GENDER ROLES IN THE AFRICAN CULTURE: IMPLICATIONS FOR THE SPREAD OF HIV/AIDS

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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety, or in part, submitted it for obtaining any qualification.

February 2010

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ABSTRACT

The AIDS epidemic presently engulfing South Africa is mostly based on heterosexual transmission. This paper discusses the male role in African culture in the HIV and AIDS context. Issues facing African women, domestic violence in particular, remain a pervasive problem. Women have not yet reached a level of equality and are still being dominated by their male partners. Women's subordination can be directly linked to the increasing number of women becoming infected with HIV/AIDS, especially within the African cultural context. Culture plays a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa, where the values of extended family and community significantly influence the behaviour of the individual. The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS prevention and control efforts. As the impact of HIV/AIDS in South Africa remains unabated, a culture-centred approach to prevention, care and support is increasingly desirable as a critical strategy. The focus of prevention of the heterosexual AIDS epidemic has been on women. The role of men in sexual decision-making has not been emphasized enough in AIDS prevention approaches. As a result, the heterosexual epidemic for women continues unabated because of the lack of attention to the behaviour of male sex partners. Discussion focuses on the cultural and contemporary sexual culture as shaping factors in the enactment of high-risk sexual behaviour. There are numerous social, political, cultural and economic factors affecting the HIV pandemic in the SA region. The main ones are: low status of women and male dominance in sexual and economic relations; sexual abuse (of particularly young girls); historic and current separation of families resulting from the migrant labour system which resulted in multiple sexual partners; high use of sex workers due to single-sex quarters at the workplace; cultural resistance to the use of condoms; high rates of other STD's; and high levels of poverty and other inequalities such as health access and education. Stigma about HIV is also a barrier to reaching the most vulnerable, including those already infected. The paper draws the conclusion that discrimination against women, coupled with male dominance in all aspects of social structures; polygamous marriages were prescribed and supervised by male-dominated social structures has increased the prevalence rate of HIV/AIDS in the African cultural context.

OPSOMMING

Die HIV/Vigs pandemie wat tans Suid Afrika oorweldig is meestal die gevolg van heteroseksuele oordrag. Hierdie verhandeling bespreek die manlike rol in die Afrika kultuur in die konteks van MIV en Vigs. Aspekte wat die Afrika vroue in die gesig staar in terme van gesinsgeweld bly `n aanhoudende probleem. Vroue word steeds deur hul manlike maats gedomineer word en dus steeds nie `n vlak van gelykheid bereik het nie. Die onderdrukking van vroue kan direk gekoppel word aan die toenemende aantal vroue wat met MIV/Vigs geïnfekteer word – veral in die Afrika konteks. Kultuur speel 'n kritieke rol in die bepaling van die gesondheidsvlak van die individu, gesin en gemeenskap. Dit is besonder relevant in die Afrika konteks, waar die waardes van `n uitgebreide gesin en gemeenskap 'n enorme invloed het op die optrede van `n individu. Hierdie optrede in verhouding tot die gesin en gemeenskap is `n geweldige factor wat implikasies het op seksuele gedrag en op pogings tot voorkoming en beheer van MIV/Vigs. Terwyl die impak van MIV/Vigs in Suid Afrika ongesteurd voortstu, word `n kultuur gesentreerde benadering tot voorkoming, versorging en ondersteuning toenemend nodig as `n kritieke strategie. Die fokus op die voorkoming van die heteroseksuele Vigs pandemie was tot nou toe op vroue. Die rol van mans in seksuele besluitneming was tot dusvêr nie voldoende beklemtoon in Vigs voorkomende benaderings nie. Die gevolg is dat die heteroseksuele Vigs pandemie vir vroue ongesteurd voortduur weens die gebrek aan aandag op die gedrag van manlike seksmaats. Bespreking fokus op die kulturele en kontemporêre seksuele kultuur as vormende faktore in die uitvoer van hoë risiko seksuele gedrag. Daar is verskeie sosiale, politieke, kulturele en ekonomiese faktore wat die MIV/Vigs pandemie in die streek beïnvloed. Die belangrikstes is: lae status van vroue; manlike dominasie in seksuele en ekonomiese verhoudings; seksuele mishandeling – veral van jong meisies; historiese en huidige skeiding van gesinne voortspruitend uit die stelsel van trekarbeid – wat aanleiding gegee het tot `n verskeidenheid van seksuele maats; die hoë voorkoms van sekswerkers agv enkelgeslag woonkwartiere by die werksplek; kulturele weerstand teen die gebruik van kondome; hoë voorkoms van seksueel oordraagbare siektes; hoë vlakke van armoede en ander ongelykhede soos toegang tot gesondheidsdienste en onderwys. Die stigma van MIV/Vigs is ook `n hindernis in die bereiking van die mees kwesbare, insluitend die wat geïnfekteer is. Hierdie verhandeling maak die gevolgtrekking dat diskriminasie teen vroue, gekoppel met manlike dominasie in alle

aspekte van sosiale strukture; poligamiese huwelike wat voorgeskryf word en onder toesig is van manlik gedomineerde sosiale strukture, die voorkoms van MIV/Vigs in die Afrika kulturele konteks verhoog het.

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CHAPTER 1
INTRODUCTION

The impact of the HIV/AIDS epidemic in South Africa continues to be a problem. Research has shown that the main form of HIV transmission is heterosexual sex. In Africa, and according to African culture, men are permitted to have more sex partners than women, and often free to engage in commercial sex. The spread of HIV and AIDS cannot be controlled until we have clearly and adequately dealt with problematic areas in African cultural traditions and common myths about sex. The following areas are some of the areas that will need to be examined in the fight against HIV and AIDS:

Males with multi-partners

Polygamy is still very common in the rural villages in South Africa. Men have a choice of marrying more than one wife whereas women are treated as subjects of men and they do not have this choice. Beside polygamy, men seem to have the freedom to sleep with whomever they want at whatever time. In this regard, traditional leaders act as role models. King Mswati chooses a new wife every time when there is reed dance celebration; King Goodwill has more than one wife; the current State President of the country has more than one wife, to mention a few.

Domestic violence

Women in South Africa have gained substantial rights and opportunities since 1994, but this has not yet adequately dealt with inequalities which are still very prevalent among the genders. African culture continues to promote patriarchy in many ways and this perpetuates the subordination of women. One major issue surrounding women in South Africa is the problem of violence. Abuse against women and children is still extremely common and feeds into the culture and tradition of male dominance. Because women are still refused rights and are seen as inferior to men, they are more likely to be mistreated at the work-place, in the community and at a personal level. Women are viewed as the property of men, first of their fathers and then, when they get married, of their husbands. This is encouraging male dominance and also increases and

encourages violence against women. In order to stop the spread of the HIV/AIDS pandemic, women need to be given power and control over themselves and their sexual lives. If women are given the authority that they deserve, men will not be able to make decisions for women regarding sexual practices. These issues regarding women's rights and equality have an important and substantial impact on the continuing spread of HIV/AIDS.

Gender

In African culture and African traditional life, gender is defined according to roles and functions in the society. It is what it means to be male or female in a certain society that shapes the opportunities one is offered in life, the roles one may play, and the kinds of relationships one may have. These produce social norms in Africa that strongly influence the spread of HIV infection. For women, risk-taking and vulnerability to infection are increased by norms that make it inappropriate for women to be knowledgeable about sexuality or to seek advice on contraception. Gender norms also influence the way in which family members experience and cope with HIV and with AIDS deaths. The attention for prevention is taken away from men and their roles in the society. One good example is highlighted by Daniell (2009) who in his article said that "virginity testing of girls helps to draw attention away from the role of men in the maturing epidemic, consideration of which has been conspicuously absent in the popular discourse on AIDS at all levels of South African society".

Accommodating young people

Adults often assume that young people are too young to discuss and be concerned about sex. However, these assumptions are often based on their own embarrassment about the subject and prevent young people from having access to the information they need for healthy relationships. There is a much needed provision of accurate information on sexual and reproductive health and suggested activities aimed at exploring values and attitudes in relation to culture and the changing world. Schools can be a site of vulnerability to HIV infection where girls, in particular, are at risk from abuse by teachers and older pupils. Young men need to reflect about how traditional and negative male behaviours affect their own lives and how they can construct

alternative ways of interacting in their intimate relationships. We need to understand how young people make decisions and what influences their behaviours. For young people, norms that discourage access to information and services for safer sex can mislead them in cultures where HIV is seen as a sign of sexual promiscuity. Gender norms shape the way men and women infected with HIV are perceived, in that HIV-positive women face greater stigmatization and rejection than men.

Male homosexual behaviour

Currently very few services exist which address the needs of sexually active male homosexuals. They often experience discrimination when accessing many health care services. Many people are ignorant or have no knowledge at all on the issues which are affecting people, particularly men who have sex with men and gay men, particularly in relation to their sexual health.

The African male attitude towards HIV/AIDS and its prevention

African men are suspicious of HIV and AIDS prevention strategies. Many men see these programs as birth control programs. Others find it difficult to understand how one can are condoms and still enjoy sex. Condom usage prevents ‘flesh to flesh’ contact in sex. There is also a belief that this practice wastes one’s ‘bullets’ (i.e. sperm), which might be against God and ancestors.

THE STATEMENT OF THE PROBLEM

Male dominance in an African culture is a factor in the spread of HIV and AIDS in South Africa. The current rate of HIV/AIDS infection in South Africa is very high. For most women it is almost impossible to contemplate assertiveness in a sexual relationship with a man and negotiate safer sex. There are few projects that have attempted to deal with male dominance in South Africa. Some of these projects deal specifically with the abuse of women and rape. There are very few programs that serve men on HIV and AIDS issues.

Purpose

The goal of this study is to discover how men can recognize that their role is key in HIV prevention. Men should be involved in campaigns against HIV and AIDS and be educated on how they relate to women sexually.

Significance of the study

This study is very important to all men, especially to African men who struggle with the understanding that HIV and AIDS is real and that they can contribute in curbing the epidemic. The study will benefit us all. HIV and AIDS are affecting all sectors in our societies, and there is an urgent need to intervene. The benefits of the study will be that it will open up opportunities for men to be involved in the prevention and caring of those who are affected and infected by HIV and AIDS.

RESEARCH QUESTIONS AND PROPOSITIONS

The research questions

With the foregoing in mind, I will explore issues related to the training and education of men in fighting HIV and AIDS by endeavouring to answer the following questions:

- How can women fight AIDS without the co-operation of men?
- Does my culture mean I must sleep with my brother's wife?
- How do gender roles affect our health?

Propositions

Educating men towards greater awareness of HIV/AIDS prevention and care will have a positive influence towards HIV and AIDS prevention and will have an impact in intervening against the spread of HIV and AIDS.

- In order to fight HIV and AIDS effectively, we need to promote the participation of men in community-based HIV/AIDS prevention and care.

- Macro-economic and political factors are still in favour of men in South Africa and this exacerbates gender inequalities. Women do not have control over matters related to their sexual and reproductive health, and thus do not have greater access to economic opportunities and resources. This inequality has the effect of increasing the already rapid spread of the epidemic.
- Because of gender inequality women, especially the young and the poor are the most affected by the HIV/AIDS pandemic.
- Men should be engaged in reflection of their traditional roles as guardians against HIV and AIDS in their communities, families and work-place.
- Men need to assume more responsibility for preventing HIV transmission.

THE RATIONALE FOR THE STUDY

A lot has been written on the subject of women's vulnerability, cultural norms making it difficult to fight HIV and AIDS and on gender issues which helps to clarify the gender roles and the need to be aware of gender injustices and inequality. There is, however, very little written on the elements of African culture that helps to spread the infection. The state, public and private sector have worked together in different levels to stop the spread of HIV and AIDS. The government of South Africa together with all NGO, CBOs and FBOs support the main strategy of prevention: Abstain, Be faithful and Condomise (ABC). The media is also playing a role with programs such as Soul City, Lovelife and many others. South Africa, which has the highest number of people living with HIV and suffering from AIDS, has suffered severely with people responding in different ways to the epidemic. Some religious groups have seen HIV and AIDS as a punishment from God(s) or ancestors for the evil people have committed. The ABC prevention strategy has met different criticism, especially from men who do not believe that they can enjoy sex with condom usage. There are also those that believe that HIV and AIDS was a man-made attempt to wipe out a certain group of people. In response to all these claims, people have come up with theories on how to heal, protect and prevent themselves from contracting HIV and AIDS. Unfortunately those who are powerless in our societies bear the brunt of these wrong beliefs about AIDS. Women and youth are abused and raped. Young girls are raped with some believing that sleeping with a virgin is a cure for AIDS. Some influential men in South Africa have come up with strategies to educate men against these abuses and to openly admit the wrongfulness of

both abuse and rape. Two such projects are Real Men Care and Million Men March. These are all good attempts, but they haven't yet struck a cord in men's hearts and minds that will awaken them and to see the reality. There are men today who do not believe in HIV and AIDS; they have their own interpretation of the diseases. Some men see it as women's diseases because many women are infected, some are afraid, feel helpless and not know how to respond to the epidemic.

POSSIBLE RESULTS

Men will realize that their propensity to control women is undermining interventions against the spread of HIV and AIDS. Men will begin to understand how to protect themselves, their families, and the community at large from AIDS without compromising their roles as head of families. Younger men will learn to respect people of the opposite sex and they will learn to control their sexual urges and use preventive measures in sexual relationships. They will be encouraged to rethink gender issues and disparities in gender roles. The research will help to find ways to encourage men to talk about their sexuality and safety and their responsibility to their wives, partners and children. Political, corporate and traditional leadership should be persuaded to publicly acknowledge the issue of HIV/AIDS and to promote men's responsibility, including:

- Increase in condom use.
- Decrease in domestic violence.
- Some myths of HIV transmission will disappear.
- Married women more able to negotiate safe sex practice.

CHAPTER DIVISIONS

Chapter 1 — Introduction

Chapter 2 — The Global State of HIV/AIDS

Chapter 3 — Culture and HIV/AIDS

Chapter 4 — Method

Chapter 5 — Results and Discussion

Chapter 6 — Conclusions and Recommendations

CONCLUSION

There are cultural norms among the African people which promote male dominance and treat women as subordinate to men. These norms influence the continuing spread of HIV and AIDS. Many of these are ingrained within the cultural values and beliefs. Until these cultural norms are dealt with, the problems surrounding women and HIV and AIDS cannot be addressed and combated. Women deserve to be respected and treated as equals by their male counterparts, especially when it has such a large influence over the possibility of life and death. Men, at the same time, are seen as powerful people in the culture and fail to respect women and youth. Unless we deal with this lack of respect for women and youth, HIV and AIDS will continue to haunt us in South Africa.

CHAPTER 2
THE HIV/AIDS PANDEMIC

HIV and AIDS have had a devastating effect in South Africa, and a young productive generation is dying in the prime of their lives. Life expectancy dropped tremendously in South Africa due to the devastating impacts of HIV and AIDS. South Africa is not winning the battle; we need to pursue extraordinary measures to fight the battle of HIV and AIDS. All members of society need to be mobilized to fight the infection.

The global state of HIV/AIDS

The Joint United Nations Programs on HIV/AIDS (UNAIDS and WHO), estimated the number of people living with HIV at the end of 2006 to be 39.5 million people worldwide. While approximately 10% of the world's population lives in sub-Saharan Africa, an enormous 64% of all people living with HIV live in this region including 77% of all women living with HIV (Strategic Plan for South Africa, 2007-2011:19; http://www.unaids.org/pub/Global Report/2008 21:05:2009).

Since the first cases of Acquired ImmunoDeficiency Syndrome (AIDS) were reported in 1981, infection with Human Immunodeficiency Virus (HIV) has grown to pandemic proportions, resulting in an estimated 65 million infections and 25 million deaths. During 2005 alone, an estimated 2.8 million people died from AIDS, 4.1 million were newly infected with HIV, and 38.6 million were living with HIV. A report, published on the eve of the sixteenth International AIDS Conference (August 13-18, 2006, in Toronto, Canada), summarizes selected regional trends in the HIV/AIDS pandemic, based largely on data from the *2006 Report on the Global AIDS Epidemic* by the Joint United Nations Programs on HIV/AIDS (see graphs 1-3 below).

Sub-Saharan Africa

Sub-Saharan Africa is home to approximately 64% of the world population living with HIV. It is more heavily affected by HIV/AIDS than any other region of the world. An estimated 22 million people were living with HIV at the end of 2007 and approximately 1.9 million additional people were infected with HIV during that year. In just the past year, the AIDS epidemic in Africa has

claimed the lives of an estimated 1.5 million people in this region. More than eleven million children have been orphaned by AIDS.

South Africa

The UN report on 2007 (UN 2008 Global Report on the HIV and AIDS Epidemic) around 5.7 million South Africans were estimated as having HIV or AIDS, including 300 000 children under the age of 15 years and 350 000 people died from AIDS in South Africa in 2007. Women face a greater risk of HIV infection. According to this report, on average, in South Africa there are three women infected with HIV for every two men who are infected. The difference is greatest in the 15-24 age groups, where three young women for every one young man are infected.

According to the World Health Organization (WHO), Southern Africa is the epicenter of the AIDS epidemic; all countries in the region except Angola have an estimated adult HIV prevalence exceeding 10%. In Botswana, Lesotho, Swaziland, and Zimbabwe, the estimated adult HIV prevalence exceeds 20%. Transmission is primarily through heterosexual contact, and more women are HIV infected than men. South Africa, with an HIV prevalence of 18.8% and 5.5 million persons living with HIV, has, along with India, the largest number of persons living with HIV in the world (WHO 2006; http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5531a1.htm 25/03/2009).

The trends of HIV/AIDS

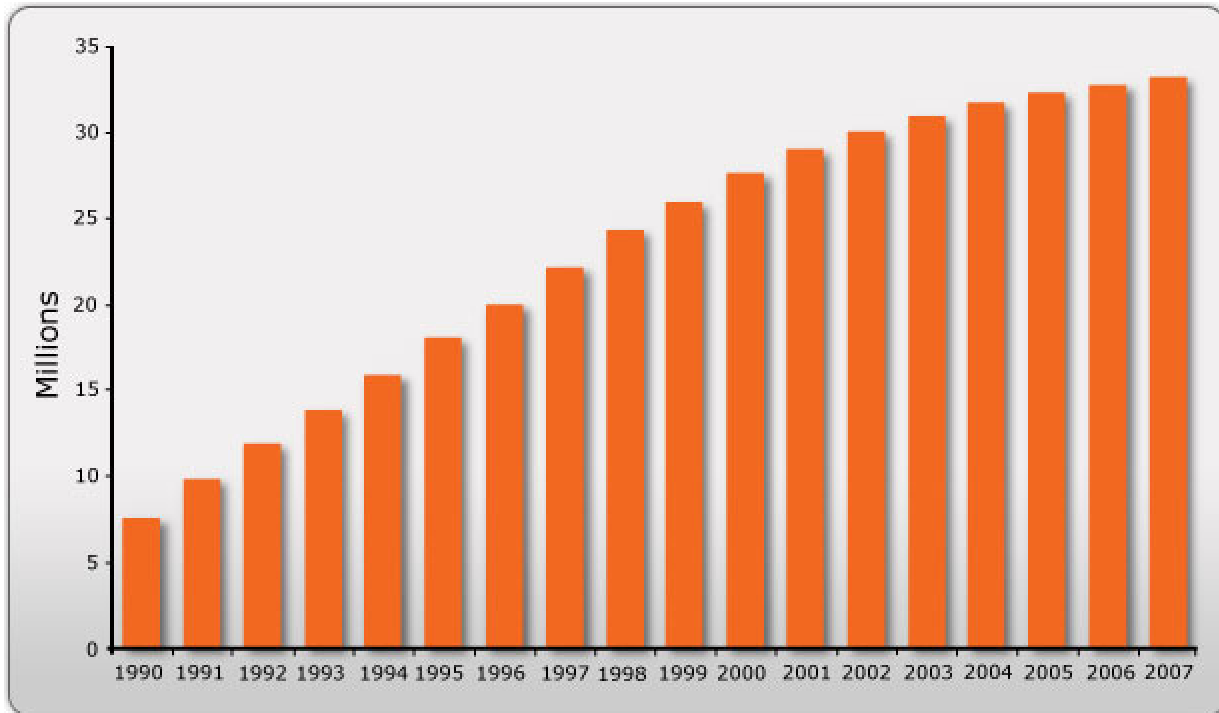
According to the Global Report published by UNAIDS and WHO in July 2008 (end of 2007), on the world epidemic of HIV and AIDS, the following graphs represent the global statistics and the third one shows the prevalent of HIV/AIDS in South Africa by provinces:

Fig.1: Regional statistics for HIV/AIDS, end of 2007

Region	People living with HIV/AIDS	People newly infected	Adult prevalence	Deaths
Sub-Saharan Africa	22.0 million	1.9 million	5.0%	1.5 million
North Africa & Middle East	380,000	40,000	0.3%	27,000
Asia	5 million	380,000	0.3%	380,000
Oceania	74,000	13,000	0.4%	1,000
Latin America	1.7 million	140,000	0.5%	63,000
Caribbean	230,000	20,000	1.1%	14,000
Eastern Europe & Central Asia	1.5 million	110,000	0.8%	58,000
North America, Western & Central Europe	2.0 million	81,000	0.4%	31,000
Global Total	33.0 million	2.7 million	0.8%	2.0 million

(Sources:http://www.unaids/en/KnowledgeCentre/HIVData/GlobalReport 2008; http://www.avert.org/worldstats.htm)

Fig. 2 below shows how the numbers of people living with HIV have risen from around 8 million in 1990 to 33 million by the end of 2007.



Sources: http://www.unaids/en/KnowledgeCentre/HIVData/GlobalReport 2008;

http://www.avert.org/worldstats.htm

Fig. 3 below is the estimates of HIV prevalence among South Africans, by age and sex, 2008

Age	Male prevalence %	Female prevalence %
2-14	3.0	2.0
15-19	2.5	6.7
20-24	5.1	21.1
25-29	15.7	32.7
30-34	25.8	29.1
35-39	18.5	24.8
40-44	19.2	16.3
45-49	6.4	14.1
50-54	10.4	10.2
55-59	6.2	7.7
60+	3.5	1.8
Total	7.9	13.6

(Sources: http://www.unaids/en/KnowledgeCentre/HIVData/GlobalReport 2008;

http://www.avert.org/worldstats.htm)

During 2007, more than two and a half million adults and children became infected with HIV.

TRANSMISSION

Sexual transmission

Sexual transmission is the main cause of HIV/AIDS in South Africa. It occurs with the contact between sexual secretions of one person with another. Women and children abuse, in the form of rape and sexual assaults, greatly increase the risk of HIV transmission. Condoms are rarely employed and physical trauma to the vagina occurs, facilitating the transmission of HIV. Sexually-transmitted infections and diseases also increase the risk of HIV transmission and infection through the disruption of the epithelial wall through the genital ulceration.

Blood transmission

This transmission route is particularly relevant to intravenous drug users, hemophiliacs and recipients of blood transfusions and blood products. Sharing and reusing syringes contaminated with HIV-infected blood represents a major risk of infection with HIV. This route can also affect people who give and receive tattoos and piercings. The virus can also be transmitted through medical injections. The WHO estimates that approximately 2.5% of all HIV infections in sub-Saharan Africa are transmitted through unsafe healthcare injections. Because of this, the United Nations General Assembly has urged the nations of the world to implement precautions to prevent HIV transmission by health workers.

Mother-to-child transmission

The mother to child transmission (MTCT) can happen in various ways: during the last weeks of pregnancy, at childbirth, in delivery and breastfeeding. During the last weeks of pregnancy and at labour and delivery, the infection can be passed on to the child through the uterus. The risk of infection is higher during pregnancy, labour and delivery to mothers who do not take antiretroviral therapy and very low to those who take treatment. According to AVERT, an international AIDS charity, there is 1% chance of transmission to mothers who take ARVs and 25% to mothers who do not take treatment during their pregnancy. Breastfeeding also increases the risk of transmission by about 4 %. (http://www.avert.org/pmtct-hiv.htm 25:07:2009). The

chances of children getting infected are very high but, when mothers take interventions, the chances are reduced significantly.

The impact of HIV/AIDS in sub-Saharan Africa

UNAIDS (2008) gave the following report on the impact HIV/AIDS is having on many parts of African society (including South Africa). The points below describe some of the major effects of the AIDS epidemic.

- In many countries of sub-Saharan Africa, AIDS is erasing decades of progress made in extending life expectancy. Millions of adults are dying from AIDS while they are still young, or in early middle age. Average life expectancy in sub-Saharan Africa is now 47 years, when it could have been 62 without AIDS.
- The effect of the AIDS epidemic on households can be very can be devastating. Many families are losing their income earners. In other cases, people have to provide AIDS care at home for sick relatives, reducing their capacity to earn money for their family. Many of those dying of AIDS have surviving partners who are themselves infected and in need of care. They leave behind orphans, grieving and struggling to survive without a parent's care.
- In the affected countries, the HIV/AIDS epidemic is putting strain on the health sector. As the epidemic develops, the demand for care for those living with HIV rises, as does the number of health workers affected.
- Schools are heavily affected by HIV/AIDS. This a major concern, because schools can play a vital role in reducing the impact of the epidemic, through education and support.
- HIV/AIDS dramatically affects labour, setting back economic activity and social progress. The vast majority of people living with HIV/AIDS in South Africa are between the ages of 15 and 49 i.e. in the prime of their working lives. Employers, schools, factories and hospitals have to train additional staff to replace those at the workplace that become too ill to work.
- Through its impacts on the labour force, households and enterprises, HIV/AIDS can act as a significant brake on economic growth and development. HIV/AIDS is already

having a major affect on Africa's economic development, and in turn, this affects Africa's ability to cope with the epidemic (UNAIDS 2009 'Report on the global AIDS epidemic').

HIV PREVENTION

The ABC approach

South Africa has adopted the ABC strategy approach which has successfully been used in other African countries. This ABC approach consists of three components: Abstain, Be Faithful and Condomise.

Abstinence — The ABC approach encourages people to abstain from sex until marriage as the most effective way to avoid HIV infection. In other countries like Uganda, the program developed skills for practicing abstinence and encouraged participants to adopt social norms that would help and encourage abstinence.

Be Faithful — In addition to abstinence, the ABC approach encourages participants to eliminate extramarital affairs and multi-sex partners. It encourages people to practice fidelity within their marriages and other sexual relationships.

Condomise — The use of condoms is the third and final components of the ABC strategy. Condoms play a key role in preventing HIV infection. People should, however, be instructed how to use a condom. Education plays a key role in dispelling the myths about condoms. Many African men struggle with the idea of condom use, seeing it as a ”waste of sperm”. There are also religious reasons why people think it is wrong to use condoms. Strong socio-cultural ideologies oppose condom use in medium- to long-term relationships. In many areas, marriage is women's primary risk factor, with 60-80% of HIV positive women in the sub-region reported to have had sexual relations only with their husbands or primary partners (http://www.aids.orgza/hiv.htm#7). While AIDS education and awareness strategies deployed in South Africa did alert people, they were insufficient to promote or sustain behavior change.

Voluntary HIV counselling and testing (VCT)

The provision of voluntary HIV counselling and testing (VCT) is an important part of any national prevention program. It is widely recognized that individuals living with HIV who are aware of their status are less likely to transmit HIV infection to others, and that through testing they can be directed to care and support that can help them to stay healthy. VCT also provides benefits for those who test negative, in that their behaviour may change as a result of the test. The provision of VCT has become easier, cheaper and more effective as a result of the introduction of rapid HIV testing, which allows individuals to be tested and find out the results on the same day. VCT could – and indeed needs to be – made more widely available in every part of the country.

Treatment

There is no treatment for HIV/AIDS, but drugs which helped people who have tested HIV positive to live relatively normal, healthy lives have been made available. The AntiRetroViral drugs (ARVs) delay the progression of HIV to AIDS. There are still, however, a number of impediments to ARV provision. The distribution of these drugs requires money, a well-structured health system and a sufficient supply of healthcare workers. The majority of people in South Africa live in townships and rural areas where the delivery of ARV is difficult. In the poverty-stricken areas, where ARVs have been made available to people, the challenge remains since people need to travel to get to the centres where the drugs are distributed. In addition to financial burden are poor healthcare facilities and a shortage of medical professionals.

Attempts are currently being made to make microbicide[1] available. This could be a significant breakthrough in protecting women against HIV. Women could apply such a microbicide without their partner even knowing. It is likely to be some time before a microbicide is ready for use, though, and even when it is, women will only use it if they have an awareness and understanding of HIV and AIDS. To promote this, a greater emphasis needs to be placed on educating women and girls about AIDS, and adapting education systems (which are currently male-dominated) to their needs (HIV and AIDS in Africa http://www.avert.org/aafrica.htm 25/03/2009).

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[1] Cream rubbed by women on the vagina to prevent infection or transmission of HIV.

Stigma and discrimination

HIV/AIDS has become one of the most stigmatized medical conditions in the world. According to UNAIDS (2006) stigma interferes with HIV prevention, diagnoses and treatment. HIV-related stigma and discrimination remains an enormous barrier to the fight against AIDS. Fear of discrimination often prevents people from getting tested, seeking treatment and admitting their HIV status publicly. AIDS education is needed in Africa to combat the ignorance that causes people to discriminate. The fear and prejudice that lies at the core of HIV/AIDS discrimination needs to be tackled at both community and national levels. Stigma appears to be more severe for women than for men.

The vulnerable groups

In many parts of Africa, as elsewhere in the world, the AIDS epidemic is aggravated by social and economic inequalities between men and women. Women and girls commonly face discrimination in terms of access to education, employment, credit, health care, land and inheritance. These factors can all put women in a position where they are particularly vulnerable to HIV infection. In South Africa, more than 60% of those living with HIV are female.

Women

Women, especially Black women, have been on the bottom rung of the ladder in terms of participation in the economic, social, and political life of the country. For many years Black women have experienced triple oppression — discriminated against on the basis of their class, race and gender. Some practical challenges facing women because of these three forms of oppression relate to violence against and abuse of women, poverty and poor health status in general. Although patriarchal attitudes are changing, with men participating in efforts to address challenges such as violence against women. The differences between men and women are evident. A youth study by the Reproductive Health Research Unit (RHRU: 2002) found that among the 10% of youth who were HIV positive, 77% were female. In additional to biological, economic, social and other cultural vulnerabilities, women are more likely to experience sexual abuse and violence, in particular domestic violence and rape.

Children

Children under the age of 18 comprise 40% of the population of South Africa. In 2004, it was estimated that there are 2.2 million orphaned children (meaning 13% of all children under 18 have lost either a mother or father); nearly half of all orphans were estimated to have lost parents as a result of AIDS (UNAIDS, UNICEF, USAID 2004) . Some of the worst affected children – those in deeply impoverished households – may experience various forms of physical, material and psychosocial deprivation and assaults on their health as a result of poverty and/or a lack of parental care and a nurturing environment. Often, these children are separated from caregivers and siblings and sent to stay with other relatives or other carers or social networks. A significant number of children in South Africa are living with HIV and AIDS. According to the 2005 HSRC survey, there is an estimated 129 621 children aged 2-4 years and 214 102 children aged 5-9 in 2005 living with HIV or AIDS. HIV is thought to have contributed to an increase of 42% in under-five mortality in this country in 2004. Children are vulnerable to HIV infection through mother-to-child transmission and child sexual abuse.

Commercial sex workers (CSW)

Sex workers are predominantly female. Sex workers are at high risk of HIV infection and are vulnerable as a result of high partner turnover and a limited capacity to ensure safe sex during each and every sexual encounter.

Conclusion

In African culture, sexual relationships are dominated by men, meaning that women cannot always practice safe sex even when they know the risks involved. The AIDS epidemic has had a huge impact on women, which has been exacerbated by their submissive role within society and their biological vulnerability to HIV infection. Biologically, women are twice more likely to become infected with HIV through unprotected heterosexual intercourse than men. In the African culture, women are less likely to be able to negotiate safe sex and condom use and are more likely to be subjected to non-consensual sex.

CHAPTER 3
CULTURE AND HIV/AIDS

We seem not able to win the HIV/AIDS battle in South Africa. Many questions come to mind when we think of the devastating effects of HIV/AIDS: how can HIV/AIDS infections continue to rise at such levels given the many efforts to educate people on how to protect themselves? Who has not heard that HIV causes AIDS? How many times should we hear the message of 'Abstaining, Be faithful and Condomise (ABC) and take it to heart before everyone is affected? How can people choose to have multiple sex partners in such risky times?

Culture is often shown to be a factor in the various ways that HIV/AIDS has impacted on the African population. These factors range from beliefs and values regarding sex and sexuality (including when to become sexually active and the number of sexual partners) and condom use in South Africa (Shisana & Simbayi, 2002). A related issue is the cultural practice that encourages vagina dryness for enhanced friction for the penis (Kun, 1998). Parker and Aggleton (2003) examined the influence of the broader contexts of culture in AIDS-related stigma and accompanying denial, and concluded that stigma could not be fully examined outside the cultural contexts that give it meaning. In a three-year project funded by UNAIDS to develop a new direction for HIV/AIDS prevention in Africa, Asia, Latin America and the Caribbean, culture was one of the five key domains that was recommended to become central in HIV/AIDS prevention, care and support, particularly in Africa (Airhihenbuwa, Makinwa & Obregon, 2000).These and other socio-cultural issues stress the need for culture to be at the centre of Africa's prevention and control efforts.

UNDERSTANDING CULTURE

Universal culture

Culture is an integral part of every society. It is a learned pattern of behaviour and ways in which a person lives his or her life. Culture is essential for the existence of a society, because it binds people together. In the explicit sense of the term, culture constitutes the music, food, arts and literature of a society. However, these are only the products of culture followed by the society

and cannot be defined as culture (Parson 1949). There are also cultural universals; these are certain behavioural traits and patterns that are shared by all cultures around the world. For instance, classifying relations based on blood relations and marriage, differentiating between good and bad, having some form of art, use of jewellery, classifying people according to gender and age, etc., are common in all cultures of the world. Although every society has a specific culture, there are certain elements of culture that are universal. Cultural universals consist of those patterns relative to behaviour and the products of human action which may be inherited, that is, passed on from generation to generation independently of the biological genes. Culture is something that a person learns from his family and surroundings, and is not ingrained in him from birth. It does not have any biological connection because, even if a person is brought up in a culture different from that in which he was born, he imbibes the culture of the society where he grows up.

A definition of culture

Mazrui (1986) defines culture as "a system of interrelated values active enough to influence and condition perception, judgment, communication, and behaviour in a given society". It is a configuration of learned behaviours and results of behaviour whose component elements are shared and transmitted by the members of a particular society. Culture is the shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them. It consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artefacts; the essential core of culture consists of traditional ideas and especially their attached values. According to the English anthropologist Taylor, culture is 'that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society" (see Kroeber & Kluckhohn 1952; Lederach 1995, Linton 1945; Parson 1949 Kartha n/p http://www.buzzle.com/articles/what-is-culture.html 6/2/2009).

It is also not a hidden fact that some people feel the need to follow the beliefs and traditions of their own culture, even though they might be not subscribing to certain ideologies within. Every society has a different culture, where people share a specific language, traditions, behaviours,

perceptions and beliefs. Culture gives them an identity which makes them unique and different from people of other cultures. When people of different cultures migrate and settle in another society, the culture of that society becomes the dominant culture and those of the immigrants form the subculture of the community. Usually, people who settle in other nations imbibe the new culture while at the same time strive to preserve their own.

World-view

Bediako (2006) states that culture comprises far more than just music, dance, artefacts and the like by pointing out that “our culture is our world-view, that is, fundamental to our understanding of who we are, where we have come from and where we are going. It is everything in us and around us that defines us and shapes us.”

World-view can be viewed as several layers of culture. Kwast (1981) explains it well when he says “One helpful method is to view a culture, visualizing several successive layers, or levels of understanding, as one moves into the real heart of culture.” Three layers of culture are: the behaviour; what is done? The values; what is good or best? The beliefs; what is true? And the worldview; what is real?

World-view signifies the image people have of the nature of the world and life and their place and responsibility within the greater whole. A world-view is all embracing and provides people with the big picture of the context within which they must live. Every person has a world view. People may not always be aware of the picture which determines the way they see, experience and live this life (Shutte 1993). Mbiti (1969), for example, believes that the individual has little latitude for self-determination outside the context of the traditional African family and community. He writes:

> "Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say: 'I am, because we are; and since we are, therefore I am.' This is a cardinal point in the understanding of the African view of man" (p, 109).

Culture is the “superglue that binds people together and gives them a sense of identity and continuity, which is almost impenetrable” (Kwast 1981). It can be depicted as a concentric circle with behavior on the other layer and world-view at the other. Heselgrave (1991) likened world-view to coloured glasses through which people see themselves and the universe around them.

Understanding world-views as the core of every culture explains the confusion that some people have at the level of beliefs. Magezi (2007) says “one`s world-view provides a system of beliefs which are reflected in one’s actual values and behaviour. Sometimes a new competing system of beliefs is introduced, like Christianity, but the world-view remains unchallenged and unchanged, so values and behaviour reflect on the old belief system including perceptions of sickness and suffering and HIV/AIDS”.

The traditional African family in South Africa is patriarchal; men are considered the heads of their households. Women and children are expected to defer to men's authority. Polygamous marriages (multiple wives) are permitted where the husband has the means to pay the *lobolo* (bride wealth) for each, and to maintain them properly. Women are expected to leave their families to live with their husband's family.

This behaviour is based on the value that it is good to respect men as heads of families and as leaders in society. It is based on the conviction and belief that God (god) appointed men as heads and leaders of women and the whole community. Because of respect for God (god) and ancestors who play an intermediary role between God and men, men must thus be obeyed. But Nyasani is very helpful in warning against not scrutinizing cultural beliefs and practices, he says:

> [Norms of culture] are merely received but never subjected to the scrutiny of reason to establish their viability and practicability in the society.... Maybe it is because of this lack of personal involvement and personal scrutiny that has tended to work to the disadvantage of the Africans, especially where they are faced with a critical situation of reckoning about their own destiny and even dignity (1997:63-69).

Regardless of the disciplinary basis on which the definition is advanced, it is generally understood that culture is the foundation on which health behaviour in general and HIV/AIDS in particular is expressed and through which health must be defined and understood.

MALE DOMINANCE ENCOURAGES THE SPREAD OF HIV/AIDS

Domestic violence in South Africa

While women are considered equal and have gained many rights in South Africa, there is still discrimination, not only in the law, but in daily interactions among women and men. Many men believe they are the custodians of African culture and regard women as inferior, and believe that women should obey men. They feel a woman's place is in the home where her main duty is to bear and raise children. While women have gained substantial rights and opportunities in recent decades, inequality among the genders is still very prevalent. African culture continues to promote patriarchy in many ways and this perpetuates the subordination of women. Abuse against women is still extremely common and encourages the tradition of male dominance. This has a substantial impact on the continuing spread of HIV/AIDS. The culture continues to endorse the subordination of women through many of its cultural practices. Many of these ideas which encourage male dominance also increase the acceptance and justification of violence against women. Throughout history, men have been given the right to control women and have exercised whatever means they felt necessary to achieve this domination. Women were viewed as the property of their fathers and then of their husbands; a woman was required to obey a man's command and the husband was permitted, even encouraged, to punish her for misbehaviour in the form of a beating and torture. The use of power and control in the form of sexual, emotional, or physical violence is central to the perpetuation of female abuse. Asserting power over women allows men to establish "male control and dominance", not only in relationships, but also in the beliefs and structures of society (Wallace, 2005).

Power of men

The power of men in an African culture is exacerbated by media, sports and various forms of entertainment. The idea of male dominance within our society is portrayed by media. It has become an outward reflection of our culture's values and beliefs. The gender roles portrayed by the media become accepted. It glamorizes rape, murder, and other crimes against women. This makes men the most powerful and aggressive people in the culture (Cuklanz, 2000). On the other hand, the media presents women in soap operas, magazines and novels as subjects for men's pleasure and how they should behave correctly for a man. Men's sports send the same message

in teaching men how to be in control and in power (Van Zoonen, 1994). Women's lack of status gives them very little bargaining power in sexual relationships. They may insist that their husbands use condoms but have very little chance of persuading them to do so (Magezi 2007).Until these embedded cultural norms are altered, the problems surrounding women and AIDS cannot be addressed and combated.

Multiple partners

In an article by Gqola, *Pressure to be promiscuous,* she has clearly articulated the problem:

> Sex with multiple partners is so entrenched in South Africa that it is a religion, a basic moral philosophy for most people here. It is often simply called culture or, specifically, African culture. Political leaders who marry an increasing number of wives and royalty that flaunts an equal number of wives and concubines are highly visible (Mail and Guardian 11/02/09).

Gqola points out that, among the Zulu and Xhosa people, there are two terms given to men that promote multi-sexual partnership by men which promotes this: *isoka* (playboy) and *amakrwala (initiated men).* The first one, (*isoka*), is a compliment to those who are demonstrably promiscuous, straight African men. This pressure to be promiscuous to prove manhood is quite pervasive. The second one (*amakrwala*) is about the myth of newly-initiated men who "need to have sexual intercourse with a woman other than their regular sexual partners upon exit from initiation school. This is ostensibly to avoid passing on misfortune to the valued girlfriend, even though the source of such misfortune is unidentified" (Gqola 2009). Magezi (2007) includes in his lists of factors influencing the spread of HIV/AIDS, gender inequality and multiple partnerships and the commercial sex industry. All these factors are practiced by men in their sexual activities. Louw (1995) confirms this in his article, *Pastoral care for the person with AIDS in African context*, by highlighting the fact that the African male is traditionally polygamous and has several wives or sexual partners. Despite the effects of modern life in tribal customs, polygamy and concubanage are still accepted as normal cultural practices among Africans.

The gender-related impact of HIV/AIDS

Because of the very different roles and responsibilities assumed by men and women, an HIV-related illness in the family affects men and women differently, and its impact also varies depending on whether the person who falls ill is female or male. Much like the pattern of concurrent multiple sexual partnering, intergenerational sex (with age disparities of five years or more) is common throughout the country. Sexual exchange for food and clothes is increasingly being replaced by exchanges of cell phones and money. Where the balance of power is so deeply entrenched in favour of men, as is the case in our part of the world, differences in age and economic status often results in severe oppressive implications for women and girls.

Added to this is the problem that dangerous myths and misconceptions about HIV/AIDS abound. 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. Beliefs such as this give people a false sense of their level of risk, and contribute to confusion about how HIV is transmitted.

People who do possess some knowledge about HIV often do not protect themselves because they lack the skills, support or incentives to adopt safe behaviours. High levels of awareness among the youth, a population group particularly vulnerable and significant as regards the spread of HIV/Aids, have not led, in many cases, to sufficient behavioural change. Young people may lack the skills to negotiate abstinence or condom use, or be fearful or embarrassed to talk with their partner about sex. 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.

Cultural norms and practices

In some African cultures, there are traditional cultural practices which clearly suppress and discriminate against women and youth. Magubane identifies these practices which are prevalent in many African cultures by pointing out that:

> In the Tswana society, gender and age distinction have been long been an important maker of status in Tswana society. The former was exhibited in many ways: men and women set apart in social gatherings, and some cases such as *Kgotla*[2] (council place) were for men only. Sons were, and in some cases still are, preferred and women who bore only daughters were often despised. Male superiority was reinforced in daily life like for example at meals men and initiated boys sat together and were served first and women ate with children. Legally women were and often still are perpetual minors and are to remain under a male guardian (1998).

Certain prevalent cultural norms and practices related to sexuality contribute to the risk of HIV infection. Rose-Innes (2006) gives the following examples which apply to our culture in Africa:

- There is a negative attitude towards condom use, as well as difficulties negotiating and following through with their use. Men in southern Africa regularly do not want to use condoms because of a belief that "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.
- Certain sexual practices, such as dry sex (where the vagina is expected to be small and dry), and unprotected anal sex, carry a high risk of HIV because they cause abrasions to the lining of the vagina or anus.
- In cultures where virginity is a condition for marriage, girls may protect their virginity by engaging in unprotected anal sex.
- The importance of fertility in African communities may hinder the practice of safer sex. Young women who are under pressure to prove their fertility prior to marriage may try to fall pregnant, and therefore do not use condoms or abstain from sex. Fathering many children is also seen as a sign of virile masculinity.
- Polygamy is practiced in some parts of southern Africa. Even where traditional polygamy is no longer the norm, men tend to have more sexual partners and to use the services of sex workers. This is condoned by the widespread belief that males are biologically programmed to need sex with more than one woman.
- Urbanization and migrant labour expose people to a variety of new cultural influences with the result that traditional and modern values often co-exist. Certain traditional values

[2] A Tswana word for a traditional council or assembly

that could serve to protect people from HIV infection, such as abstinence from sex before marriage, are being eroded by cultural modernization.

TRADITIONAL CULTURE AND THE SPREAD OF HIV/AIDS

Elements of traditional culture and subservient female roles are pushing HIV/AIDS infection rates up in Africa. A number of commonly-observed traditional practices are now recognized as being directly responsible for the spread of HIV/AIDS.

Male-dominated society

In African culture, decision-making has traditionally been a male prerogative. Family planning decisions, therefore, lie with the man. Women may be subjected to continuous childbirth by their husbands or in-laws against their will.

Gender inequality

Lack of respect for women's human rights, gender-based violence and lack of access to gender-sensitive sexual health education and services leave women and girls disproportionately vulnerable to HIV. That is why gender inequality has to be addressed in HIV prevention programming. As we enter the third decade of HIV/AIDS, women, especially the young and the poor, are the most affected. Because gender inequality fuels the HIV/AIDS pandemic, it is imperative that women and girls speak out, set priorities for action and lead the global response to the crisis. Young men need to reflect about how traditional and negative male behaviours affect their own lives and how they can construct alternative ways of interacting in their intimate relationships.

Gender inequality and male dominance

South African 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 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.

Women's inferior status affords them little or no power to protect themselves by insisting on condom use or refusing sex. Many women also lack economic power and feel they cannot risk losing their partners, and thus their source of financial support, by denying them sex or deciding to leave an abusive relationship.

Men are given license to be sexually adventurous and aggressive, without taking responsibility for their actions. Women's respectability is derived from the traditional roles of wife, home-maker and mother. Childbearing and satisfying her husband, sexually and otherwise, are key expectations for a wife even if she is aware that her husband is unfaithful. Refusing a husband sex can result in rejection and violence.

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.

Leclerc-Madlala[3] thinks that there is not enough emphasis on changing men's behaviour. In her article in the *Christian Science Monitor,* she points out that

> *Awareness* levels around the world are higher than they've ever been, but so is the pace at which the virus spread, according to the report. The real hurdle… is translating awareness into behaviour change, and the effort often runs up against longstanding and strongly held cultural values. (http://www.csmonitor.com/2004/1201/p06s01-woaf.html 17:08:2009).

She thinks that there is not enough emphasis on changing men's behaviour. She believes that a key solution is for male African leaders — whether politicians, sports figures, or traditional rulers — to take a stand, admit publicly that men's behaviour is a problem, and urge men to change.

Cravero agrees with Leclerc-Madlala and adds by saying:

[3] *Suzanne Leclerc-Madlala* is Professor of Anthropology and the Director of the Anthropology Programme at the University of KwaZulu-Natal

> "The prevention strategies are missing the point. Women do not have the economic power or social choices over their lives to put the information into practice," she said, during a press conference in London last week. "We tell women to abstain when they have no right. We tell them to be faithful when they cannot ask their partners to be faithful. We tell them to use a condom when they have no power to do so" (http://www.csmonitor.com/2004/1201/p06s01-woaf.html 17:08:2009).

Other practices that undermines the status of women is widow inheritance and widow cleansing, and polygamy (some of the key ones), which are dangerous to women's health because the parties involved do not test for HIV. Aside from these traditional practices are the social norms which dictate that females differ from males. Culturally, male youth has been led to believe it is a sign of manhood to be able to control relationships. Females are brought up to believe that males are superior in all spheres of life and should be the masters of sexual relationships. In addition, rigid implementation of traditional practices such as *ilobolo*[4] payments make women men's property. These encourage men to be promiscuous while women are often expected to remain pure.

CULTURE AND SEXUALITY IN THE AFRICA CONTEXT

Sex is a taboo topic

In Africa, HIV/AIDS is mainly a sexually-transmitted disease. Matters to do with sex are traditionally taboo topics in the traditional African communication. They are thought to be private subjects, not befitting public discourse. While sex is, and will always remain, a private affair, the consequence of sexual promiscuity, HIV/AIDS, is of increasing public concern, given its far-reaching and devastating effect on societies in Africa. The dilemma is that one cannot, for instance, discuss HIV/AIDS without mentioning the sexual behaviour of those at risk of contracting HIV. The subject of sex and condom use in relation to HIV/AIDS on television or radio can especially be very discomforting for a mixed audience of parents and their children or a visiting father- or mother-in-law, together with the son- or daughter-in-law and his/her adolescent children in a family living room. It is therefore not uncommon for the hosts to switch off the channel on which such programs are being aired to avert a sense of guilt and shame.

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[4] Equavalent to a western understanding of dowry or bride's wealth, the meaning in the Nguni context is more of an appreciation of the parents by the son-in-law.

AIDS, sexuality and gender in Africa

How can women fight AIDS without the co-operation of men? A recent global shift towards the recognition that men are driving the AIDS epidemic raises two key challenges: to devise campaigns which treat men as individuals, and secondly to remember that what needs changing is not individual men and women, but the relations between them. Women are the main carers when people fall sick, for example. They support orphans and provide the backbone for most voluntary efforts to raise awareness and change behaviour. However, almost everywhere, women struggle with minimal support from men and inadequate resources. In some cases, men even sabotage their efforts (Banyini, 2009[5]). Women have so far been passive in sexual relationships, with little participation in decisions or suggestions relating to their role in sexual activity, although liberated women stand a better chance of persuading their partners to use safer sexual practices aimed at reducing infection risk (Tongni 1997).

African views of sickness and HIV/AIDS

Magezi (2007) citing Berinyuu (1988) in *Pastoral Care to the Sick in Africa,* says that the notion of sickness in Africa, including HIV/AIDS, is personalistic. A "personalistic medical system is one in which disease is explained as being due to the active purposeful intervention of an agent, who may be human (a witch or sorcerer), non-human (a ghost, an ancestor, an evil spirit) or supernatural (a deity or often a very powerful being)." Hence, within the African conceptual framework, though AIDS may be attributed to a naturalistic cause (HIV), there is always a supernatural link (Magezi 2007). Throughout Zulu history (as with most traditional groups in Africa), it can be seen that there has been hardly an aspect of traditional Zulu life in which religion has not played a part: in warfare, in ceremonies, in different stages and crises in people's personal lives, in source from which help and guidance can be delivered after appropriate propitiation through sacrificial offerings" (Magubane 1998). Mbiti (1969) affirms these by saying African people are "notoriously religious"; they take their religion everywhere they go.

[5] Mercy Banyini is the SAHARA Journal Manager, Social Aspects of HIV/AIDS Research Alliance, Human Science Research Council, South Africa.

Conclusion

Culture is not hereditary, but it is an acquired concern which touches and influences all aspects of our humanity. It means that it can be unlearned to a certain extent or be acquired by a foreigner. Because a person is influenced by the culture in which he or she is born even before birth – culture is already acquired at this stage, mostly on an unconscious level – people will probably never be able to evade the influence of "home/maternal culture" even if someone would reject or try to unlearn it. It is probably for the same reason that, in spite of wholeheartedly identifying with another culture, it is impossible for someone outside a certain culture to know and experience that culture in all its different facets in the same way as someone who is born in that culture. Culture is central to HIV/AIDS prevention, care and support in Africa. Behavioural analysis and intervention points of entry into a community should focus on culture rather than on individual behaviours, as commonly done in HIV/AIDS interventions.

CHAPTER 4
METHOD

This chapter seeks to familiarize the reader with the method that was adopted in conducting the study. The research design will be discussed; methodological considerations include the sample strategy, data collection strategy and data analysis strategy. Furthermore, the limitations of this research are highlighted.

Research Design

This study was an exploratory, qualitative study which sought to explore the perceptions that South African Black males have, and contribution thereof, concerning the nature and extent of HIV and AIDS epidemic in South Africa. The study was confined to the townships around Cape Town. According to Tutty, Rothery & Grinnell (1996), an exploratory, qualitative research approach allows for an inquiry into people's perceptions, experiences, opinions and attitudes towards a certain topic (Christensen 2001). Thus, adopting this research approach enabled the researcher to gain insight into the meanings, motivations, and values that specific Black males attach to their culture and are problematic in the spread of HIV/AIDS. A combination of open-ended and closed-ended questions was used. Open-ended questions allow the respondents to answer any way they please and closed-ended questions require respondents to choose from a limited number of predetermined responses (Christensen 2001). A convenience sample chooses the individuals that are easiest to reach or sampling that is done easy.

The basic survey structure

There were 150 people who were targeted and received the questionnaires, but only 127 people responded. Although this was a very good response, many questions were not answered correctly in the survey. Reasons for this could be that there was difficulty in understanding and answering the questions. There are four sections in this survey. The first section deals with personal information such as age, status, religious affiliation, locality and the position held in the community. The second section is about the understanding of the HIV/AIDS epidemic. The third is about voluntary testing, and the last, the fourth, looks at relationships and safe sex. The target

groups were asked 40 questions. In the first section, there were 8 questions, 11 questions in the second section, 8 questions in the third and 13 questions in the last section.

Methods of data collection

According to Christensen, there is a variety of methods for collecting survey data. The most popular methods are face-to-face, telephone, and mail (2001). Both qualitative and convenience sampling was used to collect and analyze data.

Questionnaire construction

It was necessary to construct a number of questions that will provide an answer to the research question. In constructing these questions, it is imperative that the researcher have an explicitly identified research question. An explicit research question states what the researcher wishes to know (Christensen 2001).

Data collection issues

Surveys are prone to limitations emanating from the use of the general population as respondents. A variety of reasons (the level of education of respondents, clarity of questions, ability to recall events and the willingness to supply the correct information, etc.) can impact on the quality of information collected in these types of surveys. In this respect, one can also refer to the sizes of the samples, sampling methodologies, and training, which all have a bearing on the data.

Sample strategy

The participants of this study were obtained through the use of a non-probability sampling method. In particular, the availability sampling strategy was used in selecting the target groups. An availability sample is selected from people who are (1) easily contactable, (2) in close proximity to the researcher, and (3) are willing to be recruited as participants (Dudley, 2005).

When approached, the chairman of the Khayelitsha Rainbow Soccer League, the principal of the Emmaus Bible Schools in Khayelitsha and the TAC (Treatment Action Campaign) in Khayelitsha agreed to allow their members to participate in the study (see Appendices 2, 3 and 4 for their letter of agreement).

Data collection strategy

The data collection strategy will be discussed as follows:

- Qualitative Data Collection Approach;
- Data Collection Instruments;
- Apparatus for Capturing Qualitative Data; and
- Steps in Data Collection Strategy.

Qualitative data collection strategy

Face-to-face in-depth interviews were conducted with the sample of 16 pastors. In-depth interviews have been defined as a conversation with the purpose of understanding the experiences of other people and the meaning that they attach to these experiences (De Vos, 2002). The in-depth interview, making use of a semi-structured interview schedule to guide interviews in the data collection process, encompasses a qualitative approach suitable for obtaining information for this exploratory study (Dudley, 2005).

Data collection instruments

A semi-structured interview schedule was developed as a guide for conducting the in-depth interviews in order for a level of consistency to be maintained between interviews (Marshall & Rossman, 1995). The interview schedule which was utilized can be found in the appendix. The interview schedule was, however, used as a flexible guide thereby allowing the researcher to explore the individual opinions and explanations of participants (De Vos, 2002). A checklist illustrating both development and welfare projects was included as part of the interview schedule. Participants were requested to indicate the items they considered to be social

development in practice. This checklist therefore allowed the researcher to gain insight into the way in which participants conceptualized social development, revealing differences which existed between their concrete understanding of social development and their theoretical understanding which was elicited from the rest of the interview schedule.

Apparatus for capturing qualitative data

A questionnaire survey was used and more papers were made available for more answers, especially to respond to the open-ended questions.

Steps in data collection strategy

1. Permission was gained from the leadership of EBS, TAC and Rainbow Soccer League to conduct the study through their members and students.

2. Pilot interview schedule: Four members of the community which were not included in the sample were selected. Interviews were scheduled with the participants in order to give the researcher an opportunity to test the interview schedule. According to De Vos (2002), the purpose of conducting a pilot study includes determining the effectiveness of data collection instruments in order to protect against possible errors which may occur while conducting one's study. Once the pilot interviews had been conducted, the wording as well as the ordering of the interview schedule was refined.

3. Sample contacted: Participants were contacted in order to arrange appointments for in-depth interviews to be conducted at their convenience.

DATA ANALYSIS STRATEGY

Data obtained during the in-depth interviews was analyzed according to the qualitative data analysis strategy. Thus the tape recorded interviews were transcribed and analyzed according to categories and themes that emerged. In order to achieve this, cross-sectional or categorical indexing was used to identify categories that were common throughout the different interviews

(Mason, 2002). This process required the use of an adaptation of Tesch's (1990) eight steps as a guideline for analyzing the qualitative data. In summary, this means that the transcriptions were read through a number of times while notes were made. These notes were then used to identify the themes and categories that emerged from the text (De Vos, 2002). Thus a theme analysis uncovered the common patterns as well as a range of differences in participants' responses (Dudley, 2005). The checklist was analyzed according to the number of times participants ticked certain boxes. Simple bar charts were developed to present these findings graphically.

REASERCH LIMITATIONS

Choice of research design

Making use of a research design which was predominantly qualitative in nature meant that subjective data would be gained, which depended solely on the meaning attached to it by participants. While the purpose of an exploratory study is to gain data of such a nature, there are limitations associated with such data due to the subjectivity of its nature (De Vos, 2002).

Sampling

The non-probability sample used in this study is relatively small. As it is a non-probability sample the findings cannot be generalized. However, while one may not be able to generalize the findings, these findings may still be useful to other research studies within the same field.

Qualitative data analysis strategy

Making use of the qualitative data analysis strategy to interpret the data means that data may be open to further interpretation. Therefore the researcher's interpretation could be biased, be affected by his ability to make critical judgments, and be dependent on the knowledge that he has concerning the field of study.

Researcher's experience

The researcher has conducted a study of this magnitude before for an MTh with the South African Theological Seminary. He has completed two research studies using qualitative research designs both at an Honours level and Masters Level covering the relevant research material required to conduct a mixed methodology research study.

Conclusion

This chapter has presented the research design and methodology that was adopted in the execution of the study. The main limitations which were taken into consideration were also discussed. The following chapter presents the findings of the research study.

CHAPTER 5
RESULTS AND DISCUSSION

The intention of this section is to evaluate the understanding of and the involvement of Black African men in South Africa in HIV/AIDS. The survey was done in the townships around Cape Town. An attempt was made to obtain a good balance of various groups representing men in the townships. The data also attempted to collect a good representation in terms of age, religious people, community and those who are infected or affected by HIV/AIDS in one way or other. The survey was very helpful in formulating an understanding of HIV/AIDS by Black South African men.

Modus operandi

The respondents were carefully selected to present a good balance of male community in the township churches of the Western Cape. Although 150 people were targeted, number only 133 questionnaires were returned. Six of those returned were spoiled and were not used in the analysis. The sample was finally taken from 127 questionnaires returned and not spoiled. This was still a good return of questionnaires and is still a good proportion. An attempt was made to survey as wide a spread of age group, religious affiliation and location as possible. Respondents were made aware of the fact that the survey was anonymous and confidential. Although the survey was hand delivered, no record was kept of persons who submitted the surveys. The bulk of the surveys were distributed through the pastors' fraternity, soccer leagues and through community leaders. There were no records kept of the distributors or the recipients. The letters were written to all the leadership of the above organizations requesting permission to do the survey. The copies of the letters are attached as appendices 2, 3 and 4.

Respondents were requested to cross `x` as their responses. Some questions offered more than one option for choice. Some questions were open-ended but very few were filled in in the space provided for this purpose.

Data analysis

In this chapter, the most important findings revealed by the survey are recorded, analyzed and interpreted.

1. Personal Information

Question 1.1 Age groups

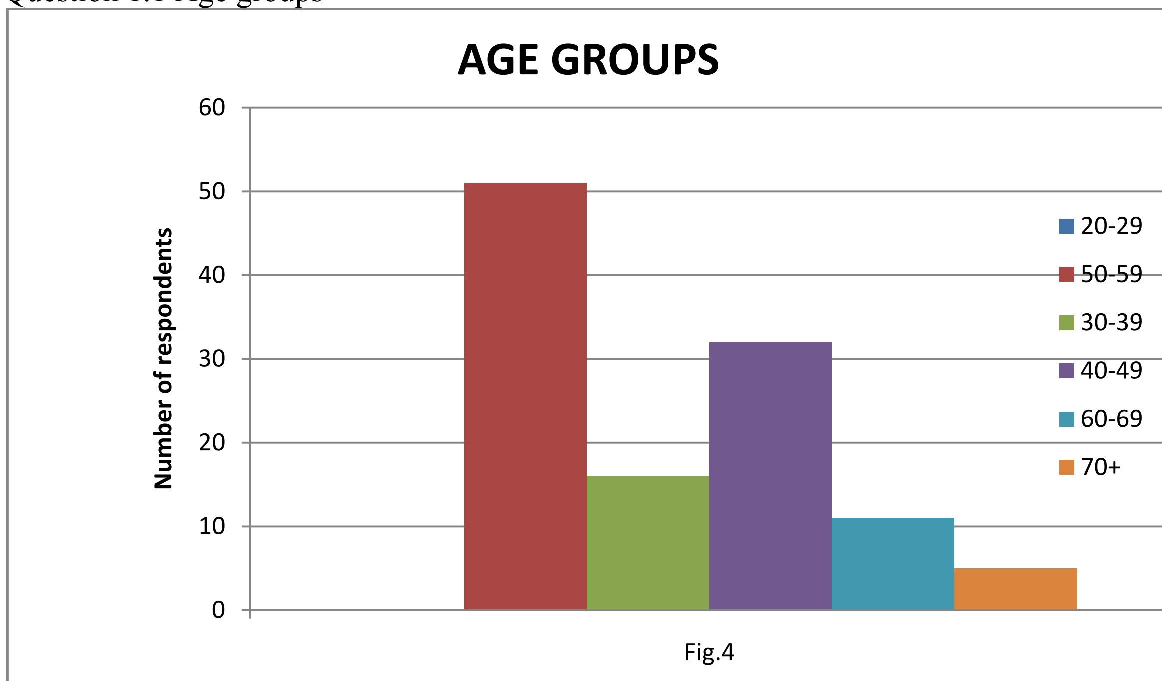


Fig.4

Question 1.2 Marital status

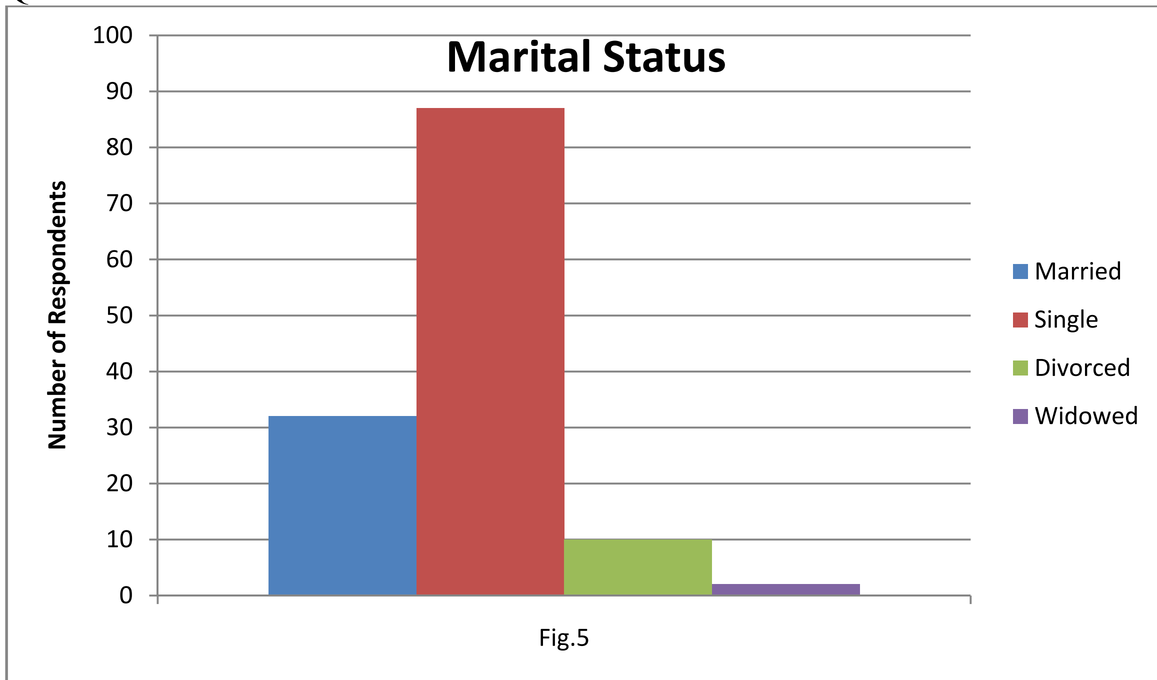


Fig.5

Question 1.3 Current Employment status

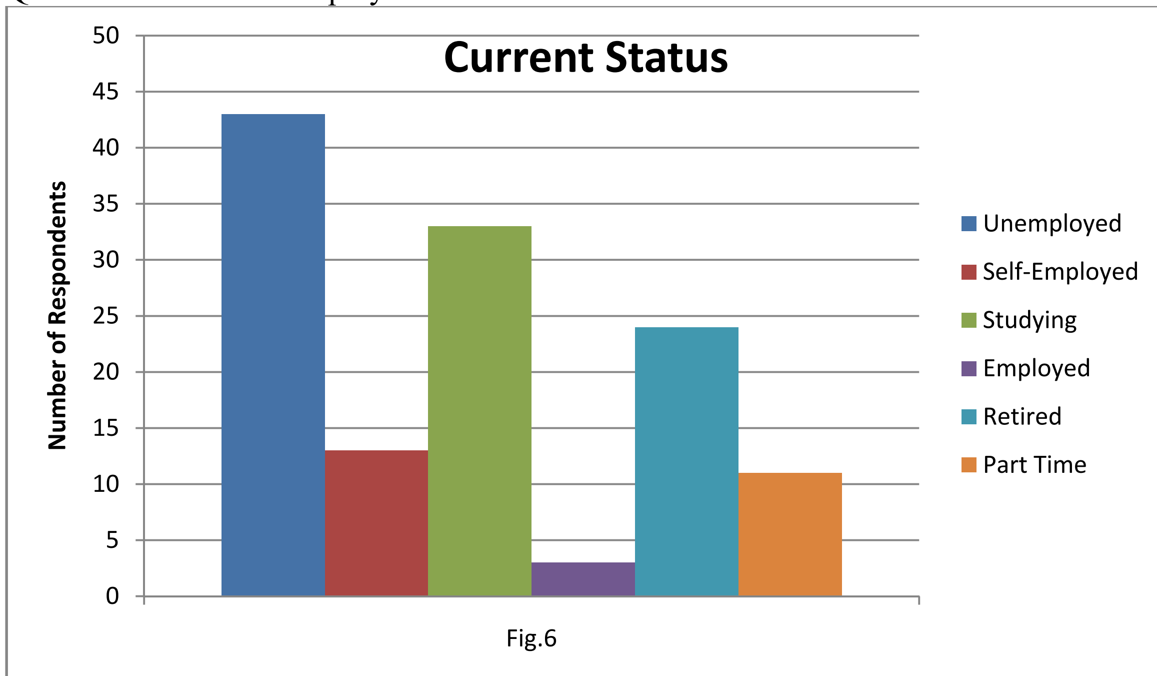


Fig.6

Question 1.4 Place of birth

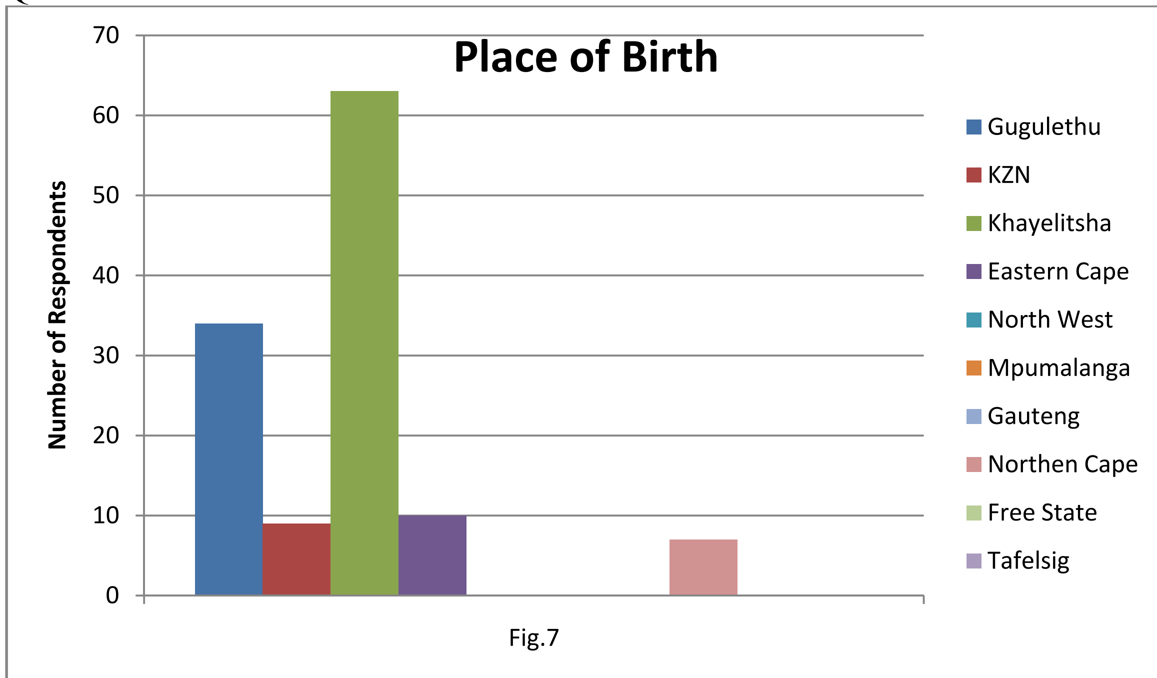


Fig.7

Question 1.5 Place where the respondents grew up

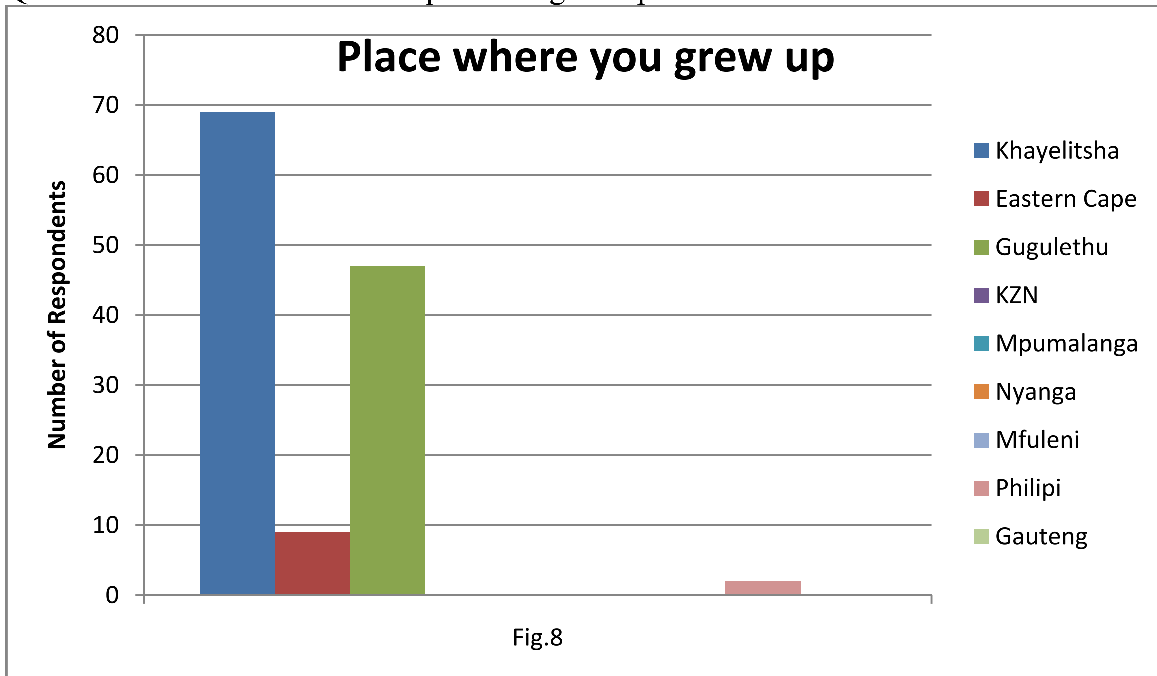


Fig.8

Question 1.6 Position of influence in the community

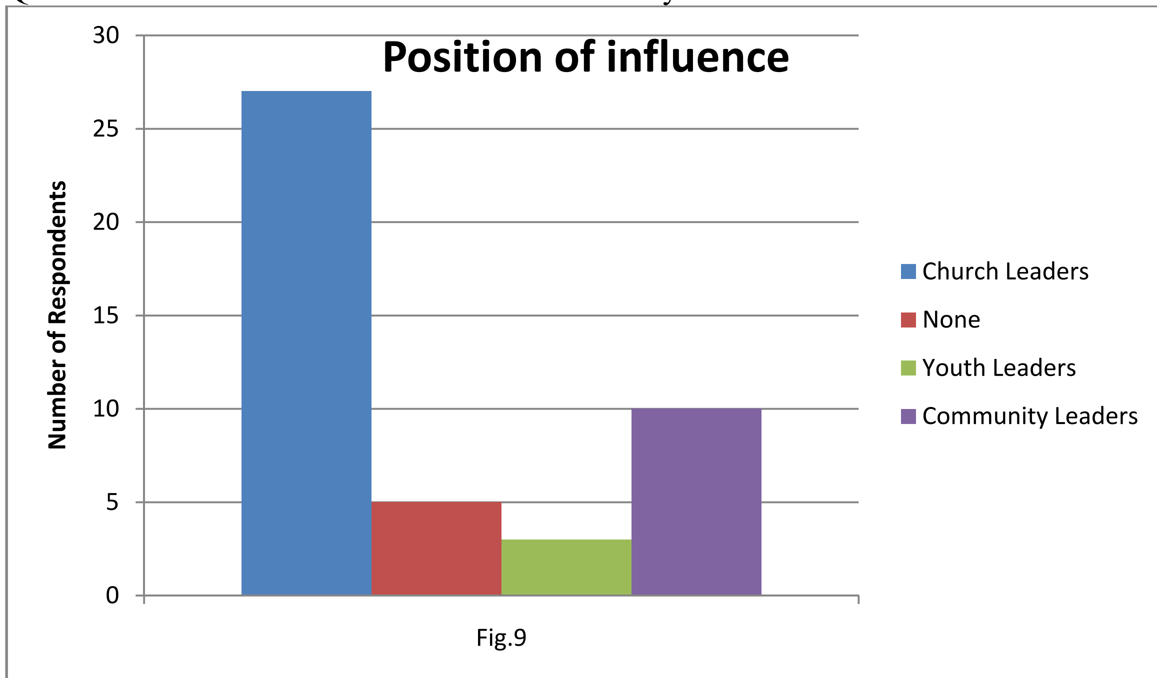


Fig.9

Question 1.7 Religious affiliation

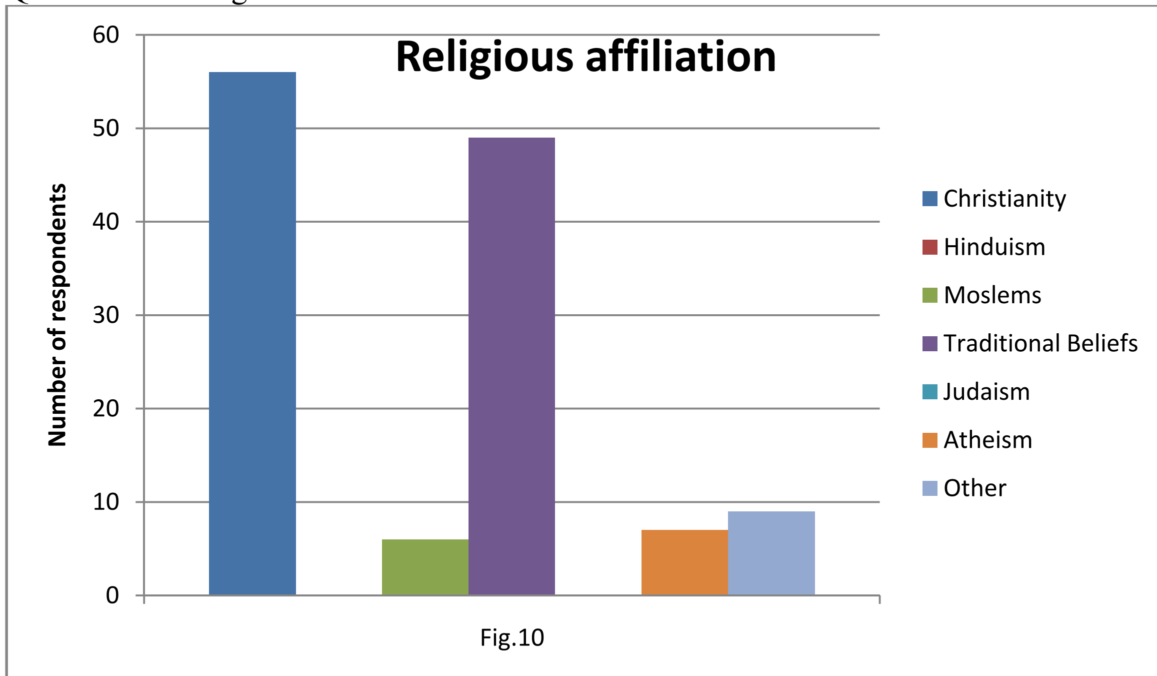
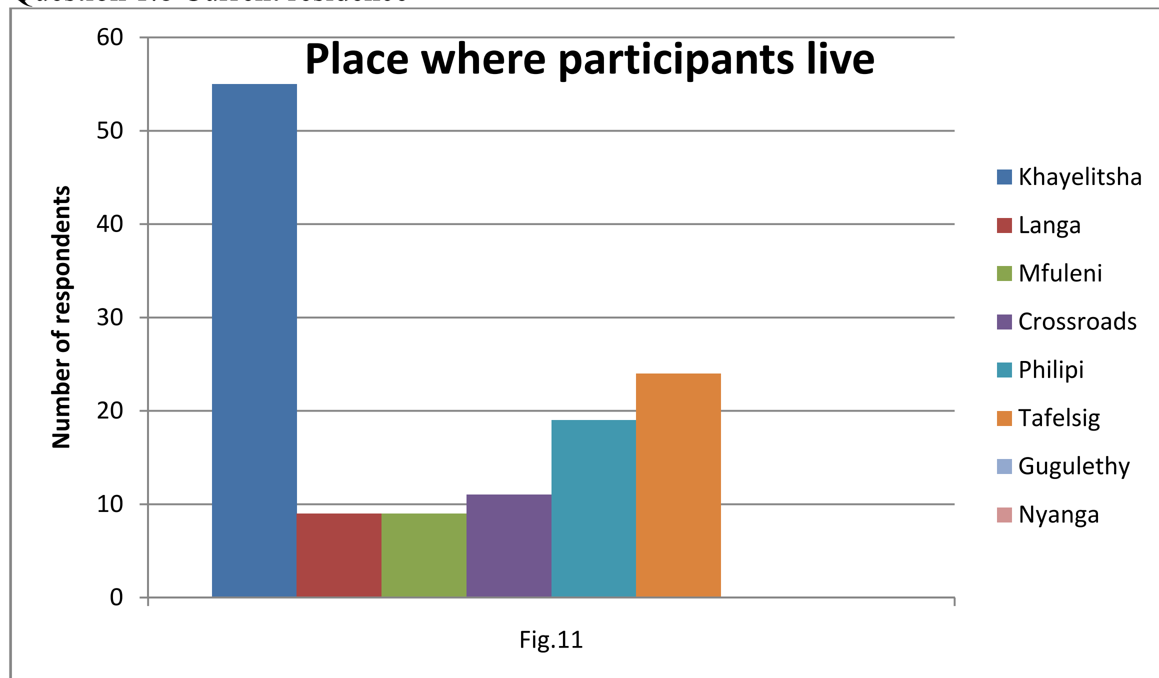


Fig.10

Question 1.8 Current residence



2. Understanding of HIV/AIDS epidemic

Question 2.1.Have you ever thought about HIV infection?

Of the participants, 98% of them have thought about HIV infection as affecting somebody else, not themselves. Although they have heard of and seen funerals of people who lived with HIV/AIDS, this does not help them to realize that they might become infected. Eighty participants have been affected by HIV/AIDS through a close member of family.

Question 2.2.What do we see in HIV infection that is not there in other infectious diseases?

The participants acknowledged that HIV infection differs from other infections because the outcome might be AIDS, which kills. They were also aware that there is no treatment for HIV/AIDS. The following illustrates response given:

"AIDS kill people; there is no cure for it" (*Participant L*).

"Many people have died through the HIV and AIDS more than any other known disease" (*Participant J*)

Other responses showed some ignorance of HIV/AIDS:

"Our ancestors knew how to cure this; it's not different from other sexual transmitted diseases" (*Participant L*)

"When people abandon their God given traditional practices, they invite anger from God and ancestors" (*Participant J*)

<u>Question 2.3.Why do you think South Africa has a high prevalence rate?</u>

Responses to the question were summarized as follows:

1. 40% of respondents believe that South Africans are highly and actively involved in sex.
2. 53% believe that refugees who sleep with local women pass the virus on to the women.
3. Only 5% believe that Commercial sex can spread AIDS.
4. 3% think that multisexual partners contribute to the spread of the infection.

The responses above indicate that participants were aware of high prevalence but a very small number attributed it to commercial sex and work and many sexual partners.

<u>Question 2.4.HIV can affect everybody and if you look at South Africa, it affects all groups, young and old, rich and poor. Why is this so?</u>

Only 23 people responded to this question. Between these responses, the following came out:

1. It affects all because of intergenerational sexual relationships.
2. The older, richer people give money in exchange for sex.
3. Poor people are vulnerable and are used and abused by those who offer assistance to them.

The remainder didn't respond; perhaps they didn't have the answer or they didn't know how to respond.

Question 2.5.Why do you think more Black South Africans are affected?

The answers given to this question blamed:

1. 23% poverty;
2. 19% apartheid;
3. 33% lack of education; and
4. 25% the fact that the Black population forms the majority in South Africa.

Question 2.6.Do you think young people are more affected? Why?

The reasons given for young people being more affected were:

1. Young people are sexual active.
2. Young people are not committed to one partner.
3. They are less educated on HIV/AIDS.
4. African culture does not allow parents to talk to their children about sex.
5. They are exploited by older, rich people.

Question 2.7.How do people become infected by HIV and how does this develop into AIDS?

38 respondents believe that HIV was created during apartheid to reduce the Black population. The remainder (89) believe that it get transmitted through sexual intercourse between a man and a woman. Only a very small number of participants understand that HIV causes AIDS, but even so they were not sure how it develops into AIDS.

Question 2.8.Do you think we have sufficient education on HIV/AIDS in South Africa?

The indication was that there is sufficient education on HIV/AIDS, but it does not help people to control their sexual urges which drive them to unsafe sex.

"People know about HIV/AIDS but they do not have the urge to control themselves sexually" (*Participant M*).

"No one is taking it serious but it's all over media" (*Participant N*).

Question 2.9.Why many people are still getting infected then if they know all that?

Various reasons were given:

1. 79 % believe that HIV/AIDS is a curse which can only be fixed by making peace with the gods.
2. 10% think that education alone cannot change lifestyle.
3. 11 % say poverty makes people vulnerable.

Question 2.10.How can sexual behavior be altered to break the epidemic?

It was very difficult to summarize the findings from this question because of the variety of answers given. The answers given were:

1. The government should enforce the law to change people's behaviour.
2. It is part of creation, and only God can change it.
3. People have very strong sexual desires and need to release them.
4. Good education and planning that will include people might work.
5. The church can help people to live better lives.

Question 2.11.What is the greatest challenges of HIV/AIDS in South Africa?

The great challenges faced by South Africans were listed as follows:

1. Young and productive lives are affected.
2. Experienced and skilled people are dying.
3. It has big economic impact as people look after their relatives and medication and funeral costs are very high.
4. Grandparents have to look after their grandchildren.
5. Many households are becoming more and more headed by children.

3. Voluntary HIV testing

Question 3.1.Do you think you may be at risk for HIV?

79% was uncertain in responding to this question. It seems that no one is sure if he is safe and not at risk.

Question 3.2.Have you been tested before?

Only 53 people were ever tested once in their lives. This was much less than 50% percent of the participants.

Question 3.3.Whose idea was it to get tested, yours or your partner's?

Among the 53 tested, only 21 tested voluntarily on their own, wanting to know their status. The rest was either by or through job applications that required them to know their status or through joining a program which encouraged testing; this was not an individual choice but outside influence.

Question 3.4.Have you thought about how you might react if the test came back positive?

The responses were:

1. I would kill myself.
2. I would spread (HIV/AIDS) to all my sexual partners.
3. A good number of 54 respondents were very positive, stating that they would help others not to become infected.
4. A small number of respondents, 18 people, believe that African traditional healers can heal the infection.

Question 3.5.Would negative results change anything you are doing?

There was uncertainty in responding to this question. Many people seem not to think that there is anything wrong with their lifestyles.

Question 3.6.What would a test result mean for you?

Like question 3.5, above this question was not well answered, perhaps because of the same reasons as above.

Question 3.7.Are there any reasons, other than risk of exposure, that bring people in for testing?

The same number of 21 respondents who responded in question 3.3 who voluntarily tested mentioned that they would do it to know their status. The rest think that one gets tested when he show symptoms or becomes very sick.

Question 3.8.Do you see yourself getting tested in the future? For what purpose?

The responses were all indicating a desire to be tested but no purpose was mentioned for the testing.

4. Relationships and safe sex

Question 4.1.What is safer sex for you?

The participants' responses were summarized in the following manner:

1. Using condoms.
2. Have one sexual partner.
3. Using traditional ways of *ukusoma* (a Zulu word for oral sex).

This showed that the participants understood what is meant by safe sex.

Question 4.2.Have you ever had any condoms feel uncomfortable or break?

All respondents recorded that condoms are very uncomfortable to use. No one has had ever an experience of a condom breaking while having sex.

Question 4.3.Do you think using alcohol or drugs affects your decision to use condoms?

The responses indicated that alcohol and drugs are a problem. When people are under influence, they do not think about safety.

Question 4.4.What decides whether you use condoms or not with your partner(s)?

Twenty-eight respondents agreed that condoms should be used to protect oneself from infection but they also agreed that there should be a mutual understanding between the partners. All other respondents indicated that it is up to an individual to decide; especially when one have sex with a stranger.

Question 4.5.How do you know when to use condoms with a certain person?

The response to the question can be summarized:

1. When you have a sex with a sex worker.
2. When you have sex with someone you do not trust.

3. When you have sex with someone who does not seem well.
4. When you have sex with a stranger.

Question 4.6.How do you think your partner feels (or would feel) about that?

The response to this question showed how female sexual partners are treated as “junior” partners in sexual matters. It was very clear that the purpose of sex is for a man’s satisfaction. Other partners are passive and their feelings are not important.

Question 4.7.Have any of your partners complained about using condoms?

The answers to this question were very vague, supporting the findings in question 4.6 those female partners are passive and their participation is for the men’s sexual fulfilment only.

Question 4.8.When was the last time you used a condom?

Only 23 (17 from the 20-29 age group and six from the 30-39 age group) indicated that they used condoms in the previous couple of weeks or months. The rest were not sure when they last used condoms. This response proves:

1. Age group more sexual active 20-29 and 30-39
2. that the majority of men do not use condoms or are not involved in safe sex.

Question 4.9.What is it that you specifically don’t like about condoms?

The answers to this question can be summarized as follows:

1. condoms are messy;
2. sex is *inyama enyameni*[6] meaning flesh to flesh condoms form a barrier; and
3. waste of sperm.

Question 4.10.Do you think the cultural tradition of *ukungena* is acceptable today?

Almost all respondents see the goodness of the *ukungena* tradition but pointed out that it is not desirable today to commit oneself to a life commitment (to one partner). In sexual matters, most

[6] A belief that condoms prevents one from having and enjoying sex directly, literally means flesh to flesh

men believe that it is their given right to ”service” women who do not have their own men or husbands.

Question 4.11.How does gender affect our health?

Beside the twenty pastors who are in the age group of 30-39 and 40-49, and 15 men, the rest think that women who are sexually immoral bring health problems.

Question 4.12.How can women fight against AIDS without the co-operation of men?

1. Respondents from young people see a great need to fight HIV/AIDS together.
2. All the 27 who are marked to be in some kind of leadership believe that it should be both women and men together.
3. The rest believe that if Africans retain their traditional norms where women are educated and trained to be responsible mothers and wives, the problem would be solved.

The group that responded with point 3 above clearly blame it on women and their departure from African traditional ways of living.

Question 4.12.1.If you or your partner cannot enjoy sexual intercourse, who is to be blamed?

The response to this question confirmed that African men believe sex is for their satisfaction only. It is not important whether a female sexual partner enjoys sex or not. The enjoyment and satisfaction is for the men. Women's role in sex is twofold according to the findings:

1. To make a man happy.
2. To bear children.

Question 4.13.What do you think of *ilobolo*?

All respondents agree that *ilobolo* is part of the African culture but a few problems were raised in regard to *ilobolo*:

1. It needs to be decreased to suit the economical needs of today.
2. Women need to be reminded that a man pays it for the services he gets in return from his wife.
3. Many men believe that its significance is to prove men's seniority to women hence they (the men) paid for their wives. This shows how men think about paying for their wives as commodities.

Question 4.14.What do you think is a women's role in sexual relationship?

Although 87 respondents believe that a women's role is to please men in sexual matters, few men see it as a mutual thing between two partners:

"God created us different roles but of equal nature" (*Participant B*).

"It takes two to tango otherwise its called rape" (*Participant G*).

"You cannot enjoy it if your partner is not happy" (*Participant F*)

Summary

It was clear from the survey that entrenched cultural beliefs among men in South Africa actively encourage the spread of HIV/AIDS. Africans are still very traditional and their sexual behaviour is ingrained and totally against safe sexual practices, like condom use and monogamous relationships that limit the spread of HIV. African leaders in almost all spheres of life seemed to be calling upon people to maintain centuries-old cultural beliefs and practices. Not all these practices are bad but unfortunately some seem to encourage men to have more than one sexual partner. The following is a summary and interpretation of the findings of the present study, it confirms the beliefs of people that:

- In African culture, decision-making is traditionally a male prerogative. Sexual matters and decisions, therefore, lie with the man.
- There are men who still believe that a role of a woman is solely that of homemaker and in child bearing.
- Men are driven by their sexual urges, and behaviour is determined by social norms. They role is impregnate women and leave to them (women) to take care of their children. Of course, this distorted and corrupted practice is not found in communal African culture.
- Men still believe in the practice of *kungena,* or wife inheritance, whereby a widow becomes the wife of the deceased man's brother, a practice found to spread HIV.

- Elements of traditional culture and subservient female roles are pushing HIV/AIDS infection rates up to unprecedented levels.
- Traditional practices such as *ukulobola* (dowry payments) make women men's property.
- *Isoka* (a Zulu word for a playboy) is still popular among young men in South Africa. It encourages men to be promiscuous while women are expected to remain pure.
- Men feel that the ABC strategy gets into the way of procreation.

Conclusion

HIV/AIDS cannot be stopped unless there is a change in people's sexual behaviour. This change will come through men playing their role in prevention and interventions. Men should be involved. We need strategies that will bring them in and help them to see that women have not taken away men’s rights. Male sense of "displacement and irrelevance", combined with poverty and unemployment, undermines male self-esteem. There is a feeling of rejection and feeling of guilt with the result that men feel blamed for all social evils. They react by withdrawing themselves and do not feel part of the solution. This will drive the rising HIV infection rates up more and more. All stakeholders should find ways of bringing men in, in a way that they would be empowered and perceive manhood in a new and healthy way for all our citizens.

CHAPTER 6

CONCLUSIONS, SUMMARY AND RECOMMENDATIONS

In South Africa the government and other organizations are working very hard to improve the situation of women in the country. Many of the practices that are culturally suppressive to women are not promoted by the government but are instead ingrained within the cultural values and beliefs. The issues of male dominance and women subservience need to be addressed at the base level by educating both men and women about gender roles and the need for equality. Men should be actively mobilized to work towards improving the situation of women. It will take time and perseverance to change African cultural beliefs about gender in South Africa but it is not impossible. Cultural beliefs and traditions can be followed without harming and hurting women and their rights. It has been shown that polygamy leads to the transmission of HIV. Women cannot address the issue of polygamy without men's involvement. Cultural norms promoting male dominance serve to continue the subordination of women, which directly affects the continuing spread of the disease among women. Until these norms are altered, the problems surrounding women and AIDS cannot be addressed and combated.

CONCLUSIONS

This research project has shown that, although there has been so much effort made to educate people on HIV/AIDS and so much awareness has been made through the media, government projects and other organizations such as CBOs, FBOs and NGOs, the figures continue to increase and they are not stabilizing. The campaigns on prevention are not succeeding. The high level of new HIV infections occurring in South Africa reflects the difficulties that have been faced by AIDS education and prevention campaigns.

Based on the results obtained and discussions made, the following conclusions could be made.

- Many men still hold the view that they are beneficiaries of African culture, which might be misinterpreted as male privilege and discrimination against women.
- Working with men and boys to transform and confront culture is one of the ways to end the spread of HIV/AIDS gender inequality and women abuse.

- Women should be involved in helping men to promote women's empowerment and equality and in the struggle to combat the spread of HIV/AIDS in South Africa.
- Given the dominance of patriarchal ideologies and systems and the relationship between the low status of women and the spread of HIV/AIDS, there is even a more compelling reasons for involving men and boys in the struggle for gender equality.
- Men will not give up the power and control they have over women unless they are engaged in finding the solution.
- Most men feel left out and their rights "given away" to women, but there are some who are sensitive to people of the opposite sex and want to treat them as mothers, sisters, wives and daughters. These men can be mobilized to engage others to change without abandoning that which is good in an African culture like community and the concept of *ubuntu*[7] and many other positive elements in the culture.
- Gender analysis becomes a key tool for the unearthing of the unequal gender and power relations as the root cause of many of the social and economic ills facing society. The unequal impact of the HIV/AIDS pandemic on females relative to males is a crucial revelation from gender analysis. The powerlessness of women and girls to change their own situations is one of the obstacles that must be addressed.
- Because of the power that men enjoy, it is crucial that they become agents of transformation and part of the solution to combating the HIV/AIDS epidemic.

African households are overflowing with women victims of HIV/AIDS who contracted the virus through their husbands, boyfriends and other sexual partners. Some of these women are victims of rape, polygamous relationships, incest, economic hardship and despair that drove them to commercial sex work. Most interventions have not addressed critical African cultural issues that drive the spread of HIV/AIDS. Most interventions have succeeded in educating women and youth. They (women) are already doing a lot to cope with the pandemic, but men hold the remaining part of the solution.

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[7] Concept of living together in the community with caring and loving, and sharing.

Further research topics

The following could be further research topics:

- Promoting the participation of men in the battle against HIV and AIDS.
- Engaging men in reflection of African traditional roles in the context of HIV and AIDS.
- The concept of *ubuntu* and HIV/AIDS.
- The involvement of men in gender-related issues that promote the spread of HIV/AIDS.

RECOMMENDATIONS

Bearing in mind some of the main conclusions which have emerged from this study, the following recommendations are offered:

Men should be included in the fight against HIV/AIDS

There is a need for greater emphasis on working with men since the main form of transmission is heterosexual and it is usually men who have more than one sexual partner. HIV/AIDS programmes in prevention and care usually target women. The cultural norms among the African people which promote male dominance and treat women as subordinate to men should be dealt with in order to address and combat problems surrounding women and HIV/AIDS.
The lack of respect for women and youth by men who are seen as powerful people in the culture should be dealt with by all structures in our society. The government could play a major role in seeing that this lack is dealt with. Engaging men in the fight against HIV/AIDS is critical to addressing the pandemic's gender-based inequalities. Creative and inclusive programs ensuring that men are aware of the oppressive effects on women and oppressive practices should be developed. More men must be involved in programs that are geared towards prevention, which is important in curbing the spread of the disease.

The whole community should be involved

The centrality of culture must be addressed more rigorously in each country, recognizing that culture needs to transform if the pandemic is to be halted. They also agreed to strengthen gender

and HIV/AIDS policies and to share best practices between men and women, whether in marriage relationship as husband and wife and in other relationships such between a girlfriend and a boyfriend. The community-based education, which includes cultural and traditional leaders, is the only means to secure behavioral change. Men should be specifically targeted as members of communities, leaders, workers, parents and spouses and be involved in learning through educational programmes, and in designing interventions to reach other men.

Efforts to recruit and train male care givers should encouraged

Home-based care and support has traditionally been the responsibility of women. Engaging men in giving care brings them face-to-face with the realities of HIV/AIDS and the need for change. Creating forums for men to share, discuss and agree on action is an effective way of mobilizing their support and changing their attitudes and behaviour. Activities include developing new rites of passage, which take into consideration the changing roles of men in society, and particularly recognising the principles of gender equality that are gradually being accepted as a social norm. Boys' camps are another common activity where they learn new values under the guidance of men and older youths.

Reaching men and boys at all levels of society

Programs should be implemented at the grassroots level, communicating with people in familiar ways that are consistent with the local culture, and include all members of society, as opposed to targeting certain high-risk groups. This will mean that everyone in a community is exposed to the consequences of HIV/AIDS. Men should be encouraged to open such issues for discussion among themselves and influence others to test. Peer education in schools and work places is an effective strategy in maintaining and encouraging behavioral change. Sex education in school, out of school, peer clubs, community groups, games clubs, universities, colleges and work places can attract large audiences of men and boys. Transform male attitudes and sexual behaviour. This requires the mobilisation and involvement of men and boys from a very young stage of their lives to adulthood.

Masculinity and HIV/AIDS

The concept of masculinity differs from one society to the other, depending on the socio-cultural situation. It is defined as a set of attributes, values, functions and behaviors that are considered normal conditions of men in a given culture. The socialisation of boys and men regarding sexuality is one of the areas of masculinity that is of major concern today in the face of the HIV/AIDS, especially in Africa. Most men and boys are socialised to believe that they are entitled to have sex and that it is natural to have many partners. Informal polygamy is seen as being a right to have sex with many women without obligations of fidelity or responsibility to the women or the children conceived in these relations. Men are placed at risk by masculine values, which discourage them from protecting themselves. In a recent consultation with some men in Nairobi, the risky behaviour many of them indulge in was attributed to the way they were socialized and brought up to show masculine prowess and power over women and girls. The need for creating a new masculinity has become popular as more men seek to understand how to transform male behaviour. Men often play the role of protector and provider for their families; now it is time for them to take their role to another level and protect their families from HIV and AIDS. Men must take the initiative and protect themselves and their families from HIV and AIDS.

How can men help to stop the spread of HIV/AIDS

There are many HIV voluntary counselling and testing sites all over the country and many of them offer a quality service for free, but somehow most men are reluctant to go for testing. If men want to become the heroes in the fight against HIV and AIDS, they must be brave enough to go for HIV counselling and testing. VCT can mean a new beginning for an individual whether the result is negative or positive. Building partnerships between women and men and transforming socialisation processes is the key strategy for addressing one of the root causes of the spread of the pandemic, the unequal gender power relations. The fight against the HIV/AIDS pandemic requires the effort of everybody in society, especially men who hold the power of decision-making at every level, from the bedroom to the state houses and other power bases of policy, politics and resources.

Encouraging partnerships between women and men

The world will never be the same again; women's liberation movement is growing and getting more attention. Men are beginning to realise that the acceptance of equality as a reality is a pre-requisite for the inevitable social transformation. Men have started rethinking their roles and status regarding other issues such as reproductive health and family responsibility, including the nurturing and care of children. The role of men in socialising boys to develop a new masculinity is one of the areas where programmes for the empowerment of the girl child have motivated men to act to empower the boy child. Men can also be mobilized to support the campaign of men against the spread of HIV/AIDS, including the protection of women and girls.

CONCLUSION

What is clear from every study is that there is an exceptionally severe epidemic of HIV/AIDS in South Africa. There are a number of things that can be done in order to reduce the burden of the epidemic among women. This epidemic affects all parts of the population, though women are more likely to be infected than men. Many tens of thousands of people are dying. For South Africa there are tremendous challenges remaining in the fields of HIV education, prevention and care. Meanwhile, and for as long as the status quo remains, more and more women and girls will continue to lose their lives. The hope for winning the fight with HIV/AIDS pandemic lies in changing the attitudes and behaviour of men and boys. Men are not afraid of being equal with women and are willing to change their behaviour and attitudes. This should include developing new masculine and feminine ideologies, especially among the youth. The involvement of men in programmes for gender equality, and especially the fight against the spread of the HIV/AIDS pandemic is essential.

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APPENDICES

APPENDIX 1

The intention of this questionnaire is to assess the understanding and the involvement of Black South African men in the HIV and AIDS epidemic. Any information provided will remain private and confidential. The research is done by Siegfried Ngubane for the purpose of research for the degree of MPhil in HIV and AIDS Management, Stellenbosch University.

1. **Personal Information**

Please mark the appropriate box with "X".

1.1 In what age group are you?

-19	20-29	30-39	40-49	50-59	60+

1.2 What is your marital status?

	Married
	Single
	Divorced
	Other

If other, please specify

1.3 What is your current status?

	Student
	Unemployment
	Employed
	Pensioner
	Self-employed
	Other

If other, please specify

1.4 Where were you born?

	W. Cape

	KZN
	E.Cape
	Gauteng
	Mpumalanga
	N.West
	Limpopo
	Free State
	N. Cape
	Other

If other, please specify

1.5 Where did you grow up?

	W. Cape
	KZN
	E.Cape
	Gauteng
	Mpumalanga
	N.West
	Limpopo
	Free State
	N.Cape
	Other

If other, please specify

1.6 Any position of influence in the community?

	Religious leader
	Community leader
	Youth leader
	Other

If other, please specify

1.7 What is your religious affiliation?

	Christianity
	Hinduism
	Islamic

	Traditional Beliefs
	Judaism
	Atheist
	Other

If other, please specify

1.8 Where do you now live?

	Khayelitsha
	Gugulethu
	Nyanga
	Langa
	Crossroads
	Phillipi
	Mfuleni
	Other

If other, please specify

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2. Understanding the HIV/AIDS epidemic

2.1 Have you ever thought about HIV infection?
2.2 What do we see in HIV infection that is not there in other infectious diseases?
2.3 Why do you think South Africa has a high prevalence rate?
2.4 HIV can affect everybody and if you look at South Africa, it affects all groups, young and old, rich and poor. Why is this so?
2.5 Why do you think more Black South Africans are affected?
2.6 Do you think young people are more affected? Why?
2.7 How do people become infected by HIV and how does this develop into AIDS?
2.8 Do you think we have enough education on HIV/AIDS in South Africa?
2.9 Why many people are still getting infected then if they have this education?
2.10 How can sexual behaviour be altered to break the epidemic?
2.11 What are the greatest challenges of HIV/AIDS in South Africa?

3. Voluntary HIV Testing

3.1 Do you think you may be at risk for HIV?
3.2 Have you been tested before?
3.3 Whose idea was it to get tested? Yours or your partner's?
3.4 Have you thought about how you might react if the test came back positive?
3.5 Would a negative result change anything you are doing?
3.6 What would a test result mean for you?
3.7 Are there any reasons, other than risk of exposure, that bring people in for testing?
3.8 Do you see yourself getting tested in the future? For what purpose?

4. Relationships and Safe Sex

4.1 What is safer sex for you?
4.2 Have you ever experienced any condoms feeling uncomfortable or breaking?
4.3 Do you think using alcohol or drugs affects your decisions to use condoms?
4.4 How do you decide whether you use condoms or not with your partner(s)?
4.5 How do you know when to use condoms with a certain person?
4.6 How do you think your partner feels (or would feel) about that?
4.7 Have any of your partners complained about using condoms?
4.8 When was the last time you used a condom?
4.9 What is it that you specifically don't like about condoms?
4.10 Do you think the cultural tradition of *ukungena* is acceptable today?
4.11 How does gender affect our health?
4.12 How can women fight AIDS without the co-operation of men?
4.13 If you or your partner cannot enjoy sexual intercourse, who is to be blamed?
4.14 What do you think of *ilobolo*?
4.15 What do you think is a women's role in a sexual relationship?

THANK YOU FOR YOUR HELP!

Appendix 2
Date: 04/08/2009

TO WHOM IT MAY CONCERN

This is to confirm that Rev Siegfried Ngubane has the permission of the Khayelitsha Rainbow Soccer League to do research in connection with his M.Phil. thesis on HIV/AIDS Management.

Yours faithfully
CS Samente
Coordinator
Rainbow Soccer League

APPENDIX 3

TO WHOM IT MAY CONCERN

Re- Rev. Siegfried John Ngubane

This is to confirm that Rev. Siegfried Ngubane has the permission of the Emmaus Bible School to do research in connection with his M.Phil. degree in HIV and AIDS.

Yours faithfully
G Mashalaba
Administrator
Date: 013/08/2009

APPENDIX 3

Was given permission but delayed in writing and sending a letter permitting the research to do the study