention paid to ordinary people who have managed to live positively despite the burden of the disease in their lives. The one thing that people have taken away from the media is that AIDS means nothing but death. The message that has been dispensed therefore has been one that has bordered on negativity instead of hope. The high level of negativity has thus meant that people afraid of talking about AIDS and they are also very weary of any future prospects when one is infected with the virus. HIV/AIDS prevention programs in South Africa have not had a positive contribution in so far as informing the public. The image that has been burnt onto people's minds is of a killer disease that knows no boundaries. In order for

prevention programs to be effective, they should instead be focusing on giving people the right tools to make informed decisions, informed decisions that will lead them to making positive choices.

In the study sample, 27% of the participants who heard about AIDS from other people and they often painted a very ominous picture about AIDS. Most often than not, information acquired from those who have little knowledge about the subject matter leads to the recipients of the information getting inaccurate information from ill-advised sources. As a result, there were participants who heard about HIV/AIDS from ordinary people in the street and they often had the wrong information about HIV/AIDS. A typical response from someone who has heard about AIDS from other people would sound thus:

“I heard from a lot of people that AIDS kills people who sleep around with many women. So I think that means AIDS affects those who have many partners”

Another respondent had this to say:

“How can one not know about AIDS? It’s the only thing that people talk about lately. Wherever you go, people are always talking about AIDS and how it kills people.”

Most people have a distorted view of HIV, of AIDS and its sufferers, to them AIDS kills promiscuous people who sleep around with many partners without using condoms. This view is often held true by many members of society because that is how AIDS sufferers have been portrayed. They have been portrayed as shameless people who have been promiscuous and deserve everything that is coming to them. However, there are often personal stories to be told by AIDS and they paint a totally different picture than the one often presented. The primary misconception with most people is that HIV and AIDS are one and the same thing. Most of the participants used the terms HIV and AIDS interchangeably, an indication that there is still misunderstanding about which comes first, the virus or the syndrome. Much of this confusion can also be attributed to the little knowledge that people have regarding the scientific intricacies of the illness. In most black communities being HIV positive already means that one has full blown AIDS and this is the message that is being passed from one person to the next. The responses from the participants therefore indicate that there is still a lot of work to be done in terms of giving people the correct information regarding the epidemic.

There were nine participants (8.1%) who said that they knew about AIDS from visits to the clinics where the nurses mentioned HIV/AIDS and told them how it is transmitted.

One respondent who went to the clinic and on his visit there the nurse told him about HIV:

“Yes, the nurse at the clinic told us about it, she told us that one can get it in different ways, one can get it through exchange of body fluids, sharing needles and the nurses also told us that we should always be careful and use condoms.”

Another respondent said this:

“The nurses at the clinic talk about AIDS and they always tell us that we should use always condoms if we want to be safe.”

The health department is supposed to be at the forefront of dispensing information and yet it seems like the only message being preached is that of death. There were only sixteen participants (14.4%) who had personally experienced the effects of AIDS and this is the one group that had change of attitude because they got to know first hand that HIV/AIDS really does exist. There has been an argument that most of the people that have changed their minds about AIDS have done so because of being exposed to the virus and its harrowing effects. There was also another respondent who knew about AIDS from personal experience and had been traumatised by the effects of the epidemic on his family. This is his response:

“I lost my only daughter due to AIDS, I didn’t know anything about it, and now my one child is dead because of this thing”

It has been said by many a researcher that the most convincing way for people to know that AIDS exists is to be exposed to the virus in order to know that it is a real disease. The participants in the study who had been exposed to the virus had turned from their beliefs that HIV did not exist and they believed that HIV is real.

5.3.1.1 Modes of HIV transmission

There has been some confusion around the issue of how HIV is transmitted because people generally associate promiscuity with HIV transmission. For many people, when a person has multiple sexual partners this automatically means that the person will be infected with the virus. It is not surprising therefore that the primary mode of HIV transmission that people mentioned is sex. For some people, it has been hard to reconcile sex and HIV transmission since many people believe that sex is natural and it cannot therefore be responsible for transmitting such a deadly disease.

One respondent said:

“I have heard that HIV is transmitted through sex, it is sad that such a dangerous thing is transmitted through one of the most enjoyable things which are sex.”

Another respondent added by saying:

“The nurses said that you can get it through having sex without a condom. I don’t know how true that is, it just does not make sense to me because sex has been around for a long time. Why now?”

There also seems to be a perception that if one person who has multiple partners does not get infected then it means that HIV is not transmitted through sex or does not exist at all. There was one respondent who brought up this issue:

“Yes, I know how it transmitted. They say that it is transmitted through sex and I don’t believe that because there is a guy I know who changes girlfriends all the time and he is not sick. If that guy does not get sick then there is no such thing as HIV.”

The above statement suggests that people do not have the necessary information to inform their perceptions about the virus. To assume that a person is not infected because of the absence of physical symptoms is to say that people who have HIV look differently from other people. This has led to people believing that if a person is not physically strained then that means the absence of infection.

Amongst the black population, weight loss has been more or less a determining symptom of whether someone has the virus or not. As a result, when someone has lost weight the only logical conclusion that people reach is to say that the person is HIV positive.

In all the time that HIV has been brought to the fore, condoms have been said to be the one thing that can prevent the spread of the virus. This has led to some people being skeptical about the importance of condoms, one respondent pointed out that there are many people who do not use condoms and yet they are not infected with HIV despite having many sexual partners.

“Yes, people say HIV is transmitted through sex without condoms. I still don’t believe it because many people that I know do not use condoms but they are still alive and well.”

This has in many ways planted a seed of doubt for a lot of people because of the demonstration effect: if someone that is openly promiscuous and does not use condoms does not get infected people suddenly think that HIV/AIDS does not exist. This they do without taking any other factors into consideration. In many black communities, open promiscuity guarantees nothing but HIV infection.

There were few participants who knew that there are different modes of HIV transmission, one respondent mentioned all the possible sources of infection:

“I know how HIV is transmitted, the sister at the clinic said that HIV is transmitted through unprotected sex, through exchange of body fluids and an infected mother can also pass it to her unborn child.”

Another respondent mentioned body fluids as another mode of transmission:

“I’ve heard somewhere that a person can get HIV through body fluids but I don’t know how that would work because they also say that you cannot get HIV from saliva.”

The above response dispels many of the myths that surround HIV. The majority of people, especially in black communities, assume that only promiscuous people get infected with HIV. If communities were to learn that HIV is transmitted in many ways, there would be less discrimination and stigma against those who are infected with the disease.

5.3.1.2 Extent to which participants believe that AIDS exists.

The extent to which participants believed AIDS existed depended on a variety of factors such as messages in the media, the perception participants had about AIDS and the most influential factor being exposed to people who are infected with the virus.

One respondent gave this reply when asked about whether he believes AIDS exists:

“My daughter is HIV positive and she said one day she will have AIDS, before this I never thought that AIDS existed but now it is in my family and I am forced to accept that it is real”

A response from someone who experienced HIV/AIDS first hand:

“Before my daughter told me that she was sick I never believed that AIDS exists; now I believe that it exist.”

From the responses given above, the exposure to those who have been infected by the virus is convincing to the participants that HIV is real. To some of the participants, the harsh reality of people dying and close relatives being infected with the virus presents the world of those who are trying to deal

Exposure to the virus is but one way of ensuring that people understand the reality that virus does exist and that it is real. Those who have personal stories to tell about the virus attest to its existence and also recognise the need to take HIV seriously.

Some of the participants do not believe that HIV/AIDS exists; to them HIV/AIDS is a conspiracy to reduce the black population across the world. This belief has been fuelled by the fact that Africa is the one continent that has been most ravaged by the epidemic. Most of the participants who did not believe that AIDS exist said that because they have not seen anyone who has died from the disease.

One respondent summed it up this way:

“Personally, I don’t think that AIDS exists. It is just a ploy by white people to stop us from having sex, having babies and multiplying. Besides, I have never seen anyone dying of AIDS”

Another respondent gave this response:

“No, AIDS does not exist. It is just there to scare people; I have never met anyone who says he has it.”

The AIDS epidemic has been met with a lot of skepticism from many people, even though all of the participants know about it, there was still a lot of suspicion about the origin of the virus and its purpose. There was one respondent in particular who took special interest in reading about the virus and the various conspiracy theories around it.

“I have been reading a lot about AIDS in my spare time, and we are not being told the truth. There are so many things we don’t know about where HIV and AIDS are

concerned. Scientists are not telling us the real story about AIDS. In America AIDS was meant to kill gays and here in Africa it was meant to kill black people.”

The above statements echo a sentiment that is held by many members of the African population who believe that in South Africa HIV/AIDS was deliberately spread by apartheid forces in order to reduce the black population. An admission made by apartheid operatives at the Truth and Reconciliation Commission regarding the matter has been used by people to justify their belief that HIV was especially made for the destruction of the black population.

5.3.1.3 Participants beliefs on whether HIV/AIDS can be cured.

There has been a continuous debate in the medical fraternity regarding the prospects of a cure for HIV/AIDS. Here in South Africa, there has been a lot of confusion on whether HIV can be cured; traditional healers are pitted against western doctors with their claims that they have herbs that can cure AIDS. Staunch believers in traditional medicine strongly believe in traditional healers and a recent claim by some traditional healers that they can cure HIV/AIDS has made this belief even stronger.

In the study, there were sixty one participants (55.4%) who believed that AIDS cannot be cured, albeit they had different reasons; there were sixteen participants (14.4%) who said that AIDS can be cured by traditional healers and the remaining thirty one participants (28.1%) did not know whether HIV can be cured or not. While the majority of the participants did not believe that AIDS can be cured, their reasons differed significantly. Of those participants who believed that HIV/AIDS cannot be cured, very few of them understood the medical reasons for this as many believed that traditional healers can cure AIDS.

One of the participants said:

“Everything can be cured, what is so special about AIDS? I think traditional doctors can cure AIDS but people do not believe it.”

Another respondent echoed the same sentiment:

“Traditional healers say they have herbs that can cure AIDS and I believe that. Western doctors dispute that because they don’t understand traditional herbs.”

There were other participants who did believe that HIV cannot be cured because of the complexity of the virus. There was one respondent made this statement:

“No, AIDS cannot be cured. Many people are misled into believing that it can be cured by traditional healers but it cannot. Even doctors cannot cure AIDS.”

Another respondent held the same view:

“Unfortunately, there is no known cure for HIV. It is such a pity because most people believe that AIDS can be cured by traditional healers.”

Many of the participants who believed that AIDS cannot be cured cited unwillingness from Western doctors as the main reason why there was no cure for HIV. There still is suspicion regarding the fact that HIV is incurable, there were participants who stated that if western doctors wanted HIV to be curable it would be.

“HIV is nothing but a ploy from white people, who has ever heard of a disease that cannot be cured?”

What is evident from the responses is that there is still enormous confusion regarding whether HIV can be cured. The fact that African people are the most infected group in the world has done nothing to alleviate the confusion around HIV. Part of the problem is the way in which information is conveyed to people. There has been no proper channeling of information, there has been very little or no challenge made as far as traditional beliefs are concerned and there is a dichotomy between traditional and western doctors. This has led to many people being confused and at the moment, there is no solution in sight to ease the confusion.

5.3.2. Importance attached to condom use

The second broad theme identified was the importance participants attached to condom use. Participants were asked whether they believed condoms could stop the spread of AIDS. There were mixed responses regarding the matter with a total of sixty four participants not believing that condoms work and they cited various reasons for this.

There were twelve of participants (10.8%) who believed that the spread of HIV could only be stopped through behaviour modification, these participants stated that condoms alone cannot save the life of a person because people have to take care of themselves.

“No, condoms should be used as a safety measure. The only way that people can stop the spread of HIV is by being careful and taking care of themselves. Trust yourself and not a condom”

One respondent also expressed his distrust where condoms are concerned:

“It’s very funny that you should ask that because doctors talk about condoms as if they are the only solution but I believe that only behaviour can stop AIDS”

Out of the hundred and eleven participants, there were sixteen participants (14.4%) who believed that condoms were helpful in stopping the spread of HIV. These participants seemed to demonstrate an understanding of the role that condoms play in terms of protection.

One respondent had this to say:

“Condoms definitely do help as they are a form of protection and I think that every one should use them.”

Another respondent said:

“Yes, condoms should be used as a safety measure but the problem is that people are being careless because they know will use condoms.”

There are a variety of reasons why people do not believe in condoms; one of those reasons is that condoms are seen to be fuelling promiscuity. When condoms were first introduced, they were said to be the only solution against HIV. This led to many people believing that even if they were careless as long as they used condoms. As a result, many people associate condoms with promiscuity and thus refrain from using them.

There is one respondent who added:

“I don’t believe in condoms because if my wife says we should use a condom then I would think that she is being unfaithful when I am not around.”

There was another respondent who said:

“I don’t believe in using condoms, condoms are only for people who sleep around”

There was also another group among the participants who believed that condoms do not work at all. These participants added that condoms could not be trusted at all. One of the participants said:

“Condoms do not work, they burst, and they leak so it is very easy to get HIV.”

Negotiating condom use is never an easy issue, as can be seen from the above responses. One of the things that have been constant is that those who do not trust condoms have their own specific reasons as to why they do not think condoms can help stop the spread of HIV. One thing remains clear; condom use is very much dependent on the perceptions and knowledge that people have. If condoms are to be used effectively in the fight against, the strategy used to convey information has to recognise the perceptions that inform and dictate people’s behaviour.

Participants were also asked whether they knew any co-workers who used condoms. The majority of the participants, seventy five in total (68.1%), indicated that they did not know if their co-workers used condoms, there were 17 participants (15.4%) who stated explicitly that none of their co-workers use condoms and there were sixteen participants that they know some of their co-workers who do use condoms.

5.3.3 Participants attitudes regarding working with people who are infected with HIV

The final broad theme in Section B dealt with the attitudes participants have regarding working with people who are infected with HIV. The first question that the participants were asked is if they knew any co-workers who were infected with HIV; an overwhelming majority, 80 participants, 72% in total, said that they did not know of any co-workers that were infected. There were only 7 participants (6.3%) who said that they did know of co-workers who were infected and eight participants said that they do not know what a person with HIV looks like so they would not be in a position to say whether they knew of any co-worker that was infected with the virus. Participants also said that there were co-workers that were suspected of being infected with the virus but because of the stigma attached to HIV these co-workers were not willing to reveal their status.

One respondent said:

“There are some people here at work that look sick but do not want to disclose their status because they are scared.”

Another respondent added:

“We don’t know anyone here at work that has the disease because people hide themselves if they have this disease. People think that it is shameful to have HIV because people say those who get HIV are people who sleep around.”

People are at times reluctant to talk about their private lives with their co-workers, if a person is infected it becomes very difficult to reveal to co-workers because they feel that their private lives do not spill into the workplace.

It is often difficult for people to know if other co-workers are infected because of the stigma attached to HIV, people who are infected would rather keep quiet about their status in order to avoid being ostracised.

The second question that participants were asked is whether it is safe to work with people who are HIV positive. A total of fifty three participants said that it was safe, while there were thirteen participants who said that for them it was not safe and there were forty four participants who did not know whether it was safe to work with someone who is infected with HIV. The group of participants who did not know whether it is safe added that they did not have sufficient information to make a conclusion regarding their safety.

Participants were asked if co-workers that are HIV positive should continue working. There were fifty six participants (50.4%) that said that co-workers that are HIV positive should continue working provided they are still strong, there were eleven participants (9.9%) who said that they should stop working, while a further twenty one participants (18.9%) said that it should remain the individual's personal choice to work and there were twenty one participants (18.9%) who said that they don't know.

5.3.4 Participants perceptions regarding HIV training

The last section of the questionnaire dealt with the training that the participants had received regarding HIV. There were only eleven participants (9.9%) who had received training and they did not specify when they had received the training. Nine of the participants (8.1%) who received the training said it was useful to them, seven participants indicated that the training did in fact change their perceptions regarding HIV and there were eighty participants (72%) who said that they thought the training should be offered to all employees in the council.

This is what participants said:

“Yes I think more people should be made aware of HIV and how to prevent it.”

Another respondent added by saying:

“There is a need for training because most of the people who work here are not informed about HIV so they need to know about it”

There is an overwhelming need for the training of workers in the local government sector. The majority of the participants have indicated that they would not be opposed to training as it would give them the necessary knowledge that they need in order to equip themselves.

5.4 Conclusion

This chapter has been a summary of the research findings. The empirical part of the study was designed to be qualitative in nature. The findings of the research were given in qualitative nature in order to give the reader a lucid picture of the knowledge, attitudes and perceptions that the participants about the issues put before. Also, the aim of the qualitative presentation was to show that HIV/AIDS is real and it affects real people. The knowledge that people about HIV/AIDS have goes a long way in forming their attitudes towards the virus. It was therefore essential to represent their views as accurately as possible.

CHAPTER 6

INTEPRETATION OF THE FINDINGS

6.1 Introduction

The previous chapter dealt with the findings of the study. The study is qualitative in nature and as such, the responses findings were presented in the words of the participants so as to paint a clear picture concerning the knowledge, attitudes and perceptions of workers regarding HIV/AIDS.

6.2 Knowledge about HIV/AIDS

Knowledge about HIV/AIDS is based on so many factors and this knowledge can be manifested in different ways. It can be manifested through behaviour modification and in some cases it can be manifested through disregarding all the warnings that come along with the knowledge. There are varying levels of knowledge about the disease and this was evident from the findings of the study. All of the participants knew about AIDS but the manner in which they demonstrated this knowledge varied greatly. Knowledge about a particular subject is based on many factors, for the participants, knowledge about HIV/AIDS depended on what they had heard about the virus and also on what they have seen. It has been said that South Africa is a largely AIDS aware population but this knowledge is at times distorted because of the manner in which information is presented. One would assume that knowledge about the virus would translate into an acknowledgement that AIDS is real and it does exist. What is evident from the findings is that while the participants admitted to having some level of knowledge on HIV/AIDS, acknowledging its existence was not guaranteed.

Many of the participants who pointed out that they know about AIDS from other people demonstrated to have limited knowledge about the virus, including the modes of transmission and the curability of the disease. The participants who heard about AIDS from other people also doubted the existence of AIDS. One of the worrying factors about the South African epidemic is that while there are millions of people who are infected with the virus, there are people who say that they have never seen anyone with HIV and thus do not believe that it does exist. The existence of HIV has been disputed by many people because HIV has been said to be a disease that affects the

promiscuous and the sexually careless. There has been an expectation amongst communities that those that are deemed to be promiscuous should undoubtedly be infected with the virus. When this does not transpire people go back to their doubtful states and begin to say that HIV does not exist. This has meant that the belief that HIV exists is based on being exposed to someone that is living with the virus.

One factor that has remained puzzling through out the study is that the municipality has a highly visible campaign against HIV/AIDS. There are pamphlets, booklets, posters and condoms in highly visible places that all council employees have access to. Perhaps the problem has been the manner in which this prevention campaign has been handled. It has been argued through out this research that in order for prevention campaigns to be effective, they need to cater for the audience that they are being aimed at. It is not enough to make visible the information; the audience should clearly understand the content in order to make the envisaged behaviour modification.

The one aspect of HIV that has continued to confuse is whether it is curable. Participants were very particular about the issue as they doubted whether there is indeed a known disease that cannot be cured. South Africa is made up of people who have different cultural belief systems and these systems indubitably influence the way in which they perceive things. One can safely say that there is a huge majority of black people who strongly believe in the use of traditional medicine and they believe that traditional healers can cure everything, HIV included. It is this belief that has continued to inform people's perceptions about the curability of HIV. Participants strongly believed that there is no disease that cannot be cured and they believed that AIDS can also be cured. To a certain extent, participants based this perception on cultural beliefs instead of medical reasoning. Prevention campaigns have always sought to explain to people the dangers of AIDS from a medical perspective instead of taking into consideration account the social repertoires inform people's responses to the virus. It is very unfortunate that all the prevention campaigns have not seen the need to challenge people's responses to the virus because ultimately, it is these responses that shape how people behave.

The way in which HIV is transmitted has been a source of many a debate, participants also brought up this issue. According to the HSRC, here in South Africa 90% of HIV infections are due to penetrative sexual intercourse. This would mean that sexual

transmission, both homo- and heterosexual, can be said to be the primary mode of transmission; to many of the participants this represented something of a contradiction. Sex has been around since the creation of man, HIV is relatively new phenomenon that became prevalent late in the 20th century and yet it has managed to kill more people than any epidemic in recent history. What many of the participants did not understand is that if sex has been around since the dawn of time, why is HIV only beginning to kill people now? To many participants, sex is viewed as a source of pleasure and a form of entertainment, especially for those workers who are migrants and whose families do not live with them. For some of the participants, it has become very difficult to accept that sex can also lead to such a painful death.

There were few participants who understood that sex was not the only mode of transmission when it came to HIV. Very few references, however, were made to mother to child transmission as a possible mode of getting HIV. The way in which HIV has been presented in the media and by other people in general has been that HIV is a sexual disease, as a result, participants did not see the need to know other modes of transmission because to them sexual transmission is the most emphasised.

By and large, the impression obtained from the participants regarding their knowledge about HIV/AIDS was a dual one. The first one pertains to the view that HIV/AIDS is a fatal disease that is incurable. This view stems from the information provided by the media, information passed on by word of mouth and also information gathered from health professionals. One thing that can be said is that even though participants had information at their disposal, this has not lead to the desired behaviour modification and reasons for this will be discussed in subsequent sections of this chapter.

6.3 HIV/AIDS prevention and sexual behaviour

It has often been assumed that if one is made aware of the dangers surrounding a particular thing, one would take the necessary precautionary measures required for protection. The same thing applies when it comes to HIV/AIDS; it has been assumed that once people are made aware of the dangers of the disease and been provided with the necessary tools to prevent transmission, people will use these tools in order to protect themselves. This rationale has informed many of the prevention campaigns that are aimed at curbing the spread of HIV/AIDS. The results however, are very different

form the anticipated ones. Participants were fully aware of how HIV is transmitted and the possible things that one can do to avoid being infected. Limiting unsafe sexual behaviour, avoiding contact of body fluids and sharing of needles are some of the precautionary measures in this context that can be taken in order to minimise one's exposure to the virus. Participants were indeed knowledgeable about what to and not do in order to prevent HIV transmission. This knowledge however did not translate into the appropriate behaviour modification as only sixteen participants admitted to using condoms. There were participants who had multiple sexual partners and yet they did not use condoms with any of their partners.

Condom use is very rarely an individual choice; it is based on many factors such social pressures, socially constructed sexual identities, sexual power relations and to some extent cultural influences.

When talking about self-efficacy, one implies that an individual has the power to make decisions based on individual preferences. When talking about sexual behaviour, self-efficacy rarely plays a role. At most times, sexual behaviour is not shaped by individual choices but rather by social pressures. Socially, the idea that men are virile beings that should at all times validate their masculinity is the motivating factor behind many of the participants having multiple partners and not use condoms with those partners. It has been said that a real man shows his virility by having many sexual partners and making sure that all of those partners are satisfied. Satisfaction, at most times, is not associated with condom use. The participants pointed out that condoms take away sexual pleasure and having sex with a condom can never be the same as having it flesh-on-flesh. It is this notion that has led to many of the participants disregarding condoms as an important part of their sexual routine. It has always been thought that promoting condom use would alone ensure that people take sexual responsibility for their health by using protection. What has been evident however is the opposite; condom use has not been on the agenda for the majority of the sexually active population. This lack of condom use can be attributed to many factors, the primary one being the resulting undertones in relation to the use of condoms in relationships. Condoms have been portrayed as things to be used only by promiscuous people and not by those in stable and loving relationships.

Condom use, to a large extent is also based on power relations. In sexual relationships it is the man that has the power and if the female insists on using a condom the insistence often falls on deaf ears. There have been many occasions where male partners have refused to use condoms with their wives by virtue of the fact that they are married, to these male partners the very fact that they are married automatically means that condoms will never be part of the sexual routine. Participants in the study indicated that the man should be the man that decides about condoms, the woman has no say in the matter. A typical labourer in the municipality is someone that is unskilled, has very little education and subscribes to traditional beliefs. It is in this context that responses to condom use should be understood. Understanding these responses does not mean that they are justifiable; instead it means that one can understand the reasoning behind some of these responses. Many participants still hold on to their traditional roles of being real men; these traditional cultural roles dictate that real men wear the pants in relationships and dominate every aspect thereof. The disadvantaged position of women in society is that which forces them to tolerate situations that put their lives in danger; situations that force them to conform to discriminatory gender roles and situations that further entrench male dominance in society.

Looking at the responses offered in this study, one can deduce that messages and education campaigns regarding condoms should never be seen as being clear. Their reception depends on a number of factors as mentioned above.

6.4 Insight regarding those who are infected with HIV/AIDS

Stigma and discrimination has followed those who are infected with HIV since the disease became common two decades ago. The stigma arises from the fact that HIV was initially said to be a disease that exclusively affects the gay community, it was later said to be a disease for the promiscuous and this is the perception that many people still have regarding those who are infected with the virus. In the study, what became evident is that stigma and discrimination are not as high as originally anticipated; this is not because people are informed but rather a result of being used to the disease. HIV is the one subject that has continued to dominate the news in every aspect, the participants indicated that while they do have doubts about the disease, they are now used to talking about the virus and they no longer discriminate against those who are infected as much as they used to.

Safety in the workplace is one of the most contentious issues that HIV brings up; people are persistently worried about accidents that might happen and the possible consequences thereof. In the study, participants worried about their health; mainly because they did not have the necessary information regarding the possible modes of transmission within the workplace. Awareness in the workplace has not focused on possible accidents that might happen which will require people to take the necessary pre-cautionary measures. To the labourers, HIV is transmitted through sex and that is all they know. There were very few labourers that had the knowledge that HIV can also be transmitted through body fluids and blood.

Offering training in the workplace is one of the ways to ensure that people the necessary information regarding the virus. The majority of the participants in the study had never received training from the employer. Lack of financial and human resources due to budgetary constraints have made it difficult for the health workers within the council to offer proper training to all workers. It is clear that there is a dire need for training as the participants have said so themselves, they need to be given proper training in order for them to make informed choices and protect themselves accordingly. It is clear from the responses given that the participants have very little awareness about the virus. Information that the participants is based on conversations they have heard with other people, for some of the participants it is based on what they have heard from health professionals and for the select few that have had personal experiences with the virus. The level of knowledge that the participants have indicates that there is still a lot of work to be done in terms of educating the participants about the dangers of the epidemic and myths that cause misperceptions.

6.5 Conclusion

In the interests of behaviour modification, this study has sought to better understand the attitudes that inform behaviour. In most instances, these attitudes are informed by knowledge, beliefs and perceptions. The level of knowledge that the participants had about HIV/AIDS reflects the confusion that has characterised the understanding of the epidemic by simple people in the street. While there were participants who were well informed about the disease, the majority of participants relied on word of mouth and distorted messages from the media for information. The participants' attitudes towards condoms also reflect the societal norms that discourage the use of condoms among real

men. The perceptions about what is considered to be risk behaviour are also dependent on subjective social norms that do not frown upon extramarital affairs.

CHAPTER 7

OVERVIEW AND RECOMMENDATIONS

7.1 Overview

Throughout this study, it has been argued that prevention programs are failing because of their failure to take into account the social and environmental influences that shape people's behaviour. Sexual behaviour is at the very core of the AIDS epidemic; it has been assumed that by giving people information that they need, they will then be in a position to make the appropriate behaviour modification. Unfortunately, this has not been the case. Many a prevention program have focused on medical information about the virus without taking into account the perceptions, attitudes and beliefs that shape how people respond to the virus. It has been established in this study that there is still a lot of confusion regarding HIV, its different modes of transmission and also whether it is curable. The level of awareness about HIV amongst the participants indicated that there is still a lot of work to be done in terms of properly informing people about HIV. This is in itself a paradox because information about AIDS is readily available and widely accessible to all sectors of the population and yet there is no progress made in changing people's attitudes and perceptions towards the virus.

There are two questions that have consistently been asked in the South African context and they have yet to be answered.

- Why do people knowingly engage in sexual behaviour that could lead to a slow and premature death?
- Why do the best intentioned attempts to stem the tide of the HIV epidemic have so little impact?

It is a very challenging task to attempt to change the attitudes and perceptions that people have; it is even more challenging when those attitudes and perceptions have to do with HIV. It is never easy trying to convince adults to change their way of thinking particularly when those ways of thinking are based on strong cultural beliefs and social networks. Initially, prevention programs were aimed at giving people information and seldom addressed the social factors that act as hindrances by virtue of being very

influential on people's behaviours. The challenge for those involved in designing HIV prevention programs is to understand social repertoires through which information is received and filtered.

7.2 Recommendations

In light of the findings, the following recommendations are proposed.

7.2.1 HIV prevention programs

Designing effective prevention programs is not easy. It is a process that involves understanding the audience that the message is aimed and furthermore, it is a process that involves understanding the social networks through which information filters. Many a prevention program has been created without taking into cognisance the factors that will influence how this information is received. One cannot convey a message to a 50 year old man in exactly the same manner as to an 18 year old. Attitudes, world experiences and perceptions are different; they would thus form different social filters. It is therefore appropriate that training and prevention programs should be particular to the audience being targeted. In light of the findings of the study, the following are recommended:

- That the municipality institute a continuous training program aimed at providing HIV/AIDS education
- Such a program should not only focus on enlightening people but it should also seek to challenge the very attitudes, perceptions and beliefs that shape how the workers respond to the virus.
- It is also recommended that training programs to be instituted should be sensitive to the social networks that shape people's behaviour, such networks do not dictate how a person responds to the virus, but they also go a long way in determining how a person behaves in relation to prevention.
- Another issue of concern is the manner in which information is being distributed. It has been assumed that just because the information is there then the employees will be interested in the information. It is therefore recommended that there should be a follow up process to assess whether the information provided is indeed being used as was intended.

7.3 Limitations of the study

It can never be easy understanding attitudes and perceptions in one sitting. The researcher attempted as much as possible to convey the responses as they were. Human behaviour is complex and it cannot be totally understood, the study therefore does not claim to be the absolute in terms of representing the views and perceptions of the respondents. The study does, however, provide valuable insight into the minds of the participants who form an important part of the economy.

The one limitation of the study is that time constraints made it impossible for the study to be conducted on a wider scale. It would have been very insightful for the study to be done in more than one municipality. The study is helpful in identifying the most crucial elements of prevention programs in municipalities that will need to be revisited in order for those programs to be effective.

7.4 Conclusion

HIV/AIDS has presented the world with a very challenging war. Each and every part of the world has been affected, some countries more affected than others. Sub-Saharan Africa is the one region that is the hardest hit by the epidemic and recent statistics indicate that this is not about to change anytime soon.

The challenge presented by the HIV epidemic is even greater in South Africa because of the misunderstanding and confusion that surrounds the epidemic. Changing behaviour, challenging existing perceptions, beliefs and attitudes is an almost impossible task to perform but if the world is to win the war against HIV, it is a task that has to be performed. It has been argued throughout this research that behaviour modification can only be attained through the proper use of communication channels, understanding social networks and social repertoires that shape and dictate individual behaviour. At the very centre of the HIV pandemic is the lack of understanding of how social processes impact and influence attitudes and ultimately, behaviour. In order for the battle to be won, there should be

The fight against HIV does not belong to the government alone; it rests with each person that wants to see an end to the epidemic. Individual behaviour will ultimately dictate whether the fight is won; in the meantime, each possible avenue should be exhausted in finding a solution.

BIBLIOGRAPHY

AA Van Niekerk, LM Kopelman. 2005. Ethics & AIDS in Africa. Claremont. S.A.

AIDS Foundation South Africa 2006. Trends and Challenges.

<http://www.aids.org.za/hiv.htm>

Babbie, E. 2002. The basics of Social Research. Belmont: Wadsworth Thomson Learning.

Babbie, E. & Mouton, R. 2001. The practice of Social Research. Cape Town: Oxford University Press Southern Africa.

Barker, F. 2002. The South African Labour Market. Pretoria: Van Schaik.

Barnett, T & Whiteside, A. 2002. AIDS in the 21st Century: Disease and Globalization. New York: Palgrave Macmillan.

Bureau for Economic Research. 2006. The Macroeconomic Impact of HIV/AIDS under Alternative Scenarios on the South African Economy. University of Stellenbosch: Bureau for Economic Research.

Bureau of Market Research. 2004. The projected economic impact of HIV/AIDS in South Africa: 2003-2015. Pretoria: UNISA Bureau of Market Research.

Campbell, C. 1997. Migrancy, Masculine Identities and AIDS: The Psychosocial Context of HIV transmission in South African Gold Mines. Social Science and Medicine.

Crewe, M. 2002. Reflections on the South African HIV/AIDS epidemic. Society in Transition.

Crothers, C. 2001. Social Factors Affecting HIV/AIDS in South Africa. Society in Transition.

Department of Health. 2006. Key points about HIV/AIDS.

<http://www.healthinsite.net/health/HealthProfile.dll/eCareGeneral?wid=12&sh=10&tp=1>

Dickinson, D. 2004. Corporate South Africa's response to HIV/AIDS: Why so slow? Journal of South African Studies.

Dladla, M. 2001. Speaking to rural women whose partners are migrants. Society in Transition. 32(1), 79-82.

Emfuleni Local Municipality. 2006. HIV/AIDS Workplace Policy. Human Resources Management Division.

Gumede, M. 2005. Thabo Mbeki: The battle for the soul of the ANC. Cape Town: Zebra Press.

Kelly, M. 2002. Preventing HIV transmission through education. Perspectives in education. 20, 1-12.

Larry B.Christensen. 2007. Experimental Methodology 10th Edition. Pearson Education, Inc.

Maharaj, P. 2004. Perception of HIV risk infection in marital and cohabiting partnerships. African Journal of AIDS Research. 3(2):131-137.

Maharaj, P. 2001. Male attitudes to family planning in the era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa. Journal of Southern African Studies. 27(2): 245-257.

May, T. 1997. Social research methods: Issues, methods and process. Buckingham: Open University Press.

Mngomezulu, D. 2002. An investigation of the impact of HIV/AIDS on small business in the Sedibeng Region. Potchefstroom University.

Moodley, N. 2006. Business Dig Deep after Ignoring HIV Crisis.

<http://www.busrep.co.za/index.php?fSectionId=552&fArticleId=3298384>

Nattrass, N. 2004. *The Moral Economy of AIDS in South Africa*. Cambridge: Cambridge University Press.

Neuman, W.L. 2000. *Social Research Methods: Qualitative and Quantitative Approaches*. Boston: Allyn and Bacon.

Quattek, K. 2000. *The Economic Impact of AIDS on South Africa: A Dark Cloud on the Horizon*. Johannesburg: ING Barings.

Shisana, O., Rehle, T., Louw, J., Zungu-Dirwayi, N., Dana, P. & Rispel, L. 2006. Public Perceptions on National Health Insurance: Moving Towards Universal Health Coverage in South Africa. *South African Medical Journal*. 96(9):814-818.

Shisana, O.; Rehle, T.; Simbayi, L. & Mbele, N. 2005. *South African national HIV Prevalence, HIV Incidence, Behaviour and Communication Survey 2005*. Human Sciences Research Council.

Shisana, O. & Simbayi, L. 2002. *Nelson Mandela/ HSRC Study of HIV/AIDS: South African National HIV Prevalence, Behavioral Risks & Mass Media. Household Survey*

Statistics South Africa. 2006. *Mid-year Population Estimates*.

<http://www.statssa.gov.za/publications/statsdownload.asp?PPN=P0302&SCH=3713>

Treichler, P. 1999. *How to use Theory in an Epidemic: Cultural Chronicles of AIDS*. Durham, NC: Duke University Press.

UNAIDS and WHO a. 2007. *AIDS Epidemic Update: July 2006*. Switzerland

UNAIDS and WHO b. 2006. *AIDS Epidemic Update: December 2004*. Switzerland.

UNAIDS. 2000. *Education in the world*. International Institute for Educational Planning. Paris: IIEP Publications

UNESCO. 2002. HIV/AIDS and Education: A Strategic Approach. International Institute for Educational Planning. Paris: IIEP Publications

Whiteside, A. & Sunter, C. 2000. AIDS: The Challenge for SA. Cape Town: Human & Rousseau.

World Bank. 2003. Local Government Responses to HIV/AIDS: A handbook. New York: The World Bank Group.

Annexure: 1



EMFULENI LOCAL MUNICIPALITY

Inter Office Memo

To:	Organisational Development Manager: L Tsitsiba
From:	Occupational Health Practitioner: MM Motsukunyane
Date:	12 August 2008
Subject:	Request to conduct on duty research study

Dear Sir

I hereby request your permission to conduct a research study: The impact of work-based HIV/AIDS interventions on Knowledge, Attitude, and Perceptions of workers in local municipality. The study is a requirement for Masters Degree in HIV/AIDS Management at Stellenbosch University.

The study will be conducted through the use of questionnaires, interviews to the participants at the Occupational Health Clinic and at their workplaces.

The outcome of the research study will assist in improving the quality of service in Occupational Health Clinic and Employee Assistance Programme.

Thank you,

MM Motsukunyane (OHNP)

Approved

L Tsitsiba (OD Manager)

Not Approved

L Tsitsiba (OD Manager)

Annexure: 2

Dear Respondent

I am a Masters student registered at the University of Stellenbosch. I am currently conducting a study into the knowledge, attitudes and perceptions of workers in the Municipality.

It would be greatly appreciated if you could form part of this study. Confidentiality is guaranteed and everything that is said will be treated with the strictest confidence.

Thank you.

MM Motsukunyane

Occupational Health Practitioner

Annexure: 3

Respondent no.

QUESTIONNAIRE: KNOWLEDGE, ATTITUDES AND PERCEPTIONS ABOUT HIV/AIDS

SECTION A: BIOGRAPHICAL INFORMATION

Sex

Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
------	--------------------------	--------	--------------------------

Age

Years

Marital Status

Single	<input type="checkbox"/>	Married	<input type="checkbox"/>	Widowed	<input type="checkbox"/>	Divorced	<input type="checkbox"/>
--------	--------------------------	---------	--------------------------	---------	--------------------------	----------	--------------------------

Home language

--

Highest school qualification

Standard	<input type="checkbox"/>	Other	<input type="checkbox"/>
----------	--------------------------	-------	--------------------------

Type of dwelling

Own House	<input type="checkbox"/>	Flat	<input type="checkbox"/>	Hostel	<input type="checkbox"/>	Renting	<input type="checkbox"/>
-----------	--------------------------	------	--------------------------	--------	--------------------------	---------	--------------------------

Number of years with current employer

Years

SECTION B: KNOWLEDGE, ATTITUDES AND PRACTICES ON AIDS

1. Do you know anything about AIDS?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If yes please explain

2. Do you know HIV is transmitted?

3. When was the first time you heard of AIDS?

4. Do you believe that AIDS exists?

5. Do you think that AIDS can be cured?

6. In your opinion, do condoms help stop the spread of AIDS?

7. Do you use condoms regularly?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

8. If yes, how often?

Always	<input type="checkbox"/>	Seldom	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
--------	--------------------------	--------	--------------------------	-----------	--------------------------

9. Do your co-workers use condoms?

10. Do you have more than one sexual partner?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

11. If yes, do you use condoms with all your partners?

Always	<input type="checkbox"/>	Seldom	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
--------	--------------------------	--------	--------------------------	-----------	--------------------------

12. Have you ever used the services of a commercial sex worker?

13. Do you know of any of your colleagues that use commercial sex workers?

14. Do you know any of your co-workers that are HIV positive?

15. Do you think it is safe to work with people who have HIV/AIDS?

16. Do you think co-workers with HIV/AIDS should continue working?

SECTION C: TRAINING

1. In the years that you worked here, have you received any HIV training?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2. If yes, when last did you receive training?

3. Was the training useful to you? Please explain your answer.

4. Did the training change your views about HIV/AIDS?

5. Should the municipality provide training for all workers?
