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EXPLORING COMMUNITY-BASED HIV/AIDS AWARENESS CREATION AMONG THE GUSII PEOPLE OF KENYA

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Abstract

The study purposed to investigate the exploring community-based HIV/AIDS awareness creation among the Gusii people of Kenya. The study used a case study design. The target population was 300,000 people affected and infected by HIV and AIDS epidemic within Kisii Municipality. From an accessible population of 500 people, a sample size of 239 was purposively selected, out of which 128 PLWHAS were support group members, whereas 74 were not, and 25 were family caregivers. Data were collected using questionnaires. The reliability of the instruments was confirmed. The questionnaires yielded a reliability coefficient of 0.7 15. SPSS version 12.5 for windows) was used to analyse data. The t-tests were employed to establish whether there were any differences between support group attendances, gender and stress levels of PLW AS. On the other hand, the Chi-square test was employed to establish whether there was any association between Mwanyagetinge Community-Based Care and awareness and prevention of HIV/A DS. The study established that the Mwanyagetinge community-based care programme had significantly contributed to raising their level of awareness and mobilising PLWHAS to be agents of prevention rather than spread. With the adverse effects of HIV in our society and schools, counselling curricula in the universities should include an in-depth and mandatory study on the PLWHAS.

Key terms: Impact, community-based care, Mwanyagetinge, raising awareness.

1.0 INTRODUCTION

HIV/AIDS is a silent epidemic spreading all over the world rapidly, posing a major threat to human y. However, the life of an infected person can be prolonged through positive living, which implies counselling, provision of care, support and nutrition (Tuju, 1996). The cure or vaccine against this viral disease is yet to be found, but antiretroviral (ARVS) slow down HIV replication to the point that the viral load in the blood is reduced to undetectable levels (UNAIDS, 2008). UNAIDS (2006) conducted a study and found that a combination of therapy with three drugs reduces the risk of death by 85per cent and declines the trends in incidences of opportunistic disease s. The rate of death of persons living with HIV/AIDS (PLWHAS) has been reduced in developed countries where ARVS are readily available. However, the case is different in developing country s. The situation in developing countries is the pressing need to provide treatment essential to alleviate suffering and mitigate the devastating effect of HIV/AIDS (UNAIDS, 2006). The transmission in expectant mothers in developing countries can be reduced by ART to 50per cent.

UNAIDS (2006) study update indicates that 4.8 million got infected with HIV in 2003, which has no comparison to the previous years. O'Leavy (2002) estimates that by the year 2002, AIDS had claimed 13.9 million lives worldwide, with 16,000 new infections occurring daily. It is estimated that 37.8 million people are living with HIV/AIDS virus in the world, 25 million of them are Africans, and 20 million of those infected have already passed away since the first case was discovered in 1981.

People who are infected with HIV/AIDS are discriminated against in society. They are labelled by society as immoral and deserving of their predicament. They undergo self-blame, humiliation and social discrimination, which greatly affect their stress levels, and affect them psychologically y. Many hospital wards are congested and unaffordable to many poor PLW S. HIV/AIDS is a terminal illness that compromises the immunity of an infected person and requires a long period of management of opportunistic infections, which is done either in the community, at home or in hospital. Irrational thinking results in inappropriate emotions and ineffective behaviours, resulting in dysfunction in families. People with HIV often suffer severe bouts of depression and, later in the illness, can experience many cognitive problems due to the viruses in the brain. This can not only lead to feelings of being scatter-brained but can also cause a significant amount of anxiety as the cognition become more noticeable. According to HIV/AIDS strategic plan 2003 – 2007, Kisii municipality showed a stable but high prevalence of HIV/AIDS; hence about one person in every five is infected or affected by the disease. Community-based care approach has emerged as a holistic and collaborative effort by the hospital, the family and the home of the patients to enhance the quality of life of PLW S. This approach involves those infected and affected by HIV/AIDS and encompasses social support, counselling and nursing care (NASCOP, 2002). The PLWHAS are encouraged to learn and discuss HIV/AIDS openly, dispel myths about its transmission, and reduce stigma and bullied stress levels of clients by mobilising the family and community y. The study focused on investigating the impact of Mwanyagetinge community-based care on raising awareness levels and preventing the spread of HIV/AIDS in Kisii municipality.

2.0 LITERATURE REVIEW

The health sector is affected by an increased burden of caring for those who are infected by HIV/A DS. The percentage of resources allocated to HIV/AIDS is high (30 per cent) compared to other diseases like

malaria (15 per cent) (NASCOP, 2002). The bed occupancy is also high (20per cent) in government hospitals (UNAIDS, 2004). The health sector is also responsible for delivering effective services and implementing many prevention programmes such as STIs control, condom promotion and distribution and health education. Primary prevention is important in helping those not infected, while secondary prevention is geared towards helping those already infected (Jackson, 2002).

Efforts designed to reduce new infections, mainly through prevention, awareness campaigns and VCT services, should be intensified. Taking the test is a very important outcome of awareness and prevention campaigns; therefore, the significant place that these campaigns (should) occupy in the war against AIDS. VCT services have gained prominence worldwide as a keystone for all anti-AIDS activities. Great benefits accrue from early diagnosis of HIV status since those affected can promptly start taking life-prolonging ARVs and adopting other steps to improve their lives; for the government, VCT data are invaluable; they form a backbone for planning and spending on healthcare and economic and social support for those affected. Most targeted AIDS interventions should be centered on the outcomes of correct data on the diagnosis of individuals in Kenya. Even awareness campaigns should be anchored on data from VCT services.

Policies and interventions that gravitate around and are informed by VCT services, however, may not be sustainable owing to the low number of people willing to be tested for HP//A DS. Therefore, there is a need to promote testing by creating appropriate incentive mechanisms, and this means incentives being put in place to encourage obstinate people to know their HIV status. Primarily, the choice to take the test will depend on the implications of the results of the test and the incentives available to the individual.

The concept of “abstinence” can be understood in two senses. In one sense, it is used in the pre-marital context where it would entail abstinence from all pre-marital sex. In the second sense, it is used in the marital context where it would be enjoined upon both the spouses to abstain from all extra-marital sex and remain faithful to one another all their lives. Abstinence from sexual relations in order to achieve a satisfactory minimisation of the HIV infection rate in our modem societies is a common contemporary prescript. It should be noted that “abstinence from sexual activity” is not necessarily a religious prescription for the control of HIV infection ns. Yes, it is true that abstinence has been recommended by various religious institutions, but it does not imply that it is basically a religious strategy. Abstinence is simply a reasonable strategy from a moral, cultural, philosophical, social as well as religious point of view. There is nothing morally wrong with “abstinence from sexual relations” in the war against A DS. There are practical difficulties founded on seemingly valid grounds that indicate that abstinence as the solution for permanently bridling the menace of HIV/AIDS may not be quite workable. One of the difficulties is that the advocates of “abstinence” simply contend that humans should abstain from sexual relations to avoid contracting HIV/ADS. In other words, only sexless relationships should prevail in society.

The advocates do not clarify the following contentious issues:

- Is abstinence from sex to be exercised indefinitely?
- If not, for how long shall we abstain?

- Should we abstain for one month or thirty to fifty years after which the awaited medical cure will be achieved?
- With no clear vision of when the medical cure would be possible, how do we expect humans to abstain indefinitely?
- To what extent would prolonged abstinence affect procreation and the African population, for example?
- Is it the youths only that should abstain, or every man and woman?
- Is abstinence a desirable condition for all times, or is it only recommended during our current war against H1V/A DS? Supposing a permanent cure is found tomorrow, shall we then stop advocating for abstinence?
- How would an externally imposed precept of abstinence work vis-à-vis the individual's existential freedom that I commented on in an earlier chapter?
- Another problem with abstinence is that it is not (100%) successful. Its (100%) success is dependent on its (100%) successful application.

If we prescribe abstinence to our teenagers and others not yet married, then we shall have to assume that each one of them will practice it every single day of his or her life until he or she gets married. But as is evident from the workings of human nature, not all human beings are 100% perfect. What if even (1%) of followers of abstinence stumbled just once in their pre-marital lies? What if some of the (100%) perfect also "backslid" just once? That "just once" episode would be enough to wipe out most of the fruits of years of abstinence by (99%) of others. And we do hear all the time of the occasional "backsliding" of serious "believers", don't we? Then, in the marital context, the concept of abstinence works on equally tricky rounds. Here we are talking of two individuals, each with his or her own distinctive personality and existential freedom. And we are expecting that *each* of the two individuals should practice abstinence throughout their whole life. In the marital context of the current HIV regime, even the time-honoured religious doctrines of individualism and divine punishment would need a radical re-interpretation. Take, for example, the following quoted biblical text from Ezekiel: "The soul who sins shall die, the son shall not bear the guilt of the father, nor the father bears the guilt of the son. The righteousness of the righteous man shall be upon him, and the wickedness of the wicked shall be upon him". [Ezekiel 18:20]

Now let us look at the above text in the light of the following case of today. Here is a married couple. One of the spouses is "righteous" and abstains from all extra-marital sex and remains absolutely faithful to his or her partner. The partner is "wick d". He or she engages in extra-marital sex and contracts HIV. The infected "wicked" spouse infects the uninfected "righteous" spouse. Both the wicked and the righteous perish together in AIDS; their children bear the "wickedness" of their late parents and also die eventually, even though the children themselves were innocent and among their parents, only one was "wicked." We may extend this case study to include another married couple where both the spouses were equally righteous and faithful to one another. One of them stumbled just once, after which he or she duly repented and was restored to his or her father. But unfortunately, this innocent partner contracted HIV in that "just once" episode and infected the other partner. This story would also end in the same tragic way as that in the first case on the first day. So, as we can see, the 100% success of the precept of abstinence is dependent on so many variables. However, my purpose in raising the above issues was not to preach

against abstinence; I was merely thinking aloud about some of the practical difficulties associated with the concept of abstinence. Indeed, our war against the AIDS pandemic is quite a serious one. We need to consider every available strategy and subject it to rigorous scrutiny with the view to making it more effective and work le. The situation on the ground is already more than appalling.

As of the year 2000, the UNAIDS/WHO estimated that (80%) of children living with HIV in the world are Africans (Gayle, & Hill, 2001). Apparently, these children were infected by their own parents. This would imply that parents who are not yet HIV positive should abstain from sexual relations in order to remain safe. The problem of street children in our metropolises has not been solved, and now we have a distinct category of children known as AIDS orphans. How did this latter category become orphans? They did because their parents died of AIDS. Do we see how spouses and parents have wreaked enormous havoc in our modern societies through HIV infection? Parents die from AIDS in large numbers, abandoning children to a bleak future. Unless African governments and charitable institutions intervene to help them become a useful member of society, these children face the horrible future of becoming HIV carriers. Such a ghastly scenario inspires us to keep the option of abstinence open in our war against AIDS. Instead of prescribing it blindly out of religious zeal, we should critically assess its possible failure rate and make it more workable.

Using a condom to prevent the threatening pandemic is another much preached-albeit controversial-strategy. It is noteworthy that the condom was originally introduced as a contraceptive measure and not as prevention against HIV/ A DS. Of course, when the condom was introduced over 50 years ago, there was no HIV/AIDS t en. Eventuality the condom came to be regarded as a preventive device against STDs. Now, in our times, the condom has started donning a third hat, that of a much-touted preventive device against HIV/AIDS.

Right from its introduction, the poor have had to fight a grand battle mainly on two fronts. On the one front, there are those (especially in Africa) who do not like condom use on personal grounds based on their own individual freedom. In other words, such men and women reject condom use simply because it becomes a barrier to the natural sexual pleasure commonly known as '*nyama kwa nyama'* (flesh to flesh h). For such a group of people (and they could number in tens of millions across Africa), the free availability of the condom is useless since they would not use it anyway. Many African governments have ensured that condoms are issued to people free of charge in public clinics and hospitals. Yet HIV infections are increasing, other STDs are rampant, and many people want abortion to be legalised. Thus, there is evidence that most adults are unwilling to submit, perhaps consistently, to the use of condoms.

So, the campaign for the free availability of condoms will need to be accompanied by an equally (perhaps more) zealous campaign to exhort people *to use condoms, for heaven's sake!*

On the other front, there are those who reject condom use on religious and moral grounds. Opposition to condom use on religious grounds comes mainly because of its originally intended contraceptive purpose. The teachings of certain religions enjoin upon their followers to desist from any form of birth control by artificial means, such as condom- use. This would mean that if our super-scientists could come up with a

super-condom that could give (100%) protection against HIV/AIDS but not interfere with the conception of new babies, then it seems likely that many religious opponents to condom-use might hold their horses!

The opposition to condom use on moral grounds comes from those who argue that if we recommend condom use to people, and say nothing about the moral wrongs of engaging in pre-marital and extra-marital sex, then we are merely encouraging them to continue having pre-marital and extra-marital sex so long as it remains "safe-sex." Thus, the opponents argue that the recommendation of condom use would become a gateway to immoral licence. This view may be illustrated by a large amount of public opinion published frequently. For instance, a letter to the editor of a Kenyan Daily was published by Dr Stephen K. Karanja (Karanja, 2001). In his letter entitled "Why Dishing Condoms Is Not the Ultimate Solution", Dr Karanja posts that "whoever engages in irresponsible sex must be ready to pay the physical, emotional and spiritual consequences. These include multiple venereal diseases, including AIDS" (Karanja, 2001). He points out that dishing out condoms is not the ultimate remedy for safe sex. Besides, he underscores the fact that condoms do fail to protect, and anyone using it must take other precautionary measures such as checking their expiry date and ensuring that it was stored under the required conditions. He maintains that condoms may fail as a result of "breakage, spillage, porosity, slippage, poor storage and transportation, use of oil-based lubricants, improper usage, bursting and low-quality [production]" (Karanja, 2001).

Apart from the opponents of condom use on personal grounds and those on religion-moral grounds, there may be a third group of condom-bashers. This third group may overlap with the first two. In other words, it may consist of those who despise condom- use on personal grounds but give their spite a moral and religious camouflage. Members of this third overlapping group may also number in millions. While condom use cannot certainly be recommended as an all-time, all-successful strategy to combat HIV/AIDS, those who categorically oppose it are not without their own problems. There are those who reject it on personal grounds—simply because they do not like it. These people have a serious problem, as they tend to defeat the massive and costly effort of the free distribution of condoms by the governments and other bodies. The problem becomes more complicated when they hide behind religion-moral rhetoric to defend their personal preference of having sex without condoms. This would call for a change of personal attitude facilitated by a suitable programmer of community education. Also, the other group of opponents to condom use—those on religion-moral grounds—have certain serious philosophical, ethical and theological problems.

One problem is that they preach an ethic of retribution—pre-marital and extra-marital sex is sinful. You must abstain from it or engage in it without condoms and suffer the punishment in terms of contracting STDs or HIV, or both. Such is the position of Stephen Karanja, quoted above. But then, as I have pointed out above, this approach entails the very serious danger of spreading the 'punishment" to innocent spouses and even unborn children. Even if the Bible says "the soul who sins shall die", nowhere does: it say, "The soul who sins should pass the punishment onto another— innocent—soul!"

Another problem with the opponents to condom use on religious-moral grounds is that they seem to preach an ethic of fear— practice abstinence or else...! But abstinence as a religious-moral precept is good for its own sake. It should be preached as a good and desirable thing for all times, not simply because its

violation entails the fear of possible HIV infection and death in the current ties. What if the magic cure to AIDS is found tomorrow, and the cause of fear is permanently removed? Shall we then stop preaching abstinence? And how are the followers of abstinence, especially young people who have been forced to practice abstinence out of fear of death, supposed to react in such a fearless situation? Would they not go on a reckless immoral spree releasing their pent-up anger and suppressed desire, thereby plunging the society into moral chaos worse than AIDS?

Finally, the opponents of condom use on religious-moral grounds prescribe abstinence as *the only* available and acceptable alternative to condom- use. But, as I noted earlier, abstinence to has its own problems. Hence, in regard to the moral unpopularity of condom use, in the current HIV crisis, we are confronted with two conflicting moral alternatives:

a) “We ought to discourage irresponsible sexual relations in the form of infidelity, promiscuity or adultery by rejecting the introduction of condoms for safe sex.
b) Moreover, we ought to attempt to salvage some lives by recommending condom use in view of the danger of spreading the virus.

Among the above-listed options, “a” is morally desirable, but it entails the dangers of spreading HIV infection and possible death to others—even morally upright and innocent people. Option “b” is morally undesirable but offers the chance to salvage some lies. What shall we do h re? As we are entangled in the moral dilemma of choosing between the above two alternatives, we note that we are being called upon to choose between two undesirable options open to us. The process is guided by the principle of lesser or eater evil pertinent to the options. Our criteria from an ethical viewpoint would be to choose the course of action that may probably combat the eater e il. An evaluation of the two options “a” and “b” would reveal that “b” is seemingly the greater evil if we fail to comply with the moral value and duty involved in it. Therefore, the recommendation of condom use to save some lives from AIDS supersedes the contention that doing so would result in irresponsible sexual relations.

3.0 FINDINGS AND DISCUSSION

Awareness and Prevention of HIV/AIDS

The purpose is to identify the impact of Mwanyagetinge Community based care on raising the awareness of level and prevention of the spread of HIV/AIDS in Kisii municipality. The findings are presented and discussed as follows:

1) Level of Disclosure

The research established that (99.5%) of the PLWHAS had already disclosed their status to someone. However, the rest were no-respondents, and it was not possible to establish whether they actually did not disclose or they had just ignored the item on the question re. Table 1 shows the distribution frequencies of the category of people to whom the PLWHAS had disclosed their status.

Table 1: The People to Whom PLWHAS had Disclosed Their Status

To who have you disclosed your status?	Frequency	Percentage
Spouse	39	19.3
Children	10	5.0
Relatives	14	6.9
Neighbour	11	5.4
Caregivers	101	50.0
Media	11	5.4
Parents	15	7.4
Non-Respondents	1	0.5
Total	**202**	**100**

Table 1 indicates that (19.3%) had disclosed their status to their spouses, (7.4%) to their parents, (6.9%) to relatives, and (5.4%) to the media, with a similar percentage disclosing it to neighbours. Most of the (50%) had disclosed this to their caregivers. Lastly, about (5%) admitted to having disclosed their status to their child en. Disclosing someone's zero positive status is a mutual process that requires a warm relationship in the ongoing counselling and social support motivated by community-based care approach has significantly encouraged PLWHAS and can reduce stress levels and social discrimination and disclose their status, among others. Social discrimination prohibits disclosure of seropositive status to PLWHAS can be a tool in fighting social discrimination, but only if they overcome self-stigma and discloses their HIV status to others. Disclosure about one's HIV status is evidence that one is ready to fight the social discrimination associated with the disease. However, the opportunity cost of deciding to disclose your HIV status to others is great. Society has treated PLWHAS as second-class citizens ns. Revealing HIV status to others puts them at risk of discrimination, yet efforts must be made to openly talk about their status to others so as to encourage prevention and behaviour change. Denial about one's status is a major challenge that requires intensive counselling and education to overcome so that PLWHAS can take their rightful part in the fight and prevention of the further spread of HIV/A DS. PLWHAS may conceal their status to their children as they are terrified about the reaction to this painful experience. A half of PLWHAS felt comfortable revealing their status to the caregivers (50%). On the other hand, only (5%) had revealed their status to their children. At one time during our group discussion, the PLWHAS highlighted the following reasons why they fear going public about their status:-

i. Stigmatised by others in society
ii. Gossiping about their health by neighbours.
iii. Desertion by immediate family on realising your status.
iv. It's a traumatic experience for children
v. Fear of losing their job
vi. Fear of violation of one's human rights by others who see them as a 'guinea pig' or experimental material to be used to see what happens to their life as they live with the virus.

Denial of one's status is a major challenge that requires intensive counselling and education to overcome so that PLWHAS can take their rightful part in the fight and prevention of the further spread of HIV/A S. In personal interviews, the researcher conducted PLWHAS who expressed that disclosure about ones zero status was a gigantic t k. Many times partners have concealed their HIV status from their spouse. A widowed PLWHAS aged 30 years reported that;

"My Husband died of paralysis complications caused by HIV/AI '. I nursed him for two years before he died, yet he never told me he was HIV posit e. But only cheated me that he had ulcers and hid all hospital documents".
(Interview notes: 30/9/2010)

Many parents find it difficult to reveal that they are suffering from HIV/AIDS to their children for fear of traumatising them since HIV status is associated with guilt, secrecy, social stigma and discrimination n. A PLWHAS who was a mother of four children reported that:

"My children have always expressed the desire to see how a PLWHAS looks like when we talk informally at h e. I fear to let them know I am a living example since I have the virus". (Interview notes: 30/10/2010)

2) Awareness of Transmission of HIV/AIDS
Research findings established that (14.9%) contracted the infection through blood transfusion, (9.9%) from unsterilised injections and (5%) contracted it through open wounds while giving c re. The bulk of the PLWHAS contracted it through having unprotected sexual intercourse. These findings are presented in table 2.

Table 2: Awareness of Source of Individual PLWHAS Infection

Which mode do you think you contracted your infection?	Frequency	Per cent
Blood transfusion	30	14.9
Use of unsterilised injection	20	9.9
Through sexual intercourse	142	70.3
Through open wounds, while caregiving	10	5.0
Total	**202**	**100**

The research sought to establish what the PLWHAS thought with regard to infections through coughing, sneezing at or sharing a glass with an infected person. About (9.9%) of the respondents thought that it was somehow possible, (29.7%) felt it was possible, and (60.4%) thought that it was impossible le. Significantly, the level of awareness of the transmission of HIV/AIDS is very high among PLW AS. A large percentage of the HIV virus cannot be transmitted through sneezing or sharing items. As seen in table 2, (70.3%) of PLWHAS admitted that they very likely got infected through its spread. This is in agreement with other research done in Kenya on AIDS knowledge (Cabrera et al., 1996). On the other hand, (24.8%) presumed it was due to unsterilised injections or blood transfusions. This is in agreement with Murrah and Kiarie (2002), who reported that over (50%) of HIV/AIDS infections result from heterosexual contacts in Kenya. Even after infection, (59.8%) of PLWHAS are actively involved in sexual intercourse weekly. The key issue

here is that many sexual partners, increased frequency of sexual contact, combined with unprotected sexual partners, increased frequency of sexual contacts combined unprotected sexual contact led to the fast spread of HIV/AIDS and re-infection of PLWHAS, leading to a faster death. Getahun et al. (2010) recommend never having sex as the surest way to avoid getting HIV through sex. This is not realistic to many people, especially the married.

Table 3: Awareness of Source of HIV/AIDS Infections

Do you think coughing, sneezing or sharing glasses can give you HIV/AIDS?	Frequency	Per cent
Somehow possible	20	9.9
Very possible	60	29.7
Impossible	122	60.4
Total	**202**	**100**

3) Awareness of Dangers of HIV/AIDS to Health

The study sought to establish whether the PLWHAS were adequately informed of the dangers of HIV/AIDS to their health. Those who felt they had been adequately informed were (84.2%) of the same le. This data is presented in table 4. According to Cabrera et al. (1996), knowledge of AIDs is generally high to ay. This view concurs with the outcome of this research findings. During the research, it emerged that (84.2%) of PLWHAS in Mwanyagetinge community-based care programmes were informed of the dangers of HIV/AIDS to their health. Insignificantly, only (15.8%) exhibited ignorance of their plight, as presented in table 4. The philosophy of Mwanyagetinge community-based care is to offer constant education on HIV/AIDS to PLWHAS and families in their natural setting.

Table 4: Awareness of Dangers of HIV/AIDS to the Health of PLWHAS

Have you been informed of the dangers of HIV/AIDS to your health?	Freq.	Per cent
Yes	170	84.2
No	32	15.8
Total	**202**	**100**

4) Awareness of Prevention

The respondents were asked to state from their experience of HIV/AIDS the best way to prevent the further spread of the scourge. The results are presented in Table 5.

Table 5: Effective Method to Prevent the Spread of HIV/AIDS Infection Rate

The best method of preventing HIV/AIDS spread	Frequency	Percentage
Abstinence	102	50.5
Use of Condom	90	44.6
Use of antiretroviral drugs	10	5.0
Total	**202**	**100**

Table 5 indicates that (50.5%) of the respondents supported abstinence as the best method of preventing HIV/AIDS spread. Others representing (44.6%) of the respondents indicated the use of condoms was the best way to prevent the perpetuation of HIV/AIDS infection, while (5%) supported the use of antiretroviral drugs. When the PLWHAS virus is not manifesting any physical clinical symptoms among PLWHAS, they may continue their sexual life as usual; hence continue spreading the HIV Vi us. As the clinical symptoms take effect, their physical attractiveness deteriorates and combined with social stigma, PLWHAS lose interest in sexual activities. Abstinence is an effective strategy for control of the HIV/AIDS virus if only practised as soon as the HIV/AIDS status diagnosis is m de. When PLWHAS cannot abstain, the option of condom use is available le. About (44.6%) of PLWHAS in the Mwanyagetinge Community, based care programme had adopted the use of condoms as a positive living strategy. Correct and consistent use of condoms has the potential to be a highly effective means of HIV control (O'Leavy, 2002). About (59.8%) of PLWHAS engaged in sexual intercourse almost weekly. Such a high frequency of engagement in sexual intercourse results in re-infection hence hastening the onset of the AIDS stage. Introducing negotiations in the use of a condom in a sexual relationship is a sensitive reproductive health issue, which may be interpreted to mean distrust of a sexual partner. Early diagnosis of HIV infection should encourage the individual to avoid risky sexual behaviours.

Table 6: What do PLWHAS Think of Caregivers Wearing Gloves?

	Frequency	**Per cent**
To prevent the carer and I from possible infection	122	60.4
A sign of hate and fear	80	39.6
Total	**202**	**100**

Respondents also stated their opinion of caregivers wearing gloves when attending to them. About (60.4%) claimed it was to protect them from possible infection, and (39.6%) thought it was a sign of hate and f ar. The data is presented in table 6; as already stated above, (39.6%) felt stigmatised when they saw their caregivers use gloves. The best prevention strategy against the spread of HIV/AIDS, according to (50.5%) PLWHAS, was sexual abstinence. People already infected with the HIV Virus must avoid re-infection or infecting others since abstinence is the ideal sexual behaviour for them, but practicality about its effectiveness is an issue for PLWHAS to make an informed choice. It is, therefore, clear that Mwanyagetinge Community based care programme has significantly contributed to raising. The level of awareness and mobilising PLWHAS to be agents of prevention rather than spreading the disease to others.

4.0 CONCLUSION AND RECOMMENDATIONS

Conclusion: It was established that the Mwanyagetinge community-based care programme had significantly contributed to raising their level of awareness and mobilising PLWHAS to be agents of prevention rather than spread.

Recommendations: With the impact of HIV/AIDS on our society and schools, the counselling curriculum in the universities should include an in-depth and mandatory study on the PLW AS. It is important for the church to reflect on theological teachings that form foundations for pastoral counselling on what defines

their positive living and as far as sexuality is concerned for PLWHAS who are married. Nzioka (1994) asserts that complete sexual abstinence is not only unrealistic but also unnatural and impractical, particularly in marriage. The impracticality of abstinence in such a context ought to be appreciated, just as the emphasis on the ineffectiveness of a condom.

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