*"WHEN I SAY I, THEY HEAR ME"*

# THE PARTICIPATION OF MEN IN HIV INTERVENTIONS: RESPONSES FROM MEN IN THE IMBIZO MEN'S HEALTH PROJECT, SOWETO, JOHANNESBURG, SOUTH AFRICA.

ABIGAIL RUTH DREYER
Student Number: 9334860

A mini-thesis submitted in partial fulfillment of the requirements for the degree of Masters in Public Health at the School of Public Health,
University of the Western Cape

Supervisor: Dr Ruth Stern

October 2009

**10 Keywords:** South Africa
Soweto
Men
Imbizo Project
HIV/AIDS
male participation
male focused interventions
gender norms
gender inequities
qualitative research

"The freedom of authentic masculinity is an amazing thing to see. It produces a "divine elasticity" in men. Finally they can lead with firmness, then submit with humility. They can challenge with a cutting edge, then encourage with enthusiasm. They can fight aggressively for just causes, then moments later weep over suffering."

*Bill Hybels (1990:38)*

## Acronyms

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| BCC | Behavoiur Change Communication |
| CHW | Community Health Worker |
| FGD | Focus Group Discussion |
| GBV | Gender based violence |
| HIV | Human Immunodeficiency Virus |
| IMBIZO | The **Imbizo Men's Health Project** also referred to as **Imbizo Project**. (This is not an acronym) |
| MAP | The **Men as Partners** Project. |
| PPASA | Planned Parenthood Association of South Africa |
| SMS | Short Message Service or Silent Messaging Service (**SMS**) is a cellphone communication service. |
| SRH | Sexual and Reproductive Health |
| STIs | Sexually Transmitted Infections |
| VCT | Voluntary Counselling and Testing |
| WHO | World Health Organization |

**ABSTRACT**

The unequal balance of power between women and men, which has its roots in gender norms, contributes to both male and female vulnerability to HIV and sexually transmitted infections (STIs). Yet most HIV prevention activities target only women. There are, however, a range of civil society organisations that are currently working to promote gender equity and HIV prevention among men in South Africa. Evaluations have shown the benefit of this approach in changing men's attitudes towards women. However, they have offered limited understanding about what it is that specifically encourages men to participate in these programmes

One such project, in Soweto is the Imbizo Men's Health Project (an HIV/AIDS prevention initiative of HIVSA. The project is designed to encourage and educate men about importance of testing for HIV/AIDS. The objective of the project is to enable men to embrace/ adopt VCT as an entry to care, treatment, support and healthy lifestyles.

This research aimed to explore why the Imbizo Men's Health Project is successful in encouraging men to participate in an HIV focused intervention by exploring what the respondents perceived to be the essential elements required for the constructive involvement of men in health related HIV prevention programmes. It used the qualitative research method of six focus group discussions to gather data. The study population was participants from the Imbizo Men's Health Project. A purposive sample of 40 men aged 18- 35 years old living in Soweto were selected from this study population. The content of the focus group discussions was analysed to identify recurring themes and perceptions, and the key suggestions made by the respondents.

The results showed that men are participating in HIV programmes. One of the main reasons men first attended and joined the programme was due to pressure from a mother or partner. In instances where men were encouraged to participate by staff working on the project it was clear that because staff on the

project are male, their encouragement was seen as relevant, and it had similarities to the encouragement from friends. The findings revealed that the men did have sufficient correct information to reduce their risky behaviour patterns and that behaviour *change* is the missing link in reducing the transmission of HIV in our communities. Reasons that supported ongoing participation included the desire to learn more HIV/AIDS information, the opportunity for self empowerment and the peer education possibility. It was interesting that men valued the psychosocial benefits as a reason that supported their ongoing participation, although they were also pleased there were no explicit discussions on their gender roles as men. Programme design is important as this also impacted on the participation. Besides the supportive environment and male staff, respondents noted that having a high factual focus made participation meaningful in their everyday lives. In conclusion, males identified the need to recruit other males based on their experiences because men would participate if they wanted to and not because they were forced to.

It is recommended that the design of programmes reflect the daily experiences of men, and the issues that are of interest to them. The work needs to continue to involve men as valued contributors in together seeking the solutions. It is also recommended that further investigation of programmes where men actively participate need to be undertaken so that good practice models may be designed.

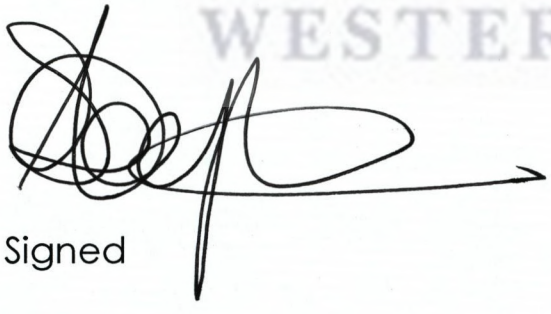
It is hoped that the recommendations emanating from this research can inform the future planning of other male focused interventions aimed at reducing HIV infection.

## DECLARATION

I declare that *The Participation of Men in HIV Interventions: Responses from Men in the Imbizo Men's Health Project, Soweto, Johannesburg, South Africa* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.



Abigail Ruth Dreyer 29th October 2009



Signed

## ACKNOWLEDGEMENTS

I acknowledge this thesis as a true test of participation and thank those who embarked on this journey with me and gave me the support to focus my attention.

I thank the countless friends and colleagues for their interest, valued academic support and faith in me throughout the period of this study– for being the perfect supporters by never asking why a thesis should take so long to complete.

I thank, Geoff, Annette, and Edna for all their guidance, for asking the challenging questions, for their gentleness and encouragement extended to me and not forgetting their willingness to be my proof readers!

To Paula and Mateo, for your confidence in my abilities, faith in my efforts and most importantly for being there and urging me to do more than I thought I am able to do. This is your work too.

I would like to express my gratitude to my supervisor, Dr Ruth Stern for her strong direction, dedication, guidance and constructive criticism throughout this work.

And *finally* - I would especially like to thank all those whom I interviewed, as well as those who participated, all of whom constantly reminded me that men do make a difference.

# TABLE OF CONTENTS

# CHAPTER 1: A DESCRIPTION OF THE STUDY

## 1.1 INTRODUCTION

The unequal balance of power between women and men, which has its roots in gender norms and role definitions, contributes to male and consequently female vulnerability to HIV and sexually transmitted infections (STIs). It is impossible to ignore that the behavior of men and women differ when it comes to the use of health services. One of the biggest problems facing HIV-awareness campaigns is how to engage successfully with men. The education of men on HIV and AIDS is seen as a key area to changing male attitudes and sexual behaviour to reduce the spread of the AIDS pandemic.

Contemporary gender roles[1] encourage men to equate risky behavior with manliness[2] and, conversely, to regard health seeking behaviors as *"unmanly"* (Courtenay, 1998). While there is an acknowledgement of men's roles and responsibilities in understanding gender norms, there have been surprisingly few interventions that link gender roles and their impact on health related issues. It is important to recognise this impact on a health issue like HIV, for example. To acknowledge the need for addressing gender roles and their impact on health related issues, will help to reduce risk behavior and therefore transmission.

---

[1] Gender roles refers to the set of attitudes and behaviors socially expected from the members of a particular gender identity, within a specific culture. Gender roles, unlike natural human genders, are socially constructed and change over time.
Assessed from Wikipedia on the 21st February 2010 http://en.wikipedia.org/wiki/Gender_role

[2] manliness - the trait of being manly; having the characteristics of an adult male
Assessed from Free Dictionary on the 24th February 2010 http://www.thefreedictionary.com/manliness

There are a range of civil society organisations in South Africa that are currently working to promote gender equality and sexual and reproductive health. Organisations such as Fathers Speak Out, Men as Partners (MAP)[3] Network, Sonke Gender Justice's One Man Can, Imbizo Men's Health Project (Imbizo) and the South African Men's Forum, are focused on reaching men and fathers.

The above organisations employ a number of different strategies to involve men constructively in their work to address masculinity, gender-based violence, reproductive health and HIV/AIDS. Many focus exclusively on education and training, others include community mobilisation and activism in their scope of work. EngenderHealth is one such organisation. They initiated the MAP programme in 1998 with a local partner, Planned Parenthood Association of South Africa. The aims of the MAP programme were as follows:

- To challenge the attitudes, values and behaviors of men that compromise their own health and safety as well as the health and safety of women and children.
- To encourage men to become actively involved in HIV/AIDS related prevention, care and support activities.
- To work towards preventing gender-based violence (GBV).

Evaluations done of the work conducted by Gauteng-based organisations implementing the MAP programme, indicate that many men found the workshops to be powerful, 'life-changing' experiences (Greig & Peacock, 2005; Siegfried *et al.*, 2005; Peacock, 2003). Asked to question

[3] A HIV/AIDS prevention initiative of an international reproductive health NGO, EngenderHealth. Engender Health aims to foreground the gendered nature of HIV/AIDS, and, in particular, highlight and address the role of men in preventing HIV infections. The focus of the project is largely on youth aged 18 to 25 years. This is an age group identified as being at particularly high risk for HIV infection.

and challenge gender stereotypes and inequities they had always taken for granted, some workshop participants reported fundamental shifts in their perceptions of women and of what it means to be a man.

The site of this research is a Gauteng based intervention - The Imbizo Men's Health Project which started operating in June 2007 to provide post HIV test support to males, as an entry point to care, treatment and support. Imbizo Men's Health Project recruits male clients from the broader Soweto area, focusing on the places that men frequent. Imbizo targets males who have accessed VCT, those who want to access VCT and those who need more information about HIV/AIDS and other men's health related issues.

Imbizo's post-test services focus on:

- reducing risk behavior through education;
- encouraging responsible sexual behavior (awareness and education);
- advocating the delay of the sexual debut, especially amongst adolescents and youth;
- promoting abstinence, and encouraging faithfulness and loyalty;
- demonstrating condom usage and educating men on consistent use of condoms; and
- encouraging men to test their HIV status regularly and to support their partners to do the same.

There is no formal relationship between the Imbizo Men's Health Project and MAP. However they do work with the same target group i.e. men. MAP has documented their work well and regularly evaluated their project. The work of Imbizo Men's Health Project has as yet, not been

sufficiently documented or evaluated. Therefore this study relates to this need.

From June 2007 to March 2008 Imbizo Men's Health Project recruited and encouraged 2380 males to test their HIV status. Imbizo Men's Health Project encourages men to participate in a dialogue about their health status. Men are invited to test for HIV and are immediately drawn into a dialogue with a Community Outreach Officer to discuss their fears and possible resistance to testing. Prior to the HIV test, as required by South African legislation, all men are counselled by a qualified lay counsellor on the ramifications of a positive or negative result. Once men have tested, they are again drawn into a conversation by the Community Outreach Officer to assess further service needs, regardless of the result of the test. All men are encouraged to attend workshops and / or support groups where issues of masculinity and gender are challenged by a qualified facilitator. The project encourages HIV negative males to stay negative through risk reduction assessments. Retesting is encouraged to preclude sero-conversion stage. It supports men who test HIV positive to access treatment and support networks, and to also live healthy lifestyles. The MAP project deepens this dialogue by also encouraging these men to challenge prevailing norms of gender and masculinity.



## 1.2 PROBLEM STATEMENT

Organisational evaluations of projects such as the EngenderHealth Men as Partners (MAP) project have indicated a change in men's attitudes after the interventions. However, they have offered limited understanding about what it is that specifically encourages men to participate in men's health programmes and to remain involved in the programmes on a longer term basis.

It is clear that gender norms inform the development of the attitudes for men regarding how they view health and how they participate in health related interventions. Programme staff are faced with the constant challenge of ensuring that their programmes for men remain relevant to the particular needs of men, and remain sufficiently creative to keep men involved so that they can benefit over time. We cannot fail to recognise that it is difficult for men to participate without addressing how their constructed gender norms and beliefs feed into, and explain, their resistance to attending health related interventions.

## 1.3 STUDY PURPOSE

Despite the general reluctance of men to participate in reproductive health services, men have consistently participated in the various focus areas of the Imbizo Men's Health Project. This study explored why men have so actively involved themselves in the project. This insight will be used to further strengthen the Imbizo Men's Health Project, and inform and improve the planning of other interventions aimed at increasing the involvement of men in Gender Based Violence prevention, Sexual and Reproductive Health (SRH), and HIV prevention initiatives.

# CHAPTER 2: THE LITERATURE REVIEW

## 2.1 MALE PARTICIPATION IN HEALTH PROGRAMMES

Across the world, men are working creatively to end violence, prevent HIV/ AIDS and foster gender equality. In Nicaragua, the Men's Group of Managua launched a national campaign making the connection between Hurricane Mitch and increased male violence against women, based on the theme "Violence against women: A disaster that men CAN do something about" (Peacock, 2003b).

It was observed by (Awad *et al.* 2004; Brown, Sorrell & Raffaelli, 2005; Skhosana *et al.* 2006) that men are more reluctant than women to participate in HIV programmes, such as Voluntary Counselling and Testing (VCT) for individuals and for couples. A reluctance to participate in support groups for people living with HIV (PLWH) and antiretroviral (ARV) programmes has also been observed in studies. Consequently, men have been noted to be invisible in HIV programmes and in accessing these services (Skhosana *et al.* 2006).



In Brazil, Instituto Promundo works with young men in the urban slums surrounding Rio de Janeiro and Sao Paulo to promote gender-equitable values and practices. The Male Initiative of the Society for Women on AIDS in Kenya works in remote rural communities to encourage men to support their partner's full participation in prevention of mother-to-child transmission programmes (Barker, 2005).

Similarly, in South Africa, EngenderHealth has worked together with a wide range of

organizations and institutions to implement the Men as Partners Programme (MAP), which uses a human rights framework to promote gender equality and greater male activism through a combination of community education, grassroots organizing and advocacy for effective implementation of policies and legislation (Peacock and Levack, 2004). It is clearly important that rather than perceiving gender as a 'women's issue', we need to think in terms of relations of power and powerlessness, in which both women and men may experience vulnerability, rather than treating 'maleness' as powerful and problematic in itself (Cornwall, 2000)

## 2.2 GENDER ROLES

Many of the initiatives mentioned above draw upon three interconnected principles, each related to an understanding of the many negative ways in which the unequal balance of power between men and women plays itself out. Contemporary gender roles are seen as conferring on men the ability to influence and/or determine the reproductive health choices made by women – whether these choices are about utilization of health care services, family planning, condom usage or sexual abstinence. For example, the female condom is already available for use in South Africa after a national roll out scheme, but access remains limited for most women in part due to men's attitudes towards their use (Mantell, Scheepers, and Karim 2000; Warren and Philpott 2003).

According to Barker and Loewenstein (1997) contemporary gender roles are viewed as also compromising men's health by encouraging men to equate a range of risky behaviours – the use of violence; alcohol and substance use; the pursuit of multiple sexual partners; the

domination of women – with being 'manly'. It has also been recognised that some experiences of living with HIV/AIDS have a gender dimension, as different issues and concerns confront men and women. Simultaneously, these gender roles may encourage men to view health-seeking behaviours as a sign of weakness. In his study Levack, (2005) noted that participants associated HIV testing with the beginning of *"a healthy man's downfall"* (2005: 13). Similarly it was reflected by Beck in his study that men are often reluctant to use health services because of the belief that it is unmanly and that doing so would indicate weakness to their peers (Beck, 2004).

While gendered beliefs may prevent men from seeking health care, they may also contribute to increasing men's health risks. Gendered patterns of alcohol consumption are a good example of this. Patterns of drinking are embedded in the social, cultural and gender relations of a society. Historically, drinking has been socially acceptable primarily for men. In some societies, alcohol use has taken on a symbolic role as a marker of gender difference. Alcohol use is linked to social reputation, for both men and women, and in some societies is associated with the gender regulation of the public face of people's lives. Alcohol consumption is a risk factor for gender-based violence and for the sexual de-inhibition that contributes to the spread of HIV/AIDS (Shisana and Simbayi, 2002). Such gender roles leave men especially vulnerable to HIV infection, decrease the likelihood that they will seek HIV testing, and increase the likelihood of contributing to actions and situations that could spread the virus.

Contemporary gender roles also confer on men the power to influence and often determine the reproductive health choices made by women – about the use of health care facilities, family

planning, condom use, abstinence (Peacock, 2003b). Spurred on by the recognition that men's attitudes and behaviours are absolutely pivotal to the success of sexual and reproductive health programmes, many development agencies and NGOs have designed initiatives to encourage positive male involvement.

## 2.3 RECOGNISING MALE INFLUENCE AND POWER

A number of researchers attribute gender inequality as a factor that influences the vulnerability of males (Brown *et al.* 2005; Campbell, 2001; Campbell, 2003; Chimbiri, 2007; Levack, 2005; Maharaj, 2001; Mane & Aggleton, 2001; Morrell & Ouzgane, 2005; Upton, 2001). Van Donk (2002) for example, cites research done in Thailand where men living with HIV/AIDS are beneficiaries of more money spent on their health care than on women. Jackson (2002: 88) cautions however that *"gender inequality, violence and HIV risk also occur in affluent groups particularly where men's wealth and earning power greatly exceed that of women."* Awad *et al.* (2004) and Akpende *et al.* (2002) observed that men are more reluctant than women to participate in HIV programmes, resulting in a low demand for VCT services in some areas (Fylkesnes, 2000). According to local research, men in South Africa were found to account for only 21% of all clients receiving VCT and may thus be seen to be falling through the cracks within the prevention programmes (IRIN, 2005). This further increases their vulnerability to HIV infection.

The view that social justice requires remedies of recognition and remedies of redistribution has been described by Fraser (1997) who notes that certain groups, such as women, have a lesser

value in society than men. He further points out that if women are not revalued, they will not be treated as social citizens, and so not accorded rights that are usually associated with citizenship. Recognition of rights, part of the process of treating all people with dignity, is an essential foundation for equality (Fredman 2002).

The 1994 International Cairo Conference on Population and Development's (ICPD) Programme of Action affirms the need to promote gender equality in all spheres of life and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles' (UNFP, 1994). This commitment was followed up at the Fourth World Conference on Women held in Beijing in 1995, where discussions provided a foundation for including men in efforts to improve the status of citizenship women.

Within our societies there are many men who continue to hold power and privilege over women and seek to safeguard that power. However, it is promising that there are some men who reject fixed gender divisions and harmful versions of masculinity[4], and who are more open to alternative, 'gender-equitable' masculinities. Seeing the effects of gender discrimination on women they care deeply about, or becoming more aware of the benefits of involved fatherhood, have motivated some men to change (Barker and Loewenstein, 1997).

For programmes to be effective it is crucial that they also focus on men's specific needs and vulnerabilities. There have been many efforts to make sexual and reproductive health services more 'male-friendly', by having male-only nights, separate entrances or waiting areas, hiring

[4] masculinity - the trait of behaving in ways considered typical for men
Assessed from Free Dictionary on the 24th February 2010 http://www.thefreedictionary.com/manliness

more male clinic staff, offering free condoms, and training staff to treat male patients with sensitivity (WHO 2007; Jewkes *et al.* 2008; Sorrell & Raffaelli, 2005; Skhosana *et al.* 2006).

## 2.4 GENDER AND CULTURE

Within these discussions there has been the need to explore what is meant by gender equality. Hunter (2005) argues that gender is more than a one dimensional expression of male power. Instead, he suggests that the coming together of male power in some domains with men's weakness in others has been responsible for the creation of the violence and risky masculinities so often tragically noted in the era of HIV/AIDS. Hunter's notions of gender and culture have implications for HIV/AIDS interventions, as these notions of gender and culture do not support a situation where public health workers can easily 'map' and then 'modify' men's behaviour through education. Instead, Hunter speaks of gender and culture as being constructed through contestations in everyday life where material and cultural change are inseparable, and where 'education' is but one of a number of shapers of culture.



Another relevant aspect in the debate about gender and culture is the use of the term pro-feminist by men (Flood 2002). According to Flood feminism is a movement and a body of ideas developed primarily by, for and about women. As men can never fully know what it is like to be a woman, Flood argues that if men call themselves 'feminists', they run the risk of colonising feminism or looking like they're saying they have all the answers to the challenges being faced (Flood, 2002).

Gender is defined as a social symbolic creation where societal values, beliefs are preferred ways of organising the collective life (Simpson, 2005). Society therefore utilises physiological characteristics to distinguish between male and female thus the terms sex and gender being used. In some cases these terms can be used to mean the same thing. The difference therefore is that while sex is physiological, gender is learnt and more complex (Mane & Aggleton, 2001; Simpson, 2005; Zlotnick, 2002).

Societal values of what makes a man (masculinity) or woman (femininity) will then be taught to individuals. This is achieved through the use of various traditions and customs, which form as a part of different cultures (Seidler, 2006). Wood says that this means that from birth an individual is brought up and *"encouraged to conform to gender that society prescribes for us"* (1994: 21). It follows then that the roles that each gender performs are socially engineered as well as expected. Playing the expected and socially constructed role of a man means that men have to present the different facets of this term. That is, men have to play different roles in society that are reflective of the different events of their manhood (Walker, 2005; Walker *et al.* 2004). According to Hartup and Zook (1960, in Zlotnick, 2002) these behaviours are then reinforced by peers who have a similar upbringing; school activities such as subjects taught, play and active behaviour. Masculinity is one way of understanding what may be seen as the only way and sometimes the right way of being a man.

It is important to note that masculinity is not static, but changes in line with changes in societal relationships (Brown *et al.* 2005; Connell, 1995; Mane & Aggleton, 2001; Zlotnick, 2002).

Traditional gender roles are also now being challenged in South African society, especially following the publication of Connell's (1995) 'Masculinities'. This publication has highlighted that men are not monolithic and that their experiences, understandings and embodiments of what it means to be a man are shaped by and reflect their life experiences. This is supported by the work of Barker and Ricardo (2005) who examine the power dimensions between men to show how the challenge of coming to adulthood requires gender-specific ways of addressing the gender roles. The authors caution that masculinity should not be oversimplified or generalised, noting that there is no single sub-Saharan African young man; and there is no single version of masculinity in the sub-Saharan African setting.

## 2.5 THE IMPACT OF GENDER INEQUALITY ON SEXUAL HEALTH AND HIV TRANSMISSION

In her article, *Targeting Men for a Change: AIDS discourse and activism in Africa,* Janet Bujra, states that "AIDS is gendered" (2000:9). She argues that the nature of patriarchy filtered into the spread of the disease keeps women extremely vulnerable to infection, and consequently that interventions with men are required for addressing the health of women. However, as Elson and Evers (1998) point out, considerations of gender in relation to health tend to remain focused on women as users of services, or as service providers, rather than addressing the gendered dimensions of health itself.

Yet the behaviour of men puts both them and their partners at risk. When men equate manhood with dominance and aggression, sexual conquest and fearlessness, research shows they are also

likely to exhibit more negative condom attitudes and less consistent condom use (Noar & Morokoff, 2001). The risk to both the men and their partnership has been recognised by UNAIDS (1999) in their 2000-2001World Aids Campaign on Men and Boys. Reducing gender inequality therefore requires changing social norms, attitudes and behaviours through a comprehensive set of policies and strategies. This is possible as the Instituto Promundo in Brazil proved for condom use among young men. The study indicated that young men with more equitable gender norm scale scores were 2.4 times as likely to use condoms with a primary partner at the last sexual encounter. (Pulerwitz, Barker & Segundo, 2004)

The mentality of men in South Africa towards women and HIV/AIDS is ingrained in the gendering of boys. According to Morrell and Lahoucine therefore, *"in order to reduce the transmission of HIV/AIDS, many prevention initiatives have begun to work with young men in an attempt to reshape masculinity"* (2005:13). This process in turn strives to create positive change in the lives of young men, who will eventually play a role in the HIV/AIDS epidemic.



While educational programmes have brought HIV into the spotlight and made people aware of the dangers and ways of preventing infection, HIV testing has been met with a fierce resistance especially from men (Beardsell, 1994; Jackson, 2002; Skhosana *et al.* 2006; Walker *et al.* 2004). Attempts to try and explain this resistance to behaviour change has been analysed using various theoretical stances and models.

Although some studies have been conducted on gender differences between males and females, more studies are still needed to explore the influence of masculinity on health and illness,

particularly HIV/AIDS. It has been observed that men are more reluctant than women to participate in HIV programmes such as Voluntary Counselling and Testing (VCT) for individuals and couples, support groups for people living with HIV (PLWH) and antiretroviral (ARV) programmes (Awad *et al.* 2004; Brown *et al.* 2005; Skhosana *et al.* 2006). According to Carter (2004), VCT practices have mainly focused on counselling women with the expectation that partners will be informed should the results be HIV positive. However, this expectation has not been met as women fear partner violence, breakdown of the relationships and / or social stigma (Akpende *et al.* 2002; Fylkesnes, 2000; Mane & Aggleton, 2001).

## 2.6 IMPLICATIONS FOR HIV PREVENTION PROGRAMME DEVELOPMENT

Studies have revealed that many men are not testing for HIV (Bowleg, 2004; Britton & William, 1999; Jackson, 2002). Recommendations have included the need to get male involvement. To realize this we need to understand the reasons why men are not testing for HIV as this would be an important step towards developing new strategies and programmes that promote HIV testing amongst men. Today, due to a lack of men's participation in HIV programmes, many men do not know their HIV status (UNAIDS, 2006). This has possible implications for the spread of HIV infections. INTERFUND (2004) posits that it is only through addressing and transforming the norms, values and behaviours that endorse the perpetuation and spread of HIV infection that we have the opportunity to curb the epidemic.

A number of studies have been conducted around HIV/AIDS, however the increase in incidence rates indicates that the problems that exist around the pandemic are far from being

resolved. To illustrate this point, individuals are still engaging in unprotected sex despite being fully aware of the dangers of such actions (Beardsell, 1994; Helman, 2007; Hunter, 2001; Jackson, 2002; Maharaj, 2001; Moses & Plumber, 1994; Uitenbroek, 1994; Upton, 2001). Implementing behaviour change therefore appears to be a difficult area, and this has implications for transmission of the human immunodeficiency virus (HIV). The ideas behind behaviour change models are that once people are aware of the dangers they will be more likely to have themselves tested for HIV. As Beardsell (1994) stated, assumptions were made in relation to having an HIV test, that once an individual tested HIV positive; the diagnosis would lead to behaviour change, but this is not always the case (Campbell, 2003; Helman, 2007; Kalipeni & Gosh, 2007; Long, 2005).

Orubuloye, Caldwell & Caldwell *et al.* (1997) have argued that there has been a consistent failure to enquire into men's belief systems in relation to sex and sexuality. Where researchers have enquired into men's beliefs, findings have sometimes confounded commonly held views about male attitudes with the opinions of respondents themselves.



The importance of developing an understanding of these belief systems is important, for as Jones and Wasserheit (1991) have pointed out, heterosexual men are key to controlling the spread of sexually transmitted infections (STIs)—including HIV. STIs are shown to be more easily transmitted from men to women than women to men. According to Harlap, Kost and Forrest (1991), women are twice as likely to become infected by a variety of sexually transmitted pathogens as men. Aral (1993) shows that the efficiency of male to female transmission of HIV is approximately four times higher than female to male transmission.

Aside from the increased biological risk of transmission, women are described as being at high risk of HIV infection owing to social and cultural norms of behaviour. Greene and Biddlecom (1997) say that this means women cannot decline sexual intercourse with their partners, or insist upon the use of barrier methods for protection during intercourse. Moreover, these same social and cultural norms often assume that it is acceptable for men to seek sexual pleasure outside of the home, thereby increasing the risk of acquiring HIV (Moses *et al.* 1994).

Masculinities among young men are clearly changing in Africa, as in the rest of the world. Morrell (2002) suggests that the dimension of the AIDS epidemic in South Africa and the devastation of families are forcing younger men to question gender norms and attitudes. Morrell argues that with an increasing number of young (adolescent) boys taking on roles as primary care givers within the family due to the devastation of HIV/AIDS in their personal lives, the notions of traditional manhood is changing. But not so for older black men. Morrell cites the example of anti apartheid activists who resisted class and racial oppression but were also simultaneously defending their masculinity by perpetuating their powers over women within a cultural context.



## 2.7 THE FOCUS OF HIV PREVENTION PROGRAMMES

Most HIV/AIDS intervention programmes have been historically targeted towards women because they have been identified as being more sociologically and biologically vulnerable to HIV/AIDS. These programmes have addressed the specific gender needs of women: empowerment, life skills, information and education on reproductive health issues, increasing

awareness and prevention of sexually transmitted infections (STIs) and HIV/AIDS. Existing programmes in clinics such as Family Planning Programmes and Voluntary Counselling and Testing (VCT) give women the opportunity to be counselled, gain access to sexual health talks and support groups. However, the result of these kinds of programmes is that there has been an increase in the gap between men and women's knowledge on these issues (Mane & Aggleton in Gupta, Whelan & Allendorf, 2003).

The number of initiatives that are focusing on men is increasing, including in South Africa (Greig & Peacock, 2005; Siegfried *et al.* 2005; Peacock, 2003). Literature on how we get men to participate is limited. This study aims to contribute towards redressing this limitation.

There is now a rich milieu of organisations, units, programs and other attempts to transform masculinities and involve men constructively in gender relations, gender based violence, sexual and reproductive health and HIV. Initiated in 1993, the Cape Town based 5in6 Project appears to be the first recorded organised male constructive engagement with men's gender based violence against women, children and communities. It became most visible and audible through its Ordinary Heroes campaign that encouraged people to submit stories about 'good men' in their lives in order to make visible the 5 in 6 men who, some statistics claimed were non-violent. The project also ran preventative and awareness raising training workshops for men in corporate, government, farms and civic communities (HST 2006).

## 2.8 THE ROLE OF THE STAFF WORKING IN HEALTH INTERVENTIONS IN SOUTH AFRICA

In a study developed in 1990s in the United Kingdom, 96% of HIV/AIDS patients interviewed reported that the attitudes of health personnel were more important to them than their competency or the effectiveness of the treatment (Beedham & Wilson-Barnett 1995). Similarly there was a perception that counsellors themselves needed to upgrade the knowledge that they had on HIV. This was also highlighted by Boerma and Bennett (1997) who said that updating health workers knowledge is essential in them providing efficient service to their clients.

A survey amongst doctors in the USA in 1991 showed that 83% of respondents lacked adequate knowledge of AIDS, (Gerbert, *et al.* 1991) despite the disease having been first reported in the USA over a decade before. In addition 79.6% of doctors in Northern Ireland were uncertain about having appropriate counselling skills (Boyd *et al.* 1990).



Accurate knowledge depends on accurate information for all staff working on health related interventions. A particular need in terms of HIV knowledge for healthcare workers is the health workers primarily need precise information on how HIV is and is not transmitted. Secondary information, includes such facts as the impact of stigma on people with HIV/AIDS, the realities of sexual behavior and the different ways in which the lives of men and women are affected by the disease.

A second critical element for health workers to be able to deliver effective HIV services is overcoming fear and stigma around HIV (UNAIDS, 2000). Stigma and discrimination in the health care setting could jeopardise HIV prevention efforts and HIV care, especially if infected health care workers are unsupported. The health sector has been identified as one of the areas in which discrimination occurs (Mahendra et al. 2007). Studies have documented negative attitudes to PLWHA in health care settings in Nigeria and elsewhere (Adelekan *et al.* 1995; Fido & Al Kamezi, 2002; Hentgen *et al.* 2002; Quach *et al.* 2005; Reis *et al.* 2005).

While it is clear that knowledge of the basic facts of HIV transmission reduces fear, there is less evidence that secondary information has had a significant impact on health workers' attitudes; this may be because fewer projects include such information, because the information was not accurate or was poorly conveyed or for other reasons that are as yet not understood (Brown *et al.* 2003). Interventions that only provide information are less effective in reducing stigma than interventions, which combine information with skills building. Skills building, which help health workers to interact with patients in a respectful and non-discriminatory manner, can take many forms. Brown suggests methods like role-play,imagery and group desensitization using relaxation exercises as new techniques to defuse tension (Brown *et al.* 2003).

Using lay members in the community to provide health care is a practice with a long history in South Africa (Tollman, 1994). The development and implementation of community health worker programmes grew during the 1970s and 1980s, following the Alma-Ata Declaration (Declaration, 1978) and in response to the inadequate provision of primary health care under

apartheid. A community health worker (CHW) may be defined as 'any health worker delivering health care, trained in the context of the intervention, and having no formal professional, certificated or degreed tertiary education' (Lewin *et al.* 2005). This means that any staff member working on a health intervention can be classified as a CHW and it is therefore important to recognize that similarly accurate knowledge depends on accurate information for all staff working on health related interventions.

## 2.9 USE OF APPROPRIATE TECHNOLOGIES AND METHODS

There is a positive relationship between education level and rate of infection. This is linked to many factors like increased mobility, rural versus urban location, economic poverty and gender to just name a few. In South Africa these same factors affected access to education. It therefore is noteworthy to view education as a factor in changing behaviour related to risk and vulnerability.



Peer education has been widely advocated as alternative or complementary to interventions presented by adults (UNAIDS, 1999) and is becoming an increasingly popular method for promoting behavioural change in HIV prevention programmes (Campbell & Foulis, 2002; Finger *et al.* 2002; Harrison *et al.* 2000; Horizons, 1999; Mantell *et al.* 2006; Sikkema *et al.* 2000). Similarly group discussions and debate can contribute to the development of new collective norms of behaviour and relationships (Campbell & Mac Phail, 2002).

In the study by (Keen-Rhinehart *et al.* 2009) students involved in both interactive methods had

significantly higher correct responses on the assessment when compared with students who had been exposed to the material through traditional lectures. Student responses from evaluations indicated that they found the incorporation of interactive teaching methods to be a positive experience that improved their ability to understand and retain class material. In addition, students seemed to prefer this type of teaching when compared with instruction using traditional lectures. Employing interactive methodology not only improves retention of the subject matter but also enhances the overall course experience of the participants.

The poor HIV awareness among low-literacy populations in rural areas is less surprising in light of the results of a recent survey that revealed similarly low HIV awareness among Indian lawmakers (Rabinowitz, 2006). Such findings suggest that the current HIV awareness programs, which focus mostly on high-risk groups, are not able to convey accurate or comprehensive awareness to the rest of the population, leaving them vulnerable to HIV infection and likely to harbor unnecessary fears and stigma against people living with HIV.



Due to the low literacy in communities, materials with simple messages on HIV/AIDS were developed. The contents were based on the *'Health Belief Model'* (Rosenstock *et al.* 1988), to teach people about their own personal susceptibility to HIV/AIDS, the impact of HIV infection on their lives, ways they can reduce their own risk, and strategies to overcome barriers to individual change. Behaviour change communication (BCC) remains an important and strategic input into the process of reducing the number of new HIV infections globally. Promoting positive change in behaviour is a complex process requiring an understanding of culture, as well as behaviour. BCC approaches recognise that presenting facts alone does not

ensure behaviour change. BCC strategies are designed to accommodate the stage of behaviour adoption of an individual or group and to cultivate skills integrally needed to enable and sustain change (Rogers, 1992).

When considering the above it remains clear that many questions remain that require solutions, in order to improve the impact of our interventions.

# CHAPTER 3: STUDY AIMS AND OBJECTIVES

## 3.1 AIM OF THE STUDY

The aim of this study was to explore the elements that make the Imbizo Men's Programme successful in encouraging men to participate in an HIV focused intervention in Soweto, South Africa.

## 3.2 OBJECTIVES

The objectives of the study were:

- To explore with male respondents from the Imbizo Project their experiences and opinions about their participation and involvement in the Project
- To identify the elements of the Imbizo Project that the respondents considered to be essential in encouraging and facilitating their participation, both at the outset, and on an on-going basis within the Project
- To identify additional elements that the respondents thought would further enhance the participation of men in the project
- To use the information gained to inform other similar HIV prevention projects targeting men by participating in active dialogue or forums with other projects and making information gleaned from the thesis available for project and policy planning.

## 3.3 METHODOLOGY

### 3.3.1 STUDY DESIGN

The research took the form of an exploratory, qualitative study. A qualitative study was selected in order to facilitate an in-depth exploration of the themes being investigated. This allowed the researcher to record the diversity of experiences, views and meanings that the different respondents had in relation to the issues under investigation and how these relate to the broader social context. Qualitative research takes an interpretive, naturalistic approach to its subject matter; attempting to make sense of, or interpret, phenomena in terms of the meanings that people bring to them (Denzin and Lincoln, 1994).

### 3.3.2 STUDY POPULATION

The study population consisted of males who have participated in the Imbizo Men's Project.

### 3.3.3 SAMPLE SIZE

Forty four respondents between the ages of 17 and 42 years of age were recruited for the study. The respondents were all unemployed males. 18 had an HIV positive status and 26 were HIV negative. Four were married. The remaining 40 participants, 32 were unmarried and not in a current relationship, eight participants were currently in a relationships with multiple concurrent partners. All the respondents spoke isiZulu as a first language, but all spoke English as a second or third home language.

### 3.3.4 SAMPLING PROCEDURE

The study sought to recruit a heterogeneous group of males of different ages who had attended the Project for varying lengths of time ranging from 2 months to three years. This was recognised as important in order to bring out the diverse experiences of the respondents. Systematic, non-probabilistic sampling, or purposeful sampling (Nachmias and Nichmias 1992), was therefore used to select participants. By purposefully selecting a sample of diverse and, what Patton (1987) refers to as information-rich cases, the study attempted to draw on the diversity in the group and their range of experience.

Respondents attending one of the Project events were invited to voluntarily participate in the discussions via sms (text messages on their cell phones). In the sms they were asked to send a yes reply if they were interested and willing to participate. From the yes replies groups of eight were clustered randomly, and a date and time for the discussions was sent to them.



### 3.3.5 DATA COLLECTION

The data collection method used in this study was focus group discussions (FGDs). These were selected in preference to interviews as they provided the opportunity for respondents to reflect on their own views, as well as to listen to others. They could consider what had been said, and develop their arguments further through this dialogue.

Six focus groups were conducted in total. The time for each focus group varied between 60 minutes and 80 minutes. Four focus groups involved 8 respondents and 2 focus groups involved 6 respondents. The focus group discussions took place at the Project offices at Chris

Hani Baragwanath Hospital. These discussions were conducted by the primary researcher during February and March 2009, using a set of questions to guide the discussion, that was based on the objectives of the study and informed by the literature review.

In order to get the participants comfortable and talking, they were asked to describe their participation in the Imbizo Men's Health Project. Questions asked participants the ways they had been involved in HIV programmes, what encouraged their participation, what they thought would encourage other men, what they perceived as the challenges men experienced when participating and their perceived limitations of current Health interventions and HIV programmes.

The predominant language in this part of Soweto is isiZulu. The discussions were in both isiZulu and English, although, respondents expressed most of their experiences in isiZulu. Respondents were exceptionally receptive to the questions asked, and engaging discussions flowed.



The researcher was aided by a male assistant researcher, who was a staff member employed on the project fulltime and familiar with the participants. This assistant took notes, assessed body language and other non-verbal interactions during the first two discussions. However, after these initial two group discussions, it was considered unnecessary as the concern that males would not respond as openly in the presence of the primary researcher , a female, was found to be incorrect. The language requirements were also catered for. When required the respondents provided translation from Zulu for the researcher, who does not speak Zulu, to get an understanding of what was being discussed. The focus group discussions were tape recorded

and then transcribed and, where necessary, translated into English. The researcher also kept a diary of her observations which was drawn on during the data analysis. The notes captured by the assistant researcher from the first two discussions were also used in the analysis. In addition, the assistant researcher continued to read the notes taken during the remaining discussions and also assisted the researcher during the coding. The same interview guide was used for all the FGD's.

### 3.3.6 DATA ANALYSIS

According to Glesne and Peshkin data analysis *" involves organising what you have seen, heard, and read so that you can make sense of what you have learnt"* (1992:127). This process essentially involves the creation of explanations, the development of theories, and the linking of the stories gleaned with others (Glesne & Peshkin, 1992).

Data collection and data analysis took place concurrently. This enabled the researcher to identify patterns that emerged during the course of the focus groups, and to refine the discussion topics for subsequent groups.



Qualitative data obtained from the transcripts of the focus groups was content analyzed (Patton, 1987) to identify coherent and important examples and patterns. The first step of the analysis process involved multiple readings of the transcripts to identify perceptions, feelings, attitudes and understanding. This was done with the assistant researcher. This allowed common understandings and experiences to surface from the data. The relevant words, sentences, and paragraphs were then coded, and codes were classified into themes which

formed the basis of the analysis. The extent to which there was consistency in the emerging themes was also recorded.

General themes that emanated from all the participants' responses were recorded and additional unexpected findings were also noted. The categorisation (or coding) stopped when no new themes emerged from the data. Themes were then classified in accordance with the interview questions, but not exclusively, due to the tendency of themes to overlap.

As well as assisting with data analysis, the assistant researcher provided valuable input into the cultural nuances of the participants. An example of this was the body language that the respondents displayed during the discussions. The respondents would sit rather closely huddled around in the circle. The researcher could not interpret this occurrence but the assistant researcher explained it to be a practice that they had adopted during other discussions that took place within the Project. It was therefore assumed that the practice adopted while conducting discussions within the Project was replicated in any further discussion the respondents participated in.



### 3.3.7 VALIDITY

The validity of the findings of social research is an important issue, especially given the popular perception among some scientists that qualitative research is not scientific. Mays and Pope describe this as "*qualitative research [that] is often criticised for lacking scientific rigour*" (1995 :105). This study, in recording the experiences, feelings and opinions of a group of stakeholders about a particular issue at a particular point in time, claimed to offer *the views*

or *interpretations* on the subject under discussion.

The procedures to ensure rigour, included discussions with the assistant researcher about the interview schedule, and the dynamics and nuances within the focus groups. In addition, by assisting with the data analysis, the assistant researcher was able to counter any bias or lack of awareness that there may have been on the part of the primary researcher, as well as to compare the interpretation of the content with her. The key themes or categories which were generated from the research, were also presented to the assistant researcher for validation.

In addition, the supervisor commented on the data analysis, to check the veracity and appropriateness of the themes generated. This method, in which the category system of the researcher is checked by another person, has been suggested as a sound approach by many authors (Burnard, 1991; Silverman, 2000). Patton says that in that way, appropriate 'checks and balances' (1987:60) are used to increase the strength and rigor of the research findings. In order to further assess the validity of the findings, the researcher contrasted the material drawn from the interviews with information gathered from the available literature.



## 3.4 ETHICAL CONSIDERATIONS

Participation by respondents in the study was voluntary and participants were aware that they could withdraw at any point during the course of the research process. They were each provided with a letter explaining the research study, requesting their participation and assuring them of confidentiality (Participant Information Sheet Appendix 1). However, it was explained

to respondents that confidentiality could not be fully guaranteed as the confidentiality circle necessarily extended to the other focus group participants.

Their consent was sought and a consent form was available for them to sign. (Participant Consent Form Appendix 2). It was anticipated that the research would cause no harm to the research participants. However, debriefing support was available from the Imbizo team in case any of the informants required emotional support or counselling as a result of the research process. Ethical approval was granted by the University of Western Cape.

# CHAPTER 4: RESULTS

In order to better understand the respondents in this study, an indication of their socio-demographic characteristics is described, followed by a description of the motivating factors that encouraged their participation in this project. These perceptions are reported as themes that emerged during the focus group discussions.

The section concludes with a description of what the respondents felt would enhance the participation of other men in similar interventions.

## 4.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS

A total of 44 males participated in this study. The ages of the participants ranged from 17 – 42 years. The ages were nine respondents between 17 – 25, 13 between 26 – 32 and 22 between 33 – 42. Although the study intended to recruit males of varying ages, the 33-42 year old age range was most represented.



All the respondents in this study were unemployed males. This may also explain their availability to participate in the study as well as the willingness to have participated in the Imbizo Men's Health Project.

Respondents' education level ranged from basic education to tertiary institutions. 28 respondents had basic education, nine were high school graduates and three were tertiary institution graduates. Four of the respondents had not received any formal education.

Four were married, eight had partners and the remaining 32 were single.

All the respondents were isiZulu first language speakers, but all spoke English as a second or third language.

## 4.2 DESCRIPTION OF PARTICIPATION IN PROJECT

The participation of the respondents in the project ranged from two months to three years.

> *"I started participating and started getting SMS's and also they were really nice so they asked me if I can bring a friend because I joined in 2007, late 2007 and was still coming to the events"* (Respondent A6)

This meant that the respondent had participated in the project for nearly two years.

In general, the respondents were long-term participants in the project.



Twenty-eight of the respondents have had more than two years of constant participating, albeit in different activities.

The post test support activities included one-on-one counselling, support groups, workshops, project events, project campaigns and project research or feedback.

Usually respondents with longstanding participation had participated in all of the activities over the period, as shown by one respondent who said,

*"I joined in 2006. If you want to know something, you should go to that workshop'. They have many workshops that just give you information."* (Respondent D4).

Participation across activities reflected the differing needs expressed by the respondents in joining the project.

All 44 had received one-on-one counselling when they tested.

- 26 respondents had received one-on-one counselling more than once at some time in the project.
- 38 respondents had participated in support groups;
- 26 had attended one project workshop with 34 respondents having attended more than one project workshop;
- 28 respondents had attended one project event with 22 having had attended more than one project;
- 28 respondents had attended and participated in a project campaign;
- 40 respondents had provided data or participated in project feedback over this period. The difference in the participation across activities reflected the differing needs expressed by the respondents for joining the project.

In reflecting on the findings of this study, the researcher began by noting the reasons that men initially decided to engage with the project.

These reasons ranged from pressure from a parent or partner, to concern about their own risky

behaviours and a desire to learn about safer sexual practices. These reasons, along with the reasons for their ongoing participation, are noted below.

Also described is the importance of incentives and food in motivating men to attend meetings.

## 4.3 REASONS WHY THE MEN FIRST ATTENDED THE PROJECT

It was clear that different factors motivated the respondents to participate.

### 4.3.1 PRESSURE FROM MOTHERS' OR FRIENDS

The respondents spoke about encouragement from their mothers. Although only two blatant references were quoted, in the groups there was agreement form the other participants when this was mentioned.

> *"That's why I joined Imbizo because my mom, yeah, like she told me about it. She works with prisoners and kept telling me about HIV."* (Respondent F2)

> *"I, um, been with a girl and, uh, my mother, my mother is social worker. And they all said the same thing."* (Respondent E4).

This seems to be indicative of mothers (women) being more aware of health interventions, and having participated in them themselves.

Six respondents talked about their experience of pressure from a friend which resulted in them joining. Men indicated more enthusiasm when the friend was from his own experience of his involvement in the project.

> *"Okay, one of my friends was coming to attend a workshop, I came along but when it was time for the workshop to start I decided to come and test, and then we went together to the workshop."* (Respondent C4)

Men's initial intention to just test and not join the project, was due to the encouragement from friends, as a result they agreed to participate in further activities. For example, one respondent noted that,

> *"The reason I came here was to get tested. Then thereafter I got a friend through Imbizo then they asked me if I'd be interested or what. Then I said yes I am. What did I have to lose?"* (Respondent B2)



### 4.3.2 CONCERN ABOUT RISKY BEHAVIOURS

Respondents in this study were aware of their risky behaviours and how it could affect their health. One respondent stated,

> *"I knew that having many partners was not good, so I joined because I had to hear men talk about how they changed and started doing things right."* (Respondent C7).

This demonstrated that men often do, in fact, have the correct information to implement risk reduction behaviours and that it is behavioural *change* that is the missing link in reducing the

transmission of HIV in our communities.

Inconsistent condom usage was also linked to risky behaviour patterns with one respondent saying that

> *"Everyone says that men do use condoms so why were they using it and not me. I needed to find out"* (Respondent D6)

Another respondent said

> *"Sometimes I do [use a condom] sometimes I don't. It is mostly when I am drunk. I needed to learn how to be better at it [using a condom]. "* (Respondent F1)

These descriptions reinforce the findings that it is not the lack of awareness of risky behaviour that motivated men to attend. It was more to do with having the behaviour explained, alternatives explored, and hearing how other males were experiencing the same challenges of risky behaviour.



## 4.4 REASONS THAT SUPPORTED ONGOING PARTICIPATION

### 4.4.1 DESIRE TO LEARN MORE ABOUT HIV/AIDS

Despite the fact that the men were aware of the modes of transmission, they recognized the importance of learning more about HIV and AIDS. They valued the additional educational component offered by the Imbizo Project. A respondent noted:

> *"The fact that they offer more than just HIV information"* (Respondent C5)

The respondent was unable to express what the "more" was, but he was clear that it was of value. This view was supported in relation to one's knowledge about HIV status.

> *"First thing is being negative is a good thing, so if you know that you are negative there's no way that you can be ashamed of being in Imbizo, wanting to know more about STI and HIV, cancer etc. So I can say I know a lot."* (Respondent D6)

They also noted the difference between themselves and women, noting that unlike the experiences of women, they do not access information about HIV/AIDS with ease and confidence. This was reflected in the experience of one respondent.

> *"And the other thing I think it's because we as guys are scared to go out and ask about information about HIV and AIDS, and as a guy it's not easy for me to come to the clinic with my friends when I've got this disease. But not so scary anymore because now I have other reasons to come."* (Respondent D2)



### 4.4.2 PEER EDUCATION AND EMPOWERMENT

As discussions continued, the respondents shared a common reason underlying the desire to learn more, this being the need to share information with others. In addition to sharing what they have learnt with their families the men decided that they should try to spread knowledge about HIV/AIDS and men's health issues in their broader communities.

> *"Yes, I was getting information and helping others learn about HIV and AIDS."* (Respondent A3)

The respondents also recognized that one never has all the information one needs, and that continued updates on HIV/AIDS information were important.

> *"Like I'm becoming involved by talking with my friends and my family. They keep saying how I need to know more."* (Respondent A3)

The workshops in particular were valued for their educational role.
A respondent shared how the confidence he gained from learning and knowing that he now had correct information enabled him to share the information with others.

> *"Because I didn't know much HIV and AIDS, but now since I've joined Imbizo I've got more experience and more light on HIV and AIDS. So I've got that information from Imbizo and then I did take it out to other guys who didn't know about Imbizo."* (Respondent F5)



Although phrased in isiZulu respondents reiterated the desire to want to help others. This included,

> *"Ukuba usizo kwabanye abantu"* (Respondent F3) and
>
> *" Ukunceda abanye a Bantu"* (Respondent D3 )

A strong theme of empowerment emerged from the discussions. Men expressed their appreciation of information on health issues that they had learned in the workshops.
This comment reflects the empowerment experienced by a respondent.

*"But since I joined this, then I was getting more strong and then I didn't feel any pain anymore and then I asked the doctor questions, I know where I'm going and I know where I'm coming from and that makes me feel powerful. So I must also let other peoples know that HIV and AIDS is not only a thing that kills everybody"* (Respondent F5)

*"I would say I've learned a lot, and the thing that I like most about Imbizo, because as a guy you don't go around getting information about HIV, but now since that I understand more I am more free to say whatever about HIV to anyone."* (Respondent A5)

### 4.4.3 THE PSYCHOSOCIAL BENEFITS

The participation for the respondents has had a positive effect on their lives. The psychological benefits of participating was difficult to express but when probed respondents spoke about the "invisible" that was hard to show.



Being part of the pack/group was expressed as "Uyilunga phakathi kwabaningi" (Respondent E2) or the "in crowd" as "Phakathi kwe yihlwele" (Respondent D2)

## 4.5 FRAMEWORK AND IDEOLOGIES THAT UNDERPIN THE PROJECT

### 4.5.1 LOW EMOTIONAL, HIGH FACTUAL

Respondents spoke about their experiences in other projects where this was part of the methodologies used to focus on HIV/AIDS information. The Imbizo project adopted an

approach that was highly factual with limited reference to feelings, emotions and challenging masculinities. Respondents appreciated this approach as it was different to the other interventions they had participated in. As they pointed out, the reason they joined Imbizo was the need for HIV/AIDS information and not for reflections on their experiences. Respondents reinforced this by saying that,

*"I got what I came for. [The information] "* (Respondent B2) and

*"It was not like we spoke about our lives. It was just the facts. "* (Respondent A5)

One respondent expressed this as,

*"There was no think of a time or this is what it is to be a man. It was just the facts...HIV is, window period, viral load, just the facts. "* (Respondent D4)

While another stated that,

*"I was part of another project we had to sit in a circle and think back to our childhood. It was that girly stuff. "* (Respondent C6)



Similarly a respondents' experience of another project was expressed as being one where,

*"All the men were hugging and this was different. It was strange...that was not why I was there. It was just the facts and men being men. "* (Respondent E3)

It was made clear by the men that they did not appreciate an approach that had too much focus on emotions and feelings, or that challenged their concepts of masculinity. When seeking factual information they wanted to get the facts first. The focus on feelings could come later.

### 4.5.2 SUPPORTIVE ENVIRONMENT

Respondents spoke at length about the ease with which they were able to speak in a group setting with other men.

> *"There are many things that we don't know,....., you find it easier to share your situation because there are other men that have the same experience and know more than you. Most times it is difficult to say you don't know everything, and that you are still ignorant about many things."*(Respondent B3)

Another respondent felt that,

> *"So I also encourage people to go to Imbizo or whatever support group is around there. These days support groups are not for only people who are HIV positive only; they are for everybody. At least if you have a group of people where you can share this same understanding you feel much comfortable and free."* (Respondent A6)



These comments reflected the view of most men; that is was easy to speak in the presence of other men and that they did not feel judged or inhibited.

One respondent noted that,

> *"Then I decided, no, I must have something like a support group because I needed to have good information about my situation. Because when you go and see the doctor you just complain about your sickness. There's no time to ask many questions .....So that's why I think I came here to be able to talk to other men and be closer. Men*

*discuss things about men's stuff."* (Respondent C8)

### 4.5.3 MALE STAFF

The most common reason the men gave for remaining with the project was that they trusted that staff had the knowledge and would be able to support them. In this project the staff's treatment of the respondents was much appreciated.

*"They help us, like when you're talking to a stranger I think you are more free than when you are talking with somebody who knows you, because once you talk to somebody who knows you they start judging you, and calling you names and all that."* (Respondent F7)

*"They treat us all equally. That's what I like"* (Respondent C4)

The importance of responding to males in such a way that they feel included was also stressed. All the participants commented on some interaction they personally had with a staff member from the Project. The all male interaction was noted and there was also refrence to the manner in which this interaction occurred.

One respondent said that,

*"They've given us support and that support is encouraging us, and they are willing to share any information"* (Respondent E4), while

Another respondent concurred with this perception of staff,

*"And another thing, I mean here they are well trained. So if you can go and tell your friend..., here they are well trained and you can trust them."*

(Respondent B4)

The encouragement and support provided by staff resulted in men being receptive to the service, as noted by respondents who said that,

*"Actually what helped for me was the encouragement, encouraging us in a positive way."* (Respondent D5)

*"But if it's somebody different it's taking the burden out of you. You're relieving all your stresses into them, and then after talking to a stranger you feel free. And other thing, they don't discriminate."* (Respondent F7)



## 4.6 MEDIUMS OF IMPLEMENTATION

### 4.6.1 USE OF TECHNOLOGY

Respondents identified the use of SMS's (text messages on mobile phones) as innovative and believed was a good strategy to keep the men connected.

*Since January this year [2009] I've been getting SMS's...* (Respondent D4).

*"I started participating and started getting SMS's and also they were really nice...*

(Respondent A6)

When asked why SMS's were effective, respondents noted that,

*"SMS's are personal because no one has my phone but me."* (Respondent C5) and

*"SMS's are good because I always have my phone with me."* (Respondent B1)

The use of what everyone else is using, provided a "trendy" inclusion for one respondent, who said,

*"I think it is cool that they use SMS's, when my phone goes beep beep and I say' oh it is Imbizo, it's like they are contacting me because I am so important."* (Respondent D2)

Anonymity about participation was appreciated,

*"When my girlfriend reads the message, it has no private details. I just say they got my number from a competition."* (Respondent A7)



### 4.6.2 THE INFLUENCE OF INCENTIVES AND FOOD

When further probed about the ways used to create interest, respondents shared with discomfort, that they were influenced by the incentives distributed by the project. These items were of great value to the respondents. One respondent said that,

*"Also a lot of the pamphlets and books and stuff, my friends want it too and I say go and join and then you will get some too."* (Respondent F3)

This comment reflected that other people often showed interest in where the items were acquired.

*"I wear the t-shirt and cap and lots of people ask me where I got it."*

(Respondent C5)

This raises the impact of branding and how influential it is in communities. It need not be items of clothing, even when literature is branded, it becomes attractive, and so an enticement.

In some instances even the presence of food and refreshments encouraged participation. Respondents shared this with lots of laughter and embarrassment. The embarrassment was linked to not wanting it to be misrepresented. They come for the information but it is really is beneficial that they have food, too. Even though it is not the reason they attend it does make the attendance more pleasant.

*"Once we have finished eating we can work and listen better. Sometimes we listen first and then we eat at the end"* (Respondent F6)



Confirmed by another respondent,

*"First of all there's the breakfast. Cup of tea and some biscuits, and then its lunch; burger, chicken, chips and some juice. And besides that information, that's given to us is good."* (Respondent C5)

With all the respondents being unemployed, a simple meal was appreciated and was seem to be an important factor in encouraging the participation.

*"For me, yes food, [Laughter] its food for me like chicken"* (Respondent C8)

## 4.7 WHAT WOULD ENCOURAGE OTHER MEN TO PARTICIPATE

When asked what would encourage other men to participate, respondents were clear that this would include some of the same elements. They also noted that for other men to participate it would be important to be creative and dynamic in the methods used to recruit new participants to the project.

*"Some men are difficult and sometimes they do the opposite just because you said so."* (Respondent F5)

There was a feeling that it is challenging to recruit other men and one respondent mentioned that,

*"They [men] change their minds all the time. It is like that nagging wife, she goes on and on... [laughter] when you say come and test, come and join they say yes I will but at the back of their minds they are think, no ways."* (Respondent B8)

*"The only way to get men there is to use your experience. When I say I, they hear me. Like with I tested instead of you must go test."* (Respondent E4)

It was clear that using sport as an opportunity is something that many projects have not utilized enough.

*"We like sport, maybe to come and test at soccer games."* (Respondent C3)

It was repeatedly highlighted that men would participate if they wanted to and not because they were forced to.

> *"Ukufuna ukwenza hayi ukuphoqoleka"* (Respondent F1) and "Ukwenza into ngokukhululeka hhayi ngengcindezi" (Respondent D6) both different ways of saying "I don't want to do something I am forced to do".

## 4.8 SUMMARY OF RESULTS

Whilst one cannot underestimate the interest and willingness of men to participate in HIV / Health interventions, it is clear that many factors influence their participation. If one is encouraged to participate and feels that they are benefiting from this in some way, they are more likely to stay involved.

Missing from the results are issues like violence, relationships and blame. This was not mentioned by the participants and would require further investigation.

# CHAPTER 5: DISCUSSION

In South Africa, there is a lack of information around the factors that motivate men to either participate or to avoid participating in health care interventions.

Several studies have noted that men tend to be more reluctant to seek medical attention than women (Lindsey, 1990; Zlotnick, 2002). There is a clear need to implement projects and programmes that aim to engage men constructively in addressing their health care concerns.

This is of particular importance in South Africa, where the HIV prevalence rate, and incidence of gender based violence, is among the highest in the world (Jewkes *et al.* 2008). In order to achieve this, it might be necessary to move away from viewpoints that construct men as 'the problem' (Jackson, 2002) and work to engage men in 'positive' approaches to sexual health (Awad *et al.* 2004).



Forsythe *et al.* (2002) maintain that giving people the opportunity to know their status is one of the strategies for addressing the HIV/AIDS epidemic. It is clear that male participation in health interventions is possible, and the results of this study suggest that assumptions of men's non-participation in health and HIV services should be reconsidered.

However, it is necessary to understand the features of such services that either encourage or discourage men from participating.

Imbizo Men's Health Project deliberately did not adopt the attitude of men being the problem. The Project sought to facilitate the participation of men in a programme addressing gender based violence, reproductive health and HIV in a positive and affirming manner which recognised men as part of the solution.

## 5.1 FACTORS THAT SUPPORTED PARTICIPATION IN IMBIZO

The socio demographic characteristics of the respondents in this study were noteworthy as they mirror the statistics on HIV infection in South Africa. As UNAIDS (2008) statistics show, men in the age group 18 to 35 have the highest prevalence rate of HIV infection. The majority of respondents were within this age group. Other characteristics that have been linked to HIV risk include marital status and employment status.

Most of the men in this study were unmarried and unemployed. Most of the respondents were HIV negative.



### 5.1.1 WOMEN ENCOURAGING MEN

Being health conscious implies that individuals have an awareness of risks that may affect their health, and men are perceived as not having that awareness. Skhosana *et al.* note: "*In general men do not take as many opportunities as women in keeping up with HIV/AIDS- related information*" (2006: 23). Similarly, in Garson's study, a middle aged male participant revealed that men are cowards when it came to facing health related issues in general, and HIV in particular. Evidently, *"we are weak and ignorant about our health"* (2005: 5).

Research indicates that women are also more active in participating in interventions related to health. These studies do not, however, take into account the potential of women's greater awareness of health issues in influencing their male partners' or sons' health seeking behaviour. Women display a certain familiarity with seeking help and support and this was reflected in this study by the influence that women played in encouraging men to participate in the Project.

The majority of the respondents in the study described how influential their mothers and / or female partners were in getting them to test their HIV status in the first place.

These findings are reflected in South African society where the older women play an educative role in the lives of their sons. Culturally, within the community from which the respondents were drawn, mothers are powerful, influential and often significant catalysts for change. Women hold a notable influence over their young adult children, particularly when they are still living at home for both economic and cultural reasons. The economic position of men and women, and the way this is clearly shaped by culture and the traditions means that male domination and female subordination has changed over time (Brown *et al.* 2005; Connell, 1995; Mane & Aggleton, 2001; Zlotnick, 2002).

Burawoy, Krotov & Lytkina put forward the view that an *involution to households* also means an *involution to traditional and cultural norms* and values (Burawoy *et al.* 2000). They are of opinion that because of modernisation and gender awareness, it is possible to see the new forms in which the power and influence of women have changed.

The fact that the majority of the respondents were unemployed and therefore dependent, as well as encouraged to join by mothers is a potentially important finding. It suggests that the effectiveness of HIV services in recruiting men may be increased through messages targeting the women in their lives.

### 5.1.2 MALE-SPECIFIC PROGRAMME FOCUS

A significant finding in this study was that men will participate in programmes if they are seen to be relevant and appropriate for them.

Contrary to studies that report men as lacking in awareness of health-related issues (Skhosana *et al.* 2006), they are more likely to take an active interest in their health if they perceive the programmes as having taken explicitly male-specific concerns into account.

Rather than being absent, the men in this study were participating and were enthusiastic about their participation. This reinforces the importance of ensuring the appropriateness of the activities in the lives of the respondents. It may also explain that successful and meaningful participation needs to be based on what Cornwall describes as *"an ethic of commitment to social transformation"* (2003:1326).

The need expressed in the study was for the men to increase their knowledge about men's health issues in general as well as to normalise their experiences in comparison to other men. They also wished for sustainable behaviour change in their own lives and to seek support and clarification from other men with similar challenges. One of these challenges is their need to

stay healthy in light of the HIV pandemic.

### 5.1.3 EMPOWERMENT AND PEER EDUCATION

Empowerment is different from Peer Education in that empowerment is something that happens on a personal level and a Peer Educator is a role that is played from a position of knowledge that is imparted to others. However, theses are inter-related. Not only did respondents identify their interest in participating in Peer Education work but also regarded this experience as empowering on a personal level.

Peer education and support involves the training and use of individuals from the target group to educate and support their peers. Peer-led interventions are based on the assumption that behaviour is socially influenced and that behavioural norms are developed through interaction (Campbell & MacPhail, 2002; Sikkema *et al.* 2000).

This highlighted the opportunity to use participants in this project as educators in their community. Men are eager to share the information with others and therefore it is important that they have the correct information to avoid the dissemination of incorrect messages.

There is a confidence that has been instilled in the men to talk about HIV/AIDS with their families and in their communities. In sharing what they have learnt through the group with a wider audience, the men are helping to address this need for education around HIV and AIDS.

This was seen as a very positive aspect of the work of the project and is indicative of the positive roles that men are trying to shape for themselves in their society.

### 5.1.4 SAFE SPACES AND MALE PARTICIPATION

Men's groups may be a means of challenging destructive masculine values by offering culturally 'safe spaces' in which men can examine their ideology, values and behaviour and develop new ways of being and behaving.

They also provide a culturally safe forum in which men can discuss difficult and embarrassing issues without fear of shame or ridicule, for example, impotence. The safe space in Imbizo has provided such an environment where the men can support each other on a more emotional level and where they can advise each other and discuss their problems.

The facilitation of a 'safe space' also appeared to have a psychological benefit to the men, allowing them to be comfortable, open and therefore able to talk freely. The provision of psycho-social support in contexts of high HIV prevalence is widely noted as an important aspect of HIV prevention services (Skhosana *et al.* 2006). However, this has generally referred to a safe space for women. This study showed that males also benefit from safe spaces.

The men noted that they felt comfortable discussing their existing or potential HIV positive status after participating, and that it was important to them that they could access information and support when they needed it. This echoes findings from the study by Swacker (1975, in Lindsey, 1990) about the role of support groups.

In the findings the abstract expressions around being part of the pack/group were described as a crucial factor for participation. Although respondents have not been able to articulate it clearly, the feeling of belonging created a platform which allowed them to trust the space and regard it as a safe environment in which they could address issues of concern.

### 5.1.5 ADDRESSING MASCULINITY, HEALTH CARE AND PARTICIPATION

The finding that men do participate in the project for periods ranging from one month to two years is noteworthy. The males' responses in this study clearly reflected that their participation in no way challenged them to change their masculine ideologies.

The Imbizo Men's Health Project did not use any framework and it did not aim to create any activism on the part of the respondents.

The men in the study reported feeling comfortable talking about issues of sexual health and broader health care in the context of the Imbizo project. Contrary to their explicit reference to only wanting factual information and not behaviour / emotional challenges, the men did engage in discussions of gender identity and masculine ideologies. Imbizo is a male only, safe and non-judgemental space.

The all male group atmosphere was important, and it was highlighted as one of the primary reasons for their participation. Similar findings are noted by Kalichman, Sikkema & Somlai (1994) who argue that men may feel uncomfortable in settings where they are required to

discuss personal issues with female health care workers. In the context of masculine identities in South Africa, and globally, which emphasise strength as central to 'being a man', it is important to acknowledge these difficulties.

The men reported that they preferred to access the project rather than other resources available to them because it did not require them to talk about their feelings and emotions, but rather focused on providing factual information about HIV and health.

This is similar to the study by Keen-Rhinehart *et al.* (2009), where students involved in interactive methods indicated a positive experience and improved retention of the material. The interactive methodologies adopted by Imbizo are designed to help participants examine their beliefs on various issues and consider alternative perspectives, in recognition of their reluctance to discuss their emotions or attend health facilities. This explains the reason given by respondents for their participation in the context of the all male, fact-based focus of the approach which was used in the Imbizo project.



This is in contrast to the approach documented by MAP (Men as Partners) which aims to encourage men to address other aspects of their masculine ideologies, such as socialisation, fatherhood and positive role models.

As noted, for males, reflecting on socialisation, exploring gender relations and unpacking masculinities can be uncomfortable. It is therefore important to employ different strategies for different age groups. This is particularly important, given the perception by health care workers

that men do not participate and consequently do not voice their opinions and emotions. This has been described by Beck (2004) as men being reluctant to use health services because of the belief that it is unmanly and that doing so would indicate weakness to their peers.

### 5.1.6 THE ROLE OF STAFF

Staff are integral to the successful implementation of such interventions. Important characteristics of staff members include understanding, flexibility, adaptability and some level of creativity and motivation. It was significant that the participants held a certain level of trust in the staff members as this enhanced their ability to develop a secure and ongoing connectedness with the Project.

This is in contrast to the study of Pool *et al.* (2001) which noted that hospital and clinic staff tended to gossip and as a result, were not trusted with information. Pool *et al.* found that patients who were HIV positive were less willing to inform staff of their HIV status as they were concerned about what the staff "*might do with that information*" (2001: 610). The passion and energy that Imbizo staff used to recruit and sustain participation is perceived by the men as caring and supportive.

The consensus was that each individual they came across was treated as an individual with separate needs. This seems to have been useful in instances where men had to return for repeat treatment as well as referrals.

During the 1990's studies undertaken in many developed countries identified lack of training,

lack of adequate medical knowledge and a lack of experience as the main reason that health care workers did not want to treat HIV infected patients (Abadie and Hoffman, 1992; Weinberger *et al.* 1992; Commonwealth AIDS Research Grant Committee Working Party, 1990). Similarly there was a perception that counsellors themselves needed to upgrade the knowledge that they had on HIV in order to provide an efficient service to their clients (Boerma and Bennett 1997).

Fear, stigma and discrimination have continued to accompany the HIV pandemic (UNAIDS, 2000). Stigma and discrimination in the health care setting could jeopardise HIV prevention efforts and HIV care, especially if infected health care workers are unsupported.

At Imbizo, a motivating factor was the active encouragement by staff to participate. Although the staff implement the activities in the project, they also are key in the marketing of the project and its activities, and it was clear that the men responded to the encouragement. This was also due to the fact that all staff on the project were male, so their encouragement was seen as relevant, and it had similarities to the encouragement from friends. Trust is a key aspect of a support system and the high level of trust between the group members and the staff is critical for the implementation of a male focused intervention.

### 5.1.7 MECHANISMS FOR ATTRACTING MEN

The methodologies used to communicate information, as well as the methods used to attract the participation of males have an impact.

The example of the respondents' appreciation for receiving SMS notification is an example of appropriate and relevant technology for the age group in the study. Furthermore the distribution of branded clothing and educational materials was seen within this group as an effective way of creating interest and maintaining participation. It would seem that understanding, flexibility, adaptability and some level of creativity and motivation are required in order to successfully interact with different ages of the male population in relation to HIV related issues.

The undocumented, internal controversy in NGO's regarding the use of food as an incentive to attract participants to any health intervention or research is unresolved. We need to take cognisance of the fact that research and health interventions are often aimed at the poor, where hunger is often a primary incentive for participation. We cannot overlook the fact that something as simple as a meal could bring people together to actively participate.

Approaches to make sexual and reproductive health services more 'male-friendly' have been described (Boyd and Moore, 1998 in Flood, 2005). The men in this study have also highlighted this as a strategy, suggesting, for example, that football was a means of approaching men. Soccer clubs provide existing networks where men can readily be accessed. Messages relayed at soccer matches are often able to reach many men at one time in an environment in which they have indicated in the discussions they are most comfortable. They perceive the male only, safe space, low emotional and high factual environment as non threatening to their concepts of masculinity. Other predominantly male environments, not mentioned by respondents, could also include gyms; boxing clubs, pool (snooker) bars.

### 5.1.8 CONCLUDING COMMENTS

While we cannot underestimate the interest and willingness of men to participate in HIV / health interventions, we need to acknowledge that if a man is encouraged to participate and feels that he is benefiting from this participation in some way, he is more likely to stay involved. The Imbizo study has provided valuable evidence to show that this can be achieved through sensitivity and respect for men as part of the solution.

# CHAPTER 6: CONCLUSION

## 6.1 LIMITATIONS

Inevitably, as in all studies, there were limitations. The following were noted:

1. The researcher in qualitative research plays an integral role in the design of the data-gathering instrument. As noted, the researcher is currently employed within the project. This had an impact in her ability to maintain objectivity. This limitation was countered by the validation measures noted above.
2. As the researcher is not an isiZulu speaker she had to rely on the assistant for translation as well as an interpretation of some of the cultural and linguistic nuances and subtleties. This involved translation during the process of transcribing. As with most translations some of the impact and importance of what was said may have been lost.
3. It must also be acknowledged that the researcher was female, different in relation to social class, age, and race to the respondents. Male responses to interview questions may have been influenced or biased due to the fact that a female researcher conducted the interviews. Taking the above into account in a qualitative research study, where the role of the researcher is central – and many would suggest *is* in fact the instrument in qualitative research (Gifford, 1996), is crucial. The impact that the gender of the researcher could have had on respondents in the study was considered by the researcher in the collection of data and the analysis phase so as not to influence the process and outcome of the findings.

4. This was a small study based on the limited scope for a minithesis and this would impact on the generalisability of the findings. This is particularly important, given that some of the findings about male participation are different to conclusions drawn in the literature. However, it is worth noting that the samples were drawn from a study population of men who have attended Imbizo for a significant period of time, which implies that other men too find the approach valuable.

## 6.2 CONCLUSION

To strategically address and support positive changes in gender relations, we need to ensure that men and women continue to form their gender identities while living positively in societies devastated by HIV. Many need guidance, not only in their private lives, but also in how to 'mainstream' HIV/AIDS within their social and professional milieus.

The vital role of sexual relations in the transmission of HIV has brought into the open, debates on men, women, sexuality and gender relations. These debates link to the wider field of human rights, women's rights, and the rights of sexual minorities. AIDS gives us an entry point to place gender relations, as well as male involvement and responsibility in sexual and reproductive health, firmly on the political and developmental agenda.

There is a perception that men do not use health services, and do not have health and well being information.

This study has demonstrated that men will participate if programmes are relevant, appropriate, fact-driven, have added value and do not explicitly engage in a human rights or gender framework. It has also demonstrated that men, who are involved, are eager to share information with others.

Much remains to be done in terms of understanding and responding to male risk behaviours for real progress to be made in reversing the impact of the HIV/AIDS pandemic. Many important initiatives, pilot interventions and educational efforts have been successfully carried out and they show that change is possible.

## 6.3 RECOMMENDATIONS

The experience of Imbizo Men's Health Project has provided several valuable insights into what can encourage men to participate in health programmes. It has also provided notions of how men define their roles, after having participated in this Project. On the basis of this, it is recommended that:



### 6.3.1 PROGRAMME DESIGN

The design of programmes needs to be more compatible with the daily experiences of men. Design should not jeopardise, overtly challenge or compromise men's sense of their own masculinity.

Practical examples of such programme design needs to emphasize:

- the connection between HIV/AIDS and sexual and gender based violence
- prevention of HIV
- involving men as partners and community stakeholders who participate more peer education activities within the community
- building on links with other programmes like MAP, One man Can, and Brothers for Life.

### 6.1.2 MEN'S FEELINGS

It is vital to acknowledge men's contribution and role in HIV prevention, both as responsible partners and as vulnerable groups. Men need to be approached as valued contributors in a joint search for solutions. This will limit men's feeling of vulnerability and marginalisation.

### 6.1.3 ACCESSING MEN

Interventions should be in different formats, and range from informal discussions, peer education and mediation, advertisements and information dissemination to participatory workshops and South African Qualifications Authority (SAQA) accredited training. The following are recommended:

- Radio talk shows and short and understandable messages for men to encourage access to existing health services. An extensive radio campaign is recommended since radio is the most accessible medium for people in poorer communities and requires no level of literacy.
- The inclusion of issues around masculinity, HIV and AIDS and men's empowerment in reality shows screened on television
- T-shirt campaign with slogans promoting men's contribution

- Marches to showcase male participation by combining with initiatives such as One man Can and a One Million Men March
- An extensive broad based SMS campaign with messages to challenge notions of masculinity and say what "real" men do
- Accessing men at sport stadia, sports clubs, clinics, pubs, shebeens, gyms, shopping centres
- Working with traditional leaders and looking at issues around circumcision
- Going on a national tour to promote Men's Health services at hospitals, clinics and schools

### 6.1.4 SUPPORTING WOMEN

Women are potentially core change agents in issues around HIV/AIDS and men. The health programmes aimed to offer help, support and empowerment to women need to include how women are themselves empowered to encourage men to participate and access health related services. The women need to join support groups where regular meetings could serve as further encouragement. The sharing of successes and training are also important.

Use women politicians and community leaders as role models to speak out about the encouraging role they play in the lives of men.

### 6.1.5 HIV AND AIDS, GENDER AND MALE PARTICIPATION

Structures and organisations that deal with HIV/AIDS need to put more effort into gender awareness and those whose work in the field of gender relations need to adapt to the reality of

HIV/AIDS.

This would involve the development of revised policies, priorities and training models to better support male participation.

### 6.1.6 GENDER TRAINING: NEW EQUITABLE MASCULINITIES

More effort needs to be put into developing appropriate gender training in ways that are not going to deter men from participating. Men's conceptions of dominant masculinity have to be challenged.

The concept of 'new equitable masculinities' need to be mainstreamed into programmes that address the issues related to gender equity and male awareness, support and involvement.

### 6.1.7 FURTHER RESEARCH

Further investigation of Programmes where men are active participants needs to be undertaken so that good practice models may be designed. Further research needs to be conducted to determine:

- what particular characteristics of these activities increase knowledge and behaviour change
- whether there are other interactive activities that would be just as effective.

**REFERENCE LIST**

Abadie, R. & Hoffman, E. (1992) Physician practices and attitudes on HIV-related issues: a survey of LSMS primary care physicians. *J La State Med Soc.* 144(6):283-288.

Adelekan, M.L., Jolayemi, S.O., Ndom, R.J.E., Adegboye, J., Babatunde, S., Tunde-Ayimode, M., *et al.* (1995). Caring for people with AIDS in a Nigerian teaching Hospital: Staff attitudes and knowledge. *AIDS Care,* 7, S63-S72.

Akpende, G. O., Lawal, R. S. & Momoh, S. O. (2002) Perception of voluntary screening for paediatric HIV response to post-test counselling by Nigerian parents. *AIDS Care,* 14(5), 683-697.

Aral S. (1993) Heterosexual transmission of HIV: the role of other sexually transmitted infections and behavior and its epidemiology, prevention and control. *Annual Review of Public Health*, 14:451–467.

Awad, G.H., Sagrestano, L.M., Kittleson, M.J., & Sarvela, P. (2004) Development of a measure of barriers to HIV testing among individuals at risk. *AIDS Education and Prevention*, 16(2), 115-125.

Barker, G. (2005). *Dying to be Men*. London: Routledge.

Barker, G. (2006) *Engaging boys and men to empower girls: reflections from practice and evidence of impact.* United Nations [UN] Division for the Advancement of Women (DAW)

Barker, G. & Loewenstein, I. (1997) Where the boys are: Attitudes related to masculinity, fatherhood and violence toward women among low income adolescent and young adult males in Rio de Janeiro,Brazil. *Youth and Society* 29(2): 166–196.

Barker, G. & Ricardo, C. (June 2005). *Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict, and Violence.* Paper presented at the World Bank Seminar on Conflict Prevention & Reconstruction. Paper No 26/June 2005, Washingston DC.

Barnett, B. (1997) Gender Norms Affect Adolescents. *Network*, 17, 3, 10-13.

Beardsell, S. (1994). Should wider HIV testing be encouraged on the grounds of HIV prevention? *AIDS Care*, 6(1), 5-19.

Beck D. (2004) Men and ARVs: *How does being a Man affect Access to Antiretroviral Therapy in South Africa?. An Investigation among Xhosa-Speaking Men in Khayelitsha*. CSSR Working Paper no. 80. Centre for Social Science Research. Cape Town: University of Cape Town.

Beedham, H. & Wilson-Barnett, J. (1995) HIV and AIDS care: Consumers' views on needs and services, *Journal of Advanced Nursing,* 17, 21-27 (in Surlis & Hyde 2001)

Boerma, T. & Bennett, J. (1997). Costs of HIV programmes. In J. Ng'weshemi, T. Boerma, J. Bennett & D. Schapink. (eds.). *HIV prevention and AIDS care in Africa: a district level approach*. The Netherlands: Royal Tropical Institute: 353-370.

Bowleg, L. (2004). Love, Sex, and Masculinity in Socio-cultural Context: HIV concerns and Condom use among African American men in Heterosexual Relationships. *Men and Masculinities*, 7(2), 166-186.

Boyd, JS., Kerr, S., Maw, RD., Finnighan, EA. & Kilbane, PK. (1990) Knowledge of HIV infection and AIDS ,and attitudes to testing and counseling among general practitioners in Northern Ireland. *British Journal General Practise*; 40: 158-60

Britton, C. & William, P. (1999). *Understanding the culture of masculinity and creating effective prevention messages*. Paper presented at the National HIV Prevention Conference Aug 29-Sept.1, 1999.
[Online] Accessed on January 4, 2009 from: http://0-biblioline.nisc.com.innopac.wits.ac.za

Brown, J., Sorrell, J. & Raffaelli, M. (2005). An exploratory study of constructions of masculinity, sexuality and HIV/AIDS in Namibia, Southern Africa. *Culture, Health and Sexuality*, 7(6), 585- 598.

Brown, L., Macintyre, K. & Trujillo, L. (2003) Interventions to reduce HIV/AIDS stigma: what have we learned? *AIDS Education and Prevention,* 15 (1) 49-69

Bujra, J. (2000) Targeting Men for a Change: AIDS Discourse and Activism in Africa. *Agenda* 44: 7-14.

Burawoy, M. Krotov, P. & Lytkina, T. (2000). Involution and Destitution in Capitalist Russia. *Ethnography*, 1: 43-65.

Burnard, P. (1991). A method of analyzing interview transcripts in qualitative research. *Nurse Education Today*. 11 (6):461—466.

Campbell, C. (2001). *Going underground and going after women*. In R. Morrell, (ed). Changing men in Southern Africa. Pietermaritzburg: University of Natal Press. (275-296).

Campbell, C. (2003). *'Letting them die': How HIV/AIDS prevention programmes often fail.* Cape Town: Double Story Books.

Campbell, C. & Foulis, C.A. (2002). Creating contexts that support youth-led HIV prevention in schools. *Society in Transition*, 33(3), 339-356.

Campbell, C. & MacPhail, C. (2002). Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. *Social Science and*

*Medicine*, 55(2), 331-345.

Chimbiri, A.M. (2007). The condom is an 'intruder' in marriage: evidence from rural Malawi. *Social Science and Medicine*, 64, 1102-1115.

Connell, R. W. (1995). *Masculinities*. Cambridge: Polity Press.

Commonwealth AIDS Research Grant Committee Working Party. (1990) Attitudes, knowledge and behaviour of GP in relation to HIV infection and AIDS. *Med J Aust*, 153(1): 5-12.

Cornwall, A. (2000). Missing men? Reflections on men, masculinities and gender and development. *IDS Bulletin*. 31, 18–27.

Courtenay, W.H. (1998) College men's health: An overview and a call to action. *Journal of American College Health* 46(6):279-290.

Declaration of Alma-Ata (1978) *International conference on primary health care*. Alma-Ata, USSR, Sept 6 – 12. [Online] Accessed December 28, 2008 from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

Denzin, N.K. Lincoln, Y.S. eds. (1994) *Handbook of qualitative research.* London: Sage Publications.

Elson, D. and Evers, B. (1998) *Sector Programme Support: The Health Sector. A gender-aware analysis.* Genecon Unit, Graduate School of Social Sciences: University of Manchester.

Engender Health. (2004). Men as partners, country by country. International Journal of men's health. [Online] Accessed December 28, 2008 from: http://www.engenderhealth.org/ia..wwm/countries.html.

Fido, A., & Al Kazemi, R. (2002). Survey of HIV/AIDS knowledge and attitudes of Kuwaiti family physicians. *Family Practice,* 19, 682-684.

Finger, B., Lapetina, M. & Pribila, M. (Eds) (2002). *Intervention strategies that work for youth: Summary of the FOCUS on young adults program report.*

Flood , M. (2002) *Frequently asked questions about pro-feminist men and pro-feminist men's politics*. [Online] Accessed November 06, 2008 from http://www.xyonline.net/articles.shtml

Forsythe,S., Arthur,G., Ngatia,G., Mutemi, R, Odhiambo, J. & Gilks, C. (2002). Assessing the cost and willingness to pay for voluntary HIV counselling and testing in Kenya. *Health Policy and Planning, 17(2),* 187- 195.

Fraser, N. (1997) *Justice Interruptus: Critical Reflections on the "Postsocialist" Condition.* New York: Routledge.

Fredman, S. (2002) *Discrimination Law.* Oxford: Oxford University Press.

Fylkesnes, K. (2000). Consent for HIV counselling and testing. *The Lancet*, 356, 43.

Garson, P. (2005). *"Men think we bring the disease": challenges facing HIV-positive mothers in Soweto.* [Online] Accessed July 4, 2007 from: http://www.phru.co.za/images/stories/pdf/baby_steps.pdf

Gerbert, B., Maguire, BT., Bleecker, T., Coates, TJ. & McPhee, SJ. (1991) Primary care physicians and AIDS. Attitudinal and structural barriers to care. *JAMA* 266(20): 2837-42.

Gifford, S. (1996) Qualitative Research: The Soft Option? Health Promotion *Journal of Australia*, 6 (1): 58 - 61.

Glesne, C. & Peshkin, A. (1992). *Becoming qualitative researchers*. New York: Longman.

Greene, ME. & Biddlecom, AE. (1997) *Absent and problematic men: demographic accounts of male reproductive roles.* New York, NY, Population Council.

Greig A. (2001) *Political Connections: Men, Gender and Violence*, unpublished first draft prepared for the United Nations International Research and Training Institute for the Advancement of Women (INSTRAW).

Greig, A. & Peacock, D. (2005) *The South African Men as Partners Network: Promising Practices Guide.* unpublished report on the South African Men as Partners Network.

Gupta, R., Whelan, D., & Allendorf, K., (2003). *Integrating gender into HIV/AIDS programmes: A review paper.* Departments of Gender and Women's Health, Family and Community Health. WHO.

Harlap, S, & Kost .K, & Forrest, J. (1991) *Preventing pregnancy, protecting health: a new look at birth control choices in the United States.* New York, NY, Alan Guttmacher Institute.

Harrison, A., Smit, J.A. & Myer, L. (2000). Prevention of HIV/AIDS in South Africa: A review of behaviour change interventions, evidence and options for the future. *South African Journal of Science*, 96(6), 285-291.

Health Systems Trust, HST, (2006) *South African Health Review.* Health Systems Trust, Durban

Helman, C.G. (2007). *Culture, health and illness* (5th ed.). London: Hodder Arnold.

Hentgen, V., Jaureguiberry, S., Ramiliarisoa, A., Andrianantoandro, V., & Belec, M. (2002). Knowledge, attitude and practices of health personnel with regard to HIV/AIDS in Tamatave (Madagascar). *Bulletin de la societe depathologie exotique* 95(2), 103-8. [Online] Accessed on May 4, 2009 in English from Pub Med from Bull Soc Pathol Exot.

Horizons Program Report (2001) *Integrating HIV Prevention and Care into Maternal and child Health Care Settings. Lessons Learned from Horizons studies.*

Hunter, M. (2005). Cultural politics and masculinities: Multiple-partners in historical perspective in KwaZulu-Natal. *Culture, Health & Sexuality*, 7(3), 209–223

Hybels Bill (1990) *Honest to God?: becoming an authentic Christian.* Michigan: Zondervan Publishing House.

IRIN (2005). *South Africa: men falling through the cracks*. United Nations Integrated Regional Information Networks. [Online] Accessed on December 28, 2008 from: http://www.aegis.com/news/irin/2005/IR050766.html.

INTERFUND (2004). *Working with men to end gender-based violence.* INTERFUND, Republic of South Africa.

Jackson, H. (2002). *AIDS Africa: Continent in Crisis.* Zimbabwe: SAFAIDS.

Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Koss, M., Puren, A. & Duvvury, N. (2008) Impact of Stepping Stones on HIV, HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. *British Medical Journal* BMJ;337:1-11.

Jones, RB. & Wasserheit, JN. (1991) Introduction to the biology and natural history of sexually transmitted diseases. In: JN Wasserheit. *et al*, eds. *Research issues in human behavior and sexually transmitted diseases in the AIDS era.* Washington, DC, American Society for Microbiology.

Kalichman, S. C., Sikkema, K. J. & Somlai, A. (1996). People living with HIV infection who attend and do not attend support groups: a pilot study of needs, characteristics and experiences. *AIDS Care, 8(5),* 589- 599.

Kalipeni, E. & Gosh, J. (2007). Concern and practice among men about HIV/AIDS in low socio- economic income areas of Lilongwe, Malawi. *Social Science and Medicine*, 64, 1116-1127.

Keen-Rhinehart, E., Eisen, A. , Eaton, D. & McCormack, K. (2009) Interactive Methods for Teaching Action Potentials, an Example of Teaching Innovation from Neuroscience Postdoctoral Fellows in the Fellowships in Research and Science Teaching (FIRST) Program. *The Journal of Undergraduate Neuroscience Education*, 7(2): 74-79

Levack A. (2001) Educating men in South Africa on gender issues. *SIECUS Rep* 29(5):13-15.

Levack, A. (2005). *Understanding men's low utilization of VCT and men's role in PMTCT in Soweto.* Personal correspondence. University of Washington.

Lewin, SA., Dick, J., Pond, P. *et al.* (2005) Lay health workers in primary and community health care. *The Cochrane Database of Systematic Reviews* Issue 1(4015): 1152-1163.

Lindsey, L.L. (1990). *Gender roles: A Sociological Perspective.* New Jersey: Prentice- Hall Inc.

Long, C. (2005). *Contradicting maternity: HIV- positive motherhood in South Africa.* Unpublished PhD report. Darwin College, University of Cambridge. London.

Maharaj, P. (2001). Male attitudes to Family Planning in the era of HIV/AIDS: evidence from KwaZulu- Natal, South Africa. *Journal of Southern African Studies,* 27(2), 245-257.

Mahendra, VS., Gilborn, L., Bharat, S., Mudoi, R., Gupta, I., George, B. *et al.*(2007). Understanding and measuring AIDS related stigma in health care settings: A developing country perspective, *Journal of Social Aspects of HIV/AIDS,* 4, 616-625.

Mane, P. & Aggleton, P. (2001). Gender and HIV/AIDS: What do Men Have to do with it? *Current Sociology*, 49 (6), 23-37.

Mantell, J.E., Harrison, A., Hoffman, S., Smit, J.A., Stein, Z.A. & Exner,T.M. (2006).The *Mpondombili* project: Preventing HIV/AIDS and unintended pregnancy among rural South African school-going adolescents. *Reproductive Health Matters*, 14(28), 113-122.

Mantell, JE., Scheepers, E. & Karim, QA. (2000) Introducing the female condom through the public health sector: experiences from South Africa. *AIDS Care*. 2(5): 589-601

Mays N. and Pope C. (1995) Qualitative Research: *BMJ*; 311:109-112

Morrell, R. (2001). The Times *of Change: Men and Masculinity in South Africa.* In R. Morrell. (ed). *Changing Men in Southern Africa*. (pp.1-35) Scottsville, South Africa: University of Natal Press.

Morrell, R., (2002). Men, Movements, and Gender Transformation in South Africa. *The Journal of Men's Studies* 10 (3): 309.

Morrell, R and Lahoucine, O. Eds. (2005) *African Masculinities: Men in Africa from the late Nineteenth Century to the Present.* South Africa: University of KwaZulu-Natal Press.

Morrell, R. & Ouzgane, L. (2005). *African Masculinities: Men in Africa from the late nineteen-century to the present.* Scottsville: University of Kwa -Zulu Natal Press.

Moses, S. & Plummer, F.A. (1994). Health education, counselling and the underlying causes of the HIV epidemic in sub- Saharan Africa. *AIDS Care*, 6(2), 123- 127.

Noar, S.M. & Morokoff, P.J. (2001) The Relationship between Masculinity Ideology, Condom Attitudes, and Condom Use Stage of Change: A Structural Equation Modeling Approach.

*International Journal of Men's Health* 1(1).

Nachmias, C. F. & Nichmias, D. (1992) *Research Methods in the Social Sciences*: Martins Press, Incl

Naidoo, K. (1997) The men march. *Agenda(* 36): 94-96

Orubuloye, I.O., Caldwell, J.C. & Caldwell, P. (1997) Perceived Male Sexual Needs and Male Sexual Behaviour in Southwest Nigeria. *Social Science and Medicine* 44, 8, 1195-1207.

Patton, M.Q. (1987). *How to use Qualitative Methods in Evaluation*. Newbury Park: Sage Publications

Peacock, D.(2002) Que No Nos Separen Fronteras. *Movement*, Summer 2000.

Peacock D. (2003) *Men as Partners: South African Men Respond to Violence against Women and HIV/AIDS.* Journal of Social Work Perspectives, San Francisco: San Francisco State University Press

Peacock D. (2003b). Building on a Legacy of Social Justice Activism: Enlisting Men as Gender Justice Activists in South Africa. *Men and Masculinities* 5(3): 325–28.