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INDIGENOUS KNOWLEDGE AND PRACTICE IN HIV/AIDS EDUCATION AND PREVENTION WITH PARTICULAR REFERENCE TO WOMEN

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The HIV pandemic is highlighting time and again the historical discrimination against women. It's time for women to take back control over the choices made about their bodies and their health. (Mason, 1997 as quoted by Togni, 1997:6)

OPSOMMING

Die klem sal tans op die voorkoming van MIV/VIGS wees, want behandeling is te duur in ontwikkelende lande insluitende Suid-Afrika. Voorkoming sluit 'n onderrigkomponent in. Om doeltreffend te wees moet onderrig nie net kennis verskaf nie, maar persone motiveer om bewus te raak van houdings, waardes en gedrag wat 'n risiko inhou. Alhoewel voorkoming van MIV/VIGS op drie vlakke gelyktydig behoort te geskied, word in hierdie artikel slegs op primêre voorkoming gefokus met vroue as die teikengroep. Aandag word geskenk aan faktore wat bydra tot die groter risiko van vroue vir MIV-infeksie soos hulle biologiese kwesbaarheid en die sosio-kulturele en ekonomiese faktore waaraan hulle onderhewig is.

Met betrekking tot primêre voorkoming word hoofsaaklik gefokus op biomediese en gedragsintervensie en voorkomende onderrigprogramme. Ten slotte word tegnieke en strategieë van VIGS-voorkoming en onderrig wat spesifiek op vroue as teikengroep gerig is, bespreek.

INTRODUCTION

HIV prevention is at a cross-roads (O'Reilly, Msiska, Mouli & Islam, 1999:150). The approaches that have characterised mainstream HIV prevention during the last 15 years do not reflect our growing understanding of the broad social and cultural dimensions of sexual behaviour. Our understanding of how to address these broader social and cultural determinants is only now developing. Some of the most innovative work in HIV prevention is being carried out in the developing world, work that forces those in industrialised countries to question the very premises upon which they try to intervene.

Current treatments are too costly to help curb the disease in developing countries such as South Africa. Laird (2001:262) is of the opinion that AIDS has never been a curable condition, but it is an entirely preventable one. Thus, for the foreseeable future at least, the emphasis will be on prevention.

The assumption of this paper is therefore that prevention is the only cure for HIV/AIDS and is more cost effective than treatment (Kellerman, 2000:204; Whiteside & Sunter, 2000:137). Prevention involves an educational component and for this reason researchers believe that the only current solution to the problem of curbing HIV lies in the education of potential high-risk groups (Simbayi, 1999:154). The significance of education and its role in AIDS prevention can no longer be debated. It is the key to HIV/AIDS prevention because HIV transmission can be prevented through informed and responsible behaviour. To be effective education must motivate people to recognise personal risk and take action to change behaviours that put them at risk. Various countries in Africa have underlined the importance of education and have integrated AIDS

education in their public health education programmes and primary health care services (Kellerman, 2000:205).

In this paper indigenous knowledge is regarded as local knowledge that is unique to a given culture or society. Indigenous practice keeps in mind local circumstances, cultural values and differences and ethics and is appropriate and relevant to a specific socio-cultural context. According to Cohen (1992:14), the concept "indigenous" is central to our thinking about culture, values, family, community and human services.

Prevention of HIV/AIDS should occur on three levels simultaneously. This paper is primarily concerned with primary prevention, although secondary and tertiary prevention should never be ignored.

HIV/AIDS AND ITS EPIDEMIOLOGY

HIV/AIDS and its epidemiology have the following characteristics, which will result in it having a far greater economic and social impact than other more prevalent diseases.

Fatality rate

HIV infection generally leads to full-blown AIDS. There is at present neither a proven cure nor an effective vaccine to prevent the spread of AIDS.

Demographic distribution

According to Chifakatsha (1999:208), AIDS affects young adults in their economically most productive years. Two major population groups in Africa are affected by the epidemic, namely the zero-to-four age group by vertical transmission and the prime-aged adults through heterosexual intercourse. Women are especially vulnerable and comprise 52% of the adult persons living with HIV in Africa and they are becoming infected at a significantly younger age than men (UNAIDS, 2001 :1). More than half of them are under the age of 25 and many have been exposed to AIDS in early adolescence. For every 13 men infected, 37 women are infected; in other words for every infected man there are three women infected (Egnal, 2001:20).

HIV affects both the elite and the poor

This characteristic is unlike the characteristics of many other endemic diseases in Africa and has broad repercussions for economic development.

The widespread nature of the epidemic

Crude adult death rates in most African countries have doubled or tripled, with AIDS as the major cause of adult mortality. AIDS threatens to erase or negate past improvements in child health as it is also a growing cause of child mortality (Chipfakatsha, 1999:207-208).

Regional and demographic dimensions of the HIV pandemic

Over three quarters of the world's population live in the developing countries, which include all of Africa, Latin America, Asia (excepting Japan) and Oceania (excepting Australia and New Zealand). HIV/AIDS will have its greatest impact on women in the developing world, where unprotected heterosexual intercourse has been and will continue to be the predominant practice

(Raffaelli & Pranke, 1995:219-221). It is estimated that 80% of all HIV-positive women in the world are currently found in Sub-Saharan Africa⁴ which includes South Africa.

FACTORS THAT CONTRIBUTE TO WOMEN'S RISK OF HIV INFECTION

Women are at risk of HIV infection not primarily because they engage in "high-risk behaviour", but because they are constrained by social, economic and cultural factors beyond their control. The social and health consequences of AIDS fall the heaviest upon women as wives, mothers, sex workers and carers (Laird, 2001:260). According to Raffaelli & Pranke (1995:228), there are three main sets of factors that contribute to the increasing number of HIV infections among women:

Biological vulnerability

Women are more biologically vulnerable to HIV infection during heterosexual intercourse. The presence of other sexually transmitted diseases (STDs) also increases the risk of transmission and many women have asymptomatic or undiagnosed STDs.

In adolescence and throughout their productive years women lack adequate counselling and access to sexual and reproductive health services and health education programmes. The result of this is an increased risk of unwanted and early pregnancy, HIV infection and other sexually transmitted diseases as well as unsafe abortions and complications related to pregnancy and child birth (UNAIDS, 2001:2).

A major barrier to preventing vertical transmission of HIV/AIDS is that in most African cultures childbearing is greatly valued. Women who do not have children may be subject to divorce and public censure. Because of this attitude seropositive women are unwilling to tell their partners about their serostatus. Given the value of childbearing, programmes aimed at limiting the fertility of HIV-positive women have been largely unsuccessful.

Epidemiological vulnerability

Women's sexual partners sometimes tend to be older men who are likely to have had previous sexual partners and thus more likely to be infected with HIV. Women are infected at younger ages than men. In Sub-Saharan Africa HIV rates peak for women in the 20-24 age group. Because many countries lack reliable blood-testing programmes, blood transfusions continue to be a risk factor for HIV among women of reproductive age.

Socio-cultural and economic factors

Poverty

Poverty can minimise life options and sexual behaviour for women. Women are more likely to be poor and uneducated than men and are thus dependent on men for the survival of their children. In the context of unequal relationships and in settings where their wage-earning abilities are limited, women may be afraid to risk angering or losing their partners by bringing up the issue of condom use or monogamy. Because of economic constraints and the disruption of the traditional family

4 Sub-Sahara Africa

Angola; Benin; Botswana; Burkina Faso; Burundi; Cameroon; Cape Verde; Central African Republic; Chad; Comoros; Congo; Congo Democratic Republic; Cote d'Ivoire; Equatorial Guinea; Eritrea; Ethiopia; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Kenya; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mauritius; Mozambique; Namibia; Niger; Nigeria; Rwanda; Sao Tome and Principe; Senegal; Seychelles; Sierra Leone; Somalia; South Africa; Swaziland; Tanzania; Togo; Uganda; Zambia; Zimbabwe

and social systems, many women must exchange sex for money, goods, favours and other services in order to survive.

The acute and chronic poverty of urban households leads to their eventual breakdown and the migration of children to the streets (UNAIDS, 2001:4).

Of particular concern is the prevalence in low-income communities of domestic violence and coerced sex, which may make it useless or even dangerous to recommend the use of condoms.

Sexual behaviour and gender roles

Other socio-cultural factors that further increase women's vulnerability are beliefs about sexual behaviour and gender roles. Many societies value female virginity at marriage but grant sexual freedom to unmarried men. Many women in developing countries do not use any method of family planning and condoms are rarely the method of choice (Raffaelli & Pranke, 1995:221).

Multiple sexual partner behaviours are widespread and frequently occur in countries in Africa.

Customary law

A woman cannot be the beneficiary of her deceased husband's estate in neither patrilineal or matrilineal systems. Customary inheritance laws usually leave widows with nothing and may also result in the removal of children. Even where inheritance laws exist, it is usually difficult to enforce them.

Illiteracy and lack of knowledge

According to the World Bank in 1995 female illiteracy is around 39% as opposed to 62% for males in Sub-Saharan Africa (Laird, 2001:261). Knowledge of AIDS among a vast number of African people remains poor due to illiteracy, limited education and lack of access to HIV/AIDS information. Due to a lack of knowledge, there are perceptions that AIDS is a curse, which serves to reinforce risky and futile behaviour.

Individuals lack information on how to prevent infection and the spread of the disease. Carers may turn to witchcraft to seek a cure for a stricken relative (Ferreira, 2000:2).

Influence on households

In rural areas women provide the bulk of subsistence labour in agriculture. Most men spend their lives as migrant labourers. The wife is left in charge of the children and of the property belonging to the absent male. The morbidity and mortality of women have a greater impact on the African household than that of the male. Infected women pass on their infections to their unborn children, who never grow up to become adults.

The consequences of the HIV/AIDS epidemic on rural populations include a decline in educational status due to the fact that children, particularly girls, are forced to leave school in order to cope with the tasks of caring for siblings and ill parents (UNAIDS, 2001:3). Changes in the social system occur as households adapt to the impact of HIV/AIDS such as the break up of families and an increasing number of orphans and rural poor. If women themselves succumb to AIDS there is no one to take over these important duties (Chipifakacha, 1999:210-214).

Women and older women carers

More women than men are caregivers of people with AIDS which means they are saddled with the triple burden of caring for the children, the elderly and people living with AIDS. Girl children and older women may find themselves at the head of households.

As a result of AIDS-related illness and deaths there were fewer adults of normal parenting age, so the burden of caring for grandchildren and AIDS orphans is increasingly falling on older persons, typically maternal grandmothers.

Households with AIDS orphans headed by grandmothers suffer abject poverty and usually fall below the poverty line. The needs and problems of orphaned children with which grandmothers must cope are multiple (Ferreira, 2000:2).

Gender inequalities

Gender inequalities are a major factor in the AIDS epidemic. The differing attributes and roles that society assigns to males and females have a profound effect on their ability to protect themselves against HIV/AIDS and cope with its impact.

Vulnerability to AIDS is often engendered by a lack of respect for the rights of women and children namely the right to education and information, freedom of expression and association, the rights to liberty and security, freedom from inhuman and degrading treatment and the right to privacy and confidentiality (UNAIDS, 2001:1).

There is growing evidence that a large share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres (UNAIDS, 2001:2). The fear of violence makes it more difficult for women to refuse unsafe sex.

According to Parry and Karim (1999:82), the following factors mean that South Africa is at great risk of developing a severe HIV/AIDS epidemic: very high levels of STDs; high levels of rape and violent sex; unwillingness to use (or unavailability of) condoms and the use of anal sex by some as a method of contraception; "dry" sex; the entrenched system of migrant labour; the growing commercial sex industry; high levels of poverty and income inequality; the low status of women in society and in relationships; and social norms that encourage or accept high numbers of sexual partners.

PRIMARY PREVENTION OF HIV/AIDS

In its simplest form prevention is stopping an event before it occurs. Prevention has many forms and goals. Drawing from the public health categories of prevention, efforts there focus on three distinct levels: primary, secondary and tertiary. Each level suggests a focus for service development and implementation (Wheeler, 2000:189).

Primary prevention, often considered "true prevention", emphasises stopping an event before it happens. In HIV/AIDS work this is typically operationalised as preventing a new infection (an uninfected person from becoming HIV-infected). Since HIV is an acquired disorder, the primary form of prevention is an essential weapon in the arsenal to stop the spread of AIDS (Wheeler, 2000:189-190). It is the surest way of preventing the spread of AIDS individually and collectively.

At present prevention at primary level is one of the most important objectives of those concerned with limiting the tragedy that HIV diseases and their consequences bring to women, children and men alike.

Different types of interventions are considered.

Biomedical interventions

According to Wheeler (2000:191), social workers who are familiar with technological and biomedical advances are more effective. Biomedical interventions include the following:

Barrier methods

The use of barrier methods to prevent the transmission of HIV is based on the idea of stopping live viruses from ever touching the genital mucosa. Barriers can be physical (i.e. male and female condoms) and chemical (spermicides, micro bides). Some contraceptive devices (i.e. diaphragms, lubricated condoms) are a combination of physical and chemical barriers.

Currently all barrier methods of HIV prevention are contraceptives. Most barrier methods available require the knowledge and/or co-operation of the male partner in order to be used effectively.

Female-controlled barrier methods such as spermicides, diaphragms and cervical caps remain unproven as HIV-prevention techniques (Lawson, Katzenstein & Vermund, 1999:49). Male-controlled barriers, such as the male latex condom and to some extent the female condom, represent the best available technology for prevention of HIV at present.

Other biomedical interventions include the following:

- Diagnosis, treatment and control of sexually transmitted diseases (STDs); and tuberculosis (TB);
- Therapy to reduce perinatal transmission;
- Discovery and/or development of vaccines and affordable antiretroviral therapies (Lawson, *et al.*, 1999:43);
- Addressing issues relating to blood transfusion and HIV. There are many strategies to protect the blood supply, but their implementation requires significant effort and resources. Resources are often lacking in developing countries. Relatively little effort has been expended in developing and testing biomedical interventions for the prevention of HIV (Lawson *et al.*, 1999:45).

Behavioural interventions

Van Dyk (1999:125) claims that behavioural change is the only weapon against HIV infection and AIDS. She admits that it is unfortunately the most difficult and complex weapon to use because people find it extremely difficult to change their sexual behaviour as sex is pleasurable and often has a symbolic meaning. The social worker must recognise that risk behaviour, particularly as it relates to the modes of HIV/AIDS transmission, is a personal matter. Many factors influence individuals and it is likely that each person will display a unique configuration of attributes that ultimately influence his or her risk behaviour. There are multiple factors that need to be considered in connection with behavioural change in client systems. They are as follows:

- *Knowledge alone is insufficient to change people's behaviour. This is especially true of long-term, lifelong behavioural changes associated with pleasure centres (sex and drugs) typically considered as private and intimate matters;*
- *Our attempt to sway attitudes and values underlying our desire to effect behavioural change through the introduction of knowledge is highly influenced by antecedent forces and they are difficult to change in one-shot or short-lived exchanges between client and social worker. It is*

beneficial in the process of promoting behaviour change and to develop an understanding and appreciation of the significance of the target behaviour in the client's life.

- *Skills* associated with risk behaviour reduction is frequently an area for intervention by the social worker, but often skills alone are not enough. The latter is particularly the case when skills are not introduced within the context of the client's life.
- *Context* plays a powerful role in health promotion and health behaviour change. Context is a factor that cannot be overlooked (Wheeler, 2000:191-193).

Behavioural theories/models for intervention

Behavioural interventions for individuals, couples and groups have largely been based on social psychological theories/models of behaviour.

No single psychosocial theory dominates the field of HIV prevention, but a host of theories such as the Health Belief Model, the AIDS Risk Reduction Model and Diffusion Theory have been applied to designing HIV-prevention programmes.

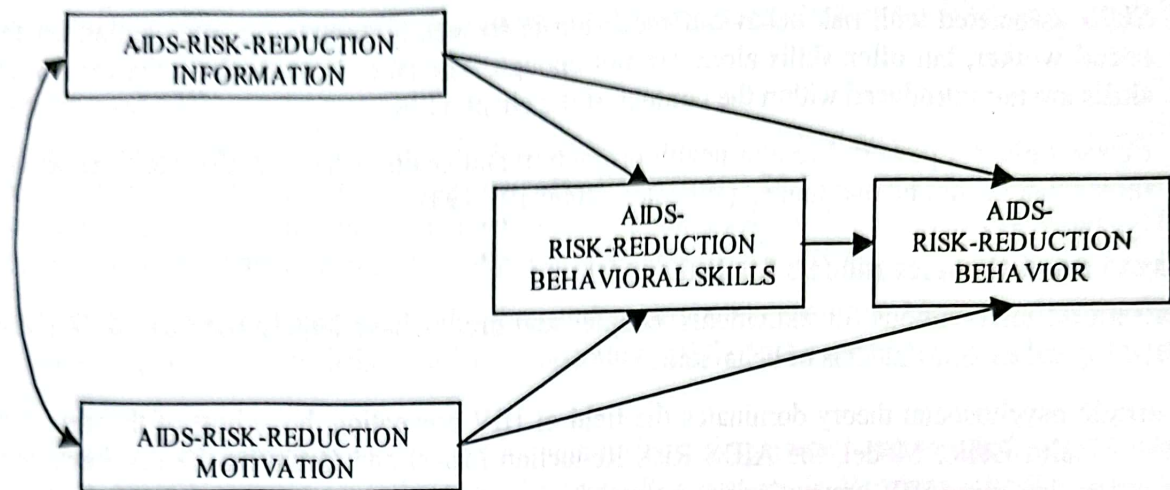
According to Wingood and Di Clemente (1999:188), the Social Cognitive Theory is perhaps the most widely used theory in the field. The underlying assumption of the cognitive theory is that behaviour is dynamic and depends on environmental and personal constructs that influence each other simultaneously. The social cognitive theory is often articulated with a focus on four critical constructs or cornerstones namely:

- enhancing knowledge of risk prevention;
- promoting acquisition and proficiency in HIV-preventive skills;
- enhancing self-efficacy; and
- fostering protective peer norms.

The Skills Model of AIDS Risk Behaviour Change by Fisher & Fisher (1996:103-104) is also focused on because it can readily be applied to the design, implementation and evaluation of population-specific interventions targeted at any group at risk of HIV infection (especially young adults). According to the model, the following are the three fundamental determinants of AIDS-preventive behaviour:

- (i) information that is directly relevant to AIDS transmission and prevention;
- (ii) motivation to engage in AIDS-preventive behaviour, including personal and social motivation and perceptions of personal vulnerability;
- (iii) behavioural skills (including objective skills for performing such behaviours and a sense of self-efficacy for doing so) (see Figure 1).

FIGURE 1



(Fisher & Fisher, 1996:4)

The levels of each of these determinants should be increased to promote the initiation and maintenance of AIDS-preventive behaviour.

Individual counselling

O'Reilly *et al.* (1999:143) define individual counselling for HIV-prevention purposes as an interactive process in which a trained counsellor assists a client in developing and rehearsing a personal risk-reduction strategy including, if necessary, role-playing of important steps that might be required. Topics typically addressed in counselling for HIV prevention include informing partners of HIV serostatus and introducing condom use into new and existing relationships.

Group interventions

Group counselling has also been tried in the developing world. Group facilitators of counselling, socialisation and remediation groups can provide information on HIV prevention, how to adopt positive attitudes toward health and learning about unsafe behaviours. Interventions must be more than basic HIV/AIDS information. Eclectic strategies can be used to help improve the clients' coping skills, management of emotions and intimacy problems (Pinto, 2000:83).

Task groups and mutual aid groups (self-help groups) that are initiated by a social worker, but function independently can be implemented.

Community interventions

Attempts to intervene through the communities in which people live or even to change the structures in those communities are becoming more common in HIV prevention.

Modern community-level interventions do not only focus on the behaviours that place people at risk, but on the social, cultural, psychological and environmental factors that characterise communities. The range of potential intervention points extends beyond the individual. They affect the individual by facilitating decisions about behaviours, by increasing access to risk-reduction supplies such as condoms and disposable syringes, and by increasing social acceptance of risk reduction (O'Reilly *et al.*, 1999:145).

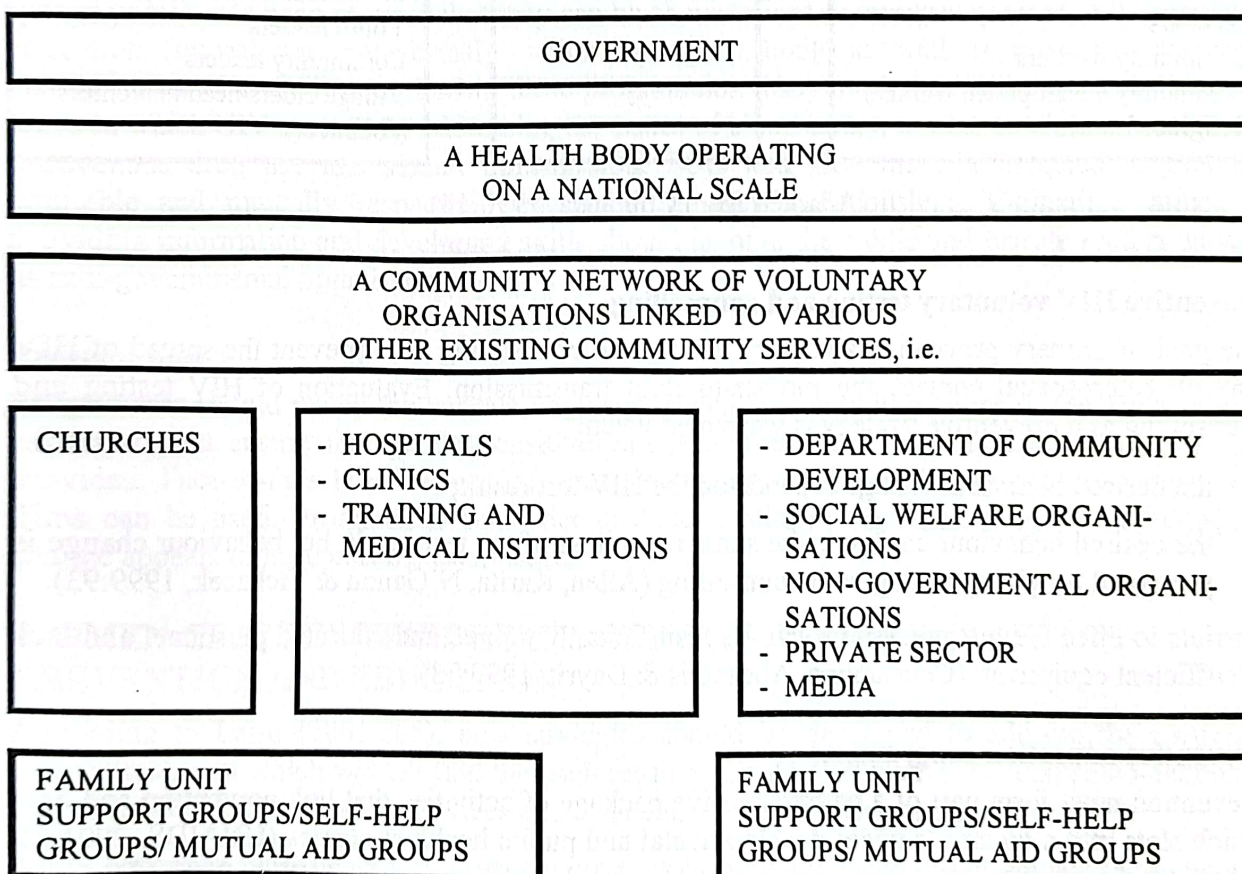
Social support systems/networks

Social support systems/networks provide services in the community. Two major categories of social support systems/networks can be delineated. Formal social support systems are those falling under the auspices of a welfare organisation and are sponsored services rendered by professionals (Ngatsane, 1993:53-54). A network of voluntary organisations with links to professional services could enable continuation and co-ordination of HIV/AIDS prevention and education services.

Laird (2001:261) emphasises that managing the AIDS pandemic in Sub-Saharan Africa demands an entirely different approach by social welfare agencies and non-governmental organisations to that of their counterparts in Europe and America: "Development and community workers in Africa must innovate beyond the formulations of Western industrialized societies."

A community-based network of services as presented schematically below in Figure 2 could be developed by social workers to combat the AIDS problem on a large scale.

**FIGURE 2
COMMUNITY-BASED NETWORK**

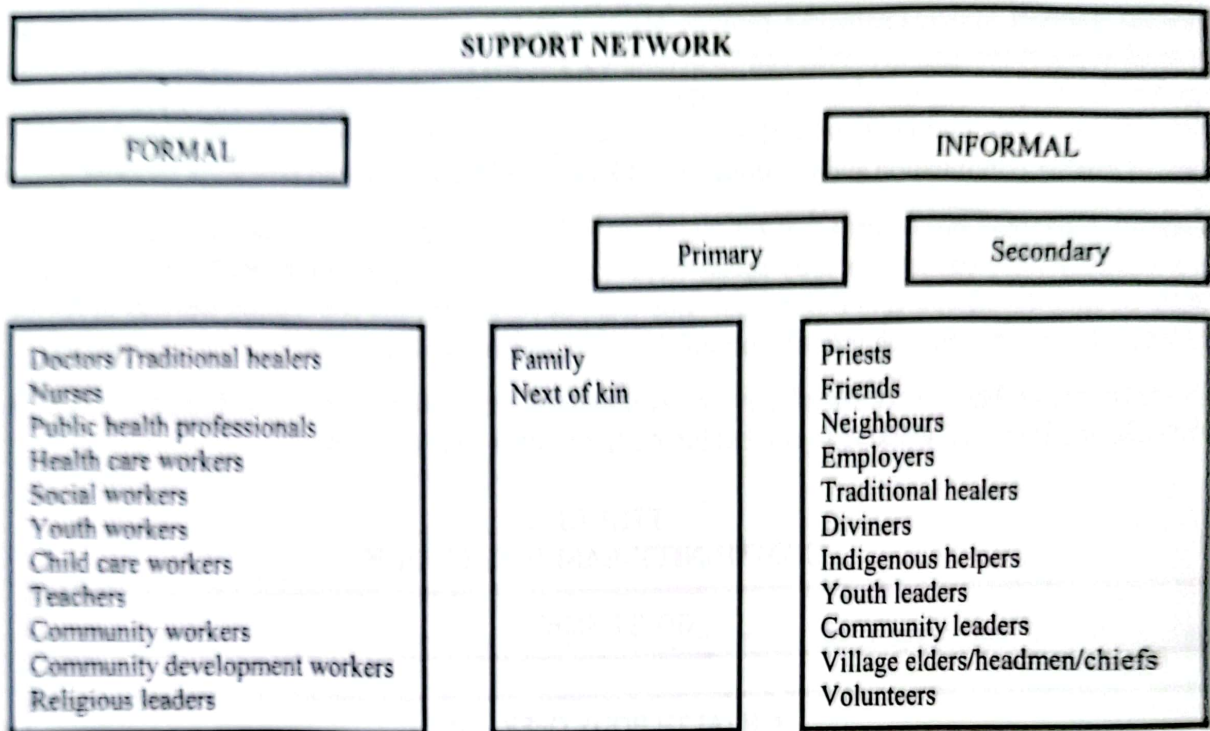


(Adapted from Schurink, 1990:21)

Informal and formal support systems/networks provide help to those in need without the protocol of formal rules and procedures as applicable in the social service delivery systems (Ngatsane, 1993:54).

In Figure 3 below a support network of persons that could be involved in the prevention of HIV/AIDS is diagrammatically illustrated.

FIGURE 3



(Adapted from Chikanda, 1990:14)

Preventive HIV voluntary testing and counselling

The goal of primary preventive voluntary testing and counselling is to prevent the spread of HIV through heterosexual contact and mother-to-child transmission. Evaluation of HIV testing and counselling as a preventive strategy is warranted when:

- the desired behaviour change depends on the HIV test result;
- the desired behaviour change is the same regardless of the test result, but behaviour change is promoted by giving testing with counselling (Allen, Karita, N'Gandu & Tichacek, 1999:93).

Barriers to effective testing systems can be insufficiently trained and educated personnel and lack of sufficient equipment (Constantine, Abesamis & Dayrit, 1999:73).

Preventive education programmes

Prevention must form part of a comprehensive package of activities that link prevention and care which slots into a country's wider developmental and public health strategies (UNAIDS, 2001:2). A holistic approach to education and care must be developed and sustained (RSA, 2000:15).

Programme outcomes

In the context of this paper a "programme" is defined as an intervention which involves the following:

- situational analysis of life styles and traditions to determine risk behaviour;
- assessment of required and available resources;
- barriers to the implementation of the programme; and

- strategies to promote change (Wessels, 1996:9).

The aim of developing a programme is to further the primary prevention of the transmission of HIV infection. In addition to this overall goal, objectives can be written and formulated as measurable behavioural outcomes (see Annexure 1).

Management

Preventive education programmes must be supported and boosted by public policies that increase the visibility of the epidemic while decreasing stigma associated with it. The active support of community leaders must also be obtained. Political commitment must be received from community leadership from grassroots level right up to the country's highest political level. Opinion leaders, role models and the inspiration and leadership of people living with HIV/AIDS must all be involved (UNAIDS, 2001:2).

Target groups

Programmes must focus on important vulnerable populations and geographic areas where the spread of HIV has been so rapid that they can be characterised as emergency areas. All avenues of education (formal and non-formal), which includes schools as well as broader community channels, must be used to implement these programmes. They must also concentrate on the main ways in which HIV spreads by addressing the issues of blood safety, mother-to-child transmission, intravenous drug use and sexual transmission. Boys and girls must be targeted to promote equitable and mutually respectful behaviours in sexual relationships. Campaigns aimed at providing information and developing skills should involve the public and private sectors as well as non-governmental organisations.

Prerequisites

Programmes should match the various linguistic, social and cultural realities of the groups being addressed and ensure that gender-sensitive and gender-balanced services and information are provided. Face-to-face health education preceded by approaches including videos, dramas and films can be used. Programmes must demonstrate continued vigilance, even when behaviour change appears to have become established.

WOMEN-CENTRED TECHNIQUES AND STRATEGIES FOR AIDS PREVENTION AND EDUCATION

According to Laird (2001:265), new strategies should be developed to address the particular circumstances in which women find themselves; they should start from the actual socio-economic and cultural contexts of women's lives and be anchored in the African social milieu.

AIDS education must be part of a broader strategy to improve the health of women in general, to increase self-actualisation and to improve the overall quality of life of women. Women must be involved in the design and implementation of HIV/AIDS-prevention programmes as well as change those policies that discriminate against women and increase their vulnerability to HIV.

The long-term solution to preventing AIDS among women lies in bringing about major structural environmental changes; improved availability of and access to health services; the creation of affordable housing for women and their families; education and job training and the removal of legal barriers to women's financial independence. Obviously such changes to improve the status of women will not be achieved in the near future (Raffaelli & Pranke, 1995:238).

Counselling different groups of women

Women who visit health care institutions must receive education on AIDS and brochures with the necessary information should be made available. Counselling by health care professionals must be offered to the following groups of females, preferably before they become pregnant: women with many sex partners; women whose husbands or sex partners have or have had multiple sexual contacts; women whose partners are bisexual or intravenous drug users; women who have had HIV-positive partners; women who visit family planning; prenatal or antenatal clinics; women who visit TB and STD clinics; women who are HIV positive; and women who are rape survivors.

School nurses and nurses working in family planning clinics should counsel teenagers about the risk of unsafe sex and on prevention of HIV infection.

Empowerment of women and girls

According to Worth (1989) as quoted by Wessels (1996:47), female inequality intensified by deprived socio-economic circumstances and cultural biases has become a major cause of the HIV epidemic.

Women are often unable to insist on preventive measures such as condom use or monogamy because they have little power relative to men. Programmes are needed not only to give women information about HIV and their options for protecting themselves, but also to teach them skills for negotiating with their partners and to foster community norms that support prevention.

Dangerous cultural practices that put women's health at great risk such as a man inheriting a deceased brother's wife, widowhood rights on the death of a spouse or boys raiding girls' huts and forcing them to have sex, do still exist. Women must be empowered to question, if not totally reject, these risky practices.

Targeting men for prevention programmes

Prevention programmes should also target men, emphasising their role in protecting their partners and children. Studies suggest that men can be induced to reduce unsafe sex, at least in the context of sex with non-primary partners or when they are aware of their own risk. Motivating men to use condoms with their primary sex partners will be more challenging.

Work among heterosexual men must expand. Concentrating exclusively on women's options for prevention of AIDS may have the unintended effect of stigmatising women and placing all responsibility on them for protecting the health of their sexual partnership (Gollub, 1995:44).

Promotion of alternatives to condoms

Due to the following barriers to condom use in long-term relationships, alternative prevention strategies are urgently needed: cost and availability issues; association of condoms with infidelity, mistrust and prostitution; misconceptions about condoms and perceptions of diminished sexual enjoyment.

Barriers to condom social marketing need to be removed in order to improve availability and accessibility in HIV-prevention programmes (Goodridge & Lampley, 1999:357-358). Condom distribution through non-traditional outlets and in high-transmission areas must be expanded (RSA, 2000:6).

Promotion of health education

The aim of health education in AIDS-prevention programmes should also be the promotion of physical and mental health. People should be motivated to take responsibility for their own health and that of their communities (Van Dyk, 1999:135).

One way to reduce the spread of HIV is to increase efforts to diagnose and treat conventional STDs. Because women often avoid STD clinics or do not know they are infected, STD detection, treatment and preventive services should be delivered in health care settings such as primary health care clinics, maternal and health clinics where women seek care for themselves and their children. Because childbearing is tremendously important to most women, integrating HIV/AIDS-prevention programmes into maternal and health care clinics and programmes would make HIV prevention more salient.

Youth- and gender-friendly reproductive health services must be bolstered if they are to accommodate mother-to-child transmission prevention programmes. Women's access to antenatal and delivery care should be improved (UNAIDS, 2001:3). Women should be counselled on safer sex, pregnancy, the possibility of abortion, breast-feeding and contraception (Van Dyk, 1999:136-141).

Health education, family planning, and changing people's sexual behaviour must be complemented with community-based and gender-sensitive approaches (Malawi SDNP, 2001:4).

Mass media programmes

Mass media programmes representing real-life situations through radio dramas, plays and write-ups in newspaper columns can model healthy behaviours. The popular theatre used to present informal community productions written, directed and produced by novice community members can also help to shape changing attitudes and new behaviours (Goodridge & Lamptey, 1999:337-338).

Mass media information and education programmes for the general public are often the first step in national AIDS-prevention efforts. They are designed to:

- Improve knowledge about AIDS;
- Enhance awareness;
- Promote safer sexual behaviour;
- Reduce misconceptions about HIV transmission;
- Prevent discrimination against those infected with HIV;
- Mobilise public support for people living with HIV and AIDS (Goodridge & Lamptey, 1999:332).

Education of children and adolescents about sex and gender roles

The best time to teach children how to avoid HIV infection is before they become sexually active. WHO has urged all countries to implement school-based sex education as a means of curtailing the AIDS pandemic because many youths in developing countries leave school at an early age. Sex education should begin in primary school and be supplemented with community-based programmes (Raffaely & Pranke, 1995:231).

Basic sex education, the improvement of girls' knowledge and understanding of their own bodies, the encouragement of communication about sex and responsibility among boys and girls who are not yet sexually active are of crucial importance (Gollub, 1995:73).

The acquisition of life skills

Clients must be helped to develop responsible and effective coping skills such as the following: assertiveness, self-efficacy, a strong self-concept and self-awareness, a belief in one's right to make choices; the handling of pressure; problem-solving abilities and effective communication and negotiation skills. Women in particular should be taught to be more self-assertive and self-efficient in sexual matters. Various strategies like role-play and social modelling can be used to establish life skills (Van Dyk, 1999:135-136).

Interventions related to power and gender issues

Connell (1999:192) identified the critical components of existing theories on gender and developed an Integrative Social Structural Theory of Gender. According to him, there are three major components that characterise the relationships between men and women: the sexual division of labour, the sexual division of power, and the division of affective attachments and social norms. These three overlapping but distinct components serve to explain the culturally bound gender roles assumed by men and women and are dependent on each other:

- The sexual division of labour refers to the allocation of women and men to different occupations;
- Inequalities in power between the sexes form the basis for the sexual division of power;
- Appropriate sexual behaviour for women is dictated by the sexual division of affective attachments and social norms.

Prevention intervention for women can't be based on the three mentioned components (see Annexure 2).

CONCLUSION

- In spite of many interventions the spread of HIV has reached epidemic proportions in Sub-Saharan Africa and in South Africa in particular. More than 50% of HIV-positive adults are women.
- The basic elements of successful prevention include sex health education, behaviour change interventions, voluntary HIV counselling and testing, promotion of the condom and female condom, and screening and testing of sexually transmitted infections and tuberculosis.
- HIV-prevention programmes should take into account indigenous knowledge and the potent influence of socio-economic and cultural factors on women's lives. Change through individual and community empowerment informed by a holistic understanding of the local context must take place.

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