

# **The effect of the behaviour of black South African men of Mthatha district on HIV/AIDS prevalence**

by  
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## **DECLARATION**

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## Summary

This study has attempted to investigate the effects that behaviour of Black South African men has on HIV/AIDS prevalence at three communities in Mthatha District viz: Qokolweni, Zimbane and Corana Administrative Areas. This research sought to investigate the social background and the behaviour patterns of men and how that affects women in relation to HIV/AIDS prevalence.

Participants were randomly selected i.e. 60 participants from each community. Interview schedules were used ranging from open to closed questions. This allowed participants to be free to bring up whatever they wished and allowed them to be free to answer in whichever manner they wished. The purpose here was to get to know their honest feelings.

In responding to the research question the researcher looked at the following manifestations of men's behaviour in relation to HIV/AIDS prevalence: gender inequities and male dominance, behavioural patterns, cultural background and socialization, physical and social violence and rape.

The following barriers to intervention were identified: socio-cultural issues, low levels of condom use, cultural stereo types, stigma and discrimination, lack of knowledge and misconceptions about HIV/AIDS, poverty and commercialisation of sex.

The findings showed that there is a relationship between behaviour patterns and HIV/AIDS prevalence; that the socio-cultural background contributes negatively on the behaviour and mannerisms of men as they grow from boyhood to adulthood; that there is a relationship between the refusal to use condoms amongst boys and HIV/AIDS prevalence. Unsafe sex significantly spreads not only HIV/AIDS but also sexually transmitted diseases. The investigation also indicated that behaviour changes cannot occur overnight and that in the meantime the relationship still exists between the inability to change negative behaviour and HIV/AIDS prevalence.

It was found that there is a relationship between the refusal to use condoms amongst boys and HIV/AIDS prevalence. Unsafe sex significantly spreads not only HIV/AIDS but all sexually transmitted diseases.

The test results also indicated a relationship between non-negotiation of sexual activities and HIV/AIDS perpetration. Some men engage in sexual activities such as dry sex which render women vulnerable to HIV/AIDS without caring for what they do or how their partners feels.

## **Opsoming**

Hierdie studie ondersoek die invloed van die gedrag van swart mans in die Mthatha distrik op die voorkoms van MIV/Vigs. Die meer spesifieke doel van die ondersoek is 'n ontleding van die sosiale agtergrond en gedragspatrone van mans en die wyse waarop dit vrouens ten opsigte van MIV/Vigs beïnvloed.

Deelnemers was ewekansig geselekteer en 60 deelnemers is vanuit elke gemeenskap in die steekproef ingesluit. Die vraelys was oop-einde ten einde maksimum geleentheid aan deelnemers te bied om hulle werklik gevoel uit te spreek.

Bevindinge van die studie het aangetoon dat daar 'n beduidende verwantskap bestaan tussen die gedragspatrone van die mans in die steekproef en die voorkoms van MIV/Vigs in die studiegebied.

Daar is verder bevind dat daar 'n beduidende verband bestaan tussen seuns se weiering om kondome te gebruik en die voorkoms van MIV/Vigs. Die noodwendige negatiewe gevolg van hierdie gedragspatroon word in die studie bespreek.

Voorstelle word gemaak vir aksies wat moontlik die gedragspatrone van mans kan aanpas ten einde die voorkoms van MIV/Vigs op hierdie wyse te probeer voorkom.

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## **CHAPTER 1                    BACKGROUND OF THE STUDY**

### **1.1 Introduction**

Sexual partners, regardless of whether they are in the institution of marriage or in a relationship outside of this institution are in a unique position to promote HIV/AIDS prevention particularly in relation to their attitudes and behaviours. The situation in Africa has shown definitely that AIDS flourishes most evidently in a society where women are particularly vulnerable. Women would be more vulnerable if they cannot express themselves freely on how they feel where sex is concerned. Klugman, and Hlatshwayo (2001) support the above and argue that sexual rights, a more inclusive term which focuses on the ability of men and women to make choices about the expression of their sexuality and their sexual lives, including who they have sex with and how, is important in the context of HIV/AIDS. This means that a dialogue is necessary between sexual partners. The researcher found that there is a feeling among black males that sex is their prerogative, and because of that the researcher concluded based on the findings and available literature, that their sex partners will always be vulnerable, whilst the spread of HIV/AIDS is on the increase.

Bell (2002), in her overview report on gender and HIV/AIDS, argued that in black communities HIV/AIDS is not only driven by gender inequality, it entrenches gender inequality, putting women, men and children further at risk. Defining and stigmatising those 'at risk' as men who have sex with men, sex workers and drug users has until recently obscured the increasing infection rate among now heterosexual people. The masculinity of men is associated with dominance, and to be feminine with passivity. This association is complex and may differ in different historical and cultural contexts. Despite any differences what is clear is that societies regard male desires as important and women are perceived to be the passive recipients of male passion (Doyal 2001). Rose-Innes 2009, in her article, socio-cultural aspects of HIV/AIDS says that South Africa is considered to be one of the worst affected countries, by HIV/AIDS in the world. Amongst the complex reasons for this are certain socio-cultural factors which are responsible for the rapid spread of the disease. These include gender inequality and male dominance, sexual violence, cultural beliefs and practices.

Many women acknowledge that their partners are not monogamous, but that they do not have the opportunity and space to think through, analyze and personalize what this could mean for them. It is this and other risky behaviours of men that perpetrate the scourge of HIV/AIDS. Although there is a "family code" which promotes marital fidelity from men and women, the reality is that women are expected to be faithful while men are not. Traditional practices increase women's vulnerability. Tallis (2002), argued that "widow inheritance and female genital mutilation which were outlawed in 1999 are still practiced in many countries".

It is further argued that the South African culture is generally male-dominated, with women accorded a lower status in society than their male counterparts. Men are socialized to believe that women are inferior and should be under their control; women on the other hand are socialized to over-respect men and act submissively towards them. The resulting unequal power relation between the sexes, particularly when negotiating sexual



encounters, increases women's vulnerability to HIV infection and accelerates the epidemic (Rose-Innes 2006).

There is a crucial need to transform because of HIV/AIDS so that women can have equal power so that both men and women could be less vulnerable. According to Gupta (2002) interventions in relationships are crucial so that transformation may occur. Both men and women have to be involved for the sake of the disease.

The researcher has observed that attitudes and behaviours towards women are formed during adolescence so it is important to try and influence men's attitude at this time. This notion is supported by the discussions that were carried on in (2002) in Gender/AIDS LISTSERVE, Instituto Promudo in Rio de Janeiro, Brazil where they worked on a project engaging young men who were opposed to gender-based violence (Instituto Promundo 2002). Men and boys were empowered on developing insight into both positive and negative masculine constructs of gender based violence.

## **1.2 Conceptualisation**

The researcher anticipated that their show of interest might make peers get suspicious of their status. There was a need for the researcher to sit down with the group and explain some issues such as, confidentiality, however the research process was delayed as some members of the group may shunned away from the research program because they needed to identify with the larger group of peers.

The research participants were reached at their homes; this in many cases was their time of relaxation or a time when they were doing their household chores, which meant that, they are not really free. Their agreeing to participate depended on whether they viewed the study as important for them and their children's future. The researcher took cognizance of the fact that the participants are rural people who either are illiterate or semi-illiterate.

There could also be a need to administer these interviews at the times most convenient to the participants. For the researcher, what is of interest is to know how the participants view what is being researched i.e. male behaviours which are seen as a way of life amongst adult black males. A set of interview questions were prepared to guide respondents towards the expected outcomes.

## **1.3. Procedures**

The researcher has observed that in black communities' males show off their masculinity in a negative way. This undermines the status of women and subjects them to being subservient in a relationship, where manhood without sex is viewed as incomplete. The biggest problem is that sex is not negotiated amongst the partners. Women therefore see themselves as being helpers or tools in creating a satisfying environment for their partners. Emmanuel, Kondowe, and Mulera (1999) argue that Malawians hold cultural values, beliefs and practices where women are devalued in status and have significantly less control over the nature and

frequency of their sexual contacts. Van Niekerk (2001) further argues that condoms are a technology hardly recognizable with African sexual practices.

The researcher has observed that men go to circumcision schools and come back 'proudly men' with a lot of power related behaviours. One wonders whether at those schools young men get empowered on how to ill treat women.

Mr. Mocumbi, Mozambique's Prime Minister and former Minister of Health, a physician and a board member of the International Women's Health Coalition, made a statement in the *New York Times* that AIDS is spreading rapidly amongst heterosexuals because of gender inequalities (Nwanma 2001). In Mozambique for example the overall rate of HIV infection amongst young women is twice that of boys their age, this is so not because girls are promiscuous but because those who try to negotiate condom use commonly face violence or rejection.

#### **1.4 Research objectives**

The researcher had to formulate the following set of objectives in order to respond to the research question:

- Refusal to use condoms amongst men increases HIV/AIDS prevalence.
- The inability to negotiate sexual activity increases HIV/AIDS prevalence.
- Determine the underlying gender inequality and socio-cultural barriers in the complexities of HIV/AIDS.
- The inability to institute behavioural change and self-control over sex increases HIV/AIDS prevalence.

#### **1.5 The scope of the study**

For the sake of the study, the researcher randomly selected three rural communities in the Mthatha district, those being Qokolweni, Corana and Zimbane Administrative Areas. These communities are on the outskirts of Mthatha district and are characterized by high levels of illiteracy, unemployment and a high HIV/AIDS prevalence. The concentration is on the adolescent males and females of the said communities.

#### **1.6 Significance of the study**

Certain socio-cultural aspects have been identified to be responsible for the rapid spread of HIV/AIDS in South Africa (Rose-Innes 2006). The researcher, through interview questions, examined the possible causes of HIV prevalence. These empirical findings will help in establishing exactly what men do to contribute to the scourge of HIV/AIDS. The researcher will now be in a position to make recommendations to the policy makers or government departments and non-governmental organizations in making informed decisions on the kinds

of interventions that need to be implemented in addressing and empowering women in relation to HIV/AIDS.

### **1.7 Definition of terms**

1.7.1. HIV: is a virus that causes AIDS. HIV stands for ‘Human Immunodeficiency Virus’ (Kanabus 2011)

1.7.2. AIDS: stands for the ‘Acquired Immune Deficiency Syndrome’. It is a serious condition in which the body’s defenses against some illnesses are broken down which means that people with AIDS can get many different kinds of diseases which a healthy person’s body would normally fight off quite easily (Kanabus 2011).

1.7.3. Safer Sex: means using a condom during sexual intercourse which when used correctly can be effective in the prevention of HIV/AIDS (Kanabus 2011)

1.7.4. Gender: is the socially constructed roles and responsibilities that are assigned to men and women (Tallis 2003).

1.7.5. Power: Concepts of power include power as resource, as dominance and as empowerment (Allen 1999).

1.7.6. Empowerment: is the capacity of women to increase their own self-reliance and internal strength. This is identified as the right to determine choices in life and to influence the direction of change through the ability to gain control over material and non-material resources. It literally refers to people taking control over their own lives, gaining the ability to do things to change and define their own agendas. It involves rising above barriers, confronting and overcoming fear and doing things never thought possible (Kabeer’s based on the work of Lukes).

1.7.7. Transformation: is the radical alteration of the processes and structures which reproduce women’s subordinate position as a gender, which encourages individual change and collective action. This includes enabling women to collectively take control of their lives, to organize and help each other, to make demand on the state for support and on society for change (Young 1997:372).

## **CHAPTER 2            LITERATURE REVIEW**

### **2.1 Introduction**

“In traditional African societies generally there are stereotypes which contribute extensively towards the male behaviours. Stereotypes are a set of beliefs about a group of people including attributes and social identity people are likely to display. Stereotyping implies that certain thoughts, actions and perceptions are accepted as the rule, and that the practicing of it eliminates other roles or realities. Examples of stereotyped beliefs are that men are intellectually superior to females, women generally become uncomfortable in a man’s world etc” (Erwee, 1998). Erwee 1998 quoting Lewis 1990 goes on to say that in the South African culture the traditional female roles are still highly regarded and qualities such as subservience, supportiveness and submission are met with approval.

### **2.2 Manifestations of men’s behaviour in relation to HIV/AIDS prevalence.**

#### **2.2.1 Gender inequalities and male dominance**

Whatever is going on with HIV/AIDS can emanate from the unequal gender relations which are particularly visible in the special vulnerability of women to HIV and Aids in developing countries, and in men’s risk taking behaviours. Gender inequality is fuelling the overall course of the epidemic (Aggleton and Mane 1999).

According to Meursing and Sibindi (quoted by River 1999), the AIDS epidemic thrives on rigid sex-role definitions. These gender roles emanate from two distinct ways, these being cultural background and socializations. The way children are socialized may define their behaviours later on in life. Unfortunately the way men are socialized emphasize these behavioural patterns and could lead to susceptibility to HIV/AIDS.

#### **2.2.2 Behavioural patterns**

Parker, Colvin and Birdsall (2006) are in support of the link between HIV/AIDS prevalence and behaviour assert that, the age of sex debut is one of the major factors which influences HIV risk. Early sexual debut, they maintain is linked to having a greater lifetime number of sexual partners; the earlier the sexual debut, the greater the risk of HIV infection.

Age-mixing and sexual-networking are important behavioural determinants of HIV infection and HIV risk has been shown to be higher among young people with sexual partners who are five or more years older than themselves (Parker, et al. 2006). Shisana, et al., (2008) in the HSRC survey, further argues that males aged 15 – 19 who had female partners five or more years older than they had a HIV prevalence of 19.0% in comparison to 3.0% for males who had partners within five years of their age group.

Lamkefa, (quoted by Nwanma, 2001), says that men think they have the liberty to have as many wives or girlfriends as they want thereby contributing greatly to the spread of HIV/AIDS. Nwanma also quotes Akpan, a Nigerian media executive, who agrees with all

the above and further highlights the inordinate power than men have over women in economic, political and family life.

It is observed by the researcher that both sexes have entrenched ideas about suitable masculine or feminine behaviour. These behaviours always enforce gender inequality and sexual double standards, and lead to unsafe sexual practices. In such contexts abstinence and monogamy are often seen as unnatural for men, who try to prove themselves “manly” by repeated sexual encounters and often the aggression that accompanies these.

Men in such relationships have ideas and behaviours such as sex on demand taken as part of marriage “deal”; being violent is taken as a sign of love and affection. Sex viewed like this could be taken as necessary to maintain health and gender identity.

The above views serve to justify men’s sexual behaviour to some extent. They also give men freedom and a licence to be sexually adventurous and aggressive towards women without being questioned or taking responsibility for their actions.

### **2.2.3 Cultural background and socialization**

In the South African context the scourge of HIV/AIDS is still on the increase and the reasons for this are very complex though they are mainly hinged on the socio-cultural factors e.g.: Gender inequalities and male dominance, physical and sexual violence, political transition and the legacy of apartheid, stigma and discrimination to mention just a few (Rose-Innes 2006).

The South African black culture is generally male-dominated, with women accorded a lower status than men are. Men are socialized to believe that women are inferior and should be under their control, women are on the other hand socialized to over-respect men and act submissively towards them. The resulting unequal power relation between the sexes, particularly when negotiating sexual encounters, increases women’s vulnerability to HIV and fuel the epidemic (Rose-Innes 2006)

It is then alleged in the health 24 medical document that women, because of their inferior status have no power to protect themselves or insist on condom use. This could be so with some women because they lack the economic power and dare not risk losing their partners, by denying them sex or deciding to leave an abusive relationship (Rose-Innes 2006).

### **2.2.4 Physical and sexual violence**

Male dominance is coupled with physical and sexual violence in South Africa. To maintain the cultural status men often use violence to prove that they are “real men” and have to show that they have a duty to control women. When a relationship is physically abusive it limits women’s ability to negotiate safer sex, this will always mean that men won’t use condoms thus rendering women more vulnerable and perpetrates the spread of HIV/AIDS. In some cases women may not even raise the issue of safer sex for fear of a violent response.

Violence in South Africa has become a norm, maybe because of the apartheid history of the country, where people generally were violent towards the regime. During this transition it is observed that this violence has been diverted to families. It has been a familiar practice or maybe an accepted way of solving conflicts and wielding power especially by men to women. It has been unfortunate that the early years of the HIV/AIDS epidemic in South Africa coincided with the end of the apartheid legacy, a time which has come with societal instability. Another real problem occurred when the revolutionary cadres such as Umkhonto We Sizwe returned from the north of South African borders in 1994 from areas of high HIV prevalence. Again refugees from the neighbouring African countries also entered the country, often bringing new strains of the virus.

### **2.2.5 Rape**

In South Africa presently women have about a one in three chances of being raped in a lifetime, have among the highest sexual violence statistics in the world with obvious implications for the spread of HIV/AIDS. The genital injuries that result from forced sex increase the likelihood of HIV infection. When virgins and children are raped, the trauma is more severe and the risk of infection even higher. In cases of gang rape, exposure to multiple assailants further increases the risk of transmission (Rose-Innes 2006).

What has been observed is that the increasing numbers of rapes of female children may represent men's attempts to seek sexual relations with young girls to avoid HIV infection or because of the belief that sex with a virgin will cure AIDS.

### **2.2.6 Cultural background and HIV/AIDS**

USAID, (2001) says that certain cultural traditional and emerging modern cultural practices contribute to the spread of HIV/AIDS. For example, sexual activity begins at a young age for both females and males, either within marriage or outside of it. The researcher has observed this practice to be true amongst men and women of the areas of research.

Silanda (1999) argues that in the Zambia Sexual Behaviour Survey, of (1998) it was reported that the average age of first sex is 16.3 years for females and 16.4 for males. In Mozambique, the Demographic Health Survey (DHS) it was found that the median age for first intercourse is 16.0 years for males and 18.3 years for females.

Nwanma (2001) quoting Mr Ubon Akpan in support of the above further says that in many African cultures, adultery is considered a "female crime", while men are permitted to "parade" multiple women.

### **2.2.7 Circumcision and HIV/AIDS prevalence**

Van Howe (1999) agrees that in some cultures circumcision was part of the coming of age ritual during which the boy was taught how to relate to women and how to maintain discipline in sexual matters. He further avers that this teaching may have helped reduce high risk behaviours, now the teaching has disappeared, instead as a proof of manhood, sexual intercourse often follows soon after circumcision.

This often takes place in the commercial sex market with a circumcision wound that has not completely healed. This has resulted in circumcision fitting a coherent social pattern of restraint and has been replaced with high risk behaviours. Researchers further maintain that the use of dirty instruments and mass ritual events, including group circumcision, may increase the number of young boys developing HIV infections. Despite all the risks mentioned above, circumcision is a practise that cannot be done away with, because in many black cultures a boy is not a man unless he has undergone circumcision regardless of any circumstances.

## **2.3 What are the barriers to interventions?**

### **2.3.1. Socio-cultural issues**

Rose-Innes (2006) asserts that certain prevalent cultural norms and practices related to sexuality contribute to the risk to HIV infection, for example; dry sex where the vagina is expected to be small and dry and unprotected anal sex carry a high risk of HIV because of the abrasions to the lining of the vagina or anus.

It is further argued that in cultures where virginity is a condition for marriage, girls may protect their virginity by engaging in unprotected anal sex. On the other hand fertility in African communities may hinder the practice of safer sex because young women are always under pressure to prove their fertility prior to marriage by falling pregnant and therefore do not use condoms or abstain from sex. Fathering many children is also seen as a sign of virile masculinity.

In his report of the UNFPA, Mbugua (2000) contends that a few policies and programmes in response to HIV/AIDS are informed by the real-life situations of men and women: how they live and work in urban and in rural areas, and the complex network of relationships and structures that shape their lives. Yet, these experiences are all well-known and well documented. Both men and women live in accordance with widely shared notions of what it is to be a man, or to be a woman. These ideas he further avers, about typically feminine or masculine characteristics, abilities and expectations determine how men and women behave in various situations.

Such ideas and expectations are learned from families, friends, schools, the workplace, religious and cultural institutions, and the media and opinion leaders. Since these are learned responses, it is evident that leaders can and should play an aggressive role in changing those norms about femininity and masculinity that support the spread of HIV/AIDS.

Among the learned behaviours that make the response to the HIV/AIDS pandemic in Africa difficult are those related to power in relationships between men and women, and those related to sexuality, as well as those related to the division of labour. These need to be addressed openly and transparently by leaders to halt the spread of HIV/AIDS. With regard to power, there is a perception in many cultures that a woman's sexuality is owned not by the woman herself but by other male members of the family. Bride wealth is often the symbolic

manifestation of this perception. In too many instances, women do not exercise the choice, but are instead told, when to become sexually active, through various rites of passage, often at too early an age. They are told when and whom to marry; how to have sexual relations, which may involve using dangerous herbs; when to have children and whether or not they can use contraception; and even what to do about household expenditures. This type of male power is supported by tradition and social norms.

Women learn that their first loyalty is to kin and families, causing them to act in ways that reinforce rather than challenge their own subordination. Such control and power over women's sexuality and reproductive behaviour also leads to women's abdication of responsibility over their own sexual and reproductive health because of the powerlessness that they experience. This has dire consequences with respect to HIV/AIDS.

### **2.3.2 Low levels of condom use**

Consistent condom use, one of the few effective strategies available to prevent HIV transmission, seems to be problematic for men and in consequence for women, Hulton and Falkingham, (quoted by River, et.al. 1999) further maintained that, there is some negativity towards condoms, as well as difficulties negotiating and following through with their use. Black men in Sub Saharan Africa regularly do not want to use condoms, because of the beliefs such as "flesh to flesh" sex is equated with masculinity and is necessary for male health. Condoms also have strong associations of unfaithfulness, lack of trust and love, and disease.

Van Howe (1999) argues that the American men are reluctant too to use condoms. There is a suggestion that American men are resisting a layer of latex that would further decrease sensation from a glans already desensitized from the keratinisation following circumcision, it is also maintained that condoms are more likely to fall off the circumcised penis. This low acceptance of condoms may be responsible for the high rate of STD's in the United States, the only industrialized country that has failed to control bacteria STD's during the AIDS era. Research has shown that in some Sub-Saharan countries such as Zimbabwe, there is a high level of condom awareness however it is difficult to get married men to use condoms since condoms are considered to be for prostitutes.

### **2.3.3 Cultural stereotypes**

According to UNAIDS (quoted by Nwanma, 2001) there are cultures in the Sub-Saharan Africa that still embrace widow inheritance with or without the woman's consent. Women are socialized not to refuse sexual engagement with the husband regardless of the number of sexual relationships he might be having. This is done under the cloak of respect for the husband or any other male that commands respect by virtue of being a relative, be it an uncle, guardian, or father-in-law, at the expense of the woman autonomy. UNAIDS, 2002 further avers that, in many cultures, fathering a child is regarded as a proof of masculinity. This belief virtually proscribes condom use, providing increased opportunities for HIV infection within the family.



### **2.3.4 Stigma and discrimination**

Stigma as described by Parker and Aggleton (2003) has been described as a dynamic process of devaluation that 'significantly discredits' an individual in the eyes of others. The qualities to which stigma adheres can be quite arbitrary, for example; skin colour, manner of speaking, or sexual preference. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy.

Parker, et al (2003), further contends that stigma and discrimination have often been seen as a primary barrier to HIV prevention and the provision of treatment, care and support. They maintain that stigma and discrimination are a catch all, for the many complex barriers to addressing the disease.

They further maintain that stigma may be felt and experienced by people living with HIV and AIDS and even the assumptions of being stigmatized. Stigma negatively impacts on the psychological well-being and on the process of coping with HIV/AIDS.

In South Africa for instance, there is a well-established constitutional and legal framework supporting PLHA which is a useful backdrop to enriching non-discrimination, the expanded system of practical support for legal and right-related issues through government and civil society groups is required.

People who are infected may be reluctant to adopt behaviour that might signal their HIV-positive status to others. For example, a married HIV-positive man may not use a condom to have sex with his wife and an HIV-positive mother may continue to breastfeed her baby. Many people might not want to get tested for fear of their community finding out about their status. The violence often suffered by young homosexuals as a result of social stigma may cause them to hide their sexuality and not access information that could help protect them against HIV infection.

### **2.3.5 Lack of knowledge and misconceptions about HIV/AIDS**

Burgoyne and Drummond (2008) say that the overall levels of awareness of correct modes of transmission varied across three South African studies. Men and women in a Black South African township had fairly good HIV/AIDS knowledge overall, with 83% of participants giving correct answers on a test on the methods of HIV/AIDS transmission. Youths living in a black South African township had similar levels of HIV/AIDS related knowledge. However, very low levels of HIV knowledge were found amongst rural residents in South Africa after they had received a diagnosis of AIDS. The participants were attending support groups for HIV/AIDS, and were unemployed, had minimal education (none had completed high school), and were diagnosed because they were already showing signs of AIDS. They knew little about HIV/AIDS except for the information they had received from the mass media and word of mouth. All had heard of HIV/AIDS before their diagnosis, but knew little else about HIV/AIDS until they attended support group meetings.

The above shows that in South Africa, the majority of people have heard about HIV/AIDS and have a fairly good level of knowledge of the basic facts i.e. that the disease is spread sexually and that condoms reduce the risk. There are nonetheless still many people especially those with low level of formal education who still lack access to accurate, relevant information on HIV/AIDS and sexuality, who are unaware of the risk.

In addition to all the problems there are dangerous myths and misconceptions about HIV/AIDS. These include believing that the virus can be contracted by sharing food, that infected people can be recognized by their symptoms, and perhaps the most notorious of all, the belief that sex with a virgin can cure the disease. It is these and many others which give people a false sense of their level of risk, and contribute to the confusion about how HIV is transmitted. It is noted that a general lack of open discussion and guidance about sexuality is often lacking in the home and many young people pick up misinformation from their peers instead.

### **2.3.6 Poverty**

Cohen (2006) argues that poverty is associated with weak endowments of human and financial resources. He further purports that poverty manifests it's self in the low levels of education, low levels of literacy, very low remarkable skill if any, poor health status and low labour productivity.

High levels of unemployment and an inadequate welfare system have led to widespread poverty, which renders people more vulnerable to contracting HIV because of the following factors which are the daily struggles of survival overriding any concerns people living in poverty might have about contracting HIV.

Desperate poor people migrate in search of work and "survival" sex-work is particularly conducive to the spread of HIV/AIDS: again people living in places where death through violence or disease is commonplace, to protect one against infection is low when HIV is only one of the many threats to health and life. Poverty may also breed low levels of respect for the self and others, and thus a lack of incentive to value and protect lives.

Foreman (2000) says that any forms of intervention that are either communicated through radios, television, internet and other media hardly ever reach the poor communities where there are no health care centres, infrastructure or available drugs. Van Niekerk et. al, (2001) to emphasize the above, echoes that poverty is the social context through which HIV/AIDS thrives and as such forms a barrier to interventions. In poor communities, sex is a valuable currency, and for many women it is the only currency they have. Fifteen-year-old girls in rich countries are not usually attracted to men in their thirties and forties, because there is little that these older men can offer them. In Africa, fifteen-year old girls are seduced by the promise of luxuries they cannot afford such as clothes, cosmetics and even school fees.

As women grow older and find other means of earning a living, sex becomes more an expression of love and affection than of financial need. But as long as communities remain

impoverished and as long as women are dependent on men, men will offer money or presents to get the sex they want and women will offer sex to get the resources they need.

### **2.3.7 Commercialisation of sex**

Rose-Innes (2006) contend that in the South African culture it has become prominent that sexuality is frequently seen as a resource that can be used to gain economic benefits which undoubtedly contributes towards the HIV/AIDS epidemic. The growth and development of a relatively affluent black middle class with a desire for material goods and a sexual culture that associates sex with gifts is fast growing to be a problem.

These men gain social prestige by showing off material possessions and being associated with several women. Young women are often persuaded to have sex with “sugar daddies” older, wealthier man in exchange for money or gifts. Young women infected with HIV by sugar daddies then infect younger men, who in turn infect other young women and in time become HIV-positive older men themselves.

## **2.4 Practical intervention to alleviate men’s behaviour towards HIV/AIDS infections.**

### **2.4.1 HIV/AIDS programmes should be developed and be inclusive of men**

Nwanma (2001) argues that Nigeria’s control trade-union federation believes that a lot of attention should be given to men in the struggle to control the disease. Nwanma goes on to say that such examples of positive action could be in line with the “Man Make a Difference” campaign of the joint UN Programme on HIV/AIDS (UNAIDS) and other anti-AIDS organizations. The goal must be to complement prevention programmes for women and girls with work that more directly involve men as well. UNAIDS report, further emphasizes that the time is ripe to start seeing men not as some kind of problem, but as part of the solution.

### **2.4.2 Cultural practices that alter men’s behaviour**

Nwanma (2001) agrees with Nwankwo of the Women Leadership Group a non-governmental organization (NGO) in Nigeria, and believes that aspects of traditional culture can themselves be utilized to alter men’s behaviour. She further argues that although men exercise considerable power over women in traditional African cultures, those norms also obligate men to take care of their wives, children and other family members, after all “real men protect women from HIV/AIDS”.

Foreman (2000) contends that men’s sexual behaviour is deeply rooted in the cultures they grow up in. Boys grow up believing that it is “natural” for men to have frequent sex and that having many sexual partners is a sign of virility. Girls grow up believing it is their “duty” to satisfy men. Both men and women perpetuate these attitudes men by the examples they give and women by accepting them.

Traditional polygamy gave men authority over their wives, but when it was respected, it limited the likelihood of transmission of disease. Today in many communities traditional

polygamy has often given way to an informal version, where a man's right to have more than one wife is often interpreted as right to as many women as they wish.

### **2.4.3 Pushing condom use**

Countries like Nigeria have taken a practical approach after observing that women are at a disadvantage in negotiating sexual relations with men and are using such organizations as the NLC to try and convince men who belong to its affiliated unions to use condoms. In the same country the labour federation seeks to help its members identify the dangers and issues involved with wayward male behaviours.

Men are helped to reach their own conclusions and make their own decisions about the spread of HIV/AIDS. These organizations as they have big membership of trade unionists, teachers, and non-academics staff at educational institutions etc. are in a unique position to carry the anti-AIDS message down to the grassroots level.

### **2.4.4 The involvement of churches**

Mershak (2004) in a conference held in Bangkok, Thailand reported that the church has over the years been important to society generally in terms of information dissemination towards behaviour change, however about 20 years into the HIV/AIDS pandemics, the church in Africa especially Nigeria has lagged in its role of making accessible HIV/AIDS information to members and the society at large.

The Aid for AIDS/Design for the Family (AFA/DF) a project of Scripture Union Africa region works with schools and churches in making HIV/AIDS information accessible to the society in over 26 countries in Africa. Recently its survey among, 886 church ministers drawn from the 6 geopolitical zones in partnership with SIM pastors Book set project revealed that: 40% of the ministers agreed that church response has been slow, 46% said they rarely carried out HIV/AIDS campaigns in their churches. 5.5% said they had never attempted HIV/AIDS education in their churches. The observation of Health week by the churches was adjudged helpful in making HIV/AIDS information accessible to the members agreed 89%.

The ministers think the most important issue in HIV/AIDS in the church is sex education 44%. Churches in Nigeria are yet to utilise the opportunities for HIV/AIDS information dissemination as they are a force for behaviour change in the society. If "access for all" is to be achieved, churches must play their role in information dissemination in the community focusing on sex education and declaring "Health week" at all levels in Nigeria, Africa and the world in general.

Reverend Warren D, of the Regional AIDS Interfaith Network, (quoted by Pelley, S. 2009) speaking from the pulpit said ministers can frame attitudes of love and acceptance rather than judgment. To promote that change, Warren founded RAIN in 1992, to bring ministers together and try to change attitudes.

Slowly, African-American ministers are beginning to recognize the urgent need to take action on the HIV-AIDS epidemic in the black community. In the five years that Friendship Baptist has offered on-site services, Jones says only 50 to 60 church members have been tested for HIV at church. Pastor Alexander maintains that the church must step forward and clarify it as a disease like any other disease.

From the above it is clear that churches are to be involved as they are also meeting believers every Sunday. Some churches already have started educating its members about the dangers of HIV/AIDS. Men are far more likely to infect women with HIV/AIDS than the other way round. Some churches make HIV/AIDS testing a precondition for a marriage it conducts, so that those who are innocent do not enter into trouble unknowingly. Churches are also in a position to teach men that the purpose of marriage is not only sex and that men should honour their wives and give them due respect.

#### **2.4.5 Women's empowerment is crucial**

The empowerment of women is fundamental for reducing their vulnerability to infections. Women have less control over sexual communication, a substantial number of programmes have concentrated on work to empower girls and women but these seem to fail to be inclusive of boys and men (Mbizvo and Basset 1996).

Although there are still no clear-cut answers and there is very little data to establish the impact of the efforts that have been tried, it is possible to look back and identify clear-cut categories of approaches that fall at different points on a continuum from damaging to empowering.

Rose-Innes (2006), contends that health and education sectors should work together to develop prevention programmes in schools which enhance awareness of gender inequality among boys and school staff, as well as girls themselves. These should expand to reach girls and boys who do not attend school. This is expected to reduce girl's continuing vulnerability to violence, coercive sex and HIV infection.

Gupta (2000) says that providing women with a female condom or a microbicides is an example of such programming. It recognizes that the male condom is a male-controlled technology and it takes account of the imbalance in power in sexual interactions that makes it difficult for women to negotiate condom use by providing women with an alternate, woman-initiated technology.

Efforts to integrate STD treatment services with family planning services to help women access such services without fear of social censure is another example of such an approach. We know that such pragmatic approaches to programming are useful and necessary because they respond to a felt need and often significantly improve women's access to protection, treatment, or care.

It is further contended that other programs that seek to transform gender relations include efforts to work with couples as the unit of intervention, rather than with individual women or

men. Couple counselling in HIV testing clinics to help couples deal with the results of their tests and in family planning programs that promote dual protection against both unwanted pregnancy and infection are recent examples of efforts that seek to reduce the negative impacts of the gender power imbalance by including both partners in the intervention.

- To empower women we must:
- Educate women. Give them the information they need about their bodies and sex. Information is power and women have the right to receive it.
- Give women the skills they need to use a condom. Make them condom literate. Provide skills training on communication about sex and foster inter-partner communication.
- Improve women's access to economic resources. Ensure that they have property and inheritance rights, have access to credit, receive equal pay for equal work, and have the financial, marketing and business skills necessary to help their businesses grow.
- Have access to the agricultural extension services to ensure the highest yield from their land, have access to formal sector employment, and are protected in the informal sector from exploitation and abuse.
- Ensure that women have access to health services and that they have HIV and STI prevention technologies that they can control, such as the female condom and microbicides. And support the development of an AIDS vaccine that is safe, effective, and accessible to women and young girls.
- Increase social support for women who are struggling to change existing gender norms by giving those opportunities to meet in groups, visibly in communities; by strengthening local women's organizations and providing them with adequate resources; and by promoting sexual and family responsibility among boys and men.
- Move the topic of violence against women from the private sphere to the public sphere. This is not a personal issue it is a gross violation of women's rights and is has significant negative implications for the health of communities and for economic development.
- And, to give women a voice, provide them with the opportunity to create a group identity separate from that of the family because for many women the family is often the social institution that enforces strict adherence to traditional gender norms; and promote women's decision-making at the household, community, and national level by promoting women's leadership and participation. (Gupta 2000)

## CHAPTER 3 RESEARCH METHODS AND PROCEDURES

### 3.1 Introduction

This chapter deals with hypotheses, sampling, instruments, and administration of questionnaires and data analysis techniques. The purpose for the research is to determine the relationship between the women's vulnerability to HIV/AIDS in the rural areas of Corana, Qokolweni and Zimbane and their cultural background and the effects of men's sexual behaviour on them. The aim of the study is to find out those aspects which might expose these women and render them vulnerable to HIV/AIDS and possible ways of reducing this vulnerability.

### 3.2 Hypotheses

#### 3.2.1 Research questions

The literature review and observation of boys/men behaviours with their partners has raised a number of questions, namely:

**Question 1:** Is there a relationship between the cultural background, socialization of boys/men and women's vulnerability to HIV/AIDS?

**Question 2:** Is there a relationship between the circumcision of boys to manhood and the development of HIV infection for both men and women?

**Question 3:** Is there a relationship between low levels of condom use by adolescent boys and men and women's vulnerability to HIV/AIDS?

**Question 4:** Is there a relationship between women's economic status and their vulnerability to HIV/AIDS?

The literature review, observations and assumptions of black adolescent boys and men's behaviour in as far as their sexual activities are concerned, have helped the researcher to formulate the following research hypotheses:-

**Hypotheses 1:** There is a relationship between the cultural background (socialization) of boys to manhood and the development of HIV/AIDS infection on both men and women.

**Hypotheses 2:** There is a relationship between the circumcision of black adolescent boys and men and the development of HIV/AIDS infection for both men and women.

**Hypotheses 3:** There is a relationship between low levels of condom use by adolescent boys and men and women's vulnerability to HIV/AIDS infection.

**Hypotheses 4:** There is a relationship between women's economic status and their vulnerability to HIV/AIDS infection.

### **3.2.2 Null Hypotheses**

The above hypotheses have been reformulated as null hypotheses. The researcher's findings will either accept or reject the null hypotheses. The null hypotheses are formulated as follows:

**Null Hypotheses 1:** There is no relationship between cultural background (socialization) of adolescent boys and men and women's vulnerability to HIV/AIDS.

**Null Hypotheses 2:** There is no relationship between the circumcision of adolescent boys and men and the development of HIV/AIDS infection for both men and women.

**Null Hypotheses 3:** There is no relationship between the low levels of condom use by adolescent boys and men and women's vulnerability to HIV/AIDS.

**Null Hypotheses 4:** There is no relationship between women's economic status and their vulnerability to HIV/AIDS.

### **3.3. Selection of research sites and sampling**

#### **3.3.1. Sampling method**

Because of the problems that may occur if the sampling is not correctly done or is done haphazardly, the researcher has to be very careful. Larry (2007) argues that haphazard sampling is a non-probability sampling where the participants' selection is based on convenience because it invariably includes participants that are readily available. For the purpose of generalization and inference the researcher had to avoid haphazard sampling technique but instead used random sampling in view of the constraints and limitations as sighted above.

The randomization was of benefit to the researcher in that it is a control technique that makes all participants equal in their groups by making sure that every member in the group is given equal chance of being assigned to or being a group member. (Larry 2007).

According to Ferguson (quoted by Larry, 2007) further emphasizes that random sampling is such that every member of the population has equal probability of being in it. It is further averted that the use of this random selection technique ensures that the sample is representative of the population from which it was drawn. This gives the researcher a chance after looking and evaluating all the probabilities to generalize the results of the experiment back to the population. The term "random" itself, theoretically refers to assumption about equal probability of events.

#### **3.3.2 Sampling size**

Out of 600 males from 3 rural communities of the Eastern Cape, Mthatha, the researcher randomly selected 180 males, which is approximately 30 per cent of the male population. It was not possible to engage 600 males in these 3 rural communities because of finance, time constraints and the availability of the participants themselves.



The researcher singled out 30 adolescent boys and 30 men in each rural village namely: Corana, Qokolweni and Zimbane. This made a total population of 60 participants from each village.

The researcher decided on the 30 per cent sample size because of the probability of a false null hypotheses being rejected on the basis of power. Larry (2007) argues that the power increases as the number of participants increases. The researcher opted for 180 males on that basis.

### **3.3.3 Data collecting methods**

Qualitative methods were used. Various methods of data collection were necessary because of the nature of the study; these were interviews, naturalistic observations and documentary analysis.

This is so because in these rural communities many of the participants cannot read nor write. The level of illiteracy among the participants made the researcher to explore these various methods as it is argued that more than one sources result in a good research study (Finn 1994)

## **3.4 An overview of the data collecting methods used**

### **3.4.1 Interviews**

The researcher used a face to face method. The participants were interviewed at their houses in their normal environment. With the illiterate people this method does not intimidate them much, this also allows for both confidentiality and the ease of expression. This as opposed to the telephone method which is rather expensive and as Groves, Fowler, Couper, Lepkowski and Singer (2009) suggest that, the telephone method is about half as expensive as the face to face interview. Rogers (1976) supports the above and further argues that information collected through the telephone method is comparable to that obtained through face to face.

Larry (2007) maintains that the survey is a method of collecting standardized information by interviewing a representative sample of a population. The various methods of collecting survey data include personal interview, which is face to face, telephone method, mail method and electronic survey.

The telephone seems to be one of the easier, more efficient and more adequate but the level of development and infrastructure in these communities would hinder progress as the telephones are still a luxury that people still aspire for. This is the case with the mail method and all the various electronic surveys like then e-mail and the web based survey

### **3.4.2 Naturalistic observation**

This is a technique that enables the investigator to collect data on naturally occurring behaviour, as the participants are in their natural environment, Larry (2007). Due to time constraints the researcher could not spend much time on this method, nevertheless, much has been gained out of it, because here the researcher was able to catch the participants at their base. The idea was to observe issues of gender inequalities as they unfold within the

community setting through behaviours that men do to make women vulnerable just because they are born women and are socialized to believing that they are inferior. It is these behaviours that render women vulnerable.

Naturalistic observation enables the observer to remain unobstructed when recording natural behaviours and participants actions are not artificial. They do things they naturally do in their day to day life. Larry (2007) argues that naturalistic observation does not only provide a description of the characteristics and range of behaviours, but also the significance of the behaviours.

### **3.4.3 Documentary analysis**

Documentary analysis is very involved in that it covers a broad analysis of events. To cover the needs of this particular research, the researcher used the Health Care Centre which is situated at Qokolweni Administrative Area which is used by the neighbouring villages.

The aim was to get to know whether these centres in their records do not have any information about (ulwaluko) circumcision school where young men are normally sent every school holiday to be circumcised and be taught about manhood. This is of interest to the researcher as these young men are observed to show a lot of arrogance and show off in as far as their manhood is concerned after this ritual.

These Health Care Centres are primarily manned by women; they are also supposed to be a primary source of documentary data and literature review with different books and programmes on HIV/AIDS, documents on men's behaviour. The real aim is to get any documentary evidence on the programmes that these young men are exposed to at the initiation schools. These were sourced as secondary sources of documentary data. Documents on the programmes they go through at the schools are very limited, very little is documented to this effect. The researcher had to rely on oral literature for this specific regard.

With all the limitations that the researcher encountered, this method of data collection is recommended as it allows the researcher to obtain information through unobstructive research.

### **3.4.4 Type of questions**

Here questionnaires were structured into two categories, viz:-

the open ended questions

the close ended questions

They were structured so that they answer the researcher's questions about men's behaviour, socialisation, susceptibility to HIV/AIDS, cultural background, low levels of condom use, cultural stereotypes regarding gender inequalities and roles.

The open ended questions were used to enable the participants to answer in any way they please. The answers were written down by the researcher. The use of this type of questions

enabled the researcher to get to the underlying issues in answering the research questions. At this level participants do not just give answers to questions but have space to elaborate more on their personal experience and knowledge as gained through socialization or historical background.

## **CHAPTER 4 DATA ANALYSIS**

### **4.1 Introduction**

The study looked at the answers from the participants and interpreted the data collected. There was further analysis of the population and then the sample that was used for the research.

### **4.2 Analysis and interpretation of the participants biographic data**

This is an overview of the research population. Three communities in the rural outskirts of the Mthatha district were identified for the purpose of the study namely: Qokolweni, Corana and Zimbane administrative area. These communities have high levels of illiteracy, unemployment, poverty and are ravaged with HIV/AIDS prevalence.

At Qokolweni administrative area there is one Junior Secondary School and a Senior Secondary School. Under normal circumstances this community is supposed to be having children at school and the question of illiteracy would be answered. This is not the case though because the level of illiteracy in this area which has approximately 250 homesteads with an average of 5 children per home is very high. What has been observed is that these children do get to primary school but 45% of them drop out at Grade 6 mainly because of lack of school amenities. It is evident in some rural schools that very few learners get to high school level; this is the case even with this community. This in all perpetuates the levels of illiteracy.

This is an underdeveloped area with no health care centre and infrastructure such as electricity, running water and telephones. Out there the fields are lying fallow except for a few which seem to have yielded the previous year. There is no evident production which may bring food to the homes. People here are unemployed and lack the skills which may make them employable. Men and young initiates from circumcision schools sit around homestead kraals and periodically visit local shebeens; this could lead one to conclude that men lack any substantial form of work or duty.

At Corana there is a Junior Secondary school and no high school at all, unlike the above area where at least there is a high school. This is a very big area with approximately 400 homesteads with an average of 5 children per homestead. The level of illiteracy is very high ranging between 60–70%. There is also evidence of underdevelopment and lack of infrastructure. The level of unemployment amongst the men is approximately 60 per cent and they lack skills which could render them employable, this makes them fully depend on seasonal jobs.

The Zimbane Administrative Area is no exception to the above. This area is ravaged by unemployment, poverty, illiteracy and lack of infrastructure.

What is common in the three communities is that men are holding high societal positions in their churches, community structures and overall running of the community. They are poverty stricken due to unemployment and underdevelopment.

### **4.3 Demographic profile**

#### **4.3.1 Total population**

The total population of men in the (3) three administrative areas of the study is 600 distributed amongst the 3 administrative areas.

#### **4.3.2 Gender**

For the purpose of this study the researcher concentrated on the males of the (3) three administrative areas of the Mthatha district which are Qokolweni, Corana and Zimbane.

#### **4.3.3 Age group**

The study covers men ranging between 15–45 years which forms part of the sexually active group.

#### **4.3.4 Educational level**

The study established that 90% of the participants have very low levels of literacy with 60% unable to read and write and 10% have grade 6 as their highest level of education whilst 10% have at least passed grade 12.

#### **4.3.5 Social background**

The study revealed that 80% of the participants are married and 30% are in polygamous relationships. The study revealed that 15% of those men involved in polygamous relationships are with girls far younger than themselves whilst 20% of the participants are single and are also in multi-sexual relationships.

The study also indicated that 30% of the participants were employed in permanent jobs. It was further discovered that 40% of these men have been in short term or seasonal kinds of employment that were not sustaining them. Their employment was either dependent on availability of jobs to be done or is just seasonal. The last 30% of these men were not employed at all, however they were subsistence farmers who had few livestock and were growing some vegetable and mealies.

### **4.4 The relationship between the behaviour of men and the HIV/AIDS prevalence**

After assessing the relationship between the behaviour of men and the HIV/AIDS prevalence, the researcher observed that the men's behaviour manifests itself in the following:

- 1 Gender inequalities and male dominance
- 2 Behavioural patterns
- 3 Cultural background and socialization
- 4 Physical and social violence
- 5 Rape

#### 4.5 How does the behaviour of men fuel HIV/AIDS prevalence?

The participants were asked whether there is a discussion with their partners prior to sexual intercourse. It was established that 20% of the participants do have discussions with their partners before they engage in sexual intercourse whereas 70% were saying culturally, engagement in sexual intercourse is a man's prerogative, so they do not discuss anything with the woman and 10% said discussions are dependent on their mood for that particular day and that they were never socialized to discuss sexual intercourse.

- *The participants were asked whether they were not aware that the use of condoms would assist in lowering the HIV/AIDS prevalence.*

It was established that 75% of the participants did not know of any correlation between condom use and HIV/AIDS and have never used a condom before and 5% were using condoms and were keen to use them though in their area this was not regular due to unavailability of these condoms. They thought if condoms could be made available all the time and used regularly, this could help prevent the spread of HIV/AIDS. Twenty per cent were saying when growing up parents never told them of any condoms and were not prepared to use any condoms. They were not socialized in condom use.

- *The participants were asked whether they feel women should have a say in matters involving sexual intercourse.*

The study revealed that 80% said culturally women are to listen and obey men in everything so sexual intercourse is no exception. About 10% felt that women could also have a say whilst 10% was just indifferent not keen to reveal their feelings to this.

- *The participants were asked how they solve conflicts within their families*

The study showed that 80% of the participants felt that it is difficult to discuss anything with women because they shout so they are forced to beat them up to silence them. About 15% said that culturally men take decisions when there is a problem as they are the heads of families and 5% said they engage women in problem solving so as to resolve family conflicts.

- *The participants were asked whether they feel that rape perpetuates HIV/AIDS prevalence.*

It was established that 50% answered that when they rape a virgin they are cleansing themselves of HIV/AIDS whilst 30% felt that the way females dress may make them feel like raping them and that they see no correlation between rape and HIV/AIDS. Twenty per cent said that rape does perpetuate HIV/AIDS prevalence.

- *Participants were asked whether they would use condoms if their partners would bring them with a view to using them as a measure of HIV/AIDS prevention.*

The answer from 60% of the participants was that they would not use condoms brought to them by women as women know nothing about sex and have to listen and do as their male partners instruct them to do. About 20% felt that they could try them and 20% felt condoms

would not give them the satisfaction they deserve from sexual intercourse and that they do not know anything about HIV/AIDS prevention.

- *Participants were asked whether being in a polygamous relationship contributes towards the spread of HIV/AIDS*

Seventy per cent of the participants perceive polygamy as posing no problem, for polygamy has been a cultural practice for generations and has posed no problem therefore they do not see how it could suddenly be a threat to anyone. About 20% said engaging in polygamous or multi-sexual relationships spreads HIV/AIDS, whereas 10% felt that regardless of a person's sexual orientation in this case a polygamous or monogamous relationship, HIV/AIDS is HIV/AIDS and everyone would definitely contract it.

- *The participants were asked whether they do engage in dry sex and how their partners fell about dry sex.*

Sixty five per cent answered that they know dry sex and have engaged in it sometimes. They love it because it increases their satisfaction though their partners do not approve of it because they reckon it's painful to them. Twenty five per cent said that they do not care about how partners feel about dry sex, they themselves love it and 15% were sensitive to the women's feelings and answered that though they would love trying it, they do not love to offend their partners.

- *The participants were asked whether they perceive sex on demand as a marriage deal.*

Eighty per cent said that sex on demand is a sign of love and affection and shows male or gender identity, whilst 16% said that sex on demand is not a marriage deal. On the other hand 4% said sex is a man's prerogative and that they should demand it as and when they need it.

#### **4.6 Barriers to interventions**

- *The participants were asked whether they feel polygamy should be stopped during this era of HIV/AIDS*

Fifty five per cent answered that there is no correlation between HIV/AIDS and polygamy. Thirty per cent said males are biologically programmed to need sex with more than one woman so they cannot stay and have sex with one woman, whilst 15% felt this is a matter which needs attention and discussions with community members.

- *The participants were asked if they do not perceive a risk of contracting HIV/AIDS when engaging in sexual intercourse without using a condom.*

Seventy two per cent perceived no risk and they further maintain that condoms have strong associations with love and lack of trust. Twenty three per cent felt that their partners would not infect them and five per cent were indifferent.

- *The participants were asked whether there is a relationship between widow inheritance and HIV/AIDS prevalence*

Seventy six per cent answered and said that it is an African culture to inherit a widow within the same family so that she can continue bearing children for the family and this practice has nothing to do with the spread of HIV/AIDS, whilst twenty four per cent felt men are just greedy for women and agreed that this practice could perpetuate the disease.

- *The participants were asked whether they could go for voluntary counselling and testing and if not, why?*

Eighty per cent answered that they would never go for VCT for fear of stigma and discrimination. Fifteen per cent on the other hand felt that if they would be assured of secrecy or if testing would be done in a clinic that is not within the same community they would consider it. Five per cent felt they would go for testing especially if they would be counselled prior and after testing so as to know what to do if they are found positive.

- *The participants were asked on how they get information pertaining to HIV/AIDS*

Sixty per cent revealed that they are only informed at the Health Care Centre's and twenty per cent said that they heard about HIV/AIDS when they visited the hospital. Another Twenty per cent said they heard about HIV/AIDS from the radio.

- *Participants were asked who they perceive to be at risk of contracting HIV/AIDS*

Seventy five per cent thought that it is prostitutes and men who sleep with other men who are at risk. Fifteen per cent felt that miners and truck drivers and other people who work away from their families were at risk. Whilst ten per cent said that anyone who is not faithful to his/her partner or anyone who does not use a condom is at risk of contracting HIV/AIDS.

- *The participants were asked whether they feel prejudiced by living in the outskirts, in as far as HIV/AIDS knowledge is concerned.*

Sixty eight per cent feels that their living in the outskirts prejudices them in as far as gaining information about HIV/AIDS. Thirty per cent do not feel prejudiced at all whilst two per cent feel that being in the outskirts has nothing to do with HIV/AIDS

- *The participants were asked their view about falling in love with young girls with regards to the spread of HIV/AIDS.*

Eighty per cent did not see a problem with sleeping with young girls though they are aware that the young girls are bound to have other younger partners. Another 20% said young girls with older men could spread HIV/AIDS through the exchange of partners and therefore sleeping with young girls was wrong.

#### **4.7 Findings**

The study has established that the males of the (3) three communities of Mthatha district namely: - Qokolweni, Corana and Zimbane administrative areas have a behaviour which perpetrates women's vulnerability and therefore fuels HIV/AIDS prevalence. From the responses given by participants it is clear that they do not use condoms because they see no



correlation between condom use and HIV/AIDS. This is based on their cultural beliefs that to use condoms is to be western, whereas they want to father a number of children to show their masculinity.

Eighty per cent felt that they need not negotiate sex with partners because women have a low status in the social structure. Rape is viewed by men as something they do because women are asking for it through their dress code and like behaviour. Dry sex and sex on demand as a marriage deal, also contributes to factors that leave women vulnerable thus fuelling HIV/AIDS prevalence. The issue of polygamous relationship also prevailed with 70% of participants embracing such practices.

Barriers to interventions have been established inter alia as lack of knowledge and misconceptions about HIV/AIDS, with 75% of participants perceiving that it is the prostitutes, miners and truck drivers who are at risk of contracting HIV/AIDS. The issue of stigma and discrimination formed part of the barrier to intervention hence 80% of the participants said they would never go for VCT for fear of stigma and discrimination.

The behaviour of Black South African men in the communities which formed part of the research study have been found to fuel the HIV/AIDS prevalence and is therefore a barrier to HIV/AIDS.

## CHAPTER 5 RESULTS OF THE STUDY

### 5.1 Summary

The study investigated the effects that behaviour of black South African men of the Mthatha district has on HIV/AIDS prevalence.

The main aim was to look into the nature of the different behaviour patterns shown by men which lead to women's vulnerability to HIV/AIDS. Naturalistic observations and interviews to prove whether the adolescent boys and men's behaviour could bring to the fore their social backgrounds based on their cultures.

The second purpose of the study was to find out whether circumcision of adolescent boys to men had any impact on the development of HIV/AIDS.

The third purpose of the study was to find out whether the low levels of condom use by adolescence boys and men could result in the vulnerability of women to HIV/AIDS infection. Interviews were used in this regard were participants gave verbal answers to questions.

The following null hypotheses were formulated:

- (i) There is no relationship between the cultural background and socialization of adolescent boys and men and women's vulnerability to HIV/AIDS.
- (ii) There is no relationship between the circumcision of adolescent boys to manhood and the development of HIV infections for both men and women.
- (iii) There is no relationship between the low levels of condom use by adolescent boys and men and women's vulnerability to HIV/AIDS.
- (iv) There is no relationship between women's economic status and their vulnerability to HIV/AIDS.

The instruments used were:

- (i) Surveys and the naturalistic observations to trace the social background and behaviour patterns of the participants.
- (ii) Questionnaires for those participants who could read and write to determine condom use, cultural background, socialization, and their economic status compared to that of their partners were administered.
- (iii) Documentary analysis for the researcher to understand the participant's behaviours more accurately.

Questions administered on the chosen sample in each area were scored and analysed, the researcher visited the participants at their homes and the interviews were conducted at their naturalistic venues.

The study revealed the following about the hypotheses:

- (a) There is a relationship between cultural background and socialization of adolescent boys and men and HIV/AIDS prevalence.
- (b) There is a relationship between the circumcision of boys and men and the perpetration of HIV/AIDS prevalence.
- (c) There is a relationship between low levels of condom use by adolescent boys/ men and women's vulnerability to HIV/AIDS infection.
- (d) There is a relationship between women's economic status and their vulnerability to HIV/AIDS.

## **CHAPTER 6 CONCLUSION AND RECOMMENDATIONS**

### **6.1 Introduction**

Reflecting back on the study it is clear that there are effects that male behaviour has on the spread and prevalence of HIV/AIDS in the rural villages of Corana, Qokolweni and Zimbane, as the objectives and the conclusion show from the findings of the study.

### **6.2 Conclusion**

The Literature review on men's behaviour has been done with special reference to the effects such behaviour bears on the vulnerability and susceptibility of their female partners to HIV/AIDS. The study revealed that issues of gender inequalities, socialization, cultural values and norms, condom usage, rape of female virgins are all underlying issues that female partners have to put up with and are struggling with on a daily basis in their fight against HIV/AIDS prevalence (River et.al. 1999).

The cultural norms and values, such as polygamous relationships, lack of infrastructure, like clinics, results in communities not being exposed to information, getting marginalized and isolated thus creating barriers to interventions. Polygamous relationships and age mixing render women voiceless and increase their risk of contracting the disease (Parker et. al., 2006).

The women's inability to exercise control over their sexuality has been evident amongst the participants, suggesting that there is a need for a multi-faceted approach in trying to curb the spread of HIV/AIDS. Within the confines of marriage, women are often no longer in control of their own bodies, as they are expected always to consent to having sex. In many countries, there is no legal recognition of rape within marriage. Sex for women is more closely linked to reproduction than for pleasure (De Kat-Reynen 2001).

With the high HIV/AIDS prevalence the challenge is what can be done to empower women so that they can have voice especially rural, illiterate women. This is important because as long as men are still perceived as having a high social ranking, their behaviours will always manifest themselves negatively in issues involving females. Men's bossy attitudes need a paradigm shift, something which can never be realized overnight. This problem is now very glaring especially with the advent of HIV/AIDS.

It became very obvious during the interviews that the intervention process should be made to suit different communities, thereby taking cognizance of the diverse cultural beliefs and social levels that people find themselves in.

The study has further established that the poor rural communities of Corana, Qokolweni and Zimbane have deep rooted cultural beliefs that are embraced by men at the detriment and expense of women and these manifest in negative male behaviours which when put together fuel the spread of HIV/AIDS.

Poverty and illiteracy seem to perpetuate female dependency on men deeming females more and more susceptible and vulnerable to HIV/AIDS and it is clear that marriages do not form any protection against HIV/AIDS to married women, as the husbands engage in multi sexual relationships that go unchallenged.

### **6.3. Recommendations**

The following recommendations and suggestions are made on how to intervene in the HIV/AIDS prevalence:

- There is an urgent need to empower both men and women and that should be linked with the HIV/AIDS programmes.
- Support groups should be established were men and women meeting to share and educate each other outside the home environment on the mechanisms of dealing with HIV/AIDS.
- Health care centres are a necessity especially for the rural people where access to information is limited to the extent of being streamlined to gossip.
- Sustainable projects related to HIV/AIDS need to be established and be monitored and evaluated to make sure that their modus operandi is not lost.
- People are dying in large numbers old and young, so the government needs to commit money, personnel and time to work vigorously both on preventative and sustainable means of fighting the spread of the disease and this the involvement of communities themselves.
- Great care should be taken to educate men, at the same time women should be also involved so that their mind set may change.
- A strong activism is necessary against women and children's violence and abuse. This should not be a once off affair. People need to be made conscious of this abuse until they internalise what is expected of them.
- Socio-culturally people are exposed differently, taking this into consideration; programmes should be adopted and adapted to suit peoples various needs. This could be possible only if the local people could be also being fully involved in the development of such programmes.

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Addenda

Addendum A.

**THE EFFECT OF THE BEHAVIOUR OF BLACK SOUTH AFRICAN  
MEN OF MTHATHA DISTRICT ON HIV/AIDS PREVALENCE**

**INTERVIEW QUESTIONS FOR THE PARTICIPANTS**

**BY:** Nomava Madikizela

**SUPERVISOR:** Prof. Johan CD Augustyn

**STELLENBOSCH UNIVERSITY**

This interview was conducted for research purposes, upholding high levels of confidentiality and respect for the participant's dignity / great cognisance of the level of literacy amongst the participants has been taken care of. The questions were administered orally and the responses were also orally.

Date: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**PRE-TEST FOR YOUNG ADULT MALES**

Questions were carefully translated to mother tongue for the participants one by one for easy and better understanding. The researcher explained why the survey was conducted i.e. to improve the participant's status and to educate young boys and young men on HIV/AIDS infection and prevention. It was explained that their participation in this survey is important and is completely voluntary. If they agree to answer these questions, they will answer questions regarding themselves, their ideas, attitudes and behaviour regarding different aspects of HIV/ AIDS spreading and prevention. Their answers would be kept confidential and only the researchers and study personnel would have access to this information. The researcher had to complete questionnaires herself and be kept in such a manner as to guarantee their privacy.

An X mark will indicate that they agree or a blank will be left if you do not agree.

I agree to answer the questions and do so in a completely voluntary manner. I understand that my responses will be kept confidential.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Year: \_\_\_\_\_

**Cultural Background (Socialisation)**

<p>1. When there is a problem with your partner do you talk or do you report to the elders</p>	<ul style="list-style-type: none"> <li>• Don't talk about it</li> <li>• Used to talk but stopped</li> <li>• Talk about the problem between the two of us</li> </ul>
<p>2. Why do you find it hard to communicate problems with women</p>	<ul style="list-style-type: none"> <li>• Men are men don't need any advise</li> <li>• Women do not understand issues</li> <li>• They shout and fail to reason</li> </ul>
<p>3. Are you in polygamous relationship?</p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
<p>4. Do you think it is necessary to have more than one partner? Why? (They need to explain themselves)</p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
<p>5. During the HIV /AIDS era do you think widow inheritance could still be done? Why?</p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
<p>6. Why should widows be inherited</p>	<ul style="list-style-type: none"> <li>• To bear more children</li> <li>• So that they get lovers within the family</li> <li>• So that the bride price that was paid is not wasted.</li> <li>• No one should be inherited.</li> </ul>

### Circumcision of Adolescent Boys and Men

1. If you are given a chance would you go for voluntary counselling and testing, if not why?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
2. How do you get to know about HIV/AIDS?	<ul style="list-style-type: none"> <li>• At the clinic</li> <li>• At the circumcision school</li> <li>• Nowhere</li> <li>• T.V.</li> <li>• Radios</li> </ul>
3. Do you feel prejudiced by living in the outskirts, in rural areas in as far HIV/AIDS is concerned?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
4. What are the lessons taught at circumcision school?	<ul style="list-style-type: none"> <li>• Manhood</li> <li>• Behaviour</li> <li>• Nothing specific</li> </ul>
5. Who do you perceive to be at risk of contracting HIV/AIDS?	<ul style="list-style-type: none"> <li>• Uncircumcised boys</li> <li>• Men who sleep with men</li> <li>• Men with many women</li> </ul>

## Condom Use

1. Have you ever been educated about family planning? By who?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Clinic</li> <li>• Hospital</li> </ul>
2. Do you know of any family planning method?	<ul style="list-style-type: none"> <li>• Pills</li> <li>• Injection</li> <li>• Loop</li> <li>• Condom</li> <li>• None</li> </ul>
3. Are you aware that condom use can minimize / lower the spread of HIV/AIDS? Explain.	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No.</li> </ul>
4. How often do you use a condom during sexual intercourse?	<ul style="list-style-type: none"> <li>• Sometimes</li> <li>• Always</li> <li>• Never</li> </ul>
5. Would you engage in sexual intercourse without a condom?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
6. Are condoms easily accessible in your locality?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
7. Do you feel comfortable/embarrassed using a condom during sexual intercourse?	<ul style="list-style-type: none"> <li>• Not at all</li> <li>• Sometimes</li> <li>• Yes</li> <li>• No</li> </ul>
8. Would you use condoms regularly if they were always accessible?	<ul style="list-style-type: none"> <li>• On demand</li> <li>• When available</li> <li>• Never</li> <li>• Yes</li> </ul>
9. Are you aware that engaging in sexual intercourse without a condom puts you at risk of contracting HIV/AIDS?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No.</li> </ul>
10. Do you believe having sexual intercourse with a young girl (virgin) cleanses one of HIV/AIDS	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
11. Are you aware that having sex with young girls without a condom perpetrates HIV/AIDS?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>

**Women's' Economic Status**

1. Do you know that a woman has a right to say "no" to sexual intercourses?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
2. Do you think that a woman is obliged to engage in sexual intercourse with a man?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• When she wants to</li> </ul>
3. Do you expect your partner to bring a condom when you are to get engaged in sexual intercourse?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
4. Do you believe in giving your partner an opportunity to express her needs concerning sex? (Explain)	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No.</li> </ul>
5. Do you think women are more susceptible to HIV/AIDs? Why?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
6. Do you believe that women accept having sexual intercourse with man for getting support in return?	<ul style="list-style-type: none"> <li>• Some do.</li> <li>• Not at all</li> <li>• Yes</li> </ul>
7. Child bearing- What is your perception of women and sex	<ul style="list-style-type: none"> <li>• They sleep for money</li> <li>• They also enjoy sex</li> <li>• They love having children</li> </ul>