

BLAMING THE OTHERS: REFUGEE MEN AND HIV RISK IN CAPE TOWN

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requirements
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November 13, 2006

Declaration

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I hereby declare that the thesis on topic: **Blaming the others: refugee men and HIV risk in Cape Town** is of my own work and that I have received no other assistance than stated sources and citations.

Place: Cape Town

Date: November 15, 2006

Signature:.....



List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
CBD	Central Business District
DHA	Department of Home Affairs
DoH	Department of Health
DRC	Democratic Republic of the Congo
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IEC	Information Education and Communication
MDGs	Millennium Development Goals
MTCT	Mother to child transmission
NACCSA	National AIDS Coordinating Committee of South Africa
NGOs	Non Governmental Organizations
NSPs	National Strategic Plans
OAU	Organization of African Unity
PEP	Post-exposure prophylaxis
RRO	Refugee Reception Offices
SADC	Southern Africa Development Community
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Programme on HIV/AIDS
UNESCO	United Nations Education Science and Culture Organization
UNHCR	United Nations High Commissioner for Refugees
USAID	United State Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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ABSTRACT

South Africa is home to 135000 refugees of whom 80% are men (Landau2003: 15). Many have fled their countries as a result of political or religious persecution, war, famine, and starvation or for fear of these phenomena. Refugees in South Africa have been subjected to perceptions ranging from them as being ‘polluted’ to them being a risk group. These perceptions have influenced people’s view that refugees are a potential source of the HIV infection that is ravaging the South African society. Those who regard refugees as a polluted risk group, base their arguments on issues of public health, emphasizing the risk that refugees pose to the local urban communities in which they are located.

A critical analysis of the issues and the way in which refugees are being blamed, suggests that the AIDS pandemic is an additional way in which refugees are being ‘othered’ and how this allows South African men to be blinded to their own vulnerability to HIV infection or to the need to change their own sexual behaviour.

The attitude of South African men, who blame refugees for bringing HIV into the country and for the spread of the virus, makes the problem someone else’s, not their own. The situation aggravates the discrimination refugee men already experience. The accusations levelled against refugees diminish any sense of responsibility within the wider South African and refugee communities of the need to act collectively to prevent and effectively handle the crisis.

The analysis of the study findings is based on the overall objective, to examine the effect of blame on refugee men in Cape Town and their risk of HIV infection. In addition, possible recommendations are made for the effective HIV/AIDS prevention and a reduction of blame so that harmonious relationships between refugees and their host communities might be fostered.

This study describes the way in which perceptions regarding refugee men being a polluted risk group came into being. The following qualitative and quantitative research methods were applied in this study in order to gather the relevant information: semi-structured interviews, participant observations, and semi-structured questionnaires in order to profile the sexual behaviour of the group concerned, and to ascertain the relationship between blame and the risk of HIV infection. A literature review, which provides a theoretical framework and background to the study, was conducted.

The participants were South African and refugee adult men aged between 23 and 35 years of age who were on a particular site in the city centre of Cape Town. The assessment involved repeated interviews with 20 key-informants and participant-observation on site of the 20 key-informant interviewed. 5 interviews were conducted with South Africans and 15 with refugee men. Most South African respondents said that they believed refugee men to be not only polluted but a potential risk group and as such rightly blamed for the spread of HIV and STDs. Most of the refugee respondents felt that risky sexual behaviour put one at risk of HIV infection. The findings pointed to a separating of the way in which refugee men were blamed and their risk of HIV infection. While being blamed could not be correlated directly to a rise in the risk of infection, the process of social exclusion associated with blame reduce access to community support strategies designed to reduce the threat of HIV and AIDS and thereby indirectly affects risk for initial HIV infection and for progression of HIV into AIDS.

CHAPTER ONE

INTRODUCTION

1.1 Background and purpose of the study

The mass movement and relocation of people as a result of war, natural disaster and lack of employment, and the spread of HIV are critical social and developmental issues that Africa and much of the world face today. Goal number six of the Millennium Development Goals (MDGs) is to halt and begin to reverse the spread of HIV/AIDS, and begin to reverse the incidence of malaria and other major diseases, at the turn of the 21st Century (Spiegel and Tavel-Harroff 2006: 16).

The perceived link between mobile populations and the spread of HIV is most evident in Sub-Saharan Africa. Mobile populations and HIV appears most strongly in Sub-Saharan Africa partly because of the numbers of armed conflicts which have driven large number of people from their regular dwellings, thereby resulting in internal displacement or in their seeking safety beyond their countries' borders. Much has been written about mobile population and the spread of HIV. It is estimated that these dislocated populations in Africa have an overall HIV prevalence rate of between 7, 5 per cent and 8.5 per cent (UNAIDS 2001: 25).

A pluralistic society like South Africa generally seems to be accommodating and to have had few demands on immigrants for conformity. This attitude has probably contributed to the mass influx of refugees, who mostly come from war-torn areas where health-care facilities have fallen apart and, no proper sanitation and other social problems exist. But that does not guarantee a conflict-free environment locally. Instead, the continued rise of HIV and the high rate of unemployment have prompted some South Africans to perceive refugee men as a risk group and a potential pool of contamination to the host society (Nobel 1987: 82).

Literature about HIV/AIDS in Sub-Saharan Africa indicates that the Southern African region is the most affected by the pandemic. South Africa, in turn is considered to be amongst the hardest hit countries in the region with a prevalence rate between 20-26% of the population aged between 15-49 (Williamson 2004:5).

The phenomenon of being a 'refugee' conceals a variety of reasons for people having left their countries of origin, often making it difficult to establish with certainty the real factors that generate a mass exodus. In most cases, however, it is war, persecution and fear. Along with the perception that refugee men are a risk group is the perception of them as constituting an 'other'. The 'othering' perception operates on an instrumental level because it pursues the aim of trying to shift blame towards refugees and descriptive level because it tends to isolate refugees from the host community (Douglas 1976:120). The latter is the more obvious one and is used to distinguish between citizens and non-citizens. Because refugee men cannot legally claim to be South African citizens, I find the use of 'other' in this context legitimate. The idea of 'other' on an instrumental level involves the idea of refugee men as "out of place", in the societal system and geographical sense. Drawing on the ideas of Mary Douglas (1976), I argue that refugee men are in a way viewed as representing and bringing with them potential disorder, such as diseases and violence, and are accordingly seen as 'dangerous'. In a society that is experiencing an alarming increase in HIV infection, things and people 'out of place' are viewed as agents or carriers of dis-ease (Ibid, 125). Refugee men then are perceived as a risk group, which is potentially polluted. The primary function of the concept of 'othering' is to separate, accuse and demarcate. Ideas of othering operate through emphases on the differences between 'within and without', 'above and below', 'polluted and clean' - i.e. citizens and non-citizens, those who have a legal claim on the resources of the state and those who do not, local people and foreigners, South Africans and people fleeing from poor or strife-ridden countries where basic health services have collapsed, etcetera. I argue that such 'othering' affects perceptions in some quarters of South African society of refugee men as a risk group (Douglas 1976: 111). To suggest that the perceptions of being a risk group apply mainly to refugee men (as opposed to women), it will be important to understand what "refugees" mean as I seek to study their lives in this

era of HIV/AIDS and the effect of ‘othering’ on them. It is important to study their attitudes and their knowledge of HIV. The more we understand refugees the more it will assist in analysing ‘othering’ and the situation regarding the risk of HIV infection. The understanding of refugees as being ‘out of place’ involves reflecting on the relationship between ‘order and disorder’, ‘being and non-being’, and ‘form and formlessness’. This simply means that refugees who are believed to be out of place, their behaviour do not reflect the behavioural pattern found amongst the host South Africans, everything refugees do appears to be senseless and dangerous to the well being of the host South Africans (Douglas 1976: 109).

Thus, a refugee is one who *“owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality”* (Naicker and Nair 2000: 13).

The refugees, who are the subject of this study, are refugees by default because of the huge backlog at the Department of Home Affairs in determining their status. The majority of these ‘refugees’ are in fact asylum-seekers who are allowed to live in South Africa legally pending the determination of their status. In other words, this study will deal with asylum-seekers who view themselves as refugees living in South Africa. African refugees constitute a big portion of the general African foreign population living in South Africa.

In this study, I will look at refugee men as being perceived as a risk group and as ‘other’. I will also give attention to the risk factors of HIV infection whilst living in South Africa. Because of the disruption in their familial, culture and societal structures and constraints, and because they nevertheless have sexual needs, adult male refugees face the possible risk of HIV infection (Joffe 1999: 45). The main objective of this study is to investigate the societal perception of refugee men as being a risk group, being polluted, ‘out of place’ and the consequent risk of HIV infection they might face. It will also determine

the factors that could expose them to the risk of HIV infection while living in exile in South Africa. It will discuss the process of ‘othering’ as it serves South Africans. This investigation involves a case study of refugee men living in Cape Town and trading at Green Market Square. The study is relevant to South Africa as it seeks to find the best strategy to fight discrimination, xenophobia and the spread of HIV amongst its general population and within refugee groups. The study will postulate the influence of relocation on the risky behaviour for men in general, not simply that of refugees. It will assess whether the sexual behaviour in which refugee men engage whilst away from their home puts them at risk of HIV infection.

It is my fervant hope that the recommendations of this study will help institutions that assist refugees, to develop appropriate policies which would reduce the risk of refugee men becoming infected with HIV and contribute to a reduction in the level of discrimination and xenophobia that they experience.

1.2. Rationale for the research

“The history of disease is replete with examples of blaming foreigners, often resident across the border of a neighbouring country” (Chirwa 1998: 57).

The spread of disease in South Africa has led to the perception that ‘polluted’ outsiders inflicted the disease upon South Africans. The perception of refugee men as being a risk group has made some people in South Africa believe that HIV is a disease brought into the country by ‘outsiders’ or by people who are ‘out of place’. In this study the ‘other’ are refugee men. People who hold this perception believe that the ‘other’ should be blamed since they crossed the country’s borders and are polluting what is ‘inside’. By blaming the ‘other’, some South Africans believe themselves to be protected from the danger of infection and free from having to take any personal responsibility for their own sexual behaviour. Refugee men are viewed as more dangerous than other immigrants, because they have been ‘tainted’ or ‘infected’ by what happened in their country of origin such as war, hunger and HIV. Refugees are an ‘unknown entity’ who have fled from blighted countries and are therefore viewed as especially dangerous. Many studies have shown

that people often think they themselves are not at risk because ‘others’ are carriers of infection. HIV is often viewed as an infection brought by ‘outsiders’, such as the refugees to South Africa. The perception of them as a polluted risk group was further strengthened in South Africa with the diagnosis of HIV amongst 13,000 Malawian miners between 1988 and 1992. These miners were subsequently repatriated on account of the fear that they would spread HIV in South Africa (Chirwa 1998: 65).

Mpe (2001: 3ff) states,

“ This AIDS, according to popular understanding, was caused by foreign germs that travelled down from the Central and Western part of Africa...More specifically, certain newspaper articles attributed the source of the virus that caused AIDS to species called the green monkey, which people in some parts of West Africa were said to eat as meat thereby contracting the disease. Deduced from such media reports that AIDS’s travel route into South Africa was through the Black African foreigners.”

This account gives a clear indication of the perception of the ‘other’ as the risk group because they are ‘out of place’ and because the environment in which they previously lived was ‘polluted’ in some or other way. They thus are seen as presenting the eminent danger of carrying infectious diseases due to their uncleanness. Any contact with the polluted ‘other’ is considered to hold the possibility of the transmission of disease. These perceptions are fuelled by the media’s portrayal of African refugees as being a problem and a danger that the public should avoid and not associate with. Some uninformed members of the South African society have made blatant sweeping generalisations concerning refugees. The perception of the ‘other’ being a potential danger in the spread of HIV because of their ‘foreign germs’ can only increase the blame levelled at African refugees (KhanTicha 2003: 56).

The effect of the perception of the ‘other’ being a dangerous group will serve as the framework as I attempt to explore the risk of HIV infection amongst refugee men. I will endeavour to explore whether the idea that refugee men are health threat or pool of possible contagion group contributes to the danger of HIV infection. The study of

HIV/AIDS and refugees in Cape Town is an issue, which needs serious consideration (Danso and McDonald 2001: 116).

In this study I aim to investigate whether living in a foreign urban setting creates behavioural changes, or increases or decreases the possibility of HIV infection amongst refugees. There is very little written concerning refugee men and their risk of HIV infection compared to the recorded information regarding refugee women and adolescents. Harris (2001: 5) says: *“documented and undocumented, refugees are frequently treated as a homogenous category of illegal immigrants.”* My argument is that some people still believe that refugees are illegal immigrants. The amount of interaction between refugees and South Africans has resulted in them being treated as a homogenous group of illegal immigrants. The granting of refugee status in terms of the immigration regulations means that every individual refugee is able to live in his or her country of exile legally. Refugees in South Africa enjoy freedom of movement and this might well contribute to the risk of exposure to HIV, especially for those who live in an urban setting because of the high level of integration.

The majority of refugees in urban areas are male. The United Nations High Commissioner for Refugees' (UNHCR) policy on urban refugees seeks to encourage self-reliance and does not encourage long-term dependency. The view held by UNHCR is that refugee men living in an urban setting are more adaptable and self-reliant, and therefore their support of them is usually in the form of once-off assistance. UNHCR does not offer open-ended commitments to refugees (UNHCR 1997).

Because refugees living in an urban setting are constantly on the move in search for better living conditions they are often difficult to reach with programs and with the provision and establishment of services such as clinics. The challenges refugees' faces are often related to accommodation, employment and health care. Some live in overcrowded households.

The general living conditions of refugees might also prompt some local people to perceive them as a polluted risk group, criminals or, at least, “other” because of these

perceptions and the resentment they receive from the local South African population who resent their increasing competition over scarce resources, refugees might well experience a degree of stress. This in turn might cause them to turn to sex as one of the more easily available enjoyable activities (Morell 2001: 276). *“Sometime when I feel stressed because things did not go the way I planned or when our local brothers are telling you their usual nonsense such as taking their job opportunities, stealing their girls, you know! I will just go to my girl friend talk and enjoy ourselves in a very intimate way, you know! That is my best way to release the stresses”* (Refugee man at Green Market Square). The daily challenges such as having enough money to meet everyday needs and to pay for trading space that refugee men face at Green Market Square seem to be more stressful than the danger of dying of AIDS.

The lack of literature on the topic of refugee men and their risk of HIV infection is a gap this research will endeavour to address. The study will explore the relationship between the “othering” experienced by refugee men who trade in Cape Town’s Green Market Square and their behaviour, which places them at risk of HIV infection. While the literature reviewed in chapter 2 indicates a correlation between blame, stigma, “othering” and increased vulnerability for risk behaviour, the researcher seeks to understand if and how this dynamic plays out in the lives and conscious awareness of refugee men.

1.3 The research problem

The mass movement of refugees and the high rate of HIV infection are two of the major challenges facing Sub-Saharan Africa. South Africa is home to many refugees from other parts of the African continent and is one of the countries hardest hit by the AIDS pandemic. This has led to the perception that the disease was brought to South Africa by ‘contaminated’ groups of migrants. In this sense emigrants and refugees alike are seen to be polluted risk groups and the ‘other’ who should be held responsible or blamed for the spread of HIV/AIDS. It is important, however to distinguish between refugees and migrants in terms of the reason why people left their countries. A migrant’s decision to leave his/her country of birth is usually based on the desire to positively improve his/her

social or economic living conditions. Refugees, on the other hand, leave their countries because of the need to escape drastically deteriorating conditions of existence and civil war. It is the deteriorating conditions of existence, which have caused some people to view them as infected risk groups who present the danger of transmitting diseases (Chirwa 1998: 68). This perception was fuelled by the repatriation of Malawian workers by the South African authorities. Malawian miners were not refugees in South Africa but because they were an outside population group, they were suspected of bringing HIV into South Africa (Ibid, 70).

Chirwa points out (1998: 58):

Foreign workers and hawkers are viewed as a threat to local populations because they compete for the available jobs and other facilities.” He goes further to argue that, “In such an environment, the politics of disease, and HIV/AIDS in particular, can hardly be separated from general xenophobia associated with the competition of jobs and other economic facilities (Ibid, 58).

Refugees constitute the majority of foreign workers and hawkers who are regarded as a threat by the local people. Refugee men are accused of being infected (and thus being polluted) with HIV either in their country of origin or en route as they travelled to escape deterioration in their conditions of existence. These conditions ranged from health care to personal safety. A xenophobic attitude towards refugees has emerged as result of the perceived danger they pose. In contemporary South Africa, blaming refugees for the ills of the nation has extended to the accusation by some South Africans that refugees and foreigners were ‘tainted’ or infected by what happened in their countries of origin and because of this, they are considered an especially dangerous group (Boaden 2002: 22). These accusations are most often aimed specifically at refugee men. They are regarded as people to be avoided.

Boaden points out, “*in the townships refugee men are accused of stealing women from their boyfriends and spreading HIV*” (2002:18). Although relationships between refugee men and local girls cannot be avoided, the claim that they ‘steal’ local women increases the perception that refugee men are dangerous. They should not associate with local women because they might ‘pollute’ them. Some local men did, however, acknowledge

that their girlfriends were attracted to foreigners because they were well treated by them (Douglas 1976: 99).

This research attempts to offer a better understanding of the process of blame and to contribute to the establishment of strategies, which would reduce the blame, put on refugee men for the presence of HIV/AIDS in South Africa. The magnitude of HIV in South Africa cannot be underestimated and the inter-connectedness between mobile population groups and the spread of disease is well documented. Mobility and the spread of HIV are linked because mobility has the potential to promote or create vulnerability, since the itinerant person generally has less or no access to HIV/AIDS information, health services, preventative measures or the treatment of sexually transmitted infections (STIs). Their sexual behaviour is viewed as risky because they have multiple partners, some of whom are commercial sex workers. Urban refugees are made more vulnerable by the fact that preventative programmes often do not reach them (Crush, Lurie, William, Dodson et al. 2005: 10& 20-22).

During the last decade Africa has experienced violent conflict, especially in the Democratic Republic of the Congo (DRC), Burundi, Angola, Ethiopia, Eritrea, Sudan, Burundi and Rwanda, which has led to the mass population movement towards the Southern part of the continent, where most countries experienced an already serious problem with poverty and HIV amongst its own population. South Africa is home to about 135,000 refugees who fled conflict-ravaged countries and some of whom fled the economic hardship in their home countries; and the bulk of these are refugees who are to be found in the urban areas of South Africa (UNHCR 2006: 210).

HIV, along with poverty and unemployment, continues to be a massive challenge, which the South African government faces and endeavours to eradicate. Poverty and unemployment, coupled with the presence of refugees, makes the equation more complex to tackle. Given the above situation, this study, which focuses on refugee men and their risk of HIV infection, attempts to answer the following research questions:

- How does blame affect general vulnerability and the risk of HIV infection amongst refugee men in Cape Town?
- Does individual sexual behaviour place refugee men at risk of HIV infection?
- What type of social behaviour would increase/decrease the risk of HIV infection amongst refugee men in Cape Town?

1.4 African Displacement

During the twentieth century, the African continent witnessed large numbers of people being displaced by war, poverty, conflict, persecution and famine. It is estimated that there are about 3.5 million refugees in Africa who are victims of forces beyond their control (Okoth-Obbo 2000: 45). According to the United Nations, African refugees make up about 88% of all refugees worldwide. The large-scale displacement of African people grew to such an extent that in 1951 the United Nations was called to define the term “refugees.” It did so in Article 1 of its Convention on the Status of Refugees as the following: A refugee refers to a person who: “*owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality*” (Naicker and Nair 2000: 13). In other words, a refugee is someone who is compelled to leave or abandon his/her home due to civil strife (war), fear of persecution or again invasion and violence. This definition emphasises the extent of victimization caused by events for which refugees are not responsible (Ibid, 13).

1.5 Why South Africa as destination?

Nobel (1987:37) points out that, “most migration theories are based on the analysis of so called ‘push-pull’ factors, whereby the motivation to migrate is inferred from structural factors.” In the case of refugees, the push factors is the worsening political conditions, which may lead to the destruction of lives or fear of being persecuted because of political affiliation or religious belief in their countries of origin. The pull factors for choosing

South Africa might be diverse; the primary consideration in refugees' choice of South Africa is that refugees are not hosted in the camps as is the case in some Southern African countries such as Zambia, Namibia and Zimbabwe. South Africa has a policy of integrating refugees into the general population. According to the South African draft Refugee White Paper of 1998:

“The government acknowledges that full protection of refugees requires the attainment of a degree of self-sufficiency and local integration within the host community for the duration of their exile. In fact, it is only by becoming self-sufficient that refugees can lead a productive life, which would make them assets to the host country” (South Africa Draft Refugee White Paper. 1998).

The idea behind this policy is to reduce the government burden of having the sole responsibility meeting the needs of the refugees as well as making them self-reliant. The already meagre resources at the government disposal, present serious challenges in meeting the needs of its own populations and integrating refugees with the local population allows the government to incorporate services obtained through international assistance to be used by both refugees and local population. The second pull factor is the international image of good democracy and freedom that exist in South Africa compared to other countries within the African continent. The third pull factor is the level of economic stability of South Africa in relation to other African countries (Harris 2001: 7).

These three principal pull factors have made South Africa an attractive destination for refugees and immigrants alike. The first pull factor has influenced the influx of refugees into South Africa, as Landau (2003:38) says “refugees who choose South Africa as their destination tend to be adaptable, educated and resourceful since they aspire to better lives than to be assisted in a refugee camp.” The resourcefulness and adaptability of refugees living in South Africa, has led to the creation of new business ventures like parking attendants and hair braiding, to name just two. With these new businesses come work opportunities for both refugees and South Africans, although these jobs are in the informal sector of the economy. On the one hand, South Africa's policy of integrating refugees into the mainstream society, which could be seen as a primary pull factor. This policy can be seen as leading factor to the influx of refugee in South Africa. On the other hand, this policy also has contributed to the emergence of refugees as a perceived risk

group, as ‘polluted’ and “other”. Thus, in turn had effect of them being blamed for social ills such as crime, HIV and high unemployment rates experience by South African (Ibid, 38).

Generally refugees are forced to flee from their own countries due to political instability and civil strife (war and ethnic conflict) where; they feel helpless and powerless to protect themselves against persecution, moral insult or physical assault. All these compounded gives us an idea of the choices made by those refugees who have successfully settled in South Africa, why they chose South African as their safe heaven.

1.6 Anti- foreigner discourses

In 2005 a Burundian security guard was murdered at Nyanga junction, Cape Town by local people. They, shot him with his own company pistol, then cut his head off and put it in his own bag. The Burundian beheading depicts the deep anti-foreigner sentiment that exists in South African society (Khoisan 2005: 1).

As a linguistic construct, ‘African foreigners’ has emerged in South African public discourse as a threat to the job and commodity markets as seen in section 1.3 of this research. The alleged abuse of social services is also repeatedly blamed on foreigners. I will argue that it is difficult for South Africans to prove such accusations, but it has at times contributed to serious tensions between locals and foreigners, particularly in the townships (Cape Times 2006:3).

The responses can to some extent be attributed to the fact that refugees are an ‘unknown entity’ in some quarters of South African society and people easily believe that they are a problem and a threat to the well being of the society (Ibid, 3).

Being ‘out of place’ ‘different’, African foreigners in general, and refugee men in particular, are particularly vulnerable to harassment from some of the law enforcement agents, who often have difficulties in accepting their identity documents as legitimate.

Some are perceived as criminals and the media reinforce such ideas by, negatively depicting refugees in banners such as ‘Africa’s flood of misery pours in Cape Town’ (Cape Argus 1999). The uninformed public see them as a threat to jobs and other economic opportunities. Yet refugees are as much at risk of contracting HIV as other population groups (Padayachee 2006: 370).

It is important to note that the notion that ‘outside’ groupings are somehow ‘contaminating’ exacerbates the view that refugees imperil the ‘inside’. Those who are believed to endanger the innocent (South Africans) should be rejected and even, as in the case of the Burundian, be exterminated. This situation puts South Africans in a position of authority over the refugees, with those holding such position are often endowed with explicit powers to care or hate (Harris 2001).

The ‘othering’ of refugees can lead to prejudice and discrimination against them (Dodds 2004: 10).

As I have alluded above, the media have played a part in the development of anti-foreigner discourses, and its role can be seen in headlines in Cape Town newspapers, which refer to “relentless refugee tide sweeping into South Africa”; “illegal immigration alarming”; “thousands of refugees make city their home”; “Africa’s flood of misery pours into Cape Town”; “Africa floods into Cape Town”; “city haven for victims of Africa’s wars and woes”, and “Western Cape paying plenty to deport aliens” (Boaden 2002: 19-20).

I believe newspaper headlines, serve to validate the already existing perception of refugees as a polluting, risk group that endangers the health of the host population and which should not be associated with. The way refugees are sometimes portrayed by the media, can be seen as a form of accusation attempting to regulate refugees’ situation by vindicating the ‘us’ and condemning the ‘other’ in the face of dreadful disease such as HIV (Ibid. 11).

Apart from the media, another factor that could have influenced the anti-foreigners sentiment amongst some local people emanate from the isolation that South Africa had experienced during Apartheid regime. Throughout that period South Africa did not host refugees but rather a 'refugee-producing' country. But since the fall of Apartheid, South Africa has become home to many African refugees. The presence of these refugees, with men constituting the majority, has led to some local people seeing them as job snatchers, wooers of local women, criminals and potential disease carriers since they are come from areas, where health care systems have long collapsed due to war (Boaden 2002: 19).

Refugees are believed to fill every corner of South African cities, threatening the social fabric of the nation (Mpe 2001:26). In addition, the anti-foreigner attitude has reinforced ideas about 'them' versus 'us'. The perception of refugees as 'other' also influenced radical sentiments against refugees and the impression that they are polluting South African society with HIV, unemployment and crime, to name but a few (Ticha 2003: 69).

A Cape Argus article of June 30th, 2005, writes that:

“There is a disturbing increase in xenophobic violence, which has led to the deaths of eight refugees in the past nine months in the Western Cape.”

If these allegations are something to go by, it shows how 'othering' can make refugees vulnerable to attacks by those who see them as 'such.' The Cape Argus article goes further by saying that:

“Perpetrators know refugees are aware of their vulnerability and that they have neither the support of the local authorities.”

The vulnerability of refugees is born out of the perception that they are seen as an 'unknown entity' who have put a severe pressure on social services and infrastructure. Their vulnerability is further aggravated with the perception that refugees bring within them diseases that affects the host population. In addition, the xenophobic tendencies on the part of some members of the host population have increased refugees' vulnerability to accusation and sometime attacks (Hook and Eagle 2002: 172).

Crush (2001:15) states that:

“South Africans not only hold negative attitudes towards black African foreigners, they also have a readily accessible set of stereotypes with which to justify or rationalise their negative attitudes.”

Stereotypes, which South Africans justify, their negative attitudes could be considered as the foundation in which “*othering*” is embedded. These negative attitudes have further led to hatred and hostility towards refugees. The local media has played a major role in perpetuating negative stereotypes about African foreigners in general and refugees in particular (Hook and Eagle 2002: 171).

Harris 2001 noted that:

“There has been little endeavour by the authorities or the media to construct narratives that would counter xenophobia directed against African foreigners.”

The public pronouncement directed against African foreigners by some prominent figures of society, aggravate the situation and support the perception that foreigners are polluting and are putting severe pressure on social services and infrastructure. Mr. Mangosuthu Buthelezi, then Minister of Home Affairs, shared this perception when he publicly stated:

“If we as South Africans are going to compete for scarce resources with millions of aliens who are pouring into South Africa, then we can bid goodbye to our Reconstruction and Development Programme” (Human Right Watch 1998: 20).

The aliens who compete for scarce in South Africa, are often those coming from African countries while aliens from the West are viewed by some as investors therefore they do not compete for scarce resources. This negative perception about refugees, as seen in the media and as expressed by some political leaders, describes what Bayoumi and Rubin (2000: 91) said: “no one will have failed to note how ‘the unknown’ has always signified danger and threat...”

I have to argue that Apartheid played a role in this anti-foreigner attitude of some South Africans. Apartheid era isolation was reinforced even by bodily separation and enforced through strict demarcations that prevented homeland inhabitants from freely commuting to another, and the same situation was real for homelands and the rest of the African

continent. As a result, South Africans seem not to be prepared for the new form immigration, which has led to the influx of refugees in the post-Apartheid South Africa

1.7 Structure of the thesis

This thesis is divided into six chapters. The second chapter will develop a theoretical basis for the study and explore the main concepts and terms. The theory attempts to ground the practical research procedure and the research tools used by the researcher to try to provide an answer to the research question practically in order to assess the research hypothesis.

Chapter three comprise the methodology of the study, wherein data source and collection method, analysis, limitations of the research, measuring instruments and experiences and constraints in the field will be explained.

Chapter four contains the description of the case study location through the presentation of socio-economic and refugee situation in the country.

Chapter five contains research findings and analysis. The thesis concludes with chapter six, Conclusions and Recommendations.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL APPROACHES

This chapter will endeavour to provide an answer to the research question using the existing literature and theory on the topic.

2.1 Definition of main Terms and Concepts

2.1.1 HIV and AIDS risk

The Human Immunodeficiency Virus or HIV is a virus that enters the human body from the outside and renders weak the body's natural ability to protect itself against infection and disease. Due to the body's inability to protect itself against infection and disease, this situation then will cause a situation known as the Acquired Immune Deficiency Syndrome (Van Dyk 2004: 3, 13).

AIDS occurs; as a result of the immune system not fighting off infections that the body is normally able to withstand. At this stage, the infected person becomes more susceptible to a variety of infections, known as opportunistic infections. HIV is found in different body fluids, but it is more concentrated in the blood, semen and vaginal fluids. Nevertheless, HIV can be found also in other fluids such as saliva, tears, sweat and urine but its concentration in these fluids are too low for probable transmission. HIV infection occurs when the virus finds a way to access the bloodstream and it must be in sufficient quantities in the vaginal fluid, semen, and blood or breast milk. In other words the transmission is possible when a HIV infected individual's body fluids come into direct contact with the body of another individual (Ibid, 32).

The virus is primarily transmitted in the following way:

1. By sexual intercourse: HIV can be sexually transmitted through having unprotected penetrative vaginal or anal intercourse or oral sexual contact with an

- HIV infected person. This can be in a heterosexual (opposite sex: men and women) or homosexual (same sexes) relation. Heterosexual intercourse is responsible for 70 percent of all HIV infections experience worldwide. The risk appears to be greater during unprotected sex especially when there are presences of sores or sexually transmitted infections (STIs) or when one of the partners has a high viral load (Jackson 2002:83).
2. Through contaminated blood: The HIV is transmitted from one individual to another by receiving contaminated blood during blood transfusion, or by using a needle contaminated with HIV infected blood to inject medicine, or when an injury occurs as result of a blood contaminated needle, syringes, razor blades or other spiky instruments (Van Dyk 2004: 38).
 3. By sharing toothbrushes when there is cut in the mouth (Soul City 2005: 7).
 4. Transmission from mother to child (MTCT) also known, as vertical transmission is one of the leading causes of HIV infection in children. The virus can be transmitted from an infected mother to her baby while in the womb (during pregnancy), through contaminated blood during childbirth, or while breastfeeding (Van Dyk 2004: 43).
 5. Injecting drug use. Sharing needles or syringes for the purpose of injecting drugs with an HIV infected individual, the virus can be transmitted. This practice is common among intravenous drug users. There is an easy transmission with this practice because drugs are directly injected into the bloodstream (UNAIDS 2000: 74).

The avoidance of virus transmission can be possible only when any types of sexual encounters are done using proactive measures (such as condom), when people do not share needles to inject drugs instead they are give disposable needles. A thorough blood screening process should be conducted before any blood transfusion is administered to individuals. An HIV infected mother should refrain from breastfeeding their child. Applying the above preventive knowledge on the way in which the virus is transmitted from one individual to another is a very crucial step in avoiding the risk of becomes

infected with the virus. Risk behaviours that allow for transmission of HIV include having unprotected sex or sharing needles while injecting drug.

Joffe (1999:4) says that: “*risk refer to the probability of a negative outcome, accompanied by the magnitude of the damage which it will do.*” Alluding to Joffe, risky behaviour in the era of HIV, is having unprotected sex, sharing needles while injecting drug and these have negative outcome and the magnitude of it damage is incalculable. With refugee populations, life away from home and the sudden separation from a regular sexual partner because of incidents like war, often compel such individual to seek another sexual partner as he or she seeks to meet sexual needs and to find comfort. Men, who are suddenly forced to flee their country due to events beyond their control, may experience uncertainty about their possible return to their home country. Their uncertainty about the future may lead to the temptation of engaging into risky behaviour which often may involve unprotected sex with multiple partners. Consequently, the adoption of new sexual lifestyle can then place refugees at increase risk of contracting HIV (Morrell 2001: 277).

Apart from the fact that refugees often move from low HIV prevalence areas to areas of high prevalence, factors such as limited access to health care and, lack of education increase the level of risk of HIV infection. Increased access to health will provide refugees information about treatment of sexually transmitted diseases and HIV testing. Access to condoms and education will help them to make sound decisions when engaging into sexual activities (Roberts 2004).

Sabatier (1988:9) says. “*It is behaviour and not one’s belonging that is the operative risk factor with most modes of HIV transmissions.*” The perception held that refugee men are risk group or polluted denotes the fact that risk is linked with one’s social group.

However, risk can also be seen as related to low levels of social cohesion, weak social norms and broken family structures that confront refugees’ lives. A combination of these factors can easily generate a risk milieu for the transmission of HIV (Jackson 2002: 84).

2.1.2 Mobility and HIV risk

Mobility refers to the desirable or undesirable movement of an individual or a group to a location other than their original dwelling place. This movement might be either permanent or temporary, within their country's borders (internal) or beyond (international) and for a variety of reasons. It could be willingly or unwillingly undertaken. Mobility can heighten an individual's susceptibility to the risk of HIV infection. While on the move, mobile individuals might be involved in sexual activity with casual partners at each place they pass through before reaching their place of destination. Hence their involvement with multiple casual sexual partners can increase susceptibility to the risk of HIV infection. Once settled at their final destination, they might still continue with the practice of engaging into casual sex with multiple partners. In addition, a change of casual sexual partners can be the result of the economic status, which they might have earned in their host country (Guinness; Kumaranayake and LSPHH 2002:2-3).

I would argue that although individual refugees might be integrated or have settled down in their host society, the fact that some of them are single men living away from their families, could account for the stimulation of a strong need for sex. This would increase the conditions necessary for the spreading of sexually transmitted diseases.

“If you wanted to spread a sexually transmitted disease, you would take thousands of young men away from their families, isolate them in single sex dwellings, and give them easy access to alcohol and commercial sex.” (Jackson 2000: 312).

Men away from their normal environment and living in isolation will often have strong sexual appetites. This is evident from a study amongst migrant mineworkers in Carleton Ville in Gauteng Province, South Africa, who were housed in single-sex hostels. The study revealed that the level of HIV-infection was in the region of 25%. I have to make it clear that despite living in single-sex accommodation, the risk of HIV-infection in this type of environment emanates from heterosexual relationships (Morell 2001: 275).

The intake of alcohol suppresses the individual's ability to make sound decisions before engaging in sex and undermines the likelihood of condom use (Morojele *et al.* 2006:222).

A large number of refugee males living in South Africa are single who, because of the lack of family responsibility, are very mobile. Mobility itself, however, should not be constructed as tantamount to a vulnerability to HIV-infection in a manner that removes individual' behaviour from equation (Jackson 2000:34).

In the Western Cape the majority of refugees are found in the Cape metropolitan areas rather than in the rural areas. Generally they move between Cape Town and the other big metropolitan cities of South Africa such as Johannesburg and Durban. The prevalence rate of HIV in the Cape metropolitan area is 8.1% compared to the provincial prevalence rate of 7.1% (Van Donk 2002: 1-2). Mobility gives a sense of anonymity, which facilitates sexual freedom. Refugee men are difficult to reach with preventative education. According to a study conducted in a rural KwaZulu-Natal community, people who had recently changed their place of residence were three times more likely to be HIV-infected than those who had not (Lurie et al 1997: 19).

Empirical data has shown that mobility itself is a risk factor for HIV-infection. Mobility is sometimes motivated by the search for employment opportunities in cities because of the likelihood of finding better employment. Cities are considered to be a sexually permissive environment. Mobile individuals are more likely to engage in sexual behaviour that increases their risk of HIV-infection than a non-mobile individual (Brockhoff and Biddlecom 1999:834).

Brockhoff and Biddlecom point out that *“riskier sexual behaviour among mobile groups have been attributed to three factors which are predisposing individual characteristics; change in individual attributes due to mobility, notably separation from partner; and exposure to new social environment, featuring different sexual norms, opportunities and constraints that result in behavioural change.”* (1999: 835).

From the start it should be noted that despite an individual being mobile, mobility as a phenomenon should not be equated to risk. Mobility however, can motivate or create conditions favourable for people becoming vulnerable to high-risk sexual behaviour (Ibid, 835).

The Southern Africa Development Community (SADC) region consists of 12 countries namely: South Africa, Mauritius, Mozambique, Namibia, Botswana, Democratic Republic of Congo, Angola, Zambia, Lesotho, Swaziland, Malawi and Zimbabwe. It is in this region that there is great mobility amongst the population in part due to good road infrastructures. It is ascertained that mobility encourages people to be promiscuous and to indulge in short-term relationships, whether social or sexual (Hans-Petter Boe and Crush 2005:25). Research has shown that mobility is an important contributing factor for the spread of the AIDS pandemic in the Southern Africa. Mobility can be from rural to urban areas or cross-border (between neighbouring countries in the region). The economic development and the infrastructure of the region unwittingly induces mobility (Ibid, 24).

In the SADC region much of the population movement is attributed to socio-economic factors such as employment and trade, and to war and natural disasters (Jackson 2002: 84).

Labour mobility in South Africa is believed to have contributed to the spread of HIV and sexually transmitted diseases. The seasonal work mobility refugees are involved in might cause them to become unstable and their unstable lifestyle could have a bearing on their sexual behaviour. Thus mobility, coupled with sexual activity, could be a contributing factor to the risk of HIV infection. Although it has been said that mobility exposes mobile individuals to the risk of HIV infection. However, mobile individuals could be at risk of contracting and of exposing others to infection, especially if they indulge in unprotected sex with many partners in every place they visit (Ezekiel et al 2004:182). The factors, which render mobile individuals susceptible to the risk of HIV infection, will be discussed in detail in the section that follows.

2.1.3 Discrimination and the risk of HIV infection

Zastrow and Kirst-Ashman (2004:187) state, “*Discrimination may involve abusive physical actions or unequal treatment of people.*” Soul City (2004:11) defines discrimination as “*the way that people actively identify and act against others because of their race, status, origin and so on.*”

Discrimination, as experienced by refugee men, is the result of the perception that some local people have of them being a polluted risk group, which is out of place. This discrimination may be caused by the fact that they appear to be a problem and an unknown entity to some local people. Adding to such stigmatised constructions is the fact that many refugee men come from war-torn countries where health facilities have been completely eradicated as a result of war. At the same time they are also perceived as a risk group because some people believe that they lack the societal norms which should guide their sexual behaviour and that refugees present risks to the host country [South Africa] (Padayachee 2006:270).

The perception that refugee men are a risk group can be seen in statements made by some South African men such as: “*since foreigners have moved to South Africa, there are a lot of diseases such HIV and STDs. Once a male foreigner moves to an area, girls become attracted to him because of the money the man offers them. If you want to die quick, fall in love with a girl who was involved sexually with a foreign man. Foreigners must stop sleeping around with our girls because they are giving them HIV*” (South African man at Green Market Square).

The statement above is an example of the perception that refugee men are a risk group as well as a problem to the host population because their presence signifies danger and the potential pollution of the host society because of the possibility that refugee men will infect local girls with HIV. The message that this sends out is that one should not mix with them for fear of becoming infected with HIV.

Malkki (1995: 8) acknowledges the existence of this perception when she says, “*Asylum states and international agencies dealing with refugees such as the United Nations High Commissioner for Refugees (UNHCR), sometime ‘tend to share the premise that refugees are ‘a problem, not just ordinary people worthy of respect and human dignity.’*”

I would argue that the attitude of asylum states and international agencies as pointed out by Malkki and the perception held by some local people at times encourages discrimination against refugee men. One group perceives them to be polluted ‘other’ and a risk group and the next group views them as a problem and not just ordinary people worthy of respect and human dignity.

Discrimination is also expressed through comments like these: “*Apart from the money, our girls follow foreigners because they dress nicely. But these foreigners do not have genuine love for our local girls; they want them just for sexual pleasure. Most foreigners stop in Johannesburg before coming to Cape Town. While in Johannesburg they become infected with HIV and then come with it to Cape Town. African foreigners need to be screened before entering South Africa because their HIV is killing us*” (South African respondent, Green Market Square).

These comments support the view that African foreigners in general and refugee men in particular, are a polluted risk group. In addition, these comments denote discriminatory sentiments, especially with the suggestion that African foreigners entering South Africa should be screened. Discrimination in these comments is conceived of in terms of purity and impurity with refugee men being the most impure and being those whose impurities increase danger and pollution to the more “pure” South Africans (Naicker and Nair 2000: 13). Interestingly, however, the respondent was unaware of the contraction in his own statement and thinking. While he blamed African foreigners for bringing HIV to Cape Town, he refined his accusation by stating that the “ stop in Johannesburg” before coming to the Cape and that it is the stay in Johannesburg that exposes the refugee men to HIV in first place.

The South Africa Green Paper on International Migration of May 1997 argues, “Refugees’ protection is fundamentally a human rights issue.” (Green Paper 1997: 20) Regrettably, although these principles are clearly stated on paper their implementation leaves much to be desired. At an international level, the International Refugees Law requires that refugees should have non-discriminatory access to services in the country of asylum (Williams 2000: 10-11).

The perception that refugee men are a risk group or a polluted ‘*other*’ indicates the inability of some local people to build meaningful relationships with African foreigners. Malkki (1995: 12) argues: “It is the refugee who reveals to us the defective society in which we live. He is a kind of mirror through whose suffering we can see the injustice, the oppression and the maltreatment of the powerless ‘them’ by the powerful ‘us’.”

I would argue that defective elements of South African society are revealed in expression of increasing competition between local population and refugees over scarce resources such as jobs and housing. The perception is that refugees should be blamed for the shortage of services and the pressure on the infrastructure of the host population.

Discrimination entails treating refugee men as a polluted risk group because they are an unknown entity who often originate from war-torn countries where health-care has crumbled. Refugee men are perceived to be a polluted risk group, which is believed to present an eminent danger to some local South Africans. Whoever comes into contact with refugees could be infected with disease. It is believed by some South Africans that the mass influx of refugees in the urban centres of South Africa in the early 1990s has had a dramatic impact on the patterns of sickness and health. The concept of disease and problems of sanitation have influenced the development of a discriminative attitude. It is believed that refugee men have infectious diseases. However, the underlying factor leading to this perception is not one’s refugee status or being out of place, but the discriminatory access to scarce resources based on one being an unknown entity (Chirwa 1998: 54).

Discrimination against the ‘*others*’ who are an unknown entity and who are potentially seen as polluted and an HIV risk-enhancing group could prevent them from seeking appropriate information regarding HIV (Williams 2000, Dodds 2004).

I therefore argue that the discriminatory attitude towards refugees is exacerbated through the perception that refugees are a polluted risk group, are associated with the danger of infection and disease, particularly HIV. Such perceptions have reinforced the feeling of ‘us’ in good health, precious and needing to be protected against ‘them,’ who are more susceptible to infectious diseases and have no access to adequate health care (Williamson 2004: 22).

The ‘othering’ attitude that has developed amongst some South Africans and expressed toward the mass influx of refugees, allows South Africans to believe it is their right not only to differentiate between themselves and refugees (the ‘other’) but also to blame refugee for the fantasy health threat refugee men pose to the nation (Sabatier 1988: 108).

Discrimination, then, is used to convey the message to the refugee population that there is no space in South Africa to accommodate them. While South Africans worry about their own vulnerability to refugees, such unwillingness and the discriminatory attitudes on the part of South Africans themselves create risk situations for refugee populations as they influence the behavioural patterns of those who have been ‘*othered*’ (Said and Hitches 2001: 239-241).

2.1.4 Prejudice

‘Treating refugees and displaced persons as special risk groups would only further enhance their marginal status and stigmatise refugees.’ (Long 1997: 87)

The fact that refugee men are perceived as a polluted risk group, has not only led to discrimination but to prejudice from local South Africans (the “in-group”) towards refugee men (the “out-group”). Prejudice is defined in Zastrow and Kirst-Ashman (2004:

187) as an “*opinion about an individual, group, or phenomenon that is developed without proof or systematic evidence.*” Prejudice is a combination of stereotyped beliefs and negative attitudes. Discriminatory prejudice upholds dominion, influence, and the defence of interests and rights. Prejudice generates a sense of ‘othering’ because local South Africans differentiate themselves from ‘others’ due to their nationality, origin, language, occupation, status and appearance. The above-mentioned differences do indeed exist and when employed in the process of ‘othering’ of refugees allows for South Africans to feel both superior to and protected from refugee populations. As an example of this dynamic, in the era of the AIDS pandemic, South Africans share the false supposition that HIV continues to travel to South Africa via black African foreigners and that black foreigners pose a risk to a mythologically HIV-free South African populations (Van Dijk 1987: 195-198).

Prejudice may be on the increase because of the presence of refugees in South Africa and the changes in the social landscape that are believed to have happened as result of the refugees’ presence in South Africa. Popular belief has it that the presence of the refugees is believed to have created social problems because refugees are believed to have occupied every space, competed for scarce resources and taken local women to satisfy their sexual needs. Refugee status has made these people subject to insults by some local South Africans.

Malkki (1995: 65) argues, “*These remembered insults seemed to serve as retrospective inventories of the kind of stigma that could be expected to attach to refugeeeness.*” To have come from war-torn countries is to have been carrying infectious diseases and to be abnormal. It is thought that refugees coming out of war zones should be treated as if they were a health hazard that required cleansing. The insults made against refugees by some South Africans, have completely ignored the suffering and traumatic experiences that some refugees have had during their flight to South Africa (Said and Hitchens 2001:114).

The prejudice that refugee men experience may be attributed to the fact that, in relation to the host South Africans, they are outside the ordinary social system. The difference

between ‘us’ (local South Africans) and ‘others’ (refugee men) has played a major role in influencing prejudice directed against refugees. Some South Africans see refugees as parasites whose presence represents a threat to society (Malkki 1995: 15).

2.1.5 Health, education and HIV risk

Health is a condition of absolute physical, mental and social well-being. Good mental health enables a person to make sound decisions and responsible choices concerning life issues. Bad choices and decisions might well destroy his or her life and physical health. Good choices and decisions enable individuals to be productive as they seek to rebuild their lives (World Health Organization 1997). Within the context of HIV, the complete mental, physical and social well-being of an individual will decrease his/her level of exposure to the risk of HIV infection. The only way that one can know that one is in good mental and physical health is by having easy access to health-care. Often the way men live their lives away from their original place of dwelling makes it difficult for them to give priority to their health needs. In the context of this study health will be used to refer more to the aspect of social well-being and will include individual refugee’s behaviour, which might expose them to the risk of HIV infection.

Broadly speaking, education is the gradual process of acquiring knowledge or activities that impart knowledge and skill. In the context of HIV, education plays an important role. United Nations Education Science and Culture Organization (UNESCO) recognises that when people are offered learning opportunities, they enable them to develop good knowledge, skills, competencies, values and attitudes that will limit the transmission and impact of the pandemic (2004: 5).

UNESCO has established a prevention education approach, which has as an aim to ‘tackle people’s mindset and the culture within which they originated in order to produce the attitudes, impart skills and to maintain the energy necessary for changing behaviour to reduce risk and vulnerability.’ Since HIV does not have any available cure, UNESCO believes that education is the best way to prevent the spread of the AIDS pandemic

because education is the basis for developing the behaviours that can reduce the individual risk and vulnerability, since risk and vulnerability are features contributing to the spread of HIV. Furthermore, education can be used as a tool to empower individuals to make free and informed decisions, in particular about sexual activity and condom use (Ibid, 14, 17).

For the purpose of this study the term ‘education’ will refer to refugee knowledge about the HIV infection transmission mode and the factors that increase the risk of HIV infection in a given population.

2.1.6 Marginalization, the “other” and the risk of HIV

“Exile is one of the saddest fates ...fleeing was a particularly dreadful punishment since it not only meant years of aimless wandering away from family and familiar places, but also meant being a sort of permanent outcast, someone who never felt at home, and was always at odds with the environment, inconsolable about the past, bitter about the present and the future.” (Bayoumi and Rubin 2000: 369).



According to Joffe (1999: 18) the word ‘other’ generally includes those outside of, and implicitly subordinate to the dominant group. He states: “a distinctive aspect of being ‘other’ is that one is the object of someone else’s fantasies, but not a subject with agency and voice (Ibid, 18). Joffe’s aspect of ‘other’ concurs with Edward Said’s idea of ‘Orient’ (Joffe 1999).

Spiegel and Nankoe (2004: 21) state,

“Throughout history, marginalized populations have been blamed for the spread of disease. Often inadequate living and working conditions render them more vulnerable to various illnesses. Theories of disease causation versus the actual reality of a disease feed upon each other as the poor get not only the blame, but also the disease. Such a self-fulfilling prophecy has also characterised the

HIV/AIDS pandemic. Refugees are often doubly discriminated against: firstly for simply being refugees and secondly for being falsely accused of bringing HIV and AIDS with them into host countries of asylum.” (Spiegel, P.B. & Nankoe, A.2004)

I would argue that the situation that led to the existence of refugees has contributed to some extent to refugees being marginalized. Refugees are perceived as dangerous. The danger that they present is as a result of being polluted, literally out of place and not belonging to the host's social system. The blame leveled against refugee men for the spread of HIV amongst the host population is an attempt to regulate the dreadful situation caused by HIV. It is an attempt to vindicate the hosts' perceptions and their condemnation of the 'other' (Douglas 1976: 103).

The image of refugee men as a primary source of HIV infection does, in some way, benefit the local population. Blaming foreigners takes the spotlight off the host population as the possible source and carriers of HIV infection. It protects the host community from the stigma associated with HIV and AIDS. It allows the host community to avoid traumatic self-reflection and consideration of the possibility of being infected with HIV and being responsible for having transmitted it to other people (Said 1995: 40).

Being an unknown entity to some South Africans has resulted in much suffering for refugee men. As those who are believed to be a health hazard, they have been marginalized. They are not seen as victims of forces beyond their control. Some South Africans attribute their prevailing health and social misery to the presence of refugees. Refugees have consequently been blamed. Although I would argue that refugee men seem to be resilient, they have doubtless been affected both emotionally and psychologically by the accusations levelled against them (Douglas 1976: 15).

The significance of this research project lies in the mere fact that refugees and HIV are two contentious contemporary issues affecting politics, society, education and religion. The magnitude of the problem gives the research project much significance.

2.1.7 The refugee

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

A person who, because of well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling, to avail himself of the protection of that country.(UNHCR 1991: 10)

The 1969 OAU Convention further expands the definition by saying that the term refugee shall apply to:

Every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality (Article 1(2) of the 1969 OAU Convention Governing the Specific Aspects of Refugee Problem in Africa).

In this study, the term refugee and asylum seeker men will be used interchangeably. The inclusion of asylum seekers is justified by the fact that South Africa has a backlog of more than 117,000 pending asylum claims in July 2005 compared to 28,000 recognised refugees in July 2005 (UNHCR Global appeal 2006: 211).

In the South African context the term refugee encompasses both recognised refugee and asylum seekers. The three main international legal instruments serve to guide the protection process of refugees in the state of asylum. The protection that the host country

has to provide to refugees encompasses the entire scope of the refugee's life. In the case of this study, the protection provided by the host government and UNHCR should include protection from risk of HIV apart from physical and material assistance that refugees may enjoy (Okoth-Obbo 2000: 42-43). Yet single male asylum seekers and refugees in South Africa are not considered to be vulnerable groups by the UNHCR and are therefore not targeted by their assistance programs (Belvedere et al 2003: 181).

The following section will explore the AIDS pandemic and the blame that ensues as a result of the deadly nature of the disease. Because HIV and AIDS are the focus of this research, the research will try to unpack the different trends of blame in the age of the AIDS pandemic.

2.2 AIDS pandemic and Blame

2.2.1 Pattern of blame: past and present

The HIV infection rate in South Africa is at the present time higher than it is in the other countries in Sub-Saharan Africa from where the majority of refugees originated. Blatantly blaming refugees defies reality and hampers people's ability to fight the common enemy of HIV (Sabatier 1988: 78).

As stated earlier, the proliferation of blame in South Africa is used as a means to deny and to avoid facing the fate of the result of this particular disease. The refugees' presence in an era of HIV and AIDS has been considered a health threat to the nation (Said and Hitchens 2001: 149). As a result of the South African experience with Malawian mineworkers, a belief has been born that African foreigners are HIV carriers. In the case of this research, this belief has become the lens through which 'refugeeness' is experienced, and it has shaped the language, perception and form of the encounter between refugee men and local South Africans (Chirwa 1998: 55).

It is a common pattern throughout history that whenever a disease surfaces, others are blamed for the disease. South Africa is not exempt from this attitude. Deacon et al.

(2005) have called it: “not me - others are to blame.” By shifting the blame to ‘others’, those who do the blaming believe that their risk of being infected is reduced. In this case the refugees are being seen as ‘others’ who are constructed as being the source of HIV infection but are in fact at higher risk for HIV in their host country of South Africa than they were at home (Deacon 2005: 7).

Whenever an epidemic has erupted in South Africa, blame has always been the response. In the late nineteenth century syphilis was believed to have been brought onto South Africa shores by the gold and diamond miners; the spread of smallpox in Cape Town in 1840, 1858 and 1882 was blamed on the ‘dirty Malays’ by whites and they even went as far as blaming Muslims of infecting them purposely; the bubonic plague was blamed on the unhygienic Africans by the whites; Africans who believed that the whites wanted to exterminate put the blame for ‘Spanish’ flu on them; typhus and Asian flu was blamed on the newly recruited mineworkers in 1920, 1930 and 1957, and later in the century with the appearance of HIV, blame was widespread. The first group to be blamed were male homosexuals; the second, heterosexual Africans and the third and fourth groups were the migrant mineworkers from Malawi, discharged South African Defence Force soldiers and the returning African National Congress cadres in the 1980s and the early 1990s. The type of blame that manifested with the appearance of the AIDS pandemic in South Africa exemplifies reaction to previous epidemics (Kauffman 2004:32-33).

The ‘blaming-the-others’ (outsiders) attitude is not particular to South Africa. Kauffman (2004: 34) notes: “*In 429BC, some Athenians blamed the Peloponnesians for the plague...; in 1349 Jews in Germany were blamed for the Black Death and in 1830 Russians identified Polish agents as the bringers of cholera to their country.*” The fact that one group attributes the fault to another group, separates “us” from “them.” Those who blame have the tendency of saying that they have been invaded from without and have been polluted by outside agents (Ibid, 34).

With the fall of the Apartheid regime in the early 1990s, South Africa experienced a mass influx of African foreigners. Amongst them were refugees who, because of the

alarming high rate of HIV infection in South Africa, are being blamed for bringing the disease with them. Sabatier (1988:9) describes blame as the third epidemic when he writes: *'that even the apparition of influenza has historically prompted a social response based on blaming others for the spreading of the disease by their deviant behaviour.'*

The aftermath of the repatriation of Malawian mine workers led to the development of the common perception that outsiders inflicted HIV upon South Africa. The emergence of HIV amongst the Malawian mine workers gave rise to their being blamed at the end of the 20th century and the beginning of 21st century South Africa. The diagnosis of HIV amongst Malawians has heightened the blaming of foreigners and refugees in particular (Chirwa 1998:57-58).

Previously, infectious diseases in South Africa were always associated with the marginalized. In the case of the AIDS pandemic, blame is used as a means of self-justification and to create distance between 'us' and 'them'. This results in the 'other' being forced to carry the burden of the disease as they appear to be polluted and contaminated in the eyes of local South Africans (Joffe 1999:76). The history of blame in South Africa has evolved drastically and has even resulted in bodily harm being inflicted in some cases (Hook and Eagle 2002:170).

2.2.2 Blame as Social representation

In South Africa, blame as social representation evolved as a result of the repatriation of 13000 Malawian mineworkers between 1988 and 1992, with 200 of them testing HIV positive. From that period on, blame became a way of dealing with foreigners in general and refugee males in particular (Chirwa 1998: 53), with democratic South Africans, according to Joffe (1999: 91), blaming refugees for being HIV carriers and becoming the way in which local South Africans represent refugee men socially (Joffe 1999: 91).

The representation of refugee males as the ones to be blamed is an egocentric illusion on the part of local South Africans, because they have attributed a high level of blame to

refugee men who are linked with the spreading of HIV in South Africa. One might argue further by saying that there is a strong inclination in society to identify with what is good and to attribute misfortune to the 'other'. Attributing misfortune to the 'other' is the same as accusing someone of witchcraft. Both are considered dangerous. The identification with what is good is an attempt to control the situation by justifying oneself and accusing the other (Douglas 1976: 103).

Refugee men are victims and have to live with the weight of carrying the blame for the misfortune of the AIDS pandemic. Refugee lives have already been tampered with in their countries of origin and this has caused local people to believe that their situation is deserved. This has led to the creation of 'us,' local South Africans otherwise described as 'good people,' and 'them,' refugee males, otherwise described as 'bad people'. Favourable consequences are to good people and unfavourable consequences to bad people. Bad people should, therefore, be victimised and blamed for the AIDS pandemic that is ravaging South Africa (Joffe 1999: 64-67).

It is interesting to observe how social representation has evolved over the years as the AIDS pandemic has spread. It has been noted that ordinary South Africans interpret refugeeness differently by ascribing a different representation to refugees. Ascribing a different representation to refugee men has, to a certain extent, made refugee men more vulnerable to victimization and blame. Refugees are not to be found in every corner of Cape Town. The majority of them are to be found in the Cape Metropolitan area. The local media plays a big role in the construction of a social representation of refugees because it is a powerful tool in the disseminating and filtering of information to the wider community. Media propaganda contributes to the formation of beliefs and stereotypes. It can be argued that the media has played an important role in the structuring of the social representation of refugee men as being the subject of blame for the HIV infection. In other words, one could confidently say that the media has contributed to the shaping of the debate around the presence of refugees in South Africa in general and in Cape Town in particular. Refugees have been represented in some quarters as a health danger; or as those who always steal women from their South African boyfriends. Through the social

representation they receive, their status can only be seen as undesirable and useless (Orfali 2002: 405-408).

Williams (2000: 11) points out that the need to blame someone or some group without considering and dealing with the historical and structural causes of one's own problems inevitably leads to the type of violent action against those people often described as "aliens" or "amakwerekwere." (is a derogatory term used to designate black African foreigners). In the context of HIV, and from what has been pointed out by Williams, attempts have been made to try and find where the disease originated from but all these have failed, leaving speculation to gain territory about the origin of the AIDS pandemic and opening a space for blame being attributed to a particular individual or group being the source of the disease. One can note a shift in attention. Instead of finding out the factors which contribute to the increase of the risk for the rapid spread of the disease, most efforts are directed to finding the culprit to blame. Refugee men have been identified as the culprit (Ibid, 11).

In line with the idea of the social representation of refugee men as the subjects of blame, one could argue that because refugee men are perceived to be a polluted risk group who appear to be out of place, these perceptions have made refugee men the object of the misfortune that occurs within the society in which they live (Malkki 1995: 170).

The representation of refugees as the subjects of blame for the spread of HIV diverts attention away from the need to tackle the source of the disease. Do those who point fingers take any responsibility themselves? I propose that one of the most serious distortions of blame occurs when it singles out one group at the expense of the broader network of responsibility in society. The social representation of refugee men diverts attention away from the need to admit one's responsibility for the disease. False social representation and scapegoating form part of the same continuum. Since refugee men are seen as a soft target and the least able to resist any accusations because of their vulnerable position, blame is put on them minimizing the blamer's need to take responsibility for the

source of the disease. Representing refugee men as culprits can be translated into what is described as: 'I suffer: someone must be blamed for it.' (Williams 2003: 438-442).

Moscovici (2001: 38) has argued that "people who belong to other cultures are often viewed as a disturbance. They appear like us and yet are not, and are thus described as uncultured, barbarian, irrational and so on. In fact, those who have been exiled to the very frontiers of our society are there without being there; perceived without being perceived." Here, one can argue that blame as a social representation operates as a means to disregard and dehumanise refugee men. Some South Africans acknowledge that, although being refugees, they are our African brothers. However, in some quarters refugee men are seen as the '*other*' who are different and not like us. A fear of those who appear different is forged because of the deadly nature of HIV. The fact that the origin of the AIDS pandemic is not well known creates controversy and, added to that, it leads to a false, incorrect social representation. Blame as the social representation of refugee men echoes Said and Hitchen's (2001: 152) statement that "*we* are never terrorists; it's Moslems, Arabs and Communists who are."

Blame as a social representation has contributed to the increase sense of vulnerability for refugee men towards local South Africans, who accuse refugee men of spreading HIV infection in South Africa. The sense vulnerability refugee men may experience can come in a form of stigmatization or else discrimination, and prejudice (Ibid, 154).

The social representation of refugee men in regards to the AIDS pandemic is the result of existing ideas about the previous epidemics. Blame and representing refugee men as '*others*' is best understood through "anchoring" which can be described as "a set of ideas, images and language embraced by group members paving the way for classification, naming, making the alien, creating threatening events such as the AIDS pandemic and making a particular group of people representative" (Joffe 1999: 94).

The perception about refugee men being a polluted risk group might have contributed to the blame, which might further have intensified the social representation of refugee men. This attitude of some local South Africans is to label refugee men as culprits, the very

men who are already victims. Because of the way some South Africans perceive refugee men, it would be easy for refugee men to develop an identity crisis or challenged to juggle multiple identities. One might argue that the juggling of identities has caused some refugees to conceal their refugee status. For these refugees, concealing their status may become a coping mechanism to escape blame. “The juggling of identities may work as an enabling, empowering strategy to render their ordinary behaviour inapprehensible in the public domain where they are often the soft targets of blame. Apart from using it as a particular social representation, blame is also a label, which further victimizes the victims” (Malkki 1995: 157-158).

In trying to analyse the social representation experienced by the refugee men in the form of blame, one needs to be careful not to fall into the trap of socially representing the host population in the process of addressing the treatment of refugee men. The emergence of epidemics has been linked to ‘others’ such as refugees in Cape Town, South Africa. However, as mentioned in the passage above, careful analysis of the situation must avoid socially representing the host population, since not all local people regard refugee men as being responsible for the disease. One should not disregard the fact that refugee men might, to some extent, see themselves as responsible for the crisis. In essence, social representation seeks to promote the positive identity of the in-group in contrast to the out-group (Joffe 1999: 103).

2.2.3 Blame as stigma

The incurable nature of HIV has led people to distance themselves from those who are perceived to be polluted in order to deny their fear of the risk of becoming infected. Goffman (1963: 25) defined stigma as “an attribute that is significantly discrediting and a stigmatised person as one who possesses an undesired difference.” Goffman continues,

Stigma is conceptualised by society on the basis of what constitute difference, and it is applied by the society through rules and sanctions towards the affected individual or group. It is in this context that attitudes and perceptions about HIV may have been formed and enacted to alienate and discredit people those who are seen as more likely to be affected by the disease than other (1963: 28).

The general perception amongst people is that 'it will not happen to us because we are part of the "good" group.' Analogously, stigmatisation contributes to the development of a sense of not being vulnerable amongst those people who believe they are part of the "good" group. The sense of invincibility helps controls their anxiety. The stigma of blame gives those who see themselves as part of the good group (South Africans) a false sense of security. Symbolic stigma is seen to function only in providing protection from fear and anxiety to the good group, but not from their becoming infected with the disease (Stein 2003: 8). By choosing to shame refugee men, local South Africans may not be aware that shame does not motivate change or promote good acts (Lamb 1996:13).

Aggleton (2000:9) argues in a UNAIDS report, "*Stigma is a powerful means of social control applied by marginalizing, excluding and exercising power over individuals who display certain traits.*" Stigmatisation is the result of the fear and anxiety that local South Africans display towards the disease. Could one argue that the attitude of shaming marginalized groups of black Africans, considering them dirty, in ill health and 'savage' rather than 'cultivated' has been inherited from the British colonialists? Referring to black Africans as dirty and diseased, they were alluding that their moral and physical condition was degenerate. They depicted a black body as absorbent, stinking, clammy and potentially contagious, compared to their white bodies, which were "clean, contained and controlled" (Lupton 1999:131).

In today's democratic South Africa the situation remains similar. The shaming now is between Africans themselves compared to white and black previously. The thinking is that it is 'not me but them who are causing havoc in our clean communities' (Ibid, 131). There is an overriding belief that HIV is linked to the 'other' nations and groups (Joffe 1999:39). Refugee men always appear to be in the position of both 'outsider' and 'other' and of the incorporated weaker partner of South Africans (Said 1995: 208).

Lamb (1996: 11) argues that, "the more you blame a person, the more ashamed he feels and the greater his tendency will be to hide his head, deny his wrongdoing, or look outward for causality." Blame as a stigma can cause stigmatised refugee males to suffer

what Joffe (1999: 44) calls ‘identity ambivalence’ since they appear not to respond according to society’s norms and are therefore considered odd. Identity ambivalence causes refugee men to feel ashamed and, in the process, develop a ‘spoiled identity’. The internalisation of blame might well contribute to the development of a spoiled identity (Ibid, 44-45).

Refugee men are believed to have a great sense of resilience despite the blame they experience from the local men at the market. While spending time at the market listening to their conversations, they rightly pointed out to the researcher that: *“Although sometimes we can feel confused by the way our identities are interpreted, one thing we can guarantee you is that we will never try to internalise our so called spoiled identities because when the local men are not happy with you they will turn to call names. We just have to let it sink and move on with our daily businesses.”* (Refugee man at Green Market Square).

Barnett and Whiteside (2002:66) have argued: *“The disease has been used to stigmatise various out-groups. Foreigners, those people who are blacks. People have used these labels, and many more to identify those who are to be stigmatised.”*

Coetzee (2002: 121) points out that the United Nations High Commissioner for Refugees (UNHCR) considers the local integration of refugees a preferred durable solution. However, the degree of blame levelled at refugees and the extent of their interaction with local South Africans, have served to foster tremendous levels of xenophobia. As refugees live side by side with the local population in South Africa, fertile ground is created for blaming to take place (Ibid, 121).

In using blame as a stigma, refugee men are represented in the surrounding Cape Town townships as the ones spreading the problems including HIV and as agents of contamination. Stigma leads to fear and anxiety amongst those who have been stigmatised. This is the main reason for the dominant group to use blame, to protect themselves from having to face the AIDS pandemic, making it something refugee men

have to internalise. Their fear and anxiety might not only be as a result of being blamed for causing the AIDS pandemic but also of seeking proper information concerning HIV from the local service providers (Lupton 1999: 141-142). Refugees are victims of forces beyond their control and, in their country of refuge they are victims of blame resulting in 'blaming the victim for being a victim' (Douglas 1995: 135).

Those who assign blame view refugee men as a social risk and 'other'. They distinguish between pure and impure, infected and uninfected people groups asserting that 'we' will not mix with them because 'we' are pure and belong to the social system and the 'other' are polluted and outside the social system. This attitude offers a measure of protection (Kopelman 2002:241). Their desire is to blame the origin of the disease on a particular group (refugee men) in order to protect themselves (local South Africans). It can be said that those who do the blaming are in denial and are merely building their own superior identities at the expense of those they choose to undermine (Stein 2003:10).

The nature of the treatment that refugee men are subject to causes some of them to conceal their status as refugees and one can extrapolate, HIV positive. I would argue that if anyone is stigmatised and othered for being HIV positive, he or she will hide away, not seek help and therefore live at a much higher level of risk for not being able to care properly for him or herself. Among some refugee men, there is an interesting accusation which has led to the 'not me – others' attitude within their own group (Malkki 1995:160). Malkki goes further to argue that, 'labelling refugee men as the 'other', polluted and a risk group' fosters stigmatisation, prejudice and discrimination' (Ibid, 161). Blame as a symbolic stigma also promotes the idea of categorizing 'others' as being 'the risk group' (Levine and Ross 2002: 95).

The constant blame that refugee men receive makes them feel worthless and soulless. These feelings could increase the development of risky behaviour (Lamb 1996: 26). The manner in which blame is used to stigmatise refugee men, has resulted in my 'theory of invulnerability.' The invulnerability theory has caused the host population to believe strongly that 'others' are the source of the disease and that they are most at risk of being infected. This theory is at the centre of the debate on blame and has resulted in a means of framing the 'other'. Framing

(stigma) depicts refugee males essentially as lacking legality, 'as a threat to the constructed homogeneity of national and local communities; as socially deviant and a moral and physical contaminant of the imagined body public.' In this context, the possibility of reconciliation between the constructed 'them' and the imagined 'us' is almost non-existent (Haynes, Devereux and Breen 2004:8).

I will argue that blame serves as a means to exercise power to reinforce the already weakened social structure of refugee men, in relation to what is acceptable and desirable. In so doing, the blamers seek to exclude those who are found to be deviant and contaminated. Blaming can also be used to frame or represent refugee men as being the 'other' who are polluted or infected whilst the 'us' are pure or not infected. Blame can also be seen as a way to justify the action of some South African against refugee men.

Said (2001: 13) has observed that: *"the problem is the use of the word terrorist as political weapon designed to protect the strong as well as to legitimise official military action against innocents."* HIV and AIDS may have been used as a means by some members of the host communities to shield their vulnerability as well as to legitimise blame being levelled at refugees (Ibid, 13).

Goffman's (1963) extensive work on stigma studied the way in which the blame put on people can affect the way they behave. Dodds (2004:17) states that: 'because they are being blamed, refugees have felt increasingly marginalized and hence their vulnerability to infection has been heightened.' Out of fear of stigma, refugees may deny that there is a problem, which later can lead to the development of a false sense of security, thinking that their behaviour cannot put them at risk of HIV infection. Conversely, they may become reluctant in seeking proper protection whenever they engage in sexual intercourse. Stigma can also lead to fear of undertaking an HIV test (Soul City 2005: 14). Stigma has a depressing effect on those whose social expectations of normality do not equal those of others in terms of health, social behaviour and appearance. Refugees are subjected to the judgements of the host communities and are blamed for the host community's suffering (Dodds 2004:1).

The host community is quick to blame refugees for their problems such as crime, unemployment, wage depreciation and the decline in health services. Many of these are beyond their control, especially the HIV and AIDS crisis. (Okoth-Obbo 2000: 47). Epidemics such as HIV and AIDS and others have historically provoked social responses based on blaming others for bringing the disease (Sabatier1988: 2). Drawing from Sabatier's work on blaming others, refugees are doubly traumatised by some members of the host community who perceive refugee men as a risk population group as well as blame them for the spread of HIV and the trauma of having to leave the instability and civil war in their country of origin (Ibid, 3).

Atrill (2001:3) argues: *“When people are blamed for being the source of an epidemic such HIV and AIDS, discussions around the subject of HIV and AIDS is obstructed and, as a result, the risk of infection is heightened due to fear.”* The failure of the host community to understand that refugees should not be blamed, leads to the development of low-self esteem amongst refugees which in turn contributes to alcohol abuse, drug use and risky sexual behaviour (Ibid.4). The blame and discrimination that refugees experience might well lead them to choose not to avail themselves of health care and the HIV and AIDS information which is available (Ibid, 5).

2.2.4 Blame as self-purification

South Africans who use blame might well be running away from having to face the awfulness of the AIDS pandemic. An attitude of self-purification denotes that “we” citizens are different from “them” black African foreigners because “we” are pure and part of the social system and they are not part of the same social system. Blaming black African foreigners in general and refugees in particular is something some South Africans have come to dismiss as slanderous prejudice. They have not taken the time to discover what it means to those who have to live with it on a daily basis. The claim of purity on

the part of some South Africans can be equated with other claims regarding the pervasive opposition between good and evil, us and them, pure and corrupt. The differences between pure and polluted can become associated with a distinction between ‘us’ and the ‘others’ (Malkki 1995:145).

Self-purification may have taken on the function of labelling, while labelling may allow those who perceive refugee men as polluted to overlook the role of their own behaviour in bringing and spreading HIV. Self-purification can also entertain the belief that refugees represent a health threat to the host population. This type of blame might well lead to the uninformed person believing that the term ‘refugee’ is synonymous to ‘bringers of disease.’ This situation indeed put refugee men in a very awkward position in term of the refugee status they hold. Is HIV the real issue or is blaming just another way of reclaiming power and control over refugees by the local population? The fact remains that refugee men’s risk for HIV infection can also be increased as they continue to sojourn in South Africa if no effort is made to address the things that expose them to risk. Thus far there is no indication of a strong connection between blame and the risk of HIV infection for refugee men. This, however, does not validate or condone self-purification at the expense of an already marginalized people. Refugees need to be considered as members of the wider South African society and need to be allowed to forge a social identity (Ibid.233).

Exploring the dynamics of blame, it is important for this study to analyse the factors that may make refugee men vulnerable to the risk of HIV.

2.3 Refugee males and Vulnerability

2.3.1 Refugee men’s exposure to the risk of HIV

“The very sense of masculinity that assists men in their day-to-day survival also serves to heighten their exposure to the risk for HIV infection” (Campbell 1997: 278).

Refugees have faced the increased danger of HIV infection throughout their journey - from the time conflict erupted in their country of origin, during the flight from their homeland, as well as during their settlement in the country of refuge. Apart from the fact that refugees might move from low HIV prevalence areas to areas of high HIV prevalence (Robert 2004), and adding factors such as limited access to health care, lack of education and social discrimination increase the level of risk of HIV infection (Ibid, 2004). While most refugees might have applied for refugee status on arrival in South Africa, I will argue that not all refugees left their respective countries because of fear of being persecuted or due to civil war. Most refugees understood, even before leaving their countries that they would have to take up refugee status upon their arrival in South Africa as a mean to guarantee their long stay in South Africa. They were aware of the benefits that supposedly came with refugee status (Steinberg 2005: 27). With their expectations not being met and with the lack of community and social norms, many refugee men find themselves at the margins of the society and tend to turn to sex as a source of comfort and as a means of relieving their frustrations. Men who have lost their partners might well seek to replace the former partner by new ones (Williamson 2004: 13).

Sabatier (1988:9) says, *“It is behaviour and not one’s belonging that is the operative risk factor with most modes of HIV transmissions.”* He continues into saying that we need to start talking of ‘high risk behaviour’ rather than ‘a high risk group’ (Ibid.9). Sabatier’s argument serves to dispel a misconception about perception held against refugees’ communities. Refugees often experience low social cohesion, weak social norms and family structures. The combination of factors such as excessive alcohol intake; social dislocation; social exclusion, and sexual behaviour could generate a risk milieu for the transmission of HIV and AIDS (Jackson 2002: 84).

Jackson (2002) states in UNAIDS (2001:5), *“physical, financial and social insecurity erodes habitual caring and coping mechanisms of individuals, with these conditions refugees are rendered disproportionately vulnerable to HIV and AIDS.”* Social exclusion, combined with open discrimination, can lead people to develop very low self-esteem that may in turn lead to high-risk sexual behaviour. Refugee men are often viewed

as the perpetrator of the violence such as war, which led to the flight from their homeland, and in South Africa they are accused of bringing the disease. Being accused thus, refugee men have become afraid of having an HIV test and added to the fear of HIV testing is the fear of victimization. Of course, not knowing their status can also result in refugees unwittingly passing on the virus to sexual partners within their refugee communities and the host communities (Atrill 2001: 6). The dehumanised image of the victim, which some South Africans have developed and propagated, can be instrumental in enhancing blame and discrimination (Said 2001:241).

It is well documented that women are more exposed to the risk of HIV infection due biological and social factors, notwithstanding the fact that men are also exposed to risk for HIV. The risk that refugee men may be exposed to is often the result of their own personal behaviour. Once they are settled down and have access to resources, they will tend to have multiple sexual partners and engage into risky sexual activities such as unprotected sexual intercourse with sex workers (McDonald 2000:112).

In addition, some refugee men may prefer to have sexual intercourse with casual partners such as sex-workers, to avoid establishing a long term or permanent relationships. For those refugee men who have little access to resources and even for those who have increased access to resources, sex may present the occasional opportunity to experience comfort and intimacy. Since it is occasional, sex without a condom may appear to be desirable. Sex is known to be an important part of a man's social network. Many men do not have the opportunity to express their masculinity due to their lower economic status. Living away from their families they have a tendency to opt for frequent sex with multiple partners as a means of expressing their masculinity (Campbell 2003: 33-34).

Those men who come from countries with a lower HIV prevalence often ignore the host country's HIV prevention messages because they regard themselves being less at risk compared to those who are seemingly more 'at risk.' Another factor that can be noted is their removal from the traditional forms of social control, which contribute towards the reduction of 'risky' sexual behaviour in their country of origin. The majority of refugee men living in Cape Town are young and with no dependents for whom they are

responsible. Added to this they are part of urbanization, a process that increases population density, anonymity, and insecurity, and hence the risk of infection (Crush 2004: 33).

Seeking to help refugee men reduce the risk of HIV infection is about encouraging abstinence, faithfulness, and condom use. It is about equal access to health care and effective human rights legislation. These are vitally important elements. HIV meanders intricately into our social relationships, into the very structure of our everyday life. Therefore, we need to ask serious questions about the experiences of refugee men as they sojourn in Cape Town. Due to the freedom of movement that refugees enjoy in South Africa, it is difficult to estimate the degree of risk that refugee men face. Even an estimated 5% to 10% constitutes a significant problem, which needs to be addressed effectively.

In male circles there is the existence of hegemonic masculinity notions, which help expose those types of masculinity, which become more prominent and dominant in given settings. Those men who do not meet the requirements laid down by hegemonic masculinity and who are not constant in themselves, are considered unsuccessful and powerless, since within a society certain forms of masculinity are probably 'culturally dignified' (Morrell 2001: 271). Notions of masculinity are not something that all men adhere to regardless of their popularity at a given period of time.

Those who do not adhere to the popular versions of masculinity find themselves discriminated against. As men believe that they are invincible against any given disease, let alone life-threatening diseases. Men who face uncertain future, they appear to be risk-takers. In terms of the AIDS pandemic, too little has been said about the degree of risk that men face in an age of HIV (Rivers and Aggleton 1999: 4-5).

2.3.2 Social Dislocation

“Social and civil dislocation due to conflict has been found to be a significant causal factor in the spread of the HIV and AIDS pandemics” (Williamson 2004: 12).

Jackson (2002:317) argues that ‘social dislocation is one of the most significant contributing factors to putting people at risk of HIV infection.’ Social dislocation can be understood as a phenomenon, which splits communities and families apart, destroying the very structures and support systems that safeguard them. Since refugees are socially dislocated, they are often separated from the communities and families to which they belong for an unknown period of time. The breaking down of structures and support systems contributes towards the development of risky sexual behaviour among a dislocated population (Ibid, 317).

Jackson states the dislocation in the context of HIV is the *“breakdown that clearly precipitates a rapidly increasing viral spread.”* (2002: 32). Although dislocation or displacement as such cannot be seen to be synonymous with the risk of HIV infection, it is the circumstances surrounding displacement and the accompanying behaviour that increases the risk (UNAIDS 2001:5).

The World Bank (2000:18) has pointed out that: *“Social restructuring as experienced during dislocation and low social cohesion, which is described as a measure of a community’s capacity or strength to cope with stress, render refugees, in this case, vulnerable to HIV infection”*. These two factors can be seen as elements that fuel the spread of the epidemic. The kind of social dislocation that refugees experience appears to be different from the armed forces, traders, university and high school students, labourers and miners. The above-mentioned groups’ dislocation is voluntary, whereas refugees’ dislocation is involuntary. Moreover, the situation of dislocation puts them at risk in one-way or another (Miller 1988: 172).

People, who are socially dislocated, such as refugees in the case of this study, are faced with the potential risk of HIV infection, especially young female refugees. Host communities cannot afford to ignore their potential risk of infection, and the much-

needed protection that should be undertaken on behalf of both groups. The problem of poverty and insecurity that the displaced population encounters increases the possibility of lowered sexual inhibitions, casual and transactional sex. This is what puts them at risk of HIV infection. It can also be noted that some refugee men are more concerned with day-to-day need for survival, and it is likely for them to take precedence over concerns about HIV infection, even if it were tenuously within their control to shield themselves (Jackson 2002: 33-35, Padayachee 2006: 370).

2.3.3 Social exclusion

“The vulnerability of migrants (to HIV) is closely linked to their relation of power in the host society (Gorovitz, 1994) and the degree of discrimination they experience” (Sabatier 1996:90).

Social exclusion occurs when people experience a combination of problems simultaneously such as low income, bad health and family breakdown. Since most refugees have a low income, poor housing and experience family breakdown, the resultant social exclusion could place refugee men at the risk of HIV infection. Refugees who have had to flee their home countries by forces beyond their control, have left their familiar society and culture and are now part of a new society and culture which is difficult to understand, and where discrimination, blame and prejudice against black foreigners is commonplace. For some refugee men, there are more important concerns than HIV prevention and sexual health. For those whose main concern is employment and basic daily needs, the possibility of HIV infection may be a relatively distant threat. Some refugee men may deny that HIV infection is an issue. The denial of the presence of HIV for fear of stigmatisation, has led to the neglect of sexual health issues. HIV is often not debated openly, which in turn contributes to the risk of HIV infection (Atrill et al. 2001: 1-4).

The exclusion that refugee men experience could present an obstacle to their personal and public health, discouraging them from seeking appropriate health information or going for voluntary counselling and testing (VCT). Those refugee men, who know that their

sexual behaviour might expose them to the risk of HIV infection, fear the consequences of being diagnosed HIV-positive. In a socially excluded community, where one's peers are one's support base, being diagnosed HIV-positive could well lead to the exclusion from one's peers and worse, have the host community's exclusion reinforced. There can be no argument against the fact that there is tremendous stigma attached to being HIV-positive in most communities, whether refugee or host. Fear of social exclusion makes it difficult for people with risky sexual behaviour to consider healthcare as their primary priority. Hence, the possibility of spreading the disease unwittingly to the community is increased. Refugees are, by the nature of their circumstances; increasingly at risk by not prioritising their healthcare, and media and public attitude towards them is generally pejorative, humiliating and even physically threatening (Ibid, 8-9).

Fernandez (1998) suggests that isolation leads to increased sexual needs. I concur with Fernandez's suggestion due to the fact that social exclusion leads to an obvious isolation which, as he points out, leads to increased sexual needs especially amongst single or married men who are uncertain about returning to their respective communities or countries and re-uniting with their regular partners.

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2.3.4 Male Sexual behaviour

Men are expected to be sexually experienced, leading some to seek this experience at all costs, regardless of whether or not they feel affection or respect for their partners (Jackson 2002: 90).

South's Africa refugee population is urban-based and the urban setting often hosts a myriad of people from different cultural, social, economic, religious and political backgrounds. The mixture of people from different backgrounds, joined with a detachment from habitual forms of influence and control, and the likelihood to remain out of sight, coupled with the financial capability to adopt a different lifestyle, can influence change in social norms, values and practices, and more especially sexual behaviour (Van Donk 2002: 4).

Sabatier (1988:78) observes that, “*the pluralism of urban life leaves individuals without the strict regulation of sex.*” He continues, “*the urban man has both money and leisure to enjoy a lifestyle which includes extensive and varied sexual activities.*” The high level of interaction between refugees and the host community in South Africa contributes to an increase in sexual behaviour between the groups, a factor that might be just about absent amongst refugees living in camps. The dispersal of refugees amongst the host population increases the risk of HIV infection. The urban setting in which refugees are found is considered to be generally a higher HIV prevalence environment. The risk of transmission depends on comparative HIV prevalence of the two groups as well as the length and the mode of their interaction. The level of integration that refugees have reached in South African cities encourages a great deal of sexual interaction between them and the host population (Khaw, Salama et al 2000: 185).

Most men have a tendency to have many sexual partners over a short period of time or in their lifetimes. The changing of sexual partners puts men at a greater risk of HIV infection. Having had many sexual relationships might well make a man popular and important in the eyes of his peers (Foreman 1998: 5). The above-mentioned contact is not foreign amongst refugee men.

The sexual behaviour that an individual adopts may depend on the socio-cultural environment in which he finds himself. Although not all-sexual behaviour is risky, it becomes risky through risky encounters. Risk can be heightened by the indulgence of numerous sexual partners, neglecting to use a condom or STI infection. Coast (2004:12) argues that: “urban areas are perceived as anonymous places where there is a loosening of familial and community control on sexual behaviour.” Urban areas enhance a sense of social disillusionment, which in turn may expose men to risky sexual behaviour leading to the possible risk of HIV infection. Refugees in South Africa are housed in urban areas and have general freedom of movement, which allows them to be self-reliant. These two elements may induce behavioural changes, especially amongst male refugee, married or unmarried since they are generally more mobile than their female counter-parts. Urban

areas should be regarded as risky sexual behaviour environments. Nevertheless, risky sexual behaviour in the urban area remains a matter of individual decision or choice (Ibid, 2004:12).

Men who come from countries with a lower HIV prevalence might often ignore the host country's HIV prevention messages because they regard themselves being less at risk compared to those who are seemingly more 'at risk.' The majority of refugee men living in Cape Town are young and with no dependents whom they are accountable to. In addition, they are part of urbanization, a process that increases population density, anonymity, and insecurity, and hence the risk of infection. Most refugees are originated from countries with poor level of urbanization compare to the Cape Town urban setting, potentially prompting refugees to adopt the urban lifestyle (Crush 2004: 33).

With exposure to a more modern city, men tend to embrace the lifestyle and practices of the other city dwellers without measuring the effects thereof. The new lifestyle and practices might well affect their lives negatively. Refugee men should be helped to reduce the adverse effects that may occur with the adoption of new lifestyles and practices. In this situation, refugee men who might be exposed to the risk of HIV infection should be encouraged to abstain, to be faithful to one sexual partner, and to use condom every time they have sexual intercourse. Equal access to health care and effective human rights legislation need to be encouraged. These are vitally important elements. HIV meanders intricately into our social relationships, into the very structure of our everyday life. Therefore, we need to ask serious questions about the experiences of refugee men as they sojourn in Cape Town. Due to the freedom of movement that refugees enjoy in South Africa, it is difficult to estimate the degree of risk that refugee men face (Padayachee 2006: 370).

2.3.5 Alcohol, men and the risk of HIV infection

Alcohol is a central nervous depressant, and in moderate quantities impairs judgement. Alcohol can therefore increase risk for HIV transmission by diminishing personal control; increase risk-taking, diminishing perception of risk

from unprotected sex, or by simply increasing sexual activity (Mbulaiteye et al. 2000: 911).

In many countries, alcohol consumption appears to be an important social activity for men to pass the time. Drinking as a social activity for men seems to promote a sense of identity and friendship. It is important to understand that alcohol consumption in itself is not harmful. However, excessive alcohol intake could lead men to act irresponsibly and to engage in risky sexual behaviour. In most of the major cities in the world, the places where alcohol is sold, such as nightclubs, bars and pubs are likely to attract commercial sex workers (Scalways 2001: 12).

The heavy consumption of alcohol is a major health concern in South Africa and, because it has been identified as one of the main contributing factors to risky sexual behaviour, it has been acknowledged as an indirect contributor to the transmission of HIV. Studies conducted amongst adults in sub-Saharan Africa have repeatedly revealed the link between alcohol abuse and HIV infection (Morojele, Kachieng'a, Mokoko et al 2006:218). In addition, alcohol use is associated with other sexually transmitted infections and diseases, as well as with risky sexual behaviour, such as having multiple sex partners and an increased level of unprotected sex (Ibid, 218).

Scalways (2001: 12) states, "I still regret the time I had sex without a condom and yet I had it in my pocket. I failed to use it because I was too drunk to think properly. I wanted to enjoy sex so much that I did not think about protecting myself with a condom." This statement is a clear illustration of the risk of HIV infection through a high level of alcohol consumption. Men who lack healthy recreational activities can be vulnerable to excessive alcohol consumption and the possibility of risky sexual behaviour (Ibid, 12).

The high level of alcohol intake amongst men combined with the large number of women involved in commercial sex work is fertile ground for the spread of HIV. Refugee men in the case of this research could well find themselves in the situation of being tempted to drink excessively due to the lack of proper recreational activities, boredom or loneliness. Alcohol and sex can be an alternative activity in which boredom and loneliness is

released, albeit that they are employed or involved in informal business. Since high alcohol intake might lead to sexual activity, it is this activity that puts them at the risk of HIV infection (Scalways 2006: 11).

Alcohol consumption plays an important role in the epidemic. The high level of consumption amongst men both young and old across the world, has led to many high risk activities such as unprotected sexual intercourse, sexual violence and so on. The habit of excessive alcohol intake with the purpose of becoming drunk is said to be on the rise in many developing countries (Ibid, 13).

Alcohol consumption is not peculiar to refugee men; it affects those living in camps and those not living in camps. Every individual reacts differently to the effect of alcohol. For some, increased alcohol consumption makes them flirtatious, sexually provocative and courageous. For others it increases the levels of sexual arousal and desire especially when possible casual sexual partners or commercial sex workers were present. Casual sexual encounters occur often amongst men who drink in bars and shebeens (Morojele, Kachieng'a, Mokoko et al 2006: 222).

A further effect of alcohol consumption is that the use of a condom becomes a low priority. The long-term benefits that condom-use yields are often outweighed by the present need for sexual pleasure. Morojele et al. (2006: 224) state, "Men, when intoxicated and having a resultant strong sexual urge, could lessen the likelihood that they would consider the potential negative long-term consequences of unprotected or other types of risky sex." He continues by saying that there is a lack of discipline when one is under the influence of alcohol and little thought is given to the future. Only the present is important. Alcohol consumption induces impaired control and reduces the possibility of responsible behaviour. Sexual encounters that occur when under the influence of alcohol are often unplanned, spontaneous and sometimes inevitable. Alcohol consumption can leave one without any feeling of responsibility about using protective measures or heeding the possible dangers of sexual intercourse. More often than not, risky sexual behaviour ensues (Ibid, 224). For many men, alcohol is a major contributing factor to the

reduction of their sense of responsibility. Minimal blame and stigma is attributed to the man who admits to having had casual sex when drunk (Jackson 2002: 89).

A sexual network study conducted in a Cape Town Township revealed that 94% of all the venues where new forms of sexual partnerships or companionships occurred were either formal or informal establishments, which served alcohol. In most establishments where alcohol was served, condoms were not available. Discussion about condoms or the refusal to have unprotected vaginal intercourse was not a dominant factor. Although not all alcohol consumption occurs within a sexual context that which did increase the likelihood of the failure to use condoms or oil-based lubricants with condoms (Simbayi et al. 2004: 435,439). Refugee men risk of HIV is both direct and indirect. Direct may be because refugee men lifestyle such alcohol, sexual behaviour and indirect because refugee men are stigmatised as well as socially excluded. These indirectly prevent refugees from seeking appropriate medical help when necessary.



CHAPTER THREE

METHODOLOGY

The researcher relied on both quantitative and qualitative methods of data collection for this study. During a period of two months fieldwork, the researcher focused on 20 men engaging in continual conversations, participant observation and sitting for many hours with all the participants while they were trading at the market. The men themselves were traders at the Green Market Square in downtown Cape Town. All questionnaires were administered in French and English by the researcher himself. The interviews did not use any form of electronic equipment. A conversational style of interview was used and notes were taken for the researcher to reflect on after the completion of the interviews. The researcher conducted repeated interviews with 20 respondents. During the interviews refugee respondents were asked open-ended questions to determine their perception of the blame and South African respondents were also asked open-ended questions to determine their perception of refugee men being a risk group. In the same line, closed questions were asked to ascertain their perceptions of risk for HIV. The collection of data was dependant on the respondents' own reports and special attention was paid to the accuracy of the reports on behaviour that was personal and intimate. Issues of validity were of concern, not least because self-reports of sexual behaviour and of being "othered" are difficult to authenticate.

Data was mostly collected from male Congolese refugees and smaller number of refugee men from other African countries which, concerning the current research, is an acknowledged shortcoming. Several factors affected the availability of 'participant observation.' The observations were conducted to enable the researcher to directly observe the level of interaction and the different patterns of behaviour among refugee men and South African men. My assistance in installing their trading stands and their products, and my participation in their discussions on subjects such as soccer and society in general was appreciated. The questionnaire was restricted to heterosexual behaviour. The qualitative data was collected from participant observation, participation in trading

activities and discussions, key informant interviews, responses to open-ended questions, extended discussions with individuals and overheard conversations. The study site was Green Market Square, Cape Town Central Business District (CBD). The refugee men were randomly chosen in the market. By identifying the gathering place, the interviewer was able to recruit refugee males for the survey. A completion rate of 90% was obtained. The respondents were chosen for interviews based on their availability, and a 0% refusal rate was achieved. There were significant differences in the socio-demographic characteristics (marital status, educational level, and age distribution) in the sample. The fieldwork was conducted from February to April 2006.

3.1 Data collection methods

The data for this research was drawn from studies designed to measure attitudes, knowledge, perceptions, and risk-related behaviour in the male refugee population in relation to HIV. The dependent variable in this study was the awareness of the risk of infection. The independent variable was clustered into the following groups:

- Demographic variables indicating socio-cultural experiences
- Awareness of HIV information
- Knowledge of HIV modes of transmission
- HIV risk-related behaviour
- Preventive measures in response to the threat of HIV.

The dependent variable was measured by means of the question: In terms of an individual's risk of being infected with HIV, do you consider yourself to be at a greater, minimal or no risk at all of becoming infected with HIV? The answers to the variable were divided into two groups: (i) not aware of the risk and (ii) aware of the risk ('great risk' or 'minimal risk' answer).

The socio-demographic variables used were age, income, marital status, health and education.

Concerning awareness of HIV information, two objectives were set: (i) the degree of awareness of information and (ii) the accuracy of the information. This allowed the researcher to gauge the extent of the knowledge that both male refugees and South African males had acquired via community nearness and individual experience. Knowledge about HIV and the mode of transmission was measured using a scale containing objects connected to the spread of the HI Virus.

HIV infection risk behaviour. This was measured using self-reports of four risk-related sexual practices, which had occurred in the last twelve months:

- The number of different sexual partners
- Heterosexual or homosexual activity
- The use of condoms in any sexual activity
- Injecting drugs (sharing needles).
- Preventive measures.

To ascertain whether current behaviour represents a move away from the perceived high-risk activities of the past, refugees and South Africans alike were asked if they had taken preventive measures against HIV infection by changing their behaviour in the past twelve months in reaction to the terminal nature of AIDS.

Primary data was mostly gathered through the survey amongst refugee males in Cape Town. Semi-structured questionnaires were given to a sample of ten refugee males and ten South African males in Cape Town. All the respondents were arbitrarily selected from their trading places. In order to design the sampling frame for this study, the informal network of the refugees and asylum seekers was relied on. The male refugees in the market were identified with the help of fellow refugee trader and they were mobilised with the help of their fellow traders at the market.

The supporting data of this study came from Statistics South Africa, the main data reservoir for the Republic and for international organizations such UNAIDS, UNHCR and WHO as well as data from the Department of Home Affairs and the Health

Department. Other official papers were also consulted. Data from these institutions and organizations is highly valued because of its reliability. Making reference to them helped reduce the inaccuracy of limited secondary data.

3.2 Constraints

An attempt was made to include in the sample study refugee men from refugee-producing countries who were trading at the Green Market Square flea market. Over a period of time, however, some became reluctant and showed less interest in participating in the study for a variety of reasons and were no longer interested in participating in a meaningful way to the study. A second constraint was that in the study only focused on refugee men trading at Green Market Square with the result that potential refugee groups might well be missed or ignored. The third constraint was that the study did not include refugee women and even in the local South Africans sample only males were surveyed. Much empirical evidence shows that women are more vulnerable to HIV infection and their inclusion might have made a significant contribution to this study. Including a large number of groups of refugee men from different backgrounds would have provided greater insight into their experience of being blamed and of their HIV risk. For those reasons it is necessary to regard this as a pilot study. Any generalization resulting from this study must be treated cautiously. The sample is not designed to be statistically representative because the number of refugees interviewed was relatively small. In addition, the results of this study should not be interpreted as showing causal relationships.

3.3 Measuring tools

Since many refugees have experienced traumatic situations in their journey of refuge and in their country of asylum and with HIV often being associated with sexual behaviour, using direct or sensitive questions during the interviews might have led to embarrassment when responding directly and honestly. Hurtful memories might also have been recalled. Direct and sensitive questions such as “Are you traumatised?” or “Have you been

sleeping around with girls?” could not be asked because the respondents would have been unlikely to provide an honest answer. The researcher was able to obtain answers indirectly from the same respondents through the “participant observation” tool. This tool allowed the researcher to hide the actual reason for his presence by becoming a participant. This technique allowed for the integration of the researcher into the group being observed as one of its members, partaking in all activities without disturbing the group’s behaviour. It has been deemed valuable for studies concerning minority groups (Bless and Smith 1995: 105) like that of the refugee males in Cape Town.

The researcher used open-ended questions and the semi-structured questionnaire consisted of both open and close-ended questions. The choice was influenced partially by the fact that the study was conducted amongst adult refugees. The questions asked covered such things as the causes of their flight and the treatment they had received in the country of asylum. Many responded with an “I don’t care” attitude. Their response was determined by the turn of events, which took them by surprise and made them abandon their valuables. This proved that most refugee men are very resilient. The researcher had to alter the measuring tool in order to obtain this factor.

3.4 Field constraints

Refugees belong to the category, which is often seen as politically sensitive, and doing research among them can be an unusually complex process. Apart from that, there was an element of suspicion and fear towards the researcher. The researcher was suspected of being a government agent on a spying mission to gather information and knowledge, which might result in harm being done to the refugees. Being an independent researcher with no link to either a local Non-Governmental Organizations (NGOs) or organization with which they were familiar made it difficult and created a sense of fear about conversation. In order to avoid an atmosphere of fear and suspicion, the researcher was compelled to deal mainly with refugees from the Democratic Republic of the Congo (D.R.C.) because they were willing and not suspicious to discuss openly their situation with the researcher whereas the other nationalities were reluctant to participate in a

discussion. The creation of relationships with Congolese informants was not that easy and the researcher had to start with one informant who introduced the researcher to his friends and to refugees from other nationalities. Efforts to work with married refugee men were frustrated for a number of reasons. The most significant of these was that they seemed to see the process as an intrusion into their present and past sexual life because of the fact that the researcher was an unmarried male, whom for them, was not entitled to discuss sexually related matters with married men.

Those to whom the researcher managed to speak did so in short sentences and with considerable reserve. It would, of course, be difficult to draw far-reaching conclusions concerning the beliefs of the individuals who were so reluctant to be informants. Amongst the majority in the sample, the researcher had to provide detailed and frequent explanations of his academic and personal life in order to dispel suspicion and to build a relationship of trust. Being a noisy place where business is conducted, the researcher had to suffer frequent disturbances and interruptions in the market. The researcher encountered difficulties when dealing with the local population due to their low level of education and therefore had to change his approach when interviewing South Africans. The inability to interact with South African respondents whom were dominantly Xhosa speaking which made it difficult for the researcher to have in depth interaction with South African respondents on the issue of blame.

Despite all the constraints encountered, the study was able to gather adequate, consistent and valid data, which allowed for the clear justification of the link that exists between the variables that were used in this study.

CHAPTER FOUR

GENERAL DESCRIPTION OF THE CASE STUDY LOCATION, CAPE TOWN

4.1 The state of the AIDS pandemic in South Africa: Overview

The new democratic South Africa inherited the consequences of the destructive policy of Apartheid, which was characterized by social disturbance, racial and gender discrimination, and an inequitable distribution of resources, which had a negative effect on the majority of its peoples. Poverty-related infections that include HIV, had an enormous effect on the formerly disadvantage groups. South Africa is one of the countries in sub-Saharan Africa most affected by the AIDS epidemic, despite high levels of awareness of the disease. The factors that contributed to the fuelling of HIV in South Africa include behavioural factors such as unprotected sexual intercourse, multiple sex partners and the high prevalence of sexually transmitted diseases. The underlying causes include socio-economic factors such as migrant labour, lack of formal education, stigma and discrimination, and the low status of women. Public AIDS awareness campaigns in South Africa emphasize change in sexual behaviour, including abstinence, condom use, monogamy and reduction of sexual partners. The assumption is that people will respond to risk in a way that reflects their HIV awareness levels. So far, some major achievements are evident from the various interventions undertaken in South Africa. Both refugee men and women are aware of AIDS and know of its sexual transmission. The government of South Africa has made tremendous efforts towards raising national awareness about HIV problem. In 1992 the National AIDS Coordinating Committee of South Africa (NACCSA) was established. Within the context of HIV, the first cases emerged in the late 1980s in South Africa. Lack of commitment and an inappropriate response from the Apartheid regime at that time did not contribute to the slowing down of the disease in its early phase. South Africa became aware of HIV through the contribution of the African National Congress (ANC) in 1992, almost 11 years after the first few cases were identified in the country. By the end of 1990, the heterosexual pattern had emerged as being the dominant form of transmission compared to the homosexual and bisexual form

of transmission in the reported cases. The AIDS pandemic was decidedly heterosexual. By 1996, up to 3% of the total population and 7.5% of the sexually active population was infected with HIV (Department of Health of S.A. 2005:2).

According to USAID's 2004: 2, "South Africa has more people living with HIV than any other country in the world. Adult HIV prevalence is estimated at 20 per cent." This shows that HIV is a major challenge facing South Africa's continuing growth. The South African government is faced with the challenge of preventing further infection, providing treatment to the infected and caring for those who are in need of compassion. This situation makes it difficult to prioritise the needs of refugees with regard to HIV care and prevention (S.A. Department of Health 2001: ii).

The public health sector is already experiencing difficulty in coping with the rise in the number of people in need of care. Those with HIV-related sicknesses occupy a considerable percentage of beds in South Africa's public health facilities. The necessary drugs are not accessible to all HIV-positive patients since many HIV sufferers cannot afford them. The South African government is challenged with providing appropriate treatment to its citizens within the constraints of limited resources. HIV continues to be the single biggest health-care and social issue in South Africa (Whiteside & Sunter 2000:141-143).

In 2001, it was estimated that 4.7million South Africans were already living with HIV (S.A.Department of Health 2001:ii). According to the South African National HIV/AIDS survey 2005, HIV prevalence is estimated to have reached 10.8% in the whole population and 16.2% amongst all people aged 15-49 years old. Although HIV remains a big challenge, the South African government has embarked on a prevention campaign, which is the foundation of the country's response to the AIDS pandemic. A wide range of prevention activities has been initiated, including information education and communication (IEC), post-exposure prophylaxis (PEP), and syndrome management of Sexually Transmitted Infection (STIs). The key intervention of all is the delay of the sexual debut (Department of Health 2006: 6).

4.2 Cape Town's demographic situation

Cape Town is the third largest city in South Africa. It is the provincial capital of the Western Province as well as the legislative capital of South Africa. Cape Town is located on the coast and at the edge of the African continental escarpment. Cape Town has a land area of 2.499Km². Compare to the other cities of South Africa, Cape Town is larger but has a lower population density of 1.158/Km². Cape Town has a population of 2,893,251 people. 48.13% the population is Coloured; 31% Blacks; 18.75% Caucasians and 1.43% Asians. It is estimated that about 46.6% of the general population is under the age of 24, while 5% is above the age of 65. The average age of the population of Cape Town is 26. The city has an overall unemployment rate of 19.4%. The black population makes up 58.3% of the unemployed, Coloured 38.1%, Caucasians 3.1% and Asians 0.5% (Statistics South Africa 2001). In terms of education, it is estimated that 4.2% of the residents 20 years of age and older are without any form of schooling; 11.8% of the residents have had some level of primary school education; 7.1% have managed to complete primary school level; 38.9% have had some level of high school education, 25.4% have managed to complete high school; 12.6% have a level of education above high school. Overall, 38.0% of Cape Town's residents have completed high school (Ibid 2001).

4.3 Cape Town's refugee population

As of July 2005, there were over 28.000 asylum seekers who had been granted refugee status, and 117.000 pending asylum claims in all Refugee Reception Offices (RRO) in the main urban centres in South Africa (UNHCR 2006: 211). Approximately 40.000 refugees are said to be living in Cape Town, including asylum seekers since they have temporary legal permits. 80% of the refugee population living in Cape Town are males and the UNHCR recognised the fact most males refugee are urban based. The dominant

refugee group in most of the main urban centres consists of refugees from the Democratic Republic of the Congo, followed by Somalia, Angola, Burundi and Rwanda. Urban-based refugees are often self-reliant and do not depend much on service providers such as the host country's government institutions or local Non-governmental Organizations (NGOs). In comparison, the host population relies heavily on government services (UNHCR 2003:318). Most refugees in Cape Town are single males (Western Cape Provincial government 2002: 9).

Refugee communities, I have to argue, exist because of certain forms of support structures or networks. Those refugees who have been in the country for an extended period are willing to support those who have just arrived. In terms of spatial organisation, there are areas defined by both refugees and locals as being 'refugee' or 'migrant' areas. This spatial organization can be seen particularly in the market setting where one finds large numbers of vendors who come from other parts of Africa. Most new refugees have relatively few acquaintances or family members in Cape Town. Many of them experience hardship along their journey to South Africa. The hardship of their journey makes one wonder why they leave one form of hardship only to find themselves relegated to the margin of society. Part of their hardship is the uncertainty of legal status. Without the legal right to remain in the country, they face deportation. Those with 'asylum seeker' status must wait up to 2 years before a decision is made and then the majority of applications are often rejected. Even those with refugee status fear that the government might change its policy towards them and deny them their rights. This analysis is based on the common experiences of African foreigners living in Cape Town.

Being labelled 'refugee' also occurs from outside the legal status with terms such as *amakwerekwere* (**Amakwerekwere**: a derogatory term meaning 'foreigners'). The use of this term has led to feelings of difference and isolation. Although South Africa has had a long and extensive history of regional migration, especially within the mining industry context, refugees and migrants are viewed as a new group of people who have arrived in South Africa as a response to the end of Apartheid and the 'liberalisation' of the immigration policy (Peberdy 1998: 187).

The press has used terms such as ‘flood’ and ‘wave’ (Danso and McDonald 2001: 130). Refugees have this label inscribed on them - they are something *other*, because they are something new.

4.5 The situation of refugee males

Refugee males are not treated separately and are included in the overall refugee population living in South Africa. The growing backlog of asylum claims at the Department of Home Affairs (DHA) makes the protection and assistance of refugees difficult. The backlog leaves many refugees without proper documentation and makes it difficult for refugees to access any meaningful form of employment or social service (UNHCR global Appeal 2006:211). Compared to their women counterparts, refugee men are in the forefront in terms of finding employment and other means of survival. They encounter many difficulties in the form of discrimination, prejudice and xenophobia. There is no reliable data, which focuses on the condition of refugee men in terms of their access to employment opportunities, health care, education and other social services. There is strong compelling evidence that the condition of refugees living in South Africa leaves much to be desired. When it comes to matters relating to health, refugee men do not care much for making use of health services. In most cases, refugee men prioritise employment and documentation rather than health. This might be partially explained by the fact that not having proper identity documents hinders and even prevents opportunities for secure employment (belvedere, Mogodi and Kimmie 2003:131).

Refugee men in some cases are not regarded to be vulnerable by the organizations responsible for their protection. With the exhaustion and stress of having to find employment and get proper documentation, sexual pleasure might be the only available recreational or relaxation activity for refugee men. The living conditions of most refugee men provide limited opportunities for good social support and for forging emotionally sustaining, intimate relationships. Prioritising employment and documentation over their

health and well-being, might place refugees men at a particular risk of contracting HIV (Morrell 2001: 276).

While most of refugee men experience changed circumstances in the country offering them asylum, these changes may also lead to increased personal risk due to factors such as separation from a regular sexual partner, overcrowded living conditions, stresses and vulnerability associated with these circumstantial changes. For some, there is a strong need for money to meet their daily needs while they are still unemployed. For others, the anonymity of being a foreigner, especially facing uncertainty about the prospect of establishing stable lives, this can then lead to an increase in sexual activities. In addition, loneliness, frustration and peer pressure can make it hard for some men to resist adopting high-risk behaviour (UNAIDS 2001: 11).

4.6 Refugee males and HIV infection in Cape Town

The self-reliant approach of urban refugees makes the institution's responsibility for the protection and well being of these groups of people challenging. Spiegel and Nankoe (2004: 21) had noticed that 'there are significant numbers of predominantly male urban refugees with HIV.' Despite the above observation, South Africa's HIV/AIDS/STD/TB strategic plan of 2000-2005 does not make specific mention of refugees being amongst the groups most vulnerable to HIV infection. The UNHCR strategy for urban refugees in South Africa suggests that many refugees are becoming vulnerable and there is a need to concentrate more on a caring and maintenance approach in order to ensure the well-being of both the population and the refugees. Refugees and the host population interact daily, and therefore, omitting refugees from National Strategic Plans (NSPs) could well undermine effective HIV/AIDS prevention and care efforts (Ibid, 23). The South African HIV/AIDS/STD/TB plan stressed the following strategies in including its entire population. These are:

- Effective and culturally appropriate information, education and communication (IEC) strategies;

- Increased access and acceptability to voluntary HIV testing and counselling;
- Improved STD management and the promotion of increased condom use in order to reduce STD and HIV transmission.

These strategies will be structured in the area of prevention, treatment, care and support, and human and legal rights (S.A. Department of Health 2000: 16).

The situation in which many refugees find themselves has a negative impact on their lives, as the battle to access education, secure meaningful employment and access health care services is increased by the confusion regarding the question of who is to be held responsible for their well-being. From the provincial government's point of view, refugees are seen as the responsibility of the Department of Home Affairs and the national government sees refugees as UNHCR's property. This dilemma puts refugees in an extremely vulnerable position, one that increases the likelihood of the risk of HIV infection. The effective inclusion of refugees in the national, and even in the provincial HIV/AIDS plan, is slow in happening. It is perhaps that they are seen as the 'other' who do not belong in South Africa and perhaps that their inclusion could induce the migration of those who are already infected with HIV. The fact that the refugees are seen as a problem or burden in the face of a high prevalence rate raises a concern regarding their risk of HIV infection. Most HIV prevention programmes are geared towards protecting women because they are more vulnerable to the virus. However, it is men who are less likely to pay attention to their sexual health and safety, and engage in alcohol and other substance abuse (Ganguly, Medappa and Srivastava 2000: 2). The refugees' location is more important than their status when referring to the spread of HIV. Refugees who are hosted in camps experience a lower and more stable HIV prevalence than those living amongst the host population (Keith 2005: 30).

4.7 The source of income for refugees

The primary source of income amongst refugees living in the major cities of South Africa is employment wages. This constitutes 55%, with informal trading being a further 12%.

These two constitute the dominant sources of income amongst refugees living in South Africa (Belvedere, Mogodi and Kimmie 2003: 61). Although some refugees are formally employed, others work in the informal sector; generally refugees in Cape Town face huge challenges to earn a decent income. UNHCR opts for a strategy of self-reliance when it comes to dealing with urban-based refugees. This means that only the most vulnerable refugees are assisted and not those who are active. In most case the active members are men (Spiegel and Nankoe 2004: 22). Despite the challenges that life in urban area presents such as housing, and employment, the approach of self-reliance by UNHCR; have to some extent have helped some refugee men to attain a certain degree of becoming productive members of the host society. For some refugee men, the approach may have yield results in terms of improving the standard of living (Noble 1987: 75).

Most refugee men try to be self-sufficient. The economic self-sufficiency attained by refugee men is either through formal and/or informal employment. The informal sector employment may include activities such as selling goods on the street or at the flea market. All these constitute a source of income, which allows refugees to survive whilst in their country of asylum. Some local NGOs provide some form of assistance for refugees, especially those who are new in the country and who are potential sources of income. This type of income is not permanent because of its time limit. The refugees involved in studying are mainly in the informal employment. Informal employment constitutes their main source of income and livelihood. I will argue that although it is possible for refugees to obtain some degree of self-sufficiency, the level of self-sufficiency remains very low. This might be because some refugee men find it difficult to secure formal employment, leaving them in the informal employment market, which does not offer much security and certainty (Ibid, 98). In addition, other factors like the mere size of the refugee population, and the skill and occupational structure of refugee men could make the self-reliance unattainable.

4.8 HIV/AIDS and refugee health care

In Cape Town, as in all the other major South African cities where refugees are located, there are no specific health-care facilities or clinics designed for use exclusively by refugees both in terms of HIV health-care or other health-related issues. Apart from the discrimination and blame that refugees experience, their urban-based status makes it difficult to design a particular health-care plan that would solely target refugees. Among male refugees, health related matters are a low priority, although Cape Metropolitan has ten Reproductive Health Services. The province is currently dealing with the burden of treating diseases such as Tuberculosis and HIV/AIDS (Western Cape Health Department 2001). In terms of reproductive health care, Belvedere et al (2003: 147) point out that 'refugee males do not use reproduction health care services.' The HIV/AIDS reproductive health-care is an important programme in disseminating HIV prevention in communities due to the fact that in these services HIV counselling is provided for both negative and positive people. Information, education and communication resources are made available in the languages spoken and understood by refugees (Ibid, 147, Ganguly, Medappa and Srivastava 2000: 2). Refugees in urban centres do not always live in organized communities and therefore do not have the same access to the health-care services that refugees in camps might have. The frequent non-usage of health-care facilities on the part of urban refugees may partially be as a result of their self-reliant lifestyle (Keith 2005:26).

The effect of living in camps or in urban settings often reduces the refugees' sense of power over their personal lives and their future health needs, rendering them less effective when making decisions about their own lives and futures (Carballo and Frajzngier 2001: 8).

CHAPTER FIVE**RESEARCH FINDINGS AND ANALYSIS*****5.1 Refugee males, South African males and a HIV-risk study******5.1.1 Personal Profile*****5.1.1.1 Age**

This section records the age of the refugee males and the South African males who were interviewed at Green Market Square:

Table.1 Age distribution of the refugees interviewed with the South Africans interviewed

	Refugee males		South African males	
Age group	Count	Percentage	Count	Percentage
21-30	5	33%	3	60%
30-35	10	77%	2	40%

From table 1 it is clear that two thirds of the refugee men were in the thirty to thirty five year age cohorts whereas 60% of the South Africans were in the twenty to thirty year cohorts. The average age for all the respondents together was only 31. Those interviewed were thus relatively young.

5.1.1.2 Marital status of respondents

Of the 20 respondents, only 4 were married. There was a difference between the two sample groups. All the married respondents were refugees and of the 4 married refugees; only one was married to a local South African girl. South African respondents said that they were living with their girlfriends. When asked why they hadn't got married, they said that they did not want to be controlled by their wives.

5.1.1.3 Countries of origin of the respondents

Figure 1: Description of respondents by country of origin

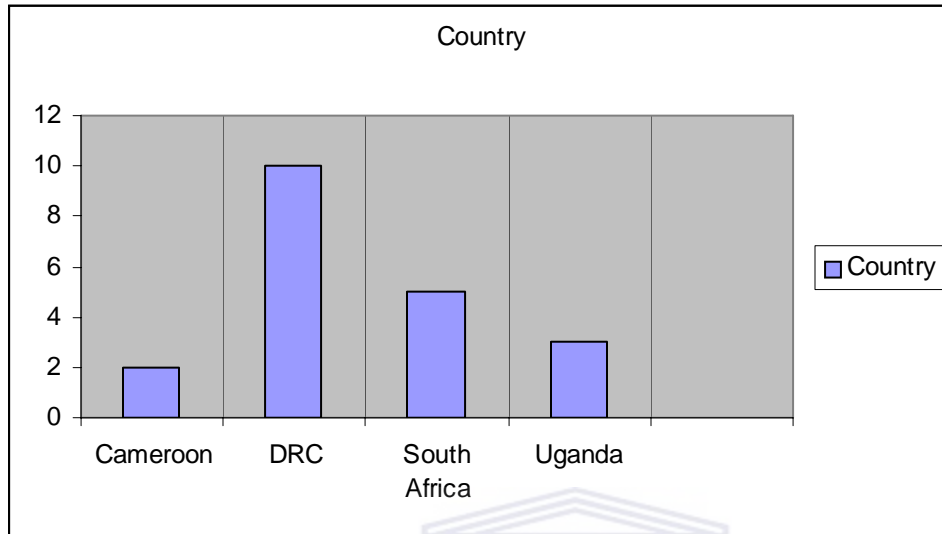


Figure 1 shows that there were more Congolese refugee respondents in the sample groups.

5.1.1.4 Living conditions of the respondents according to their status

Table 2 Comparing the living circumstances of the refugees and South Africans

	Refugee males		South African males	
	Count	Percentage	Count	Percentage
Mix sex accommodation	6	40%	-	-
Single sex accommodation (with more than one person or one person)	9	60%	5	100%

Table 2 shows that most of the refugee males in Cape Town live in shared accommodation, referred to as a ‘commune.’ Of the refugees living in mixed sex

accommodation in Cape Town, the “female counterpart” was 40% (6 of 15 persons) whilst the percentage of males living in single sex accommodation was 60% (9 of 15 persons). Of the South African respondents, 100% (5 of 5 persons) were not living in mixed sex accommodation. All the South African respondents were living alone and not sharing a house with other people. When asked why they preferred to share accommodation, the refugee respondents replied that it cut down the cost of rental, which would be unaffordable for any individual living alone.

5.1.1.5 Area of residence

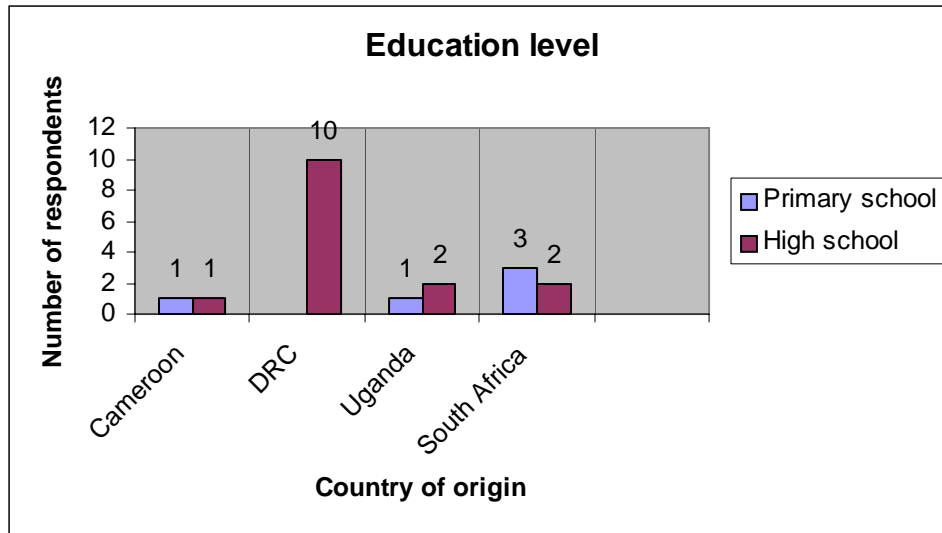
Table 3 Comparing the distribution of area of residence between refugees and South Africans

	Refugees		South Africans	
	Count	Percentage	Count	Percentage
Suburbs	13	87%	-	-
Townships	2	13%	5	100%

Table 3 shows that most of the refugee respondents were living in a suburb compared to the South African respondents who were living in the townships. When asked why they preferred to live in the suburbs rather than in the township where the cost of rental was much cheaper, they answered that they feared xenophobic attacks and treatment. One refugee respondent said: “in the township they accuse us of stealing their women and spreading HIV”(Interview with a refugee men at Green Market Square). Apart from the fear of a xenophobic attitude, they mentioned the benefit of the proximity of their areas of residence to the Central Business District.

5.1.1.6 Educational status of the respondents by countries of origin

Figure 2: Distribution of refugees and South Africans according to their level of Education.



The figure above indicates that a large proportion of Congolese refugees who come to South Africa are fairly well educated. 75% of the respondents had completed Matric (Secondary/High school certificate). The sample group had no respondents who did not have at least some tertiary education. 25% of the respondents in the sample group had some level of primary education only. If one compares these figures to figures from the demographic situation of Cape Town, one finds that refugees in the sample group tended to have higher levels of education than the South Africans.

To illustrate, 40% of the South Africans had completed high school, whilst only 60% of the South Africans in the sample group had completed primary education compared to 13% of the refugees. Male refugees were significantly more likely to have completed high school education prior to migration.

5.1.2 Blame and HIV risk

Table 4: Comparing beliefs concerning blame and the risk for HIV infection (To be re worked).

Situation	Refugees				South Africans			
	Disagree (Count)	Agree (Count)	Total (Count)	Total (%)	Agree (Count)	Disagree (Count)	Total (Count)	Total (%)
HIV is a disease brought into South Africa by foreigners	15	0	15	100%	5	0	5	100%
When blamed it is possible to engage into risky sexual behaviour	15	0	15	100%	5	0	5	100%
It is right to direct blame into a specific group	12	3	15	100%	3	2	5	100%
When blaming it is possible to feel protected of HIV	15	0	15	100%	3	2	5	100%

It is evident from table 4 that refugee males residing Cape Town were opposed to the blame-inducing risk of HIV infection and the protection that blaming could offer against contracting the disease, compared to the South Africans who believed that blaming a specific group for HIV would reduce the likelihood of their becoming infected.

The table does not show the percentage of refugees or South Africans who did agree with the situation.

The researcher asked the South Africans whether blaming African foreigners made them feel protected. The responses showed that 15% (3 of 5 persons) felt protected whilst 25% (5 of 5 persons) believed that HIV was a disease, which was brought to South Africa by foreigners.

Concerning the question as to how the foreigners brought the disease to South Africa, the statement below describes the beliefs of the South African men in the study sample group: “Since foreigners have moved to South Africa, there are a lot of diseases such as HIV and STDs. Once a male foreigner moves to an area, girls become attracted to him because of the money the men offer them”. He goes further saying: “if you want to die quick, fall in love with a girl who was involved with a foreign man. Foreigners must stop sleeping around with our girls because they are giving them HIV.”(Interview with a South African man at Green Market Square)

Some of the comments that South African men have made go as follows: “These amakwerekwere come nice looking, and dress nice as well and the girls will run after them sometime for money, and other stuff that we ignore and if it’s not them who bring the diseases to us, I do not see how else the disease can get into South Africa. But one sad thing is that these foreigners do not have genuine love for our local girls, they want them just for sexual pleasure.” “Most foreigners stop in Johannesburg before coming to Cape Town. While in Johannesburg they become infected with HIV and then come with it to Cape Town.” “Foreigners need to be screened before entering South Africa because their HIV/AIDS is killing us.”

Of the South Africans who disagreed with the situation, the comments below describe their feelings: “Because we are South Africans we do not accept other people and that is why we accuse foreigners of bringing HIV into South Africa.” “I don’t believe that foreigners are the source of HIV in South Africa.” “If it were true that HIV was imported from outside, we would have seen strict immigration control being implemented

in order to monitor peoples’ movements. Since it has not been implemented, it is difficult to hold one group responsible for the spread of the disease.”

To further probe the impact of blame, the refugees were asked whether they had ever considered the statements presented in table 5 below.

Table 5: Beliefs on whether blame induces risky behaviour:

Situation	Refugees		
	Disagree (Count)	Disagree (%)	Total (Count)
It is true that your present sexual behaviour is the result of blame.	14	93.3%	15
When in love with a South African girl it is impossible to care about her well-being.	13	86.7%	15
It is appropriate to have unprotected sex with South African girl.	13	86.7%	15
It is true that you are at risk of getting HIV due to blame.	15	100%	15

It is evident from table 5 that the refugee men exposed to the risk of HIV infection had nothing to do with the blame they experienced and that the situation wouldn’t lead to an individual becoming infected with HIV.

The researcher asked the refugee men whether or not the blame they had had placed on them had changed their initial sexual behaviour. The responses showed that 6.7% (1 of 15 persons) had changed their initial sexual behaviour compared with 93.3% (14 of 15 persons) whose initial sexual behaviour had not been affected.

Asked whether being blame heightened their risk of becoming infected with HIV, 100% (15 of 15 persons) said that they believed there to be no link between being blamed and the risk of becoming infected with HIV. 13.3% (2 of 15 persons) said that they had engaged in unprotected sex with a South African girl at one time or another. It is evident from this data that all the nationalities represented in the sample group were aware that unprotected sexual intercourse was the means by which an individual could become infected with HIV and not being blamed. The following statement made by a refugee man from Congo shows clearly that blame has nothing with one’s risk of becoming

infected with HIV, *“The HIV risk my brother, is about personal sexual behaviour and has nothing to do with blame. We Congolese men are known to change our girlfriends as often as we do with our clothes! So, tell me my brother, where is the effect of being blamed?”* Refugee man from Cameroon commented: *“Another thing I have to tell you, my brother, is that the blame the South Africans put on us is just out of frustration because when you do business with them, they are nice to you but once there is no more business they turn against you, saying that we Makwerekwere think this country belongs to us. You know what we might probably be at less risk for HIV than the local men who blame us”*

“The spoiled identity is not my real identity and there is no reason to worry about it. I will always stand strong in the midst of negative criticism and not succumbed to spoiled identity.” He went further to say that blame has indirect effects, especially to them. Especially when they are ill, they are sometimes afraid of seeking appropriate medical attention and information because if they happen to have an infection such as STIs or HIV, then the local South Africans will be vindicated.

5.1.3 Primary health care

Table 6: Where the different nationalities go for primary health care:

	Public hospital	Local public Clinic	Pharmacy	Other places	Don't use this service	Total Count
Cameroon	0%	50%	0%	50%	0%	2
DRC	20%	10%	0%	20%	60%	10
South Africa	0%	60%	0%	40%	0%	5
Uganda	0%	67%	0%	0%	33%	3

Respondents from DRC were the most likely to use public hospitals for primary health care, whereas respondents from South Africa and Uganda were more likely to rely on local (community) public clinics. Respondents from DRC were the least likely to make

use of primary care services. No respondents made use of pharmacies to deal with primary health-care problems.

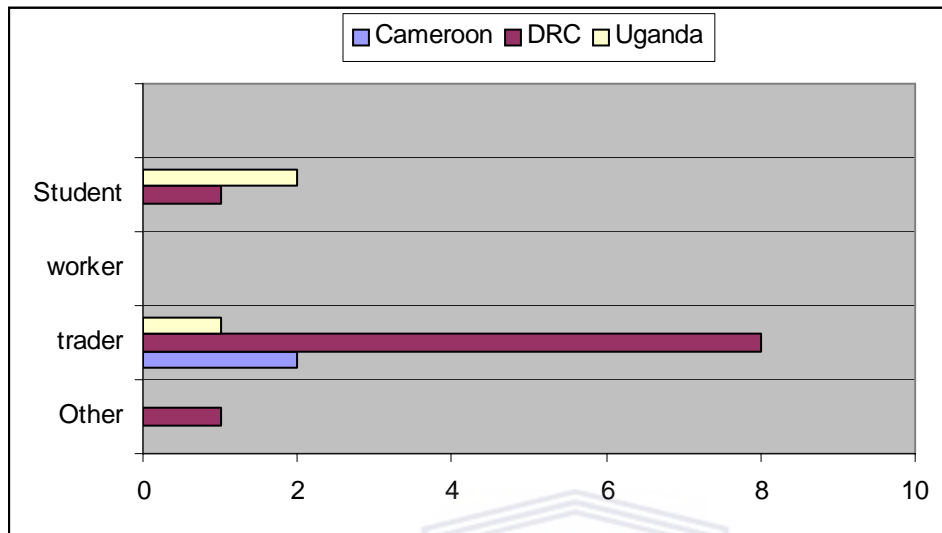
Regarding bad treatment having been received amongst those who did not make use of primary health-care services, 35% indicated that they had never had a major health problem. Refugee man from Congo commented, “When I have the flu or a headache, I don’t see the need to go and queue in a public hospital or clinic. I prefer to go to Shoprite and buy a Panado because it is a quick, hassle-free remedy.” Another Refugee man from Congo said, “When I have a stomach ache or any other problem, I just lie on the bed for a day and take Enos. I feel better the next day.” Refugee man from Uganda said, “I don’t go to a public hospital or clinic because all the red tape makes you sicker than you were before.”

Other places that South Africans go to are traditional doctors or sangomas. Refugees go to supermarkets such as Shoprite or Pick n’Pay where they buy painkiller tablets. None of the refugee respondents who go to public hospitals or community clinics mentioned anything about xenophobic treatment being a problem preventing them from using the services.

When asked why they did not make use of public hospitals the South Africans said that distance was a major factor compared with the easy accessibility of community clinics. None of the respondents mentioned using health-care services for major health issues such as TB or STIs. They used them mainly for minor health problems. None of the respondents in the sample groups made use of pharmacies for reasons of cost. Medical attention is mostly free in public hospitals and community clinics and where payment is required it is minimal and affordable. Overall, health-care appeared to be a low priority for both South African men and refugee men at the market.

5.1.4 Source of livelihood

Figure 3: Number of refugee men and their occupation according to country of origin



According to figure 3, most of the male refugee respondents were full-time traders (53,3% of 15 respondents); Uganda had more respondents who were partial traders (partial meaning combining studies and trading) - 67%(2 of 3 respondents).

Respondents from Cameroon were the only ones involved in full-time trading. Respondents from DRC were involved in other activities such as assisting in movie shoots, playing soccer and singing in bands. Some comments made were: “I prefer trading because it gives me flexibility to do other things such as attending my soccer training sessions during the week,” (Refugee man from Congo). Another one said: “Because I own a business I am exempt from having to produce my Section 22 Asylum-seeker Permit and from being accountable to anyone.” Refugee man from Cameroon said, “Trading is more advantageous because at the end of each day you go home with some cash money, compared to formal work where you have to wait until the end of the month before you get paid. At the end of each day I am able to spoil myself with a glass of beer or wine and enjoy life.”

5.1.5 Perception of HIV risk

Do you see yourself at risk of becoming infected with HIV in Cape Town?

Figure 4: Perceived risk of HIV infection by country of origin

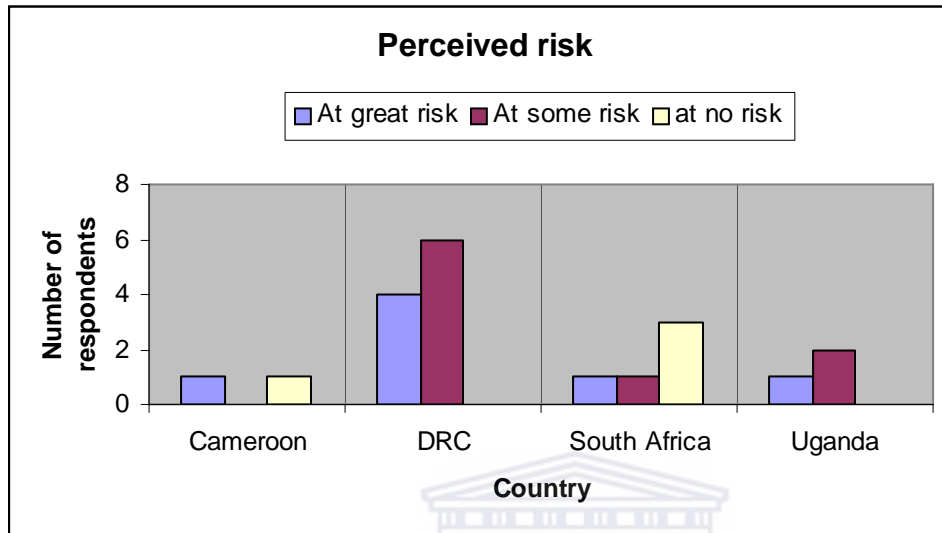


Figure 4 shows that more South African respondents (3 of 5 persons) believe that they are at no risk of becoming infected with HIV. Respondents from DRC believe they are at great risk, whilst those from Cameroon and Uganda regard themselves to be at some risk. From the evidence gathered during the interviews, respondents believing themselves to be at no risk said things like, “Only God can protect you and the rest is not protection, my friend.”

“You know, my brother, this HIV that you tell me about does not exist. People just want to discourage us.” DRC respondents who believe themselves to be at risk, made statements as follows, “The South African government does not provide us with any material assistance but they have provided us with women free of charge who are easy to get as well.” “In the market here I have one girlfriend. I get many others when I go clubbing in town. Without fear I have to tell you that most of us Congolese who are trading here, are obsessed with skirts and spend a lot of time talking about girls. HIV, however, is not my main concern unfortunately.” “Look, my brother, once I am under the influence of alcohol, I look for a girl to satisfy my sexual drive.” “When I have sex

with a casual partner, I really don't need to know her past sexual history since we are not going to meet and develop a long lasting relationship. Finding out about her would be a waste of time, believe me." (Refugee men from Congo)

While some men interviewed perceive themselves being at risk of HIV infection, the extent to which refugee men continue to engage into sexual risky behaviour could not be established.

5.1.6 HIV/AIDS information

65% of the respondents believed that they were well informed about HIV through printed materials, billboards and the airwaves. 25% believed that information was not always accurate and often confusing because of the terminology that was used to convey the message to the general public. 10% said that the information they have about HIV was gained through personal experience by knowing a friend or someone in social proximity who had been diagnosed HIV-positive or who had died of AIDS. Although most respondents were exposed to HIV information, those from South Africa and Uganda had been much more exposed to more complex HIV. South Africans and Ugandans exposure to more information is probably because of the impact that the AIDS pandemic has had in their respective countries and because of the extensive outreach programmes that are ran throughout the year. The basic information that the Congolese and Cameroonian respondents had is probably because most of HIV information in South Africa is printed in English, which they can understand. From my personal experience as a Congolese, I have observed that, generally, Congolese do not like to read much although they may be educated.

5.1.6.1 Knowledge concerning the transmission of HIV

Tab.7: Knowledge among refugee concerning the transmission of HIV

Transmission modes	Green Market Square (Cape Town)		
	Yes (count)	Yes (%)	Total (Count)
Unprotected anal and vaginal intercourse	15	100%	15
Dry kissing	2	13.3%	15
Direct contact with an infected blood	14	93.3%	15
Toilet seat	3	20%	15
Sharing toothbrushes	13	86.7%	15
Donating blood	1	6.7%	15
Sharing needles to inject drugs	12	80%	15
Touching	1	6.7%	15
Insect bites	1	6.7%	15
Circumcision instruments	7	46.7%	15
Living with a person with HIV	0	0%	15
Sharing razor blades	15	100%	15
Masturbation	1	6.7%	15
Drinking alcohol	1	6.7%	15

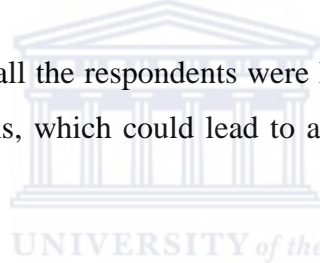
Table 7 shows that, in general, refugee respondents have some understanding concerning the modes of HIV/AIDS transmission. The mode of transmission about which a significant number of refugees (7 of 15 persons) had no knowledge was “circumcision instruments”. The other differences in the respondents’ knowledge of transmission are statistically unimportant, although 2 respondents (13.3%) did not know that “sharing toothbrushes” could lead to HIV infection.

To further investigate HIV their knowledge concerning transmission modes, the respondents were asked to consider the statements in table 8 below

Table 8 Certainty about HIV transmission mechanisms amongst refugees

Mechanisms	Green Market Square		
	Disagree (Count)	Disagree (%)	Total (Count)
It is safe to have unprotected sex with a fellow man	14	93.3%	15
When under influence of alcohol it is impossible to think about using condom.	12	80%	15
It is safe to have sex once with casual partners without condom	13	86.7%	15
It is impossible for a man to become infected with HIV by having sex with a woman infected with AIDS	15	100%	15
Protected sex should apply only when having sex with commercial sex workers	15	100%	15
Sexual contact is the only mode of transmission for HIV	14	93.3%	15

It is evident from Table 8 that all the respondents were knowledgeable about the fatality of the disease and the situations, which could lead to an individual being infected with HIV.



When asked how the information had changed their lives, 93.3% (14 of 15 persons) said that they had become aware that unprotected sex with men or women was dangerous and that condoms should be used. 0% (0 of 15 persons) was practicing abstinence. 100% (15 of 15 persons) were sexually active and using condoms. 13.3% (2 of 15 persons) used condoms only when engaging in sexual intercourse with commercial sex workers. 6.7% (1 of 15 persons) did not use condoms when engaging in anal sex with male partners. 2 out of 4 married couples used condoms whilst the other 2 did not.

5.1.7 HIV sexual risk practice

Table 9: Risky sexual behaviour for HIV infection amongst refugees

Risk sexual practice in the past 12months	Respondents			
	Yes (Count)	No (Count)	Total (%)	Total (Count)
Multiple sexual partners	2	11	86.7%	15
Bisexual, homosexual activity	0	15	100%	15
Use of condom in anal and vaginal sexual encounter	11	2	86.7%	15
Oral sex	1	13	93.3%	15
Group sex	0	15	100%	15

Table 9 shows that the refugee respondents had not, on average, been involved in risky sexual behaviour in the past twelve months. 2 respondents admitted that they had not used condoms in either vaginal or anal sexual encounters, whilst 2 had had multiple sexual partners in the past 12 months and 1 had practiced oral sex. Group sex, bisexual and homosexual practices had not been practiced in the 12 months prior to the survey.

When asked how much they knew about the past sexual history of their partners, those with multiple partners and were not using condoms, admitted that they did not know much. Respondents who had multiple sexual partners commented, “Changing women is a way of proving one’s masculinity and of avoiding being looked down upon by one’s friends.” “It is better to change women than to have anal sex with a man because I don’t want my peers to call me funny names.”

5.1.8 Condom use during sexual encounters

Table10: Frequency of condom use amongst refugee men

Country	Respondents			
	Condom use when engaging to sexual intercourse			
	Always	Sometimes	Never	Total
Cameroon	1	1	0	2
DRC	6	3	1	10
Uganda	1	1	1	3
Total	8	5	2	15

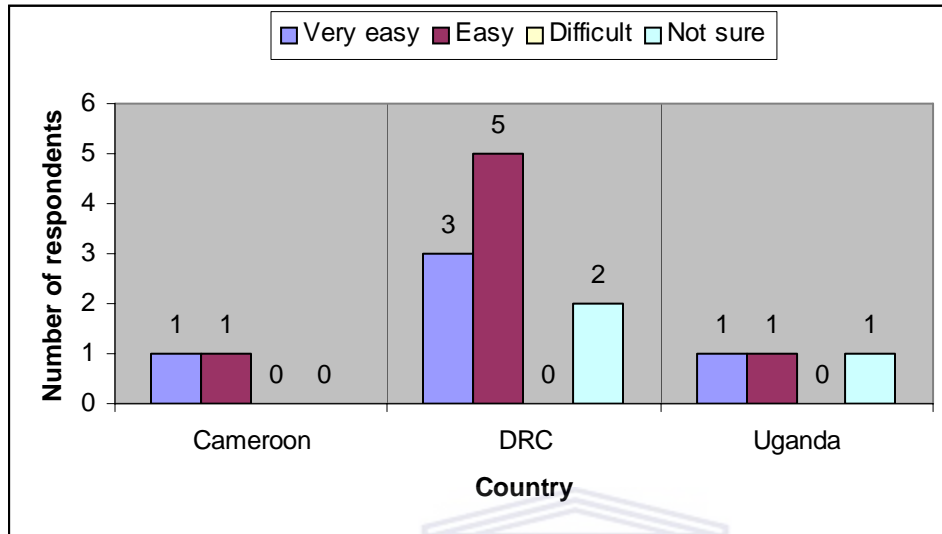
Table 10 shows that 53.3% always used condoms, 33,3% (5 of 15 persons) sometimes and 1 respondent never. Of the 10 sexually active respondents from DRC, 60% (6 persons) always used condoms and 30% (3 persons) sometimes.

Of those from Cameroon, 1 always used condoms and the other sometimes. Those from Uganda and DRC said they never used condoms.

When asked how frequent do you use condoms? The Cameroon respondents replied, “When I left DRC I was aware of the high rate of HIV and therefore I decided to use a condom in order to reduce my risk of becoming infected. Condoms are freely available in South Africa. I am young and I want to fulfil my life’s dreams. HIV is like the landmines in Angola!” A refugee man from Congo who had never used a condom said, “Our community is full young guys, each one master of his own life. No one can teach me how to behave or what type of precautions to take! I will adopt the lifestyle that pleases me.”

5.1.8.1 The availability of condoms in Cape Town

Figure 5: Condom availability



As the above figure shows, 47% of the respondents from these three countries (7 of 15) found condoms easily available, compared to 33% (5 of 15) who found them very easily available. None of the respondents had difficulty in accessing condoms when needed.

5.2 Analysis of the findings

This chapter aim to answer the research question:

Do blame, individuals’ behaviour change, income, education and health increase the levels of HIV risk experience by refugee men in urban Cape Town?

This question is to be answered through the analysis of findings from the investigation, interviews conducted and secondary information based on the variables used in the study namely: income, health and education and HIV risk.

In the same process, the hypothesis in which this study rests will also be either acknowledged or discarded. The hypothesis was that: “The urban location of refugee men

and the blame they face may be the contributing factors that increases the risk to contract HIV”

5.2.1 Discussion of the findings

5.2.1.1 Refugee men in Cape Town and HIV risk

In this study an attempt was made to identify the factor that puts refugee men at an increased risk of contracting HIV. Some measures of HIV risk were used as tools for analysis. These included: the impact of blame in refugee’s men behaviour; knowledge on HIV transmission modes and belief on transmission mechanisms; the effectiveness of HIV transmission knowledge among refugee men and use of condom during sexual encounters.

- *The impact of blame in refugee’s men behaviour.*

The high incidence of youngish men unaccompanied by females has resulted in a high incidence of romantic relationship with local females, which has led to accusations that these foreigners are stealing our women (Boaden 2002: 15).

The response to the question whether blame induces risky behaviour amongst refugee men in interviewed at Green Market Square, Cape Town indicated that the majority of refugees in Green Market Square, Cape Town said their behaviour had nothing to do with blame. One refugee respondent rightly said: *“South African guys will only be nice with you in most of the case when you are talking money with them but when there is no money, eh! They will start to call you all sorts of names and it is at that time they will also start blame for their troubles.”*

The risky behaviour occurred as a result of peer pressure, competition and proof of masculinity. Refugees acknowledged being at risk but changing sexual partners was the most uplift way and it was not a matter of concern.

“Sleeping with woman may bring luck to the business” (refugee man from Congo).

The risky behaviour among refugee men at the market could be partially because of regular access to cash, which could expose one to alcohol and later raise the sexual desire. One could ask the question of knowing why would refugee men at the market have a tendency of changing sexual partners while aware of the risk they may face? The possible reason could be that the majority of men are single and do not have proper recreational time, and had access to cash on daily basis. These situations had led to sexual relations becoming a leisure activity. It is important, however to note that the majority of refugees in the market indicated that blame did not contribute to risk behaviour found amongst refugee men. As the majority also said that they do not care about South African attitude towards them.

“Although they blame us for whatever reason, I don’t care. I have to be determined and try to rebuild my life. What I went through before reaching South Africa is more than what I experience here. I will carry on doing what I do best my brother. I should not bother much about their unfounded blame.” (Refugee men at the Market)

Neither the blame nor jealousy that South African men have against them will stop them from enjoying relationships with South African women.

Although blame is an obvious reaction whenever there is a deadly disease such as HIV, the level of HIV risk that refugees face cannot be attributed to blame. The data that was collected shows that in general, the majority of refugee respondents associated the risk for HIV infection with personal behaviour. It is also evident that in the face of blame, refugees in the study showed no signs of worry or of being depressed. The lack of worry amongst refugee men was expressed in the following words:

“You know that in life you will always have people who will love you and those who will hate. Sometime their hatred against you is because you are successful, if you are not guilty of any wrongdoing why then bother. The blame that some of us are subject to, I see it as result of our business success. I can also say it because their women are attracted to us. When it comes on the issue of HIV, like refugee men, South Africans also can contribute to the spread of the HIV. We all run after girls for sex either protected or unprotected is up to each one of us to tell.”

(Interview with refugee man, held on February 22nd, 2006 at Green Market Square).

It is important, however to analyse the level of knowledge on HIV transmission modes and belief regarding transmission mechanisms.

- *Knowledge on HIV transmission modes and beliefs on HIV transmission mechanisms.*

Knowledge on how HIV is transmitted is essential to behaviour change. The data that was collected shows that in general, refugees at Green market Square were knowledgeable of the HIV transmissions patterns. Examples of the comments from the refugee men are:

- “You can’t get AIDS from sharing the same toilet seat with HIV infected person. You get it through contaminated blood or sharing razor or else needle.”
- “Having unprotected anal and vaginal sex”

The findings also show that refugees are knowledgeable about the situations that could expose a person to the likelihood of contracting HIV.

The level of knowledge on transmission patterns and situations that could lead to an individual contracting HIV amongst refugee men at Green Market Square could be attributed to HIV prevention programmes and it could also be as a consequence of nationwide massive campaign against the pandemic by provincial and national government articulated in the National Strategic Framework for HIV and AIDS and STIs (Department of Health S.A. 2006:3).

However, knowing the facts about HIV transmissions patterns alone is not enough to describe the degree of HIV risk; it serves as the basis upon which individuals can use in making decisions to alter their behaviour. Conversely, for an individual to describe their behaviours as risky for HIV infection there should be the elements of knowledge in the transmission patterns and protective actions against HIV infection.

It should not be surprising, when we consider that individual risky behaviour, and not lack of knowledge alone, results in HIV transmission. As expected of the known transmission modes, having unprotected sex, engaging in sexual intercourse with multiple sexual partners, sharing non-sterilized needles were associated with higher risk while not using a condom within a relationship that is believed to be monogamous is not associated with high risk.

The knowledge of HIV is consistently high amongst refugee men at Green Market Square but knowledge is often not enough to change behaviour (Coast 2004:6).

Knowledge of transmission patterns and of situations that can lead to becoming infected was high amongst the refugee men at the Green Market Square. But it was also necessary to try and find out if the application of the knowledge had an impact on modifying refugee men behaviour. The study was able to establish this through the question on whether their knowledge on HIV had altered the behaviour of refugee men.

- *Impact of knowledge of HIV transmission routes and beliefs on HIV transmission mechanisms.*

The response to the question points out that the majority of refugee men in Green Market Square believed that their lives had changed. However, the types of change that had occurred differ from refugee's country of origin. For refugees from Congo, they said their lives have changed because they knew that unprotected sexual intercourse with casual partner and having multiple sexual partners was potentially riskier. Condoms use was the only mean to reduce the risk when engaging into sexual activity. Refugees from Uganda knew that they should know their partners past sexual history before engaging into sexual activity because knowing partners sexual history will help one to take appropriate preventive measures. Otherwise, avoid completely engaging in sexual intercourse with the partner. Refugees from Cameroon knew that engaging into sexual activity under the influence of alcohol could be dangerous and one need to be sober before engaging into sexual intercourse with either regular or casual partner. The different impact that knowledge of HIV transmission routes and belief on HIV transmission mechanisms had on refugees could be partially attributed in mode of socialization of each group. Although

is very difficult to have reliable proof on lives change amongst these various group of refugees, but it is important to note that the majority of refugees at Green Market Square pointed out that information that they have about HIV had changed their lives.

- *Frequency of condoms use amongst refugees engaging to sexual activity*

“Each sex act carries a small risk that is repeated whenever people have unprotected sex, adding up to many opportunities for infection.” (Jackson 2002: 83).

To date, frequent use of condom during sex is certainly the most effective way to decrease the risk of HIV and other sexually transmitted infection transmission (Ibid, 106). It is eminent from the data collected that condom use was common practice amongst refugee men at the Market. The explanation to the overall condoms use could be attributed part by the level of awareness amongst refugee men about the HIV prevalence rate in South Africa and their exposure to HIV information. However, there were discrepancies on the condoms usage frequency amongst various respondent groups. Some respondents say they always use condom when engaging to sexual encounters and other say they use condom sometimes. The level of education amongst the study respondents caused the discrepancy. Research conducted amongst men in KwaZulu- Natal found that condom use is often higher amongst the better educated than the less educated (Maharaj 2005: 192).

The evidence on condom accessibility in Cape Town from our data could be another explanation to validate the common use of condoms amongst refugees. The majority acknowledged having an easy access to condoms. The study conducted in 2005 by Human Sciences Research Council (HSRC) shows clear evidence of efficient condom distribution systems in South Africa, with 90% of young and adult age group have acknowledged having easy access to condoms. The easy accessibility is because of the distribution pattern of condoms in the public spaces such as train stations, public toilets and public clinics. This was done through the Department of Health’s procurement and distribution programme (HSRC 2005: 71).

Although data collected shows wide spread of condoms use amongst refugees at Green Market Square condoms are not always used to reduce the likelihood of an individual contracting HIV. Holmes (2003:95) points out,

Man is likely to use condoms to prevent a short-term consequence such as an STI or pregnancy than a long-term consequence such as AIDS.

Differences in condom use as shown in the data collected can also be explained by how individuals perceive their risk of contracting HIV. Those respondents, who said they used condoms sometimes, usually did so when they met their sexual partners for the first time. As their relationship grew, they tended to stop using condoms in order to show mutual trust.

Maharaj (2005: 191) explains,

Condoms are more commonly associated with casual relationship, rather than on-going, long-term relationships. In long-term relationships, many people do not consider themselves at risk because they trust their partners. However, men feel that it is important to always use condoms in short-term relationships, because of the fear of sexually transmitted infections including HIV.

The inconsistency of condom use amongst men who responded, “I use condoms sometime or occasionally”, could be attributed in part to the common complaint amongst men that condoms interrupt sexual activity, cause discomfort and spoil the pleasure of flesh-to-flesh sexual contact. Hence the unavailability of condoms could not be linked with the inconsistency of its usage in the South African context since condoms are widely distributed and easily accessible (Peltzer 2003: 258, Maharaj 2005: 190).

In addition, Peltzer reasons that the lack of a consistent use of condoms is because of alcohol. As Ganguly et al (2000: 4) also argue, condom use is a male-controlled method of their partner sexuality. The responsibility of a male is to protect himself from becoming infected and to ensure that his partners do not either. In addition, Ganguly et al say it becomes difficult for males to assume responsibility when under the influence of alcohol and therefore the correct and consistent use of condoms may be difficult (Ibid, 4).

Another factor that could justify the lack of consistent use of condoms amongst men was that condoms reduced sexual enjoyment. The majority of respondent reported have had sexual intercourse with a female partner prior to the study and some had sexual intercourse while the study was been conducted. The study found that more than 86.7% of the respondents were aware that condoms offer protection against HIV infection. Human Sciences Research Council study also found that the majority of the respondents indicated that they use condom for HIV prevention, pregnancy prevention and then STI prevention (HSRC 2005: 71)

5.2.2 Education and HIV risk

Ignorance is one of the major reasons for the epidemic being out of control. The need of preventive and general education should flow from this type of ignorance closely connected with the epidemic, especially in a country with high prevalence rates. Education as an essential tool in combating the spread and extenuating the effects of HIV, it has contributed towards making individuals aware that they are at risk and why and how prevalence can be reduced (UNESCO 2004:14). A study of the education situation amongst refugee men at Green Market Square shows that, refugees had attained high level of education, which consisted of high school completion the maximum. There was a lack of interest for furthering studies amongst refugees at the market. This could be explained by the fact that South African government and UNHCR have a self-reliance approach for urban refugees, which does not make provision for further education. Conversely, there was no evidence of formal HIV/AIDS preventive education amongst refugees at the Market. Although there was no formal preventive education refugees showed a good level of knowledge.

The data shows that in general, refugee men at Green Market Square are knowledgeable about HIV, an analysis into whether their inability to further their studies affects HIV/AIDS knowledge; frequency of condoms use, showed that there is no such inconsistency. The level of knowledge of HIV/AIDS found amongst refugees at the

market is often the result of non-formal preventive education that is received through public information, mass media or community organizations that to some extent contribute to the prevention effort. Although knowledge acquired through formal or non-formal education is not sufficient but indispensable. Nevertheless, UNESCO (2004: 14) also points out that,

Knowledge provides protection against individual vulnerability and gives tools for understanding and avoiding risk. It creates a context in which the epidemic can be discussed and understood, and in which those affected and infected are cared for and included in society.

Despite refugees at the market being knowledgeable about the modes of HIV transmission, they would still be at risk and vulnerable to HIV infection if their personal behaviour was risky. For this reason the type of education, which is considered the cornerstone of the development of the kind of behaviour that would contribute towards decreasing the risk and vulnerability of infection should be maintained and reinforced. Having received the proper education, refugees should be equipped to make correct and informed decisions regarding sexual relationships and condom use (Ibid, 17).

Although most of the refugee men interviewed had a high level of education, their working environment could make them pay less attention to their sexual health and safety. Although it is often thought that a higher level of education might increase one's awareness of the risk of HIV infection, evidence shows the opposite. Individuals with a high level of education have been found to have an increased degree of casual sexual activity (Akwara, Madise and Hinde 2003: 391).

5.2.3 Perceived risk

The findings suggest that the majority of the refugee respondents at the market consider themselves at risk of contracting HIV. This is in contrast to the South African men who were interviewed at the market who see themselves less at risk of contracting HIV. This

could be explained by the fact that some of the South African respondents believed that HIV was predominantly found amongst male foreigners. Despite the high prevalence rate of HIV infection in South Africa, the male South African respondents did not consider themselves to be at a greater risk of contracting HIV. Similarly, being a refugee was not considered to be an increased risk and refugee men did not consider themselves at risk. The study found that viewing a particular group as more vulnerable to HIV infection might cease if proper information was distributed. Considering that knowledge concerning HIV has increased extensively over the past few years in almost every country the association between such knowledge and sexual behaviour as found in sexually active populations remains unclear.

Akwara, Madise and Hinde (2003: 391) also argue,

Associations between level of AIDS awareness and the number of partners and self-perceived risk are non-existent. In their argument they found that individual had a fatalistic attitude towards AIDS. This fatalism has been noted where individuals are aware of modes of transmission and prevention and yet continue to engage in risky sexual practices.”

Evidence from this study shows that refugee men at the market are perceived to be at risk of HIV infection. This was due to the fact that their information and general awareness of HIV/AIDS has been received through the media. In their case, the media has influenced their perception of the risk of HIV infection and behaviour. However Akwara *et al.*, also found that:

People perception of risk may depend upon how much they trust the accuracy of the information receives.” Akwara et al. go further in saying that neither increased exposure to the media and greater belief in the accuracy of the media as neither source of information about AIDS nor knowledge of the facts about HIV/AIDS transmission affected people’s perception of risk (2003: 392).

Because of the difficulty in assessing the trustworthiness of the information received during an interview and a true indication of the respondent’s lifestyle, the perception of risk and sexual behaviour in any population group is not easy to ascertain. Nevertheless, those refugee men who perceived themselves to be at risk of HIV infection, mentioned factors such as the number and type of lifetime sexual partners, personal and partner’s past or current sexual behaviour, consistency of condom use with each casual partner,

knowledge of their sexual partner's HIV status, and indirectly, the level of HIV prevalence amongst the host population or country. The study found that the refugees' perceived risk was influenced in part by the individual's sexual behaviour and by their belief about the HIV prevalence rate in South Africa. The South African men in the market did not perceive themselves to be at risk. They did not feel vulnerable. The attitude amongst the South African men at the market can be referred to as "optimistic bias: the tendency to consider one's risk as less than that faced by others" (Timmins, Gallois *et al.* 1998: 194).

The fact that refugee men believed the HIV prevalence rate to be quite high in their host country has led them to perceive that the risk for contracting HIV is high. It would appear that the risk being perceived as high by refugee men is unnecessary. It is not considered a condition bad enough to call for them to alter their individual behaviour, especially in relation to sexual behaviour. In addition, it has been demonstrated that men's attitude toward HIV risk exposure is not perfectly matched to their sexual behaviour. Another way to explain the gap between attitudes and behaviours is that there is often a discrepancy between a belief held and actual sexual behaviour within a specific situation. People often may believe one thing but do not always act according to that principle in a situation once the individual has taken account the range of contextual factors. This is often the case when behaviour involves both sexual behaviour and some risk of harm. In the context of HIV/AIDS especially, people are afraid to portray themselves as promiscuous or immoral. They seek to portray themselves as well behaved. Most of the refugee men in the study were aware that certain types of behaviour placed them at risk, and that their present behaviour significantly influenced their perceptions of their own risk of HIV infection.

"Although we might be at lesser risk for HIV but I have to admit that the risk is still there. We are self-selected group as we are trying to build better lives and therefore perhaps we are less likely to put our own lives sometime at risk for harm and may be we are less likely also to have HIV" (Refugee man at the market).

My findings suggest that the South African men who took part in the study underestimated the risk of HIV transmission when exposed to the virus and did not accurately measure the real risk.

As Klepinger *et al.* (1993: 81) argues,

Men tend to overestimate transmission rates and underestimate exposure risk and their perceptions of the risk of exposure are more salient to their personal concern about AIDS and their HIV related risk behaviour than are general perceptions about the probability of transmission.

The refugee respondents who were not engaging in sexual activity during the period of the interviews tended to perceive their risk of contracting HIV as being very low while those who were engaging to sexual activity during the same period perceived themselves as being at risk of contracting HIV, although they did not see their risk to be very high.

5.2.4 Source of livelihood

The researcher considered analysing sources of livelihood and income because in this study the refugees' source of income provided them with cash on a daily basis. The source of income for the refugee men in my sample was trading in curios at Green Market Square. Trading in curios enabled them to have cash on a daily basis and this might lead to the emergence of sexual relationships with local women or women from their own refugee community.

Refugee men were asked, "How do you feel having cash in your pocket?"

Refugees at the market reckoned that having cash would make any person happy.

Examples of the comments from the refugees at the market are:

"I feel good that day because I can afford a beer as well as have a nice time with my girlfriend."

Another respondent said

"Cash will make ladies to run after you, especially here at the market these local girls will be after you only when they see you with bucks. I also take advantage of

my money to enjoy them. Since they say there is nothing for mahala, so I do not spend my money for mahala without again.”

The study found that all the respondents at the market did not view access to daily cash money in the same light. 2 of the 15 respondents, who appeared to be married, viewed the cash as a meaningful source of income to maintain their household and themselves. 12 of the 15 respondents, who were single, considered cash as a tool for forging sexual relationships with women as well as for drinking. Although, not all the money was spent on women and beers, they reckoned that they spent around 60% of their money unproductively.

The researcher found that the refugee men's source of income exposed them to a risk of HIV infection, especially those who were unmarried. As the prevalence of HIV infection in the heterosexual population rises, the behaviour of 80% of the unmarried refugees at the market could place them at risk of HIV infection.

The factors that influenced refugee men were peer pressure, prestige, loneliness and the need for companionship. None of their behaviour was motivated by genuine love. Consequently, their source of income might become the source of risk for some refugee men at the market since it provides them with a means to have multiple sexual partners.

The likelihood of buying sex from commercial sex workers also existed amongst the single refugee men at the market. 2 of the 12 single refugee men indicated that he had visited commercial sex workers. When asked concerning their motivation for visiting commercial sex workers, they commented:

“When you visit Commercial Sex Workers you do not discuss about establishing a permanent relationship rather you discuss about sex and the price of it, finish.”

(Refugee man at the market).

The researcher found that the one factor related to visiting commercial sex workers was low social and economic status. 10 of the 12 refugee men, who had not visited commercial sex workers, saw themselves as having the financial muscle to maintain

multiple casual sexual partners. It came down to the prestige of being able to change sexual partners.

Amongst the refugee men at the market, the researcher noted sexual behaviour differences: 20% of the refugees sought to be faithful to their regular partners and the remaining 80% sought to have casual sexual partners, which could place them at risk of HIV infection. Those refugees who were in casual sexual relationships indicated that some of their sexual partners could be found within the market, especially amongst the girls they employ as customer assistants. In most cases they were local girls with a low level of education. Refugee men were asked about their choice to have sexual relationships with girls with a low level of education.

“Less educated girls are easy to negotiate sexual relationship with them, especially in presence of money since most of them have a low social and economic status.” (Refugee man).

The research has found that the ethnic diversity of the South African population was one element that motivated unmarried refugee men to change sexual partners whenever they were in possession of money. 12 of the 15 respondents mentioned that ethnic diversity was the motivating factor behind their change of sexual partners. When the researcher inquired why ethnic diversity should be a factor for seeking to change sexual partners, some refugee men said:

“Where we are coming you have only one population group, so all girls appear to be the same and there is no great deal for change of sexual partners” (Refugee man).

“In South Africa you have Xhosa, coloured, Indian, Zulu, white and so on, you must know that all of them are not the same when having sexual intercourse with; for example Xhosas with their physical shape, one will always seek to know what good can come out of them when you are with them” (Refugee man from Congo).

“When it comes on white girls, when I need them, I have to go where they trade sex because of the legacy of the past it very difficult to get one in plain light”
(Refugee man from Uganda).

The study also found that the source of income, compounded with the environment where the income is earned and the status of these refugee men, creates a breeding space for risky sexual behaviour to take place. Analysing the comments made by some respondents, the study found that refugee men’s feeling of personal vulnerability was subjective and varied in context and time. Thus, the sexual behaviour of these refugee men is more likely to be based upon subjective perceptions of risk rather than actual risk (Akwaru *et al.* 2003: 401).

The study shows that 2 of 15 respondents were not involved in changing sexual partners. The two were both married. Therefore, marriage provided checks and balances in their sexual behaviour compared to those who were not married. In addition, societal norms in the African context expected faithfulness in marriage. On the other hand, divorce paves the way for freedom from marital obligations and increases the chances of previously married men embarking on risky sexual behaviour, as in the case of unmarried refugee men who had multiple sexual partners (Ibid, 401).

Refugee men’s sexual behaviour, particularly those who were not married, suggested that risk was not based on personal behaviour or that of their partner, but on the level of AIDS morbidity and mortality within the refugee community or in their work environment, which is the market where they conduct their trading.

These results show strong evidence of an association between sexual behaviour amongst refugee men at the Green Market Square and their economic status. The significance of the effect of their source of income suggests that refugee men’s casual sexual relations could be partly motivated by the daily possession of cash through their trading activity. There is also great homogeneity with regard to celibacy and sexual behaviour of some refugee men at the market. Since there were no norms, which should govern sexual

behaviour amongst the refugee men who were not married, they had the freedom to adopt the type of sexual behaviour acceptable to their peers.

5.2.5 Living Condition and HIV risk

The study has found that the fact that they lived in mixed-sex accommodation had little to no influence on the sexual behaviour of refugee men, compared to those who were living in single sex accommodation. The married refugee men and South African men were omitted in this discussion since they were not living in shared accommodation.

Talking to the refugees on living in single sex accommodation, the issue of sex and alcohol was the focal point in most of their discussions.

“Every time we come together, you will hardly hear us discussing about politics for example, at least we can discuss football but the topic that will dominate our discussion time will obviously be women and often we discuss around a glass of beer. That is the life of most men in our situation.” (Refugee man from Cameroon)

The data collected from refugee men who were not married showed that 80% of the respondents living in the single sex accommodation felt that this did not increase the risk of HIV infection but that pressure from the group encouraged one to seek many different sexual partners in order to conform to the trend amongst other group members. This became clear through the explanation provided by one respondent who said:

The main reason for us living in a shared accommodation is to cut down the cost of rent since accommodation is very expensive around Cape Town, especially in the suburbs. The issue of women is far from being the main reason of living in the single sex accommodation. Women issue arises as we familiarise with one another lifestyle in the house. (Refugee man from Uganda).

The above explanation could be that refugee men face difficulties obtaining cheap individual accommodation or else they simply feel comfortable living with their countrymen. The majority of these refugee men were in their late 20s and early 30s who

were seeking a new life in a foreign country with good prospects. Unfortunately they were faced with this accommodation challenge.

“I have to admit to you that life is tough, being criticized or being blamed, I am not going to give up or succumb because of that,” (Refugee man from Congo).

From this discussion it can be seen that refugee men’s exposure to the risk of HIV infection is not associated with the type of accommodation in which they live but rather with their personal lifestyle. Living in single sex accommodation could play an influential role in the altering of one’s original behaviour pattern. The study found that only 1 of 13 respondents was sharing a house with several countrywomen and the likelihood of him being influenced by the women was non-existent. This could be explained partly because there was less interaction amongst them. A respondent explain: *It is inappropriate (laugh) for a man to have a sexual discussion with a woman who is not your girlfriend and the same apply to the woman.* (Refugee man from Congo).

5.2.6 Health and HIV risk

The study observed that there was a difference in the respondents’ use of health facilities. The South African men indicated that they used medical doctors or community clinics for their health needs. Consulting medical doctors, however, was for the more complicated illnesses and not for headaches or stomachaches. In the case of headaches, community clinics were mentioned as the preferred place to visit. The South African men showed a slight concern about their health. The pattern of health-seeking behaviour amongst the South African respondents was in part due to the fact that treatment at these community clinics was free of charge.

Taylor (2001: 793) also suggested that,

Health choices are more likely to be made if the individual believes that they are susceptible to the disease, that it is serious, and that the proposed healthy choice will be successful with the benefits outweighing the costs.

The study found that the respondents consulted health services mostly when there was an illness. None consulted the health facilities for check-up purposes. Furthermore, none of the South African respondents found the need for voluntary counselling tests (VCT) for HIV or for Sexually Transmitted Infections (STIs). This might explain the respondents' tendency to offer an apparent justification for their reluctance to take an HIV test or to visit sexually transmitted diseases clinics. Although some of them mentioned the dreadful nature of HIV, fear of rejection, stigma and labelling, they did not explicitly state that their reluctance to undergo a test because of their belief that they are not at risk. Their sense of invulnerability was noted in some of the statements they made;

Ja, man, I do not share my girl with the foreigners why should worry about HIV and on top of that why (sneeze) should I go for a test while I am well looking. (South African man)

I do not visit prostitutes as other people do. I have my girls in the township and I make sure that (eh. eh.) they are well looked after. (South African man).

This attitude by the South African respondents may be associated with the fact that they view the possibility of being HIV positive as remote. In this case it is difficult to encourage such individuals to have an HIV test (Ibid, 794).

The study found a strong sense of invulnerability towards HIV infection amongst some South African respondents at the market. This became evident through the construction of the male identity as strong and resilient to diseases and the perception that 'other' (refugee men) are at risk. Research conducted amongst heterosexuals also found that,

Evidence of low risk individuals seeking an HIV test to relieve anxiety arises when mass media campaigns or intense news media coverage of heterosexual higher risk of contracting HIV are followed by significant increases in the numbers of heterosexual seeking HIV tests (Taylor 2001:794).

The study shows that compared to the refugee respondents, the South African respondents did not use pharmacies or retail shops as alternatives to clinics when there

was a health need. The difference in health behaviour between the two groups is the result of the good health-care system in South Africa versus the ill-functioning health-care systems in most of the refugee respondents' countries of origin.

According to findings by the National Refugee Baseline Survey in South Africa, female refugees visited more local public clinics for primary health care needs, while males were the least likely to use these services. The reason for the higher number of females refugee visits to these services was partially because females are often responsible for taking care of their children and any health problems that they might encounter (Belvedere *et al.* 2003:148).

For some refugee men the reduced interest in visiting health-care facilities is highlighted by the following statement:

I am aware that I should sometime give my health needs a first priority, but my concern is if you go to the clinic and they find that you have an infectious disease, can you see that you are going to make your life more miserable since we are blamed of carrying diseases and spreading it around.

I am not a medical doctor, to be able to know if the result I will get from the clinic will be the reflect of my problem, my friend you never know since everything is possible in this world that we are living. (Refugee man from Uganda).

The majority of refugee respondents indicated that the nature of their work, which requires one's daily presence in order to earn a living and to pay for the trading space, was a key determinant in not prioritising their health needs. Neither blame nor xenophobia was identified to be the cause of health being the last priority amongst refugee men although the services were almost free of charge. Free services are often provided by the community clinics.

Some of the men seemed to be proud for having health needs as their last priority:

A genuine man is the one who does not get sick every time and does seek medical attention even it is a headache or stomach pain. My friend, I do not want to put myself under unnecessary pressure of going to get tested for HIV, I am really fine. By seeking an HIV test is like I am going to provoke a sleeping lion, which even yourself you know that is not going to help me to live my life fully. (Refugee man from Congo).

However, the majority of the respondents acknowledged that when faced with a serious health complaint they were compelled to seek medical attention. The study found that even though they did not visit the clinic in the event of illness, they did not visit traditional doctors, witch doctors or herbalists for treatment either. Refugee males were more likely to use retail shops to purchase medicines in the event of illness compared to their South African respondents.

The researcher also found a strong resilience against illness amongst the refugee males. It was also found that 14 of 15 were not in the habit of visiting a health facility for a normal health check up. This might justify the low rate of use of health services amongst the refugee men. The results show that 13 of 15 refugee respondents had experienced a serious health problem, which had led them to seek medical attention or admission to a health institution. All the refugee men knew that HIV and STIs continued to be significant public health problems that South Africa is facing (South Africa Department of Health 2002: 12).

Studies on men's sexual concerns have shown that men of all age groups have reproductive health concerns but tend to ignore minor sicknesses and avoid seeking treatment for their conditions. Some do not realize that they have a problem that needs appropriate medical attention or help and when it comes to reproductive health services, they perceive them as being synonymous to maternal or child healthcare. This discourages them from visiting healthcare facilities (Schensul, Verma and Nastasi 2004: 199). A similar situation was noticeable in this research because none of respondents

made mention of consulting sexually transmitted diseases clinics or local clinics for HIV or STI information. This was the case amongst refugee respondents and their South African counterparts.

Forrest (2001:261) also found that,

Men tend to conceal their vulnerability; they take more health risks, are reluctant to ask for help or information, and are less knowledgeable of their own health as well as that of their partner. They are socialized to be decision makers, to emphasize rationality, concreteness, and practicality, and to reject emotionality and overt expression of feeling.

Although data shows that generally refugee males were more knowledgeable about the HIV mode of transmission and the situations that could expose them to the risk of becoming infected with the disease, this did not translate into realizing the need to seek appropriate medical information, apart from their general knowledge of the diseases.

The study found that the majority of the respondents did not know that having a sexually transmitted disease could increase the risk of contracting HIV. This evidence shows that consulting health care facilities for medical care and health related information, especially appropriate sexually transmitted diseases information and services, would have enhanced both the refugee and the South African respondents' knowledge concerning HIV infection.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

This research set out to study the issue of blame in the context of refugees and HIV risk and to assess if HIV risk that refugee men may be exposed to is the result of blame or is caused by refugee men's own behaviour. To be able to do this, the research has explored the patterns of blame as experienced by refugees living in Cape Town, South Africa and the way in which blame has made refugees to be seen as "other" who are responsible for the spread of HIV. The ensuing accusation has at the same time diminished the sense of responsibility within the wider community to collectively prevent or tackle the crisis more effectively. Instead most of the effort has been wasted in trying to find the culprit. The research then tries to shift focus from blame into looking at the factors that may make refugee men vulnerable to HIV. What becomes clear from the analysis of the situation is that these two factors; blame and HIV risk, are not connected. Except that HIV could lead to an individual being blamed. In contrary, blame cannot lead an individual being exposed to HIV risk. The risk factors for HIV that was discussed in this study is not particular to refugee men but it is the same problem within the whole society. African foreigners in many countries have been blamed for the spread of AIDS. However, the intensity and manifestations may vary across societies and contexts often depending on the level at which the epidemic is affecting the societies. The intensity and manifestation of the epidemic in South Africa has made some South Africans to direct much of the blame towards refugees. The study attempted to argue that the vulnerability of refugee men could be increased not by blame or by perceiving them as polluted or a risk group 'other' but rather by factors such as social exclusion, social dislocation, sexual behaviour and heavy alcohol intake behaviour. These factors together with discrimination, prejudice and stigma attached to refugeeness need to be addressed if preventative measures are to have more than a superficial effect in the fight against HIV. Refugee respondents during the interviews have clearly disassociated their risk for HIV

with blame; they reckoned that their individual behaviour has more to do with the possible risk for HIV infection. Consistent with other studies, stigma and discrimination as experienced by refugee men whether real or perceived, is a dynamic attached to the AIDS pandemic, which is affecting the refugee community. Consequently, refugee men have been suspected of being infected or a risk group. The suspicion or perception of refugee men being infected (polluted) was often motivated out of a need to inflict blame and punishment because of the health threat refugee men appear to carry (Malcolm et al 1998: 356).

Despite the fact that statistics were used to study one of the problems that refugee men face, I should note that refugees are more than the statistics, they are human beings who should be treated with respect and dignity, who should be protected as everybody else in this country, people who should have right to information, to protection, to opinion and to proper health care. In this process we need to create a space for these men to investigate their own vulnerabilities around sexuality. I should also note that the spoiled identity that the literature reports refugee men as having seems not to be a reality in the case of these men from Green Market Square, the men possibly being at less risk than their South African counterparts and perhaps not having succumbed to spoiled identity because most of them are determined and a self-selected group as they are trying to rebuild their lives, making them perhaps less likely to put their own lives at risk for harm than their South African colleagues at the market. They have a very resilient attitude and do not give up in the midst of difficulty. It is essential that refugee men be mobilised into taking action for and on behalf of their own communities. They are not a 'risk group', but they are a stigmatised, discriminated, marginalized, disempowered group, and these factors present a major obstacle to the development of critical consciousness and social capital, which are so important for the success of HIV prevention. Despite the perception of them being polluted and a risk group, refugee men are actively involved in constructing a positive identity about themselves as pure, normal and strong. It should be noted that little is written on refugees and HIV and indeed there is a greater need for more research to be undertaken in the context of HIV risk in South Africa refugees' population in general and men in particular, since men are believed to bring and spread diseases in their

community. Finally, it is at this point that I would like to address my own perceptions and experiences as a black foreign man living in Cape Town, who had experienced exclusion by some South Africans for the mere fact of doing things differently and not conforming to some society norms, and with these came the accusations of taking South Africans jobs and invading their space by creating havoc in some aspects of their social lives such education, health care, housing, security and employments. Having to go through these situations, made me want to explore more in depth these situations with a particular attention to the refugee men in the era of HIV. Refugees being foreigners and men as myself, made it a little bit easy to understand their situation but the fact of having a refugee status made them to suffer more since they had to compete a long side South Africans in the employment market and health care provision. Undertaking this research has been the most insightful journey in learning about the lives of refugee men and the challenge of building a new life in place where your identity or status is seen as an eminent health danger to the host population. Studying refugee men lives and behaviours was both difficult and insightful. Difficult because refugees are seen as problem to some institutions and persons rather than being seen as human beings worthy of respect and dignity, and insightful because refugees are committed to build their lives in the midst of all accusations and their level of awareness to the HIV infection. In the process of conducting this research I have become aware of the need to be protective of my country and its resources, and to fight all sort of discrimination, prejudice and stereotype against foreigners living in my country. The type of treatment that refugees experience in South Africa; made me to question rather the so called “ubuntu spirit” that Africans have championed as well as to question who really should be held responsible for bringing and spreading HIV in South Africa. The mere fact of being a foreigner for some South Africans is in itself a source of problems because being a foreigner for some South Africans means that you should be single out as HIV carrier, criminal, as the one who is destroying the employment market and furthermore the one who is stealing women. I partially identify myself with some of the issues such as the self-purification attitude, stigmatisation and social exclusion that I have discussed in this research. Blaming others for our misconduct and inability to response effectively to situation such HIV, will lead

to what African foreigners in general and refugee men particular have to go through sometime in regular basis.

Based on the collected data, risk for HIV could not be attributed to ‘othering’ or ‘blame’. Therefore the hypothesis that “blame directly induces the individual to risk for HIV infection” does not hold, while indirectly the blame affects refugee men’s behaviour in a way such as not seeking appropriate HIV information and medical attention in case of illnesses.

Given the context in which refugee men find themselves, I feel it is necessary to make the following recommendations.

1. We need to develop prevention strategies that seek to reduce the vulnerability of refugee men

The many HIV/AIDS policies and strategic plans are in place in organizations dealing with refugees and the host governments. However, few national strategic plans include refugee men as vulnerable group. The underlying causes of vulnerability of refugee men are seldom-mentioned compare to those of their female refugee counterparts. In addition, there are questions about the extent to which such policies are in fact being implemented. As long as the vulnerability of refugee men is not addressed, response to reduce refugee male vulnerability to HIV will be ineffective. One effective and important way of developing more appropriate policies is to encourage the participation of refugees in decision forums.

While encouraging refugees’ participation, there is also a need to integrate refugee men into the host country strategic plans on HIV as vulnerable group and separate strategies should be developed to address to tackle this vulnerability.

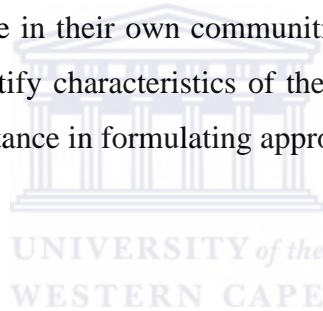
2. Refugee men need to be given conceptual tools and methods that help them to understand the social conditioning that may expose them to risk of HIV infection.
3. We must develop ways to foster a harmonious integration with less accusations and conflicts between refugee men and South African men, whereby.
4. Conduct more research to inform policies and programme on refugees men
Amongst the aspect that require more research and analysis are:

Refugee men vulnerability. Approximately 80 per cent of urban refugees are men, yet there has been very little research done on refugee men as vulnerable group.

- Refugee men who have sex with men. The research encountered anecdotal evidence of sexual relationship between men, especially in single sex living environment. This is a less explored terrain within many African societies and much more among refugee men, since too little is known about the character of these relationship and what possible role they might play in the transmission of HIV in refugees' community and host population.
 - Research and analysis needs to be done in the area of sexual behaviour and networking patterns in which refugee men participate in relation with their risk of spreading and contracting the HIV infection to their own community and the host population.
 - Urban location impact studies. Little is known about how HIV affects the refugee men in the urban areas and what could be the most effective responses to HIV would entail.
 - Local men must be supported in creating positive perception of refugee men and positive strategies for their future together with refugees' population, and the idea that there are different and more positive ways to think about refugee men should be promoted.
5. Countries that receive refugees need to adopt health policies and practices that will remove prejudice, discrimination, stigma and linguistic barriers to their access to health
 6. Prevention and care interventions addressing HIV/AIDS/STD and reproductive health of refugee population should include refugee facilitators. Refugees have to be involved at all phases, from planning then carry out to evaluating health promotion and services delivery programmes in the refugees' community.
 7. Some refugee men were unaware that sexually transmitted diseases or infections increase susceptibility to HIV infection. For this reason, I would recommend that

prevention programmes should put a lot of emphasis on sexually transmitted infection and encourage men to seek appropriate medical treatment, and information and abstain from sexual activities when STIs symptoms are detected.

8. Refugee men should be encourage to undertake a voluntary counselling test (VCT) because the knowledge of one's HIV status is an important step of prevention programme since the knowledge of HIV status will help in addressing HIV prevention risk to other as well as prevention the spreading of the disease within the refugees community and the host population.
9. Effort should be made to identify the negative experiences of refugees in host countries as we seek to find lasting solutions, which will ensure that refugees have equal access to information, treatment, and most crucially, to resources which enable them to intervene in their own communities to combat HIV. Again effort should be made to identify characteristics of the refugee community, which can also be of greater importance in formulating appropriate policy.



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APPENDIX

QUESTIONNAIRE

HIV/AIDS Risk (Refugee men Characteristic)

A. Interviewee Profile characteristics

1. Age.....

2. Gender: Male

3. Education level: None

Primary

Secondary

University

Others (specify)

4. Employment Yes No

b) If yes please specify

.....

5. Marital status

Single

Married

6. Which country are you from?

B. Life experiences in Cape Town

7. Where do you live in Cape Town?

- Suburb Informal settlement (Township)

b) With whom do you live?

- Alone
 With female friends
 With male friends
 With family

8. What is your main source of livelihood?

- Trading
 Other

Specify other: _____

9. Do you believe that blame affects your behaviour?

Yes

No

If yes specify how? _____

b) Are you at risk for HIV due to blame?

Yes

No

If no specify: _____

c) Do you think that refugee men should be blamed for spreading HIV?

Yes

No

If yes specify why they should be blamed? _____

d) How often do you encounter blame?

- Always
- Sometime
- Never

C. Accessibility of health services

10. Where do you most often go for primary health care?

- Public hospital
- Community clinic
- Pharmacy
- Other places
- Never



Specify other: _____

11. Do you seek medical attention when you are ill?

- All the time
- Sometimes
- Never

12. If not 'all the time' why not?

- Can't afford medical fees

Long waiting period

Discrimination (Blame)

Location of medical centers

Other

Specify Other: _____

13. Do you worry about your health?

Always

Sometimes

Never

14. How easy is it to access condoms in Cape Town?

Very easy

Easy

Difficult

Not sure



15. Do you pay to get condoms from distribution points?

Yes

No

16. How frequent do you use condom when engaging into sexual intercourse?

Always

Sometimes

Never

C. Education/ information about HIV/AIDS and the risk

17. How do you perceive your risk of becoming infected with HIV/AIDS?

Great risk

Some risk

No risk

Specify no risk: _____

18. How much do you know about the past sexual practices of your casual partners?

A lot

A little

Nothing

19. If nothing, why do you not see the need of finding out her past sexual history?

20. Where do you get HIV/AIDS information?

Media

Clinics

NGOs

Health workers/ social workers

Friends

Others

21. How accurate are the information that you receive from the above mention sources?

Always accurate

Sometimes accurate

Never accurate

22. How is HIV/AIDS transmitted?

	<i>YES</i>	<i>NO</i>
Unprotected anal and vaginal intercourse		
Dry kissing		
Direct contact with an infected blood		
Toilet seat		
Sharing toothbrushes		
Donating blood		
Sharing needles to inject drugs		
Touching		
Insect bites		


Circumcision instruments		
Living with a person with HIV		
Sharing razor blades		
Masturbation		
Drinking alcohol		

23. Do you consider the following sexual risk practice or not?

	<i>Agree</i>	<i>Disagree</i>
It is safe to have unprotected sex with a fellow man		
When under influence of alcohol it is impossible to think about using condom.		
It is safe to have sex once with casual partners without condom		
It is impossible for a man to become infected with HIV by having sex with a woman infected with AIDS		
Protected sex should apply only when having sex with commercial sex workers		

Sexual contact is the only mode of transmission for HIV		
---	--	--

24. Would you consider the following sexual behaviour as extremely risky or not?

Risk sexual practice in the past 12months	<i>Yes</i>	<i>Not</i>
Multiple sexual partners		
Bisexual, homosexual activity		
Use of condom in anal and vaginal sexual encounter		
Oral sex		
Group sex		
		

25. If yes, why this sexual behaviour is extremely risky?

26. Do you think that the information about HIV/AIDS transmission mode has changed your lifestyle?

Yes

No

b) If yes, how did it change your lifestyle?

27. Do you know anyone in the market or in your community diagnosed as having HIV or having been infected with the AIDS virus?

Yes

No

28. Do you think that having STI can expose you to risk for HIV infection?

Yes

No

29. How much do you know about STIs relation with HIV infection?

A lot

Little

Nothing

30. Do you see HIV infection as seriously fatal?

Always

Sometimes

Never

31. Do you consider yourself to be at a greater, minimal or no risk at all of becoming infected with HIV?

Not aware of the risk

Aware of the risk: a) 'great risk' or b) 'minimal risk' answer.

32. Are you traumatised?

Yes

No

If yes, please explain-----

33. Have you been sleeping around?

Yes

No

34. How do you feel when you have cash money?

