

CHAPTER 1

Background to the study

1.1 INTRODUCTION

The origin of acquired immunodeficiency syndrome (AIDS) has been widely speculated and debated. No one knows exactly where it comes from. Some say it comes from the vervet African Green monkey in central Africa, others say it is a punishment from God. Questions about the origin of AIDS are always asked wherever this disease is discussed (Department of Health 2001b:28).

In 1983, the human immunodeficiency virus (HIV) was discovered to be the cause of AIDS. The rate of new infection is increasing rapidly. Some countries and communities are more vulnerable to HIV infection than others. Of the approximately 34,3 million HIV infections worldwide, about 90% occur in poor (developing) countries (Health Systems Development Unit 2001:3).

The study focuses on the perceptions of HIV/AIDS of clients visiting clinics in the Mutale area of the Limpopo Province. This chapter discusses the problem, purpose of the study, research question, research design and methodology, measures to ensure trustworthiness and ethical considerations. Terms used in the study are also defined.

1.2 BACKGROUND TO THE STUDY

South Africa is among the countries experiencing the greatest increase in incidences of HIV infection in the world. According to the HIV/AIDS and STD Strategic Plan (South Africa 2000-2005), there are approximately 4,2 million South Africans living with HIV/AIDS and it is estimated that by the year 2005 the number will have risen to 6 million. Statistics show a high

rate of people living with HIV/AIDS in South Africa, particularly in rural communities (*Nursing Update* 2004:30).

More than 28 million Africans are HIV-positive and a further 17 million have already died of AIDS. If the current trends do not change, there will be more than 40 million AIDS orphans in Africa by 2010. (Johnson 2002:3). Table 1.1 represents the HIV/AIDS statistics for Sub-Saharan Africa for December 2001.

Table 1.1 HIV/AIDS statistic in Sub-Saharan Africa, December 2001

REGION	ADULTS AND CHILDREN LIVING WITH HIV/AIDS	ADULTS AND CHILDREN NEWLY INFECTED WITH HIV/AIDS	ADULTS PREVALENCE RATE %	PERCENTAGE OF HIV PEOPLE WHO ARE FEMALE %
Sub-Saharan Africa	28 100 000	3 400 000	8,4	55,0

Source: Johnson (2002:3)

Apart from the rising rate of HIV/AIDS, the nutritional status of an individual is known to play an important role in decelerating the progression of HIV to AIDS, improving quality of life, and decreasing the prevalence and severity of infectious complications of HIV/AIDS (*Nursing Update* 2004:26). To slow down the HIV virus and keep the body strong, people should eat healthy food like fruit, vegetables, milk and brown bread.

Improving nutrition from the moment people knew they are infected may delay the point of which they have to start antiretroviral drugs. Increasing the amount of fresh fruits, vegetables and water can reduce some of the side effects of antiretrovirals medicines. Food can help to make the use of ART less difficult and reduce the risk of becoming resistant. Nutritional assessment and support in the form of supplements and micronutrients are offered to HIV patients (Department of Health 2005:7).

Although good nutrition plays an important role, people's thinking and perceptions about HIV/AIDS determine whether they find it important to protect themselves or not. For example, people who do not believe in the existence of HIV or people who believe that HIV only attacks people who are promiscuous will not see the need to practise safe sex. Therefore in the process of pointing a finger at others, people forget to protect themselves and thus render themselves susceptible to infection (Department of Health 2001b:55).

In most African countries women are at higher risk of infection with HIV than man. Women infected with HIV face a number of problems i.e. their own infection, the risk of passing it on to their partners and the risk of infecting their children. Many factors play a role in increasing the risk of infection in woman. Women are receptive partners in sexual act. They are at risk because of social conditions that do not give them control over their own bodies (Bassin 1996:94).

People's cultural beliefs can put them at risk of infection. Van Dyk (in Goldstein, Pretorius & Stuart 2003:17) states that in Africa, many believe witchcraft is the causal agent in HIV transmission and AIDS. Belief in witches provides people with meaning and potential answers that science cannot give. People who believe in witchcraft as the cause of illness will find it difficult to believe the virus theory. People's belief system, then, can be the cause of susceptibility to HIV infection.

Exercise is an important part of any nutrition programme. Exercise helps to build lean muscle and prevent wasting. It increases the level of oxygen in the blood, gets nutrients to the cell, and helps get rid of cholesterol, burns off excess adrenaline and help treat depression. It increases the body's temperature and keeps the immune system's lymph glands working well (Department of Health 2005:5).

Religion, like culture, also plays an important role. Ashforth (in Goldstein et al 2003:18) states that cultural and religious traditions sometimes complicate reaction to HIV/AIDS and hinder the possibility of encouraging communication about safe sex. Some people see themselves above the level of getting infection because of the superiority of their religion or an irrational

perception of their righteousness. Such beliefs make them disregard the basic things and thus become targets of infection.

Once HIV infection has occurred, the range of options is increasing to slow its progression to AIDS. The use of antiretroviral drugs is introduced. ARVs are leading to a dramatic reduction in AIDS and AIDS-related deaths. ARVs slow down HIV replication and reduce the viral load to very low and even undetectable levels, allowing CD4 counts to recover. (Jackson 2002:70).

Deetlefs, Greeff and Koen (2003:24) note that many nurses have predominantly negative attitudes towards HIV-positive patients. The Department of Health (2001a:21) points out that people often have negative attitudes towards people with HIV/AIDS because of wrong ideas about the disease. HIV-positive people need love and support but people are afraid to be around them. They are blamed for being HIV-positive and deprived of their rights. Because of fear of blame, shame, rejection and stigma attached to AIDS, some HIV positive patients would not like to divulge their status to any other person. As a result, the disease progresses rapidly.

The issue of HIV infection in pregnant woman has received much attention. Routine testing is recommended for all pregnant woman, testing is always done with the woman`s informed of pregnancy or continue with the pregnancy. Counselling, appropriate antenatal care and strategies to reduce the risk of HIV transmission to the baby is done accordingly (Bassin 1996:95).

Vaccines against many viruses are highly successful. People who have been successfully vaccinated will be HIV antibody positive and require antigen test to detect actual infection. Several HIV vaccine trials have been initiated from late 1990s onwards (Jackson 2002:78).

Access to information on one`s HIV status is human right. People have the right to know their HIV so that they can protect themselves and others from infection. VCT services provide a supportive venue for learning this essential health information.

PMTCT is dealing with antenatal services to help prevent HIV transmission to the baby. Hospitals, Clinics and other setting are providing PMTCT and VCT services (Jackson 2002:188).

In many countries around the world, people with HIV and sometimes their relatives have formed support groups. These groups are powerful forces for the rights of people with HIV, challenging discrimination and advocating for access to treatment. Support groups are promoting counselling and support services, and seeking legal protection for human rights. This background led to the following statement of the problem.

1.3 PROBLEM STATEMENT

The researcher is an HIV/AIDS counsellor working in a community clinic in the Mutale area in Limpopo Province where she met many clients who are HIV-positive. From the day-to-day interventions the researcher realised that many people in the community believe in witchcraft as a cause of illness. The community is characterised by formal and informal polygamy and the men believe that to prove their manhood they need to have multiple sexual partners. It is difficult for an HIV-positive woman to disclose her status and introduce a condom in the family as the man is the head of the family and believes that illness is a result of witchcraft. The HIV virus is spread easily as the man may have many sexual partners.

The researcher realised that the community needed basic information about HIV/AIDS and how it is spread. Consequently, the researcher considered it important to explore and describe the clients' perceptions of HIV/AIDS in the Mutale area in Limpopo Province in order to develop relevant interventions to deal with this problem.

1.4 OBJECTIVES OF THE STUDY

The study aimed to

- explore and describe the perceptions of HIV/AIDS of clients attending a community clinic in the Mutale area in Limpopo Province
- develop guidelines to facilitate an understanding of HIV/ADS by clients and the community in the Mutale area in Limpopo Province

1.5 RESEARCH QUESTIONS

In order to achieve the objectives, the following research questions guided this study:

- What are the perceptions of HIV/AIDS of clients attending a community clinic in the Mutale area in Limpopo Province?
- Which guidelines can be formulated by community nurses to facilitate an understanding of HIV/AIDS by clients and the community?

1.6 DEFINITION OF TERMS

The following key terms were used in this study as defined below.

- **AIDS**

Collins English Dictionary (1991:30) defines AIDS as "acronym for acquired immune- (or immuno-) deficiency syndrome: a condition, caused by a virus, in which certain white blood cells (lymphocytes) are destroyed, resulting in loss of the body's ability to protect itself against disease. AIDS is transmitted by sexual intercourse, through infected blood and blood products, and through the placenta".

- **HIV**

Collins English Dictionary (1991:738) defines HIV as "abbreviation for human immunodeficiency virus; the cause of AIDS. Two strains have been identified: HIV-1 and HIV-2." The Department of Health (2001b:6) describes HIV as "a kind of virus that gets into your body

through semen or vaginal fluid, infected blood and mother-to-child transmission, causing a disease AIDS”.

- **Unprotected sex**

According to the Department of Health (2001a:7), “unprotected sex and unsafe sex mean the same thing. It means not always using a condom when having sex.”

- **Client**

Collins English Dictionary (1991:304) defines client as “a person, company, etc., that seeks the advice of a professional man or woman; a customer”.

- **Perception**

Collins English Dictionary (1991:1156) defines perception as “the act or the effect of perceiving; insight or intuition gained by perceiving; way of perceiving; awareness or consciousness”.

1.7 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of the study consisted of meta-theoretical, theoretical and methodological assumptions, which functioned as determinants for the research decisions. The researcher entered the field and conducted fieldwork without any preset theoretical frame of reference. The researcher used bracketing and intuiting. After data analysis, the results reflected within the paradigm guiding the study.

1.8 RESEARCH DESIGN

The researcher used a qualitative design, which is explorative, descriptive and contextual in nature. The purpose was to explore and describe the perceptions of HIV/AIDS of clients

attending a community clinic in the Mutale area in Limpopo Province and to develop guidelines to facilitate their understanding of HIV/AIDS.

1.9 RESEARCH METHODOLOGY

1.9.1 Population

Melville and Goddard (1996:29) describe a population as “any group that is the subject of research interest”. Ndagi (1994:75) states that population is sometimes referred to as “the universe” and is defined as “the entire group whose characteristics are to be estimated”. Gay (1996:172) describes the population as “the group of interest to the researcher, the group to which the researcher would like the results of the study to be generalisable”.

According to De Vos (1994:190), population is “a term that sets boundaries on the study units. It is the totality of person, events, organisation units concerned with a research problem.” In this study, the population consisted of the clients who attended a community clinic in the Mutale area in Limpopo Province.

1.9.2 Sampling

Polit and Hungler (1995:652) define sampling as “the process of selecting a portion of the population to present the entire population”. Huysamen (1994:39) states that a sample is “a number of individuals selected from a population for a study”. Schumacher and McMillan (1993:598) define a sample as “a number of individuals selected from a population for a study”. Purposive sampling was used in this study. Purposive sampling is “a method based on the judgement of the researcher regarding subjects or objects that are typical or representative of the phenomenon being studied or who are knowledgeable about the questions at issue” (Brink 1996:141). The researcher’s inclusion criteria for the sample were as follows:

- Participants were of both male and female gender.

- Participants' ages ranged from 20 and 60 years.
- Participation was voluntary.
- Informed consent was obtained.
- Participants were clients attending a community clinic.
- Participants lived in the Mutale area in Limpopo Province.

1.9.3 Sample size

Tuckman (1978:205) points out that there are no specific rules on how to obtain an adequate sample.

In qualitative research, when purposive sampling was used, the researcher did not know in advance how many participants were needed. Data was collected until data saturation was reached. Sampling stopped when no new information was gathered and the participants gave experiences given by others (Brink 1996:141).

1.10 TRUSTWORTHINESS

Trustworthiness was used in the evaluation of qualitative data. Lincoln and Guba's (1985) model of trustworthiness was used to ensure trustworthiness. The model was based on four criteria of trustworthiness: truth-value, applicability, consistency and neutrality.

1.10.1 Truth-value

Truth-value asked whether the researcher has established confidence in the truth of finding particular inquiry (Polit & Hungler 1995:326).

The researcher remained in the field for a long time interacting with the participants. Both phenomenological individual and focus group interviews and field notes were used as data-collection methods. A combination of qualitative research design and explorative, descriptive

and contextual research was used with reference to the literature reviewed. The focus was on clients attending a community clinic in the Mutale area.

1.10.2 Applicability

Applicability refers to “the extent to which the findings of a particular inquiry have applicability in other contexts or with other participants” (Polit & Hungler 1995:3620). Transferability was used to ensure applicability. Purposive sample of clients attending a community clinic in the Mutale area was used and a dense description given, including direct quotes.

1.10.3 Consistency

Consistency asked how researchers can determine whether the findings of an enquiry would be repeated if the enquiry were replicated with participants in a similar context. Dependability was used to ensure consistency. The exact method of data gathering, analysis and interpretation was described.

1.10.4 Neutrality

Neutrality asked how researchers can establish the degree to which the participants determine the findings of an enquiry. Conformability was used to ensure neutrality.

The findings were discussed with peers who have experience of qualitative research until agreement was reached.

1.11 ETHICAL CONSIDERATIONS

1.11.1 Permission to conduct a study

Approval and permission to conduct the study was requested from the regional office.

1.11.2 Rights of the participants

The researcher respected the following rights of the participants:

- **Right not to be harmed physically or psychologically**

The researcher responded appropriately and humanely to the participants, avoided probing for information that will harm the participants, and left sensitive or difficult questions until a later stage.

- **Right to self-determination and informed voluntary consent**

Permission was obtained from the participants in the form of consent for interviews (Polit & Hungler 1991). The purpose of the study was explained to the participants and all procedures discussed with them. Possible pain, discomfort, stress and loss of dignity that may accompany the research process were discussed with the participants.

- **Right to privacy**

Respondents were assured of privacy and asked not to give their names (Thanyani 1998:31). The researcher ensured that their privacy is protected when interviewing the participants.

- **Right to confidentiality**

Confidentiality refers to the researcher's ability to keep data protected. Participants were assured that any information provided will not be published or reported in a manner that could identify them (Burns & Grove 1993 cited in Mavundla 2000:1571).

- **Right to anonymity**

Anonymity refers to participants' right to be unidentified. The participants' names and addresses appeared nowhere in the study. Each participant was provided with a number and asked to generate their own identification codes.

- **Right to self-respect**

The researcher was not judgmental towards the participants and accepted what they say as the truth.

- **Right to refuse to participate or withdraw from participation**

The participants were told that they have the right to refuse to participate in the study without any penalty. They were also be told that they can withdraw from the study at any time should they wish to do so.

1.12 OUTLINE OF THE STUDY

Chapter 1 described the background to, rationale for and objectives of the study.

Chapter 2 discusses the research design and methodology in detail.

Chapter 3 discusses the data analysis and interpretation with reference to the literature reviewed.

Chapter 4 concludes the study, discusses its limitations and makes recommendations for educating clients and further research.

1.13 CONCLUSION

Chapter 1 described the study, including the background and rationale, problem statement, objectives and research design and methodology.

Chapter 2 discusses the research design in detail.