

**AWARENESS OF AIDS AMONG STD CLINIC ATTENDERS IN
THE CAPE PENINSULA**

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1. ABSTRACT

This descriptive study aimed to determine the knowledge, attitudes and practices about AIDS among Sexually Transmitted Disease (STD) clinic attenders in the Cape Peninsula. A questionnaire containing open and closed questions in the appropriate language (English, Afrikaans or Xhosa) was administered by trained clinic staff to 306 patients in 9 of the 29 STD Clinics in the region. The study was requested by the local authorities to initiate and improve AIDS education programmes within the STD clinics. 306 patients were interviewed in 9 clinics.

The median age of attenders was 25 years. The median period of residence in the peninsula was 7 years. Knowledge of AIDS is reasonably good when tested by true/false questions but much worse when tested by open questions. Knowledge bears little relationship to practice. There is inadequate awareness of the asymptomatic carrier state, the incurability of AIDS and ways to prevent AIDS. Sexual practice is high risk. Condom use is extremely low especially in the African areas where only 9,6% used a condom in the past year. Prostitution is perceived to be a common occurrence in attenders' communities. There is a low perception of risk to self. The most important beliefs militating against condom use are that they are unacceptable to partners and peer group. More information about AIDS was requested by 90% of patients and a strong preference was

expressed for programmes to be conducted in the patient's home language.

This study supports the urgent need for an AIDS education and counselling programmes for patients with STD's in the region. Recommendations include the need to address the emotions, attitudes and beliefs that affect behaviour as well as to convey knowledge. Condom acceptability poses a major problem that will need to be addressed. Patients with STDs represent an extremely important core group for HIV transmission to others in the community and need specific attention and resources.

Key Words: AIDS/SEXUALLY TRANSMITTED DISEASES/HEALTH EDUCATION

2. INTRODUCTION

The HIV/AIDS epidemic constitutes one of the greatest threats to public health this century. In the absence of a cure or vaccine, health education to promote behavioural change has been widely advocated and used. Priority AIDS education programmes should be targeted and designed for individuals involved in high risk behaviour. Patients with sexually transmitted diseases (STD's) have been identified as an important group in this respect.

There are 29 STD Clinics in the Cape Peninsula administered by the Cape Town City Council or Western Cape Regional Services Council. The clinics treated 18 000 new cases of STD's and had a total of 37 000 patient attendances during 1989.

This thesis reports on a descriptive study of the knowledge, attitudes, beliefs and practices (KAP) about AIDS of STD clinic attenders in the Cape Peninsula. The study was requested by the local authorities mentioned above in order to design a health education programme for their 29 STD Clinics.

The report begins with a review of the interrelationship between AIDS and other STD's and provides a motivation for targeting health education programmes at STD clinics (section 3.1). This is followed by a review of some health education issues related to AIDS including a motivation for studies of knowledge, attitudes, beliefs and practices about AIDS. This

information is widely regarded as important in developing targeted, locally applicable health education programmes (section 3.2). A review of some gender issues relating to AIDS education follows (section 3.3).

This is followed by the sections outlining the aim of the study (section 4) and its objectives (section 5). The study's methodology follows (section 6). The study used a participatory approach where health educators, nurses and policy makers within the STD Clinic services were actively involved in all the phases of the study.

This is followed by presentation of results in section 7 and their discussion in section 8. Recommendations arising from the study are made in section 9. The appendices (section 12) include both questionnaires (Afrikaans and Xhosa) and a presentation of results in order of questions on questionnaire.

At all stages the researchers collaborated very closely and successfully with the local authorities. Staff working in the STD Clinics received a considerable amount of training as part of the study. The results of the study were presented to policy makers, health educators, professional nurses and doctors working within the clinics in four highly successful meetings. Already changes are being initiated as a result of the study. The study also prepares the ground for an intervention study to be conducted in the STD clinics.

3. LITERATURE REVIEW

3.1 AIDS AND SEXUALLY TRANSMITTED DISEASES

I will begin this section by providing an epidemiological model for the spread of STD's including HIV/AIDS.

To be sustained in a human population, a STD must succeed in infecting a human host, who on average, transmits the infection to at least one susceptible person. The reproductive rate (R) is defined by this number.¹ If the number is greater than 1, the prevalence of infection increases, if less than one the prevalence declines. Infection is maintained at endemic levels when R equals exactly one.

The reproductive rate is determined by 3 interacting variables: a measure of infectivity or transmissibility (b), a measure of duration of infectiousness in years(d) and a measure of interaction rates between susceptibles and infectors (sex partner change rate/year) (c).

$$R = b*d*c$$

The critical behavioural risk factor affecting reproductive rate is the number of sexual partners or rate of sex partner change.

There is considerable variation in the number of sexual partners between individuals. The results of one study are shown in Figure 1.

Figure 1. Distribution of number of sexual partners.

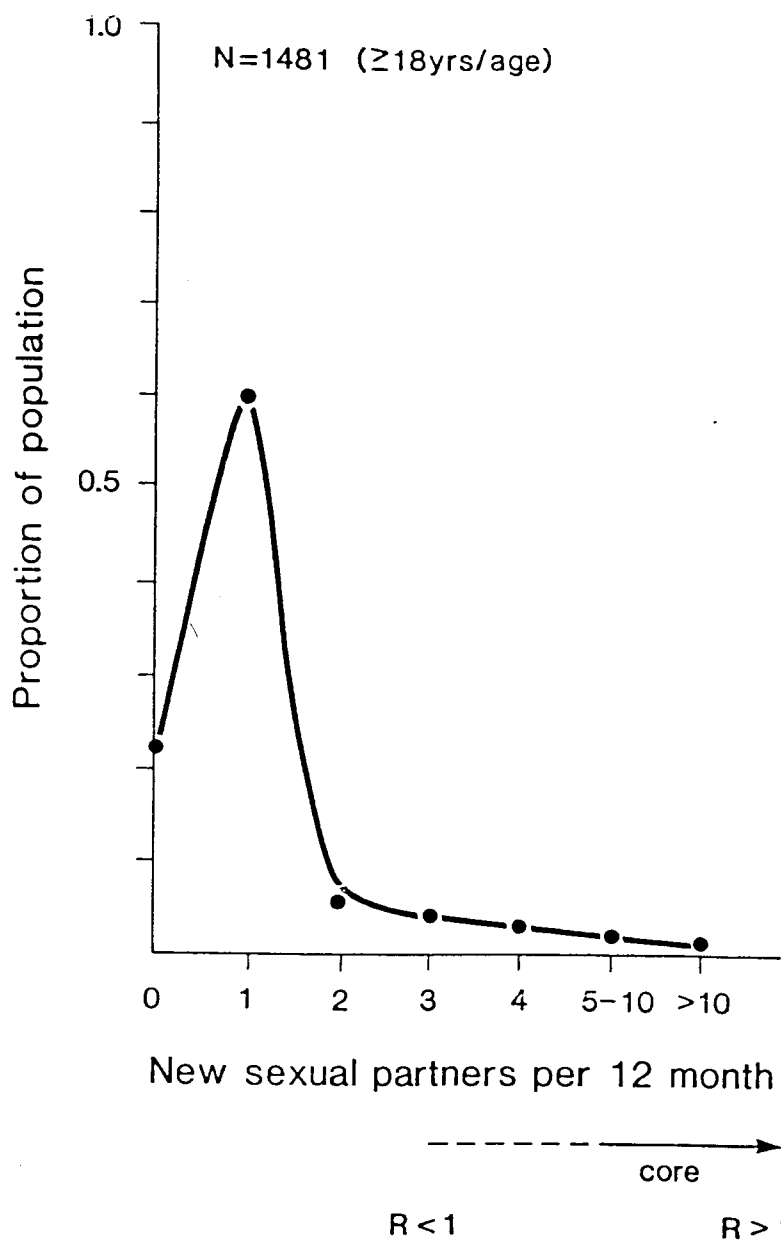


Figure 1 The distribution of the number of new sexual partners in the prior 12 months in a random sample of 1481 individuals in the United States. (Data from Centers for Disease Control: Number of sex partners and potential risk of sexual exposure to human immunodeficiency virus. MMWR 37:565-568, 1988.)

A long tail of individuals who have high rates of new partner acquisition is observed. Although only a minority of the population, these individuals are vital to the perpetuation of STD's. They have a high rate of prevalence and incidence of STD's, act as a reservoir of infection, and are the source of infection to others. They may be termed "core group" members or "high frequency transmitters of STD's".^{1,2} These individuals sustain STD transmission because only they maintain the reproductive rate of infection > 1 . Any change in behaviour among core group members affects HIV transmission more than change in others.

STD Clinics and patients with STD's have been identified as an important target for HIV intervention strategies.^{1,3,4,5,6} I will discuss several reasons for this.

- (1) Patients with STD's are at increased risk of contracting HIV infection.

Several studies have reported or predicted increasing levels of HIV seroprevalence among patients with STD's. Padayachee and Schall⁷ using HIV seroprevalence data calculated the odds ratios of being HIV-positive in various groups as compared to male blood donors who had the lowest seroprevalence rate. The results are shown in Table 1.

Table 1. Odds ratio of being HIV positive

	Odds ratio	95% confidence interval		
Male blood donors (whole of South Africa)	Baseline			
Antenatal clinics (greater Johannesburg area)	1,7	1,3	-	2,3
Female blood donors (whole of South Africa)	1,5	1,1	-	2,0
Family planning clinics (greater Johannesburg area)	4,8	2,8	-	8,1
STD clinics, miners	5,8	4,6	-	7,3
STD clinic, men (greater Johannesburg area)	7,2	5,0	-	10,3

STD attenders are clearly more at risk compared to other sentinel groups. In a study at a Johannesburg STD clinic seroprevalence was 2,9%. They predicted this would rise to 7,3% at end of 1990 and 17% at end of 1991. O'Farrell⁸ reported a 2,9% seropositive rate among recurrent STD clinic attenders in a Durban clinic in 1988. In the Western Cape in 1989 there was a seropositive rate of 0,7% in STD clinics compared to 0.075% in antenatal clinic attenders.⁹

Nunn¹⁰ quotes a study from Nairobi, Kenya on men with a genital ulcer. HIV seropositivity was 3% in 1981, 6% in 1982, 14% in 1983 and 15% in 1985. In a Zambian study of STD patients HIV seropositivity was found in 37% of recurrent and 20% of first time attenders.¹⁰

There are several reasons for this increased risk to STD attenders:

(1.1) HIV/AIDS is itself a sexually transmitted disease and indeed in South Africa the predominant mode of transmission of HIV is by sex. Since 1987 heterosexual transmission has become the most important mode of spread of the virus in South Africa.^{8,11,12}

(1.2) Patients with a STD are at increased risk for contracting HIV infection because of behavioural risk factors. STD attenders and particularly repeat attenders are more likely to have a high sex partner change rate and practise other risky behaviours such as visiting prostitutes and are less likely to use condoms and other protective strategies.¹

(1.3) Patients with a STD are at increased risk for contracting HIV infection because of biological risk factors. Genital ulcers constitute an important cofactor for HIV infection. STD attenders with genital ulcers have been repeatedly shown to be at greater risk for HIV infection than their non ulcerative STD counterparts.^{1,3,5,13,14}

For example a Zimbabwean study found that 60% of the wives of seropositive men were seropositive. Men with a history of genital ulcer disease (GUD) were more likely to have a seropositive wife (relative

risk 1,94; 95% confidence interval = 1,62 to 15,13).¹⁵

A Kenyan prospective study of men who acquired a STD from a prostitute demonstrated that seroconverters were more likely to present with GUD than urethritis (relative risk 7,7).¹⁶

Genital ulcers are far more prevalent in African and other developing countries than in developed countries. In developing countries the proportion of patients with STD's who present with ulcers ranges from 10% to 30% compared to 2% to 5% in developed countries.¹³

Many studies have suggested that this may be the predominant reason for the heterosexual epidemic in some African countries compared to the homosexual epidemic in developed countries.⁵

- (2) The group is geographically accessible at points of treatment such as STD Clinics and primary care centres. At STD Clinics in particular access can be gained to this group of individuals at higher risk for acquiring HIV infection.
- (3) When a person practising high risk behaviour contracts a disease he may feel more vulnerable and experience less

denial and greater dissatisfaction with his current behaviour, factors which are favourable to health education.^{17,18} Thus when a person practising high risk sexual behaviour contracts an STD (s)he may be more open to health education and behavioural change.

- (4) Although no national data is available on numbers of patients with STD's in South Africa it is clear from Medical Officer of Health (MOH) reports of municipal areas that there are hundreds of thousands of patients treated yearly for STD's. For example MOH reports for the City of Cape Town and Western Cape Regional Services Council report 37000 attendances at STD clinics in 1989. Models have suggested that the STD group will, because of its large size and because of the behavioural and biological factors mentioned above, contribute very significantly to the growth of the HIV epidemic in South Africa.
- (5) Some STD attenders are already infected with the HIV (dual infection) and as discussed above are more likely to be already infected than other sentinel groups. Health education to promote behaviour change in those already infected is clearly desirable.

In addition HIV infection accentuates the clinical manifestations of other STD's such as syphilis, warts and herpes as well as making their treatment more difficult.

All the above point to the importance of the STD Clinic as a specific target for AIDS intervention programmes.

Internationally STD services have been faced with an increasing number of incurable viral STD's (HIV, herpes, HPV), STD's that are more difficult to diagnose (chlamydia) and increasing drug resistance (gonococcus, chancroid).⁶ All this has led to an increased emphasis on prevention programmes focussing on education. Numerous studies have recommended that control efforts against AIDS should go hand in hand with efforts against other STD's and have called for strengthening of programmes for STD control.^{1,3,4,5,6}

3.2 AIDS AND HEALTH EDUCATION

The HIV/AIDS epidemic is a major threat to public health in South Africa . In the absence of a cure or vaccine for AIDS, health education to promote behavioural change is an extremely important strategy for control of the disease.^{19,20,21,22,23,24} That behaviour can change is well demonstrated in a cohort study of 313 homosexual men in San Francisco. Followed from 1978 to 1988, HIV seroconversion rates were reduced from 19,6% in 1982 to 1,8% in 1988, coincident with a decrease in the average number of partners for receptive anal intercourse from 16 to less than 0,1 per year. This trend paralleled the number of cases of gonococcal proctitis which fell from 4675 cases in 1978 to 169 cases in 1988.²⁵ Although many other education interventions have not

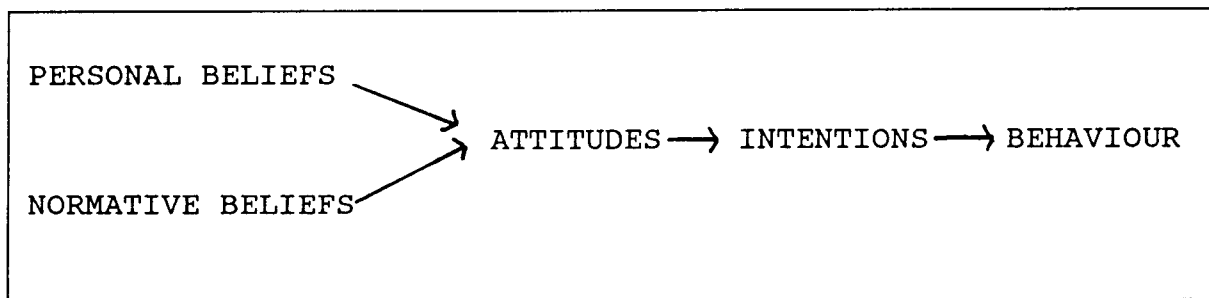
managed to achieve such dramatic impact, successful behaviour change in the homosexual community continues to motivate preventive efforts aimed at other target groups.

In order to plan and evaluate health education programmes it is essential to have a good understanding of local knowledge, attitudes, beliefs, and sexual practice (KAP or KABP) concerning AIDS. According to the World Health Organization such information is fundamental to the planning of AIDS prevention and control programmes, especially to the development of educational strategies.¹⁹ The WHO have developed their own detailed questionnaire on this subject.²⁶ Obtaining this information should be a priority within each AIDS programme. To permit cross-national comparisons, studies should use standardized methods to the maximum extent possible.

It is essential that AIDS education programmes be evaluated.^{24,27,28} Recently attempts have been made to begin evaluating South African programmes^{29,30,31} and much greater emphasis will need to be placed on this area in the future. Padayachee has briefly reviewed different types of evaluation research of AIDS prevention programmes including formative, process, outcome and impact evaluation.³⁰ KAP studies have frequently been used to design education programmes and as part of formative and outcome evaluation of these programmes.^{28,32}

There are a number of models which have been used to explain behaviour. The model that I have used predominantly in this study is based on the Theory of Reasoned Action developed by of Ajzen and Fishbein.³³ According to this model, when predicting behaviour, the variable most closely correlated with actual behaviour is intentional behaviour i.e. the behaviour that person expresses an intention to carry out. Intentional behaviour is determined by the individuals attitude to that behaviour. Ajzen uses the term "attitude" to refer to the overall acceptance or non-acceptance of a specific behaviour or object. Each attitude is determined by a number of beliefs each of which has its own relative importance to the individual. Beliefs may be personal (i.e. one's own beliefs) or they may be normative or referent: terms used by Ajzen to mean the individual's perception of the beliefs of important other people around them. This is shown in Figure 2.

Figure 2. Ajzen's theory of reasoned action



For example a person may have a wide variety of beliefs about condoms. She may believe that they protect against AIDS and

pregnancy (personal beliefs) but also believes that they would be construed by her partner as lack of trust and would be seen by her mother as unnatural (normative beliefs). If the beliefs favouring condom use are outweighed by those against it then her overall attitude towards condoms is unfavourable. She is unlikely to intend to use them or to actually use them.

What follows is a review and comparison of the findings of other studies of knowledge, attitudes and practice about AIDS. In reviewing the literature many studies of different populations were found but very few of STD attenders.^{32,34} There are also few published (KAP) studies from the Western Cape region. The author has therefore chosen to include other South African studies which are more likely to be generalizable to the population studied in this report. A study of township high school children in Cape Town is frequently referred to because the residential areas and ages (median 17 years vs. 23,5 years) of respondents are similar to the current (STD) study. In reviewing these studies there are several methodological issues to consider:

- (1) The studies use different methodologies. These include interviews, administered questionnaires, postal questionnaires and focus groups. Self-administered anonymous questionnaires are difficult to use in developing countries where illiteracy is high. The relative merits of qualitative and quantitative research methodologies are well reviewed by Ankrah.³⁵ Quantitative

surveys have the advantages of providing measurable data which can be compared to other studies. Hypotheses can be tested and responses measured. The delicate nature of the subject of sex and the unlikeliness of honest self-reporting in the survey situation motivate for more use of qualitative methods such as focus groups.

- (2) The studies use different questionnaires. Available questionnaires usually require adaptation to local content. However they may differ considerably in choice of questions and in difficulty. For example one questionnaire used to test the knowledge of homosexual men in California was subsequently tested on students of a masters level sex therapy course who only scored 57% on average.²⁸ Most of those questions would be too difficult and unsuitable to use in a South African township. In comparing studies it is important to identify critical areas of knowledge, attitudes, beliefs and practice that are essential to safe practice. In reviewing the studies I have attempted to extract some of these critical areas.
- (3) Published studies are often abbreviated. One is often not told which specific replies are responses to closed and which to open questions. The questionnaire is usually not published and one is sometimes uncertain as to the exact question asked.

- (4) It is extremely difficult in each setting to assess how sexual behaviour and attitudes reported by interviewees correlate with their actual behaviour and attitudes. Privacy, confidentiality etc. may influence reporting greatly.
- (5) Summary statements such as "knowledge was good" mean different things to different authors. Some scoring systems used are not standard. For these reasons I will try as mentioned above to examine certain critical areas of knowledge, attitudes, beliefs and practice.

KNOWLEDGE OF AIDS

In reviewing and comparing reported knowledge the 5 methodological considerations discussed above should be borne in mind. The areas of critical knowledge that I have identified are as follows. The person should have heard of AIDS, should know that sex is the predominant mode of transmission and that it is a serious disease (fatal and no cure). They should understand the concept of latency or silent carrier status and should know how to prevent (protect themselves against) the disease. These form the basis of much health education material on AIDS.

The great majority of South Africans have heard of AIDS: Cape Town students 92%,³⁶ miners 95%,³⁷ Lamontville (Durban) mothers 100%.³⁸ Awareness of AIDS among STD attenders in

Durban rose from 81% in January 1988 to 88% in September 1988 after an AIDS campaign.³²

Sex was commonly perceived to be a mode of transmission. Sex was the most common means of transmission mentioned by Cape Town students (64%).³⁶ All Lamontville (Durban) mothers knew about heterosexual transmission.³⁸ Already by 1988 98% of Durban STD attenders who had heard of AIDS agreed that it could be transmitted by sex.³²

That one can die from AIDS was known by 86% of Cape Town students³⁶ and 91% of Durban STD attenders.³²

That AIDS is incurable was not generally known. 48% of Durban STD attenders, 69% of Cape Town students and two thirds of Lamontville (Durban) mothers were unaware that AIDS is incurable.^{32,36,38}

The concept of latency was poorly understood. 62% of Cape Town students were not aware that one can get AIDS from someone who looks healthy.³⁶

This was also found in a study of two STD clinics in Illinois (U.S.A.) where 52% of attenders thought that the signs and symptoms of AIDS would appear within a month.³⁴

How AIDS can be prevented is probably the single most important knowledge question. That AIDS can be prevented by

having one or reducing the number of sexual partners was mentioned or agreed to by 2-14% of Cape Town students,³⁶ 49% of miners,³⁷ 96% of Lamontville mothers³⁸ and 95% of a group of British (Doncaster) 19 year olds.³⁹ That AIDS can be prevented by using condoms was mentioned or agreed to by 15% of Zimbabwean teacher trainees⁴⁰, 34% of the miners, 72% of Durban STD attenders, 80% of the Cape Town students, 98% of the Lamontville mothers and 95% of the Doncaster 19 year olds.

O'Farrell reported that more than half the questions were incorrectly answered in a Durban STD Clinic.³² In contrast Miller reported that 78% of (difficult) questions were correctly answered by Californian gay men.²⁸

BEHAVIOUR

Actual sexual behaviour (as opposed to reported sexual behaviour) is extremely difficult and usually impossible to determine so researchers rely on reported behaviour. This is often an extremely sensitive matter and replies may be greatly influenced by issues such as perceptions of confidentiality and of interviewers' expectations.

A study of urban black mothers, for example, had to remove questions on sexual partners after the pilot study, because most mothers refused to answer them.³⁸ In a study of Zimbabwe teacher trainees 18% reported being upset by at least one section of the questionnaire especially that related to

personal sexual practices.⁴⁰ Ankrah, in an interesting review of methodological problems in studying AIDS prevention, describes some of the limitations of quantitative survey methods in dealing with issues such as sex. The delicate nature of the questions and the contrived nature of interview situation may lead to withholding of information and dishonest reporting of sexual practices.³⁵

The rate of sexpartner change and condom usage are two critical behaviours.

Two or more sexual partners since the beginning of the year (9 months) was reported by 4% of female high school students (Cape Town), 11% of male students <18 years and 24% of males >18 years.²³ 25% of female and 49% of male STD attenders in Durban reported two or more partners in the previous month ($p = 0.001$).³² Most other South African studies reviewed did not question respondents about this important parameter usually because of its sensitivity.

Sexual intercourse often begins at an early age in South African townships. A study done among school students in Cape Town found that 75% reported having had sex.³⁶ It is well known that a high teenage pregnancy rate exists in many areas of low socio-economic status.³⁸

Kinsey's surveys published in 1948 and 1953 showed that by the age of 20, 73% of men and 20% of women had engaged in

premarital sexual intercourse. 50% of married males and 25% of married females had at least one episode of sex outside marriage. Reinish et al reviewed six American data sets and estimated that 37% (range 25 - 50 percent) of husbands have at least one additional partner during marriage.⁴¹ That behaviour can change was reported earlier where in a cohort study of 313 homosexual men in San Francisco followed from 1978 to 1988 there was a decrease in the average number of partners for receptive anal intercourse from 16 to less than 0,1 per year.²⁵

Condom usage is as follows:

- None of the urban black mothers surveyed in Lamontville had used a condom.³⁸
- 9% of Durban STD attenders used a condom in 1988.³²
- 11% of school students (Cape Town) had ever used a condom.³⁶
- 24% of miners always and 8% sometimes used a condom. 67% never used one.³⁷
- 30% of attenders in an American STD Clinic used condoms at least 25% of the time.³⁴

Contact with a prostitute in the last month was reported by 2,1% of miners. Reinisch et al based on data from four American studies estimate in 1988 that 33% of males (range 30-45%) have ever had sex with a prostitute.⁴¹

A history of a STD, which is one indicator of sexual behaviour, was reported by 27% of black goldminers. Single

persons were significantly more likely to report having an STD (40% vs.23%).³⁷

ATTITUDES AND BELIEFS

The word "attitudes" is used somewhat differently by different authors. To some, the term attitudes refers to feelings or emotions. As described above Ajzen uses the term attitude to refer to the overall acceptance or non-acceptance of a specific behaviour or thing. Attitude to any specific behaviour is determined by various beliefs each of which has its own relative importance.

Many studies have insufficiently explored the wide range of beliefs that affect behaviour.

The perception by an individual of his/her personal susceptibility to any given condition has been shown to be an important predictor of behaviour.⁴² Lack of perception of risk of AIDS to oneself has been commonly reported in foreign studies. A Scottish study used focus groups to pretest an AIDS educational pamphlet.²⁴ Most of the participants did not regard themselves as being at risk for AIDS and therefore did not see the pamphlet as having implications for their own behaviour.

Some studies found that AIDS was associated by respondents with particularly high risk groups and not with "ordinary"

people. In a Scottish study AIDS was associated with homosexuals and addicts, who were generally regarded as "dirty", shameful and unnatural.²⁴

Most South African studies reviewed found that respondents had negative attitudes towards condoms. Condoms were condemned by 90% of focus group members in a Johannesburg study of black adults.³¹ Interestingly 91% of Lamontville mothers said they would like their partners to use condoms.³⁸

The beliefs militating against condom use include:

- Condoms were felt to represent lack of trust between partners.^{31,36} The major reason given by miners (57%) for not using condoms was that they trusted their partner.³⁷
- Women expressed fear that suggesting a condom would make their partner angry.³¹
- Suggesting the use of a condom might make a partner think that one had a STD.³¹
- Condoms interfere with pleasure or feeling.^{34,36}
- Condoms are not romantic.³⁴
- Condoms are uncomfortable.³⁴
- Condoms may break or for various other reasons lack efficacy.³⁴
- Condoms, because of the reasons already mentioned, would create tension, sour relationships and cause confrontations.³¹
- Beliefs that other measures will protect eg regular visits to clinic.³⁶

Beliefs promoting condom use include:

- Condoms prevent pregnancy i.e. use for contraceptive purposes.³¹

In a study of STD attenders in Illinois protection against pregnancy and STD's were the major reasons cited for using condoms and protection against AIDS ranked only 8th.³⁴

- Condoms protect against STD's.^{34,36}
- Condoms protect against AIDS.³⁶
- Condoms are useful if you mistrust your partner.³⁶
- Normative or referent beliefs (i.e perception of beliefs of other significant people) are important as illustrated in some of the examples above. Among STD attenders in Illinois the most significant referent (normative belief) influencing condom use decision making was "mother" in younger subjects and "sexual partner" in older subjects.³⁴

RELATIONSHIP BETWEEN KNOWLEDGE, ATTITUDES AND BEHAVIOUR

Adequate knowledge is essential to behavioural change. Some studies have shown a relationship between knowledge and sexual risk behaviours.^{28,42} All studies which have found low knowledge scores have recommended that information must be conveyed in health education programmes. However several studies have showed a poor correlation of knowledge with behaviour.^{34,38,43} In a study of STD attenders in Illinois no statistical significance was found between AIDS-knowledge scores and condom-use behaviour. While 80% of Cape Town students said that condoms could prevent AIDS only 11% had

used them.³⁶ 91% of Lamontville mothers said they would like their partners to use condoms but none had ever managed to get their partners to use them.³⁸ The main reasons for this discrepancy centre around the importance of a wide variety of beliefs and attitudes which also influence behaviour.^{33,34} Understanding and addressing these beliefs and attitudes, discussed in the section above, is vitally important for AIDS education programmes.

The following study for example focuses on the importance of perception of risk to self. Hasting et al, from the Advertising Research Unit in the Dept of Marketing at a Scottish University, used focus groups to evaluate and redraft an AIDS education leaflet.²⁴ In their study none of the respondents saw the material as being directed at them personally but rather at some other high risk group. Most did not regard themselves as being at much risk for AIDS and did not see the leaflet as having direct implications for their own sexual behaviour. On the basis of their findings Hastings et al were able to redraft the leaflet. They noted that communication problems are extensive and difficult and stress the importance of consumer research in developing mass media material.

3.3 AIDS AND WOMEN

AIDS, since it is spread predominantly by sex, occurs in a social context where gender issues are of vital importance.

There is some evidence from countries where heterosexual intercourse is the major mode of spread of HIV infection, that females have a higher HIV seroprevalence than males.^{32,44} In a recent study in Natal/Kwazulu⁴⁴ the prevalence of HIV infection was 1,6% in females and 0,4% in males (relative risk = 4, CI: 1,8-8,6).

It has been suggested that it is usually the male partner who introduces HIV infection into the family unit.⁴⁵ Among the initial 75 couples seen at a HIV Clinic in Zimbabwe, reported risk factors for AIDS were more prevalent among men than among women. Only in two of the 75 couples was the wife seropositive and the husband seronegative.

Some of the gender issues which put women at risk for HIV infection and need to be considered in health education are:

- (1) Economic dependence: In many parts of the world especially in developing countries women are through a wide variety of mechanisms inhibited from entering employment and earning a sufficient wage. For many women, sexual relationships with men either within marriage or

outside, have become inextricably linked to economic and social survival.

In patrilineal societies women may not be able to inherit land and may have limited property rights. Societies frequently discourage women from working.

This economic dependence considerably decreases the personal power of a woman. She may enter into a relationship largely because of the material needs. She may find it impossible to leave a relationship even if she knows her partner has other sexual partners or impossible to risk jeopardizing the relationship by insisting on the use of condoms.

According to Bassett and Mhloyi in an excellent review, "The exchange of sex for money or other goods or services covers a broad range of arrangements. Many are not socially considered to be prostitution. Some of these women sell single sexual encounters. Probably more common are situations in which men pay for ongoing sexual and domestic services. They may range from sporadic payments to stable live-in partnerships ... most would not enter into liaisons without financial compensation, and none would consider themselves prostitutes."⁴⁵

- (2) The migrant labour system has been extremely important in the spread of STD's including AIDS. The family separation

occurring with urbanization and migration allow both partners especially the travelling man access to other partners. Labour migration, long absences, increasing family breakdown and social instability have been well described.^{46,47} The spread of AIDS along the routes of truck drivers has been well documented.

- (3) Cultural sexual practices in societies often permit men to have a number of sexual partners, often seeing this as a sign of machismo or virility. STD's may be seen as a rite of passage. In contrast there are often strong social sanctions against women engaging in extramarital sex.
- (4) The use of a condom depends mainly on the active participation of the male. Various attempts are in progress to manufacture and market a "female condom" or other barrier methods that a woman can control.
- (5) Women in many parts of the world have a subordinate position in society as well as in the male-female relationship.

In a relationship where the man is the powerful and dominant force, it is difficult for the women to initiate and insist on safe sexual practices. It has been argued that the major problem in fighting AIDS is one of empowering women to say "no" to unprotected

intercourse.⁴⁸ Educational programmes need to incorporate the transfer of skills required to negotiate a change in sexual behaviour with the other partner who has more power in the relationship.⁴⁸

In developing countries teenagers often commence sex at an early age. Teenage pregnancy is common. 75% of black school pupils in Cape Town had already had sexual intercourse.³⁶ Access to contraceptives is limited in many regions. By the age of 20-24 years 75% of women in Zimbabwe have been married.⁴⁵

- (6) Rape and violence against women are frequent in South Africa. 18000 rapes were reported to the South African police in 1987 but several studies including one from the Western Cape have shown that only approximately 7% of rapes are reported.⁵²
- 7) Since in many families and societies it is women who take on the largest burden of caring for the sick, it is women who will care for the growing number of AIDS sick.
- (8) While women may potentially play a central role in society in the dissemination of information about AIDS there is not much evidence of this occurring in South Africa at present. Indeed in a study of urban mothers in Lamontville, not one mother surveyed had spoken to her teenage child about AIDS.³⁸

4. PURPOSE AND AIM

4.1 PURPOSE

The overall purpose of the study was to provide information to the local authority to inform the development of a locally appropriate health education programme about AIDS and HIV infection for attenders of Sexually Transmitted Disease Clinics in the Cape Peninsula.

4.2 AIM

The aim of the study was to determine the knowledge, attitudes, beliefs and practices about AIDS among STD attenders in the Cape Peninsula.

5. OBJECTIVES

To measure:

- 1) Certain demographic characteristics of STD attenders such as age distribution and length of residence period in the Cape Peninsula.
- 2) Patients knowledge of:
 - (a) methods of prevention of HIV infection
 - (b) modes of spread of the disease
 - (c) risk factors for HIV infection
 - (d) condoms

- 3) Patients current sources of information about AIDS
Patients preferred source of health education about AIDS.
- 4) Certain attitudes and beliefs relating to AIDS especially:
 - (a) their perception of the risk of AIDS to themselves and to society.
 - (b) their fears about AIDS.
 - (c) their desire for more information about AIDS.
 - (d) their attitudes to condoms
- 4) Certain aspects of sexual practice relating to spread of AIDS namely:
 - (a) number of sexual contacts in the last year.
 - (b) use of condoms
 - (c) change in sexual activity since hearing about AIDS.

To assess the relationships between patients' knowledge, attitudes and sexual practices and to relate these to area of residence and sex.

6. METHODOLOGY

6.1 STUDY DESIGN

This was a descriptive study.

6.2 STUDY POPULATION

There are 29 STD Clinics in the Cape Peninsula administered by the Cape Town City Council or Western Cape Regional Services Council. The clinics treated 18 000 new cases of STD's and had a total of 37 000 patient attendances during 1989.

The population consisted of all patients attending STD clinics in the Cape Peninsula from August to November 1990.

Case definition: Any patient who attended an STD Clinic.

Exclusion criteria: Nil

Inclusion criteria: All patients who attended the clinic were included in the study including those who were subsequently found not to be suffering from a STD.

6.3 SAMPLING

The 29 STD clinics in the Cape Peninsula were divided into four strata: clinics in recently established African

shantytowns, clinics in established African townships, clinics in "Coloured" residential areas and clinics in inner city areas of Cape Town¹. An equal number of patients were to be interviewed within each stratum. In order to achieve this most efficiently with the limited resources available clinics with the largest patient load (as determined from annual reports) were selected. These nine clinics together treated 75% of all the patients treated by the STD Clinics in 1989. 40 patients of each gender were chosen within each stratum to provide a reasonable variation in outcome. This number was also the maximum that could be handled logistically. The clinics selected and number of patients to be interviewed are shown below.

Table 2. Patients to be interviewed by area and sex

Stratum	Clinic Area	Total	Male	Female
Coloured	Mitchells Plain			
	Elsies River	80	40	40
African township	Kasselsvlei			
	Guguletu	80	40	40
Shantytown	Nyanga			
	Site BD	80	40	40
Inner City	Site C			
	Spencer Road	80	40	40
	Woodstock			
Total		320	160	160

¹ At the time of data collection apartheid legislation had separated South Africans racially for many decades and it is sometimes impossible to describe our health experience without resorting to such terminology.

At each clinic patients were systematically sampled and individually interviewed by a trained interviewer before seeing the doctor.

The sampling interval rate at each clinic was calculated from the number of patients expected per day divided by number of patients to be interviewed per day.

An equal number of men and women were interviewed in each clinic. This was done by interviewing men and women alternately. Thus if the 15th patient in the above example was not a woman then the next woman would be interviewed.

6.4 QUESTIONNAIRE DESIGN

Patients were interviewed using a structured questionnaire. The questionnaire was extensively adapted from the WHO Interview Schedule for Knowledge, Attitudes, Beliefs and Practices on AIDS.²⁶

Great efforts were made to produce a locally relevant and useful questionnaire by adopting a consultative approach in its design. Firstly existing questionnaires were carefully reviewed.^{26,36,39}

A series of meetings were held with STD Clinic workers including interviewers, doctors, nursing staff, health educators and service managers. These groups made numerous

recommendations about the choice of questions and their wording.

In particular the group of 12 interviewers made detailed comments during a series of meetings as well as during the process of translating and piloting the questionnaire. Changes were made at each of these stages. For example certain questions about sexual practice such as contact with prostitutes were thought to be too sensitive and had to be rephrased.

Existing questionnaires available at the time contained predominantly closed questions. Because of the limitations of these, an attempt was made to include a number of appropriate open ended questions.

The WHO AIDS Prime Messages were used as a basic test of literacy.⁴⁹

The questionnaire was translated into Xhosa and Afrikaans by the interviewers as a group and independently checked by backtranslation. Particular attention had to be given in the translation to using words that were neither too difficult nor too crude. This method of translation using a group although time consuming was found to be an excellent way of producing a clear and colloquially acceptable translation of terms that are potentially very sensitive. A copy of the English-Afrikaans questionnaire is found in Appendix 1.

A copy of the English-Xhosa questionnaire is found in Appendix 2.

For nonresponders only basic demographic data was collected.

6.5 INTERVIEWERS AND THEIR TRAINING

The twelve interviewers were senior nursing sisters and health educators currently working in the STD Clinics. They speak the same home language as the patients, Afrikaans or Xhosa. Interviewers were carefully trained during four training sessions. The training included roleplaying the interview situation, translating the questionnaire, using the questionnaire, discussing the pilot study and emphasizing privacy, respect, a non-judgmental accepting manner and the standardization of words, tone and emphasis.

6.6 PILOT STUDY

A pilot study was done involving all 12 interviewers, each of whom interviewed 2 patients. This led to several changes in the questionnaire. For example intravenous drug abuse was considered to be so rare that the question was removed from the final questionnaire. The pilot study helped in the training of the interviewers.

6.7 ANALYSIS

Entering of data and preliminary analysis was done using SAS⁵⁰ and Epi-info version 5.0.⁵¹

6.8 FUNDING

The study was supported by a grant from the Medical Research Council.

6.9 ETHICAL AND LEGAL CONSIDERATIONS

Ethical approval for the study was given by the Ethics Committee of the University of Cape Town. Permission was sought from each patient and patients were assured of confidentiality (see introduction to interview schedule - Appendix 1). Interviews were conducted in private.

An average interview lasted from 25 to 30 minutes.

The study was conducted from August to November 1990.

7. RESULTS

Results are presented for the sample and are not weighted for the different sizes of the populations in the area and sex strata.

DEMOGRAPHIC DATA

Of the 320 planned interviews, 306 were in fact attempted and 303 of these patients agreed to participate (response rate 99%). 46,6% of the patients interviewed were male and 53,4% female. Table 3 shows the breakdown of these clinics by strata and residence period in the Cape Peninsula. The shantytowns had a median residence period of 2 years compared to 22,5 years in the Coloured areas. Men had a median residence period of 17 years compared to 4 years for women.

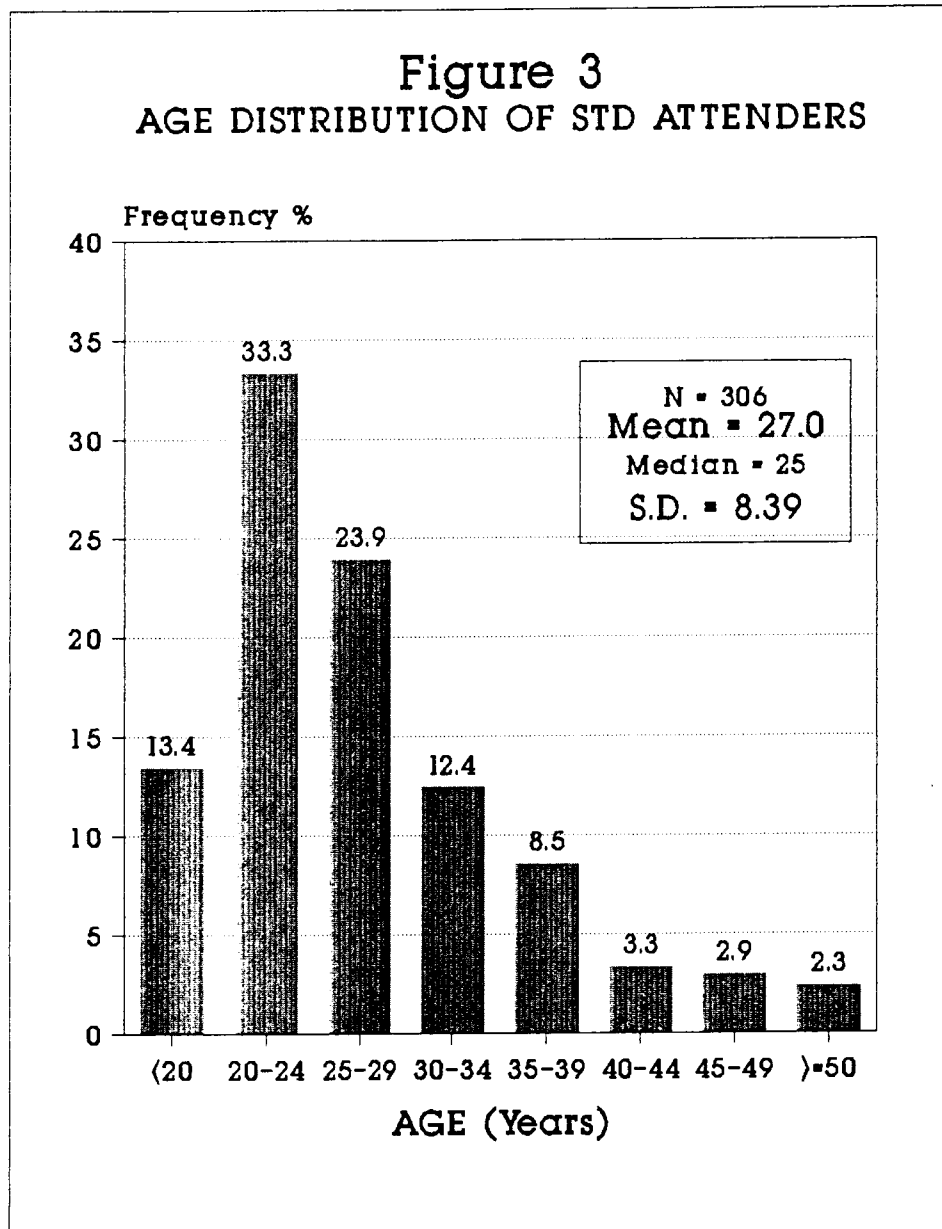
Table 3: STD clinics by stratum and residence period

Stratum	Clinic area	Residence period (years)*		
		Median	Mean	S.D.
Inner City N = 78	Salt River Woodstock	5	11,7	13,1
Coloured N = 87	Mitchells Plain Elsies River Kasselsvlei	22,5	22	13,1
African shantytowns N = 67	Khayelitsha Site B and Site C	2	2,7	2,8
African townships N = 74	Guguletu Nyanga	8	11,9	10,6
Total N = 306	All	7	12,8	13

*Median period of residence in Cape Peninsula

56,6% of those who had stayed in Cape Town less than five years came from the Transkei (an "independent" homeland).

Age distribution is shown in Figure 3. 91,5% were less than 40 years. 55% of attenders in African areas were less than 25 years.



32,4% of males and 34% of females were married.

KNOWLEDGE ABOUT AIDS

Patients' knowledge of AIDS as tested by true/false questions is shown in Table 4. However knowledge as tested by open questions was considerably poorer.

Table 4. Knowledge of AIDS #

	Yes	No	Don't Know
Have you heard of AIDS	97	2	1
Can one die of AIDS	96	0	4
Is there a cure	21	56	23
Is there a test for AIDS	78	3	19
Can a person have AIDS but not feel sick	62	20	17
Can one get AIDS from someone who looks healthy	69	17	13
Condoms can prevent AIDS	78	5	17
AIDS can be prevented by having only one faithful partner	93	3	4

Knowledge as tested by closed questions. Knowledge as tested by open questions was considerably less.

Almost all (97%) had heard of AIDS. 96% knew that it is a fatal disease but only 56% knew it is incurable. 78% knew there is a test for AIDS.

KNOWLEDGE OF TRANSMISSION

When asked how AIDS is spread, 92% of attenders mentioned sexual intercourse. Variation of replies included sex with many partners (59%), sex with someone infected (15,3%) and sex with homosexuals or with people of other race groups (8,4%). Incorrect modes of spread by casual contact were spontaneously

mentioned by 16,5%. Most agreed that the chance of catching AIDS is greater if one has more than one sexual partner (87%).

Spread by blood and blood products was only mentioned by 16% and no respondents mentioned perinatal spread.

KNOWLEDGE OF PREVENTION

Despite most individuals agreeing that fewer sexual partners (93%) and condoms (78%) can prevent AIDS, only 47,1% and 44,5% respectively spontaneously mentioned these methods when asked how AIDS could be prevented.

False beliefs about prevention included avoiding sex with people who do not wash (64,3% agreed), avoiding people who cough and spit (51,9% agreed), eating a healthy diet (45,7% agreed) and using injectable contraceptives (18,5% agreed). 18% spontaneously replied that AIDS could be prevented by attending the health services or by having a medical checkup.

KNOWLEDGE OF LATENCY AND CARRIER STATE

62% of respondents agreed that one could have AIDS but not feel sick and 69% agreed one could get AIDS from someone who looks healthy.

Men and women did not differ significantly in their knowledge of AIDS.

Knowledge differences between area strata were also generally not significant.

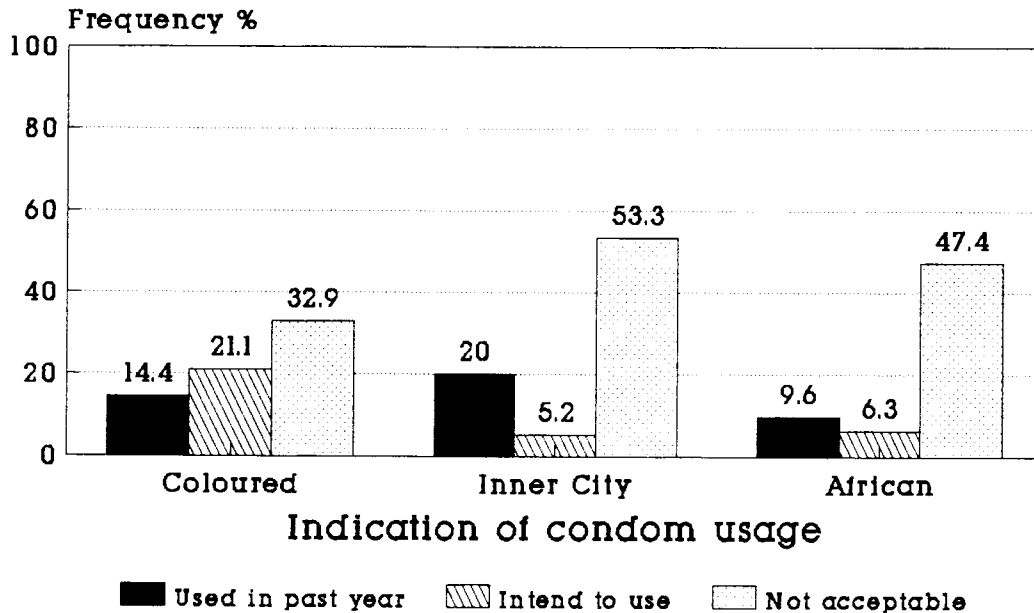
SEXUAL PRACTICE

25% of females and 64% of males reported 2 or more sexual partners since the beginning of the year (average of 9 months). Males reported a mean of 2,45 sexual partners (median = 2) and females a mean of 1,31 partners (median = 1) (Chi Sq = 50.75, $p < 0,0000001$). Of the area strata, inner city attenders reported the highest number of partners (median = 2; 56% reported 2 or more partners since the beginning of the year).

46% of unmarried attenders and 36% of married attenders reported 2 or more partners since the beginning of the year ($p = 0,10$).

Condom usage is shown in Figure 4. 23,1% of the patients indicated having ever used a condom, but only 13,6% used one in the past year. Usage was lowest amongst women where only 7% used a condom in the past year compared to 20% among men) and in the two African strata where only 9,6% used a condom in the past year.

Figure 4
INDICATION OF CONDOM USAGE
BY STD ATTENDERS



Interviewees generally agreed that prostitution takes place in their communities (81,3%) with 64,6% of these indicating that it takes place a lot as opposed to a little. In the shantytowns 65% of attenders perceived that prostitution takes place a lot.

In the Coloured areas 82,3% of attenders acknowledged homosexuality as occurring in the community as opposed to 30,1% in the African townships and 15,2% in the shantytowns. This is shown in Table 5. Attenders in the Coloured areas perceive homosexuality to be significantly more common than attenders in other areas (chi-square = 61 $p < 0.00001$).

Table 5. Perception of frequency of homosexuality (N = 302)

Area	Homosexuality occurs	Occurs a lot
Coloured	82%	37%
Inner City	49%	15%
Township	30%	11%
Shantytown	15%	3%

Intravenous drug abuse was perceived to be so rare in all strata in the pilot study that the question was removed from the final questionnaire.

Behaviour change was reported by 46,8% since learning about AIDS. This included having one partner or avoiding many partners (29,7%), using a condom (6,1%) and "knowing your partner" (3,4%).

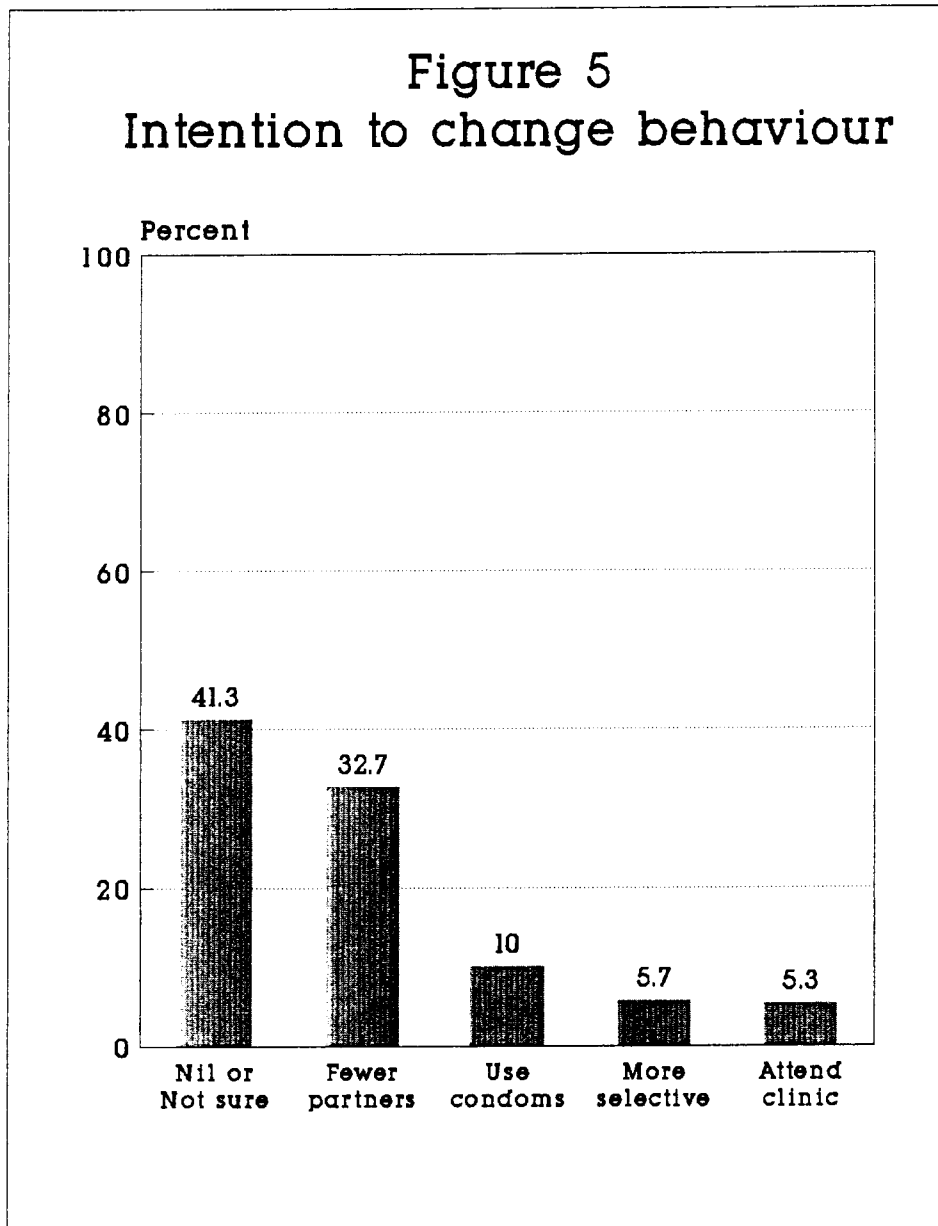
Two or more episodes of STD in the last 2 years were reported by 32,6% of men and 7% of women (chi square = 21,1 $p < 0,00001$). Highest among the area strata was the inner city where 35% of attenders reported two or more episodes (compared to an average of 20% in the other strata; $p = 0,016$).

ATTITUDES, BELIEFS AND INTENTIONS

Intention to change behaviour

Interviewees were asked whether they were planning to make any changes in their lives because of what they knew about AIDS. Intention to change their sexual behaviour is shown in Figure

5. An intention to reduce number of partners was expressed by 33% and to use condoms by 10%.

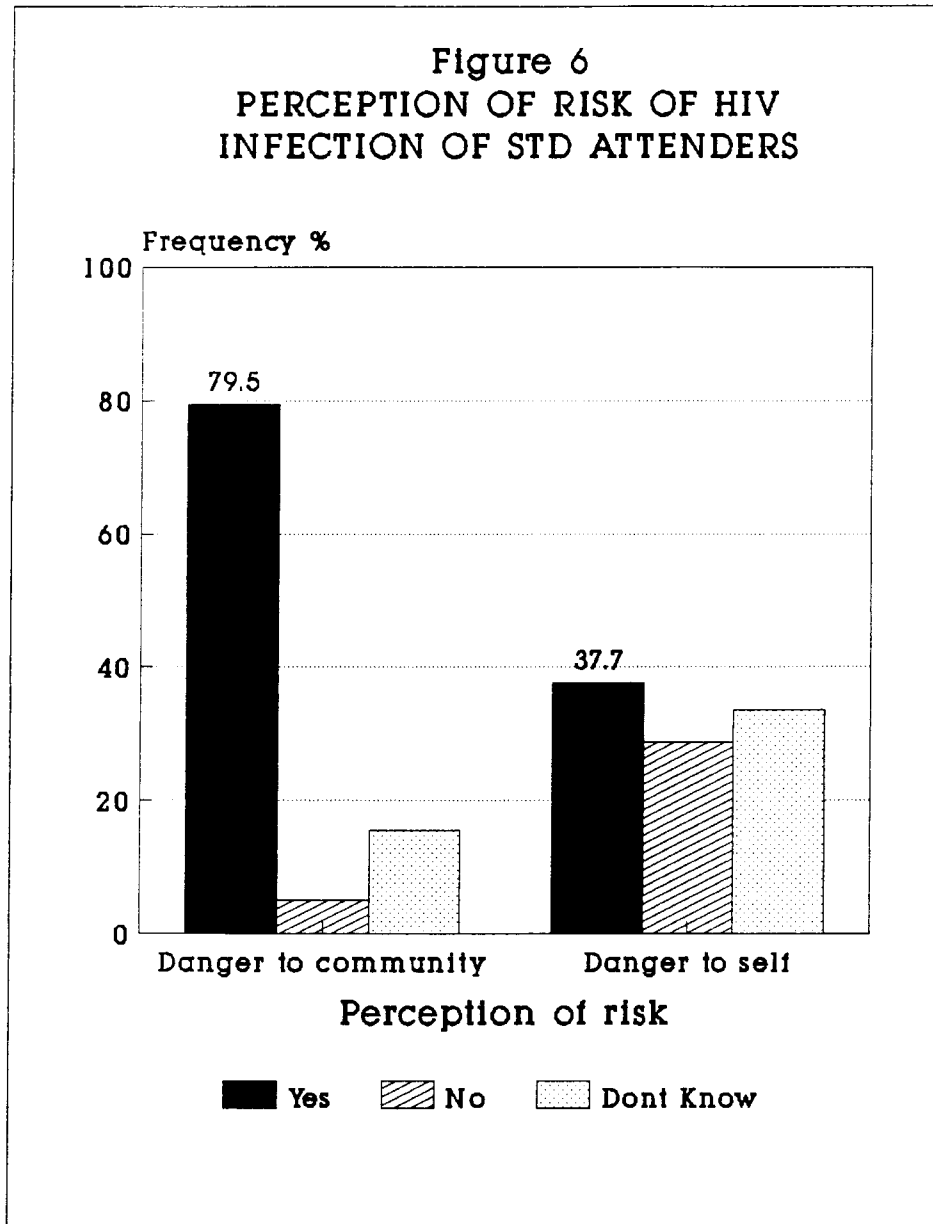


Women expressed significantly less intention to change (45% vs 63% for men, $p < 0,001$). This included decreasing partners (30% vs 36%, $p = 0,29$). Only 6% intended to use condoms (vs 13% of men, $p = 0,03$). Intention to use condoms was also extremely low

in the inner city (5%), African townships(4%) and shantytowns (8%).

Perception of risk

Patients' perception of risk of AIDS is shown in Figure 6.



81% perceived that there is a risk to the community and 57% that this was a serious risk. However only 38,6% perceived

there to be a chance that they themselves might get AIDS and only 10,2% perceived this to be a big chance. Shantytown attenders were more likely to perceive themselves to be at risk (49% vs 36% $p < 0,0003$).

84% disagreed with the statement "AIDS is not a problem because it is a Whites disease". Attenders were asked which people are more likely to catch AIDS. Responses are shown in Table 6.

Table 6.

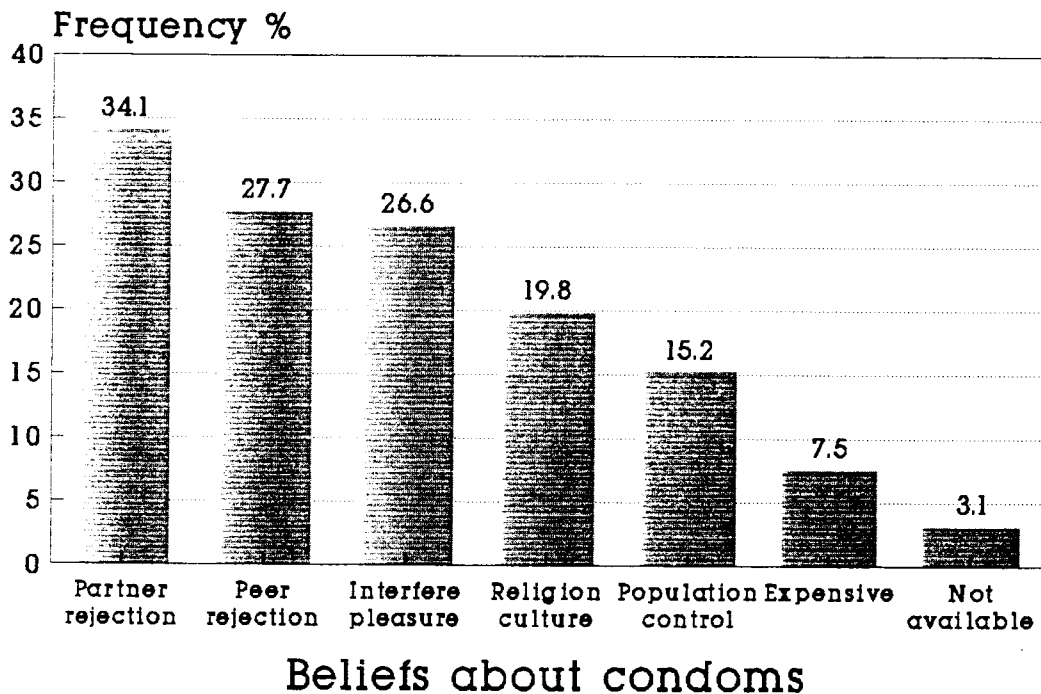
<u>People considered more likely to catch AIDS</u>	<u>Percentage</u>
People with many sexual partners	22%
Anybody	19%
Prostitutes	16%
Blacks/Whites/Coloureds	10%/9%/1%
Homosexuals/bisexuals	10%
Men/women	7%/6%
Don't know	11%

Condoms

Patients' intention to use condoms and attitude to condoms is shown in Figure 4. Only 10% of patients expressed an intention to use condoms and this was lowest in the African strata (6,3%). 45% agreed with the statement "condom usage is not acceptable to me". Women were less likely to see condom usage as unacceptable (39% vs 51% for men, $p < 0.05$). There was considerable uncertainty about condoms and the response "don't know" was recorded on average 29,1% in questions relating to beliefs about condoms.

Patients' beliefs militating against condom use are shown in Figure 7. Each of the percentages shown represents those who agreed with the given statement in a closed question. Women were less likely than men to believe that condoms interfered with pleasure (17% vs 29%, $p < 0.05$).

Figure 7
BELIEFS OF STD ATTENDERS ABOUT CONDOMS



Patients were asked what worries them the most about AIDS. The three biggest worries expressed were that AIDS kills (46%), AIDS is incurable (25%) and AIDS is infectious (11%).

21% of the patients agreed with the statement "It is an acceptable part of our culture to have several wives".

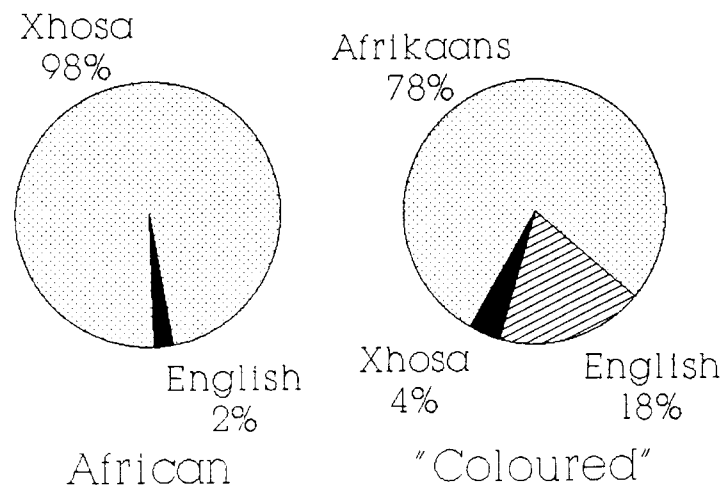
Acceptability and nature of health education

89,6% of patients said that they would like to receive more information about AIDS. Most patients perceived that they knew little or nothing about AIDS (68,7%) whereas 31,3% said they knew a moderate amount or a lot.

Attendees were asked, using an open-ended question, which media they preferred for AIDS education at the clinic. Preferred media include talks or lectures (48%), videos or films (35%) and pamphlets (33%). 6% specifically requested to see an "AIDS sufferer".

Patients overwhelmingly requested health education to be provided in their own languages, particularly in the African areas where 97% requested that educational material should be in Xhosa. This is demonstrated in Figure 8. At present English and Afrikaans are commonly used.

Figure 8
Language preference by area



83% of attenders were able to read and explain the meaning of a simple AIDS educational message. These findings were similar in all strata.

Patients were asked, using an open-ended question, how the community should be educated about AIDS. The most popular methods are community meetings (38%), TV and films (29%), newspapers and magazines (26%), pamphlet distribution (23%) and radio (20%). Calling or addressing meetings was the most popular method in African areas (48%) as well as for patients attending inner city clinics, most of whom live in these areas.

Patients were asked what they would like to know about AIDS. Their requests for information are shown in Appendix 3 (Q9). The most common question asked by patients is what the signs and symptoms of AIDS are.

8. DISCUSSION

DEMOGRAPHIC DATA

The age of the sample is young with a median age of 25 years (23,5 years for attenders in the African strata). The young age of the sample is consistent with other studies of STD attenders.⁶ This emphasizes the need for education programmes in schools and for adolescents.

The short median residence time in the Cape Peninsula of patients with STD's (7 years) reflects the importance of social instability in the region in the spread of STD's including AIDS. This is consistent with other studies which have described the importance of social upheaval, migrant labour and family breakdown in the spread of STD's including AIDS.^{46,47} Attenders from the shantytowns have a median residence time of 2 years. They are thus most likely to be exposed to these social factors which predispose to the acquiring of STD's and are likely to be least aware of the health services.

That women had a dramatically shorter median residence time in the Peninsula (4 years compared to 17 years for men) is consistent with our understanding of the migrant labour system where men migrated to the cities to seek jobs leaving women to care for families. Given the recent repeal of legislation barring many Blacks from residential rights in the region and the deteriorating economies of several of these homelands many women have recently migrated into urban areas including the Western Cape. The result also suggests that these recently urbanized women are at increased risk for STD's including HIV.

It is interesting to note the fact that 33% of attenders both male and female are married. This suggests that extra-marital relationships are not uncommon.

KNOWLEDGE

Basic knowledge about AIDS appears fairly good when tested with true/false questions. 78% of questions in Table 2 were correctly answered. However knowledge as tested by open questions was far more superficial. For example when asked to mention all the ways they knew to prevent AIDS only 47% of attenders spontaneously mentioned decreasing partners and only 45% mentioned using condoms. When asked what they would like to know about AIDS, most patients requested information on many basic issues about AIDS. Furthermore the subjective impression of the interviewers, ascertained in group discussions after the study, was that knowledge is very superficial.

The great majority of attenders have heard of AIDS, know that it is fatal and know that it is transmissible by sex. This is consistent with studies of Cape Town students³⁶, Durban STD attenders³², miners³⁷ and Lamontville mothers.³⁸

Many attenders (44%) were not aware that AIDS is incurable. This was also found in some other studies (also see literature review 3.2).^{32,36,38} Knowledge of the incurability of AIDS is part of understanding the severity and health consequences of the disease. O'Farrell has suggested that use of drugs and drug trials for AIDS and HIV infection may contribute to this misunderstanding.³²

The concept of latency or silent carrier state is not well understood. This was also found in a study of Cape Town students³⁶ and among STD attenders in Illinois.³⁴ Understanding the latency of HIV infection is an important part of knowledge relating to transmission. The poor understanding of this concept by STD attenders in this study is consistent with the low perception of personal susceptibility to HIV infection expressed by them.

Knowledge of prevention was fair when tested by true/false questions but unsatisfactory when tested by open questions (see above). The perception that AIDS can be prevented by medical checkups was frequently expressed and may be an important unspoken reason for medical visits.

Thus certain critical areas of knowledge of AIDS are inadequately understood by STD attenders. These are knowledge of the silent carrier state, the incurability of AIDS and knowledge of prevention.

PRACTICE

The author expected sexual practice to be high risk since the patients are all STD attenders.

64% of males and 25% of females did report 2 or more sexual partners since the beginning of the year. These figures are higher than those reported among miners³⁸ and Cape Town high

school students.³⁶ The subjective impression of interviewers, gained during group discussions, was however that there was considerable under-reporting of numbers of sexual partners.

Sexual behaviour, as one author so aptly states, is a difficult thing to observe. The difficulties of interpreting and using **reported** sexual practice as an outcome measure of behaviour change has been discussed by several authors³⁵ and was mentioned in the literature review. Various authors have grappled with the issue of obtaining reliable or truthful answers from respondents about such sensitive issues as sexual behaviour and it is clear that serious biases may result. Qualitative research methods are more useful for studying certain aspects of sexual behaviour and much more of this type of qualitative research is necessary in the whole area of sexuality.

Females reported significantly fewer partners than males. This is consistent with literature from many countries which describes how societies often permit men to have a number of sexual partners seeing this as a sign of virility but have strong social sanctions against women engaging in extramarital sex. This is also consistent with the Zimbabwean study previously quoted which suggested that it is usually the male partner who introduces HIV infection into the family unit (based on seroprevalence studies among couples).

The extent to which females may have underreported the number of partners is unknown. Only 1% of females reported more than 3 partners since the beginning of the year. Since a group of female STD attenders may be expected to include at least some prostitutes and women with multiple sexual partners the author suspects that under-reporting has occurred.

Condom usage is indeed extremely poor. This is consistent with other South African studies.^{34,36,37,38} That condom use among women is significantly less than among men (7% vs. 20%) is also consistent with other studies. For example no Lamontville mothers had ever used a condom although many wished to.³⁸ This may be attributed partly to the fact that condom usage depends so much on the active participation of the male. Various attempts are in progress to make and market a "female condom" or barrier contraceptive that a woman can control.

It is interesting to note that condom usage is equally low (10%) in the established African townships and the shantytowns. However 70% of those who have used condoms in these areas used them in the past year compared with 46% in the Coloured areas. This suggests that condom use although low may be increasing in these areas.

It is of concern that 33% of males and 35% of inner city attenders report more than 2 episodes of STD over the previous 2 years. When a patient "repeats" or presents with a second STD this has been called a surrogate marker of a core group

member.¹ Core group members are at particular risk for acquiring HIV infection. The figures may even be higher as some respondents may not have included their current illness. A very significant difference in number of STD's is reported by men and women (33% vs 7%). This may well reflect the higher number of sexual partners reported by men but may also be partly due to the fact that certain STD's are less symptomatic in women.

It was considered too sensitive to ask respondents if they had visited a prostitute or had homosexual intercourse so these two questions were phrased to ask about perception of commonness in own community.

Prostitution is generally perceived to be common (81% say it occurs and 63% of these say it occurs a lot). It is interesting to note that it is perceived to be most common by shantytown attenders.

Homosexuality is clearly perceived to be significantly more common in the Coloured stratum. Homosexuality is certainly reported in the African townships (30%) with 11% saying it occurs commonly.

ATTITUDES, BELIEFS AND INTENTIONS

That sexual practice was high risk while knowledge was fairly high is an important finding. Various studies have found the

correlation between knowledge and behaviour change to be low and have suggested that attitudes, beliefs and intentions are more important in determining behaviour.^{33,34,38,43}

According to Ajzen intention to change is closely related to actual future behavioural change.³³ Patients' intention to change their behaviour is relatively low with 32,7% intending to decrease the number of partners and only 10% intending to use condoms. Intention to use condoms is extremely low among women, the inner city and both African strata. This bodes poorly for condom use. The fact that females report fewer partners than males may account partly for the fact that their intention to change is less than that of males.

Various authors have shown that the perception of risk to self (perceived susceptibility) is an important determinant of behaviour.⁴² In our sample, perception of risk to self is small especially considering the high risk behaviour of patients and that they had presented with a STD.

Low perception of risk to self is often associated with the perception that others are at risk. A Scottish study pretesting an educational pamphlet found that most did not regard the pamphlet as being directed at them but at extremely promiscuous homosexuals or addicts who were generally seen as "dirty" and unnatural.²⁴ This study did not demonstrate much stigmatization of any one particular group. However there is evidence that attenders attributed risk to other groups. 46%

said that prostitutes (16%), other races (14%), homosexuals (10%) or the other sex (5%) were more likely to catch AIDS. The perception that AIDS is a homosexual disease, so common in the developed countries, is not widely shared (10%). Only 41% said that anyone (19%) or people with more partners (22%) are at higher risk but it is unclear from this question how many partners is considered to constitute a risk. Other studies have shown that some only regard highly promiscuous people to be at risk.

Actual use and intention to use condoms are extremely low. Attitudes to condoms are negative. The unfavourable beliefs expressed about condoms relate especially to the normative beliefs of lack of acceptance by partner and peer group. These findings are consistent with other studies where condoms were perceived to represent lack of trust between partners or to suggest that one or other partner might have a STD, factors which were seen to create tensions, anger and confrontations.^{31,36,37} These findings are also consistent with theoretical frameworks which emphasize the importance of normative beliefs in determining behaviour.^{33,42}

That condoms interfered with pleasure was also a significant belief, which is consistent with other studies.^{34,36} It has been suggested that perceived enjoyment of various sexual behaviours influences the extent to which they are performed. For example learning to "eroticize" condom use significantly increases positive attitudes towards condoms.⁴² Health

education should suggest ways to increase the enjoyment of low risk activities. The belief that condom usage was against one's religion or culture was also expressed.

Unfavourable beliefs of these kinds appear far more common than beliefs about inaccessibility or expensiveness and it is essential that they be addressed by health education programmes. These findings are consistent with an AIDS risk reduction model proposed by Catania in which cost and accessibility of condoms are only likely to be seriously considered in the final stage of a psychological process which begins with labelling one's own behaviour as risky for contracting HIV infection.⁴² There is considerable unfamiliarity with condoms and 75,5% of attenders have never used a condom. It may be that beliefs about condoms may be better assessed by qualitative research methods.

There may be indications that attitudes and beliefs about condoms although unfavourable are improving. Beliefs are not nearly as unfavourable as practice. 35% of attenders disagreed with the statement "condoms are unacceptable to me". Attenders also expressed beliefs favourable to the use of condoms such as condoms can prevent STD's (80% agreed) and condoms can prevent AIDS (77% agreed) and these should be reinforced. That 61% of those who have ever used a condom, used it in the past year, indicate that condom use is increasing.

In one study of STD attenders protection against pregnancy and STD's were the major reasons cited for using condoms with protection against AIDS ranking only eighth.³⁴ These benefits of condoms should also be promoted in health education programmes.

Beliefs and attitudes about number of sexual partners were not explored in detail in the study. 93% agreed that AIDS could be prevented by having one faithful partner, a belief favourable to reducing partners. This should be reinforced in health education programmes.

This study found it difficult to explore personal and cultural beliefs affecting sexual practice using a highly structured questionnaire.

Beliefs promoting more partners were particularly difficult to explore by the methodology of this study. That it was acceptable to have several wives was agreed to by 21% while 72% disagreed. However there was overwhelming disagreement with statements such as "there's no point worrying about AIDS when one has to worry about food, money and unemployment", "everyone has to go (die) sometime so why worry about getting ill" and the statement "society often admires people with many sexual partners" was so widely rejected that it was removed from the pilot study. These difficulties suggest that qualitative methods may be more useful in eliciting beliefs about multiple partners. It is clearly essential to address

the beliefs that promote multiple partners and those that promote faithful relationships if behaviour is to change.

Only 37% of attenders expressed an intention to reduce number of partners, but this is considerably more than any other intention expressed. This suggests that at present reducing number of partners is likely to be the most acceptable behaviour change.

HEALTH EDUCATION

Patients expressed an overwhelming desire for AIDS education by the clinics and health services and generally perceived their own knowledge to be deficient. These findings strongly suggest that AIDS education programmes if sensitively introduced would be acceptable to patients. The number of patients who could read a simple AIDS educational message in their own language was surprisingly high. However various literacy groups in the Cape Peninsula have reported a very low level of functional literacy so written material should be as simple and clearly written as possible (personal communication Adult Literacy Project).

The most common question asked by patients about AIDS concerns the signs and symptoms of the disease. It is a major problem for health education that AIDS is at present an invisible disease (only 1,6% said that they had known someone with AIDS). It is important for health education programmes to

address this need for an image of AIDS as well as the associated concept of latency which is poorly understood.

It is important to note that patients consider community meetings the best way of educating the community about AIDS and health educators should make use of this opportunity. Patients also consider the mass media such as television and radio as important ways of educating the community about AIDS. These media are widely used in many countries and are underutilized in South Africa for AIDS education.

STUDY METHODOLOGY AND LIMITATIONS

The response rate was very high at 99%.

Great efforts were made to reduce bias in the study. Interviewers were carefully trained in 4 training sessions and were involved in many phases of questionnaire design. The questionnaire, based on a WHO questionnaire, went through numerous drafts and refinements. The pilot study helped to identify certain problems. These are discussed in more detail in the methodology section.

It was considered not necessary and difficult to specifically measure the validity of many questions on the questionnaire. For most of the questions no easy check of validity was possible. Certain questions were asked in a number of ways to improve validity. For example patients were asked about

knowledge of prevention of AIDS, a key measurement, in an open question and in closed questions (see appendix 1 questions 11,20). While 78% agreed that using condoms could prevent AIDS, only 44,5% mentioned this in response to the open question. In addition patients were asked what they would like to know about AIDS and many asked questions about prevention. It might have been possible to compare certain aspects of reported practice with the patient's record but this was not done because of limitations of resources.

The results presented are those of the sample and are in certain cases not generalizable to the whole STD population since they have not been weighted for the different sizes of the sex and area strata. The author is currently in the process of doing further analysis of the data to produce a weighted analysis.

Although much valuable information has been gained from the study, it has become clear to the author that quantitative studies in the field of AIDS education do have their limitations. These have been discussed above and relate particularly to the sensitive nature of human sexuality. Far more use needs to be made of qualitative research methods.

9. SUMMARY AND RECOMMENDATIONS

- 1) The study has shown high risk sexual behaviour among STD attenders thus highlighting the urgent need for an AIDS education and counselling programme in the STD clinics in the Cape Peninsula. Increased resources need to be allocated to STD programmes because of the importance of this target group in controlling the HIV epidemic. Selected clinics should be used to pilot specific more in-depth programmes and interventions in general should be continually evaluated. The programme will need to consider the consultation itself, a counselling educational input on a one to one basis and group work. Appropriate messages will need to be decided on, suitable media developed and an adequate number of staff trained. Protocols for HIV testing in association with a counselling educational input should be developed.
- 2) STD attenders are usually young adults (median age is 25 years, 23,5 years in African strata) so programmes need to be acceptable to and targeted at people of this age group. The young age of STD attenders also emphasizes the need for AIDS prevention and education programmes in schools and for adolescents.
- 3) Given the short median residence period of STD attenders and particularly female attenders in the Cape Peninsula it is recommended that recently urbanized communities

receive particular attention in providing AIDS education programmes and raising awareness of health services.

- 4) Knowledge needs to be improved. Particular areas of inadequate knowledge are: understanding of concepts of latency/carrier state for HIV, the fact that AIDS is incurable and ways to prevent AIDS. Attenders asked specific questions about AIDS and these should be addressed (see appendix 3, question 9).
- 5) Recurrent episodes of STD's over the past two years were reported by 32,6% of men and 35% of inner city attenders. Recurrent attenders are at particular risk for HIV infection and need specific attention.
- 6) When educating on high risk behaviour, programmes should focus on heterosexual spread including prostitution. The risks of anal intercourse should be included. At this stage the risks of intravenous drug abuse should be a minimal part of a STD education programme.
- 7) Knowledge correlates poorly with practice in this and several other reported studies. While education programmes must provide information to improve and reinforce knowledge, attention to a range of attitudes and beliefs is very important in leading to behaviour change. For example STD attenders have a low perception of risk to self, so educational material needs to be

designed so that attenders are more likely to see it as being directed at them personally and having implications for their own sexual behaviour. Some beliefs relating to condom usage are discussed in point 9. Beliefs that promote safe sexual practice need to be promoted whereas unfavourable beliefs should be addressed.

- 8) Patients generally perceive a high degree of risk to the community but much less to themselves. It is essential for programmes to address this problem so that respondents are able to see media as being directed at themselves and not some other more high risk group.
- 9) There are major problems with condom acceptability and this area will need particular attention. In particular beliefs about lack of acceptability to partner, peer group or culture and beliefs that they decrease pleasure need to be addressed. 75% of attenders have never used a condom and attenders should be encouraged and shown how to open, examine and experiment with using a condom.
- 10) More local research is necessary in the area of sexuality, relationships and how best to promote behavioural change. Qualitative research methods are likely to be most appropriate.
- 11) The programme cannot work in isolation (as many beliefs are normative - relating to perceptions of peer group and

partner acceptability) and school based programmes and programmes involving the mass media need to be greatly increased. More use should be made of community meetings which were perceived to be the best way of educating the community.

- 12) Educational material should be provided in the patient's home language.

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APPENDIX 1

1) Introduction to the English/Afrikaans interview schedule:

We are busy preparing an education programme for patients here on AIDS. In order that we are able to best educate and teach people about AIDS we are asking people what they already know and what they think about this illness. We will not ask for your name at all and everything you tell us will be kept completely confidential. Do you give permission for me to ask you some questions? (If yes continue) Please try to answer questions as carefully as possible. If you do not understand a question please say so and I will repeat it or explain it to you.

If no ask questions 1 - 5.

Ensure patient has not been interviewed before.

Any additional comment may be written at the back.

	<input type="checkbox"/>			
		1		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		2	3	4
Clinic	<input type="checkbox"/>			
		5		
Interviewer	<input type="checkbox"/>	<input type="checkbox"/>		
		6	7	

(2)

QUESTIONNAIRE

1. Sex

Male

Female

8

2. What is your age?
Hoe oud is jy/u?

_____ years

9 10

3. Where do you live?
In watter area woon jy/u?

11 12

4. How long have you lived in Cape Town?
Hoe lank woon jy/u al in Kaapstad?

_____ years

13 14

IF LESS THAN 5 YEARS
INDIEN MINDER AS 5 JAARWhere do you come from?
Waar kom jy/u vandaan?

15 16

5. Have you heard of the disease called AIDS?
Het jy/u al ooit van AIDS/VIGS gehoor?

Yes/Ja

No/Nee

Don't know/Weet nie

17

IF NO GO TO QUESTION 29

6. I am interested to know how much you think you know about this disease called AIDS. Would you say you know:

Ek wil graag weet hoeveel jy/u dink jy/u weet van AIDS/VIGS:

A lot/*Baie*

A moderate amount/*Genoeg*

A little/'n *Bietjie*

Nothing/*Niks nie*

18

7. How much of a danger do you think AIDS is to your local community today? Would you say that it is :

In die gemeenskap waar jy/u woon, hoe gevaarlik dink jy/u is AIDS:

No danger at all/*Geen gevaar nie*

Some danger/*Bietjie gevaarlik*

Serious danger/*Baie gevaarlik*

Don't know, not sure/*Weet nie, onseker*

19

8. What worries you most about this disease called AIDS?

Wat bekommer jou die meeste omtrent AIDS?

20 21 22

9. What other things would you like to know about AIDS?

Is daar nog iets wat jy/u wil weet omtrent AIDS?

23 24 25

26 27

10. Is there a chance that you yourself might catch AIDS?

Dink jy/u dat daar 'n kans is dat jy die siekte sal opdoen?

- Yes/Ja
- No/Nee
- Don't know/Weet nie 28

IF YES would you say that it is a
INDIEN JA sal jy sê dit is:

- Small chance/Klein kansie
- Big chance/Groot kans
- Don't know, not sure/Weet nie, nie seker nie 29

11. Can a person prevent AIDS?

Kan 'n persoon AIDS voorkom/verhoed?

- Yes/Ja
- No/Nee
- Don't know/Weet nie 30

IF YES Please tell me all the ways you know to prevent AIDS?

INDIEN JA Kan jy/u vir my al die maniere opnoem waarvan jy/u weet om AIDS te verhoed?

- 31
- 32
- 33
- 34
- 35

12. How does one get AIDS? Please tell me all the ways you know.

Hoe kan 'n persoon AIDS/VIGS kry? Vertel vir ons al die maniere waarvan jy weet.

36
 37
 38
 39
 40

13. Of all the ways you have mentioned, which one do you think is most important in South Africa?

Van al die maniere wat jy/u opgenoem het, watter een is die belangrikste vir Suid-Afrika?

41 42

14. Is there a cure for AIDS ?
 Kan AIDS/VIGS genees word?

Yes/Ja

No/Nee

Uncertain/Onseker

43

15. Can one die of AIDS?

Kan 'n mens doodgaan van AIDS/VIGS?

Yes/Ja

No/Nee

Uncertain/Onseker

44

16. Have you ever known anyone who has AIDS?
*Het jy/u al ooit iemand ontmoet wat AIDS/VIGS
 het?*

Yes/Ja

No/Nee

Uncertain/Onseker

45

17. Which people in South Africa are more likely to
 catch AIDS?
*Watter soort mense na u/jou mening in
 Suid-Afrika kry AIDS?*

46 47 48

49 50

SOME OF THE FOLLOWING QUESTIONS MAY BE VERY PERSONAL
 If you do not want to answer any of these questions,
 please tell me and I will go on to the next question.

**SOMMIGE VAN DIE VOLGENDE VRAE MAG 'N BIETJIE PERSOON-
 LIK WEES**

*As jy/u voel jy/u wil nie enige van die volgende vrae
 beantwoord nie, sê maar net, dan gaan ons voort na die
 volgende vraag.*

18. Have you made any changes in your life as a
 result of what you know about AIDS?
*Noudat jy/u van AIDS/VIGS gehoor het, het jy/u
 enige veranderings in u lewensstyl/"lifestyle"
 gemaak?*

Yes/Ja

No/Nee

Don't know/Weet nie

51

IF YES What changes have you made?
 INDIEN JA Wat was die veranderings?

52 53

54 55

19. Are you planning to make any changes in your life because of what you know about AIDS?
 Noudat jy/u meer van AIDS/VIGS weet is jy/u van plan om enige veranderings te maak in jou/u lewensstyl?

Yes/Ja

No/Nee

Don't know/Weet nie

56

IF YES What kind of changes are you planning to make?
 INDIEN JA Watter soort veranderings is jy/u van plan om te maak?

57 58

59 60

20. People say many things about how one avoids catching AIDS. Please say if you agree, disagree or are uncertain.

Agree = A Disagree = D Uncertain = U

In your opinion can one avoid catching AIDS by:

Die mense sê baie oor hoe 'n mens AIDS/VIGS kan verhoed. Sê vir my of jy saamtem, nie saam stem nie, of is jy onseker oor die volgende:

'n mens kan AIDS verhoed deur:

Stem saam = S Nie saam stem nie = N Onseker = O

- | | | | |
|---|--------------------------|--------------------------|----|
| Using the injection that prevents pregnancy
<i>Die "family planning injection" te gebruik</i> | <input type="checkbox"/> | <input type="checkbox"/> | 61 |
| Using condoms
<i>Kondome/"FL"/reënjassies te gebruik</i> | <input type="checkbox"/> | <input type="checkbox"/> | 62 |
| Eating a healthy diet
<i>Gesond te eet</i> | <input type="checkbox"/> | <input type="checkbox"/> | 63 |
| Avoiding sex with prostitutes
<i>Seks met prostitute te vermy</i> | <input type="checkbox"/> | <input type="checkbox"/> | 64 |
| Avoiding people who cough and spit
<i>Mense wat hoes en spoeg te vermy</i> | <input type="checkbox"/> | <input type="checkbox"/> | 65 |
| Having only one faithful partner
<i>Een getroue seksmaat te hê</i> | <input type="checkbox"/> | <input type="checkbox"/> | 66 |
| Not having sex with someone you think may have many partners.
<i>Seks te vermy met 'n persoon wat rondslaap/baie seksmaats het.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 67 |
| Avoiding people who don't wash
<i>Mense te vermy wat nie was nie</i> | <input type="checkbox"/> | <input type="checkbox"/> | 68 |
| 21. Do you think a person can have AIDS but not feel sick in any way?
<i>Dink jy/u 'n persoon kan AIDS/VIGS hê sonder om siek te voel?</i> | | | |
| Yes/Ja | <input type="checkbox"/> | | |
| No/Nee | <input type="checkbox"/> | | |
| Don't know/Weet nie | <input type="checkbox"/> | <input type="checkbox"/> | 69 |

22. Do you think one could get AIDS from someone who looks healthy?
Dink jy/u dis moontlik dat 'n mens AIDS/VIGS kan kry van 'n persoon wat gesond lyk?

Yes/Ja

No/Nee

Don't know/Weet nie

70

23. Is there a test for AIDS
Kan 'n mens getoets word vir AIDS/VIGS?

Yes/Ja

No/Nee

Don't know/Weet nie

71

24. People say many things about AIDS. Please tell me whether you agree, disagree or are uncertain about the following statements

Agree = A Disagree = D Uncertain = U

Die mense sê baie dinge oor AIDS/VIGS. Nou moet jy/u sê of jy saamstem, nie saamstem nie, of onseker is.

Stem saam = S Nie saam stem nie = N Onseker = O

It is an acceptable part of our culture to have several wives.

Dit is aanvaarbaar in ons gemeenskap om meer as een vrou te hê.

72

2

1

Everyone has to go (die) sometime so why worry about getting ill.

Ons moet tog almal sterwe, so hoekom moet jy/u bekommerd wees oor siek word.

2

Family planning methods including condoms are bad because they are there to decrease our numbers

Gesinsbeplanning is nie goed nie, want die staat gebruik dit om ons minder te maak.

3

AIDS is not a problem because it is a White disease

AIDS/VIGS is nie ons probleem nie, net die wit mense kry dit.

4

Only homosexuals get AIDS

Net homoseksuele kry AIDS/VIGS.

5

Married people can't get AIDS

Getroude mense kry nie AIDS/VIGS nie.

6

There is no point worrying about AIDS when one has to worry about food, money and unemployment
'n Mens het genoeg bekommernisse oor kos, geld en werk om nog bekommerd oor AIDS/VIGS te wees.

7

Ordinary people won't get AIDS

Gewone mense kry nie AIDS/VIGS nie.

8

The chance of catching AIDS is greater if you have more than one sexual partner

Om AIDS/VIGS te kry moet 'n mens meer as een seksmaat hê.

9

I have already heard so much about AIDS that I don't want to hear any more

Ek het al so baie van AIDS/VIGS gehoor ek is al op/moeg daarvan.

10

25. Do you know what a condom or F.L. is?

Weet jy/u wat 'n kondoom/FL/reënjassie/protection is?

Yes/Ja

No/Nee

11

IF NO: Men can wear a condom during sex to prevent pregnancy. Have you heard of this method?
 INDIEN NEE: Mans kan dit gebruik om swangerskappe te voorkom. Het jy/u al van hierdie manier gehoor?

Yes/Ja No/Nee Don't know/Weet nie

12

26. Have you ever used a condom?
 Het jy/u al ooit so iets gebruik?

Yes/Ja No/Nee Don't know/Weet nie

13

IF YES: Have you used one in the past year?
 INDIEN JA: Het jy/u al so iets oor die afgelope jaar gebruik?

Yes/Ja No/Nee

14

27. People say many things about condoms. Tell me if you agree, disagree or are uncertain about the following statements.

Agree = A Disagree = D Uncertain = U

Die mense sê baie dinge oor FL's/Kondome. Ek gaan vir jou/u 'n paar van die dinge noem en dan moet jy sê of jy saam, nie stem nie of onseker is.

Stem saam = S Nie saam stem nie = N Onseker = O

Condoms interfere with sexual pleasure
 'n Mens kry nie die plesier uit seks as jy 'n kondoom/FL gebruik nie

15

- | | | | |
|---|--------------------------|--------------------------|----|
| Condom use is against my religion or culture
<i>Dit is teen my geloof of kultuur om kondome te gebruik.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 16 |
| My boyfriend or girlfriend would not accept the use of a condom
<i>My seksmaat sal nie tevrede wees as ek 'n kondoom/FL gebruik nie.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 17 |
| Condoms are easy to get if you need them
<i>Dit is maklik om 'n kondoom/FL in die hande te kry as jy dit nodig het.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 18 |
| Condoms are easy to use
<i>Dis maklik om 'n kondoom te gebruik.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 19 |
| None of my friends use condoms
<i>Nie een van my vriende gebruik 'n kondoom/FL nie.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 20 |
| The price of condoms is too high to use all the time
<i>Kondome/FL's is te duur om altyd te gebruik.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 21 |
| Condoms can prevent venereal disease or "drop" if used properly
<i>Jy sal nie VD/vuilsiekte kry as jy kondome/FL's reg gebruik nie.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 22 |
| Condoms can prevent AIDS if used properly
<i>Jy sal nie AIDS/VIGS kry as jy kondome/FL's reg gebruik nie.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 23 |
| Using condoms is not acceptable to me
<i>Ek hou nie daarvan om kondome/FL's te gebruik nie.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 24 |
| 28. Would you like to receive more information about AIDS?
<i>Is daar nog iets wat jy/u oor AIDS/VIGS wil weet?</i> | | | |
| Yes/Ja | <input type="checkbox"/> | | |
| No/Nee | <input type="checkbox"/> | | |
| Don't know/Weet nie | <input type="checkbox"/> | <input type="checkbox"/> | 25 |

29. Where would you prefer to get your information on AIDS?
 Waar sal jy/u verkies om inligting oor AIDS/VIGS te kry?

26 27

 28 29

30. In which language would you prefer to get information about AIDS: In Afrikaans, English or Xhosa?

30

31 This clinic would like to provide people coming to the clinic with information about AIDS.

How would you like the clinic to provide this information?

Hierdie kliniek wil graag mense wat hier kom inligting gee in verband met AIDS. Hoe sal jy/u wil hê dat hierdie inligting aangebied moet word?

31 32 33

 34 35

32. The community needs information about AIDS. What is the best way you think to educate the community about AIDS?

Die gemeenskap benodig inligting omtrent AIDS. Hoe dink jy is die beste manier om die gemeenskap op te voed omtrent AIDS.

36 37 38

 39 40

33. Are you married?
Is jy/u getroud?

Yes/Ja

No/Nee

41

IF YES Where does your wife/husband live?
(Specify town)
INDIEN JA: Waar woon jou vrou/man

42 43

34. Men sometimes have sex with other men. Do you think in our community that this happens?
Somtyds het mans seks met ander mans. Dink jy/u dit gebeur in ons gemeenskap?

Yes/Ja

No/Nee

Don't know/Weet nie

44

IF YES: Does this happen:
INDIEN JA: Gebeur dit:

A little/'n bietjie

A lot/baie

Don't know/weet nie

45

35. People sometimes pay money for sex. Do you think that members of our community pay money for sex?
Mense betaal somtyds vir seks. Dink jy/u dat mense in ons gemeenskap vir seks betaal?

Yes/Ja

No/Nee

46

IF YES: Does this happen:
 INDIEN JA: Gebeur dit:

A little/'n bietjie

A lot/baie

Don't know/weet nie

47

I AM NOW GOING TO ASK YOU TWO QUESTIONS ABOUT YOUR ILLNESS

36. How many times in the last 2 years have you suffered from a sexually transmitted disease? (Is it the first time?)
 Hoeveel keer in die laaste 2 jaar het jy/u V.D.? gehad? (Is dit die eerste keer?)

48 49

37. Sexually transmitted diseases are easily transmitted by sex and all partners need to be examined. Can you tell me how many sexual partners have you had since the beginning of this year?
 Vuilsiekte/geslagsiekte is maklik oordraagbaar en almal wat seksuele kontak met so 'n persoon gehad het, moet kom vir ondersoek. Kan u/jy vir my sê hoeveel seksmaats het jy/u van die begin van die jaar tot nou gehad?

50 51

I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR EDUCATIONAL BACKGROUND

38. In what standard did you leave school?
 In watter standerd het jy/u die skool verlaat?

52

39. Can you read?
Kan jy/u lees?

Yes/Ja

No/Nee

53

IF YES: Could you read this paragraph and in your own words tell me what you understand by it?

INDIEN JA: *Kan jy/u die volgende lees en sê wat jy/u daarby verstaan het?*

Good understanding

Partial understanding

Poor or no understanding

54

The questionnaire is now finished. Thank you very much for your cooperation. You can now move on to the doctor.

He/she is willing to answer any question you have about AIDS.

PLEASE DO NOT HESITATE TO ASK.

Read point 5 only

AIDS

Prime Messages

1. AIDS is an incurable disease which can be passed on by sexual intercourse, by infected blood, and by infected mothers to their unborn and newborn children.
AIDS is 'n ongeneesbare siekte wat kan versprei word deur seks, besmette bloed of deur moeders wat AIDS het en dit dan oordra na hulle ongebore of nuwe babas.

2. Safe sex means being sure that neither partner is infected, remaining mutually faithful, and using a condom if in doubt.
Veilige seks bedoel dat jy seker is dat nie een van u seksmaats besmet is met AIDS nie, getrou bly aan een seksmaat, en 'n kondoom gebruik as jy/u onseker is.

3. Any injection with an unsterilised needle or syringe is dangerous.
Enige inspuiting wat gegee word met 'n ongeste­riliseerde/vuil naald of spuit is gevaarlik.

4. Women with the AIDS virus should avoid becoming pregnant.
Vrouens wat AIDS het moet nie swanger word nie.

5. All parents should tell their children how to avoid getting AIDS.
Ouers behoort aan hulle kinders te sê hoe om AIDS te voorkom.

APPENDIX 2

1) Introduction to the Xhosa/English interview schedule:

We are busy preparing an education programme for patients here on AIDS. In order that we are able to best educate and teach people about AIDS we are asking people what they already know and what they think about this illness.

We will not ask for your name at all and everything you tell us will be kept completely confidential. Do you give permission for me to ask you some questions? (If yes continue) Please try to answer questions as carefully as possible. If you do not understand a question please say so and I will repeat it or explain it to you.

If no ask questions 1 - 5.

Ensure patient has not been interviewed before.

Any additional comment may be written at the back.

1

2 3 4

Clinic.....

5

Interviewer.....

6 7

(2)

QUESTIONNAIRE

1. Sex
- Male
- Female 8
2. What is your age? _____ years 9 10
Mingaphi iminyaka yakho?
3. Where do you live? 11 12
Uhlala kweyiphi indawo?

4. How long have you lived in Cape Town? 13 14
Unexesha elingakanani uhlala apha eKapa?
 _____ years

IF LESS THAN 5 YEARS

Where do you come from? 15 16
Uvela kweyiphi indawo okanye ilali?

5. Have you heard of the disease called AIDS? 17
Ukhe weva na ngesifo l- AIDS (Gawulayo)?
- Yes/Ewe
- No/Hayi
- Don't know/Andazi

IF NO GO TO QUESTION 29

6. I am interested to know how much you think you know about this disease called AIDS. Would you say you know:
Ndingathanda ukwazi ukuba wazi kangakanani na ngesi sifo i-AIDS?

- A lot/*Wazi kakhulu*
- A moderate amount/*Ulwazana*
- A little/*Ufifi*
- Nothing/*Awazi nto tu*

18

7. How much of a danger do you think AIDS is to your local community today? Would you say that it is :
Iyingozi kangakanani na i-AIDS apha ekuhlaleni?

- No danger at all/*Ayinabungozi*
- Some danger/*Inobungozi*
- Serious danger/*Iyingozi kakhulu*
- Don't know, not sure/*Andazi - Andiqinisekanga*

19

8. What worries you most about this disease called AIDS?
Yintoni olona loyiko lwakho ngesifo i-AIDS?

20 21 22

9. What other things would you like to know about AIDS?
Zinto zini kanye ofuna ukuzazi nge - AIDS?

23 24

25 26 27

10. Is there a chance that you might get AIDS?
Ucinga ukuba ungayifumana i-AIDS?

Yes/Ewe

No/Hayi

Don't know/Andazi

28

(If yes: *ukuba ewe:*)

Is it a: *ingaba:*

Small chance/*amathuba mancinci*

Big chance/*amathuba makhulu*

Don't know, not sure/*Andazi -*

Andiqinisekanga

29

11. Can a person prevent AIDS?
Ungayithintela na i-AIDS?

Yes/Ewe

No/Hayi

Don't know/Andazi

30

IF YES Please tell me all the ways you know to prevent AIDS?

Ndixelele iindlela ozaziyo onokuthi uzikhusele ngayo kwi-AIDS?

31 32 33

34 35

12. How does one get AIDS? Please tell me all the ways you know.
Umntu uyifumana njani i-AIDS - ndixelele zonke iindlela ozaziyo?

36 37 38

39 40

13. Of all the ways you have mentioned, which one do you think is most important in South Africa?
Kuzo zonke ezi ndlela uzixelileyo yeyiphi eyona ucinga ukuba ibalulekile emzantsi -Afrika?

41 42

14. Is there a cure for AIDS ?
Inganyangwa i-AIDS?

Yes/Ewe

No/Hayi

Uncertain/Andiqinisekanga

43

15. Can one die of AIDS?
Iyabulala i-AIDS?

Yes/Ewe

No/Hayi

Uncertain/Andiqinisekanga

44

16. Have you ever known anyone who has AIDS?
Ukhona umntu omaziyo one - AIDS?

Yes/Ewe

No/Hayi

Uncertain/Andiqinisekanga

45

17. Which people in South Africa are more likely to catch AIDS?
Ngobani abasemngciphekweni wokufumana i-AIDS apha emzantsi - Afrika?

46 47 48

49 50

SOME OF THE FOLLOWING QUESTIONS MAY BE VERY PERSONAL

If you do not want to answer any of these questions, please tell me and I will go on to the next question.

18. Have you made any changes in your life as a result of what you know about AIDS?
Zikhona inguqulelo othe wazenza ebomini bakho ngenxa ye-AIDS?

Yes/Ewe

No/Hayi

Don't know/Andazi

51

IF YES What changes have you made?
Ziziphi inguqulelo othe wazenza?

52 53

54 55

19. Are you planning to make any changes in your life because of what you know about AIDS?
Kukho zinguqulelo ozimisele ukuzenza kubomi bakho ngenxa yolwazi lwakho nge-AIDS?

Yes/Ewe

No/Hayi

Don't know/Andazi

56

IF YES What kind of changes are you planning to make?
Zeziphi iinguqulelo ozimisele ukuzenza?

57 58

59 60

20. People say many things about how one avoids catching AIDS. Please say if you agree, disagree or are uncertain.
 Agree = A Disagree = D Uncertain = U
Uyavuma Awuvumi Awuqinisekanga
Zininzi iindlela abathi abantu bangazikhusela ngazo kwi-AIDS. Nceda utsho ukuba uyavumelana, akuvumelani okanye akuqinisekanga ngezi zinto zilandelayo;

AIDS can be prevented by:
i-AIDS ingakhuselwa:

Using the injection that prevents pregnancy
Ngokusebenzisa inaliti yocwangciso

61

Using condoms
Ngokusebenzisa isingxobo (condom)

62

Eating a healthy diet
Ngokukutya ukutya okuya egazini

63

Avoiding sex with prostitutes
Ngokungalali nentombazana ethengisa ngomzimba wayo

64

- | | | | |
|---|--------------------------|--------------------------|----|
| Avoiding people who cough and spit
<i>Ngokungadibaniselani nabantu
abakhohlela batshice</i> | <input type="checkbox"/> | <input type="checkbox"/> | 65 |
| Having only one faithful partner
<i>Ngokubanesithandwa esinye
esithembekileyo</i> | <input type="checkbox"/> | <input type="checkbox"/> | 66 |
| Not having sex with someone you
think may have many partners.
<i>Ngokungalali nomntu omranelayo ukuba
une zithandwa - ezininzi.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 67 |
| Avoiding people who don't wash
<i>Ngokungalali nabantu abangacocekanga.</i> | <input type="checkbox"/> | <input type="checkbox"/> | 68 |
| 21. Do you think a person can have AIDS but not feel
sick in any way?
<i>Ucinga ukuba unganayo i-AIDS kodwa unga
bonakalisi iimpawu zokugula?</i> | | | |
| Yes/Ewe | <input type="checkbox"/> | | |
| No/Hayi | <input type="checkbox"/> | | |
| Don't know/Andazi | <input type="checkbox"/> | <input type="checkbox"/> | 69 |
| 22. Do you think one could get AIDS from someone who
looks healthy?
<i>Ucinga ukuba ungayifamana iAIDS kumntu
okhangeleka ephelile?</i> | | | |
| Yes/Ewe | <input type="checkbox"/> | | |
| No/Hayi | <input type="checkbox"/> | | |
| Don't know/Andazi | <input type="checkbox"/> | <input type="checkbox"/> | 70 |

23. Is there a test for AIDS
Xa ucinga ingabonwa i-AIDS egazini?

Yes/Ewe

No/Hayi

Don't know/Andazi

71

24. People say many things about AIDS. Please tell me whether you agree, disagree or are uncertain about the following statements

Agree = A Disagree = D Uncertain = U
Uyavuma Awuvumi Awuqinisekanga

Abantu bethetha izinto ezininzi nge - AIDS. Ndixelele ukuba uyavumelana na okanye awuvumelani okanye awuqinisekanga ngezindlela zilandelayo.

It is an acceptable part of our culture to have several wives.

Isithethe sethu sisivumela ukuba sibenabafazi abaninzi.

72

Everyone has to go (die) sometime so why worry about getting ill
Sonke sizakufa - uzihluphelani ngokugula.

2

1

2

Family planning methods including condoms are bad because they are there to decrease our numbers
Ucwangciso - ntsapho alulunganga kuba lucutha inani lwethu.

3

AIDS is not a problem because it is a White disease

I - AIDS ayiyonkgxaki kuba sisifo - sabamhlophe.

Only homosexuals get AIDS
Sisifo samadoda alalanayo okanye iimofie.

4

5

Married people can't get AIDS
Abantu abatshatileyo abanakubanayo i - AIDS.

6

There is no point worrying about AIDS when one
 has to worry about food, money and unemployment
*Akukho mfuneko yokuzihlupha nge - AIDS xa
 ungenamali, - ungenakutya, - ungasebenzi.*

7

Ordinary people won't get AIDS.
Nabanina akangeyifumana i - AIDS.

8

The chance of catching AIDS is greater if you
 have more than one sexual partner.
*Ithuba lokuthi ufumane i - AIDS likhulu xa unabantu
 abanizi olalana nabo.*

9

I have already heard so much about AIDS that I
 don't want to hear any more.
Ndive kakhulu nge - AIDS andisafuni kuva nto tu.

10

25. Do you know what a condom or F.L. is?
Uyayazi ikhondom/isingxobo/F.L.?

Yes/Ewe

No/Hayi

11

IF NO: Men can wear a condom during sex to prevent
 pregnancy. Have you heard of this method?

*Ukuba HAYI: Amadoda angayinxiba ikhondom
 ukuthintela ukuba angamithisi.
 Wakhe weva ngolu hlobo?*

Yes/Ewe

No/Hayi

Don't know/Andazi

12

26. Have you ever used a condom?
 Wakhe wayisebenzisa na ikhondom? Okany e
 iqabane lakho?

Yes/Ewe

No/Hayi

Don't know/Andazi

13

IF YES: Have you used one in the past year?
 Ubukhe wayisebenzisa na kulo nyaka udlulileyo?

Yes/Ewe

No/Hayi

14

27. People say many things about condoms. Tell me if
 you agree, disagree or are uncertain about the
 following statements.

Agree = A Disagree = D Uncertain = U
 Uyavuma Awuvumi Awuqinisekanga

Abantu bathetha izinto ezininzi ngee khondoms
 ndixelele ukuba uyangqina okanye awungqinelani okanye
 akuqinisekanga nezi zinto zilandelayo.

Condoms interfere with sexual pleasure.
 i Khondoms ziphazamisa ulonwabo lokulalana
 (isondo).

15

Condom use is against my religion or culture.
 Ukusebenzisa ikhondom akuvumelani nenkolo
 yam okanye isiko lam.

16

My boyfriend or girlfriend would not accept
 the use of a condom.
 Isithandwa sam asinakuvuma ukuba ndisebenzise
 okanye ikhondom.

17

Condoms are easy to get if you need them.
Ikhondoms zifumaneka lula xa uzifuna.

18

Condoms are easy to use.
Kulula ukusebenzisa ikhondom.

19

None of my friends use condoms
*Akukho nomnye kwizihlobo zam nezithandwa zam
 osebenzisa ikhondom.*

20

The price of condoms is too high to use all
 the time.
*Ikhondoms zi duru xa uzakuzisebenzisa lonke
 ixesha.*

21

Condoms can prevent venereal disease or "drop"
 if used properly.
*Ikhondoms zingayithintela i-VD ukuba
 zisetyenziswa ngendlela.*

22

Condoms can prevent AIDS if used properly.
*Ikhondoms zingayithintela i- AIDS ukuba
 zisetyenziswa ngendlela.*

23

Using condoms is not acceptable to me.
Andithandi ukusebenzisa ikhondom.

24

28. Would you like to receive more information about
 AIDS?
*Ungathanda ukuba nolwazi oluphangaleleyo nge
 - AIDS?*

Yes/Ewe

No/Hayi

Don't know/Andazi
Andiqisekanga

25

29. Where would you prefer to get your information on
 AIDS?
Ungathanda ukulufumana phi na ulwazi nge - AIDS?

26 27

28 29

30. In which language would you prefer to get information about AIDS: in Xhosa, English or Afrikaans?

Ungathanda ukulufumana ngaluphi ulwimi ulwazi nge - AIDS: ngesixhosa, ngesingesi, ngeAfrikaans

.....

30

31. This clinic would like to provide people coming to the clinic with information about AIDS. How would you like the clinic to provide this information?

Le kliniki ingathanda ukunika abantu abeza apha ulwazi nge-AIDS wena ungathanda yenziwe njani le nto?

.....

.....

.....

31 32 33

34 35

32. The community needs information about AIDS. What is the best way you think to educate the community about AIDS?

Kuyimfuneka ukuba uluntu lufumane ulwazi ngesifo seAIDS. Ucinga ukuba ingaloluphi olona hlobo lulungileyo ikuyenza loo nto?

.....

.....

.....

36 37 38

38 40

33. Are you married?
Utshatile?

Yes/*Ewe*

No/*Hayi*

41

IF YES Where does your wife/husband live?
 (specify town)

Uhlala phi umfazi wakho okanye umyeni?

.....

42 43

34. Men sometimes have sex with other men. Do you think in our community/area that this happens?
Maxawambi amadoda ayalalana. Ucinga ukuba oku kuyenzeka kule ndawo ukuyo?

Yes/*Ewe*

No/*Hayi*

Don't know/*Andazi*

44

(If yes: *ukuba ewe:*)
 Does this happen: *lento yenzeka:*

A little/*Kancici*

A lot/*kakhulu*

Don't know/*andazi*

45

35. People sometimes pay money for sex. Do you think that members of our community pay money for sex?
Maxawambi abantu bathi bazuze imali okanye bahlawulwe ngokulalwa (i-sex); ucinga ukuba oku kuyenzeka eluntwini lwethu?

Yes/*Ewe*

No/*Hayi*

Don't know/*Andazi*

46

(If yes: *ukuba ewe:*)

Does this happen: *lento yenzeka*:

A little/*Kancici*

A lot/*kakhulu*

Don't know/*andazi*

47

I AM NOW GOING TO ASK YOU TWO QUESTIONS ABOUT YOUR ILLNESS

36. How many times in the last 2 years have you suffered from a sexually transmitted disease? (Is it the first time?)
Ukhe wahlaselwa kangaphi na sisifo igcushuwa kule minyaka mibini idlulileyo? (ingaba kokokuqala)

48

37. Sexually transmitted diseases are easily transmitted by sex and all partners need to be examined. Can you tell me how many sexual partners have you had in since the beginning of this year?

Izifo zobudoda nabufazi zifumaneka lula ngokulalana yaye bonke abalalanayo kufuneka beqwalaselwe. Ungandixelela ke ukuba zingaphi izithandwa othe walala nazo ukususela oko lo nyaka uqalile?

49 50

I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR EDUCATIONAL BACKGROUND

38. In what standard did you leave school?
Uyeke kweliphi na ibanga esikolweni?

51 52

39. Can you read?
Uyakwazi na ukufunda?

Yes/*Ewe*

No/*Hayi*

53

IF YES: Could you read this paragraph and in your own word tell me what you understand by it.

Ukuba EWE: Ungandifundela na esi sicutshulwa ukuze ke. Undixelele okuvileyo kuso ngawakho amazwi?

Good understanding

Partial understanding

Poor or no understanding

54

The questionnaire is now finished. Thank you very much for your cooperation. You can now move on to the doctor.

He/she is willing to answer any question you have about AIDS.

PLEASE DO NOT HESITATE TO ASK.

Read point 5 only

AIDS

Prime Messages

1. AIDS is an incurable disease which can be passed on by sexual intercourse, by infected blood, and by infected mothers to their unborn and newborn children.

I-AIDS sisifo esinganyangekiyo kwaye iyosulela ngokulalana, igazi elinalentsholongwane ye - AIDS ndawonye nomama abakhulelweyo abathi bona bosulele iintsana zabo ezingekazalwa.

2. Safe sex means being sure that neither partner is infected, remaining mutually faithful, and using a condom if in doubt.

Ukulalana okukhuselekileyo kuthetha ukuba nithembane nesithandwa sakho, niqiniseke ukuba akukho wosulelekileyo. Xa kukho ukungaqiniseki sebenzisani ikhondom.

3. Any injection with an unsterilised needle or syringe is dangerous.

Nayiphina inaliti yesitofu ebisele - isetyenzisiwe komnye umntu iyingozi.

4. Women with the AIDS virus should avoid becoming pregnant.

Abafazi abanalentsholongwane ye-AIDS kufuneka baluthintele umitho.

5. All parents should tell their children how to avoid getting AIDS.

Bonke abazali kufuneka babaxelele abantwana indlela yokuzikhusela kwesi sifo i - AIDS.

APPENDIX 3

RESULTS

In this section results will given in the order of questions in the questionnaire. Results will be given for the group as a whole. However when a significant difference was found between females and males or between strata, these will be listed as well. Results will be rounded off to the nearest whole number. Results will only be presented numerically here and not graphically. Only percentages and not the actual numbers will be presented because of space considerations. The results of certain questions are not included. The complete results which number several hundred pages are available from the writer.

Y=Yes N=No DK=Don't know
 Agree / Disagree / Don't know will also be presented
 as Y / N / DK

1. Male 47% Female 53%

2. <u>YEARS</u>	<u>FEMALE (%)</u>	<u>MALE (%)</u>	<u>ALL (%)</u>
<15	1%	1%	1%
15-19	12%	12%	12%
20-24	33%	33%	33%
25-29	30	17%	24%
30-34	10%	15%	12%
35-39	10%	6%	8%
>40	3%	15%	9%
Mean =	26 years	28,2 years	27 years
Median =	25 years	26 years	
S.D. =	7,1 years	9,5 years	8,4 years

4a. <u>Residence#</u>	<u>Female (%)</u>	<u>Male (%)</u>	<u>All (%)</u>
0-4 years	55%	32%	45%
5-9 years	10%	12%	11%
10-14 years	6%	3%	5%
15+ years	29%	53%	39%
Median =	17 years	4 years	6,5 years

Residence# = duration of residence in Cape Town

5. Y 97% N 2% DK 1%

6. A lot	6%
A moderate amount	26%
A little	60%
Nothing	8%

7. No danger at all	5%
Some danger	24%
Serious danger	57%
Don't know	14%

8. <u>Greatest worry about AIDS</u>	<u>Percentage</u>
AIDS kills	49%
AIDS is incurable	26%
Infectious / sexually transmitted	12%
Social isolation / lose job	4%
Other	9%

9. <u>Information requested about AIDS</u>	<u>Percentage</u>
Symptoms and signs	37%
eg How would one feel sick if one had AIDS?	
What are the signs of AIDS on a person?	
How does one know one has AIDS?	
Causes and spread	35%
eg How does one get AIDS?	
What causes it?	
Methods of prevention	16%
eg How to prevent it?	
Cure and treatment	15%
eg. Is it curable?	
How can it be cured?	
Why is it incurable?	
Origin of AIDS	10%
eg Where does it come from?	
Where to get help or information	7%

10a. Y 39% N 29% DK 32%

	Coloured	Inner city	Township	Shantytown	All
Y	36%	33%	37%	49%	39%

b. Small chance	42%
Big chance	27%
Don't know	36%

Percentage of all attenders saying a big chance#					
	Coloured	Inner city	Township	Shantytown	All
Big	7%	4%	7%	25%	10%

#all refers to all attenders answering part a.

11a. Y 90% N 5% DK 4%

b. <u>Perceived ways of preventing AIDS</u>	<u>Percent</u>
Decrease number of sexual partners	47%
Use condoms	45%
More selective in partner choice	20%
Medical checkups	18%
Avoiding casual contact (eg kissing)	8%

12. and 13.

<u>Perceived mode of transmission Of AIDS</u>	<u>Q12 Percentage</u>	<u>Q13 Percentage</u>
Sex-with many partners	54%	55%
-with someone infected	14%	7%
-with prostitutes	5%	3%
-with other races / homosexuals	7%	8%
-other	26%	23%
-total		95%
Infected blood or needles	16%	2%
Casual contact (i.e incorrect)	16%	2%

14. Y 21% N 56% DK 23%

15. Y 96% N 0% DK 4%

16. Y 2% N 97% DK 1%

17. <u>People considered more likely to catch AIDS</u>	<u>Percentage</u>
People with many sexual partners	22%
Anybody	19%
Prostitutes	16%
Blacks /Whites / Coloureds	10% / 9% / 1%
Homosexuals / bisexuals	10%
Men / women	7% / 6%
Don't know	11%

18a. Y 47% N 51% DK 2%

b. <u>Kind of change made</u>	<u>Percentage#</u>	<u>Percentage\$</u>
1 partner / reduce partners	67%	30%
Use condoms	14%	6%
More selective / know background	8%	3%
Visit clinic / doctor	6%	3%

Percentage# = percentage of Y reporting this change

Percentage\$ = percentage of all attenders reporting this change.

19a. Y 59% N 29% DK 12%

	Females	Males
Y	45%	63%

b. <u>Kind of change planned</u>	<u>Percentage#</u>	<u>Percentage\$</u>
1 partner / reduce partners	57%	33%
Use condoms	17%	10%
More selective / know background	10%	6%
Visit clinic / doctor	9%	5%

Percentage# = percentage of Y planning this change
 Percentage\$ = percentage of all attenders planning this change.

	Female	Male
Reduce partners	36%	30%
Use condoms	6%	13%

	Coloured	Inner city	Township	Shantytown
Reduce partners	20%	44%	33%	34%
Use condom	21%	5%	4%	8%

20a. Y 19% N 51% DK 30%

b. Y 78% N 7% DK 15%

c. Y 46% N 31% DK 23%

d. Y 91% N 5% DK 4%

e. Y 51% N 26% DK 23%

f. Y 93% N 3% DK 4%

g. Y 89% N 7% DK 4%

h. Y 65% N 20% DK 15%

21. Y 63% N 20% DK 17%

22. Y 69% N 17% DK 13%

23. Y 78% N 3% DK 19%

24a. Y 21% N 72% DK 7%

b. Y 7% N 87% DK 7%

c. Y 15% N 77% DK 8%

d. Y 8% N 84% DK 7%

e. Y 19% N 64% DK 17%

f. Y 13% N 75% DK 12%

g. Y 3% N 86% DK 10%

h. Y 26% N 64% DK 10%

i. Y 87% N 9% DK 4%

j. Y 6% N 88% DK 6%

25a. Y 92% N 8%

26a. Y 23% N 76% DK 1%

	Female	Male
Y	15%	30%

	Coloured	Inner City	African township	Shantytown
Y	33%	29%	15%	13%

b. Y 61% N 39% (i.e % of Y)

	Coloured	Inner City	African township	Shantytown
	46%	68%	70%	75%

Percentage of all attenders who used condom in past year #

	Male	Female	All
	20%	7%	13.6%

	Coloured	Inner City	African township	Shantytown
	14%	20%	10%	10%

(# all refers here to all attenders who answered 26a)

27a. Y 24% N 31% DK 45%

b. Y 20% N 55% DK 25%

c. Y 34% N 32% DK 33%

d. Y 80% N 3% DK 17%

e. Y 61% N 5% DK 33%

f. Y 28% N 20% DK 52%

g. Y 8% N 61% DK 32%

h. Y 80% N 4% DK 16%

i. Y 78% N 5% DK 17%

j. Y 45% N 35% DK 21%

	Females	Males
Y	39%	51%
N	37%	32%

28. Y 90% N 8% DK 2%

In the Coloured stratum 29% said they did not want more information about AIDS compared to 0% in the other strata.

29. Clinic/doctor/nurse	85%
Other	15%

30.	Coloured	Inner city	African	All
Xhosa	4%	51%	94%	57%
Afrikaans	71%	9%	0%	23%
English	17%	23%	2%	12%
Combination / other	8%	15%	3%	8%

31. Preferred way to educate at clinic	Percentage
Talks / lecture	48
Video /TV /Film	35
Pamphlets	33
Show a person with AIDS	6

32. Preferred way to educate community	Percentage
Calling or addressing meetings eg clinic/community centre	41
TV / Video / Film	29
Pamphlets	23
Radio	20
Other media (newspapers)	26

Calling or addressing meetings was mentioned by 27% in the Coloured stratum and 48% in the other strata.

33a. Y 33% N 67%

34a. Y 46% N 37% DK 17%

	Coloured	Inner city	African township	shantytown
Y	82%	49%	30%	15%

b. Y 27% N 37% DK 37%

Percentage of all respondents answering a lot#

	Coloured	Inner city	African township	Shantytown
Lot	37%	15%	11%	3%

all refers to all respondents replying to part a)

35a. Y 81% N 12% DK 7%

b A little 18%
A lot 63%
Don't know 19%

Percentage of all respondents answering a lot#

	Coloured	Inner city	African township	Shantytown
Lot	40%	59%	51%	65%

all refers to all respondents replying to part a)

36. Number of STD's	<u>FEMALE(%)</u>	<u>MALE(%)</u>	<u>ALL(%)</u>
0	21%	9%	15%
1	71%	59%	65%
2	5%	26%	15%
3	1%	5%	3%
4+	1%	2%	2%
Mean	0,9	1,3	

2 or more STD's	Coloured 16%	Inner city 35%	African township 27%	shantytown 20%
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37. Partners	<u>FEMALE(%)</u>	<u>MALE(%)</u>	<u>ALL(%)</u>
0	2%	4%	3%
1	74%	32%	54%
2	20%	32%	26%
3	3%	13%	7%
4	1%	8%	4%
5+	1%	11%	5%
Mean	1,3	2,4	
S.D.	0,9	2,5	
Median	1	2	

2 or more partners	Coloured 37%	Inner City 56%	African township 44%	Shantytown 34%
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38.

39a. Y 94% N 6%

b Good understanding	83%
Partial understanding	13%
Poor or no understanding	4%