



Research Analysis of the Community in Rendering HIV/AIDS Care

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ABSTRACT

AIDS prevention largely depends on health education and behavioural changes based on AIDS awareness. Ignorance of the disease and of the mode of transmission of the virus can generate fear and prejudice against those who are infected and those who are providing care to the patients living with HIV/AIDS. There is a need to facilitate the initiation and the strengthening of home based care in HIV/AIDS and to empower the community preparedness against the disease. Objectives to identify the leadership structure in the families and community to assess the preparedness of the community for rendering care when the need arises. This study was a cross sectional study design, conducted in the coverage limits of primary health centre, Venkatachalam, Nellore Taluk, Nellore District, among 1332 samples. It was concluded only 30% of the study population knew that HIV is a virus. In the study population, only 44% knew that there is no complete cure for HIV/AIDS. It was observed from the focus group discussion that the groups were aware regarding the basic modes of transmission but still many misconceptions with regard to modes of transmission was still prevailing.

KEYWORDS :

Introduction:

One of the important facts concerning home based care of HIV affected individuals is the stigma attached to the condition. This is of utmost concern because it is both the cause and effect of secrecy and denial, which are both reasons for HIV transmission. This stigma still remains a formidable barrier to testing even where treatment is available. So, by assessing the prevailing knowledge with respect to the misconception of HIV/AIDS in the community, we can delineate the role of the community, the need to take effective control of the situation.

The present study attempts to assess the status in order to facilitate the initiation and the strengthening of home based care in HIV/AIDS and to empower the community preparedness against the disease.

Objectives:

- To assess perceptions regarding HIV/AIDS among the people aged more than 13 years of age
- To identify the leadership structure in the families and community to assess the preparedness of the community for rendering care when the need arises.

Review of Literature:

USAID publication (2003) "Leadership at the Community level for improved access to care, support and treatment" has identified 2 basic things in mobilising resources to support community empowerment for improved access to care, support and treatment. They are (a) availability of resources and (b) skills. Following are the identified list of main groups of list of resources:- human resources, material goods, free service and facilities, technical assistance, money, contacting NGOs /local governments and submitting proposals, asking for donations, running a small business, running fund raising events and advocating for public resources to be made available. It is considered essential to bridge the gap between prevention, care, support and treatment.

Xiaodong Tan et al (2007) in his Study on "HIV/AIDS Knowledge, Attitudes and Behaviors Assessment of Chinese Students" had the objective to assess students' knowledge, attitudes and practices on HIV and AIDS. Study results indicated that the ma-

jority of Undergraduates had a moderate level of HIV and AIDS knowledge, acceptance and attitudes towards people with HIV and AIDS. Boys had more acceptance and positive attitudes towards people with HIV and AIDS than girls. A peer educational program to talk about self-esteem, healthy sexual attitudes, being human-accepting and loving should be developed in the near future.

Mercy Nahmo (2009) conducted a study on obstacles to local level HIV competence in rural Zimbabwe; putting HIV prevention in context. Objective was to highlight how pre-existing social dynamics may have influenced community "readiness" to derive optimal benefit from the intervention, using the concept of "the AIDS competent community". Methodology: We analysed 44 interviews and 11 focus groups with local people. Results and Discussion: Despite high levels of HIV/AIDS-related knowledge, there were several ways gender, poverty and low literacy may have undermined its perceived relevance to peoples' lives. There were many potential community strengths and resources. There were high levels of HIV/AIDS-related knowledge. Public denial of HIV/AIDS masked huge reservoirs of private support and kindness to AIDS-affected family and friends. There were many strong community organisations and clubs, potentially forming the springboard for more empowered community responses to HIV/AIDS. It was concluded that HIV/AIDS programmers should pay greater attention to community readiness for interventions, especially around: (1) identifying and anticipating pre-existing obstacles to programme success and (2) mobilising the social assets that exist, even in contexts of poverty and gender inequality.

Methodology:

This study was a cross sectional study design, conducted in the coverage limits of primary health centre, Venkatachalam, Nellore Taluk, Nellore District. The Venkatachalam Primary Health Centre (PHC) caters to a population of approximately 21,372, people living in 36 villages. A total of 1332 samples were selected using cluster sampling technique.

Inclusion criteria: People aged more than 13 years.

Exclusion criteria: People who were not willing to participate in the study were excluded from this study.

Study Instrument:

To assess the preparedness of the community to assume the responsibility for care, focus group discussions were held with community members listed below.

1. Formal and informal Panchayat members – 1 FGD
2. Teachers of schools and colleges - 1 FGD
3. Youth groups – 1 FGDs
4. PHC staffs – 1FGD
5. Anganwadi workers – 1 FGD

Core questions for FGDs for all groups

- What is HIV
- What is AIDS
- How does it spread
- List activities/efforts in your village in place for prevention and control of HIV/AIDS since the last 1 year/10 years
- Supposing more cases of HIV/AIDS occur, how much is community/panchayat/government are ready to face.

A facilitator among the group was provided with a check list to facilitate the group discussion The facilitator was putting down a statement at a time and the members were encouraged to discuss the statement. The investigator was observing the process and noted the points that emerged which were pertinent to the statement proposed by the facilitator. The handouts which was given to the participants and explained by the investigator helped in clarifying the doubts raised by the participants.

Statistical analysis:

Chi-square test is used to test the significance difference be-

Distribution of the study population by education and age group

Table 4

EDUCATION	AGE GROUP					TOTAL
	13-23	24-33	34-43	44-53	>53	
Not literate	34(9.09%)	116(25.1%)	98(29.3%)	59(17.6%)	28(8.4%)	335(25.1%)
Primary	12(3.20%)	27(5.82%)	18(20.2%)	10(11.2%)	22(24.7%)	89(6.6%)
Secondary	29(7.75%)	66(14.28%)	35(22.3%)	22(14%)	5(3.2%)	157(11.7%)
Higher secondary	162(43.3%)	173(37.4%)	96(20.4%)	21(4.5%)	18(3.8%)	470(35.2%)
PUC	92(24.59%)	46(9.95%)	24(14%)	6(3.5%)	3(2%)	171(12.8%)
Graduate	40(10.69%)	29(6.27%)	18(18.4%)	10(10%)	1(1%)	98(7.35%)
Post graduate	5(1.33%)	5(1.08%)	1(8.3%)	1(8.3%)	0	12(0.90%)
TOTAL	374(100%)	462(100%)	290(100. %)	129(100%)	77(100%)	1332(100%)

Numbers in parenthesis denote column percentage

It was observed that majority 470(35.28%) had education upto higher secondary level. Post graduates constituted 12(0.90%) of the study population. In the age group 13-23, 162(43.31%) were educated upto higher secondary and only 5(1.3%) were post graduates. In the age group of 24-33, 173(37.44%) were educated upto higher secondary and only 5(1.08%) were post graduates. In the age group of 34-43, 98 out of 290 i.e. (33.79%) were not literate and only 1(0.34%) were post graduates. In the age group of 44-53, 59(45.73%) were not literate and only 1(0.77%) were post graduates. In the age group >53, 28(36.36%) were not literates and 4(1.2%) were graduates. In the present study 335 of 1332(25%) were not literate. In the present study 470(35.28%) had studied upto higher secondary.

Perceptions regarding HIV-AIDS among the study population

Table 6

Variables	Yes	No	Do not know
1) HIV is a virus	379(29.4%)	363(27.25%)	590(44.3%)

tween the knowledge with respect to sex, marital status, literacy and occupation.

Results and Discussion:

Age and Sex Distribution of the study population

Table1

Age group	SEX		Total
	Male	Female	
13-23	204(23.77%)	170(35.86%)	374(28.07%)
24-33	286(33.33%)	176(37.13%)	462(34.68%)
34-43	199(23.19%)	90(18.98%)	290(21.77%)
44-53	98(11.42%)	32(6.75%)	129(9.68%)
>53	71(8.27%)	6(1.26%)	77(5.78%)
Total	858(100%)	474(100%)	1332(100%)

Numbers in parenthesis denote column percentage It was observed that majority 462 (34.68%) of the subjects in the study population were in the age group of 24-33 years and the proportion of males and females in the same age group was observed to be 286(33.3%) and 176(37.13%) respectively. The least i.e., 5.7% of subjects were observed to be those aged 53 years and above. Consistent decrease in the number of females over the age of 34 years in the study population was due to lack of willingness to participate in the study

2) Are the words HIV and AIDS one and the same	544(40.8%)	201(15.1%)	587(44%)
3) How a HIV person is diagnosed	647(48.5%)	186(14%)	499(37.4%)
4) Is there complete cure	174(13%)	588(44.2%)	570(42.8%)
5) Is treatment available to prolong life	735(55.2%)	55(4.1%)	542(40.7%)
6) If you need HIV test, do you know where to go	643(48.2%)	7(0.5%)	682(51.2%)
7)If you need HIV treatment, do you know where to go	622(46.7%)	8(0.6%)	703(52.8%)
8) Do you fear your child becoming infected with HIV if he/she plays with a child with HIV	191(14.3%)	645(48.4%)	497(37.3%)

9) Do you buy vegetables from a shop keeper living with HIV/AIDS	630(47.3%)	238(17.9%)	464(34.8%)
10) Should a child living with HIV be able to attend school	618(46.4%)	243(18.2%)	472(35.4%)
11) Would you be embarrassed to be seen in public with a friend who is known to have HIV/AIDS	185(13.9%)	688(51.6%)	460(34.5%)

N=1332 Numbers in parenthesis denote percentage of N

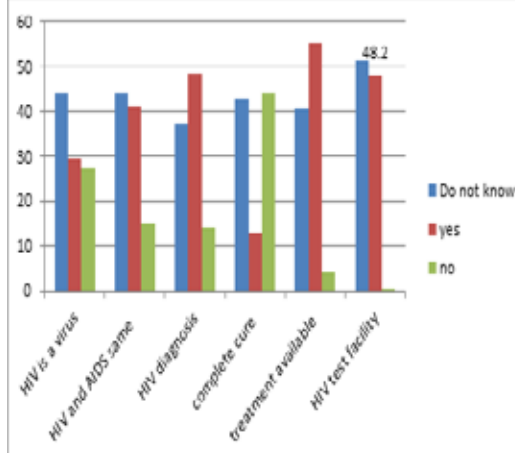


Fig: 1 Prevalence of perception on HIV/AIDS

Sudha et.al (2005) had observed in her study that the awareness of HIV/AIDS were sketchy and had incorrect perception about the mode of transmission and prevention. W.AI Serourietal (2000) had observed that despite a majority of study population being aware of the major modes of transmission there were large areas of misconception that would impede the management of the situation.

It is seen that in the present study, the misconceptions other than the modes of transmission varied from 40.8% for saying both HIV and AIDS are one and the same to 27.25% for saying that HIV is not a virus but the most striking thing here is majority of them had neither correct response nor the misconception.

Focus Group Discussion:

All the groups participated in focus group discussion, were willing to address their communities through staging drama and role plays to eliminate wrong beliefs related to HIV/AIDS. Further they volunteered to promote the use of condoms in their community. They strongly felt that the testing for HIV should be made compulsory for all those intending to marry. They felt an urgent need to screen all antenatal mothers for HIV and strongly felt that it should be a routine testing.

Panchayat members, teachers, anganwadi workers and youth groups were ready to address the commercial sex workers and help them to change their behaviour. They even volunteered to get them some other occupation for their livelihood. Thus it was inferred from focus group discussion that the community is willing to provide care and support for HIV affected individuals either in their own homes or any other community based initiatives. Only one group was prejudiced and said that they would rather keep HIV/AIDS affected individuals separately a kilometre away from the village.

It was perceived that it was possible to build up on these strengths in the community and at the same time take appropriate measures to address the prevailing misconceptions in order to improve the care and support initiatives.

Conclusion:

It was concluded that the neighbourhood groups, village groups, self help and women's group are likely vehicles for the effective spread of knowledge in the community. From the fo-

cus group discussion it was observed that there is a positive attitude among the study subjects in providing care and support to the individuals affected with HIV/AIDS.

The study has brought into light some of the important issues and immense and urgent efforts are needed towards making people more caring and accepting the People Living with HIV/AIDS, which can be mainly achieved through raising the levels of knowledge about HIV and its ways of transmission.

Recommendations:

A lot of misconceptions are prevailing in the community with respect to HIV/AIDS. So with these prevailing misconceptions the home based care will be inappropriate at this stage in the community. So, it has to be addressed by conducting a need based, targeted, and focused Information, Education and Communication activities in the villages as a priority primary measure.

The local groups in the community like Teachers of the schools and colleges, youth groups and the Anganwadi teachers etc. should be first educated regarding these misconceptions and later they can be involved in conducting Information, Education and Communication (IEC) activities to the community.

Limitations:

The Restriction in asking questions concerning sexual beliefs and behaviours as was observed in the pilot study, made me to slightly change the questionnaire.

Because of the nature of the questionnaire, the honesty of individual's responses may be questioned.

Acknowledgement:

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