

**The personal perception of HIV and AIDS related infection risk among African  
Refugee communities of Cape Town**

by

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## ABSTRACT

Political instability involving civil wars which had been prevailing mostly within the African Great Lakes Region caused great numbers since the 1990s of civilian populations to move to and fro within the borders and sometimes beyond its frontiers in search of both safer homes and better living conditions. Socio-economic hardships experienced by these people constrained them to engage in various migration movements, thus making them more vulnerable to a variety of diseases and pandemics, among which Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). Sub-Saharan Africa has been bearing the brunt of HIV pandemic, and South Africa is believed to have the highest HIV prevalence. The present study was a quantitative survey exploring personal perception of HIV infection risk among African émigré communities of the Cape Metropolitan area. Only thirty four heterosexual active participants, who had joined their partners in South Africa after a certain period of temporary separation, were considered for final analysis using descriptive statistics. A relatively high perception of HIV infection risk was found among both males and females. However, the perceived risk did not necessarily determine sexual behaviour. No significant reciprocal relationship was found between the perceived risk and one important sexual risk behaviour. HIV and AIDS related stigma was found to be relatively high and the use of condoms prejudiced by tendencies of personal moralistic values. The present study has made relevant recommendations as to promote more preventive behaviours among the present African émigré community.

## OPSOMMING

Politiese onstabielheid wat burgeroorloë meebring kom sedert die 1990's meestal in die Groot Mere-streek van Afrika voor en het veroorsaak dat groot groepe van burgerlike bevolkings heen en weer tussen grense beweeg en soms grense oorsteek op soek na beter en veiliger tuistes en beter lewensomstandighede. Die sosio-ekonomiese ontberings wat deur hierdie mense ervaar is het hulle verplig om by verskeie migrasiebewegings betrokke te raak. Dit het hulle kwesbaar gemaak vir 'n verskeidenheid siektes en pandemies, waaronder die menslike immuniteitsgebreksvirus (MIV) en verworwe immuniteitsgebreksindroom (Vigs). Sub-Sahara-Afrika het die ergste van die MIV-pandemie getrotseer en Suid-Afrika het na bewering die hoogste MIV-voorkoms.

Hierdie studie is 'n kwantitatiewe opname wat die persoonlike persepsie van die risiko van MIV-infeksie onder Afrika-uitgeweke gemeenskappe in die Kaapse Metropoolgebied ondersoek het. Slegs 34 heteroseksuele, seksueel aktiewe deelnemers wat na 'n tydperk van tydelike skeiding by hul (lewens) maats in Suid-Afrika aangesluit het, is vir die finale analise oorweeg met behulp van beskrywende statistiek. Onder mans sowel as vroue is 'n relatief hoë persepsie van infeksierisiko gevind. Die waargenome risiko het egter nie noodwendig seksuele gedrag bepaal nie. Geen beduidende omgekeerde verhouding is tussen die waargenome risiko en een belangrike seksuele risikogedragaspek gevind nie. Daar is bevind dat MIV en Vigsverwante stigma relatief hoog is en dat daar weens tendense van persoonlike moralistiese waardes vooroordeel teen die gebruik van kondome bestaan.

Hierdie studie het relevante aanbevelings gedoen om meer voorkomende gedragpatrone onder die huidige Afrika-uitgeweke gemeenskap te bevorder.

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## CHAPTER ONE

### INTRODUCTION

#### 1.1 Introduction

Political instability involving civil wars which had been prevailing within different sub-Saharan Africa's countries, mostly within the African Great Lakes Region (Rwanda, Burundi, Democratic Republic of the Congo – DRC -) since the 1990s caused large numbers of civilian populations to move to and fro within the borders of the region and sometimes beyond its frontiers, either as internally displaced people (IDPs) and/or refugees, in search of both safer homes and better living conditions. Socio-economic hardships experienced by the affected people, as a result of perpetuating civil wars and their aftermaths constrained them to engage in increasing various migration movements, thus making them more vulnerable to a variety of diseases and pandemics, among which Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), which have been proved to have been affecting mostly women and children, more particularly within the sub-Saharan Africa (Agbibo, 2010). As sustained by The Kaizer Foundation (2013) HIV primarily affects those in their most productive years where about half of new infections are among under age 25.

According to The Regional Fact Sheet (UNAIDS, 2012) in 2011 an estimated 1.8 million new infections in sub-Saharan Africa have been recorded; between 2009 and 2011 newly infected children with HIV in sub-Saharan fell by 24%. In 2011 coverage of services to prevent mother-to child transmission (PMTCT) of HIV in this area in Africa reached 59%. Surveys conducted between 2004 and 2011 in 14 countries in sub-Saharan Africa found significant increases in the percentage of adults who had an HIV test in the previous 12 months and were informed of their status. In 2011 it was estimated 56% received treatment compared to a global average of 54% indicating that wider access to treatment is saving lives. Antiretroviral therapy has added approximately 9 million life-years in the area since 1995. Moreover, according to UNAIDS (2012) in 2011 both 69 % of the global population living with HIV (PLHIV) and 92% of those positive pregnant women were living in this part of the continent. Additionally, a number of African countries, among which South Africa have already achieved more than 60% coverage of HIV treatment and even



Rwanda, Botswana, Namibia, Swaziland and Zambia have already achieved more than 80% which must have contributed to the maintenance of higher level of HIV prevalence within the sub-Saharan Africa region.

According to UNAIDS (2009) as cited in IAS2009 (2009) the number of people on HIV treatment at the start of the programme in 2004 was only 50 000 and had risen to about 550 000 in 2008. Additionally all refugees and asylum seekers who were holders of valid permits, were entitled to similar medical services and treatment as South Africans citizens, including access to HAART (highly active retroviral therapy, namely the HIV treatment). It is therefore assumed within South Africa, every person living with HIV and AIDS who would meet all the South Africa's HIV treatment protocols and visit any relevant public health facility, will enjoy the benefits of HAART. As further argued by IAS2009 (2009) South Africa has the highest HIV prevalence in the world, with more than 5.7million people living with the disease. Furthermore, one in every five adults South Africans is living with HIV represented by 59% of women aged 15 and over, 1.4 million of children have been orphaned and almost 1 000 AIDS-related deaths occur in this country every day. It is estimated 71% of deaths among those aged 15–49 are AIDS related.

## **1.2 Background**

Perpetuating civil wars and political instabilities which had been affecting the African continent in general, since early 1960s during the 'Africa's independence waves', right through to the 1990-1994 Rwandan war which was crowned by the 1994 Rwandan Tutsi genocide and its aftermaths, caused a great number of men, women and children to flee their homelands seeking safer homes and better life opportunities.

The Rwandan political crisis of 1990–1994 did not only affect the whole African Great Lakes Region, but its impact was felt more likely through the whole sub-Saharan Africa; particularly within the southern Africa area. It happened that men were leaving first, whereas women (and children) had to stay behind and would join their respective husbands later in their respective new hosting countries. It was more likely within this context that African refugee communities, amongst others Rwandans, Burundians and Congolese were established in Cape Town. According

to the United Nations High Commissioner for Refugees (UNHCR, 2013) by the end of 2011 an estimate of 220 000 asylum-seekers were registered in South Africa. Legislation has changed and this has made access to asylum challenging, particularly for individuals from non-neighbouring countries, which may be denied refuge in South Africa on the basis of the 'first country of asylum' policy. Tighter border controls, implemented to reduce irregular movements and fraudulent asylum claims by immigrants, have also played a role in lessening the number of applications. About 63 000 people from the beginning of December 2011, mainly from Angola, Burundi, the DRC, Rwanda and Somalia had been recognized as refugees in South Africa. They have been granted freedom of movement, have received permission to engage in work and the right to access basic social services through grants. These grants are those provided by the Department of Social Development through the South African Social Security Agency (SASSA). The problematic processes of applying for and issuing of Refugee ID Cards, resulting from the relatively ambiguous Department of Home Affairs modus operandi, more particularly when it comes to refugees affairs, have made it difficult for refugees to enjoy these rights fully (UNHCR, 2013). However, refugees and asylum seekers have equally free access to medical services as do citizens from South Africa. It is generally maintained with regard to sexual practices among the immigrant milieu that unprotected sex is a common practice among these respective African communities of Cape Town, thus increasing their risk of HIV infection. However, it is unclear how these refugee communities of Cape Town perceive their personal risk of HIV infection. The present study was interested in exploring the experiences of heterosexual African émigré communities living in South Africa, namely in the Cape Metropolitan area. Alleged sexual behaviour patterns of these communities have created a research need particularly with regard to risk perception of HIV infection and vulnerability.

### **1.3 Definition of key concepts**

*Mobility* refers to moving from one's ordinary place of residence, mostly in village or rural area, and move to town in search of work or a better living.

*HIV* stands for Human Immunodeficiency Virus. *AIDS* stands for Acquired Immune Deficiency Syndrome (the disease caused by HIV).

*Vulnerability:* HIV related vulnerability refers to the probability, basically how easy it is for someone (namely the degree of exposition to HIV) to get infected with HIV.

*HIV Test* refers to one's voluntary blood test (or body fluid/s), which detects HIV antibodies in the system, to determine some one's HIV status.

*Perception of risk:* with regard to HIV, the risk conception of HIV infection refers to the awareness and mostly the consciousness of someone as to adopt either preventive or risky sexual behaviours.

*HIV and AIDS knowledge* refers to both the amount and the accuracy of information that someone has with regard to HIV and AIDS, more particularly as related to HIV prevention and AIDS care.

*Émigré/immigrant:* in the present paper, émigré and immigrant will be used interchangeably, and refer to people from outside of South Africa, who, as a result of insecurity and precarious living conditions, had fled from their home countries and came to South Africa, seeking either asylum or better living conditions or both, and had been staying in Cape Town as refugees.

*Refugees* are people who had fled their countries due to a well - founded fear of persecution (on the basis of race, religion, nationality, political opinion, etc.,) and who cannot or do not wish to return back to their respective home countries (The Mobility Project, 2001).

*Asylum seekers* are refugees to be.

*African:* in the present study, African/s refers to immigrant/s from Africa's countries (as to distinguish them from those from Asia or Western countries) that had been staying in South Africa as refugees.

*African Great Lakes Region:* the Africa's geographical part of Rwanda, Burundi and DRC.

In the present study the terms "Refugee/s", "asylum seekers", "immigrants" or "émigrés" will be interchangeably used to mean the same thing.

*Internally displaced persons (IDPs):* people who have fled their homes as a result of civil war for instance, but who remain within the borders of their home country.

#### **1.4 Motivation of the present research project**

The FIKELELA HIV/AIDS Project, an Anglican Church's initiative to respond to the pandemic and currently operating from the Cape Town Diocese premises presented an HIV and AIDS Peer-education workshop among Rwandan refugees of Cape Town in 2012. The twenty five participants had been randomly selected as participation was free, voluntary and opened to each Rwandan immigrant of Cape Town who was 18 years or older.

During the workshop experience participants were narrating and sharing their respective stories related to HIV and AIDS. Five married women (out of fifteen) reported how on the very first night of their arrival in Cape Town when joining their husbands, they had to acquiesce to unprotected sexual intercourses despite their inner worries with regard to the unknown HIV status of their respective husbands, after a period of temporary separation, varying from two to ten years. Normally, sexual issues are handled as taboos within the Rwandan ethos. It was therefore very surprising how these women had the courage of sharing their HIV and AIDS related concerns. Although Rwandan women are culturally socialised to provide for their respective husbands' sexual needs and satisfy them no matter how that might be at the wives' expense, men should at least have been cautious enough as either to initiate the use of condom or abstain until they have ascertained their HIV status through testing. Additionally, some women sustained that since their arrival in South Africa until the day the workshop took place, their husbands had never used condom nor suggested any HIV test, and instead they had been continuously enjoying unprotected intimate relationships with their respective spouses.

Furthermore, inasmuch as sub-Saharan Africa's societies tend to share socio-cultural similarities of patriarchy and woman status-quo features, it was therefore reasonable to assumingly apply experiences of Rwandan refugee women and men (relating to their risky sexual behaviours, with regard to the very first sexual intercourse with their respective spouses in South Africa) to the rest of African refugees, who were in this country under similar circumstances.

Finally, it is believed concerns of those women and their respective first sexual experiences in South Africa, with regard to personal perception of HIV infection and

AIDS among these communities were worth of investigation, with intention to suggest more preventive guidelines.

### **1.5 Research question**

What is the degree of risk perception relating to HIV infection among sexually active African refugees of Cape Town?

### **1.6 Objectives of the study**

The objectives of the present study were:

- (i) To determine the personal risk perception of HIV infection among African refugee communities of the Cape Metropolitan area;
- (ii) To establish the existence of any reciprocal relationship between the perceived risk and sexual risk behaviour;
- (iii) To assess the personal knowledge of African refugees within the Cape Town area with regard to HIV and AIDS;
- (iv) To explore their personal attitudes towards condom use; HIV testing and HIV and AIDS related stigma;
- (v) To identify gaps between personal HIV related beliefs (myths) and knowledge as compared to existing medical facts;
- (vi) To make recommendations related to effective preventive sexual behaviours to relevant HIV and AIDS policy makers and programme designers as relating to refugee communities of Cape Town.

### **1.7 Aims of the study**

The aim of the study is to explore the experiences of heterosexual African refugees living in South Africa, more particularly with regard to risk perception of HIV infection and vulnerability, in order to provide them with more preventive guidelines. Further there is a need to establish whether there would be any reciprocal relationship between the HIV and AIDS perceived risk behaviour and one most important sexual behaviour, namely the first sex performed in South Africa. In this case it is the first sexual intercourse participants had with their respective sexual partners/spouses in South Africa; assumingly when one of the partners from outside of South Africa joined her/ his counterpart to continue their relationship after a certain period of

temporary separation; or one party had joined the other one to start a new relationship in South Africa; or the participant (a refugee) had found a local (basically South African) sexual partner to start a new relationship.

The participants were selected on the basis of them being immigrants from Africa's countries and had been staying in the Republic at least for the last twelve months.

### **1.8 Research methodology**

The research design is a survey (quantitative data) exploring sexual attitudes of African refugees towards HIV and AIDS, by asking defined questions from whose answers a score could be derived (Louw & Edwards, 1997).

Initially, random sampling would be the sampling technique to be used, however, it was not practical to interact with members of Cape Town émigré community in public places and ask them to participate in the study. Eventually snowball sampling was used which seemed to be the most suitable for the circumstances. Snowball sampling refers to a technique whereby researchers start with some participants whom they know, who then be referred to other potential participants who might be likely to meet the inclusion characteristic (Christensen, et al., 2011, p.159). A sample of fifty four participants was selected among members of the African émigré community of Cape Town. A questionnaire was used as data collection instrument and data were analysed using descriptive statistics.

### **1.9 Outline of chapters**

Chapter one briefly introduces the socio-political back ground of participants, basically the pushing factors from their respective homelands and pulling factors into South Africa. A brief exploration relating to the motivation together with the research methodology highlights some of the limitations of the study in question.

Chapter two is a review of relevant and accessed literature, related to HIV and AIDS in general and on the perception of the infection and vulnerability in particular.

Chapter three covers the research methodology and its relevant concepts, from the problem statement, to the objectives of the study. Furthermore, quantitative research approach and the snowball sampling technique are explained.

Chapter four is the reporting of the results, namely the analysis and the interpretation thereof.

Chapter five provides conclusions and recommendations.

### **1.10 Limitations**

The limitations identified in this study are:

- Only refugees from Rwanda were included in the study.
- The émigré communities in Cape Town did not have a sound understanding of English.
- Married couples were interviewed and singles were excluded.

### **1.11 Conclusion**

When individuals leave their home country and become refugees they have to face new challenges in their adopted environment.

## CHAPTER TWO

### LITTERATURE REVIEW

#### 2.1 Introduction

HIV is principally a sexually transmitted infection between two individuals. It has been scientifically proven HIV causes AIDS and the main routes of transmission vary according to regional patterns. As suggested by current studies, most of HIV infections within sub-Saharan Africa are through heterosexual contacts whereas in the Western countries high rates of infection incidences were found among men who have sex with men (MSM) and injected drug users (IDUs) (Likatavicius & van de Laar, 2012).

According to The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2011) 72% of all AIDS global deaths took place in 2007 Sub-Saharan countries. The epidemic continues to be most severe in southern Africa, with South Africa having more people living with HIV (an estimated 5.6 million) than any other country in the world. Almost half of the deaths from AIDS-related diseases in 2010 occurred in southern Africa. As further sustained by UNAIDS (2012) around 34 million people were living with HIV at the end of 2011 with an estimated 0.8% of adults between 15–49 years being HIV positive. However, HIV and AIDS prevalence statistics display marked differences according to countries and/or regions. Additionally, one person among every twenty adult people (4.9%) within this area in Africa is living with the virus, which makes approximately 69% of HIV positive people worldwide (UNAIDS 2012). Moreover, comparisons of Rwandan statistics of the year 2000 and those of 2010 gave an indication of significant increases of risky sexual behaviours related to unprotected sexual activities among both males and females who were younger than 15 years and of engaging in multiple sexual partnerships among both men and women who were between 15–49 years. Rwandans to date tend to be reluctant with regard to the use of condom as far as their respective sexual intimacies are concerned. The tendency of low levels of condom use among sub-Saharan's communities have been argued by various authorities, among which a study by Lammers, Wijnbergbergen and Willebrands (2011), exploring gender differences, HIV risk perception and condom use among market vendors in Lagos – Nigeria. As suggested by same study, the famous ABC – Abstain, Be faithful and



use Condom – has now been incorporated in most prevention campaigns around the world. Despite this knowledge, people still engage in unprotected sex, even in countries with high prevalence rates, where unprotected sex entails high risks.

## **2.2 Migration and HIV and AIDS**

According to the Global Commission on International Migration (2005), nearly half of the migrants in the world today are women. Additionally, as suggested by a research project conducted in southern Africa by The Mobility Project (2005) the vulnerability of female migrants to HIV infection is due to many factors including the spreading of the infection, social isolation, poverty, low levels of education and lack of access to health care services such as testing and treatment for sexually transmitted infections (STIs). Women are particularly vulnerable in these circumstances and in particular migrant ones had higher incidence of HIV with increased sexual risk behaviour, compared to non-migrants. Violence and rape were also potential HIV risk factors for mobile women both for economic immigrant women or asylum seekers and refugees. Similarly, rape and / or sexual assault might have happened to African immigrant women (particularly Rwandans), either during wars in their respective countries or on their way to South Africa.

As sustained by a report of The International Organisation for Migration (IMO, 2004, as cited in The Mobility Project, 2005) the incidence of stressful work with an increased risk of physical injury may induce a feeling of hopelessness in which the dangers of contracting HIV are outweighed by other pressing concerns and needs. According same sources, when individual's daily life is a struggle HIV and AIDS appears to be a distant threat and their feeling of disempowerment throws a shadow over a life style where their health is of no concern. Mobile populations including migrants were among vulnerable populations mainly for reasons which may include lack of hygiene, poverty, powerlessness and the precarious family situation which accompany their situation. As argued by Grow and Desmond (2007) referring to schooling systems, one obvious implication of HIV and AIDS epidemic is that girls are more likely to be infected than boys and are more likely to be withdrawn from schools than boys and more likely to be held back to provide care for the infected party and for siblings. As further argued by same sources, girls were also more likely than boys to become the victims of sexual exploitation and may be driven to this

course as a means of personal survival and household support. Grow and Desmond's (2007) arguments also corroborate a concern which most of African men refugees should consider, namely that most of them are in South Africa as a result not only of the insecurity which had been prevailing in their respective countries, but also of hardship resulting from the aftermaths of those wars. Consequently, it is reasoned it could happen not only to school girls but also women in relationships as a result of daily life hardships. Therefore, their respective husbands who managed to immigrate to South Africa, leaving them behind should consider either a prior HIV Test before engaging again in sexual activities with their wives or using condoms until they have tested HIV negative.

A study by Lammers, et al.,(2011) revealed not only there was low risk perception of engaging in unprotected sex among their participants but also they did not have the knowledge condoms prevent HIV infection, which appeared to be the best predictors for risky behaviour among men. The lack of knowledge as related to using condom as means of HIV prevention was also important predictor for risky behaviour among single females. These factors, however, do not explain sexual behaviour of married women who appear to be aware of the HIV prevention use of condom but tend to continue acquiescing to unsafe sex. It was therefore suggested it is due to a lack of bargaining power in HIV prevention decisions among married females. Power imbalances, as relating to safer sex negotiation among heterosexual couples in the sub-Saharan region had been repeatedly reported by various authorities. A study by Akwara, Madise and Hinde (2003) exploring perception of risk of HIV and AIDS and sexual behaviour in Kenya suggested marital status influences perception of the risk of HIV infection and sexual behaviour. Additionally, non- married women may have some ability to negotiate safer sex, whereas their married counterparts face extra challenges because of the fear of being suspected of promiscuity by their spouses, which may lead to unwanted consequences such as separation or even divorce. This causes married women to acquiesce more often in unsafe sexual practices, even if they suspect or are aware of their husband's extra marital relationships. Assumingly, this argument may explain the passive sexual attitudes of the Rwandan women (from the FIKLELA workshop) of engaging in unsafe sexual intercourses with their husbands, despite their deep and inwards wishes and need to

suggest an HIV test and also their inability to express their concerns and will for condom use.

As Akwara et al., (2003) further maintained, knowledge of AIDS has increased remarkably over the years and is almost common in most sub-Saharan countries, but the association between such knowledge and sexual behaviours is rather ambiguous. Providing a possible explanation for the weak link between knowledge, perceived risk and behaviour, some sources further argued respondents had fatalistic attitude towards AIDS, as the expression of 'after all you have to die of something' was cited to justify high risk behaviours. This fatalism had been noted in other researches where participants were aware of modes of transmission and prevention and yet continued to engage in risky sexual practices. This also would explain the careless attitudes of the African immigrant men of engaging in unsafe sexual intercourses, despite the amount and the accuracy of HIV and AIDS related information through mass media which they had been exposed to, more particularly in South Africa.

According to The Policy Project (2001, as cited in Mpazayabo, 2012) generally in patriarchal societies women have lower power of control over their sexuality and are socialised from their early childhood to be obedient and submissive to males. A woman would be expected to please her male partner, even if such sexual encounters would be harmful to her own health and/or life. Furthermore, both male interests and tendency to passiveness put women at higher risk of contracting HIV despite their faithfulness while living in their respective heterosexual relationships. This would justify the passiveness of most of Rwandan women, as they consent to unprotected sex with their husbands, although they had joined them after a long period of separation and this can equally be applied to the rest of the African émigré community in South Africa with similar background conditions. As further sustained by same sources, in war-like conditions the threat of forced sex is a weapon used by men against women and girls and in turn, women and girls may agree to sexual relationships in exchange for some level of physical and material security.

Rwandan women might also have experienced similar realities, (as well as other African women within similar situations) as a result of the Rwandan war of 1990–1994 and its aftermaths. This war and its destructive impact on the whole Rwandan

social fabric lead to a massive exodus of civilians mostly men, among which these refugees and asylum seekers in South Africa, which led to having these immigrants being more vulnerable to HIV and easily exposed to risk and infection, all along the way from their home land.

The Policy Project (2001) indicate HIV can be controlled if not tackled by positive changes in human sexual or other HIV related behaviours; eighty percent of the global adult population are still HIV negative. Most of them are aware of HIV and AIDS and therefore should be responsible enough to seize the opportunity to protect themselves from both HIV infection and AIDS disease. However, according to (Kalicham, 1997 as cited in UNAIDS, 1999) although people if given correct information about transmission and prevention will lead to behavioural change, education alone is not sufficient to induce behavioural change amongst individuals. Therefore a more efficient approach which takes into consideration individual's psychosocial and cognitive context to educate people in practical skills to reduce their risk for HIV infection needs to be adopted.

Furthermore, it was argued research exploring the extent to which indigenous beliefs may be influencing people's decisions about safer sex could offer useful insights for AIDS prevention programs (Liddell, Barrett & Bydawell, 2004). According to Akwara et al., (2003) religious people considered HIV and AIDS as a disease that affected those who had sinned against God; whereas some other people believed a healthy looking person cannot carry HIV. This belief can lead to exposure to HIV infection since people are unlikely to take precautions when having sexual intercourses with healthy looking partners. As further argued another belief which can influence the perception of HIV infection is the way that illness is viewed; while some may see AIDS as a punishment for immoral behaviours, those who see their lifestyle as being morally upright may perceive their chance of being infected by HIV to be very low. Possibly, this attitude can also explain why those Rwandan males have been engaging in unprotected sex with their wives without either a prior HIV test or using condoms, despite the prior long period of them being apart from each other as it is a common moral value for a Rwandan woman to be sexually sober as she is expected to avail herself only for her only one sexual partner. Furthermore, as argued by Van Niekerk (2005, as cited in van Niekerk & Kopelman, 2005, p. 62) while commenting on women's vulnerability, not only women were physically more prone to become

infected than men during normal sexual encounters, but also their social and economic status role dictated by culture put them at greater risk; and also they tend to be financially depending on their male sexual partners.

Although academic and empirical work investigating the vulnerability of both men and women with regard to HIV and AIDS have been conducted, more should be added to the body of knowledge with regard to men's risk perception as relating to infection and more particularly among immigrant populations; focussing on refugees and asylum seekers, a category of populations which is classified as chronic poor (The Mobility Project, 2001).

According to (Haour–Knipe & Grondin, 2001, as cited in The Mobility Project, 2001) the move to a different cultural context in search of work can also mean isolation from protective social rules, which can increase vulnerability to HIV.

Migration and mobility are complex realities with far reaching consequences and reasons for it range from professional aspirations to life threatening catastrophes. Both the system of migrant labour and refugees and asylum seekers migrating patterns in southern Africa, which happened to compel the males to leave their female partners behind, in typical impoverished areas, is a key factor in the pattern of the region's HIV epidemic (The Mobility Project, 2001). HIV and AIDS responses to be effective have to address all stages of the migration process. As most of current approaches to HIV and AIDS prevention are based largely on persuading individuals to change behaviours, without due regard for the social, cultural and economic contexts in which behaviours are shaped and lodged; it is worth highlighting that any HIV and AIDS response programme that ignores the cultural, economic and sociological aspects of HIV and AIDS is unlikely to meet with success (The Mobility Project, 2001). However, it needs also to be stressed that people organise their universe through cultural and social biases and choose what to fear and how to behave based on their worldviews and patterns of cultural and social norms, leading to selection and preferences of some risky behaviours over others, just to suit one's lifestyle. Furthermore, social structures define and shape risk perception in societies, but under normal conditions, each one uses own free moral agency to make own choices of behaviours. Thus risk is usually individualised and therefore, through this process of individualisation, risk becomes associated with

choices, responsibility and blame, and the individual rather than society is held accountable for negative outcomes (Tsasis & Nirupama, 2008).

Lammers et al., (2011) argue if it is in a particular culture or a lack of female bargaining power, HIV prevention campaigns might be more efficient when focused towards males. Painter (2001) adds by referring to media based interventions which were not enough focused on heterosexual relationships as they would for instance encourage men as members of a gender category to use condoms with non-regular sexual partners, particularly female sex workers. However, when depicting two heterosexual partners together, such as married couples, these messages would be rather more often concerned with the technicalities of safer sex (namely proper condom use) than with processes of communications and negotiations. These media messages therefore tend to miss the very point of 'communication, negotiation, sexual power bargaining and sharing', which actually appear to be the kernel of either safer sex and prevention or HIV infection risk and vulnerability among heterosexual couples, more particularly with married sub-Saharan women. According to Higgins, Hoffman and Dworkin (2010) recognition is given to the vulnerability model where women's HIV risk is mentioned instead of including men. Women should be sexually saved and protected but men's bad behaviour is the unalterable source of the problem. However, some innovative international programs were breaking new ground, suggesting the benefits of examining masculinity's relationships to HIV prevention for both women's and men's health. It was in this regard for instance that in South Africa, Men As Partners, worked directly with men to create more equitable gender norms by reducing violence against women and helping both sexes attend to their health needs; One Man Campaign, created by Sonke Gender Justice sought to provide critical space for men to reflect on the practice of masculinities, reshape their understanding of their own and others' HIV and AIDS vulnerabilities and risks, and encourage them to change their views and practices of sexual and domestic violence. The South Africa's Medical Research Council refined, implemented, and evaluated Stepping Stones, an HIV prevention effort involving women and men, which focused on gender equity, HIV prevention and anti-violence work.

## 2.3 Conclusion

Should any intervention programmes be implemented among African émigré community of Cape Town, it needs to be stressed that dishing out 'Eurocentric cooked meals' to this concerned community might not work, as most of African women and men still hold very strongly on respective cultural norms surrounding sexuality. For instance, assertiveness skills training programme for women will be more unlikely to be successful among Rwandan women who would rather prefer to remain passive in their sexual relationships with their husbands than risking their marriage, as an outgoing woman is considered a 'bad and insolent one' in Rwandan moral ethos. Nonetheless, as maintained by the objectives of the present research project, and seeing that cultural norms do not change overnight, more particularly those related to sexual behaviours, there will be a need to acknowledge it and then a moral obligation and responsibility to suggest more preventive sexual alternatives. Moreover both men and women will need to be involved in any relevant decision making processes, as at a certain extent, those decisions would affect their happiness, wellbeing and lives as a whole. Last but not least, it would be wiser and more objective to conceive policies and keep all the endeavours within the African socio – cultural frame work. As attempted by the present study, assessing their perception of HIV risk and their knowledge gape via self - rated risk behaviours is deemed the very first step of involving them in the whole process of assessing their needs with regard to HIV and AIDS education.

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 Introduction

It is commonly believed sub-Saharan Africa's societies had been patriarchal up to date, whose norms uphold the supremacy of men over women. Socialisation put more focus on the moral rearing of females than males, whereas early sexual encounters might be tolerated for boys, girls are expected to behave soberly with high expectations of getting married as virgins. Should a girl fall pregnant outside the wedlock it is considered an abominable event, she would be seriously blamed and would be more likely to be morally considered a social pariah and will have to bear both the psychological scars and social stigma of that "abomination" for the rest of her life; whereas nobody would actually be concerned with the morality of her male counterpart. Additionally, the daily life's hardships experienced by men refugees in the Cape Metropolitan area is assumed to have led to a very low perception of HIV related risk infection, resulting in unsafe sexual practices and explaining why they seemed not to see the necessity of a prior HIV Test or of the use of condom. Finally, the present study had anticipated to establish that, the break-up of stable relationships and the loss of mutual support, as well as loosening of cultural and familial controls on social behaviours must have influenced men to engage in risky sexual behaviours prior the arrival of their respective wives in South Africa, resulting in fatalism tendencies and inhibiting any HIV prevention drives.

#### 3.2 Problem statement

According to UNAIDS (2012) there was an increasing number of Rwandans, younger than fifteen years, who had been engaging in risky sexual activities, as well as an increasing number of adults involved with sexual multi-partnerships. The Rwandans' attitude of being reluctant when it comes to the use of condoms was expressed by the first sexual encounters when they arrived in Cape Town.

Therefore the present study's aim is to find an empirical answer to the following question: "What is the degree of personal risk perception of HIV infection and related vulnerability among African immigrants of the Cape Metropolitan area?"



### **3.3 Objectives of the study**

The objectives of the present study were:

- (i) To determine the personal risk perception of HIV infection and vulnerability among African refugee communities of the Cape Metropolitan area;
- (ii) To establish any reciprocal relationship between the perceived risk and sexual risk behaviour;
- (iii) To assess the personal knowledge of African refugee community within the Cape Town area with regard to HIV and AIDS;
- (iv) To explore their personal attitudes towards condom use, HIV testing and HIV and AIDS related stigma;
- (v) To identify gaps between personal HIV related beliefs (myths) and knowledge as compared to existing medical facts;
- (vi) To make recommendations related to effective preventive sexual behaviours to relevant HIV and AIDS policy makers and programme designers with regard to this community.

### **3.4 Research approach**

As suggested by (Louw & Edwards, 1997) qualitative methods collect information in the form of words and sentences which provide an in-depth understanding of the nature of what people experience. Furthermore, although it is not always possible to make comparisons and draw general conclusions, people reading a report can obtain a deeper and more human understanding of what has been discovered. Additionally, according to (Louw & Edwards, 1997) quantitative methods refer to the use of numbers in collecting or working with research data. One of the advantages of using quantitative methods in social sciences is that they provide a basis of comparing one result with another, whereas among others, one of their disadvantages is that some psychological phenomena are difficult to quantify and emphasising quantitative research may keep the researcher's attention on simple and superficial aspects of human nature. Inasmuch as variables such as the degree of HIV risk perception and frequencies of using condoms were involved, the research design of the present study was a survey (quantitative data) exploring sexual

attitudes of African immigrants towards HIV and AIDS by asking defined questions from whose answers a score could be derived (Louw & Edwards, 1997).

### **3.5 Sampling**

The target group was sexually active adults, both males and females among African émigré communities, members of Cape Town, who were over 18 years of age and were also expected to have good English communication skills (reading, writing and speaking). Making the sample more representative, random sampling was initially the one technique to be utilised for selection. However in practice, it happened that it was not as easy as anticipated to get potential participants' full attention in public places. Finding them at their respective residential area was equally challenging, both men and women tend to get up early morning and would go out to look for their daily bread. It was therefore within this context that snowball sampling was preferred to be an appropriate way to move forward, whereby the very first few participants would refer the researcher to other potential participants who are more likely to meet the required criteria of inclusion in the study (Christensen et al., 2011).

Section one contains biographical information to be recorded from the participants in the study. Section two, mainly dealing with knowledge of HIV and AIDS, risk perception of HIV infection and HIV and AIDS related sexual behaviours is an English relevant set of selected questions adapted from Anderson, Beutel and Maughan – Brown (2007 – Centre for Social Science Research – University of Cape Town); Lammers, Wijnbergan and Willebrands (2011 – University of Rotterdam & University of Amsterdam); Napper, Fisher and Reynolds (2011 – Center for Behavioural Research and Services, California State University) and Tlou (2009 – University of South Africa) . This set of selected questions was relatively modified and combined to be used as instrument to collect data. A copy of the questionnaire was handed over to each and every participant to be completed straight away and was returned back to the researcher as soon as the participant deemed it completed. A copy of the questionnaire was annexed as Appendix “A”. Table 3.1 refers to the arithmetical representation of the raw sample.

**Table 3.1****The Raw Sample**

Gender	Number of participants	Currently in relationship	Currently Not in relationship	Came together with heterosexual partner in SA	Joined each other with heterosexual partner in SA
Female	30	27	3	7	<b>19</b>
Male	24	19	5	3	<b>15</b>
Total	54	46	8	10	<b>34</b>

**3.6 Conclusion**

As reflecting in table 3.1, nineteen out of twenty seven women (70.4%) that were in sexual relationship had joined their respective husbands (sexual partners) in South Africa; and fifteen out of nineteen men (78.9%) had been joined by their respective wives (sexual partners) in South Africa. The joining in question, for both women and men referred either to couples which had been in sexual relationship in their homelands and then had to get apart for a certain period of time to be joined together again later in South Africa; or to people who had never been in relationship before as couples back in their home countries, and happened to start their sexual relationship right here in South Africa. Same conditions also apply to any immigrant, who participated being in sexual relationship with a South African citizen. The following chapter will yield more relevant details.

## CHAPTER FOUR

### REPORTING OF RESULTS

#### 4.1 Introduction

Only participants who were heterosexually active during the time the present study were being conducted were considered for the final analysis. Those partners who joined each other in South Africa after a certain period of temporary separation or who started their sexual relationship for the first time in South Africa were included.

#### 4.2 Problem statement

Unprotected sex had been alleged to be a common practice among the émigré communities of Cape Town. As it emerged from the FIKELELA HIV and AIDS peer education workshop among Rwandan refugees, a number of females who participated in the workshop were in sexual relationship in Rwanda their homeland. Due to circumstances beyond their control, they had to part from their respective sexual partners, to join them later in South Africa after a certain period of temporary separation. However, as maintained by all of those women, they had been acquiescing to unsafe sexual intercourses against their innermost will just because socially, they are expected to supply sexual needs of their husbands, despite both health and life could be risk involved. Anticipating that either those women or their male sexual counterparts must have been engaging in extra marital relationships while away from each other should have been a motivation to consider either condom use or pre-HIV test before those concerned couples commenced engaging in sexual intimacies. However, those couples had just been enjoying themselves without any concern with regard to risk of HIV infection and/or vulnerability. Therefore the research question was: "What is the degree of personal perception of HIV infection risk and vulnerability among African refugees of Cape Town?".

#### 4.3 Objectives of the study

The objectives of the present study were:

- (i) To determine the personal risk perception of HIV infection and vulnerability among African refugee communities of the Cape Metropolitan area;

- (ii) To establish any reciprocal relationship between the perceived risk and one most important sexual behaviour;
- (iii) To assess the personal knowledge of African refugee community within the Cape Town area with regard to HIV and AIDS;
- (iv) To explore their personal attitudes towards condom use, HIV testing and HIV and AIDS related stigma;
- (v) To identify gaps between personal HIV related beliefs (myths) and knowledge as compared to existing medical facts;
- (vi) To make recommendations related to effective preventive sexual behaviours to relevant HIV and AIDS policy makers and programme designers with regard to this community.

#### **4.4 Measurements**

The first aim of the study was to explore the experiences of heterosexual African refugees living in South Africa, more particularly with regard to personal perception of HIV infection risk and vulnerability in order to provide them with more preventive guidelines.

The second aim was to establish whether there would be any reciprocal relationship between HIV and AIDS perceived risk such as the very first sex performed in South Africa.

Personal risk perception of HIV infection was determined by asking the following question: “How risky do you perceive it is ‘engaging in unprotected sex?’”. Respondents had the option to choose just one suggestion from a “seven – point” Likert item, ranging from “not at all risky” to “extremely risky”.

Reciprocal relationship between the perceived risk and one very important sexual behaviour was measured by the question: “During my first sexual intercourse (full penetration) which I had in South Africa: (and respondents had to choose just one of the five following proposed options): “I used condom”; “I did not use condom”; “I can’t remember”; “I do not want to answer this question”.

Knowledge of HIV and AIDS was assessed by answering the following question: “Do you know anybody who was dead as a result of AIDS related illness?” and respondents had to choose between “Yes” or “No”.

As to assess their respective attitude related to both the use of condom and client initiated testing and counselling (CITC), and knowledge of HIV prevention methods, respondents were asked to state at least three advantages and three disadvantages of condom use, with regard to how they felt about always using condom during sexual intercourse. Equally, respondents were asked to state at least three advantages and three disadvantages of how they felt about seeking voluntary counselling and testing for HIV.

To measure subjective norms towards the use of condom and CICT for HIV, respondents were asked to both indicate and rate at least three important people in their lives (“important others”) who would approve of them using condom during sexual intercourse and / or seeking HIV-CITC services. Rating was on a five – point Likert scale, ranging from one (1: the extremely low rating) to five (5: the extremely high rating).

Myths and misconceptions related to HIV and AIDS were identified using seven “True / False” items.

Individual’s feelings of vulnerability to HIV were assessed by rating the statement: “There is a chance, no matter how small, that I could get HIV” on a “six – point” Likert scale, ranging from “Strongly disagree” rated 1, as the lowest score (suggesting lower feeling of vulnerability), to “Strongly agree” rated 6 as the highest score (suggesting higher feeling of vulnerability to HIV).

#### **4.5 Findings of the study**

There were 34 heterosexually active participants who were included in the final analysis, 9 (26.5%) fell under the category of between 18–30 years old; 16 (47%) were between 31–40 years, while 9 (26.5%) were between 41 and 50 years old.

Education level was: 2 (5.9%) had primary school as highest education; while 17 (50%) had completed high school as their highest education and 15 (44.1%) had a tertiary education level.

Employment: 15 (44.1%) out of thirty four were employed the time the present study had been conducted; whereas 9 (26.5%) were self – employed; and 10 (29.4%) were not working. Twenty three (67.6%) of which 14 females (60.1%) and 9 males

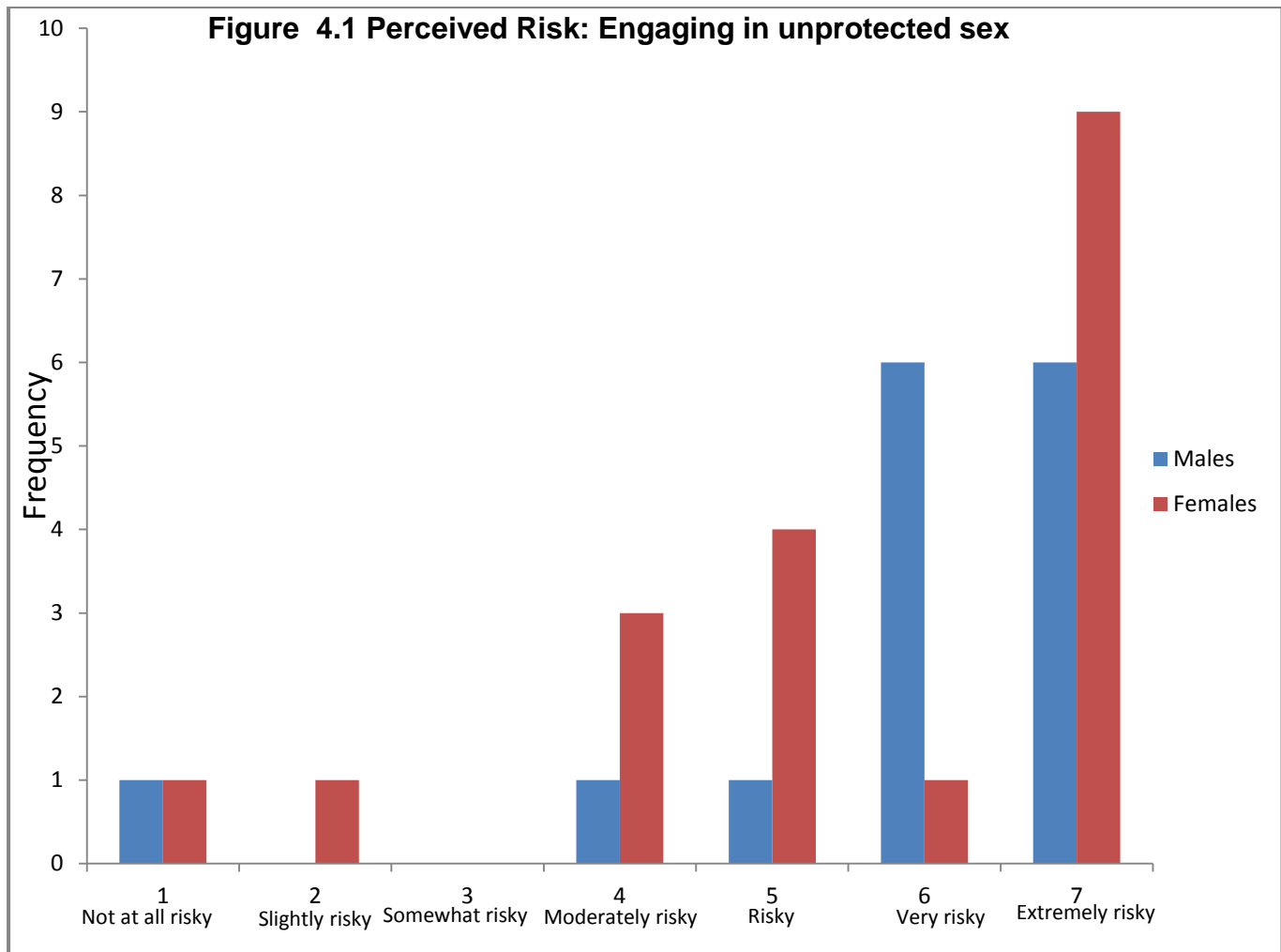
(39.1%) had joined their sexual partners in South Africa after a certain period of temporarily separation; and 11 (32.4%) among which 5 women (45.5%) and 4 men (36.4%) had met their sexual partners in South Africa for the very first time to start the relationship which they were involved.

Concerning HIV and AIDS perceived risk and attitudes towards condom use, table 4.1 reveals only 1 female (5.3%) and 1 male (6.7%) believed engaging in unprotected sex was 'not at all risky'; while 9 females (47.4%) and 6 males (40%) believed it was 'extremely risky'. Furthermore 4 females (21%) and 1 male (6.7%) believed engaging in unprotected sex was 'risky'; while 1 female (5.3%) and 6 males (40%) admitted engaging in unprotected sex was 'very risky' (table 4.1 & figure 4.1).

**Table 4.1**

**Frequency distribution of Perceived Risk: engaging in unprotected sex**

	<b>Males</b>	<b>%</b>	<b>Females</b>	<b>%</b>
<b>Not at all risky</b>	<b>1</b>	<b>6.7</b>	<b>1</b>	<b>5.3</b>
<b>Slightly risky</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>5.3</b>
<b>Somewhat risky</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Moderately risky</b>	<b>1</b>	<b>6.7</b>	<b>3</b>	<b>15.8</b>
<b>Risky</b>	<b>1</b>	<b>6.7</b>	<b>4</b>	<b>21.1</b>
<b>Very risky</b>	<b>6</b>	<b>40</b>	<b>1</b>	<b>5.3</b>
<b>Extremely risky</b>	<b>6</b>	<b>40</b>	<b>9</b>	<b>47.4</b>
<b>Total</b>	<b>15</b>	<b>100</b>	<b>19</b>	<b>100</b>



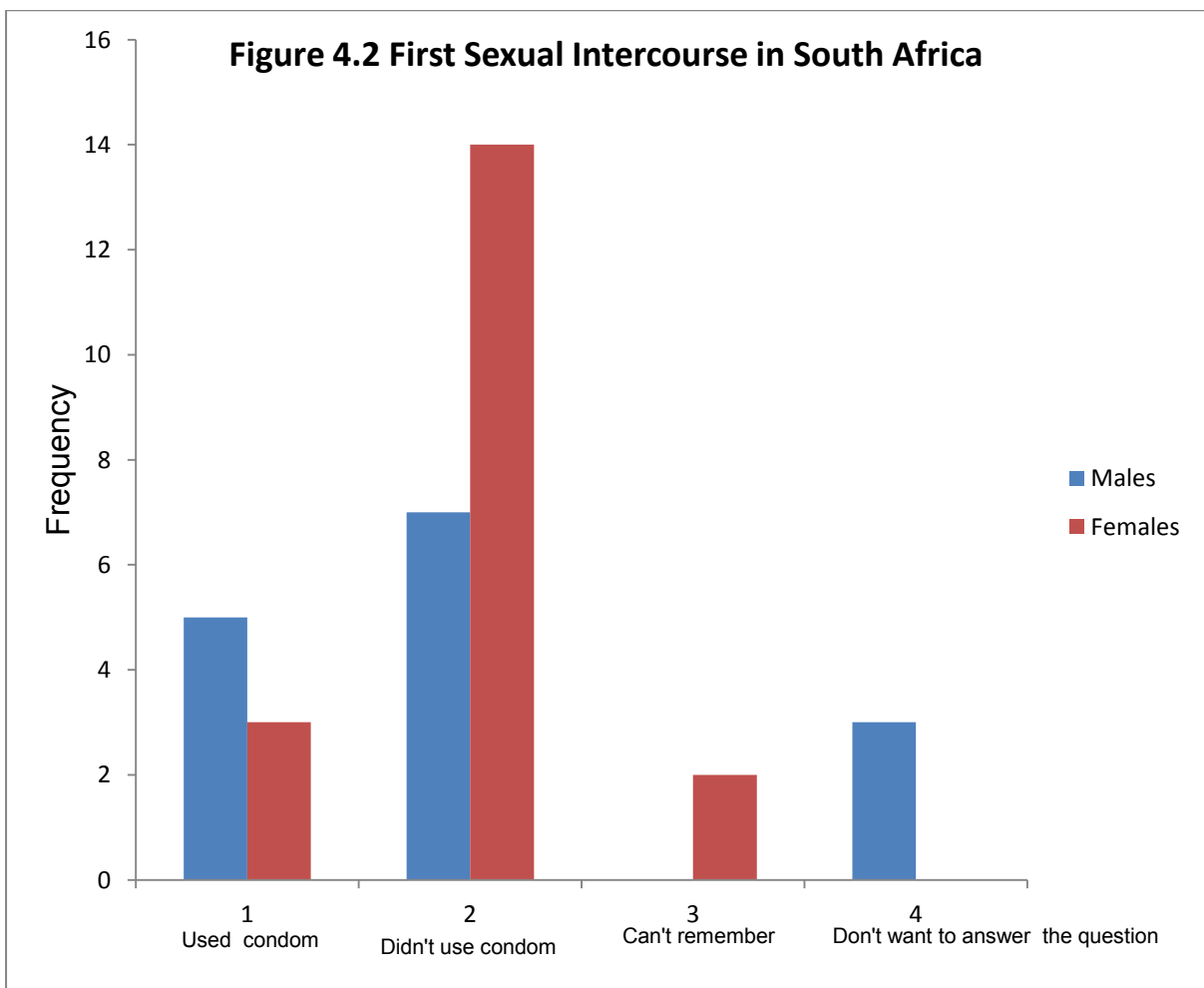
According to figure 4.1 with regard to the first sexual intercourse performed by the 34 participants of which 19 females (55.9%) and 15 males (44.1%) had with their respective sexual partners in South Africa. Twenty one out of 34 (61.8%) among which 7 males out of 15 (46.7%) and 14 females out of 19 (73.7%) did not use condoms, while only 8 (23.5%) of which only 3 females out of 19 (15.8%) and 5 males out of 15 (33.3%) used condom, while 2 females (10.5%) could not remember whether they had used them with regard to that specific sexual encounter; 3 men (20%) did not provide an answer.



**Table 4.2**

**Frequency distribution of First Sexual Intercourse in South Africa**

	<b>Males</b>	<b>%</b>	<b>Females</b>	<b>%</b>
<b>Used condom</b>	<b>5</b>	<b>33.3</b>	<b>3</b>	<b>15.8</b>
<b>Didn't use condom</b>	<b>7</b>	<b>46.7</b>	<b>14</b>	<b>73.7</b>
<b>Can't remember</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>10.5</b>
<b>Don't want to answer the question</b>	<b>3</b>	<b>20</b>	<b>0</b>	<b>0</b>
<b>Total</b>	<b>15</b>	<b>100</b>	<b>19</b>	<b>100</b>

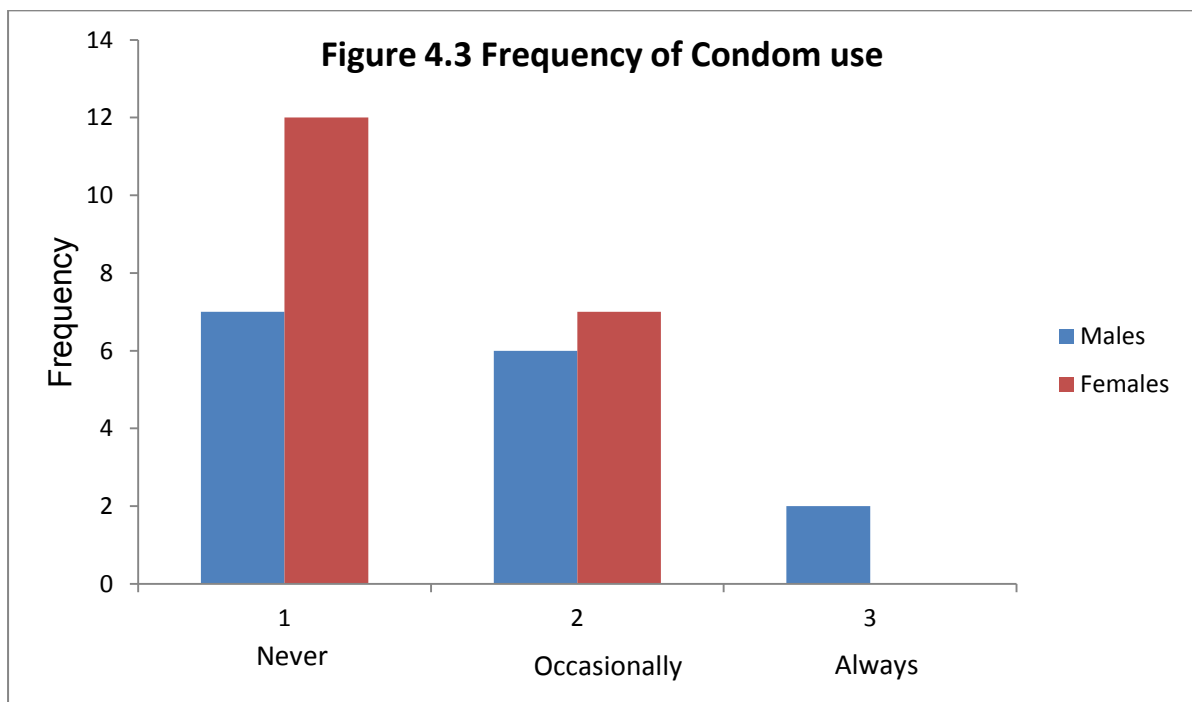


Furthermore, as relating to the first sexual intercourse, 17 females (89.5%) knew their husbands (sexual partners) were HIV negative; while only 1 (5.3%) were aware her partner was HIV positive and 1 (5.3%) was not sure about her partner's status. Additionally, 6 males (40%) suggested they knew their respective partners were HIV negative; whereas 6 (40%) indicated they were not sure about their partners' status and 3 (20%) did not answer the question.

As far as attitudes towards condom use was concerned (table 4.3) only 2 (13%) of the males have always used condom, while 6 (40%) of males and 7 (36.8%) of females occasionally used condoms. Additionally, 7 (46.7%) males and 12 (63.2%) female respondents had never used condoms (table 4.3 & figure 4.3).

**Table 4.3**  
**Frequency distribution of Condom use**

	<b>Males</b>	<b>%</b>	<b>Females</b>	<b>%</b>
<b>Never</b>	<b>7</b>	<b>46.7</b>	<b>12</b>	<b>63.2</b>
<b>Occasionally</b>	<b>6</b>	<b>40</b>	<b>7</b>	<b>36.8</b>
<b>Always</b>	<b>2</b>	<b>13.3</b>	<b>0</b>	<b>0</b>
<b>Total</b>	<b>15</b>	<b>100</b>	<b>19</b>	<b>100</b>



Relating to both knowledge and awareness of HIV and AIDS, all 19 females (100%) and 14 males (93.3%) had already heard about it; while only 1 male (6.7%) had no knowledge. Additionally, all 19 female participants (100%) knew somebody living with HIV and/or AIDS; while only 8 males (53.3%) knew somebody living with it and 7 (46.7%) other males did not know of anybody living with the infections. Furthermore, 18 females (94.7%) and 10 males (66.7%) suggested they knew somebody who had died of AIDS; and only 1 female (5.3%) and 5 males (33.3%) did not know of anybody who had passed due to the infection.

Concerning myths and misconceptions in comparison with medical facts related to HIV and AIDS, 2 females (10.5%) and zero men (0%) indicated mosquitoes' bites can cause HIV infection; 1 female (5.3%) and 1 male (6.7%) suggested people can get infected with HIV only if they have sex with prostitutes while 1 female (5.3%) and zero men (0%) believed sharing the same plate with HIV positive people can cause the infection and 2 females (10.5%) and 1 male (6.7%) believed a healthy looking person can never be HIV positive. Additionally, 4 females (21%) and 6 males (40%) said people can get HIV only through unprotected sexual acts while 7 females (36.8%) and 7 males (46.7%) believed some kinds of condom cause HIV infection. Furthermore, 3 females (15.8%) and 1 male (6.7%) believed having sex with a virgin would cure AIDS.

HIV and AIDS related stigma and discrimination were still experienced among African immigrants of Cape Town, as 8 females (42.1%) and 11 males (73.3%) wanted it to remain a secret, should any of their relatives get infected with HIV. However, only 3 females (15.8%) and 6 males (40%) suggested they would not allow a baby sitters to continue looking after their child, should they be HIV positive. Furthermore, 16 (84.2%) of the 19 females and 10 (66.7%) of the 15 males knew their HIV status; while only 7 females (36.8%) and 3 males (20%) had volunteered for a HIV test within the last six months, namely between June–December 2013.

Regarding subjective norms related to condom use and seeking HIV client initiated testing and counselling (HIV–CITC) services, partners of 6 female respondents (31.6%) had recommended the use of condoms, while zero female participants (0%) felt the same. Basically no female participant had indicated to have ever had suggested condom use to her sexual partner. Six females (31.6%) and 6 males

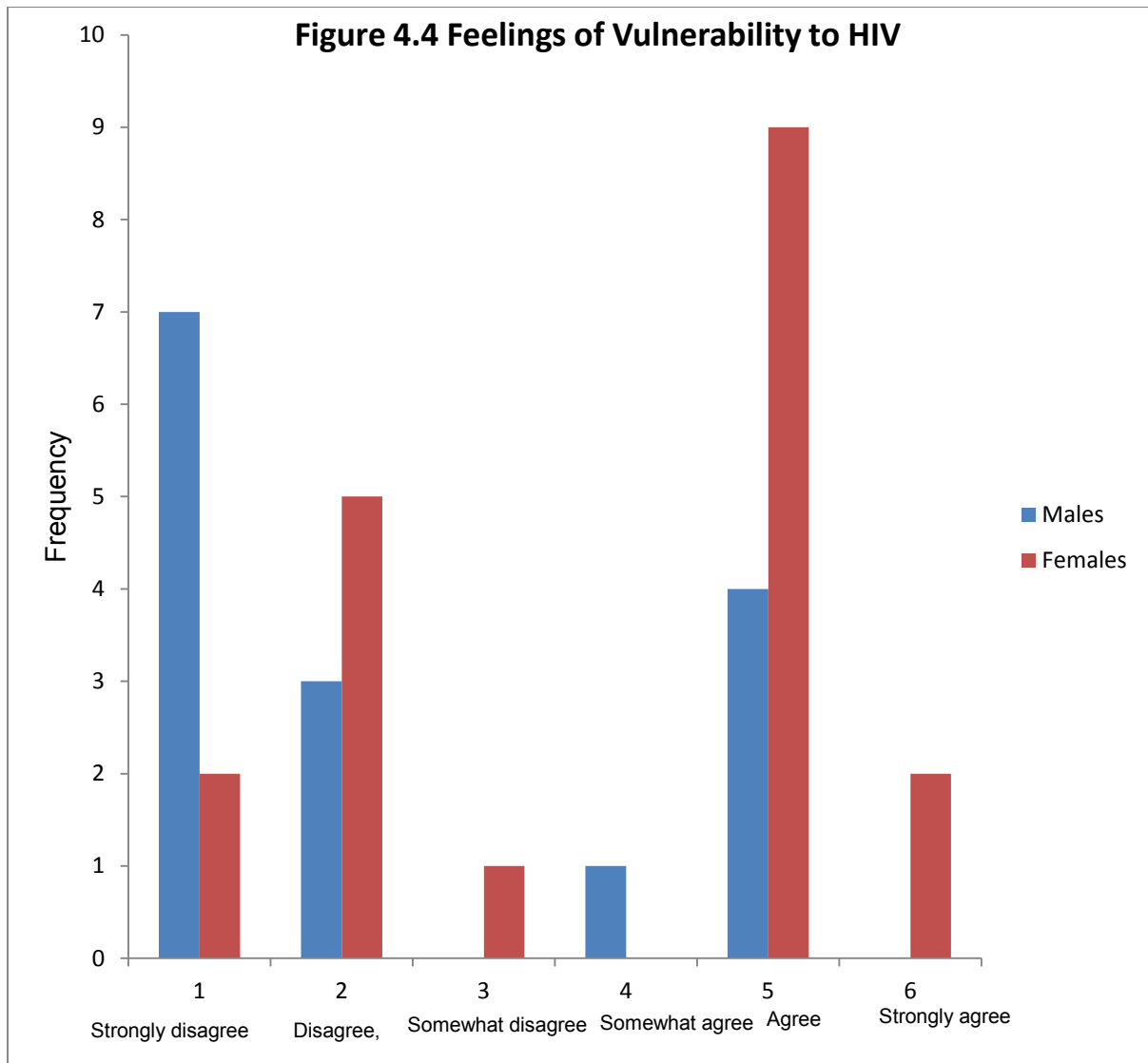
(40%) had recommended HIV client initiated testing (CITC) to their respective partners; while 8 males (53.3%) and 3 females (15.8%) had not answered this question.

Concerning attitude towards condom use and CITC, 15 females (78.9%) and 11 males (73.3%) knew each other's HIV status; one of the indicated advantages of having an HIV test and using a condom is a safer HIV prevention method. Additionally, 15 females (78.9%) said using condoms was one of the safer prevention methods of unwanted pregnancies, although they further indicated their respective tendencies as to prefer using some other preventive methods such as injection and /or pills rather than condom. Furthermore, 2 females (10.5%) suggested using condoms reduced the level of sexual sensation, while 2 males (13.3%) maintained condom use is for prostitutes and not for married people.

Table 4.4 reflects 46.7% of males and 10.5% of female respondents strongly disagreed, while only 2 females (10.5%) versus zero males (0%) strongly agreed to feel vulnerable to HIV. Additionally, 26.7% of males and 47.4% of females agreed there was a chance no matter how small it would be they could get HIV (table 4.4 & figure 4.4).

**Table 4.4****Frequency distribution of Feelings of Vulnerability to HIV**

	<b>Males</b>	<b>%</b>	<b>Females</b>	<b>%</b>
<b>Strongly disagree</b>	<b>7</b>	<b>46.7</b>	<b>2</b>	<b>10.5</b>
<b>Disagree</b>	<b>3</b>	<b>20</b>	<b>5</b>	<b>26.3</b>
<b>Somewhat disagree</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>5.3</b>
<b>Somewhat agree</b>	<b>1</b>	<b>6.7</b>	<b>0</b>	<b>0</b>
<b>Agree</b>	<b>4</b>	<b>26.7</b>	<b>9</b>	<b>47.4</b>
<b>Strongly agree</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>10.5</b>
<b>Total</b>	<b>15</b>	<b>100</b>	<b>19</b>	<b>100</b>



The difference between HIV and AIDS, 16 females (84.2%) and 9 males (60%) had knowledge of the difference referring to HIV as the virus and AIDS as the disease caused by HIV. However, 3 females (15.8%) and 6 males (40%) did not provide an answer.

#### 4.6 Conclusion

The findings of the present study were as much informing as alarming. Basically, HIV and AIDS related knowledge and awareness were widespread among the studied community inasmuch as 100% of female and 97.3% of male respondents indicated they knew about and were aware of HIV and AIDS. However both knowledge and awareness as relating to HIV and AIDS did not always neither influence nor predict preventive sexual behaviour among this community, as 46.7% of males and 63.2% of females indicated they would never use condoms.

## CHAPTER FIVE

### CONCLUSION AND RECOMMENDATIONS

#### 5.1 Introduction

Under normal conditions, people and couples could be responsible for the choices they make, that could affect in one way or the other their health in particular and both their lives and wellbeing at large. However, it is necessary to be more objective in this regard, because the African refugee communities of Cape Town are considered the object of the present study, they are patriarchal societies, wherein women had been socialised to be always available for their respective male sexual partners as far as sexual pleasures are concerned. These women consider 'normal conditions' whereas it is all about cultural norms and social status quo of women which perpetuate the circle of male interests, gender power inequality, *inter alia*, on both health's and life's expense of the African refugee women in Cape Town.

#### 5.2 Conclusion

The main interest of the present research, via its objectives, was centred on establishing the degree of personal perception of risk relating to HIV infection. Accordingly the degree of personal perception of HIV infection risk among the African immigrants of the Cape Metropolitan area was found to be relatively very high among women and men, as well as HIV and AIDS related knowledge and awareness which appeared also to be very high among these communities.

**Objective one - to determine the personal risk perception of HIV infection and vulnerability among African refugee communities of the Cape Metropolitan area:**

The degree of personal perception of HIV infection risk among the African immigrants of the Cape Metropolitan area is relatively high, among both women and men. However, HIV related perceived risk did not necessarily determine sexual behaviours among these communities. The use of condom was found to be prejudiced on basis of individual moral values. Additionally the use of condom was deemed a promiscuous practice and tended to be influenced by both subjective norms and personal attitudes although more likely at different extents.

Furthermore, despite relatively high HIV and AIDS knowledge and awareness among African refugees of Cape Town, there were still gaps of knowledge with regard to HIV and AIDS related issues, medical facts, myths and misconceptions which needed to be addressed.

**Objective two – to establish any reciprocal relationship between the perceived risk and sexual risk behaviour:**

The present study established there is no significant relationship between the perceived risks related to HIV infection and sexual risk behaviour among the studied community as the perceived risk in question did not necessarily neither influence nor predict sexual behaviour. Actually the number of both male and female respondents who believed engaging in unprotected sex was risky on one hand and who indicated never using condom on the other hand, outweighed at a greater extent the number of those who suggested otherwise. The concerned contradicting opinions are a good indication, suggesting an absence of evident significant reciprocal relationship between the perceived and sexual risk behaviour among this community.

**Objective three - to assess the personal knowledge of African refugee community within the Cape Town area with regard to HIV and AIDS:**

HIV and AIDS related knowledge is relatively very high and HIV and AIDS awareness wide spread among the studied community. However, both knowledge and awareness as relating to HIV and AIDS did not always predict preventive sexual behaviour among this community. Subjective norms, attitudes and socio - cultural values tend to influence sexual behaviours among African refugee community of Cape Town, more than relevant mere knowledge.

**Objective four - to explore their personal attitudes towards condom use, HIV testing and HIV and AIDS related stigma:**

Among the respondents personal attitudes towards condom use, HIV testing and its related stigma tend to be influenced by both subjective norms and individual moral values. Condom use is generally prejudiced among the émigré community of Cape Metropolitan area, as it is considered a promiscuous behaviour which should not be neither introduced nor promoted among regular heterosexual couples. Furthermore, HIV-Client initiated testing and counselling (HIV – CITC) is widespread among this



community and HIV and AIDS related stigma and discrimination are still relatively high.

**Objective five - to identify gaps between personal HIV related beliefs (myths) and knowledge as compared to existing medical facts:**

HIV and AIDS related myths and misconceptions, which tend to be more based on individual worldviews than empirical evidences as compared to currently existing medical facts, more particularly with regard to HIV modes of transmission and AIDS care, are still prominently evident among the respondents.

**Objective six - to make recommendations related to effective preventive sexual behaviours to relevant HIV and AIDS policy makers and programme designers with regard to the studied community:**

Based on the findings of the study, a number of relevant recommendations is made as an attempt to suggest optional HIV and AIDS response approaches intended to address related issues, which are currently prevailing among the respondents. Suggestions are made to focus more on economic, social and cultural context within which sexual behaviours are shaped among the African émigré community of Cape Metropolitan area, rather than merely insisting on HIV and AIDS related sexual behaviour change.

### **5.3 Conclusion**

According to the findings of the present study, the personal perceived risk related to HIV infection did not always determine nor predict sexual behaviour. Thus there was no significant reciprocal relationship between the perceived risk and the most important sexual behaviour, namely the very first sexual intercourse which respondents had in South Africa with their respective partners, as while 47.4% of females and 40% of males have indicated engaging in unprotected sex was extremely risky, only 15.8% of female and 33.3% of male respondents used condom during the first sexual intercourse in question, against which the personal perception with regard to HIV infection risk was to be measured.

## 5.4 Recommendations

Despite both knowledge and awareness as relating to HIV and AIDS and personal perception of HIV infection, there was no significant reciprocal relationship between the perceived risk and sexual behaviour experienced by respondents in South Africa, after a certain period of temporary separation with respective sexual partners, which was a good indication as to what knowledge and/or awareness do not necessary influence (sexual) behaviour. Additionally, education is not sufficient to induce behavioural change amongst people's life in general and individuals in particular. Therefore:

- A more practical approach which takes into consideration individual's economic, psychosocial and cognitive context to educate people in life skills to reduce their risk for HIV infection need to be adopted. In this regard, HIV and AIDS response programmes should focus on educating males among these African émigré communities, more particularly as relating to gender power imbalances, involving among other dimensions, sexual power bargaining; both sexual communication and negotiation; and challenges of sex related taboos and myths which are still highly upheld by their respective indigenous moral and socio – cultural ethos .
- Pro–active approach while planning how to deal with the émigré community health issues, including HIV and AIDS management, more particularly by taking into consideration their respective socio-cultural and language aspects is needed.
- However, both a certain degree of precaution as first to understand their real world and a prior community needs assessment with regard to HIV and AIDS would be needed, should any intervention programme be implemented among these émigré communities of Cape Town.

## 5.5 Further research

The limitations of the study were identified and it is recommended they can be overcome by paying attention to them in detail. It is therefore recommended studies designed and conducted in mother tongues and/or official languages of potential participants be considered in the nearest future.

It is also recommended participants of the present study and the rest of the African émigré community of Cape Town find ways of improving their English communication skills, as English is a key tool in their process of reintegration within South African social life.

Additionally, it is recommended further studies among émigré communities of the Cape Metropolitan area, do consider socio-cultural diversity and include not only African immigrants but also others from the East and the West, in order to yield more insight and add to the existing body of knowledge. Finally the research sample should include single individuals to provide insight into all the situations they experience within the framework of the research.

## **5.6 Conclusion**

Generally, despite global knowledge of HIV, both its routes of transmission and the methods of prevention modes and global efforts to comprehensively and effectively respond to the HIV and AIDS pandemic, AIDS related illnesses are taking away thousands of human lives on daily basis. Until an effective vaccine is found, it appears efforts deployed by the global community are more unlikely to lead to a 'HIV - free generation', inasmuch as HIV is transmitted through specific human behaviours, which behaviours are more unlikely to change within the foreseeable future. It is therefore in the interests of the global community not only focussing on HAART, but also to equally invest more capital and efforts in prevention; education programmes, mainly prioritising HIV and AIDS economic and socio-cultural related issues and behaviour change of the target groups. Particularly, ignoring the dimension of effectively empowering the African émigré community of Cape Town as relating to HIV and AIDS issues is to neglect a strategic portion of the Western Cape's populations and would constitute a potential impediment not only to provincial but also to national efforts of HIV and AIDS Management.

Most of current approaches on HIV and AIDS prevention are based largely on persuading individuals to change behaviours, without due regard for the social, cultural and economic contexts in which behaviours are shaped and lodged; once again it is worth highlighting any HIV and AIDS response programme that ignores the cultural, economic and sociological aspects of HIV and AIDS is unlikely to meet with success.

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**APPENDIX A: QUESTIONNAIRE**

**PART ONE**

**SECTION ONE: BIOGRAPHICAL INFORMATION**

**Question 1: Age group**

Please indicate your age group by placing an “X” in the appropriate box:

1	2	3	4	5
Under 18	18 -30	31 – 40	41 -50	Over 51

**Question 2: Gender**

Please indicate your gender by placing an “X” in the appropriate box:

0	1
Female	Male

**Question 3: Academic status**

Please indicate your highest grade of education passed (e.g. Grade 10, BA, BSc, Masters., PhD, etc.) by placing an “X” in the appropriate box:

1	2	3
Primary education	Secondary education	Tertiary education

**Question 4: Socio – sexual status**

Please indicate your current status by placing an “X” in the appropriate box:

1	2
I am in a sexual relationship	I am not in a sexual relationship



**Question 5: Socio – economic status**

Please indicate your current occupational status by placing an “X” in the following appropriate box:

1	2	3
I am employed	I am self – employed	I am not working

**Question 6: Sexual orientation**

Please indicate your current sexual orientation by placing an “X” in the appropriate box:

1	2	3
Homosexual	Heterosexual	Bisexual

**Question 7: Sexual relationships**

Please indicate “YES” or “NO” or “Not Applicable” whether the following statements do apply to you:

7.1. My husband / my wife/ sexual partner/ and I joined each other later in South Africa after a certain period of temporary separation:

1	2	3
Yes	No	Not applicable

7.2. I and my wife / husband / sexual partner came together to South Africa:

1	2	3
Yes	No	Not applicable

7.3. My current sexual partner and I have met for the first time in South Africa:

1	2	3
Yes	No	Not applicable

**SECTION TWO: HIV and AIDS KNOWLEDGE, AWARENESS, RISK**

**PERCEPTION and BEHAVIOURS**

**Question 8: First sexual intercourse in South Africa**

Please answer the following questions according to your best knowledge by placing an “X” in the appropriate box below:

8.1. During my first sexual intercourse (full penetration) which I had in South Africa:

1	2	3	4
Did use condom	Did not use condom	Can't remember	Do not want to answer this question

8.2. During my first sexual intercourse (full penetration) which I had in South Africa, I knew that my partner with whom I was having sex in that moment was:

1	2	3	4	5
HIV Negative	HIV Positive	I was not sure	Knowing it that time was not that important for me that time	I do not want to answer this question

**Question 9: HIV and AIDS knowledge, awareness and prevention**

Please answer the following questions by placing an “X” in the appropriate boxes, or by filling in the provided places:

9.1. Have you ever heard of HIV and AIDS?

1	2
Yes	No

9.2. Do you know of anybody who is living with HIV and AIDS?

1	2
Yes	No

9.3. Do you know of anybody who was dead as a result of AIDS related illness?

1	2
Yes	No

**Question 10. Misconceptions on ways of HIV transmission and AIDS**

Please answer the following questions by placing an “X” in the appropriate boxes below:

10.1. People can get HIV from mosquitoes bites:

1	2
True	False

10.2. You can contract HIV only if you have sex with prostitutes:

1	2
True	False

10.3. Eating from same plate with an HIV infected person can transmit HIV:

1	2
True	False

10.4. A healthy looking person can never be HIV positive:

1	2
True	False

10.5. HIV can only be transmitted via unprotected sexual intercourse:

1	2
True	False

10.6. Some kinds of condom can influence the transmission of HIV:

1	2
True	False

10.7. Having sex with a virgin young girl will cure AIDS:

1	2
True	False

**Question 11. HIV and AIDS related stigma**

Please answer the following questions by placing an “X” in the appropriate boxes:

11.1. If a member of your family got infected with HIV, would you like it to remain a secret?

1	2	3
Yes	No	I am not sure

11.2. If you learn that your baby sitter is living with HIV but has not AIDS yet, would you still allow him /her to continue looking after your child?

1	2	3
Yes	No	I am not sure

**Question 12. HIV and AIDS perceived risk, vulnerability and attitudes toward use of Condom and HIV testing and counselling:**

Please answer the following questions, to the best of your emotions and attitudes and feelings related to how vulnerable you are to HIV, and to how often you think about your risk to HIV infection. Please indicate it by placing an “X” in the appropriate boxes bellow. Please just mark one answer’s box for each question:

12.1. How risky do you perceive it is “engaging in unprotected sex”?

Not at all risky	Slightly risky	Somewhat risky	Moderately risky	Risky	Very risky	Extremely risky
1	2	3	4	5	6	7

12.2. I worry about getting infected with HIV:

None of the time	Some of the time	A moderate amount of time	A lot of time	All the time
1	2	3	4	5

12.3. I feel that I am unlikely (I got greater chances of not getting HIV) to get infected with HIV:

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6

12.4. There is a chance , no matter how small, I could get HIV:

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6

12.5. Do you know your current HIV status?

1	2
Yes	No

12.6. Did you have any HIV test between June 2013 - December 2013?

1	2
Yes	No

12.7. How often do you use condom?

1	2	3
Never	Occasionally	Always

12.8. How easy or difficult will it be for you to always use condom during sexual intercourse? Please indicate it by placing an “X” in the appropriate box below:

1	2	3	4	5	6	7
Very easy	Easy	Not easy at all	Uncertain	Not difficult at all	Difficult	Very difficult

12.9. How easy or difficult will it be for you to seek voluntary counselling and testing for HIV? Please indicate it by placing an “X” in the appropriate box below:

1	2	3	4	5	6	7
Very easy	Easy	Not easy at all	Uncertain	Not difficult at all	Difficult	Very difficult

## PART TWO: ESSAY QUESTIONS

### Question 13: Subjective norms

**13.1.** There might be people or groups of people who are important to you and would approve of you using condom during sexual intercourse. In the spaces provided below, please use the left column to list at least three of those people or groups of people. Please do not state their real names, but state only their respective relationship or association with you (e.g. my mother, my sexual partner, my colleagues, etc). Please use the 5 – point rating scale on the right column and rate their level of approval: **1** would indicate **an extremely low** rating and **5** would indicate an **extremely high** rating.

- My.....1.....2.....3.....4.....5
- My.....1.....2.....3.....4.....5
- My.....1.....2.....3.....4.....5

**13.2.** There might be people or groups of people who are important to you and would approve of you seeking voluntary counselling and testing for HIV. In the spaces provided below, please use the left column to list at least three of those people or groups of people. Please do not state their real names, but state only their respective relationship or association with you (e.g. my mother, my sexual partner, my colleagues, etc). Please use the 5 – point rating scale on the right column and rate their level of approval: **1** would indicate **an extremely low** rating and **5** would indicate an **extremely high** rating.

- My.....1.....2.....3.....4.....5
- My.....1.....2.....3.....4.....5
- My.....1.....2.....3.....4.....5

### Question 14: Attitudes towards the Client initiated counselling and testing (CICT) and the use of condom

**14.1.** How do you feel about seeking voluntary counselling and testing for HIV?  
Please state at least three advantages and three disadvantages.

- ❖ Advantages:

1. ....  
.....
2. ....  
.....
3. ....  
.....

❖ Disadvantages:

1. ....  
.....
2. ....  
.....
3. ....  
.....

14.2. How do you feel about always using condom during sexual intercourse?  
Please state at least three advantages and three disadvantages.

❖ Advantages:

1. ....  
.....
2. ....  
.....
3. ....  
.....

❖ Disadvantages:

1. ....  
.....
2. ....  
.....
3. ....  
.....



**Question 15: Knowledge of the difference between HIV and AIDS**

15.1. HIV is the.....  
.....  
.....

15.2. Whereas AIDS is the.....  
.....  
.....

**Question 16: Prevention of HIV**

Please name at least (3) three things that someone can do to reduce the risk of contracting HIV?

1. ....  
.....
2. ....  
.....
3. ....  
.....

**THANK YOU SO MUCH FOR AVAILING YOURSELF AND OFFERING  
YOUR TIME TO  
FILL IN THE PRESENT QUESTIONNAIRE**