

# **AN INVESTIGATION ON THE RESPONSES OF MEN TO AN HIV-POSITIVE DIAGNOSIS**

**Thozamile Qubuda**

Assignment presented in partial fulfilment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University



Study leader: Mr Gary Eva

April 2005

***Declaration***

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

Signature:

Date:

## Summary

This research investigates the responses of men to an HIV-positive diagnosis. It was conducted in the light of anecdotal evidence that many men respond to an HIV-positive test result by vowing to infect women, so as not to die alone, or out of a sense of revenge.

An explorative-descriptive approach was used. Data was gathered by the use of three research tools:

- Pre-test questionnaires
- Post-test interviews
- Post-test focus groups

There was no sample for this study, it represent 100% of men who visited the Voluntary Counselling and Testing (VCT) clinic from June to October 2004. Hundred and fifty respondents filled in pre-test questionnaires and the same respondents were interviewed after. Focus group discussions were conducted as a method to collect qualitative data that was required and the information in which way “people’s feelings, thinking, perceptions and point of views” can be obtained. Respondents participated in focus groups discussions in ten groups in different days in the Kayamandi Primary Health Care Centre to develop a better understanding of gender base violence, an issue that I have identified as a priority for the men of Kayamandi. The focus groups lasted one and a half to two hours.

The data generated was analysed both quantitatively and qualitatively. The findings indicated that after post-test counselling, 17% of respondents openly said they would infect other people. This is a disturbing scenario. I do not know whether, with time and follow up counselling, there will be a change of mind with this 17%. On the other hand, after post-test counselling 83% said they would protect themselves and others. There were all sots of group dynamics: those that believed in maintaining their culture, and those that said things must change to suit the present situation. The

people on the shacks were more tribal with their partners in the hostels. The respondents in formal houses were more liberal.

The study's recommendation draws attention to the need for the inclusion of men in reproductive health and a follow up counselling were both partners are involved. As an urgent need, I would like to concentrate on the 17% who say they will infect other people so as not to die alone. This group represents a huge portion of people living in the shacks. They are unemployed, less educated, and tribal in nature.

## Opsomming

Die doel van hierdie navorsing was om die reaksie van mans, wat MIV positief gediagnoseer is, te ondersoek. 'n Verkennend-beskrywende benadering is gebruik en die data is ingesamel deur middel van voor-toets vraelyste, na-toets onderhoude sowel as na-toets fokusgroepe. Die proefpersone het bestaan uit 150 mans wat die Kayamandi kliniek vir vrywillige toetsing en berading tussen Junie en Oktober in 2004 besoek het.

Daar is mans wat na die na-toets berading aangedui het dat hul ander mense met hul MIV sal infekteer, eerder as om alleen met die virus te moet leef. Daar is verskillende menings tussen die proefpersone gevind, die wat glo om hul kultuur voort te sit en ander wat besef dat hul seksuele gedrag verander moet word om by hul huidige situasie aan te pas. Daar is bevind dat die inwoners van die krothuse meer gesag oor hul seksuele maats uitoefen as die wat in die hostelle woon. Die persone wat in die formele huise woon was egter meer liberaal in die verband.

Daar word aanbeveel dat mans deel moet wees van reprodktiewe gesondheid en opvolg benadering saam met hul seksuele maats bywoon. Daar moet dringend aandag geskenk word aan die groep wat aangedui het dat hul ander sal infekteer eerder as om alleen met die virus saam te leef. Hierdie groep verteenwoordig 'n groot deel van die mense wat in krothuse woon, is werkloos, ongeskoold en gesaghebbend.

## **1. Introduction**

In South Africa, like in many parts of the world, the attitudes, values and behaviours of many men all too often contribute to a host of public health problems such as domestic and sexual violence, increasing rates of sexually transmitted infections (STIs) – including HIV and AIDS – and high rates of maternal and infant mortality. However, as these vignettes also make clear, men can, and often do, play a critical role in promoting gender equity, preventing violence, and fostering constructive involvement in sexual and reproductive health.

Spurred by the recognition that men's attitudes and behaviours can either impede or promote sexual and reproductive health, many sexual and reproductive health organisations across the world have launched initiatives that encourage positive male involvement and that draw connections between a range of issues that are often dealt with in isolation of each other, but that are all interconnected in important ways. This case study investigates the responses of men to an HIV-positive diagnosis. The aim of this piece of research is to help contribute to the creating of meaningful opportunities for men from all walks of life to examine contemporary gender and cultural norms – challenging those that compromise health and well-being, and celebrating those that promote healthy thriving communities.

## **2. Kayamandi as a study area**

Kayamandi is located on the slopes of the Papegaaiberg, on the northern outskirts of Stellenbosch. It is a predominantly African township that is physically separated from the town of Stellenbosch by a bridge and a railway line. It has a population of over 17 200 people. There are three housing segments within this township, namely the formal housing area, the informal settlement and the hostel area. About 77% of the inhabitants live in informal housing on small tracts of land, presenting a uniquely accessible area which exhibits social problems facing most urban areas in South Africa today. It also provides an opportunity to study urban social problems in a

developing community, and their relationship to the quality of life as perceived by the inhabitants of the area.

The study area was chosen due to its easy access to me, and my experience of working there in the HIV and AIDS field, especially the prevention of mother to child transmission programme (PMTCT). Women mostly come alone to the clinic for HIV-testing, without their partners. A few of them have experienced domestic violence after disclosing their HIV status, and some have been abandoned by their partners. This helped trigger this investigation of the responses of men when they are diagnosed as HIV-positive, so as to get a better understanding of how to involve men in reproductive health.

### **3. The context in Kayamandi**

In South Africa, HIV flourishes most in areas that are burdened by unemployment, homelessness, welfare dependency, prostitution, crime, a high school dropout rate and social unrest. Kayamandi is no exception. The impact of unemployment, illiteracy, and a general environment of lawlessness – all commonly considered contributing factors towards criminal behaviour – this seems to be a factor in HIV infection. The poor are more likely to become migrant labourers or commercial sex workers as a survival strategy. HIV prevalence has also been tied to levels of social cohesion, or the number of unifying bonds between members of a community. Areas which struggle with violence, high rates of crime, substance abuse, substandard housing, overcrowding and unsanitary living conditions are also likely to be plagued by unemployment, domestic abuse, dysfunctional relationships, and a lack of security and stability. Furthermore, the uneducated and illiterate are less likely to be reached by HIV education programmes, and have lower levels of knowledge and awareness about HIV/AIDS. Finally, people in marginalized communities are less likely to have access to health care, and thus more likely to suffer from untreated STIs, which increases the probability of HIV transmission.

#### **4. Problem Statement**

Just ten years after celebrating the end of apartheid, South Africans now find themselves faced with yet another bitter struggle. This time the battle is against HIV and AIDS, and violence against women – twin epidemics that are both driven in critical ways by social norms about gender, power and violence, and which currently threaten the lives of millions of South Africans.

The statistics make startlingly clear the extent and severity of these two public health crises. In many parts of the country, up to 30% of adults are estimated to be HIV positive (South African Medical Research Council, 2001). 5-7 million South Africans are expected to die from AIDS-related diseases by the year 2010 (South African Medical Research Council, 2001). The statistics on violence against women are no less disquieting. South African Police Services (SAPS) statistics claim that about 249 cases of rape were reported to the police in 1999; while Rape Crisis Cape Town argues that the real figure is at least 20 times higher: the equivalent of one rape in every 23 seconds. These figures give South Africa the highest per capita rate of reported rape in the world.

The HIV and AIDS epidemic disproportionately affects women's lives both in terms of rates of infection and the burden of care and support they carry for those with AIDS related illnesses. Indeed, young women are much more likely to be infected than men. A recent report conducted by the University of the Witwatersrand in April 2004 indicates that women make up 77% of the 10% of South African youth, between the ages of 15-24, who are infected with HIV.

Women's greater vulnerability to HIV/AIDS is in part explained by the very high levels of sexual and domestic violence reported across the country – some of the highest levels reported anywhere in the world. For instance, almost one-third of sexually active women (30%) reported that they did not want to have their first sexual encounter and that they were coerced into sex (Pettiforr A, Rees H, Stevens A:



2002).

Based on the above South African context on gender-based violence one must ask, as a problem statement, whether an HIV positive diagnosis in men results in a risky sexual behaviour, thus infecting women deliberately out of a sense of revenge.

## **5. Research Hypothesis**

My hypothesis is that the response of some men in Kayamandi, will respond when they are diagnosed as HIV-positive, with both risky sexual behaviour, and wishing to infect women deliberately out of a sense of revenge.

## **6. Aim and Objectives**

The aim of the study is to ascertain if the above hypothesis is correct – in other words, to ascertain the attitudes of men in Kayamandi after an HIV positive diagnosis, and the extent to which the hypothesis is correct. Additionally, I wanted to gain a better understanding of how to involve men in the reproductive health programmes.

I would like this study to contribute in a small way, with others, to challenge the gender order, empower men to reduce gender based violence and risky sexual behaviour when men are diagnosed as HIV positive. Among broader objectives, for this study to contribute to educating male peer educators to teach other men to challenge the gender order in Kayamandi and try to link Kayamandi men to other Man as Partners (MAP) against HIV and AIDS and gender-based violence organisations in the Western Cape and South Africa. This will be done through workshops that will be conducted with selected peer educators from men of diverse backgrounds.

## 7. Review of related literature

### 7.1 Why focus on men

On 22 November 2000 the Gender AIDS Forum (GAF) hosted its first forum entitled “Involving Men” at the University of Natal, Durban. The purpose of the forum was to discuss the extent to which men are involved in the fight against HIV and AIDS, and to look at ways to involve men. Guest speakers were Gethwana Makhaye of Targeted AIDS Interventions (TAI) and University of Natal, Gender studies lecturer, Vasu Reddy. Reddy’s presentation focussed on the significance of involving men, whether involving men addresses or challenges gender equality, and the best approaches to involving men as a way of promoting gender equality. He stated that the implications of involving men in gender and HIV and AIDS contexts would include examining:

- ❖ how men spread HIV;
- ❖ factors relating to women’s vulnerability and approaches to changing male behaviour;
- ❖ definitions of masculinity and femininity; and
- ❖ how the power relations between men and women could change to create an enabling environment for both sexes to protect each other (Agenda 47, 2001:107).

Literature is available on muscularity (Goldberg: 1976; Forsteau: 1974; Plec & Sawyer, 1974; Farrel: 1974). These authors have brought to consciousness the issues of men. Among them were male fears of appearing vulnerable, the lack of intimate communication between men, the ignoring of their health in their pursuit of money and power, the inability to express feelings, the need always to be in control regardless of the negative consequences and men’s total reliance on intellect and reason at the expense of more intuitive modes of knowing. All these issues struck a deep chord within men. Over the past 12 years, South African men’s groups have

reflected on the inherent contradictions of the traditional male role. Through genuine communication, it was discovered that beneath a masculine facade of toughness and arrogance, were sensitive, hurting little boys who felt they had to be strong, unfeeling, and invulnerable to be accepted. Once the little boy was given permission to come forward and voice his feelings and thoughts, each man discovered a sense of acceptance and freedom that he had lost through years of socialization.

Our denial of our feelings resulted in unexpected outbursts of anger at those we love and an inner deadness that covered up our loneliness and frustration, and HIV infection has made these feelings worse.

Despite living in the so-called liberated era, most males are still being raised in ways significantly different from females. Boys are more likely than girls to be encouraged to play aggressively (Hyde & Linn, 1986), to be physically punished for wrong actions (Hartley, 1974), and to be discouraged by parents as well as by peers from exhibiting behaviour that diverges from prescribed gender norms (Fagot, 1978, 1985). Crying and expressing feelings are often kept in check by older males, including many fathers, who remind young boys that “only girls cry”. It is not surprising that television fantasy and cartoon heroes convey messages of male heroics through strength, determination, and dominance (Greenberg, 1982). As the boy toddler grows, his behaviour is subtly reinforced by his family, peers and media heroes to equate maleness with toughness, competitiveness, and dominance and to avoid “feminine” qualities, such as dependency, submissiveness and emotional expressiveness. “No sissy stuff” is the phrase that David & Brannon (David and Brannon, 1976) coined to describe the avoidance of femininity at all costs. Because many fathers have been raised in a restrictive male culture defined by what they do, they perpetuate the sense of separateness in their son by maintaining emotional distance and reinforce independent and autonomous behaviour (Chodorow, 1978; Dinnerstein, 1976; Gilligan, 1982).

While the fear of serostatus disclosure has been clearly linked with fears of violence,

in the reported experience of individuals and of organisations dealing with gender-based violence and HIV/AIDS, the culprit was a male partner but the focus of empowerment was women. In a UNIFEM (PW : VC – Z R, 2002) study on the impact of HIV/AIDS on communities in Zimbabwe revealed that, even if women were educated about HIV/AIDS, their economic dependence on men left them feeling “helpless” to negotiate safe sex. Evidence in relation to condom negotiation, voluntary counselling and testing and the uptake of interventions to prevent HIV transmission from mother to child points in the same direction: women’s empowerment and safety depend also on changes in the attitudes and deeds of men and boys. The 2000-2001 World Aids Campaign was aimed at involving men (particularly young men) more fully in the fight against AIDS. The Campaign, with its slogans “Men Make a Difference” and “I Care...Do You?” highlighted how harmful gender roles make men and women more vulnerable to HIV and how men could make positive contributions to the fight against the epidemic (American Association for World Health, 2000).

## **7.2 An African view of sexuality**

In the traditional African set-up, status and power are awarded to person, and social control is determined by cultural values (Nicholas & Durrheim, 1995). Most females are not given equality with males (Luiz et al., 1995; Mjoli, 1997). Most women are lacking in power and social status, and are often economically dependent on their husband or lover (Ackerman, 1985; Bozzoli, 1983; Lemmer, 1999; Orubuloye et al., 1993; Schoepf, et al, 1991; Strebel, 1995; Ulin, 1992).

Most African men are governed by the concept of machismo that leads to a power imbalance in the relationships between men and women (Lindegger & Wood, 1995). Most Africans show highly authoritarian attitudes as a result of a firm patriarchal upbringing. It seems as if this patriarchal nature is intensified by the presence of strong authoritarian norms, which are linked to a rigorous sex-role differentiation (Heaven & Niewoudt, 1981; Lemmer, 1989). It is the man who is in control, who

makes decisions and who dominates (Cock, 1987; Friedman, 1993; Orubuloye et al., 1993; Pizzi, 1992). Therefore, most women largely remain receivers of attitudes regarding their roles as defined to them by men, and have no sexual rights in their relationships with men (Lemmer, 1989; Luiz et al., 1995).

It also seems that one of the most powerful forms of control over women's sexuality is their fear of a violent reaction when they refuse to consent to husbands' or lovers' unsafe sexual practices or insist on condom use (Strebel, 1995). The wife's refusal of the husband's sexual attention may cause her to be cast out of the marriage (Orubuloye et al., 1993). In spite of this vulnerable position of most women, some health workers expect women to take responsibility for men's sexual behaviour (Gwede & McDermott, 1992; Strebel, 1995), including HIV testing during antenatal clinic visits during pregnancy.

It also appears that African women's prejudiced legal standing, determined by both customary as well as Western law, is another problem. Until recently African women were minors before the law (Friedman, 1993; Lemmer, 1989). The result was that traditional laws, which were originally aimed at granting some protection to African women, lost their inherent flexibility when they became institutionalised by white legislators – to the detriment of the interests of African women (Lemmer, 1989; Wilson, 1983). Therefore Mamphela (1987, p.68) emphasised that a “personal revolution in attitudes...” is needed within most African societies before African women are finally emancipated. Although there has been some progress with this emancipation process of women, interventionists still have a great deal of work to do if they want to change certain traditional cultural values and expectations of gender roles that may contribute to high-risk sexual behaviour in African communities (Friedman,1993). I suggest that interventions should not only focus on the emancipation of women, but also on redefining men's co-responsibility for the spread of HIV.

## **8. Research Methodology**

### **8.1 Research design**

The research design of the study can be described as exploratory and descriptive, as it dealt with a research area about which not much is known in this country, namely an investigation on the responses of men to an HIV-positive diagnosis. This case study was conducted in the light of anecdotal evidence that many men respond to an HIV-positive test result by vowing to infect women, so as not to die alone, or out of a sense of revenge Grinnell & De Vos (Grinnell & De Vos, 1998:124) also explain that exploratory research is suitable when the area of research is not well developed and therefore it is more “sensible” to apply this design as a method of inquiry (Grinnell R.M Jr, 1988:225). A participatory research approach has been the focus on the research. There is a growing recognition, in much community-based work that research should be carried out with the people being studied rather than on them (Jackson, 1992; Whitmore, 1999; Cornwall & Jewkes, 1995). Participatory approaches are also based on an argument that research should benefit the community being studied rather than just the research and policy makers – which the value of research lies in the changes it brings to communities, rather than simply in the knowledge gained (Jackson, 1992; Cornwall & Jewkes, 1995).

The research is qualitative, in order to locate the sexual practices of urban men within the cultural, political, social and economic context in which they operate. The quotes are drawn from individual pre-test questionnaire and post-test interviews on the Voluntary Test and Counselling Programs of the local municipality clinics and single sex focus groups of 150 men between the ages of 18 – 45, from Kayamandi. It was interesting to note that men below 18 i.e. 12-17, I just wonder where are they, is it possible that this group does not have HIV or is this group in Kayamandi not sexually active, an inquiry is needed in this area. This also include the group above 45 i.e. 46 upwards, is this group using other facilities for HIV testing or is this group using services in the work place which is good. It may happen that these groups

come late for treatment when they are really sick. This needs to be followed up, in the place of employment. While quotes are drawn from men from Kayamandi it is likely they can be generalised to other similar township contexts.

## **8.2 Sampling**

There was no sample for this study, it represent 100% of men who visited the Voluntary Counselling and Testing (VCT) clinic from June to October 2004. Hundred and fifty respondents filled in pre-test questionnaires and the same respondents were post-test interviewed. Four focus groups were chosen as the method of qualitative data collection regarding information relating to “people’s feeling, thinking, perceptions and point of view” (Krueger & Casey, 2000: 10).

## **8.3 Data gathering**

Three research tools were used for collecting data:

- pre-test questionnaires
- post-test interviews
- post-test focus groups

Four focus groups were chosen as the method of qualitative data collection regarding information relating to “people’s feeling, thinking perceptions and point of view” (Krueger & Casey, 2000:10). Interview methods were applied using the clinic format of voluntary counselling and testing. Pre-test questionnaires were administered, and post-test interviews were conducted.

The key characteristics distinguishing focus groups, namely the interaction between the participants to provide information and insight (Gibbs, 1997) was found to be especially beneficial. Stewart and Shamdasani (1990:16), who spell out various advantages of focus groups, such as the interactive way of obtaining information from groups of people in a relatively brief period in cost-effective ways and obtaining results that are easily understood, provide a convincing argument for using focus

groups for this study. Another advantage was the flexibility provided by focus groups, possibly their “greatest strength” (Morgan, 1997:16). This flexibility provided both the respondents and the researcher with scope to focus on discussions while also adjusting to differences in the composition, interests and levels of sophistication of the different groups.

The benefit to the respondents in the focus groups was highlighted by the respondents themselves (cf. Gibbs, 1997), stating that they are of value and that they were “involved in something which they feel will make a difference”, thereby leading to a sense of empowerment, was considered a positive by-product of this method.

## **9. Results**

### **9.1 Biographical details**

#### **9.1.1 General characteristics of questionnaire and interview of respondents**

**Location and Number of Men Surveyed:** Overall, 150 respondents filled in pre-test questionnaires and the same group were post-test interviewed, this was conducted among male respondents who attended the Voluntary Counselling and Testing Clinic in the Kayamandi Primary Health Care Centre. Participants were from three different locations in Kayamandi township: 116 (77%) respondents were from the hostels, 20 (13%) from the informal settlement and 14 (10%) were from the area of formal housing.

**Age:** The respondents ranged in age from 18 to 45. In both settings i.e. hostel dwellers, informal settlement and formal houses. The number of respondents in the various age groups was comparable. It was interesting to note that men below 18 i.e. 12-17 I just wonder where are they, is it possible that this group does not have HIV or is this group in Kayamandi not sexually active, an inquiry is needed in this area. This also includes the group above 45 .i.e. 46 upwards, is this group using other facilities



for HIV testing or is this group using services in the workplace which will be good. It may happen that these groups come late for treatment when they are really sick. This also needs to be followed up in their workplaces.

**Home Language:** Respondents spoke a variety of languages reflective of Kayamandi which attracts a lot of migrant labourers. The language spectrums reflect the migrant nature of large parts of Kayamandi types of population that are regularly associated in the literature with higher vulnerability to HIV infections. Most respondents spoke isiXhosa (47%), followed by isiZulu (15%), Setswana (13%), Sesotho (12%), and North Sotho (9%); the remaining (4%) spoke other South African languages.

**Condom use:** Condom use was particularly low among young men aged 18 to 24, men with no education, and men who were married. Only 11% of respondents were currently using condoms. Of the condom users, 75% reported using condoms all of the time while 25% used them only sometimes. The primary sources of condoms as reported by men were clinics (85%), followed by pharmacies (20%) and the workplace (6%). Very few individuals reported getting their condoms from private doctors (3%).

**Sexually Transmitted Infections (STIs):** The percentage of respondents who previously had a sexually transmitted infections (STIs) was high overall (35%), with those between the ages 21 and 40 more likely to have had an STI (47%). When compared by residential area, the informal settlement had the highest number (59%) of informal settlement respondents who reported having had an STI before, as well as the fewest respondents who had ever used a condom (24%) from the informal settlement.

**Dry Sex:** Responses from men on whether they preferred their partner to be wet or dry during sex:

Wet (37%)

Dry (24%)

No preference (15%)

Do not know (19%)

No comments (5%)

The most common reason mentioned for preferring dry sex were enjoyment and the misconception that a wet vagina could only be the result of an STI or previous sexual contact with another partner. As dry sex include the artificial use of herbs and other substances that causes friction and bruising of the vaginal mucosa which predisposes the women to the entry point of the HIV. This is of great concern when one quarter of the respondents chooses such a risky method which exposes them to HIV infection.

### 9.1.2. Types of groups

- Young men from school

**Findings on gender issues:** This group did not mind about equal rights between men and women. Gender sensitivity was more demonstrated by younger men and by those with more education. This sensitivity was shared mostly by youth from the formal houses. The hostel and informal settlement were having a slightly different view. These two groups want to be equal with women on other aspects, but in terms of making sexual decision they want to make the final word.

**Findings on relationships and sexual decision making:** Adolescent males reported feeling pressured to have sex in romantic relationships. Social norms among many teens in this group support adolescent sexual activity. They stated that it is becoming fashionable for teenagers to have sex, and that teens don't fear being known as sexually active.

**Findings on sexual assault:** Most of the men agreed that rape is wrong. However, the men's definition of rape varied. Some young men did not consider it

rape if: a husband forces sex upon his partner: or when a woman consents to sex, then changes her mind and a man still forces sex upon her. One youth from the group from the informal settlement said, "Once a man is aroused, it is too late to stop. A man cannot control himself once he is sexually excited".

**Findings on sexual abuse:** Many young men acknowledge that the problem of sexual abuse exists in their communities. A perpetrator is often known to family members of the survivor – father, stepfathers, older brothers, uncles etc. The youth want to prevent the sexual abuse by engaging in peer education in their school and sports. The youth out of school did not know how to intervene in this community problem, they did not have a strategy, and most of this group were uneducated and were from the informal settlement and the hostel. It was logic for me to note that there were a lot of similarities among the hostel and informal settlement.

**Findings on physical abuse:** Many young men often cited the abuse of women as a "cultural accepted" practice, this view was mostly shared by the youth on the informal settlement and the hostels. The youth on the formal houses were more smart, they were using the knowledge from school in the life skill classes, when asked questions they refer to their source from the life orientation class.

Men's thoughts on the causes of violence against women: Most of these youth cited three main topics; alcohol, unemployment and unfaithfulness – men having relationships with other women. On alcohol most youth from the informal settlement said when they are drunk they find themselves involved in gender based violence because of minor disagreement, and misuse of money while drunk. This problem was less cited by the group on the formal housing. I think the drunkenness on the hostel and informal settlements is due to loneliness and lack of parental guidance as most of these youth are new in Kayamandi, looking for better job opportunities. On unemployment a heated debate broke out between the groups, the educated youth did not see the relationship between unemployment and violence against women; they cited that men are abusing

women even if they are employed. The youth from the other areas i.e. hostel and shacks said when women are working they look down upon men; they claim that women loose respect of unemployed men, so they restore respect by instilling fear by beating up their partners. On unfaithfulness, the group agree with each other that men can have more than one partner, but they did not agree that women have the same right to have multi-sexual partners. They also agree that if they have found out that their partner is cheating they will beat her up as a solution, only a few of this group said they will terminate the relationship.

- Youth out of school

Most of the responses cited by the youth in school were almost the same except that there was a lack of knowledge of HIV and AIDS in this group and most of the solution did not have strategies on solving some of the challenges that are facing the Kayamandi youth. This youth did not have access to information like their schooling partners. I have observe when I am driving around, that most of this group are standing on street corners looking for jobs I believe it is difficult to get information on health matters.

- Unemployed men

This was the most interesting group with diverse responses. On closer inspection it turned out that the general health scores of the people in the squatter area and the hostels were lower than those of people living in the formal housing area. Certain personal problems also showed a significant relationship with living area, namely a shortage of money for food, a place to stay and the financing of children's education; fear of dismissal; self-consciousness; suicidal thoughts; poor appetites; beliefs of bewitchment especially those that were diagnosed as HIV-positive; depression and a feeling of unhappiness.

The following personal problems or stressful situations all correlated significantly with gender: poor relationship with employer; tearfulness; feelings of anxiety without reason; frequent headaches; sexual activity outside the marriage or

relationship; alcoholism of spouse or lover; violence in the marriage or relationship; children's involvement with gang activities, as well as the respondent's own use of alcohol and drugs. Most of the 17% of men who wish to infect women are from the squatters and hostels.

### **9.1.3 Education**

Education levels were uniformly high amongst all groups. Close to 60% of all groups had completed primary education and more than 25% of people in the informal houses as well as hostel dwellers has completed secondary education. There was no significant difference between the educational levels reached by men from the informal settlement.

### **9.1.4 Employment**

Unemployment was very high among people living in Kayamandi but especially so for people in the informal settlement. The men in the formal houses were in full-time employment mostly in the municipality and other sectors. Those that live in the hostel were in full time, and some were in part time employment. The majority of the men in the informal settlement said they live on part time jobs and they have to wait at the nearby robots to be picked up by constructors and farmers.

## **9.2 Knowledge of HIV/AIDS**

There was a very poor knowledge of HIV and AIDS. Only 30% knew the difference between HIV and AIDS. Most men perceive HIV transmission as transmitted only by sex through dirty blood from a woman. Eighty-five percent of the men did not know about the notion of a window period, which put them at more risk of infection. Eighty-five percent knew that condoms can prevent HIV but 100% did not know about HIV re-infection with HIV if you already have the virus. Most respondents only knew of the taking of blood to test HIV, but they did not differentiate between sexual transmitted infections like gonorrhoea etc. Most respondents (80%) did not understand mother to child transmission (MTCT).

Most respondents (95%) do not know about infant feeding putting mothers at risk of mixed feeding in fear of men. A number of treatment options exist for people testing HIV positive: 92% of respondents are unaware of these options. Regarding physical symptoms, 85% did not know the symptoms except for loss of weight and skin disease.

### **9.3 Client's consent for HIV test**

Most respondents (60%) gave consent, for the HIV test, 25% declined, 10% want to think about it, and only 5% will come in later for test – some of them were so advised by staff when deemed that they are not ready. The result of the rapid test showed only 6% to be HIV-positive and 1% tests were undetermined, so the Elisa-test was done.

### **9.4 Post-test counselling**

Prevention strategies were discussed with those who tested HIV-negative. With those that were HIV-positive immediate concerns were identified, and emotional containment dealt with. Follow-up dates were given.

### **9.5 Risk assessment**

Various reasons were given by respondents for HIV testing: 80% just wanted to know their status, while the rest were advised by health care professionals to test for HIV owing to their medical condition (e.g. TB, Shingles, fungal infection, etc.). Most respondents (44%) had previous sexually transmitted infection (STI) i.e. 66 respondents out of these men 30 were treated for STIs and 10 were not treated. Regarding the number of sexual partners in the previous 5 years, most men i.e. 70% had more than one partner. Regarding condom use, 65% claimed that they always use condoms for protective sex – 25% sometimes use condoms, and 15% never use condom. Willingness to inform partners 56% and 44% were not willing to inform their partners. On willingness to practice safe sex 88% are willing and only 12% were not willing to practice safe sex. Regarding respondents' views of risk, 65% view HIV as a medium to high risk, 25% view HIV as low risk and 15% view HIV as no risk at all.

## **9.6 Support structure**

Regarding who the respondent would tell if he tested HIV-positive, 55 of the respondents (37%) said they would tell their partners; 50 (33%) said they would tell their family; 25 men (17%) said they will tell no one; and 20 (13%) said they would tell their friends.

## **9.7 How men reacted when diagnosed HIV-positive**

After post-test counselling, 17% of respondents openly said they would infect other people. This is a disturbing scenario. I do not know whether, with time and follow up counselling, there will be a change of mind with this 17%. On the other hand, after post-test counselling 83% said they would protect themselves and others. There were all sorts of group dynamics regarding reactions to a positive diagnosis. Immediately there were two groups: those that believed in maintaining their culture, and those that said things must change to suit the present situation. The people on the shacks were more tribal with their partners in the hostels. The respondents in formal houses were more liberal.

In focus groups conducted with respondents who live the informal settlement, many respondents identified traditional gender roles and the fear of losing respect from their peers as a significant deterrent to participating in care and support activities. When asked what might prevent other men from playing a more active role, men identified a number of obstacles. In one group, men answered that some men would see work traditionally performed by women as an “affront to their dignity“. Others answered that many men simply did not have the knowledge or skills necessary to provide support or to be more involved in domestic activities and would not want to risk being seen as ignorant or incompetent. Additionally, some men discussed being afraid that their involvement in care and support activities might create the perception that they themselves were HIV positive, which they fear might lead to stigma and social exclusion (cf. Kruger, 2003).

These focus group discussions, then, suggest that it is imperative that interventions focus not only on increasing men's awareness of the need for their involvement in care and support but also on the need to explore and shift social norms at the community level so that more men can provide the support their conscience tells them is necessary. A recent report on men's increased involvement in care and support activities in Zimbabwe makes it clear that when given a sense of permission and the necessary skills, men can indeed change. According to the report, "The male volunteers assist in bathing, feeding and doing chores for patients, such as fetching firewood and food. They also provide financial assistance for buying drugs, or when patients need to be taken to clinics or to hospital to have opportunistic infections treated. As one man from a rural community not far from Harare put it, "As men, we never view ourselves as crucial in providing care to those being claimed by the AIDS pandemic, choosing instead to spend most of our time at Juru Growth Point (a central business centre), drinking beer. But things changed last year when councillors in various districts of Goromozi approached us and urged us to become involved" (Gender-AIDS, Zimbabwe, Listserve; 17 May 2004).

## **10. Recommendations**

Experience gained through this research suggests several ways in which gender can be addressed in the context of men and HIV prevention intervention.

- When men and women are aware of each other's health needs they are more likely to receive needed services. Strengthening communication between partners about family planning and involving men in health promotion can lead to better health for the entire family.
- As an urgent need, I would like to concentrate on the 17% who say they will infect other people so as not to die alone. This group represents a huge portion of people living in the shacks. They are unemployed, less educated, and tribal in nature. Although they claim to have cultural originality, they might have abused it for their benefit.
- I recommend that the other respondents (83%) be monitored closely, because



they may, due to time factors and frustrations, join the angry ones.

- As to the Counselling Services, they should do follow-up counselling so that pressing issues are clarified and the client is assisted before engaging in distractive behaviour. An unconditional acceptance by health care workers and family is needed in these cases.
- Non-Profit Organizations (NPOs) in Kayamandi must use a human rights framework to get men to recognize the ways in which contemporary gender roles mirror the oppressive relations of power under Apartheid, leaving women vulnerable to domestic and sexual violence and thereby severely compromising women's ability to protect themselves from HIV and AIDS.
- The NPOs, in the service of promoting gender equity and protecting women from HIV and AIDS, must draw the connections between sexism and racism, and other forms of oppression, and strive to get men to see the ways in which gender equity is a fundamental human right of comparable importance to those fought for during the anti-apartheid years.
- Nearly a decade after grassroots or community mobilization brought about an end to Apartheid, people continue to work to address community needs and to promote social justice – very often using structures inherited from the anti-apartheid struggle itself. In townships across the country, the civics associations provide a compelling example. The civics, as they are known in South Africa, are examples of grassroots democracy taking place in small but formalized groups with elected leaders from the street, block and neighbourhood levels meeting on a weekly basis to address local issues and concerns. There is, then, an extensive and well-documented history of people working together in groups to address social justice and human rights issues. I suggest that the issues of HIV infection prevention, gender based violence, and counselling of infected individuals and their families be similarly addressed.

## **11. Suggestions for future research**

- While it is generally known that physical abuse seldom comes alone, the relationship between physical abuse and other forms of abuse would need to be more closely investigated particularly in relation to responses of men to a positive HIV or AIDS diagnosis.
- The relationship between anticipated partner violence on disclosure of an HIV-positive result and the actual experience of disclosure would have to be researched and documented. It has important consequences for de-stigmatisation of HIV and for counselling and support.
- Further research on ways to assist HIV support groups and their members so that they can meet the huge emotional and practical demands made of them.
- More research studies, which encourage the active participation of communities affected, by HIV and link research to promoting change.
- A follow-up study to see whether those respondents in this study, who tested positive for HIV and wanting to practice safe sex (83%) will keep on practising safe sex or not, and those who tested positive, and claiming to want to infect others (17%), will change their mind-set with continued love and support.

## **12. Conclusion**

Evidence from this study (supported by anecdotal evidence), suggests that persons living with HIV may continue practicing risky sexual behaviour. In this study of men in Kayamandi, 17% admitted to wish to continue to infect others while 83% promised to practice safe sex. The time is ripe to start seeing men not as only some kind of a problem, but as a part of the solution. As fathers, sons, brothers and friends men have much to give. A lot of health education is needed among men themselves. When men and women are aware of each other's health needs they are more likely to receive needed services. Strengthening communication between partners about family planning and involving men in health promotion can lead to better health for the entire family. Strong partnership between men and women mean healthier families, communities and nations.

### 13. References

- Abrahams, N., Jewkes, R. & Laubscher, R. (1999). "I do not believe in Democracy in the home". *Men's Relationships with and abuse of women*. Cape Town: MRC.
- Ackermann, D.M. (1985). *Women and ministries* (Unpublished master's thesis). University of South Africa: Pretoria.
- Bozzoli, B. (1983). "Marxism, feminism and South African studies". *Journal of South African Studies*, 9(2), 139-171.
- American Association for World Health. (2000). Men make a difference <http://www.Aawhworldhealth.org.whyfocusonmen> .
- Chodorow, N. (1978). *The reproduction of mothering*. Berkeley and Los Angeles: University of California Press.
- Cock, J. (1987). "Trapped workers: Constraints and contradictions experienced by black women in contemporary South Africa." *Women's studies International forum*, 3(1), 133-140).
- Connell, R.W. (1995). *Masculinities*, Los Angeles: University of California Press.
- Cornwall, A. and Jewkes, R. (1995). "What is participatory research?" *Social Science and Medicine* 41: 1667-1676.
- Cornwall, A. & Lindisfarne, N. (1994). "Dislocating masculinity: gender, power and anthropology" in A Cornwall and N Lindisfarne (Eds) *Dislocating masculinity: Comparative Ethnographics*, London: Routledge.
- David, D. & Brannon, R. (1976). *The forty-nine percent majority*. Reading MA: Addison-Wesley.
- De Vos, A.S. (1998). *Research at grass roots. A primer for the caring professions*. Pretoria: Van Schaik Publishers.
- Dinnerstein, D. (1976). *The Mermaid and the Minotaur: Sexual arrangements and human malaise*. New York: Harper and Row.
- Fagot, B. (1978). "The influence of sex on parental reaction to toddler children". *Child Development*: 49, 459-465.

- Fagot, B. (1985). "A cautionary note: Parent's socialization of boys and girls". *Sex Roles* 12, 471-476.
- Farrell, W. (1974). *The liberated man*. New York: Random House.
- Forsteanu, M. (1974). *The male machine*. New York: McGraw-Hill.
- Friedman, M. (1993). "Gender and development – the need for women empowerment programmes in South Africa". *AIDS Bulletin*, 2(1), 18-19.
- Gibbs, A. (1997). *Focus groups. Social Research Update* (17 March, 2002) Available <http://www.soc.survey.ac.uk/sru19.html>.
- Goldberg, H. (1976). *The hazards of being male*. New York: NY; New American Library.
- Gilligan, C. (1982). *In a different voice*. Cambridge, MA: Harvard University Press.
- Grinnell, R.M. Jnr. (1988). *Social work research and evaluation* 3<sup>rd</sup> edition. Itasca, Ill: FE Peacock Publishers.
- Greenberg B. (1982). *Television and role socialization. An overview. In national Institute of Mental Health, Television and behaviour: Ten years of scientific progress and implication for the eighties* (pp 179-190) Washington DC: US Government Printing Office.
- Gwede, C. & McDermott, R.J. "AIDS in Sub-Saharan Africa: Implication for health education". *AIDS Education and Prevention*, 4(4), 350-361.
- Hanmer, J. (1981). "Male violence and the social control of women: In: *Feminist Anthology Collective (Eds) No Turning Back*. London: The Women Press.
- Hartley, R. (1974). Sex role pressures and the socialization of the male child. In J Pleck and J Sawyer (Eds) *Men and masculinity* (pp 7-13) Englewood Cliffs, NJ: Prentice-Hall.
- Heaven, P.C.L. & Niewoudt, J.M..(1981). "Authoritarian attitudes in South Africa". *Journal of Social Psychology*, 115,277-278.
- Hyde, J. & Linn. M. (1986). *The psychology of gender*. Baltimore MD: Johns Hopkins University Press.
- Jackson, H. (1992). *AIDS: Action Now*. Aids Counselling Trust, Harare.
- Krueger, R. & Casey, M.A. (2000). *Focus groups. A practical guide for applied research* (3<sup>rd</sup> Ed) Thousand Oaks: Sage Publications.
- Lemmer, E.M. (1989). "Invisible barriers: Attitudes towards women in South Africa". *South*

*African Journal of Sociology*, 20(1), 30-37

- Lindegger, G. & Wood, G. (1995). "The AIDS crisis: Review of psychological issues and implications, with special references to the South African situation". *South African Journal of Psychology*, 25(1), 1-11.
- Luiz, J., Roets, L & Smar, H. (1994). "The AIDS threat in South Africa. What lies ahead?" *Africa Insight*, 25(1), 3136.
- Makhaye, G. & Reddy, V. (2001). *Men are part of the Solution: Gender AIDS Forum (GAF)*. University of Natal: 22 November 2000. Durban. Agenda 47, 2001: 107.
- Mamphela, R. (1987). "Life in transition". *Leadership SA*, 6(5), 67-71.
- Mjoli, Q.T. (1987). "The role of the psychologist in culturally diverse Southern Africa". *Development Southern Africa*, 88. Johannesburg: Macmillan.
- Morgan, D.L. (1997). *Focus groups as qualitative research* (2<sup>nd</sup> ed). Thousand Oak: Sage Publications.
- Morrel, R. (2001). *Changing Men in Southern Africa*, Pietermaritzburg and London: University of Natal.
- Nicholas, L. & Durrheim, K. (1995). Religiosity, AIDS and sexuality knowledge, attitudes, beliefs and practices of black South African first-year university students. *Psychological Reports*, 77, 1328-1330.
- Orubuloye, I.O., Caldwell, J.C. & Caldwell, P. (1993). "African women's control over their sexuality in an era of AIDS". *Social Science Medicine*, 37(7), 859-872.
- Pettifor, A., Rees, H. & Stevens, A. (2004). *HIV & Sexual Behaviour Among Young South Africans: A Survey of 15-24 Year Olds*, University of the Witwatersrand.
- Pleck, J.H. & Sawyer, J. (1974). *Men and Masculinity*. Englewood Cliffs, NJ: Prentice-Hill.
- Selikow, T., Zulu, B. & Cedras, E. (2002). "The ingagara, the regte and the cherry: HIV and AIDS and youth culture in contemporary urban township". *Agenda* 53, 2002: 28.
- Schoepf, B.G., Engundu, W., Nkera, R.W., Ntsomo, P. & Schoepf, C. (1991). "Gender, Power and Risk of AIDS in Zaire", In: M. Turshen, *Women and health in Africa*, (pp.187-203). Trenton: Africa World Press.
- Stewart, D.W. & Shandasami, P.M. (1990). *Focus groups. Theory and practice*. Newbury

Park: Sage Publications.

Strebel, A. (1995). Whose epidemic is it? Reviewing the literature on women and AIDS. *South African Journal of Psychology*, 25 (1), 12-20.

Tallis, V. (2000). "Gendering the response to HIV/AIDS: Challenging gender inequality" in: *Agenda*, 44.

Thorpe, M. (2002). "Masculinity in an HIV intervention, Briefing". *Agenda* 53: 2002, 68.

Ulin, P.R. (1992). "African women and AIDS: Negotiating behavioural change". *Social Science Medicine*, 34(1), 63-73.

UNIFEM, Positive Women: Voices and Choices, Zimbabwe Report 2002.

Whitemore, E. (1994). *To tell the truth: Working with oppressed groups in participatory approach to inquiry in participation in human inquiry*, Ed, Reason P Sage London.

Wilton, T. (1997). *A Gendering AIDS: Deconstructing Sex, Text and Epidemic*, London: Sage Publications.

Wilson, M. (1983). The changing status of South African women. *South African Outlook*, 113 (1339), 11-13.