

**Assessing health-related knowledge, attitudes and behaviours of
HIV-positive Africans accessing services in Gugulethu Township,
Cape Town.**

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Assignment presented in partial fulfilment of the requirements for the degree of Master of
Philosophy (HIV/AIDS Management) at Stellenbosch University



Study leader: Mr Gary Eva

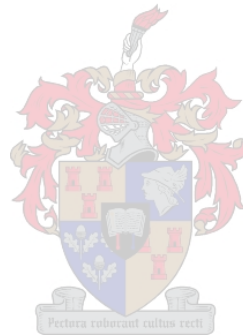
December 2005

Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Summary

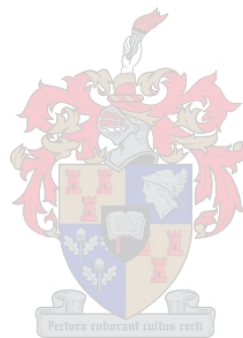
HIV prevalence in the Western Cape, traditionally the lowest in South Africa, has jumped to higher than 10 percent for the first time – from 8,6 percent in 2001 to 12,4 percent in 2004. However, the statistic is not totally unexpected, considering the pandemic in the province is running five or six years behind the rest of the country. The figure comes from the 2002 national HIV antenatal survey. The Western Cape may continue to record the lowest rate in South Africa, but prevalence is obviously climbing fast. In addition, 19 of the 25 health districts in the Western Cape had recorded increases in the HIV rate (Department of Health, Western Cape). Syphilis rates in this province however, continued to drop, from 2,9 percent of pregnant women surveyed in 2001, to two percent in the most recent figures. Extrapolations based on a model developed by the national health department estimate that 5,3 million South Africans were HIV positive at the end of last year – up from 4,74 million in 2001.

It is estimated that last year 2,95 million women between the ages of 15 and 49, and 2,3 million men in the same age group, were infected with HIV. Nearly 100 000 babies became infected too, via mother-to-child transmission. In her preface to the report, national health minister The Hannan Crusaid ARV Treatment Centre is the result of a partnership between the Western Cape government and UK-based HIV/Aids fundraising organisation Crusaid (Department of Health, 2004).

The facility is rendering services such as counseling and the supply of the ARV treatment to the people of Gugulethu and surrounding communities. Approximately 38 000 of Gugulethu's 340 000 population could be HIV-positive. The provincial government donated R3,2-million towards building the site, while Crusaid invested R5,6-million (Department of Health, Western Cape: 2004).

Various services run by the statutory and voluntary sector have been set up to help meet the increasing demand for HIV related support and care amongst this population. However, there is relatively limited data on HIV-related knowledge, sexual attitudes and practices amongst Africans living with HIV in the township. Similarly, their access to HIV-related services within the district remains relatively undocumented. The aims of this project were to collect preliminary data regarding HIV related knowledge, attitudes and practices (KAP) amongst

HIV positive Africans accessing services in Gugulethu Township. To assess the feasibility of collecting KAP data amongst this population, qualitative and quantitative methods were used in a synergistic fashion, allowing a methodology to emerge in line with the real lives of HIV positive African residents and providers in the district. The methodology was closely linked to user-consultation with HIV-positive Africans who played a key role in defining and developing the research questions and the eventual survey tool.



Opsomming

Die voorkoms van MIV in die Wes-Kaap, tradisioneel die laagste in Suid-Afrika, het vir die eerste keer gestyg tot hoër as 10 persent – van 8,6 persent in 2001 tot 12,4 persent in 2004. Hierdie statistiek is nietemin nie total onverwags nie, aangesien die pandemie in die provinsie se ontwikkeling vyf of ses jaar agter die res van die land is. Hierdie syfer kom van die 2002 nasionale MIV opname van swanger vroue. Die Wes-Kaap mag wel die laagste koers in Suid-Afrika bly opteken, maar die voorkoms van MIV klim klaarblyklik vinnig. Boonop het 19 van die 25 gesondheidsdistrikte in die Wes-Kaap 'n toename in MIV koerse vermeld (Departement van Gesondheid, Wes-Kaap). Sifilis koerse in hierdie provinsie het egter bly afneem, van 2,9 persent van swanger vroue in 'n 2001 opname, tot 2 persent volgens die mees onlangse syfers. Ekstrapolasies gebaseer op 'n model ontwikkel deur die nasionale gesondheidsdepartement beraam dat 5,3 miljoen Suid-Afrikanes teen die einde van verlede jaar MIV-positief was – 'n styging van 4,74 miljoen in 2001.

Dit word beraam dat 2,95 miljoen vroue tussen die ouderdomme van 15 en 49, en 2,3 miljoen mans in dieselfde ouderdomsgroep, verlede jaar met MIV besmet is. Min of meer 100 000 babas is ook via moeder-tot-kind transmissie besmet. Die Hannan Crusaid ARV Behandelings Sentrum is die uitslag van 'n vennootskap tussen die Wes-Kaapse regering en VK-gebaseerde MIV/VIGS fondsinsamelings organisasie. (Departement van Gesondheid, 2004).

Hierdie fasiliteit lewer diense soos berading en die lewering van ARV behandeling aan die mense van Gugulethu en die nabygeleë gemeenskappe. Ongeveer 38 000 van Gugulethu se 340 000 inwoners kan MIV-positief. Die provinsiale regering het R3.2-miljoen geskenk vir die bou van die perseel, terwyl Crusaid R5.6-miljoen belê het (Departement van Gesondheid, Wes-Kaap: 2004).

Verskeie diense, wat deur die statutêre en voluntêre serktore bestuur word, is aan die gang gesit om die groeiende vraag vir MIV-verwante steun en sorg onder hierdie mense te voorsien. Nogtans, daar is relatief beperkte data oor MIV-verwante kennis, seksuele houdings and praktyke onder Swart inwoners met MIV in die nedersetting. Insgelyks, hul toegang tot MIV-verwant dienste in die distrik bly relatief ongedokumenteer. Die doelwitte van hierdie projek was om preliminêre data te versamel met betrekking tot MIV-verwante

kennis, houdings en praktyke (KAP) onder MIV-positiewe Swart inwoners wat diense in Gugulethu gebruik. Om die uitvoorbaarheid van die versameling van KAP data onder hierdie inwoners te skat is kwalitatiewe en kwantitatiewe metodes synergisties gebruik, om 'n metodologie te laat ontstaan wat in lyn is met die aktuele lewens van HIV-positiewe Swart inwoners en besorgers in die distrik. Die metodologie was nou gekoppel aan gebruikers-konsultasie met MIV-positiewe Swart inwoners wie 'n sleutelrol gespeel het in die definieering en ontwikkeling van die navorsingsvrae en eventuele opname gereedskap.

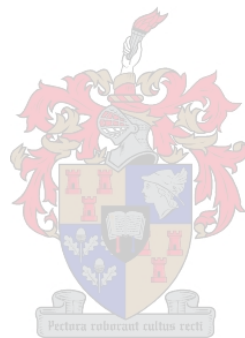
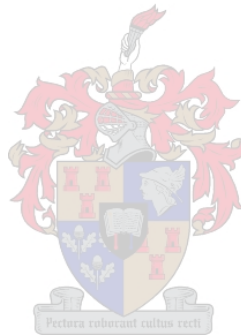


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1. Introduction

Most African clients accessing services in this clinic were aged most between 30-39 years – the age cohorts in decreasing order of visits were 35-39, 30-34, followed by those aged 40-44, 25-29 and 45-49. Few were between the ages of 18-24 and above 50 years. This age profile has implications for health promotion initiatives: the age group of clients is predominantly comprised of people for whom sexual partnership and childbearing are important. I suggest that health promotion targeting this population should be intensified as far as reducing the risk of re-infection and/or mother to child HIV transmission. The township is believed to have the province's highest HIV/AIDS rate, with around 38,000 of its estimated 340,000 population living with the virus. The residents in Gugulethu are exclusively black and almost all poor - unemployment runs at 60% and some estimates put the number of people with HIV at three out of every 10 people. This is the reason for choosing this population and using the word Africans.

The Policy Frameworks



The first national sexual health strategy in South Africa was developed around the principles of the National Health Service Plan (Department of Health, 2000). The National Health Service plan set out a sustained investment that aimed at improved efficiency, value for money as well as a more patient-centered approach. Taking the principles of the National Health Services Plan, within the context of gender health, meant representation by key stakeholders in decision-making, partnership and narrowing the health [sexual] divide.

The sexual health strategy calls for a reduction in the rates of transmission of HIV and other sexually transmitted infections as well as the prevalence of undiagnosed HIV and other sexually transmitted infections (Department of Health, 2002). In its National HIV and Sexual Health Strategy Implementation Action Plan (DOH, 2002), the Department of Health called for better support for people living with HIV as well as the engagement of HIV positive people in the development of policy and services. The HIV prevention framework calls for a sound evidence base for the effective HIV prevention interventions that would work towards the set national target of a 25% reduction in the rates of newly acquired infections by 2007.

As the focus of the study was narrow, and on a small local level, I consulted (a) literature on policy in which the area of the study is located, I also (b) looked at literature on interviewing HIV infected respondents in poor areas – here I found little from other developing countries, e.g. other African countries, South America and India, and nothing from studies of poorer enclaves of cities in wealthier countries. As this modest study is not intended to be a comparative analysis with findings in areas similar to Gugulethu, elsewhere in South Africa and Africa, but only a qualitative investigation in the dynamics of this community, I thought it would be a valuable exercise to concentrate, methodologically as well in the formulation of the structure of the study, on input for local level stakeholders.

Reviewed literature that informed the development of the African HIV Prevention Framework (Chinouya and Reynolds, 2001) found major gaps regarding the ways of knowing about Africans affected by HIV and these gaps were:

- The sexual health-promotion needs of HIV positive Africans are unknown and subsequently, there is a need to explore the sexual practices and HIV knowledge amongst people infected with HIV; and HIV is still a stigmatized condition amongst this population;
- Poor clinical post-test monitoring;
- Little is known about the disclosure patterns amongst this population;
- Living with HIV cannot be dismissed from a social context that is marked by marginalization, stigmatization and racism.

2. The aims of this study

The aim of this study, and thus this report, is to identify risk factors associated with HIV transmission amongst a sample of HIV positive respondents from the African communities accessing HIV-related services in Gugulethu Township. To examine these risk factors, this report will:

- Map the inventory of HIV services targeting HIV positive Africans in Gugulethu and service utilisation amongst the respondents;
- Describe the demographic characteristics of HIV positive respondents who took part in the study;

- Examine their reported knowledge of HIV transmission;
- Examine their reported sexual attitudes;
- Map their reported sexual behaviours;
- Explore the implications of the respondents' HIV related knowledge, attitudes and reported behaviours for health promotion; and
- Make recommendations based on the findings of the study.

3. The Methods

The research methods were based around a user involvement model in the development of research tools (the survey questionnaire) and the research process (i.e. the recruitment of participants).

3.1. Aims and Objectives

The project aimed to assess the feasibility of exploring HIV-related knowledge and sexual behaviours amongst black Africans living with the virus and accessing HIV-related services in the Gugulethu. The primary objective of the project was to develop evidence-based interventions informed by the experiences of Africans accessing HIV-related services and resident in the township. The specific objectives of the project were:

- To assess HIV-related knowledge, attitudes and practices (KAP) amongst this population;
- To explore knowledge related to the use of combination therapies and respondent's understanding of medical terms (viral load, resistance);
- To ascertain the nature and frequency of disclosure of HIV status to sexual partners;
- To collate and disseminate the methodology;
- To make evidence-based recommendations on how the sexual health promotion needs of HIV positive Africans accessing services in Gugulethu can be met.

The project was conducted in inter-related phases that included:

- Mapping HIV service providers;

- Developing the questionnaire in close consultation with providers and service users; and
- The survey questionnaire

3.2. The Mapping Phase

The mapping exercise was important as it provided a framework of stakeholders namely the local providers and consumers of HIV-related services as well as the spectrum of services offered. The mapping phase informed the research process, as these stakeholders were essential in developing the survey questionnaire as well as informing the research process including the recruitment methods. To help develop the mapping framework a list of HIV service providers and consumers in Gugulethu was constructed using the local AIDS directory, AIDS newsletters and local undocumented networks. The directory of services, though exhaustive, however at times failed to capture the latest developments within the informal settlements. Most of the latest development missed by written forms of communications included:

- New community-led projects or community groups that were set up after the documentation of the written materials about local services;
- Social housing for Africans moved to Gugulethu Township due to migration;
- Informal support networks of people living with the virus. To fill in the gaps identified above, I worked with local consumers and providers mapping these developments, with the stake holder's narratives shaping the researcher's pathways into these 'new communities'. Taking on board the new communities and developments, a list of stakeholders from the statutory, voluntary and unregistered service providers were then constructed. The list was then categorized into the following:
 - Advocacy services;
 - Complementary therapies;
 - Medical services;
 - Social services;
 - Support (groups) services;
 - Informal networks

Informed by this list, stakeholders were contacted, made aware of the services in their community, and then encouraged to engage in the project. To get their 'voices' in the processes, a steering group was set up.

3.3. Recruitment in Support Groups

Before recruitment commenced in support groups, it was very important to gain access from the support group workers. Aims and objectives of the project and the contents of the questionnaire were discussed with the workers. Support group workers informed respondents about the project and a date and time were set when recruitment would take place. People in support groups were generally keen to complete the questionnaire. Each respondent completed their own questionnaire and a Xhosa version of the questionnaire was made available for Xhosas who could not understand English.

Overall, most respondents were able to complete the questionnaire unaided. They were able to read and answer the questionnaire within thirty minutes and often reported that they had come to the group on that particular day to complete the questionnaire. A non-probability sampling technique was applied. A purposive sample of two hundred respondents was selected from information obtained on antiretroviral (ARV) register in Gugulethu ARV Hannan treatment Centre. The respondents were chosen from ARV register, first permission was asked from them. Introductory visits were made to discuss the purpose and processes of the sessions and obtain permission and cooperation from respondents participating in the study. The HIV positive status of persons was confidentially disclosed in order to enable the selection of the respondents in the sample and that ethical clearance was gained from the Department of Health, Western Cape as well as the University of Stellenbosch research ethics committee.

3.4. Recruiting in Clinics

Access to the clinic was negotiated with nurses and doctors. They often set the dates for recruitment to match HIV clinic dates when African clients had appointments booked. In most cases the maximum number of clients booked in each clinic was usually less than ten. Recruiting participants in clinics proved more time consuming and difficult, compared with

support groups and community-based agencies. The recruitment had to ‘fit in’ with the daily clinic routines.

I had to skillful and be able to ‘fit into’ this routine whilst at the same time be pro-active, diplomatic and sensitive in approaching clients. My observations indicate that compared with support group recruitment, there was limited time for completing the questionnaire and respondents were more concerned about confidentiality and appeared more distressed. When asked to comment on these observations, some medical professionals commented that in clinics, people have to face the reality of living with HIV. It is in clinic settings that respondents were informed about the ways they were responding to medical treatments with details of their prognosis discussed. Clinic professionals often also assisted with the recruitment. This involved those approaching clients to take part in the study. Regarding potential bias, refer to section 5.1.

4. Research Findings

Two hundred men and women living with HIV agreed to participate and subsequently completed the questionnaire. The participants were recruited in HIV clinics, community based organizations, and support groups. There was a clear gender difference across the total sample, with more women (73%) than men (27%) completing the questionnaire. The recruitment sites may well explain the gender distribution of the respondents. The majority of the women were recruited in support groups that were mainly attended by HIV-positive women.

It was observed that more women than men visited these locations during the recruitment phase. Intuitively, the distribution of male and female respondents may well reflect the gender bias in accessing services or service development. More women than men are targeted for interventions in Gugulethu. During the recruitment phase there were more ‘women only’ spaces compared to those targeting African men living with HIV and/or AIDS.

4.1. Residency

Respondents were asked about their residential houses and street numbers so as to get a picture of the geographical distribution of African HIV service consumers in the informal settlements. When asked to provide the first half of their home and street number, only 21% of the respondents reported a residency house and street number that was within the Gugulethu Township. A further 12% provided home and street numbers that were not around Gugulethu but within other areas. This could suggest that the majority of the respondents reside in the townships and informal settlements, an approach might well be more appropriate in developing research methodologies targeting this population living in informal settlements.

4.2. Age

Respondents were asked to indicate their age group. Results showed that almost three quarters (74%) of the respondents were aged between 25-39 years. Thirty percent of the respondents were aged between ages 35-39, 28% between 30-34 years, and 17% between 25-29 years. Twelve percent were aged 40-44 and 6% were 50 years or older. Few (2%) were 18-24 and 2% were 45-59. Thirteen of the respondents did not respond to this question. The data shows that most of the respondents were drawn from an age profile for which relationship formation and childbearing were part of an important aspect of their lives. This has important implications for mother to child transmission and indeed transmission between sexual partners.

4.3. Relationship Status

Respondents were also asked about their marital status and respondents were more likely to be in a co-habiting relationship. Thirty-six percent of the female and 21% of the male respondents were single and had never been married, 20% of women and 20% of the men were widowed, divorced or separated, whilst 17% of the female and 21% of the male respondents were married and their spouses were non-resident of the Western Cape. Eighteen percent of the females and males (9%) reported that they were actively seeking a

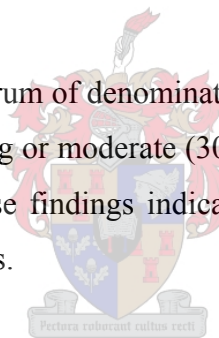
partner. Fewer respondents had a co-resident spouse as 7% (women) and 18% (men) were married and living together, or were cohabiting (6% women and 9% men).

4.4. Self perceived health

Respondents were asked how they perceived their health given their positive HIV diagnosis. Most respondents reported their health favourably with 77% of the male and 76% of the female respondents perceiving their health as ‘excellent’ or ‘good’. Almost a quarter of the male (23%) and female respondents (24%) reported their health negatively (i.e. not so good or poor). This could also be reflective of the recruitment process as people who perceived their health favourably were more likely to have attended the social venues (e.g. support groups) where the respondents were recruited.

4.5. Religion

The respondents belonged to a spectrum of denominations with the majority (65%) reporting that their religious beliefs were strong or moderate (30%). A few (5%) reported that they did not have any religious beliefs. These findings indicate that for most respondents, religion played an important part in their lives.



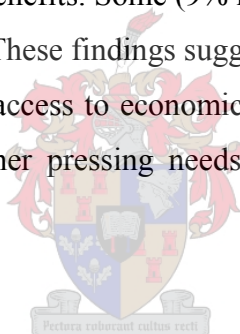
4.6. Socio-economic circumstances

Most respondents had received some formal education with proportionately more women (10%) than men (5%) reporting primary/elementary education or secondary (women = 41% and men = 30%) as the highest educational achievement. Proportionately more male respondents (63%) than women (48%) reported college/university education as the highest achieved. Men (2%) and women (1%) reported ‘Other’ educational qualifications as the highest achieved.

Respondents were asked ‘*which of the following best describes what you were doing in the last 6 months?*’ and the results are tabulated in the table below.

Activities in the last 6 months	Male respondents	Female respondents
Full time college	18	17
Full time employment	15	8
Unemployed and registered for grant	42	39
Unemployed and not registered for grant	14	18
Part-Time employment	2	8
Unable to work (long term illness/disability)	9	10
Total (%)	100	100

Most (42% men and 39% women) respondents were registered for benefits, and studying (18% males and 17% females), or in part-time employment (2% males and 8% females). Fourteen percent of the male respondents and 18% of the female respondents were unemployed and not registered for benefits. Some (9% men and 10% women) were unable to work due to an illness or disability. These findings suggest that despite their high educational levels, the respondents had limited access to economic resources and poverty characterized their lives. Due to poverty and other pressing needs, the presence of HIV may be less prioritized.



4.7. Service Utilization

Respondents were asked when they were diagnosed with HIV. More than half of the sample (53%) had known their HIV status in the past two years whilst less than a third (28%) had known between 3-5 years ago. Ten percent had known their diagnosis between 6-7 years ago and 9% between 8 and 10 years ago. Respondents were asked ‘what are you doing to manage HIV?’ Respondents used a wide range of strategies. At times these were in combination with other strategies and these included taking anti-HIV tablets (77%) or relying on nutrition (41%), religion (33%), complimentary therapies (31%), herbal medicines (4%) or traditional healers (1%). There were some (4%) who reported that they were doing nothing to manage the virus.

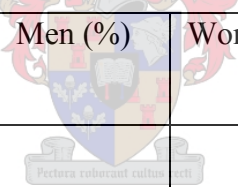
These results show that the respondents were active participants in the management of their health and used various strategies to manage the virus. There were gender variations in service utilization. Though more women accessed antenatal services, more men reported the

use of childcare services than women. Men were more likely to be accessing housing and dietary services than women.

When asked how long they had been accessing services, less than half (44%) had been accessing HIV-related services for longer than a year whilst almost a third (34%) had accessed the services for less than a year. Few (21%) reported that they had never accessed services in Gugulethu.

4.8. Disclosure

Respondents were asked “Have you told anyone about your HIV positive diagnosis?” Of the 200 responses to this question, 79% of the men and 86% of the women said yes (79%). Respondents were further asked who they had told. A result showing the significant other who had been told of their positive diagnosis is shown. The results above show that respondents were more likely to tell a professional person such as GP, nurse or social worker. [See table below].



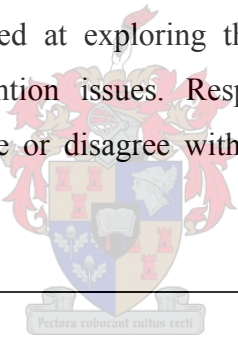
Who has been told of their positive diagnosis?	Men (%)	Women (%)
Mother	27	34
Father	18	15
Brother	32	30
Sister	39	51
Partner	32	33
Friend(s)	45	47
General medical practitioner	61	66
Nurse or S/Worker	61	64
Kids	1	13
Others	5	7

4.9. Religion and adherence

As noted earlier in this report, respondents, on the whole, claim that religion played an important part in their lives. Respondents were also asked the importance of religion on adherence to taking medication, and it was reported as important in taking the medication as prescribed. There were marked gender differences in reporting as more female (56%) than male (44%) respondents reported that religion was important in taking the medication as prescribed. The implications of these results are important as health care workers may well need to be aware of the importance of religious beliefs in the lives of HIV positive Africans and be able to locate religious beliefs as an important variable in taking the medication as prescribed.

4.10. HIV-Related Knowledge

The survey questionnaire also aimed at exploring the respondents' knowledge of HIV transmission, treatment and prevention issues. Respondents were given a set of 26 statements, which they had to agree or disagree with. The table, below, summarizes the response from the respondents.

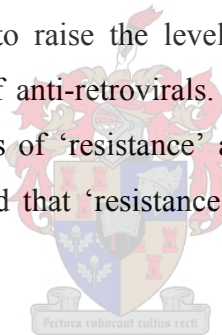


Statement	True %	False %	Don't know %
One can get cured of HIV in RSA	16	74	10
An undetected viral load means I cannot pass HIV to some else	8	80	12
A pregnant woman taking HIV tablets can effectively reduce the risk of passing on HIV to her unborn baby	75	10	15
Resistance means my partner cannot catch HIV from me [what does this mean?]	7	83	10
Prayer can cure HIV	21	66	13
Africa Traditional medicine can cure HIV	6	73	21

About a quarter (26%) of the respondents were not sure if one could be cured of HIV in the RSA as some (16%) believed that one could get cured of HIV whilst 10% did not know. A

majority (75%) believed that one could not get cured of HIV in the RSA. There were no marked gender differences in their levels of awareness as 15% of the men and 16% of the women believed that one could get cured of HIV. Health promotion interventions need to build on this level of awareness regarding HIV treatment in the RSA. Some respondents (8%) thought that an ‘undetectable viral load’ meant that they could not pass HIV to anyone whilst 12% were not sure about the answer.

A majority (80%) thought that the statement was false. There were some marked gender differences in their reporting as 10% of the women and 2% of the men believed that an undetectable viral load meant that they could not pass HIV to someone. Fifteen percent of the respondents did not know that a pregnant woman taking HIV tablets could effectively reduce the risk of passing on HIV to her unborn baby whilst 10% reported that this was not true. However the majority (75%) reported that a pregnant woman taking HIV tablets could effectively reduce the risk of passing on HIV to her unborn baby. These findings suggest that health promotion should continue to raise the levels of awareness regarding the risk of vertical transmission and the use of anti-retrovirals. Seventeen percent of the respondents were not certain of the implications of ‘resistance’ as 10% did not know the meaning of ‘resistance’, and whilst 7% believed that ‘resistance’ means that my partner cannot catch HIV from me.



The majority (83%) of the respondents did not agree with the statement ‘resistance means my partner cannot catch HIV from me’. Although a majority of the respondents (66%) did not believe that prayer cured HIV, almost a quarter (21%) believed that prayer cured HIV and 13% were not sure. There were slight gender differences in their beliefs as proportionately more women (23%) than men (14%) believed that prayer could cure HIV and 13% of the women and 11% of the men were not sure. Some respondents (21%) were not sure of the role of African Traditional Medicine as a cure for HIV, and others (6%) believed that complimentary therapies could cure HIV. Most respondents (73%) did not agree with the statement that African Traditional Medicine could cure HIV.

4.11. Attitudes towards prevention

The respondents were presented with a set of attitudinal statements to explore beliefs regarding condom use, disclosure and HIV. The table captures some of the respondents' reported beliefs regarding condom use, disclosure and HIV. The beliefs regarding disclosure suggest that most of the respondents (67%) believed that they expected someone to tell them about their HIV status whilst a few (15%) were not sure and 18% disagreed with the statement. Further, more than half of the respondents (55%) were not sure whether they would use condoms for ever, whilst less than a third (30%) agreed with this statement and 15% disagreed. Nearly half the respondents (40%) reported that it is difficult to use condoms with a new partner and 5% did not agree with the statement.

Statement	Agree (%)	Disagree (%)	Not Sure (%)
I'd expect someone to tell me their HIV status before we have sex	67	18	15
I'd expect to tell my partner about my diagnosis before we have sex	72	15	13
I don't expect to use condoms for ever	30	15	55
It is difficult to use condoms during sexual intercourse with new partners	40	5	54
Most people who are important to me do not think I should use condoms with new partners	12	5	82

4.12. Credible sources of information

The respondents were also asked 'if you were to receive information from someone about HIV (how to live with HIV and how to protect yourself and others from HIV) which of the following would you trust most'. The respondents had a list of persons to select from. Health care professionals were the most trusted people to give health promotion information, then community health workers as well as peers. Slightly more women than men also reported religious leaders as most important in disseminating sexual health promotion information. Traditional healers were less trusted to give information. Similar proportions of people felt

that elders, peers and community health promotion workers were a credible source of information.

The implications of these findings are important, as health care workers (i.e. nurses and doctor) have to play a major role in imparting information regarding living with HIV as well as protecting others from the virus. The competency of nurses and doctors in Gugulethu ARV clinic to take on this role in a systematic way is unknown and it may be that service providers may well need to build the health promoting capacity of their health care professionals.

4.13. Sexual Behaviour

This section of the report examines the respondents' reported sexual behaviour. In particular, the report examines sexual orientation, sexual partnerships, condoms use and pregnancy/reproduction. The respondents were asked the biological sex of their sexual partners in the last year. Of the 178 who responded to this question, 89% reported that their sexual partners in the last year were of the opposite sex (80% of the men and 93% of the women). The remaining 20% of the men reported same sex partners, with no men reporting both sexes. Of the women, 5% reported same sex partners with 2% reporting partners of both sexes. These are important findings as the needs of homosexual and bisexual African men and women are unknown. Respondents were then asked about their sexual behaviour over four different time spans; their most recent partner, partners in the previous 4 weeks, the previous six months, and the previous one-year.

- **Previous 4 weeks**

When asked on how many occasions in the last four weeks had they had sex (vaginal, anal or oral intercourse), of the 150 who responded (70%), 24% of the men and 35% of the women reported no occasions of sexual intercourse, with 11% of the men and 15% of the women reporting one occasion. The remaining 65% of the men reported sex on two or more occasions, with 50% of the women reporting sex on two or more occasions.

When asked how many of these occasions of sex in the last four weeks were with a new sexual partner, 57% of the men and 64% of the women reported that none of these occasions was with a new partner, 26% of the men and 20% of the women reported that there was one new partner, 6% of the men and 9% of the women reported two new partners, with 11% of the men and 5% of the women reporting that they had sex over the previous 4 weeks with 3 or more new partners.

They were then asked if they had used condoms on any occasion when having sex in the last 4 weeks. A total of 200 responded to this question, with (26%) reporting that they had not had sex in the previous 4 weeks. Of the remaining, 60% reported condom use on every occasion, 21% reported condom use on some occasions with 19% reporting no condom use on any occasion. Thus, 40% of the respondents reported occasional or no condom use if they had been sexually active in the previous 4 weeks; however, this dropped to 29% if you include all the people responding to this question, as 26% had not been sexually active.

- **Previous 6 months**

When asked how many different partners they had had sexual intercourse within the previous 6 months, 150/200 participants responded (75%). Of these, 21% of the men and 25% of the women reported that they had no partners, 36% of the men and 52% reported one partner, and 26% of men and 9% of women reported two sexual partners, with 17% of men and 8% of women reporting 3 or more different sexual partners in the previous 6 months. When asked how many of these partners were new partners, of the 135/200 that responded 44% of the men and 53% of the women reported that none of these were new partners, with 31% of the men and 34% of the women reporting that one of these partners was new.

Respondents were asked how many of these partners in the previous 6 months were new; of the 135 people who responded to this question, 44% of the men and 53% of the women said that none of the partners in the previous 6 months were new, with 31% of the men and 34% of the women reporting that only one of those partners was new, and

the remaining 25% of men and 13% of women reporting that two or more of those partners in the previous 6 months were new partners.

- **Last year**

Respondents were asked if they had ever had sexual intercourse without using a condom in the last year. Of the 158 who responded to this question (79%), 37% of the men and 41% of the women reported that they had sexual intercourse without a condom. The remaining 61% of men and women reported that they had used condoms on all occasions in the past year. When asked with how many different partners they had sex with in the previous year without using a condom, 32% of the men and 42% of the women reported no condom use with one partner, and 30% of men and 19% of women reporting no condom use with two or more partners in the previous year. Approximately 40% of the men and women did not report unprotected sexual intercourse in the previous year.

- **Most recent partner**

Respondents were further asked “thinking of your most recent partner: was a condom used on that most recent occasion?” Of those who responded to this question (86%), 27% of the men and 35% of the women reported no condom use when last having sex. When asked if their most recent partner was a new partner, 29% of the men and 34% of the women reported that it was the first occasion. When asked what kind of relationship they had with their most recent sexual partner, 22% of both men and women reported a casual relationship with that partner, with 29% of men and 22% of women reporting that they were married to their most recent sexual partner, and the remaining respondents reporting that their most recent sexual partner was their regular partner.

- **Reproduction and Pregnancy**

Respondents were asked about pregnancy intentions and outcomes after their positive HIV diagnosis. Overall 6% of the respondents reported that they themselves had conceived or had made a woman pregnant since diagnosis. Male respondents (12%) were more likely to report having been involved in conception, with 4% of women reporting

that they had become pregnant since the time of their diagnosis. Respondents were also asked if they or their partners had had given birth since the time of their positive HIV diagnosis. Overall, 15% of the respondents reported that they or their partners had given birth since the time of the diagnosis. Female respondents (18%) were proportionately more likely to report having a baby since the time of diagnosis than their male counterparts (6%).

5. Discussions

The Project aimed to develop a methodology for assessing sexual health risk factors in HIV-positive members of Gugulethu's African communities. It aimed to assess the feasibility of obtaining such information from both formal and informal statutory and community based organisations and structures, and in turn, to provide preliminary data that helps inform the prevention needs to service providers and the communities themselves.

The sample size of 200 represents participants from a number of different communities; it is difficult to generalise on the basis of such a heterogeneous sample. The findings however provide some initial indications of sexual behaviours and attitudes among this target group. Further work needs to be undertaken to validate the findings by comparing with other sexual behaviour surveys and through more detailed investigation.

The data collected and outlined in this report suggest significant levels of need in the HIV positive section of Gugulethu African communities. The data suggest that there are small but significant gaps in HIV-related knowledge within this target population. It also suggests significant levels of sexual behaviour that places both the individual living with HIV and their sexual partners at risk of transmitting HIV and other STI's. In itself, this data suggests that greater efforts need to be made in addressing these needs. Before providing recommendations to this effect, it would be appropriate to place the current data in context and in perspective relative to other target groups.

5.1. Caution

A study of this nature may have many potential sources of bias, including selection bias (due to recruitment from social venues); participation bias (due to respondents reluctance or willingness to participate in a survey of this nature); and reporting bias (difficulties in reporting true behaviours due to memory lapses or concerns about social acceptance). As the respondents in the sample were recruited from a variety of venues, systematic differences may exist between those who attend these venues and those who do not (e.g. age and economic power). Further, the sample may be skewed towards respondents who were more open to talk about sexual matters.

Respondents could also have been embarrassed by completing questionnaires on private matters (sexual lifestyles) in public venues thus biasing the sample to those who felt at ease to talk about sex, or leading to under-reporting of risk or unconventional sexual lifestyles. Caution should therefore be taken in generalizing these findings to the overall population of Gugulethu and its surrounds, and also South Africa.



6. Conclusion and Recommendations

The project aimed to collect KAP (Knowledge, Attitude and Practices) data amongst a sample of HIV positive Africans accessing services in Gugulethu. The feasibility of collecting this information was also to be assessed. This section of the report outlines the implications of some of the key findings in relation to health promotion and future work. The project has shown that it is feasible to conduct a sexual behavioural study with HIV positive Africans accessing services in Gugulethu. The blurred geographical boundaries in accessing HIV related services indicate that African clients access services with minimum regard of these boundaries.

A larger study should be undertaken to assess the levels of HIV-related knowledge, attitudes and behaviour across all of the areas in the Republic of South Africa where significant African communities reside, and that this be incorporated in to the national HIV Behavioural Surveillance Programme. People living with HIV, service providers and researchers need to

work collaboratively in developing and designing the research process and the eventual tools. Importantly, people living with HIV should feel that the research is of benefit in the short and long term. Service providers are also key to the research process. It was through collaborative work with service providers that access to this population was made possible.

The research capacity of service providers should be built upon. It is recommended that particular note be made of the role of religion and religious leaders in influencing African community knowledge and attitudes regarding HIV and its management. The respondents were active participants in the management of their health and they bring along various complex issues that affect their interpretations of medical care. Religion played a major factor in adherence to medical prescriptions – this relates to the pro-life principle of most religions, and that taking medication that alleviates suffering and improves health will be seen as pro-creation. Health care professionals need to be aware of this important factor; more research is needed to explore the ways in which religion may play a positive role in health behaviour. However, more health promotion work and education needs to be invested in understanding the relationship between prayer and HIV cure. The role of religious and community leaders in health promotion is vital within subgroups of HIV infected African communities.

It is recommended that specific resources be allocated towards a system for supporting such leaders in providing clear and accurate information regarding HIV and its treatment. It is recommended that service providers be made aware of potential confusion around concepts such as ‘resistance’ and ‘undetectable viral load’, and take care when explaining such issues to HIV positive Africans. It is clear that clinicians need to be very careful when discussing issues such as resistance and undetectable viral load.

Specific training around this issue is recommended. It is recommended that health promotion service providers review their prevention programmes and increasingly incorporate factors relevant to members of the African communities who are already living with HIV.

It is recommended that peer interventions be aimed at younger members of the African community who are HIV positive. Preliminary analysis of the data suggests that there are a sub-group of HIV positive Africans who consider their peers as the most credible source of

information regarding primary and secondary prevention. The use of contemporary music, dance and theatre need to be explored as effective vectors for conveying health promotion messages



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