

Knowledge, Attitudes and Practices Regarding HIV and AIDS among University Employees

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Abstract: HIV and AIDS have caused serious impacts on sustainable development in all sectors of the economy including higher education. The need to assess risk in higher education in Africa is lacking. This piece of work adds on to existing knowledge on HIV and AIDS among higher education institutions on knowledge, attitudes and practices regarding the epidemic. An HIV and AIDS Knowledge, Attitudes and Practices analysis was conducted among university employees. Data was collected using 100 questionnaires and 12 in-depth interviews from both academic and non academic staff and descriptive statistics were used to analyse data from questionnaires and thematic content analysis was carried out to analyse interviews. The results show that there are high knowledge levels above 80% of HIV and AIDS, STIs among both academic and non-academic staff of all age groups and there is no significant difference between age groups and job categories. Reported attitudes show low risk attitudes. This however does not require that universities should not implement comprehensive HIV and AIDS programmes because the impact of the epidemic can not be ignored.

Keywords: HIV, AIDS, knowledge, attitudes, practices, university employees.

I. INTRODUCTION

HIV and AIDS are placing enormous challenges on the higher education sector by weakening demand and access to education, depleting financial and human resources and weakening the quality of service delivery (UNESCO, 2006). Kelly (2005) found an overwhelming silence at institutional and individual levels regarding HIV and AIDS, a lack of information and hard data and an imperfect knowledge of disease and its impact on institutions of higher learning. The University of Zimbabwe was created in 1957 to provide education, training and advisory services to the nation. It has 10 faculties located in the northern suburb of Mount Pleasant. Its mission statement is to enable its clients and clients and customers to make meaningful contributions to sustainable development in Zimbabwe through the provision of quality education, training and advisory services on a needs oriented basis. Although no research has been conducted to assess the impact of HIV and AIDS on the University of Zimbabwe, the impacts of the epidemic can not be ignored. Both academic and non-academic staff and students are affected by HIV and AIDS leading to losses of trained/skilled, competent personnel especially those who would have served the university for a long time. Their skills which are an integral part of the development of the institution are thus lost. During the primary HIV infection period, affected members of staff and students tend to be off-sick, on and off, for several month and their performance while at work or in their studies is grossly compromised by the illness. Without supportive services their condition deteriorates and their productivity becomes minimal. Usually the affected individuals are breadwinners hence the implication on their families makes it even more difficult for them to work competently and eventually they succumb to HIV and AIDS at the terminal stage and go off work/studies permanently until their death.

The aim of this study was to assess and describe the HIV and AIDS knowledge, attitudes and practices of employees at University of Zimbabwe. The objectives were:

- To measure the overall knowledge levels as well as attitudes and sexual practices of university employees on HIV and STIs.
- To measure risky sexual behaviours of university employees.
- To give recommendations on HIV and AIDS programming in higher education

II. RESEARCH METHODOLOGY

The Health Belief Model was used as a conceptual framework to investigate knowledge, attitudes and practices regarding HIV and AIDS among university employees. This model holds that health behaviour derives from an individual's socio-demographic characteristics, knowledge and attitudes and identifies six beliefs for a person to have in order to change behaviour: (Kalichman, 1998). A mixed research design involving quantitative data and qualitative data was used in this study. A mixed research design was selected to triangulate data collection instruments and test the consistency of findings obtained through questionnaires by using interviews. The use of interviews also ensured richness and detail on knowledge, attitudes and practices regarding HIV and AIDS among university of Zimbabwe employees through probing issues that were not well covered in questionnaires. The study population consisted of men and women employed at the University of Zimbabwe both teaching and non-teaching staff. The age groups were 18-65 with varying education levels, gender and marital/ relationship status. There was no restriction placed on ethnicity or racial background nor was data collected on these variables. The size of the target population was 3000 employees. One hundred employees were targeted for the study. Participants were approached by the researcher and requested to participate in the study during lunch.

Data for this research was collected using questionnaires and interviews. The questionnaire consisted of closed-form questions and a few descriptive, explanatory type questions. The questionnaire explored background characteristics (independent variables) which include age, sex, job grade, employment duration with company and marital status. The dependent variables included knowledge, attitudes and sexual practices relating to HIV and AIDS. Questions regarding the effectiveness of the workplace health education programme were also included. The self administered questionnaire designed by the researcher was based on and adapted from the ACCA Toolbox (GTZ, 2004). The study questionnaire consists of one hundred and twenty-four (124) questions.

Interviews were used to follow-up to areas that were not clearly covered by questionnaires. Field notes were taken during interviewing and where necessary direct quotations were made.

The instrument used is a questionnaire to measure the knowledge, attitudes and practices of a specific workforce. Content validity determines whether the instrument used really measures the concepts we expect it to measure. (De Vos, et al. 2002) The questionnaire used for this survey explored specific questions to measure the dependent variables in order to get certain quantitative data. De Vos describes content validity as a judgmental process whereby colleagues establish the validity of the content. As face validity refers to what the instrument appears to measure, (De Vos, et al. 2002) the questionnaire measured what was assumed however to enable further analysis of data, it might have been advisable to use a combined quantitative qualitative methodology combining the questionnaire with an interview. Because such personal and sensitive information is required from the respondents, it is possible that some respondents omitted to answer questions that they might have found to be private. Reliability describes "degree of consistency or agreement between two independently derived set of scores; and as the extent to which independent administrations of the same instrument yield the same (or similar results) under comparable conditions." (De Vos, 2003:168). Data from questionnaires was analysed using Statistical Package for Social Sciences (SPSS) descriptive statistics. Interviews were analysed using content analysis.

III. RESULTS

This chapter discusses the demographic data that include age, job grade and employment duration with company. The main findings of the survey will be reported in the form of descriptive and multiple comparative statistics; identifying significant differences between groups on knowledge, attitudes and behaviour / practices of respondents.

General Knowledge:

This index measures the number of correct responses on general HIV and AIDS knowledge questions. The following data provides a breakdown of the responses based on the different questions asked.

- 81% have said that most people who have HIV and AIDS do not show signs immediately.
- 90% believe that there is not a cure for HIV and AIDS.
- 93% believe that traditional healers cannot cure HIV and AIDS.
- 96% believe that having sex with a virgin does not cure HIV and AIDS.
- 40% believe that you cannot be re-infected with HIV and AIDS if you are already HIV+. The correct response to this particular question have ranged from 30% (56-65 age group) to well above 80% correct responses for all the other age groups. It is concerning that the general knowledge on re-infection among all responses is so low.

Knowledge of Transmission and Prevention:

This measure deals with the number of correct responses on questions dealing with transmission and prevention on HIV and AIDS. The majority of participants, between 74% and 80%, correctly indicated that one HIV from (1) a mosquito bite, (2) eating food prepared by an HIV+ person, (3) sharing toilet facilities with an HIV + person, or (4) sharing kitchen utensils with an HIV+ person. A small minority, between 1.3 and 5%, incorrectly indicated that one can acquire HIV from the above mentioned interactions, and between 13% and 18% of participants were unsure about the transmission risks associated with these interactions.

Knowledge of STI:

The mean of knowledge of STI and age is 2.6 out of 3 calculating an average of 87% knowledge level. All the age groups have an above 80% knowledge level except for the 56-65 age groups that has a 55% knowledge level. However, as mentioned previously, this age group could have been implicated negatively by the low number of participants.

Eighty-five percent of the respondents indicated that they get most of their information about STI and prevention from magazines/newspapers, 10% health clinic and 5% did not respond to this question. None indicated that they get information on STIs from the workplace.

Knowledge of ART:

80.3% believe that ART does not cure AIDS and 15% know how to access ART

Attitudes:

The questions on attitudes focused on attitudes towards co-worker and acquaintances with HIV and AIDS (stigma). These questions explored whether participants knew anyone who are infected with the virus, whether there are aspects for blame, attitudes towards life-expectancy of persons living with HIV and AIDS, risk of family to be exposed to HIV infection, attitudes toward company sponsored programmes, beliefs on disclosing HIV status, care and support for people living with HIV and AIDS, and attitudes toward the effects of the pandemic on the individual, the family, the community and the company (workplace). The stigmatization index reports on the stigmatization level of the respondents.

The general attitude of HIV and AIDS of the sample indicates attitudes that are more positive. The negative attitudes reported are minimal; only two respondents (1.9%) reported that people who are HIV positive disgust them.

- 6% of respondents indicated that people with the virus should be isolated.
- All the other responses are positive including that HIV positive people must be supported, that they are considered to be normal. (See table 22).
- 23% indicated that they feel sorry for an HIV positive person.
- 23% said they feel they are at risk working with someone who is HIV positive mainly when providing first aid or when injured, the risk of getting infected through blood.

All respondents (100%) noted that people with HIV should be cared for and not isolated but treated like other people with any other chronic illness. However, 64% would take care of someone dying of AIDS.

Sexual Practices:

Questions on sexual practice explored the sexual behaviours of participants, how often they had sex, the age when they first had sex, HIV testing, number of sexual partners, faithfulness of sexual partners, possible sexual risky behaviours (sex worker/prostitutes), condom use, alcohol use and sexual behaviour, homosexual sex, oral sex, anal sex, and STIs. The aim of these questions was to assess a baseline of sexual practices and to compare knowledge and attitudes with self-reported sexual practices. As attitudes toward condom-use are an important factor of sexual practice, it will be discussed as part of sexual practices.

As indicated before attitudes toward condom-use is closely link with sexual practices thus reported under this section instead of under attitudes.

- The youngest age of having had sex was 14,
- 55% had sex before the age of 18.
- 95 % have had sex, which is to be expected in an adult working environment.
- 32% have gone for a HIV test.

Attitudes towards Condom Use:

- 23% believed that people who use condoms have sex often/too much
- 88% believed that condoms can protect them from HIV and AIDS
- 21% believed that condoms tear easily
- 67% felt that when they use condoms they do not have fun.

Risk Behaviour:

- 5% indicated that one cannot get HIV and AIDS from having many sexual partners.
- 16% have received treatment for STI's
- 8% believes that there is a cure for HIV and AIDS
- 8% reported that one cannot get HIV after a single sexual intercourse.

IV. DISCUSSION

This research add on to existing knowledge on HIV and AIDS risk assessment in higher education workplaces given that there is data on HIV and AIDS among higher education employees is scarce. It provides data on knowledge, attitudes, beliefs and practices among university employees. Data obtained from this research is consistent with findings from other studies which showed that there is a general awareness of HIV and AIDS in Zimbabwe. Reports on sexual behaviour show normal adult sexual behaviour although there is a general feeling that the use of condoms reduces sexual pleasure which may reduce the likelihood of condom use and increase unprotected sex.

V. CONCLUSION

The results show that there are high knowledge levels above 80% of HIV and AIDS, STIs among both academic and non-academic staff of all age groups and there is no significant difference between age groups and job categories. Reported attitudes show low risk attitudes. This however does not require that universities should not implement comprehensive HIV and AIDS programmes because the impact of the epidemic can not be ignored.

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