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SOCIAL WORK RESEARCH ON THE FEELINGS AND PERCEPTIONS OF AIDS PATIENTS IN A SOUTH AFRICAN CLINIC

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INTRODUCTION

A qualitative approach was followed in order to gain in-depth information on the topic. Qualitative research has to a large measure been neglected by social scientists due to various reasons. However, during the last decade, there has been a shift in emphasis in the teaching of qualitative research methods in South African schools of Social Work and hopefully this shift will also take place in Social Work practice. The philosophy of qualitative research is by and large similar to that of Social Work practice, although the emphasis of research and therapeutic intervention differ. The research project was done on the perceptions and feelings of HIV/AIDS patients at the Wola Nani Clinic for AIDS-patients at the Potchefstroom Hospital. Participant observation and semi-structured interviewing were utilised as data-gathering methods for the mentioned project.

In this article focus will be placed on the HIV/AIDS scenario in South `Africa, after which the research set-up at the clinic will be described. Qualitative research, participant observation and semi-structured interviewing will be discussed in order to place the empirical study, that will be reported on in this paper, in perspective. The rest of the paper will be devoted to the various sections of the empirical investigation.

THE HIV/AIDS SCENARIO IN SOUTH AFRICA

South Africa is experiencing one of the most serious HIV problems in the world. More than 3,6 million South Africans were already HIV-POSITIVE by the end of December 1998 (Beeld, 4 March 1999). The World Health Organisation declared at the end of 1998 that at least 30 million people over the world were HIV-POSITIVE, that 11,7 million had already died and that 83% of them were from Africa (Beeld, 12 February 1999). Beeld (25 November 1998) reported that one out of every 10 people diagnosed HIV-POSITIVE in that particular year, were from South Africa. In South Africa and a few other Southern African countries with high infection rates, life expectancy declined from 64 to 47 years (Beeld, 25 November 1998). Fraser-Moleketi expects that 500,000 people will die annually due to AIDS-related diseases and that more or less 1,600 people are infected daily with the HIV-virus in South Africa (Beeld, 28 February 1999). Fraser-Moleketi (1999:1) stated that of all pregnant mothers attending pre-birth clinics countrywide, 22,8% were HIV-positive, that there existed a phenomenal increase in HIV-infection amongst pregnant teenagers (15 to 19 years old) and that about 9,000 children were born annually being HIV-POSITIVE. At the moment South Africa already has about 100,000 AIDS orphans and this figure will rise to more or less 1,6 million by the year 2008.

According to Bernstein and Van Rooyen (1994:376-380); Valdiserri (1989:271) and Viljoen (1990:335-341) Africa and specifically South Africa have some special cultural features regarding the illness. Polygamy, prostitution, migrant labour, mobility of the population, weakening of family and community ties, the status of women, poverty, diet, urbanisation, the presence of STD's, health beliefs, traditional healers, condom use, unrest, crime and violence can be mentioned as cultural features. Normal immune functioning is critically dependent on good nutritional status. Certain foods are preferentially utilised in most African countries. The major meals are bulky, and the staple food eaten does not provide the energy, protein and the other essential nutrients for good health (Watson, 1994:21). It can thus be speculated that malnourished Africans may constitute a special risk group for AIDS (Watson, 1994:26).

A culture of silence and fear has developed around the illness and infected persons refrain from disclosing their HIV-status because they fear rejection and isolation from their community. Very few people admit to knowing somebody being infected and relatives and friends are said to be dying of a 'long illness' or 'slim disease' (Fraser-Moleketi, 1999:1). In the words of Poindexter and Linsk (1999:56) HIV must be brought 'out of the closet' that will necessitate major societal and structural shifts. By knowing the status of partners, people will at least have the choice to have or not to have sexual relationships with people being infected by the HIV-virus. AIDS is such a serious threat to society that it should be discussed openly, the patients should come to the front and tell about the consequences of the illness and how it can be prevented. According to Beeld (29 December 1998) this is the only way that the discrimination and stigmatisation against the illness will diminish. South Africa will only then be able to ascertain scientifically what the real extent of the illness is. This will also help government to curb the spread of the illness and to help all the infected and their partners (Beeld, 4 March 1999).

An enthusiastic search is on for a cure for AIDS, but the results are slow. Hopeful signs are however seen at the moment after the announcement of the development of the drug Inactivin by the Medical University of South Africa (Medunsa) in co-operation with an Irish company (Beeld, 12 March 1999). Even the most optimistic scientist knows that a cure will only give partial protection against the illness, according to the Panos Institute, London (Beeld, 12 February 1999). Training of people with the correct knowledge is definitely the key to curb the problem. Although there is really no such thing as safe sex, training regarding safer sex practices can help to curb the infection rate.

The following examples of activities which play a role in the problem in South Africa can be mentioned:

- An individual computer based training scheme has been introduced by some companies for people in their work place. This program can be worked through on an individual basis in own time and repeated if necessary. This program is aimed at the economically active labour force that has a basic level of literacy. This course includes the following topics: ways of being infected, prevention, symptoms, addresses and contact persons at the AIDS centres countrywide. The training concludes with a questionnaire to be completed by the respondent, in order to see what level of knowledge has been reached (Beeld, 28 February 1999).

- Griesel and Wege (1998) were the co-editors of a National AIDS Database consisting of a 468 page alphabetical list of all persons and organisations working in the AIDS-field in South Africa with the aim to network everybody in this field.

- A train journey from the north to the south of South Africa took place during March 1999 and was a "moving conference" of representatives from the Cabinet and Provincial Executive Councils and women's organisations from all over the country. This conference had as its aim to engage and workshop with communities on a broad range of issues related to HIV/AIDS and violence against woman. All the events were covered by the mass media (Fraser-Moleketi, 1999:6-7).

The National Plan of Action comprises the following five aspects, namely: prevention should be applied to all social groups, especially those who are marginal in poor and remote communities; sustainable programmes to empower woman to combat the spread of the disease; a culture of disclosure, prevention and support; national events will be utilised to galvanise woman into programmes of mass action at grassroots level and the mobilisation of women for mass action during 1999 and rolling mass action in 2000 (Fraser-Moleketi, 1999:2). Fraser-Moleketi (1999:2) said that the message should be: "Woman are breaking the silence, condemning the violence and mobilising to restore the nation!"

QUALITATIVE RESEARCH

It is difficult to define qualitative research in a way that will satisfy everybody. Denzin and Lincoln (1994:2) see qualitative research as follows: "...a multi-perspective approach (utilising different qualitative techniques and data collection methods) to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meanings that the subjects attach to it." Mark (1996:211); Marlow (1993:232) and York (1997:186) add to qualitative research the utilising of open-ended questions in which people can express their answers in their own narrative description of events and relationships.

Qualitative research is naturalistic in nature, meaning the minimising of the presuppositions with which the phenomenon being studied are approached and a searching, holistic description and interpretation of the meaning that people or the community attach to their everyday behaviours and situation (Creswell, 1994:145; De Vos, Strydom, Fouche, Poggenpoel & Schurink, 1998:240-241; Grinnell, 1993:53; Tutty, Rothery & Grinnell, 1996:4; Yegidis & Weinbach, 1996:107 and York, 1997:261). In qualitative research an inductive form of reasoning (meaning the researcher starts with detailed, specific observations of the world and move towards more abstract generalisations and ideas and to study a small number of cases in depth in order to discover the nature of the phenomena under investigation) is used and aims at understanding phenomena within a particular context (Barker, 1997:185; Creswell, 1994:145; Hammersley, 1989:165; Neuman, 1997:46 and Yegidis & Weinbach, 1996:107). Bryman (1988:63); De Vos *et al.* (1998:242); Hammersley (1989:156) and Tutty *et al.* (1996:v) add that the qualitative researcher aims to understand reality (the real world setting; the natural setting) by discovering and contextualising with minimal intervention, the meaning that people in a specific setting attach to it and produces descriptive data in the participant's own written or spoken words.

There have always been conflicting interests between the qualitative and quantitative paradigms in the social sciences. Mark (1996:211) enlightens the dilemma between qualitative and quantitative research by saying: "In reality, we should be aware that both quantitative (numerical) procedures and qualitative (narrative) procedures can be used in both research paradigms. It is true, however, that positivistic researchers favour quantitative results, whereas qualitative researchers favour qualitative or narrative results." Each compliments the other – meanings cannot be ignored when we are dealing with numbers, and numbers cannot be ignored when we are dealing with meanings (Dey, 1993:28). Qualitative methods have been seen by many as the best way to carry out research in the complex world of social work practice and has been described as a hand in a well-fitting glove (Padgett, 1998:373).

Erlandson, Harris, Skipper and Allen (1993:53); Neuman (1997:32) and Tutty *et al.* (1996:39) add that the selection of a suitable site and the gaining of access are of critical importance in naturalistic research, because the study has to be conducted in a particular native setting where people from the population you wish to study can be met. The research project was done in an AIDS Clinic in a semi-urban area of South Africa, namely Potchefstroom. This clinic, namely the Wola Nani Clinic (meaning 'to embrace'), forms part of the greater Potchefstroom Hospital. This clinic functions as an out-patient facility, meaning that it is open to the public Mondays to Fridays from 8:00 to 17:00 hours. The Wola Nani Clinic is staffed by a supervisor, a second in charge and four volunteers. The volunteers have as their task the training of patients in matters of health care, condom use and good nutritional habits. The supervisor and co-supervisor have the task of visiting facilities like schools and factories where groups of people are given preventative training on the risks of AIDS and proper health care.

Ethical issues, comprising of the rights, values and desires of informants and the confidential anonymous treatment of all information of patients and the clinic, were of utmost importance in this particular project (Creswell, 1994:165). Due to the ethical considerations attached to qualitative research and the confidential nature of the problem under study the researcher had to get written permission from the superintendent and the committee (existing of professional people working in this field, like medical doctors and nursing staff) of the Potchefstroom Hospital. Written informed consent by each participant was also required by the clinic to cover them from any claims that might be put forward by respondents. All these conditions of entry to a research site and the building of relationships are important in initiating a research project (Erlandson *et al.*, 1993:71; Grinnell, 1993:60). Bryman (1988:46); De Vos *et al.* (1998:90) and Royse (1995:286) say that unstructured, semi-structured or in-depth interviewing and participant observation are the data-collecting methods used most often by researchers in the qualitative paradigm.

PARTICIPANT OBSERVATION

Observation can be seen as the systematic noticing and description of situations, behaviours and artefacts in the social setting under study (Erlandson *et al.*, 1993:94). Observation is characterised by the fact that the researcher can be involved with the community and the respondents in various ways. The role of the researcher can vary from total observer to total participant (Bryman, 1988:48; Dane, 1990:158-160; Williams, Tutty & Grinnell, 1995:266-267 and Yegidis & Weinbach, 1996:151). Each and every researcher will have to decide on the advantages and disadvantages of the role to occupy as well as the aims of the investigation.

In this research project the researcher took the role of participant observer and had to become part of the particular community without changing anything to the naturalness thereof, or if that was not possible, to try and change as little as possible. The researcher decided on a participating and obtrusive role due to the fact that the patients were overall relaxed and mixed freely with each other. The researcher thought that by keeping only to himself and by observing in a rather unobtrusive manner, will only lead to the patients being interested in the activities of the researcher and thus influencing their behaviour (Bailey, 1994:247). By mixing naturally with the patients without asking questions and by avoiding being interested or inquisitive in their well-being and social activities, focused less attention on the researcher and thus created more of a 'normal' situation.

Williams *et al.* (1995:266) add that it is not easy to observe, participate and record data simultaneously. Morse (1997:4) mentions that the presentation of qualitative data is an art because of the difficulty to reproduce descriptive data without losing the richness and essence of the actual message. Rubin and Babbie (1997:394) say that a researcher must use the notes in order to recreate as many details of the day's experiences as possible. The recording of proper field notes during the sessions was important, but it had to be written up in a more formal manner as soon as possible and eventually in the final report (Dane, 1990: 161-163; Muller, 1995:65; Sheppard, 1995:270; Singleton, Straits, Straits & McAllister, 1988:300; Tedlock, 1991:69 and Tripodi, 1983:80).

The researcher attended the clinic on 11 occasions for more or less two hours at a time. The trust of the staff and volunteers had to be earned by the researcher before the project could really start. These visits aimed at observation and participation in the everyday situation and interaction at the clinic, in order to become part of the research site. In this way the researcher could gain more knowledge on such a clinic, the patients and their world and could prepare himself for the kind of questions to be put to patients during the sessions of semi-structured interviewing. The participant observational sessions were thus merely a steppingstone for the actual interviewing sessions – the main emphasis of this study was thus on interviewing a selection of patients in a qualitative manner. The observations made were thus a means of having more substantial interviews with a number of respondents. Erlandson *et al.* (1993:136-137) say that persistent observation by way of prolonged engagement serves to temper distortion caused by the researcher's presence. In this manner scope and depth could be reached in the observation and the researcher was to a large extent able to become part of the world of the respondents (Preston-Whyte, 1985:7; Sheppard, 1995:270; Van der Burgh, 1988:63).

It was observed that the patients acted like a large family and were glad to see each other on each and every occasion. The atmosphere was one of mutual concern, support and interest in each other. Tea was regularly served and patients were sitting round and chatting to each other - the conversations operated on topics not only associated with their health status, but with general aspects of daily living, for example income, housing and family. Naturally everything that were discussed could broadly be brought into the life situation of the HIV-POSITIVE patient, like joblessness, the family situation and housing problems due to their illness. It was obvious that the patients got much from being with other people in the same situation. They felt understood and mutually supported by the group. It was obvious that the clinic, and specifically the group of patients, substituted the workplace and family situation for many of the patients.

SEMI-STRUCTURED INTERVIEWS

Semi-structured interviewing, in this case particularly the face-to-face interview, helped the researcher to understand the closed worlds of individuals, their families and their communities (De Vos *et al.*, 1998:297; Tutty *et al.*, 1996:56). The content of the interviews was planned in advance and were thus more structured than informal interviews (Rubin & Babbie, 1997:390). On the other hand subjects were given a much freer reign than in the typical structured interview (Bryman, 1988:46). To record the comments of participants was not easy due to many biases and the great variety of answers and their complexity (Bless & Higson-Smith, 1995:110).

Due to proper preparation the researcher had enough insight in the situation of patients and could conduct the interviews with confidence, the necessary empathy and a relationship of mutual trust, individualisation and confidentiality. From the data and insight gathered from the participant observation sessions as well as appropriate literature studied, a semi-structured schedule were drawn up for the individual interviews. Except for some identifying particulars and a few scaled questions on which respondents had to mark 'Yes', 'Uncertain' or 'No', the overall schedule consisted of open-ended questions. On these open-ended questions respondents had to comprehensively motivate their viewpoints on some issues as well as their feelings and attitudes on being HIV-POSITIVE. They were also encouraged to talk about and elaborate on anything else that they wished.

Eighty six patients were asked to participate in the interview sessions, of whom 26 refused to take part. The reasons given for not participating in the study were as follow: 12 gave confidentiality as a reason (although they were fully briefed on the confidentiality aspects of the information given to the researcher), 8 wanted nothing to do with more information on AIDS and the other 6 mentioned no particular reason for not participating in the study. Sixty consenting respondents were interviewed over a five months period.

EMPIRICAL DATA

The empirical data has been organised according to the sections of the schedule. The schedule consists of 8 sections and will be discussed per section. Certain identifying particulars, background to the illness, ways in which HIV/AIDS can be transmitted, the development of the problem, the consequences of the problem, support systems, preventative measures and a general section will thus be discussed.

SECTION 1: IDENTIFYING PARTICULARS

The following particulars of respondents will be discussed: sex, age, marital status, number of children and highest qualification.

- GENDER OF RESPONDENT

Seventeen (28,3%) of the respondents were male, while 43 (71,7%) were female. This number consisted of the first sixty patients who were prepared to participate in the inquiry and does not necessarily represent the gender of patients at this or any other clinic in South Africa. On average the numbers for the Wola Nani clinic is 20% male against 80% female.

- AGE OF RESPONDENT

Respondents had to give their specific age on their last birthday. The age of respondents varied from 17 to 39 years, with the mean age being 25,55 years. The largest number was in the 25 year old group (18,3%), whilst the second place was taken by the 24 and 30 year old group (both comprising of 13,3% each). More than half of all new HIV-infections is in the age group of 15 to 24 years (Beeld, 25 November 1998).

- MARITAL STATUS

It was interesting to note that 55 (91,7%) of the respondents were "single", 4 (6,7%) were "married" and only 1 (1,7%) gave their status as "divorced".

- NUMBER OF CHILDREN

The largest group, namely 17 (28,3%) had only one child, whilst the second category, namely 15 (25%) had no children. The third largest group had two children, namely 13 (21,7%). There were 9 (15%) of the respondents who had three children, 5 (8,3%) who had four children and only 1 (1,7%) who had five children. Of the respondents 45 (75%) had at least one child. This means that a large number of the respondents had at least one illegitimate child.

- HIGHEST QUALIFICATION

The largest group, namely 25 (41,7%) had a grade 12 qualification, which is the highest secondary school qualification one can gain in South Africa. The second largest group, namely 19 (31,7%) had only a grade 8 qualification, whilst 16 (26,7%) had a grade 10 qualification.

SECTION 2: BACKGROUND TO THE ILLNESS

In this section four qualitative questions on the background to the illness will be discussed.

- THE TERM HIV/AIDS

Barker (1997:168) describes the status of being HIV (Human immunodeficiency virus) in the following words: "A result of a blood test that has determined the existence of antibodies to the human immunodeficiency virus (HIV)." Poindexter and Linsk (1999:46) see HIV as following: "...the trajectory of the illness that is caused by the retrovirus, whether symptomatic or asymptotic; symptomatic, or end-stage HIV-disease, often is referred to as AIDS…tend to experience a series of unpredictable medical, emotional, and social crises."

Two types of HIV have been identified. HIV 1 is found worldwide, while HIV 2 appears mainly in central Africa. The progression of infection is however similar. Blood, semen, vaginal secretions, and breast milk have been implicated in the transmission of HIV. HIV is transmitted by unprotected penetrative sexual intercourse with an infected person, by infected hypodermic needles, by medical transfusion of untreated blood, and from infected mother to child. HIV infection and infectiousness are presumed to be lifelong (Barker, 1997: 172).

Following infection, symptoms include night sweats, swollen lymph nodes, and mild fever. The acute phase is brief and precedes the development of antibody responses, which usually takes place six to 12 weeks after infection. This is referred to as the window period where the individual is infectious, but the infection is not detected on antibody tests. Following the acute phase, stage 1 lasts from a few months to many years, during which the infected person is mostly asymptomatic but infectious. The symptoms of stage 2 include a range of mild infections, weight loss, and fatigue. Stage 3 includes episodic occurrences of pulmonary tuberculosis, pneumonia, persistent fever, excessive weight loss, and other symptoms.

Stage 4, the last stage of HIV-infection, is that of full-blown AIDS (Acquired immune deficiency syndrome) (Serote, 1998:10). AIDS can be regarded as a syndrome, meaning that infection with this human retrovirus can produce many different clinical signs and symptoms that occur together and characterise a disorder (Gong, 1985:1; Valdiserri, 1989:1 and Watson, 1994:2). At this stage the immune system is so severely suppressed that the body cannot defend itself against infection, patients become susceptible to diseases called opportunistic infections and the body ultimately loses the capacity to defend itself against fatal infections (Barker, 1997:4).

The following responses can be regarded as being representative of the correct viewpoints of the overwhelming majority of respondents:

"It is a killing disease/germ/ virus." (11)

"This disease weakens the immune system until the person dies." (10)

"AIDS is the last stage of HIV-infection." (5)

"The HIV-infected person can easily get opportunistic infections." (5)

"It can only spread through sexual intimacy."

"I have the virus in my body that will turn to AIDS eventually and will leave me weak and dying."

The following responses can not necessarily be regarded as incorrect, but these respondents do not have the full picture:

"The virus goes from one person to another." (2)

"The virus goes from mother to child."

"Once you are HIV-POSITIVE you have to protect yourself by way of good nutritional habits."

"HIV and AIDS is one thing."

"You get HIV from someone that is already infected."

"It is a homosexual disease."

"Is it only black people that can get the virus? "

"The disease started with white people."

"HIV is a common illness."

It is thus obvious from the before mentioned data that most patients could define HIV/AIDS. There are however some patients that had little knowledge of the disease, although they have been HIV-POSITIVE for some time, attending the clinic on a regular basis and had already been counselled on AIDS and it's effects.

- THERE IS CURRENTLY A WORLD-WIDE ANXIETY REGARDING HIV/AIDS

On this question researcher wanted to know whether respondents thought that the anxiety on AIDS was out of context and not a true reflection of the disease. Almost half of the respondents did not answer this question.

The following are representative of the positive reactions:

"There is a tremendous increase in infection rates, especially in Africa." (17)

"The anxiety is warranted because I have seen people dying in our ward at the hospital and at home."(4)

"AIDS is for real!" (3)

"People all over are living and dying with AIDS." (3)

"Anxiety over the problem is necessary so that everybody can have knowledge on the disease."(2)

The following responses can be regarded as representative of the few negative reactions:

"The so-called world-wide anxiety about the illness brings unnecessary anxiety to AIDS-patients."(3)

"People are over concerned about AIDS." (2)

"I believe it because the papers say so."

- PEOPLE AFFECTED BY HIV/AIDS

With this question researcher wanted to ascertain whether respondents believed that only certain people are affected by the illness. Surprisingly the majority of respondents reacted by saying the following:

"Everybody is affected by AIDS regardless of race, religion or sexual orientation!"(33)

A large group of respondents however responded as follows:

"Only people are affected that do not practice safe sex, it is by using a condom." (12)

"Only young people are affected by the problem." (7)

"Any person who is sexually active." (4)

"Only people that are unfaithful to their sexual partners."(2)

"It seems only Blacks are affected."

On this statement there was obvious misunderstanding with many respondents. This should be rectified in AIDS campaigns so that the idea can spread that anybody can be affected by this disease.

- THE FUSS ABOUT AIDS IS UNNECESSARY AND IS ONLY A WAY OF SCARING PEOPLE

This question aimed at ascertaining respondent's opinion on the statement that the fuss about AIDS is unnecessary and is only a way of scaring people. The following remarks can be mentioned as representative of the positive viewpoints of respondents:

"AIDS is real and there is no cure!" (18)

"AIDS increases at a terrible rate and more fuss, demonstrations and awareness campaigns about the disease is necessary." (6)

"People must know how to prevent this illness." (5)

"I have firsthand experience of the disease and it is terrible!" (3)

"In our community people are buried every day!" (3)

"The fuss about AIDS is not to scare people, but to spread the truth." (2)

Most respondents mentioned the seriousness of the problem and the necessity of awareness campaigns. Rhodes and Hartnoll (1996:17) add the following: "Many…interventions fail because of the targeted social group's inability to comprehend or accept the rational model of behaviour that the intervention presumes." Adolescents tend to engage in risk-taking behaviour as part of a their transitional state – previously accepted parental and authoritative values are now questioned and tested (Valdiserri, 1989:109).

Some people responded in a negative manner as following:

"The fuss is unnecessary because I have seen people living normally with the virus."

"AIDS is a traditional disease."

"Where does this illness come from? - I would like to know!"

It is thus evident that the overwhelming majority of respondents felt that this statement is not true, whilst only three people responded positively.

SECTION 3: WAYS IN WHICH HIV/AIDS CAN BE TRANSMITTED

In this section 12 quantitative questions were asked about various ways in which HIV/AIDS can be transmitted. Respondents had to mark 'Yes', 'Uncertain' or 'No' at each statement.

- BY USING THE SAME TOILET AS AN HIV-INFECTED PERSON.

A large number of respondents, namely 54 (90%), responded correctly with a negative reply. Only 3 (5%) said that it is possible to contract HIV/AIDS by using the same toilet as an infected person, whilst the same number was uncertain.

- CONTACT BETWEEN A BROKEN SECTION OF SKIN WITH HIV-INFECTED BLOOD

Forty (66,7%) of respondents gave a positive answer to this statement, which can be regarded as the correct opinion. Eighteen (30%) responded uncertain, whilst only 2 (3,3%) said that it is not possible that you can get AIDS from contact between a broken section of your skin with HIV-infected blood.

- BY GREETING AN HIV-INFECTED PERSON BY HAND

Fifty-one (85%) of respondents answered correctly by saying that it is not possible to get AIDS by greeting a HIV-infected person by hand. Eight (13,3%) reacted uncertain, whilst only 1 (1,7%) said that it was possible.

- BY KISSING AN HIV-INFECTED PERSON

In this case there was nobody who responded with a yes, yet 19 (31,7%) reacted uncertain. The vast majority, namely 41 (68,3%), said it is not possible to get AIDS by kissing an HIV-infected person.

- BY CONTACT WITH SALIVA OF AN HIV-INFECTED PERSON

The largest group in this case, namely 32 (53,3%), reacted with uncertainty to this statement. Twenty (33,3%) of the respondents responded correctly by saying no to this statement, whilst 8 (13,3%) said that it is possible to contract AIDS by way of contact with saliva of an HIV-infected person.

- BY RE-USING INJECTION NEEDLES OF INFECTED PERSONS

An overwhelming majority of 53 (88,3%) responded correctly by saying that it is possible to contract AIDS by re-using injection needles of infected persons. Only 4 (6,7%) said no to this statement, whilst 3 (5,0%) reacted with uncertainty. To use the same syringe on multiple patients play an important role in transmitting AIDS through blood (Gong, 1985:XVIII). Interventions to prevent transmission of HIV among drug injectors have so far focused on drug use, drug injecting and syringe sharing – little focus was however put on the sexual risk behaviour of drug abusers (Rhodes & Hartnoll, 1996:10-11).

- BY SHARING CUTLERY WITH AN INFECTED PERSON

Again an overwhelming majority, 51 (85%), reacted correctly by saying that it is not possible to contract AIDS by sharing cutlery with an infected person. Six (10%) reacted with uncertainty and only 3 (5,0%) gave a positive reaction to this statement.

- BY TALKING TO AN INFECTED PERSON

In this case there was nobody who reacted positively, whilst the overwhelming majority, 53 (88,3%), reacted correctly by saying that it is not possible to contract AIDS merely by talking to an infected person. Seven (11,7%), of the respondents reacted uncertainly on this question.

- MOSQUITOES AND PETS CAN INFECT HUMAN BEINGS WITH THE VIRUS

In this case there was also nobody who reacted positively. Thirty-four (56,7%) responded correctly by saying that it is not possible to get AIDS from mosquitoes and pets. A large number, namely 26 (43,3%) reacted with uncertainty.

- BY NORMAL CONTACT WITH INFECTED BLOOD

Thirty-two (53,3%) respondents reacted correctly by saying that it is not possible to get AIDS by way of normal contact with infected blood. Seventeen (28,3%) said that it is possible, against 11 (18,3%) who were uncertain.

- TRANSFER OF THE VIRUS CAN TAKE PLACE FROM MOTHER TO HER BABY

Fifty (83,3%) of the respondents reacted correctly by saying that it is possible to spread AIDS by way of the virus from an infected mother to her baby. Seven (11,7%) reacted with uncertainty, whilst only 3 (5,0%) said no to this statement. The ability of a woman to transfer HIV-infection postnatal to her child through breast-feeding has been proved, the greatest risk being present if the mother experiences a primary HIV-infection in the postnatal period (Valdiserri, 1989:272 and Watson, 1994:12). Countering decades of promoting breast-feeding for infants, the United Nations is issuing recommendations intended to discourage woman infected with the AIDS-virus from breast-feeding. They also advise that all HIV-infected woman be informed of the risks of breast-feeding before deciding whether to let their new-born be breast fed or not – the problem is however that a large percentage of infected people in developing countries do not know that they are infected (UNAIDS, 1998:12-13). The availability of clean water supplies and breast milk substitutes, which are likely to be in short supply in areas of extreme poverty, is however important if mothers are advised not to breast-feed their babies.

- TATTOOING AND THE MAKING OF HOLES IN PARTS OF THE BODY WITH UN-STERILISED APPARATUS CAN LEAD TO THE SPREAD OF THE VIRUS

Forty (66,7%) of the respondents reacted correctly by saying that tattooing and the making of holes in parts of the body with non-sterile apparatus, can lead to the spread of the virus. Nineteen (31,7%) responded with uncertainty, whilst only 1 (1,7%) of the respondents said no to this statement.

Seeing that the respondents were all HIV-POSITIVE and have been attending the clinic for some time, it was understandable that respondents had a satisfactory knowledge of the disease. Statement 5 was however an exception with only 33,3% of the respondents who said that it is not possible to get AIDS from contact with the saliva of a HIV-infected person. A number of statements had a high uncertain response, for instance statements 5 (53,3%), 9 (43,3%), 4 and 12 (31,7% each) and 2 (30,0%).

SECTION 4: THE DEVELOPMENT OF THE PROBLEM

Three qualitative questions were put to respondents on the development of the problem.

- THE CAUSES OF THE PROBLEM

A couple of respondents admitted to the cause of their problem in the following words:

“I had no income and was working as a commercial sex worker.” (10)

“I had unsafe sexual intercourse with many people.” (7)

“By not using a condom every time I had intercourse with my partner.” (5)

“I was faithful to my one and only partner, but now I know that my partner was sleeping around.”(2)

“I only had sex once.”

Some respondents misunderstood the question and answered wrongly in the following responses:

“I went for a STD test.” (6)

“I was pregnant and had to do a test.” (4)

“I had unusual signs and symptoms, like an unusual vaginal discharge, coughing, sores and night sweating.” (4)

Some respondents were ignorant about the cause of their problem:

“I do not know where I have come into contact with the virus.” (3)

"Stress caused my problem." (2)

"I had a skin problem and that caused my problem."

"Chronic headaches caused my problem."

Just more than 40% of the respondents gave their cause for contracting the disease as they saw it. Almost 25% of the respondents misunderstood the question. Almost 12% of the respondents were ignorant of what really caused their problem, whilst 15% gave no response to the question.

THE REASONS WHY RESPONDENTS HAD THEMSELVES TESTED

The following were given as the reasons for being tested:

"My doctor advised me to go for a test because I had symptoms like loosing weight, a rash all over my body, swollen glands, difficulty to urinate and night sweating. " (17)

"Because I was pregnant and every pregnant woman is tested automatically." (11)

"I was feeling generally 'not well' for at least a year and decided on my own to get tested."(6)

"My child was diagnosed HIV-POSITIVE after birth and subsequently I had myself tested."(4)

"I was only inquisitive and had the test done." (4)

"I am a commercial sex worker and wanted to know my HIV-status." (4)

"My partner was blaming me for 'sleeping around' and I wanted to proof to him that he was wrong." (4)

"I was very ill and felt like dying - was taken to hospital by ambulance." (2)

"I attended a workshop on AIDS and decided to have myself tested."

"I did not trust my partner and had myself tested."

"Before I got married I wanted to proof to my boyfriend that I was well."

"I was tested without my consent."

Only two respondents did not answer this question. It is significant that more than a third of the respondents went to see their doctor with certain symptoms and were advised to have an HIV-test done. The second largest group of responses, namely almost 20%, were the pregnant women who attended a clinic and were automatically tested. The almost 7% response of mothers who had themselves tested only after their children were diagnosed HIV-POSITIVE, was an interesting finding. It is also interesting that only one respondent had himself tested due to the information gained at a workshop.

- FEELINGS WHEN THE RESULTS OF THE TEST WERE MADE KNOWN

The following negative feelings can be seen as being representative of the total group:

"I did not believe the diagnosis and was in total denial of the problem - what did I do wrong?" (16)

"I was angry." (7)

"I felt depressed and rejected." (6)

"I was shocked." (5)

"Feelings of hopelessness and sadness overwhelmed me - what about my children?"(4)

"I was frightened and did not know what to do - death was suddenly a reality." (4)

"I blamed my partner and felt deep feelings of hatred towards the person." (3)

"I felt like killing myself." (2)

"I felt like killing my partner." (2)

"I was furious towards my counsellor." (2)

"I could not stop crying."

Understandably almost all of the respondents had negative feelings like anger, depression, rejection, shock, hopelessness, sadness and fear. Denial was the overwhelming emotion of a large number of the respondents. Blaming others for the problem and feelings of suicide and murder were present with a couple of respondents. Two respondents had negative feelings of blaming the counsellor, which could also be understood in these circumstances.

The following few respondents had feelings of being relieved, freed and to make the best of life:

"I was relieved and 'free' because at least now I knew what the infection on my 'private parts' was all about." (5)

"I could only blame myself and accept the situation – now I can start living." (2)

"I thought that this is not the end of my life, I am going to fight the disease and make the best of every opportunity."

SECTION 5: THE CONSEQUENCES OF THE PROBLEM

In this section five qualitative questions on the consequences of the problem for respondents were discussed.

- THE PERSONAL EFFECT OF THE PROBLEM

The following can be seen as being representative of the personal effect of the problem on respondents:

"I have to guard my HIV-status with the utmost secrecy that nobody should know."(21)

"I am afraid to tell my partner that I am HIV-POSITIVE, because he will leave me." (9)

"Stigmatisation, prejudice and discrimination by the community." (7)

"The sure knowledge that I am going to die overwhelms me." (6)

"What is going to happen to my children once I cannot support them?" (5)

"How long will I have to wait for a cure for this disease?" (4)

"My partner said that I was to blame for the problem - left me with nothing seeing that we had no legal marriage contract." (2)

"I have no place to stay and are forced to stay with my brother and his family in a two roomed flat."

"No support from my husband."

"Due to the illness I will never be able to have children of my own."

The fact that so many respondents (more that a third) kept their HIV-status a closely guarded secret, is problematic seeing that they are lonely and desperate because they have no support systems and have to cope with the problem on their own. Another third of the respondents had negative expectations of the future in one way or another. Being afraid to tell the partner of the diagnosis, was evident with about 15% of the respondents, whilst discrimination by the community at large was faced by more than 11%.

- THE CURRENT MOST SERIOUS PHYSICAL PROBLEM

The following responses are representative of the most serious physical problems encountered by respondents:

"Loosing weight." (21)

"Tuberculosis and chronic coughing." (17)

"Skin irritations and sores." (11)

"I am tired all the time." (11)

"Night sweating." (9)

"I have chronic diarrhoea." (6)

"Pains in my chest." (3)

"Problems with my private parts." (3)

"I have no appetite." (2)

"Continuous pains in my legs."

"Pains in all my joints."

The total in this case was more than the number of respondents due to the fact that most of the respondents gave two and three physical symptoms. Almost 16% of the respondents answered that they had no physical symptoms at this stage - probably the one's that were asymptomatic only for a short time at the time that the interviewing took place. From the data it is clear that unexplained weight loss, tuberculosis and chronic coughing, skin irritations and sores, tiredness and night sweating posed the biggest problems for respondents. Gong (1985:1) and Watson (1994:1) agree with the before mentioned symptoms and add the following: loss of appetite, fever, swollen glands, persistent diarrhoea, anorexia, shortness of breath, oral thrush and bruising/bleeding.

- THE CURRENT MOST SERIOUS EMOTIONAL PROBLEM

The following can be mentioned as being representative of the most serious emotional problems experienced by respondents:

"I feel depressed all the time." (24)

"Anxiety." (8)

"I am bitter towards everybody." (7)

"Stress." (6)

"Worry and sad about my children that will stay behind." (4)

"I deny my problem." (4)

"I feel anger towards the community." (4)

"I fear the opinion of others." (4)

"Rejection by family members and the community." (4)

"Uncertainty about life after death." (3)

"I feel lonely most of the time." (3)

"I cannot think straight - I have a mental block and feel mentally disturbed." (3)

"Thinking morbid thoughts about death." (2)

"People are hostile towards me." (2)

"I have regrets about things that I have said to other people." (2)

The totals in this case were also more than the number of respondents because some respondents listed two and even three emotional symptoms. Some 10% responded by saying that they had no emotional problems at this stage – this could also be a denial reaction. It is evident that almost half of the respondents mentioned depression as their major emotional problem. Anxiety, bitterness, hostility and stress were in the second place, whilst many other emotions scored about the same low response. Gong (1985:39) and Watson (1994:2) support these findings and add the major role that depression, delusions, hallucinations, paranoia, confusion and dementia play in this illness. Gong (1985:180) also mentions the fear of death as being realistic and a frightening happening in the lives of AIDS patients.

ANY OTHER PROBLEMS EXPERIENCED CURRENTLY experienced

A couple of other problems were mentioned, besides the physical and emotional problems discussed in the previous two sections. As examples of 'other problems' the following can be mentioned:

"It seems that everybody on the street knows that I am HIV-POSITIVE." (14)

"I do not know what to answer people that ask questions about me losing weight and sores on the body."(4)

"Bad treatment by nurses." (3)

"Curiosity and nosiness of volunteer workers." (2)

"I have no income due to the fact that I have lost my job due to my ill health."

"I was fired from my job as soon as my HIV-status became known."

"I do not enjoy sex like before."

The feeling that everybody knows their HIV-status was mentioned by 25% of the respondents. This is quite an understandable reaction with most people facing any particular problem. Other problems that were mentioned can be summarised as not knowing what to answer people and bad treatment by nurses and volunteers.

- THE INFLUENCE OF THE PROBLEM ON FUTURE PROSPECTS

The following responses can be regarded as being representative of the qualitative responses on the influence of the problem on future prospects:

"I will never see my children growing up – who is going to take care of them?" (11)

"I will never have healthy children of my own." (9)

"I will always be treated with discrimination and rejection by the community. This will result in loneliness and isolation." (7)

"I feel sad about my relationship with my partner that has been terminated." (7)

"All my wonderful dreams have come to nothing." (7)

"I am going to die before my time – before I have reached my goal!"(5)

"Death is facing me at all times." (2)

"I feel sad to leave my poor parents behind."

"I am going to get very ill very soon."

"My career is coming to nothing."

"I will still keep on hoping for a cure for the disease."

Concern for their children without parents was mentioned by more that 18% of the respondents, whilst the fact that they will never have healthy children of their own, were mentioned by 15% of the respondents. Unfulfilled dreams, relationships with partners that were terminated, as well as discrimination, rejection, loneliness and isolation all received about 12% response. The ever-present threat of death and dying was also mentioned by almost 12% as well. Marcenko and Samost (1999:36, 44) support the notion of HIV-POSITIVE mothers' way of coping with the infection, particularly as it relates to parenting and their concerns, preferences and plans for the future care of their children. These mothers also live with discrimination, stigmatisation and oppression for them and their children, a fact evidenced by the term 'AIDS orphans'. Poindexter and Linsk (1999: 56) also mentioned the stigmatised status that has been ascribed to people living with HIV, like discrimination and a lack of support.

SECTION 6: SUPPORT SYSTEMS

In this section one quantitative question and two qualitative questions on support systems were discussed with respondents.

- ADEQUATE SUPPORT SYSTEMS IN DAILY FUNCTIONING

Respondents had to mark anyone of the following four categories on the statement whether they had adequate support systems in their daily functioning, namely definitely yes, yes, no or definitely no. The definitely no category had the highest response, namely 24 (40%), whilst the yes category had the second highest response, namely 18 (30%). If the definitely yes and yes responses are calculated together, 24 (40%) of the respondents had adequate support systems. If the no and definitely no responses are added up, it can be seen that 36 (60%) of the respondents did not dispose of adequate support systems. The motivation for these responses will be given in the next discussion.

- THE MOTIVATION OF THE RESPONSES

Exactly a third of the respondents, namely 20, did not motivate their response to the previous question. The remaining 40 respondents that motivated their response can be divided into 16 (40%) positive remarks against 24(60%) negative responses. The respondents who motivated their positive response, can be qualitatively quoted in the following words:

"I belong to a support group that has weekly meetings." (6)

"I have a proper job and caring colleagues." (2)

"My parents support me fully." (2)

"My partner."

The following negative responses to the previous question, can be mentioned as following:

"Nobody knows of my HIV-status – so I just have to cope on my own." (9)

"My volunteer worker from the clinic is my only support system – I see him once a month." (6)

"My family turned their back on me and I am totally lost!"

"I am very weak and have nobody to support me."

Of the positive responses more than 37% respondents mentioned a weekly functioning support group. It can however be remarked that a support group is a wonderful means of supporting people, but what happens to the patient in between the weekly meetings? Of the negative responses, concern can be raised for the more than 37% respondents that have to cope on their own due to the fact that nobody knows of their HIV-status. The same apply for the 25% respondents that have the volunteer from the clinic as their only support and then only with monthly contacts.

- SUPPORT SYSTEMS IN ORDER OF VALUE DERIVED

Naturally only the 24 (40%) of the respondents that declared that they had support systems, could rank it in order of the value derived from it. The following can be regarded as being representative of respondents' support systems:

"The staff and patients at the Wola Nani Clinic are wonderful." (9)

"My parents and direct family (brothers and sisters) means a lot to me." (7)

"God is my only support and all my trust is in Him."

"My friends support me tremendously."

"My relatives."

"My partner supports me."

The finding that the clinic is the most valuable support system to respondents (more than 37% mentioned it) can be seen as positive and as a motivation for the establishment of even more clinics of this nature. It was also interesting to note that the family took second place with just over 29% of the respondents. That a clinic could mean more than the family bond can be regarded with interest and say something for mutual trust and support in the family. Only one respondent mentioned the partner as a support system, which can be regarded as surprising seeing that all of them had partners at some or other stage.

SECTION 7: PREVENTATIVE MEASURES

One qualitative and one quantitative question were put to respondents in order to ascertain their opinion on preventative measures for the problem.

- SUGGESTIONS FOR PREVENTATIVE MEASURES FOR THE PROBLEM IN SOUTH AFRICA

Some respondents gave more than one suggestion for preventative measures for the problem. The following can be mentioned as examples of positive suggestions to prevent the problem in South Africa:

"Education and the correct information on HIV is urgently needed – people do not believe what the virus can do to them." (24)

"Women's rights and powers should be recognised!" (9)

"Cheap medical treatment is important to help patients." (5)

"All parties involved, like the home, the school and the church should work together to combat the problem." (3)

"Medicine and traditional healers must work together to combat the problem." (3)

"A moral obligation to be faithful to your partner is the only solution to this problem." (3)

"People that know that they are infected and do not abstain from sex, should be punished in one way or another." (2)

"Infected people should abstain from sex for moral reasons."

Noteworthy is the overwhelming support for education and the passing on of the correct information. According to Rhodes and Hartnoll (1996:4) all interventions should aim at risk reduction and behaviour change. A common misconception is that healthy behavioural patterns can be induced merely by informing people of the dangers of unhealthy behaviour (Valdiserri, 1989:91). The everyday shared norms, values and practices of a peer group or community is important in influencing individual behaviour changes (Rhodes & Hartnoll, 1996:177). Fraser-Moleketi (1999:1) support education and especially the practical side of it in the following words: "The problem facing the country is that most people do not see any evidence to suggest that HIV/AIDS poses a major threat to the nation." The empowerment of women was also stated by a fair number of respondents. Fraser-Moleketi (1999:2) adds the following: "Women who are educated, informed, free to decide what to do with their lives constitutes an efficient weapon in the fight against health problems such as HIV/AIDS. The fight against HIV/AIDS must become an assertion of women's basic human rights. Women must break the silence about the taboos around and the violence of HIV/AIDS." Reinforcements in the overall community norms and practices are of utmost importance – not only individual change, but community change should be advocated. All the other suggestions had rather little backing, but it is of interest to take note of. Gong (1985:129) supports the moral issues by saying that blatant carelessness will almost certainly damage health and may amount to moral irresponsibility. People with AIDS or exposed to AIDS have a moral responsibility to take reasonable precautions to protect their own health and the health of others, meaning the modification of sexual behaviour and refraining from donating blood (Gong, 1985:131-132).

The following can be regarded as rather negative suggestions to prevent the problem due to the fact that these suggestions are not practical.

"Condoms must be distributed to all parts of our country."(16)

"Young people must be restricted by law to have sex before they are legally married."(3)

"A cure must immediately be discovered for this illness."

Condoms are not 100% safe. Safer sex is not just about condoms – commercial sex workers should be negotiating condom use with clients or reach agreement about having other kinds of nonpenetrative sex. Rhodes and Hartnoll (1996:105) say that skills and confidence should be developed in order to be assertive in relationships. You can also not force people to abstain from extra-marital sexual relationships. A cure for the illness is also not available at this moment, although hopeful signs for a cure is presently coming to the forefront (Beeld, 12 March 1999).

- THE AGE GROUP ON WHOM PREVENTION SHOULD BE FOCUSED

On this quantitative question respondents had to mark any one of seven categories, namely under 7 years, 7-11 years, 12-15 years, 16-18 years, 19-21 years, 22-24 years and over 25 years. Most of the respondents marked the 12-15 years category, namely 23 (38,3%). The second largest group fell in the category of 16-18 years, namely 18 (30,0%). Thus almost 70% of the respondents targeted the age group 12-18 years. Most people would surely agree with this response because the youth has to be reached after puberty has started, but before actual sexual activity has set in. For this reason 18 years is perhaps too old. The group 12-16 years would thus be the ideal age group to target for preventative education.

SECTION 8: GENERAL

By way of concluding the schedule two qualitative questions were put to respondents on any further viewpoints on HIV/AIDS and any general viewpoints they might have that were not discussed previously in the schedule.

- FURTHER VIEWPOINTS ON HIV/AIDS

Fifty-three respondents gave further viewpoints on HIV/AIDS. The following can be regarded as being representative of the viewpoints:

"The community should be much more accepting of these patients." (13)

"All possible efforts should be done to find a cure for this disease – what will happen to future generations?" (7)

"Educating the youth should be the main aim – not only a theoretical training, but allow consenting patients to tell their story to the youth." (5)

"Something should urgently be done to the stigmatisation and discriminatory practices of health workers." (5)

"The treatment of patients should improve." (3)

"Free medical care should be offered to all patients." (3)

"Traditional healers should be banned from practice – they cannot cure the disease, but only suppress it."(2)

"Traditional healers should be made part of the medical solution for AIDS." (2)

"Straight talk on AIDS is important – for too long we have spoken of AIDS in 'soft' terms!"

"The government budget for this illness should be increased – spend less money on arms!"

"Sheltered employment projects should be erected for patients so that they can earn a living for themselves."

"People should be tested for HIV, even without their consent."

"Everybody's HIV-status should be made known to the community in order that the public can be aware of these people."

"Infected people should be in isolation (like in prisons) in order not to infect more people."

From these further viewpoints it was realised that more than 33% of the people who responded to this question (namely 53), mentioned discriminatory behaviour by health workers and the community at large. Gong (1985:131-132) says that society at large has the same obligation to people with AIDS as it has to others who need assistance in maintaining their health and the treatment of illness in general. To find an urgent cure for this disease, was a priority with over 13% of the respondents, whilst more than 11% mentioned free and improved medical care for all HIV-patients. Educating the youth was once again mentioned by more than 9% of the respondents. Some responses for and against traditional healers were brought up by just over 7%. For the rest, six interesting but very personal, viewpoints were discussed by a couple of individual respondents.

- FURTHER GENERAL VIEWPOINTS

Only 16 respondents gave further general viewpoints. These viewpoints could be classified into the following four broad categories:

"On the macro-level the government should start with job creating projects to eradicate poverty – once poverty is addressed, problems like AIDS will also diminish."(6)

"The high levels of crime should be addressed – then problems like AIDS will also disappear." (4)

Non-stop prayer for our country is the only solution for all our problems!" (3)

"Life skills training and workshops in the broadest sense of the word (like conflict management and the value of sound relationships) should be done from our biggest city to our smallest village!" (3)

A lack of adequate resources and appropriately managed programs could result in a curtailment of treatment facilities, like the distribution of condoms and other contraceptive services for women of child-bearing age, the use of sterilised medical equipment, laboratory services for testing patients and screening blood and ongoing surveillance activities to monitor the spread of the epidemic (Valdiserri, 1989:273).

FINDINGS AND RECOMMENDATIONS

- South Africa has one of the most serious HIV/AIDS problems in the world. A culture of silence exists in South Africa regarding this illness. All efforts should be made to break the silence.
- Participant observation and semi-structured interviewing were found to be of excellent value in the qualitative paradigm of the social sciences.
- On the small sample of this study the profile of HIV/AIDS patients is: single, young (plus-minus 25 years old), female, moderately qualified with at least one illegitimate child.
- Respondents had a fair knowledge of the term HIV/AIDS, could give their opinions on the crises of AIDS, the people affected by the disease and ways in which the disease can be transmitted.
- Most of the respondents could explain the cause of their illness, the reasons why they had themselves tested and the feelings when the results were made known.
- The wide range of negative emotions on future prospects, was interesting and is definitely a field for future research.

- The majority of respondents did not have adequate support systems and need further attention form social scientists.
- Excellent suggestions were made for preventative measures for the problem. Proper education consisting of the correct information, coupled with the practical aspects of the illness, and having patients as speakers at seminars, were mentioned. The focus group for prevention should be 12-16 years. The empowerment of women also received support, as well as the moral obligation of patients towards partners and the community at large.
- A large number of respondents pleaded for less stigmatisation and discriminatory practices towards patients by health workers and the community.
- On a macro-level suggestions were made towards the eradication of poverty, crime and corruption. Respondents felt that this would address the real issues in South Africa that have an influence on the AIDS problem. Life skills training and workshops in the broadest sense of the word should also play an important role in educating people for life.

SUMMARY

This study was implemented in an AIDS clinic in order to gain the perceptions and feelings of a number of patients. Participant observation and semi-structured interviewing were used as the data-collection methods for the study. The South African Aids scenario was discussed with emphasis on the empirical study. Besides a number of quantitative questions to put the study in perspective, the main emphasis of the study was on qualitative data regarding the consequences of the problem, support systems and preventative measures for the disease.

REFERENCES

BAILEY, KD 1994. **Methods of social research.** New York: The Free Press.

BARKER, RL 1997. **The social work dictionary**. Washington: NASW Press.

BEELD 25 November 1998, 29 December 1998, 12 February 1999, 28 February 1999, 4 March 1999 and 12 March 1999. Johannesburg: South African daily newspaper.

BERNSTEIN, AJ & VAN ROOYEN, CAJ 1994. Sociocultural factors and their importance in working with people with AIDS in South Africa. **Social Work/Maatskaplike Werk**, 30(4):375-382.

BLESS, C & HIGSON-SMITH, C 1995. **Fundamentals of social research methods – an African perspective.** Johannesburg: Juta & Co.

BRYMAN, A 1988. **Quantity and quality in social research.** London: Routledge.

CRESWELL, JW 1994. **Research design: Qualitative and quantitative approaches.** London: Sage.

DANE, FC 1990. **Research methods.** California: Brooks/Cole Publishing Company.

DENZIN, NK & LINCOLN, YS 1994. **Handbook of qualitative research.** Thousand Oaks: Sage.

DE VOS, AS; STRYDOM, H; FOUCHE, CB; POGGENPOEL, M. & SCHURINK, EW 1998. **Research at grass roots: a primer for the caring professions.** Pretoria: JL van Schaik Academic.

DEY, I 1993. **Qualitative data analysis: a user-friendly guide for social scientists.** London: Routledge.

ERLANDSON, DA; HARRIS, EL; SKIPPER, BL & ALLEN, SD 1993. **Doing naturalistic inquiry: a guide to methods.** London: Sage.

FRASER-MOLEKETI, GJ 1999. Women in partnership against AIDS. **Newsletter.** Pretoria: Ministry for Welfare and Population Development, 1-8, 26 January.

GONG, V 1985. **Understanding AIDS: a comprehensive guide.** London: Cambridge University Press.

GRIESEL, RD & WEGE, JW 1998. **South African AIDS Network: A directory of The National Aids Database.** Pretoria: Department of Health.

GRINNELL, RM 1993. **Social work research and evaluation.** Itasca: FE Peacock Publishers.

HAMMERSLEY, M 1989. **The dilemma of qualitative method: Herbert Blumer and the Chicago Tradition.** London: Routledge.

MARCENKO, MO & SAMOST, L 1999. Living with HIV/AIDS: The voices of HIV-positive mothers. **Social Work,** 44(1):36-45.

MARK, R 1996. **Research made simple: A handbook for social workers.** London: Sage.

MARLOW, C 1993. **Research methods for generalist social work.** Pacific Grove: Brooks/Cole Publishing Company.

MORSE, JM 1997. **Completing a qualitative project: Details and dialogue.** London: Sage.

MULLER, JH 1995. Care of the dying by physicians-in-training. **Research on Aging,** 17(1):65-88.

NEUMAN, WL 1997. **Social research methods: qualitative and quantitative approaches.** Boston: Allyn and Bacon.

PADGETT, DK 1998. Does the glove really fit? Qualitative research and clinical social work practice. **Social Work,** 43(4): 373-381.

POINDEXTER, CC & LINSK, NL 1999. HIV-related stigma in a sample of HIV-affected older female African American caregivers. **Social Work,** 44(1):46-61.

PRESTON-WHYTE, EM 1985. Understanding how other people think and behave: Participant observation and ethnographic interviewing as a resource to fields of practice such as social work, nursing and teaching. (Lecture delivered on 5 October 1985 as part of a course in research possibilities for practice disciplines.) Johannesburg: Rand Afrikaans University.

RHODES, T & HARTNOLL, R 1996. **AIDS, drugs and prevention: perspectives on individual and community action.** London: Routledge.

ROYSE, D 1995. **Research methods in social work.** Chicago: Nelson-Hall Publishers.

RUBIN, A & BABBIE, E 1997. **Research methods for social work.** Pacific Grove: Brooks/Cole Publishing Company.

SEROTE, YM 1998. HIV/AIDS patients' management of depression. Johannesburg: Rand Afrikaans University. (MA Thesis)

SHEPPARD, M 1995. Social work, social science and practice wisdom. **The British Journal of Social Work,** 25(3):265-293.

SINGLETON, R; STRAITS, BC; STRAITS, MM & MCALLISTER, RJ 1988. **Approaches to social research.** New York: Oxford University Press.

TEDLOCK, B 1991. From participant observation to the observation of participation: the emergence of narrative ethnography. **Journal of Anthropological Research,** 47:69-94.

TRIPODI, T 1983. **Evaluative research for social workers.** New Jersey: Prentice-Hall.

TUTTY, LM; ROTHERY, MA & GRINNELL, RM 1996. **Qualitative research for social workers.** Boston: Allyn & Bacon.

UNAIDS, 1998. United Nations discourages breast-feeding to curb AIDS. **Aids Scan,** 10(3):12-13.

VALDISERRI, RO 1989. **Preventing AIDS: the design of effective programs.** London: Rutgers University Press.

VAN DER BURGH, C 1988. **The methodology of participant observation: introduction to qualitative research methods.** Pretoria: Human Sciences Research Council.

VILJOEN, AT 1990. VIGS in Afrika, met spesiale verwysing na Suid-Afrika. **Koers,** 55(3):329-343.

WATSON, RR 1994. **Nutrition and AIDS.** London: CRC Press.

WILLIAMS, M; TUTTY, LM & GRINNELL, RM 1995. **Research in social work: an introduction.** Itasca: FE Peacock Publishers.

YEGIDIS, BL & WEINBACH, RW 1996. **Research methods for social workers.** Boston: Allyn & Bacon.

YORK, RO 1997. **Building basic competencies in social work research: An experiential approach.** Boston: Allyn and Bacon.