

**EXPLORING HIV/AIDS KNOWLEDGE, ATTITUDES AND PRACTICES OF CONGOLESE
REFUGEES IN CAPE TOWN**

by
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Declaration

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centres for Disease Control and Prevention
CTRC	Cape Town Refugee Centre
HIT	Health Information Team
HBC	Home Base care
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IRD	International Relief and Development
JRS	Jésuite réfugiée services
MISP	Minimum initial services package
MSM	Men who have sex with men
NGO	Nongovernmental organizations
PEP	Post-exposure prophylaxis
PMTCT	Prevention from mother to child transmission
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
UN	United Nations
UNAIDS:	Joint United Nations programme on HIV / AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WRC	Women's Refugee Commission

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Abstract

This study aims to explore the existing knowledge, attitudes and practices regarding HIV/AIDS among Congolese refugees living in Cape Town in order to create awareness and suggest possible measures to avert the spread of the pandemic among them. The target population are Congolese refugees living in Cape Town, with a refugee or an asylum seeker status. Due to the total population and difficulties in contacting them, the participants (50) were randomly selected among traders and hair dressers.

The study used a quantitative research design. The Desk Top Market train station in Cape Town is an open market place where most Congolese traders sell their goods to the public. The data were collected at this market area in Cape Town using a questionnaire. To avoid any possible discrimination or stigmatisation resulting from being identified as a refugee in the study, the Congolese were contacted from the market place without screening them on the basis of their status. The participants were, however, required to tick their status in a box provided on the questionnaire. Furthermore, strict confidentiality was maintained to avoid the possible stigmatisation arising from the Congolese traders' refugee status.

According to the findings Congolese refugees have knowledge about HIV/AIDS and the route of transmission. The majority knows how to protect themselves against HIV/AIDS but it seems this protection discontinues shortly after a quick trust between them and their partners. It may be because most refugees are in need of financial protection on their arrival so they do not have any other choice than to let it go. During the process of data collection there was an opportunity to discuss with some of them protection and most of them stated that condom use is not safe as condoms break often.

Many Congolese do not believe in male circumcision for the reduction of risk because 100% of them are circumcised and some still have contracted HIV/AIDS. Some of Congolese does believe HIV can be cured because they have seen people who were cured through prayers. The findings also indicate the level of awareness is very low in this community because they still believe they can just by looking at other individuals they can detect if someone is HIV positive or not.

Opsomming

Hierdie studie was daarop toegespits om die bestaande kennis, houdings en praktyke met betrekking tot MIV/vigs onder Kongolese vlugtelinge in Kaapstad te ondersoek ten einde bewustheid te wek en moontlike maatreëls voor te stel om te keer dat die pandemie onder hulle versprei. Die teikenpopulasie was Kongolese wat in Kaapstad woon en oor vlugteling- of asielsoekerstatus beskik. Weens die groot omvang van die ondersoekpopulasie en uitdagings om met hulle in verbinding te tree, het die navorser lukraak vyftig (50) deelnemers uit die geleedere van handelaars en haarkappers gekies.

Die data is met behulp van 'n vraelys by die Desk Top-mark op Kaapstad-stasie ingesamel. Die studie het van 'n kwantitatiewe navorsingsontwerp gebruik gemaak. Die Desk Top-mark by Kaapstad-stasie is 'n buitelogmark waar die meeste Kongolese handelaars hul goedere aan die publiek verkoop. Om te voorkom dat enigeen wat in die studie as 'n vlugteling geïdentifiseer word enige moontlike diskriminasie of stigma ervaar, het die navorser voor die voet onderhoude met Kongolese by die mark gevoer sonder om hulle na hul verblyfstatus uit te vra. Die deelnemers moes egter hul status op die vraelys aandui deur die toepaslike blokkie te merk. Voorts is streng vertroulikheid gehandhaaf om enige moontlike stigma vanweë die respondente se vlugtelingstatus te voorkom.

Die bevindinge toon dat Kongolese vlugtelinge wél oor 'n mate van kennis van MIV/vigs en die verspreiding daarvan beskik. Die meeste respondente weet hoe om hulself teen MIV/vigs te beskerm, hoewel daardie beskerming oënskynlik gestaak word kort nadat hulle 'n vertrouensverhouding met hul bedmaats ontwikkel. Dít kan daaraan toegeskryf word dat die meeste vlugtelinge met hul aankoms in die land finansiële beskerming nodig het en dus nie anders kan as om veilige sekspraktyke te laat vaar indien hul bedmaats daarop aandrang nie. Gedurende die proses van data-insameling was daar geleentheid vir gesprek met die respondente, waaruit geblyk het dat kondoomgebruik na hulle mening nie juis veilig is nie, aangesien kondome dikwels breek.

Min Kongolese glo dat manlike besnydenis die gevaar van MIV/vigs verminder, aangesien hulle almal besny is, maar sommige steeds MIV/vigs opdoen. Sommige glo dat MIV/vigs genees kan word, omdat hulle getuies was van hoe mense deur gebed gesond geword het. Die bevindinge dui ook op 'n baie lae bewustheidsvlak in hierdie gemeenskap: Baie glo steeds dat 'n mens met die blote oog kan bepaal of iemand MIV-positief is of nie.

CHAPTER 1

INTRODUCTION

1.1 Introduction

The impact of the HIV/AIDS pandemic has been documented as one of the challenges still being experienced by citizens of most nations. The UNAIDS estimates indicate people living with HIV/AIDS are 29.5 million are in Sub-Saharan Africa, where adult HIV prevalence is considerably higher than in any other part of the world (UNAIDS, 2010). A group of 40 million people were living with HIV/AIDS in 2010; more than 96% of new HIV infections took place in low and middle income countries. The global HIV/AIDS pandemic reflects the gross socio-economic and health inequalities between countries and people within a country. According to the International Organisation for Migration (IOM, 2008) approximately 192 million people (3% of the world's population) were international migrants in 2008. Migrant populations, largely people from Sub-Saharan Africa, represent a growing proportion of both AIDS cases and HIV infections reported in the 27 European Union countries plus Norway and Iceland during 1999–2008. The proportions of migrants from Sub-Saharan Africa among heterosexual and mother-to-child HIV transmission reports are high (UNAIDS, 2009).

1.2 Background of the study

According to Williamson (2008) HIV/AIDS in Sub-Saharan Africa indicates the Southern Africa region is the most affected by the pandemic. South Africa is considered to be amongst the hardest hit countries in the region with a prevalence rate between 20-26% of population aged 15-49. Thus migration places people in situations of heightened needs; in many regions of the world, migrants face severe integration problems. Social exclusion experienced by migrants makes them highly vulnerable to HIV/AIDS and other related complications. The most common reasons of individuals migrating are to seek economic improvement, to escape civil wars, hunger, political upheaval and natural disasters where people may be granted refugee status (UNCHR, 2010).

As a multi-cultural society, South Africa seems to be the new destination for refugees in Africa and there are few constraints on migrants for integrating with the local population. This factor contributes probably to the rising number of migrants who are from the war-torn countries such as the DR Congo, Burundi, Kenya, Somalia, Ivory Coast, Liberia and other countries where health care facilities have fallen apart and social problems continue to exist. South Africa hosts 565 520 refugees of whom 18 970 are Congolese and 2 760 live in Cape

Town (UNHCR, 2012). Migrants are frequently affected by strong barriers to HIV/AIDS prevention and care including cultural, socio-economic and language barriers which makes HIV prevalence to be high among people in movement (UNAIDS, 2009). However, little has been done to make the HIV/AIDS prevention services accessible and available in the Congolese migrants' languages (Congolese language: French, Lingala, Swahili, Kikongo and Tshiluba) they should have the knowledge needed to adopt attitudes and practices which can prevent them from getting infected with HIV.

As part of migrants in South Africa, Congolese refugees are by default; this is related where the department of Home Affairs has a backlog in determining their refugee's status. Therefore, the majority of Congolese refugees are asylum seekers who are allowed to legally live, work or study in South Africa while they are waiting for the determination of their status. The Congolese sample was specifically chosen due to the ever-increasing population of Congolese migrants or refugees escaping from the DRC war to South Africa. Hence it is important for the stakeholders to also consider educating these Congolese in their efforts to reduce the impact of HIV/AIDS in South Africa. Most of the efforts to date are geared towards combating HIV/AIDS target the indigenous South Africans. These measures to be effective in dealing with HIV/AIDS there is a need to also educate other significant non-South African group populations such as the Congolese.

1.3 Problem statement

Studies have reported the global burden of poor economic development, overwhelmed health care systems, decreasing life expectancy, deteriorating child survival rates and increasing number of orphans related to HIV/AIDS (Gottlieb, 2009). The devastating effects of HIV/AIDS call for dedicated and sustained acceleration of prevention strategies against the transmission of the virus since everybody is at risk of either being infected or affected. Previous studies have shown HIV/AIDS awareness can lead to increased perception of risk and thus a reduction in risky sexual behaviours.

Most of the Congolese refugees living in South Africa are in a situation that makes their lives vulnerable to HIV/AIDS. They are far from their immediate environment, where family norms, customs and beliefs constitute a corridor of protection; refugees freely adopt a risky sexual behavioural approach, which increase their vulnerability of getting infected with HIV. Another factor is the linguistic barrier where most of the Congolese refugees experience a great challenge in learning, speaking and understanding the host country's languages of which Afrikaans, English and isiXhosa are the most common in Cape Town. The linguistic barrier

impacts negatively in their understanding of brochures, HIV/AIDS programmes or any other documents related to HIV/AIDS prevention delivered in the media.

Awareness is important in the decision-making when an individual deals with challenges such as pertaining to having sex with or without a condom. However, the significant numbers of studies which have been done on knowledge, attitudes and practices with regards to HIV/AIDS have only addressed these concerns for other population groups. Nothing or little has been conducted to assess the level of knowledge, attitudes and practices with regards to HIV/AIDS transmission for Congolese refugees living in Cape Town. Therefore, this study investigates the knowledge, attitudes and practices with regards to HIV/AIDS transmission of Congolese refugees in Cape Town.

1.4 Research question

What are the knowledge, attitudes and practices of Congolese refugees living in Cape Town towards HIV/AIDS?

1.5 Aim and objectives of the study

This study aims to explore the existing knowledge, attitudes and practices regarding HIV/AIDS among Congolese refugees living in Cape Town in order to create awareness and suggest possible measures to avert the spread of the pandemic among them.

The objectives are:

- ❖ To assess Congolese refugees' knowledge, attitudes and risky practices regarding HIV/AIDS
- ❖ To examine and establish factors which contribute to the high risky behaviour adopted by Congolese refugees
- ❖ To provide guidelines and a set of recommendations for HIV/AIDS planners, policies makers and NGOs for intervention

1.6 Significance of the study

Prior to this research, a few studies have been conducted on knowledge, attitudes and practices with regard to HIV/AIDS among refugees in general but this study focuses on Congolese refugees living in Cape Town in particular. Thus, the findings of the study will provide adequate information to HIV/AIDS planners, policy makers, NGOs and UN agencies in designing an HIV/AIDS awareness programme to fill the gap among Congolese refugees.

1.7 Limitations of the study

The study had limitations which should be acknowledged. First, the study findings cannot be generalised to the broader population of Congolese living in Cape Town without further replication. Besides a bigger sample size has the advantage of enhancing the statistical power of the study.

The second limitation relates to the measuring instruments used in this study. The instruments used are self-report measures. Future studies should use knowledge, attitude and practice with high reliability coefficients. Furthermore, self-report measures have the problem of making participants respond in a way that is socially desirable.

Future studies should develop and evaluate HIV/AIDS models that help increase constant awareness. Further research can be conducted in other provinces of South Africa among Congolese Refugees.

1.8 Definition of key concepts

HIV/AIDS: Evian (2000), Van Dyk (2001) and Kaplan & Sadock (2003) decided on AIDS as the acronym for Acquired Immune Deficiency Syndrome. HIV means Human Immunodeficiency Virus which enters the body from outside. Immunity refers to the body's natural essential ability to defend itself against infections and diseases, while deficiency refers to the body's immune system is weakened so that it can no longer defend itself against passing infections. A syndrome is a medical term which states to a set, or collection of specific signs and symptoms that occur together and that are typical of a particular pathological condition.

Knowledge: According to Collins Cobuild dictionary Knowledge is the information and understanding about a subject which a person has in his or her mind or which is shared by all human beings.

Attitudes: Attitude can be defined as a way someone thinks and feels about something.

Practices: Practice is a normal or standard way of doing things in order to acquire a skill.

Refugee: The 1951 United Nations Convention relating to the Status of refugees, the 1967 Protocol relating to the Status of Refugees and the 1969 Organisation of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa are instruments which have recognised that the definition of a refugee is a key element for their claim to protection.

According to the 1951 Convention, the term refugee is defined as: a person who, because of well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling, to avail himself of the protection of that country (UNHCR, 1991). The 1969 OAU Convention further expands the definition by saying that the term refugee shall apply to: every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality (Article 1(2) of the 1969 OAU Convention Governing the Specific Aspects of Refugee Problem in Africa). Gibney (2004) in his book, *The Ethics and Politics of Asylum: Liberal Democracy and the response to refugees*, exposes the conflict between the claim of refugees and those escaping desperate economic situations to a secure place of residence and the claim of citizens to act together to limit access to the territory and resources of their community.

Milner (2009) in his book, *Refugees, the State and the Politics of Asylum in Africa*, explains why in the late 1980s many African states became more reluctant to host refugees, contrary to policies of open-doors in the 1960s.

Asylum seeker: The terms asylum-seeker and refugee are often confused: an asylum-seeker is someone who says he or she is a refugee, but whose claim has not yet been definitively evaluated. National asylum systems are there to decide which asylum-seekers actually qualify for international protection. Those judged through proper procedures not to be refugees, nor to be in need of any other form of international protection, can be sent back to their home countries. The efficiency of the asylum system is key. If the asylum system is both fast and fair, then people who know they are not refugees have little incentive to make a claim in the first place, thereby benefitting both the host country and the refugees for whom the system is intended. During mass movements of refugees (usually as a result of conflicts or generalized violence as opposed to individual persecution), there is not - and never will be - a capacity to conduct individual asylum interviews for everyone who has crossed the border. Nor is it usually necessary, since in such circumstances it is generally evident why they have fled. As a result, such groups are often declared "prima facie" refugees (UNHCR, 2008).

1.9 Research Methodology

A quantitative descriptive method has been selected to conduct the research. Data were collected using a convenience sampling which allowed the researcher to select the available Congolese refugees trading at the Desk Top market.

A questionnaire will be used to elicit responses from the participants focussing on: Demographic information, knowledge of HIV/AIDS, attitude towards HIV/AIDS testing and practice with regards to HIV/AIDS risk transmission. The data gathered from the responses will be analysed and displayed as percentages and frequencies.

1.10 Outline of Chapters

The first chapter which introduces the study contains the introduction, the background, the research question, aim and objectives the study, the limitations and the definitions of keys concepts. Chapter 2 contains a review of literature; chapter 3 explains the methodology the research used to conduct the study; chapter 4 looks at data analysis and discusses the findings of the study. Finally, chapter 5 contains the conclusion and recommendations.

1.11 Conclusion

The study focuses on a group of Congolese refugees living in Cape Town. The aim of the research is to determine their attitudes, knowledge and risk transmission.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The integration of refugees in some countries health program poses serious problems. In South Africa, the liberal constitution provides in particular a number of rights for refugees and other immigrants. Thus the United Nations High Commission for Refugees (UNHCR) and its partners maintain discussions with the South African Government to integrate refugees and other immigrants living with HIV/AIDS in the present health system, as the country is signatory of international agreements on the rights of refugees and other immigrants. Assistance for people living with HIV involves reducing xenophobia and any other kind of discrimination preventing the donor access to the above service. To do this, efforts should be combined by the various partners involved in locating and clearly identify communities where refugees live and thus strengthen the necessary steps to building the measures in relation to HIV/AIDS. The statistics and the prevalence rate of HIV/AIDS in the country should also be brought to the attention of the refugee communities. This is in view of allowing UN agencies and other NGOs to access programs that can help refugees to acquire the necessary knowledge about the epidemic and thus be able to protect themselves (UNHCR, 2003).

Generally refugees are frequently exposed to high risks of sexually transmitted infections including HIV; was noted before the crisis in the Democratic Republic of Congo. However, control of sexually transmitted infections can contribute to reducing the transmission of HIV/AIDS in areas where its infections are common (WHO, 2003). Naturally, the answers vary according to the different stages of the crisis involving refugees; sets based minimum initial service package (PSIM) a concept developed after consultation between the various partners (NGOs, research institutes, UN agencies and). This concept (PSIM) contains important elements for the fight against STIs in communities of refugees and includes:

- Awareness campaigns to inform and encourage the refugees' integration taken in the health system of the host country;
- The promotion and distribution of condoms in refugees communities;
- The management of STIs using the syndromic models of the World Health Organization;
- Prevention of congenital infection at birth.

2.2. International situation

A study conducted in the Western Australia on peer education for strengthening health knowledge in communities of refugees from West Africa had concluded refugees' health was poor compared to native (Kelaheer, Williams & Maderson, 1999). The study states refugees women were at high risk for chronic diseases, HIV/AIDS and even early death (Gates & McDonald 19975). The major reason being the low level of education and poverty (Kabira Gachukia and Matiangi, 1997). The same study also found African immigrants had a low level of HIV knowledge, its modes of transmission as well as means of protection which result from poor attitudes towards people living with HIV and condom use (Drummond, Mizan, Burgoyne & Wright, 2007).

The same study noted they also had less knowledge about nutrition and attach less interest in physical exercise. All of these shortcomings contribute to the high STIs risk infection, particularly the risk of HIV contagion, cardiovascular disease as well as mental illness. Given the increasing number of refugees in the Western Australia, refugee's integration in the country's health system has become a major challenge and public health concern (Australian Government department of immigration and citizenship, 2007). The high risk of STIs and HIV knowledge deficit in the West African refugee's communities in Australia raise the importance of awareness campaigns and community health promotion among refugees and other immigrants. Furthermore, their cultures and beliefs are barriers to open communication about sexuality and behavior change (Harmsena, Meeuwesenb Van Vieringene, Bersena & Beuijnzeelsb, 2007).

Convey information about HIV/AIDS and STIs may be an easy task but instituting it into practice in order to influence behavior change is never an easy task (Majumdar & Roberts, 1998). However, it is preferable this kind of information is conveyed by refugees peer educators than by people from elsewhere (Horizon, 1999). Hence, the concept of peer educators in reference to paraprofessionals, health workers and other social agents (Kochen, Voorham, Bandsman & Swart, 2001).

In the Netherlands peer education is one of the main strategies used to promote health principles in refugees' communities and other immigrants (Voorham & Visser, 2003). There is to date a significant global movement of peer education in the awareness and prevention of HIV and other STIs especially in the developing countries (Auerbach & Coates, 2000; UNAIDS, 2009). The effectiveness of this method is related to the voluntary members of the infected and affected communities engaged in awareness campaigns (James, 2002). Peer educators have an advantage to reach people even in the most difficult social strata to convince, because they are recruited from the same communities (Parkin & McKeganey,

2000; Westhoff & Hopman-Rock, 2003). Peer educators convey reliable information and are good role models, the reason why proper training is needed to equip them with the necessary knowledge.

A study in a poor community of Belfast in Romania found after training, knowledge about HIV and the use of harmful substances declined in refugees and other immigrants' communities (McAleavy, Crystal & Kelly, 2006).

According to a study in Congolese refugee's camp in Syangungu (Rwanda) there was an increase of 21.6% in HIV knowledge and reproductive health after 40hours peer education training enabling peer educators to conduct a thorough awareness campaign in the communities of refugees. The same study also noted in the six months following the activities of the campaign, a decrease of 1.8% was observed in risk behavior in the same camp (James, 2002).

In a study conducted on the refugees' sexual health in some African countries, including Uganda and Tanzania, the peer education approach was used for prevention against the transmission of HIV and STIs. Therefore, a decrease in HIV transmission was observed accompanied by change in attitudes towards HIV and people living with it, but also a radical behavior change in communities of refugees involved in this study. The study also found condom use declined within the 24 months following this study, but the curve was quickly raised to an acceptable level in the communities themselves (Laukaamm-Josten et. al., 2007).

A study carried out in a Rwandan refugee camp in Tanzania on prevention of HIV/ IDS and STIs had shown that during the month of April 1994, at the start of the Rwandan genocide, an estimated 300 000 people were established in one refugees camp (UNAIDS, 2008). There was no intense rescue operation organized in an environment where the HIV prevalence rate was so high. In this same environment, refugees lived in the conditions allowing the spread of HIV because of the following reasons:

- Families disintegration with many divided families and a large number of widows and widowers
- Poverty;
- The economic and financial dependency;
- A high level of violence and especially sexual violence.

In addition, sexual, commercial and non-commercial interactions between refugees and indigenous Tanzanians transmission were very high risk factor for HIV and STIs infection for

people living around the refugee camps. The same study also noted that HIV epidemiology among Rwandan refugees and native Tanzanians presented a rapid transmission of the virus because of the refugees' integration among local population. HIV prevalence rate among Rwandan refugees in urban areas was high 35% more than among those living in rural areas (5%) and Tanzanian native in the Ngara District 7% (UNAIDS, 2008).

Another study carried out in the refugee camp in Guinea Conakry had established the comparison between the level of HIV knowledge and its risk perception as well as behavior change in a survey based on refugee communities including 698 sexually active people (man and woman among Sierra Leonean refugees in Guinea Conakry). The study found the degree of HIV knowledge was not associated with the level of risk perception and the non-use of condom. This study concluded the relationship between the levels of HIV knowledge, risk perception and behavior change should be in the context of a broader community health program in the refugees camps (UNHCR, 2010).

The low knowledge level of HIV related to the lack of behavior change is often the result of a lack of awareness and information campaigns among refugees but also the misuse of resource interest in this kind of programs, resources unfortunately are only found in the same study. In this way, awareness campaigns on HIV prevention and behavior change initiated for refugees should also take into account the low condom use and so other approaches such as male circumcision and mother to child transmission to curb the spread of the HIV virus (UNHCR, 2010).

In the context of restrictive measures for asylum seekers in Europe, the health system for refugees was a concern because it is different from other social benefits such as housing and access to employment (UNHCR, 2010). It is normally justified in a population with a poor health situation at their borders given the safeguards of the local population against the HIV transmission, STIs and other chronic diseases. However, human rights defenders suggest the provisions on public health should be inclusive and accessible to all (UNHCR, WHO, UNAIDS, 2009).

Refugees' access to the health system have been reported all over Europe; inequalities between native and refugees persist despite the development of antiretroviral (ARV) therapy that allowed the conversion of the HIV/AIDS in a manageable epidemic that can be mastered worldwide (Del Amo et. al., 2001). The same study mentioned immigration is often the result of multi-sectoral crises and armed conflicts, but HIV has become a factor of discrimination and marginalization both for refugees and other migrants as well as the locals (Bröring et. al., 2003). However, the access of refugees living with HIV/AIDS in the health

system in the host country requires the involvement of all parties; UN agencies managing refugees program and the host governments (UNHCR, UNAIDS, 2010).

In host countries, the number of refugees and asylum seekers living with HIV has increased significantly since these refugees come from countries where human rights violations, persecution, armed conflict and degradation of health system place them in crowded conditions, exposing them to HIV infection and STIs (Farmer, 1995).

A study of the UK Government's concern to integrate refugees in the country's health system demonstrated the government and some health partners were opposed to this amalgamation and seek to limit the influx of refugees due to HIV (Flynn, 2003). Refugees and other immigrants are among the most marginalized and are doubly stigmatized if it turns out they are infected with HIV (Dodds et al., 2004). In relation to the cultures of origin, the study suggested ways that can facilitate the integration of refugees in the host country health system with emphasis on the international agreements to which these countries are signatories.

2.3 Practices towards HIV/AIDS

In 2006, a study conducted by UNHCR in refugees camps and host communities in Kawambwa and Mporokoso in Zambia had shown that young boys living in the camps became sexually active at the age of 17 years, 16 years for girls in the camps and 16 years for people living around the Kawambwa refugee camp. The Mporokoso refugee camp represents boys and girls who become sexually active at the age of 18 years including the local communities. In both camps the age for first marriage was 22 years for men and 21 years in the host communities. Thus, the age difference of marriage is one year between refugees and indigenous (UNHCR, 2006). Polygamous marriages are more common among refugees than among the natives. In the Kawambwa refugee camp, 15% of married men are polygamous against 8% in host communities. For women, 21% of the refugees are in polygamous households in Kawambwa camp against 7% in host communities. In Mporokoso camp, 9% of the refugee men are polygamous against 4% in the host community. Conversely, 12% of refugee women and 10% of women in polygamous households (UNHCR, 2006). The same study found condom use is lower among the refugees than indigenous people of all ages. In both camps 18% of refugees used condoms against 47% against in the host community (UNHCR, 2006).

2.4 Attitudes towards HIV/AIDS

A study in Nyarugushu refugee camp in Tanzania demonstrated in a systematic selection of refugees (n = 1140) and those living with HIV (n = 182) that the risk of transmission increases with the movement of population from one place to another, especially those involved in transactional sex for financial reasons and material needs despite efforts to raise awareness about HIV in the camp. The study noted results of HIV awareness campaigns enable refugees to take their own initiatives to protect themselves against HIV by using condoms (UNHCR, 2007).

According to a study conducted by Elsevier (2007) people living with HIV were less faithful to their partners and were involved in multiple sexual relationships with casual partners without the use of any method of protection. The same study had demonstrated the positive impact of peer education in the refugee camps. Furthermore the study suggests the use of radio messages that can serve as agents to reach a large number of refugees and thus strengthen sex education for those living with HIV (Elsevier, 2007).

According to Williamson (2006) in many host countries, refugees are seen as a group of people at high risk because of the growth of HIV prevalence rate in the country of origin, their vulnerability as a victim of violation of most basic human rights, war and rape. But also the negative message popularized in the media that correlate between HIV/AIDS and further Africa are propellant of discrimination against refugees (Williamson, 2004).

UNHCR noted the correlation between HIV/AIDS and the status of refugees contribute to hostile climate socially and politically against them in the host country. However, refugees have already been victims of multiple violations in their home countries, they are once again marginalized and discriminated in the host country where access to employment, education and healthcare are sometimes not easily available; they are often accused of bringing HIV in host countries (UNHCR, 2006).

2.5 Summary

This second chapter analyses the existing and academic studies on refugees and HIV in general in South Africa and internationally with a focus on refugee's knowledge, attitudes and practices towards HIV/AIDS.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

A research design is the researcher's overall plan for obtaining answers to the research questions guiding the study (Burns & Grove, 2009). This study used a quantitative descriptive design in order to explore the knowledge, attitude and practices of Congolese refugees living in Cape Town.

3.2 Research question

What are the knowledge, attitudes and practices of Congolese refugees living in Cape Town?

3.3 Aim and objectives of the study

This study aims to explore the existing knowledge, attitudes and practices regarding HIV/AIDS among Congolese refugees living in Cape Town in order to create awareness and suggest possible measures to avert the spread of the pandemic among them.

- ❖ To assess Congolese refugees' knowledge, attitudes and risky practices regarding HIV/AIDS
- ❖ To examine and establish factors which contribute to the high risky behaviour adopted by Congolese refugees
- ❖ To provide guidelines and a set of recommendations for HIV/AIDS planners, policies makers and NGOs for intervention

3.4 Research approach

The main objective of this study was to assess the knowledge, attitudes and practices of Congolese refugees living in Cape Town.

According to (Burns & Grove, 2009) a research design is the researcher's overall plan for obtaining answers to the research questions guiding the study. This study used a quantitative descriptive design in order to reach the objective mentioned above.

A convenience sampling method was employed for this study. This includes participants who are readily available and agree to participate in a study (Christensen Larry & Tuner, 2011).

Both quantitative and qualitative research are used in many studies, quantitative research explain phenomena using numerical data that are analysed using mathematically based methods (in particular statistics), whereas qualitative research seeks to answer question about why and how people behave in the way they do; provides in-depth information about human behaviour (Christensen Larry & Tuner, 2011).

3.4.1 Advantage of a quantitative research

Quantitative research allows the researcher to measure and analyse data and the relationship between an independent and dependent variables in detail. This is advantageous because the researcher is more objective about the findings of the research. Quantitative research can be used to test hypotheses in experiments because of its ability to measure data using statistics (Christensen Larry & Tuner, 2011).

3.4.2 Advantage of the qualitative research

Qualitative research is useful during the early stages of a study when the researcher may be unsure of exactly what will be studied or what to focus on. This type of research does not need a strict design plan before it begins. This gives the researcher freedom to let the study unfold more naturally. Another advantage to qualitative research is the researcher gains more detailed and rich data in the form of comprehensive written descriptions or visual evidence, such as photographs. This type of research looks at context and social meaning and how it affects individuals, which is advantageous particularly in the social sciences (Christensen, Larry & Tuner, 2011).

3.4.3 Disadvantages of Quantitative Research

According Christensen Larry and Turner (2011) the main disadvantage of quantitative research is the context of the study or experiment is ignored. Quantitative research does not study objects in a natural setting or discuss the meaning thereof have for different people as qualitative research does. Another disadvantage is a large sample of the population must be studied; the larger the sample of people researched the more statistically accurate the results will be.

3.5 Sampling

A non-probability sampling approach was chosen for the study because the convenience sampling technique was the most useful to select the sample. The main reason for this is justified for the study is a market where most Congolese refugees sell their goods and many of them own shops and hair salon. Thus, respondents were readily available and agree to participate in a study (Christensen, Larry & Tuner, 2011).

The target population is Congolese refugees living in Cape Town, with a refugee or an asylum seeker status. Due to the large size and difficulties in getting hold of them, the researcher randomly selected fifty (50) participants among traders and hair makers.

3.6 Data collection

A questionnaire was administered to the participants.

The questionnaire comprised four parts:

- ❖ Part 1 focuses on demographic background of participants.
- ❖ Part 2 related to the knowledge regarding HIV/AIDS.
- ❖ Part 3 related to Congolese refugee's attitudes scale towards HIV testing and people living with HIV.
- ❖ Part 4 related to practices with regards to HIV risk transmission.

3.7 Procedure

The data was collected at the Desk Top Market train station in Cape Town. This is an open market place where most Congolese traders sell their goods to the public. To avoid any possible discrimination or stigmatisation resulting from being identified as a refugee in the study, they were interviewed from the market place without screening them on the basis of their status. The participants were, however, required to tick their status in a box provided on the questionnaire. Furthermore, strict confidentiality was maintained to avoid the possible stigmatisation arising from the Congolese traders' refugee status. A counsellor was available to help assist individuals experiencing some discomfort after the study especially after being identified as refugees. The counsellor's name and telephone was given to the affected participants. The participants were given a questionnaire which includes a biographical section and the appropriate sections on knowledge and attitude towards HIV/AIDS. After completing the questionnaire, the participants were required to put their papers in an envelope provided and then deposit in a sealed box which was supplied by the researcher. This was mainly done to ensure confidentiality and anonymity.

3.8 Ethical considerations

Ethical approval was obtained from Stellenbosch University ethics committee. A consent form was given to the participants after they had each received a written explanation of the study; principles of autonomy and fairness were upheld. Thus, participants who wished to withdraw from the study were advised to do so at any stage of the data collection. They were assured they would not be coerced to continue and they would not be disadvantaged in any way by the researcher or the outcomes of the study. Participants were assured of

confidentiality and anonymity. To keep their identities confidential, all study materials were stored in a secured locker. These materials will remain protected for a period of two years.

3.9 Data analysis

The data which was collected by means of the questionnaire was subjected to a standard quantitative data analysis using the Statistical Package for Social Sciences (SPSS) software, with the assistance of a qualified statistician.

3.10 Summary

In this chapter the researcher reviewed the methods and techniques used to select the participants in the study for data collection. A total of 50 Congolese refugee traders, hair dressers at the Desk Top market were chosen to participate in this study; these refugees were used to represent the target population for this research. Population was used as the size of the target group is small enough to include everyone in the study. A self-administered questionnaire were distributed and collected within a month.

CHAPTER 4

RESULTS AND DISCUSSION OF RESEARCH RESULTS

4.1 Introduction

This chapter aims at presenting and analysis of findings. The respondents were given the questionnaire to read the instructions before completing. They were assured of confidentiality and the survey was voluntary. Those who were prepared to continue to participate in the study were given the opportunity to complete the questionnaires. Questions were asked in the form of being self-administered in a four-point scale, namely strongly agrees, agree, strongly disagree and disagree. Open-ended questions were asked at the end as a form of general questions to gain deeper insight into the possible underlying problems. A total number of 50 refugees participated in the study. The participation and response rate was 100%, all of the participants returned a completed questionnaire. The questionnaire had 04 sections, which included demographic details of respondents, their knowledge, attitudes, and practices on HIV/AIDS.

4.2 Research question

What are the knowledge, attitudes and practices of Congolese refugees living in Cape Town towards HIV/AIDS?

4.3 Aim and objectives of the study

This study aims to explore the existing knowledge, attitudes and practices regarding HIV/AIDS among Congolese refugees living in Cape Town in order to create awareness and suggest possible measures to avert the spread of the pandemic among them.

- ❖ To assess Congolese refugees' knowledge, attitudes and risky practices regarding HIV/AIDS
- ❖ To examine and establish factors which contribute to the high risky behaviour adopted by Congolese refugees
- ❖ To provide guidelines and a set of recommendations for HIV/AIDS planners, policies makers and NGOs for intervention

4.4 Biographical information

Age, gender and education deemed to be of interest in the study (table 4.1).

Table 4.1
Biographical information

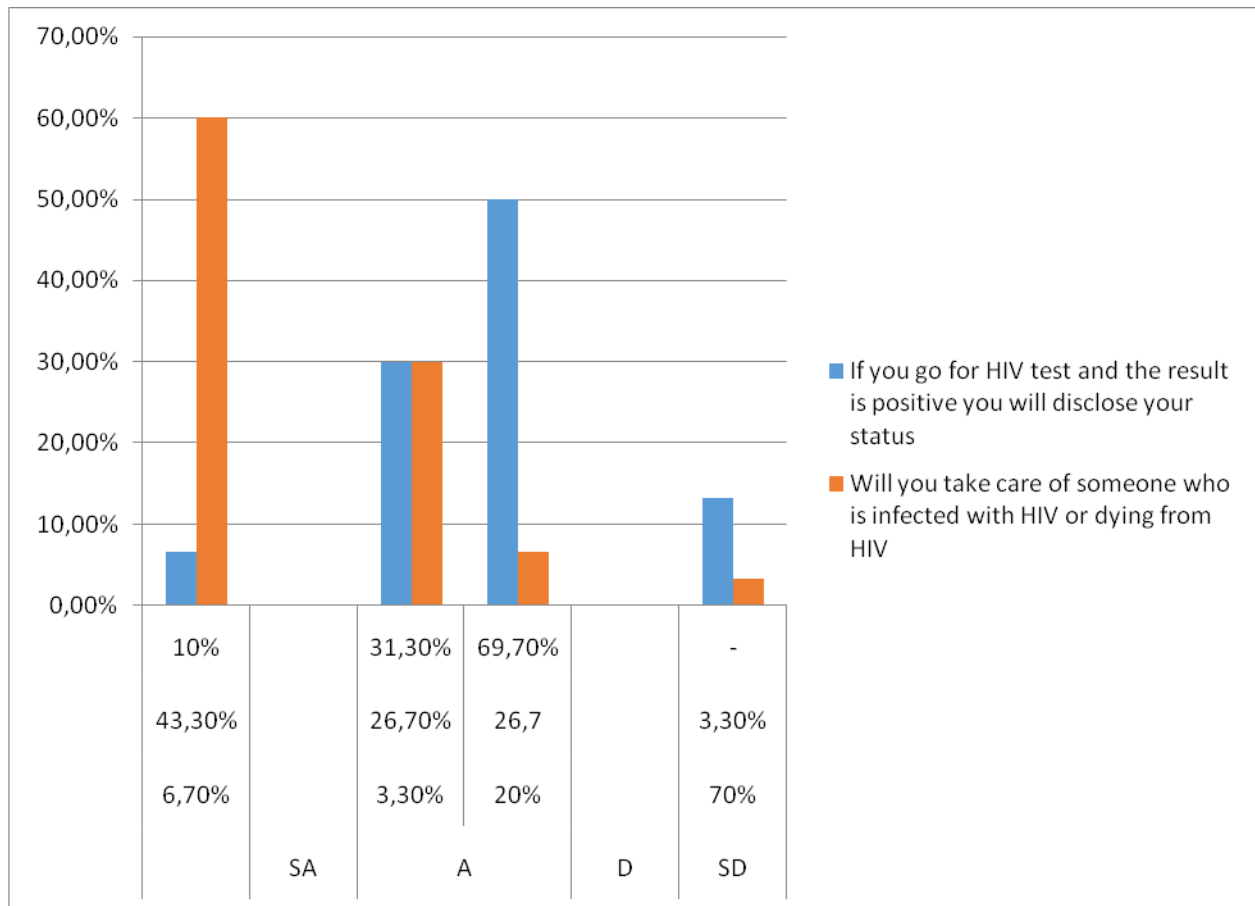
Variable	Frequencies	Cumulative Percentage
Age:	8	26.7%
	13	43.3%
	9	30%
	30	100%
Gender:	14	46.7%
	16	53.3%
	30	100%
	-	-
Education:	1	3.3 %
	25	83.3%
	3	10%
	1	3.3%

According to table 4.1, 43.3% of participants are between the ages of 31 and 40 years, 30% are between 18 and 30 years and finally 26, 7% are between the age of 41 and 50 years. This indicates the majority of refugees trading at the Top Desk market are between the ages of 31 and 40 years old. The majority (53.3%) of participants were female and 47.7% were male. The 83.3% of participants have high school certificate, 10% have Diploma, 3.3% have degree and 3.3% have Primary school certificate.

4.5 Knowledge based questions

The aim of the study was to determine the knowledge of the Congolese refugees living in Cape Town towards HIV/AIDS

Figure 4.1
Knowledge of HIV/AIDS



According to figure 4.1 the majority of participants will take care of someone who is infected with HIV or dying from HIV and the majority cases disclose their status if their results are positive.

When asked if the participants have enough information about HIV/AIDS 76.7% responded in the positive.

A group represented by 70% agree they know how to protect themselves from being infected with HIV.

A total of 43, 3% agree a person can get HIV by having sex with an HIV positive person - where 23.3% strongly agree while 33.3% were in disagreement. A group represented by 56.7% agree a person has a greater chance of getting HIV by having sex with more than one sexual partner

Only 13% disagree using condoms at all times can prevents a person from getting HIV while 83.3% was in agreement. Amongst the group 97.7% people did not support the notion that one can be cured by having sex with a virgin while.

Results show 93.3% of respondents was in agreement male circumcision helps with the prevention of HIV. About 70% of participants disagree that HIV/AIDS can be cured.

4.6 Can you disclose your status after being tested positive for HIV?

The majority of participants will take care of someone who is infected with HIV or dying from the infection and the majority are prepared to disclose their status if their results are positive. When asked if the participants have enough information about HIV/AIDS 76.7% individuals agreed. There were 56.7% that agreed they know where to get information about HIV.

A group represented by 70% agree they know how to protect themselves from being infected with HIV. A total of 43.3% agree a person can get HIV by having sex with an HIV positive person 23.3% strongly agree while 33.3% were on the negative side.

A group represented by 80% was positive where a person has a greater chance of getting HIV by having sex with more than one sexual partner. Only 13% disagree using condom at all times can prevents a person from getting HIV while 83.3% gave positive responses.

Among the participants a majority of 70% strongly disagree people can be cured by having sex with a virgin. Results show 60% of respondents strongly agree on the question about male circumcision helps with the prevention of HIV while 70% of participants disagree HIV/AIDS can be cured.

4.7 Practices based questions

The objective of the practices based questions was to explore Congolese practices toward HIV/AIDS transmission.

Figure 4.2
PRACTICES TOWARDS HIV/AIDS

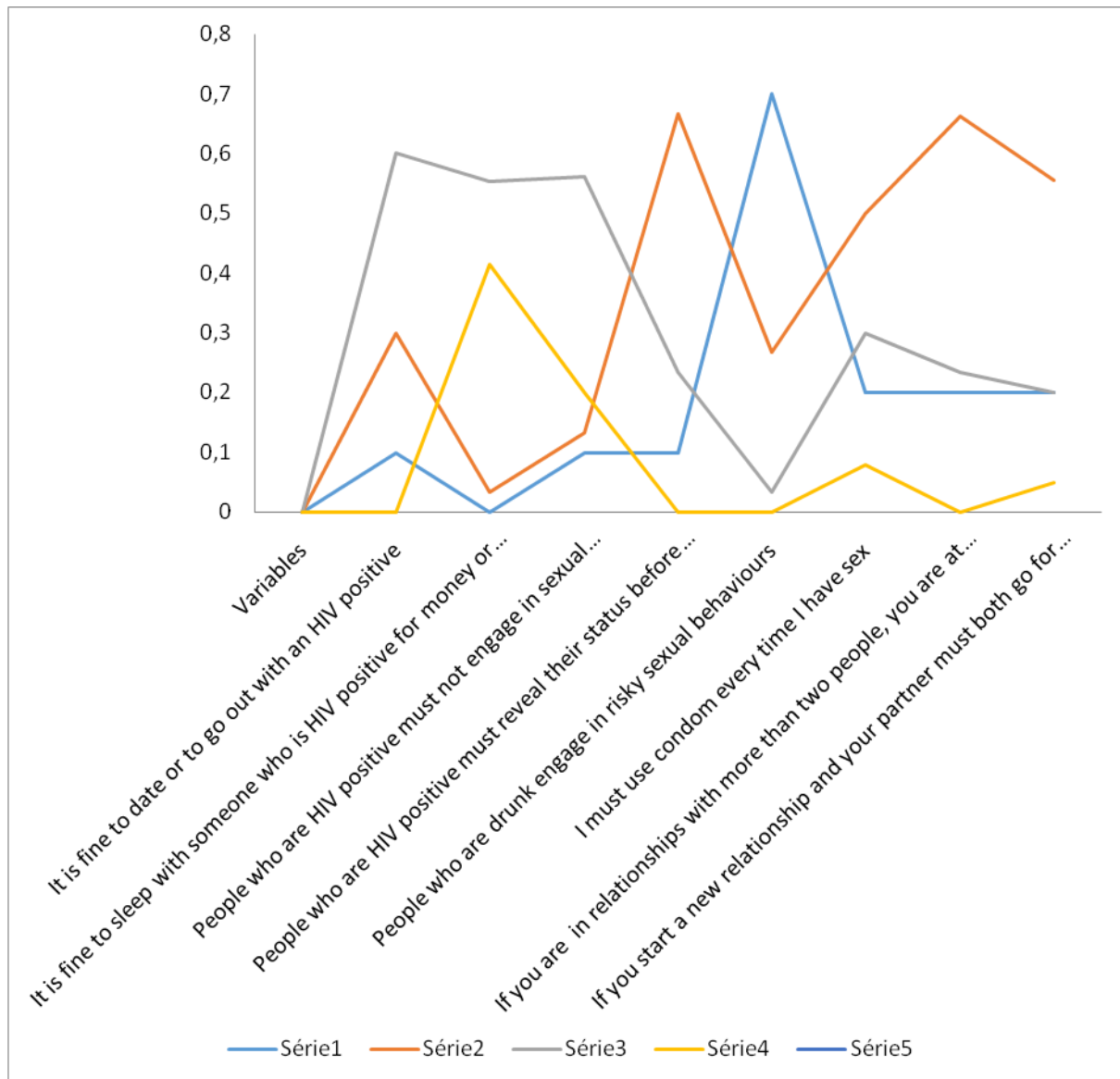


Figure 4.2 reflects the results indicate only 10% of the sample reasoned they can easily see who is infected with HIV. Respondents expressed their opinion concerning the irresponsibility of HIV positive individuals was represented by 70%. There were 69.7% who disagree people with HIV are treated well in their communities. A total of respondents 36.7% agreed if they go for a HIV test and the result is positive they will disclose their status. About 63.3% were positive they will take care of someone who is infected with HIV or dying from the infections.

4.8 Attitudes based questions

The objective of the attitudes based questions is to explore Congolese refugees attitudes toward people living with HIV/AIDS (in refugee's community or with the host community).

Figure 4.3

Attitudes towards people living with HIV/AIDS

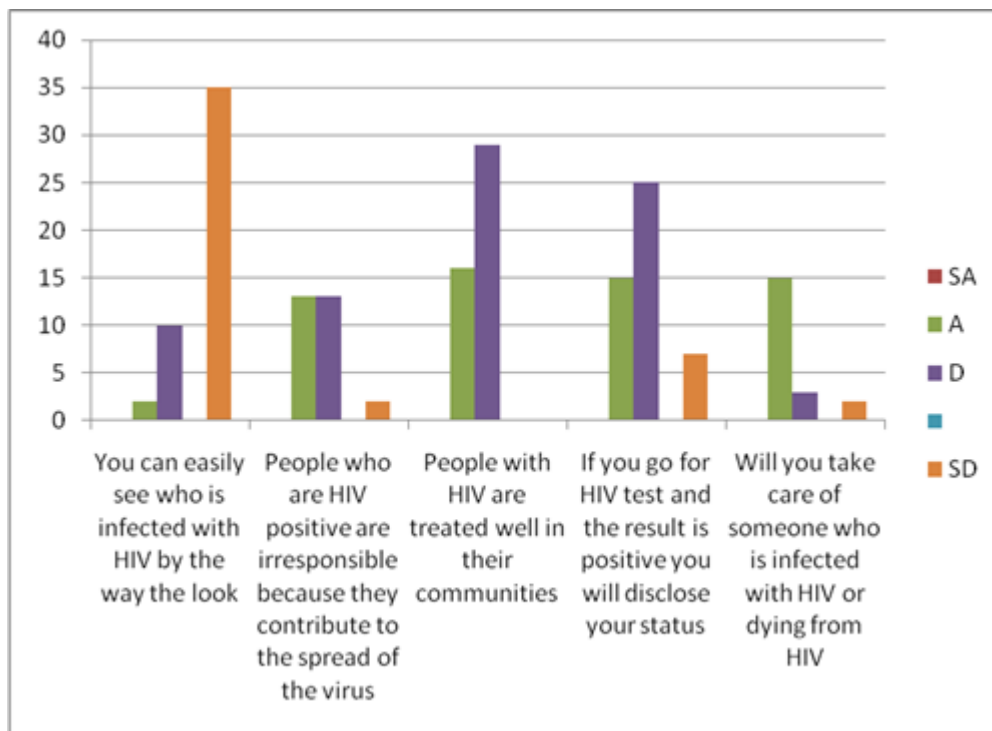


Figure 3 indicate when asked if the participants have enough information about HIV/AIDS 66.7% agreed on the question. Responding to this question 70% agree they know how to protect themselves from being infected with HIV. Some 43.3% agree a person can become infected by having sex with an HIV positive person while 10% strongly disagree. A group of 80% of the respondents gave a positive response where a person has a greater chance of getting HIV by having sex with more than one sexual partner.

Among the participants 83.3% of individuals were in agreement using a condom at all times can prevents a person from getting HIV. A total of 70% of participants strongly disagree people can be cured by having sex with a virgin. There were 93.3% of the respondents who were in agreement on the question related to male circumcision helping with the prevention of HIV.

4.9 Summary

This chapter presented the findings of the study in which Congolese refugees living in Cape Town demonstrated high levels of knowledge of HIV/AIDS. However, negative attitudes and practices towards HIV/AIDS and people living with HIV are still high in their community.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The purpose of this study was to explore the existing knowledge, attitudes and practices regarding HIV/AIDS among Congolese refugees living in Cape Town in order to create awareness and suggest possible measures to avert the spread of the pandemic among them. The problem the study aimed to solve was what are the knowledge, attitudes and practices of Congolese refugees living in Cape Town towards HIV/AIDS?

5.2 Objective one: To assess Congolese refugees' knowledge, attitudes and risky practices regarding HIV/AIDS

Based on the findings of this study, it could be concluded the knowledge of HIV/AIDS is high among Congolese refugees. Despite this knowledge, their attitude and practices towards HIV/AIDS epidemic is not encouraging. The risk of contracting the disease is still high, demonstrated by their risky sexual habits as it has been observed in the study and they constitute a community with high level of stigma and discrimination. The findings show condom use condom-use by Congolese refugees is low, regardless of whether they know condoms can reduce the risk of HIV infection.

5.3 Objective two: To examine and establish factors which contribute to the high risky behaviour adopted by Congolese refugees

The following are the main factors which contribute to the high risky behaviour adopted by refugees in general and by Congolese refugees in particular.

➤ **The loss of traditional support of social networks**

During flight refugees are detached from their families and their social network. Emotional, social and physical insecurity places victims of forced displacement in a situation of disfranchisement. This situation forces families to restore to unconventional methods to reach basic needs. Women are coerced to trade sex for protection and food either during the flight or in the country of asylum (Piot, 2001).

➤ **Vulnerability in the context of asylum country.**

The relationship between HIV and mobility is complex and far more interwoven with factors of social network support, socioeconomic status and HIV prevalence in the host state (IOM, 2008).

➤ **Social exclusion**

In the context of South Africa, refugees face pressure when seeking health care, employment as well as accessing other socioeconomic rights. These pressures are rooted in xenophobia and racism as much as self-exclusion. On the one hand, there is a stressful relation with the host community and on the other there are those who wish to maintain their private space to ensure personal empowerment.

➤ **Stigma and Discrimination**

Stigma and discrimination is a social process by which individuals are discriminated against because of their behaviour, race, gender or any social practice that is seen as deviant in their community. Stigma reduces the individual's social role and acceptance therefore stigmatized individuals or groups are excluded from mainstream activities and duties as expected from individuals of equal status due to deviance (Goffman, 1963). Stigma associated with HIV is recognized to be the hardest form of social isolation as it involves a mixture of shame, contempt and anger not only towards HIV positive people but also to people linked to the illness. High HIV prevalence differs in its conception from one community to the other. Block (2009) argues a community judges a person living with HIV based on the way they were infected.

5.4 Objective three: To provide guidelines and a set of recommendations for HIV/AIDS planners, policies makers and NGOs for intervention

The findings seem to indicate most of the Congolese refugees have the knowledge about HIV/AIDS and the route of transmission. The majority of Congolese appear to be acquainted with some knowledge on how to protect themselves against HIV/AIDS. However, it seem this protection discontinues shortly after a quick trust between them and their partners. This can be because most refugees are in need of financial protection on their arrival so they do not have any other choice than to comply with pressure. During the process of data collection there was an opportunity to discuss with some of them where most of them stated that condom use is not very safe as condoms break often. The participants do not believe male circumcision will help for the reduction of risk because 100% of them are circumcised but some have contracted HIV/AIDS. Some of the Congolese believe HIV can be eradicated because they have seen people who were cured from it by prayers. The findings also

indicate the level of awareness is low in this community because they still believe they can just by looking detect if someone is HIV positive or not.

5.5 Revisit the limitations

Further research can be conducted by a more represented sample of the Congolese population in South Africa to ensure higher validity.

Although a questionnaire enables a researcher to elicit responses there is the danger of social desirability. Often respondents provide answers to satisfy the researcher and look more favourable. Other research approaches could be considered to increase the reliability of the study.

Future studies should develop and evaluate HIV/AIDS models that help increase constant awareness. Further research can be conducted in other provinces of South Africa among Congolese Refugees.

5.6 Recommendations

The following suggestions are provided in order to improve the HIV knowledge, attitudes and practices of Congolese refugee living in Cape Town in particular and in South Africa in general.

- ❖ Other organisations similar to CTRC must be put in place within all the suburbs and township around the city to enable all refugees to get access to the adequate information about HIV/AIDS.
- ❖ UN agencies and NGOs working with refugees should consider the linguistic barriers around Congolese refugees in Cape Town with regards to HIV awareness and protection.
- ❖ HIV/AIDS awareness campaigns should be done regularly in French, Lingala, Swahili and Tshiluba.
- ❖ Refugees must be educated on HIV prevention and living positively to improve their knowledge within their community.

- ❖ Partnership with the South African Government, NGOs and inter-governmental organizations should remain a defining feature of all UNHCR programs on HIV/AIDS in Cape Town/ South Africa.

5.6 Conclusion

The study results show Congolese refugees have adequate knowledge about HIV and most of them know how to protect themselves from the virus. Their behaviour with regards to people living with HIV is positive. However, there are some who are infected just because of lack of language ability. They are not able to understand and to communicate with their partners properly or even with other people living with them. It is difficult for them to know the past of their partners and how they have been behaving sexually to enable them to take precaution in their future.

The Cape Town Refugee Centre did take action recently by putting in place some pamphlets about HIV/AIDS in French which is still not adequate according to the large number of refugees in the Cape Town as the Centre is just a small organisation which is only located in the southern suburb.. It is difficult for everyone to go to the city of Cape Town to get a pamphlet because of the distance and transport constraints. The centre is also only open twice a week from 9 am to 14 pm for refugees.

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APPENDIX 1

ANONYMOUS QUESTIONNAIRE FOR CONGOLESE REFUGEES (English version)

Part 1: Demographic information

1. What is your age range?

18-30 31-40 41-50

2. What is your gender?

Male Female

3. What is the highest level of education you have completed?

Primary school High school certificate Diploma Degree Postgraduate degree

1 2 3 4 5

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4. How long have you been in South Africa?

1- 3yrs 4- 6yrs 7-9yrs 10- 12yrs

1 2 3 4

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5. Are you employed?

formally employed Self-employed Unemployed

1 2 3

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Continue

Part 2: Knowledge based questions

Statement	Strongly agree	Agree	Disagree	Strongly disagree
6. I believe I have enough information about HIV/AIDS				
7. I know where to get more information about HIV/AIDS				
8. I know how to protect myself from being infected with HIV				
9. A person can get HIV/AIDS by having unprotected sex with an HIV positive person.				
10. A person has a greater chance of getting HIV by having sex with more than one sexual partner.				
11. Using a condom at all times prevents a person from getting HIV.				
12. People with HIV can be cured by having sex with a virgin.				
13. Male circumcision helps with the prevention of HIV infection.				
14. HIV/AIDS can be cured.				

Part 3: Attitudes based questions

Statement	Strongly agree	Agree	Disagree	Strongly disagree
15. You can easily see who is infected with HIV by the way they look.				
16. People who are HIV positive are irresponsible because they contribute to the spread of the virus.				
17. People with HIV/AIDS are treated well in their communities.				

18. If you go for HIV test and the result is positive, you will disclose your HIV status.				
19. Will you take care of someone who is infected with HIV or dying from HIV/AIDS related diseases				
20. I would not feel comfortable to demonstrate in public how male and female condoms should be used.				

Part 4: Practice questions

Statement	Strongly agree	Agree	Disagree	Strongly disagree
21. It is fine to go out with or date someone who is HIV positive?				
22. It is fine to sleep with someone who is HIV positive for money in order to buy a cell phone?				
23. People who are HIV positive must not engage in sexual intercourse at all.				
24. People who are HIV+ must reveal their status to their partners before they engage in sexual intercourse				
25. People who are drunk engage in risky sexual behaviours.				
26. I must use a condom every time I have sex with someone?				
27. If you are in relationships with more than two people at the same time, you are at risk of getting HIV?				
28. If you start a new relationship you and your partner must both go for an HIV test before engaging in sexual intercourse.				

If you feel that you need some more knowledge on HIV/AIDS please feel free to collect some pamphlets from the Cape Town Refugee centre at the following address:

Cape Town Refugee Centre

F12 First Floor

Wynberg Centre

123 Main road Wynberg

Tel: 021 762 9670

They are available in many languages including French.

Thank You for Taking Part in This Study



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APPENDIX 2.

QUESTIONS ANONYMES POUR LES REFUGIES CONGOLAIS

Partie 1: Information démographique

1. Quel âge avez-vous?

18-30 31-40 41-50

2. Quel est votre sexe

Homme Femme

3. Quel est le plus haut niveau de scolarité que vous avez complété?

Primaire secondaire Baccalauréat Graduat Licence Post- universitaire

1 2 3 4 5

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

4. Depuis combien d'années êtes-vous en Afrique du sud?

1-3ans 4-6ans 7-9ans 10-12ans

1 2 3 4

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

5. Travaillez-vous?

emploi formel sans emploi emploi libéral

1 2 3

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Partie 2: Questions fondées sur la connaissance

Déclarations	Entièrement d'accord	D'accord	Pas d'accord	Fortement en désaccord
6. Je crois que j'ai suffisamment d'information sur le VIH / Sida.				
7. Je sais où trouver plus d'informations sur le VIH.				
8. Je sais comment me protéger contre l'infection par le VIH.				
9. Une personne peut contracter le VIH / sida en ayant des rapports sexuels non protégés avec une personne séropositive.				
10. Une personne a plus de chance de contracter le VIH en ayant des rapports sexuels avec plus d'un partenaire sexuel.				
11. L'utilisation d'un condom en tout temps empêche une personne de contracter le VIH.				
12. Les personnes vivant avec le VIH peuvent être guéries en ayant des relations sexuelles avec une vierge.				
13. La circoncision contribue à la prévention de l'infection à VIH.				
14. VIH / sida se guérit.				

Partie 3 : Questions fondées sur le comportement

Déclarations	Entièrement d'accord	D'accord	Pas d'accord	Fortement en désaccord
15. Je me sens bien informés sur le VIH.				
16. Vous pouvez facilement voir qui est infecté par le VIH à la façon dont ils				

regardent.				
17. Les gens qui sont séropositifs sont irresponsables car ils contribuent à la propagation du virus.				
18. Les personnes vivant avec le VIH / SIDA sont bien traités dans leurs communautés.				
19. Il est facile de savoir que vous avez le VIH sans prendre un essai.				
20. VIH / Sida est un problème énorme en Namibie qui touchent tout le monde, y compris vous.				

Partie 4 : Questions fondées sur la pratique

Déclarations	Entièrement d'accord	D'accord	Pas d'accord	Fortement en désaccord
21. Il est bon de sortir ou sortir avec quelqu'un qui est séropositif.				
22. Il est bon de dormir avec quelqu'un pour de l'argent afin d'acheter un téléphone portable ou une robe.				
23. Les gens qui sont séropositifs ne doivent pas s'engager dans des relations sexuelles à tous.				
24. Les gens qui sont VIH + doivent révéler leur statut à leurs partenaires avant de s'engager dans des relations sexuelles.				
25. Les gens qui sont ivres s'engagent dans des comportements sexuels à risque.				
26. Je dois utiliser un condom chaque fois que j'ai des rapports sexuels avec quelqu'un?				
27. Si vous êtes dans les relations avec				

plus de deux personnes en même temps, vous êtes à risque de contracter le VIH?				
28. Si vous commencez une nouvelle relation est ce que vous et votre partenaire devez aussi aller pour un test VIH avant de s'engager dans des relations sexuelles.				

Si vous voulez avoir plus des connaissances sur le HIV/SIDA contacter le Centre des Refugies de Cape Town sur l'adresse suivante:

F12 First Floor

Wynberg Centre

123 Main road Wynberg

Tel: 021 762 9670.

Il y a des documents en francais.

Merci d'avoir participer a cette recherche



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CITY HEALTH

September 3, 2013

Ms Corneille Kalawu
Africa Centre for HIV/AIDS Management
Stellenbosch University
56 Pinaar St
PO Box 7129
Somerset West

Dear Ms Kalawu

The Cape Town City Health Directorate offers its support for this study which will explore the existing knowledge, attitudes and practices regarding the risk transmission of HIV/AIDS among Congolese refugees living in Cape Town, in order to create awareness and suggest possible measures to avert the spread of the disease among them.

As the Executive Director of City Health I am aware of the diversity of the population groups in our city. I recognize that your research could provide a valuable contribution to our understanding of behavioral drivers of transmission amongst Congolese refugees, and that it may also provide insights that are more broadly applicable across other population groups.

I wish you all the best with your proposal and look forward to working with you, as you undertake this initiative.

Yours sincerely

Dr Zandile Mahlangu
EXECUTIVE DIRECTOR: CITY HEALTH