THE INFLUENCE OF SOCIAL CAPITAL ON HIV PREVENTION WITH REFUGEES FROM BUKAVU/ DEMOCRATIC REPUBLIC OF CONGO LIVING IN DURBAN, SOUTH AFRICA

BY

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DECLARATION

I hereby declare that this dissertation, unless otherwise indicated in the text, is my own original work. All citations, references and borrowed ideas have been duly acknowledged. This research has not previously been submitted to any other institution for any degree or examination purposes.

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Mulumeoderhwa Buhendwa

DEDICATION

This study is dedicated to my wife NZIGIRE KALUNZI Love and our children Clarice Buhendwa, Joshua Buhendwa, Naomi Buhendwa, Rebecca Buhendwa, Angel Buhendwa, Nicol Buhendwa, David Buhendwa and my niece Baraka Kitoko, who supported me with everything they had and endured my absence even when it seemed unbearable.

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ABSTRACT

The study focused on the influence of social capital on HIV prevention with French speaking refugees living in Durban, South Africa. The overview of the existing literature shows a growing attentiveness to the role of social and environmental influences on HIV risk behaviours. The understanding of HIV-risk behaviours has moved from an earlier consideration of individual risk to ecological models with the understanding that behaviours are rooted in the economic, environment, and social structure. Overall, the data from interviews and focus group discussions in this study confirms that it is necessary to take a broad ecological perspective when considering HIV risk and protection. Social capital is clearly important but needs to be considered in relation to the complexities highlighted in the study in order to add vital insight into the considerations of what will add value to HIV intervention work with the refugee community.

The overall objective of the study was to contribute to an understanding of how social capital, specifically on a social bonding level, operates as a risk or protective factor for the spread of HIV amongst French speaking refugees from Bukavu, DRC, living in Durban, South Africa. More specifically the researcher wanted to understand how the elements of social capital (trust, norms, reciprocity and networks) on a social bonding level, act as risk or protective factors in the spread of HIV in relation to condom use, HIV counselling and testing and stigma. The research found that social capital can act as both a protective factor in some circumstances and a risk factor in others. Trust, norms, reciprocity and social networks are complex elements in the refugee community and influenced by a myriad of factors including the past and present stressors that are prevalent in the community. In turn these all have an effect on HIV prevention and need to be understood clearly. Without such a clear understanding, interventions offered to the community may well not lead to behaviour change that helps in the prevention of HIV. These findings are important as generally the impression is that the lack of policy and interventions to include refugees in services is the reason for high HIV risk. In addition literature shows that higher social capital leads to better health status. From the data in the current study one can conclude that any interventions and policy guidelines would have to be tailored to meet the specific needs and complexities inherent in this target group. Findings in this study confirm the complexity of issues relating to HIV prevention. It became clear that the answers are not simple. While social capital

has been found to be a useful component in generating support in a community, binding relations and having an overall positive effect; it appears that the situation is not this simple. The elements of social capital (trust, reciprocity, norms and social networks) were all apparent in the community, particularly at a bonding level, but at times worked in support of members and at other times appeared to work against them. This was especially the case in relation to issues surrounding HIV.

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1.1 Introduction

The aim of this chapter is to give a general introduction to the study. The chapter offers the overview of the whole dissertation, background of the study, the statement of the research problem, importance of the study, and the research questions addressed in the study.

1.2 Background and outline of research problem.

UNAIDS (2014) has estimated that about 36 million people worldwide have been living with HIV, and that about 20 million people have already died. The place worst hit by the epidemic has been the centre of sub-Saharan Africa. Sub-Saharan Africa is considered to be the most HIV affected region globally (UNAIDS, 2014). This report showed that in 2007, approximately more than three quarters of all HIV deaths worldwide occurred in sub-Saharan Africa where it has been estimated that there are 5.5 million (4.9 million – 6.1 million) people infected with HIV. In South Africa alone, over 20% of the adult population is recorded to be HIV-positive and up to 1,600 new infections are projected to occur daily (UNAIDS, 2002).

The overall HIV prevalence rate in South Africa is estimated to be about 10%, with the total number of people living with HIV estimated to be 5,26 million in 2013. More than half (55%) of all South Africans infected with HIV are said to reside in the Gauteng and KwaZulu-Natal provinces (Dorrington, Bradshaw, Johnson & Budlender, 2004; UNAIDS, 2007). According to UNAIDS (2007), the Province of KwaZulu-Natal had the highest overall HIV prevalence rate of 16.5%. The prevalence of HIV among antenatal attendees in the province soared at 39.1% (Department of Health, 2007). Yet, it is not only the infection rate that is alarming but also South Africa is a popular destination for most Africans from countries affected by war and political instabilities.

Haour-Knipe & Rector (1996) demonstrated that migration has shaped and influenced the spread of HIV globally. This means that the migration of people and populations are significant factors to consider in the spread of the virus. Migration is considered one of the many social factors that must be taken into account in relation to the HIV epidemic (Decosas & Adrien, 1997; Mabey & Mayaud, 1997).

The actual number of migrants entering South Africa in recent years is unknown. It is estimated that there are about 1.6 million cross-border migrants residing in South Africa (CoRMSA, 2009). It is well known that migrant populations are at an increased risk of both HIV and poor health in general. Studies have demonstrated that migrants are more likely to have multiple sexual partners and therefore are at higher risk of HIV infection and STDs (Sexually Transmitted Diseases) than are non-migrants (Magis-Rodriguez et al., 2009). Today there is general acknowledgment that mobile populations are considered to be more vulnerable to the risk of HIV infection than nonmobile populations (Camlin et al., 2010).

Even though asylum seekers and refugees are a low political priority for many host countries' governments and their local authorities (Jacobsen, 2006) a study conducted by Crush, Williams, Gouws & Lurie (2005) on HIV and migration in South Africa noted that special consideration should be given to people who have a high risk of HIV infection. This would include not only commercial sex workers and youth but also migrants and their partners. In the past migration studies have focussed mainly on the determinants of migration and not significantly on the health consequences (Crush et al., 2005; MacDonald, 1996). Studies that have linked migration and health have looked predominantly at migrants at their place of work, particularly on the gold mines, and to a considerably lesser degree on vulnerability to infection among migrants (Packard & Coetzee, 1995). Research on the relationship between the process of migration and vulnerability to infection is relatively new (Campbell, 2003; Cohen, 2003). However, there are a myriad of factors that need to be considered in relation to HIV and health among migrants and refugees.

Factors such as legal obstacles, social exclusion, marginalisation, language difficulties, religious and cultural beliefs, taboos, poverty and inadequate knowledge of HIV within migrant

communities also may contribute to HIV vulnerability among migrant populations (Brummer, 2002; Decosas, Kane, Anarfi, Sodji, & Wagner, 1995; Girdler-Brown, 1998; Setayesh, RoudiFahimi, Feki, & Ashford, 2014). Apart from a general communication problem due to the language barrier, there is also a problem associated to a culture of not talking about sex in public spaces. The other issue that may increase the vulnerability of French speaking refugees is low income and not being targeted in the intervention programmes as vulnerable groups. Inability to understand South African languages forms a barrier to accessing prevention programmes but people negotiate sex without using language which increases risk. This can constitute a danger for both refugees and South Africa citizens if there are no corrective measures. Neglecting to address the French speaking refugee's health issues can have a negative effect on the general well-being and overall health of the whole population.

1.3 Rationale and significance of the study

Social capital has been described as a significant factor influencing the prevention of HIV and the social support given upon infection (Campbell, 2001). It has been argued that the success of healthpromotion interventions is the extent to which they mobilise current sources of social capital or the extent to which they boost the development of new sources of social capital (Campbell, 2001). A better understanding of the relationship between HIV risk and social capital has the potential to better inform and influence HIV prevention activities (Poundstone, Strathdee, & Celentano, 2004). It is understood that social capital can be used to stimulate psychosocial attributes that uphold the adoption and ongoing preservation of behaviours that are considered to be important in the protection against HIV infection (Campbell & MacPhail, 2002). It has been hypothesised that people could be healthier in communities which have higher levels of social capital (Campbell & MacPhail, 2002). Baum (1999b) argues, however, that although some forms of social capital are associated with positive and beneficial outcomes in various contexts, this might not always prove to be the case. As stated, the principal focus of migration studies has been on the determinants of migration instead of the health consequences of being a migrant (Crush et al., 2005; MacDonald, 1996). Studies that link migration and health have looked mainly at migrants in relation to their work and less on their vulnerability to infection (Packard & Coetzee, 1995).

Research considering the relationship between migration and vulnerability is thus considered new and requiring further investigation (Campbell, 2003; Cohen, 2003).

In local research, an investigation of the elements of social capital across levels has been carried out in KwaZulu-Natal for the purposes of attaining insight into the support and care of people living with HIV/AIDS in a rural setting. Findings from this study indicate that social capital is a useful framework to apply in geographically defined spaces and where resources are limited, although the very lack of resources itself can be considered the principal challenge for social capital in HIV/AIDS. The lack of resources also meant that most activity took place on a social bonding level, and that good quality relationships were considered more helpful than a larger number of less supportive relationships. However, even one good relationship was considered important in terms of resilience and social support. Low resources, further, appeared to contribute to a decline in social norms and cohesion leading to difficulties surrounding HIV care and support (Sliep, Dageid, Akintola & Duckert, 2011). Although the focus in this study is on HIV prevention it is clear that the operation of social capital is both important and complex in a low resource community such as the refugee population and in relation to support mechanisms around the spread of HIV. An understanding of social networks can reveal both the hidden complexities of a particular community and possibilities for increasing social support (Sliep, 2006).

The issue of HIV prevention among French speaking refugees in Durban South Africa remains under-researched. It is hoped that the results of this study will inform an intervention to bridge the gap. A good understanding of the relationship between social capital and HIV risk could make a contribution to prevention strategies for refugees within South Africa (Poundstone et al., 2004). This study seeks to contribute to an understanding, principally on a bonding level, of how the elements of social capital such as norms, reciprocity, trust, and social networks influence condom use, stigma around HIV and Voluntary Counseling and HIV Testing and how this contributes as a risk or protective factor for HIV prevention among refugees.

1.4 Research objectives and questions

The overall objective of the study is:
To contribute to an understanding of how social capital, specifically on a social bonding level, operates as a risk or protective factor for the spread of HIV amongst French speaking refugees from Bukavu, DRC, living in Durban, South Africa.

More specifically:
To understand how the elements of social capital (trust, norms, reciprocity and networks) on a social bonding level, act as risk or protective factors in the spread of HIV in relation to:

- condom use
- HIV counselling and testing
- stigma.

Research questions:
How does social capital, on the social bonding level, operate as a risk or protective factor in relation to the spread of HIV amongst French speaking refugees from Bukavu, DRC, living in Durban, South Africa?

- How do trust, norms, reciprocity and networks operate as risk or protective factors in relation to condom use?
- How do trust, norms, reciprocity and networks operate as risk or protective factors in relation to HIV counselling and testing?
- How do trust, norms, reciprocity and networks operate as risk or protective factors in relation to stigma?

1.5 Ethical issues

Ethical clearance for this study was given by the University of KwaZulu-Natal (UKZN) Ethics Committee under reference number HSS/0784/012M. See chapter 3 for more details 0regarding ethical procedures.

1.6 Structure of dissertation:

Chapter 1 gives a general introduction to the study. It provides a background of the study on the influence of social capital on HIV prevention with French speaking refugees, the statement of the research problem, significance of the study, as well as the research questions addressed in the study. The ethical clearance details are also provided.

Chapter 2 is a review of the literature. This chapter gives a review of the literature on the influence of social capital on HIV prevention (with refugees or forced migrants) from a social ecological perspective. It sets out the theoretical framework of the study. The review draws on three different but interconnected bodies of literature: 1) Ecological social capital 2) Social capital and HIV prevention 3) Migration and HIV. Although these three bodies of literature are wide, only aspects most relevant to this study are considered. Social capital is reviewed in terms of the larger social, economic and environmental context and considered in terms of its links to HIV prevention and care. More specifically the influence of social capital is investigated in relation to condom use, HIV Counselling and Testing and stigma. The relevant literature is then located within the broader context of migration.

Chapter 3 describes the qualitative research method used to collect data. This chapter looks at the study design, study area, sampling methods, data collection procedures, data analysis, ethical issues, and validity and reliability of the study. Limitations of the study are also considered.

Chapter4 presents, analyses and discusses the data that was collected from the interviews and focus group discussions with the research sample of refugees from Bukavu residing in Durban South Africa. This chapter provides its findings on how the elements of social capital (trust, norms, reciprocity and networks) on a social bonding level, act as risk or protective factors in the spread of HIV in relation to condom use, HIV counselling and testing; and stigma. Results obtained from the analysis are presented and discussed in this section.

Chapter 5 presents the conclusion, recommendations and considerations for further research.

- ***References:*** Primary sources, relevant published and unpublished researches.
- ***Appendices***

CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter gives a review of the literature on the influence of social capital on HIV prevention from a social ecological perspective. As the sample population in this study is French speaking refugees from Bukavu, DRC, living in EThekweni, focus will also be on HIV prevention among refugees and forced migrants and the factors that have an impact on similar populations.

In the beginning of the pandemic HIV prevention programmes tended to be individual-focused rather than looking more broadly at context. Such a focus was based on assumptions that risk behaviours are based on conscious decisions that are the consequence of rational choices. With increased awareness of the impact of environment and the role of social and structural influences on HIV risk behaviours, the understanding of HIV-risk behaviours has moved from their earlier understanding of individual risk to ecological models. This took place alongside an increased understanding that behaviours generally are rooted in the economic, environment, and social structures (Waldo & Coates, 2000). Within such a conceptualisation, the influence of social capital on HIV prevention among refugees and migrants should be approached from an ecological perspective because migration is interconnected with other structural macro factors that may affect HIV prevention and transmission. Social capital is an ecological dimension that consists of social bonding, bridging and linking levels. These levels reveal the different types of social capital that they support between individuals, groups and communities. In this study specific attention is given to the bonding level to understand how the elements of social capital such as norms, reciprocity, trust, and social networks influence condom use, stigma around HIV, and HIV Counselling and Testing (HCT) and how these contribute as either risk or protective factors for HIV prevention.

The review draws on three different but interconnected bodies of literature:

1) Ecological social capital

2) Social capital and HIV prevention

3) Migration and HIV prevention

Although these three bodies of literature are wide, only aspects most relevant to this study are considered. The first body of literature reviews social capital in the larger social, economic, and environment context. The second body of literature reviews the influence of social capital on HIV prevention issues such as stigma, condom use and HCT. The third body of literature locates the study within the broader context of migration and issues relevant to the research population.

The overall purpose of the chapter is to review the literature on how social capital may affect HIV behaviours and prevention possibilities and whether a strengthening of social capital on a bonding level, taking into account the elements of trust, norms, reciprocity and social networks, operates as a protective factor against the spread of HIV or may, in some circumstances, increase the risk involved in the spread of HIV in relation to the research population.

2.2 Theoretical Framework: Ecological Social Capital

2.2.1 Introduction to the theoretical framework

The aim of this section is to present the theoretical basis of the study**.** A theory, as explained in Shikumo's (2008) work, helps in bringing to the fore the various structured ideas from the research. At the same time, it acts as a point of origin for the views and ideas in the discussion. Bertrand and Hughes (2005) recognise the fact that texts are constructed on some type of conceptual framework that is sometimes made explicit but at times is not. However, the value or advantage of working within a theoretical framework "places the knowledge presented in a broader epistemological and ontological field" (ibid). Bertrand and Hughes (2005 p. 262) aptly describe a theory as a "set of concepts, derived from and contributing to a model, which together explain a phenomenon or practice". This study was drawn from the theory of social capital and is conceptualised within an ecological systems framework.

2.2.2 Ecological Systems Perspective

Hawley (1950), stated that the term "Ecology" is a descriptive word used to depict the complex relationships that are present between organisms and the environment. The conceptualisation of social ecology to social phenomena started many years ago by a group of researchers based at the University of California at Irvine (Whiteley, 1999). One of the founders of the social ecology theory, Dave Taylor, quoted by Whiteley (1999), listed the six principles of social ecology analysis as follows:

> [a] Identify a phenomenon as a social problem; [b] View the problem from multiple levels and methods of analysis; [c] Utilise and apply diverse theoretical perspectives; [d] Recognise human-environment interactions as dynamic and active processes; [e] Consider the social, historical, cultural, and institutional contexts of people-environment relations; [f] Understand people's lives in an everyday sense.

As highlighted in the introduction, HIV prevention programmes have historically been focused on changing individual behaviours without taking into account the wider environmental, social and economic influences that play a role in behaviour change. There has over time been a shift towards an ecological approach for a better understanding of HIV risk behaviour (Waldo & Coates, 2000). Condom use, for example, is not only determined by individual choice. It is also influenced by the degree to which social conditions may or may not enable such behaviours. Within such a conceptualisation, the influence of social capital on HIV prevention with refugees from Bukavu should be approached from an ecological perspective. This is because migration is interconnected with other structural macro factors that may facilitate HIV prevention and transmission. Migration may be seen as a crucial social vulnerability because it is interconnected with other structural macro factors that may facilitate HIV prevention and transmission.

2.2.3 Ecological social capital

Social capital is an ecological dimension of our society that focuses on the features of social structures that enable the functioning and actions of members of the community (Colman, 1988). Ecological perspectives and theories developed over time with the idea of working within the bigger picture, beyond a narrow focus of the individual standing alone, but following an overall more holistic approach. The focus with an ecological approach is to look beyond individuals and to take into account the environment in which that individual lives (Bronfenbrenner, 1999). Research has shown that some environmental features may have an equal (if not greater) effect than individual features on people's sexual risk behaviours and therefore on the prevention of HIV transmission (Rotheram-Borus, 2001). Environmental and structural factors are often referred to as those factors outside of the person that may affect individual risk behaviours (Des Jarlais, 2000; Parker, Eston, & Klein, 2000; Sumartojo, Doll, Holtgrave, Gayle, & Merson, 2000). Researchers and those in the field have recognised the value of a perspective that extends intervention work and investigational research beyond the individual-level to the economic, social and political structural factors that increase exposure of migrants to HIV infection (Tawil, Verster, & O'Reilly, 1995; Wohlfeiler, 2000). Social capital as defined below is viewed as part of a wider ecological perspective of looking beyond just individual behaviour and encompassing wider social aspects that impact on that behaviour.

2.2.4 Social Capital Theory: What is social capital?

Social capital as a broad framework has been applied in a many different contexts to explain the ability of some communities to solve difficulties through collective action (Falk, Golding, & Balatti, 2000). The concept has been analysed in different disciplines and for different purposes which increases its complexity. It has been used and applied by a significant number of social science disciplines such as sociology, psychology, economics and political science to cite a few (Burt, 1997; Coleman, 1988; Portes; 1998 Putnam, 1995). Recently, social capital theory has also informed research involving HIV responses. Public health researchers have documented social capital as a valuable tool that can be used, both practically and theoretically, to explain the effects

and results of health interventions (Campbell, 2001; Kawachi, Kennedy, Lochner & ProthrowStith, 1997). Sliep (2006) argued that HIV is not only an individual problem and that it can worsen or improve depending on the social context and collective response. Although the focus is not taken away from the individual, it is through enhancing social conscience that collective efficacy and action can develop to increase the overall well-being of everyone infected and affected (Sliep, 2006).

The concept of social capital is quite new and still in the process of being refined, developed and advanced in order to be established as one of the influential theories in the social sciences. The actual term "social capital" was first described by Durkheim (1951) as relating to the strength that a group has over the individual members of that group. This concept was further developed by Portes (2000) who suggested that individual development and health are often influenced by factors that operate outside the particular person's realm of influence. He further suggested that it is by community participation and neighbourhood-based actions that many of the goals relating to health might be achieved (Lomas, 1998; Welshman, 2006). One of the most influential social capital theorists within public health and community development, Robert Putnam, defined social capital as referring to characteristics of social organisation such as networks, norms, and social trust that assist with cooperation and coordination for overall communal benefit (Putnam, 1995).

In the context of this study, the following definitions widely used in the literature are important. Social capital is defined by Berkman and Kawachi (2000) as "those features of social structures such as levels of interpersonal trust and norms of reciprocity and mutual aid which act as resources for individuals and facilitate collective action". Researchers in the international development field have conceptualised social capital in two parts: structural and cognitive social capital (De Silva, Harpham, Huttly, Bartolini, & Penny, 2007). Structural social capital includes the number of groups and networks an individual belongs to as an indicator of the resources available to that individual, or a measure of how an individual receives information. Cognitive features might include perceptions of trust and reciprocity in one's neighbours (De Silva et al., 2006). Social Capital Theory is explained in terms of levels including social bonding, social bridging and social linking as well as the elements of social capital. Although there are arguments about social capital

measurements, there is some agreement on its levels and elements. The categorisations and levels are described in further detail below.

2.2.5 Integrative approaches to social capital

Rothstein and Stolle (2003) have stated that "social capital" can be defined both at an individual and collective level. At an individual level, it can be seen as the number of contacts a person has in the community, and also the extent to which these contacts have trust in each another. At the collective level, importance is placed on the accumulated measurements of average social contacts and networks, and the level of trust that is entrenched in them. In terms of such an integrative approach it is the existing individual social ties that are the base for collective social capital. Via reciprocal relations each individual in the community can then benefit by having access to resources that then form a part of the larger social structures and can give benefits to the larger group rather than just to individuals.

2.2.6 Individual and collective social capital

Bourdieu (1985) argues that social capital comprises resources amassed by individuals as a result of their involvement in wider social networks. Individual benefits can then result from relationships with others via networking. In accord with Bourdieu, Lin (2001) defines social capital as "resources embedded in one's social network, resources that can be mobilised through ties in networks." Furthermore, Flap (2004) states that social networks can build important capital that an individual can then use to enable them to achieve their own intended goals. Amisi and Ballard (2004), mentioned that Congolese social networks provide important information about the process of migration, including migration routes, the costs involved, details relating to accommodation, information about job prospects, and various techniques for survival during their stay in Durban. Individual social capital may be useful in this study to understand how French speaking refugees from Bukavu/DRC, living in Durban communicate with each other around HIV prevention and how this may contribute as a risk or protective factor.

Individuals may join social networks so that they are better able to get access to social support even if it is the collective efforts that bring shared benefits which, in turn, are supportive of individual members of the network (Rothstein and Stolle, 2003). Coleman (1988) and Woolcock (1998) also see social capital as a collective property which results from members' participation and involvement in different informal and formal associations. The main issue is that members of these networks or associations commonly benefit from such collective actions. This matches with Putnam's definition of social capital which has been described above. Campbell, Williams and Gilgen (2002), in their study which explores the value of an HIV peer-education program in rural South Africa, found that both young women and men who belonged to sports clubs were found to be less likely to be HIV-positive but individuals in savings group accompanied by social festivities had higher risk of infection. Collective social capital may be helpful to understand how the elements of social capital such as norms, reciprocity, trust, and social networks influence condoms use, stigma around HIV, and HIV Counselling and Testing in this study.

2.2.7 Classifications of social capital

2.2.7.1 Structural and Cognitive Social Capital

De Silva et al (2006) classified social capital in two parts: structural and cognitive social capital. Structural social capital is focussed on the degree to which people partake in informal and formal associations and various other forms of social activity (Harpham, Grant & Thomas, 2002; Uphoff & Wijayaratna, 2000). Such participation enables collaboration and aids in the creation of shared benefits through reciprocal and collective actions (Hitt, Lee & Yucel, 2002). Cognitive social capital includes attitudes, values, norms, beliefs and reciprocity all of which are viewed as resources held between members of a group interacting with each other within the social networks. The cognitive constituent also comprises perceptions of sharing, support, and trust. As such, it prompts individuals towards reciprocally advantageous collective actions (Krishna & Uphoff, 2002; Uphoff, 1999).

In regard to classification, structural social capital has been divided into bonding, bridging and linking (Putnam 2000; Woolcock, 2001). Narayan and Pritchett (1997) have defined bonding social capital as the relationships formed within social networks that are made up of homogeneous groups. This involves individuals who are closely tied to each other through networking. Bonding social capital includes both informal and formal groups, clubs and associations. In relation to bridging social capital the links are formed outside the boundaries of the different social groups (Putnam, 2000). As a result, bridging social capital spreads to individuals, social groups and organisations cutting across different levels and communities, and as such have vertical ties (Naraya & Pritchett, 1997; Wallis, Crocker & Schlechter, 1998). At the linking level, social capital is described as including the relationships between individuals and groups from different societies and situations. Linking social capable facilitates members in accessing a diverse array of ideas, information and resources (Woolcock, 2001). In this study, the definition of social capital advocated given by Putnam, including cognitive and structural descriptions, have been used.

2.2.7.2 The structural dimension: Levels of social capital

The theory of social capital can be analysed under three levels namely: bonding, bridging and linking. These levels reveal the different types of social capital that they promote. The structural dimension of social capital that these levels promote may be seen as the overall pattern of connections between persons: who you connect with and how you connect with them (Burt, 1992). Simply, this means that your position in a social structure gives you certain privileges and access to advantageous information that can develop you as a person which in turn can help you to get favours such as job referrals and access to certain resources, for example, HIV preventions services which people who do not have the same access as you, would not easily obtain (Tsai & Ghoshal, 1998). Burt (1997) states that it is the strategic position that one holds which provides crucial information and support for one to act decisively in decision making. In addition, Coleman (1990) stated that social networks are one of the most important aspects of social capital because the flow of information within and between groups facilitates an informed action that an individual can use as a source of support from members of those groups and networks.

It is also important to note that the flow of information about HIV may be much stronger within groups than between groups. This can have both positive and negative attributes at the same time because crucial information and favours can be exhausted within close ties whereas the person who needs it the most might be outside of the immediate group but part of the wider network (Lin, 1999). Individuals need strong social networks to generate social capital that yield positive results (Portes, 1998).

Social bonding

Social bonding refers to the strong ties that are shared amongst dense, closely related and inward looking social networks. Examples include networks among family members, church groups, close friends, or ethnic fraternal organisations (Warschauer, 2003). These bonds are characteristically inward-focused and can serve as social protection mechanisms when a community member is facing a crisis. Bonds within the community encourage reciprocity and reinforce trust which are regarded as important factors in social capital generation. Previous studies have demonstrated that bonding social capital can be essential for the circulation of information, monitoring deviancy, forming health norms, creating mutual care and support for the vulnerable, especially those infected and affected by HIV (Patulny, 2003).

Social bonding ties are closely investigated in this study as networks at this level are apparent among the French speaking refugees and are used widely as social protection mechanisms owing to the vulnerability of the community. The social bonding level in this study, refers to how French speaking refugees from Bukavu/DRC living in Durban communicate with each other around HIV prevention, the levels of trust and reciprocity that exist between family, friends and neighbours; and how existing social networks act as either risk or protective factors in the spread of HIV in the community.

Bridging social capital

Bridging social capital describes linkages and connections that range beyond the margins of the close community and intersect with other homogeneous groupings (Warschauer, 2003). Social bridging integrates the levels and nature of contact and engagement between different social groups or communities. It brings people in contact with resources and benefits that are accrued from having a wide and varied range of social contacts. It is even more useful in dislocated communities where there is limited existing trust and supporting networks amongst different groups and these would need to be linked to networks of influence outside of their geographical location (Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006). This level of social capital is critical for the success of civil society such as NGOs, CBOs and FBOs because it facilitates opportunities for increasing networks for exchange, wider participation, and builds channels where those who generally have little access to formal avenues can voice their concerns (World Bank, 2003). These civic networks nurture norms of reciprocity which, in turn, reinforce attitudes of trust within a society. They also improve the efficacy of communication and social organisation that is essential in promoting HIV prevention (Putnam, 1995).

While the main focus of this study is on social capital at a bonding level, there is some overlap at the various levels and participation of the refugee community in HIV prevention programmes offered by churches and community based organisations also forms a part of this investigation. Members of churches, for example, may be both friends and neighbours that are linked at a bonding level, or may form part of a wider bridging network. Social bridging in this research refers to how refugees French speaking from Bukavu/DRC living in Durban participate in HIV prevention programs offered by churches and community based organisation and how this research population views the co-ordination and collaboration between leaders, churches, NGOs and CBOs and other relevant programs.

Linking social capital

Linking social capital looks at the connections between people who are in various positions of power. It involves the consideration of relationships among those within a hierarchy in which there are different degrees of power. Linking social capital is considered critical for obtaining support from organisations that have been formally established (Grootaert, 1998). It is different from the bonding and bridging levels because it is focused on relationships between individuals and groups who do not hold the same degree of power. An example of linking social capital would involve links between an NGO that promotes HIV prevention and the Department of Social Development to obtain funding for people at high risk in their communities (Ogden, Esim, & Grown, 2006). Social linking is concerned with vertical linkages that allow essential responses to HIV prevention. As stated, this study will focus more specifically on social capital at a bonding level, however, social linking aspects that may be of relevance would include how refugees from Bukavu/DRC living in Durban access HIV prevention programs offered by government and social media, how these programs and policies are viewed and their effect as protective or risk factors in the prevention
n of HIV among community members.

2.2.7.3 Elements of cognitive social capital

Research has shown that cognitive social capital is usually characterised by elements such as trust, norms, networks and reciprocity shared between individuals, group members or community members **(**De Silva et al., 2007). These above elements of social capital are further explained below.

Trust

Trust has been described as “the expectation that arises within a community of regular, honest and cooperative behaviour, based on commonly shared norms, on the part of other members of the community” (Fukuyama, 1995). Social trust refers to the extent to which individuals believe that

others mean what they say and will act accordingly (Leach, Neil, Pelkey and Sabatier, 2002). Social trust is very important in order to understand social capital that symbolises a relationship of reliance since it is easier to influence or persuade someone that you trust or who trusts you.

Trust, therefore, is one of the main elements that sustain social capital between and among people and groups facilitating cooperation and coordination for mutual benefit (Putnam, 1995). As a trusting relationship develops inside a network, actors build up relations of trustworthiness that may become important information for other actors in the network (Tsai & Ghoshal, 1998). Within communities where people are affected by HIV, trust may diminishes stigma and discrimination and encourages those infected to disclose their HIV status which in turn helps them to access HIV Counselling and Testing for their benefit. Research has also shown that a high level of trust among partners may lead them to unprotected sex.

Norms

According to Putnam (1995) and Colman (1988), social norms are commonly perceived as a way to determine what models of behaviour are expected in a particular social context and also which forms of behaviour are socially approved and valued by the particular community. Social norms are further conceptualised as implicit and explicit rules that a community uses for defining appropriate and inappropriate behaviours, values, attitudes and beliefs. They are also seen as customary rules of behaviour that coordinate our how we should interact with others. Social norms are believed to play a key role in the preservation of social behaviours even though they may also act as barriers to altering social behaviours (Bettenhausen & Murnighan, 1991; Coleman, 1990; Myers & Bishop, 1970; Newcomb, 1958; Tittle, 1977). Research has shown that changing social norms is an effective method of bringing about more long lasting social-level behaviour change. Altering, for example, the culture of love of dry sex and refusal of use of condoms, may function as a protective factor for HIV prevention. Even though changing social norms has been found to be very difficult; once new norms are introduced they can be self-sustaining (Zucker, 1977). This is because once a particular way of doing things has become established as a rule, it often continues

in force because it is desirable to conform to a rule where there is an expectation that others are also going to conform to the same rule (Posner, 2000).

Reciprocity

Dickhaut and McCabe (1995) refer to reciprocity as the type of social capital that is rooted within personal relations whereby one gives to someone else expecting returns at an uncertain future date. Reciprocity is also understood as a form of social capital whereby a person acts for the benefit of another or provides a service for another at personal cost. There is, however, generally an expectation that this favour or kindness will be reciprocated at some time in the future if there is a need. Onyx and Bullen (2000) have found that in communities where reciprocity is common, people care about each other's needs and interests. However, in communities where people are battling to meet their basic needs such as shelter, food and water; this may not always be the case. Women and girls may, for example, be forced to exchange sexual services for protection, money or food as a means of survival.

Social networks

Cohen and Prusak (2001) refer to social networks as the ties between individuals or groups. Under social capital theory networks can be informal or formal. Formal networks comprise networks developed via formal organisations such as association and voluntary organisations, while informal networks consist of friendships, family, neighbour and work related ties (Pollack, 2004). Fine and Lapavitsas (2004) have expanded on the concept by distinguishing between social capital that is created at different levels, for example, the family, neighbourhood, organisational, community or at a political level. Social capital can be used to stimulate psychosocial qualities that are supportive of the adoption of behaviours that are protective against HIV infection. However, connecting with people at high risk such as sex workers, may contribute as a risk factor for HIV prevention. Members of networks can include a number of social spheres of influence, for example, family, friends, sexual partners, neighbours, and co-employees. Members of social networks are also the primary sources of information about the social environment. Such information can be used by

members to monitor their behaviour (Wasserman & Galaskiewicz, 1994). Both formal and informal social networks may be helpful in understanding how social capital operates as a risk or protective factor for HIV prevention among French speaking refugees from Bukavu living in Durban South Africa.

2.2.8 Benefits of social capital

It has been contended that Putnam's (1995, 2000, 2001) concept of social capital, although developed in the fields of economics and political science, may offer a useful conceptual tool for investigating the relationship between health and community-level relationships and networks (Baum 1999b; Gillies, Tolley and Wolstenholme, 1996; Kawachi, et al., 1997; Lomas, 1998). In Putnam's view, 'social capital' is the community cohesion or solidarity that is a consequence of the positive aspects of a community life. This stems especially from high levels of 'civic engagement' and as shown through membership of local voluntary associations. This type of membership is believed to be related to the positive community norms of reciprocity and trust between community members.

Research in Italy and Tanzania revealed that high degrees of social capital are related to a number of positive economic and political outcomes (Narayan and Pritchett, 1997; Putnam, 1995). As a result of the connection between social capital and positive health outcomes, researchers have also argued that Putnam's idea of social capital may be helpfully applied in the area of health promotion to help what has been called by Tawil, Verster and O'Reilly (1995) a "health-enabling community". Such a community facilitates and promotes health-enhancing behaviour. It is also generally characterised by positive community relationships and networks that can act as buffers against stress that is health-damaging. The impact of following a social capital approach in HIV prevention more specifically is detailed below.

2.3 HIV and Social Capital

2.3.1 HIV Overview

UNAIDS (2007) estimated that about 39.5 million people worldwide were living with HIV and 2015 statistics state that at the end of 2014 there were 36.9 million (34.3 million – 41.4 million) people globally living with HIV (UNAID, 2015). SubSaharan Africa is considered to be the most HIV affected region in the world (UNAIDS, 2004). This report showed that approximately more than three quarters of all HIV deaths globally in 2007 occurred in sub-Saharan Africa with an estimated 5.5 million (4.9 million–6.1 million) people living with HIV. In South Africa alone, over 20% of the adult population is recorded to be HIV positive and up to 1,600 new infections are projected to occur daily (UNAIDS, 2002). The total number of people living with HIV in South Africa in 2015 is estimated to be 6.19 million with an estimated 11.2% of the total population HIV positive (Statistics South Africa, 2015).

The overall HIV prevalence rate in South Africa is estimated to be about 10%, with the total number of people living with HIV estimated to be 5, 26 million in 2013. More than half (55%) of all South Africans infected with HIV reside in the Gauteng and KwaZulu-Natal provinces (Dorrington, Bradshaw, Johnson & Budlender, 2004; UNAIDS, 2007). According to (UNAIDS 2007), the Province of KwaZulu-Natal had the highest overall HIV prevalence rate of 16.5%. The prevalence of HIV among antenatal attendees in the province soars at 39.1% (Department of Health, 2007). Not only is the national infection rate alarming, but the problem is amplified as South Africa is also a popular destination for many African refugees from countries affected by war and political instabilities and this brings with it an additional dimension to the way the spread of HIV is to be viewed on the continent (Haour-Knipe & Rector, 1996). This is further detailed below in the discussion on migration.

2.3.2 Social capital as a factor influencing HIV prevention and support

Social capital is viewed as a significant factor influencing HIV prevention and social support systems after HIV infection (Campbell, 2001). It has been argued that the success of healthpromotion interventions is measured in relation to the extent to which they use and organise existing sources of social capital or boost the development of new sources of social capital (Campbell, 2001). Therefore, more insight into the relationship between HIV risk and social capital is needed to inform prevention activities (Poundstone, Strathdee, & Celentano, 2004). Social capital can help to promote psychosocial qualities that support behaviours that are protective against HIV risk and infection (Campbell & MacPhail, 2002). It has been hypothesised that people might be more healthy in communities where there are high degrees of social capital (Campbell & MacPhail, 2002).

Baum (1999b), however, argues that some forms of social capital may not always have beneficial outcomes. She states that it may be necessary to differentiate between positive (health-enhancing) social capital and negative ('anti-social') capital. Well-functioning community networks may have protective effects with beneficial material and social resources flowing within them. In addition to providing ways in which information can be exchanged, these networks may influence community norms around gender relations, communication and sexual negotiation. Individuals with wider networks and deeper trust relationships may provide role modelling for health promotive behaviour such as condom use or access to HIV testing. It is the more unified geographic and social communities that may be better able to take collective action and therefore to respond to issues of common priority, for example, HIV.

In the few existing studies examining social capital effects on health outcomes in South Africa, data suggest a strong, if not complicated, relationship between social capital measures and HIV vulnerability (e.g., Campbell et al., 2002; Grootaert, 2004). South Africa is reported to be one of the most hightly HIV affected countries in the world, and many believe the high occurrence, in part relates to the government's historical response to the disease. In a working paper for the World Bank, Grootaert (2004) described research that finds significant links between social capital, HIV

infection, and risk behaviours especially among young adults. Other research has found that perceived social capital is affected by group membership, makeup of a group and the amount of participation within a group. A study by Campbell, Williams and Gilgen (2002) exploring the effectiveness of an HIV peer-education program in rural areas of South Africa stated that social capital was strongly related to health behaviours; although it did not always promote positive health behaviours. Researchers found that the link between social capital and high-risk HIV behaviours varied across gender and group. For example, although young men and women who belonged to sports clubs were found to be less likely to be HIV-positive, individuals in savings groups accompanied by social festivities had a higher risk of infection. Young men in the savings/ social groups were more likely to be HIV-positive and young women were more likely to partake in high-risk behaviours (that is, have casual partners) (Campbell, Williams, & Gilgen, 2002). These studies suggest that social capital components like group membership and group characteristics play some role, albeit complicated, in HIV related risk behaviour.

In her investigation of an rigorous program designed to reduce HIV transmission in a South African mining community, Campbell (2002) pointed out that a lack of community cohesion and the transformation of sexual and social norms related to chronic poverty and dislocation all played a significant part in limiting the impact of what had been considered a well-conceived intervention (Campbell, 2003). Community involvement is now seen as a ‘‘critical enabler’’ of effective HIV responses as it provides prospects for dialogue around HIV, which preferably leads to (1) sharing knowledge; (2) critical thinking about impediments to health-promoting behaviour change, and discussions around local strategies for solving these; (3) a sense of local ownership and responsibility for contributing to the prevention of HIV rather than passive reliance on NGO’s and government; (4) identification of both group and individual strengths; (5) bonding social capital: a sense of cohesion and solidarity; and (6) bridging social capital: links with supportive external groupings in the private, public and NGO sectors (Nhamo, Campbell, & Gregson, 2010).

Behaviour change is heavily influenced by interpersonal communication which plays an important role in mediating their impacts on behaviour (Halperin, Russel, Trezesniewski, Gross, & Dweck, 2011; Muchini et al., 2011). Group membership in some contexts may have a particular protective

effect against HIV infection as well as lowering the amount of stigma and improving the uptake of HIV-related services (1999-2004). Being a member of a group that accommodates discussion of HIV is considered more protective than those groups which do not accommodate this (Gregson et al., 2011).

Group memberships may also facilitate the development of solidarity and comradeship which may increase individual confidence, self-efficacy, and overall social skills. Campbell et al. (2002) in their research focused in an urban mining community in South Africa indicated that young women who are involved in local community groups had a better chance of escaping HIV. However, this depended on various factors including the functioning of the group, why the group was formed and education levels of participants. The above study showed that young women who were content within their groups were more likely to avoid HIV than others. However, those who were not content within their groups were less likely to avoid HIV infection than those who were not a part of a group at all. It was also found that young women in certain types of group (for example, youth groups) were more likely to avoid HIV, while those in various other types of groups were in even more danger of HIV infection (for example, savings clubs and political parties).

An action research study aimed at facilitating HIV related dialogue amongst 123 members of 15 community groups demonstrated numerous ways in which group memberships aided in developing positive reactions to HIV in Manicaland and Uganda (Scott, Campbell, Gregson, Nhamo, & Nyamukapa, 2011). In Manicaland, where stigma around HIV reduced prospects for open and public discussion around HIV/AIDS, conversations amongst group members helped them to process and share information, to confide emotional personal stories of suffering, to discuss positive models of effective responses, to work together towards realistic action plans and to brainstorm different ways of finding assistance. Dialogue within groups also gave members the opportunity to challenge each other's misconceptions about HIV/AIDS. Sometimes, however, group debate resulted in impractical ideas or punitive suggestions that could actually increase stigma, for example, beating youth to enforce abstinence, or imprisoning people for extramarital sex. There may be also occasional times when groups share incorrect information, for example, that condoms "did not work". Dialogue in some cases strengthened a sense of dependence and

helplessness, and group members talked unproductively about the lack of solutions available for solving problems surrounding HIV. Group dialogue in some cases also recycled obstructive beliefs, for example, that the only solutions were outside intervention and external funding for HIV activities, (Scott et al., 2011).

A study of dialogue within church groups focused on external limitations on group dialogue as an instrument of change (Nhamo et al., 2011a). Over an 18-month period 18 community conversations (involving 6 groups at 3 different points in time) including a total of 77 participants were conducted in an attempt to facilitate positive engagement in relation to HIV amongst members of the church. Locally trained facilitators conducted community conversations to encourage discussion about social problems and to look for local solutions for solving them (UNDP, 2004). In the above study, conversations aided the development of encouraging action plans and a sense of common purpose towards helping people with HIV, for example, with food and going to clinics. The potential success of plans that were made was aided by increasing Anti-Retroviral Treatment availability in Manicaland. This improved the community's engagement with local health services and renewed their sense of hope. Unfortunately, the execution of the plans was spoiled by bad harvests, poverty and political unrest. Nhamo's (2011a) study also emphasised the differences that are found amongst denominational groups. In the Apostolic and Catholic (but not Anglican) groups there were conversations that reinforced disapproval of condoms and other stigmatising attitudes such as HIV resulting from ''bad'' sexual relationships (Nhamo et al., 2011a).

Some groups also allow for "bridging" social capital where young people are put in contact with diverse groupings and in some cases more powerful groups whose assistance and support could improve the chances of a programme's success (Campbell & Mzaidume, 2001). For example, local health department officials could attend women's group meetings and in that way become more attuned to the need for more female clinics. In this sense, they provide "bridging" social capital that can be an influential way of working towards collectively negotiated decisions. Some decisions may then be built on ideas and information collected from members who also participate in other groups that have a more heterogeneous membership. Therefore, communities where

heterogeneous and homogeneous groups both operate and have overlapping memberships can be particularly important for the building of new social norms that are supportive of safer behaviour and constructive psychosocial attitudes (Cambell, 2001).

Campbell, Nair, & Maimane (2007) mentioned that the networks obtained in bonding social capital may allow safe spaces for dialogue, promotes responsibility for the HIV epidemic and empowers one with a sense of responsibility in relation to HIV prevention. The authors further argue that high levels of trust among people within the same group may lead them to disclose their HIV status to one another. On the other hand, high levels of trust also may lead people within the same group to engage in more sexual risky behaviour and therefore increase their vulnerability to HIV infection.

Campbell and MacPhail (2002) suggest that it is possible for social groups in ideal situations to create safe spaces for the youth to develop critical insights to better understand the construction of gender relations within conditions of poverty and how these may negatively influence sexual health. It has been argued by Freire (1993) that it is important to have a critical understanding of the obstacles to behaviour change before effective strategies for overcoming these obstacles can be achieved. Such processes have the ability to allow for a social environment that better supports people to understand their vulnerability in regard to HIV. They may then be in a better position to negotiate collective decisions about the need to change their behaviour and to develop a stronger sense of self efficacy. This would then enable real action (Campbell and MacPhail, 2002).

It is important not to forget, however, that the influence of group memberships on sexual behaviour will not be positive in every case. Strong supporters of social capital argue that the links between health and social capital are complex, and that there is much work still to be done in investigating this complexity (Coleman, 1988). In some contexts, for example, strong social networks between young men may strengthen macho attitudes towards sexuality, and preserve unequal gender relations, both of which are viewed as facilitating an increase HIV transmission. Social networks that function in such a way are referred to as "anti-social capital" (Baum, 1999a; Portes and Landolt, 1996) and could enable identities and norms that work as barriers to the development of the psychosocial behaviours and qualities that are needed to avoid HIV infection. Interestingly,

Gregson et al. (2013) found that women belonging to local groups that received external sponsorship from churches, NGOs, or political groups had an increased chance of becoming HIV positive when compared to members of groups that were unsponsored. Baume (1999a) also showed that some cohesive communities can sometimes be characterised by fear, racism, distrust and exclusion of outsiders. Such a context would not be health for those who are part of the community or for outsiders who do not agree with the majority of the community.

Norm change, although complex and not always positive as described above, may still be considered a relevant strategy for HIV prevention and control high risk populations. However, altering norms, for example to promote condom use, can prove difficult especially where open conversations about HIV and sexual behaviour are believed to be unacceptable (Smith, Lucas & Latkin, 1999). Smith et al. (1999), in a study involving drug users in Baltimore, found that HIV is an uncommon topic of conversation. In cases where HIV was discussed, it was usually in the form of rumours about infected individuals. Such a lack of HIV-related conversation can lead to a situation where people become cautious of talking about an issue at all for fear that other people will think it is undesirable (Noelle-Neumann, 1977).

2.3.3 Social capital and HIV risk

As highlighted above, research in southern Africa suggests that social capital does have the potential to effect susceptibility to HIV infection (Campbell et al., 2002; Gregson et al., 2004; Nyanzi, nyanzi, Wolff, & Whitworth, 2005; Poundstone et al., 2004). Campbell et al. (2007), have argued that risk behaviours are not randomly spread within a population, but are produced and preserved through environmentally and socially structured social interactions.

A study conducted by Campbell et al. (2002) in rural South Africa demonstrated that male members of households with higher levels of Cognitive Social Capital (CSC) were associated with protective patterns of condom use and psychosocial characteristics, and were therefor less likely to be HIV positive. In contrast, there were a number of noteworthy links between Structural Social Capital (SSC) and HIV risk in females. Females living in households with higher levels of SSC

had more protective patterns of condom use. There was also evidence of greater openness to discuss sex, better overall communication, and increased levels of collective action. However, conversely, there were also indications that higher levels of SSC were linked with higher HIV prevalence. The above study suggested that social capital has a significant impact on HIV risk in a rural South African context, but does so in a way that is nuanced and complex.

The association between HIV risk and social capital was slightly different for female household members. Here, CSC and SSC were both related to protective psychosocial qualities including openness, better communication, and increased participation in collective action. Strong community relationships that demonstrate reciprocity, mutual support, and collective mobilisation around issues common to all, are linked to lower levels of HIV risk among men and to a lesser extent among women. This further emphasises that not all forms of social capital result in health promotive or protective behaviours (Campbell et al. 2002).

2.3.4 Social Capital and HIV Stigma

Although a global effort have been taken to stop the spread of HIV, stigmatising attitudes continue to challenge treatment and prevention. Stigma against persons living with HIV/AIDS (PLHA) has been shown to be a barrier to seeking care, HIV testing and prevention education. Stigma is experienced as a result of social norms that reduce a characteristic or a condition to an inferior status or they are viewed as inappropriate (Link & Phelan, 2001). Stigma has also been described as a reaction to fear or to a perceived threat (Ogden & Nyblade, 2005). Other studies have shown that stigma may be seen as a social process related to morality, control or power (Alonzo, 1995). Even though some diseases (for example, leprosy and tuberculosis) have been stigmatised as a result of a mix of the processes referred to above, the role of perceived morality is very noticeable in stigma related to HIV.

Several sources and forms of stigma are discussed in the literature. A primary source of stigma is fear of transmission by a PLHA. The various forms of stigma include community stigma, enacted stigma, and internalised stigma (Berger et al., 2001; Steward et al., 2008). Community stigma

refers to perceived community norms about and behaviours toward PLHA (de Bruyn, 2002); enacted stigma measures how people would act towards PLHA (Swendeman et al., 2006) and internalised stigma arises when an uninfected person believes in stigmatising PLHA, or when a PLHA believes that she or he deserves to be stigmatised (Thomas, 2005). The fear of infection by PLHA, of unsought disclosure to family or community, and of a sexual partner's reaction (which can include sexual and physical violence) upon disclosing HIV-positive status have been found by various global studies to act as barriers to attending HIV support services (Here et al., 2003; Lawyers' Collective, 2004; Keusch et al., 2006; Dada, & Sliep, 2011). Other barriers that have been researched include fear of prejudice from health providers and unsupportive community norms (Chandrasekaran, et al., 2006; Naidu & Sliep, 2011).

Fear associated with stigma reportedly affects a range of risky HIV health behaviours: individuals' decisions not to access HIV Counselling and Testing (Day et al., 2003; Kalichman & Simbayi, 2003), HIV-positive individuals' poor adherence rates to ARV therapy (Weiser et al., 2003), poor safe sex behaviours (condom use) (Volk & Koopman, 2001), and increased risk of mother-to-child transmission (Thorne & Newell, 2003). A recent survey conducted in South African households recorded robust levels of stigmatising attitudes (Kalichman & Simbayi, 2004). Furthermore, stigma can lead to discrimination, rejection and abuse that can increase the social consequences of HIV that can cause additional stress to those infected and affected (Lie & Biswalo, 1994).

Social capital may be an important strategy to help reduce stigma and bring about better care and prevention outcomes for those infected by HIV for many reasons. Firstly, in a majority of cases, stigma is rooted in the community or health system (Mawar, Pandit, & Mahajan, 2005). Secondly, research has shown that when aspects of social capital are strengthened, for example social support and networks, positive HIV related outcomes are attained (Campbell et al., 2002; Gregson, Terceira, Mushati, Nyamukapa, & Campbell, 2004). HIV-related stigma is complex because it can refer to personal feelings that people have towards others with HIV (personal stigma) and perceptions of how others feel about individuals with HIV (attributed stigma). One may not have any negative feelings about individuals with HIV but feel that other people in their community do.

Also, it is possible that if the community is seen as having negative feelings toward people with HIV, this may provide justification for personally condoning stigmatising attitudes and behaviours (Visser, Kershaw, Makin, & Forsyth, 2008).

Research in health-related and psychosocial behaviours increasingly suggests that attitudes and behaviours, such as stigma, are not purely products of individual choice but largely predetermined by processes of socialisation in health behaviour that reproduce and perpetuate certain health effects (Singh-Manoux & Marmot, 2005). Early studies have demonstrated that communication about sex and sexual health among men takes place among members of close personal networks. These networks both inform and positively influence sexual decisions about seeking social support and care (Sivaram et al, 2007). Studies in Tanzania and South Africa have revealed that membership in community groups and participating in voluntary activities were factors linked with lower HIV prevalence (Campbell et al., 2002). Macro analysis of data from youth in the United States has proposed that social capital measures are linked with higher rates of protective sexual behaviours (Crosby, Holtgrave, DiClemente, Wingood, & Gayle, 2003). However, female PLHA experience more stigma and at higher levels. Further they are also generally more likely to be blamed for their infection than men (Alert, 2002; Solomon, Chakraborty, Yepthomi, & Detels, 2004).

2.3.5 Environmental influences on behaviour

Behavioural settings, which provide a space in which people can be connected by various forms of social interaction, have also been found to influence individuals' behaviour (Barker & Wright, 1955; Barker, 1978; Wicker, 1987). Certain settings, in which risk behaviour is encouraged or people are mixing with high risk individuals, together with their attendant behaviour norms, may increase a person's HIV risk (Latkin, Mandell, Vlahov, 1996; Rhodes et al., 1999; Rhodes, 2002).

Studies show that an individual's presence at certain settings, for example, brothels, bars, bathhouses, public transport stations, or shooting galleries, have been linked with higher HIV risk. Research has also shown links between the types of settings in which people go to meet sexual partners and the risk profiles of people who often go there (Richwald et al., 1988; Weir et al.,

2003). Such places that are considered high risk settings also often have a high occurrence of substance use (Sivaram et al., 2004). Bars, for example, have been closely investigated as they are often considered places where friendships and sexual networks operate.

Behavioural settings have been considered a way of defining a social network as they are often intricately related to each other. Further, organisational membership may include an intersection of social networks, norms and settings (Halkitis, Green, Mourgues, 2005). Gregson et al. (2004) found that among young women in rural Zimbabwe, the type of organisational membership was associated with HIV serostatus (Gregson et al., 2004). However, migrants in many cases cannot rely on the resources that arise from being a member in a social organisation and thereby have more limited social capital which in turn can affect their health (Hawe & Shiell, 2000; Kawachi & Berkman, 2000).

2.3.6 The role of social capital in HIV interventions

The results of various community intervention trials for HIV prevention within industrialised countries that contain an element of social capital strengthening have been positive (CDC, 1999; Sikkema et al., 2005). Various innovative HIV programmes, operating in high-risk environments (for example, in gay bars or low-income housing developments), have shown success in decreasing vulnerability to HIV. This has been done by working through opinion leaders, role models, and established social networks to encourage community awareness and mobilisation around solutions. In a number of ways, these interventions focus on ways to encourage the type of social mobilisation that has been linked to a decrease in HIV infection as shown in examples in Uganda and San Francisco. According to Wohlfeiler (2002), there was an eight-fold reduction in new HIV infection rates over a four year period among gay men in San Francisco. Wohlfeiler (2002), noted that most of the behaviour change occurred quickly and simultaneously with, rather than as a result of, the establishment of a number of HIV prevention agencies. Wohlfeiler attributes this to effective mobilisation efforts, particularly among a socially active, educated and well-resourced community that was facing a direct threat. Further, the health initiatives were planned only after considerable discussion with and participation of the gay community.

Green, Halperin, Nantulya, and Hogle (2006), also showed that in Uganda, between 1990 and 2005, there were reductions observed in antenatal HIV prevalence from 30% to less than 10%. They further argued that such reductions were not seen in neighbouring countries, for example Kenya. Again, it has been advocated that effective social mobilisation, particularly through peerto-peer networks, favourably strengthened the dramatic decrease in HIV prevalence (Epstein, 2007).

Using a social capital lens in community HIV prevention programmes has the possibility to show how and whether such programmes can aid effective social mobilisation, and may illuminate the interplay of cognitive and structural social capital in supporting these effects. Further, deeper insight into the social processes related to intervention application and acceptance has implications for other programs. A social capital discourse may be able to increase our understanding of risk behaviour and risk environments. It may also be able to provide a theoretical bridge between social contexts and resulting health consequences. While there are issues such as inequality, poverty, social exclusion and gender that seem unapproachable, interventions dealing with these issues are increasingly considered to be essential despite being under-developed in the public health reaction to HIV (Blankenship, Friedman, Dworkin, & Mantell, 2006; Parker et al., 2000; Sumartojo et al., 2000).

2.4 Migration, Refugees and HIV

2.4.1 Definitions

The United Nations defines a migrant as: “any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country.” (UNAIDS, 2001, p. 4). Migrants are generally seen as people who move places for voluntary reasons, either internally or internationally. Internally displaced persons (IDPs) and refugees, on the other hand, are seen as people who are forced to move involuntarily. Reasons for this commonly include moving in the case of wars or other forms of violent conflict. Various forms of human rights abuse are also a cause of involuntary migration. A refugee is a “person who because

of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, resides outside the country of his or her nationality" (UNAIDS, 2001, p. 4).

2.4.2 Migration: General effects and HIV

Increasing migration flows and high rates of HIV are regarded as two of the world's most critical social issues, especially in developing countries that have been regarded as sending and receiving the highest numbers of migrants across the world (UNAIDS, 2009). In recent years international migration has increased due to globalisation, war, political and economic instability, and limited economic opportunities in developing countries (Hepburn and Taran, 2001; Stalker, 2001). Usually people migrate for various reasons, such as fear of war or conflict, the search for work or higher pay, study, or just the opportunity to make a better life (Adepoju, 1998; Maharaj & Moodley, 2000; Stalker, 2001). Recent advances in transport systems and communication have allowed people to move more and faster, causing mass migrations between and within developing countries and from developing to industrialised countries (Carballo, Grocutt, & Hadzihasanovic, 1996).

Haour-Knipe & Rector (1996) have demonstrated that migration has influenced the spread of HIV world-wide. This means that the movement of individual people and groups of people are significant factors effecting the spread of HIV infection rates. Migration is ranged among many other social factors that play a role in the HIV epidemic (Decosas & Adrien, 1997; Mabey & Mayaud, 1997). It is well known that migrant populations are at increased risk for HIV and poor health in general. Studies have demonstrated that migrants are more likely to have multiple sexual partners and therefore are at higher risk of HIV infection and STDs (Sexually Transmitted Diseases) than are non-migrants (Magis-Rodriguez et al., 2009). There is increased acceptance that mobile populations are likely to be more vulnerable to HIV infection than populations that are non-mobile (Camlinet al., 2010).

Even though refugees and asylum seekers may constitute a low political priority for host governments and local authorities (Jacobsen, 2006) research by Crush et al. (2005) on migration

and HIV in South Africa mentioned that special focus should be placed on people who face a high risk of infection. This would include not only commercial sex workers and youth, but also migrants and their partners. In the past the main focus in migration studies has looked at the causes of migration rather than focussing on the health consequences that arise (Crush et al., 2005; McDonald, 1998). Further, studies that have linked migration and health have not focused sufficiently on the extent of migrant vulnerability to infection (Packard & Coetzee, 1995).

Migration to South Africa from other countries has increased since the fall of the apartheid government in 1994 (Handmaker & Parsely, 2001; Massey, 2006). The fall of apartheid brought with it new reasons and better prospects for migration across borders in the southern African region. The actual number of migrants entering South Africa in recent years is unknown. It is estimated that there may be about 1.6 million cross-border migrants in South Africa (CoRMSA, 2009). Movement of individuals and groups are regarded as significant in the spread of HIV/AIDS (Haour-Knipe & Rector, 1996) and it is regarded as one of many social factors that have contributed to the spread of HIV/ AIDS (Decosas & Adrien, 1997; Mabey & Mayaud, 1997).

Research conducted by Nunn, Wagner, Kamali, Kengeya-Kayondo, & Mulder (1995) on migration and HIV in Uganda showed a strong relationship between migration and HIV infection. This study demonstrated that people who changed their places of residence within a five year period were three times more vulnerable to HIV infection than people who did not move for more than ten years. Further, those that moved often generally had more sexual partners than those from stable populations. Research that has investigated the effects of migration on HIV in South Africa has demonstrated that people who have recently changed their residence and are more mobile are more likely to be at higher risk of HIV infection and other sexually transmitted diseases (STDs) than those who have more constant living arrangements (Brewer et al., 1998; Lagarde, Pison, & Enel, 1996; Mbizvo, & Bassett, 1996; Pison, Le Guenno, Lagarde, Enel, & Seck, 1993). Population movement can facilitate situations whereby girls and women are forced to exchange sex for food, money, shelter and protection with greater exposure to HIV infection as a consequence (Khaw, Salama, Burkholder, & Dondero, 2000). A study conducted in Africa indicated that migrant

women were more likely than migrant men to report having multiple sexual partners, lower rates of condom use, and higher rates of HIV infection (Camlin et al., 2010).

Migration in itself is not a risk factor for HIV but it is the circumstances and high risk behaviour associated with migration that increases exposure and risk (UNAIDS, 2001). As stated above, population movement can generate circumstances in which women and girls are forced into exchanging sex for survival reasons and can therefore be exposed to HIV (Khaw et al., 2000). Mass population displacement can also increase exposure when people move from areas of low to high HIV prevalence. For example, the HIV prevalence rate in the DRC is 4.2%, and in the Bukavu region, the most affected by war and sexual violence, it is 6.3% (UNAID, 2009); compared to Kwazulu-Natal that has a prevalence rate of 16.8%, and a prevalence rate of 37.4% among antenatal attendees (Treatment Action Campaign, 2009). However, this may be due to under reporting and less testing in the DRC.

Factors such as marginalisation, language problems, social exclusion, legal barriers, religious and cultural beliefs, poverty and limited knowledge of HIV within migrant communities also may contribute to HIV vulnerability among migrant populations (Brummer, 2002; Decosas et al., 1995; Girdler-Brown, 1998). Apart from a general communication problem due to the language barrier, there is also a problem associated to a culture of not talking about sex in public spaces.

There are a number of social constructions and power especially in relation to gender, class and culture that may also play a significant role on vulnerability of HIV among migrants. Studies show that a women's level of power in relationships plays a critical role in aiding or impeding protected sexual intercourse (Pulerwitz, Gortmaker, & De Jong, 2000). For example, abstinence may not protect women who are forced to have sex, faithfulness may not offer protection to a wife whose husband has multiple partners or was infected prior to marriage. Further, condom use may require the cooperation of the male partner. Evidence shows that girls and women in financial difficulty will be more likely to accept intercourse without using a condom in cases where male partners offer greater financial reward (Marten, 2005). This situation may increase vulnerability to HIV/ among female migrants.

In South Africa, the specific associations between health and migration, including not only the health of migrants themselves but also those that they meet, are under researched. As noted, emphasis in the past has been on the causes of migration and there has been little focus on the health consequences of migration (Crush et al., 2005; McDonald, 1998). Although research in this area looking at the relationship between the overall process of migration and increased vulnerability to HIV infection is more recent (Campbell 2001; Cohen 2003); there appear to be a myriad of effects that require further investigation and an ecological perspective necessitates a closer and more detailed exploration of this, including the ongoing effects of war and the other causes of displacement on health.

2.4.3 Effects of war and displacement on DRC refugees

War and population displacement may be a significant recognised risk factor for HIV transmission. It is often presumed that the rates of HIV transmission may increase in the context of violent conflict. This is a result of a high degree of sexual violence, displacement and poverty, all of which may generate a high risk environment for the spread of HIV (UNAIDS, 2009). It is argued that the political conflict and war in DRC since 1996 have contributed more to the spread of new HIV infections and therefore increased high HIV prevalence in DRC. In DRC, human rights nongovernment organisations (NGOs) have estimated that hundreds of thousands of women and girls have been raped in the conflict since 1998 (Meger, 2010). A report from Amnesty International indicated that the Eastern province was the most affected by the conflict. Further, at least 40,000 female civilians were raped over a ten year period during the conflict in the DRC (Cherie, 2006). The United Nations reported 27,000 sexual assaults in South Kivu province (UNAIDS, 20052006). According to the United Nations Population Fund (UNFPA, 2009) an average of 1,100 rape cases are reported each month. The HIV prevalence rate in the DRC is 4.2%, compared to 6.3% in the Bukavu region which is most affected by war and sexual violence (UNAIDS, 2004).

Bukavu, the capital of South Kivu province, is a city with about 600,000 inhabitants and is located on the southern shore of Lake Kivu in eastern DRC which borders Rwanda (Culbert et al., 2007). There has been chronic conflict in this region since 1996, which has involved many internal rebel armies and the bordering states of Uganda, Rwanda, and Burundi. The war in DRC has been estimated to have resulted in the death of over 3.9 million people between 1998 and 2004 (Coghlan et al., 2006). This situation has caused many people to flee out of the country to South Africa as it is regarded as the preferred destination of many refugees from Bukavu. The Eastern province which is close to the border of Rwanda, Uganda, Burundi and Tanzania has suffered the most from the consequences of war. People cross over to Tanzania and Mozambique up to Durban where South Africa is seen as a good place to trade, work, access vital services, and find refuge.

The exact number of refugees from Bukavu living in Durban is also unknown. However, an estimated 14,069 refugees from DRC were living in South Africa in 2007 (Mullagee, & Manicom, 2010). A study conducted by Vearey (2008) on migration, access to ART, and survivalist livelihood strategies in Johannesburg, South Africa revealed that various protective policies and guidelines do exist within South Africa to safeguard access to healthcare for all, including migrants. However, there is currently little understanding of HIV prevention among French speaking refugees from Bukavu, Republic Democratic of Congo, living in Durban and the issues remain under-researched. It is hoped that the results of this study will inform an intervention to bridge the gap. A good understanding of the relationship between social capital and HIV risk could make a contribution to prevention strategies for refugees within South Africa (Poundstone et al., 2004).

2.4.4 Socio-economic implications of migration and HIV

Much of the literature has attempted to explain why some countries and communities have higher and more HIV than others. In South Africa, the main elements of the risk environment that are believed to increase vulnerability to HIV include extreme economic and social inequality; poverty and underdevelopment within this setting; labour migration; and deep-rooted gender inequalities

resulting in high levels of sexual and physical violence against women and girls (Fenton, 2004; Gilbert & Walker, 2002; Mane, Gupta, & Weiss, 1994; Parker et al., 2000; Rao Gupta, 2002; Watts, & Garcia-Moreno, 2000; UNAIDS, 1999, 2002). The 'risk environment' outlines features of social situations that are principally outside a person's control but still have a huge effect on the level of ill health in current populations (Rhodes et al., 2005). Social capital has been put forward as a conceptual framework that can highlight the links between individual health outcomes (including HIV) and the risk environment (Berkman & Kawachi, 2001; Szreter & Woolcock, 2004). There are a number of ways in which social capital might affect the pervasiveness and spreading of HIV in populations such as mixing within high risk 'core-groups' like sex workers (Mann & Tarantola, 1996).

Population movement has thus been structurally linked to both social inequity and economic disadvantage (Soskolne & Shtarkshall, 2002; Gillies et al., 1996). In poorer countries and in the poorer inner-city communities of more developed countries, poverty and deprivation have emerged as significant structural factors influencing HIV transmission (Nicoll & Gill, 1999; Parker et al., 2000; Sikkema et al., 1996; Singer, 1994; Zierler et al., 2000). Research has shown that HIV transmission can unduly affect economically underprivileged groups who are also suffering generally from an array of social inequalities (Heffernan, 2002). Poverty is clearly linked not only to the resources of a particular person or family, but also to the community that the person is living in. "Being poor is more than a matter of living under a specified income. Being poor influences all aspects of a person's and a community's life" (Ratele, 2007, p. 223). Although poverty is often defined using statistics or in terms of income, it has been recognized as a multidimensional concept and other key dimensions need to be considered including, among others: access to resources needed for survival, the opportunity to participate in community life, and living conditions (Ratele, 2007). Poverty has been shown to increase the risk of HIV transmission among migrants. In many poor countries, for example, poverty is viewed as the main reason leading to the migration of women from rural areas to urban areas where they then frequently become involved in the sex trade out of necessity.

2.4.5 Knowledge of HIV and risk perception among migrants

Adopting safer sexual behaviour is assumed to be based on a number of psychosocial qualities, including knowledge about HIV/AIDS and perceived personal vulnerability. There are various studies that have explored the knowledge of HIV and perception of risk among international migrants. These studies have shown that international migrants have generally lower levels of knowledge about HIV and lower perception of self-risk for HIV infection than the general population. An ethnographic study of potential HIV risk behaviours among Ethiopians and Eritreans in the United States showed that participants were aware of HIV and its impact but some also believed that one could be infected through mosquitoes or touching an infected person (Beyene, 2000). A crosssectional survey of 748 migrants from five sub-Saharan African communities in London, United Kingdom found a low perception of risk among immigrants (Fenton, Chinouya, Davidson, & Copas, 2002). Erwin, Morgan, Britten, Gray, and Peters (2002) also found a low self-perceived risk of infection among Africans in the United Kingdom. This study also demonstrated that national and ethnic identification was important for HIV awareness. Awareness of HIV was proportional to HIV frequency in the country of origin. However, this awareness was not translated to behaviour change as many had a low perception of risk such as that one had to continue sexual practices outside the norm (sex outside marriage) that could increase the risk of infection.

2.4.6 Risk behaviour among international migrants

Since the early 1980's when using condoms was first suggested to prevent HIV transmission, there has been growing evidence in support of the effectiveness of this approach (UNIAID 2001). Research has shown that when condoms have been used reliably and consistently, protection rates are as high as 95% (Pinkerton & Abramson, 1997). In many populations condom use has not been well accepted and not consistently used even as a contraceptive device. It has been found, for example, that some people may use condoms effectively with specific partners (eg. customers of sex workers), but using condoms with steady or regular partners might not be frequent or consistent (Foss, Hossain, Vickerman & Watts, 2007). Frequent sexual encounters, multiple sexual partners, and inconsistent condom use can all lead to an increase in HIV risk. Many studies have

demonstrated the connections between these factors and HIV risk (Aral & Holmes, 1999; Eng & Butler, 1997; Rosenberg, Gurvey, Adler, Dunlop, & Ellen, 1999).

Research has shown that there is a wide range of factors associated with sexual risk behaviours among migrants. Studies have shown that international migrants engage in high risk sexual behaviours, which may be responsible for the high rates of HIV observed among them. For example, a study conducted by Beyene (2002) showed that female participants in that study did not ask about their partners' sexual history before having sex with them. They also did not discuss the use of condoms because they feared that it might cause their partner to suspect them and leave them. Therefore the use of condoms was usually determined by the male sexual partner's decision. Among men in Beyene's 2002 study, unprotected sex was more common with persons of the same ethnic group than with American women who usually insisted that a condom be used. The study also found that 'cultural notions of trust' was more important than the knowledge that participants had about protection. Therefore participants who initially used condoms with female sexual partners stopped using them after some time in the relationship (Beyene, 2000). A study by Fenton et al (2002) revealed that condom use at last sexual intercourse was confirmed by only 46% of men and 43% of women. Over 40% of study participants stated that they had sexual intercourse with one or more sexual partners in the year preceding the study. Beyene (2002) found that Ethiopians and Eritreans living in the United States had unprotected sex with multiple partners and frequently used alcohol and illicit drugs before having sex.

Another study conducted in Amsterdam, the Netherlands, also found high-risk behaviour among migrants (Gras, Weide, Langendam, Coutinho, & van den Hoek, 1999). This involved a crosssectional survey of 1660 migrant men and women, which also tested for HIV antibodies among the migrants. In the above study, for instance, 45% of migrant men compared to 6% of non-migrant men, in a relationship for more than one year, reported sex outside their primary relationship. In this study also, participants reported having multiple partners.

A quantitative study conducted by Chirwa (1997) among Malawian migrant mine workers who were repatriated from the mines in South Africa showed that migrants engaged in risky sexual

practices. Migrants had sex with commercial sex workers while in transit centres in Lilongwe and Blantyre on the way to and from South Africa. These transit centres were surrounded by clubs where local women sold sex. Participants reported that they purchased sex in exchange for women's shoes or ear rings, blankets or a set of bed sheets bought from South Africa. Participants also indicated that they had sex with commercial sex workers in South Africa and that some had sex with other men in their hostels on the mines.

Results from studies conducted in Asia also support the hypothesis that migrants are more at risk of infection with HIV than are non-migrants. In a study conducted in Doti District in western Nepal, Poudel, Jimba, Okumura, Joshi, and Wakai (2004) investigated the social and behavioural mechanisms that may influence the vulnerability of Nepalese migrants to India. The qualitative study was conducted with 53 male migrants who had worked in India but were home on recess. The study revealed that migration to India played a crucial role in initiating and establishing highrisk behaviour for the transmission of HIV. Extramarital sex has not been frequent among the villagers before they migrated to India. However, a large percentage of participants joined informal social groups once in India. The migrants participated in the activities of these groups, which include frequent sex with sex workers. Peer norms and pressure, use of alcohol, cheaper or free sex with sex workers, single life and low perceived vulnerability to HIV were identified as some of the factors that influenced migrants' decisions to partake in extramarital sex.

Researchers have tried to improve their understanding of the place of infection of international migrants. Some studies suggest that migrants mainly bring infection with them into the country of destination, others suggest that they acquire infection after arrival in the countries while others suggest that migrants may become infected when they visit their countries of origin. The study by Beyene (2000) among Ethiopians and Eritreans showed that some of the participants were infected before migrating to the United States. Fenton et al. (2002) demonstrated that many of the migrants infected in the United Kingdom may have been infected before migrating to the United Kingdom or because of maintaining culturally prescribed practices such as dry sex, which place them at increased risk of HIV transmission. Another study conducted by Harawa, Blingham, Cochran,

Greenland and Cunningham (2002) found that HIV-positive foreign clients were infected after immigrating to the United States.

Other studies such as Gras et al. (1999) showed that many of the migrants in their study reported having sex with new partners when they visited their countries of origin. In addition, a cross sectional survey of 756 migrants from five sub-Saharan communities living in the United Kingdom conducted by Fenton et al. (2002) proved that 43% of men and 46% of women had travelled to their home countries in the five years preceding the study and that 40% of men and 21% of women reported having acquired new sexual partners during their visit. Studies have also revealed that international migrants engage in risky sexual practices that could contribute to the spread of HIV when they return to their home countries. Beyene (2000) showed that migrants who travelled to their home countries (Ethiopia and Eritrea) were more attractive, than local men, to local women with whom they had unprotected sexual intercourse. In the study conducted by Poudel and colleagues (2004) it is shown that participants who returned home to Nepal continued to have risky sex because they had gained new social status as a returned migrant in the village. Their wealth and social status made them attractive to young women of the village with whom they had sex. The same study continued to show that some participants who had not had extramarital sex in India agreed to have extramarital sex when they returned to the village. In this study participants reported that more than 15 migrant men who returned from India had died of HIV in the five years preceding the study, despite this migrants still felt that village women could not be infected and therefore it was safer to have sex with them

2.4.7 Migration stress and psychosocial resources

The risk of HIV is but one of the many stressors faced by migrants. It is also often seen as less important than the myriad other stressors experienced through migration and displacement. Despite a high level of stress and risk, psychosocial moderating resources like control, social support and coping tactics are in most cases limited or may not be suitable for the new social and economic context (Thoits, 1995). This can increase migrants' vulnerability and ability to

effectively copy with exposure to HIV. Migration-specific stressors are compounded by limited resources, all of which can negatively affect access to HIV prevention programmes.

It is well known that the use and availability of prevention services are often limited in the case of populations who are not fully integrated in a particular community. This can be for a variety of reasons, for example the services may not be suited to their particular needs, or there may be psychosocial or economic barriers that prevent access (Kawachi & Berkman, 2000). Further, HIV prevention communication for the general public does not always reach migrants due to cultural and language differences. Some barriers to accessing health services may also arise from bidirectional cultural misunderstandings and are not always only unidirectional.

2.4.8 Sexual networking and risk behaviour among migrants

Patterns of migration have a direct effect on the amount of disruption that results in relation to the family and social systems. Patterns may include, for example, immigration of single-sex individuals (usually male labourers) or whole families. The breakdown on these systems by migration can have a detrimental effect of the ratio of women to men (Thomas & Thomas, 1999); and therefore also on the sexual health of the group (Decosas, 1996; Campbell & Williams, 1999; Lurie, 2000; Parker, 1996).

Looking at the individual level, the migration pattern can influence risk behaviour and sexual networking. The risk of having of having parallel but different lives is high among male migrant workers who may, for example, be faithful husbands with wives in their home country but have commercial sex or multiple partners in their host country (Wolffers et al., 2000). These migrants run the risk of becoming what has been termed ‘‘bridge populations.’’ This entails the transfer of HIV from a high-risk population to a low-risk population (Morris, Podhisita, Wawer, & Handcock, 1996).

In cases where whole family groups move together, sexual networking takes place principally within the migrant population. The danger in such cases is that any added risk within such a closed

group can lead to a speedy increase of the virus. In cases where members of communities and their environments are constantly changing with frequent in and out-migration, maintaining safe sexual behaviour is not easy, again increasing the risk of HIV. There is often a mix of both infected and uninfected people and in some cases the social norms that favour safer sex may weaken (Wohlfeiler, 2000). Also linked with sexual risk-taking are other factors including the degree of intergenerational connectedness in a family which may be diminished during migration and lead to a breakdown of family traditions (Landau, Cole, Tuttle, Clements & Stanton, 2000). This can lead to increased stress in the family and a collapse established sexual behaviour norms.

2.4.9 Factors that place refugees at risk for HIV infection

Various factors have been found to increase the risk of HIV transmission amongst refugees including: social instability, displacement, increased mobility, exploitation, abuse, sexual and gender-based violence, poverty, food insecurity, lack of access to health services, and a lack of culturally and linguistically appropriate health information (The President's Emergency Plan for AIDS Relief, 2006).

Given the fact that refugees are taken away from their homes and communities, they lose their livelihoods and networks. This breakdown of social networks and lack of access to institutions diminishes unity in the community and can weaken social and sexual norms that usually direct behaviour. Displacement and conflict make women and children, especially girls, extremely vulnerable to the risk of HIV. In many cases, rape is used as a weapon of war during conflict and women and girls are also exposed to sexual exploitation and violence in their host locations. Because of their struggle to survive, they are frequently forced to exchange sexual services for food, protection or money.

2.4.10 Cultural norms, loss and beliefs

The predominant cultural norms in a community regarding sexual health, sexuality and HIV are significant determinants of HIV transmission and prevention (Decosas et al., 1995). This means

that migrants may be at increased risk when they keep their own cultural norms or in cases where they experience cultural losses without assuming any of the cultural values of the host community. People in the host community are also introduced to new socio-cultural systems and norms that may be different from their own. The interaction between migrants and local community members governs the specific "geographical–cultural–time-context." It is, therefore, not only the position of the migrant that is exceptional, it is the unique interaction between the different cultures and the dominant conditions at a given point in place and time that can have an effect on HIV rates (Crawford, 1994).

The level of cultural alienation felt by the migrant in relation to the host community can set up barriers again participation in health services and programmes. This could also lead to stress, confusion or resistance to change that may. This, in turn, could result in risky health behaviour. To more deeply understand the cultural context and HIV risk within that context, it is important to look beyond personal values and beliefs (Tawil, Verster, & O'Reilly, 1995). It is, further, important to understand that different views of the "self" (in Western cultures as a production of the individual; and in traditional cultures as a production of the family and community) may be different for migrants (Airhihenbuwa & Obregon, 2000). The meaning of "self" is also important in respect of how people perceive individuals with HIV as "other" and as a threat to their safety (Crawford, 1994). In some case, migrants may be looked upon as the "others" who carry HIV. HIV may also be viewed as "other", beyond the person's control, or something outside.

2.4.11 Refugees and HIV prevention programs

According to UNHCR, national HIV programs should ensure that refugees are an integral part of national efforts of HIV prevention and that they are able to have access to HIV testing and counselling, treatment, care and support (UNHCR 2009). Refugee Rights (2008) revealed that South Africans, recognised refugees and asylum seekers are all at risk of contracting HIV. The refugee rights recommend that those who want to know their HIV status should have access to local HCT services. However, this is still a challenge in South Africa because refugee and asylum seekers speak many different languages and they also may require confidential interpretation as

part of their HCT process because they are also entitled to pre- and post-test counselling and follow up support after the test (Refugee Rights, March 2008).

UNAIDS (2007) point out that in many host countries, despite the rights given to refugees under international refugee and human rights law, refugees are still not guaranteed the health related services they need. In addition, UNAIDS (2007) states that despite the progress in antiretroviral therapy in many countries, a very small number of refugees have access to it. Thus, an inclusive national response is needed to attend to the HIV-related needs of refugees; and local communities should be viewed as an effective route towards the reduction of HIV transmission.

2.4.11.1 Obstacles to access of HIV support for migrants

There are many challenges that limit the refugees to access to some HIV services that exist in their host countries. The President's Emergency Plan for AIDS Relief Report on Refugees and Internally Displaced Persons, highlighted the following: skills and language obstacles, including the lack of staff who understand both the languages and culture of the displaced populations and HIV; exclusion of refugees from participation in national strategic plans for health, especially HIV; location of many refugees in remote areas limiting their ability to access health services; and poor roads leading to refugee camps which also limit the provision of health services (The President's Emergency Plan for AIDS Relief, 2006).

2.4.11.2 Obstacles in relation to HCT

According to (UNAIDS, 2002) HCT is a process in which a person is counselled to enable him or her to make an informed decision about whether to test for HIV (UNAIDS, 2002). HCT has been shown to play a role in both HIV prevention and for people with the infection as an entry point to care (UNAIDS, 2001).

UNAIDS Global report (2010) highlights that HCT facilitates HIV treatment and care and prevention activities, increases the awareness of people living with the disease of their own status

and encourages them to take protective measures; and increases social awareness of the situation. UNAIDS Global report 2010 maintains that HCT can reduce stigma and discrimination towards people living with HIV (UNAIDS Global report 2010). UNAIDS (2002) states the knowledge of serostatus through HCT can be a motivating force encouraging people to adopt safer sexual behaviour. This enables seropositive people to prevent their partners from getting infected as well (UNAIDS, 2002). A further point is that HCT assists with access to prevention services for seronegative people. This includes access to various interventions, for example, reducing motherto-child transmission (MTCT) of HIV and prevention of opportunistic infections (for example, tuberculosis). It also facilitates access to other medical and support services that can help people living with HIV to enjoy longer and healthier lives (UNAIDS, 2002).

According to the European Centre for Disease Prevention and Control (2010) there is solid evidence to show the benefits of an early diagnosis and treatment of HIV. Early diagnosis can lead to better prospects for the person who can expect a good quality life, low morbidity, and a near normal life expectancy. Evidence also reveals public health benefits as people who have been diagnosed generally adopt safer sexual behaviour and there is a reduction in infection as a result of the antiretroviral treatment. Further, the cost of treatment and ongoing care for people diagnosed early is considerably lower than for those diagnosed at a later stage (ECDC, 2010).

Awareness of the barriers to HIV testing is considered critical in designing effective related programmes (UNAIDS, 2000). Despite this, it has been highlighted by UNAIDS (2000) that access to HCT services is still limited and the response often low. There is an argument in many countries with a high-prevalence rate that HCT is not easily accessible and that people are often afraid of finding out their serostatus as there is insufficient support and care following testing (UNAIDS, 2000)

Extensive literature has been published on barriers to HCT by Tharao, Calzavara, & Myers (2001). These barriers to HIV testing include a number of aspects: stereotypes and myths regarding HIV infection (for example, fear of being labelled gay); lack of accurate information about HIV and HIV health related services; and practices and beliefs about health and healthcare (for example,

not wanting to share or discuss health issues with others, being hesitant to get medical advice unless sick, believing that one should not fear death). Further barriers involve health providers not understanding the language; cultural issues and differences challenging immigrants; and fear of testing HIV-positive and the related perceived consequences for self and the community. These consequences can include, for example, stigma, isolation from the community, not wanting to find out if sick, possible negative effect on immigration status, apprehensions about confidentiality, and possible further discrimination for the whole community (Tharao et al., n.d).

Nguyen, Oosterhoff, Ngoc, Wright and Hardon (2008) reviewed literature on barriers to HCT among pregnant woman and found the most important barriers to use of services was fear of stigma attached to the interpretation by the community and discrimination, poor counselling or lack thereof, and lack of awareness on PMTCT opportunities. Worryingly, Nguyen et al. (2008) found that some health care staff were not willing to give proper care to HIV positive pregnant women, generally because of a lack of knowledge and their own fears (Nguyen et al, 2008). According to the, ECDC (2010) barriers to HIV testing exist at various levels, including at institutional, healthcare provider and individual level.

2.5 Conclusion

The overview of the existing literature shows that there is an increased attentiveness towards the roles played by social structural and environmental influences on HIV risk behaviours. Earlier understandings of risk behaviour have moved from individual models to ecological models, with growing recognition that risk behaviours are rooted in the economic, environment, and social structure (Waldo & Coates, 2000). The review of the literature has revealed that war and population displacement may be recognised as significant risk factors for HIV transmission and need to be taken into account as part of the larger picture. In relation to social capital, although previous studies have shown that strong social capital can lead to healthier societies it is still a contested field. This is especially true for HIV prevention. In relation to HIV, the results of previous studies have been mixed. In some situations it has been argued that high levels of social capital and community cohesion may be result in protective behaviour and can facilitate more effective

collective responses to the HIV epidemic. Sliep (2006), for example, showed that it is through enhancing social conscience that collective efficacy and action can develop to increase the overall wellbeing of everyone infected and affected. However, in other situations group membership has also been a risk factor for HIV infection (Epstein, 2007). Literature has also shown for example that fear associated with stigma reportedly affects a range of risky HIV health behaviours: individuals' decisions not to access HIV Counselling and Testing (Day et al., 2003; Kalichman & Simbayi, 2003), HIV-positive individuals' poor adherence rates to ARV therapy (Weiser et al., 2003), and poor safe sex behaviours (condom use) (Volk & Koopman, 2001), and increased risk of mother-to-child transmission (Thorne & Newell, 2003).

There have been few attempts to understand how social capital operates as a risk or protective factor for HIV among refugees in general and more specifically in relation to French speaking refugees from Bukavu /DRC living in Durban South. The researcher is not aware of any studies that have looked specifically at the influence of social capital on HIV prevention with French speaking refugees from Bukavu/DRC living in Durban South Africa.

This proposed research seeks to contribute to the understanding of how the elements of social capital, especially at a bonding level, such as norms, reciprocity, trust, and social networks influence condoms use, stigma around HIV, and HCT and how this contributes as a risk or protective factor for HIV prevention among members of the research population. Although, in reality illegal refugees are probably at even a greater risk for HIV than legal refugees this study focused only on legal refugees, predominantly because illegal refugees may not be willing to talk to someone they do not know for security reasons.

CHAPTER 3

METHODOLOGY AND DESIGN

3.1 Introduction

The aim of this chapter is to present the methodology used in this study. This chapter is divided into eight sections: study design, study area, study sample, data collection procedures (semi

structured interviews and focus group discussions), data analysis, the role of the translator, ethical considerations, and validity and reliability.

3.2 Study Design

In many cases it is the nature of a research project that dictates the approach that will be used to gather information and thereafter analyse the data, interpret the findings in order to achieve the objectives of the study. This study follows the principles of a qualitative research approach. The approach relies on multiple types of subjective data and the investigation of people in particular situations in their natural environment, which includes nonnumeric data such as words, pictures and images. Qualitative research as "a research form, approach or strategy allows for a different view of the theme that is studied and in which the participants have a more open-ended way of giving their views and demonstrating their actions". This research form endeavours to provide a unique explanation about a particular situation (Wimmer & Dominic, 1991).

Qualitative research enables the researcher to gain a deep understanding of the research participant's perceptions and their point of view (Frankfort-Nachmias, 1992; Leedy & Ormrod, 2005). It helps to find insights, perceptions and a deeper understanding of phenomena under study as it calls for a drawing out participants' stories and experiences which would not be sufficiently shown through a statistical quantitative research method (Creswell, 1998). This method is used to gain insight into people's behaviours, attitudes, their culture, their value systems and to look more closely at their motivations, concerns, aspirations, or lifestyles (Babbie, & Mouton, 2001).

The research focus for this study was on the influence of social capital on HIV prevention. Qualitative research in this study attempted to render greater understanding of how social capital at a bonding level influences the use of condoms, stigma, HIV Counselling and Testing (HCT) among French speaking refugees from Bukavu /DRC living in Durban South Africa with the view of understanding how social capital functions as a risk or protective factor for HIV prevention among them.

3.3 Study Area

This study was conducted in the metropolitan area where the majority of French speaking refugees are located on Dr Pixley KaSeme Street and Mahatma Gandhi Road in the city of EThekwini (Durban). Dr Pixley KaSeme Street is situated within the central business district of Durban Central while Mahatma Gandhi Road is located in the South Beach region of the city close to the Durban port and Addington Hospital. Congolese refugees represent the biggest group among the refugee community who live in Durban. The Congolese refugee community in Durban are a vulnerable and poor community resulting from a lack of access to social protection and formal employment, difficulties in obtaining trading licences, and inadequate access to trading sites in the informal economy in which they participate as their only source of income. Poverty and lack of access to resources means that refugees are forced to rely heavily on family ties to survive.

3.4 Selection of research sample: Purposive sampling

The study population included French speaking refugees from Bukavu/DRC living in Durban South Africa. Sampling is the process of selecting a representative number from the entire study population for interview purposes in order to draw generalisable conclusions about the population. Sampling techniques help to save labour, time, and money by reducing the numbers of cases involved. It allows for effort to be focused on high quality information from a small number of cases (Mann, & Tarantola, 1996).

Blaxter, Hughes and Tight (2001) classified sampling into two groups: probability and nonprobability sampling. In a random sample, each person in the universe has an equal probability of being chosen for the sample (Bailey, 1982) and is chosen indiscriminately and not favoured by personal choice. The study used purposive sampling which is a non-random sampling technique where a researcher specifies the characteristics of the population of interest and then locates individuals who have those characteristics. Polit and Hungler (1999) justify the advantages of purposive sampling as allowing the researcher to select the sample based on knowledge of the phenomena of the study.

During the study twenty-four French speaking refugees aged between 18 and 35 years of age were selected. The participants were all from Bukavu and had been living legally in South Africa for a period of no longer than one year. Six single young women, six single young men, six married women (legally married and /or those who live together as a couple), and six married men were interviewed in order to identify which categories are more likely to be at higher HIV infection risk than others. The research participants' were purposefully chosen by the researcher as a member of the community to get a range of views across gender and married and unmarried participants. Participants were also selected according to availability and willingness to participate in the study. This was done with a view to understanding, at a social bonding level, how the elements of social capital such as norms, reciprocity, trust, and social networks influence condoms use, stigma around HIV, and HCT; and how this contributes as a risk or protective factor for HIV prevention among French speaking refugees in these categories.

3.5 Data Collection Procedures

3.5.1 Overview

The study used qualitative data from several sources. At the start of the research two focus groups were conducted with the sample. This was followed by in-depth interviews with four participants from each group. In order to delve even more deeply into issues that arose from earlier data sets, a further series of four in-depth interviews were conducted with selected participants. The researchers own experience, as a DRC refugee, has also been explored to further understand the data. Details in relation to each data set are provided below**.**

Ethical procedures were followed prior to the collection of data through the use of consent and information forms, informing participants of the nature of the study and advising them of voluntary nature of participation, their right to withdraw from the study at any time, confidentiality, and anonymity of data. Permission was obtained from the participants to audio record interviews.

3.5.2 Focus group discussions

Focus groups are regarded as a form of group interview that focus on communication between the researcher and participants using group interaction as part of the method to produce data (Shedlin & Schreiber, 1995). The focus group is a method of collecting data in a group situation where a moderator leads a discussion with a small group of people. It empowers individuals and groups to have a voice. In this study focus groups were semi-structured and a relaxed atmosphere was ensured.

The questions were designed to flow logically, going from less sensitive questions to more personal, due to the sensitivity of the topic. Moreover, given the sensitivity of the topic, the in-depth interviews were used to collect personal information that participants did not feel comfortable to disclose during the focus groups. In this study, focus group discussions were done before one on one interviews and trust between the researcher and respondents was created at this stage. Two focus groups were conducted in South beach Durban: one for men only, another for women only, with eight participants in each. The reason for this was to allow participants to express themselves freely. The focus group discussions were recorded with the consent of participants and notes were taken. The duration of each focus group ranged from 45 minutes to one hour in order to encourage free sharing.

Questions used to guide the focus group discussion were translated from English to French as most of the participants come from the French African speaking areas. The focus groups were conducted by the researcher and a female research assistant in 2013 at the Durban Mission Church corner of Mazeppa Street and Winder Street in Point road South beach as this was a central meeting place for participants. The main topics covered in the focus group were to explore at a bonding level, how the elements of social capital such as norms, reciprocity, trust, and social networks influence condoms use, stigma around HIV, and HCT. A copy of the focus group guide is attached and marked Annexure “A”.

3.5.3 In-depth interviews

The focus group discussions were followed by in-depth interviews with sixteen of the participants. Participants from the focus groups were invited to voluntarily participate in in-depth interviews that took place within two weeks following each focus group. Kumar (1996) defines an in-depth interview as any person-to-person interaction between two or more individuals with a specific purpose in mind. It involves open-ended questions asked by a researcher to respondents. The interviewer uses a topic guide which does not rely on a structured question set. Probing techniques were used to encourage respondents to give the fullest possible answers.

All the interviews were conducted privately at the Durban Mission Church office in Durban South beach. The interviews were conducted by the researcher and a research assistant. Interviews were recorded with the permission of those interviewed and notes were taken in case of recording problems. The duration of interviews ranged from 45 minutes to one hour. Each question was explained briefly to ensure that the respondents understood the questions. Care was taken to avoid divulging the opinions of either the interviewer or the researcher assistant.

The aim of the interviews was to attempt to understand how social capital influences the use of condom, stigma, and HCT among the research participants. The in-depth interviews enabled the researcher to collect personal information that participants may not have felt comfortable to disclose during the focus groups. A qualified female French speaking refugee researcher assistant was employed to conduct interviews for female participants who may not have felt comfortable to talk openly to the researcher who is male due to the sensitivity of the topic. Questions to guide interviews were translated from English to French as most of the participants come from the French African speaking areas. A copy of the interview guide is attached and marked Annexure “B”. Responses from the participants were recorded and later transcribed in English. Observations from each interview (such as emotional responses and attitudes) were recorded during the interview in order to more fully understand participants’ responses to the questions.

Four additional in-depth interviews using four people from the original sample (one married man, one married woman, one single man, and one single woman) were conducted in 2015 to probe even further the information obtained. The researcher wanted to explore more deeply the complexities involved in understanding HIV risk and protection and how social capital elements such as trust, norms, social networks and reciprocity may in some cases have positive effects while in others there may be negative effects. The researcher used a topic guide to more deeply understand the issues raised. A copy of the interview guide used for the second round of interviews is attached and marked Annexure "C".

3.5.4 Researcher Interview

While collecting the data it emerged that the researcher also had insider knowledge of the subject that had not emerged in the interviews or focus group. It was decided to interview the researcher as well as an additional set of data, as the researcher is also a member of the French speaking refugee community living in Durban. An in-depth interview was conducted by the research supervisor with the researcher to probe his own experience. The researcher considered it to be of value to examine his own experience as both a master's student with access to HIV information and as a member of the refugee community. It was important to probe further whether the impact of information received through his studies at university had an impact on his norms and values as shared by others in the community leading to possible differences in behaviour change in relation to HIV protection. Such information was considered useful to better inform recommendations for intervention work in the community.

3.6 The Role of a Research assistant.

A qualified female French speaking refugee research assistant was employed to conduct the focus group for women and to interview female participants who were not comfortable to talk openly to the opposite sex due to the sensitivity of the topic. The research assistant received training from the researcher on the methodology used in this study.

3.7 Data Analysis

All the recorded interviews and focus groups were translated and transcribed to facilitate analysis of data. Riessman (1993) describes the process of transcription as an excellent way for the researcher to familiarise herself or himself with the data, even while at times seeming timeconsuming and frustrating. Transcripts were read and re-read so that the researcher could familiarise himself with the content. Thematic analysis was used to analyse findings. Themes that could be grouped together in relation to elements of social capital on a bonding level were identified. In this way the researcher read the data for themes addressed by the theory but also read with an openness to new themes that could emerge relevant to the research population. The themes were then coded and this was followed by an elaboration of each theme. Thereafter the researcher interpreted and verified all common patterns in each of the transcripts. Data were analysed according to major themes and patterns in the study. Specific attention was given to the social capital framework elements which include trust, reciprocity, norms and social networks apparent on the bonding level. Braun and Clarke, (2006), stated that with thematic analysis it is important that the theoretical framework and methods chosen by the researcher match what the researcher wants to know. The researcher must make conscious and deliberate decisions in this regard.

During coding, important questions such as ‘what counted as a theme and what ‘size’ a theme needed to be were produced. Boyatzis (1998 p. 168) defined a theme as “a pattern in the information that at minimum describes and organises the possible observations and at maximum interprets aspects of the phenomenon”. Braun and Clarke (2006) describe a theme as capturing something important about the data which must be significant in relation to the research question. The theme characterises a level of patterned response or meaning within the data (Braun and Clarke, 2006).

A theme in this study constituted arose where it captured something important about the theory in relation to the influence of social capital on HIV prevention with French speaking refugees from Bukavu living in Durban South Africa. The analysis in this study followed the seven phases of the theory led thematic analysis identified by Boyatzis (1998). Firstly, the researcher has to familiarise

him/herself with the collected data. Secondly, data is transcribed, read and re-read while noting down the initial ideas. Thirdly, interesting features of the data that match the theoretical categories are coded in a thematic manner across the whole data set, allotting data relevant to each theoretical category. Fourthly, potential themes are thought out and relevant data is put under each potential theme. Fifthly, themes are reviewed checking to be sure that the themes match the theoretical categories and also to be sure that the coded extracts match the themes generating a thematic 'map' of the analysis. The sixth step is an ongoing analysis which helps to refine the specifics of each theme, looking at the overall story the analysis tells, and helps generate names and clear definitions for each theme. Lastly, a report is produced that presents a final opportunity for analysis. The final product is presented by using a selection of rich, meaningful extract examples, final analysis of selected extracts, and ensuring that the analysis is related back to the research question and the literature. These seven stages were strictly adhered to in the present study. This technique was useful in this research because it allowed for a deep exploration of the themes relating to the research subject and the various elements that are explored in a study relating to social capital at a bonding level.

3.8 Ethical issues

Ethics can be regarded as a human concern of what is right and wrong, good and evil. What counts as good or evil varies across ages, cultures; there is a convergence which overrides what is known as cultural relativity (Babbie, & Mouton, 2001). In this research, ethical issues were taken into consideration. Data collection was done after the researcher obtained ethical clearance from the school of applied human sciences, University of KwaZulu-Natal.

All participants were given a Participant Consent form written in both English and French. A copy of the consent form is attached and marked Annexure "D". The aim and objectives of the study were explained to the participants and they were informed that their participation was voluntary. The researcher obtained written informed consent from every participant and their confidentiality and privacy was respected throughout the process of the study. Their names were kept anonymous. Given that French speaking refugees living in Durban may have experienced traumatic or stressful

circumstances, the possibility of follow-up counselling was made available for persons interviewed who wanted to make use of this service. Masters students from the school of psychology at the University of Kwazulu-Natal under supervision of their supervisor offered personal and group counselling to persons interviewed who wanted to make use of this service.

3.9 Validity and Reliability

In qualitative research validity refers to the authenticity of the study while reliability refers to how dependable and consistent a research study is. Neuman and Robson (2004) stated that in order to maintain validity in a qualitative study, the researcher has to give a truthful, undistorted account of the informants' opinions, experiences and understanding. However, there is a common acceptance among social scientists that an objective and definitive view of reality cannot exist.
Burnard, Gill, Stewart, Treasure, and Chadwic (2008) have suggested two strategic ways of having data analyses validated by others: participant validation, and peer-review. Participant validation consists of going back to participants and asking them to carefully read through the transcripts and analysis and asking them to confirm or contest the researcher's interpretation of data. The authors argue that this process is hugely time consuming and, if it does not take place fairly soon after data collection and analysis, participants may have changed their views because of temporal effect and possible differences in their situation. There may also be a problem of how to present such information to people who are not academically inclined. They further argue that the process of peer review consists of one other suitable experienced researcher independently reviewing and exploring the interview transcripts, data analysis and the themes that emerged from data. They believe that this process may help to protect against the possibility for lone researcher bias and help to give extra insights into themes and theory development. However, again, they mentioned that some researchers question the value of this, as it is conceivable that each of the researchers may interpret the data, or sections of the data, differently.

Although there are many arguments to accept the trustworthiness of qualitative research, Guba (1981) proposed four criteria he believes necessary for consideration by qualitative researchers in the quest for a trustworthy study: a) credibility (rather than internal validity); b) transferability

(rather than external validity/generalisability); c) dependability (rather than reliability); and d) confirmability (rather than objectivity).

In dealing with credibility, researchers try to show that a true picture of the phenomenon being studied is being presented. For transferability, they give enough detail of the context of the fieldwork for the reader to be able to decide whether the study environment is similar to other settings or situations and whether the findings can then be justifiably be applied to other settings. The dependability condition is difficult to meet in qualitative work, however researchers should at least attempt to ensure that a future investigator would be able to repeat the study. In order to make sure that the analysis process is rigorous and systematic, the whole body of collected data must be completely analysed (Burnard et al., 2008). Where fitting, this should include a search for relevant contrary views.

In the present study, credibility was ensured by essentially reading, and re-reading the data repeatedly to search for and identify emerging themes in the constant search for understanding of the meaning of the data and to provide a true picture. The researcher also provided a detailed explication of how the data was collected and analysed to help the reader to critically assess the value of the study. Further, a detailed explanation of the research population and their context has been set out so that readers may be able to decide whether the data is applicable in other similar contexts. The researcher has also been careful to demonstrate that the findings in his analysis emerge from the data by using verbatim quotes from the participants involved to back up assumptions and arguments made in discussion. The use of a combination of focus groups and indepth interviews conducted over time were also to ensure that the researcher was able to check and confirm various findings with the participants and to probe more deeply in cases where the data was not clear from the start. Shortfalls and limitations were acknowledged and have been set out in more detail below.

3.10 Limitations of the study

This study reflected the experiences of 24 refugees from Bukavu (Democratic Republic of the Congo) currently living in Durban. Therefore, as the results presented refer to a small number of

refugees from one geographic location; they cannot be generalised to all the French speaking refugees living in Durban or the country. However, as discussed above their context has been clearly set out so that similarities with other populations could be recognised. Further, given the fact that this study touched on sensitive issues because it explores participants' sexual behaviour and migration experiences this could have inhibited the information provided by the participants which is common to other social science research focusing on sensitive issues. It is possible that participants may not have been completely truthful or they may have exaggerated some of their responses. In addition to the above, participants may have regarded the researcher as a person who could bring solutions to their problems or as someone coming to inspect them, which could affect the information given. Caution was taken during the interviews and focus groups to minimise these limitations and provide clear explanations to the participants of the purpose and scope of the research and the need for honesty.

Account also needs to be taken of the need to translate the data from French to English. In some instances it is possible that some of the meaning was lost and various phrases that were common in French may not have the full impact of their meaning in the English version. The researcher was aware of these possible limitations and took precautions, through doing a series of interviews to try to ensure that the data was correctly analysed.

3.11 Conclusion

A qualitative method was chosen for this study as such an approach is appropriate for exploring the experience of participants perceptions of HIV and whether the elements of social capital have a negative or positive impact on HIV transmission. This research used a diverse data set consisting of focus groups, in-depth interviews, and an interview with the researcher to get a broad understanding of the issues influencing HIV transmission among refugees.

CHAPTER FOUR
PRESENTATION OF DATA, ANALYSIS AND DISCUSSION

4.1 Introduction

The aim of this chapter is to present the results of the study and to analyse and discuss the data collected from the selected research participants in the interviews and focus group discussions. Social capital was used as a theoretical framework for this study. The data was analysed based on the elements of social capital including: trust, reciprocity, and social norms which falls under the levels of social capital (bonding, bridging, and linking). Specific attention was given to the operation of these elements at the bonding level and how these elements contribute as risk or protective factor around HIV. The reason for focusing on the bonding level was that early discussions and information from work with the refugee community showed that participants, as refugees in a foreign country are very reliant on family, friends and neighbours for general social and economic support and the researcher found that it would be important to consider whether these strong social networks and ties at a bonding level also worked as protective factors in relation to HIV prevention or could possibly add to risk behaviour. Further, the participants reported that they had little knowledge or access to networks on a bridging or linking level. They reported very limited or no access HIV prevention programs offered by churches and community based organisations and had limited knowledge of the co-ordination and collaboration between leaders, churches, NGOs and CBOs and other relevant programs within the refugee setting in Durban. Community members also report very limited assistance from government in terms of health and welfare support. Choosing to focus on the bonding level in no way detracts from the importance of social capital at a bridging or linking level and especially the significance of an apparent lack of support at these levels.

Focus in this study has also been placed on the risk and protective factors in the spread of HIV specifically in the case of condom use, HCT and stigma. The reason for this choice is that the literature highlights these areas as increasing the risk of HIV. Further, these areas emerged throughout the research as areas of concern and risk. Data indicates others areas of importance,

for example, male circumcision, but in most cases elements of social capital seemed to work in various complex and interactive ways either for or against the use of condoms in relationships (particularly in relation to trust and mistrust), going for counselling and pervading stigma among both males and females in a community unable to communicate openly about sexual behaviour and therefore unable to openly manage prejudice and risk.

The social capital factors discussed above are looked at broadly in keeping with an ecological perspective to bring in the contextual factors that may be relevant to the topic, especially social, cultural, economic and political aspects that influence the lives of refugees and how these may impact on HIV prevention. The themes highlighted below have been drawn from the data and reflect the complexity of the lives of members of the research community which cannot be separated from the seemingly more direct influences on HIV risk and protective behaviours. For this reason, during the analysis, the researcher read for themes addressed by social capital theory as well as for new themes that emerged considering the context of the research population and their status as refugees.

Various themes were identified during the analysis and clustered together as set out below. These are considered under the following headings: Effects of migration; Social capital and migration; and Social capital and HIV risk and protection. The first cluster focuses on the general effects of migration including the reasons for migration and relocation difficulties. The economic and psycho-social challenges that result from migration are included here to highlight the hardships surrounding the participants as refugees since these appear to play a strong role in relation to perceptions towards HIV prevention and where therefore included in the results. The second major theme looks at social capital in relation to migration and refugees generally. The importance of social networks for refugees living in a foreign country became clear from the data as did issues of trust and mistrust among members of the community. These are important to consider when exploring the possible positive and negative effects of social capital around HIV on the research population. The third major theme cluster focuses most directly on social capital and HIV risk and protective factors; looking closely at the elements of trust, norms, reciprocity and networks in relation to condom use, stigma and VTC. The effect of these on HIV risk, support and behaviour

change also emerges in relation to these elements and are discussed. The outline is illustrated below:

Effects of Migration

- Push and pull factors (reasons for migration)
- Relocation difficulties
- Economic challenges
    - Poverty and social exclusion
    - Income generation and job stress
- Psycho-social challenges
    - Mental health status
    - Tension between refugees and locals

Linking migration to social capital

- Importance of social networks
- Impact of social support and relationships among community members
- General lack of trust in the community

Social capital and HIV risk and protection

- Trust and mistrust relating to HIV risk
- The struggle for reciprocity and HIV risk
- Social networks and HIV support
- Social Norms and HIV Behaviour change
    - Lack of communication around HIV
    - HIV knowledge and misconceptions
    - Links between knowledge, norms and practice

Responses from the participants are included to illustrate findings and justify the analysis. Direct quotations are presented in italics.

4.2 Effects of Migration

4.2.1 Push and pull factors (reasons for migrations)

French speaking refugees' decisions to migrate to Durban are a result of socioeconomic factors. The majority of respondents indicated that war, and limited economic opportunities were the main reasons that pushed them to migrate to Durban, South Africa, *"I came to South Africa because rebels were killing and raping women and girls in our village."* Another participant added, *"I came to South Africa because there are more job opportunities here than in Congo. Here I thought I can work and improve my life and the life of my family but things are not moving well."* Most French speaking refugees from Bukavu/DRC living in Durban indicated that they came to Durban because they knew someone who lived there or they had heard that the living conditions were better, *"I have a friend here in Durban. I called him and he encouraged me to come to Durban. I came here but I can't find a proper job. I am only working as a car guard."*

Social networks are an important factor that permit French speaking refugees from Bukavu to integrate in Durban, *"My brother introduced me to a security company where I am working.*" Political and ethnic conflict, and economic reasons are the primary factors that pushed French speaking refugees from Bukavu to Durban, and social networks facilitated the process. The relevance of social networks are discussed in further detail below.

It also appears that French speaking refugees from Bukavu living in Durban came to South Africa with the idea of moving to another developed country, especially the United States of America. As one respondent stated during the focus group discussion, *"If the government of South Africa is not able to take care of refugees, it should let us go to America. I will try to go to other countries. Life is so hard in South Africa."* Durban has been seen as a destination for French speaking refugees who wish to stay in South Africa for a short period before proceeding to other countries. They wish to either move to another country or return to Congo, as one female participant stated during her

personal interview, *"I wish to relocate to America or go back to my country. My husband left me with three children without a job."*

4.2.2 Relocation difficulties

French speaking refugees from Bukavu who fail to cope with the difficulties of their living situations in Durban decide to relocate to other provinces of South Africa as this female participant stated during the focus group discussion, "*Next month I am going to try if I can get a job in Johannesburg. My friend who lives there told me that he can help me to get a job in a hair salon*". Another young female participant added, "*If I won't find a job I will go back to a refugee camp in Namibia, Mozambique, Botswana or Zimbabwe*".

A young married women stood up and said: "*You don't know what you are saying. Do you know the sufferings that are in a refugee camp? For me, I rather do all my best to go to Europe, America, Australia, or Asia where legal, social and economic conditions are better than South Africa. My sister who had an opportunity to be resettled in America from refugee camp in Mozambique told me that refugees are well treated there and they get jobs easily."*

From the above statement, it appears that French speaking refugees living in Durban are still in contact with other refugees who live outside Durban and South Africa.

4.2.3 Economic challenges

4.2.3.1 Poverty and social exclusion

In this study, social exclusion involves a lack of entitlement to social-economic basic needs. These include access to employment (in informal and formal sectors), health care and social services, education, police protection, and equal status before the law (Baruti, 2006). With regard to employment, which, in many cases facilitates the integration of foreigners in their host country

and affords them independence and dignity, the general perception of participants showed that DRC refugees feel excluded from the mainstream economy:

"I became a trader because I did not have an opportunity to work in my field. I am a trained nurse with more than three years work experience but I have unsuccessfully applied for a South African Nursing Council registration number for nine months. I have not yet got my trading licence. Every day the police take away my clothes and shoes that I am selling in free market." (Female Respondent).

Respondents believed that the Department of Home Affairs is responsible for the social exclusion that they are facing in Durban because it did not provide them with the correct identification document (ID) and that this has barred them from education and employment. One of the respondents stated,

"*I know it is the department of Home Affairs that is playing this game of giving us inappropriate identification documents which do not allow us to get the trading permit, work, study, or open a bank account. South Africa government doesn't like us here. They should let us go to America.*"

Participants also stated that poverty was a risk factor for HIV infection as narrated by one of the women participants during her personal interview, *"We know about HIV but... what can we do. Life is so hard in South Africa. Women are forced to exchange sex for money or service."* Another participant added, *"Ah, ah life is so hard in South Africa. We are in a foreign country, we have to take what is available to us we don't have a choice."*

All participants in this study indicated that their monthly income is not able to sustain them or cover their basic needs as illustrated below,

"*My salary is not even able to cover rent. We are sharing a bachelor flat with two families. It is not easy, it is a source of conflict especially between us women and children. It is difficult to get a job as a refugee."*

Research in South Africa has found that unemployment, overcrowding, general poverty and low levels of education seem to be associated to lower levels of knowledge about HIV/AIDS and higher levels of adolescent sexual activity (Preston-Whyte & Zondi, 1991). Poverty is often the main reason for women experiencing harsh economic circumstances to agree to sexual relationships with men in exchange for money (Adams & Marshall, 1998). This exchange of sex for money or various gifts sometimes happens without condoms if the man offers more money (Adams & Marshall, 1998). It appears from the above, that the risk of future illness is not prioritized as highly as fulfilling immediate economic needs especially where resources and opportunities are scarce. Migration and economic factors affecting the research population are apparent in their influence on HIV behaviour. Whitefield (1999) in his research on high school learners found that adolescents with lower socio-economic status (SES) experienced far more physical abuse and rape and attempted rape within relationships than adolescents with high SES.

4.2.3.2 Income generation and job stress

French speaking refugees economic well-being differs according to the limitations and opportunities that refugees face at a specific time. The interviews and focus group discussions made it clear that the types of income earning activities that participants were involved in depended on social ties and networks that they established on their arrival. Congolese refugees take any opportunities they can in order to build their livelihoods,

"We are in a foreign country, we have to take what is available to us we don't have a choice. I didn't know that one day I could be a security guard because I finished university back home in education. Many women and girls have become prostitutes because of the hard life in South Africa."

The focus group discussions and interviews revealed that French speaking refugees from Bukavu living in Durban are mostly active in car guarding, shoemaking and repairs, hairdressing, informal

prostitution and child care as these seem to be sectors in which they can most easily get a job to survive.

The majority of participants described their work environments as stressful, leading to high levels of anxiety, distrust and feelings of helplessness arising from the view that they lacked control over their futures. They felt stressed as illustrated by this young security guard who said, *"Back home, security guard jobs are done by old uneducated people but in South Africa either you are young or educated you are forced to do this kind of job because you have no other option."* Another young security guard added,

"This job is very stressful; people think we are street people and thieves. The money that we get is not even able to pay our rents. I wonder how married people manage to pay their rent because us single young people we are sharing a room for four to six people."

Another young male participant, who cuts hair, stated,

"It is difficult to get a job as a refugee. I think it is easier to start up your own business than getting a job with employers. It is very difficult for employers to hire a foreigner. You need to show some paper work which will not be easy in our case xenophobia is even in the institution level."

Many refugees are not happy with their stay in South Africa; they say that they are being treated unfairly by the people and the government. They are deprived of basic human rights because they live in flats where the conditions are not suitable for them to raise families. In this study, for example, participants said that it is often possible to find four families staying in a two bedroom flat. This creates conflict especially in terms of sharing resources like water and electricity since many of the occupants are unemployed.

4.2.4 Psycho-social challenges

4.2.4.1 Mental health status

Apalata, Kibiribiri, Knight & Lutge (2007) have stated that many refugee women who have fled from war may have been victims of rape and witnesses to their children's abuse, exploitation and malnourishment and could be more susceptive to the disease during the process of displacement. Venema, Garretsen, & Van Der Maas (1995) also indicated that even when migrants feel they are better off in their new situation than in their original homes, their socio-economic status in the new place is still usually lower than that of the resident population. Participants in the present study reported that life in the DRC pre-migration was easier than the life they now experience in South Africa as they discuss how they were able to live off natural resources and could therefore be self-sustaining. They spoke about their big houses with spacious rooms and a time when they still had privacy. However, their post migration experience in South Africa has been very different and their expectations have not been met. The refugees now face distrust, limited housing, lack of privacy, scarcity of resources, and poverty resulting in a feeling of hopelessness. All participants reported feelings of frustration. They felt frustrated over their occupational prospects because struggling had made them lose hope for future accomplishments. The participants increasingly doubted their own ability to succeed in South Africa, especially with today's competitive job market and the increase of anti–immigrant feelings. Some participants attributed this situation to their personal inability to achieve professional success in South Africa as mentioned by a young married man participant,

"*Our wives will run away from us because we are not making any progress financially. You are a man but you are not able to provide for your family. The girls in our community want guys who have a good job, and who makes good money.*"

Many young married male participants reported feelings of depression. They understood that they would not be able to fulfil their dreams of material success, which in many cases was their original

motive for immigration. They considered themselves failures and incompetents. A 32-year-old car guard commented,

"*I am so depressed at this time. I have a bachelor degree in accounting and I was working as a financial manager at a big company back home, so when I came, I was looking for that kind of job over here. But I could not find it. Because you have to go again to school to get that kind of degree and then only you can a get a good job over here.*"

Data showed that women participants felt the same; as this women shared, "*At home I was a school teacher but here I am working as security car guard. I know it is the department of Home Affairs that is playing this game of giving us inappropriate identification documents which do not allow us to get appropriated job."*

French speaking refugee women particularly experience great psychological suffering for the following reasons: their daily experience of isolation within their homes; the lack of opportunity and employment; and the long periods of time being left alone to think about ones dire situation only compounds the psychological difficulties in living that daily reality.

Participants in this study indicated that the main stressor is low income and not being able to meet basic needs. As participants have indicated, "*Our salary is not even able to cover rent. We live in shared accommodation."* Lazarus & Folkman (1984) have indicated from a stress theory standpoint that life events necessitating migration and daily migration-related hardships, including being forced to deal with constant changes, deplete social capital. Further, cross cultural interactions in a foreign environment are also very stressful. The risk of HIV is therefore just one of many stressors experienced by migrants. Further, these are accompanied by low coping resources and a very limited sense of control. Social support is often also limited and in some cases can be inappropriate to the migrant's new context. All these factors increase the immigrants' risk of exposure to HIV and their ability to cope effectively. The authors further indicated that, the road from social capital to personal risk may exceed economic barriers and involve migration-specific psychosocial stressors. These stressors together with limited personal resources further effect

migrants accessing health care and prevention programmes. This, in turn, can affect later sexual behaviour. Kawachi & Berkman (2000) concluded that attending to economic barriers alone is not sufficient and that efforts need to be made to overcome the variety of barriers that prevent less integrated populations from accessing necessary services. On top of limited social capital and cultural alienation, migrants also often experience racism, discrimination and stigmatisation. Such reactions can operate as increased risk factors for immigrants, like refugees from Bukavu who came from a low HIV prevalence country to a high HIV prevalence one.

4.2.4.2 Tension between refugees and locals

As highlighted above, French speaking refugees from Bukavu face various issues of a social, political, and economic nature in Durban. On the social front, French speaking refugees in Durban live in isolation from other groups. They live in shared flats and rooms with their countrymen. They very rarely socialise with the local South African community or other refugee communities as their social networks rotate around their own community, *"I have no social interaction with South Africans because we can't hear each other but also because they don't like us. They call us Makwerekwere."* This can partly be attributed to their inability to speak local South African languages as they speak mainly French, Swahili and other dialects spoken in DRC. Therefore, this has prevented them from participating in the social life of other communities.

French speaking refugees from Bukavu living in South Africa face discrimination and stigma from the local community and they feel that many South Africans misunderstand and don't like them:

"Everywhere we are called makwerekwere. You ask for a job they ask you to bring green ID which we don't have because our IDs are red. They think that we are here because we are poor in our country. They tell us that we came to take their jobs and their wives."

The attitude of locals towards foreigners was reported to be comparatively better in Congo than South Africa. French speaking refugees from Bukavu stated that they treat their guests better than

South Africans, *"In Congo we consider foreigners as angels of God that bring blessings to the country."* The respondents believed that their good social interactions back in Congo help create the transparent social networks that exist between them,

"Here everything is measured in terms of money. In Congo you respect your guest and the treatment you offer is in no way related to what you might gain from the friendship. But South Africans expect some kind of monetary benefit from friendship."

Some participants communicated their discontent with the ways in which they were treated by South Africans. They explained that some South Africans intimidate migrants and believe that they are superior to people from other African countries: "*South African think we are stupid because we can't speak their languages."*

French speaking refugees not only have limited contact with the local South African community, but also non-governmental organisations. Participants said that they have not been in contact with any organisation that works with refugees in South Africa. They stated that their only contact was with the government through contacting the Department of Home Affairs,

"It is strange that in this country I have not seen or heard of any organisation that works with refugees. Our relationship is directly with the South African government. I have never heard of any United Nations organisation concerned with the issues of refugees in South Africa. At home affairs they just give you a refugee permit and that's all."

It became apparent from the early discussions and interviews that there is very little in the way of bridging and linking social capital and this greatly limits opportunities in the refugee community. This is one of the reasons that this research is focussed primarily on the bonding level, however this does not take away from the significance of understanding the impact of bridging and linking social capital with refugees and in relation to HIV, especially in terms of an ecological perspective. Further research in this regard would be highly recommended.

4.3 Linking migration to social capital

4.3.1 Importance of social networks

Social networks are very strong in the Congolese community. They link Congolese refugees to their home country. All participants were in regular contact with their families in Congo by telephone, e–mail, or by sending gifts along with others going to visit Congo. *"I know what my family is going through in DRC. I cannot abandon them. I sent them some money or other gifts like clothes or shoes to help them."* All participants trusted in their families' care. Family for participants does not mean only parents and biological siblings but also extended family members like grandparents and cousins. "*My mother died in the war but it is my responsibility to take care of my father, sisters and cousins" (Participant B).* Participants displayed a strong sense of responsibility and were committed to financially helping their families that they had left behind. Maintaining links with family and home gave participants a sense of purpose and contentment. In this way they felt closer to their families despite geographical separation. Cultural norms and strong family values worked to strengthened their will to make correct decisions. *"Here, I think a lot about my sister in DRC. I want to see her getting married. I am saving money for her. I don't want to mess up with girls her*", said a security car guard worker, aged 35.

Congolese social networks also provide important information for migrants. Information about migration costs and routes, initial options for accommodation, employment opportunities, and other techniques for survival necessary during their stay in a new country (Amisi and Ballard, 2004). When Congolese refugees first arrive in the country, their initial instinct is to find people who are also from the DRC. They identify them by language, hairstyles, clothing, appearance and a way of walking. The quote below provides an example of what happened to a participant on his arrival in Durban. It shows how reliance is placed on social networking with people from their home country and speaking the same language, in this case, among hairdressers from the Congo,

"The taxi dropped us at Umgeni Road. I had no valid permit, I looked around and asked a black lady where I could meet the refugee population. She told me to walk along Umgeni Road and ask

people inside tents who were cutting hair. I saw a tent and people speaking Swahili...luckily they were from Bukavu, they took me home, gave me food and found a job for me."

This is an example of social capital operating as a protective factor among French speaking refugees' living in Durban.

4.3.2 Impact of social support and relationships

The participants identified peer social support as the type of social capital resource most influential on their coping responses to stress. Their peers were primarily Congolese who were a similar age, generally from the same place (Bukavu), and often from the same occupation. These relationships generally started with introductions from shared friends. Participants spent time with their peers after work, during weekends, during off days, meeting at bars, or at one another's flat.

Trust, norms, social networks and reciprocity were the most valued characteristics the participants found in social support from their peers. The majority of participants reported trusting peer relationships, *"I like to share a flat and my problem with someone who can help me."* They shared their personal problems with others who had been through similar experiences. Peers and friends were a source of information and social support. They helped with daily chores like shopping, gave information about transport, and helped with job-related skills, such as helping others learn English to communicate with customers (owners of cars that they look after). A 32-year-old car guard said, "*My friend took me to movies and to English classes to learn English. He told me even if you don't understand, keep continuing. So now, I am learning English."* Closeness also fostered trust in peers for practical advice on personal difficulties. *"My friends understand me because they are also in the same situation*", commented a hairdresser, aged 27.

Participants identified reciprocity as vital to peer relationships. These offered feelings of "togetherness" and the expectation of reciprocal aid, "*I am grateful to what my fallow refugees from home did to me. They gave me food, clothes, place to sleep, and connected me to the security car guard that I am doing. I will do the same to the new comers.*" A 31-year-old house keeper said,

"I'm little scared because if I get sick, you know, I have to go to the doctor myself but I know that one of my friends can come with me?" A 32-year-old hair dresser added, *"Your friends can help to take you to the hospital but refugees talk too much!"*

Overall, responses from participants revealed that social networks play a key role in the Congolese refugee's lives. They serve as a buffer to social exclusion and help with the daily frustrations that refugees are confronted with in Durban. French speaking refugees also form a social network that protect each other in times of unforeseen and difficult events such as illness, death or being arrested by the police. Congolese refugees' networks that have been established in Durban stem from the networks from their home country where governments were unable to provide for the basic needs of citizens. Congolese have had to rely on their social connections in both the informal and formal sectors of the economy so that they can earn a living (Amisi & Ballard, 2004). Religious connections also play a crucial role in refugees' Congolese life, *"When I came to South Africa, I had no place to sleep, I spent six months sleeping on the floor in the Church and my brothers in Christ find a security job for me.*" Another Muslim participant said: "*My friend took me to the mosque and after prayer they gave me clothes, shoes and food."*

The social groups that have formed strong connections and cooperation between French speaking refugees living in Durban of the same status, appears to have been enabled by the homogeneous nature of people living in the same area and coming from the same province. Participants in the study reported that they experienced many psycho-socio-economic problems that they were not capable of resolving without support from each other. This meant that French speaking refugees who knew and also trusted each other formed social groups or networks to provide support to one another, *"We pull our efforts together to support each other because we do not have support from any organisation"* (Young female participant). Bonding social capital therefore improved reciprocal relations and social support.

In general it appears from the data that social networking and social support have a positive impact on the life of the research participants. Social networks play a key role in Congolese refugees' lives and serve as a way round the social exclusion they otherwise face in Durban. As discussed, this is

supported by research which stresses their importance as creating a social net against unexpected and difficult occurrences like illness and death (Amisi and Ballard, 2004). Given the fact that most Congolese refugees are without legal access to any form of employment or trading licences because they are unable to access work permits which require a South African identity document, Congolese refugees need support from each other in order to make a living and to access the most basic needs. This indicates that social capital on a bonding level, supporting each other within their community, is vitally important to migrants and refugees especially when they first arrive in a foreign country. However, data showed that participants in this study felt they needed to return favours by providing sex as illustrated bellow, "*This country is forcing us to do what we did not intend to do. If I ended up falling in love with him it because he supported me so much when my husband rejected me with three children."*

4.3.3 General lack of trust in the community

Despite the high levels of social support mentioned above, during the interviews participants frequently mentioned a lack of trust within the Congolese refugee community in Durban. This lack of trust may stem from the ethnic and political conflict and successive wars in the DRC as well as the social exclusion that they face in South Africa. This situation has caused the respondents to be suspicious about everyone including the networks on whom they are dependent for survival. Mistrust among French speaking refugees is illustrated by this participant's response during focus group A,

"*I will not trust anybody anymore. One of my flatmates from the DRC sent a letter to my father telling them that I had become a drunkard. He said that the only thing I am doing in South Africa is to drink beer and go out with Zulu girls. Therefore my friend advised my parent to not send me money anymore because I could not use it to study. Then my father and the whole family believed him and became angry with me and changed their mind. Can you understand those lies? I have tried my best to explain and convince my parents but they refused. My parents dropped me because of my friend…Can you imagine that?"*

Interviews revealed that the behaviour described by the participant's friends is similar to that of many other refugees. This behaviour may be explained by the frustration, disappointment, and lack of hope in a positive future and by the loss of, "old values and norms about essential issues such as the relationship between husbands and wives" (Turner, 1999, p. 9). Consequently, many Congolese refugees become involved in drinking and drug use and sometimes violence to help them to forget their circumstances in Durban (Baruti, 2006). In cases where husbands are not able to continue supporting their families, informal divorce is frequent. Further, some married individuals have to get involved in informal prostitution as the only way to make a living as this woman participant stated during the interview, *"My husband abandoned me with four children without job, how do you thing I can pay my rent or take care of my children. This country has forced us to do what we did not intend to do."*

Many Congolese refugees also do not trust people from other nationalities which may be the result of bad past experiences. Refugees have, in many cases, fallen victim to criminals who robbed them of personal belongings and money during their travels from the DRC. For example, this young male participant stated during the focus group discussion,

"Mozambicans are thieves, when we were coming to South Africa, Mozambicans polices arrested us because we had no visa and took all our money and left us in the road. Then one Mozambican guy offered to guide us by bus to the South African border without travel documents. We agreed and trusted him, he took our bags and he promised us he would sell our clothes and bring us back the money but he run away."

Data showed in my interviews and focus group discussions that experiences such as the one explained above have made refugees very cautious of trusting others. Congolese refugees have also had a bad experience of mistrust toward South African nurses as one female participant illustrated, *"I don't trust these nurses and their medicine. If you can't speak their languages they treat you like you are not a human being."* The above statement may be due to the fact that French speaking refugees in Durban cannot speak, or hear English or IsiZulu, the languages most commonly spoken in KwaZulu-Natal.

Trust has been described by Fukuyama (1995) as the expectation that arises in a community where there is regular cooperative and honest behaviour between members which is based on commonly shared norms. Social trust refers to the extent to which individuals believe that others mean what they say and will act accordingly. Social trust is very important in order to understand social capital in that it symbolises a relationship of reliance since it is easier to influence someone that you trust or who trusts you. The idea of trust is used to be able to predict acceptance of behaviours by individuals, community members, civic society and government agencies (Leachet al., 2002). Therefore, trust is one of the main elements that sustain social capital between and among people and groups facilitating cooperation and coordination for mutual benefit (Putnam, 1995). As a trusting relationship develops inside a network, actors build up relations of trustworthiness that may become important information for others in the social network (Tsai & Ghoshal, 1998). The element of trust will be considered in further detail below in regard to its impact on HIV risk and protection; however, it appears that these underlying issues of mistrust among community members and between refugees and South Africans may also play a significant role affecting trust within relationships and towards perceptions of HIV.

4.4 Social capital and HIV risk and protection

4.4.1 Trust and mistrust relating to HIV risk

Within communities where people are affected by HIV, trust may diminish stigma and discrimination and encourages those infected to disclose their HIV status which in turn helps them to access HIV Counselling and Testing for their benefit. Research has also shown that high levels of trust among partners may lead them to have unprotected sex (Fukuyama 1995). It appears from the literature that trust may generally be seen as both a supportive and protective factor in sustaining a supportive environment for a community and in relation to HIV; but may in some circumstances add to risk where “trust” results in unprotected sex in relationships (Posner, 2000). In this research, trust was found to be another risk factor for HIV transmission among both married men and women, and single men and women in the research population. This has been shown in

the responses of participants during their semi-structured interviews and in the discussion in the focus groups. One married male participant during his semi-structured interview said, *"I only have sex with a woman that I trust. I look at her physical appearance; if she looks healthy then I know that she does not have HIV."* Another single male participant said, *"I can't use condom with my regular partner because I trust her."* Similarly during the focus group discussion, this single young male participant said, *"I double condoms when I am having sex with South African women but for Congolese women I trust them and I don't use a condom because they don't have HIV."* A young single female participant said, "*I don't trust condoms because the use of condom is not part of our culture. I wash my vagina with hot water after having unprotected sex in order to kill HIV virus."* Trust between married couples also raised various risk problems, especially for females. A married female participant said,

"Asking your husband to use a condom is to disrespect him and it shows lack of trust. If you ask your husband to use condom, he can ask you where did you learn about condom and you can be in trouble."

Another participant said, *"If people see you with condom they can think you are a prostitute."* However, during the focus group discussion a male participant also noted the difficulty of using condoms in a relationship, *"For other women and girls who are not my regular partners, sometimes I do use a condom but with my own wife I can't use a condom because my wife trusts me and I can't compromise her trust."* Respondent "D", a male, replied*, "I trust my wife and she trusts me too. Why should I use condom for a wife that I paid lobola for? If you keep on using condom regularly it will reduce your sexual power."* The consequences of such a belief was demonstrated by the response of one married women "C" during her semi-structured interview who said, "*I had unprotected sex with my husband before we got married because I trusted him but now we are both HIV positive including our first child."*

Stanecki and Walker (2002) indicated that in sub-Saharan Africa the majority of newly HIV infected women contracted the virus from their husbands within marriage. Involvement of women

in transactional sex for survival may also result in transmitting the virus to their husbands. For example, a female participant in the study indicated during her semi-structured interview,

"I don't think faithfulness can work in a couple where the husband is not able to provide for the needs of his wife. In South Africa life is so hard for us; this life is forcing women to exchange sex for money."

This may be due to the fact that all females' participants in this study were not working. They were depending on income from their husbands and boyfriends.

Mistrust is regarded as a lack of trust or confidence resulting from suspicion (Organization for Economic Co-operation and Development, 2001). Lack of trust in the DRC refugee community, as discussed above, may be rooted in consecutive wars due to political and ethnic conflict in DRC and the way they are treated in South Africa. During interviews with participants they frequently mentioned the lack of trust among themselves and the lack of trust between themselves and South Africans. Mistrust in this study was the main cause for high levels of stigma and the reason for not going for HIV Counselling and Testing within the sample population. This is regarded as a risk factor for HIV prevention. During the focus group discussion one participant 'A' said, "*I don't trust refugees. They talk too much and they may disclose your HIV status and you will die with shame."* Along similar lines, respondent 'C' said, *"I don't trust anybody, people talk too much; you never know; people can disclose your HIV status and the community will reject you or gossip about you."* Another participant 'F' said,

"I don't go for HIV testing because I don't trust those nurses I tested for myself and my blood still red which mean that I don't have HIV. I know that South African black people don't love foreigners they may put HIV in your blood."

Respondent 'D' continued to say, "*I never go for voluntary counselling and HIV test in South Africa because of language barrier and I don't like to take interpreter from my community when I want to go for HIV test or counselling because I don't know their heart."*

Further, in regard to condom use, participant 'G' said*, "I don't trust condoms, I heard that white people put a product inside to make black people sexually weak and not be able to have children."* Reinforcing such message to each other may increase their risk of infection.

According to Mosoetsa (2004), lack of trust among community members may lead to the breakdown of social cohesion in most communities. Mistrust has hindered refugees from going for HIV Counselling and Testing because they believe that the nurses or counsellors will inject them with HIV virus and that their fellow community members will gossip about them. Participants said during focus group discussions and interviews that they don't like to use friends in the community as interpreters because they don't trust them and they think that they will tell everyone about their HIV status, *"Refugees talk too much, you never know they can disclose your HIV status and you will be in trouble. My friend no longer comes to Church because the prophet disclosed his HIV status" (FGD).*

Stigma and discrimination are among the top obstacles to effective HIV/AIDS prevention, treatment, care and support (Bond, Chase & Aggleton 2002). Stigma consists of the social expression of negative beliefs and attitudes that contribute to processes of marginalisation, isolation, rejection and the harm of others (Skinner & Mfecane, 2004). Birdsall and Kelly (2005) argued that people with HIV/AIDS may be suspected by others as "contagious" and this leaves them feeling rejected and undesirable which could lead to withdrawal and isolation. In the study population, it emerged from the findings that stigma and discrimination are rooted in the community-level knowledge about HIV. This was illustrated by participant "C" during the focus group discussion when she said, *"I can't sleep in the same bed or shake hands of an HIV positive person."* Akintola (2005) also affirmed that stigma and discrimination are some of the major challenges in combating HIV/AIDS.

4.4.2 The struggle for reciprocity and HIV risk

Dickhaut and McCabe (1995) refer to reciprocity as the type of social capital that is rooted within personal relations whereby one gives to someone else expecting returns at an uncertain future date.

Although Onyx & Bullen (2000) found that in a community where reciprocity is strong, people care about each other's needs and interest, in communities where people struggle to meet even their basic needs women and girls are often forced to exchange sexual services to secure these basic needs.

The interviews and focus group discussions in this study showed that the majority of people who participated in this study were struggling to meet their basic needs which were interpreted as leaving them with little choice. As this participant said, *"what else can you do if your boss insist to have sex with him or to quit the job. Life is imposing women and girls to do what they don't like."* Another participant added: *"Men in these no longer give anything for nothing, my mother told me to be careful about them but what can I do if my parents are not able to meet my basic needs.*" Poverty is frequently the reason why women have to trade sex for money (Adams & Marshall, 1998).

The above situation is not exclusive to woman. A young male participant indicated during his personal interview that men are also facing the same challenges as women. He shared his personal experience and said,

"At the car parking where I am working as car guards, many men ask me to have sex with them. In exchange they will change my life, they will help me to go back to school or do a good business."

This story was confirmed by many participants during focus group discussions as illustrated by this statement, *"these days things have changed. Even men are getting married to other men, at work we are approached by other man to have sex with them to get money or a job (hahahaaaa!)"* Participant E (FGD). The above expression of astonishment may be due to the fact that the majority of participants belonged to a religious group and come from a region where such a form of marriage is considered socially unacceptable. This, as discussed, was confirmed in the literature by Onyx & Bullen (2000) who found that in communities where people are having difficulties fulfilling their basic needs, women and girls often have to exchange sex for financial support.

During focus group discussions and interviews, the majority of participants stated that they cannot accept to die alone once they contract HIV, "*I cannot accept to die alone with HIV, I must give it to another person because they gave it to me too."* Such a belief may be rooted in their own interpretation of the old testament scripture in the Bible as the majority of participants' agreed, *"Even the Bible said eye for an eye and tooth for a tooth."* Carrying out such a belief would clearly operate as a risk factor for HIV prevention among the refugee community.

The study indicates that reciprocity takes on a more complex meaning in a under-resourced setting and is supportive of the view that an ecological perspective is necessary to try to begin to understand the give and take in social relationships and their impact on HIV in such circumstances.

4.4.3 Social networks and HIV support

Coleman (1990) stated that social networks are one of the most important aspects of social capital because the flow of information within and between groups facilitates an informed action that an individual can use as a source of support from members of those groups and networks. Campbell et al. (2007) mentioned that the networks obtained in bonding social capital may allow safe spaces for dialogue, promote responsibility for the HIV epidemic and empowers one with a sense of responsibility in relation to HIV prevention.

Lin (2001), argued that the flow of information about HIV may be much stronger within groups than between groups. In contrast, in response to the question about whether participants were able to freely talk about HIV in their relationships and among family and friends, participants responded as follow, *"We are afraid of talking about HIV" (FGD).* Another participant said, "*You can't talk about HIV with your partner he can think you are a prostitute" (FGD).* Another women participant added, *"You can't talk about HIV with your friend because your friend may suspect you and think that you are HIV positive and exclude you in the group" (FGD).* In response to the question to whom would you disclose your HIV status, participants responded*, "I don't trust refugees; you never know people can disclose your HIV status and the community will reject you and gossip about you."* Participants continued to say, '*I prefer to not know my HIV status because if I test HIV*

positive I can die quickly or kill myself. I know there is no cure for it, there is no need for me to test HIV." Previous research has shown that fear associated with stigma reportedly affects a range of risky HIV health behaviours: individuals' decisions not to access HIV Counselling and Testing (Day et al., 2003; Kalichman & Simbayi, 2003), HIV-positive individuals' poor adherence rates to ARV therapy (Weiser et al., 2003), poor safe sex behaviours (condom use) (Volk & Koopman, 2001), and increased risk of mother-to-child transmission (Thorne & Newell, 2003).

However, Campbell et al. (2007) mentioned that high levels of trust among people within the same group may lead them to disclose their HIV status to one another. The above research showed that high levels of trust also may lead people within the same group to engage in more risky sexual behaviour and therefore increase their vulnerability to HIV infection. On the question "have you ever used condom with your regular partner" during personal interviews, participant 'D' replied, "*I can't try to ask my partner to use condom, he can think I don't trust him or love him."* A risk potential linkage is a bond between two people that can lead to the spread of infection if the infectious agent is present. For HIV infection, risk-potential linkages are for example having sex together. An example of this for sexually transmitted diseases for which condoms offer effective protection would be to look only at sex without a condom as defining a risk potential linkage. Research has shown that presenting condoms in a sexual encounter is seen as breaking the intimacy and spoiling the romance of the situation (Meyer-Weitz et al., 1998; Wood & Foster, 1995). Men and women both believe that condoms are associated with promiscuity, HIV and other STDs; so that proposing the use of condoms suggests either that one mistrusts their partner or has an STD (Meyer-Weitz et al., 1998; NPPHCN, 1996; Richter, 1996). It is also commonly assumed that long-term and loving relationships involve less risk. This is the case even when a partner's HIV status has not been disclosed. Condoms are therefore used mainly for casual encounters or "secret lovers" rather than with one's regular partner (MacPhail & Campbell, 2001).

Even though generally there appears to be strong social support within the refugee population (as is evidence above with members of the community generously helping others who arrive from the DRC to find accommodation and work); this support appears to weaken in relation to HIV and is closely inter-related with issues of trust and mistrust. It will be discussed in further detail below

that there are strong taboos against talking about sex and this seems to be the case both in close groupings and in the wider community. Holding such a position leads to a lack of communication and support in an area where it is well needed and also fuels stigma and discrimination. Close links are apparent also between the operation of social norms and the type of social support that is considered appropriate and therefore cannot be studied in isolation.

4.4.4 Social norms and HIV behaviour change

According to Putnam (1995) and Colman (1988), social norms are commonly perceived as a way to decide what models of behaviour are expected in particular social contexts and the types of behaviour that would be approved of socially. Social norms are further conceptualised as implicit and explicit rules that a community uses to determine appropriate values, attitudes and beliefs. They are also seen as customary rules of behaviour that manage our interactions with others. Social norms play an important role in maintaining social behaviours even though they also present barriers to behaviour change (Bettenhausen & Murnighan, 1991; Coleman, 1990; Myers & Bishop, 1970; Newcomb, 1958; Tittle, 1977). Studies have shown that changing social norms is an effective way to produce sustained behaviour change at a social level. Altering, for example, the culture of love of dry sex and refusal to use condoms among the refugee population could function as a protective factor for HIV prevention. Even though changing social norms has been found to be difficult, once new norms have been established they are generally self-sustaining (Zucker, 1977).

During focus group discussions and interviews all participants in this study expressed the love of flesh to flesh dry sex and the culture of not using condoms, *"Condom use is not our culture, I love flesh to flesh dry sex"* (FGP). The study showed that after a particular way of doing things becomes recognised as a rule, it usually then continues in force as it is desirable to conform to a rule when there is an expectation that other people are also going to conform (Posner, 2000). Altering norms in order to encourage the use of condoms, however, can be difficult in cases where talking about HIV and sexual behaviour is generally considered unacceptable. Participants in this study during focus groups discussions and in interviews indicated that public discussion about issues related to

sex is a taboo. This was illustrated in the following statements*: "In our culture it is a taboo to discuss in public about issues related to sex. I can't talk about HIV because people may think I have it" (Participant A, FCG)*.

Smith et al. (1999), in a study involving drug users in Baltimore where HIV is not often discussed, have found that changing norms may be a relevant strategy for HIV prevention and control. When HIV was discussed, it was usually in the form of rumours regarding people being infected. Such a lack of discussion often leads to situations where people become hesitant of talking about the topic as they are afraid that others will find it socially unacceptable (Noelle-Neumann, 1977). Communication between partners about condom use and STD risk has been found to be strongly associated with readiness to use condoms. Discussion about condoms, however, is not easy and conversations are often difficult and limited (Meyer-Weitz, Reddy, Weijts, Van den Borne, & Kok, 1998). Similarly, the culture of not talking openly about issues related to sex is seen as a risk factor for HIV prevention among the research population. Such lack of communication is discussed in more detail below.

Airhihenbuwa & Obregon (2000) mentioned that traditional African cultures are often patriarchal and can be oppressive towards females. Researchers on HIV prevention in Africa have demonstrated that when gender discrimination is culturally entrenched is can increase the risk of HIV infection for women (Ng'weshemi, Boerma, Bennett, & Schapink, 1997; Webb, 1997). Meyer-Weitz et al. (1998) mentioned that there is a belief that it is part of man's nature to desire many women, and therefore being with only one woman goes against his essence. While women in such relationships may be punished, often violently, if believed to be unfaithful (Mac- Phail & Campbell, 2000; Meyer-Weitz et al., 1998; Whitefield, 1999), their male partners in the relationship often claim the right to have many sexual partners (Meyer-Weitz et al., 1998; Richter, 1996). Where is there is such an uneven balance of power in the relationship, the woman's ability to exercise safer sex is inhibited by her partners stronger position. Many participants in the current study came to believe this, too as it is illustrated by the following comment made by a male participant, "*A man cannot be satisfied with one women."* Another female participant said, "*You cannot ask a man who paid his lobola for you to use condom no matter what."* The idea of a man

having unprotected sex with many partners is well researched in South Africa (Mac- Phail & Campbell, 2000). Generally in male dominated relationships the male partner controls sexual activity. This, together with a culture of violence, can then stop girls and women from insisting that condoms are used (Meyer-Weitz et al., 1998; Varga & Makubalo, 1996). Many people defend unprotected sex that is impulsive by arguing that sexual desire is natural and should not be controlled (Meyer-Weitz et al., 1998).

Culture plays a critical role in shaping the health of the individual and the family and, in turn, effects the whole community. This is considered especially applicable in the African context where the values of extended family and their community considerably influence individual behaviour. The way that an individual behaves in relation to the family and the community is believed to be a significant cultural factor that has repercussions for HIV prevention (Airhihenbuwa, & Obregon, 2000). In the refugee community many of the men and women are reluctant to use condoms because of the lack of knowledge about HIV. Men are believed to be dominant and superior because of culture and that makes women vulnerable since they are unable to negotiate condom use within and outside marriage. Many women also do not have any economic power and believe that they cannot take the risk of losing their partners, who in many cases are their sole source of financial support.

4.4.4.1 Lack of communication around HIV

In relation to communication around HIV, data shows that participants responses to the question how often do you talk about HIV and to whom do you talk to indicated that respondents found it difficult to talk to each other about HIV because it is a topic related to sex and also because it is considered culturally inappropriate. "*I can't talk about HIV because people may think I have HIV and they may reject me in our community",* (Married woman FGD). Another women participants added, "*In our family it is a taboo to talk in public about a topic related to sex, you can't even pronounce the term sex in our language it is a shameful term and disrespect to pronounce it; parents do not talk about sex to their children even if they are grown up, a women cannot carry a condom because she will be assimilated to a prostitute. If people can see you with condom they*

will say you are a prostitute." A male participant said, *"If I see my partner with condoms I can think she is a prostitute who know too much and if she ask me to use condoms I can think she doesn't trust me."*

This is also apparent form the literature in other communities. As mentioned above, Smith et al. (1999) found that HIV is infrequently discussed between drug users in Baltimore. When HIV was talked about it usually related to rumours about infected people. Individuals therefore found it difficult to bring up a topic that they believed others would find unacceptable (Noelle-Neumann, 1977).

4.4.4.2 HIV knowledge and misconceptions

As a result of lack of communication around the subject of sex, it becomes important to question the level of knowledge regarding HIV. Further, a lack of knowledge and misconceptions surrounding HIV came through strongly in the data. This section explores participants' knowledge of HIV in term of its transmission, prevention, and the way it contributes as a risk or protective factor for the sample population. Studies that have investigated the knowledge of HIV and perception of risk among international migrants found that international migrants have generally lower levels of knowledge about HIV and lower perception of self-risk for HIV infection than the general population (Crush et al., 2005). A study on awareness and behaviour related to HIV/AIDS/ISTs and sexuality among young people in a South African setting found that awareness and knowledge about these conditions were high, however, participants reported little or no change in behaviour that could lead to the prevention of these diseases (James, Reddy, Taylor, and Jinabhai, 2004). A study that investigated HIV risk behaviours among Ethiopians and Eritreans in the United States founded that participants were aware of HIV and its impact but some also believed that one could be infected through sharing crockery or touching an infected person (Beyene, 2000). Another cross-sectional survey of 748 migrants from five sub-Saharan African communities in London, United Kingdom found a low perception of risk among immigrants (Fenton et al., 2002). Peltzer (2003) stated, in a study conducted in Phalaborwa in Limpopo Province, that although rural inhabitants had a moderate knowledge of HIV, there were still many

myths and misconceptions about it. Similar findings regarding misconceptions and myths about the spread of HIV have been made in this study but there appear to be differences between male and female knowledge and understanding of the risks of HIV infection.

Young male refugees, both single and married, who participated in this study knew that HIV could be contracted by: having unprotected sex with infected partners, infected blood transfusions, an HIV positive mother to her unborn child, and by use of contaminated injection needles. They also stated that one could protect oneself from sexual transmission of HIV by abstaining from having sex, being faithful, using condoms, and being circumcised. However, data in this study also indicates that female refugees from the population sample had lower levels of knowledge about HIV than men. Single and married women's knowledge about HIV was not always accurate. As one of the women participants said during the focus group discussion, *"I know that people can get HIV through mosquito or touching an infected person."* Further misconceptions and myths about HIV were also founded among young women refugee participants in the study as illustrated by this young single woman during personal interview, "*After having unprotected sex, I run quickly in the bath room to wash my vagina with hot water to kill HIV virus.*" Another married women during focus group discussion said, *"I know that people can get HIV through mosquito."* Participant "B" during her personal interview said,

"I don't believe that an HIV positive women can give birth to an HIV negative child because HIV is in the sperm. Every month I test myself for HIV by putting my blood on a white paper and looks if it is black then I know that I am HIV positive."

Taking into consideration the above testing practice and misunderstanding of HIV prevention and the kind of impact that these would have on other individuals, especially in Africa where there is significant HIV denial and a lot of myths about HIV. Participants' knowledge (or lack thereof) about HIV in this study operates as a risk factor for HIV prevention among the sample population. Studies in South Africa demonstrated that the virgin cleansing myth (an incorrect belief that having sex with a girl virgin or child virgin can remove the HIV virus in the body) has caused innocent children and young girls to be raped and have become victims of HIV infection (Kawachi &

Berkman, 2000). Similarly, if this belief about self-testing and washing the vagina with hot water after having unprotect sex spreads, many people may adopt these practices and infect others and therefore contribute to the spread of new HIV infection in South Africa. These practices were mostly reported among woman. This may be due to the culture of women not talking openly about issues related to sex and their difference in power relations (the domination of men over women). This difference in power relationships is increased by the practice of paying "lobola" or "dote," a bridal payment, which gives the husband further power over his wife as he has "paid" for her. This was illustrated by the response of one male participant during the focus group discussion who said, "*In relation to sex, women have no choices; they must do what man asked them to do because we paid lobola for them."*

4.4.4.3 Links between knowledge, norms and practice

Although this research found that single and married male participants knew how HIV could be contracted and prevented, there was practically no association between HIV knowledge and the practice of safer sex in this study among single and married men. This research found that both married and unmarried young males were engaging in unprotected sex because they believed that circumcision could fully protect them from getting HIV, *"There is no need for me to use condom to protect myself from getting HIV because I am circumcised."* Another women participant said, "*All my sexual partners are from Congo, I trust them their circumcised I can't ask them to use condoms."* Although male circumcision has been shown to reduce HIV acquisition in men by over 50 percent in Uganda (UNAIDS, 2007), this does not give a hundred percent protection. Demographic and Health Surveys (DHS) which included HIV testing have found that HIV prevalence was lower among circumcised than uncircumcised men in Uganda and Kenya, but in Malawi and Lesotho HIV prevalence was higher among circumcised men (Mishra, 2006).

Further, despite knowledge of various facts regarding the spread of HIV as illustrated above, the study also found that there was also a low perception of risk of HIV infection and actual behaviour change in keeping with this knowledge. As this young single man indicated during his personal interview, *"I like flesh to flesh dry sex because it gives me more sexual pleasure.*" As has been

illustrated throughout, despite some knowledge of the protective value of condom use, condoms are often not used either because it decreases sexual pleasure, or because it may show a lack of trust in relationships. In many other cases condoms are not used because there is a perception that other Congolese people can be trusted not to have HIV, while this is not always the case with South African partners. This indicates a very complex dynamic in operation between knowledge and practice.

The DRC refugee community living in Durban is a religious community who, as a result, predominately believe that abstinence is the most acceptable form of prevention. Considering the data from the researcher's personal interview to get more insight into these aspects, he acknowledges that despite his level of study as a master's student with all his knowledge about family planning and knowledge about HIV prevention, he still struggles to believe in and practice family planning except for abstinence. His perceptions relating to various methods of contraception are strongly routed in his religious beliefs and culture. The issue that arises from family planning is that the power of the family is linked to the number of children one has, this is a symbol of a man's riches, esteem and honour in the community. However, this issue also has a religious component as the researcher's wife believes that she must not stop having children because it is a sin if one prevents reproduction. The same religion is shared by many others in the community where the research took place. Fear that others will find it unacceptable to use contraception may also lead people to have more children. During the interview the researcher himself stated that it is as a result of these beliefs and strongly held values that he and his wife have six children. Religion is a difficult and controversial territory to enter, however this study had not incorporated an in-depth exploration of the effects of religious beliefs but rather to understand how beliefs and norms operate as risk or protective factors for HIV prevention.

Strong cultural beliefs may also result in stigma and discrimination from other members of the community. For example, in the Congolese culture if other people find out that a few months after you get married that your wife is not yet pregnant, they start laughing at you and conclude that you are not a man according to their culture. If also they discover that you used any contraceptive method they consider you a killer and automatically exclude you from the group. Holding such

strong beliefs may lead one to having more children that you are able to support and also to expose people to HIV risk in cases where one of the couple is not faithful. It is well known that having knowledge about HIV and even the intention to behave in a protective way do not necessarily translate into safer practices (Beyene, 2000). This appears to be the same for many populations and is not necessarily different for the refugee community who are part of this research. However, it may be worth considering whether particular norms and values are held more closely by those who have been dislocated, as a way of holding onto home and culture. The answers to this have not come out clearly from the research but would need to be followed up in future research.

The predominant cultural norms in a community in relation to sexual health, sexuality, and HIV are significant factors relating to the spread of HIV (Decosas et al., 1995). Migrants are considered to possibly be at greater risk than others as they often keep their own cultural norms or can have cultural loss but do not always attain the cultural values of the new community at the same time. Depending on the level of cultural alienation and loss, barriers may be formed hindering participation in health services and programmes. This could result in extreme stress, confusion, or resistance to change that may, in turn, result in increased risky sexual health behaviours.

4.5 Summary of findings and discussion

Findings in this study confirm the complexity of issues relating to HIV prevention, care and support. It became clear that the answers are not simple. While social capital has been found to be a useful component in generating support in a community, binding relations and having an overall positive effect; it appears that the situation is not that simple. Having in-depth knowledge about HIV also did not lead to use of condom in the marriage. The elements of social capital (trust, reciprocity, norms and social networks) were all apparent in the community, particularly at a bonding level, but at times worked in support of members and at others appeared to work against them. This was especially the case in relation to issues surrounding HIV.

Trust, for example, appears particularly complex in relation to being both necessary for community cohesion but, in some cases, leading to risk where “too much” trust is expected, for example

between partners in a relationship. In such cases, partners may be expected to trust one another completely and therefore are not free to use condoms or to question their partners HIV status. A mix of trust and mistrust is apparent in the research community and it seems to operate differently at different levels. Even where so-called "trust" was operating between, for example, married couples, it often led to unprotected sex, operating as a risk rather than a protective factor. Perhaps this can be seen as a misconception about the nature of trust which should not be "blind" but rather enable discussion in relationships. However, both social norms and power relations seemed to work against the type of trust which facilitates communication, discussion and individual choice.

Reciprocity, too, becomes difficult because of low resources and appears to be used more as a tool or way of getting money out of necessity. In this way is may also operate as risk factor for HIV, rather than the usual supportive role it could provide. Social networks appear very strong generally and participants acknowledge the supportive roles played by members of their community in time of need. But, again because of various norms (for example, that it is taboo to talk about sex in public) members of the community are not always able to support each other in regard to HIV.

The study showed that in many cases there is insufficient knowledge about HIV and many myths and misconceptions, and even where there was knowledge in most cases behaviour or practice did not follow. For example, condom use was still low where participants knew they could prevent infection. Data from the study therefore indicates that it would not necessarily work to just do an intervention by passing on knowledge and information regarding HIV prevention. One would need to go deeper and consider the complexities, consider looking closing at the norms that are blocking communication and support in relation to HIV care and perhaps re-framing them in a different ways. For example, it may be necessary to consider the social norms relating to what it means to be a man in the community. Does this mean that it is necessary to have unprotected sex and many children? Or could it mean that that you are a man for looking after your spouse and family?

Overall, the data confirms that it is necessary to take a broad ecological perspective when considering HIV risk and protection. Social capital is clearly important but needs to be considered

in relation to the complexities discussed and, in doing so, can then add vital insight into the considerations of what will add value to intervention work with this particular refugee community. Both policy and interventions should take the complexities of the different contexts of refugees into consideration and develop tailored responses.

CHAPTER FIVE
CONCLUSION AND RECOMMENDATIONS

5.1 Ecological perspective

The overview of the existing literature shows that increased attention is given to the roles played by the social structural and environmental influences on HIV risk behaviours. The general understanding of HIV-risk behaviours has moved from an earlier focus on individual risk to ecological models with the awareness that behaviours are rooted in the economic, environment, and social structure (Waldo & Coates, 2000). Overall, the data in this study confirms that it is necessary to take a broad ecological perspective when considering HIV risk and protection. Social capital is clearly important but needs to be considered in relation to the complexities highlighted in the study in order to add vital insight into the considerations of what will add value to HIV intervention work with this particular refugee community.

5.2 Understanding the mechanisms of social capital

The focus of this study on understanding the mechanisms of social capital at a bonding level in relation to HIV prevention revealed that social capital is indeed important in the refugee community in general but that it can also operate adversely depending on the context in which it is operating. The interviews and focus group discussions made it clear that the types of income generating activities used by participants depend on social ties and networks that are established on their arrival in the new country. Social networks are very strong in the Congolese community as they link Congolese refugees to their home country. Congolese social networks also offer valuable information about costs, routes, jobs, accommodation and other information necessary for surviving in a new city.

Trust, norms, social networks and reciprocity were the most valued characteristics the participants found in social support from their peers. The social groups that have formed strong ties, cooperation and interaction between French speaking refugees living in Durban of the same status,

appears to have been facilitated by the homogeneous nature of people living in the same area and coming from the same province. Participants in the study reported that they experienced many psycho-socio-economic problems that they were not capable of resolving without support from each other. This meant that French speaking refugees who knew and trusted each other formed social groups or networks to provide support to one another. In general it appears from the data that social networking and social support have a positive impact on the life of the research participants. Social networks play a significant role in providing a reaction to the social exclusion refugees often face from the local community in Durban. This is supported by the literature which stresses their importance as they act as a social net against unforeseen hardships like illness or arrest by the police (Amisi and Ballard, 2004). Congolese refugees need to support each other as they are often denied access to the legal system and formal and informal employment or trading. It is difficult to obtain the necessary identity documents and trading licences needed to be able to make a living and to access basic needs. This indicates that social capital on a bonding level, supporting each other within family and community, is vitally important to migrants and refugees especially when they first arrive in a foreign country.

The data did, however, also show that participants in this study in many cases felt obligations to return favours and, without resources, this often meant returning favours by providing sex. Further, despite the high levels of social support mentioned above, during the interviews participants frequently voiced a lack of trust within their own refugee community in South Africa. This lack of trust may have its roots in the ethnic and political conflict and successive wars in the DRC as well as the social exclusion that they face in South Africa. This situation has caused the respondents to be suspicious about everyone including the networks which are considered a necessary part of their survival. As trust is considered one of the main elements that sustain social capital between and among people and groups facilitating cooperation and coordination for mutual benefit (Putnam, 1995); it is important to consider how it operates within a community.

Generally, as a trusting relationship develops inside a network, actors build up relations of trustworthiness that may offer important support and information for others in the social network (Tsai & Ghoshal, 1998). In this research, however, trust was found to be a risk factor for HIV

transmission among both married men and women, and single men and women in the research population with data revealing the difficulty of using condoms in a relationship; revealing their HIV status as a result of possible stigma, and trusting translators and nurses enough to go for HCT. Mistrust in this study was the main cause of high levels of stigma and the reason for not going for HCT within the sample population. Mistrust has hindered refugees from going for HCT because they also believe that the nurses or counsellors will inject them with the HIV virus and that their fellow community members will gossip about them. Although Campbell et al. (2007) have found that high levels of trust among people within the same group may lead them to disclose their HIV status to one another; this research showed that high levels of trust often led people within the same group to engage in more risky sexual behaviour and therefore increase their vulnerability to HIV infection, without being able to openly speak about it.

Further, although Onyx & Bullen (2000) found that in a community where reciprocity is strong, people care about each other's needs and interest; in communities where people are struggling to find money for basic needs it becomes necessary for women to exchange sex for money or food. The interviews and focus group discussions in this study showed that the majority of people who participated in this study were struggling to meet their basic needs which were interpreted as leaving them with little choice. The study indicates that reciprocity does indeed take on a more complex meaning in an under-resourced setting such as in the struggling refugee community and supports the view that relationships need to be considered within their context, and that a broad ecological view is essential to understand the impact of reciprocity in relation to HIV prevention.

Regarding support and networks, although, overall the data indicates that there is strong social support within the refugee population especially in relation to helping each other with accommodation and work as discussed above; this support is not as freely given in relation to HIV when issues of mistrust, stigma and prejudice arise. The data revealed that there appear to be close links between the type of social support that is given and social and cultural norms. For example, visitors are treated as welcome guests in the Congolese community and helped with food and accommodation; but as sex is a taboo subject in the community the same support is not given in cases where members need assistance where they are concerned about their HIV status. Being

able to communicate with one's partner about condom use and STD risk has been found to be closely related to self-reported use and a willingness to use condoms. However, as both the literature and the data shows, it is difficult for people to talk about condoms (Meyer-Weitz et al., 1997). Similarly, the culture of not talking openly about issues related to sex is seen as a risk factor for HIV prevention among the research population. Such lack of communication has caused many of the men and women to be reluctant to use condoms largely because of both cultural beliefs and in some cases a lack of knowledge about HIV. Men are believed to be dominant and superior because of culture and that makes women vulnerable since they are unable to negotiate condom use within and outside marriage. Many women find that they cannot risk losing their partners as they are financially dependent on them for survival and financial support. In relation to communication around HIV in the research population, as discussed above, data shows that participants found it difficult, if not impossible, to talk to each other about HIV because it is a topic related to sex and also because it is considered culturally inappropriate. The silence around sex and HIV, and the fact that the silence is embedded in cultural norms, is a significant and strong risk factor in HIV prevention.

5.3 Overview of refugee context and HIV prevention practices

The review of the literature has revealed that war and population displacement may be recognised as significant risk factors for HIV transmission. Further, as discussed above, while some forms of social capital might be associated with beneficial outcomes in relation to the prevention of HIV in some contexts; this is not always be the case. Adoption of safe sexual behaviour is presumed to be founded on a number of psychosocial characteristics, including perceived vulnerability and knowledge about HIV. As a result of lack of communication around the subject of sex it becomes important to question the level of knowledge regarding HIV among French speaking refugees. Further, a lack of knowledge and misconceptions surrounding HIV came through strongly in the data as strong contributors to risk behaviour in relation to HIV.

This study explored participants' knowledge of HIV in term of its transmission, prevention, and the way it contributes as a risk or protective factor for the sample population within a social capital

framework. Young male refugees, both single and married, who participated in this study knew that HIV could be contracted by: having unprotected sex with infected partners, infected blood transfusions, an HIV positive mother to unborn child, and by use of contaminated injection needles. They also stated that one could protect oneself from sexual transmission of HIV by abstaining from having sex, being faithful, using condoms, and being circumcised. However, data in this study also indicates that female refugees from the population sample had lower levels of knowledge about HIV than men. Single and married women's knowledge about HIV was not always accurate and many misconceptions and myths about HIV were found particularly among young women refugee participants in the study. Participants' knowledge (or lack thereof) about HIV coupled with a number of cultural beliefs made apparent in this study operate as risk factors for HIV prevention among the sample population. For example, beliefs about self-testing and washing the vagina with hot water after having unprotected sex. Many people may adopt these practices and infect others and therefore contribute to the spread of new HIV infection in South Africa. This may also be due to the culture of women not talking openly about issues related to sex and their difference in power relations (the domination of men over women).

Although this research found that single and married male participants knew how HIV could be contracted and prevented, there was practically no association between HIV knowledge and the practice of safer sexual behaviours in this study among single and married men. This research found that both married and unmarried young males were engaging in unprotected sex because they believed that circumcision could fully protect them from getting HIV. Although male circumcision has been shown to reduce HIV acquisition in men by over 50 percent in Uganda (UNAIDS, 2007), this does not give a hundred percent protection. Further, despite knowledge of various facts regarding the spread of HIV as illustrated above, the study also found that there was also a low perception of risk of HIV infection and actual behaviour change in keeping with this knowledge. In many other cases condoms are not used because there is a perception that other Congolese people can be trusted not to have HIV, while this is not always the case with South African partners. This indicates a very complex dynamic in operation between knowledge and practice.

The DRC refugee community living in Durban is a religious community who believe that abstinence is the most acceptable form of prevention of pregnancy. Considering the data from the researcher's personal interview revealed that despite a high level of knowledge there remains an internal struggle to accept and practice family planning apart from making use of abstinence. The internal struggle was around knowledge on the one hand and cultural and religious beliefs on the other. Strong cultural beliefs may also result in stigma and discrimination from other members of the community. For example, in the Congolese culture, if other people find out that a few months after you get married your wife is not yet pregnant, they start laughing at you and conclude that you are not a man. It is important therefore to consider the complex dynamic between knowledge and practice in light of complexities in the operation of the elements of social capital – trust, norms, reciprocity and social support. Understanding social capital at a bonding level and the dynamics at work between sexual partners and expectations and norms in the community can lead to a better understanding of how to approach HIV prevention in a particular community.

5.4 Recommendations for future intervention work

This research identified that the main gaps in achieving adequate HIV prevention among French speaking refugees in Durban, South Africa include:

- Limited understanding of the complexities involved in HIV prevention in the research sample;
- Limited research on the relationship between social capital and HIV prevention and the importance thereof;
- Limited awareness of HIV risk and although there is partial knowledge in some cases, there are still many misconceptions present, and knowledge is seldom translated into practice;
- More in-depth knowledge needed on the role and intersection of religion and culture;
- Lack of access to and participation in HIV preventions programs;
- Lack of resources and poverty;
- Lack of government support in overall health promotion and HIV prevention.

The main findings from the study also shows that it is vital to understand the overall ecological complexities involved in working with the refugee community:

[1] The overall context of the particular community, especially in relation to the complexities surrounding a refugee community, and the socio, political and economic resources need to be well studied and considered before developing an intervention.

[2] It is important to understand how social capital operates within a community, and in which circumstances it operates as a protective or risk factor.

[3] Social support groups, networks and reciprocity are vital in a low resource community but the complexities of how they operate need to be understood to further explore how a general positive support system could be used to help with the prevention of HIV.

[4] Cultural beliefs and norms have a strong influence on behaviour and need to be clearly understood in relation to their effect on HIV prevention strategies so that they can be taken into account as part of the intervention strategy.

[5] Work with married couples and understanding the complexity of relationship dynamics would have to form part of future interventions.

In light of the above findings it is clear that it is not enough just to impart a set of facts or HIV information; HIV intervention programs need to be carefully designed to take the factors outlined above into account. Based on the above, the following recommendations are proposed: On a social bonding level it will be important to promote education about HIV prevention and to promote dialogue and discussion to alter misconceptions about culture and the nature of trust. It would be important to promote discussion in relationships and facilitate communication. Any intervention designed to promote HIV prevention among French speaking refugees would need to go deeper and consider the complexities made apparent in the research, consider looking closing at the norms that are blocking communication and support in relation to HIV and perhaps re-framing them in a different ways. For example, it may be necessary to consider the social norms relating to what it means to be a man in the community, what it means to protect your partner, and to pass on that information to the new generation (youth).

In regard to the above recommendations, a key aspect to consider for capacity building and to increase the possibility of behaviour change in the community is the importance of participation of community members. A way needs to be found to enable individuals, families and communities

(and more widely, relevant health workers) to collectively understand the effects of HIV and to develop local action within their own context. People who are directly experiencing the effects of HIV need to be involved in a process designed to engage their abilities and strengths (Sliep, 2006). Examples may include participatory action research, narrative theatre (Sliep, 2006) or facilitating self-help groups. Self-help groups are considered an important form of social bonding that, together with services providing psychosocial support, may assist in building stronger networks for members to cope collectively with issues such as HIV (Sliep, Dageid, Akintola & Ducket, 2011).

Although the social bridging and linking levels were not fully investigated in this study it became clear through the focus groups discussions and interviews that there is very little social capital at these levels in the research community. Social capital at these levels is still considered vital to fully support the community at all levels. This is in keeping with local studies on social capital and HIV care and support (Sliep et al., 2011). Local NGOS, and local government should target or include French speaking refugees living in Durban in their HIV prevention programs, possibly using their faith based organisations in which the majority of these refugees are members. Further studies should be conducted to consider policies that would ensure that government offers proper support for refugees in South Africa as it is the case in other countries. Government should facilitate and fund NGOs that focus on HIV prevention among refugees living in Durban. Services must consider the culture of the refugee community and be given in their language

5.5 Shortfalls and limitations

As discussed in more detail in chapter 3 of the study there are various limitations that need to be considered. These include:

- the small sample size (24 refugees) currently living in Durban which makes it difficult to generalise findings;
- the sensitivity of the study which may have led to a lack of complete honesty or openness among participants;
- translation difficulties; and

- the fact that the researcher is well known in the community and there may have been expectations of providing solutions to current problems which may have skewed the information given.

Caution was taken during the interviews and focus group discussions to minimise these limitations and provide clear explanations to the participants of the purpose and scope of the research and the need for honesty and to ensure accurate information was obtained. This was done through providing clear information about the research; using a female translator for female participants; and providing a clear context in which the work was done.

Only focusing on the bonding level can also be considered a limitation as this meant leaving out vital information on the bridging and linking levels. Consideration of all three levels is considered really important and integral to taking a holistic approach.

5.6 Additional areas for Further Research

There is an overall need for research that seeks to explain the underlying socio-cultural factors that expose forced migrants to HIV infection. On a social bonding level this study showed, as highlighted above, that social norms strongly influence behaviour change. This has also been found to be the case in many other studies and with other communities. It would be necessary in the case of a refugee or migrant population to consider further whether these communities hold onto their cultural norms more strongly because of their displacement and what the consequences of this are. Further studies are also needed to investigate the extent to which families can provide care and support for people living with HIV among French speaking refugees living in Durban South Africa; and how to facilitate communication around the silence of HIV.

As the current research explores social capital primarily on a bonding level, research is also needed to explore both the social bridging and linking levels. It will be important to understand how French speaking refugees from Bukavu/DRC living in Durban participate in HIV prevention programs offered by churches and community based organisations and how this research population views

the co-ordination and collaboration between leaders, churches, NGOs and CBOs and other relevant programs. On a linking level, further research is recommended to find out about refugee experiences with government programs and social media.

5.7 Concluding summary

Findings in this study confirm the complexity of issues relating to HIV prevention. While social capital has been found to be a useful component in generating support in a community, binding relations and having an overall positive effect; it appears that the situation is not this simple. The elements of social capital (trust, reciprocity, norms and social networks) were all apparent in the community, particularly at a bonding level, but at times worked in support of members and at others appeared to work against them. This was especially the case in relation to issues surrounding HIV.

The overall objective of the study was to contribute to an understanding of how social capital, specifically on a social bonding level, operates as a risk or protective factor for the spread of HIV amongst French speaking refugees from Bukavu, DRC, living in Durban, South Africa. More specifically the researcher wanted to understand how the elements of social capital (trust, norms, reciprocity and networks) on a social bonding level, act as risk or protective factors in the spread of HIV in relation to condom use; HIV counselling and testing; and stigma. The research found that social capital can act as both a protective factor in some circumstances and a risk factor in others. Trust, norms, reciprocity and social networks are complex elements in the refugee community and influenced by a myriad of factors including the past and present stressors that are prevalent in the community. In turn these all have an effect on HIV prevention and need to be understood clearly. Without such a clear understanding, interventions offered to the community may well not lead to behaviour change that helps in the prevention of HIV. These findings are important as generally the impression is that the lack of policy and interventions to include refugees in services is the reason for high HIV risk. From this data one can conclude that any interventions and policy guidelines would have to be tailored to meet the specific needs and complexities inherent in this target group.

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Annexure A

Focus group discussion guide questions

Section A: Demographic information

- Gender
- Age
- Marital status
- Occupation
- Group membership

Section B: The following areas will be explored in the interview. Each topic will be probed deeper depending on the answers given by the participants.

- Duration and reason for coming to South Africa.
- Social relationships (family and friends) living in Durban
- Membership of groups and networks within South Africa (including religious institutions)
- Knowledge, availability and access of health related services in Durban
- Knowledge and source of information around HIV/AIDS (from DRC and South Africa)
- Awareness of personal risk of HIV infection and reasons that contribute to vulnerability around HIV infection
- Opinions regarding communication within own group around topics of sex and HIV.
- Awareness around media programmes (radio and TV) that address HIV (both in the DRC and in South Africa)
- Expectations from the government to decrease HIV infection within refugee groups
- Ideas on how HIV prevention can be increased for French speaking refugees in Durban (within own group, within local programmes and from a National level)

Annexure B

Semi-structures Interview Guide (2013)

The influence of social capital on HIV prevention with refugees from Bukavu, Democratic Republic of Congo living in Durban South Africa

Section A: Demographic information

- Gender
- Age
- Marital status
- Occupation
- Group membership

Section B: The following areas will be explored in the interview. Each topic will be probed deeper depending on the answers given by the participants.

- Duration and reason for coming to South Africa.
- Social relationships (family and friends) living in Durban
- Membership of groups and networks within South Africa (including religious institutions)
- Knowledge, availability and access of health related services in Durban
- Knowledge and source of information around HIV/AIDS (from DRC and South Africa)
- Awareness of personal risk of HIV infection and reasons that contribute to vulnerability around HIV infection
- Opinions regarding communication within own group around topics of sex and HIV.
- Awareness around media programmes (radio and TV) that address HIV (both in the DRC and in South Africa)
- Expectations from the government to decrease HIV infection within refugee groups
- Ideas on how HIV prevention can be increased for French speaking refugees in Durban (within own group, within local programmes and from a National level)

Annexure C

Semi-structures Interview Guide (2015)

The influence of social capital on HIV prevention with refugees from Bukavu, Democratic Republic of Congo living in Durban South Africa

Section A: Demographic information

- Gender
- Age
- Marital status
- Occupation
- Group membership

Section B: The following areas will be explored in the interview. Each topic will be probed deeper depending on the answers given by the participants.

- Duration and reason for coming to South Africa.
  When and why did you come to South Africa?
  How did you know about Durban?
  Tell me how you are related to your family, friend, in South Africa and DRC
- Social relationships (family and friends) living in Durban
  Tell me about any friends or family members that you have in South Africa
- Membership of groups and networks within South Africa (including religious institutions)
  Tell me any group that you are member of
  Tell me how your group is related to other group in Durban
  How do you assist each other in your group
  Tell me about some values in your group
  How often you talk about HIV in your group
- Knowledge, availability and access of HIV prevention services in Durban
  Tell me about any think you know about HIV in term on its transmission and prevention
  Tell me about any Organization that focus on HIV prevention among French speaking refugees in Durban

Tell me how do you access to HIV prevention service such as condoms, HCT

- Source of information around HIV/AIDS (from DRC and South Africa)
  How did you know about HIV
- Awareness of personal risk of HIV infection and reasons that contribute to vulnerability around HIV infection

  How do you consider yourself to be at risk of getting infected by HIV

  Tell me what behaviour can lead someone to get HIV

  Tell me some cultural values that can expose someone to contract HIV
- Opinions regarding communication within own group around topics of sex and HIV.
  How often do you talk about HIV and to whom do you talk to?

  (friends talking about condoms, friends encouraging condom use, and friends using condoms, data showed)
- Awareness around media programmes (radio and TV) that address HIV (both in the DRC and in South Africa)
- Expectations from the government to decrease HIV infection within refugee groups
  Tell me how the Government is helping to decrease HIV infection within refugee groups

  Tell me about what the constitution of South Africa said about HIV prevention for refugees
- Ideas on how HIV prevention can be increased for French speaking refugees in Durban (within own group, within local programmes and from a National level)
- How do you think HIV prevention can be increased for French speaking refugees in Durban?

Annexure D

Letter of Introduction to Study and Consent Form

Good Morning, /afternoon /evening, my name is Mulumeoderhwa Buhendwa. I am a student from University of KwaZulu-Natal in the School of applied human sciences (Psychology).

I am researching on the influence of social capital on HIV prevention with refugees from Bukavu, Democratic Republic of Congo living in Durban South Africa.

I would like you to participate in my research. This discussion will take about 45 minutes. This research is for academic purposes and its aim is to contribute to the understanding of how social capital operates as a risk or protective factor for the spread of HIV amongst French speaking refugees from Bukavu /DRC living in Durban South Africa.

All information that you will give during this study will be kept confidential; only me and my supervisor will have access to the information. Your real names will not be used in any part of this study. I will make use of alphabets and number to identify your interview and will use a pseudonym to make sure that no one links the information you have given me to you. No one will be identified by their name in the thesis and future publication that I plan to write. Please note that the results will help us to contribute to the understanding of how best we can engage in the prevention of HIV/AIDS particularly among the French speaking refugees living in Durban South Africa. Your participation in this study is voluntary and you have the right to not talk to us if you do not want to. If you agree to take part in the study, I will ask you to sign a form as an indication that we did not force you to participate in the study. You can also end the discussion at any time if you feel uncomfortable. In case you would like to withdraw some statements/aspects that you have given already from the study or you have any complaints you can call me on 0766629899 or you can talk to my supervisor Professor Yvonne Sliep on 031-2607289.

Consent Form

I have read the information about this study and understand the explanations to me verbally. I have had my questions concerning the study answered and understand what will be required of me if I take part in this study.

Signature: _____ Date:_____