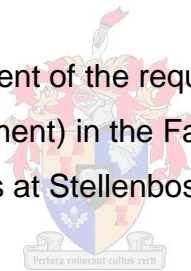


**Assessment of low HIV education programme attendance among young men
in Kagiso Mogale City, Gauteng**

by

Buyile Celiwe Buthelezi

Assignment presented in fulfillment of the requirements for the degree of Master of
Philosophy (HIV/AIDS Management) in the Faculty of Economic and Management
Sciences at Stellenbosch University



Supervisor: Ms. Anja Laas

March 2013

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 sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: March 2013

Summary

The aim of the study was to establish the factors that influence young men to attend and access HIV education programme in order to improve young men's focus on HIV education programme and to increase young men's involvement with HIV prevention initiatives. The researcher used the qualitative research method to establish factors why young men were not attending HIV education programmes in Mogale City, Gauteng.

It was found that young men are willing to attend HIV education programme that are innovative, interesting and will meet their sexual and reproductive health needs. Although they are willing to attend HIV education programmes, young men are scared of the reality of visiting clinics for testing, because clinics perpetuate stigma by separating HIV counselling and testing rooms and healthcare provider attitudes towards young men. They would also like to be part of the planning process to ensure that HIV education programmes are tailored to their needs.

Opsomming

Die oogmerk van die studie was om die faktore te bepaal wat jongmans beïnvloed om MIV-opvoedingsprogramme by te woon en toegang daartoe te verkry, ten einde jongmans se fokus op MIV-opvoedingsprogramme te verbeter en jongmans se betrokkenheid by MIV-voorkomingsinisiatiewe te verhoog. Die navorser het die kwalitatiewe navorsingsmetode gebruik om die faktore te bepaal waarom jongmans nie MIV-opvoedingsprogramme in Mogale City, Gauteng, bywoon nie.

Daar is gevind dat jongmans bereid was om MIV-opvoedingsprogramme by te woon wat innoverend en interessant is en aan hulle seksuele en reprodutiewe gesondheidsbehoefte sal voldoen. Alhoewel hulle bereid was om MIV-opvoedingsprogramme by te woon, is jongmans bang vir die werklikheid daarvan om klinieke vir toetsing te besoek, omdat klinieke stigma perpetueer deur MIV-beradingskamers en toetskamers van mekaar te skei; en vanweë gesondheidsorgverskaffers se houding teenoor jongmans. Hulle wil ook graag deel wees van die beplanningsproses om te verseker dat MIV-opvoedingsprogramme volgens hulle behoeftes aangepas word.

Table of Contents

Declaration	i
Summary	ii
Opsomming	iii
1. Introduction	1
2. Significance of the study	3
3. Research aim and objectives	4
4. Literature Review	4
4.1. Young people and HIV/AIDS	5
4.2. Gender inequality and HIV/AIDS	6
4.3. Men and HIV/AIDS	9
4.4. HIV education programmes	11
5. Research problem and research question	12
6. Research Design and Methods	13
6.1 Site selection	13
6.2 Data collection and target population	13
6.3 Ethics and confidentiality	14
7. Results	14
7.1. Findings from in-depth interviews	15
7.1.1. Sexual relationships	15
7.1.2. Reproductive health services	16
7.1.3. Community attitude	17
7.1.4. Young people and HIV/AIDS	18
7.1.5. HIV/AIDS compared to other challenges facing young men	18
7.1.6. Importance of HIV education programmes for young men	18
7.1.7. Low attendance to HIV education programmes among young men	19
7.2 Findings from Focus Group Discussions	19
7.2.1. Background information about HIV/AIDS	19
7.2.2. Community attitude	20
7.2.3. Young men and HIV/AIDS	21
7.2.4. Sources of information on HIV/AIDS communities	21
7.3. General recommendations	21
8. Discussions	22

9. Conclusion	23
10. Limitations.....	24
11. References	25
Appendices.....	29

1. Introduction

Globally, in 2012 there were 34 million people living with HIV. Young people between the ages of 15-24 are the group most affected by AIDS, accounting for 40% of all adult HIV infections worldwide. In Sub-Saharan Africa, there is an estimated 69 percent (23.5 million) people living with HIV of which 4.4% are young people age 15-24 years. The UNAIDS (2012) highlighted that young women aged 15-24 years of age are most vulnerable to HIV with infection rates twice as high as in young men, and accounting for 22% of all new HIV infections. Young people are vulnerable to the epidemic because the onset of sexual activity in this age group is recent. In South Africa, in 2012 there were 5.6 million people living with HIV infections (UNAIDS, 2012).

The impact of the HIV epidemic among young people is still growing, with 2 400 young people getting HIV infections daily (UNAIDS, 2012). South Africa is one of the countries with high rate of HIV infections as mentioned above. Subsequently, youth-friendly health services for reproductive health and HIV prevention, care and treatment are needed widely. Prevention programmes directed at young people are extremely important to combat the epidemic. This study expects to contribute towards reducing the HIV infections among young people and to support young men in accessing or seeking healthcare services.

In 2011 the Department of Education and Lead South Africa launched a campaign to promote a Bill of Responsibility aimed at young people to stand up and accept responsibilities like education and health, including HIV/AIDS. The statistics point out that HIV prevalence among young people 15 to 24 years of age is high. Now it is time for young people to take a stand and be responsible about their health as well as knowing their HIV status as well as to take preventative measures associated with HIV infections.

HIV education programmes have shown to be an effective strategy in reducing HIV transmission among young people. Programmes such as Love Life have been leading HIV prevention interventions that are focusing on young people nationwide. Some research studies reported an increase in condom use, particularly by those

less than 24 years of age that led to a decline in HIV infections. On the other hand, the most recent National Strategy Plan 2012-2016 aims to lessen the impact of HIV on youth by ensuring that young people access the services like health, education and youth development programmes.

Our government has been consistently monitoring the HIV prevalence through antenatal and syphilis prevalence surveys since 1990. It is crucial to monitor the HIV/AIDS patterns in different age groups so that we know as a country where and when to strengthen budget, prevention and to implement treatment programmes. The South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (2008) has indicated a possible turning point in the epidemic; a reduction in HIV prevalence in the teenage population, which indicates an overall decline in HIV in the teenage population of 15 to 19 years of age in 2008. If the trends are showing that it will be an ideal target group for educational prevention programmes that will result in decline in HIV/AIDS in later age groups. The figures are highlighted in Table 1.

Table 1: Estimated 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

The table above highlights high HIV prevalence among female 15–24 years that is 27.8% compared to 7.6% male prevalence in the same age group. Thus young men

are in sexual relationships with young women and the HIV prevalence will be above 20% when they are in their 30s. Most HIV infections are transmitted by heterosexual contact followed by a mother-to-child transmission during birth. This behaviour affects community members, mainly women and young people, because they are at high risk of becoming infected as soon as they become sexually active and getting involved in risky behaviours such as having unprotected sex, alcohol abuse and violence in relationships. Hence it is crucial to involve young men to HIV prevention interventions, counselling and testing as well as treatment.

South Africa has worked hard in addressing sexual risk behaviours among young people, particularly young women due to the fact that they are at high risk of HIV infection. A significant gap has been identified in literature in regards to young men's needs and concerns (Harrison, Cleland, Gouws & Frohlich 2005). Young men are a fundamental focus to combat HIV/AIDS among young people and in future.

Thus HIV education and treatment programmes are in place in South Africa and have demonstrated that they may increase knowledge about how to prevent HIV, STIs and unintended pregnancies among young people. The implementers should involve young people during the planning phase to meet young people's expectations. In school youth benefit mostly from these education programmes as they are part of the sexual education curriculum thus opening a gap for out of school youth. Programmes like LoveLife are trying to close this gap through working with out of school youth, because its programme combines sustainable awareness and education campaigns with a countrywide network of youth-friendly and outreach services. On the other hand the Department of Health has implemented healthcare services across the country that focuses on supporting young people through care and access to reproductive health services.

2. Significance of the study

Young people could play a key role in reducing HIV prevalence and infections by increasing their participation in HIV prevention or educational programmes that are already in place and in promoting healthy lifestyles (Peltzer, 2010). Our government working closely with civil society organisations to ensure that healthcare services are

accessible. Hence young men do not utilise these services due to lack of men-friendly services and healthcare provider's attitudes towards men seeking healthcare. And young men do not participate fully; it is against this background that the researcher opted to conduct this study to understand factors contributing to low participation to HIV education programmes by young men.

3. Research aim and objectives

The aim of the study was to establish the factors that influence young men to attend and access HIV education programmes and services in order to improve their focus on HIV education programmes and to increase their involvement in HIV prevention initiatives.

Specific study objectives:

- To determine the HIV education needs of young men in Kagiso
- To identify the reasons why young men do not attend HIV education programmes
- To determine how young men access HIV education programmes
- To establish if HIV education programmes are aligned to young men needs
- To make recommendations in order to increase young men's attendance to HIV education programmes

The findings of this study will provide additions or modifications to existing interventions to best suit young men's needs in increasing attendance and accessing to HIV education programmes in their respective communities.

4. Literature Review

HIV/AIDS has been in existence for over three decades and many studies have been conducted under many different subjects related to prevention and on how to improve treatment programmes including non-adherence that pose challenges to treatment efficacy. With the general growth of HIV research in the academic field it has been noted that most studies focus on young women (15 – 24 years) because

the HIV prevalence is higher than that of young men in the same age group as listed in Table 1. Young men have not been part of the focus for some time until recently where HIV policies are beginning to include men. Programmes such as Men as Partners was launched in 1998 to work with men to combat HIV/AIDS and violence against women. This programme has shown how important it is to involve men to reduce the spread and the impact of HIV/AIDS in this country.

4.1. Young people and HIV/AIDS

Young people in South Africa are at high risk of HIV infections. Because first sexual experiences may influence a young person's HIV risk and a better understanding of early sexual debut impact is needed. Early coital debut is associated with factors that may increase a young person's risk for HIV infection, such as forced sex and having older sexual partners. It is vital to promote strategies to make young people's first sexual experience safer (Pettifor, O'Brien, MacPhail, Miller & Rees 2009). Knowledge and skills encourages young people to avoid or reduce behaviours that carry a risk of HIV infection (Paul-Ebhohimhen, Poobalan & Van Teijlingen 2008; Bankole, Ahmed, Neema, Ouedraogo & Konyani 2007). Subsequently young people should make informed decisions about their sexual health and choices.

In addition HIV and sexual education is provided for in-school youth through Life Orientation curriculum. However some educators are uncomfortable about teaching this curriculum as it contradicts with their values. Selected schools have taken a step further by collaborating with local community-based organisations, to be capacitated on how to separate professional values from personal values to support young people and HIV in their respective schools and communities. Such partnerships should be strengthened for the reason that young people may continue to get support when they are out of school.

Varga (2001) reviewed the existing literature on sexual and reproductive health research and programming among boys and young men in Sub-Saharan Africa. It is evident that there is a growing body of literature on adolescent and young adult women, much less is known about male sexual and reproductive health and its potential connection to well-being, and in particular the risk of contracting and spreading HIV/AIDS. The socio-cultural factors and societal norms contribute to

individual vulnerability to HIV/AIDS, and that gender and sexuality are among the most powerful of these elements. Young women are the most vulnerable as they may be involved in transactional sex for monetary gain or good life. Varga's research featured several interrelated elements of sexuality - sexual partnerships, sexual acts, sexual meaning, sexual drives and enjoyment as well as sexual knowledge and awareness. Future interventions may possibly use these elements when addressing HIV challenges faced by young people.

A national household survey was conducted in South Africa for young people's sexual health encompassing HIV prevalence and sexual behaviours. The findings confirmed that among young people HIV prevalence for young women were disproportionate risk; there was still a need to continue to promote sexual partner reduction, consistent condom use and to implement behaviour change programmes (Pettifor, Rees, Kleinschmidt, Steffenson, MacPhail, Hlongwa-Madikizela, Vermaak & Padian, 2005). The survey has showed that young people are vulnerable to HIV infections unless they improve their sexual behaviours supported by programmes that are accessible and sustainable.

Young people are the future generations hence it is critical to communicate strategies that support behaviour change and self-responsibility about their health. Such programmes empower young people with knowledge and skills focusing in their sexual health as well as HIV/AIDS. HIV programmes that affect young people are more effective when they are engaged as partners and their visions and contributions are essential and should be part of programme design and implementation.

4.2. Gender inequality and HIV/AIDS

In Sub-Saharan Africa, literature connects adolescents' gender-related socialization and power relations to risky sexual behaviour. Most research suggests that relationship dynamics amongst adolescents are characterised by unequal decision-making between partners, fear of rejection if behavioural ideals are not met, and gender-based differences in the motivation to become sexually involved. Relationships also are driven by peer pressure to engage in early and unprotected sex to prove trust or commitment (Varga, 2003). Young women engaged in

transactional relationships with older men known as “sugar daddy” expecting to gain cash, food and transport to name just a few this acts is associated with a high risk of HIV. Young women lack power to negotiate safe sex and as a result they engage in unprotected sex. Thus many young men also engage in transactional sex with similar aged women (Jewkes, Dunkle, Nduna & Shai, 2012). Young women who are involved in transactional sex are more at risk compared to older women because they lack power to negotiate condoms and poor communication about sexual choices with their partners.

Social constructions of gender shape men’s and women’s health outcomes in important ways across a range of health issues especially HIV/AIDS issues (Peacock, Stemple, Sawires & Coates, 2009). The study acknowledged that the global literature on HIV/AIDS has paid much attention to the role of gender inequalities in facilitating the transmission of HIV. In Sub-Saharan Africa most HIV infections are transmitted through heterosexual relationships. Mostly women and girls are at high risk compared to men sometimes because of power imbalances in the society, like sexual coercion and reduced safe sex negotiating power, that contribute to increase the risk of HIV infections. Less attention, however, has been paid to how men's relationship behaviours may place them at HIV infection risks.

In most cultures society and families support men to have concurrent sexual partnerships, it is perceived as ‘men amongst men’ kind of attitude, not realising the risk involved and associated with HIV infections and the spread of HIV. Resulting at harming women and girls in the communities they live in as well as putting their health at risk. Men feel they are immune to HIV infections. Because men take longer to seek healthcare once they are HIV infected; at the end they will experience higher mortality compared to women. Cornell, Schomaker, Garone, Giddy, Hoffman, Lessells, Maskew, Prozesky, Wood, Johnson, Egger, Boule & Myer (2012) highlighted the poor health-seeking behaviours among men leading to more advanced disease at the time of antiretroviral (ART) initiation, differential rates of loss to follow-up may lead to higher mortality. It also highlighted the difference where women had higher CD4+ cell counts at ART initiation than men, which lead to slightly better absolute CD4+ cell increases on treatment.

Using six culturally specific psychometric scales developed in South Africa, Harrison, O'Sullivan, Hoffman, Dolezal & Morrell (2006) has examined men's and women's gender role and relationship norms, attitudes and beliefs in the context of ongoing partnerships. These measures were then examined in relation to four sexual risk behaviors: frequency of condom use (with primary or secondary partners) and number of partners (last 3 months and lifetime). Participants were 101 male and 199 female young adults aged 18 to 24 years, recruited from a secondary school in northern KwaZulu Natal province. The link between gender and relationship scale scores and sexual risk outcomes yielded both expected and contradictory findings. For men, more frequent condom use was associated with higher levels of partner attachment and also with stronger approval of relationship violence and dominant behaviour. For women, more frequent condom use was correlated with a lower endorsement of relationship violence (Harrison et al, 2006).

Harrison et al (2006) research indicated how men dominance and inequalities put most relationships at risk of HIV between women and men. Women may expose themselves to HIV infections by staying in abusive relationships and having sex without using a condom due to economic desperation. Gender-based violence and gender inequality are recognized as the drivers of the HIV epidemic in women, with research evidence from highly diverse cultural settings (UNAIDS 2009; Jewkes, Dunkle, Nduna & Shai, 2010). In another study that reviewed the intimate partner violence reported that HIV prevalence was significantly higher in men who had been physically violent towards their partners compared to men who had not (Jewkes, Sikweyiya, Morrell & Dunkle, 2011). Therefore violence in relationships contributes to and is associated with high HIV infections, and addressing gender violence will contribute to reduction of HIV infections and other STIs.

On the other hand researchers should not forget young people who are not yet engaging in risky sexual behaviours or become sexually active. HIV/AIDS education programmes are important for ensuring that they are prepared for situations that will put them at risk as they grow older (UNESCO, 2008). They should learn how to prevent and access effective HIV education programmes in future.

4.3. Men and HIV/AIDS

There are many factors that drives the spread of HIV infections, many studies are presenting that there is one of the strongest factors on how the epidemic spreads is the sexual behaviour and attitudes of men towards HIV and their sexual health. Working with men to achieve gender equality is important to increase access to sexual and reproductive health programmes that address men's attitudes towards sexual health and to combat HIV/AIDS in the African continent.

Men should be targeted for prevention and treatment, however, if they are not included into prevention programmes there may be an impact on mortality when not treated early, new infections and the economic impact of HIV/AIDS in Africa will be significant. Particularly men are breadwinners in many families. The reality that men are less likely to seek health care is intimately linked to perceptions of masculinity, and it also drives concurrent sexual partnerships phenomenon, violence against women all contributes to HIV prevalence (Mills, Beyrer, Birungi & Dybul, 2012).

The AIDS epidemic disproportionately affects women both in term of rates of infection and the burden of care giving and support they carry for those with AIDS-related illnesses. Although in some communities there are men who are caregivers mainly, who look after men who are living with HIV/AIDS. This is making men's caregiving more visible and has the potential to shift social norms about men's role in the care economy and increase men's involvement further. Although it is at a small scale but we are facing in the right direction in addressing gender norms in our country. Gender norms have been found to play a critical role in creating these disparities.

A rapidly expanding evidence base demonstrates that rigorously implemented initiatives targeting men can change social practices that affect the health of both sexes, particularly in the context of HIV/AIDS (Peacock et al, 2009).

Studies are showing that men who adhere to rigid notions of manhood, who equate masculinity with risk taking, dominance, and who view health seeking behaviours as a sign of weakness experience a range of poor health outcomes (Peacock et al, 2009). This is worrisome if men are not accessing healthcare services early as much

as women do. The healthcare services are provided by the government and accessible in public facilities nationally. Thus men represent only one fifth of those who get tested for HIV and only 30% of those accessing treatment (Peacock et al 2009). It was reported in the past that life expectancy at birth had declined between 2001 and 2005 but has since increased partly due to the roll-out of antiretroviral therapy. For 2011 life expectancy for males at birth increased to 57.2 years compared to 54 years in 2009 and for females increased to 62.8 years from 59 years in 2009 respectively. This increase in life expectancy at birth is expected to continue (Bradshaw, Dorrington & Laubscher, 2011). If men are not taking advantage to enrol early to antiretroviral programme, their life expectancy will not increase as expected. The government is strengthening community systems in order to expand access to services as well as early diagnosis and rapid enrolment into treatment (National Strategic Plan, 2012). These strategies are put in place to benefit everyone including men's access to healthcare services.

Men are likely to access antiretroviral therapy later in the disease progression than women and consequently access care with more compromised immune systems and at greater cost to the public health system. These gender discrepancies in HIV testing and antiretroviral therapy uptake reflect both structural and attitudinal factors (Peacock et al, 2009).

Public health systems do little to engage men. Women access health systems through prenatal services and are likely to be tested as part of prevention of mother-to-child-transmission programmes and men are not part of this programme, despite evidence that these programmes can serve as a useful entry point for testing men and to address men's sexual health issues.

Many men believe that seeking health services shows weakness and subsequently underutilize them. When HIV/AIDS services fail men, they also put the health of their sexual partners at risk. It is imperative to engage men with their sexual health in order to benefit their partners as well.

Early efforts and programmes that emerged from the International Conference on Population and Development (1994), work in three sometimes overlapping ways where they:

- serve men as clients,
- involve men in improving women's health, and/or
- work directly with men and boys to promote a positive shift away from regressive gender attitudes and behaviours.

In reality, men and boys should be involved in all levels of sexual reproductive health services. They should realise that they are partners and part of the solution in combating HIV/AIDS. Gender transformative work must utilize broader policy approaches to ensure that local interventions targeting men are taken to scale nationally and internationally. Empirical evidence demonstrates that behavioural change interventions carried out with men and boys can work (Peacock et al, 2009).

In order to plan and implement effective programmes, working with men to achieve gender equality and improve both men's and women's sexual health will need to recognize and support the efforts of increasing the numbers of men who want to work towards a more equitable world. It is evident in South Africa that men-led programmes such as One Man Can, Men Engage, Men as Partners and also campaigns like Brothers for Life show that we are focusing on a right direction in addressing issues of and factors contributing to the spread of HIV/AIDS.

The success of HIV education to reduce stigma and discrimination lies in the provision of correct information to eliminate fear and blame related to HIV. This is crucial for prevention and treatment, because people are reluctant to be tested for HIV and individuals that are unaware of their HIV infection are more likely to spread HIV.

4.4. HIV education programmes

A number of studies have viewed HIV education programmes as the solution in addressing HIV scourge among young people. The evidence that has been found by Kirby, Laris and Roller (2006) observed the positive impact on behaviour for

adolescents and young adults who attended the curriculum-and group-based sex and HIV education programmes was strong and encouraging. The evaluated programmes also showed reduced sexual behaviour and/or increased condom or contraceptive use.

HIV education programmes that are well designed seem to be the best solution to combat HIV/AIDS among young people. Most of these programmes address issues related to HIV, prevention of teenage pregnancy and youth development and are accessible by large numbers of youth through school-based curriculum. Local community-based organisations should be involved in these programmes to support youth once they are out of school as well as to benefit community members. Our government also work in partnership with community organisations to ensure that they are capacitate and equipped to support young people to meet their sexual and reproductive health needs.

Young people can make responsible decisions about their health if they are given the information, services and support necessary for adopting safe behaviours. With support young people can help educate other people and motivate them to make safe decisions. Working with young people represents one of our greatest hopes in the struggle against AIDS.

All young people, particularly those living with HIV, should have access to youth-friendly services for reproductive health and HIV prevention and care, with appropriate services for young people, who represent 4.4% of young people (15 -24 years) living with HIV in Sub-Saharan Africa (UNAIDS, 2012). Education is essential, when young people are given the tools and incentives to adopt safe behaviours, they consistently demonstrate the capability to make responsible choices and encourage others to do the same.

5. Research problem and research question

The study was focusing on young men, 18 to 24 years of age from two identified sites to develop the approach that will increase the attendance of young men to HIV education programmes in Kagiso, Mogale City.

Despite the intervention programmes that are implemented by the government, a significant number of young men do not attend youth focus HIV education programmes. The objective of this study is to establish the factors that influence young men to attend and access HIV education programmes and healthcare services. The results of this study will give a clear indication why young men do not participate in HIV education programmes. It will assist to plan effective interventions that address young people needs and promote positive youth development.

The research question is:

What are the factors that influence young men not to attend and access HIV education programmes and services?

6. Research Design and Methods

6.1 Site selection

The research study was conducted at two identified sites at Kagiso, Mogale City. The sites were selected because of accessibility for the research project and working relationship has been formed with community partners during previous interventions.

6.2 Data collection and target population

The study project utilized qualitative data collection method by conducting focus group discussions and in-depth interviews in order to collect substantive and relevant data. Data was collected from peer educators through in-depth interviews and focus group discussions with young men in two sites in Kagiso, Mogale City.

Mogale City is situated at the Western side of the Gauteng Province. It has a mixture of urban and rural with a population of about 319 614 people. Mogale City has a population that reflects a total Gauteng gender ratio due to its historical background as a centre for male migrants. According to the 2007 Community survey, it has 51.48% male and 48.52% female populations (Statistics South Africa, 2007). Evidence has shown that young people require HIV education to enable them to protect themselves from being infected, because they are often vulnerable to sexually transmitted HIV.

Of the targeted participants were to include 50 out of school young men between 18 to 24 years of age and 20 peer educators who are part of HIV education and prevention as well as sexual and reproductive health programmes.

- 42 of the 50 out of school young men participated in three focus group discussions and shared their experiences and views contributing to low participation to HIV education programmes by young men.
- 14 of the 20 peer educators were interviewed and provided their experiences, roles and responsibilities in their work with young men.

6.3 Ethics and confidentiality

The protocol outlining this study was reviewed and approved by the Ethics Committee at the University of Stellenbosch. Participation in this study at all levels was voluntary, and to ensure confidentiality, no identifiers were used and the data will be accessed by the researcher only. Participants were asked to keep the discussion confidential, particularly with regard to what personal stories shared during the discussions. The importance and study objectives were explained to participants.

During data collection, the purpose and the aim of the study was explained to all participants. The data collected was treated with confidentiality and anonymity; the data has been kept in a locked cabinet. Verbal and written consents were discussed and obtained from participants.

7. Results

The findings are presented under the two data collection methods separately or combined depending on the theme. Qualitative data are summarised using themes from recurring perceptions; main areas of agreements are aligned with the topics of discussion and issues reported.

7.1. Findings from in-depth interviews

In their daily interaction with young people, peer educators shared evidence based HIV/AIDS research findings and monitoring and evaluation outcomes. They shared advancements and new developments in the area of HIV/AIDS both at the policy, programmatic and implementation levels. They also discuss the importance of youth contribution to the reduction of HIV infections among the youth and the communities at large.

7.1.1. Sexual relationships

- *Early sexual debut*

Peer educators interviewed were of the view that young people are starting their sexual activities very early, although some youth willingly indulge in sexual activities or others are forced into it. In the first case, the underlining factors include curiosity, sense of belonging and wanting to prove to their peers, the need to satisfy economic needs, the lack of information and/or experience. In the latter case, incidence of sexual violence or rape and in some instances, cultural practices such as *ukhuthwala* “form of abduction that involves kidnapping of a girl” are at the base of early sexual debut among young people.

It is worthwhile noticing that some young people are well aware and informed. Although as they indulge in sexual activities early, they know exactly what to do; they are responsible and practice safer sex.

- *Violence within a relationship*

As it is the case in relationships among adults, violence in relationships among young people also exists. This is manifested at different layers. Peer educators indicated that emotional violence is mostly experienced by female youth than their male counterparts in cases of break of trust, disengagement and denigrating verbal exchanges from young men and female youth feel left out. Physical abuses are reported daily where women are battered and violated sexually in their homes and schools. These are a results of violent experiences one’s upbringing and gender

stereotyping; problem is the power imbalances supported by our societies cultural practices that perpetuate sexual violence.

- *Impact of violence impacts on young people's sexual and reproductive health*

In their work with young people, peer educators gave account of experiences of traumatised young people who cannot function normally and who lives in constant fear. Some young people tend to blame themselves for an unfortunate event in their lives; they cannot trust anyone to talk to in order to receive help regarding their ordeal and some simply opt to end their lives.

Violence in relationships affects some women's ability to decide on their own. For example, with regard to contraception uptake, the choice of method is clouded by fear of rejection by their partners. In some instances, force sexual intercourse damages female private parts and sometimes leads to difficulties to conceive in future.

7.1.2. Reproductive health services

- *Access to information and services, their strengths and weakness*

Peer educators pointed out that reproductive health services for young people are available in government and private hospitals/clinics as well as schools. There is also the work of non-governmental organisations and community-based organisations in providing reproductive health services.

Information is widely found in schools, newspapers, magazines, on the internet and now on cell phones. Some churches and religious gatherings do conduct talks (through youth camps/talks). However, services are disintegrated. As such there are missed opportunities in addressing youth sexual reproductive health information and services holistically. Besides, they are not tailored to suit the needs of young people (by mixing youth and adults); they are being provided by older healthcare service providers. In situations of sexual abuse, victims sometimes suffer from secondary victimisation as survivors seek support and justice. The rural and urban divide exists; in addition, services provision points are not attractive to the likes of young people.

‘Young people tend to be bored quickly with sexual reproductive health information and services only ‘.

- *Barriers to access reproductive health services by young people*

Peer educators did not want to generalise but they agree that barriers to access reproductive health services by young people do exist. These are found at the programmatic and structural levels where services, if not well planned, their coordination is not up to standard. Peer educators were of the view that services are more pronounced in major towns, some programme implementers do not understand quite well the needs of young people. This makes it difficult to provide them with adequate services. There is also the issue of lack of resources due to budget, personnel capacity and facilities.

7.1.3. Community attitude

- *Community's perception on effects of HIV/AIDS on young people*

Peer educators interviewed mentioned that communities are aware of the effects of HIV/AIDS on young people. They are worried of the fact that young people are infected and dying at a young age. This in turn affects the country demographics, its workforce and weakens its entire economy. At family level, families are devastated and they are further impoverished. The youth's dreams are short lived. Despite the burden of HIV/AIDS on young people, some of them continue to live a reckless life. However, some young people were born with HIV infection and were not aware of their HIV status. Communities are seen to be providing them with the necessary support they need.

- *Community reaction to people living with HIV*

Peer educators reported that community members react differently upon learning of an HIV positive status among them. There are mixed feelings – of negative judgement, rejected, shamefulness owing to the level of stigma surrounding HIV. Hence, the whole thing is kept a secret which is good in one way as one's situation is treated in confidentiality. On the other hand, people living with HIV die silently when something could have been done.

- *Prevention of HIV/AIDS by communities*

When asked about prevention of HIV/AIDS by communities, peer educators suggested the following:

- Shared responsibilities and application of the spirit of common unity. Some of the comment was: “The issue of HIV seems not to be about ‘them’ and ‘us’ anymore”
- Encourage best practices in terms of information sharing and treatment models
- Increase health facility utilisation. Some of the comments were: “Once respect is established and community members let off of judgmental utterances against people living with HIV/AIDS, the people living with the disease will open up and visit the facilities as they will feel they are suffering from a “normal disease”.

7.1.4. Young people and HIV/AIDS

- *Sources of information*

Peer educators stated various sources where young people receive information about HIV/AIDS. These vary from health facilities, the media, both printed and electronic including the radio/TV/newspapers. The government departments have programmes with a special focus on sharing HIV/AIDS. Other key players are the non-governmental organisations, the religious groups, public and private workplaces.

7.1.5. HIV/AIDS compared to other challenges facing young men

According to the peer educators interviewed, it becomes to separate the issue of HIV and other challenges facing young men. HIV and other challenges facing the youth are the same and all identified challenges need to be addressed holistically.

7.1.6. Importance of HIV education programmes for young men

It is in their interest for the young men to attend existing programmes aimed at addressing HIV/AIDS. Young men need to make informed decisions about their lives and these programmes which should continue emphasizing prevention, treatment

and societal acceptance can guide them. These should also be innovative, involve and develop new means of transferring information.

7.1.7. Low attendance to HIV education programmes among young men

Culturally, the youth are considered as such and they are not given a platform to share and discuss issues in the main streams by their respective societies. There are generation gaps where by programmes are drawn for young men without their full participation. Some young men simply imitate adults and identify with particular role models. They feel “immune” and distance themselves from any discussion or activity attempting to deal with the issue of HIV. Others simply loose interest if the programmes are not attractive/appealing/aligned to young men’s needs. There is also the issue of poverty, the rural and urban divide, poor or lack of infrastructure which dictates young men attendance to HIV education programmes. Some of the comment was:

‘These programs lack creativity; the youth are left out in planning and implementation of services that are meant for them’

7.2 Findings from Focus Group Discussions

7.2.1. Background information about HIV/AIDS

When asked about the number of people living with HIV/AIDS in South Africa. Their responses varied: Few people go for HIV testing, about 30% and even further, \pm 2 or 3 Million. Some participants attempted to attach a figure on the HIV infection among young people. They mentioned 7 - 8% or indicated that a high number among young people in South Africa are living with HIV/AIDS.

On prevention of HIV/AIDS, participants emphasised sexual education in school programmes to curb ignorance, the promotion of young men talks and avoidance of life styles that does promote prevention of HIV/AIDS and increase condom distribution. They also called on the involvement of parents/guardians in the HIV/AIDS prevention measures.

7.2.2. Community attitude

- *Effects of HIV/AIDS on young people*

Participants indicated that the effect of HIV/AIDS on young people is noticeable. People are talking about HIV/AIDS in schools and hangout places but depending on a particular individual, there is still lack of information within households, no communication between young people and parents/guardians and sometimes communities are negative towards someone known to be living with HIV/AIDS. Some of the comments were:

‘HIV is a bad thing’

‘We can’t talk about it, we are not sick!’

‘This sickness comes with them’

- *Community’s feeling about a member infected with HIV*

The participants’ response was split. Some mentioned the embarrassment and sense of shamefulness by the families affected. They also mentioned the lack of knowledge and lack of support, associating HIV/AIDS with death row. Others show support and refer families to support programmes such as home-based carers like Bambanani. Another group of participants indicated that HIV/AIDS remains a personal matter but communities assume or suspect if they are not sure. Some of the comments were:

‘It is witchcraft’

‘If you, it is not known, it will be assumed’

- *Prevention of HIV/AIDS in community*

The participants indicated that it is sometimes difficult to talk to young people about HIV/AIDS. Community members need to tackle ignorance, involve community and traditional leaders, sensitise young people at that young age will be beneficial for families. This can be done through conducting workshops and the use of different media platforms.

7.2.3. Young men and HIV/AIDS

The participants indicated that some young men continue taking risks and sharing sexual partners. They do not visit the clinics for the fear that their entire community will come to know of their HIV status or they will be pointed fingers that they are HIV positive when seen at clinics. Others do not visit clinics because of pride and that they do not want to be seen as cowards. On the other hand, some young men dream, they encourage positive thinking and enthusiasm, they support uptake of rapid tests and to visit health establishments.

7.2.4. Sources of information on HIV/AIDS communities

Findings from the in-depth interviews and the focus group discussions concur on the sources of information on HIV/AIDS. These include entertainment, role models, door to door campaigns, support groups, visual effect technologies, radio stations, billboards, community dialogues, soccer grounds, social gatherings and parades.

7.3. General recommendations

The peer educators and focus groups participants stated the following recommendations that would assist to encourage young men to participate in HIV education programmes.

- Have mix methods of information sharing such as the use of modern technologies and advancement in cell phones technologies to promote information sharing.
- Combine sexual reproductive health information with social events where tokens, freebies and incentives are given.
- Hold youth annual events/conferences/gathering to discuss the issues of sexual reproductive health and youth development.
- Replicate best practices and models that have been tested elsewhere.
- Revive support group programmes.
- Go and find men where they are – pubs, soccer games/grounds.
- Involve positive role models to speak to them and address their concerns
- Implement and monitor developed policies and provide same quality services

for all regardless of one's HIV status

8. Discussions

Young men and communities acknowledge the negative impact of HIV/AIDS on young men. One of the sub-objectives in the National Strategy Plan (2012) is to increase access to sexual reproductive health services with a focus to people living with HIV and young people, including provision of contraception and male condoms, an emphasis on dual protection and medical male circumcision. Provision of free sexual reproductive health information and services for young men is one way to respond to this objective.

The findings concur with other studies by Pettifor et al (2005). Sexual reproductive health information is accessible at local clinics and hospitals, in the traditional media and modern communication platforms such as social networks (MXit and Facebook). Remaining, however, is to see a full utilisation of such services by young men to their benefit.

In South Africa, access to the existing sexual reproductive health services for young men is hampered by structural and/or programmatic obstacles. Like the work of Mills et al (2012) the findings points to services being more pronounced in urban areas and also being disintegrated and/or not tailored to suit the needs of young men.

Programmes that emerged from the 1994 International Conference on Population and Development do support men's involvement to promote women's health mainly to sexual reproductive health and HIV/AIDs interventions. This approach may be taken seriously as an important prevention benefit for women and girls. Failing to engage men in HIV prevention and treatment may have an impact on household family income. As the case may be in Africa where men are typically the larger income generators, often engaged in employment outside of the home or communities (Mills et al, 2012). A small evidence is emerging indicating that programmes integrated into the workplace that offer peer education may be successful in engaging men in HIV counselling and testing, care, treatment and support (Kuwane, Appiah, Felix, Grant & Churchyard, 2009).

Young people especially young women are vulnerable to sexual violence including intimate partner violence. There is evidence that men's controlling behaviour may place women at increased risk of HIV infection even in the absence of overt violence (Dunkle & Jewkes, 2007). The findings on sexual relationships are aligned with this statement where relationships appear to be driven by peer pressures for young people to engage in early and unprotected sexual activity to prove love, trust or commitment of both young partners. Encouraging is a cohort of young men who are well informed, responsible, practicing and promoting safe sex as well as informed decision-making about their sexual reproductive health.

Men are seldom targeted in sexual reproductive health programmes and there are very few evaluations of interventions in sexual reproductive health that address issues from a focal point of masculinity, or understanding of men's needs (Sternberg & Hubley, 2004). Men play an important role, programmes such as 'Men as Partners' encourages men to become actively involved in preventing gender-based violence as well as HIV/AIDS related prevention, care and support (Peacock & Levack, 2004). The findings also show that young men are seen as key role players in combatting the scourge of HIV/AIDS in their respective communities. Therefore it becomes imperative for young men to attend HIV education programmes as mentioned by peer educators and that existing programmes should continue to emphasise prevention, treatment and acceptance among young people.

9. Conclusion

The main focus of this study was to establish factors that influence young men not to attend HIV education programmes and access services in Kagiso, Mogale City.

The researcher has found that factors that influence young men not to attend HIV education programmes should be addressed and taken into consideration when designing interventions that are focusing to young people primarily young men.

There is a perception that young men idolise older men who have multiple sexual relationships and some are known as a 'player/s' a man with more than one partner. Some of the young men during the discussion emphasized at changing this attitude starting with them first and cascading positive dialogues with their peers. Studies

have been conducted to underlined precautions that need to be taken to support young people and to involve young men in reducing HIV infections. Young men should be involved in major HIV prevention strategies and programmes in addressing risky sexual behaviours among young people and that would affect young women in the process.

The findings show that young men are willing to attend HIV education programmes that are innovative, participatory and interesting to them. Researchers and programme implementers should develop positive messages that promote positive youth development strategies instead of negative messages where men are seen as perpetrators of violence in the society.

Envisage interventions by young men and peer educators should combine sexual reproductive health information with social events, revive youth support programmes and invite young people during planning so that the implementers plan programs that should meet their needs. Innovative strategies are mostly welcomed by young men such as using mobile health initiatives to share informative messages and using mobisite that are accessible by young people to provide sexual reproductive health information using cell phones.

10. Limitations

The data collection methods engaged was appropriate given the context of the assessment under consideration. These methods provided the best information at the community level and from out of school participants. Participants were selected purposively based on their availability and they were a valuable pool as they interact with young men mostly. Focus group discussions allowed the researcher to explore participants' experiences, opinions and also allowed group interaction and exchange of knowledge where applicable. Some participants took a while to understand the questions that resulted at taking a lot of time to ensure all questions were understood. There was a lot of information and questions to discuss, however there was time limitation. Before closing the focus group discussion, the researcher was prepared to address and correct any misinformation or misconceptions that had been raised by participants and provided the correct information.

References

- Bankole, A., Ahmed, F.H, Neema, S., Ouedraogo, C. & Konyani, S. (2007). Knowledge of correct condom use and consistency among adolescents in four countries in sub-Saharan Africa. *African Journal of Reproductive Health*. 11(3): 197–220.
- Bradshaw, D., Dorrington, R. & Laubscher, R. (2011). Rapid Mortality Surveillance Report 2011. Burden of Disease Research Unit Medical Research Council, August 2012. Accessed 4 Feb 2012. <http://www.mrc.ac.za/bod/RapidMortality2011.pdf>
- Cornell, M., Schomaker, M., Garone, D.B., Giddy, J., Hoffman, C.J., Lessells, R., Maskew, M., Prozesky, H., Wood, R., Johnson, L.F., Egger, M., Boule, A. & Myer, L. (2012). Gender Differences in Survival among Adult Patients Starting Antiretroviral Therapy in South Africa: A Multicentre Cohort Study, *PLOS Medicine*, Sept 2012 Vol. 9 Issue 9, e1001304.
- Dunkle, K.L. & Jewkes, R. (2007). Effective HIV prevention requires gender-transformative work with men, *Sex Transm Infect* 2007; 83:173-174.
- Harrison, A., Cleland, J., Gouws, E. & Frohlich, J. (2005). Early sexual debut among young men in rural South Africa: heightened vulnerability to sexual risk? *Sex Transm Infect* 2005; 81: 259-261.
- Harrison, A., O'Sullivan, L.F., Hoffman, S., Dolezal, C. & Morrell, R. (2006). Gender Role and Relationship Norms among Young Adults in South Africa: Measuring the Context of Masculinity and HIV Risk, *Journal of Urban Health*. 2006 July; 83(4): 709-722.
- Jewkes, R.K., Dunkle, K., Nduna, M. & Shai, N. (2010). Intimate Partner Violence, Relationship Gender Power Inequity, and Incidence of HIV infection in young women in South Africa: A Cohort Study. *The Lancet* 367: 41–48.

Jewkes, R., Dunkle, K., Nduna, M. & Shai, N.J. (2012). Transactional Sex and HIV Incidence in a Cohort of Young Women in the Stepping Stones Trial, *J AIDS Clinic Res* 2012 3:5.

Jewkes, R., Sikweyiya, Y., Morrell, R. & Dunkle, K. (2011). The Relationship between Intimate Partner Violence, Rape and HIV amongst South Africa Men: A Cross-Sectional Study. *PLOS One* 2011 Vol 6, Issue 9, e24256.

Kirby, D.B., Laris, B.A. & Roller, L.A., (2006). Sex and HIV Education Programs: Their Impact on Sexual Behaviours of Young People Throughout the World, *Journal of Adolescent Health* 40 (2007) 206-217.

Kuwane, B., Appiah, K., Felix, M., Grant, A. & Churchyard, G. (2009). Expanding HIV care in Africa: making men matter in Johannesburg. *Lancet* 374: 1329.

Mills, E.J., Beyrer, C., Birungi, J. & Dybul, M.R. (2012). Engaging Men in Prevention and Care for HIV/AIDS in Africa, *PLOS Medicine* Feb 2012, Vol. 9:2, e1001167.

National Strategic Plan on HIV, STIs and TB: 2012 – 2016. Accessed Jan 15, 2012 <http://www.doh.gov.za/docs/stratdocs/2012/NSPfull.pdf>

Paul-Ebhohimhen, V.A., Poobalan, A. & van Teijlingen, E.R. (2008). A Systematic Review of School-based Sexual Health Interventions to Prevent STI/HIV in sub-Saharan Africa' *BMC Public Health* 8(4).

Peacock, D. & Levack, A. (2004). The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and Reproductive Health. *International Journal of Men's Health*, Vol. 3, No. 3, Fall 2004, 173–188.

Peacock, D., Stemple, L., Sawires, S. & Coates, T.J. (2009). Men, HIV/AIDS and Human Rights *NIH* 51 (Suppl 3): S119-S125.

Peltzer, K. (2010). Early sexual debut and associated factors among in-school adolescents in eight African countries. *Acta Paediatr.* 2010 Aug; 99 (8):1242-7. Epub 2010 May 19.

Pettifor, A.E., Rees, H.V., Steffenson, A., Hlongwa-Madikizela, L., MacPhail, C., Vermaak, K. & Kleinschmidt, I. (2004). HIV and Sexual Behaviour among Young South Africans: A national survey of 15-24 year olds. *Behaviour* 1(11), p 1829–1841. Available at: <http://www.rhru.co.za>

Pettifor, A., O'Brien, K., MacPhail, C., Miller, W.C. & Rees, H. (2009). Early Coital Debut and Associated HIV Risk Factors among Young Women and Men in South Africa. *International Perspectives on Sexual and Reproductive Health* Vol. 35, No. 2 (June, 2009), pp. 82-90.

Pettifor, A.E., Rees, H.V., Kleinschmidt, I., Steffenson, A.E., MacPhail, C., Hlongwa-Madikizela, L., Vermaak, K. & Padian, N.S. (2005). Young people's sexual health in South Africa: HIV prevalence and sexual behaviours from a nationally representative household survey. *AIDS* 2005, 19:1525–1534.

South African National HIV Prevalence, Incidence, Behaviour and Communication Survey. (2008). *A Turning Tide Among Teenagers?*

Statistics South Africa. (2007). *South Africa Community Survey 2007*. Available at: <http://www.statssa.gov.za/publications/statsdownload.asp>

Statistics South Africa. (2011). *Mid-Year Population estimates*. Available at: <http://www.statssa.gov.za/publications/P0302/P03022011.pdf>

Sternberg, P. & Hubley, J. (2004), *Evaluating men's involvement as a strategy in sexual and reproductive health promotion*. *Health Promotion International* Vol. 19, No. 3 Oxford university Press.

UNAIDS. (2012). Global AIDS Epidemic Global Report.

http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf

UNAIDS. (2009). Joint Action for Results, UNAIDS Outcome Framework 2009–2011, Geneva.

https://www.unaids.org/en/media/unaids/contentassets/documents/aboutunaids/programmecoordinatingboard/subcommittee/jc1713_joint_action_en.pdf

UNESCO, Director-general (2008), 'Why are we still failing our young people?'

UNESCO. (2009). A strategic approach: HIV & AIDS and education. Available at <http://unesdoc.unesco.org/images/0016/001627/162723E.pdf>

Varga, C.A. (2001). The forgotten fifty per cent: a review of sexual and reproductive health research and programs focused on boys and young men in sub-Saharan Africa African Journal of Reproductive Health, 2001 – JSTOR. Vol. 5, No. 3 (Dec., 2001), pp. 175-195.

Varga, C.A. (2003). How Gender Roles Influence Sexual and Reproductive Health among South African Adolescents, Studies in Family Planning 2003, 34(3): 160–172.

Appendix A: Focus group discussion questionnaire (Young men)

Your participation will help the researcher to understand better programs and interventions that meet young men's need and desires about HIV/AIDS education programs. The discussion should take approximately 45 minutes. The discussion will be semi-structured, guided by the following kinds of questions:

A. HIV/AIDS background information

1. How many people are living with HIV/AIDS in South Africa?
2. Out of the figure you given, how many are young people (18 to 24 years) living with HIV/AIDS?
3. What can people do to keep from getting infected? How easy or difficult is it to do these things?

B. Community attitude

1. In your opinion, how might AIDS affect young people in your community, now and in the future? Please explain,
2. How would young people in this community feel if their family member/s were infected with HIV?
3. What can young people do to help prevent HIV/AIDS in this community?

C. Young men and HIV/AIDS

1. How important do you think AIDS is compared to other problems young men face?
2. How important do you think it is for young men to attend and access HIV education programs? Reasons why young men do not attend these programs?

D. Resources

1. In your opinion, who, or what, could be good sources of information about HIV/AIDS in your community, to whom young men would really listen to? Why?

E. Closing

1. What sorts of information, programs and other support do you need to encourage and increase young men attendance to HIV education programs?

Appendix B: In-depth interview questionnaire (Peer Educators)

Your participation will help the researcher to understand better programs and interventions that meet young men's need and desires about HIV/AIDS education programs. The discussion should take approximately 45 minutes. The discussion will be semi-structured, guided by the following kinds of questions:

Interview questions dividend in themes:

Background information

1. Tell me about your SRH work.
2. In your daily peer education activities, do you interact with young men, young women or both?

Sexual relationships (including violence)

1. Do you think young people start sexual activity at an early stage?
2. How would you describe violence within a relationship?
3. Do you think there is a lot of violence, including sexual coercion among young people in your community? Please explain,
4. How do you think violence impacts young people sexual and reproductive health?

Reproductive health services

1. Where do young people get reproductive health services i.e. HIV/AIDS, contraception or STIs in your community?
2. What are the strengths or weaknesses of these services?
3. What are the obstacles for young people to obtaining services in your community?

Community attitude

1. In your opinion, how might AIDS affect young people in your community, now and in the future?
2. How would young people in this community feel if their family member/s were infected with HIV?

3. What can young people do to help prevent HIV/AIDS in this community?

Young people and HIV/AIDS

1. Where do young people especially young men get reliable information about HIV/AIDS?
2. How important do you think AIDS is compared to other challenges young men face?
3. How important do you think it is for young men to attend and access HIV education programs?
4. What are the cultural and socio-economic factors that lead to low HIV education programs attendance among young men?
5. What are the factors that influence young men not to attend and access HIV education programs?
6. Do you think existing HIV education programs are aligned to young men needs?
7. What makes it difficult for young men to adhere to HIV education programs?

A. Opinion

1. In your opinion, who will, or what, could be good sources of information about HIV/AIDS in your community, to whom young people would really listen to? Why?
2. What should those services or resources be like?

B. Closing

1. What information, programs and other support do you think we should have in place to encourage and increase young men's attendance to HIV education programs?

Thank you for your time and your contribution!