ASSESSMENT OF INFORMATION DELIVERY SYSTEMS USED FOR DISSEMINATION OF HIV/AIDS INFORMATION BY SELECTED CLINICS AT GA-MOLEPO,CAPRICORN DISTRICT IN THE LIMPOPO PROVINCE

BY

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[redacted]

Research submitted in partial fulfillment of the requirements for the degree of

MASTER OF INFORMATION STUDIES

in the

DEPARTMENT OF INFORMATION STUDIES

in the

SCHOOL OF LANGUAGES AND COMMUNICATION STUDIES

FACULTY OF HUMANITIES

at the

UNIVERSITY OF LIMPOPO

TURFLOOP CAMPUS

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OCTOBER 2008

DECLARATION

I declare that the dissertation hereby submitted to the University of Limpopo for the degree of Master of Information Studies has not previously been submitted by me for a degree at this University or any other University, that is, it is my own work in design and in execution and all material contained therein has been duly acknowledged.

Dikotla Maoka Andries

DATE: 06 October 2008

DEDICATION

This study is dedicated to my parents, Molagare Emily and Makwea Frans Dikotla and my siblings: Mogala, Mashoka, Matome, Lesiba, Mogomane and Malegola.

“Le go lena Ditlou ka moka.”

ACKNOWLEDGEMENTS

I would like to acknowledge the Creator; the almighty God to whom all thanks should begin and end. I also wish to express my sincere gratitude to the following individuals for their assistance in the completion of this study:

- My supervisors, Dr S.A Brink and Ms M.J Ntsala for your guidance, encouragement, advice, facilitating and supporting this study since its inception. Many thanks to you for persevering with me as my advisors throughout the time it took me to complete this research and write the dissertation.
- I am grateful to many people who offered me support and advice, and continued to ask me about my progress in the study, especially Mr JK Shokane, Ms MR Mahlatji and Mr M. Mphahlele. Without your interest and encouragement, it might have been abandoned.
- Ms E. Malomane and research committee in the Department of Health and Social Development for granting me permission to conduct this study.
- All respondents who were interviewed
- Many thanks to all contributors that provided constructive criticism during the preparation of the study.

ABSTRACT

The aim of the study is to investigate which of the information delivery systems (communication strategies) established at government level are used by rural clinics, and whether such information delivery systems are accessible to rural end-users. A literature review discussing and assessing the use of information delivery systems was conducted. The survey method and semi-structured interviews were used to collect data from all Clinics at Ga-Molepo. The study revealed that rural end-users cannot access HIV/AIDS information because clinics use information delivery systems which are not acceptable and accessible to them. Recommendations for further study on the subject under investigation are provided. The study assumes that with the identified barriers and recommendations at their disposal HIV/AIDS campaigners will be in a good position to identify, package and employ information delivery systems which are suitable for end-users.

TABLE OF CONTENTS

CHAPTER ONE: Introduction

CHAPTER TWO: Literature Review

CHAPTER FIVE: Data interpretation and discussion of results

CHAPTER SIX: Findings, recommendations and conclusion

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

1.1 BACKGROUND TO THE PROBLEM STATEMENT

According to Anderson (1992:12), HIV/AIDS was first officially reported in the United States of America (USA) in 1981. In South Africa, the first case of HIV/AIDS was notified in 1984. Avert Organization (2003:1) outlines that Africa is the region of the world that is most affected by HIV/AIDS. In comparison with the rates of HIV infection in Africa, those in general populations of Asia are low (UNAIDS, 2000:12).

The data on National HIV and syphilis antenatal sero-prevalence survey among antenatal clinic attendees in South Africa, 30.2 % of pregnant women were HIV positive in South Africa in 2005 (Department of Health, 2005:6). According to Dorrington, et al…(2006:1) recent projections estimate that, about 5.4 million people out of a total of nearly 48 million South Africans were HIV positive in the middle of 2006. According to Statistics South Africa (2007:1), the overall HIV-prevalence rate is approximately 11%. The number of people infected rises throughout the period and will to exceed 6 million by 2015 according to Dorrington, et al… (2006:20).

In 2006, the total population of Limpopo Province was estimated at 5 7830 605 with a growth rate of 1.4 %, a total HIV positive figure of 396 873, cumulative AIDS deaths of 121 557 and total AIDS sick 39 474 (Dorrington, et al…, 2006:70). It is disappointing that the numbers of people infected with HIV continue to rise, despite the fact that preventive strategies already exist.

Below is the Capricorn district map comprising of five municipalities, namely: Lepelle-Nkumbi, Aganang, Molemole, Blouberg, and Polokwane.

Figure 1: Capricorn district map

http://www.limpopo-dlgh.gov.za/districts_municipalities-new/introduction/capricorn.htm

The Capricorn district has 29 clinics, 2 general hospitals. Ga-Molepo is a village situated fifty (50) km away from the city of Polokwane and has five (5) clinics and one (1) mobile clinic. The names of the clinics are the following:

- Block 14 clinic
- Soetfontein clinic
- Mamushi clinic
- Molepo clinic
- Sehlale clinic

One (1) clinic operates twenty (24) hours while the other four (4) operate only during office hours (i.e. from 07h00- 16h00). It is only on Mondays and Fridays that a mobile clinic visits each village in turns. The 22 villages which comprise Ga-Molepo has an estimated population of 2000-5 000. The understandable rationale behind the practice of using mobile clinics is that

the Government has loudly and clearly, that people should not be made to walk or travel for distances of more than five kilometers for health services. Mahlo (2007) affirms this when he says that the government strategy emphasises that people should not travel more than five (5) km without accessing a health services as per norms and standards of primary health service. Further to that a clinic is expected to serve areas whose population statistics is around 10 000. As some villages have populations ranging from 2000 -5000, the population statistics of such villages are combined so that they could tally with the required specification that is required for one clinic.

People get information about HIV/AIDS from a wide range of sources including posters, television programmes, magazines, leaflets, books as well as World Wide Web (WWW). Some of these information sources are accurate while others are not. This is due to the fact that information needs related to HIV/AIDS are not limited to one clear-cut field such as conventional medicine, nor is the information needed found in one convenient place such as a traditional library. In this regard, the HIV/AIDS manual (2003:1) outlines that HIV/AIDS information, like a virus, is ever changing, mutating, multiplying, and difficult to contain. Furthermore, it is not suited to traditional methods of "containment" such as books where normal publication delays frequently render the information outdated sometimes even before the book is published.

As the impact of the HIV/AIDS epidemic grows, there is one weapon that appears to be constant in managing the virus and its devastating effects, namely information. The HIV/AIDS manual (2003:1), indicates that the right piece of information can literally make a difference between life and death, between successfully living with the HIV virus and succumbing to it.

More current sources of information like journals are needed with the special intent of highlighting new discoveries as well as to deal with some inaccuracies of HIV/AIDS messages. The provision of HIV/AIDS information is about finding out what people already know, adding to their existing knowledge about it, and correcting any misinformation, that may have crept inn (Avert Organization, 2003:1). People for example, may have heard that condoms are not effective against HIV/AIDS or that there is a cure for AIDS. It is therefore, important to provide information which can correct such wrong beliefs. Without correct information, people can be at a greater risk of contracting HIV (Avert Organization, 2003:1).

In South Africa, a number of agencies like LoveLife, AIDS Helpline, and several Non-Governmental Organisations (NGOs) are making important contributions in assisting people who are infected or affected by HIV/AIDS. The South African Broadcasting Corporation (SABC) is also actively involved in broadcasting programmes on HIV/AIDS. A long-standing programme Soul City, has been running for over five years. Some research institutions and universities are conducting regular research on the virus and results are published in various scholarly journals and national newspapers.

1.2 STATEMENT OF THE PROBLEM

In response to the HIV/AIDS epidemic, the South African government has identified information, education, communication and social mobilization as one of its strategies. This intervention is underpinned by communication strategies, like printed media, radio, TV, leaflets, billboards, and mobile media, such as taxis (Department of Health, 2000). The information delivery systems serve as a link between HIV/AIDS information and the public. Although the government has its communication strategies in place, little is known about the information delivery systems (communication strategies) that are used by rural clinics where the majority of the communities are illiterate. It does not mean that when the government has provided communication strategies that will be used effectively without nubs in the processes of delivery.

It is therefore important to evaluate the perceived success of the information systems used by rural clinics as Akukweas (2004:1) comments that, “Information, education and communication campaigns against HIV AIDS in Africa remain unfocussed, poorly funded and still subject to powerful but subtle morality and ideological battles.” Studies that are available have focused on end-users expressing views about the information delivery systems they are expected to be accessing, but very little is known about the clinics assessing HIV/AIDS information delivery systems they use to inform their communities about HIV/AIDS. There is a need for evaluation of various information delivery systems if the communication strategy of the government is to be achieved. Furthermore, the study seeks to confirm that rural clinics need information delivery systems that are unique to rural communities.

1.3 AIM OF THE STUDY

The aim of the study is to investigate which of the information delivery systems (communication strategies) established at government level are used by rural clinics, and whether such information delivery systems are accessible to rural end-user or not.

1.3.1 OBJECTIVES

i. To identify information delivery systems used by clinics to disseminate HIV/AIDS information.
ii. To establish which places clinics use to distribute HIV/AIDS information delivery systems.
iii. To determine the clinics' level of satisfaction with different information delivery systems.
iv. To find out how clinics conclude that particular information delivery system is accessible.
v. To find out if community members visiting clinics seek information on HIV/AIDS.
vi. To find out if clinics regard HIV/AIDS information made available through the multitudes of information delivery systems to be too much or not.
vii. To establish how clinics deal with language and illiteracy issues.
viii. To determine the knowledge/skills nurses have in the use of information delivery systems used in the dissemination of HIV/AIDS information.

1.4 ASSUMPTION

As much as various information delivery systems are available to clinics, rural end-users of these clinics cannot access them because of factors such as illiteracy, format, language and so forth.

1.5 RATIONALE FOR THE STUDY

The rationale for this study begins with the data that demonstrates that people, mostly youth; are at risk of HIV/AIDS infection, because they engage in untoward behaviour that places them at high risk. The indicators of high-risk behaviors include early sexual intercourse, multiple sex partners, and the indulgence in unprotected sex while under the influence of alcohol or drugs, the low rates of condom and contraceptive use, the high rate of unwanted pregnancies. It is not surprising therefore that the *National HIV and syphilis antenatal sero-prevalence survey* conducted by the Department of Health among antenatal clinic attendees in South Africa, found out that the percentage of infected people in Limpopo Province was 13.2% in 2000, 14.5% in 2001, 15.6 % in 2002 and in 2005, 30.2%.

A review on HIV/AIDS prevention and sexuality education intervention approaches demonstrates the value of HIV/AIDS information agencies contributing to HIV/AIDS prevention and sexual health promotion. Recent studies indicate that people in rural areas have relatively insufficient access to HIV/AIDS information due to poor information delivery systems used, but little research has been conducted that would enable HIV/AIDS information

providers to understand the complex nature of rural areas within differing cultural contexts. This study is an attempt to address this problem.

1.6 SIGNIFICANCE OF THE STUDY

The findings of the study will be made available to clinics, which were used in this research with the intention of helping then to identify some information barriers to HIV/AIDS information. With the identified barriers at their disposal, clinics could be able to improve their information delivery systems, i.e. they will exactly know how to package HIV/AIDS information in formats that are accessible to the targeted end-users, who are. people in rural areas. The results of the study will assist any organization, be it governmental or non-governmental, to make informed decisions regarding the provision of HIV/AIDS information. An article will also be submitted to the *South African Journal of Library and Information Science* for publication and this would add to the body of knowledge in the field.

1.7 AREA OF STUDY

The study seeks to investigate the extent to which the delivery of HIV/AIDS information by clinics to rural inhabitants at Ga-Molepo is done. As Claire et.al… (1995:17) notes, the scope of the area of study helps the researcher to limit the study to an acceptable confinement. Due to financial and time constraints, the study was limited to villages only in Ga-Molepo, which fall within the Capricorn district of the Limpopo province. According to a 2001 statistical release, the number of households in Ga-Molepo was approximately 32,702 at the time of the research.

The area consists of 22 villages (Statistics South Africa, 2001). It is approximately 60 kilometers east of the city of Polokwane.

1.8 DEFINITION OF CONCEPTS

It is proper to define unfamiliar concepts that are frequently used in this study under this section in order to facilitate easy reading of the research.

1.8.1 Access

This acceptable definition is adopted and modified from Buckland (1991:78) where the following six aspects of access are discussed:

i) Identification: A suitable source needs to be identified. In this study, the identified information delivery system has to be identified. The source identified could be a brochure, poster, or a person who is in this case, a health professional who has to provide information on HIV/AIDS. Health processionals should know which information delivery systems are accessible to the rural end-users.

ii) Availability: The inquirer needs to be able to inspect the source. For the purpose of the study, this means that the clients who visit the clinic to inquire about HIV/AIDS should access HIV/AIDS information in a format of their choice.

iii) Price to the user: If particular information delivery system contains discomforting information, or requires effort to be understood, it has to be regarded as not user-friendly and therefore, inaccessible.

iv) Cost to the provider: Not all expenditure of money and effort is borne by the inquirer. In the study, if the cost is borne by the service provider, it means the inquirer or end-user can access free information already paid for by the providers.

v) Understanding: Once physical access to a suitable source has been achieved, another condition for successful access is that the inquirer has sufficient expertise to understand it. For example, if an information delivery system is a computer, the user must be computer literate. Moreover, the information should be written in a language that is understandable by those who literate. If the recipients of the information are illiterate then the information has to be orally communicated in the language which the recipients understand.

vi) Acceptability: The inquirer may be reluctant to accept a particular source as credible or unwilling to accept the information the source because it is unacceptable. Simply put, if the language is foreign, and the terminology used is offensive then the information delivery system is inaccessible.

1.8.3 HIV/AIDS agency/campaigner/provider refers to organizations and staff members involved in the provision of HIV/AIDS to the public. In this study, these concepts are used interchangeably.

1.8.4. Information delivery systems: Information delivery systems refer to a system of functions concerning the acquisition and transfer of information, the carriers of which can be biological, personal, social or technical units. It has always had the purpose of providing information to a user or a group of users (Web Dictionary of Cybernetics and Systems, 2003). The other terms that can be used interchangeably are communication or dissemination channel/medium /strategy. Throughout this study these concepts will refer to one and the same thing. For example, a clinic may use information delivery systems such as posters, brochures, radio and oral communication to disseminate or communicate HIV/AIDS information.

1.8.5 Information overload is a condition that results from having a rapid rate of growth in the amount of information available (Paul, 2000:1). In this study, it means a lot of information that clinics get from various sources such as government and Non Profit Organizations (NPOs and other organization) to the extend that they no longer cope with the dissemination of that information.

1.8.6 'Sister in charge' refers to a senior health professional in charge of the clinic.

1.9 ORGANISATION OF THE THESIS

The study consists of the following chapters.

CHAPTER 1: INTRODUCTION

This chapter introduces the reader to the aim and motivation of the study, and the research problem as well as the area of study. In addition, concepts are defined.

CHAPTER 2: LITERATURE REVIEW

Chapter two outlines the literature survey conducted in the field. Literature review of information delivery systems is conducted. Relevant communication campaigns theories and models are also presented.

CHAPTER 3: RESEARCH METHODOLOGY

Chapter three outlines the research methodology used in the study. Moreover, the chapter explains the sample and how it was obtained. The methods of data collection as well as the methods and procedures of data analysis are also discussed.

CHAPTER 4: DATA ANALYSIS

This chapter presents and analyse the results of the study. Basics analysis is given by means of bar graphs and tables.

CHAPTER FIVE: DATA INTERPRETATION AND DISCUSSION OF RESULTS

This chapter provides interpretation of data collected from the field.

CHAPTER 6: FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

Chapter six concludes and provides major findings of the study. Furthermore, a recommendation for further study and conclusion are presented.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter introduces a critical analysis of literature reviews or studies, which were carried out in the field of Information Studies and other related fields of study. It also introduces HIV/AIDS communication theories. Furthermore, the chapter provides a review of information delivery systems used by various clinics as well as the extent to which HIV/AIDS information is accessible at Ga-Molepo.

2.2 THE IMPACT OF HIV/AIDS

According to the World Bank Group (2007:1), HIV/AIDS is not just a health problem, but also a development problem. It does so by spreading fast mostly to young people and working-age adults. HIV/AIDS affects the economy, society, family and schooling in a country, weakening the country as a whole. In addition, HIV/AIDS puts tremendous pressure on health and social services. The World Bank Group (2003:1) states that HIV/AIDS already causes a measurable fall in annual per capita growth in the hardest-hit countries of Sub-Saharan Africa and threatens to reverse their development achievements of the last 50 years.

2.2.1 The impact of HIV/AIDS on households.

HIV/AIDS increases household poverty and long-term insecurity in the context of physical and emotional suffering and bereavement (Jackson, 2002:26). Where HIV/AIDS remains highly stigmatized, the psychosocial impact will be greatest and access to community and other support will be least. In addition, Jackson (2002:26) argues that HIV/AIDS also often leads to marital and family conflict, arousing blame and suspicion regarding the source of infection and the cause of death.

2.2.2 The impact of HIV/AIDS on the workforce.

Bollinger and Stover (1999:6) lament that AIDS has a significant impact on some firms and the economy. They argue that AIDS-related illnesses and deaths of employees affect a firm by both increasing expenditures and reducing revenues. Comparative studies of East African businesses have shown that absenteeism can account for as much as 25-54% of company costs (Avert Organisation, 2007:1).

A study in several Southern African countries has found that AIDS-related absenteeism, productivity declines, health-care expenditures, and recruitment and training expenses could cut profits by at least 6-8% (Avert Organisation, 2007:1). Another recent study of 1006 companies in Southern Africa found that 9% had suffered a significant negative impact due to AIDS (Avert Organisation, 2007:1).

2.2.3 The impact of HIV/AIDS on education.

Coombe (2000:1) states that our education systems are vulnerable to HIV/AIDS and a possibility exists that fewer learners will enroll in schools and universities because most of them are likely to die of HIV/AIDS complications. HIV/AIDS positive parents/guardians, teachers and education officials are likely to be lost to the education system. In this regard, Coombe (2000:1) says that school effectiveness will decline, where 30-40% of teachers, officials and children will be ill, lack morale, and are unable to concentrate on learning, teaching and professional matters. This means careers for new generations are at high risk due to HIV/AIDS.

Under these circumstances, governments will come under increasing pressure to finance other social sectors hence contributions from parents and communities are declining, and many households are no longer willing or able to keep children in school (Coombe, 2000:14). As a result, the cost of schooling is shifted back to governments. All of this means that we must anticipate a real reversal of development gains, which further development will be more difficult, and that current development goals will be more likely to be unattainable.

There are employers who are already engaging services of HIV/AIDS and health professionals to address their employees on HIV/AIDS. For instance, the Limpopo Provincial Department of Education has a programme in conjunction with the University of Limpopo-Turfloop campus and Venda to train teachers on Basic HIV/AIDS and Counselling skills. Approximately eight hundred (800) educators were trained from November 2006- March 2007.

2.3 HIV/AIDS AND INFORMATION DELIVERY SYSTEMS

Scientific researchers conducted on HIV/AIDS so far have failed to discover an effective and affordable cure for HIV/AIDS. Mchombu (2003:1) argues that the solution lies within the social sciences to find the best way to facilitate behavioural change among the population to adapt safe practices and avoid catching the deadly disease. He further argues that the centre of human behavior change is the acquisition and application of innovative information and knowledge by individuals at risk, particularly the young people who form the majority of those who are being infected daily with the deadly virus.

The literature review shows that there are quite a number of studies on HIV/AIDS. More studies about HIV/AIDS are in the medical sciences. Most studies in this field are scientific in nature and are concerned with finding a cure for HIV/AIDS. The emphasis largely is on the government's role in providing anti-retroviral drugs to people who live with HIV/AIDS. There are many others in the field of Social Sciences and such studies are mostly concerned about providing people with basic information on HIV/AIDS and its treatment. Again there are studies in Psychology where the emphasis is on behaviour and Communication Studies where the emphasis is on communication channels.

Uhegbu and Okereke (2006:35) in their study conducted in Nigeria focused on the methods for achieving effective and sustainable HIV/AIDS information dissemination to the rural women in Imo State, Nigeria. The study found that there are various channels already used to disseminate HIV/AIDS information to the rural women, such as the establishment of the

national action committee on AIDS, the organization of conferences and talks, and the use of mass media. What is noticeable is that they may not be achieving the desired results in view of the fact that in spite of all campaigns, the rates of infection continue upward.

Merry (1997:44) argues that despite the great deal of information and a variety of information delivery systems available; there is little provision for effectively communicating information to various end users. The reason behind this might be that HIV/AIDS information campaigners do not study the social, cultural and educational backgrounds of end users and this results in appropriate information delivery systems being used for the wrong recipients. For example, one cannot disseminate information using computer resources to people who are computer illiterate, and expect such end users to obtain and use the information effectively and efficiently. The large number of people who are infected and affected by HIV/AIDS may suggest that poor information delivery systems are being used to disseminate HIV/AIDS information. This may be an indication of a gap that exists in the literature on HIV/AIDS information and communication. Therefore, this study seeks to investigate the information delivery systems used for dissemination of HIV/AIDS information.

2.4 HIV/AIDS COMMUNICATION CAMPAIGNS THEORIES AND MODELS

2.4.1 HIV/AIDS communication campaigns theories

Communication has been cast as the agent to bring changes in behaviors, which will prevent the spread of HIV/AIDS (Tinei, 2003:2). Commonly used theories and models that help to guide communication campaigns focusing on behavioral change are borrowed from social

psychology (Rawjee, 2003:15). There are also some theories borrowed from marketing and mass communication discourse. The following are some of the theories and models that may guide HIV/AIDS communication campaigns:

2.4.2 The health-belief model

This model is based on the premise that individual health behaviour is a function of perceived threat and perceived benefit (Rawjee, 2003: 16). The model maintains that an individual's perception of susceptibility, severity, benefits, barriers and the cures available would determine the possibility of the individual engaging in preventative health activity. According to Rawjee (2003: 16), perceived susceptibility refers to an individual's feelings of personal vulnerability to a condition. He further argues that these feelings may vary from individual to individual. This dimension therefore refers to one's subjective perception of the risk of contracting a condition. Perceived severity refers to an individual's concern about the seriousness of contracting an illness or leaving it untreated.

The dimension is made up of an evaluation of both medical consequences, for example, pain, disability and death and possible social consequences such as effect of the condition on work, family life and social relations. Perceived benefits refer to how an individual reacts to the message. This, of course, depends on an individual's beliefs regarding the effectiveness of the various actions available in reducing the disease threat.

Lastly, Rawjee (2003: 16) defines perceived barriers as the potential negative aspects of a particular health action, which may act as an impediment to undertaking the recommended

aspects of a particular action, which may act as an impediment to undertaking the recommended behaviour. A kind of cost-benefit analysis is thought to occur where the individual weighs the action's effectiveness against perceptions that it may be expensive, dangerous (e.g., side effects), unpleasant (for example, painful, difficult, upsetting), inconvenient and time consuming.

The health-belief model asserts that an individual's belief and readiness to take action for his or her wellbeing stems from a perceived threat of disease coming from his or her susceptibility to the disease and its possible severity. The cue to take action is a result of the individual's perception of the disease or the knowledge acquired. Behaviour is evaluated based on the estimate of the potential benefits of health seeking action to reduce susceptibility to and severity of the disease. These benefits are then assessed against the perceptions of the physical and financial barriers inherent in the health-finding effort.

The components of this model are taken from a well-established body of psychological and behavioural theory. Rawjee (2003: 17) cites Maiman, (1974) who indicates that behaviour depends mainly on the following two variables: the value placed by an individual on a particular goal and the individual's estimate of the likelihood that a given action would achieve that goal**.** When these variables were conceptualized in the context of health related behaviour, it corresponded to the desire to avoid illness and the belief that a specific health action would prevent illness (Epstein, 1997:21). In this model, susceptibility to and severity of the health related issue serve as a basis for the individual to act and the perception of benefits provides the path of action. The mass media and awareness campaigns are examples of 'cues to action'

and this in turn supposedly serves as a stimulus to trigger the decision-making process of the individual.

Parker, et al… (2000:14) indicate that the application of this model is evident in the community mobilization project of the gay community in the United States: he argues that in the early 1980's there were high levels of promiscuity and casual sex was common among the gay community in a number of cities in United States. They experienced a harsh and frightening phenomenon as they began developing unusual cancers and lung infections that often led to death. As the death toll rose; an increasing understanding of HIV/AIDS developed and, as a result, gay men started to mobilize to set up counselling groups to deal with safer sex and took to the streets to protest for greater government commitment to fighting the epidemic. However, people continued to become infected, but over time, the cumulative effects of the interventions began to show positive results and the number of new infections dropped significantly.

The model is not without its limitations. It is individualistic, as it depicts an individual's response to preventative health messages. The model has been criticized for focusing much on abstract and conceptual beliefs. In addition, Freimuth (1992:101) argues that the model is a rational-cognitive one and assumes a rational decision-maker such as most adolescents and many adults who do not seem quite capable of discontinuing risks and optimistically perceiving themselves as invulnerable to harm. According to Epstein (1997: 23), another limitation is that the model excludes interpersonal or group influences. In view of the social nature of sexual intercourse and the influence of other factors such as the individual's beliefs, intentions, comprehension and memory recall, Epstein (1997: 23) asserts that this is an

omission of an important aspect in the context of HIV/AIDS prevention. Furthermore, this model does not take into account cultural pressures and conditions that might influence an individual's ability to take up certain health measures.

2.4.3 Diffusion of innovation theory

The theory puts emphasis on the communication process by which a new idea or product becomes known and used by a specific group. According to Rawjee (2003:18), this theory is founded largely on the empirical observations of various forms of planned communication. The theory has the following stages: awareness, interest and evaluation, followed by small-scale trial and finally, adoption or rejection of the innovation. The approach classifies individuals into groups based on how easily innovations are adopted. Groups are categorized into early adopters, early majority, late majority and laggards. In most cases, the failure of adopting innovations is attributed to psychological factors. Therefore, for innovations to be accepted psychological prejudice has to be overcome. As a result, communication is regarded as an important tool for dealing with psychological prejudices so that room for change is created. This will lead to a greater acceptance of innovations and therefore the promotion of the innovation.

Diffusion of innovation theory can also be applied to HIV/AIDS communication campaigns. In this regard, the innovation could be either the use of condoms or abstinence from sex. This theory can then be applied to a communication campaign through the use of the following stages: awareness, interest, evaluation, small-scale trial and then either rejection or acceptance of the innovation. An example of the application of this theory is seen in the LoveLife

campaign. The application of the theory uses various public figures such as Nelson Mandela and other celebrities in the media to show their commitment and support towards the LoveLife campaign.

One can argue that efforts of this nature show how the awareness stage of the diffusion of innovation can be approached. The LoveLife campaign has been designed to use colourful advertising to display various ambiguous messages, which are meant to stimulate people, particularly the youth, openly to talk about sex and this shows how the interest stage of the theory was constructed. According to LoveLife (1999), its first year concentrated on building brand awareness through an initial teaser campaign designed to create intrigue and enquiry, which focuses on sex and HIV/AIDS. At the end of its first year more than two-thirds of South Africans could identify the LoveLife brand (LoveLife 1999). LoveLife's strategy is two-pronged, i.e. to build awareness by stimulating openness and better communication about sex, sexuality, HIV/AIDS and gender relations and to develop the necessary public health services, institutional support and outreach programmes for young people.

The LoveLife campaign shows two diffusion theory stages, which are awareness, interest, evaluation and small-scale trial but the acceptance of the innovation phase is questionable. This is because the campaign has generated a lot of controversy over some of its ambiguous style of campaigning particularly in the media campaigns wherein some of those messages being conveyed cause confusion instead of clarifying it. Therefore, the limitation of this theory indicates that the initial stages of the theory may be successful but that the latter may fail. According to Freimuth (1982:103) diffusion of innovation theory is too linear and has

innovation bias. He further criticises the diffusion of innovation theory for widening gaps between the information-haves and have-nots in a social system.

2.4.4 The social marketing approach

The social marketing approach refers to the use of marketing principles and techniques to advance a social idea or behaviour (Rawjee, 2003:20). It is borrowed from marketing discourse and is applied to non-commercial transactions such as development, social change and education campaigns. Therefore, it can be used during public campaigns in order to bring about social change within the community. This social marketing approach usually operates in non-profit markets, for example, it can be used in public health and fundraising campaigns. More specially: social marketing is the design, implementation and control of programmes seeking to increase the acceptability of a social idea or cause in a target group. The primary aim of the social marketing approach is to bring about social change; this usually means that the target group has to be aware, accept the idea and change the social behaviour. It uses concepts of market segmentation, consumer research, concept development, communication facilitation, incentives and exchange theory to examine a target group's response. Parker et al… (2000:15) indicate that social marketing techniques have achieved considerable success world wide in promoting the use of condoms, contraceptives and other health products and effectively reaching millions of people who would not otherwise have had any access to these products.

Windahl et al... (1992:96) argue that the social marketing approach is made up of five elements: product, price, promotion, place and positioning. Product refers to a service or idea that needs to be marketed to a target group. Price refers to the exchange of social prices other

than money. In this case, it can refer to the time and energy the participants spend participating in the campaign. Place refers to the channel through which the product/idea is made available to the target group. Channel could be any form of mass media, which is used to reach the audience.

Promotion involves communication or persuasion activities used to create awareness of the product/service or idea amongst the target group. According to Jansen (1991:20), it is not just merely an exercise in persuasion. It means actively reaching out to the target group with the right message, packaged in the right format at the right time in order to obtain the right effects. Lastly, positioning refers to how the recipient of the message perceives the product or idea in relation to other products or ideas.

The application of social marketing techniques is prevalent in promotion of Lovers Plus condoms (Parker, 2000:8). Despite the availability of free condoms at various public places, the Society for Family Health (SFH) has set out to reach the poor by using donor subsidies to reduce the retail price of Lovers Plus condoms. These condoms are sold in chemists and supermarkets. Socially marketed condoms fill a valuable niche between free condoms and commercial brands. According to Rawjee (2003:22) social marketing techniques have achieved considerable success worldwide in promoting condoms, contraceptives and other health products and thereby effectively reaching millions of people who would not otherwise have had the access to these products.

One of the key limitations of the social marketing approach is that in practice it unfolds in a linear fashion. In this approach, the goals of the communication campaign are defined outside

the target social system, thus rendering it less useful in certain situations (Windahl et al… 1992:99). The implication in this regard is that the recipient of the message is not easily motivated by communication coming from outside with goals set by others (that is the communication planner). This is because it is difficult to accomplish a goal that is set by someone else other than oneself.

Windahl et al… (1992:98) further maintain that another limitation of social marketing is that often social marketing campaigns fail because the right publics have not been addressed. The solution to this might be to identify the key people/areas in the community to orientate and lobby their support for the goals of the campaign before it can be launched. This will greatly facilitate communication effort.

2.5 LACK OF KNOWLEDGE AND MISCONCEPTION ABOUT HIV/ AIDS

From the Health 24-News (2003:5) it appears that the majority of South Africans have heard about HIV/AIDS and have a fairly good level of knowledge of the basic facts i.e. that the disease is mostly spread sexually and that condoms reduce risk. Nevertheless, there are still many people, especially those with low levels of formal education and who lack access to accurate, relevant information on HIV/AIDS and sexuality, who are unaware of the risks (Health 24-News, 2003:5). Along with that, there are dangerous myths and misconceptions about HIV/AIDS, which continue to develop. United Nations cyberschoolbus (2003:1) states that misconceptions about HIV/AIDS are widespread among young people and vary from

culture to culture. According to Avert Organisation (2007:5), these include believing that the virus can be contracted by:

- sharing crockery and cutlery
- insect / animal bites
- touching, hugging or shaking hands
- eating food prepared by someone with HIV
- toilet seats

On the curative side of HIV/AIDS, there is the belief that having sex with a virgin can cure the disease. Science has provided us with answers to these myths. HIV is not transmitted through casual contact. Baptist Memorial Health Care, (2008:1) argues that even in family members where there is on-going close contact there have been no cases of non-sexual transmission. Over and above, these insects are not able to transmit HIV/AIDS. On the other hand Health First (2007:1) presents that HIV/AIDS does not discriminate as to age, sex, race, or sexual orientation and laments that these myths about HIV/AIDS refuse to die and it gives people a false sense of their level of risk, and contributes to confusion about how HIV is transmitted. Facts about HIV/AIDS transmission are that HIV /AIDS is passed to others by:

- direct intimate contact with body fluids, such as blood, vaginal secretions, or semen
- HIV-infected mother to her baby during pregnancy
- having sexual intercourse without a latex or plastic condom with an HIV-positive partner and sharing contaminated needles (Health First, 2006:1).

Salyer (1999:1) further states that misinformation, fear, ignorance and media sensationalism continue to fuel these myths and misconceptions. In addition to myths and misconceptions are conflicting messages from influential leaders, for example Associated Press, (2007:1) President Mbeki who used to argue that HIV does not cause AIDS, and the danger exists that many people might have contracted HIV/AIDS as a result of President Mbeki's argument. With these myths and misconceptions and conflicting information people will find it harder to get the full and accurate information necessary to prevent the spread of HIV infection and mitigate its impact (Amnesty International, 2003:1).

One interesting comment was made by Mannak (2006:1) said that Jacob Zuma, former deputy president of the country and the chairperson of the South Africa National Aids Council has invented another HIV/AIDS misconception to add on the existing ones. This occurred when he was giving a testimony during his court case. Mannak (2006:1) argues that Jacob Zuma testimony caused a lot of confusion amongst South Africans and as a result, many people do not know what and who to believe anymore.

According to Mannak (2006:1), what causes most confusion is Zuma's excuse why he had unprotected sex with a woman, whom he knew was HIV positive. He told the court that he believes that as healthy as he is, chances of being infected by HIV are minimal. Further to that, he told the court that he took a shower to reduce the risk of HIV infection after having unprotected sex (Mannak, 2006:1). This could be confusing to ordinary people who regard him as knowledgeable and reputable.

One of the signs of the wide spread confusion amongst South Africans, especially those who did not receive the right education in the first place, is the great number of phone calls received by the National Aids helpline (Mannak, 2006:1). Mhlongo (2006) of the helpline in an interview with the daily newspaper, The Star, said that the NGO was flooded by calls from confused South Africans who did not know what to believe anymore. Mhlongo (2006) cited an example of a woman who called to ask whether they should take a shower after being raped to reduce their risk of HIV infection. Many NGO's, HIV/AIDS activists and health professionals in South Africa are said to be afraid that Zuma's statement will feed risky sexual behavioural patterns, and that a simple shower will be seen as the newest weapon against AIDS (Mannak, 2006:1).

2.6 WHY SOME PEOPLE REMAIN UNINFORMED, MISINFORMED AND UNEDUCATED ABOUT HIV/AIDS

The greater majority of people in South Africa live in rural, outlying areas, and large numbers of people in those rural areas do not have electricity, radios, television, and telephones (Save Africa AIDS Project Summary, 2004:1). Therefore, communicating with them is extremely difficult. This makes many people to remain uninformed, misinformed and uneducated about HIV/AIDS in Limpopo Province. Illiteracy is a major drawback in Limpopo Province as far as dissemination of HIV/AIDS information is concerned. Government is playing a vital role in combating illiteracy in South Africa. To this end, government has an Adult Basic Education Training (ABET) programme that aims to equip illiterate adult people with basic literacy skills. As indicated (in table 1) about 33, 4% of the people above the age of 25 are illiterate. Despite

ABET programme initiatives, Limpopo Province is in the forefront of all provinces in South Africa in terms of number of adult people who are illiterate. Therefore, this translates to the fact that many people cannot be easily informed and educated about HIV/AIDS using printed literature and posters.

2.7 LEVELS OF ILITERACY IN SOUTH AFRICA

According to Rampedi (2003:8), more than 1 million people in South Africa are 15 years and older with less than a Grade 7 education and about 1.4million with less than Grade 9. So there are about one million people who are semi-illiterate or cannot read or write (less than standard 5) and those who are functionally literate (about 1.4million). It might be important here to add the provincial share of non-literate adults. There are 3, 2 million adults who cannot read or write in the whole of South Africa. The Department of Education, (2001:244) shows the following statistical information about the Provincial distribution of non-literate adults:

Table 1: **Provincial Share of Non-Literate Adults (2000)**

PROVINCE	% SHARE OF NON-LITERATE ADULTS
Limpopo	36,9%
Mpumalanga	29,4%
KwaZulu-Natal	22,9%
North-West	22,7%
Northern Cape	21,7%
Eastern Cape	20,9%
Free State	16,1%
Gauteng	9,5%
Western Cape	6,7%

The above information shows that Limpopo province has the highest number of non-literate adults. The fact is that many (36%) adult people in Limpopo Province are unable to read or write and as such, most cannot understand English, which is mostly used to disseminate the information on HIV/AIDS.

Peltzer and Promtussananon (2005:4) conducted a study on HIV/AIDS knowledge and sexual behaviour among junior secondary school students in South Africa and found that non-urban students indicated significantly less correct knowledge than urban students. Less correct knowledge about HIV/AIDS may be attributed to the said social and cultural practices. Another study, on assessment of the sexual practices and attitudes toward AIDS and condom use was conducted by Stewart et.al. (1991:772). The findings of the study were mainly

influenced by cultural beliefs. Fifty percent (50%) believed that condoms decrease sexual pleasure for men and thirty one percent (31%) thought condoms made sex inconvenient. Twenty-seven percent (27%) of those surveyed believed that a man's penis may be too large for a condom and eighteen (18%) believed that uncircumcised men could not use condoms.

National policy on HIV/AIDS for learners and educators in public schools, and students and educators in further education and training institutions, (1999:13) indicates that the provision of HIV/AIDS information should be in an accurate and scientific manner and language and terms that are understandable to end-users. The concern is that some information campaigners in Limpopo Province fail to do that and this makes people remain uninformed, misinformed, uneducated about HIV/AIDS, and vulnerable to it. The researcher is of the opinion that social norms and cultural practices are highly practised in rural areas of Limpopo province and this may in one way or another lead to people in rural areas being uninformed, misinformed and uneducated about HIV/AIDS.

2.8 IMPORTANCE OF LANGUAGE IN DISSEMINATION OF HIV/AIDS INFORMATION

Kamper (2006:77) citing McConwell and Thieberger (2001) argues that language is such an intangible part of the culture that most people are inclined to use it without consciously reflecting on it. According to Mbananga (2004:153) language plays an important role in communicating lessons or messages in the development and dissemination of information. It is

through language that culture is expressed, memory capacity is increased and survival action can be taken (Kamper, 2006:77).

2.8.1 Languages spoken in Limpopo province

South Africa.info (2007:7) indicates that Sepedi (52%), Xitsonga (22%), Tshivenda (16%) are the three dominant languages spoken in the Limpopo Province while Afrikaans and English follow them. Besides the above-mentioned languages, scores of others are spoken, for example, a “Tsotsi-taal” is widely spoken, mainly by males. It is a hybrid of Afrikaans, English and black languages, and developed in urban areas to make communication easier among the different language groups (South Africa.info, 2008:1). In essence, it is a dynamic language, with new words and phrases being invented on a regular basis. There is also a sign language for deaf people. More often than not, people living with this kind of disability find it difficult to access HIV/AIDS information services in both private and Government sector. However, there are some measures in place to ameliorate the problem. For instance, SABC news has sign language translator, who translates the spoken language to sign language.

2.8.2 Language barrier to dissemination of HIV/AIDS information

In South Africa, where there are eleven (11) different official languages, discrepancy between language spoken between patients and health professionals is extremely common (Levin, 2006:1076). For instance, in African languages it is difficult to name some sexual organs as it is against the norms and values of the Africans. Mbananga (2004:153) in his study of “Cultural clashes in reproductive health information in schools” found that in African languages, genitals

organs are not called by their real names and explicit words related to sexual intercourse are not used as it is against their culture. Instead, metaphorical language is used for genital organs and sexually related activities.

One other challenge as outlined by Madiba (2001:53), is that the use of indigenous South African languages in modern domains such as science, technology and business is hampered by lack of modern terminology in these languages. According to Madiba (2001:53), African languages have been traditionally underdeveloped compared to other languages such as English and Afrikaans. Therefore, for African languages to function in these domains too, they require a rigorous terminology development programme to enable them to be intertranslatable with English and Afrikaans.

Despite the fact that large number of people (52.1%) in Limpopo Province speaks Northern Sotho, many billboards and HIV/AIDS materials are in English. Onyancha and Ocholla (2006:88) state that English is dominant (94,8 %) in publications containing HIV/AIDS literature specific to youth and the said authors attribute this to increasing recognition of English as a medium of scientific communication and an international language that publishing houses prefer. This implies that majority of people in rural areas are excluded from accessing HIV/AIDS information as a result of using language spoken and understood by a minority of people.

Williams, et. al… (2002: 138) states that language is a problem confronting some ethnic groups in obtaining health information. The researcher argues that language problems mainly face people in rural areas where African languages are dominant; but most of the campaign

materials are in English. This may imply that government and HIV/AIDS campaigners neglect people in rural areas. By so doing, most people will be misinformed and uninformed about the HIV/AIDS disease. In this regard, Kaisernetwork Daily Reports (2003) remarks that failure to disseminate health information effectively may cost patients their health.

According to Kaizernetwork Newsday reports, (2003:1) hospital patients who speak little or no English are at greater risk of medical error or misdiagnosis if they are not provided with an interpreter. Researchers at the Access Project, a health care resource centre at Brandeis University, conducted a survey of 4,161 uninsured individuals with limited English proficiency that were treated between May and August 2000 at 23 hospitals in 16 cities (Kaizernetwork Newsday reports, 2003:1). Of those patients, 3557 said that they did not need an interpreter and 604 patients said that they did. In the latter group, 273 patients received language assistance and 331 did not. According to the study's main findings 27 % of patients without an interpreter said they left the hospital without understanding how to take their medications, compared to just 2% of those with an interpreter (Kaizernetwork Newsday reports, 2003:1). The report shows that one-third of patients without an interpreter said they would not return to the health facility.

The above research results clearly show that failure to disseminate health information effectively may cost patients their health. Different survey results have consistently found that patients experiencing language barrier problems are less satisfied with their care, less likely to have a usual source of care, less likely to keep follow-up appointments and less likely to receive preventive care.

2.9 ACCESS TO HIV/AIDS INFORMATION IN LIMPOPO PROVINCE

According to Medilinks, (2003:1) Limpopo Province has HIV/AIDS information agencies, but people living in rural areas still have little access to information and education on HIV/AIDS. By way of increasing access to HIV/AIDS information, on the 23rd of August 2003, Sello Moloto, the then MEC for Health and Welfare for Limpopo Province, unveiled an HIV/AIDS awareness billboard campaign at University of Limpopo-Turfloop campus, Mankweng, Polokwane and other places across the Limpopo Province. The campaign aims to reach individuals in both rural and urban areas of Limpopo province and 135 billboards printed in several different languages have been posted throughout the province (Medilinks, 2003:1).

Medilinks (2003:1) quoted Sello Moloto, who says that the billboards are evidence of the government's commitment to ensuring access to public information, and the messages will increase the level of knowledge about safer sex practices, encouraging interaction and communication on safer sex practices and assist in the reduction of HIV/AIDS infection.

2.10 INFORMATION DELIVERY SYSTEMS

Most studies in the world and in South Africa focus on campaigns using television, radio and print materials. Literature review does not indicate if there has been any research that was conducted by HIV/AIDS information campaigners to assess if the information disseminated is relevant, accurate and meet the needs of end-users. Studies conducted include the following:

a) A study by Modou (2001), which looked at the information communication technology and improvement of family planning, reproductive health and HIV/AIDS

issues in developing countries. The results of the study revealed that many constraints and difficulties limit the development of ICT in developing countries. The study also revealed that, the Information Society (which is characterized by conventional systems of technology transfer) contributes towards marginalizing many communities in developing countries and in Africa, constituting a great problem for people's initiatives to access information related to family planning, reproductive health and HIV/AIDS issues. In such a context, initiatives enabling different kinds of users to have effective access to appropriate ICT have become a necessity.

b) Another study by Modou (2001) was on e-mail services to diffuse HIV/AIDS information. The findings were that e-mail information service is rapid, but with telecommunications limiting access. On the other hand, the study by Kenya National Library services (KNLS, 2004:1) on disseminating information to support research, treatment and prevention related to HIV/AIDS found that providing information in formats that are useful to both health care providers and patients is still a challenge.

Another related study was a case study in Limpopo Province, wherein Van Wijk (2003:4 in FAO 2002) found that most of the material that exists in Limpopo province for health education is not yet addressing the chronic disease effects of HIV/AIDS infections.

Capricorn Voice newspaper (2007:7) published an article reflecting the findings of the survey conducted at the rural village of Ga-Maja in Limpopo Province. The study was limited to three sisters who were willing to talk to the reporters about their thoughts and impressions regarding HIV/AIDS; however, the main aim was to find out where users receive most of their

information about HIV/AIDS. Although the views of three sisters could not be generalized to be a true reflection of what is prevailing in rural areas of Ga-Maja, the following were findings of the study:

Two (2) respondents said they get most of their information from school. UNAIDS (1997:2) asserts that prevention through the school setting is recognized by almost all countries as necessary. Another respondent indicated that most of the HIV/AIDS information is from television and sometimes from her mother. On the other hand, one respondent reported that most of HIV/AIDS information she receives come from magazines and what she sees on television.

Merry (1997:44) argues that despite information being available to HIV/AIDS sufferers and a variety of information delivery systems there is a little provision for effectively communicating this to consumers. This situation could be a result of what Nwokocha and Uhegbu (2000:168) deem to be the use of inappropriate channels of information dissemination, which do not ensure accessibility to HIV/AIDS information. Another contributing factor, which makes little provision for effectively communicating information to end-users, might be that HIV/AIDS information agencies do not study the information needs of end-users and this results in using appropriate information delivery system for the wrong recipients.

2.11 Information delivery systems relevant for youths

Longitudinal data from the 1988, 1990-1991 and 1995 National Survey of Adolescent Males aged 22-26 in United States of America shows that 22% of men surveyed prefer to discuss

disease prevention topics with a health provider. Whereas 48% prefer to attend a lecture or read a brochure, 51% prefer to speak to a partner, friend or family member, and 96% prefer to hear about AIDS or STDs from the media, e.g., television advertisements, radio or magazines (Carolyn, et. al… 2000:33).

Another study titled *The New Image Teen Theatre in San Diego* found a number of positive effects of an entertainment education intervention effort (Carolyn, et.al… 2000:33-38). The study found that teenagers appreciate drama as a more effective tool for receiving HIV/AIDS information as compared to any other method.

Two recent studies by Glik (2002:42) offer equivocal results regarding the effectiveness of entertainment-education interventions that target the sexual practices of youth. A study among disadvantaged youths in Glasgow, Scotland, found that drama was not effective relative to a traditional health education approach, in improving HIV/AIDS related knowledge (Glik, 2002:42) in Elliot, Gruer, Farrow, Henderson and Cowan (1996). The study compared drama with health education seminars. This means there was no improvement in HIV/AIDS related knowledge or in attitudes toward HIV/AIDS.

Gauteng Premier, Shilowa (2003), in his speech, on the tabling of the annual HIV/AIDS report at the Gauteng Provincial Legislature, stated that in Gauteng Province, drama, dance and music have proved to be some of the most effective vehicles for communicating messages to large audiences. Shilowa (2003) further states that local traditional, gospel, youth artists and the broadcast media, especially the SABC, Kaya FM and YFM are used to communicate HIV/AIDS messages to mostly young audiences. Moreover, there is large-scale public

identification with the red ribbon and the logo, "We can make a difference", because of their communication methods. Shilowa (2003) says that now that AIDS activism is part of local youth culture, social and cultural communication interventions should strengthen identity and human values to convey HIV/AIDS messages in an inspirational context. Shilowa (2003) concluded that their communications strategy has proved to be most effective in doing that.

a) Campaigns

Kiwanuka-Tondo (2002:59) who cited Brown 1991, Domeyer, Marguard, Gibson and Snyder (1991), Lee and Davie (1997) argue that communication campaigns remain the best way to prevent the spread of HIV/AIDS in the absence of inoculation against HIV/AIDS infection. UNAIDS (2003:1) regards campaigns as one of the most effective advocacy tools in the fight against HIV/AIDS since they can mobilise support and much-needed resources. The essence of any dissemination campaign is to create awareness and influence individual behaviour (Tami Nadi State Aids Control Society, 2007:1). Therefore, campaigns can help raise global awareness around issues that continue to fuel the spread and impact of HIV/AIDS. In this regard, campaigns can use a variety of linked means, tools and tactics to articulate arguments for change or action, build momentum, create energy, engage, and involve targeted groups.

Despite the variety of linked means, tools and tactics to articulate arguments, there are certain design elements of communication campaigns that are consistently related to success. According to Kiwanuka-Tondo (2002:59) who cited Backer, Rogers, Sopory (1992), Hornik (1988, 1989), Woods, Davis, Westover 1991) this requires audience research, targeting an appropriate audience, using relevant messages and choosing appropriate channels. Among

other campaigning methods, there are human resources, print resources, information technology resources and media resources.

b) Soap operas

A recent survey of nearly 4 000 South Africans aged 15 - 24 has revealed that television programmes, such as Soul City and Soul Buddyz, play a critical role in HIV prevention in South Africa (Molefe, 2007:1).

Molefe (2007:1) asserts that television and radio have the most reach when it comes to young people in this country who are most affected by and vulnerable to infection with HIV. The young people in the Kaiser Foundation survey say they want more information about HIV/AIDS, and they are open to receiving the facts from the media. The study shows an impact statistic of 65% from Soul City and of 46% from Soul Buddyz, which are both produced by the Soul City Institute. This was compared to the next most impact programme Tsha-Tsha that came in third at 41%.

Although Molefe, (2007:1) asserts that the survey corroborates the evidence that Soul City and Soul Buddyz have a significant impact on their intended target audiences, the pressing challenge is to ensure that this awareness translates into behavior change. The Soul City TV series was named as the second most watched programme, after Generations.

Respondents mentioned that not only are programmes like Soul City important for young people as a whole, but that they have helped them make better choices about their sexual

behaviors. For children between 8 and 12 the Soul Buddyz materials and Soul Buddyz Club assist in learning and developing skills that improve their lives, schools and communities. According to Molefe, (2007:1) the Soul City / Soul Buddyz brand is firmly entrenched in the hearts and minds of even the youngest South Africans

A study among young adolescent students in Nottingham, England found positive results after the performance of an HIV/AIDS educational theatre production. There were significant knowledge gains as well as attitudinal changes, among the students (Glik, 2002:42). With regard to clinics in rural areas of Limpopo, there is no literature indicating the use of theatre and videos for educating communities on HIV/AIDS.

c) School education: integration of HIV/AIDS into Life orientation as a learning area

Many young people can be reached relatively easily through schools (UNAIDS 1997:1). Life skills education is included in the new South African schools curriculum as a learning area. According to Jennings, (2006:9) the Life Orientation area statement addresses issues relating to nutrition, diseases including HIV/AIDS and sexually transmitted diseases, safety, violence, abuse and environmental health. Integrating HIV/AIDS into curriculum bears much fruits. According to UNAIDS (1997:2) Life skills programmes are an important preventative measure as they enable young people to manage situations of risk for HIV/AIDS infection. Further to that, HIV/AIDS slowly but surely moves from being a taboo to a normal issue like any other subject in school. Jennings, (2006:8) says that life orientation learning area equip learners to live productive and meaningful lives in a transforming society. As there is a possibility that

educators may not be as knowledgeable as nurses it is imperative that the two work together. It will also be an advantage to nurses to talk to large audiences at a time.

d) Creativity and sports

If people, in particular the young, tend to pay little attention to official or traditional channels of education and information, they may more likely to listen to their favourite artists and sportsmen. The interest of young people in sports and its cultural significance has opened new opportunities for developing original Information, Education and Communication (IEC) materials.

The insert below explain the role sports heroes play.

South Africa:

Sports passion against HIV/AIDS (the LADUMA Project)

A photocomic was initiated by the National AIDS Committee of South Africa to use the passion for sports (especially soccer) among young South African boys, to raise awareness about HIV. The scenario deals with what happens to a young African from Khayalitsha, "who has big dreams for the future and a beautiful girlfriend to share them with". Moreover, he is a brilliant soccer player, who may "head for the top soccer league". Unfortunately, he has an occasional sexual relations with a girl already infected by one of his friends, without using a condom and thus is infected. He in turn infects his regular girlfriend and this almost leads to the break up of their relationship and his dreams of a soccer career. There is however, reconciliation, mutual notification and promise to practice safe sex onwards.

This photocomic includes a set of discussions, questions, destined for schools, youth groups, sports teams, church groups, political groups or even informal parties with friends. Role-playing can also be developed based on the story. Then, there is a practical demonstration on how to wear a condom. An information section is presented afterwards, in the form of questions/answers.

Source: A cultural approach to HIV/AIDS prevention and care. South Africa's experience, UNESCO, 1999.

e) Counselling

Interpersonal counselling and communication about HIV/AIDS is frequently used to communicate socio-emotive aspects of HIV/AIDS (Valente and Bharath, 1999:203). Valente and Bharath (1999:203) argue that interpersonal counselling has the following limitations:

- it can be expensive due to the cost of training and paying counsellors' fees.
- its effectiveness is often variable depending on the attributes of the counsellor and the interaction between counsellor and client.
- interpersonal communication may make an individual feel singled out, defensive, and subsequently less receptive to the counsellor's message.

f) Theatre and performance as entertainment education (edutainment)

In the developed world strategies to educate people about health issues include media based information and education campaigns, peer education and outreach programmes, community-based education and prevention activities and skills building workshops (Glik, 2002:41). Entertainment-Education (so called edutainment) approaches that use performing arts and media broadcasts to convey information about social and peer group norms, prospective health behaviours and ways to prevent disease are found world-wide (Glik, 2002:39 in Sinhal, Rogers, (1989), Piotrow, Kincaid, Rimon and Rinehart (1997). Glik (2002:39) states that the use of live theatre or dramatic arts in particular has a long history as a means to educate the public, foster social change, or influence the knowledge and behaviours of targeted populations. One can link the entertainment-education to historical roots that date back to the origins of storytelling.

Entertainment education is not as efficient at reaching large audiences as mass communication campaigns. Audience ratings showed that, in South Africa, education programmes rarely reach 500 000 viewers, whereas prime time dramas regularly attract audiences of seven million and more (UNAIDS, 2005:15). However, live performances have many benefits. Glik (2002:39) argues that live performances can draw upon the strengths of both mass and interpersonal communication. In the case of entertainment –education for example, many performances involve direct interaction with audience members. According to Glik (2002:40) audiences can provide immediate feedback (e.g. responses or applause). He further argues that live audiences are more emotionally attuned to the performers and messages, thus creating an environment that is more conducive to learning and behaviour change.

The use of theatre for dissemination of health information and its impact on audiences has consistently shown that well-designed and executed live theatre performances are able to engage audiences, influence the knowledge, attitudes and behaviours of audience members and positively impact peer, social and cultural norms Glik (2002:41) cited Conquergood (1988), Kincaid, Yun, Pitrow and Yasar, (1993). Piotrow, et. al… (1997:3) argues that in Peru, Sri Lanka and South Africa, entertainment-education efforts that involve live dramatic performances show positive attitudes about health issues among audience members, many of them youth.

Compared with the developing world, research on theatrical interventions and their impact on youth in the United States of America (USA) and Europe is sparse and results are not consistently positive (Glik, 2002:41). Glik (2002:42) argues that a study by Probart (1989),

who used drama to disseminate HIV/AIDS information to University students in the USA shows confusion and fear which exists among the respondents interviewed. Carolyn (2000:33-38) argues that drama does not influence knowledge or beliefs about HIV/AIDS.

g) Music

Music is also used as a means of disseminating HIV/AIDS information to people. An international music-led campaign is the 46664 campaign. 46664 was the prison number of Nelson Mandela on Robben Island, Cape Town. This is a groundbreaking initiative that brings together international artists, to raise awareness of HIV/AIDS (Aegis news, 2003:1). According to Aegis news (2003:1) the multi-faceted campaign combines a music launch on the Web and telephones, along with a concert, CD and DVD releases featuring artists such as 50 Cent, Anastasia, Beyonce, and many more.

Another music-led campaign is Africa Alive! (Serlemitsos, 2002:1). This is a bold multi-national initiative to improve the reproductive health and reduce the spread of HIV among African youth. The initiative uses professional artists to educate people and encourage positive behaviour change for HIV prevention. According to Serlemitsos (2002:1) Youth rallies in the form of community concerts on HIV/AIDS, reach about 10,000 people with consistent messages promoting abstinence, correct and consistent use of condoms and support for people living with HIV/AIDS. An investigation on the use of music, i.e. Africa Alive in dissemination of HIV/AIDS information was conducted. The results of the study show that nearly all (93 %) youth like to receive HIV/AIDS information through music (Serlemitsos, 2002:1).

h) Mass media

Mass media channels such as television, radio, newspapers can inform people about HIV/AIDS and convey information (Valente and Bharath, 1999:203). Media are mostly used to raise awareness, for example, newspapers could be used to publicize events and readers write letters to the letters page. HIV/AIDS information agencies could use this medium by issuing press statements and inviting reporters to events for publicity. Given the stigmatized nature of HIV/AIDS mass media channels may be less effective at persuading audiences to treat people who are living with HIV/AIDS kindly because they may not be as effective as personal contact in appealing to the emotional component of HIV infection (Valente and Bharath, 1999:203). Moreover, mass media are not interactive and may not be adapted to local community needs.

i) Radio

Radio is considered the most widespread of the mass communication media, especially if it is compared with other media such as the press, television and cinema. Atkins (1990:4) quoted Rice and Paisely, (1981: 279), indicating that all types of people listen to the radio and it is used to reach mass audiences. Many local radio stations have interactive slots, which could be used for dissemination of HIV/AIDS information.

Radio, as stated by Olson (1974:445), answers to the cultural needs of societies with oral traditions and unwritten values. Burke (1976:12) concluded that radio has some very positive characteristics to commend its use in the dissemination of innovation. From the experience of many countries throughout the world, it is clearly best used in combination with other media of

communication and with a strong supporting component of field workers who can engage listeners in that most important mode of communication, person to person. Radio provides a sense of immediacy and communicates cheaply and quickly in various languages.

Burke (1976:12) argues that using radio to disseminate HIV/AIDS information, particularly in rural areas has the following advantages:

- Wide coverage area.
- The ability to reach beyond literates
- The ability to reach beyond electrical power.
- It provides a greater sense of reality than printed materials

ii) Television

Television is a means of communication, which can hasten the spread of innovation by assisting change agents in presenting new and various materials (Tehranian 1990:257). Television can gain more complete attention from the audience for greater acceptance and retention of facts. Tehranian (1990:257) argues that television like radio can be used for disseminating information, making use of a variety of techniques, ranging from lectures and demonstrations to panel discussions, interviews, dramatisation and people participation. This can enable HIV/AIDS information agencies to use it in cases where direct contact or field visits are too expensive.

A variety of different types of information delivery systems can be used with the television medium. Tehranian (1990:257) argues that video is one of those mediums, which can be used with television. This means that if conditions allow video cassettes can enable end-users to achieve greater understanding of the information presented by HIV/AIDS information agencies. With video cassettes, end-users can watch when they want to as often as they like and with as many pauses, rewinds and replays when necessary in order to locate specific segments or sections. As with video cassettes, audiotapes give end-users increased control. End-users can listen in their own free time. They can also stop, pause and replay according to their personal preference. Audiocassettes can be presented in combination with visual materials to complement the end user's understanding.

iii) Print resources

Another way of disseminating information is through printed formats (Lambert, 1991:1). According to Tehranian, (1990:259) print media are the most widely used and the least expensive medium. They permit easy re-exposure and demand more participation on the side of the recipient, thus leading to greater individual involvement with the message (Tehranian, 1990:259).

Given this information, one can argue that print materials are very important devices and instruments for disseminating HIV/AIDS information if used effectively. This method of disseminating information can reach a larger audience as compared to spreading information by word of mouth. Among print methods (Lambert, 1991:1) mentions the following: journals, books, theses, conference proceedings, reports and trade literature. In addition, we have

newspapers, posters, signs and stickers (Tehranian, 1990:258). The major advantage of this information source is that it is reasonably permanent, tangible and verifiable.

In typical situations, both the sender and the receiver have a record of information disseminated (Heubsch, 1995:8).The information is stored for an indefinite time especially in the case of complex and lengthy communications. This means it will still be there when half hour or 15 minutes of radio or television broadcast have passed. Tehranian (1990:257) affirms that print and visual media will have a great effect when supported by broadcasting media and backed by study groups, tutors and feedback to planners or producers.

2.12 Information technology resources

Information technology resources refer to sources such as World Wide Web (www), databases, bulletin boards and other services, which are electronically based. In addition, Thomas (2001:1) says that this includes e-Health information systems, which refers to communication of health information using information technology such as Internet.

Disseminating information through the computer can deliver current, in-depth information to those who cannot physically access the information source, and it can have important advantages over hearing the same material in the lecture hall. Also, it can improve (not replace) the physical meetings, by delivering formal information in advance and shifting the emphasis toward well-informed, private, less formal working sessions at the meetings or conferences, in order to make the best possible use of such information. According to AIDS Treatment News

(1997:1), Internet's World Wide Web provides more choice of current HIV/AIDS treatment information than any other source.

AIDS Treatment News (1997:3), states that almost all information from the Internet is free. The researcher tends to disagree with the said statement because there is a subscription fee for accessing the Internet. Upon paying a subscription fee, it can be accessed at any time, from any place by telephone and computer (or from some public libraries, if the user does not have a computer). Unlike sending away information, you see what you request almost immediately so if it is not what you want, you can keep looking and follow dozens of leads in one session. According to Stuart, (1996:1) the World Wide Web is one of the most accessible tools available for academics to use. Furthermore it is user-friendly, has a low learning curve and above all it is free to most people in higher education.

With the literature reviewed on the information delivery systems mentioned, emphasis is on information technology, hence there is a general assumption that we are living in a technological era, yet most people in South Africa do not have access to information technology. As powerful as information is, it is of little value if one cannot get to it quickly and easily (Acuma Company, 2003:1). Those who have it are mostly employed and can access it from their areas of work and tertiary students can access it from their universities and technikons; however, there is still a gap between the mass of people in South Africa and information technology.

2.13 Indigenous knowledge systems

Indigenous knowledge systems (IKS) are the knowledge and practices of indigenous communities constitutive of their meaning and belief systems, as well as the substantive dimension of their practices and customs (Nel, 2006:99). Accordingly, IKS are about the knowledge, practices, values and ways of knowing and sharing in terms of which communities have survived for centuries. Health professionals providing information should know IKS and indigenous languages as they also influence HIV/AIDS information provision and dissemination. Levin (2006:1059) states that teaching points should include the rationale for learning about culture in health care as well as practical tools for productive cross-cultural clinical encounters. In addition, Levin (2006:1059) indicates that in South Africa the curriculum for health practitioners now includes courses with focus on communication with patients whose language and culture are different from the student's own.

i) Oral information

The first obvious but very important way of spreading information is by word of mouth (Lambert, et. al… 1991:1). People talk to friends and colleagues, passing on news about their own work and often including pieces of information they have read elsewhere. Lambert, et.al… (1991:1) further argues that people talking at seminars, conferences and so on also spread information in that way in a more organised fashion.

Disseminating information in this way occurs between people in face-to-face situations. Participants are able to see each other and observe facial expressions and other non-verbal

messages. The advantage of disseminating information in this way is that people have the opportunity to discuss an issue, receive immediate feedback on their comments, and change their views or messages accordingly (Joel, 2004:1). This means HIV/AIDS information campaigners could disseminate HIV/AIDS information using this method. On the other hand, Lambert, et. al…(1991:1) argue that transferring information in this way is less efficient, because it can only reach a very limited number of people as compared to media.

Uwakwe (1992) revealed the significance of the use of oral communication in dissemination of HIV/AIDS information to people in rural areas in a study: *Using culturally relevant needs-assessment research to motivate and develop community-oriented HIV/AIDS education and prevention programmes in Nigeria.* The study indicates that focus group discussions, interviews and community congresses can be used to facilitate community forum in response to HIV/AIDS, provide avenue whereby a coalition of local interest groups could provide appropriate HIV/AIDS information through traditional communication channels. Results of the study show that the use of traditional communication channels can increase community sensitisation to the HIV/AIDS problem, and higher motivation to sustain the awareness drive. Providing HIV/AIDS information through familiar traditional communication channels guarantees acceptability and accessibility Uwakwe (1992:1).

A study by Claasen-Veldsman and Snyman (2005:2) who cited Sturges and Neill (1998) concludes that in Africa the delivery method employed by any informative information service must be essentially oral because the oral mode still predominates among the rural population. In addition, Claasen-Veldsman and Snyman (2005:2) cited Maepa, (2000) who indicates that rural villagers in Limpopo Province prefer non-print materials because they are more

accustomed to acquiring information through listening, rather than reading and that their information and communication channels are still deeply rooted in orality. Therefore, the use of the printed medium for an audience with questionable reading skills renders the information inaccessible and consequently useless with little or no value Claasen-Veldsman and Snyman (2005:2).

Another related study is by Ntsala (2000) in which she studied *the use of information delivery systems for small businesses in Limpopo Province.* The study also found that oral communication in Limpopo Province is prevalent among the entrepreneurs. They use oral communication for the delivery of business information. Ntsala (2000:172) argues that in a largely illiterate environment where people are accustomed to the oral tradition it is not surprising that personal contact, i.e. oral communication, which is fairly informal, is the most preferred form of information communication.

ii) Folk media

Folk media is the creative dissemination of information through cultural and performance arts (Nester, 2004:3). Heubsch (1995:8) postulates that historically, this has been the method that people generally use to communicate. In traditional societies, folk media: drama, poems, stories, riddles, songs and dance are popularly and successfully used to disseminate messages and even to pass wisdom of older generations to the youth. According to Kidd and Colletta (1980:10), the use of traditional communication channels such as folk media and indigenous cultural institutions has increased among communication experts, media specialists and educators. Kidd and Colletta (1980:10) say this is because folk media are not merely a form of

art experience, but are a way of expressing knowledge in a manner, which is acceptable and functional. In addition, Ayaehie (2003:18) and Gana (2003:21) strongly believe that traditional mediums are suitable for health information transfer to the grassroots population. Therefore, traditional forms of communication may be used to disseminate HIV/AIDS information to youth as they have enabled different communities to maintain their cultural values.

These communication channels are people-based, use local idioms and enable new knowledge, skills and attitudes to be introduced within the framework of existing knowledge, cultural patterns, institutions, values and human resources. Kidd and Colletta (1980:281) states that folk media is the attempt by development communicators to use peoples' media for propagating the ideas of modernization. This means that messages are conveyed using people's own language, symbols and styles.

iii) Traditional leaders

Lutabingwa (2006:74) citing Mabutla (2001) indicates that the system of traditional leadership is firmly entrenched in South Africa and it represents institutions that are vibrantly portraying the enormous culture of the nation. He further states that there are more than 400 communities governed by traditional leadership in South Africa. Ga-Molepo is one of those communities governed by traditional leadership. Historically, traditional leaders served as governors of their communities with authority over all aspects of life, ranging from social welfare to judicial functions. The eThekhwini Mayor, councillor Obed Mlaba believes that traditional leaders can play a vital role in the fight against HIV/AIDS. In his speech (delivered on 6 October 2004), he indicated the importance of involving the traditional leaders in the battle against HIV/AIDS.

He indicates that traditional leaders will filter information on HIV/AIDS to the members of their tribal authorities and communities. Despite being closer to the people, in Zambia and most parts of the world, traditional leaders have been left out of development initiatives such as the fight against HIV/AIDS (Sikazwe, 2004:1).

Sikazwe (2004:1) argues that working with traditional leaders, as key players, in the fight against HIV/AIDS is one of the sure ways of combating the epidemic by challenging the negative cultural practices that perpetuate the spread of HIV/AIDS. Therefore, one may argue that it is important to include traditional leaders in the battle against HIV/AIDS, as they are very influential figures in the communities.

iv) Traditional healers

Traditional healers have a crucial role to play in the health system in South Africa and strengthening and supporting the national response to HIV/AIDS (Richter, 2003:2). The media reports in South Africa, mostly in Limpopo Province more often than not report about ritual murders associated with traditional healers and their practices. Leonard (2003:2) who refers to Van der Geest, (1992) argues that traditional healers are a source of health care for which Africans have always paid and even with the expansion of modern medicine, healers are still popular and command fees exceeding the average treatment cost at modern practitioners. A possible explanation is that healers have access to valuable and effective therapies unavailable to modern providers (Leornard, 2003:2).

As alluded to before, traditional healers play an important role in the health system; they also have a role to play in management of HIV/AIDS. Efforts were made by the South African government to include traditional healers in primary health care as well as in HIV/AIDS care and prevention. A national HIV/STD prevention programme focusing on traditional healers was started in South Africa in late 1992 (Green et. al…1995:503). A total number of 2168 traditional healers were trained in HIV/STD prevention. The training was mainly in the form of workshops, which lasted for seven (7) months. There was no literature found regarding the training of traditional healers in Limpopo Province.

2.14 THE ROLE OF LIBRARIES IN DISSEMINATING HIV/AIDS INFORMATION

a) HIV/AIDS interventions by libraries

According to National Library of Medicine (NLM) fact sheet (2005:1), comprehensive HIV/AIDS information service is vital to enable people to combat the HIV/AIDS epidemic. Scientists, physicians, educators, and other health professionals need rapid access to the latest information on AIDS research, diagnosis, treatment, control, and prevention. End users require similar access to appropriate information for decision-making about their behavioral choices and treatment. Community-based Organizations (CBOs), clinics and other types of service providers also need access to high quality, accurate and timely information for their staff and clients.

Despite a wide range of institutions involved in the production and distribution of materials on HIV/AIDS, including Government ministries, UN Agencies, NGO's, donor agencies, and private companies, the HIV/AIDS pandemic situation is as gloomy as ever, however in this regard, libraries appear to be suitable for providing such an opportunity i.e. access to information. The NLM, the world's largest medical library, has been providing HIV/AIDS information services since the HIV/AIDS crisis began in 1980.

Schoombee (2006:2) argues that published literature on libraries and HIV/AIDS written by South African scholars is currently limited to only a few articles. The existing literature on the subject include the one which appeared in *Cape Librarian* by Hart and Kabamba, (2000) and *Free State Libraries* by Le Roux, (2002). These studies emphasise that libraries must make a lasting impact on society regarding HIV/AIDS programmes by looking at collection development, outreach programmes and in-house displays about the subject.

A survey carried out at eight of the 14 public libraries in Swaziland regarding the availability of HIV/AIDS information resources indicates that:

- limited and non-current information on various subjects appealing to a select cross-section of library users is available,
- the information resources are lacking in appropriateness,
- titles are duplicated, limited resource sharing exists between regions, access is restricted and usage levels are low (Muswazi, 2000:34). Therefore, it is important for libraries to get involved in the fight against HIV/AIDS.

Mchombu (2003:1) raises the following questions about the HIV/AIDS crisis: What role can the libraries and information campaigners play in containing and managing this epidemic? How the library and information services sector can be improved to help society to combat HIV/AIDS? In an attempt to answer this question Muswazi (2000: 39) argues that libraries can contribute to the effectiveness of current efforts in the information campaign against HIV/AIDS by making available a variety of usable information resources.

Mchombu (2003:1) argues that through strategic building of information resources and community directed information services, the library services can make a major contribution towards managing and ultimately defeating this disease. Muswazi (2000:34) argues that libraries, by the nature of their information business, can provide the missing link and make a meaningful contribution to the fight against HIV/AIDS. Furthermore, it is recommended that libraries should contribute to the effectiveness of the campaign against HIV/AIDS by:

- collaborating with existing partnerships to influence the production,
- distribution and access to appropriate materials, embarking on high profile HIV/AIDS information exhibitions at public areas,
- extending information access to remote communities, and
- exploring e-mail facilities to facilitate timely access to and soliciting innovative ideas on selective dissemination of HIV/AIDS information. On the other hand, Mchombu (2003:4) says that the library and information services can thus play an important role by disseminating useful information directly to the public, as well as providing forums for debate and discussion, which enables people to learn how to avoid the disease.

According to Schoombee (2006:1) libraries as providers of information and knowledge are bound to a social, cultural and political responsibility. In this, regard all libraries whether academic or non-academic are faced with a huge responsibility of creating and promoting HIV/AIDS awareness to the public. Huber (1960) and (Lukenbill, 1994) conducted similar studies. These are international studies, which were focusing on proactive HIV/AIDS information, services, scope, rationale and infrastructures respectively. Such studies are very helpful to libraries, which are intending to be or are involved in creating and promoting HIV/AIDS awareness to the public.

2.15 HIV/AIDS INFORMATION CAMPAIGNERS

The following are National HIV/AIDS information campaigners. They use various information delivery systems for dissemination of HIV/AIDS information.

i) HIV/AIDS and STD Directorate

The HIV/AIDS and STD Directorate uses the following as its information delivery systems for disseminating HIV/AIDS information: Internet, youth road show campaigns, newsletters, including manuals, booklets, posters and leaflets (AIDS INFO, 2003:1)

ii) LoveLife

According to Kaizer Family Foundation (2007:1), LoveLife is South Africa's national HIV prevention programme for youth. It was launched in September 1999, by a consortium of

leading South African public health organisations in partnership with a coalition of more than 100 community-based organisations, the South African government, major South African media groups and private foundations.

LoveLife combines a highly visible sustained national multi-media HIV education and awareness campaign with countrywide adolescent-friendly service development in government clinics, and a national network of outreach and support programmes for youth (Kaizer Family Foundation, 2007:1). However, LoveLife has been criticized for disseminating unclear and ambiguous HIV/AIDS messages (Peng, 2006:1).

iii) AIDS helpline

The AIDS helpline provides a free national telephone counselling, information and referral service for those affected by and infected with HIV/AIDS (AIDS helpline 2003:2). It does so by providing information to callers in all eleven South African official languages. Despite the free telephone service provided in the language understood most by the client, Limpopo Province has inadequate telecommunication facilities and electricity supply for facilitating telecommunication (USAID, 2007:1). Therefore, this may make such service inaccessible to the end-users.

HIV/AIDS campaigners such as LoveLife and the Department of Health appear to have failed to successfully to drive home the HIV/AIDS prevention messages to the public, particularly the youth. This argument is based on the key findings of the survey, *HIV and sexual behaviour among young South Africans: A National Survey of 15-24 Year Olds (2004).*

According to the Kaizer Family Foundation (2007:1), the key findings were as follows:

- Overall, the HIV prevalence among 15-24 year olds was 10.2%. Among those aged 15-24 years, the prevalence among males was 4.8% and among females, it was 15.5%. For those aged 15-19 years, the prevalence among males was 2.5% and for females, it was 7.3%, and among those aged 20-24 years, the prevalence among males was 7.6% while among females it was 24.5%.
- Among sexually experienced youth, 6% reported having been forced to have sexual intercourse. This was 10% among females and 2% among males.
- Among sexually experienced youth, 52% reported using a condom at last sex. Condom use was almost identical among sexually inexperienced men and women aged 15-19 years but, among sexually experienced 20-24 year olds, females were significantly less likely to report condom use at last sex than men (44% vs. 57%).
- The highest HIV prevalence was found in KwaZulu-Natal Province (14.1%) and the lowest in Limpopo Province (4.8%). In terms of geographic area, youth living in urban informal areas had the highest HIV prevalence (17.4%).

2.16 INFORMATION OVERLOAD

The problem of information overload is widely recognized today. According to Gunderman (2006:495) information overload is a state in which we are confronted with so much information that our cognition is dulled, decision-making is impaired and mental exhaustion sets in. This state threatens the ability to perform effectively. Morris (1998:1886) indicates that in the specialty of HIV/AIDS, information overload is now an emerging "disease." Contrary to this, Green (1999:413) argues that with 80% of those affected by AIDS in the world today, there is no HIV/AIDS information overload to be treated, instead it is treatment with information that is sorely needed.

According to Edmunds (2000:2), an obvious solution to the problem of information overload is to employ specialists in information handling to carry out the acquisition of relevant information and processing and packaging the information needed as appropriately as possible.

2.17 Conclusion

In this chapter, relevant literature survey is conducted on the topic at hand. In reviewing literature, one becomes aware that there is a growing interest in literature devoted to HIV/AIDS information. The literature covers changing behaviour, communication, and many more. Very little has been written on rural health services evaluating their information delivery systems.

The literature reviewed shows that the disseminating HIV/AIDS information, is important to make ascertain that it reaches the right users; above that, one has to use the right language which the majority of the people use and understand. The other equally important factor is the selection of information delivery systems that are relevant to rural end users who range from being illiterate, functionally literate to literate. Various authors on the topic recommend oral based information systems for end users who cannot read or write. This would allow people who cannot read and write access information. The next chapter deals with the research methodology.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research methodology used to conduct the research. This includes a discussion of the methods and procedures used in developing the data collection instrument, data collection methods, sampling design and procedures for the collection of data.

3.2 Research design

Meyer (1995:280), as cited by Pearce (1996:86), explains that research design is a plan of action or framework according to which researchers decide what should be researched, how information about the subject should be obtained, how the results will be manipulated and analysed, and how the results will be reported.

The research study is both quantitative and qualitative in nature. Quantification means to measure on some numerical basis while a qualitative approach by contrast, emphasises meaning, experiences, description and so on (Silverman, 2000:41). Miles et al, (2001:43) as cited by Conduah (2001) argues that a combination of the two methods tends to take into account reliability and authenticity in research projects. For example, the quantitative method cannot elicit experiences and perceptions of respondents and this can be captured through

qualitative means. In view of the fact that each method has its own strengths and weaknesses, the researcher decided to use both methods to complement each other.

3.3 Data collection

The survey method was used in this study. It is a systematic way of collecting data by obtaining opinions or answers from selected respondents. According to Rogers and Bouey (1996: 52), the most utilized data collection method in qualitative research studies is the interview. In addition Britten, (1995:6) argues that large qualitative studies do not often interview more than 50 people. Therefore, the researcher used the interviews on that basis.

3.3.1 Interviews

The interview schedule was semi-structured and the schedules were informed by the literature review conducted and from the comments sought through informal talks with community members and health professionals. Semi-structured interviews provide greater scope for discussion and learning about the problem, opinions and views of the respondents. While there are some specific questions (closed questions) in the interview schedule, each of which may be probed or prompted, there are a lot more questions, which are completely open-ended. In short, semi-structured interviews are conducted based on a loose structure consisting of open-ended questions that define the area to be explored (Britten, 1995:2). For example, how satisfied are you about the number of people who access your HIV/AIDS information?

Sewell (2006:1) holds the view that in practice, open-ended, qualitative interview questions are often combined with more close-ended structured interview formats.

Interviews were recorded by means of notes written at the time of the interviews. Although this can interfere with the process of interviewing, it was found to be the best method as compared to notes written afterwards which are likely to miss out important details. A tape-recorded interview was avoided as it might have made some respondents uncomfortable when such a sensitive topic as HIV/AIDS was put on record.

The first part of the semi-structured interview had to do with personal information of the respondents; the second part was the background information about the clinic, and the third dealt with information delivery systems, fourth, HIV/AIDS information, fifth, staff training. The covering letter and semi-structured interview to the clinics are attached as addendum A and B.

3.3.2 Population and sampling

For the study, one rural area in the Capricorn District Municipality was selected. This was the Ga-Molepo area. The area was selected as the researcher, through informal discussions with some community members (both young and adults), realised that there are information gaps about HIV/AIDS prevention, care and symptoms. Yet these people have access to the local clinics. Clinics are known to be nodal areas for distribution of health materials (print and non-print) supplied freely by the government. In order to obtain information about the information

delivery systems used to disseminate HIV/AIDS and HIV/AIDS information the researcher decided that the starting point should be clinics.

When conducting research it is important to identify the population group. The group population is a collection of all elements either known or unknown from which a sample is drawn. Gillham (2000:19) argues that if the number of respondents or population is large, running into hundreds or even thousands, the only practicable way is to take a sample. A non-probability sample was selected using purposive sampling. David (2004:152) states that with purposive sampling, the units are selected according to the researcher's own knowledge and opinion about which ones they think will be appropriate to the specific area or study. In general, a non-probability sample is appropriate whenever the researcher does not generalize beyond a specific sample of respondents.

The study sought to generate a rich body of findings from a smaller sample rather than less detailed information from a larger group. In this case, five (5) clinics at Ga-Molepo were chosen and were all included in a study because the size of the population was easily controllable and accessible. Dudley (2004: 148) and David (2004:149), state that a survey of this nature, wherein all cases are included is called a census study. While these cases would not be representative of clinics generally, they could provide clues to the use of information delivery systems and HIV/AIDS information used by clinics in rural areas.

3.4 PILOT STUDY

It is important to ensure the reliability and validity of data collecting instruments. The researcher effected this by undertaking a pilot study. A pilot study is a small-scale study conducted prior to the actual research. According to Anderson, (1990:271) pilot testing is important, as it checks the authenticity and relevance of the data produced. It will then help classify the wording of the questions and it may indicate omissions or unanticipated answers, especially in multiple choices or in ranking questions. In addition, one may argue that a pilot study may help in identifying items that are difficult or ambiguous.

Two participants from the University of Limpopo, Turfloop campus and from Mankweng clinic were interviewed as part of the pilot study. The feedback from the participants was very helpful in assisting the researcher to refine the questions and wording before the actual respondents. Note that the results of the study are not included in the study.

3.5 LIMITATIONS OF THE STUDY

The general process of this research was not without challenges. The difficulties encountered included:

- Time delays to obtain an ethical clearance certificate from the University of Limpopo-Turfloop campus, took at least nine months.
- Having obtained the ethical clearance from the UL-Turfloop, the Limpopo Department of Health had put a moratorium on research and the study was put on hold for almost eight months.

- Financial and time constraints limited the study to only rural areas of Ga-Molepo.
- Most clinics do not have faxes, e-mail and telephones and this made ordinary contact problematic.
- Lack of current and reliable demographic statistics of Ga-Molepo was another problem.
- Due to a limited coverage of clinics, the results of the study cannot be generalized to the clinics in the Limpopo Province. While these five (5) clinics would not be representative of all clinics, they would nevertheless provide clues to factors involved.

3.6 ETHICAL CONSIDERATIONS

As part of ethical considerations, before conducting the study, permission and a list of HIV/AIDS information centres/clinics at Ga-Molepo was requested from the following committees:

i) Limpopo Department of Health.

ii) The University of Limpopo Ethics Committee.

An explanation about the study was given to participants and a consent form was given to them, duly filled in and returned. The consent form gave reasons why the study was important to undertake. Respondents were informed that they had a right either to participate or in the study or not. Above that, they were also informed about the importance of participating in the study and the researcher assured participants that the data collected would be anonymous and confidential. The response rate was quite satisfactory because all respondents participated and therefore made themselves available for interviews and were all given a consent form to complete before the interviews.

3.7 Conclusion

This chapter explains the research methodology, which was used to conduct the research. This includes a discussion of the methods and procedures used in developing the data collection instrument, data collection methods, sampling design and procedures for collecting data. In any study, depending on the topic under discussion, the researcher has to ensure that a representative sample is selected that would allow one to generalize the results. Equally important is the data collection method. In this study, interviews were used to collect the data. The interviews allowed the interviewer a chance to build on the responses from previous questions.

What was challenging during the interviews was notes taking where one does not use any technology such as a voice/tape recorder to capture the conversation. It was demanding for the interviewer to ask questions, listen and write down the notes. There were instances where one respondent talked endlessly and some of the comments were not relevant to questions asked. Some respondents said very little which caused uneasiness to an inexperienced interviewer. Lastly, the chapter dealt with limitations of the study and ethical issues. The next chapter, data analysis is provided.

CHAPTER FOUR

DATA ANALYSIS

4.1 Introduction

This chapter provides analyses of data collected from the respondents who work in the Ga-Molepo clinics. In order to analyse data bar graphs and tables were used to organise data into simpler accounts and to emphasize features of the data which are more relevant to the study.

4.2. PERSONAL INFORMATION

4.2.1 Position respondents hold in the clinic

All five respondents are at the same rank, which is a management position. This was to ensure that the sources of information (respondents) are at the same level at work. They are ‘Sisters in charge’ of the clinic and provide primary health care and HIV/AIDS information.

4.2.2 Highest educational qualification

A question on qualification was to determine the qualifications of staff members. Four of them have degrees in nursing. Only one is a qualified nurse with a diploma in general nursing.

4.3. INFORMATION AGENCY INFORMATION

Table 2: Average number of villages served by each clinic

	Number of villages	Estimated population
Clinic A	3	7000-10 000
Clinic B	6	12 000-13000
Clinic C	5	10 000-12 000
Clinic D	8	16 000-18 000
Clinic E	9	18 000-25 000

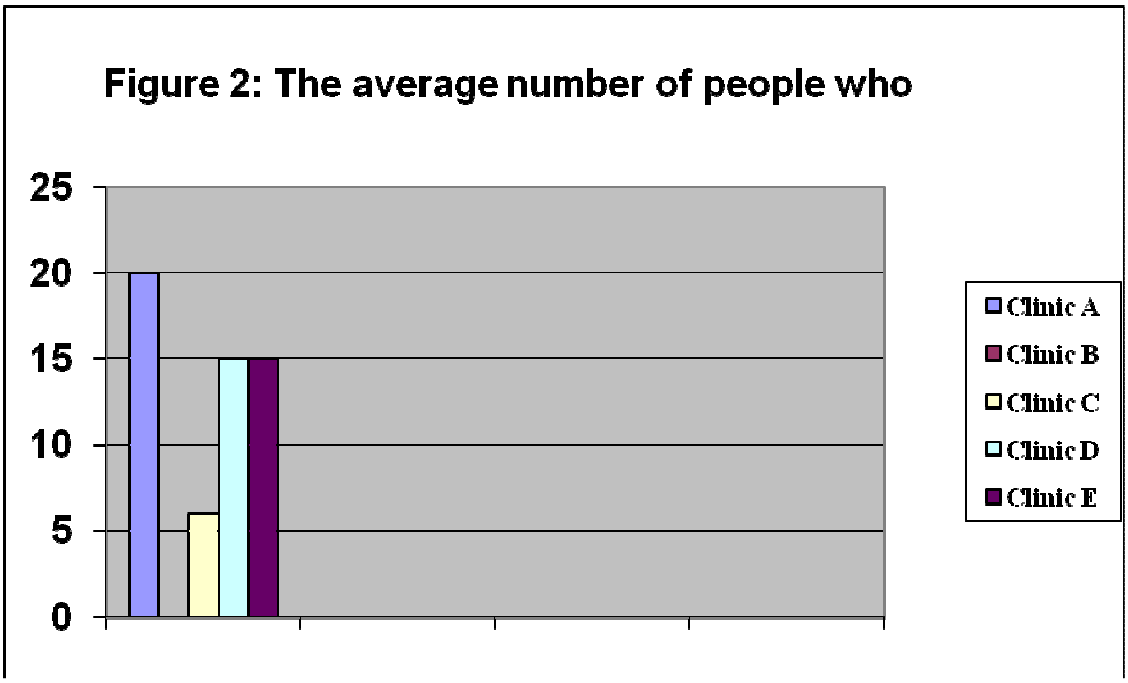
Clinics were coded A-E in order to maintain the anonymity of respondents. According to the National Health Strategic plan, each village consisting of at least 10 000 population should have a clinic. There is no authenticated evidence about the total number of people at Ga-Molepo. The above estimations were based on 1993 StatsSA statistics for people weighted in all 22 villages at Ga-Molepo. The total number of people weighted was 32 702. As already indicated the population per village is estimated between 2 000-5 000 depending on the size of the village.

Table 3: Length of time clinics have been providing HIV/AIDS information

	Time period
Clinic A	6 years
Clinic B	6 years
Clinic C	10 years
Clinic D	10 years
Clinic E	12 years

4.3.1 Clinics' daily opening hours

Four clinics open for 8 hours per day. Contrary to other clinics, one clinic indicated that it opens for 24 hours as it is better resourced than other clinics.



The above figure indicates the average number of people who seek HIV/AIDS information from each HIV/AIDS information clinic. One clinic has at least twenty (20) seek HIV/AIDS information per day. Surprisingly, one respondent reported that no people come for HIV/AIDS

information. The response was that people are ignorant, have fear of speaking about HIV/AIDS and a lack of knowledge. One clinic reported that (6) people who come for HIV/AIDS information; other two reported fifteen (15) people seek HIV/AIDS information on a daily basis.

Table 4: Satisfaction about the number of people who access HIV/AIDS information

KEY: NS- Not Satisfied **MS**- Moderately Satisfied **S**- Satisfied
VS- Very Satisfied **U**-Uncertain

	NS	MS	S	VS
Satisfaction about number of people who access your HIV/AIDS information	2	2	1	-

On whether the clinics are satisfied about the number of people visiting the clinics on a daily basis two (2) respondents were moderately satisfied, one (1) respondent indicated satisfaction. Interestingly, the respondent who indicated that no person visits the clinic for HIV/AIDS information indicated moderate satisfaction. The respondent was asked about this and changed the answer to not satisfied. The number of respondents who are not satisfied about the number of people who visit the clinics on a daily basis then became two (2). Reasons for being unsatisfied were that people are not using the available health facilities.

Table 5: Skills of staff providing HIV/AIDS information

KEY: NS- Not Satisfied **MS**- Moderately Satisfied **S**- Satisfied
VS- Very Satisfied **U**-Uncertain

	NS	MS	S	VS
Skills of staff providing HIV/AIDS information	1	1		3

Three (3) respondents were very satisfied with skills of staff providing HIV/AIDS information**,** one (1) was moderately satisfied and another one (1) was not satisfied, mainly because the training he underwent was not sufficiently intensive. Respondents were asked to use the following structured answers to respond to statements, which were outlined to them.

Table 6: Assessment of HIV/AIDS information overload

Key: SD- Strongly Disagree **D**-Disagree **A**-Agree **SA**-Strongly Agree
U-Uncertain

HIV/AIDS information overload	**Responses**				
	SD	**D**	**A**	**SA**	**U**
Too much HIV/AIDS information is being circulated all over	2	2	1	0	0
People are no longer interested in HIV/AIDS information	0	2	1	0	2
There are other organizations providing HIV/AIDS information	2	3	0	0	0

Two (2) clinics strongly disagreed that too much HIV/AIDS information is circulated by the clinics. Two (2) clinics disagreed that too much HIV/AIDS information is not circulated by the clinics. One (1) respondent agreed that too much HIV/AIDS information is by the clinics.

Two (2) respondents were uncertain as to whether people are no longer interested in HIV/AIDS information or not. Two (2) respondents disagreed with the statement that people are no longer interested in HIV/AIDS information. One (1) respondent agreed with the statement that people are no longer interested in HIV/AIDS information. Two (2) respondents strongly disagreed with the statement that there are other HIV/AIDS campaigners providing HIV/AIDS information in the community. Three (3) respondents disagreed with the statement that there are other organizations providing HIV/AIDS information.

HIV/AIDS INFORMATION DELIVERY SYSTEMS

Table 7: Information delivery systems used by clinics to disseminate HIV/AIDS information and their frequency of use by the clinic

Information delivery system	Response		
	Always	Sometimes	Never
Community radio	0	1	4
Television	0	0	5
Videos	0	2	3
Telephone	0	1	4
Newspaper	0	0	5
Magazine	0	0	5
Traditional leaders	0	4	1
Political leaders	0	3	2
Workshops	1	3	1
Community Forums	0	3	2
Professional journals	0	0	5
Pamphlets/booklets	5	0	0
Road shows	1	1	3
People living with HIV/AIDS	2	1	2
Billboards	0	0	5
Posters	4	1	0
Internet/computers	0	0	5
Drama/plays	0	4	1
Other, please specify……	0	0	0

Always

From the table above, it is clear that all five (5) clinics always use pamphlets/booklets for dissemination of HIV/AIDS information. Four (4) respondents reported that they always use posters for dissemination of HIV/AIDS information. Two (2) respondents said that they always use people living with HIV/AIDS. One (1) respondent said they always use workshops and the other respondent said they always use road shows.

Sometimes

Four (4) respondents reported that they sometimes use traditional leaders and dramas/plays. Three (3) respondents indicated that they sometimes use political leaders, workshops and community forums. Two (2) respondents said that they sometimes use videos. Five (5) respondents reported that they sometimes each use community radio, telephone, road shows and posters.

Never

Five (5) respondents said that they never use newspapers, television, magazine, professional journals, billboards and Internet/computers. Four (4) respondents said that they never use community radio and the telephone as a means of disseminating HIV/AIDS to end-users. Three (3) respondents said that they never use road shows and videos. Two (2) respondents said that they never use people living with HIV/AIDS, political leaders, community forums. Each of three (3) respondents said that they have never used traditional leaders, workshops and drama/plays. Not all respondents reported using any other information delivery system besides those indicated.

4.5. PLACE OF DISTRIBUTION

Table 8: Places that clinics use to distribute HIV/AIDS information resources

Place of distribution	Response
Own clinic	5
Schools	4
Households	4
Shops	3
Taverns	3
Tribal halls	2
Taxi ranks	1
Churches	1
Private surgeries	0
Community libraries	0
Other, please specify……	0

All five (5) clinics at Ga-Molepo indicated own clinics as the main place to distribute HIV/AIDS information resources. Schools and households are also regarded as strategic places to distribute HIV/AIDS resources and this was indicated by four (4) clinics. Three (3) respondents regarded shops and taverns as a strategic place, which they use to distribute HIV/AIDS information resources. Two (2) respondents said they regard tribal halls as a strategic place to distribute HIV/AIDS information resources. To lesser extent, a taxi rank and church are used, as indicated by one (1) respondent. None of the respondents reported private surgeries and community libraries as strategic places to distribute HIV/AIDS information resources.

4.5.1 Assessment of the effectiveness of your information delivery systems

This was an open-ended question where the respondents were asked how they measure the effectiveness of their HIV/AIDS information delivery systems. Their responses were as follows:

- Through exit interviews and questionnaires. This means that staff members assess the effectiveness of information delivery systems by asking patients some HIV/AIDS related questions about the subject on their way out.
- Through any positive response from the clients. This could be informally when individuals meet the nurses outside the working hours and indicate what information s/he gained during the community outreach talk. In other instances, friends refer individuals to clinics or relatives who attended the community outreach talk.
- Through the number of people who volunteer to undertake voluntary counselling and testing for HIV.
- Through the rate at which condoms are taken from condo-tainers at their areas of distribution
- Lastly, through observation, at work and public places as and when more people talk openly and freely about HIV/AIDS.

Table 9: Some suggested means of improving the use of HIV/AIDS information delivery systems

	No. of responses
Rely on home-based caregivers	1
Qualified staff should be provided	1
Government should provide more HIV/AIDS information and train more staff who will specifically deal with HIV/AIDS information.	1
Special transport should be provided	1
HIV/AIDS billboards should also be considered	1
More materials should be supplied regularly and such material should be written in Northern Sotho	1

One (1) respondent reported relying on home-based caregivers and further suggested that many of the home-based caregivers should be trained, as they work together as they assist patients who are based at home. Further to that, qualified staff should be provided. One (1) respondent suggested that Government should provide them with more HIV/AIDS information and train more staff who will specifically deal with HIV/AIDS information. One (1) recommended that the government should provide special transport for clinics in order to reach out to communities easily. In addition, the respondent suggested that HIV/AIDS information should be supplied regularly. Further to that, HIV/AIDS billboards should also be considered. Another respondent suggested that more materials written in Northern Sotho should be provided.

Table 10: Level of satisfaction in the use of Information delivery systems

KEY: NS- Not Satisfied **MS**- Moderately Satisfied **S**- Satisfied
VS- Very Satisfied

	NS	MS	S	VS
Level of satisfaction in the use of Information delivery systems	0	3	2	0

Two (2) respondents indicated that the clinic is satisfied about information delivery systems used to provide the HIV/AIDS information to the community. On the other hand, three (3) respondents indicated moderate satisfaction.

Table 11: Success rate of clinics in disseminating HIV/AIDS information

KEY: NG-Not Good **MG**-Moderately good **G**-Good **VG** –Very good **U**-Uncertain

	NG	MG	G	VG	U
Success in dissemination of HIV/AIDS information	0	2	3	0	0

Three (3) respondents said the success rate of clinics in disseminating HIV/AIDS information is good and two (2) respondents said that the success rate of clinics in disseminating HIV/AIDS information is moderately good

4.6. LANGUAGE

Table 12: Language/s used to disseminate HIV/AIDS information

	Response
Northern Sotho	3
Northern Sotho and English	1
Use English for certain N. Sotho words	1

Three (3) respondents stated that even though most of pamphlets and posters they distribute are in English, they use Northern Sotho as a medium to inform end-users. This is because the majority of the people living in Ga-Molepo speak Northern Sotho.

One (1) respondent reported that HIV/AIDS information resources obtainable from the Department of Health are already written in English but when the need arises, such materials are translated into Northern Sotho for easy reading and understanding.

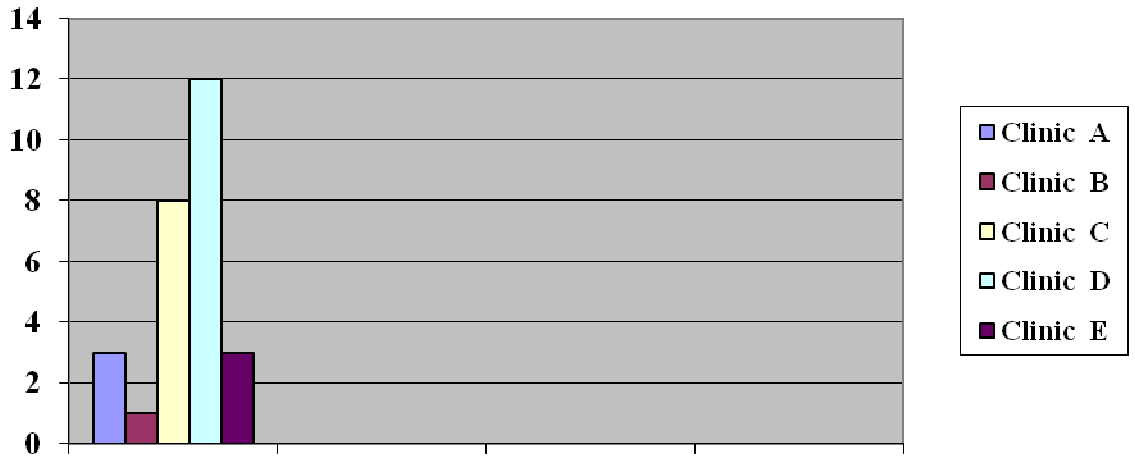
Two (2) respondents use both Northern Sotho and English for dissemination of HIV/AIDS information. The reason is that English makes it easy to talk about sexual issues and private parts. With emphasis, one respondent said, “it is very difficult to refer to private parts and talk about sexual issues using Northern Sotho”. Obermeyer (1999: 153) concurs with the above statement when he says that within particular cultures, the use of biological or factual names for reproductive organs is sometimes prohibited or regarded as a taboo.

4.6.1 Illiteracy

All respondents believe that people who rely on written delivery systems are able to read and write. One (1) respondent, who indicated illiteracy as affecting the service of providing HIV/AIDS information to a lesser extent, said that in case of illiterate end-users, nurses verbally communicate with them in the language of their preference.

4.7 STAFF DEVELOPMENT

Figure 3: Number of staff members involved in the dissemination of HIV/AIDS information



The above figure indicates the number of staff involved in dissemination of HIV/AIDS information in each clinic. One (1) respondent in clinic B reported that he is the only person involved but with assistance of the home-based caregivers engaged in dissemination of

HIV/AIDS information. The respondent cited lack of staff as the reason for his individual participation in dissemination of HIV/AIDS information in their clinics. Two (2) respondents in clinic A and E indicated that three (3) staff members were involved in dissemination of HIV/AIDS information. One (1) respondent stated that all eight (8) staff members in clinic C and all twelve (12) staff members in clinic D are involved in dissemination of HIV/AIDS information.

Table 13: Staff training on how to disseminate HIV/AIDS information

	Yes	No
Received training on how to disseminate HIV/AIDS information	3	2

Three (3) respondents reported having received training on how to disseminate HIV/AIDS information, while the other two (2) respondents reported having received no such training. All respondents attended one or more of the following workshops:

- Voluntary Counselling and Testing (VCT)
- Prevention of mother to child transmission (PMTCT)
- Couple counselling, and
- Medical management of HIV/AIDS.

Respondents who underwent training on how to disseminate HIV/AIDS information were asked to indicate their level of satisfaction about the training. One (1) respondent said he is

very satisfied about the training he received. Two (2) respondents said they are satisfied about the training they underwent.

4.7.1 Method of training

Those who received training were asked as to how they were trained. One (1) respondent indicated that training was mainly through workshops. Two (2) respondents indicated that staff members were trained through workshops and short courses.

4.8 Conclusion

In this chapter, the results of the study are presented together with various tables, which show the results of the interviews conducted. The first column of the table is a list of variable categories, and the second column shows the number of respondents. The next chapter will therefore, show an interpretation of the results of the study.

CHAPTER FIVE

DATA INTERPRETATION AND THE DISCUSSION OF RESULTS

5.1 Introduction

The previous chapter presented the results of the study and also restates the aim, and the objectives of the study as well as the assumption.

5.1.1 Aim of the study

The aim of the study is to investigate which of the information delivery systems (communication strategies) established at government level are used by rural clinics, and whether such information delivery systems are accessible to rural end-user.

5.1.2 Objectives

i. To identify information delivery systems used by clinics to disseminate HIV/AIDS information.
ii. To establish which places clinics use to distribute HIV/AIDS information delivery systems.
iii. To determine the clinics' level of satisfaction with information delivery systems they use.
iv. To find out how clinics conclude that particular information delivery system is accessible.
v. To find out if community members visit the clinics to seek HIV/AIDS information or not.

vi. To find out if clinics regard HIV/AIDS information made available through multitudes of information delivery systems to be too much or not.

vii. To establish how clinics deal with language and illiteracy issues.

viii. To determine the knowledge/skills nurses have in the use information delivery systems used in the dissemination of HIV/AIDS information.

5.1.3 Assumption

As much as various information delivery systems are available to clinics, rural end-users of these clinics cannot access them because of factors such as illiteracy, format, language to mention but a few.

This chapter includes data interpretation as well.

5.2. PERSONAL INFORMATION

5.2.1 Position of respondents in the clinic

Like with any study, it is important to select the best respondents to provide information. It is for this reason that the study had to establish the qualifications and the rank, which all respondents occupy. As pointed out earlier they are all managers in charge of clinics, four (4) of whom have a degree in nursing while only one (1) holds a diploma in nursing.

5.3. Clinics' background information

5.3.1 Clinics' background information

In South Africa, sizes of clinics are classified according to the population each clinic has to serve. The average number of people per clinic in the Capricorn District is one (1) clinic for every 14 804 people, which is below the norm of one (1) clinic per 10 000 of the population. There are meaningful differences in the ratios for the number of people per clinic in local municipality areas. Gerald and Diane (1999:1535) argue that this is largely due to "apartheid" policies, which advocated the provision of different services to each racial group. Therefore, the purpose of this question was to establish the population that each clinic serves. This question was to be linked with the number of people who visit the clinic per day asking for HIV/AIDS information and the question of whether staff members are coping with the work-load.

5.3.2 Length of time clinics have been providing HIV/AIDS information

The study revealed that clinics at Ga-Molepo started providing HIV/AIDS information some time ago. For instance, one (1) clinic was established six (6) years ago, and the other one (1) dates as far back as twelve (12) years.

5.3.3 Opening hours for clinics

Most clinics in the Limpopo Province open twenty four (24) hours but at Ga-Molepo, four (4) clinics, open eight (8) hours per day. It was found that there was only one (1) clinic that opens for twenty-four (24) hours, including Saturdays and Sundays. The clinic that opens for twenty-four (24) hours while the other four (4) are less resourced which compels it to work for eight (8) hours a day while Fridays are set aside for nursing sisters in charge to focus on administrative work.

5.3. FORMAT OF INFORMATION DELIVERY SYSTEMS

5.3.1 Information delivery systems used by HIV/AIDS campaigners

Recent literature shows that media, radio, television and newspapers are the most effective information delivery systems used to deliver various messages. The only challenge is that these services are not used in some rural areas like Ga-Molepo as they would require the clinic to pay for airtime. This includes dissemination of HIV/AIDS information. Contrary to this, clinics in rural areas of Ga-Molepo do not rely much on media as far as dissemination of HIV/AIDS information is concerned. They rely more on pamphlets and posters as the means of delivery systems for dissemination of HIV/AIDS information. Most pamphlets, posters and brochures that clinics use are from the Department of Health and are designed or provided by Non-Profit Organizations (NPOs) like LoveLife, Khomanani and UNAIDS. These pamphlets, posters and brochures are freely available to end-users as the cost is borne by the Department of Health.

Not paying for information delivery systems is one way to ensure that people who have no money or poor can access HIV/AIDS information.

Research by Uhegbu (2000:51) has shown that the media, especially newspapers, television, magazine, professional journals, billboards and Internet/computers are never used because they are not easily accessible to many rural inhabitants because they are expensive. Moreover, television and Internet/ computers require suitable infrastructure like electricity and sophisticated connections. Besides that, one has to be literate in order to understand some of the programmes that are broadcasted in English. Internet is still not accessible to the majority of rural areas and has the majority of its information written in English thus making it inaccessible to those who cannot read and write in English. There is no library at Ga-Molepo even though libraries house information on HIV/AIDS.

5.4. PLACE OF DISTRIBUTION

5.4.1 Places where HIV/AIDS information is distributed

Research results show that besides clinics, other places such as schools, households, shops and taverns are places where clinics distribute HIV/AIDS information in large quantities. These are places which are frequented by many people. Schools teach Life Orientation as a learning area and HIV/AIDS is covered as a theme. In other words, it is more of a must that learners in schools should have access to HIV/AIDS information and target some information delivery systems at schools. Although there are challenges, studies have shown that educators have a problem inability to handle this sensitive subject. In 1996, the Limpopo Department of

Education, has and is continuing to empower educators on how to facilitate the theme. In some schools, they are working together with some clinics where the nurses give classes, as they are better qualified and knowledgeable.

The minority of respondents have also reported churches, tribal halls and taxi ranks as places at which they distribute HIV/AIDS materials. Despite the tribal halls being major strategic areas where rural communities frequently gather to address community issues, they are less used to distribute HIV/AIDS materials. It is also a truism that many people gather at taxi ranks on daily basis but the majority of clinics still do not regard taxi ranks as a suitable place where they can distribute HIV/AIDS materials. No reason was given why the clinics are not distributing HIV/AIDS materials at the taxi ranks.

The absence of libraries could be seen as an obvious reasons as to why they are not regarded as possible places where HIV/AIDS information could be placed. Contrary to what Batamuze (2003) emphasised when he says, “libraries are significant information agents in meeting the demands for HIV/AIDS material. They ought to be collaborating with other organizations to build HIV/AIDS services and programmes. Libraries have a moral vindication to provide access to information for children and young adults with special attention to AIDS issues”.

When it comes to churches, a number of churches now accept that HIV/AIDS is a serious problem that needs commitment of its members. A study on religion and women’s health done in Ghana indicated that religious affiliation has a significant effect on knowledge of HIV (Takyi, 2002). De Kock (2007), Director of WHO’s Department of AIDS says

“Faith- based organizations are a vital part of civil society” and this implies that they should be used as places to distribute HIV/AIDS materials. Some rural churches could still be reluctant to address it openly, and that alone reducing it to not being the ideal place for the clinics to place some of their HIV/AIDS information resources.

Traditional leaders are sometimes used and clinics can approach them to check if they would be willing to use tribal halls for dissemination of HIV/AIDS information. The South African Minister of Health in her speech said, “Traditional leaders have certain strengths that they bring to the fight against HIV and AIDS. You are well placed to convey AIDS messages especially in rural and most remote areas of our country. We know that you command great respect amongst your communities and you have direct access to the most impoverished people in this country. This access means that as traditional leaders you have a potential to break the silence amongst our people and fight the stigma that is still associated with HIV and AIDS”.

The government in its HIV/AIDS strategic plan 2000-2004 planned to use taxis to educate and inform communities. Clinics at local level might look at the possibility of this. They should also visit the taxi ranks especially at the end of the month as it is the time when the majority of the people board taxis and buses.

5.5. HIV/AIDS INFORMATION

5.5.1 The number of people who have access to HIV/AIDS information

This study established that the largest number of people who seek HIV/AIDS information at any one time is twenty (20). This figure is based on the number of people who attend morning community education programmes that are offered by the clinics on a daily basis. Given the large numbers of the population that are supposed to be served, one wonders why such a small number visits the clinics to get HIV/AIDS information.

This study notes that stigma, discrimination and transport do have a negative impact on the number of people who attend some of the HIV/AIDS talks. As transport is not available, some people who live far away from clinics are excluded from accessing HIV/AIDS talks and brochure. High transport costs also impact negatively on HIV/AIDS talks.

On the question of too much information being circulated, a number of studies show that too much information results in information overload. Information overload is defined as a state in which people are confronted with so much information that their cognition is dulled and decision-making is impaired and mental exhaustion sets in (Gunderman, 2006:495). Even though such studies warn that too much information delivery systems and too much HIV/AIDS information being disseminated result in information overload, all five (5) respondents said that they do not experience information overload in their clinics.

5.5.2 Level of satisfaction about the number of people who have access to HIV/AIDS information

When referring to the number of people visiting the clinic, the study does not imply that these people are HIV positive or are living with AIDS. They are people who visit the clinics to access HIV/AIDS information. It would have been appropriate to ask the end-users reasons for attending HIV/AIDS talks but one can assume that reasons range from one being infected or to those who are affected.

The largest number of people who access HIV/AIDS information is twenty (20). As indicated the estimated size of population per village at Ga-Molepo is between 1 500-5 000. Based on this large number of people one may suggest that HIV/AIDS information is not easily accessible from clinics at Ga-Molepo due to factors such as ignorance, format in which information is contained, disseminated, and the physical location in which clinics are situated. This problem is not unique to the Limpopo Province. As indicated previously, the issue of physical location is problematic and this is affirmed by the study conducted by De Koker et. al… (2006: 237) when they say, in the Eastern Cape, approximately 48% of households must travel more than five kilometers, while the majority of households in the other provinces must travel further.

5.5.3 The success rate of clinics in disseminating HIV/AIDS information

The majority of respondents rated their clinics as successful as far as the dissemination of HIV/AIDS information is concerned. Three (3) respondents say that the success rate of clinics

in disseminating HIV/AIDS information is good and two (2) respondents say that the success rate of clinics in disseminating HIV/AIDS information is moderately good. Given the above statements, one may confidently say that the flow of HIV/AIDS information from clinics to end-users is well established. The satisfaction with the rate of clinics disseminating HIV/AIDS information could be attributed to the fact that the clinics never run short of materials for distribution. This assertion does not in any way suggest that end-users read or understand the information or change their behaviour towards HIV/AIDS.

5.5.4 Satisfaction of respondents regarding the use of information delivery systems

Respondents in all clinics show general satisfaction with to information delivery systems used to provide HIV/AIDS information. A list of responses clearly shows that a combination of information systems deliveries is used, at times simultaneously each complementing the other.

It is apparent that some information systems delivery methods such as billboards, radio and television could be expensive to ordinary institutions and the responsibility could be relegated to the provincial government. According to Dube (2005) study, respondents commented, “billboards are scarcely used as they are costly and to produce them one needs specialist skills and technological facilities”. About the use of radio and television, respondents state that local television and radio have the advantage of broadcasting customer- designed programmes that are suitable for addressing local needs (Dube, 2005).

5.5.5 Assessment of the effectiveness of information delivery systems

All five (5) clinics engage in various activities to evaluate the success of their information delivery systems:

- Behavioural change of patients. This means that the end user understands and makes a positive behaviour change by adhering to HIV/AIDS prevention methods. Clients inform nurses how they have changed behavior since they attended HIV/AIDS talks.
- One respondent has indicated that he conducts informal discussions with patients regarding the use of condoms. He also discusses with them the danger of having multiple sex partners and their attitudes towards HIV/AIDS. Ngobo (2004:17) in his research found that, "very few youth organizations in KwaZulu-Natal Province had developed their HIV/AIDS programmes interventions to the point of being able to regularly assess what they are doing".
- End-users reporting that they have heard about HIV and AIDS.
- Questionnaires and interviews are conducted every time when patients visit the clinic to ensure that they have received, or heard about HIV/AIDS.

5.5.6 Means of improving the use of HIV/AIDS information delivery systems

In this question, the respondents made suggestions as what has to be improved in terms of HIV/AIDS information and the information delivery systems. According to the responses they are currently working with home-based caregivers, who need to be trained on information

delivery systems and HIV/AIDS information. In most cases, home-based caregivers are not health professionals but individuals in the community who have opened their hearts to those who suffer.

5.5.7 Illiteracy

Much literature indicates that rural areas are characterised by a high rate of illiteracy. Uhegbu (2000:51) affirms this by saying that information is not easily accessible to many rural inhabitants due to factors such as poverty and illiteracy. Contrary to this, four (4) respondents claimed that the majority of people at Ga-Molepo area are literate. Respondents could have deduced this from the fact that fewer people come to the clinic, which to them mean that people read the posters/booklets and brochures or listen to radio where they hear about HIV/AIDS. If the majority of the people were literate, they may be visiting clinics to have face-to-face discussions with them. Pandford et.al… (2001: 1560) recommend the exploration of information dissemination methods that address audiences who are primarily listeners rather than readers and writers. Such methods include more indigenous audio-visual and inter-active communication methods.

On the issue of one observing the number of brochures and booklets that are picked up at the distribution places one has to highlight the fact that this does not translates mean that they are being read, understood and affecting their behaviour.

5.6. LANGUAGE

5.6.1 Language used to disseminate HIV/AIDS information

Ga-Molepo is predominantly Northern Sotho speaking. Clinics use Northern Sotho, which is a local language used and understood by many people in the area. In cases where materials are written in a foreign language such as English, nursing sisters in charge (nurse) translate them into Northern Sotho. This increases the chance of messages being understood.

As one respondent explained, there are instances where they have to use English. This is mainly when one has to name human genitals. Moreover, there are some words, which cannot be directly translated into Northern Sotho. For example, Madiba (2001:73) argues that when the concept HIV/AIDS was introduced to African communities in South Africa, there were no equivalents in their language simply because the notion was not familiar to them. As soon as the notion of HIV/AIDS became familiar, indigenous terms were created to refer to this concept. In Zulu, Xhosa, Venda for example the term intsholongwane, inzulaza and dwadzi /shimbamba were coined to refer to HIV/AIDS respectively (Madiba 2001:73). In Northern Sotho too, the term, kokwanahloko is used to refer to HIV but there is no term for AIDS.

5.7 STAFF DEVELOPMENT

5.7.1 Skills of staff providing HIV/AIDS information

Respondents believe that all nursing sisters in charge of clinics in rural communities of Ga-Molepo are knowledgeable about HIV/AIDS. This includes the dissemination of HIV/AIDS information, since all have tertiary qualifications and have been through HIV/AIDS workshops. In addition to HIV/AIDS information, thorough training on information dissemination and selection of information delivery systems is necessary.

5.7.2 Number of staff members involved in dissemination of HIV/AIDS information

Despite the small number of people who use clinics, the majority of respondents still complain about the shortage of staff at their respective clinics, which is confirmed even by reports. More staff could mean having one or more staff focusing on the dissemination of HIV/AIDS information.

5.8 Conclusion

This chapter presented the interpretation and discussion of the results. The results have shown some interesting results about the information delivery systems used by the clinics. The government has listed a number of such information systems deliveries to inform people about HIV/AIDS. Clinics being institutions within communities have analysed them and the

resources available as well as selecting the best information system deliveries, which in this case were the pamphlets, brochures and posters. Clinics have proved to be the best places to distribute HIV/AIDS information even though there is still a challenge for the clinics to explore the use of taxis, tribal halls and churches. The next chapter will be devoted to providing major findings of the study, recommendations and a conclusion.

CHAPTER SIX

FINDINGS, RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

The researcher has presented analysed and interpreted data in the previous chapter. This chapter will focus on presenting the summary of the research findings based them on the aim, objectives and an assumption as stated in the first chapter.

The study assumes that as much as various information delivery systems are available to clinics, rural end-users of these clinics cannot access them because of factors such as illiteracy, format, language and more. According to the responses, the researcher became aware that the information systems delivery methods used are mainly pamphlets, posters and brochures. They are provided by the Department of Health and are designed by bodies such as UNAIDS, Lovelife, and Khomanani. Some of these pamphlets and brochures when distributed to the clinics are already in African languages. For those written in English the nurses have to do translate them into African languages.

Yes, one would still say more is still to be done in terms of introducing information delivery systems that are more relevant to rural communities such as the use of traditional leaders and healers.

The aim of the study was to investigate which of the information delivery systems (communication strategies) established at government level are used by rural clinics, and

whether such information delivery systems are accessible to rural end-users. The results of the research support the conclusion by other researchers that some information delivery strategies established are not suitable for rural end-users.

The following results address the objectives as stated in chapter one.

Information delivery systems used by clinics to disseminate HIV/AIDS information.

This study found out that the clinics in rural areas of Ga-Molepo do not rely much on media as far as the dissemination of HIV/AIDS information is concerned. They depend more on pamphlets and posters that are from the Department of Health and are designed or provided by Non-Profit Organizations (NPOs) like LoveLife, Khomanani and UNAIDS.

Places clinics use to distribute HIV/AIDS information delivery systems

The majority of clinics at Ga-Molepo indicated clinics as the best place for the distribution of HIV/AIDS information resources while schools and households are also regarded as second best.

Clinics' level of satisfaction with the different information delivery systems.

The majority of the respondents indicated that they are moderately satisfied. This means that different information systems should be employed to ensure that they are suitable to rural end-users.

Clinics' satisfaction that particular information delivery system is accessible.

Clinics indicated that they use interviews, questionnaires and take clues from the number of people who volunteer to undertake voluntary counselling and testing for HIV. Moreover, they observe the rate at which condoms are taken from condo-tainers at their areas of distribution. Lastly, through informal communication at work and public places when more people talk openly and freely about HIV/AIDS.

Community members visiting clinics to seek information on HIV/AIDS.

The largest number of people who access HIV/AIDS information is twenty (20) in an area where the population is between 1 500-5 000. Factors alluded to such a low figure has to do either with ignorance, or the format in which information is contained. In addition, the fact that the majority of the people are found to be living far away from clinics and do not have the financial means to pay for transport, which in most cases, irregular.

Clinics' regard that HIV/AIDS information made available through multitudes of information delivery systems is not too much.

From responses of the respondents, one deduces that they do not experience information overload in their clinics. This could be the result of their reliance on fewer information delivery systems such as brochures and pamphlets.

How the clinics deal with language and illiteracy issues.

Contrary to this, four (4) respondents claimed that the majority of people at Ga-Molepo area are literate. This could be because they do take the pamphlets, brochures and posters provided by the clinics.

One good action taken by the clinics is that the majority translates materials written in English into Northern Sotho to ensure that end-users understand the message. Although there is still a challenge of having to name sensitive parts of the body such as genitals in Northern Sotho, there are words that sound better if they are not translated into Northern Sotho. Once translated, the words are likely to sound offensive to either religious sectors or sensitive people. As such, one has to say them in English.

Knowledge/skills nurses have in the use information delivery systems to disseminate HIV/AIDS information.

The results have shown that the respondents believe that all sisters in charge of clinics in rural communities of Ga-Molepo are knowledgeable about HIV/AIDS, and how HIV/AIDS information is disseminated. Above that, they have also attended HIV/AIDS workshops.

6.2 Major findings of the study

The study yielded the following major findings:

i. Major information delivery systems used by the clinics at Ga-Molepo are posters, booklets and brochures.
ii. The clinics are the main agencies for the distribution of HIV/AIDS information.
iii. Clinics use different evaluation mechanisms to evaluate information delivery systems.
iv. Few people visit clinics to seek information on HIV/AIDS.
v. There is no HIV/AIDS information overload resulting from the use of many information delivery systems, instead more HIV/AIDS information is needed.
vi. Clinics are flexible and translate English texts into Northern Sotho, even though they experience problems with the naming of human sexual organs.
vii. As much as the respondents have HIV/AIDS knowledge, workshops focusing on the selection of information delivery systems and end-user reaction to HIV/AIDS information are needed by the clinics.
viii. Transport remains a problem, as clinics are unable to visit communities living far away.

These findings support the assumption that rural end-users cannot access HIV/AIDS information because clinics use information delivery systems, which are not acceptable and accessible to them.

6.3 RECOMMENDATIONS FOR FURTHER STUDY

There are critical issues in the study, which warrant further research:

- A comparative study investigating whether people in rural areas and urban areas enjoy the same benefits as far as access to HIV/AIDS information is concerned.
- It is also imperative to investigate the end users' views regarding the information delivery systems they regard as suitable for them in the dissemination of HIV/AIDS information.
- There should be an in-depth study focusing on the end-users, where they would be able to give insight on why they do not visit the clinic for HIV/AIDS information and learn what they do with the brochures and booklets that they pick up. Do they read them? Do they still need more information on HIV/AIDS? Above all else, end-users are the only people who could clarify us on whether they are aware that the services rendered by clinics do not end with curing but also serves as health information centres.

6.4 CONCLUSION

A closer inspection of information delivery systems used by clinics at Ga-Molepo confirm that HIV/AIDS information does not reach all members of civil society due to the information delivery systems used for the dissemination of HIV/AIDS information. This does not necessarily reflect a lack of effort by clinics. There are quite a number of social factors, which make it difficult to carry out effective HIV prevention campaigns, especially in rural areas. People in rural areas suffer from all kinds of discrimination such as not having adequate access to health services, including HIV/AIDS information, due to the nature of the information delivery systems used, as well as the financial and geographical barriers. Therefore, making HIV/AIDS information accessible to people in rural areas remains one of the major challenges facing the present day government.

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Addendum A

University of Limpopo
Turfloop Campus

Department of Information Studies

Dear Sir/Madam

QUESTIONNAIRE ON INFORMATION DELIVERY SYSTEMS USED FOR THE DELIVERY OF HIV/AIDS INFORMATION IN THE CAPRICORN DISTRICT: LIMPOPO PROVINCE OF SOUTH AFRICA.

I am writing to seek your help in a study that I am carrying out. Specifically, I am aiming to assess the communication methods used in disseminating HIV/AIDS information to people at Ga-Molepo in Capricorn district of Limpopo Province.

You may be wondering how your name was chosen for the survey, I have selected ALL CLINICS at Ga-Molepo. The research is being carried out within my Masters programme in Information Studies at University of Limpopo, Turfloop campus.

You will see on the enclosed questionnaire that the questions are simple to answer and Interview may take us less than fifteen minutes to complete it. Your name's anonymity is guaranteed and the answers given will remain confidential.

Thank you.

Yours sincerely

……

Dikotla MA

Addendum B

A. PERSONAL INFORMATION

1. What is your position in the clinic?

Position	

2. What is your highest educational qualification?

	Qualification	Response
1	Grade 12	
2	Diploma in nursing	
3	Degree in nursing	
4	Post graduate in nursing	

B. INFORMATION AGENCY INFORMATION

3. Number of villages served by the clinic

Number of villages	

4. How long has your clinic been providing HIV/AIDS information?

Length of service	

5. Clinic's opening hours per day

	Clinic hours open per day	Response
1	4 hours	
2	8 hours	
3	24 hours	

6. What is the average number of people who seek for HIV/AIDS information from the clinic on a daily basis?

	No of people	Response
1	0	
2	05	
3	10	
4	15	
5	20	
6	25 and above	

7. How satisfied are you with the number of people who access your HIV/AIDS information?

KEY: **NS**- Not Satisfied **MS**- Moderately Satisfied **S**- Satisfied
VS- Very Satisfied **U**-Uncertain

NS	MS	S	VS

8. How satisfied are you about the skills of staff providing HIV/AIDS information?

NS	MS	S	VS

9. What is your opinion about the amount of HIV/AIDS information that is being made available?

Key: **SD**- Strongly Disagree **D**-Disagree **A**-Agree **SA**-Strongly Agree **U**-Uncertain

	HIV/AIDS information overload	**Response**				
		SD	**D**	**A**	**SA**	**U**
1	Too much HIV/AIDS information is being circulated all over					
2	People are no longer interested in HIV/AIDS information					
3	There are other organizations providing HIV/AIDS information					

C. **HIV/AIDS INFORMATION DELIVERY SYSTEMS**

10. How frequent does your clinic use the following Information delivery systems to disseminate HIV/AIDS information?

Information delivery system		**Response**		
		Always	**Sometimes**	**Never**
1	Community radio			
2	Television			
3	Videos			
4	Telephone			
5	Newspaper			
6	Magazine			
7	Traditional leaders			
8	Political leaders			
9	Workshops			
10	Community Forums			
11	Professional journals			
12	Pamphlets/booklets			
13	Road shows			
14	People living with HIV/AIDS			
15	Billboards			
16	Posters			
17	Internet/computers			
18	Drama/plays			
19	Other, please specify……			

D. **PLACE OF DISTRIBUTION**

11. Which of the following place/s does your clinic use to distribute some HIV/AIDS information resources?

	Place of distribution	Response
1	Own clinic	
2	Schools	
3	House holds	
4	Shops	
5	Taverns	
6	Tribal halls	
7	Taxi ranks	
8	Churches	
9	Private surgeries	
10	Community libraries	
11	Other, please specify……	

12. Can you comment on how successful is your clinic in disseminating HIV/AIDS information?

……

……

E. **LANGUAGE**

13 Which language/s does your clinic use to disseminate HIV/AIDS information?

		Response
1	Northern Sotho	
2	Northern Sotho and English	
3	Use English for certain N. Sotho words	

14. How do you rate the extent which illiteracy affect your service of providing HIV/AIDS information?

……

……

……

15. How does your clinic rate the effectiveness of the information delivery systems you use?

KEY: NG-Not Good **MG-**Moderately good **G-**Good **VG** –Very good **U-**Uncertain

NG	MG	G	VG	U

16. What suggestions can you make on improvements you will want to be considered in order to enhance the dissemination of HIV/AIDS information?

		Responses
1	Rely on home based caregivers	
2	Qualified staff should be provided	
3	Government should provide them with more HIV/AIDS information and train more staff who will specifically deal with HIV/AIDS information.	
4	Special transport should be provided	
5	HIV/AIDS billboards should also be considered	
6	More materials should be supplied regularly and such material should be written in Northern Sotho	

17. How satisfied are you with the way your clinic disseminates HIV/AIDS information?

NS	MS	S	VS

F. **STAFF DEVELOPMENT**

18. How many staff members are involved (including yourself) in the dissemination of HIV/AIDS information?

No of staff members	

19. Did you receive any formal training on how to disseminate HIV/AIDS information?

Yes	
No	

20. If yes, how were you trained?

……
……
……....

21. How satisfied are you with the training you received?

NS	MS	S	VS

THANK YOU FOR YOUR TIME!

Addendum C

UNIVERSITY OF LIMPOPO
ETHICS COMMITTEE

PROJECT TITLE: _____

PROJECT LEADER: _____

CONSENT FORM

I, _____ hereby voluntarily consent to participate in the following project: (*it is compulsory for the researcher to complete this field before submission to the ethics committee*)

I realise that:

1. The study deals with _____

2. The procedure or treatment envisaged may hold some risk for me that cannot be foreseen at this stage;

3. The Ethics Committee has approved that individuals may be approached to participate in the study.

4. The experimental protocol, ie. the extent, aims and methods of the research, has been explained to me;

5. The protocol sets out the risks that can be reasonably expected as well as possible discomfort for persons participating in the research, an explanation of the anticipated advantages for myself or others that are reasonably expected from the research and alternative procedures that may be to my advantage;

6. I will be informed of any new information that may become available during the research that may influence my willingness to continue my participation;

7. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research;

8. Any questions that I may have regarding the research, or related matters, will be answered by the researchers;

9. If I have any questions about, or problems regarding the study, or experience any undesirable effects, I may contact a member of the research team;
10. Participation in this research is voluntary and I can withdraw my participation at any stage;

11. If any medical problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor;

12. I indemnify the University of Limpopo and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

_____ _____

SIGNATURE OF RESEARCHED PERSON SIGNATURE OF WITNESS

SIGNATURE OF PERSON THAT INFORMED THE RESEARCHED PERSON

SIGNATURE OF PARENT/GUARDIAN

Signed at _____this ____day of _____2006