Refugees' perceptions of about HIV and AIDS in Ba-Phalaborwa Municipality at Limpopo Province, South Africa

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Abstract: The research aimed at exploring and describing the perceptions of the refugees at Humulani village in the Ba-Phalaborwa municipality about HIV and AIDS. The objectives including determining the gender perceptions about HIV and AIDS and also providing recommendations for ways to increase the refugees understanding of HIV and AIDS. The approach used for the research was a quantitative approach. The target population of the study was all the refugees at Humulani village. The sample comprised of both males (78) and females (122) who participated by completing questionnaires. The sample of the refugees consisted of different ethnic groups from Mozambique, Nigeria, Ghana and Zimbabwe. The questionnaire consisted of three sections, section A, B and C. the findings of the study revealed that the participants had low levels of knowledge regarding HIV and AIDS which could be attributed to their possession of false myths about HIV and AIDS. The HIV-infected refugee population in Limpopo may continue to grow if the unique needs of the refugees such as strengthening the reproductive health services, maternal and child care and family planning, improving the educational and socio-economic status is not given attention.
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1. Introduction and background

There is a geographic overlap between HIV/AIDS and STI and refugee population. Most of the refugees in the world who are mostly young adults, women and children are found in developing countries with 40% in Asia and 30% in Africa (UNHCR, 1998). The United Nations High Commission for Refugees indicates that there are approximately 42 million people worldwide who are displaced from their homelands, equivalent to one out of every 170 people globally (UNHCR, 2008). This situation results to refugees experiencing difficult living conditions characterized by poor nutrition, poverty, overcrowding, and absence of health care. These factors have been thought to increase the risk for HIV infection, which can be attributed by refugees having limited knowledge on of HIV transmission and methods of prevention (Beckwith, Delong, Desjardins, Gillani, Bazerman, Mitty, Ross & Cu-Uvin, 2008; Mayaud, 2001) The strategies to prevent the spread of HIV among refugees have often aimed to alter the behaviour of individuals, failed to take into account sufficiently the societal and contextual factors that determine vulnerability as mentioned by (UNAIDS, 2004; Beckwith, et al., 2008) and there are few data about HIV prevalence in refugee settings. Tanaka, Kunii, Hatano &Wakai (2008) indicate that some publications though a limited number, have highlighted factors associated with HIV risk in refugee operations. Various studies have further denounced the absence of reproductive health services for these population particularly women and children (Austin, Guy, Lee-Jones, McGinn, Schlecht, 2008; UNHCR, 2008; Beckwith, et al., 2008).

According to the World Health Organization (WHO), an estimated 34 million people are living with HIV worldwide, and 1.8 million died in 2010. The Sub-Saharan Africa was the most affected region of the world with 22.9 million (UNAIDS, 2011). According to Journal-AIDS (2004) the countries reported to be having the highest rate of HIV are Botswana 39%, Swaziland 33%, Namibia 23% and South Africa 20%. It is important for health professionals who work in South Africa to understand the communities' beliefs about health and sickness and to incorporate these beliefs about into HIV and AIDS programmes (Doka, 1999). In 2010 approximately 2.7 million new HIV infections occurred in Sub-Saharan Africa and the pandemic claimed the lives of an estimated 1.9 million Africans

(UNAIDS, 2011). South Africa is one of the most severely affected countries with an HIV prevalence of 15.6% in 2002 among adults aged 15-49 years (Shisana, Simbayi & Muecke, 2002) and increase to 24% in 2010. The authors further mentioned that South Africa has the largest number of people living with HIV and AIDS in the world; approximately 10% of South Africans have AIDS. It is expected to have a great impact on the lives of South African citizens including refugees. It is also estimated by the year 2010 AIDS will result in approximately 380 000 deaths a year (Molefe, 2004). It is estimated that 9 out of 10 HIV infected people in the world do not know that they are HIV positive. In absolute terms, this means that over 27 million people today are not aware of their HIV infection. In many developing countries many people with AIDS only learn of their status after they have started showing HIV and AIDS symptoms and become sick (You and AIDS, 2002).

Data on HIV prevalence in refugee situation is scarce. It is believed that refugees and other displaced populations are at risk of contracting the virus during and after displacement, due to disruption of family/social networks and health services, increased sexual violence and poverty, forcing women and girls into transactional sex for money, food or protection. These conditions of deprivation experienced by displaced populations provide fertile ground for the spread of infectious diseases including HIV/AIDS. HIV prevention campaigns, condom promotion and distribution, programs addressing gender-based violence, HIV testing and counseling, the prevention of mother-to-child transmission and anti-retroviral therapy have all been implemented in various refugee settings, reaching large proportions of those in need in some instances (IASC Guidelines, 2009, 2010 & 2012).

The prevalence of HIV in most at risk populations in Nepal is much higher with 35% of injecting drug users, 1.5% in female sex workers, 1.9% in male labour migrants and 3.2% in men who have sex with men (The UN Refugee Agency, July 2010). In Botswana, 23.9% (280,000) of adults aged 15-49 years are estimated to be HIV positive. Of these, 120,000 are estimated to be eligible for antiretroviral therapy (ART). Refugees are officially excluded from the national ART programme in Botswana and this includes PMTCT services. Similar situation is reported by Beckwith et al (2009) that there is little data on ARV utilization and outcomes for infected refugees. Thus UNHCR and Botswana Red Cross Society developed a community-based programme for pregnant refugee women living with HIV (UNHCR, June 2010).

2. Research problem

The motivation of this study came from the alarming statistics of HIV and AIDS in Ba-Phalaborwa sub-district, especially the great increase in HIV and AIDS statistics amongst refugees at Humulani village as compared to other settlements occupied by South Africans. Despite efforts to educate the community about HIV/AIDS by the Primary health-care nurses and workers, it was thus uncertain how efforts impact on the refugees' understanding and behaviour with regard to HIV/AIDS. Statistics on HIV/AIDS at Humulani refugee village increased by 65%, while statistics at other settlements increased by 30% in 2003 (Ba-Phalaborwa HIV and AIDS statistics, 2005). In 2009, the Humulani clinic October statistics revealed that out of 1460 clients who received Voluntary Counseling and Testing (VCT) 57% of them tested positive, newly diagnosed, showing the highest percentage of women (39%) as compared to 32% HIV positive women in 2005. The increase in the Ba-Phalaborwa HIV/AIDS statistics occurred despite the road shows on HIV/AIDS being conducted in the village and schools which were visited by primary health-care nurses in Humulani to educate the refugees. There is also little known about the risks and risks behaviours of refugees living in post emergency phase camps where there is continued displacement with lack of food and basic necessities due to limited aid from international donors which may further expose them to HIV/AIDS (Tanaka, Kunii, Hatano and Wakai, 2008). The aim of the study was to increase the understanding of HIV and AIDS by the refugees at Humulani village of Ba-Phalaborwa.

3. Research objectives

- To describe the refugees' perception of HIV and AIDS at Humulani village;
- To determine by gender the perceptions of HIV and AIDS at Humulani village

4. Materials and methods

This study is used as a descriptive design to identify and describe the refugees' perceptions of HIV and AIDS. Descriptive research also provides an accurate profile of a group (De Vos, 2003). Descriptive research also presents basic background information on the study. The background information for the study on refugees at Humulani village was provided for, as the questionnaires required responses about the refugees' beliefs and attitudes about HIV and AIDS which form an important component of the refugees' background. The study gave a numerical picture of the results as the responses given by participants on the questionnaires were scored, and

tables were developed from these scores (De Vos, 2003).

The study was conducted at Humulani village situated in Ba-Phalaborwa Municipality of Mopani District. Refugees largely inhabited that area. It is a rural area, which was established as an informal settlement in 1986. It is 20km from the nearest health centre, 43km from the nearest hospital and 30km from Ba-Phalaborwa sub-district primary health-care offices. The reason for choosing Humulani village was that it accommodated the largest number of refugees compared to other settlements and it was easily accessible.

The population was the refugees at Humulani Village. The population of the settlement amounted to 14915 (Census South Africa, 2003) most of the Humulani Village people were unemployed and illiterate, and the refugees originated from other African countries. The average numbers of children per household was 7. Most of them started giving birth at the age of 15 and stopped giving birth between the ages of 50 and 55.

The non-probability purposive sampling method was used. Purposive sampling was chosen as is based entirely on the judgment of the researchers and is composed of elements that contain typical attributes of the population that is refugees. Humulani village within Ba-Phalaborwa municipality which participated in the study was purposively chosen as a sample of the study because is the only refugee village. In the research only those refugees who could communicate in Xitsonga and were interested to participate were included in the sample. The sample consisted of females who have already mothered children and males. Initially, a target of a thousand participants was preferred for the study, and we only managed to locate 200 participants. This was due to the fact that the research was conducted at the clinic when client were coming for consultation and clinic has a low daily turn up of between 45-60 patients as compared to nearby health centre which consults 130-200 on a daily basis.

Data from 200 participants was collected through the use of interview questionnaire at Humulani clinic. The questionnaires were employed during the normal working hours of the clinic. As most of the refugees were illiterate, researchers conducted one-to-one interviews and completed the questionnaires. All participants answered verbally. The study was conducted over a period of 10 weeks. It did not interfere with the normal routine of the clinic as the questionnaires were administered to patients waiting in the waiting room to see the doctor or nurse.

The questionnaire consisted of a list of 50 questions which were grouped under three sub-themes. These sub-themes included HIV/AIDS Knowledge, Attitudes and Myths. The first 45 questions were close-ended questions to which the respondent could answer 'true', 'false' or 'don't know'. The respondents indicated their answers by placing a tick in the space provided below the answer of their choice. These closed-ended questions were questions on the HIV/AIDS Knowledge and Myth sub-themes only. The last 5 questions were open-ended questions where the respondents were provided with a space below the question to give their answer. These questions encompassed questions under the HIV/AIDS Attitudes and Knowledge sub-themes.

Since the respondents were illiterate or unable to fill in their responses by themselves, the researchers filled in their responses as respondents provided them verbally. These questions were asked as phrased in the questionnaires. However clarification was offered to the respondents who needed it. The setting for the research measurements was controlled as the research was conducted in a clinic where people came for consultation. It was observed therefore easier for the participants to answer questionnaire truthfully as the questions were also health related. Most participants completed the questionnaires as the importance of the research was emphasized to them (De Vos, 2003)

Data recorded in a computer and analysed to give frequencies, means and medians using the Microsoft Excel programme. A statistician did the data analysis, using the Statistic Package of Social Science (SPSS) computer programme. Permission to conduct the study was obtained from the provincial Department of Health and Social Development of Limpopo as Primary Health Care falls under these departments. The right, needs, values and desires of the participants were protected. The participants' rights, interests and wishes were considered first when choices were made regarding reporting the data. The participants were assured that they had the right to refuse to participate in the study without any penalty and also to withdraw from the study at any time they wished.

5. Results

A total of 200 questionnaires were completed and results are presented as follows:

5.1 Biographic data

The majority of the participants (29%) fall between the ages of 26-30 years, followed by participants (28%) 15-25 years of age. The findings could imply that the clinic is mostly utilized by younger people. The findings can be further argued against the problem statement that the increase statistics of HIV and AIDS at Humulani Villages at 65% affect mainly the young adults' more than older people.

The findings revealed that female (61%) came in large numbers than male (39%) due to the fact that woman in African cultures are the once who bring

children's to the clinic for consultation and the fact that man are less responsible to seek medical health than females.

The majority of respondents are Mozambicans (48%) and Zimbabweans (28.0%). The findings can be argued that they are near to the border of South Africa, and they can cross the border on foot that is easily accessing Humulani village. The findings could further be argued that high percentages of Mozambicans (43%) can be due to the fact that their home language is Xitsonga then it was easy to be included under the study.

5.2 Refugees knowledge of HIV and AIDS (n=200)

Table 1 Refugees' knowledge of HIV and AIDS (N=200)

Knowledge assessment items	**True**		**False**		**Do not know**	
	f	**%**	**f**	**%**	**f**	**%**
1. Only women can spread AIDS to men **(*)**	196	98	4	2	-	-
2. Promiscuity is the only driving force behind the AIDS epidemic **(*)**	187	93.5	13	6.6	-	-
3. Weight loss is sure indication/symptom of HIV?AIDS	186	93	11	5.5	3	1.5
4. Only men can spread AIDS **(*)**	183	91.5	17	8.5	-	-
HIV has spread so far that prevention effort are irrelevant	183	91.5	10	5	7	3.5
6. AIDS is a homosexual disease	179	89	20	10	1	0.5
7. One can only contact HIV by having repeated sexual intercourse with an HIV positive or AIDS patient	177	88.5	19	9.5	4	2
8. AIDS is a disease of gay white men in South Africa	173	86.5	20	10	7	3.5
9. A pregnant women can give AIDS to her baby **(*)**	168	84	23	11	9	4.5
10. Someone who is infected with HIV but does not yet have full blown AIDS can transfer HIV through sexual contact **(*)**	18	9	166	83	16	8
11. HIV and AIDS can be transmitted through mosquitoes	165	82.5	15	7.5	20	10
12. A mother can transmit HIV on to her child through breastfeeding **(*)**	35	17.5	163	81.5	2	1
13. If a women falls pregnant while she is HIV positive the child that she will give birth to obviously is going to be HIV positive **(*)**	160	80	30	15	10	5
14. There is a cure for AIDS	158	79	17	8.5	25	12.5
15. When both partners are HIV positive they don't need to use a condom **(*)**	153	76.5	46	23	1	0.5
16. HIV is the disease of the poor	153	76.5	20	10	7	3.5
17. People with HIV generally develop AIDS as a result of other diseases **(*)**	14	7	152	76	34	17
18. A person cannot get virus from someone with the AIDS Virus **(*)**	52	26	137	68.5	11	5.5
19. HIV and AIDS can be transmitted through semen **(*)**	31	20.5	136	68.5	23	11.5
20. Someone who looks healthy can be infected by HIV **(*)**	48	24	133	66.5	19	9.5
21. HIV and AIDS virus can be present in vaginal fluid	28	14	132	66	40	20
22.AIDS is caused by HIV	40	20	130	65	30	15
23.Someone infected with HIV get AIDS within three months	130	65	40	20	30	15
24.A person can have the AIDS virus for seven years or more without having symptoms	57	28.5	123	61.5	20	10
25.You are likely to get HIV and AIDS if your sexual partner has had sex with a lot of people **(*)**	23	11.5	107	53.5	70	35
26.HIV and AIDS can be transmitted through anal sex	41	20.5	96	48	63	31.5
27. An individual with HIV is at high risk of developing clinically active TB	21	10.5	93	46.5	86	43
28. Condoms used with spermicidal give effective protection	38	19	71	35.5	91	45.5
29.The use of condom greatly reduce the risk of HIV transmission **(*)**	31	15.5	78	39	91	45.5
30.HIV is the virus that causes AIDS	52	26	61	30	87	43.5

In the analysis the study considered responses of 50% and above to be providing the extent of Knowledge (True; False; and Don't know). Furthermore, only findings that were perceived by the researchers to have impact on the extent of the refugees' knowledge, attitudes and beliefs regarding

HIV/AIDS were discussed (*). In this only the open ended questions to explore the myth and attitude of the respondents' results were discussed.

Item1. Only women can spread AIDS to men. The overwhelming majority respondents, 98%, perceived that only women can spread AIDS to men, 2% of the respondents disagreed that only women could spread AIDS. The respondents who were interviewed during the completion of questionnaires were further asked on why only women could spread AIDS to men, some said some wore cloths that could attract men to have sex with them and the ones who indulge themselves with sex work and prostitution. Respondents showed gross lack of knowledge about HIV and AIDS and the mode of transmission as they still attach gender to the transmission of HIV not knowing that both sexes can pass on the infection. Kapiga & Saidi, (1994), Lynellyn and Ankrah, (2000), also express that when men die of HIV and AIDS women are accused of having caused the death.

Item 2. Promiscuity is the only driving force behind the AIDS epidemic. 94% of respondents indicate that their promiscuity was the only driving force behind the AIDS epidemic while 6% indicate that promiscuity was not the only driving force behind the AIDS epidemic. The respondents who were interviewed during the completion of the questionnaires were further asked why promiscuity was the driving force behind the AIDS epidemic; they responded that only people who slept around got AIDS. The findings were supported by Lynellyn and Ankrah (2000) who indicate the women in rural areas who perceive themselves to be economically vulnerable may seek more than one partner to help them make an end-meet.

Item 4. Only men can spread AIDS. 92% of the respondents indicated that only men could spread AIDS and 9% indicate that not only men could spread AIDS. This finding showed that the respondents attached AIDS with sexes. This way of thinking persisted despite HIV and AIDS celebrations that were held in the area to raise HIV and AIDS awareness, hosted by the district and provincial government at Humulani refugees' village in 16 April 2006. The celebration was done before the data collection was done.

Item 9. A pregnant woman can get AIDS to her baby. Majority of respondents, 84%, indicate that a pregnant woman could give AIDS to her baby, 12% mentioned that the pregnant woman could not give AIDS to her baby, 5% said they did not know. This finding could imply that respondents had little knowledge about differentiating HIV and AIDS. Van Dyk (2001) stated that AIDS is a collection of many conditions that manifest in the body because of HIV which is a virus that weakens the body's immune system and that it can no longer fight the diseases causing agent that invade the body. During interview researcher further asked the respondents if they ever been present in one of the HIV and AIDS of health programme that is hosted by primary health care workers in their area. The majority of respondents indicated that they never attended such health programme.

Item 12. A Mother can transmit HIV to her child through breast feeding. Eighty two percent of the respondents indicated that a mother could not transmit HIV on to her child through breast feeding, while 18% mentioned that a mother could transmit HIV on to her child through breast feeding and 1% said that the did not know. This finding shows that the majority of the respondents do not know that HIV is present in breast milk. The finding imply that respondents are not aware that the virus is present in the breast milk and the mother can transmit it to her new born during breast feeding. Blaxhult, (1990) mentions that transmission could occur if the mother's nipples are having bleeding cracks while at the same time the child has sores in the mouth. The chances of trough transmitting HIV through breast feeding between mother and child are increased if the child has diarrhea due to erosion of the elementary track. The findings was supported by Van Dyk, (2001) who maintains that most of women in rural and remote areas in Africa are expected by society to breastfeed in public and even if they are HIV positive, then the risk of infection with HIV becomes high.

Item 13. If a woman falls pregnant while she is HIV positive, the child that she will give birth to is obviously going to be HIV positive.

Eighty percent of the respondents indicate that if a woman fell pregnant while she was HIV positive, the child that she would give birth would obviously be HIV positive. 15% mentioned that if a woman fell pregnant while she was HIV positive, the child that she would give birth to would obviously not going to be HIV positive. While 5% said that they did not know. The findings would imply that the respondents do not know that during pregnancy while the fetus is still in utero the placental membranes act as a barrier against harmful agent and maternal erythrocytes are too large to pass through the placenta. According to Myles, (2000) indicates there are also chance that child can be infected with HIV as it can pass through the placenta. Van Dyk, (2001) mentioned the mother is likely to transmit the virus to her fetus during pregnancy if they become infected just before or during pregnancy or if she has an HIV/related illness or full blown AIDS. The reason being that the mother is more infectious at those phases because the HIV is viral loads is usually high and the CD4 cell count is low during the sero conversion and when the individual is ill with AIDS. Kapiga and Saidi (1994)

indicates that mother-to-child transmission can take place if the membrane are ruptured easily during labour and cutting of episiotomy were maternal blood comes into contact with the fragile skin of a newborn and transmits the HIV to the newborn. The study was supported by Biggar (1989) who mentioned that most rural women give under supervision of a traditional birth attendance who encourages pushing with each contraction which might lead to cervical tears and bleeds before birth of the baby and facilitate the transmission of the HIV. The inadequate or lack of knowledge on prevention of mother to child transmission (PMTCT) might be attributed to the fact that the refugees are from different countries as in Botswana they are excluded from the national ARV programme which includes PMTCT (UNHCR, June, 2010).

Item 18. A person cannot get virus from someone with AIDS virus. 69% of respondents mentioned that a person could get virus from someone with AIDS, 26% indicated that a person could not get virus form someone with the AIDS virus, and 5% said they did not know. According to Chi square statistics the statement was found to be significant with X^2=6.647 and p< 0.5, it was further indicated that females were significantly more knowledgeable regarding the transmission of HIV and AIDS than males. The finding therefore implies that males were significantly more knowledgeable regarding the transmission of HIV and AIDS than females. As has been discussed in item 4.

Item 19. HIV and AIDS can be transmitted through semen. Sixty – nine percent of the respondents mentioned that HIV and AIDS could not be transmitted through semen and 12% said they did not know. This finding showed poor knowledge of mode of transmission of HIV and AIDS, Herek and Glunt, (1991) state that African women do not initiate discussion about sex or tell their partners to use condoms because it is cultural inappropriate and also because it brings their sexual behaviour in to question. Therefore takes place without a condom and semen transmit HIV easily as it contains the virus.

Item 20. Someone who looks healthy can be infected with HIV. Sixty –seven percent of respondents mentioned that someone who looks healthy could not be infected by HIV, 24% said yes the person who looks healthy can be infected by HIV whereas 10% said they did not know. The respondents showed poor knowledge of stages of HIV and that the person can live long without signs and symptoms. This was persistent despite HIV and AIDS awareness, hosted by the districts and provincial government at Humulani refugees' village in 16 April 2006. Preble et al, (1990) mentions that African people believe that HIV exists only when they see an ill person.

Item 25. You are likely to get HIV and AIDS if your sexual partner has had sex with a lot of people. Fifty three percent of the respondents mentioned that you were not likely to get HIV and AIDS if your sexual partner has had sex with a lot of people. 35% said they did not know, 12% indicated you were likely to get HIV and AIDS if your partner has had sex with lot of people. The respondents who were interviewed during the completion of questionnaires indicated that sleeping around was the only way of transmitting HIV and AIDS to others. This finding shows that the respondent had poor knowledge with regards to HIV transmission. Based on the Chi square statistics it was found that there was significant difference in knowledge of HIV and AIDS transmission between males and females. X^2 =11.05 and p< 0.5, further indicated that females were significantly more knowledgeable regarding mode of transmission of HIV and AIDS than males as it was supported by Kapiga and Saidi (1994) who further expresses that females have access to health information as they are once who seek medical help than males. The study is also supported by findings that revealed that 61% of participants in the study were females.

Item 15. When both partners are HIV positive, they don't need to use to use a condom and Item 29. The use of condom greatly reduces the risk of HIV transmission. Seventy- seven percent of the respondents mentioned that when both partners were HIV positive they did not need to use condoms and 23% of respondents mentioned that when partners were HIV positive, they needed to use condoms while 1% said that did not know. Forty-five percent of the respondent perceived that they did not know whether the use of condom gave effective protection. 35% of the respondents indicated that the use of condoms did not give effective as opposed to 19% who said the use of condom gave effective protection. Seventy-seven percent of the respondents mentioned that when partners were HIV positive there was no need to use a condom. 23% indicated that they needed to use a condom and further 1% said they did not know. The findings could imply that the respondents had a negative attitude about the need to use a condom and they did not know the degree to which someone who is HIV positive can re-infect themselves thus causing themselves to develop AIDS quicker. This was reviled even though had been a great amount of awareness raising by the love life team in this area which demonstrated the proper use of condoms, among other things, and also insured the availability of condoms in public spaces like shopping malls, public toilets, shebeens and tavern. Largede et al, (1998) also state that African people believe that the flow of fluid during sexual intercourse represent the exchange of

"gifts of self" which they regarded as being important in the relationship.

The overall knowledge discovered in the current study could be considered poor or at low level, this judgment is based on the researchers' decision to use the acceptable 50% "correct responses" as an indication of good levels of knowledge, as established on sample of rural participants. In the study conducted by Tanaka et al, (2008) on knowledge and attitude, and practice of HIV prevention and HIV infection risk among Congolese refugees in Tanzania had shown an interesting finding that the refugees (63%-93%) who had heard of HIV/AIDS demonstrated high level of knowledge and attitude to HIV/AIDS and its prevention.

There are several crucial items not discussed in this article, which scored below expected percentage of 50%, which is a sign of lack of knowledge with regard to HIV and AIDS. Previous research studies (Alexander et al, 2005; Pitts et al., 1990; Sweat & Levin, 1995) have indicated that whites have consistently performed better than Blacks with regard to HIV and AIDS knowledge. However, the lower level of knowledge for Blacks may in fact be an effect of their socio-economic status, involving issues such as, poverty, migrant labour, the low status of women, literacy levels, lack of formal education, stigma and discrimination, rather than ethnicity as such these findings were revealed by (Beckwith, 2009; MacLeod-Bluver,2009; Van Dyk 2001). From the findings it is clear that respondents have a poor level of knowledge with regard to HIV and AIDS. The respondents could not differentiate between HIV and AIDS, the findings showed that the respondents have negative attitude towards the use of condoms and they also discriminate those who are HIV positive as they expect them to disclose their HIV status. The respondents did not know that there are opportunistic infections like TB that can lower the immune system and predisposes the individual to AIDS. The research conducted by Family Health (2000) revealed that women do not have control over their sex life, society expect them to do what their husbands tell them.

Refugees' perceptions regarding myths of HIV and AIDS at Humulani village

The overall prevalence of myths found by the current study indicated that myth had a negative impact on the level of HIV and AIDS knowledge held by refugees. Items under myths regarding HIV and AIDS were answered poorly, like

- HIV can be contracted by using the same toilet as an HIV positive person.
- Cleaning ceremonies should be done to widows by having sexual intercourse with an unknown person
- AIDS is caused by spirits or supernatural forces

These findings could imply that respondents had little knowledge about HIV and AIDS as they still belief that supernatural forces are behind the disease, study by Van Dyk, (2001) mentions that if education and preventive programme are to succeed in Africa, it is important for us to understand the traditional beliefs.

In conclusion, the respondents' perceptions of HIV and AIDS based myths was unexpected as there was a great amount of knowledge available about HIV and AIDS pandemic that would decrease the number of myths that these people had regarding the disease. The respondents did not know that without an open wound and mixing of blood from infected person one could not get AIDS by touching someone with AIDS. The research conducted by Lynellyn & Ankrah, (2000) revealed that in rural places, knowledge should be spread in order to fight some of the beliefs that can create ignorance about the actual cause of the disease and may lead to great spread of HIV and AIDS.

The respondents felt that the HIV client should disclose to their relatives, this finding is supported by previous research, highlighting that 19% of the respondents expected the disclosure of their relatives' status (Bruce, Shrunk, Trefethen & Slovik, 2001). The finding is consistent with previous research Al-Owaish et al, (1990) who revealed that it was surprising that the African rural group that was considered "hard hit" in terms of HIV and AIDS prevalence rates did not have a better knowledge of the dire effects of the disease.

The research conducted by Doka (1999) revealed that no AIDS programme can succeed in Africa without the help traditional healers as they are effective agents of change because they have authority in their communities.

Attitude and beliefs

A large number of respondents in the current study expressed negative and discriminatory attitudes towards family members with HIV/AIDS. The most commonly cited reason offered by people for being afraid of contracting HIV/AIDS from a family member who was infected with HIV and AIDS, was concern about accidents involving transmission via open wound, e.g. "if someone has HIV/AIDS and I have an open wound on my skin, then there would be a risk if their blood (comes) into contact with my open wound".

Another concern was*: "I have limited faith in the medical profession and therefore question their wisdom on how the spread of HIV/AIDS takes place… nobody is hundred percent sure how AIDS is spread".*

And other concern was:

"*We feel that we should know if somebody we stay with has AIDS for our own safety and to be able to join a burial society for them"*.

Majority said HIV and AIDS was "*the disease caused by promiscuity, was the disease called MAKHUME and the disease of the gay whites in South Africa".* This finding showed a poor level of knowledge of HIV and AIDS in this item. The finding is supported by Van Dyk (2001) who revealed that sexual transmitted disease was associated with witchcraft in most African countries where witchcraft is blamed for sickness, and is believed to be causal agent in HIV transmission, AIDS and death.

Is it possible for a new born to be HIV Negative while the mother is HIV positive?

The response was: *"they are sharing same blood. There is a 100% possibility of being positive"*

Some said: *"According to their cultural beliefs innocent blood can cure any dreadful disease and young blood can cure AIDS".*

This finding is consistent with the previous research Al-Owaish et al., (1999) who further revealed that it is surprising that the African rural group that was considered "hard hit" in terms of HIV and AIDS prevalence rates did not have a better knowledge of the dare effects of the disease and this finding is consistent with the previous research conducted by Preble et al, (1990) who revealed that African tradition belief that AIDS can be cured if they have sex with virgins or with girls younger than 12 years.

Limitation

In this study non probability sampling was used to identify the participating village, and the sample was representative of the population of refugee at Humulani villages in South Africa. This implies that the results might not be generalized to all refugees in South Africa.

6. Recommendations

Based on the results of this study the following recommendations could begin to address some of the perceptions that contribute to refugees' lack of HIV and AIDS knowledge at Humulani village in Limpopo province, South Africa. Tanaka et al, (2008) assert that promoting positive changes in refugee behaviour is a complex process requiring understanding their vulnerability, risk environment and behaviour.

It is recommended to assess the efficacy of the different types of HIV and AIDS programmes before implementing them. Repeated exposure to information involving video or film presentations, skill-based training, role plays and peer education have proved to be more effective in changing the attitudes than once-off, formal education programmes. Furthermore, the future HIV and AIDS education programmes and awareness campaigns need to adopt strategies that target specific groups of people to be effective (Tanaka et al, 2008) .

7. Conclusion

The HIV-infected refugee population in Limpopo may continue to grow if the unique needs of the refugees such as strengthening the reproductive health services, maternal and child care and family planning, improving the educational and socio-economic status is not given attention. Our study therefore suggests that health care workers in collaboration with the Ba-Phalaborwa municipality be encouraged to form support peer educators groups who will actively participate in the awareness education, organising peer meetings to discuss effectiveness and efficiency of their activities (Allan & Clarke, 2005; Tanaka et al, 2008).

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