

**THE KNOWLEDGE OF ANGOLAN WOMEN ABOUT THE CAUSES AND
EFFECTS OF HIV/AIDS**

by

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DECLARATION

I declare that the study on the **THE KNOWLEDGE OF ANGOLAN WOMEN ABOUT THE CAUSES AND EFFECTS OF HIV/AIDS** is my own work and that all the sources consulted, used or quoted are reliable sources and that this work has not been submitted previously in any other institution.

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THE KNOWLEDGE OF ANGOLAN WOMEN ABOUT THE CAUSES AND EFFECTS OF HIV/AIDS

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ABSTRACT

This study focussed on determining the knowledge and understanding of Angolan women pertaining to the causes and consequences of HIV/AIDS with the aim of developing an information leaflet about HIV/AIDS for disseminating information to the vulnerable community. A quantitative approach was applied using an exploratory and descriptive design, utilising a self-developed questionnaire to collect the data, from 100 females who accompanied sick children to a specific hospital in Luanda.

The findings indicated that even though the respondents were aware of certain key issues in the transmission and consequences of the HIV infection, there were many areas in which a great measure of uncertainty existed such as the causes of the disease, prevention methods, risk factors and precautions to take when living with an HIV positive person. Recommendations were made in view of enhancing the distribution of information regarding the causes and consequences of HIV and AIDS by means of different structures.

KEY TERMS

AIDS; causes and consequences; health education; HIV; knowledge of women.

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Dedication

I dedicate this dissertation

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Chapter 1

Orientation to the study

1.1	INTRODUCTION	1
1.2	BACKGROUND.....	2
1.3	SOCIAL CHARACTERISTICS OF THE PROVINCE OF LUANDA	6
1.4	PROBLEM STATEMENT	7
1.5	OBJECTIVES	8
1.6	ASSUMPTION.....	8
1.7	SIGNIFICANCE OF THE STUDY.....	8
1.8	LIMITATION OF THE STUDY FIELD.....	9
1.9	RESEARCH METHODOLOGY	10
1.10	POPULATION	10
1.11	SAMPLE	11
1.12	DATA COLLECTION INSTRUMENT.....	11
1.13	VALIDITY.....	12
1.14	RELIABILITY	13
1.15	DATA COLLECTION	13
1.16	DATA ANALYSIS	13
1.17	PRE-TESTING THE DATA COLLECTION INSTRUMENT	14
1.18	PERMISSION TO CONDUCT THE RESEARCH	14
1.19	DEFINITION OF TERMS.....	14
1.20	ETHICAL CONSIDERATIONS	18
1.21	LIMITATIONS OF THE STUDY.....	18
1.22	LAYOUT OF THE STUDY.....	18
1.23	CONCLUSION.....	18

Chapter 2

Literature review

2.1	INTRODUCTION	19
2.2	THE CONCERN ABOUT HIV/AIDS.....	19
2.3	HISTORICAL OVERVIEW.....	20
2.4	HIV/AIDS CHARACTERISATION AND VIROLOGY	23
2.4.1	Causes and transmission of HIV/AIDS	24
2.4.2	Causes of HIV infection	24
2.4.3	Transmission of HIV	27
2.5	CONSEQUENCES OF HIV/AIDS.....	30
2.5.1	Physical consequences	32
2.5.2	Psychological consequences.....	32
2.5.3	Social consequences.....	34
2.6	MEASURES TO PREVENT HIV/AIDS INFECTION	40
2.6.1	Barriers against the virus	41
2.6.2	Information, education and communication	41
2.6.3	Role of the authorities and/or government.....	42
2.7	CONCLUSION.....	43

Chapter 3

Research methodology

3.1	INTRODUCTION	44
3.2	RESEARCH DESIGN.....	44
3.3	POPULATION	45
3.4	SAMPLE	45
3.5	LIMITATION OF THE STUDY FIELD.....	46
3.6	PERMISSION TO CARRY OUT THE RESEARCH.....	46
3.7	DATA COLLECTION INSTRUMENT.....	47
3.7.1	Validity.....	48

Table of contents	Page
3.7.2 Reliability	49
3.8 PRE-TESTING THE DATA COLLECTION INSTRUMENT	49
3.9 DATA COLLECTION	50
3.10 ETHICAL CONSIDERATIONS	51
3.11 DATA ANALYSIS	51
3.12 CONCLUSION.....	52
Chapter 4	
Data analysis	
4.1 INTRODUCTION	53
4.2 DATA ANALYSIS	53
4.3 RESULTS	54
4.3.1 Section 1: Biographical data	54
4.3.1.1 Age	54
4.3.1.2 Marital status	55
4.3.1.3 Educational level of respondents.....	55
4.3.1.4 Religion.....	56
4.3.1.5 Contraception	56
4.3.1.6 Wage/salary.....	57
4.3.1.7 Types of jobs performed.....	58
4.3.1.8 Relationship to the child that is ill.....	59
4.3.2 Section 2: Obstetric history.....	60
4.3.2.1 History of the pregnancy.....	60
4.3.2.2 Total number of biological children	61
4.3.2.3 Causes of death of children.....	62
4.3.2.4 Use of contraceptives during sexual intercourse	63
4.3.3 Section C: Knowledge about sexually transmitted diseases.....	64
4.3.3.1 Acquisition of sexually transmitted diseases	64
4.3.3.2 Condom.....	65
4.3.3.3 Human immune deficiency virus (HIV)	66
4.3.3.4 AIDS	66
4.3.3.5 Concern about AIDS.....	67
4.3.3.6 Preventing infection with HIV.....	68
4.3.3.7 HIV transmission from mother to child.....	69
4.3.3.8 Factors increasing the risk of HIV transmission.....	69
4.3.3.9 Physical appearance of full-blown AIDS.....	70
4.3.3.10 Cure for HIV/AIDS	71

4.3.3.11	Risk of being infected with HIV without knowing	72
4.3.3.12	Precaution to take when living with a person with HIV/AIDS	72
4.3.3.13	HIV tested	73
4.3.3.14	Vertical transmission of HIV	75
4.3.3.15	Prevention of HIV transmission from mother to child	75
4.4	CONCLUSION	76

Chapter 5

Results, conclusions and recommendations

5.1	INTRODUCTION	77
5.2	OBJECTIVES	77
5.3	RESULTS	77
5.3.1	Biographical information	78
5.3.2	Obstetric history	79
5.3.3	Knowledge of sexually transmitted diseases (STIs), Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)	79
5.4	CONCLUSIONS	82
5.4.1	Biographical information	82
5.4.2	Obstetric history	83
5.4.3	Knowledge of STIs, HIV and AIDS	
5.5	RECOMMENDATIONS	84
5.6	RECOMMENDATIONS FOR ADDITIONAL RESEARCH	86
5.7	LIMITATIONS OF THE STUDY	87
5.8	CONCLUSION	87
	BIBLIOGRAPHY	89

Table 2.1	Effects of HIV/AIDS in some Sub-Saharan countries – 1998 (US Bureau of the Census, Washington)	35
Table 4.1	Frequency distribution of respondents according to age (n=100)	54
Table 4.2	Frequency distribution of respondents' marital status (n=100).....	55
Table 4.3	Educational level of respondents (n=100).....	55
Table 4.4	Relationship of respondent to the sick child (n=100).....	60
Table 4.5	Type of contraceptive used during sexual intercourse (n=100).....	64
Table 4.6	Ways of transmitting sexual infections (n=100).....	65
Table 4.7	Description of what a condom is (n=100).....	65
Table 4.8	Description of what HIV is (n=100).....	66
Table 4.9	Description of what AIDS is (n=100)	67
Table 4.10	Reasons for the worldwide concern about AIDS (n=100)	68
Table 4.11	Actions that may prevent infection by HIV (n=100)	68
Table 4.12	Transmission of HIV from mother to child (n=100).....	69
Table 4.13	Knowledge about the factors that increase the risk of HIV transmission (n=100)	70
Table 4.14	Signs and symptoms of a person with full-blown AIDS (n=100).....	70
Table 4.15	Precautions to be taken when living with a person with HIV/AIDS (n=100)	73
Table 4.16	The prevention of HIV transmission from mother to child (n=100).....	76

List of figures	Page
Figure 1.1 Map of Angola.....	3
Figure 1.2 Map of Luanda.....	6
Figure 2.1 Diagram summarising the factors of vulnerability	31
Figure 4.1 Percentage distribution of respondents according to religion (n=100)	56
Figure 4.2 Prohibited from using contraceptives by their religion (n=100)	57
Figure 4.3 Receiving financial payment for work done (n=100)	58
Figure 4.4 Types of jobs performed by the respondents (n=71)	59
Figure 4.5 Pregnancy history of respondents (n=100)	61
Figure 4.6 Respondents' number of biological children they had had (n=100)	62
Figure 4.7 Causes of children's' death (n=28)	63
Figure 4.8 Respondents' opinion with regard to a cure for HIV/AIDS (n=100)	71
Figure 4.9 Infection with HIV without knowing it (n=100)	72
Figure 4.10 Respondents' HIV testing (n=100)	74
Figure 4.11 Knowledge of vertical transmission of HIV (n=100)	75

List of annexures

Annexure A	Permission requested
Annexure B:	Permission granted
Annexure C	Consent form
Annexure D	Questionnaire
Annexure E	Clearance certificate

Chapter 1

Orientation to the study

1.1 INTRODUCTION

AIDS is an acronym for Acquired Immune Deficiency Syndrome. It is a fatal, sexually transmitted viral disease, identified for the first time in the United States in 1981. It is fatal as it has no cure and there has not been, up to now, any form of active or passive immunisation (Guerra 1998:13). One of the few methods of combating AIDS is prevention through the provision of information, education and communication (IEC).

Piot and Holmes (1988 in Guerra 1998:23) state that AIDS is a disease classified as a “sexually transmissible disease, known for being related to socio-economic factors and responsible for the disruption of society”. Owing to its scale and devastating impact, the spread of the Human Immune Deficiency Virus (HIV) and the resulting AIDS epidemic constitutes a global emergency. It represents one of the biggest challenges to human life and dignity, not only because it jeopardises the economic and social development of the country but also for its negative impact on the family and community relations of the individual (MINSa 2003-08:1).

In a country where there has been prolonged war, social instability prevails. In Angola, one can observe cases in which people have lost their cultural values and, faced with a situation of need, end up adopting risk behaviour in relation to sexual practices. Despite the existence of a high number (58) of national and international non-governmental organisations (NGOs) involved in informing society or carrying out awareness campaigns to fight HIV/AIDS in Angola, there is no evidence of Angolan-based studies aimed at ascertaining the level of knowledge about the disease among the population in general and specifically among women, as the most vulnerable group.

Taking into account the socio-economic characteristics of the Angolan population and the geographic movement of the population, it is estimated that a large-scale spread of the epidemic will occur in the country in the next few years (MINSa/DNSP 2003:2). One of the reasons for this is the fact that Angola has been faced with destructive internal

conflict for more than two decades, leaving the country in a complex and difficult economic and social situation.

Jackson (2001:21) points out in his study that persistent poverty and unemployment in a region can have an influence on another region due to migration, social disturbances and conflict. The geographic movement of people for business or work opportunities between provinces, and their isolated working conditions encourage maladjusted sexual practices as they visit their wives, girlfriends or husbands only a few times in a year, or never at all, and often resort to prostitutes, boyfriends or casual sexual encounters because of the absence of their partners.

In the present context and despite the various interventions applied to combat and prevent HIV, it is questioned whether Angolan women are sufficiently aware of the dangers of this disease. This study aims to determine the knowledge of the Angolan woman with regard to the causes and consequences of HIV/AIDS.

1.2 BACKGROUND

Angola is a country situated in the south-eastern coast of Africa which has an area of 1,3 million km². The climate is tropical in the north of the country and equatorial and desert-like in the south. The average temperature is between 25° and 27°C (GPL (Governo da Província de Luanda) 2002:4). This country is bordered in the north and north-east by the Democratic Republics of the Congo and Congo Brazzaville, in the east by the Republic of Zambia, in the south by the Republic of Namibia and the west by the Atlantic Ocean (figure 1.1).



Map No. 2005 Rev. 2 © 2005 by the Department of Public Information
October 2005 (Revised)

Department of Public Information
Cartographic Division

Figure 1.1

Map of Angola

(Source: <http://wikipedia.org/wiki/angola>, 26-04-2007)

The Angolan territory consists of 18 provinces, the main cities being: Luanda, Mbanza Congo, Benguela, Huambo, Cabinda, Lubango, Malanje, Namibe, Sumbe, Ndalatandu, Caxito, Dundo, Uige, Saurimo, Luena, Menongue, Kuito, and Ondjiva. Kimbundo, Kikongo, Tchokwe, Umbundu and Kuanhama are considered to be the main native languages of Bantu origin. Ethnic groups include the Ovimbundo, Bakongo, Kimbundu and others. Approximately 51% of the population belongs to the Catholic religion, 17% Protestant and 2% African religions (Arte Digital 2001:2; Mirex 2002:1-5).

Since 1983 there has been no general population census. In the year 2000, and according to the available estimates, Angola had a total population of 14 602 million inhabitants, which is equivalent to a global average density of 11,71 inhabitants per square kilometre (GPL). Furthermore, Mirex (2002:4) indicates that in 2000, approximately 3 380 million displaced people and more than 300 000 refugees were registered in the neighbouring countries. The Angolan population is essentially a young population; between 1995 and 2000, the population under 13 years of age represented, on average, 43,1% of the total population. Mirex (2002:4) estimates that the population under 17 years of age represented approximately 52,1% of the total population in 2004.

Mirex (2002:4) indicates that the economically active population represented, on average, a little more than 51% of the total population and the total percentage of those under the economically active age (between the ages of 6 and 13 years) was about 21,7%. The Angolan population is thus in an ascending phase of demographic transition. This fast growth rhythm of the population could be the result of the combination of high fertility rates with the relative regression in the general mortality rates. This data constitutes a warning with regard to the challenges encountered in the fight against HIV/AIDS.

In Angola, the war was one of the main causes of the high levels of poverty amongst the population, with profound consequences within society: the destruction of basic infrastructure, sanitation, supply of water and electricity combined with the circulation of people and goods. The war also had implications for both the political and military stability of the country and gave rise to a considerable number of displaced people and refugees. The costs of internal security considerably limited the availability of resources for public investment, with the subsequent deterioration of its structures. Added to this is the destruction brought about by the military actions, which had a devastating impact on

the education, health and basic sanitation sectors, with serious consequences for human development (MINSa 2003-08:13).

With regard to cultural values, MINSa (2003-08:13) points out that in a country emerging from prolonged war social instability prevails. In Angola one can observe cases of people losing their cultural values, and faced with a situation of poverty, ending up adopting risky behaviour with regard to sexually transmissible diseases, such as prostitution, which increases considerably the vulnerability of people, especially women.

According to Veneman (2005:2), "in the last twenty five years, 20 million people died of HIV/AIDS and life expectancy in the more affected countries dropped to approximately 30 years of age, with special relevance to developing countries". Another source indicates that in December 2004, 39,4 million people worldwide were affected with HIV/AIDS, of which 17,6 million were women (Araújo, Carilho, Claudio & Ramalho 2005:102).

Sambo (in ILO 2006:1) a WHO expert, indicates that sub-Saharan Africa has the highest percentage of people infected with HIV/AIDS, with 25 million amongst a total of 40,3 million at world level. In the same way, of five million new cases registered at world level in 2005, 3,2 million occurred in Africa. As Sambo points out, these numbers are a "true silent disaster, aggravated by factors such as poverty and ignorance". Based on this reality, the United Nations has designated Africa as the world epicentre of this epidemic, first identified 25 years ago (Lusòfonas 2006:2).

The National Government for Unity and Reconciliation (in Portuguese – Governo da Unidade e Reconciliação Nacional – GURN) (2005:56) states that in Angola the HIV prevalence rate in 2001 was 5,7%, which means that there are presently more than 350 000 people living with the virus. In 2001, the number of new annual AIDS cases amongst those living with HIV was 21 000 individuals.

According to more recent figures, it is anticipated that the prevalence rate in Angola will reach between 8,4 and 9,9% of the population in 2005 and between 12,5 and 18,8% in 2010. This means that the number of people living with HIV/AIDS should increase to approximately 638 000 to 749 000 individuals in 2005, and between 1,08 and 1,65 million individuals in 2010. The number of AIDS cases will probably increase to between

45 000 and 49 000 cases in 2005, and 89 000 to 118 000 until 2010. Deaths due to AIDS are estimated at 200 000 and 240 000 in 2005, and 516 000 until 2010. This data also indicates that life expectancy, estimated as 46 years in 2001, could decrease progressively, reaching values in the region of 39,5 to 42,5 years in 2010 (Angola/GURN 2005:56).

1.3 SOCIAL CHARACTERISTICS OF THE PROVINCE OF LUANDA

The Province of Luanda coincides with the capital city of the Republic of Angola, considered as the economic and political hub of the country. From an administrative point of view it is divided into 9 municipalities, 24 suburbs and 5 municipal wards. See figure 1.2 for an aerial view of Luanda.

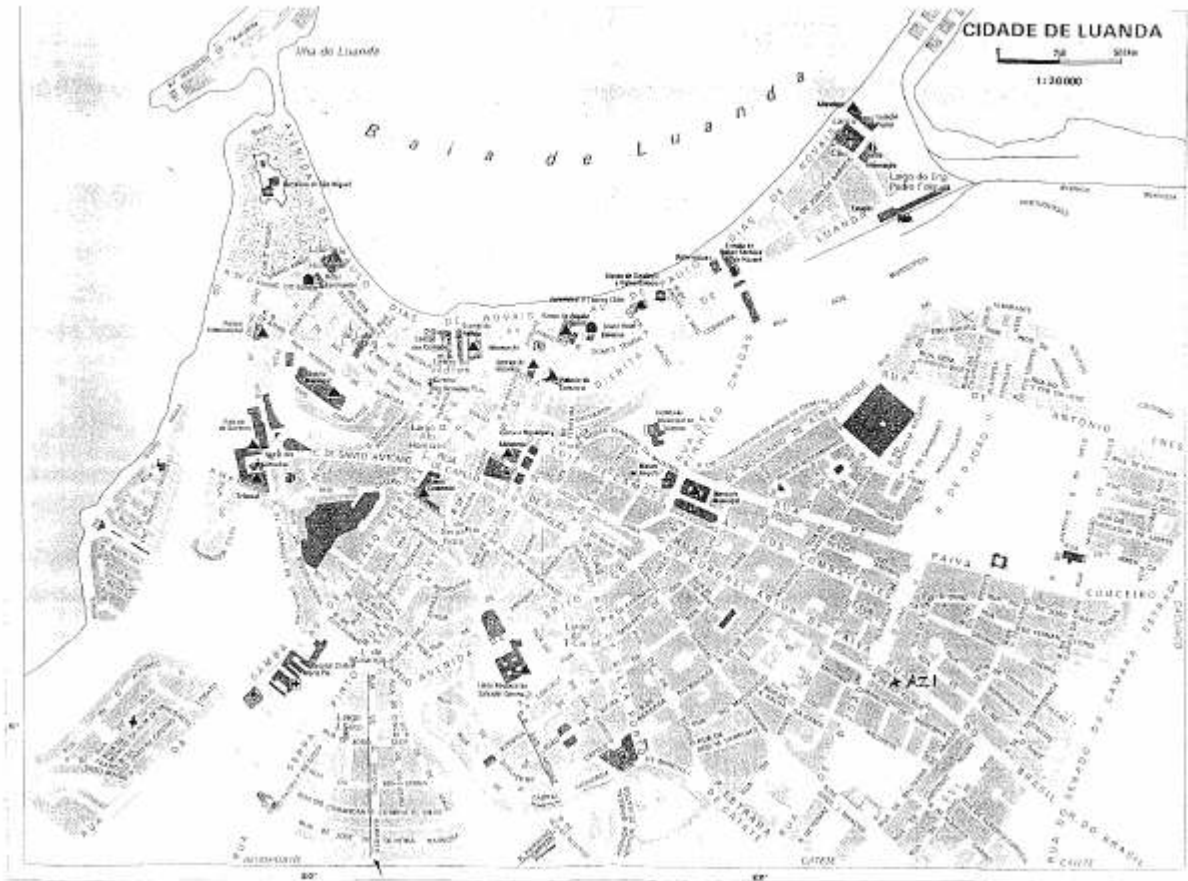


Figure 1.2
Map of Luanda

(Source: <http://wikipedia.org/wiki/angola>, 26-04-2007)

An UN estimate in 2004 calculated the total population of the Province of Luanda at 4,5 million inhabitants (Wikipédia 2006:1).

As Adra (2006:1-4), Lukombo (2006:35-43) and Wikipédia (2006:11-51) point out, in the last 30 years the city of Luanda has been subjected to a process of brutal human aggression, as a consequence of internal conflicts which prevailed in the country for more than two decades, had a devastating effect and left the country in a complex and difficult economic and social situation. Since the war restarted in 1992, close to 4 million people were left in a situation of displacement or as internal refugees, having lost practically everything they had: houses, jobs, any other means of earning a living, personal objects, families, neighbours. Rural and peri-urban areas were left basically unpopulated. In 25 years the city of Luanda went from a city of 600 000 to one with 4 million inhabitants, without any of the social infrastructures having seen any significant transformation. Today, Luanda is faced with serious problems of unemployment (67% in 1998) and poverty, notwithstanding the efforts of the government in launching training programmes and self-business projects.

Health studies have indicated that the maternal-child mortality rate in Luanda is high (1 700 for every 100 000 births) and the rate of illiteracy is estimated as being between 52% and 58,3%. Malaria, HIV/AIDS, tuberculosis, trypanosomiasis and malnutrition are some of the main causes of illness and death (Lusòfonas 2002:2). In the last six months some improvement has been registered in the surveillance indicators, in terms of housing, health and environmental health (ILO 2006:1).

1.4 PROBLEM STATEMENT

Taking into account the social and economic factors which affect Angola in a post-war environment and the escalation in HIV infection rate in the country, there is the perception that the Angolan woman, especially in the rural environment, is not informed about the dangers of being infected by HIV/AIDS.

Faced with this situation the problem is therefore that, without the necessary knowledge about the causes and consequences of HIV infection, many ignorant women may not take adequate preventative measures to safeguard themselves and their children from this disease.

Based on the introduction, background and problem stated, the following research question arises:

- What is the level of knowledge of Angolan women about the causes and consequences of HIV infection?

1.5 OBJECTIVES

The objectives of the study are to

- determine the level of knowledge and understanding of the Angolan woman about the causes and consequences of HIV infection
- develop an information leaflet about HIV/AIDS with the aim of disseminating information to a vulnerable community

1.6 ASSUMPTION

An assumption is a basic principle which is assumed to be true without the need for scientific proof (LoBiondo-Wood & Haber 2001:321). For purposes of this study, according to the data disclosed by the Angolan health authorities, the existing problems in communication (theoretical, linguistic and receptive problems) and the present socio-economic context of the Angolan woman, the study is based on the following assumption:

- Knowledge can change individual behaviour.

1.7 SIGNIFICANCE OF THE STUDY

The significance of this study is that it can contribute to women's health in the following ways:

- In Angola there are still groups of women who live in absolute ignorance with regard to HIV/AIDS and its devastating consequences, as well as with regard to their rights related to sexual health.

MINSA (2004:5) states in its *Information Bulletin*, Chapter III, Section II: Information and Education, article 17: “The population must be informed and educated about the aspects related to the sexually transmitted infections (STIs) and HIV/AIDS; in line with the directives stipulated by the Comissão Nacional de Luta contra a SIDA e Grandes Endemias [National Committee for Fighting against AIDS and Large Epidemics]”.

A study in the area of nursing focused directly on the issue of knowledge of women with regard to HIV/AIDS could fulfil an important role in the country in terms of changing women’s awareness and attitude towards sexually transmitted diseases.

- With regard to the sexual and reproductive health of women, this study could assist in the promotion of health in so far as it provides an opportunity to clarify misunderstandings, and eliminate incorrect and harmful stereotypes.
- It could promote an awareness amongst women about harmful sexual practices (such as prostitution), and in so doing promote the development of responsible sexuality.

1.8 LIMITATION OF THE STUDY FIELD

The aim of this study is to ascertain the knowledge of women of Angolan nationality residing in the province of Luanda about the causes and consequences of HIV/AIDS. This study will be carried out at a paediatric hospital in Luanda, Hospital Luis Bernardino, which is part of the public network of the Ministry of Health, providing free assistance to all children, of both genders, irrespective of their social condition.

The women (female relatives or friends) who accompany the children will be approached to participate in the study.

1.9 RESEARCH METHODOLOGY

In this study a quantitative approach will be applied, involving an exploratory and descriptive format. The use of the **quantitative approach** in this study is relevant, as it will make it possible to assess the knowledge of HIV/AIDS of the target group: the Angolan women.

Donelles (2000:1) points out that quantitative research works are based on the application of scientific methods in the collection of data and the way in which the results are presented. This whole process of gathering and analysing data goes through countless adjustments throughout time, and the application of technical standards enables the production of a vast quantity of information which can be graphically presented.

From the point of view of validity, Serapioni (2000:3) states that quantitative methods are weak in terms of internal validity (one does not always know whether they measure what one intends them to measure), but are strong in terms of external validity: the results obtained can be generalised for the whole community.

Exploratory research intends to describe or categorise a phenomenon within a group of people. It also assists the researcher to become more familiar with the problem or phenomenon; it perfects ideas. This type of research is considered flexible in so far as the researcher involves the target population by means of different data collection instruments (Polit, Beck & Hungler 2004:177). This study aims to describe the knowledge of Angolan women with regard to STI, HIV and AIDS.

The aim of **descriptive research** is to observe, describe and document aspects of a situation as it occurs in reality (Polit et al 2004:177). This study seeks to describe the factors that may influence the sexual behaviour of Angolan women so that their knowledge about HIV/AIDS can be better understood.

1.10 POPULATION

LoBiondo-Wood and Haber (2001:140-152) describe the population as a well-defined set which has certain specific characteristics; and other authors such as Polit et al

(2004:53) define population as a set of individuals or objects with some common, defining characteristics. A population can consist of people, animals, objects or events and is obtained for the study through the sampling process.

The population for this study will be Angolan women who bring a sick child to a specific paediatric hospital in the city of Luanda.

1.11 SAMPLE

A sample is a subgroup of the population (Polit et al 2004:53). These authors add that the selection of a representative sample is indispensable, as this will contribute to generalising the results. A convenience sample of 100 women will be used for this study with the aim of ensuring representativity. The criteria for inclusion of the women in the sample are: They

- must be of Angolan nationality.
- must reside in the Province of Luanda.
- have accompanied a sick child to the specific paediatric hospital in Luanda. They could be mothers, family, friends or neighbours of the child.

1.12 DATA COLLECTION INSTRUMENT

Polit et al (2004:253-272) define the instrument as the means of collecting precise information relevant to the objectives of the study. Data from a structured self-report achieved through the formulation of a set of questions in a pre-specified order (generally with a predominance of closed questions) is generally collected by means of a formal, written document designated as a data collection instrument. This instrument is known as an interview guide when the questions are posed orally, either in a face-to-face format or by telephone, and as a questionnaire when the respondents complete the questionnaire in writing.

Generally, after having been developed, these instruments are reviewed critically by colleagues or collaborators, and are then pre-tested on a small sample of respondents to ascertain whether the instrument has been formulated with clarity and impartially and whether it is useful for generating the desired information.

The data collection instrument for this study will be a self-developed questionnaire aimed at acquiring information related to STI, HIV and AIDS, besides biographical and obstetric information. The questions included in the questionnaire will be either open or closed questions. Some questions included in the questionnaire will have an open format, enabling the participants to answer them in their own words. The closed questions or fixed alternative questions are those where the alternatives for answers are specified by the researcher.

Questionnaires are less costly and require less time and effort to manage, with the advantage of total anonymity as the respondents are not required to identify themselves on the questionnaire. An important disadvantage is that children, the visually impaired, the illiterate and the elderly cannot complete the questionnaire personally.

1.13 VALIDITY

According to Polit et al (2004:291-297), validity is the degree to which an instrument measures what it is supposed to measure. Lobiondo-Wood and Haber (2001:187-198) describe the validation as an endless process; the more evidence that can be put together that the instrument is measuring what it is supposed to measure, the higher the level of trust the researchers will have in its validity.

According to LoBiondo-Wood and Haber (2001:187-191) and Polit et al (2004:292-294), there are three types of validity, which vary according to the type of information provided and with the aim of the research. They are:

- Content validity
- Construct validity
- Criterion related validity

For this study, content validity is considered appropriate. LoBiondo-Wood and Haber (2001:189) state that content validity represents the universe of the content and thus provides the structure and the basis for the formulation of questions which will adequately represent the content. The application of content validity helps the researcher to determine whether the data collection instrument and the questions

included in the instrument are representative of the content that the researcher intends to measure. Content validity is ensured by an appropriate literature review.

1.14 RELIABILITY

LoBiondo-Wood and Haber (2001:192) define reliability of a research instrument as the “level in which the instrument produces the same results over repeated measurements. Thus reliability has to do with occurrence, precision, stability, equivalence and homogeneity”. The stability of an instrument is the capability of that instrument to produce the same results over repeated testing, while homogeneity or internal consistency is achieved when all its subsections measure the same and similar characteristics.

1.15 DATA COLLECTION

LoBiondo-Wood and Haber (2001:320) and Polit et al (2004:250-253) explain the collection of data as a process aimed at gathering information provided by existing resources such as reports, historical documents, videotapes, and consultations with agents.

The basic format for collection of data for this study is self-reporting. Self-reports are the answers given by participants to the questions presented by the researcher, as is the case in an interview or questionnaire. In this study, in order to be able to achieve the specified objectives, the questions will be applied to all Angolan women in the selected sample, irrespective of their level of schooling, once they have given their informed consent to taking part in the research.

1.16 DATA ANALYSIS

Data analysis is a process in which data is organised and synthesised so that the research questions can be answered and the hypothesis can be tested (Polit et al 2004:430).

The analysis of data will be done by means of descriptive statistics and through the calculation of frequencies and percentages. Data will be presented by means of graphs

and tables. The assistance of a statistician will be required for the analysis of the data.

1.17 PRE-TESTING THE DATA COLLECTION INSTRUMENT

The pilot study is a small-scale test of the study – to obtain information aimed at improving the instrument and determining the viability of the project (Polit et al 2004:54). For the purposes of this study a pre-test was done instead of a full pilot study. In order to prevent undesirable and unpredictable problems related to this study, the intention is to submit the questionnaire to the supervisor. Once this has been approved, the pre-test was carried out with six women at the Provincial Hospital Augusto Ngangula in Luanda.

1.18 PERMISSION TO CONDUCT THE RESEARCH

In order for the research to be carried out, a letter was written to the Director General of the Paediatric Hospital of Luanda, requesting permission to be allowed access to the hospital to submit the questionnaire to women accompanying children who have been admitted or are there for consultation. The research proposal and the research instrument was submitted to the Director, together with this letter requesting permission.

1.19 DEFINITION OF TERMS

The following terms are used in the context of this study as defined below:

- **Causes**

According to Ferreira (2003:372), a cause is something that determines an event or that makes something happen. There is no effect without a cause. For this study the causes and effects of HIV/AIDS are applicable.

- **Knowledge**

Silva (2006:1) states that knowledge is understood as a set of coded information. It has an important characteristic which we do not find in material assets. Knowledge, information and all intangible or immaterial assets know no limitations, i.e., they can be reproduced ad infinitum without any loss in terms of the original knowledge. “Knowledge

is derived from information, and is a mixture of elements, which could be compared to a living system, as it grows and undergoes changes as it interacts with the environment.” Silva categorises knowledge into two types:

- **Explicit knowledge** can be manifested by means of language (grammatical statements, mathematical expressions, manuals, etc.), and is easily transmitted, systematised and communicated amongst individuals.
- **Tacit/implied knowledge** is the personal knowledge incorporated within the individual experience and involves intangible factors such as, for example, personal beliefs, perspectives, value systems, insights, intuitions, emotions and capabilities.

Blaikie 1992 (in FAO/World Bank 2006:65-70) describes knowledge as the way in which populations understand the world and the manner in which they interpret and give meaning to their experiences. Knowledge is not a discovery of some “truth” as the final objective. It is the culturally subjective understanding or conditioned product which emerges from complex and continuous processes.

- **Awareness**

According to Wikipedia (2006:1-2), awareness is a quality of the mind considered to encompass specifications such as subjectivity, self-sufficiency, opinion, wisdom and the capability to understand the relation between oneself and the environment.

- **Consequences**

According to Ferreira (2003:457), any result or effect arising from a phenomenon or context can be considered a consequence. For instance, HIV infection and subsequent AIDS can be considered a consequence of many social factors such as poverty, conflict, unemployment, migration, inequality, discrimination, deficient educational and health systems, insufficient protection of human rights, mismanagement and politics (Grupos África da Suécia 2002:1-2). The propagation of HIV/AIDS, which damages the foundations of society, especially in sub-Saharan Africa, has its origin in poverty, inequality and other factors, as discussed above, affecting especially the youth.

- **Perception**

For Benedeth (2005:1), perception is the way in which people interpret information. It is “a process of transferring physical stimulation into psychological information: a mental process through which the sensory stimuli are brought to the consciousness, including in this process feeling”. Perception is not taught, it develops – all human beings have the capability of perceiving. What differentiates people’s perception is the amount of training/preparation that each one receives throughout life in developing perceptive skills. Everything starts with self-knowledge. All people are perceptive; all that is required is to develop that capability, to train it. With regard to knowledge about the consequences and causes of HIV/AIDS, people’s perception of its danger might result in their adapting their behaviour. Adaptation can be achieved if information is transmitted to individuals at a level congruent with their understanding.

- **AIDS**

SIDA is the abbreviation in French, Spanish and Portuguese corresponding to AIDS, or Acquired Immunodeficiency Syndrome caused by HIV. After contracting the HIV virus, the person starts to gradually lose all defences of the immunological system and various signs and symptoms appear (due to opportunistic diseases). AIDS is the more serious and advanced state of HIV infection (Baptista & Gomes 2000:22; MINSA/DNSP 2003:8).

In AIDS (2003:9) the meaning of the AIDS abbreviation is explained as follows:

- A = ACQUIRED:** i.e. something which is acquired during life, which is not inherited
- I = IMMUNE:** Refers to the immune system, which is a defence system of the body, protecting a living being from pathological micro-organisms which cause diseases and infections
- D = DEFICIENCY:** Lack of or inadequacy
- S = SYNDROME:** Signs and symptoms of a disease.

- **HIV**

Viruses are microscopic agents which can cause infectious diseases. Viruses are only reproduced inside cells. The HIV acronym refers to the Human Immunodeficiency Virus, the virus that causes AIDS. In the case of HIV, its reproduction occurs in T4 cells (Baptista & Gomes 2000:22; MINSA/DNSP 2003:7). Once acquired it will cause the collapse of the immunological system, so that the organism has no resistance against serious infections and tumours which arise as a consequence of this lack of defence.

- **Vulnerability**

Vulnerability implies the susceptibility of living organisms to disease, injury or danger. They are thus more prone to encounter negative consequences of adverse events. The concept of vulnerability is relevant to an understanding of the spread of HIV infection in the population, especially as regards gender. Experiences related to issues such as sexuality, fidelity, preconceived opinions, freedom and unequal relations in terms of gender and power mean that some groups, such as women, are more vulnerable than others (Diniz 1998 in Paiva 2004:1-8).

The same author further holds that considering the vulnerability of any population group requires grasping the concept developed by Ayres and Calazans (1999), based on the work of Mann. For these authors, vulnerability must not be looked at as the probability that any individual has of being exposed to AIDS, but rather on the basis of the elements that enable one to evaluate objectively the chance that each individual or population group has of becoming contaminated.

Silva and Paiva (2006:5) point out that individual vulnerability involves both the cognitive and the behavioural dimensions, being associated with having information on the disease, perception of risk, values and beliefs; these will determine the extent to which the individual will prevent contamination and possibly use safe practices (Sanches, 1999 in Silva & Paiva 2006:5).

1.20 ETHICAL CONSIDERATIONS

It will be necessary to obtain written consent from the Angolan women included in this study, both those who are taking part in the collection of data and those taking part in the pilot study, before answering the questions. They will remain anonymous. The answers to the questions will remain completely confidential, so that in the publication of the results of the research it will not be possible to relate the answers to the respondents.

1.21 LIMITATIONS OF THE STUDY

The limitations of a study are its weak points (LoBiondo-Wood & Haber 2001:319). They include everything to do with deficiencies of the sample, problems of alignment, and weaknesses in the collection of data (Polit et al 2004:71).

1.22 LAYOUT OF THE STUDY

Chapter 1	Orientation for the study
Chapter 2	Literature review
Chapter 3	Research methodology
Chapter 4	Data analysis
Chapter 5	Results and recommendations

1.23 CONCLUSION

This orientation chapter presented the following main topics: the introduction, background, social characteristics of the Province of Luanda, problem statement, objectives, assumptions, significance of the study, limitation of the field of study, research methodology, pilot study, permission to carry out the research, definition of terms, ethical considerations, study limitations and layout of the study. It was noted in this chapter that in Angola HIV/AIDS is an issue of great concern, in view of the historical, socio-political, economic and health background of the country. The next chapter will deal with the literature review.

Chapter 2

Literature review

2.1 INTRODUCTION

According to Polit et al (2004:53, 124-139), a quantitative study is carried out within the context of prior knowledge. A detailed review of the literature provides the foundation on which the new knowledge will be based, and this is usually done before any data are collected. The same authors further stress that familiarity with the relevant research literature can assist in establishing the basis for a study that is significant, for example, for nursing. The literature study is thus the initial task for the majority of quantitative researchers. The literature review provides readers with the background necessary to understand the current knowledge on a topic and clarifies the importance of a new study. Literature reviews serve an integrating function and facilitate the accumulation of knowledge.

In order to substantiate the study and provide a background with regard to the present knowledge of the topic, a literature review was carried out on some aspects related to HIV/AIDS. The following aspects will be dealt with: a historical overview, characterisation and virology of HIV/AIDS; causes and transmission; physical, mental and social consequences of HIV/AIDS; and prevention measures.

2.2 THE CONCERN ABOUT HIV/AIDS

Worldwide, and in particular within sub-Saharan Africa, HIV/AIDS is the epidemic that presents the major concern for governments and communities. This virus assumes a particularly powerful threat, as the large financial inputs by governments and corporations and the efforts undertaken by scientists have not yet led to a major breakthrough in terms of vaccines or medication to combat this virus. HIV/AIDS continues decimating populations. Statistical data are frightening and women are the victims or belong to the most vulnerable group in relation to AIDS.

2.3 HISTORICAL OVERVIEW

AIDS has as its etiologic agent the HIV virus, of which the origin at present is still unknown. This virus has placed the world in a desperate situation as regards its cure.

According to Baptista and Gomes (2000:13), the history of human being is the history of the struggle against his own misery. Going back in time, one looks at a past permeated by disagreements and conflict, either against nature – after all, human being has confronted nature, rather than working side by side with it as might have been expected – or against himself. Wars, hunger, unfavourable weather and inclement diseases – above all infectious diseases, have attenuated and exhausted mankind in an overwhelming manner.

Baptista and Gomes (2000:14-15) point out that the first cases of HIV/AIDS were reported in 1981 by the Centre for Disease Control and Prevention (CDC) of Atlanta in the United States, an American entity engaged in the control and investigation of new and already known diseases which affect the population. At the time, a number of cases of deaths by pneumocystosis (a type of pneumonia) started being registered amongst young male homosexuals in the city of Los Angeles. In June of that same year, the CDC published an article entitled “Pneumonia by pneumocystis, Los Angeles”, in which five cases of illness were reported. Soon after, the occurrence of a tumour, the Kaposi sarcoma, until then considered as rare, was registered amongst young male homosexuals, some of whom were victims of pneumocystosis. This was, therefore, the occurrence of something new, a serious deficiency of the defence mechanisms in this group of male homosexual individuals, which manifested itself through the appearance of infection and rare tumours in people who were otherwise apparently healthy.

An investigation of the new epidemic was initiated. In August 1981. An American federal law was approved which made it compulsory to register all cases of the epidemic. Two months later, the CDC compiled and applied a questionnaire containing 500 questions, with the aim of trying to define the characteristic profile of the patients (Baptista & Gomes 2000:14).

After that, according to the same authors, it was a race against time in an attempt to try to discover the mystery of the epidemic; and, in the meanwhile, the cases were

increasing. Composites such as amyl nitrite (used as an “aphrodisiac”) and infectious agents such as cytomegalovirus (a type of virus) were exposed as the causes, but in an inconclusive manner. After the comprehensive analysis of the data available at the time, it was presumed that the new syndrome would be an infectious disease, with a probable viral aetiology, transmitted through sexual intercourse.

As well as in young male homosexuals, cases also started being detected amongst haemophiliacs treated with blood and its derivatives. A year and a half after the first cases, at the end of 1982, the CDC “baptised” the new disease, calling it AIDS, Acquired Immune Deficiency Syndrome in English, having published the first definition of the case. The disease was almost libellously labelled GRID: “Gay Related Immunodeficiency”. This did not go undetected by the lay press, which often referred to the disease as “gay cancer” in its sensational headlines.

AIDSPortugal (2005:4) made a presentation about the CDC publication (1983:101-3), including the first recommendations related to the prevention of AIDS. The CDC started working with sectors more representative of society, both government and the community, together with the media, the economic and religious sectors and community associations, with a view to informing the public about the disease, to put an end to myths and to lead the nation to take preventative actions. The prevention efforts involved the public in general, through information campaigns and programmes aimed at special-risk groups. The reaction to HIV/AIDS in the United States, more than in any other situation in history, demonstrated the need for cooperation between public entities and the affected communities.

In Angola the first case was diagnosed in 1985. The war situation made it difficult to carry out a population census as well as doing studies on HIV; thus information about the HIV prevalence in Angola is considered scarce (MINSa (Ministry of Health in Angola) 2003-08:9).

With regard to the diagnosis of the virus, during 1984 one of the first publications of a French group was entitled “Lymphadenopathy Associated Virus” (LAV), through the journal *Science*. The same group raised the possibility that the new virus could be associated with the Acquired Immune Deficiency Syndrome (AIDS). Soon after this publication, the same agent was identified in a French patient with AIDS (Kaposi

sarcoma), thus establishing a strong link between the virus and the syndrome. The virus was called LAV: from Lymphadenopathy Associated Virus. A test was then developed to detect antibodies in serum, which was called RIPA: "Radio Immunoprecipitation Assay". Following this, the first ELISA tests – from: "Enzyme linked immunoabsorbent assay" - were carried out for LAV, showing that other patients with AIDS and with lymphadenopathy had antibodies against this virus, i.e., that this virus provoked a reaction from the organism: the production of antibodies against the invader. However, the war was lost, as the virus when multiplying also destroyed the defence cells, and the antibodies merely functioned as indicators of the existence of the infection (Baptista & Gomes 2000:18; Metcalf & Venables 1997:177-185; Varella 2005:35-37).

According to Baptista and Gomes (2000:17), after the discovery of HIV in February 1983 in France through the electronic microscope, and notwithstanding the fact that the researchers had discovered the agent, research has always maintained its role in attempting to discover a cure.

In the area of prevention, many American citizens were saved by following the preventative measures. The spread of the infection in the United States decreased dramatically during 1990. The reaction to the HIV prevention campaigns in that country, more than any other situation in history, demonstrated the need for and capability of cooperation between public entities and affected communities.

Today, new strategies are needed to maintain and accelerate inter-country and inter-institutional cooperation to combat the HIV/AIDS epidemic. The advancements in treatment have altered the prevention aspects, in the same way that the realities, the perceptions and the reaction to the epidemic have undergone, as a consequence, considerable deviations. The emergence of the HAART therapeutics (Highly Active Anti-Retroviral Therapy) has considerably improved the quality of life for many infected people, but the therapeutic advancements have brought about new challenges for the prevention of HIV. History has demonstrated that prevention saves many lives but the fight to find a cure for this disease must continue (AIDSPortugal 2002:1-2).

2.4 HIV/AIDS CHARACTERISATION AND VIROLOGY

Guerra (1998:13-14) and Baptista and Gomes (2000:22-23) characterise the Human Immunodeficiency Virus as a “lent virus”. This means that the main targets of HIV are the white cells of the blood, the so-called CD4+ lymphocyte or helper (auxiliary) cells. These cells are important in the coordination and orientation of the defences of the organism (immunologic system), being considered as the strategists in the fight against the aggressors when the individual comes into contact with any micro-organism (Baptista & Gomes 2000:22).

HIV destroys the CD4+ cells and, when the number of these cells reaches specific low levels, due to the progression of the infection, the immunologic system becomes weak. As a result micro organisms such as fungi, viruses, bacteria and parasites can act more easily, causing serious illnesses which would not have occurred if the defence mechanisms had been intact. These illnesses are then called “opportunistic illnesses”,; as they occur much more frequently in people with an immunologic system somehow compromised, the microbes are there awaiting an “opportunity” to act. When these opportunistic infections occur or when the levels of lymphocytes CD4+ reach a specific level (below 200 cells/mm³ of blood), it is said that the person has AIDS, a disease which can affect different organs and systems of the organism. AIDS is fatal because it has no cure, and up to the present no type of active or passive immunisation has been discovered (Baptista & Gomes 2000:22-23; Guerra (1998:13-14). The period from the time of infection until the time the first symptoms of AIDS appear is called the period of clinical latency, and could last ten or more years (which explains why many people have the virus and do not know it, and can then infect other people). During this period carriers are called asymptomatic carriers or HIV positive people. It is therefore important that everyone knows how the virus affects people; in this way they can adjust their behaviour in order to prevent HIV infection.

2.4.1 Causes and transmission of HIV/AIDS

From the day that the clinical evidence of AIDS was first disclosed, two decades ago, the virus of the disease has spread to all corners of the world, continuing to increase rapidly. The epidemic is reversing many development advancements, decimating the lives of millions of people, making them more dependent from an economic point of view. This often happens in countries where human rights are not applied and or not respected, where the HIV/AIDS positive person easily loses his or her job and livelihood, so that his or her life almost ceases to exist. And this individual, in the absence of family support, becomes poorer than the poor, thus increasing the gap between rich and poor.

HIV is transmitted by means of contact with infected bodily fluids (Barneth & Whitsite 2002:180). Thus the population cannot afford to ignore the causes and the manner in which HIV is acquired.

2.4.2 Causes of HIV infection

The HIV virus is a problem of public health which affects men, women and children, affecting to a larger extent the population with scarce economic resources, lack of food, inadequate information about the virus and limited access to health care and information resources at public health institutions (Robles 2005:1).

Giordani (2000:37-47) lists other factors which have favoured the spreading of HIV, such as cultural factors, the lack of knowledge about the self and other factors associated with popular beliefs, taboos and preconceived ideas, myths and values related to sexuality, as well as socio-economic factors such as the pattern of sexual behaviour of the population, industrialisation, poverty, migration, the use of injectable drugs, the advent of new contraception methods, early sexual activity and a less repressive attitude of society with regard to sexual freedom. The use of erotic elements in advertising, the glamorising of sex in music, literature, films and soap operas all contribute to the fact that sexual freedom is confused with promiscuity, especially in environments where there is misinformation, where the spread of AIDS is increased substantially.

In Angola, in 1985, 8 842 000 cases of HIV/AIDS were diagnosed in women alone (MINS/DNSP:2003).

Based on epidemiological data, the MINS (2003-08:9) carried out cross-sectional studies on pregnant women during prenatal consultations at the maternity hospitals in Luanda, which revealed a rapid spread of the epidemic, with an increase in prevalence from 3,4% in 1999 to 8,6% in 2001. During a study carried out in 2001, the Province of Huíla showed a level of prevalence of 4,2%, while in Cabinda the level of prevalence increased from 6,8% in 1992 to 7,4% in 1994 and 8,5% in 1996.

In Angola, data related to HIV prevalence are fragmented. However, UNGASS (2006:4) disclosed data of a study undertaken by UNAIDS (2006) indicating the rates of the HIV/AIDS epidemic in Angola. The study indicated that during 2003 approximately 130 000 cases of women living with HIV/AIDS were notified, one year after the peace was established at country level. After three years of peace, Angola has an increasing rate of sero-prevalence, as is evident from UNAIDS (2006:1) statistics which reveal that, of the 320 000 individuals infected with HIV/AIDS in Angola, 170 000 are women between the ages of 15 and 49.

The spread of HIV amongst Angolan women follows a tendency to “feminise the epidemic”, i.e., the rate of contamination of HIV is more marked amongst women, and in particular amongst youngsters and adolescent girls.

Guimarães (2001:13) quotes the statement of Carlos César de Albuquerque (1997), who said: “the seriousness of the spread of the disease amongst females can be evaluated through the growing occurrence of cases of transmission from mother to child. Transmission, either during pregnancy, during birth or through breastfeeding is considered an important indicator of the increase of the epidemic amongst women.”

With regard to the risk of sexual transmission of HIV/AIDS, it must be pointed out that the woman is biologically more vulnerable than men. This is because the anatomical form of the vagina provides a surface of contact for male sexual secretions, which during intercourse exposes more mucous membrane, receives a larger quantity of sexual fluids and presents the possibility of more lesions in the vaginal or rectal tissue (Dias 2005:1; Varela 2005:1).

This epidemiological data is important because it indicates, to some extent, the alarming situation of the country with regard to HIV. The large number of women infected indicates that, without prevention, whether a woman is rich or poor, educated or illiterate, she is vulnerable to being infected by the disease. Thus it becomes necessary for all strata of Angolan society to become aware of and knowledgeable about measures to prevent HIV infection.

There are various factors and beliefs which are directly related to HIV transmission through sexual intercourse, such as the following:

- Promiscuity and the non-use of condoms during casual and/or unsafe sexual encounters encourage the spread of the epidemic (Annan 2004:1; Baptista & Gomes 2000:24; Dias 2005:2).
- According to Dias (2005:2), beliefs, taboos and myths are cultural factors which place the woman in a risk context: for example, the popular belief that if an infected man has sexual intercourse with a virgin this is a guarantee that he will be cured of HIV/AIDS. The same authors also report a belief that having sexual intercourse with younger women will avoid infection. On the contrary, the young woman is more vulnerable to micro-lesions, and subsequently more prone to HIV/AIDS infection as well as other sexually transmissible diseases (STDs).
- The widespread use of contraceptive methods that provide no protection against STDs is deceptive. These would need to be reinforced with condoms if they were to ensure a barrier. Examples are: oral contraceptives, intra-uterine devices (IUDs), diaphragm with spermicide, injection, periodic abstinence, emergency anti-contraception, coitus interruptus, post-coital vaginal douche (Dias 2005:2; Leal, Saito & Silva 1997:414-421).
- The existence of healing lesions in the cervix and in the genital and vaginal areas is a factor in vulnerability (Baptista & Gomes 2000:24-25; Praças 2002: 64-69).
- The nature of the sexual contact (passive or active) is a factor. The risk of transmission increases depending on the practices, and is higher, for example, in anal sex, due to the more frequent occurrence of lesions and small sores in the mucous membrane associated with this practice (Baptista & Gomes 2000:24).
- Sexual relations with an infected sexual partner are a high-risk factor (Baptista & Gomes 2000:24; Dias 2005:1; Praça 2002:65).

- Sexual partners of haemophiliacs could be at risk as these could have been infected with HIV by means of haemoderivatives through blood transfusion (MINS/DNSP 2003:11; Baptista & Gomes 2000:25).
- Sexual intercourse during menstruation can be a risk for the female if her immunological state is compromised and her partner is HIV infected (Baptista & Gomes 2000:23-25).
- Religious and political factors play a part. Religions cannot promote female slavery and oppression while following the church's doctrine (Ferreira 2003:1-3). It does, however, sometimes happen that adultery and polygamy are considered normal in some religions. According to UNAIDS (2002:3-20), religious leaders should have strategies aimed at introducing the topic OF AIDS in their services or sermons (Ferreira 2003:1-3; UNAIDS 2002:3-20.)
- in order to achieve efficient and widespread prevention, it is the responsibility of governments and leaders to include awareness campaigns in addition to the provision of education, food, information and health care services. The reduction of the cost of medication and of technologies, the development and implementation of strategies and plans for multisectoral financing to combat HIV/AIDS, and the establishment of national targets are also the responsibility of government (Ferreira 2003:1-3; UNAIDS 2002:3-20).
- The availability of antiretrovirals to introduce treatment for pregnant women, to avoid the transmission of vertical infection, is extremely important.

2.4.3 Transmission of HIV

Studies carried out from when the epidemic first emerged to the present indicate, theoretically, that HIV transmission is associated with exposure to bodily fluids and secretions contaminated with HIV, which could be blood, sperm, vaginal secretion, or a contaminated transplanted organ. Oral sex is less risky, but contamination orally is possible (AIDSMap 2005:2).

There are various types of HIV transmission. Baptista and Gomes (2000:24-25) explain the following potential routes of HIV transmission:

- Through sexual transmission such as unsafe heterosexual, homosexual and anal sexual intercourse. (Anal sex can occur between a man and a woman with the objective of avoiding an undesired pregnancy.)
- Parenteral transmission occurs through contaminated material such as blood and its derivatives, contaminated syringes and perforating or cutting instruments, especially needles, blades, scissors, or human teeth. These could be used during the practices of tattooing, male and female circumcision, suturing, infections and human bites.
- Vertical transmission from mother to child, during pregnancy, during childbirth or during breastfeeding. A high rate of child mortality has always existed in the developing countries; HIV/AIDS contributes even more to an increase in this rate, according to a study which indicates that HIV/AIDS is one of the main causes of child deaths, pointing to numbers of over 1 million infected children, particularly throughout sub-Saharan Africa (Lampreia, Desterrou & Bernardo 2002:1).
- Vertical transmission from mother to child during pregnancy and childbirth.
 - A recent study suggests that the transmission of HIV from mother to child (MTCT) can occur through small splits/cracks in the placenta during childbirth (Lampreia et al 2002:1).

When they do not have access to treatment, 25 to 35% of babies of HIV infected mothers are born infected, which is reflected in an estimate at world level of 500 000 newborn babies infected per year.

Dr Steven Meshnick, and his international team involved 149 HIV infected pregnant women in Malawi in a study to investigate this form of vertical transmission. Dr Meshnick tried to determine whether the origin of MTCT is the rupture of the barrier of the placenta (Lampreia et al 2002:1).

According to Meshnick, a certain enzyme, produced in the placenta, "is very large, normally too large to go through the natural barrier that protects the babies from any organisms that cause diseases and from the infected mother before childbirth" (Lampreia et al 2002:1). The team estimated that, if they found this enzyme in the blood of the umbilical cord, which attaches the baby to the placenta, we would be faced with an indicator of

blood exchange and of the fact that the baby was subject to the contaminated blood of the mother. The researchers suggested that MTCT occurs during the actual labour, during the period of contractions, and not when the children go through the birth canal. In this case, disinfection of the birth canal may not be as efficient as anti-retroviral treatment (ARV).

According to Meshnick “this work revealed, for this time, strong evidence that what we call placental micro-transfusions during birth is the main factor responsible for the transmission of HIV from mother to child”. This author further indicated that “one has known for a long time that if women are submitted to a caesarean section before going into labour they do not transmit the virus, while those who undergo an emergency caesarean section after going into labour transmit it. It seems that the direct passing of blood from mother to child which occurs during labour leads to the infection" (Lee 2005:1-2).

➤ Vertical transmission from mother to child during breastfeeding.

A study undertaken by Lampreia et al (2002:2) on HIV/AIDS underlined the existence of risks of transmission of HIV during breastfeeding, depending on:

- **Duration of the breastfeeding.** The longer the breastfeeding, the higher the risk of HIV transmission. It is believed that the risk of infection is more or less 5% in the first six months, 10% during the first 12 months and 15-20%, if the baby is breastfed for 24 months.
- **Breastfeeding habits.** The risk is less if the baby is fed only with maternal milk instead of using a combination of mother's milk and supplements.
- **Health of the breast.** The risk is higher if the nipples are cracked or bleed, or if the breasts have sores or are inflamed (owing to mastitis or breast abscess).
- **HIV infection of the mother.** The risk of MTCT is higher if the mother is infected during pregnancy or when she is breastfeeding.

- **Immunologic state of the mother.** The risk is higher if the level of immunity of the mother is low, due for example to inadequate nutrition or because she is in an advanced stage of the disease (AIDS) caused by HIV.

Besides the types of transmission indicated above, the MINS/DNSP (2003:10-11) quote the study done by WHO (2000) which indicates the existence of evidence that the lack of male circumcision and the high prevalence of STDs constitute a risk for HIV transmission.

Of the three ways of transmission indicated above, sexual transmission is accepted as the one route which contains the highest degree of risk situations and biological vulnerability through unprotected sexual contact, thus constituting, since the onset of the epidemic, the main type of transmission of HIV worldwide.

In Angola, based on the data collected in the reporting and notification of cases, sexual intercourse is responsible for the majority of AIDS cases. Heterosexual intercourse constitutes the main means of transmission of HIV, while there is, in total, an approximately equal ratio of infection amongst men and women (MINS/DNSP 2003-08:11).

It is universally accepted, i.e., both in the developed countries as well as in the developing countries, that only education aimed at changing the behaviour of people and the adoption of preventive measures can contain the dissemination of HIV/AIDS. Moreover, taking into account the impact of this disease on the child, the availability of sexual and reproductive health services is vital in the prevention of vertical transmission (Baptista & Gomes 2000:24-25, 75 2005:6.)

2.5 CONSEQUENCES OF HIV/AIDS

In his study on HIV/AIDS, Giordani (2000:44) confirms that the physical, social and psychological consequences are higher for women with HIV/AIDS than for men in a similar situation. The stereotypes and bias which define women in society and their low status in relation to men clearly determine the present situation with regard to the high rates of HIV/AIDS infection, and highlight their constant vulnerability to this lethal disease, irrespective of whether they are included in the risk groups or not.

According to Neves et al (2003:19), one of the most important transformations in the way of thinking about HIV/AIDS, at the beginning of the 1990s, was the change from the notion of individual risk to a new understanding of the social vulnerability to which individuals and communities are exposed. The perception of the state of vulnerability is fundamental for each citizen, whether he or she is literate or not. It is therefore possible to change the course of history through a change in personal behaviour.

In this regard, Ayres and Calazans (1999) point out that when analysing the level of individual vulnerability one must start from the premise that: “Every individual is vulnerable to HIV infection, depending on his/her risk behaviour and the means at his/her disposal to protect him/herself.” These can be mechanical means (such as the use of the condom, the use of individual syringes and needles) and internal resources such as taking assertive decisions, based on cognitive and intellectual aspects. The diagram by Giordani (2000:20), shown below in figure 2.1, demonstrates the interrelationship between some factors and individual vulnerability.

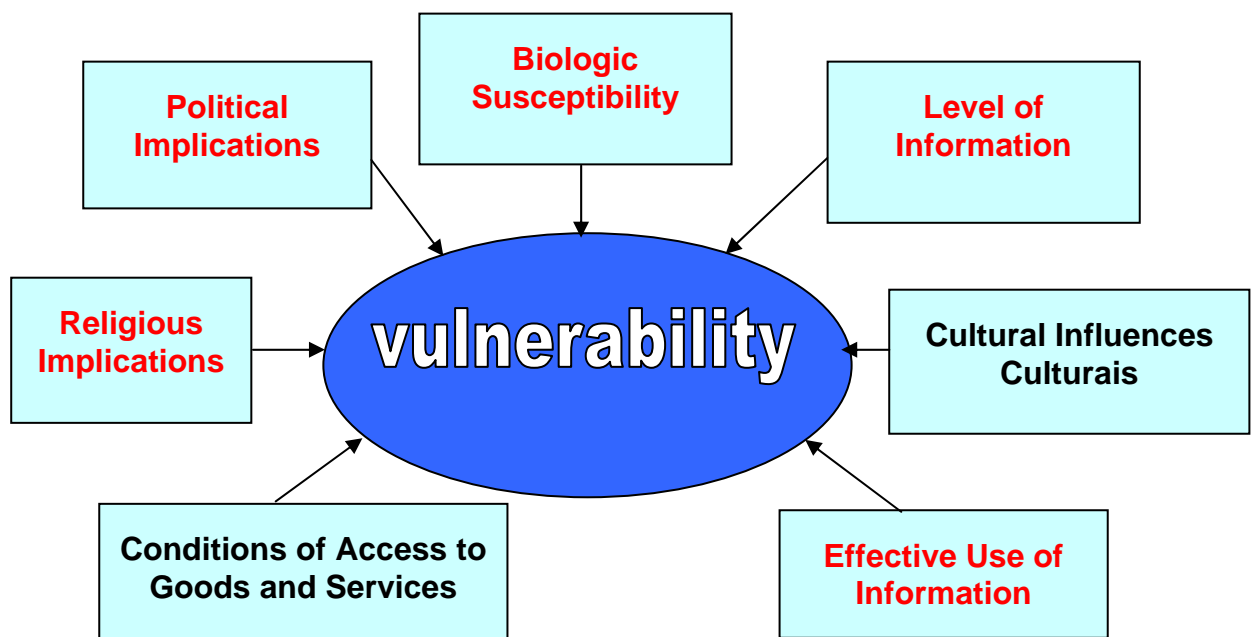


Figure 2.1
Diagram summarising the factors of vulnerability
(Giordani 2000:20)

HIV infected individuals can be more vulnerable to AIDS and even death if they are not supported by public policies of health assistance and social security assistance.

Therefore it is necessary to reduce the individual vulnerability, in particular of the woman. And it also becomes relevant to take into account that values and beliefs also have a significant influence on the adoption of safe sex practices, especially with regard to using condoms. In this regard, religion becomes an important factor, as some religions condemn the use of both the condom and divorce, often encouraging women – and men – to remain married (Silva 2006:4).

2.5.1 Physical consequences

AIDS (2003:3), AIDSPortugal (2002) and Baptista and Gomes (2000:22) point out that HIV infection produces a deficiency in the immunologic system, preventing it from performing when there is the risk of infection. By being infected with HIV the body is subject to becoming infected by other diseases that are incurable and fatal.

That happens because the HIV in the organism needs to infect other cells to develop and multiply. This new, recently formed, HIV will invade other cells, which can cause the onset of billions of HIV cells in the human organism. During the multiplication of cells, HIV can suffer mutations, which can make it resistant to one or more medications, thus rendering the virus resistant to medication. The main targets of HIV, when it attacks the immunological system, are the white cells, called lymphocytes, CD4+, or helpers.

HIV/AIDS constitutes, moreover, a major threat to women. The above authors point out the harmful effects of HIV on white cells. Besides her deteriorating health, the woman faces another problem: the risk of transmitting the virus to her child during pregnancy, childbirth or breastfeeding. Praças (2002:64) refers to the statement of AIDSPortugal (2002:1) that “50% to 70% of transmissions occur in the period close to or during childbirth”. Besides vertical transmission, the woman is considered as the major victim in heterosexual transmission (Strazza 2003:10; Mercosul Health Ministers 2004:14; Varella 2005:6).

2.5.2 Psychological consequences

Castanha (2005:10) citing Meleino (1997) warned about the state of depression of people infected with HIV. Even with the advent of anti-retroviral treatment, AIDS is still

potentially a lethal disease and to live permanently with the idea of death is always a factor which generates stress and psychological symptoms.

According to AIDSPortugal (2004:1) and Chaves (2006:6-10) fear, a sense of stigma, isolation and discrimination, shame, silencing, denial, lack of trust, distress and anguish are psychological symptoms which can be observed in an individual infected and affected by HIV/AIDS.

The stigma and discrimination associated with HIV/AIDS produce other consequences. One can point out, in particular, the serious psychological consequences of the deterioration in self-image of people due to the disease: the way in which people with HIV/AIDS are led to view themselves. In some cases, they fall into depression, and suffer from a lack of self-esteem and despair (UNAIDS 2002:5-7).

To be HIV positive constitutes a way of living which unleashes a marked psychological vulnerability, not only because this is a syndromatic reality which threatens the life of the person, but also because the therapeutic course of the disease often brings about alterations to the body image which can be potentially stigmatising, and which influence self-esteem and the self-image of the HIV carrier. The HIV positive woman experiences a number of body changes which drive her to an intra-psychic (re)-learning of her femininity, living through her interrelational daily life with what could be designated as "a new feminine condition" (Dias 2003:1-5).

These authors also describe the collateral effects of anti-retrovirals, even though the new generation of anti-retrovirals provides a new hope for these individuals. Although there is still no proven scientific evidence, bodily and metabolic changes have been noticed which are associated with the iatrogenia of the medication, such as lipodystrophy or adipose redistribution syndrome, loss of weight and/or muscle mass, as well as, amongst other symptoms, alopecia.

Giordani (2000:40) state that distress and anguish are part of AIDS, causing, from the beginning, anxiety, fear and panic owing to the fatal nature of the syndrome, followed by rebellion and the distress of enduring taboos and prejudice as a result of discrimination.

2.5.3 Social consequences

Since its emergence 25 years ago, notwithstanding the strategies adopted to reduce its dissemination, the spread of the pandemic in the developing countries is on the increase. These effects threaten the benefits of development in some of the poorer countries in the world.

The social consequences arising from HIV/AIDS are incalculable, especially in the African countries where poverty is still widespread amongst the population and where the health system is in need of reform. HIV/AIDS worsens poverty and deepens the inequalities within society.

It must moreover be pointed out that, within an environment of economic dependency, such aspects as the use of coercive sex; daily violence; exploitation; lack of negotiating power in the decisions aimed at a healthy sexual life; and the like are often prevalent, because the need for survival imposes a survival logic in which HIV is a secondary risk (Epele 2002).

Prevalence and incidence

The HIV/AIDS pandemic continues to increase at global level, but there is some hope with regard to access to treatment. The United Nations report on HIV/AIDS presented by UNAIDS (2006:1-3) discloses that every day 11 000 people are infected by the virus, i.e., 4,3 million during the course of 2006. Of the 39,5 million people living with HIV/AIDS, 37,2 million are between 15 and 49 years of age, and 2,3 million are children younger than 15 years of age. adolescents (between 15 and 24 years of age) represent 40% of new infections. Access to HIV/AIDS treatment has advanced quite substantially in the last few years, enabling many people who are infected to live longer. On the other hand, the number of women infected with HIV is the highest ever, and there are presently 17,7 million infected women worldwide (Sociedade Internacional de Comunicação (SIC) 2006 :1-3).

Reduction of life expectancy

According to Antunes (1999:1-8), the main variable to take into account in dealing with HIV/AIDS is the consequences. Antunes adds that the AIDS factor causes a drastic drop in the average life expectancy at birth. This fact demonstrates the true dimension of the epidemic and justifies the urgent need for rapid and systematic interventions on the part of governments with a view to combating HIV/AIDS.

On the basis of a study undertaken in sub-Saharan Africa, Antunes (1999:1-6) puts forward the following statistics related to life expectancy and the respective population growth in sub-Saharan Africa on 1998 data, as indicated in Table 2.1.

Table 2.1 Effects of HIV/AIDS in some sub-Saharan countries – 1998 (US Bureau of the Census, Washington)

COUNTRY	LIFE EXPECTANCY		POPULATION GROWTH RATE	
	WITHOUT AIDS %	WITH AIDS %	WITHOUT AIDS %	WITH AIDS %
South Africa	65,4	55,7	1,9	1,4
Botswana	61,5	40,1	2,4	1,1
Burkina-Faso	55,4	46,1	3,2	2,7
Burundi	55,4	45,6	4,0	3,5
Cameroon	58,6	51,4	3,2	2,8
Congo (Brazzaville)	57,2	47,1	2,7	2,2
Congo (Kinshasa)	54,4	49,3	3,3	3,0
Ivory Coast	56,5	46,2	3,0	2,4
Ethiopia	50,9	40,9	2,9	2,2
Kenya	65,6	47,6	2,5	1,7
Lesotho	62,0	54,0	3,2	1,9
Malawi	51,1	36,6	2,7	1,7
Namibia	65,3	41,5	2,9	1,6
Nigeria	57,8	53,6	3,2	3,0
Central African Rep.	56,3	46,8	2,5	2,0
Rwanda	53,9	41,9	3,2	2,5
Swaziland	58,1	38,5	3,2	2,0
Tanzania	55,2	46,4	2,6	2,1
Uganda	54,1	42,6	3,5	2,8
Zambia	56,2	37,1	3,3	2,1
Zimbabwe	64,9	39,12	2,5	1,1

Although Angola is not mentioned in the table above, one can deduce that the situation in this country is probably not very different from that in the neighbouring countries such as Zambia, the Democratic Republic of Congo, Congo Brazzaville and Namibia.

According to projections on the socio-economic impact of HIV/AIDS in Angola, this will be the most important cause of death amongst children, surpassing measles and malaria, which in the present context constitute the major causes of morbidity and mortality in children below 15 years of age (MINSa 2003-08:20).

Discrimination and marginalisation

The consequences of HIV/AIDS are enormous, affecting the individual in all aspects. According to the International Labour Organization (ILO 2006:6), within the context of development, people are faced with shortages and exclusion in the form of unemployment and under-employment, dismissal, low-quality and unproductive employment, dangerous conditions of work, low incomes, and the denial of rights to carriers of the virus (for example: they are denied jobs, residence, visas or entry into foreign countries, and it can happen that they are expelled from their homes by the spouses or family members or even assassinated).

Marginalisation is one of the most devastating consequences of being infected with HIV/AIDS. Testimonials of nurses who are in contact with patients demonstrate that at the present time AIDS still causes negative attitudes with regard to patients and families. One continues to hear stories of people with HIV who are kept away and isolated, and are forced to leave their jobs or their homes, who do not receive medical treatment or nursing assistance, who are in fact robbed of their human and civic rights.

During its global campaign against AIDS, UNAIDS (2002:7) stated that the stigma and the discrimination associated with HIV and AIDS are the biggest obstacles to sufferers' accessing help which might prevent new infections, give adequate support, assistance and treatment and alleviate the impact of the disease. This stigma and the discrimination regarding HIV/AIDS are universal, occur in all countries and all regions of the world. They originate for various reasons, which include lack of knowledge about the disease, myths about ways in which HIV is transmitted, prejudice, and irresponsible

news coverage on sexuality, on the disease and on death, on illegal drugs and the use of injectable substances.

The Declaration of Undertaking adopted by the General Assembly of the United Nations, during its Special Session about HIV/AIDS which took place in Central Asia on 18 May 2001, underlined the generalised consensus about the importance of facing the stigma and the discrimination diffused by HIV/AIDS. Shame and the stigma associated with the epidemic have all over the world silenced open discussion about the causes and adequate forms of combating it. This fact has given rise to a situation where people infected and affected by HIV feel guilty and ashamed, incapable of expressing their points of view, and fearful of not being taken seriously. This has enabled politicians and coordinators of political strategies of various countries to deny the existence of the problem or the need for any type of urgent action (UNGASS 2001:6; AIDSPortugal 2002:1-2).

Discrimination and the violation of human rights, as well as the absence of confidentiality with regard to HIV/AIDS, negatively affect prevention, support and treatment initiatives and increase the impact of the epidemic on individuals within their family and communities. This can result in the blocking of public awareness campaigns, thus making it difficult to establish services aimed at enabling the young to acquire practical competencies and to partake in urgent programmes for prevention (UNAIDS 2002:7; 2006:14).

Below are presented two concrete examples which illustrate dismissal and discrimination due to being HIV positive:

Kelly (2005:3) reports an action taken in Sweden on 25 January 2005. The European Tribunal for Human Rights made public a judgement which concluded that Sweden had violated article 5, paragraph 1 (the right to freedom and security) of the European Convention on Human Rights by inflicting compulsory isolation on an HIV-positive individual. The second example has to do with a study carried out in Maputo, Chimoio and Quelimane, in Mozambique, which reported that 21% of interviewees stated that they had lost their jobs after having declared their HIV positive status; the study further concluded that the level of discrimination, from the moment the HIV status was made known, had reached 65% of all interviewees, who were extremely affected, with cases

of being abandoned by the family, divorce and rejection, as well as lack of confidentiality (MINSAPen 2005-2009:105).

A study carried out by the Plano Nacional de Luta contra o SIDA (PNLS) [National Plan to Combat AIDS], by the United Nations Educational, Scientific and Cultural Organization (UNESCO) under the United Nations Development Programme (UNDP) (2001) about the perceptions of Angolans with regard to HIV/AIDS demonstrated that 48,4% of the people interviewed (non-specified) indicated a high level of discrimination towards people with AIDS, the majority refusing to share spaces and environment of social interaction with people living with AIDS or who were HIV positive, and in addition being opposed to these people being treated in the same health centres as they were. Misinformation about the ways in which the virus is transmitted has resulted in AIDS patients in Angola being abandoned or rejected by the family (MINSAP 2003-08:18).

Effect on families and children

OnuPortugal (2006:15-16) states that, in communities where HIV/AIDS is prevalent, most of a whole generation grows up without a perspective of a future. Cultural and social structures crumble with the subsequent increase in insecurity and lack of safety. Young girls are found to be amongst the poorest, and are especially affected by HIV, both physically and socially.

UNAIDS (2002:9) states that HIV/AIDS has “catastrophic consequences for children”. The poor and marginalised communities are generally those that receive less in material resources and are subjected to inadequate, if any, social services and HIV-prevention services. This tendency increases denial, stigma and poverty (OnuPortugal 2006:16).

At the level of the family, HIV and AIDS have devastating effects in Angola. When a member of the family falls ill or dies, the whole family suffers. To the human tragedy are added economic difficulties, resulting from the growing cost of care and reduction of the family income. The situation is aggravated as the disease develops and threatens the family’s access to food, housing and to other essential goods. “On the one hand the HIV infection has serious implications for the family’s economic situation due to an increase in expenses due to the medical care, reduction of productive capability, absenteeism and loss of employment, all intensifying the level of poverty. The effects of HIV/AIDS on

families are particularly devastating for children. Frequently, the young girls have to leave school to provide the necessary care to family members that are ill or to assist in the domestic and income-generating activities. In the case of death of the parents, the children and the young girls are forced to take on the heavy responsibilities mentioned above” (MINSa 2003-08:24-25).

The absence of affectionate and attentive parents makes many children extremely vulnerable to discrimination, to child labour and other types of exploitation, and of course, to HIV/AIDS infection. The pandemic deprives the community of a vital means of transmission of values, cultural norms, techniques and other skills to the next generation so as to enable them to survive in a time of crisis (Annan 2005:1; MINSa 2003-08:14-26).

The “Associação de Luta pelo VIH/SIDA” (Association to Combat HIV/AIDS) in Luanda, financed by Save the Children (Norway), in their *The Child, the Family and HIV/AIDS*, a survey done on a sample of 152 children younger than 18 years of age, demonstrated that a high number of children live in a situation of vulnerability and absolute need, with 89,4% being orphans as a consequence of the war, accidents or diseases, especially HIV/AIDS. Within this group it was observed that the majority of orphaned children whose mother or both parents have died due to AIDS live with their extended families, frequently in the care of people who are unemployed (50,5%) and are without any means to offer them the necessary care, including access to education and proper nutrition.

Management of the pandemic

Victorino (2000:16-17; 2004:9) and Maingi (2004:5) compare the extent of HIV/AIDS amongst developed and poor countries and point out the paradox that the HIV/AIDS disease has become, in the developed countries, a chronic, treatable and controllable disease by means of preventive actions, while in the poor countries it reaches catastrophic levels of incidence and mortality.

As far as management of this pandemic in developing countries goes, it can be deduced that the situation has worsened due to ineffective strategic planning, the lack of methodologies aimed at evaluating and managing risk, the lack of comprehensive

programmes, the dysfunction and inadequate management of existing programmes to combat HIV/AIDS, the insufficiency of funds allocated to these programmes, insufficient human resources with adequate qualifications, and mismanagement of allocated funds.

In Angola in particular, there is a need to speed up the creation and execution of national strategies about the autonomy of woman, giving them the protection of the full enjoyment of their human rights and thus reducing their vulnerability to HIV/AIDS. The introduction of measures aimed at eliminating all forms of discrimination and violence, including harmful traditional and customary law practices such as ill-treatment, rape and other forms of sexual violence, are also urgently needed (UNAIDS 2002:25).

Angolan society has benefited from a study on the rights of the HIV/AIDS positive patient through the “Carta Angolana sobre VIH/SIDA e os Direitos Humanos” [Angolan Charter on HIV/AIDS and Human Rights] (Flechnner 2005:33). This charter enables the development of an awareness in society as a whole, as it exposes a problem that was previously only associated with specific strata of society which were more exposed to and more affected by the virus.

2.6 MEASURES TO PREVENT HIV/AIDS INFECTION

As the above discussion shows, the HIV/AIDS epidemic has reached the level of a world crisis. It is one of the greatest challenges ever faced by social development and progress. In the more affected countries the epidemic can erase decades of growth, and can destroy the economy, threaten security and dismantle societies. In sub-Saharan Africa, where it already has a devastating impact, the epidemic creates a state of emergency (OIT 2001:3).

The AIDS epidemic is a problem of public health which affects human beings in every dimension, and is described by Pérez and Matos (2005:2) as a “tragedy for the poor”. Therefore it becomes imperative that communities become organised, using a variety of strategies to combat and alleviate the suffering of the population and stop the pandemic’s drastic consequences within society.

The fact that a preventive vaccine and an effective treatment for the elimination of the virus have not yet been developed has led society to establish strategies which seek to

contain the advancement of the epidemic. There are various measures, already published, for confronting the epidemic, such as:

2.6.1 Barriers against the virus

The following barriers are available as a means to prevent the introduction of semen and bodily fluids into the reproductive cavities of the female and/or the bloodstream.

Obstruction

Various studies consulted have not yet made any publications with regard to medications with an obstructive function against HIV/AIDS. However, UNAIDS is promoting the investigation of microbicide substances, in the form of creams or foams, for women to insert vaginally before having sexual intercourse; in other words, a microbicide that does not sterilise the sperm and prevent pregnancy (AIDSPortugal 2002:3).

Protective measures

The male condom is the only protective barrier in terms of safely preventing HIV when used correctly, but it prevents pregnancy.

Sterilised equipment/instruments

The use of sterilised equipment and/or instruments must be encouraged with the aim of reducing the transmission of HIV between patients. The improper use of materials or equipment is related to the advancement of the AIDS epidemic. The use of sterilised equipment such as syringes, needles and other equipment is related to the protection of human rights, which is essential for any strategy to prevent HIV/AIDS (Quaglia 2006:3).

2.6.2 Information, education and communication

The dissemination of information and adequate communication about the dangers of HIV infection is a strong weapon against the spread of HIV/AIDS. This could entail:

- Education in schools about HIV/AIDS prevention
- Awareness and involvement of communities
- Dissemination of messages to all strata of society
- Elimination of female illiteracy
- Involving women in self-care
- Protection of the more vulnerable groups: vulnerable groups such as prostitutes, ethnic minorities, migrants, professional groups with high mobility, women and prisoners should be encouraged to practise such measures as abstinence, masturbation, fidelity and use of condoms

2.6.3 Role of the authorities and/or government

The powers that be, such as governmental and private authorities have a responsibility to:

- Promote prevention programmes which take into account the circumstances, ethics and local cultural values, include information, education and communication in the languages better understood by the communities, and respect cultures, with the aim of reducing risk behaviour and promoting responsible sexual behaviour, including abstinence and fidelity
- Establish laws to make school attendance compulsory
- Invest in the youth to combat HIV/AIDS by means of more appealing techniques such as dramatisations or theatre (Duarte 2004:1), because theatre attracts many participants and can be used as a resource to disseminate information about HIV prevention
- Make available anti-retroviral medication, without discrimination, to all pregnant women infected by HIV/AIDS, so as to prevent transmission of the disease to the child
- Create national associations of people who live with HIV/AIDS, not necessarily with the aim of taking on the role of activists in the fight against the disease, but for support
- Actively participate in programmes related to HIV/AIDS
- Ensure the sustainability of projects, programmes or activities

- Allocate budgets so as to stimulate the creation of activities that generate more resources for low-income women, for example the allocation of micro-credit to women

2.7 CONCLUSION

The literature review on HIV/AIDS looked at this topic from different points of view: the character, causes and transmission of HIV/AIDS, its consequences and measures to prevent the infection.

In this chapter, several of the authors consulted stated that the AIDS epidemic is acknowledged as a global problem which is causing immense human suffering all over the world and that women are the most affected by the disease. The infection compromises the economic development of countries, increases child mortality and the number of orphans, reduces life expectancy and negatively affects the social progress of all, including women and children. In the next chapter the research methodology for this dissertation will be discussed.

Chapter 3

Research methodology

3.1 INTRODUCTION

The methodology of a project strongly influences the research process as it defines the method of carrying out the research and presenting assumptions, the methods for collection of data and measurement, and techniques of analysing data (LoBiondo-Wood & Haber 2001:116-117).

For Silva, Menezes, Pezzi and Lappoli (2001:9) the function of methodology is to show the way to do the research. It helps one to reflect and promotes a new way of looking at the world: a curious, inquisitive and creative way of looking. The authors add that the success of a research project will depend on the procedure followed, the involvement with research and the ability to choose the route for achieving the research objectives.

In this chapter aspects related to the research design, population, sample, delimitation of the field of study, ethical considerations, instruments utilised, permission to carry out the study, pilot study, collection of data and data analysis will be discussed.

3.2 RESEARCH DESIGN

Any scientific research needs to be planned before it is developed. A scientific work adequately planned, with a well-defined methodology, assists the researcher to obtain the intended and convincing result. Polit et al (2004:53) define this process of research design as the general plan for obtaining answers with regard to the issues being studied.

For this study a quantitative approach involving an exploratory and descriptive design was used to determine the knowledge of Angolan women with regard to the causes and consequences of HIV and AIDS.

Polit et al (2004:28-34; 177; 439) define quantitative, exploratory and descriptive research as follows:

- **Quantitative research** is the study of phenomena which are suitable for being measured with precision and which are quantifiable, frequently involving a rigorous and controlled design.
- **Exploratory research** seeks to simply observe and describe the phenomenon, but does, however, also investigate its complex nature and the other factors with which it is related.
- The aim of **descriptive research** is to observe, describe and document aspects of the situation. For example, in this study, one can try to determine the percentage of women who have knowledge of vertical contamination.

3.3 POPULATION

According to Silva et al (2001:32), the population (or universe of research) is the total number of individuals who have the same characteristics defined for a specific study. From a statistical point of view, Própesquisa (2005:1) states that the population or the “universe” of data is the set of elements that have some characteristic in common which may be counted, measured, weighed or organised in some way and which may serve as a basis for the characteristics to be investigated.

The focus of this study is to determine the knowledge of Angolan women regarding HIV and AIDS. Therefore the target population consists of women who reside in the province of Luanda, originating from any province in Angola. These women are mothers, family members, friends, neighbours or acquaintances who accompanied sick children to the Paediatric Hospital in Luanda.

3.4 SAMPLE

Silva et al (2001:32) define sample as part of the population or the universe selected according to a rule or plan. Within the statistical field, Própesquisa (2005:1) defines sample as a subset which is representative of the study population. This representativity of the sample is the characteristic which is highly desirable in statistics; it occurs when it represents the same general characteristics of the population from which it was taken.

In this study 100 women participated who gave their informed consent. The sample for the study was a convenience sample. To give the sample a representative nature, the following criteria were adopted: woman of Angolan nationality who accompanied a child to the Paediatric Hospital David Bernardino during the period between 27 July and 10 August 2006 and were residing in the province of Luanda. The Paediatric Hospital David Bernardino was chosen as the research field as it is a specialised institution which is part of the public network of the Ministry of Health. It assists children from 0 to 14 years of age, mostly from the medium and low strata of society.

3.5 LIMITATION OF THE STUDY FIELD

Guidelines for the development of scientific studies characterise the limitation of the study field as the geographical, spatial, temporal, sampling, technical and budgetary limitations of the research or study. In other words the limitations are a list of what will not be encompassed by the study or by the study objectives, either from a theoretical or practical point of view (i.e. the workability of the research).

This study took place in the province of Luanda, and involved women who were accompanying children admitted to or attending out-patient consultations at Emergencies at the Paediatric Hospital David Bernardino, during the period between 27 July and 10 August 2006. Women who did not fulfil these criteria were not invited to take part.

3.6 PERMISSION TO CARRY OUT THE RESEARCH

Once approval of the research project had been obtained from the Department of Health Studies at UNISA (Annexure E), approval was sought from the general management of the Paediatric Hospital David Bernardino and the following steps were followed to obtain permission to carry out this research:

- An official letter (Annexure A) requesting permission to carry out the research at this hospital was sent to the offices of the Vice-Minister of Health of Angola. Together with this official letter the research proposal and data collection instrument (Annexure D) were sent.

- Once a favourable reply was received from the offices of the Vice-Minister (Annexure B), a second official letter was written (annexure A1) addressed to the Director-General of the Paediatric Hospital, which was accompanied by the research proposal and data collection instrument and the approval from the Vice-Ministry of Health.

3.7 DATA COLLECTION INSTRUMENT

For this study the questionnaire was used as the instrument to collect data by means of self-report by the respondents, through the presentation of questions (Polit et al 2004:439).

The questionnaire was chosen for this study with the aim of speeding up the collection as well as the analysis of data. The use of the questionnaire was beneficial for the study in view of some of its advantages, such as being a less costly process, reaching a higher number of people, being able to be sent by post, and guaranteeing anonymity of the answers and the actual respondent (Propesquisa 2005:1). The questions contained in the questionnaire were open-ended and closed questions.

Rea and Parker (2000:44-46) describe certain advantages of using closed-ended questions, such as the fact that the whole set of alternatives of the answer is uniform and therefore facilitates comparisons between respondents. For data to be entered, this uniformity enables the direct transfer of data from the questionnaire into the computer, without any intermediary stages. The fixed list of possibilities in terms of answers tends to make the question clearer for the respondents.

Open-ended questions are used in situations where the limitations of the closed-ended questions overcome their conveniences, both for the interviewer and the interviewee. These are used when the researcher wants the research subjects to provide an answer in their own words or when the researcher does not know all the alternative answers (LoBiondo-Wood & Haber 2001:180).

As Rea and Parker (2000:46-47) and Polit et al (2004:254) indicate, both closed and open ended questions have strong and weak points; but both present a common point,

which is that the questionnaire cannot be applied to illiterate people. With regard to the weak points they describe the following:

- Open-ended questions: limit people from completing a higher number of questions; inevitably create a certain volume of irrelevant and repetitive information; and the statistical analysis requires a certain degree of standardisation of data, which imposes upon the researchers the interpretative, subjective and slow categorisation of the open-ended questions.
- Closed-ended questions: always hold the possibility of the interviewee being uncertain with regard to the best answer and selecting at random one of the fixed answers instead of using a personal criterion; an interviewee who misunderstands the question can select a random answer or a wrong answer; they force the interviewee to choose the “closest representation” for their real answer, in the form of a specific fixed answer (Silva et al 2001:33).

The questionnaire contained the following sections:

- Biographical data
- Obstetric history
- Knowledge of STI, HIV and AIDS

3.7.1 Validity

Validity and reliability are essential prerequisites for data collection instruments (Freitas, Oliveira, Saccol & Moscardol 2000:105-115).

Fontanella, Campos and Turato (2006:18) state that the validity of an instrument for data collection refers to its capacity to reveal the truth, enabling as a result contents which mirror reality. The questions to be answered are as follows: Does the instrument reveal (measure) correctly what it is intended to reveal (measure)? Is it a technique that leads the researcher to focus on the essence of the object? Do the different results obtained reflect real or occasional differences? Is it known that the instrument has the characteristic of referring to the measures of empirical reality?

The content of the instrument for this study was developed on the basis of the literature review carried out, related to the research topic; this ensured content validity. Once the instrument was developed, it was submitted to the researcher's supervisor and an obstetrics lecturer with experience in programmes for combating HIV/AIDS, with the aim of assessing the appropriateness, clarity and integrity of the instrument before the pre-test was carried out.

3.7.2 Reliability

Reliability refers to the levels of confidence related to a certain method or instrument that it would reproduce the same findings, if other researchers should study another sample of subjects – with the same profile – in other scenarios or at other times. The results of this study can be generalised, taking into account the methodology used to develop the instrument and the adherence to criteria for carrying out an interview or using another data collection method (Polit et al 2004:252).

Fontanella et al (2006:18) point out that “if, when those results that provided the original knowledge were related to the topic of the new study, they would throw some light on understanding the elements within that other scenario, we can say that the characteristic of *generalizability* occurred”.

3.8 PRE-TESTING THE DATA COLLECTION INSTRUMENT

According to Polit et al (2004:54) and Rea and Parker (2000:40), the pilot study is a small-scale test of the study or a pre-test with the aim of verifying the clarity, level of inclusivity and acceptability of the questionnaire and consequently improving the instrument if necessary and testing the feasibility of the study. However, a pilot study was not done but a pre-test was performed on the questionnaire to test its clarity and applicability.

The instrument was tested with five women at the Provincial Hospital Augusto Ngangula, who were family members of patients admitted to the hospital who were waiting for information about their state of health. The pre-test was carried out on 16 July 2006 and respondents took approximately thirty minutes to complete the questionnaire. During the testing of the instrument it was ascertained that with illiterate

women the interview took longer (50 minutes), owing to their need to understand the importance of the study. From the pre-test it was identified that some adjustments needed to be made to the instrument through the changing of the questions related to section 3 (knowledge of STD, HIV and AIDS) by adding a column 'I don't know'. This resulted in an improvement in the questionnaire.

3.9 DATA COLLECTION

According to Silva et al (2001:34) the collection of data is related to the problem, hypothesis or suppositions of the research and aims to obtain elements so that the objectives proposed in the research may be achieved.

The Instituto de Desenvolvimento Gerencial - IDG (2006) is of the opinion that given the importance of the process of data collection as a phase of an investigation during which the data necessary for later analysis is collected, special attention and care must be given to this phase.

The data collection took place from Monday to Sunday, from 09:00 to 18:30 with a rest of 30 minutes in between. This activity started on 27 July and ended on 10 August 2006. The following strategy was adopted to distribute and collect the questionnaires.

The women who were returning home, those who awaited outside (in the Esplanade), on the verandas, in the corridors, waiting rooms for outpatients and emergency unit, at the wards, and at the main entrance of the hospital were approached and informed that the participation of 100 Angolan women was needed to complete a questionnaire for a research project on HIV and AIDS. The aims of the study were explained and the informed consent clarified.

After the individual contact with each of the women, the first step was to explain the objective of the study and then to request their informed consent to partake in the interview voluntarily after which the consent form (Annexure C) was signed by the respondent. It was initially envisaged that most of the respondents would be able to complete the questionnaire on their own, and that only the illiterate ones would have to be assisted with the completion of the questionnaire, but this proved to be a difficult process, therefore the researcher verbally posed the questions contained in the

questionnaire to the respondents and immediately completed the questionnaire. Some women, however, refused to sign; they simply used their fingerprints or their incomplete name for reasons of lack of trust or illiteracy. Others invited family members, friends, and daughters to also complete the questionnaire.

3.10 ETHICAL CONSIDERATIONS

LoBondo-Wood and Haber (2001:159-161) and Polit et al (2004:97) point out that the following basic rights must be respected during research studies with humans: the right to self-determination, right to privacy and dignity, right to anonymity and confidentiality, right to just treatment and right to be protected against coercion and harm. This study respected the ethical criteria established for research with human beings.

After the individual contact with each of the women, the first step was to explain the objective of the study and then to request their informed consent to partake in the interview voluntarily. All the respondents who participated signed the consent form in one way or the other as explained above. Anonymity and confidentiality were ensured by not identifying the respondents either by name or number on the questionnaires. They were treated with respect and a measure of isolation was achieved during the completion of the questionnaire so that their privacy was protected.

3.11 DATA ANALYSIS

Polit et al (2004:223) point out that it is in this phase that the data is presented, interpreted, discussed and generalised. With regard to the treatment of the data analysis, Hauser (2006:58) citing Silva and Menezes (2001), state that quantitative research relates numbers and quantities, producing an analysis from the classification of data. Hauser also cites in this study Contandriopoulos et al (1997), who are of the opinion that all studies which involve quantitative data utilise descriptive analysis.

As this is a quantitative, exploratory and descriptive study, the data obtained in this study was analysed using descriptive statistics. Without statistics, the quantitative data would be a chaotic mass of numbers and without doubt the statistical procedures enable the researcher to summarise, organise, interpret and communicate the

numerical information in a sound manner. Descriptive statistics are used to describe and synthesise data (Polit et al 2004:312).

Polit et al (2004: 13) also state that “without some structure it is not possible to even distinguish the general tendencies of the data, and the distribution of frequencies is considered a method to impose order in the numerical data”.

In this study the assistance of a statistician was acquired and the process of data analysis was carried out by means of descriptive analysis, which calculated the frequencies and percentages. The capturing of data was done by using the Statistical Package for Social Sciences (SPSS) program. Once the data was processed, the results were organised in the form of tables, graphs and diagrams.

3.12 CONCLUSION

In this chapter the research methodology which shaped this project was discussed. Aspects such as the research design, population, sampling, the data collection instrument, pilot study, data collection, data analysis and ethical considerations were explained. In the next chapter, Chapter 4, the analysis of the data collected will be discussed.

Chapter 4

Data analysis

4.1 INTRODUCTION

This chapter discusses the analysis of data and interpretation of the results related to the level of knowledge of Angolan women about the causes and consequences of HIV/AIDS. One hundred questionnaires were distributed to the respondents and all 100 were returned completed for analysis, thus giving a response rate of 100%. The completed questionnaires were submitted to a statistician at UNISA for purposes of data processing and analysis. The questionnaire consisted of three sections: biographical information; obstetric history; and knowledge about STIs, HIV and AIDS. The results will be discussed in accordance with these three sections.

4.2 DATA ANALYSIS

The computer program used for the analysis is the Statistical Program for Social Sciences (SPSS), version 13. The questions contained in the questionnaire comprise categorical answers which led to categorical variables and which are analysed in specific ways.

The statistician (Professor F Steffens) provided the following explanation of the data analysis process. Summary statistics used for the responses to each individual question are frequencies, i.e. counts of how many respondents selected a particular response. These frequencies are illustrated by means of pie charts or bar charts. Bar charts are particularly useful in the case of a question that offered a number of alternatives and where the respondents were allowed to mark more than one choice (the "Yes/No" options) where the bar chart compares the frequencies of the different choices. The pie chart is used in cases where the respondents are allowed to choose only one alternative, and the pie chart then illustrates the share of the total respondents opting for each choice.

The information is presented in tables, pie graphs and bar charts. As the frequency of the 100 respondents equals the percentage of 100%, only the frequency is indicated in the tables, while only the percentage is utilised in the different types of graphs.

4.3 RESULTS

The results will now be presented based on the data accumulated by means of the questionnaire.

4.3.1 Section 1: Biographical data

The biographical information sought in this section included variables such as age, marital status, level of schooling, religion and remuneration.

4.3.1.1 Age

The respondents' age was important to ascertain the knowledge of different age groups pertaining to the topic of study.

Table 4.1 Frequency distribution of respondents according to age (n=100)

AGE	FREQUENCY
10-15 years	1
16-20 years	20
21-25 years	14
26-30 years	21
31-35 years	20
36-40 years	15
41-45 years	5
46-50 years	2
51-55 years	1
61 years and older	1
TOTAL	100

As one can observe from table 4.1, the majority (90%) of respondents who accompanied sick children to the hospital and who were interviewed belong to the age group 16-40 years. This group falls within the parameters of the fertile age group for women.

4.3.1.2 Marital status

The marital status of respondents was important, as a variable against which to match their sexual knowledge and behaviour.

Table 4.2 Frequency distribution of respondents' marital status (n=100)

MARITAL STATUS	FREQUENCY
Single	41
Married	52
Separated	4
Divorced	3
TOTAL	100

Table 4.2 indicates that just more than half (52%) the sample consisted of married women, followed by 41% who were single women.

4.3.1.3 Educational level of respondents

The educational level of respondents was important as it could be indicative of their reading and writing skills.

Table 4.3 Educational level of respondents (n=100)

EDUCATION	FREQUENCY
Grade 1-4	28
Grade 5-6	18
Grade 7-9	30
Grade 10-12	16
Higher education	3
Other	5
TOTAL	100

With regard to the level of schooling, the results show that 46% of the respondents were educated up to grade 4 or 6, while another 46% had schooling up to grade 7 or 12. Very few (8%) respondents indicated a level of schooling higher than grade 12.

4.3.1.4 Religion

Religion could be an important indicator affecting sexual practices. Religions such as Christianity, Islam, Buddhism, Catholicism, and even practices such as witchcraft are factors which affect customs regarding sexual practices.

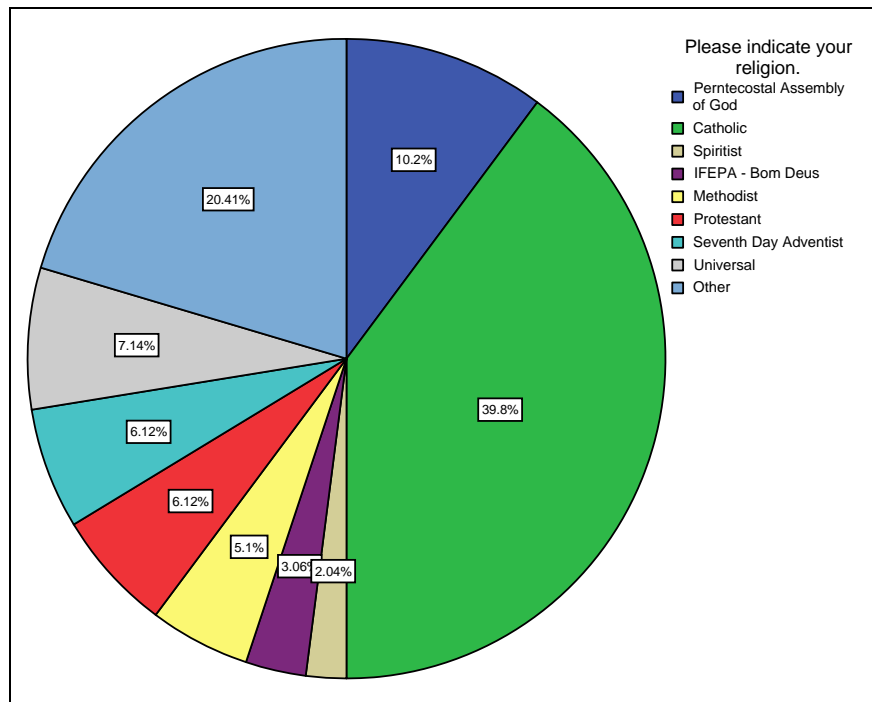


Figure 4.1

Percentage distribution of respondents according to religion (n=100)

The data indicated in figure 4.1 reveals that the highest number (40%) of respondents belonged to the Catholic faith, followed by the Pentecostal Assembly of God (20%) and other religions not identified (10%). This data is indicative of the representation of different religions within current society in Luanda.

4.3.1.5 Contraception

Respondents were asked to indicate whether their religion prohibited them from using contraceptives.

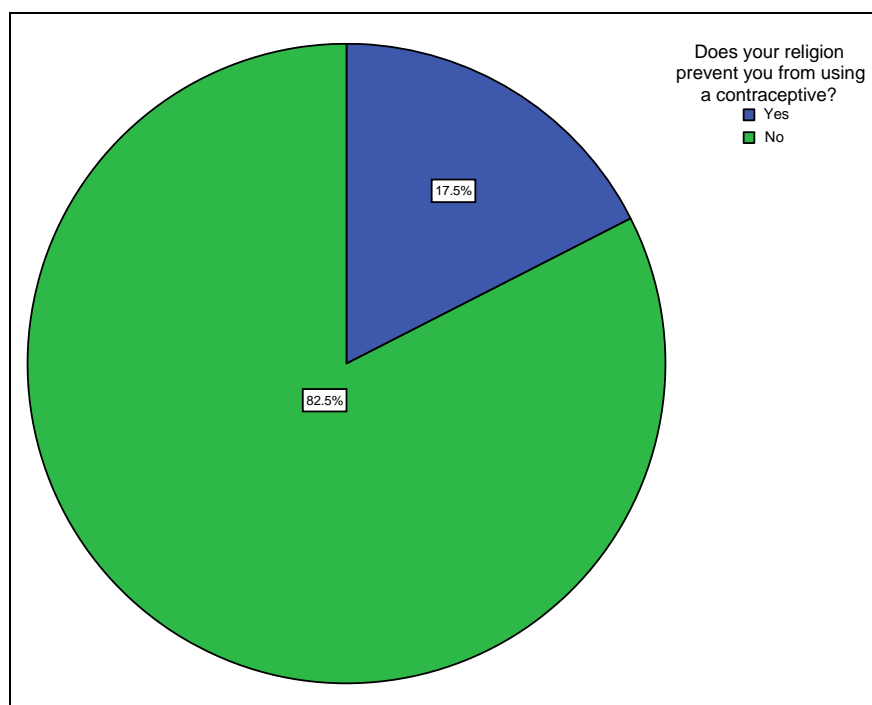


Figure 4.2
Prohibited from using contraceptives by their religion (n=80)

The use of contraceptives depends on the free will and needs of woman but can be influenced by the socio-economic context within which she finds herself and her actual state of health. But sometimes external factors influence her decisions. As can be seen from figure 4.2, the greater majority (83%) of the respondents were not prohibited from using contraceptives by their religion, while only 17% of the respondents affirmed that religion influenced them negatively in this regard; 20% of the respondents did not answer this question.

4.3.1.6 Wage/salary

The process of integrating women as part of the workforce into the labour market is a milestone in the sense that their remuneration contributes to the family income, thus reducing their dependence on the income of their partners and reducing poverty. Respondents were asked whether they worked for a salary/wage, in other words were they paid for the jobs they performed.

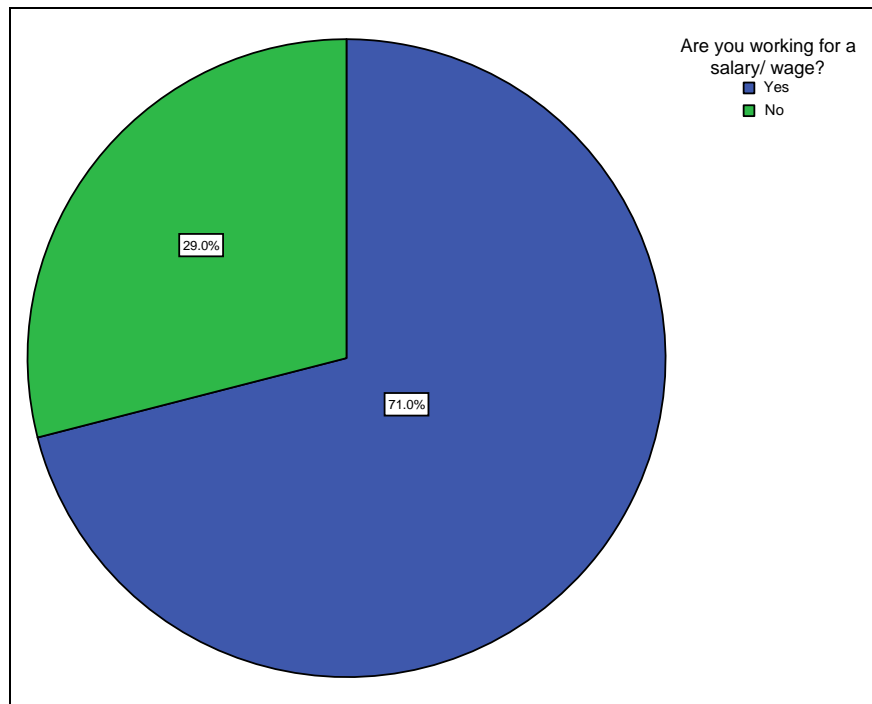


Figure 4.3

Receiving financial payment for work done (n=100)

According to figure 4.3, the majority (71%) of respondents indicated that they received either a wage or salary for the jobs they performed, whereas 29% of the respondents indicated a *no* to this question, which could be interpreted that they were either not working or did not get paid in financial terms for the jobs they performed. With regard to the inclusion of women in the labour market, Angolan women are strongly motivated to work, taking into account their social needs aggravated by a war that devastated the country for more than 25 years.

4.3.1.7 Types of job performed

The respondents who confirmed that they worked for financial remuneration in the previous question were requested to indicate what type of work they performed.

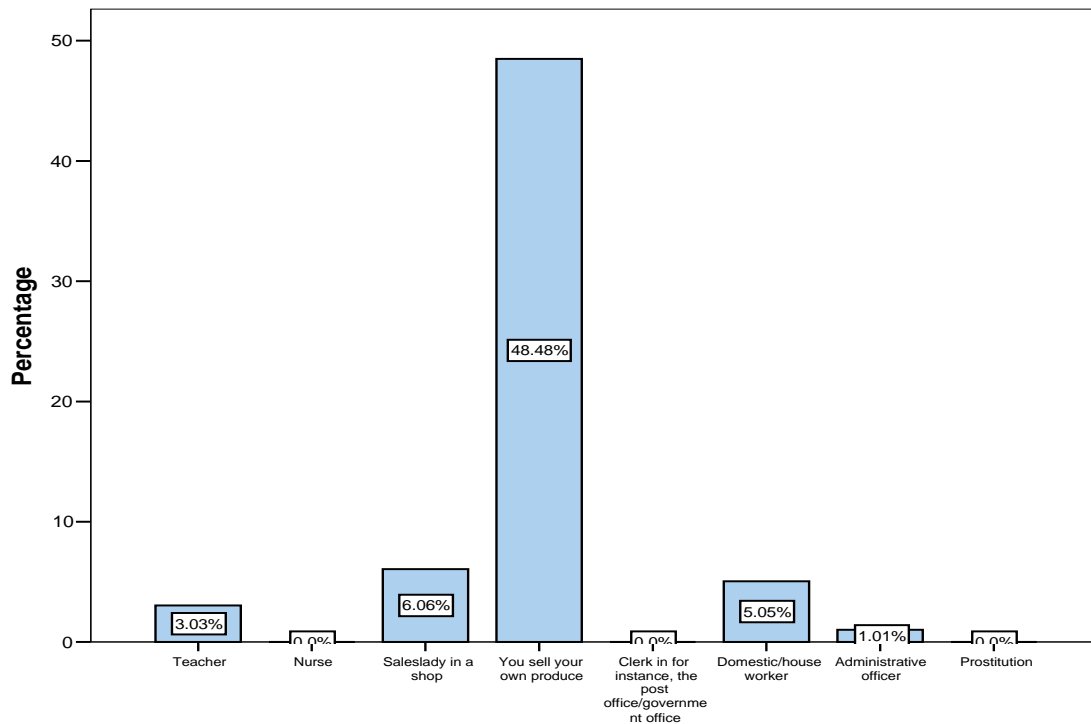


Figure 4.4

Types of job performed by the respondents (n=71)

From figure 4.4 it is clear that most (48%) of the respondents who indicated they worked for a wage or salary (n=71) earned a living by selling their own produce. Teachers only represented 3%, and domestic workers 5% of the respondents.

4.3.1.8 Relationship to the child that is ill

Generally, when the family is adequately constituted, it is from the family that the person receives all emotional and psychological support, and human values at the time of need, especially during illness. In the case of the child this is a crucial time. The presence of a family member becomes sacred in the sense that the family members surround the patient, determining how best to help the patient, resolving some problems and continuing to provide psychological and financial support during the therapeutic process. The respondents were asked to indicate their relationship to the child they accompanied to the hospital.

Table 4.4 Relationship of respondent to the sick child (n=100)

RELATIONSHIP	FREQUENCY
Mother	53
Sister	8
Grandmother	8
Aunt	22
Niece	2
Friend of the family	2
Concerned neighbour	1
Other	4
TOTAL	100

More than half (53%) of the respondents were the mothers of the sick children, and 22% were aunts, while the grandmothers and sisters each represented 8% of the respondents.

4.3.2 Section 2: Obstetric history

This section dealt with aspects such as pregnancies, live children, causes of death of children and contraception.

4.3.2.1 History of the pregnancy

The experience of women who have been pregnant is important in determining future behaviour. The respondents were requested to select from a number of alternatives those which applied to their pregnancy history.

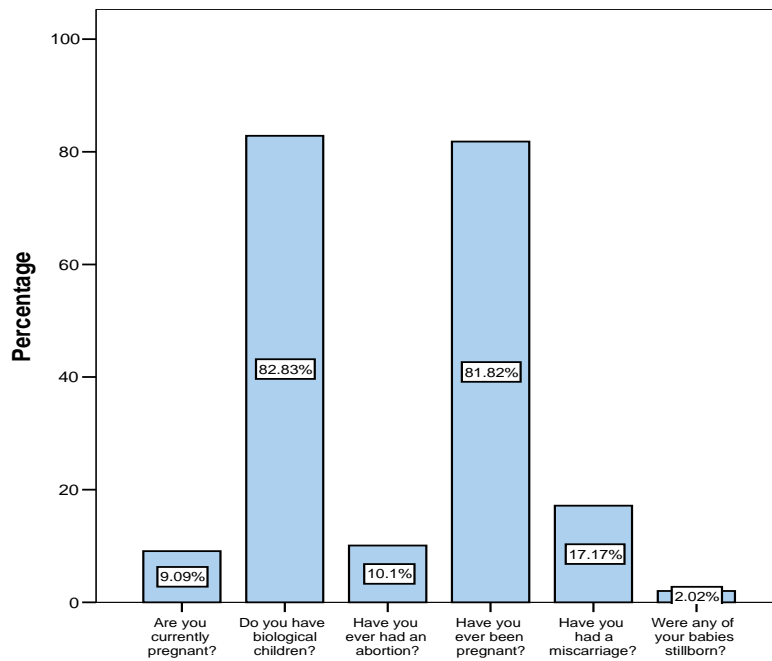


Figure 4.5

Pregnancy history of respondents (n=100)

Figure 4.5 reveals that the two events with the highest score correlate, as one would expect: 83% of the respondents have biological children and 82% indicate they have been pregnant before; 17% have had a miscarriage, 10% have had an abortion and 9% are currently pregnant.

4.3.2.2 Total number of biological children

The respondents were requested to indicate how many children they had had and how many were still alive.

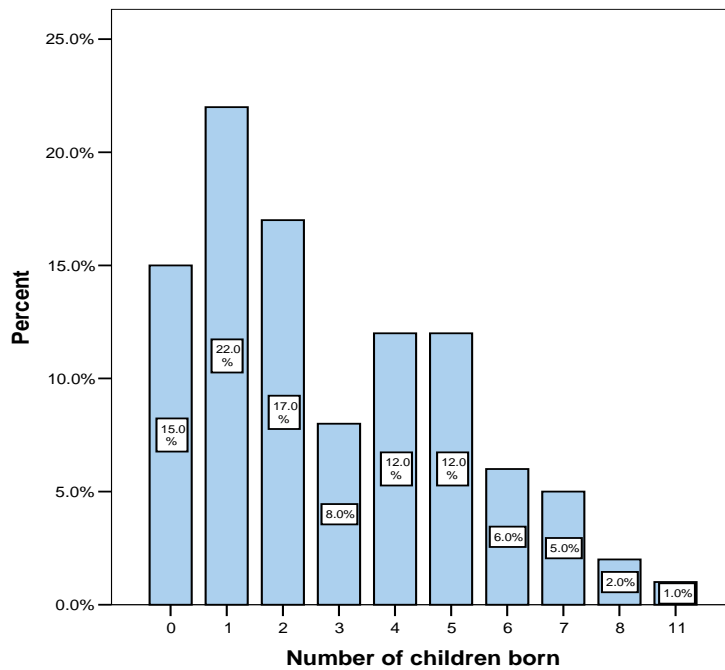


Figure 4.6

Respondents' number of biological children they had had (n=100)

From figure 4.6 it is evident that 22% of respondents had only one child, while 17% had two children. Two sets of 12% had four and five children respectively. An interesting fact is that one respondent had eleven children, while 15% did not have any children as yet. Unfortunately none of the respondents indicated how many of their children were still alive.

4.3.2.3 Causes of death of children

Data relating to the misfortune of losing children due to death was important for this study, taking into account that the mothers themselves questioned why the hospital administration forced the children's parents to take the HIV test. This served as the starting point that forced mothers to become aware of their responsibilities, of the fact that when a child is sick it is not only the child that is sick but that the parents are also involved. Respondents were asked to indicate the causes of the deaths of their children if they had had the misfortune of losing a child.

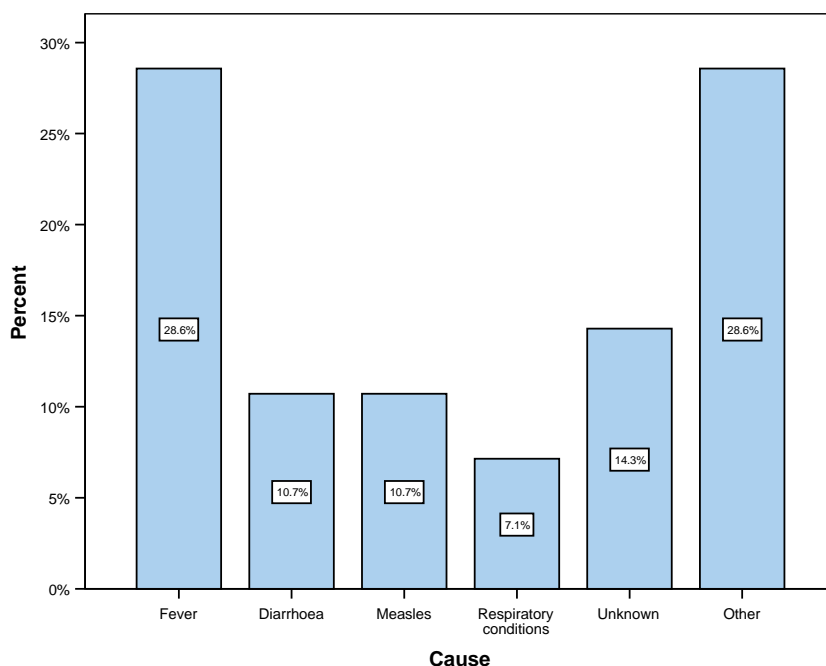


Figure 4.7

Causes of children's' deaths (n=28)

Twenty eight respondents noted that they had lost children to death. Of these 28, 8 indicated that fever was the cause, while another 8 noted *other* causes which were not specified; two sets of 3 indicated diarrhoea and measles respectively (refer to figure 4.7). No respondents indicated that any deaths occurred due to AIDS; however, 4 died of unknown causes.

4.3.2.4 Use of contraceptives during sexual intercourse

With regard to the concern for each individual, during the fertile age, to have control over their fertility, and to prevent undesired pregnancies as well as sexually transmitted infections (STIs/HIV/AIDS), it becomes necessary for people to be aware of all contraceptive methods that exist on the market. Ideally each person or couple should opt for a contraceptive method that is suitable for them.

Table 4.5 Type of contraceptive used during sexual intercourse (n=100)

CONTRACEPTIVE USED	YES	NO
Condom	23	77
Diaphragm	1	99
Pill	8	92
Coitus interruptus	3	97
IUD	1	99
Chart for fertile period	15	85
The injection	17	83
Other	6	94

From table 4.5 it is clear that condoms (23%), the injection (three-monthly progesterone) (17%) and chart for fertile period (15%) are the most common types of contraceptives used. It is disconcerting that only a quarter of the respondents used a physical protection method like the condom, considering the immense risk of being infected with HIV.

4.3.3 Section C: Knowledge about sexually transmitted diseases

In this section data pertaining to the following will be discussed: transmission of STIs, condoms, HIV, AIDS, transmission methods and predisposing factors.

4.3.3.1 Acquisition of sexually transmitted diseases

There is a close link between STIs and sexual transmission of HIV. The presence of an STI that is not treated increases the possibility of HIV infection. The respondents were asked to select, from a given list of possible ways that the transmission of sexual diseases can take place, those that they thought were applicable.

Table 4.6 Ways of transmitting sexual infections (n=100)

METHOD OF TRANSMISSION	YES	NO	DON'T KNOW
Taking a bath	24	42	34
Using dirty or contaminated water	60	17	23
Walking barefoot in the morning	55	19	26
Sharing eating and kitchen utensils with an infected person	16	53	29
Sharing washing facilities with an infected person	28	38	34
Sexual intercourse with an infected person	83	2	15
Sexual intercourse during menstruation	43	13	44
Being cursed	30	45	25
Witchcraft	30	46	24
Lack of personal hygiene	63	15	22
I don't know	23	11	19
Other	14	75	11

It is clear from table 4.6 that the respondents were very poorly informed about the actual ways in which sexually transmitted infections are transmitted. Approximately a third (between 15 and 44) of the respondents responded to the possible variables by noting *Don't know* to all the variables listed.

The majority (83%) of respondents affirmed that sexual intercourse with an infected person enables transmission, whereas a large component of the respondents selected inappropriate means of transmission; for instance 63% indicated that lack of personal hygiene, using dirty or contaminated water (60%), walking barefoot in the morning (55%), sexual intercourse during menstruation (43%), being cursed (30%), witchcraft (30%) and sharing washing facilities with an infected person (28%) could lead to infection with STIs.

4.3.3.2 Condom

Respondents were asked to indicate what they thought a condom was.

Table 4.7 Description of what a condom is (n=100)

A CONDOM IS ...	YES	NO	DON'T KNOW
Tablet	0	90	9
Instrument for sexual pleasure	10	80	10
Protective rubber to cover the penis	91	0	9
I don't know	8	34	17
Contraceptive method	48	17	34
Other	7	88	4

Table 4.7 indicates that the majority (84%) of respondents knew that a condom is a protective rubber covering the penis; however, only 48% indicated that it was also a method of contraception. Knowledge of this resource was crucial, taking into account that when there is a risk of transmission of STIs/HIV, the use of the condom offers double protection to all people as it prevents both pregnancy and STIs. It is a method that is easily used and if correctly used is in fact efficient (*Human Sexuality 2007:1*).

4.3.3.3 Human immune deficiency virus (HIV)

To test their knowledge, the respondents were asked to describe HIV in terms of a list of variables.

Table 4.8 Description of what HIV is (n=100)

HIV IS ...	YES	NO	DON'T KNOW
Disease	25	12	63
Virus	10	14	76
Bacteria	3	20	77
Microbe	4	18	78
Virus which causes AIDS	13	9	78
Don't know	2	13	76
Other	18	65	16

Table 4.8 shows that a high number of respondents, between 16 and 78 in number, *did not know* whether the variables were applicable; 25% indicated that it was a disease, and only 13% noted that it was a virus causing AIDS, which indicates that respondents are not well informed about the aetiology of HIV.

4.3.3.4 AIDS

In order to find out what the respondents knew about AIDS, they were requested to select appropriate variables from the list provided in table 4.9.

Table 4.9 Description of what AIDS is (n=100)

AIDS IS ...	YES	NO	DON'T KNOW
A disease that kills	73	1	26
A disease caused by a virus that affects the immune system	17	5	78
A terminal disease	33	9	58
A disease which causes major weight loss	59	1	40
A condition which makes one susceptible to other infections	43	6	51
A disease which causes shame	48	12	40
I don't know	11	14	37
Other	31	63	6

Most of the respondents (between 26 and 78%) *did not know* how to answer these six questions pertaining to a description of what AIDS is. Of the respondents, 73% acknowledged that AIDS is a disease that kills, but only 17% indicated that it is a disease caused by a virus that affects the immune system, while 43% indicated that it is a condition which makes a person more susceptible to other infections. Other responses were that it is a disease which causes major weight loss (59%), that it is a disease which causes shame (48%), and that it is a terminal disease (33%).

AIDS is the consequence of HIV infection and is a major cause of death all over the world; it is thus alarming that the respondents have such a poor knowledge of what AIDS is and what the consequences are. It is also evident that there is still a strong stigma attached to having AIDS.

4.3.3.5 Concern about AIDS

HIV infection and the subsequent development of AIDS is perturbing due to its rapid spread as it is a transmissible disease, transmitted mainly through sexual contact, and causes an immunological deficiency, making the body susceptible to opportunistic infections.

AIDS is a major concern all over the world as there is to date no specific vaccine or medication to combat the disease, except for anti-retrovirals which do not kill the virus, but only reduce an increase of the virus. In Africa, where there are still groups of people that do not receive antiretrovirals, children infected with the virus and left orphaned by the loss of their parents are a common occurrence, with many social implications.

Table 4.10 Reasons for the worldwide concern about AIDS (n=100)

THE IMPACT OF AIDS	YES	NO	DON'T KNOW
Affects adults, youngsters and innocent children	71	8	21
Children often become orphans	75	7	18
Deprives children of their childhood	72	9	19
The poor suffer more with the consequences of the disease	55	27	18
Leads to poverty due to loss of work	67	12	21
Destroys families	53	20	26
Isolates people suffering from the disease	55	19	25
Causes pain, debility and death	83	6	11
Has no vaccine or cure	77	8	14
Other	21	7	72

As can be seen from table 4.10, the respondents seem to be fairly well informed about the impact of AIDS on the individual and the family. Even though approximately a fifth of the respondents (between 11 and 26%) *did not know* whether the given statements were true or not, 50 to 83% positively identified the implications, such as that AIDS causes pain, debility and death (83%), it has no vaccine or cure (77%), children often become orphans (75%), it deprives children of their childhood (72%) and isolates people suffering from the disease (55%).

4.3.3.6 Preventing infection with HIV

As HIV/AIDS is such a serious condition once acquired, the respondents were requested to indicate which of the actions listed in table 4.11 could be applied to prevent their being infected with HIV.

Table 4.11 Actions that may prevent infection by HIV (n=100)

PREVENT BEING INFECTED BY HIV	YES	NO	DON'T KNOW
By being faithful to one sexual partner	88	6	6
The man must always use a condom during inter course	39	47	14
One must not share injection needles, syringes, cutting objects, used materials	80	6	14
Use only safe blood transfusions	75	6	19
Do not kiss in the mouth	12	64	24
Sexual abstinence	8	76	16
Not to socialise at home with a person who is HIV positive	14	72	14
Not to eat with an AIDS patient	21	64	25
The woman to use a diaphragm during intercourse	58	16	26
Not to touch an HIV positive person	15	67	18
Other	14	79	7

In general the respondents appeared to be fairly well informed about most of the listed actions. The major concern is the fact that only 39% of the respondents were of the opinion that the man should always use a condom during intercourse. There were again about 20% (14 to 26%) of the respondents who responded to eight of the actions by indicating a *don't know*, thus creating the impression, as with previous aspects, that there is a considerable measure of naiveté about the topic.

4.3.3.7 HIV transmission from mother to child

A frequent way of transmitting HIV is from mother to child during pregnancy, the labour process and breastfeeding, resulting in infants being HIV positive. The respondents were asked to identify from the possible ways listed in table 4.12 those which they viewed as relevant to the transmission of HIV from mother to child.

Table 4.12 Transmission of HIV from mother to child (n=100)

TRANSMISSION OF HIV FROM MOTHER TO CHILD	YES	NO	DON'T KNOW
During pregnancy by means of her blood or secretions	49	5	46
During the labour process	24	5	71
During breastfeeding	27	10	63
By fondling her child	5	46	49
Other	14	66	20

From table 4.12 it is clear that a large proportion of the respondents were not knowledgeable in this regard. Between 46 and 71% of them *did not know* whether the statements were true or false. The three known pathways of transmission were positively identified by fewer than half of the respondents, namely during pregnancy by means of blood and secretions (49%), during breastfeeding (27%) and during the labour process (24%).

4.3.3.8 Factors increasing the risk of HIV transmission

The knowledge of respondents on the predisposing factors enhancing the transmission of HIV was tested by asking them to agree or not agree on a number of aspects listed in table 4.13.

Table 4.13 Knowledge about the factors that increase the risk of HIV transmission (n=100)

RISK FACTORS	YES	NO	DON'T KNOW
Anal sex	54	6	40
French kissing	29	48	23
Blood transfusion	85	4	11
Contaminated needles or blades	88	1	11
A curse	36	49	15
Open wound	60	15	25
Insect bites	48	28	24
Bodily secretions from an infected person	65	15	20
Contact with the blood or secretions of an infected person	63	21	16
Rape	85	1	14
Other	7	8	85

Even though on average a third (11 to 40%) of the respondents indicated a *don't know* response to the listed factors, more than half of the respondents identified appropriate risk factors such as contaminated needles and blades (88%), rape (85%), blood transfusion (85%), contact with bodily secretions from an infected person (63%), and an open wound (60%). French kissing was considered by 48% of the respondents as not being a risk factor, while 36% were of the opinion that a curse was also a risk factor.

4.3.3.9 Physical appearance of full-blown AIDS

The respondents were requested to select the sign and symptoms of an HIV-infected person with full-blown AIDS.

Table 4.14 Signs and symptoms of a person with full-blown AIDS (n=100)

PHYSICAL APPEARANCE	YES	NO	DON'T KNOW
The person appears healthy	48	24	28
The person is thin and underweight	77	3	20
The person appears sad and isolated	56	11	33
The person is tired and weak	55	7	38
The person is unable to physically care for him/herself	33	13	54
The person may have fever and infections	57	5	38
The person becomes inactive	47	9	44
Other	21	68	11

Apart from the large component (20-54%) of uncertain respondents who responded with a *don't know*, it is evident from table 4.14 that the respondents were reasonably knowledgeable about the signs and symptoms of a very ill patient with full blown AIDS. Of the respondents, 77% indicated that the person is thin and underweight, the person

may have fever and infections (57%), the person appears sad and isolated (56%) and the person is tired and weak (55%). Just under half (48%) of the respondents, however, indicated that the person appears healthy, which is a misconception.

4.3.3.10 Cure for HIV/AIDS

The respondents were asked to indicate whether they thought there was a cure for HIV/AIDS; refer to figure 4.

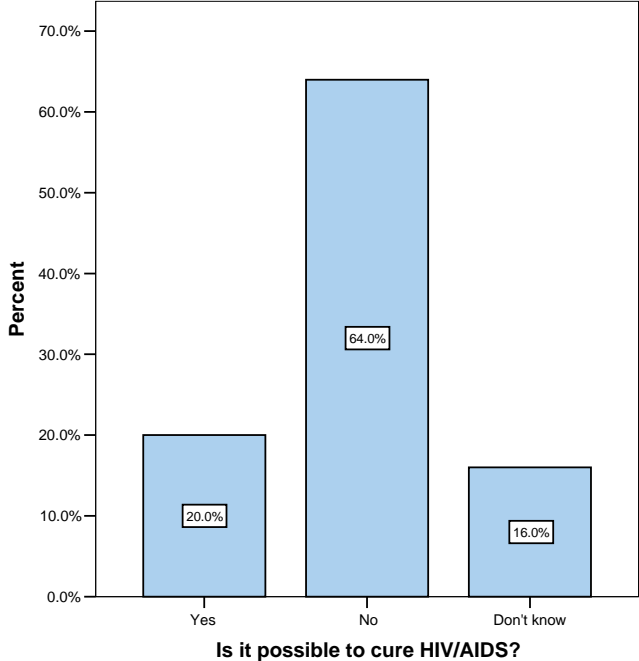


Figure 4.8
Respondents' opinion with regard to a cure for HIV/AIDS (n=100)

From the results in figure 4.8 it is evident that the majority (64%) of respondents indicated that HIV/AIDS cannot be cured, while 20% are of the opinion that there is a cure and 16% indicated *not knowing*.

4.3.3.11 Risk of being infected with HIV without knowing

It is not common practice for the general public to have themselves tested for HIV; it is therefore important to realise that one can be infected without knowing it, as the window period before becoming ill may be a number of years. The respondents were asked to indicate whether one can be infected with HIV without knowing it. Their responses are illustrated in figure 4.9.

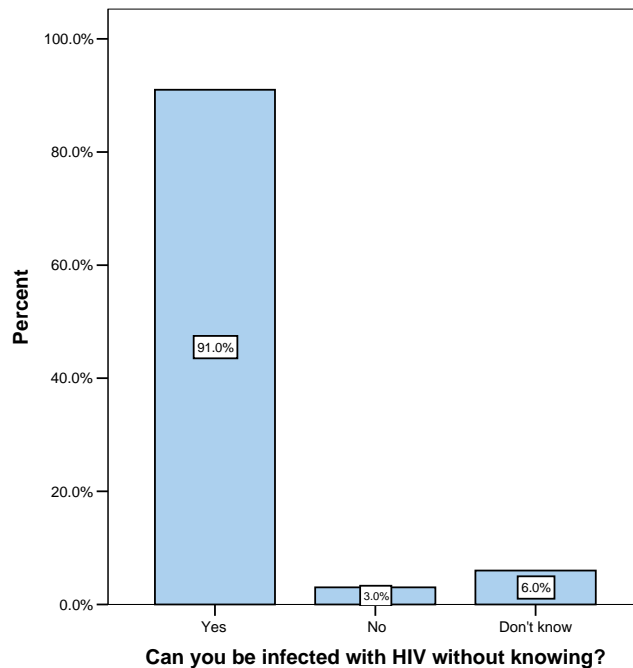


Figure 4.9
Infection with HIV without knowing it (n=100)

The greater majority (90%) of the respondents confirmed that it was indeed possible to be infected without knowing it. A reason given by more than half (56%) of the respondents for becoming infected was the unacceptable behaviour of their partners (husband, boyfriend, a stranger or friend) who might have been positive without knowing or were aware of their positive HIV status and refrained from informing their partners.

4.3.3.12 Precautions to take when living with a person with HIV/AIDS

Beliefs and attitudes with regard to HIV depend on the cognitive understanding of individuals pertaining to the virus, its transmission, predisposing factors and other

related information. The person who has a basic knowledge about the causes and consequences of HIV/AIDS is less likely to spread incorrect information about this disease. The respondents were asked to indicate which precautions should be taken when living with a person with HIV/AIDS in order to prevent infecting other members of the household.

Table 4.15 Precautions to be taken when living with a person with HIV/AIDS (n=100)

PRECAUTIONS	YES	NO	DON'T KNOW
Safe sexual practices (e.g. using a condom)	74	12	14
Avoid contact with the person's bodily fluid	78	1	21
Wash clothes wearing rubber gloves and a disinfectant	49	9	42
Avoid using the same personal objects (e.g. brush or comb)	79	4	17
Do not bath in the same bath tub	58	22	20
Do not use the same cutlery, and eating utensils	43	38	19
Refrain from using the infected person's clothes	56	27	17
Do not share the infected person's bed	46	35	18
Do not use the same toilet as the infected person	40	42	18
Wear rubber gloves when treating bleeding wounds	68	8	24
Other	27	8	65

Table 4.15 indicates that once again quite a number of respondents (14 to 42%) *did not know* whether the statements were correct or not. Other than that, most of the respondents responded positively to all the statements, showing a measure of ignorance about the ways HIV transmission can take place, for instance using the same personal objects such as brush or comb (79%), bathing in the same tub (58%), using the infected person's clothes (56%) or using the same cutlery and eating utensils. Their positive responses to avoiding contact with the person's bodily fluids (78%) and using safe sexual practices (74%) were appropriate.

4.3.3.13 HIV tested

By being HIV tested one is aware of one's status and can act accordingly in terms of behaviour, treatment and counselling. The respondents were asked to indicate if they had been tested for HIV. Refer to figure 4.10 for the outcome.

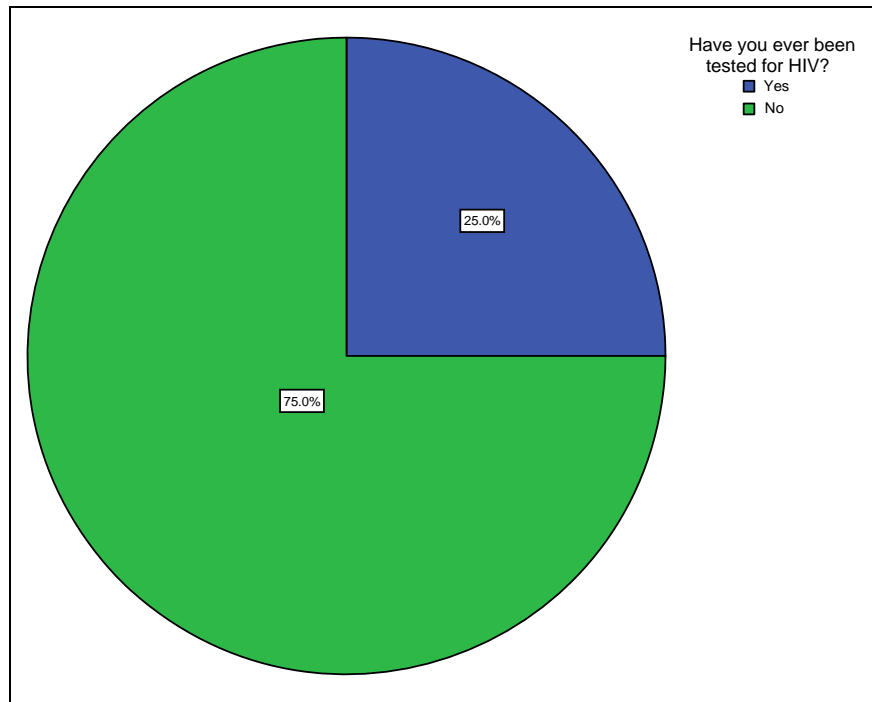


Figure 4.10
Respondents' HIV testing (n=100)

Only a quarter (25%) of the respondents had been tested for HIV. In the open question requiring them to explain why they had been tested, their responses contained the following: as a matter of routine at the health centres due to their being pregnant (12%); owing to regulations at the hospitals before being attended to as an out-patient (9%), required by doctors at the Paediatric Hospital in Luanda (3%) to compare with the analysis done on their children who were admitted.

Pregnancy constitutes the main reason for HIV testing, as is also stated in the study carried out by Canavarro and Pereira in 2000–2006 (2007:4-5), which found that 54% of women become aware of being HIV infected during their antenatal and labour periods. Identifying HIV-positive women before or during the pregnancy is vital so that the woman and the child can undergo treatment to prevent pre-natal transmission. The early identification of infected women is crucial for the health of those women and children.

4.3.3.14 Vertical transmission of HIV

In order to determine the respondents' knowledge about the vertical transmission of HIV, they were asked to consider, if a pregnant mother is HIV-positive, to what degree they thought her newborn baby would be infected with HIV.

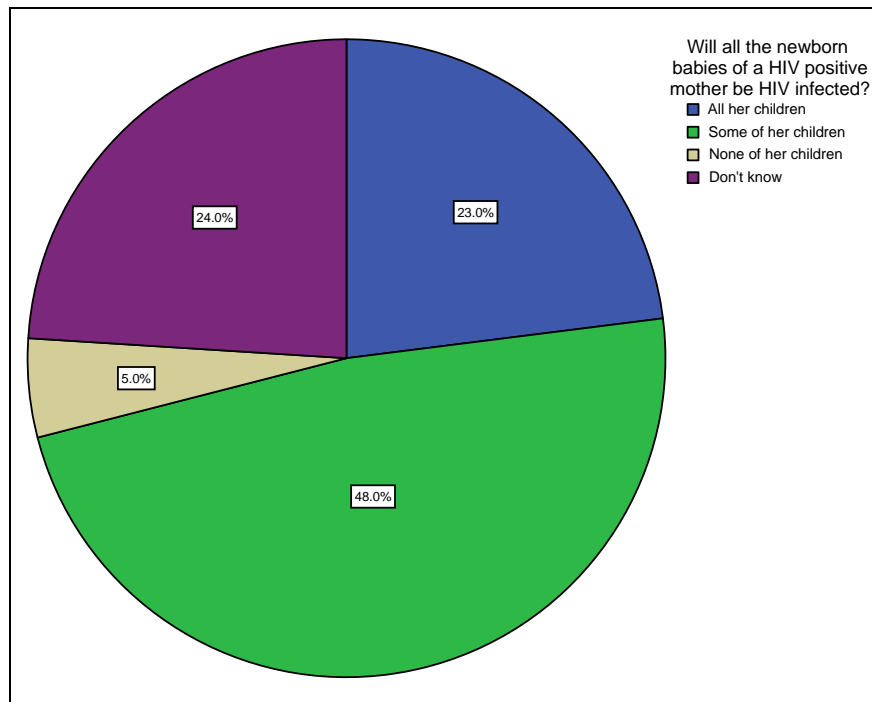


Figure 4.11
Knowledge of vertical transmission of HIV (n=100)

Figure 4.11 presents the results related to the transmission of HIV from mother to child. Forty eight percent of the respondents noted that *some* of her children would be infected, 23% indicated *all* her children, and 5% felt that none of the children would be infected by the mother. Almost a quarter (24%) of the respondents indicated that they *did not know* the answer to the question.

4.3.3.15 Prevention of HIV transmission from mother to child

The respondents were required to indicate which of the given statements could be applied to prevent the transmission of HIV from mother to child.

Table 4.16 The prevention of HIV transmission from mother to child (n=100)

PREVENTION	YES	NO	DON'T KNOW
Use of antiretroviral medication before the birth of the baby	18	1	81
Avoid breastfeeding	20	6	74
Not to have sexual intercourse during pregnancy	13	21	66
Do not do anything and wait for the baby to be born	7	16	75
Use ARV (Antiretroviral medication) while breastfeeding	11	4	85
Other	19	63	17

According to table 4.16, the respondents were mostly at a loss to know what should be done in terms of preventing the vertical transmission of HIV from mother to child, as 66 to 81% indicated that they *did not know* whether the given statements were appropriate or not. Twenty percent of the respondents indicated that breast feeding should be avoided and 18% recommended the use of antiretroviral medication before the birth of the baby. It is thus clear that most respondents did not know how vertical transmission could be prevented.

4.4 CONCLUSION

In this chapter the data was analysed and interpreted in accordance with the three sections of the questionnaire, namely, biographical data, obstetric history and knowledge about sexually transmitted diseases. The latter section was aimed at identifying the respondents' knowledge about the causes and consequences of HIV/AIDS. In their responses to most of the questions a large number of respondents indicated that they did not know what the appropriate answer was, thus giving the impression that they do not have sufficient knowledge on the topic. In the next chapter the results, conclusions and recommendations will be discussed.

Chapter 5

Results, conclusions and recommendations

5.1 INTRODUCTION

Owing to the devastating impact of the HIV/AIDS pandemic worldwide, and especially in the developing countries of Africa, countries such as Angola are forced to review their strategies in terms of taking up comprehensive programmes to deal with the situation. Considering the underdevelopment, poverty and illiteracy of many people in the developing countries, focus is being placed on educational programmes as a means of curbing the spread of HIV infection. With this background, a quantitative, exploratory and descriptive study was undertaken to determine the knowledge of Angolan women about the causes and consequences of HIV/AIDS, with the purpose of developing an information brochure for the general public about the disease and means of reducing the risk of infection.

The objectives, results, conclusions, recommendations and limitations of the study will be presented in this chapter.

5.2 OBJECTIVES

The objectives of the study were to

- determine the level of knowledge and understanding of the Angolan woman about the causes and consequences of HIV infection
- develop an information leaflet about HIV/AIDS with the aim of disseminating information to a vulnerable community

5.3 RESULTS

The results are based on the findings of the data collected from the 100 female respondents who accompanied sick children to a specific paediatric hospital. The results will be discussed in accordance with the three sections of the questionnaire,

which were: biographical information; obstetric history; and knowledge about sexually transmitted infections: (STIs), Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). It must be noted that with most of the questions there was a considerable (approximately 20% or more) number of respondents who did not answer the questions or indicated a *don't know* response, which is indicative of a lack of knowledge about the topic.

5.3.1 Biographical information

The age of most of the respondents varied between 16 and 40 years, which is considered the fertile age for human reproduction. The respondents almost equally represented married (52%) and single (41%) females.

The schooling of respondents appeared to be limited to levels beneath Grade 12, as 28% had completed grades 1-4; 18% grades 5-6; 30% grades 7-9; and 16% completed grades 10-12. Only 3% had higher education qualifications.

As far as religion is concerned, the women were predominantly Catholic (40%), with 20% representing other religions which were not specified and 10% belonging to the Pentecostal faith. Gordon and Ledger (2005:1) note that the church has a crucial role to play in the fight against the spread of HIV. Most (66%) of the respondents were not prohibited by their religion from using contraceptives.

The greater majority (71%) of the respondents worked for a wage/salary, of which most (48%) sold their own produce; there were five (5%) domestic workers and three (3%) teachers amongst the group. The fact that most people have to sell their own produce is a consequence of the lack of employment opportunities in Luanda, which is mainly due to the effects of the war, illiteracy and lack of training.

The women who accompanied the sick child to the specific hospital were mainly (53%) the mother, 22% were aunts and 8% were either a sister or a grandmother. In his study Oliveira (2007:8) points out that “the mother is the closest family member of the sick child, personifying the fulfilment of “maternal love” as we know it today”.

5.3.2 Obstetric history

It was necessary to look at the respondents' obstetric history, in order to assess their behaviour in terms of protecting themselves from possible HIV infection. According to the opinion of UNAIDS (1998), as quoted by Canavarro & Perreira (2000-2006:2), HIV infection during pregnancy is the most common obstetric complication in some developing countries.

Having questioned the respondents on their personal obstetric history, 82% indicated that they had biological children: 17% have had a miscarriage and 10% have had an abortion. As far as the number of children is concerned, 22% of women indicated having one child, 17% had two children, two sets of 12% had four and five children respectively, and one respondent (1%) indicated having eleven children.

The next question was related to the causes of death of their children who had died. Of the 28 children who had died, twelve had died due to unknown and *other* diseases, two of a respiratory condition, eight of fever, three of diarrhoea and three of measles.

With regard to the usage of contraceptives, only 23% indicated that they made use of a condom. Seventeen percent received the injection (progesterone), 15% took note of their fertile period and 8% took the Pill.

5.3.3 Knowledge of sexually transmitted diseases (STIs), Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)

In answer to questions about how sexually transmitted diseases are acquired, the general opinion (83%) was that HIV transmission took place when having sexual intercourse with an infected person, followed by: lack of personal hygiene (63%); using dirty or contaminated water (60%); walking barefoot in the morning (55%); and sexual intercourse during menstruation (43%). Other possible causes recorded were being cursed (30%); witchcraft (30%); sharing washing facilities (28%); and eating utensils (16%) and taking a bath together (24%). It is thus clear that there is a general lack of knowledge as to how HIV can actually be transmitted.

When asked to indicate what a condom is, the majority (91%) of respondents knew that it was a protective rubber covering of the penis and that it was a contraceptive method (48%). Boa Saúde (2007: 1) points out that in order for people to protect themselves and their partners against HIV/AIDS, they must have the necessary knowledge about the available protective methods.

In questions determining the knowledge of the respondents about HIV, the majority (between 63% and 78%) *did not know* the answers to the different statements. Only 25% indicated that it was a disease, and 13% knew that it was caused by a virus.

As far as AIDS is concerned, a large number (between 40 and 78%) of the respondents *did not know* whether the given statements were correct. The greater majority (73%) of the respondents did acknowledge that it was a disease that kills, that it is a disease which causes major weight loss (59%), and shame (48%), and that it makes one susceptible to other infections (43%). However, 58% did not know that it was a terminal disease.

With regard to the reason why AIDS is such a concern at world level, the majority of respondents acknowledged the negative impact of AIDS in all the listed aspects. For instance, 83% of the respondents indicated that it causes pain, debility and death, it has no vaccine or cure (77%), 75% indicated that children often become orphaned, that it deprives children of their childhood (72%), affects adults, youngsters and children (71%), and that it leads to poverty due to work loss (67%).

In order to ascertain whether the respondents knew how one can prevent oneself being infected with HIV, the following were noted: 88% accentuated being faithful to one sexual partner; 80% that one should not share injection needles, syringes or cutting objects. Safe blood transfusions were marked by 75%; that women should use a diaphragm during intercourse by 58%, but only 39% indicated that the man should always use a condom during intercourse.

With regard to the transmission of the HIV from mother to child, almost half of the respondents were uncertain and *did not know* how to respond to the listed statements. However, 49% indicated that it can be transmitted during pregnancy by means of the

mother's blood or secretions; and during breastfeeding 27%. Yet 71% indicated that they did not know whether it could be transmitted during the labour process.

When questioned about the factors that increase the risk of HIV transmission, the respondents seemed to be reasonably well informed. The following were identified as risk factors: contaminated needles and blades (88%), blood transfusions (85%), rape (85%), bodily secretions from an infected person (65%), open wounds (60%) and anal sex (54%). Yet 48% were misinformed about insect bites being a risk factor.

Regarding the physical appearance of a person infected with HIV who has full-blown AIDS, a substantial number (between 28 and 54%) of respondents did not know if the given variables were correct or not. Three quarters (77%) of the respondents indicated that the person is thin and underweight; may have fever and infections (57%); may appear isolated (56%); is tired and weak (55%); may become inactive (47%). However, 48% noted that the person appears healthy.

Twenty percent of the respondents indicated that it is possible to cure HIV/AIDS; 64% indicated this was not the case and 16% *did not know*. By far the greater majority (91%) of the respondents indicated that one can become infected without knowing it. In this regard, more than half of respondents (56%) indicated the negative behaviour of partners who do not have the courage to inform their female partners of the fact that they are HIV positive.

As regards the precautions to be followed when living with an HIV/AIDS positive person, 79% of the respondents advised avoiding using the same personal objects such as brush or comb. Avoiding contact with the person's bodily fluids was marked by 78%; adhering to safe sexual practices 74%; wearing rubber gloves when treating wounds 68%; not bathing in the same tub 58%; refraining from using the infected person's clothes, and washing clothes wearing rubber gloves and a disinfectant 49%.

The majority (75%) of the respondents had not been tested for the HIV. Those that had undergone the test did so for the following reasons: during antenatal pregnancy consultations, and according to hospital regulations where children were treated.

As far as the level of knowledge regarding the vertical transmission of the HIV from a HIV positive mother to child is concerned, 48% of the respondents indicated that *some* children will be infected, 23% indicated that *all* the children will be infected and 24 *did not* know what the rate would be.

As to means of preventing the transmission of HIV from the infected mother to the child, the respondents did not know whether the listed actions were relevant or not and showed a striking lack of knowledge on this topic. Only 20% noted that breastfeeding should be avoided, 18% indicated the use of antiretroviral medication before the birth of the baby, while 13% noted not having sexual intercourse during pregnancy.

5.4 CONCLUSIONS

The following general conclusions are drawn from the preceding results. In view of the fact that in most instances there was a substantial number of respondents who did not know what the correct response to the statements was, it can be deduced that there was a general lack of knowledge and understanding of the issues under question amongst this group of women.

5.4.1 Biographical information

- Most of the respondents had only basic schooling covering grades 1 to 9, which suggests a problem with literacy.
- The majority of respondents claimed to belong to the Catholic religion. Most of the respondents indicated that they were not prohibited by their religion from making use of contraceptives, although it is a known fact that the Catholic church does not approve of contraception.
- The majority of women worked for wages or a salary and it must also be pointed out that the majority sold their own products.
- Most of the respondents accompanying the sick children to the hospital were either their mothers or aunts.

5.4.2 Obstetric history

- The majority of respondents indicated having biological children, almost a third indicated having had either a miscarriage, abortion or stillbirth. The common number of children per respondent varied between one and five children.
- As a means of contraception, only a fifth of the respondents used a condom, and fewer used the progesterone injection and a fertility chart.

5.4.3 Knowledge of STIs, HIV and AIDS

- Having sexual intercourse with an HIV-infected person was noted as the main reason for becoming infected, followed by lack of hygiene and using dirty and contaminated water. There are thus serious misconceptions about how the virus can be transmitted.
- Most respondents knew that a condom is a physical protective method of covering the penis which is used as a contraceptive.
- A serious lack of knowledge was exhibited as to what HIV and AIDS are, although it was evident that AIDS is a disease which brings shame. However, the respondents were able to fairly strongly indicate the effects of AIDS on the sufferer and his or her family.
- As to the means through which infection by HIV can be prevented, it was noted that being faithful to one sexual partner, not sharing injection needles, syringes and so forth, and the woman wearing a diaphragm would help prevent infection. Fewer than half the respondents, however, noted the wearing of a condom as protection.
- The respondents' knowledge about the ways in which a mother transmits the virus to her baby is poor, as fewer than half indicated it could be transmitted by means of her blood and secretions; even fewer indicated breastfeeding and the labour process as ways of transmission.

- Risk factors for transmitting HIV were fairly well identified as being contaminated needles and syringes, rape, blood transfusion, bodily secretions, open wounds and anal sex.
- With regard to the physical appearance of a person with full-blown AIDS, a great measure of uncertainty existed. Respondents did, however, indicate that the person is thin and underweight, may have fever and infections, seems isolated and becomes inactive.
- Two-thirds of the respondents knew that it was not possible to cure HIV/AIDS and that it was possible to become infected without knowing it.
- With regard to the precautions to be taken when living with an HIV/AIDS person, three-quarters of the respondents noted that safe sexual practices and avoiding bodily secretions of the infected person were essential. Other than this, there were many incorrect assumptions.
- Only a quarter of the respondents had been tested for HIV, and these were for reasons such as antenatal follow up, and hospital regulations where their children were treated.
- The respondents were uncertain about the degree to which the children of an HIV positive mother could be infected at birth, and they were largely uninformed about means of preventing the transmission of the virus from mother to child.

5.5 RECOMMENDATIONS

Angola, classified as a developing country within the African context, must enhance its efforts to confront HIV/AIDS with a view to reducing the incidence rates of this pandemic. Having determined the knowledge and understanding of 100 Angolan women who accompanied a sick child to a specific hospital in Luanda with regard to the causes and consequences of HIV/AIDS, the following recommendations are made to try to address some of the knowledge deficits identified during this study.

The focus should be on the promotion of effective preventative measures supported by informative educational communication aimed at combating the spread of HIV/AIDS.

- Different means and situations can be utilised to disseminate information and health education on HIV/AIDS. The assistance and support of the national directorate tasked with combating HIV/AIDS, and NGOs and other volunteers would be required to enable the processes. Such opportunities could be:
 - Making use of the occasion when relatives and/or friends accompany children and other people to hospitals or clinics as an opportunity to provide health education in the waiting areas. The relatives and friends could sit in a room listening to messages or watching videos on HIV/AIDS. This will require support from different role-players such as hospital management, the national directorate tasked with combating HIV/AIDS, and NGOs and other volunteers, to access the necessary equipment and technology. The presentations should be diversified and enriched with songs and plays to make them more attractive.
 - Systematic distribution of pamphlets on HIV/AIDS in hospital wards and emergency units to patients, relatives and friends, in the relevant languages pertaining to the specific region. These pamphlets should also be distributed to households in a systematic way by trained HIV/AIDS advisors.
 - Encouraging the media (radio, television, newspapers), as social communication mechanisms, to report on and inform people about the disease and allow interactive communication on the topic. It is, however, important that they use a language that is understandable for all, because of the high rates of illiteracy in the country.
 - The role-players, in combating the spread of HIV/AIDS, should take the initiative in promoting talks, debates and theatre plays at public places such as squares, stadiums, markets, schools and movie theatres, and arranging campaigns and rallies led by high-level political leaders in public places such as stadiums and movie theatres.
 - The Organization for Angolan Woman (Organização da Mulher Angolana - OMA) should be encouraged, within the scope of its competence, to make

women in general aware of the dangers of HIV/AIDS and the means of protection against being infected.

- The extent of the content that should be dealt with in the different media: posters, pamphlets, talks, videos, songs, discussions and so forth, will be determined by the specific medium. However, important aspects that should be dealt in as much detail and frequency as possible are the following:
 - What is HIV/AIDS
 - Causes of the HIV infection
 - Preventative measures for males, females, the foetus and young babies
 - Vertical transmission of HIV
 - Safe sexual practices
 - Honouring relationships
 - Behavioural changes
 - Living with a person with HIV/AIDS
 - Treatment possibilities and methods
 - Importance of a balanced diet
 - Resources available for assistance in any stage of the infection or disease
- Within three months after completion of this study the researcher will submit proposals to the Ministry of Health and to the WHO Angola Office for posters aimed at informing the public about the causes and consequences of HIV/AIDS for their approval, with the intention of distributing nationally if approved.

5.6 RECOMMENDATIONS FOR ADDITIONAL RESEARCH

Further related research on the following topics is suggested, which could contribute to a better understanding of HIV and the care of AIDS patients:

- Dealing with the stigma of being HIV positive
- Caring for patients with AIDS through home-based care

5.7 LIMITATIONS OF THE STUDY

A number of limitations affected the outcomes of this study.

The fact that this study was done by means of distance education and not campus-based tuition made contact with the supervisors difficult. A further, more distressing, factor was the language problem and the fact that all communication, verbal and written, and feedback on work submitted had to be done by means of a translator. This sometimes caused confusion and delayed feedback and response times.

Amongst the limitations encountered in the collection of data was the uncooperative attitude of some women who refused to take part in the interview, without giving a reason. There were also cases of sudden interruptions of the interview (in the case of four women) owing to the prescribed times for giving their children medication or their need to replace someone from the family who was taking the child to the ward.

Another limitation was the fact that the questionnaires were not comprehensively completed, with many variables being ignored by a large number of the respondents; this made the interpretation of data difficult and leaves the impression that the true analysis of data might not have been done adequately in all instances.

5.8 CONCLUSION

This study focused on determining the knowledge and understanding of Angolan women pertaining to the causes and consequences of HIV/AIDS, with the aim of developing an information leaflet about HIV/AIDS for disseminating information to the vulnerable community. A quantitative approach was applied, using an exploratory and descriptive design, utilising a self-developed questionnaire to collect the data from 100 females who accompanied sick children to a specific hospital in Luanda.

The findings indicated that even though the respondents were aware of certain key issues in the transmission and consequences of the HIV infection, there were many areas in which a great measure of uncertainty existed, such as the causes of the disease, prevention methods, risk factors and precautions to take when living with an HIV positive person. Recommendations were made with the aim of improving the

distribution of information regarding the causes and consequences of HIV and AIDS by means of different structures.

The second objective of this study stated that an information leaflet would be developed. The outcome of this study has led to a slight revision of this objective, in the sense that the important information for dissemination has been identified and listed under the recommendations, and that the researcher will develop, instead of an information leaflet, a set of posters in accordance with the required content to inform the public in a universally acceptable manner.

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[Logo]

**REPUBLIC OF ANGOLA
South African UNIVERSITY
Higher Institute for Nursing**

Your Excellency
THE VICE-MINISTER OF HEALTH
Dr. Natália do Espírito Santo

LUANDA
22.06.2006

RE: Request to carry out research

Our most respectful greetings.

It is herewith requested your permission to conduct research at the Paediatric Hospital for purposes of a dissertation on the topic Level of Knowledge of the Angolan Woman on the causes and effects of the HIV and AIDS.

I am presently registered at the University of South Africa where I am completing my Master's degree on Health Sciences. The research project is part of the requirements to complete the referred Master's degree.

My research proposal has already been approved by the Department of Health Studies at the University of South Africa.

The aim of the research project is to collect data from one hundred (100) women who accompany sick children (admitted or not) to the Josina Machel Hospital. It is therefore necessary for the researcher to collect the data necessary for the for the research. We therefore request authorization from Your Excellency to distribute the above mentioned questionnaire to potential participants in the research.

The researcher undertakes to rigorously adhere to all ethical considerations and measures in conducting the research so as to prevent any potential damage and in order to protect the confidentiality of participants.

Annexed please find a copy of the research proposal as well as the questionnaire to be used during the research.

I would be very grateful if Your Excellency would grant me your cooperation and support in this regard, by grant me permission to conduct the research during the month of July this year.

Yours truly,

The Master's Student
Signed)
Luzizila Helena Panda

Signed) Illegible
03-07-06

[Logo]

**REPUBLIC OF ANGOLA
MINISTRY OF HEALTH
OFFICE OF THE VICE-MINISTER**

Attention:
Mrs. Luzizila Helena Panda

Luanda

OFFICIAL LETTER NO. 450/GVM^a/N^a/MS/06

RE: Authorization to carry out research

Our most cordial greetings.

Her Excellency the Vice-Minister of Health for the Hospital Sector, **Dr. Natália do Espírito Santo**, has entrusted me with the task of informing you of the official order re your letter dated 22/06/06, on the above mentioned issue, and which reads as follows:

Urgent

Dr. Luzizila must work with the Health Units which will be involved in the research, through their Directors General, to obtain the required authorization so as to enable her to collect the data required for the research. I value her willingness to complete her masters' degree.

Signed) Dr. Natália do Espírito Santo
Vice-Minister
03/07/06

Yours truly,

OFFICE OF THE VICE-MINISTER OF HEALTH FOR THE HOSPITAL SECTOR, IN
LUANDA, ON 4 JULY 2006.

THE HEAD OF THE MINISTER'S OFFICE
Signed) Illegible
MARCELINA MARIA GREGÓRIO DA SILVA

Signed)
Illegible
21.07.06

Conferred:
The Director
Luis Bernardino Hospital
Paediatrics

Opinion with regards to the request to collect data for the research "Level of knowledge of the Angolan Woman on the causes and effects of HIV and AIDS" as a requirement to obtain the master's degree, as submitted by Luzizila Helena Panda.

The opinion of the Pedagogic Committee is that it requires the following aspects to be clarified:

- type of research: qualitative or quantitative and in case of the last one, the plan for the study.
- Characteristics of the target population, i.e., specific group of children to whose mothers the questionnaire will be applied.

Additional aspects about the research, namely the format of the questionnaire and how it will be implemented, an explanation of how the collection of data will be conducted and especially the details with regards to the subsidies which will surely result from the research will be to be pointed out.

From the above it is the understanding of this committee that the candidate must submit a version, even in summarized form, of the research as well as the form for the collection of data, without prejudice of having to submit a request to the ethics and research committee of the David Bernardino Paediatric Hospital, together with the research project, the form (questionnaire) and the free and informed consent form.

Luanda, 19 July 2006

The Pedagogical Director
Signed) *Illegible*
Francisco Domingos
Paediatrics

Consent to Partake in Research

I, the undersigned,
herewith agree to:

- partake in the research on the (topic)
Level of Knowledge of the Angolan woman on the causes and effects of HIV and AIDS;
- fill in the relevant questionnaire
- authorize the researcher, to use, at her discretion, the data that I have provided in the questionnaire, for purposes of writing the researcher's report on the research that was carried out.

Furthermore I also state that it is my understanding that

- I may, at any time, discontinue my involvement in this research or withdraw my consent to partake in this research;
- the information that I have provided until such time as I withdraw my participation in this research can, however, still be used by the researcher;
- the researcher will, at all times, maintain strict confidentiality and that the identity of the participant will never be linked to the information provided;
- I will not receive any financial reward or payment for the information herewith provided or for my involvement in this project;
- I have the option to refuse to answer (any) question(s) should I feel that this/these question(s) constitute a violation of my own privacy;
- when signing this consent form to partake in the research I undertake to answer in an honest manner to all reasonable questions and not to provide any false information or in any other way purposely mislead the researcher
- I will be provided with a signed original copy of this consent form

I herewith declare that the researcher

- has explained to me the objective of this research
- has informed and explained to me the content of this consent to partake in the research
- has elucidated me on the implications of signing this consent to partake in the research

By co-signing this consent to partake in the research, the researcher undertakes to

- maintain confidential and private the identity of the participant and the information provided in the research
- organized, beforehand, an appropriate venue and time for me to partake in this project
- to keep in a safe place the duplicate of this consent to partake in the research

Signed in LUANDA on 04 AUGUST 2006.

.....
PARTICIPANT'S Signature

Signed) illegible
RESEARCHER'S Signature

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QUESTIONNAIRE FOR VERIFYING THE KNOWLEDGE OF ANGOLAN WOMAN ABOUT THE CAUSES AND CONSEQUENCES OF HIV AND AIDS

PART 1 BIOGRAPHIC INFORMATION

1. Please indicate your age group

For office use

Your age in years	Answer
1.1 10 - 15 years	1
1.2 16 - 20 years	2
1.3 21 - 25 years	3
1.4 26 - 30 years	4
1.5 31 - 35 years	5
1.6 36 - 40 years	6
1.7 41 - 45 years	7
1.8 46 - 50 years	8
1.9 51 - 55 years	9
1.10 56 - 60 years	10
1.11 61 years and older-	11

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2. What is your marital status?

Marital status	Answer
2.1 Single	1
2.2 Married	2
2.3 Separated	3
2.4 Divorced	4

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3. What is your level of schooling?

Completed level of schooling	Answer
3.1 Grade 1 to 4	1
3.2 Grade 5 to 6	2
3.3 Grade 7 to 9	3
3.4 Grade 10 to 12	4
3.5 Higher education	5
3.6 Other, please specify	6

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4. Please indicate your religion.

To which religion do you belong?	Answer
4.1 Pentecostal Assembly of God	1
4.2 Catholic	2
4.3 Spiritist	3
4.4 Salvation Army	4
4.5 IFEPAA – Bom Deus	5
4.6 Muslim	6
4.7 Methodist	7
4.8 Protestant	8
4.9 Seventh Day Adventists	9
4.10 Universal	10
4.11 Other, please specify	11

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5. Does your religion prevent you from using a contraceptive?

Does your religion prevent you to use contraceptives?	Answer
5.1 Yes	1
5.2 No	2

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6. If your answer in question 5 was YES, then please explain how your religion prevents you from using a contraceptive.

7. Are you working for a salary/ wage?

Do you have a job that you get paid for?	Answer
7.1 Yes	1
7.2 No	2

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8. If your answer in question 7 was YES, then select from the following list the job(s) you are currently being paid for.

Type of work you are being paid for?	Answer			
	YES	NO		
8.1 Teacher	1	2		10
8.2 Nurse	1	2		11
8.3 Saleslady in a shop	1	2		12
8.4 You sell your own produce	1	2		13
8.5 Clerk in for instance, the post office/government office	1	2		14
8.6 Domestic/house worker	1	2		15
8.7 Administrative officer	1	2		16
8.8 Prostitution	1	2		17
8.9 You take care of children for instance, day care or crèche	1	2		18
8.10 Executive or manager of a company	1	2		19
8.11 Other, please specify	1	2		20
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9. What is your relationship to the child you are accompanying to the hospital today? Please mark the appropriate relationship with an X.

Type of relationship with the child patient?	Answer		
9.1 Mother	1		
9.2 Sister	2		
9.3 Grandmother	3		
9.4 Aunt	4		
9.5 Niece	5		
9.6 Friend of the family	6		
9.7 Concerned neighbour	7		
9.8 Unrelated community member	8		
9.9 Health care worker	9		
9.10 Guardian	10		
9.11 Other, please specify	11		21
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SECTION 2 OBSTETRIC HISTORY

10. What is your pregnancy history? Please indicate a YES or NO for each of the following questions.

Your pregnancy history?	Answer	
	YES	NO
10.1 Are you currently pregnant?	1	2
10.2 Do you have biological children?	1	2
10.3 Have you ever had an abortion?	1	2
10.4 Have you ever been pregnant?	1	2
10.5 Have you had a miscarriage?	1	2
10.6 Were any of your babies stillborn?	1	2

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11. If you have biological children, please select the total number you had, and indicate alongside in the next column (Children still alive?) how many are still alive.

Your number of biological children?	Children still alive?
11.1 1	
11.2 2	
11.3 3	
11.4 4	
11.5 5	
11.6 6	
11.7 7	
11.8 8	
11.9 9	
11.10 10	
11.11 11 and more, please specify the number	

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12. If you had the misfortune of losing children due to death, please indicate the cause of death for each of your deceased children.

Cause of death for your deceased children?	Answer	
	Number of child deaths per disease/cause	
12.1 Fever	1	41
12.2 Diarrhoea	2	42
12.3 Measles	3	43
12.4 Chicken pox	4	44
12.5 Polio	5	45
12.6 Diphtheria	6	46
12.7 Whooping-cough	7	47
12.8 Pneumonia or other respiratory conditions	8	48
12.9 Inhalation of foreign object or matter causing suffocation	9	49
12.10 HIV/AIDS	10	50
12.11 Insect or snake bites	11	51
12.12 Trauma or accidents	12	52
12.13 Burns	13	53
12.14 Hunger	14	54
12.15 Intake of poison (such as paraffin)	15	55
12.16 Unknown cause	16	56
12.17 Other, please specify	16	57
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13. Do you or your partner use any type of contraceptive during sexual intercourse? Please indicate a YES or NO for each of the following options.

Type of contraceptive you and or your partner uses?	Answer		
	YES	NO	
13.1 Condom	1	2	58
13.2 Diaphragm	1	2	59
13.3 Pill	1	2	60
13.4 Coitus interruptus	1	2	61
13.5 Intra uterine device (IUD)	1	2	62
13.6 Chart for fertile period in menstrual cycle	1	2	63
13.7 The injection (3 Monthly progesterone)	1	2	64
13.8 Other, please specify	1	2	65
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SECTION 3 KNOWLEDGE ABOUT STI (Sexually transmitted infections), HIV (Human Immune Virus) and AIDS (Acquired Immune Deficiency Syndrome)

14. How are sexually transmissible infections acquired?

Transmission of sexual diseases can take place by	Answer		
	YES	NO	
14.1 Taking a bath	1	2	66
14.2 Using dirty or contaminated water	1	2	67
14.3 Walking barefoot in the mornings	1	2	68
14.4 Sharing the eating and kitchen utensils with an infected person	1	2	69
14.5 Sharing the washing facilities with an infected person	1	2	70
14.6 Sexual intercourse with an infected person	1	2	71
14.7 Having sexual intercourse during menstruation	1	2	72
14.8 Being cursed	1	2	73
14.9 Witchcraft	1	2	74
14.10 Lack of personal hygiene	1	2	75
14.11 I don't know	1	2	76
14.12 Other, please specify	1	2	77
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15. According to your view, what is a condom?

A condom is a	Answer		
	YES	NO	
15.1 Tablet	1	2	78
15.2 Instrument for sexual pleasure	1	2	79
15.3 Protective rubber to cover the penis	1	2	80
15.4 I don't know	1	2	81
15.5 Contraceptive method	1	2	82
15.6 Other, please specify	1	2	83
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16. What is HIV?

HIV is a	Answer	
	YES	NO
16.1 Disease	1	2
16.2 Virus	1	2
16.3 Bacteria	1	2
16.4 Microbe	1	2
16.5 Virus which causes AIDS	1	2
16.6 I don't know	1	2
16.7 Other, please specify	1	2

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17. What is AIDS?

AIDS is	Answer	
	YES	NO
17.1 A disease that kills	1	2
17.2 A disease caused by a virus which affects the immune system	1	2
17.3 A terminal disease	1	2
17.4 A disease which causes major weight loss	1	2
17.5 A condition which makes one susceptible to other infections	1	2
17.6 A disease which causes shame	1	2
17.7 I don't know	1	2
17.8 Other, please specify	1	2

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18. Why is the AIDS disease considered such a concern all over the world? Please indicate whether you AGREE or DISAGREE with each of the following statements.

The impact of AIDS?	Answer			
	I AGREE	I DIS-AGREE		
18.1 Affects adults, youngsters and innocent children	1	2		99
18.2 Children often become orphans	1	2		100
18.3 Deprives children of their childhood	1	2		101
18.4 The poor suffer more with the consequences of the disease	1	2		102
18.5 Leads to poverty due to loss of work	1	2		103
18.6 Destroys families	1	2		104
18.7 Isolates people suffering from the disease	1	2		105
18.8 Causes pain, debility and death	1	2		106
18.9 Has no vaccine or cure	1	2		107
18.10 Other, please specify	1	2		108
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19. How can one prevent being infected by HIV? Please answer YES or NO for each of the following statements.

Prevent being infected by HIV?	Answer			
	YES	NO		
19.1 By being faithful to one sexual partner	1	2		109
19.2 The man must always use a condom during intercourse	1	2		110
19.3 One must not share injection needles, syringes, cutting objects, used materials	1	2		111
19.4 Use only safe blood transfusions	1	2		112
19.5 Do not kiss in the mouth	1	2		113
19.6 Sexual abstinence	1	2		114
19.7 Not to socialize at home with a person who is HIV positive	1	2		115
19.8 Not to eat with an AIDS patient	1	2		116
19.9 The woman to use a diaphragm during intercourse	1	2		117
19.10 Not to touch an HIV positive person	1	2		118
19.11 Other, please specify	1	2		119
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20. How does the infected mother transmit the HIV infection to her children? Please answer YES or NO for each of the following statements.

Transmission of HIV infection from mother to child?	Answer			
	YES	NO		
20.1 During pregnancy by means of her blood or secretions	1	2		120
20.2 During the labour process	1	2		121
20.3 During breastfeeding	1	2		122
20.4 By fondling her child	1	2		123
20.5 Other, please specify	1	2		124
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21. Which factors increase the risk of transmission of the disease (HIV/AIDS)? Please indicate whether you AGREE or DISAGREE with each of the following factors.

Risk situation which increases the risk of HIV transmission?	Answer			
	I AGREE	I DIS-AGREE		
21.1 Anal sex	1	2		125
21.2 French kissing	1	2		126
21.3 Blood transfusion	1	2		127
21.4 Contaminated needles or blades	1	2		128
21.5 A curse	1	2		129
21.6 Open wound	1	2		130
21.7 Insect bites	1	2		131
21.8 Bodily secretions from an infected person	1	2		132
21.9 Contact with the blood or secretions of an infected person	1	2		133
21.10 Rape	1	2		134
21.11 Other, please specify	1	2		135
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22. What is the physical appearance of a person infected with HIV who has developed full blown AIDS?

Appearance of AIDS patient/person?	Answer	
	YES	NO
22.1 The person appears healthy	1	2
22.2 The person is thin and underweight	1	2
22.3 The person appears sad and isolated	1	2
22.4 The person is tired an weak	1	2
22.5 The person is unable to physically care for him/herself	1	2
22.6 The person may have fever and infections	1	2
22.7 The person becomes inactive	1	2
22.8 Other, please specify	1	2

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23. Is it possible to cure HIV/AIDS?

Cure for HIV/AIDS?	Answer
23.1 Yes	1
23.2 No	2

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24. Can you be infected with HIV without knowing?

Being infected without knowing?	Answer
24.1 Yes	1
24.2 No	2

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25. Please explain your response to question 24

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26. Which precautions must one take when living with an HIV/AIDS person to prevent infecting other members of the family?

Precautionary measures to prevent HIV infection when living with a HIV positive person?	Answer			
	I AGREE	I DIS-AGREE		
26.1 Safe sexual practices (e.g. using a condom)	1	2		146
26.2 Avoid contact with the person's bodily fluid	1	2		147
26.3 Wash clothes wearing rubber gloves and a disinfectant	1	2		148
26.4 Avoid using the same personal objects (e.g. brush or comb)	1	2		149
26.5 Do not bath in the same bath tub	1	2		150
26.6 Do not use the same cutlery, and eating utensils	1	2		151
26.7 Refrain from using the infected person's cloths	1	2		152
26.8 Do not share the infected person's bed	1	2		153
26.9 Do not use the same toilet as the infected person	1	2		154
26.10 Wear rubber gloves when treating bleeding wounds	1	2		155
26.11 Other, please specify	1	2		156

27. Have you ever been tested for HIV?

Tested for HIV?	Answer		
27.1 Yes	1		
27.2 No	2		157

28. If your answer in question 27 was YES, then please indicate the reason why you were tested.

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29. If a pregnant mother is HIV positive to what degree do you think her new born babies will be infected with HIV?

	Answer		
	All her children	Some of her children	None of her children
Will all the newborn babies of a HIV positive mother be HIV infected?	1	2	3

	158
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30. How can one prevent the transmission of HIV from mother to child?

Preventing the transmission of HIV from mother to child	Answer	
	YES	NO
30.1 Use of antiretroviral medication before the birth of the baby	1	2
30.2 Avoid breastfeeding	1	2
30.3 Not to have sexual intercourse during pregnancy	1	2
30.4 Do not do anything and wait for the baby to be born	1	2
30.5 Use ARV (Antiretroviral medication) while breastfeeding	1	2
30.6 Other, please specify	1	2

	159
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Thank you for your time and input in completing this questionnaire