ESTABLISHING EFFECTIVE FAMILY AND COMMUNITY LEVEL COMMUNICATION AS A SOCIAL VACCINE TO HIV/AIDS PREVENTION IN HAMMARSDALE, KWAZULU-NATAL

ONYEKA OKOLI

Assignment submitted in partial fulfilment of the requirement for the degree of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University

Africa Centre for HIV/AIDS Management
Faculty of Economic and Management Sciences
Study leader: Dr. Thozamile Qubuda
December 2011

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.

Student Signature
December 2011

ACKNOWLEDGEMENTS

I wish to express my utmost gratitude to God Almighty who made it possible to bring this assignment to a conclusive end in the midst of several other commitments. My sincere gratitude goes to my study leader Dr Thozamile Qubuda for his support, guide and encouragement throughout the study period especially when my morale seems to run low. I acknowledge the support and understanding shown by my wife Nkechi and my children Angel, IK and Chidi who were denied quality family time due to my studies. My gratitude goes to my brother Maduabuchi Okoli for his encouragement; Felix Okoye for assisting during the transcription of the interviews. I also appreciate the prayers and love from my mother Mrs Eunice Okoli. Finally, my heartfelt gratitude goes to all the unknown names but the most important sources of the knowledge exposed by this study, which are the study participants themselves.

This study is dedicated to the loving memory of my late father, Felix Okoli who showed and nurtured me in the right direction of life.

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ACRONYMS AND ABBREVIATIONS

AIDS = Acquired Immune Deficiency Syndrome
ARV = Antiretroviral
ART = Antiretroviral Therapy
CHC = Community Health Centre
HCT = HIV Counselling and Testing
HIV = Human Immunodeficiency Virus
HSRC = Human Science Research Council
IEC = Information Education Communication
MMC = Male Medical Circumcision
NCS = National Communication Survey
NGO = Non-Governmental Organization
PEP = Post Exposure Prophylaxis of HIV
PLWHA = People Living With HIV and AIDS
PMTCT = Prevention of Mother to Child Transmission of HIV
SAGI = South African Government Information
STD = Sexually Transmitted Diseases
UNAIDS = The Joint United Nations Programmes on HIV/AIDS
UNICEF = United Nations Children‘s Education Fund
WHO = World Health Organization

ABSTRACT

This study investigates the level of communication at family and community level and the possible hindrances thereof at Hammarsdale in Kwazulu-Natal Province. Effective communication is considered necessary as one of the effective preventive strategies in the fight against the current HIV/AIDS epidemic witnessed today in South Africa. This area of study was considered vital in the absence of an effective vaccine and definitive treatment against the virus.

The study utilized qualitative methods using structured interviews to gain an in-depth knowledge about the level of communication on sexual communication, condom utilization and HIV/AIDS prevention within the social and cultural context of the interviewed community.

The study concludes that the level of communication at both family and community level is suboptimal. The lowest communication level was found between parents and their children and vice versa. The study shows that three major factors were responsible for this communication poverty and silence, possibly fuelling the current epidemic. These are _fear', _stigma' and _culture'. The study also revealed that so far, schools and healthcare facilities serve as the most common source of information and knowledge about condom use, safer sexual practices and HIV/AIDS related information.

OPSOMMING

Hierdie studie ondersoek die vlak van kommunikasie op familie en gemeenskapsvlak en die moontlike hindernisse daarvan in Hammarsdale, KwaZulu-Natal. Effektiewe kommunikasie word as _n noodsaaklikheid beskou as een van die effektiewe voorkomingstrategieë in die stryd teen die huidige MIV/VIGS epidemie in Suid-Afrika.

Kwantitatiewe metodes is in hierdie studie gebruik deur middel van gestruktureerde onderhoude met die doel om in-diepte kennis rakende die vlak van kommunikasie rondom seksuele kommunikasie, kondom gebruik en MIV/VIGS-voorkoming binne die sosiale en kulturele konteks van die gemeenskap in te samel.

Die studie toon dat die vlak van kommunikasie op familie en gemeenskapsvlak sub-optimaal is. Die laagste kommunikasie vlak is gevind tussen ouers, hul kinders en andersom. Die studie toon dat daar drie hoof faktore was wat verantwoordelik was vir die swak kommunikasie en stilte, wat moontlik kan aanleiding gee tot die huidige epidemie. Die faktore sluit in _vrees‘, _stigma‘ en _kultuur‘. Die studie toon verder dat skole en gesondheidsorg- fasiliteite dien as die mees algemene bron van inligting en kennis rondom kondoom gebruik, veiliger seksuele praktyke en MIV/VIGS verwante inligting.

CHAPTER ONE: INTRODUCTION, PROBLEM FOMULATION, AIMS AND OBJECTIVES

1.1 INTRODUCTION, BACKGROUND AND RATIONALE

Communication is a key factor in halting the spread of HIV/AIDS. Prevention anchored on the amount and adequacy of information disseminated remains the gold standard in prevention strategies. HIV/AIDS can be viewed as a disease of ignorance and intolerance. Taboos surrounding this disease often prevent recognition, discussion and acceptance of safe practices. In the absence of vaccine and therapeutic cure, communication remains a key ingredient in the social vaccine against HIV/AIDS. Unfortunately, it has been observed that the level of communication among community members on issues relating to HIV/AIDS prevention is still suboptimal. This is anecdotal to the disease prevention. HIV/AIDS is still treated as a sacred cow. Most community members appear not comfortable discussing it, yet the problem created by this disease has continued to escalate. The same applies to issues of safer sex practices and risky behaviours. There is much silence and secrecy surrounding HIV/AIDS issues. This should be reversed by improving the communication strategies.

An individual‘s response to HIV/AIDS is strongly influenced and shaped by societal norms; by their gender and socio-economic status; by their faith, beliefs, and spiritual values; and by the prevailing governmental and policy environment for HIV/AIDS. These usually pose the main challenges to effective communication. These factors are also the major hindrances to effective communication. According to UNAIDS report (2001) the poor communication witnessed today could also been greatly contributed by the fact that HIV/AIDS deals with human behaviour

- that often involve interaction between unequal parties (e.g. a paying client versus poor commercial sex worker)
- that are shaped by deep-rooted socio-cultural traditions (e.g. patriarchy, circumcision)
- that are private and personal (e.g. sex, drug use)
- that are recurring
- that are pleasurable
- that satisfy physiological, psychological, and socio-affiliative needs
- that are considered taboo by society, therefore not easily discussed

- that are moralized by society
- that are stigmatised by society
- that are discriminated against by society

However, nothing will be left to assumption. This study will help to identify the specific factors responsible for the poor communication in the local community being studied. This will help to formulate communication strategies to enhance education and knowledge base that will help in improving HIV/AIDS prevention.

1.2 RESEARCH PROBLEM

The silence and secrecy surrounding HIV/AIDS issues has impaired proper prevention strategies in form of information dissemination. After three decades of the discovery of HIV virus, efforts to keep the virus under control has remained elusive, that the infection has grown into pandemic proportion. The death toll of this disease is quite enormous that an estimated 25 million people have died of AIDS since 1981 while 33 million people live with HIV/AIDS today (UNAIDS, 2008).

The global economic burden and loss caused by this disease is so enormous that it cannot be quantified. The disease has distorted and is still gravely affecting all sectors and facets of life till this day. These negative effects have opened the eyes of the world to the sudden realization that HIV/AIDS is not just a global health crises. It is also an economic crises, social crises, education crises, family crises and labour crises. HIV/AIDS has left no segment of the society untouched (Fauci, 2009).

The complexities surrounding this disease and the late realization that the virus has gone beyond just the scope of health sector has called for a multidisciplinary approach to finding a solution. A concerted effort is needed from individuals, families, communities and community leaders, government bodies, business organisations, non-governmental organisations, funding agencies, faith-based organisations, religious leaders, academic institutions and the research society as a whole.

This is the period when the global efforts made so far should be re-evaluated and answers to certain fundamental questions sought:

- What have we not done properly?
- Why has the epidemic continued to grow in spite of the efforts made so far ?
- Why has little or no success been made in disease prevention?
- What are the major factors retarding disease prevention?

However, hope should not be lost in the search for the solution to this epidemic that has befallen humanity today. It only calls for innovative measures, massive education, change in our social and cultural orientations and approaches, fostered responsibilities and efforts at individual and community level. Most importantly, our communication strategy on prevention messages needs to be critically evaluated and transformed. This is considered vital in the face of no potent vaccine or definitive treatment that clears the virus from the body.

1.3 RESEARCH QUESTION

The research question of this study is: Can the level of communication work as a social vaccine to prevent HIV/AIDS?

1.4 STUDY AIM

To find out the main factors preventing people from openly discussing HIV/AIDS issues in order to inform intervention policies.

1.5 OBJECTIVES

- To establish the nature of communication in the community
- To identify hindrances to communication among community members on HIV/AIDS issues
- To make suggestions and provide guidelines for intervention to improve communication about HIV/AIDS in the community.

1.6 CONCLUSION

This chapter discussed the premises on which the entire study was based. Communication has been shown to be in the centre stage for an effective HIV/AIDS prevention. Such communication that informs positive behaviour change, enforcing healthy sexual behaviour is

necessary in the face of failure to discover a potent vaccine against the virus. Neither has any drug been discovered that can eradicate the virus from the body.

This chapter also dealt with the research problem statement, research question, study aims and objectives. Chapter two will discuss the literature review in detail.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

In this section, HIV/AIDS statistics relevant to this study, the scope of barriers to communication at the personal, inter-personal, family and community level are highlighted with regards to cultural, social inequality and stigma. The impact and availability of communication or HIV/AIDS information at community level is also reviewed.

2.2 GLOBAL HIV/AIDS FACTS AND STATISTICS

According to the 2009 and 2010 UNAIDS/WHO *Report on the global AIDS epidemic update* [Online]. Available from: http://www.unaid.org/Globalreport/default.htm

- Since the first cases of AIDS were identified in 1981, more than 25 million people have died from AIDS. An estimated 1.8 million people died as a result of AIDS in 2009 alone.
- There are more than 33.2 million people living with HIV of which 15.4 million are women and 2.5 million children under the age of 15 are living with HIV globally.
- Over 6,800 people become infected daily throughout the world and over 5,700 of this quota die from AIDS-related illnesses.
- Over 2.5 million people were infected in the year 2007 including 420,000 children worldwide.

2.3 HIV/AIDS IN SUB-SAHARAN AFRICA

- An estimated 22.5 million people were living with HIV in sub-Saharan Africa at the end of 2009, including 2.3 million children.
- In 2009 only, an estimated 1.8million adults and children were newly infected
- During 2009, an estimated 1.3 million Africans died from AIDS (72% of global total of 1.8 million).
- Almost 90% of the 16.6 million children orphaned by AIDS live in sub-Saharan Africa.
- Out of the total infection rate globally, 2/3 (68%) infections are adult (15-49 years of age) from sub-Saharan Africa while 90% of the infections in children occur during nativity.
- Sub-Saharan Africa represents 68% of the global infection.

- AIDS-related illnesses until date remain the leading cause of death here in sub-Sahara Africa.
- Africa has more women than men living with HIV

2.4 HIV/AIDS IN SOUTH AFRICA

- In 2009 about 5.6 million people in South Africa live with HIV/AIDS, the largest HIV epidemic in the world.
- Estimated 1700 new infected cases are recorded daily excluding 300 000 children who are living with HIV/AIDS.
- 15-24 year-old women represent 90% of new infections in South Africa as at 2007 and 87% in 2009 (though recently studies also show a decrease infection among high school pupils which indicates a positive effect of sex education).
- According to the Department of Health, 18.3% of adult (15-49 years) were living with HIV in 2006.
- The Province of KwaZulu-Natal had HIV/AIDS prevalence rate among pregnant women in antenatal clinics was 39% in 2006, 38.7% in 2007 and 2008. In 2009, it rose to 39.5%.
- KwaZulu-Natal province has the highest HIV/AIDS prevalence (39.5%) compared to all other provinces (dominated by black Africans whose culture and values most abhors sex discussion and communication at many levels).
- The rising death rates have lowered life expectancy to 49 years for males and 52 for females.
- At least 16% of all women raped are already HIV-positive (indicating incapacitation to negotiate and/or communicate safe sex with partner/s or resistance to available sex information).
- Approximately 2/3 of women who were raped and did not receive anti-retroviral become HIV-positive.
- 20% of young men aged 25-35 are infected with HIV/AIDS in South Africa (Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S, 2008).

Obviously the report above indicates that:

- The danger of HIV/AIDS has been prominent against women and children (and young people) irrespective of the effort put internationally and nationally in minimizing this trend.
- Despite government interventions to HIV/AIDS prevention and cure, black African people seems to have impediments adhering to information provided on safe sex
- Communication, discussion and talking about HIV/AIDS between partners, families, among peers and society at large is still at very low level in KwaZulu-Natal province. As such, young people are most likely to be affected by HIV/AIDS epidemic as some aspect of their cultural values bereft them of the right to sex and HIV/AIDS (health) information.
- Despite ‗good' policies and interventions towards addressing HIV/AIDS infection rate, yet the pandemic has always been at increase which raises the question: why?

This may be considered to be suggesting the need for ideological and behavioural change at the level of individuals, family, and societal levels. But to achieve these may be easier said than done with HIV/AIDS. Sex communication remains anathema that is culturally considered taboo and ―morally" unacceptable (Pittifor, Rees & Steffenson, 2004). This so-called cultural norm of ―do not talk about sex with children and your family member" predominant among Black African cultures constitutes a formidable impediment to sex education, HIV/AIDS awareness campaign and communication. It also frustrates the fight against HIV/AIDS pandemic in South African society.

2.5 HIV/AIDS AND COMMUNICATION

As the impact of HIV/AIDS rages on especially in sub-Sahara Africa, strategic approaches need to be adopted in the prevention of new infections. The role of communication in ensuring a behavioural change as a preventive strategy has been documented in literature (WHO, 2010; UNAIDS, 2001). This is deemed necessary in the face of the poor success recorded on the various vaccine trials globally (The Seattle Times, 2007). According to a WHO report (2010), the general goal of information, education and communication is to promote and support appropriate changes in behaviour, especially among populations with high-risk behaviour. While cultural differences are likely to require different styles of

presentation of material between countries and between different target groups, the desired behaviour or behavioural changes will be similar (or even the same) which include:

- Postponement of first sexual encounter and decrease in multiple-sexual partners.
- Increase in condom use and increased use of health services to treat sexually transmitted diseases (STDs).
- Increased use of clean syringes by injecting drug users.

The next pertinent question will be to what extent is communication being carried out especially among vulnerable communities and groups. How successful has this been as a strategy in HIV/AIDS prevention? Experience has shown that there is very little communication at family and community level. Communication in this context is the sharing of information by human beings. The process can be carried out in different ways and through different media of communication.

There is still a lot of silence and secrecy surrounding HIV/AIDS issues. People are still not open and comfortable discussing HIV/AIDS issues especially in African setting (Aseka, undated). The difficulty in establishing effective HIV/AIDS programmes comes from a lack of openness, in many societies, regarding sexuality, male-female relationships, illness and death. These are taboo subjects deeply rooted in the cultures, masculinity and sexuality. The issue of moral –sin" as propounded by religion as well as stigma of all sought hamper people's disposition to talk about sex and HIV/AIDS respectively.

Holland, Ramazanoglu, Scott, Sharpe and Thompson as cited in Peltzer (2006) define sexuality as

–Not only sexual practices, but also what people know and believe about sex, particularly what they think is natural, proper and desirable. Sexuality also includes people's sexual identities in all their cultural and historical variety. This assumes that while sexuality cannot be physically divorced from the body, it is also socially constructed".

Mostly the reasons for the difficulties in open communication about sex lies in our socialization, the language available for talking about sex, and the fears many people have

about self-expression (Peltzer et al., 1990). The way we were reared as children often contributes to difficulties in talking about sexual needs in later years (Crooks & Baur, 2008). A study by Delius and Glaser (2002) revealed an alarming failure of communication between parents and their children on issues related to sexuality and HIV/AIDS. Similarly, Varga (1997) explored choices made by young men and women regarding sexual activity and the extent to which it is influenced by HIV/AIDS. It was found that communication between partners was poor, and young women appeared powerless to enforce their preferences in sexual situations. AIDS was not a significant factor in any aspect of sexual decision-making. Sociocultural factors and the state of the HIV pandemic in South Africa were offered as explanations for the findings. Such communication poverty is evidenced by the excerpt of the study interview given below which was conducted by the Human Sciences Research Council (HSRC, 2008)

'We don't talk about things like condoms, sex, or STDs. It is not that kind of relationship' (female, aged 17)

'[Sex] is a symbol of power in the affair. Once you have sex with a woman, you have a strong say in the running of the relationship' (male, aged 26)

The above comments by male and female participants are typical of the problems and conflicting needs of youth in this study navigating sexual relationships. For the young girl who provided the first comment, the bond with her boyfriend was not close enough to broach sex-related matters despite regular intercourse with him. The words of the young man reflect a clear perception of sex as a lever by which to control his partner and their relationship. The findings of the HRSC study underscore the need to focus on socio-cultural and ideological dynamics of sexual negotiation and decision-making, and ultimately of sexual behaviour itself. This will help in strategising communication messages for prevention of new infection.

The Nelson Mandela/HSRC (2008) study shows that children were more likely to receive HIV/AIDS information from school, while adults were more likely to receive HIV/AIDS information from health facilities. Health facilities rated high across all age groups as the most important source of HIV/AIDS information (Shisana & Simbayi, 2002). In general, South Africans seem to have a good awareness of HIV/AIDS, and are regularly exposed to

HIV/AIDS information via the media. But this does not appear to have translated into sufficient detailed information about the disease. There is also concern on the low exposure of the media communication broadcast to the vulnerable population especially those in rural areas and poorer households. For this reason, additional communication approaches for reaching this vulnerable population needs to be emphasized. These findings support the notion that there is still very little communication going on within the communities.

Communication strategies must be tailored to individual settings and to different sub-population within the country (McKee, Bertrand, & Berker-Benton, 2004).Experience has shown that a comprehensive communication programme is needed in both low and high prevalence areas. Well researched and well designed communication programmes have been shown to increase public discourse on and acceptance of the threat of HIV/AIDS. Experience in Uganda and China has shown that this is essential (McKee et al., 2004). Both low and high prevalent countries require intense focus on groups at high risks because of their behaviours and vulnerability, often through interpersonal communication channels specifically directed to them. Mass communication channels can complement other interventions in reaching large number of infected and affected people. Indeed, as countries realize the need to go to scale with HIV/AIDS interventions, strategic communication- a combination of mass media and interpersonal channels, together with both social and community mobilization offers great promise.

In most parts of the world, HIV is primarily a sexually transmitted infection (Klotman, Rapista, Teleshova, Micsenyi, Jarvis, Wuyuan Lu, Porter, & Chang, 2008) Development of a supportive environment requires national and community-wide discussion of relationships, sex and sexuality, risk, risk settings, risk behaviours and cultural practices that may increase the likelihood of HIV transmission. A supportive environment is also one that deals, at the national and community levels, with stigma, fear and discrimination, as well as with policy and law. Because there is currently neither a cure for HIV/AIDS nor a vaccine to prevent infection, Noar and Edgar, undated (Cited in D'Silva, Hart and Walker, 2008) pointed out that behaviour change is the key to prevention. Health communication channels such as appropriate information, education and communication materials incorporating adequate discourse within family and community members is crucial to achieving such change.

Before individuals and communities can reduce their level of risk or change their behaviour, they must first understand basic facts about HIV and AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services. They must also perceive their environment as supporting behaviour change and the maintenance of safe behaviour, as well as supportive of seeking appropriate prevention, treatment, care and support (Family Health International, 2002). Effective and open communication remains the key corner stone towards behaviour change as well as successful interventions against HIV/AIDS infection in South African society. Unfortunately, communication about HIV/AIDS issues still lack openness in many South African societies due to hindrances emanating from cultural related issues, patriarchy, masculinity, sexuality and gender.

2.6 CULTURAL PRACTICES AND HIV/AIDS COMMUNICATION

Respect for ‗elders' is a common cultural principle among many African countries. Even though male and female children are to keep this socially accepted norm, yet it is easily perverted when it comes to matters relating to sexuality. In many typical extended African family circles, women (especially young girls) run the risk of being abused and violated by their numerous uncles, fathers, stepfathers, brothers and so on. To speak out is tantamount to disrespecting an elder and it is a taboo in many African cultures and socially unacceptable to speak ill about elderly person (Pittifor et al., 2004). The victim is bound to remain silent even when the ‗elderly' rapist is HIV-positive. Although such indiscriminate treatment could be meted to young male (children) but that is not common compared to female cases (ibid.).

The implication of which include: (1) the woman in question stands a high risk of infection and would not speak out; (2) she may get pregnant or very sick and so drops out of school and would not be allowed access to ART, otherwise she may be forced to speak out by a social worker or medical assistant which possibly leads to ‗exposing' of an elder (her violator). It however also raises the question of human rights, rights to life, and dignity of human person, in this case women. Such a circumstance is indeed cruel and inhuman as the victim dies slowly but surely in silence—what one may describe as ‗cultural euthanasia'. Such thing, of course, could happen to a young male or even gay person within the same community or society and is partly tantamount to what Pittifor et al., (2004) refers to as ‗cultural silence'. We are not trying to sound revolutionary to cultures; culture is good but also dynamic; it evolves through time and is never static. This and many gruesome aspects of

culture need to be sorted out and vehemently renounced as it does the society nothing but harm and reduce the level of communication imperative in addressing the menace of HIV/AIDS. Rakoczy (2000) describes such discriminatory piece of culture as _culture of violence‘.

Furthermore, certain customary laws are not helpful in terms of equality, communication and interaction between men and women in South African society e.g the *Kwa-Zulu Act of the Code of Zulu Law, Act 16 of 1985* (Legal Resource Centre, 2008) states that:

–A woman who married according to customary laws falls under the marital power of her husband. Members of the households, regardless of age or sex, are under the control of family head with respect to all family matters”.

Anyone with a critical mind would agree that the above section of the Zulu customary law does reinforce nothing but male dominance, hence inequality in the households. The implications include: (1) that men have power to make major decisions in their households including decisions regarding reproduction and women‘s health; (2) women are relegated to the same level as the children resulting to lack of the power to negotiate and discuss safe sex with their partner; (3) only women who maintain such prescribed status are worth admirable, thus unless a woman remain _stupidly‘ subservient she would never be a good wife, mother, daughter-in-law etc. (Rakoczy, 2000). It is on this basis that men regard women as their property, and so inflicting violence upon women, strip them their power of communication and even the right to valuable information. The oppression that is often justified as the man‘s right over the wife (or woman) as her owner(s). The most stricken is that this phenomenon has been internalized as _normal‘ and _natural‘ by most women in our modern society and this hinders the level of communication in our HIV/AIDS generation.

From a cultural and societal perspective, nearly every major infectious disease has created not one but two epidemics: the illness itself and society's reaction to it. Following initial denial there is hysteria and a search for a scapegoat. The fear of infection and the ignorance of its cause have often led to uncaring and even barbaric practices (Silverman, 1998). Earlier on, it was difficult to capture the attention of either the public at large or political leaders, because AIDS seemed like "someone else's disease." Because the main mode of transmission bothers

on behavioural and risky sexual practices, the disease became seriously stigmatized, associated and attributed to immorality. Certain societies saw it as a punishment and retribution for bad behaviour. Those infected suffered various forms of rejection from their family and society.

2.7 SOCIAL/GENDER INEQUALITY AND HIV/AIDS COMMUNICATION

Power issues in our society cause some groups to be devalued and others to feel superior. Thus gender discrimination supports these inequalities and so limits the level of communication between opposite sexes (Rakoczy, 2000). Gender is not synonymous with sex; it refers to the wide expectations and norms within a society about appropriate male and female behaviour (Sanders, 2000). For instance, men can have many concubines, sex partners outside the marriage while women are expected to be responsible for reproductive and productive activities within their home.

This trend as a result of women being disempowered, subservient and excluded from certain decision-making, compromise communication balance that should exist between partners (Rakoczy, 2000). This implies that the subservient status of women denies them the opportunity, position and the right to discuss sex issues especially to negotiate conditions of sex and/or demand the use of condoms. It also increases the fear in women of being dumped in the relationship by the _domineering' men who often think and claim to have final say in their relationship matters. The escalating level of HIV/AIDS communication breakdown and discussion about sex in most African cultures cannot be systematically addressed without thorough interrogation into the practices that has its roots traceable from household structures. It is important also to note that the effects of patriarchy in hampering the fight against the HIV/AIDS epidemic among developing countries can never be overemphasized (UNAIDS, 2009). This reinforces social inequality and have gross impediment on the level of communication that exists in relationships between man and woman. It also increases the chances of HIV infection for women in most African marriages. Traditionally, an African woman has little say over sexual practices she engages.

2.8 FEAR OF STIGMA AND HIV/AIDS COMMUNICATION

Various societies have different reactions ranging from banishment to lynching in extreme situations. Community level stigma and discrimination towards people living with HIV/AIDS

is found all over the world and this creates immense fear in people living with HIV/AIDS and people who are affected by AIDS. A community's reaction to somebody living with HIV/AIDS can have an effect on that person's life due to hostility and rejection that goes with stigmatization. If the reaction is hostile a person may be ostracized and discriminated against and may be forced to leave their home, or change their daily activities such as shopping, socializing or schooling (Avert.org, 2010). These severe societal reactions have succeeded in creating more fear about the disease among families, relationships and in the work place. By so doing it hinders open communication among individuals, families and communities with regards to sex and HIV/AIDS infection. The topic HIV/AIDS is treated like a sacred cow. There still exists a lot of mirth about the disease due to poor dissemination of information with a resultant vague understanding of the disease.

2.8.1 What is stigma?

The word ~~"s~~tigma" is derived from the Greek word referring to tattoo mark. The tattoo mark was made on the people who were devoted to certain services by putting a hot iron on a particular part of the body, such as the arms or at the neck surface (Whitehead as cited in Mason, 2001:17). Later, this practice of tattooing people was secularized and spread all over the world, used especially ~~to~~ designate the marking of an individual as a slave or criminal (Mason, 2001:18). It is worth mentioning that in the early history that the concept of stigma was not static but influenced by the social changes of a given porch. Nowadays, the term stigma is used entirely differently. It is applied specifically to disgraceful phenomena and it has always a negative connotation. In the world predominated by HIV/AIDS and many other dreadful diseases, the profound and dramatic incidents that shake the foundations of the society determines their worldview and actions. In that regard, there are cultural differences in what is considered as stigma, as well as regional variations within wider social contexts. However, it is not only the deprivation of the world that is of interest, but also the accompanying semantics by which we come to know what it means to be stigmatized. There are several types of stigma such as: stigma of deformity, sexual stigma, religious stigma, cultural stigma, stigma of HIV/AIDS, among many others. Focus is concentrated on forms of stigma relevant to this study.

2.8.2 Sexual stigma

There are different types of sexuality, such as bisexuality, homosexuality and heterosexuality. The most common ones in South Africa are homosexual and heterosexual sexuality. For instance, a person with heterosexual orientation may be stigmatized as result of having a baby out of wedlock or for not having a husband. In addition, some married people are also stigmatized as a result of having too many children, some of which are nicknamed ~~–b~~aby machines".

At the family level, children and/or members of the family may individually know their sexual orientation but not allowed to discuss it. In most black African families, parents consider sex discussion by children as tantamount to thinking about it (Silverman, 1998). Although nowadays many adults discussed sexual matters in the presence of their children; sometimes some parents tacitly agree that the father talk to the male children while the mother discusses sex with female members of the family. The defect about this limited communication is that in South Africa for instance, many families are headed by the single mother making it impossible for sex talk in such families (HSRC, 2008). In some families, sex talk is done only in abhorrent situations such as when a boy or girl friend of a family member is undesirable by family members or when there is family dispute or agitation over unwanted pregnancy. Not only do they learn about sex from such indiscreet conversation but they also listen to quarrels in which whole list of sexual obscenities and technicalities are recited by concerned friends or unscrupulous parents who never wanted not to talk about sex especially with their children prior to the incident.

In the pre-colonial society, legitimate sexual activity was by no means confined to marriage. For instance there is substantial evidence of a class of women known as *amankazana* among the Xhosa and *amadikazi* in the Pondo tradition, who engaged in the regular sexual relationships with (usually married) men. Some of these women are widows, runaways from abusive marriages and some are unmarried mothers (Hunter, 1936: 236). Nobody actually expected these women to remain celibate, yet they had a lower status than married women. Sex was an acceptable life path for those who were in marriage, which implicitly means if you are sexually active and unmarried you should stay mute about it while warming up for impending stigma. However, this does not mean that unmarried people do not have sex, but the point, as it still happens today, is that attitude towards sex outside marriage is not entirely

stigma-free irrespective of so far civilization, awareness and sex education in modern era. Though relatively tolerated nowadays in comparison to post-colonial society, sexual stigma still remain an issue in the attempt to boost the level of sex talks and communication among folks, partners, families and the society at large.

2.8.3 Religious stigma

In Christianity for instance some people believe that it brought shame to sexual act in Southern Africa. There are some Christian teachings that were not accepted by some of the Christian converts because they demanded from them too much of a cultural compromise, for example, monogamy and fidelity (Rakoczy, 2000: 13). This led some men (and women) to be discrete about their extra-marital affairs. Adulterous and unmarried women were disgraced, even excommunicated by the churches, while male adultery are often overlooked or not spoken about. Pregnancy before marriage was also not acceptable and pregnant girls were required to start her Christianity teaching from the beginning and publicly request forgiveness from the congregation after serving a period of probation. If she refused to do this, she will be withheld from participating in some church activities, denied of Holy Communion, being a member of the church choir and leadership positions (Rakoczy, 2000). The fear of facing accusing fingers by not only the church members but also by the church leaders is handled with silence by many Christian converts. As such most of them prefer never to talk about their sexual endeavours or even their HIV status because as long as they are not known as violators of moral ―sin". It can be a mechanism to protect oneself from external stigma and can result in refusal or reluctance to disclose ones HIV positive status or denial of HIV/AIDS of which aggravates the infections rate.

In some African traditional societies marriage is the centre of the African community as is the patriarchal centre which puts some African women into the subservient position in their relationships (Phiri, as cited in Cox, 1998). Phiri as cited in Cox, (1998,:143) reports that some Evangelical Christian women say that, a ―good" Christian woman does not deny her husband's sexual advances except for prayers. These kinds of belief are common even in South Africa and such beliefs bereft Christian women towards discussing and communicating sex and HIV/AIDS related issues with their male partners. It also disempowers women from dialogically challenging their husband's infidelity (Phiri, as cited in Cox, 1998). This therefore leads to the conclusion that some religious norms should be revised because if they

are not presented well, can mislead the public to view religious marriages as a major risk factor in the societies especially for religious women.

2.8.4 The stigma of HIV/AIDS

South Africa has a history of segregation along racial lines. The tendency to divide between "us" and "them" also play itself out in the dynamics of how HIV/AIDS victims are treated and referred in most South African villages and townships (Avert. org, 2010). This propensity gives rise to the stigmatization that is so pervasive in HIV/AIDS discourse, together with the moral undertone that surrounds it.

HIV/AIDS Stigma manifests itself externally or internally, and has different effects. External stigma "refers to actual experience of discrimination" (UNAIDS, 2001). This includes the experience of domination, oppression and exclusion. It sometimes leads to violence against an HIV positive person. Internal stigma is the shame associated with HIV/AIDS status as well as the fear of discrimination experience by HIV positive people. In a quest to safeguard HIV/AIDS status, the individual may avoid contact with others lest his/her secret may be discovered. This means that she/he would effectively experience a social death before the physical one of which includes withheld of his/her HIV status, not talking to anyone not even family members. This is all because of the fear of being stigmatised (Bond, 2002).

According to Bond (2002) HIV/AIDS related stigma has often been identified as a primary barrier to HIV prevention, communication, as well as the provision of treatment, care and support. This is because of the belief that HIV/AIDS is somehow associated with the disgrace and shame that leads to further discrimination. This, in turn, leads to violation of the human rights of people living with HIV/AIDS. Therefore, fear of rejection, exclusion and disclosure are indeed barriers to communication so long as HIV/AIDS is concerned. Some HIV positive people or an individual can feel obliged to disclose their status to three individual sets of people such as the parents, neighbours, colleagues at work and other social acquaintances (Bond, 2002). But the negative connotations and blame that accompany HIV/AIDS infection as a result of immorality makes it quite difficult for people to communicate and to disclose their status.

2.9 AVAILABILITY AND ACCESSIBILITY OF HIV/AIDS INFORMATION AS INFLUENCING FACTOR

Most of the communication about HIV/AIDS is usually either passed at school or at healthcare facilities. Information accessibility incorporates the interplay between information needs, availability of information, utilization and the effects of information use. These four aspects are treated as problem areas to which research questions are related. The problems that impede HIV/AIDS information and communication include the distance and availability of health care resources, services like libraries, media resource centres, health facilities, low level of literacy and priority of some sources. The availability is in a large extent affected and formed by a social context in which various demands, expectations and ideas affect an individual‘s ways and possibilities to access the available information (UNAIDS 2009). For instance, the rural women and men due to ignorance, low level of education, and farness of schools and healthcare facilities may have difficulty in searching for adequate information at the appropriate time to solve their problems, socially and economically. Some rural women may or may not be aware of HIV/AIDS, but due to lack of adequate information do not believe that AIDS is real. If properly informed could lead to behavioural change of these village resident towards HIV/AIDS.

Having said earlier that about 5.6 million people were estimated living with HIV/AIDS in South Africa in 2009, more than in any other country. It is believed that in 2009, an estimated 310,000 South Africans died of AIDS. Prevalence is 17.8% among those aged 15-49, with some age groups being particularly affected. Almost one-in-three women aged 25-29, and over a quarter of men aged 30-34, are living with HIV. HIV prevalence among those aged two and older also varies by province with the Western Cape (3.8%) and Northern Cape (5.9%) being least affected, and Mpumalanga (15.4%) and KwaZulu-Natal (15.8%) at the upper end of the scale (Avert.org, 2010). Sequel to that, the South African Government launched a major HIV counselling and testing campaign (HCT) in 2010 which is hoped to mark a welcome change from South Africa's history of HIV/AIDS. By raising awareness of HIV the campaign aims to reduce the HIV incidence rate by 50% by June 2011. For this to be actualized depends hugely on availability of necessary resources needed to bring this campaign to the targeted South African masses.

HIV/AIDS infection is still high and far from the level of recession expected given Government interventions towards prevention and cure. There is evidence that testing levels have improved as the 2009 National Communications Survey found 60% of all men and women studied had been tested in the last 12 months, an increase of 36% since 2006 (Avert.org, 2010). The percentage of those ever tested also increased significantly as 2009 figures showed 32% of men and 71% of women had been tested at least once compared to 2006 figures (17% men and 38% of women). The survey also identified a link between the amount of exposure a person had to communication programs and whether the individual had been tested. These results indicate a positive development in the effectiveness of communication and awareness creation programme and the general perception towards testing in South Africa.

Those who have taken an HIV test and know their result are more likely to have a higher level of education, be in employment, have accurate HIV knowledge, and a higher perception of risk, among other factors (Avert.org, 2010). The link between testing levels and several socio-economic indicators suggests an improvement in the general standard of living would be beneficial to testing. Another significant factor determining HIV testing is whether an individual lives in a rural or urban setting, with those residing in the latter almost twice more likely to have been tested than those in the former. Testing facilities should therefore be made more accessible for hard to reach rural populations, possibly with mobile testing units.

2.9.1 HIV and sex education in schools

HIV and sex education exist in schools as part of the wider Life Orientation curriculum which was implemented in 2002 and also covers subjects such as nutrition and careers guidance. According to a comparative risk assessment for South Africa, unsafe sex ranks as the number one risk factor associated with the loss of potential years of life. The quality of the education, however, is hindered due to a lack of training of teachers, and unwillingness on the part of teachers and schools to provide this education. Training for Life Orientation often takes place outside of school hours which acts as a disincentive to training (Avert. org, 2010). The shortage of trained teachers may result in just one teacher in a school being able to teach such classes, and school management could be resistant to what is being taught. This has led teaching unions to call for a Life Orientation module to be included in all teachers training (Avert.org, 2010).

In the survey by Loyiso, Jita and Ndlalane (2009) some teachers reported feeling uncomfortable about teaching a curriculum that contradicted with their own values and beliefs. Another problem was believed to be the disadvantaged home life of the students, with some teachers believing that poor role models at home did not help to reinforce HIV prevention messages received in the classroom.

The high dropout rate in South African schools could also compromise effective HIV and sex education. This could mean it is all the more necessary to direct prevention programs towards younger children while more of them are in education and before most are sexually active.

2.9.2 AIDS awareness and communication campaigns

There are number of large scale communication campaigns related to raising awareness of HIV and AIDS as well as broader health-related issues (Avert. org, 2010). The National Communication Survey on HIV/AIDS (NCS, 2009), examines the effectiveness of 11 South African HIV/AIDS communication programmes launched by the government. In terms of HIV/AIDS knowledge as well as exposure to information, the report shows that:

- 90% of South Africans were reached by at least one of the 11 HIV/AIDS communication programmes examined in the study.
- Younger audiences had a higher level of exposure to (five or more) communication programmes (42%) than older audiences 20%.
- 86.8% of South Africans (89.6% of men, 84.1% of women) listen to the radio; 86.5% of men and 86.4% of women watch television; 56% of people (54.7% of men and 57.4% of women) read magazines; 67.3% of people (71.9% of men, 62.9% of women) read newspapers; and 18.4% of people (20.8% of men, 16.1% of women) use the Internet.
- Knowledge that male circumcision reduces the risk of HIV infection is low (7.5%) and 12-22% of men and 12-17% of women across age groups (15% in total) also believe that circumcised men do not need to use condoms.
- 61% of men and 65% of women with high exposure to communication programmes reported being tested in the past 12 months.

  This is the second such survey to be conducted, the first having taken place in 2006. The results indicate that knowledge of HIV prevention methods is high – 87% of respondents are aware of the protective effect of condoms on HIV infection. Also the knowledge of

other HIV prevention methods such as faithfulness, partner reduction and abstinence, which was very low, has improved since the 2006 NCS. The report also outlines some impediments to HIV/AIDS communication such that:

- 44.6% of respondents countrywide agreed with the statement that leaders in communities take HIV/AIDS seriously.
- A total of 61% of all sexually active people men and women have been tested – 48% of men, and 74% of women (the discrepancy due to many women being tested because they are pregnant).
- Men tend to have more casual sexual relationships, while women tend to be in more stable relationships.

In other words, men are less likely to access information provided at health centres than women. This is because of the fact that women are most likely to visit clinic as they respond to their several health needs such as: monthly injections, antenatal, child-care, vaccine, etc. (South African Government Information, 2009). On the contrary, men should arguably have better access to information, ARVs and even medical accessibility than the ‗poor' women as men have more income and represent the larger percentage of the workforce than women in our patriarchal labour market (UNAIDS, 2009). However, this phenomenon also points to the difficulties associated with sourcing male infection data as they are most likely to visit clinics or health centre only when they are very ill.

A principle part of the HIV Counselling and Testing (HCT) campaign launched in April 2010 is to scale up awareness of HIV (Avert.org, 2010). The government aims to bring about general discussion of HIV throughout the country by using the media. Strategies include publicizing the availability of free testing and counselling in health clinics through door-to-door campaigning and billboard messages, and using vox pops to highlight personal experiences and expel the myths and stigma of HIV. The government aims to cover 50% of the population with the campaign message by June 2012 (Avert.org, 2010). The percentage of both young men and women (aged 15-24years in 2006 NCS; 15-24years in 2009 NCS) who have ever been tested for HIV has increased dramatically. In 2006, 17% of men and 38% of women had been tested; in 2009, 31.8% of men and 71.2% of women had ever been tested.

The National Communication Survey on HIV/AIDS (NCS, 2009) which was released in January 2010 indicates that:

- Talking with one's sexual partner about HIV testing also increases with exposure to more communication programmes.
- People discussing testing with their partners are almost four times more likely to actually test for HIV.
- Being tested increases with exposure to the number of communication programmes.

Khomanani, meaning _caring together', ran since 2001 and was the health department's premier AIDS-awareness campaign. It used the mass media to broadcast its messages including radio announcements and the use of situational sketches on television. However, following allegations of financial discrepancies and the termination of government funding in March 2010, this campaign appears to have been significantly downgraded. Soul City and Soul Buddyz are two multi-media campaigns targeted at adults and children respectively that have a combined annual budget of R100 million and utilize broadcast, print and outdoor media to promote good sexual health and well-being (Avert.org, 2010).

The campaign Love-Life has run since 1999 and uses a wide range of media directed mainly towards teens (HSRC, 2008). It also runs youth centres or _Y-centres' around the country, which provide sexual health information, clinical services and skills development (Avert.org, 2010). In 2005, The Global Fund to Fight AIDS, Tuberculosis and Malaria withdrew funding for Love-Life questioning its performance, accounting procedures, and governance structure among other aspects (Avert.org, 2010).

According to HSRC (2008) the major survey in 2008 assessed how these campaigns are being received by the population. Over four-fifths of South Africans had seen or heard at least one aspect of the four campaigns, from less than three-quarters in 2005. Understandably, awareness messages were best received by 15-24 year olds, the target audience of many of these campaigns, with 90 percent coverage. This declined with age so that just over 60% of those aged 50 and above had seen or heard at least one of the four campaigns' messages (Avert.org, 2010). Despite the improved reach of these awareness campaigns, accurate knowledge about HIV and AIDS is poor. The worry or issue particularly is the lack of

knowledge regarding how to prevent sexual transmission of HIV/AIDS. Across all age groups and sexes less than half of all people surveyed knew of both the preventive effect of condoms and that having fewer sexual partners could reduce the risk of becoming infected. More troubling still is the fact that accurate knowledge has significantly decreased in recent years.

2.9.3 Awareness on condom use and distribution

Condom use in South Africa is growing with the percentage of those using a condom during their last sexual encounter increasing from 27% in 2002, 35% in 2005 to 62% in 2008. Younger people show the highest rates of condom use which bodes well for the future of prevention, and could explain the decline in HIV prevalence and incidence among teenagers and younger adults (Avert.org, 2010). In 2007, 256 million male condoms were distributed by the government, down from 376 million in 2006. Over 3.5 million female condoms were distributed in 2006 and 2007 (Avert.org, 2010).

The National Communication Survey on HIV/AIDS (NCS, 2009) report shows that condom use increases with exposure to more communication programmes. For those not exposed to communication programmes only 33% used condoms, while 50% of those who were exposed to all 11 programmes used condoms (This was after adjusting for 15 socio–economic variables – clearly demonstrating the effect of communication) South African Government Information (2010).

Meanwhile, condom use has been reported to be at lowest in stable (married or living together) relationships and highest by people with less stable relationships. Thus the 2009 National Communication Survey (NCS) on HIV/AIDS also found that 15% of married men and women used a condom at last sex compared to 74-83% men and 55-66% of women who had casual sex or one night encounters, identifying the need for prevention programmes to further target married couples. Although communication programmes have been very successful in promoting condom use in high risk sexual partnerships, such as with friends, people who just met or known for a while and one night encounters. The programmes need to focus more on condom messaging for people in long-term and stable relationships, such as married, living together and main partner. Condoms need to be promoted beyond HIV and AIDS prevention, to include their use in family planning and other sex related issues.

2.10 CONCLUSION

This chapter exposed sordid figures regarding the incidence and prevalence rates of the disease. The figures indicated the extent of devastation caused by this disease especially in sub-Sahara Africa. The depicted scenario is even worse in South Africa, where Kwazulu-Natal Province which coincidentally happens to be the province where this study will be carried out has the worst prevalence.

The literature implicated multiplicity of factors as responsible for the current HIV/AIDS epidemic. These factors anchor on culture, gender imbalance, ineffective communication and the fear of the HIV/AIDS stigma perpetrated by the society. Finally, it was also established from previous studies that effective communication and knowledge about prevention plays a key role in reducing the chances of infection. This fact underpins the need to scale up level of communication especially at family and community level.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter provides a detailed discussion of the methodology used to investigate the level of HIV/AIDS communication and the hindrances thereof at Hammarsdale. A research design is a general strategy for solving a research problem. It provides the overall structure for the procedure the researcher follows, the type of data the researcher collects and how he goes about getting such data, how such data will be analysed and interpreted. All these are covered in this chapter. The chapter also gave further exposition on the justification of the methods utilized, the study setting and the ethical considerations involved in the study. Finally the possible limitations encountered in the course of the study were highlighted.

3.2 RESEARCH PARADIGM

The study has made use of qualitative methods

3.3 JUSTIFICATION FOR QUALITATIVE METHODS

Qualitative research focuses on ~~"d~~escribing, interpreting and understanding" the meaning people attach to their world, how they feel and think about circumstances around them in the environment they are occupying at a particular time (Cutcliffe & McKenna, 1999). Qualitative research often employs inductive reasoning and an interpretative understanding that looks at deconstructing meanings of a particular occurrence. A qualitative research enquiry allows the researcher to acquire the descriptions or the narrative experiences from participants. Such studies in which more insight is needed about people's orientation about life, culture, sex, religion, race and social conditions; qualitative studies most often offer the best approach in getting such knowledge and meaning not easily quantified.

Macmillan & Schumacher (2006) define qualitative research as:

Inquiry in which researchers collect data in face-to-face situations by interacting with selected persons in their settings. Qualitative research describes and analyses people's individual and collective social actions, beliefs, thoughts and perceptions. Qualitative studies are important for theory generation, policy, illumination of social issues and action stimulus.

Leedy & Ormrod (2005) propose that most researchers who strive for objectivity in their research use qualitative research.

On the aforementioned premise, qualitative research was found more suitable in gaining an in depth knowledge and understanding about communication level about HIV/AIDS and the factors affecting it. This is more so as the transmission and prevention of this disease as earlier highlighted in the literature review, is well knitted within complexities of sexual, social and cultural construct.

3.4 RESEARCH DESIGN

This is an analytic research utilizing semi-structured interview with open-ended questions as the primary source of data.

The research was designed to explore and gain an in-depth understanding of people's understanding, knowledge and level of communication about HIV and AIDS. Qualitative methodologies are recommended in such instances since they enable flexibility within the interview. Focussed interviews enable the researcher to probe beneath the surface of the topic being discussed and to explore experiences in great detail, uncovering ideas that may not have been anticipated at the outset of the research (Lincoln & Guba, 1985; Britten, 1996; Burgess, 1982).

The features common to all interviews were: exploration of the informant's knowledge about HIV/AIDS, the sources of their knowledge, the level of communication about HIV/AIDS and it's prevention strategies within family, friends and community levels, their perception of the adequacy of the communication level, the possible hindrances to open and free communication and the possible suggestion on the way forward where communication is considered inadequate.

3.5 STUDY SETTING AND POPULATION

The study has been done at Hlengisizwe Community Health Centre (CHC), Hammarsdale in Kwazulu Natal. The target population group for the study are members of the surrounding communities presenting at the outpatient department of the healthcare institution. The study setting is suitable for large black and rural township in Kwazulu Natal province with an average population of 180,000 people. It has earlier been mentioned that the epicentre of HIV/AIDS in South Africa is Kwazulu Natal province. The statistics emanating from the literature indicated that KwaZulu-Natal has the highest HIV/AIDS prevalence (39.5%)

compared to all other provinces (dominated by black Africans whose culture and values most abhors sex discussion and communication at many levels). The majority of this population are also socially disadvantaged which is another factor that also fuels the epidemic.

3.6 DATA COLLECTION

The data was collected from people who presented at the outpatient department of Hlengisizwe CHC, Hammarsdale for primary healthcare services. Participants to the study were randomly selected. 10 people were interviewed after an informed consent was duly obtained. Their age range fell between 18years to 60 years according to the study design. Five of them fell within the age range of 18 years and 30 years. Three were between the age 31years to 40 years while two of them were between 41years to 60 years age. The higher number was allocated to the younger age group as this is the age group that is more sexually active and affected by the HIV/AIDS epidemic. Seven of the interviewees are female while three were male. This follows the epidemic gender proportion in South Africa where about 60% of females are affected.

Anonymity of informants was assured and pseudonyms were used in the result section. The interviews took place in a private secluded and quiet office on different days. An electronic recorder was used to record the interviews which lasted between 15 to 25 minutes.

3.7 DATA HANDLING AND RECORD KEEPING

There was strict adherence to Data Protection Act 1998 and Caldicott. Utmost confidentiality of the data was maintained throughout the duration of the study. The interview schedule, data sheets and recorded interviews was under the strict control of the principal investigator. They were safe guided under lock and key.

3.8 DATA ANALYSIS

Soon after the interviews were concluded, the recorded data was transcribed and coded by the researcher for easy analysis. The researcher used the structured questions as set out in the appendix and the responses as captured in the transcripts of the interviews to analyse the data by clustering and grouping them according to the responses of the participants under every question as formulated in the structured questions.

Interpretation of the transcripts was undertaken as an ongoing process throughout the study. Potential themes were initially identified and coded from the interview schedule but other recurring themes, raised largely by the participants were also highlighted during analysis. In certain instances, the participants were quoted verbatim to emphasize the points made

Leedy & Ormrod (2005) describe data analysis as spirals that is, in view equally applicable to a wide variety of qualitative studies. In using this view, the researcher went through the data several times and followed the following steps:

- Organise the data in the form of smaller units
- Peruse the entire data several times to get a sense of what it contains as a whole
- Identify general categories or theme, and perhaps sub-categories or sub-themes, classify and categorize accordingly
- Integrate and summarise the data for the readers. These steps might include offering presuppositions describing relationships among categories.

  Above all, the researcher must make a concerted effort to look for evidence that contradicts his or her hypothesis (Leedy & Ormrod, 2005)

Data were analysed empirically. Keys were allocated to common statements and clustered under various themes as they emerged. The structured questions formed the basis of the data analysis and at times, the participants were quoted verbatim to clarify the point they were making and to give substance to the findings.

The summary statistics of the study participants is given in the table below. Note that the names given are not the real names of the study participants but rather pseudonyms.

Table 1: Interview participants

Interview	Age	Sex	Occupation	Pseudonym
1	27	F	Unemployed	Thandeka
2	20	F	Student	Bonisiwe
3	24	F	Unemployed	Dudu
4	31	F	Educator	Busi
5	19	F	Student	Patricia
6	35	F	Cleaner	Lindiwe
7	34	M	Driver	James
8	54	M	Sickness benefit	Tulani
9	26	M	Finance officer	Jabulani
10	46	F	Human Resource Officer	Nomusa

3.9 ETHICAL CONSIDERATIONS

Securing ethical approval is very crucial to the success of any study as this protects especially the research participants. Such ethical approval was applied for and secured from the Research Ethics Committee of the University of Stellenbosch. Approval was also obtained from the institution where the study participants will be selected which is Hlengisizwe Community Health Centre, Hammarsdale. Finally, approval was also obtained from the Kwazulu Natal Department of Health‘s Research and Knowledge Management Committee, which must give authorization before any of its institutions is utilized for study.

Informed and written consent was obtained from all the study participants before they were interviewed. Confidentiality of the data and information from all the participants were maintained throughout the study period. They were also re-assured so. Information that will possibly identify the participants like name and address was not asked during the interview as such information would not contribute or influence the study findings.

The participants were made aware of their rights by the researcher. They were made aware that they had the right to withdraw from the study at any moment without recourse and that they also had the right not to answer questions they are not comfortable with. However, all the participants responded positively and addressed the questions to the best of their knowledge.

3.10 LIMITATIONS OF THE STUDY

Conducting this particular research project has been very challenging due to couple of reasons. Though the study appear not to have much ethical implications to the participants, gaining ethical approval was delayed due to circumstances beyond anyone‘s control. Possible communication gaps also contributed. This resulted in numerous delays. Valuable time was lost while waiting for ethical approval.

It would have been ideal to interview more people for more elaborated data that will give a more clear picture and situation in the large community being understudied. However considering the scope of such study, it would be very difficult to transcribe code and analyse such data considering the timeline and the limited resources available for the project.
Observations and focus group discussions which constitutes part of qualitative studies would have immensely added value and validity to the study but this was not included in the study methodology due to same reason of limitation of time and the requisite resources.

Finally, a major challenge which though did not pose as limitation to the study was the fact that the investigator‘s academic and job background is mainly medical. Medical training and practices often favour and utilize quantitative approach to studies. This type of epistemological approach to knowledge gain and research is called positivism. Being in a relatively unfamiliar research ground (qualitative approach) mean that a lot of background work and preliminary research was done on qualitative methods in order to come out with a grounded research and result. This caused the investigator more time, resources and energy.

3.11 CONCLUSION

This chapter gave a detailed step by step procedures followed in the successful collection and analysis of the data. The selection criteria for the study participants were explained which follows the epidemiologic pattern of the infection. The rationale for the procedures followed was also given. A good account of the study setting was also given. Finally, the possible challenges encountered in the course of the study were given.

In the next chapter, the detailed analysis and the study findings will be relayed.

CHAPTER FOUR: RESULTS AND DISCUSSIONS

4.1 INTRODUCTION

Chapter four gives the detailed presentation of the study findings and the implications thereof under discussion. These findings are qualitatively presented in line with the objectives of the study. The findings were also co-related to other pre-existing literatures and studies under discussion. Some of the findings were reported verbatim especially where emphasis are needed. Such reports without language or grammatical alteration were reported in italics as recorded from the study participants.

4.2 RESULTS

The data gathered from the interviews transcript has been organised into five main themes namely:

- Knowledge about HIV/AIDS infection
- Sources of knowledge
- Level of communication
- Limitations to free communications
- Way forward and suggestions

4.2.1 Knowledge about HIV/AIDS infection

It appears all the respondents have the basic understanding of HIV/AIDS as a serious disease that is contacted through unprotected sex and blood to blood contact with infected blood. Some of the respondents (two out of the ten respondents) also showed advanced knowledge by specifically describing the HIV as a virus (pathogenic organism) causing the disease. In the words of Jabulani and Nomusa:

"What I know is that HIV is a virus, it is not curable, so everyone is aware of it. In order to avoid HIV you must wear condom to have sex with your partner" (Jabulani)

"What I know about HIV/AIDS infection is that it is killing people. It also affects family members or anyone who involved or neglects the causes. You can prevent HIV but when the virus is in your body, you cannot take it out" (Nomusa)

From the aforementioned statements, a common theme about the perception of the disease is that it is a dangerous disease that is responsible for a very significant morbidity and mortality

in the community. This fact is supported by Busi‘s perception. In her words: *“I know it’s a disease that kills a lot of people in South Africa and it can be prevented”*.

There is also a good knowledge among most respondents about the endemic nature of the disease in South Africa. Most if not all are also aware that this disease is preventable. It is also interesting to discover that some of the respondents are also aware of the vertical transmission route from pregnant mother to the child. Finally, one of the respondents went further to describe the patho-physiologic mechanism of the virus in reducing the immune system that fights off infection.

4.2.2 Sources of knowledge

The main source of knowledge about HIV/AIDS in all the respondents was discovered to be schools and health institutions. While for the younger age groups, school is their primary source of knowledge, the older age group learnt more about HIV/AIDS from the health institutions (clinics, CHC‘s and hospitals). Some of them learnt from both schools and health institutions. It was discovered that those who gained their knowledge from school, did so in two principal ways: (1) As a subject teaching called _life orientation‘ (2) Peer discussions among friends in school.

The media (television, radio and newspapers) is another important source of knowledge about HIV and AIDS for some of the respondents. Disappointingly, none of the respondents admitted gaining much knowledge from their family members or community.

4.2.3 Level of communication

A varied level of communication among the respondents was elicited in this domain. While some of them admitted to communicating freely about HIV/AIDS, some do communicate with great level of reservation of who they actually talk to. For some others, communication about HIV/AIDS is _no go area‘ with very limited communication level among family members and friends. It appears that several factors affects individual‘s level of communication among which include personality type, cultural influences, family background, education level, and level of exposure to health education and communication about HIV/AIDS.

Two of the responders who have frequent contact and work experience with health institutions were very free with communication especially at their family level. It appears that the communication and health education sections they witnessed at the health institutions actually influenced their communication attributes about HIV/AIDS within their family and the community.

Communication was generally found to be much easier between friends and sisters. It was discovered among most of the respondents that the most difficult aspect of communication was between respondents and their parents. When the younger age group respondents were asked on whether they do discuss about HIV/AIDS topics with either their father or mother, most of the answers received was a blatant no for those who have parents. With one of the older respondents who have young adults and teenage children at home, she stated that they do communicate about HIV/AIDS but however, there is limitation to what they discuss as she finds it very difficult if not impossible to talk about condom use as prevention with her teenage children. She rather talks about abstinence with her children. She never advocates to her children to have sex talk less of using condom.

On community level communication about HIV/AIDS, most of the respondent agrees that there is a very limited level of communication between community members. People don‘t usually talk about it. Few acknowledged the fact that communication is gradually improving as the impact of HIV/ AIDS continue to increase in the community. However, the resounding message from most of the interviewees is that the level of communication about sex, condom use and HIV/AIDS is not adequate both at family and community level. We will however look at the possible reasons given by the respondents for the restricted level of communication within family and community level in the next section.

4.2.4 Limitations to free communications

Analysis of the various responses received on the factors responsible for low level of communication shows resounding and common themes which include: fear, stigma and culture. Few stated that ignorance is also an implicating factor.

Eight out of the ten interviewee mentioned fear as the major factor responsible for the low level of the communication witnessed. People are afraid to talk for several reasons. Further

analysis revealed that this fear is also linked to the other two factors of stigma and culture. HIV/AIDS is still a very dreaded disease and discussion about it stirs up fear in people. It is presumed that people don‘t generally like to discuss topics that raises fears and makes them uncomfortable. The fear of possible stigmatization also discourages people from discussing the topic. Discrimination and isolation of those perceived to have HIV/AIDS infection is still very rife in the community. Hence some of the response from some of the interviewee is that people fear that when they begin to talk frequently about HIV/AIDS, they could be perceived to have the infection and hence be discriminated against. Here are some of the excerpts of the responses received on the interview on the reasons for the fears and lack of impetus in talking about HIV/AIDS, sex and condomizing:

“They are afraid of discrimination or people gonna think they are positive” (Bonisiwe)
“Some people if you talk about HIV, they think you are infected so; they won’t like you, nobody wants to associate with you” (Dudu)
“They don’t want to talk about it; once you do, they will laugh and say you got it. They will then talk about you and gossip behind your back” (Busi)

Societal perception and cultural influences was also perceived to be a major barrier of free communication. In most African society, sex is not a topic that is usually talked about within family circle and the community. Most families and communities especially in African context still finds it very difficult to re-adapt to the paradigm shift brought about by the HIV/AIDS pandemic that warrants more open communication about safer sex and condom use as a preventive strategy. The interview revealed this fact. Most of the interviewee admitted that there is little or no talk about sex or condom use with their parents. Some also don‘t talk about it with their friends. The following comments from Bonisiwe throw more light on the perceived difficulties:

“Well, in my family we do talk about sex but for maybe it takes about a minute and it ends there. HIV/AIDS often doesn’t come up. I can say that my parents and relatives are a bit ashamed to share, like I said, am from a rural area; most people from rural are ashamed to discuss sex. They also don’t like condom use”.

"Well they say that as a young person, what should be in your mind is education, after which getting a job before you can think or talk about sex. But now, don't think about sex; don't even talk about it [Laughs]; meaning if you are talking about it, you are thinking about doing it. That's their belief. When you talk about it, they believe you are now thinking about doing it. So, don't talk [Chuckle]"

When Nomusa was asked how free she is in discussing condom use and safe sex her friends and children, her response was:

With the friends I have, there is really not much discussion of this condom thing and sex. With my children, to be honest with you, I only discuss the part of not having sex." She however admits to have a better and more open communication with other more distant family members and relatives.

When Lindiwe was asked how free she was with discussing about sex and condom use with friends, family and community members. She unequivocally stated that she doesn't: *'my culture does not allow me'*.

When Busi was asked how freely she discusses condom use with her relatives and family members, she responded that she only discuss about such things with her sister but not with her mother. When asked the reason for that, her response was: *"we don't talk to our parents about sex; it's our culture"*.

The role of culture in limiting communication continued to reverberate and was also highlighted by Lindiwe. She also admitted not to talk or hold discussion about sex or condom use with her friends and relatives as her culture does not allow her to do that. The same culture also imposes a concept known in isiZulu as _inhloko' which is interpreted as _head' or _superior'. Men are the _inhlokos'. She reported that this cultural concept makes it very difficult if not impossible for a woman to tell a man to use condom, rather only a man can tell a woman to use condom.

According to James, he believes that information are getting to the people through the organised efforts of the media and the clinics, however these information sometimes are like water poured on stones as people are just ignorant and uneducated.

4.2.5 Way forward and suggestions

Having elicited the various causes and limitations to free communication, the final question was asked to elicit suggestions on how to enhance a free and open communication about safer sex practices and HIV/AIDS communication strategies. Various suggestions were made by the interviewees. These suggestions are summarized in the table below:

Table 2: Respondent's suggestions to improve communication

Respondents	Suggestion
Thandeka	Community based communication by doctors and nurses to encourage community members to improve a free communication Training and commissioning community members to talk to their communities in language they understood
Bonisiwe	The use of media; more advertising drama
Dudu	The use of media The ward counsellors can assist speak to their people Individuals relentless efforts irrespective of the current obstacles
Busi	(No idea)
Patricia	More education and information dissemination to the people
Lindiwe	The political heads e.g. Jacob Zuma should lead on these communications and talks as people are intoned to listen to political leaders
James	HIV positive people should go freely into the community to disseminate the message that you can live with the disease
Tulani	(No idea)
Jabulani	Continued education on condom use when abstinence is not possible Age restriction of alcohol use and sales Prevention of drug use
Nomusa	Focus and strengthen communication at primary and high school level Use of video messages and documentaries about HIV/AIDS

	Use of churches Political leaders like president Zuma have a very wide audience. They will help strengthen communication process HIV/AIDS communication by politicians during every political gathering as people love such gathering

In summary, while two out of the ten respondents doesn‘t have a clue as to what more could be done to improve the situation beside what has already been done, the remaining eight gave various suggestion on what more could be done to improve the inadequate communication witnessed at the family and community level about HIV/AIDS prevention. The role of media and politicians was discovered to be a recurring theme among the respondents. Other interesting suggestions were also noted such as school targeted communication, video messages and community based education programme. Finally, the use of churches was also mentioned as churches are good place of spiritual gathering. Most people also consider whatever the church leaders say as truth.

4.3 DISCUSSION

The various opinion of the respondents indicated that HIV/AIDS is no longer a stranger in the society and cannot be ignored as occurred in the early stages of the epidemic. Most people as revealed by this study now have the basic knowledge about HIV/AIDS. Most are either infected or affected. One of the respondents said that her sister and her friend are infected by the virus. The impact in the society is quite devastating. The respondents agreed that HIV/AIDS is a health disaster killing lots of people. Hence there is a consensus that it should not be ignored. Though the government has continued to scale up treatment access, new infection needs to be cut down. In the face of no success recorded so far in vaccine trials and the absence of definitive treatment, prevention of the disease remains the gold standard. The level of communication and information dissemination has been shown to be the core of any preventive strategy (Bertrand et al, 2006). Though the level of information at the disposal of this community seems to have being improving as the epidemic continued to spread, it is however obvious that much still needs to be done. Free communication about HIV/AIDS is still very limited. This could be the reason why there hasn‘t been any decline in the prevalence rate till today.

The study revealed that there are three main sources of information and knowledge about HIV/AIDS. These are the schools, healthcare institutions and the media. This is in keeping with previously reported studies. (Mothibi, 2003). The role of school in equipping young people with information about safe sexual practices was quite obvious especially among the younger age group. This fact could be responsible for the trend observed below in a report by South African Government Information (SAGI, 2009) on the percentage of condom use at last sex for age and gender (see table 3 below). It will be observed that the condom use was highest among school aged men and women, but progressively decreases with increasing age. This fact re-enforces that the amount of behavioural change information/communication at one's doorsteps influences the health risk behaviours. It appears that communication as a preventive tool has not been maximized. There exist great numbers of people who are neither in school nor have a reason to regularly be at healthcare facilities. Some others also don't have access to media messages. There is a need to extend communication across board to everybody as this infection knows no border.

Table 3: Percentage condom use as at last sex, for age and gender

Age	Male	Female
16-19	79%	64%
20-24	73%	51%
25-29	57%	44%
30-34	51%	35%
35-39	38%	29%
40-44	28%	19%
45-49	28%	23%
50-55	10%	12%

http://www.info.gov.za/issues/hiv/survey_2009.htm

Emanating information has also shown that the budget for HIV/AIDS communication is meagre compared to other clinical based preventive strategies. Such budgets which often come from foreign donor are even more compromised since the global economic crises. The budgetary allocations for HIV/AIDS communication always take the worst toll when tough economic decisions and budgetary cuts are taken (Scalway, 2010). Communication

programming would be the first to be axed, including community level and mass media communication intervention. The South African government's Khomanani Campaign ended in April 2010. At the time of this paper there was no clarity as to the future of the Khomanani campaign, meaning social and behavioural communication is largely left to civil society groups and external donors.

Communication level varied widely among individuals. It was acknowledged that there is a need to scale up communication level as it is still suboptimal. The common theme observed was that communication level was lowest between parents and their children and vice versa irrespective of the age of the children. This is in keeping with the findings made by Delius & Glaser (2002). It is also not surprising that adults, some of them with children also find it difficult to discuss sexual topics, condom use and HIV/AIDS with their parents. There is a varied level of interpersonal communication between siblings, friends, and relations and at community level. It was noted that communication level depended on the closeness of the relationship. It was more open among those siblings and friends who are very close. The only close relationship that defied open communication was that between parents and their children, since it was discovered that communication level was very low irrespective of how close the respondents were to their parents. This is in tone with the cultural practices of the study population which is quite typical of most African culture and tradition. The role of culture in communication and HIV/AIDS prevention has been emphasized in the literature review of this paper. This fact was pin pointed by the respondents as a major limitation to free communication about safer sex negotiation, condom use and other preventive communication necessary in check-mating the spread of the infection. The result of this study also showed that the respondents especially the female ones agreed that their culture abhors them from discussing sexual issues. The culture also precludes superiority to the menfolk while abhorring the women from negotiating about condom use (Rakoczy, 2000). The extent of the acceptability of this cultural imposition by the women is however not known as this is beyond the scope and objectives of this study. Cultural influences could be said to be a big challenge as it ingrains and moulds people's behaviour and attitudes from childhood. These ingrained practices are usually difficult to change as it has become an acceptable way of life. This could inform the reasons for a stronger communication strategy targeted especially at the severely affected black population group who are usually limited by these cultural practices.

The result of this study highlighted that there is palpable fear in the community about HIV/AIDS. Looking at the morbidity and mortality figures earlier highlighted, these very high figures has caused untold hardship; social, economic and psychological to the affected population. There is hardly anyone who has not been affected in one way or the other, directly or indirectly. This fear is heightened by the stigma and discrimination associated with the infection. This fact was made clear by most of the respondents. Nobody wants to be isolated and discriminated by the family, friends or community members. This discrimination has been described in certain literatures as the _second epidemic'. This second epidemic could be what Bond et al (2002) described as _social death'. This means that such affected individual would effectively experience a social death before the physical one of which includes withheld of his/her HIV status, not talking to anyone not even family members. This is all because of the fear of being stigmatised (Bond et al, 2002).

Ignorance was also mentioned as a contributory factor to poor communication. This is likely as the devastating effect of HIV/AIDS is worst felt among rural and uniformed dwellers with minimal education. Education empowers and is inversely proportional to ignorance. This is to say that the more educated a person is, the more likely it is that the person will be informed. Such educated people are more likely to welcome changes in cultural practices that positively influence health. Ignorance tunnels way of thinking and prevents people from assessing and utilizing available information to bring about positive life changes.

It could therefore be deduced that HIV/AIDS thrives within the complexity of fear, stigma and culture. A vicious cycle is created in which the infection brings about this phenomenon, which in turn increases the infection rate. Medicine or science alone cannot break this vicious cycle. A strong communication strategy is needed, with unalloyed political support. Such political support has to be motivated from the top political echelon downwards. This was highlighted by most of the interview respondents when their opinion was sort on way forward. Some of them even recommended the active participation of the president Mr Jacob Zuma and other political leaders in always bringing HIV/AIDS prevention messages at the end of every political rally or public speeches. Reason being that people always gather when top politicians speaks and are intoned to listen and take whatever message emanating from them very serious. This is a remarkable suggestion that makes a lot of sense. It will now be an uphill task to convince political leaders in South Africa and other African countries to always

inculcate HIV/AIDS messages in their speech irrespective of what the principal speech or rally is for. Such move was demonstrated by the American first lady in her recent visit to South Africa. In her Soweto speech during the visit, she integrated HIV/AIDS messages to other political messages. Find the excerpt of the speech:

"You can be the generation that brings opportunity and prosperity to forgotten corners of the world and banishes hunger from this continent forever. You can be the generation that ends HIV/AIDS in our time, the generation that fights not just the disease, but the stigma of the disease, the generation that teaches the world that HIV is fully preventable, and treatable, and should never be a source of shame". (News 24, 2011)

It appears that most of the interviewees knows where the problem lies and to a great extent also knows the possible remedies. Other suggestions made by the respondents include inroads and more visibility of health workers in the community with appropriately designed communication strategies in a language they will understand. The role of media needs to be scaled up. There is great need for more education and information dissemination to the people. Everybody body needs to be targeted and incorporated in the present campaign against HIV/AIDS.

The use of HIV positive champions to reach out to the community was also emphasized. Such strategy will demystify the disease and assist in bringing other HIV positive people ashore, out from hiding. It is also likely to bring about more acceptance of HIV positive people in the community as these group are seen to be active, doing positive things about their life and other people's life. This strategy has worked very well in the past and is currently widely utilized and promoted by the apex health organisations such as WHO and UNICEF (UNICEF, 2003)

Age restriction of alcohol use and sales with stringent control of substance of abuse such drugs, marijuana, whonga was also mentioned. Communication against such social vices matched with control intervention will be of immense help. It is known that the use of alcohol and these substances of abuse to a great extent clouds one's sense of judgement and rationale thinking. Such influences definitely predispose people to a risky sexual behaviour. Caution is usually thrown to the wind. Studies have shown that those who are involved in sexual

assaults and rape are also more likely to be substance abusers (Greenfield, 1998). The earlier presented statistics in the literature of this paper also indicated that approximately 78% of rapists are HIV positive.

Primary and high school focussed communication was another vital contribution made by one of the respondents. It appears that this is a strategy that is already in practice as most of the younger age group interviewed admitted that their knowledge about HIV/AIDS was learnt at school. This highlights the importance of early communication and information dissemination in promoting healthy lifestyle in later life. The momentum gained in this area should be maintained and intensified.

One of the respondents mentioned that the churches have a role to play in the prevention of this infection. The church needs to be seen to be more active especially with respect to preventive messages. There has been much reticence on the part of the churches when it comes to communication about HIV prevention and condom use. This communication inaction is likely due to the religious doctrines of these churches. Most churches advocates abstinence and will be seen to contradict this doctrine when they preach for condom use. People are also afraid of the possible consequences that will follow should they be discovered to be HIV positive. Discrimination, rebuke, suspension and excommunication are possible consequences. These outcomes rather will fuel the epidemic as infected members will then tend not to disclose their status nor seek medical attention. My personal observation very recently in the course of my duty also confirms the reluctance of the church in welcoming health care workers for HIV related campaigns. They are major gate keepers to information and communication to their members. This experience sprouted from a recent HCT campaign to scale up HIV counselling and testing. The churches in addition to other institutions and centres where people usually gather were approached. It was observed that the churches were the least responsive to this call. They were quite apprehensive. While some blatantly refused, others used a delay tactics that they will respond in due course, but never responded. Others stated preconditions such as the nurses should not come with trousers/pants, hairs must be covered. More meetings were requested by some others in order to get further clarification. At the end, the number of people tested in the churches was quite insignificant compared to the total number of people tested in the campaign.

It is time for churches to realize that these inactions are also taking a toll on their members. HIV/AIDS have no religious, cultural, demographic, social or age barrier. Hence, its prevention must be multidisciplinary. Collective responsibility is called for. There is need for ideological and communication shifts if the fight is to be successful.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Concluding comments

This study has established that there is still a big gap in terms of interpersonal, family and community level communication about HIV/AIDS prevention. It has also proved the major source of information and knowledge about HIV/AIDS to be schools, healthcare institutions and the media. Though South African government has recorded good success in scaling up treatment access to HIV positive individuals, more need to be done. Levels of infection are still high, there are mixed levels of knowledge of HIV, and much harmful behaviour persists. Some working in the response to HIV are wearying of doing business as usual, and are looking for new solutions that can make a lasting and significant difference. Clinical HIV prevention methods are being intensified, such as male medical circumcision (MMC), post exposure prophylaxis (PEP), and prevention of mother to child transmission of HIV (PMTCT). While these methods are both timely and effective, those working with HIV communication are having their budgets cut, their programmes de-prioritised and the usefulness of their contributions questioned.

We have also been made aware by this study that communication about HIV/AIDS prevention, condom use and safer sex is lowest between parents and their siblings. This finding supports the study done by Namisi et al (2009) in which Socio-demographic variations in communication on sexuality and HIV/AIDS with parents, family members and teachers among in-school adolescents: A multi-site study in Tanzania and South Africa. In all three sites, a substantial proportion of adolescents reported not communicating with their parents about HIV/AIDS, abstinence, or condoms. The low proportion of explained variation in sexuality communication implies that silence is common across sociodemographic subgroups.

The interpersonal communication level is also low at the family and community level. The widespread reported silence suggests that general sexuality communication and communication on specific sexuality-related topics, HIV/AIDS and condom use is difficult. This study in addition to the findings from other similar researches has identified where priority interventions are needed especially in terms of communication strategies.

This study also answered the research question on the cause of the silence and secrecy about HIV/AIDS. The trio of _fear', _stigma' and _culture' were revealed to be the major factors responsible for the silence, secrecy and the poor communication witnessed today. These three implicated factors must be targeted and eliminated. Prevention of disease as popularly said is always better than its cure. Simple and strategized information brought to the doorstep of individuals, families, communities could save millions of people from contacting this infection, save millions of people from fighting the double epidemic of HIV and stigma, save millions of people from taking medication for the rest of their life; from untimely sufferings and deaths. Though cultural orientation of people is difficult to be changed, the current change in the cultural practice of uncircumcision among Zulu people is presently witnessing great success as one of the preventive strategies of HIV/AIDS infection. This has proved that there is nothing like cultural inertia. There is need for cultural dynamism in the positive direction depending on the context of the social and health needs and implications. The lessons learnt from the strategy that undid this cultural mirth can also be utilized here. The traditional rulers who were supposed to be the custodian of cultural heritage became the champions for cultural change with respect to circumcision practices. Their followers were subsequently left with little or no choice but to join in.

It is quite surprising the wealth of knowledge and the possible solution emanating from the local people interviewed in this study. The extent of the communication problem has been exposed by the respondents. The irony of it is that the same people affected also know the possible solution. The uphill task remains the transformation and utilization of such study findings by the responsible stakeholders. How resourceful and motivated are policy makers in acting on this knowledge.

In conclusion, this study demonstrates that the self-fulfilling prophecy illustrated by the spiral of silence theory might also work in reverse, moving towards a tolerant environment for PLWHA, increasing communication on safer sex, condom use and improving disease prevention. It is possible that the spiral of silence may be inoculated against, tempered, or reversed, though more research is needed. If this is the case, it is possible that, accumulated over a community, higher numbers of conversations about HIV/AIDS, safer sex and condom use may contribute to the development of a social environment that facilitates HIV prevention. Regardless of the current challenges, successes or failures, communication must

continue to be considered as an important variable in successful and scaled up HIV prevention. This epidemic must be brought to a stop. Humanity seems not to have much choice else we perish.

An effective communication strategy is a critical component of the global effort in HIV/AIDS prevention and education. Such a strategy should be grounded in a sound theory such that the resulting framework is flexible enough for application in different regional and cultural contexts (Airhihenbuwa & Obregon, 2000). Given the emphasis placed on HIV/AIDS prevention and care, mostly because of the absence of cure for or vaccination against the disease, employing effective communication strategies becomes pivotal in controlling the pandemic. Consequently, evaluating and redefining approaches to communicating relevant messages to different population and the public at large has become a critical aspect of HIV/AIDS prevention and care.

"The global HIV/AIDS epidemic is an unprecedented crisis that requires an unprecedented response. In particular it requires solidarity -- between the healthy and the sick, between rich and poor, and above all, between richer and poorer nations. We have 30 million orphans already. How many more do we have to get, to wake up?"
--Kofi Annan

5.2 Recommendations

The following recommendations are made based on the study findings:

- Re strategizing of communication methods that primarily focuses on addressing fears, stigma and those cultural practices that negates prevention of infection at community level.
- Targeting and improving parents/children communication about safer sex, condom use and HIV/AIDS
- Increasing the budgetary allocations for all facets of communication
- Promulgation of policies and legislations that mandates politicians and public figureheads to always talk about HIV/AIDS prevention during political rallies and public speeches.
- Increased participation of churches in the communication and prevention strategies

- Involvement of traditional rulers, local counsellors and community heads at the planning and implementation stages of any preventive strategies. This enhances buy-in by community members.

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APPENDIX

INTERVIEW SCHEDULE

- Tell me what you know about HIV/AIDS infection?
- What are the main sources of your knowledge about HIV/AIDS?
- How freely do you discuss or talk about HIV and AIDS with your family members, friends or within the community?
- How free are you in discussing about sex and condom use with your friends?
- How free are you in discussing about sex and condom use with your family members and close relatives?
- Do you think that people both at family level and within the community have adequate discussion about safer sex, condom use and HIV/AIDS?
- If you think that your level of communication about HIV/AIDS, sexual issues and condom use are not adequate, what are the reasons for such low level of communication?
- What are the reasons according to your understanding that inhibit or prevent people from talking openly about HIV/AIDS?
- What do you think will be done to enhance free and open communication about safer sex and HIV/AIDS issues?