

AN INVESTIGATION INTO SOCIAL CONTEXTUAL FACTORS THAT DISCOURAGE
MIDDLE-AGED MEN (30 – 58) FROM ATTENDING HIV COUNSELLING AND TESTING.
A CASE STUDY OF RATANDA HEIDELBERG, SOUTH AFRICA

By

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- Finally, I give thanks and glory to God, the Almighty, for giving me life, the power, wisdom, courage and perseverance to successfully complete this study.

DECLARATION

I, F. G. Mageto, (student no: 45970203), declare that AN INVESTIGATION INTO SOCIAL CONTEXTUAL FACTORS THAT DISCOURAGE MIDDLE-AGED MEN (30 – 58) FROM ATTENDING HIV COUNSELLING AND TESTING. A CASE STUDY OF RATANDA HEIDELBERG, SOUTH AFRICA is my own work and that all the sources that I have been indicated and acknowledged by means of complete references, and that this work has not been submitted before any other degree at any other institution.



SIGNATURE

(FG MAGETO)

2nd DECEMBER 2014

DATE

SUMMARY

This study investigated social contextual factors influencing poor uptake of HIV counselling and testing (HCT) services by middle-aged black men in Ratanda, Heidelberg. A qualitative research approach was used in which ten men and two key informants were interviewed. Themes explored were the participants' biographical characteristics; knowledge of HIV and AIDS; health-seeking behaviours; understanding of multiple sexual partnerships and male circumcision and challenges in utilising HCT services. Various social behaviour change theories formed the theoretical framework guiding this study. It was found that fear, stigma and cultural factors largely contributed to poor HCT uptake. Moreover despite the men's high HIV risk perceptions, behaviour change lags behind. Greater efforts to establish a men's forum to discuss sexual health matters in Ratanda is recommended.

Keywords: male circumcision and HIV, men's sexual health, middle-aged black men's health-seeking behaviour, multiple sexual partnerships, poor uptake of HCT.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral
FBOs	Faith-based organisations
HBM	Health Belief Model
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
MSM	Men who have sex with men
NGOs	Non-Governmental Organisations
SANAC	South African National AIDS Council
SAFAIDS	Southern African HIV and AIDS Information Dissemination Service
STIs	Sexually transmitted infections
TAC	Treatment Action Campaign
TRA	Theory of Reasoned Action
USAID	Joint United Nations Programme on HIV/AIDS
UNAIDS	United States Agency for International Development
UNGASS	United Nations General Assembly Special Session
UNISA	University of South Africa
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

CHAPTER 1: ORIENTATION OF THE RESEARCH PROBLEM

1.1 INTRODUCTION

South Africa is reportedly the country with the highest HIV prevalence in the world and the majority of the population have never been tested for the virus (Karim & Karim 2010:55; Southern African HIV and AIDS Information Dissemination Service, SAFAIDS 2011:3). Despite vigorous HIV and AIDS education and prevention campaigns, the national infection rate continues to escalate at an unacceptable rate of 5,38 million of the global burden of HIV infection (Karim, Churchyard, Karim & Lawn 2011:921). Karim et al (2009) further argue that heterosexual transmission is the dominant mode of HIV infection among adults in South Africa. The role of gender and power relations is usually not taken into cognisance as two of the factors that may render HIV and AIDS prevention programmes ineffective and contribute to the spread of the epidemic. The researcher argues that HIV intervention programmes have tended to focus on women and girls to mitigate the spread and impact of AIDS. The reproductive health needs of men have not received adequate attention (UNAIDS 2001:5).

Similarly, Swanepoel (2005:3) demonstrates that HIV intervention programmes do not empower men since these programmes do not speak directly to them. This lack of attention to a male audience reinforces traditional views of male roles, resulting in little behaviour change in respect of HIV infection. Therefore, it is necessary that the role of men in contributing to the spread of HIV infection be investigated.

Previous studies by Weisser et al (2006), Namanzi (2010) and KAIS (2007) note that HIV/AIDS awareness levels, models of testing, availability of testing sites and pre-test counselling as a procedure in testing have an effect on the uptake of HIV testing. This study sought to establish the influence of these HIV and AIDS awareness levels, models of testing, availability of testing sites and pre-test counselling on the uptake of HIV testing among middle-aged black men in Ratanda, Heidelberg.

1.2 BACKGROUND TO THE STUDY

This study sought to establish the social contextual factors that influence the uptake of HIV testing among middle-aged men (30 – 58) in Ratanda. Specifically, the study looked at the influence of HIV/AIDS knowledge and awareness, access to testing sites, models of HIV testing employed and pre-test counselling on HIV test uptake by middle aged men.

Previous studies by Weisser et al (2006), Namanzi (2010) and KAIS (2007) confirm that HIV/AIDS awareness levels, models of testing, availability of testing site and pre-test counselling as a procedure in testing have an effect on the uptake of HIV testing. This study sought to establish the influence of these HIV/AIDS awareness levels, models of testing, availability of testing site and pre-test counselling on the uptake of HIV testing among middle-aged men (30 – 58) in Ratanda Heidelberg. As a resident in the area, I have observed how scores of middle-aged black men hang around in the local taverns and pubs and boast about their multiple sexual relationships. I have noticed that black women are more inclined to utilise HCT services than middle-aged black men. Similar conclusions are drawn by Bourne, Bourne and Francis (2010:3). In addition, Levack, Raletsemo, Budaza, Hugoplan and Gonzales (2006:2) find that men tend to view health behaviour and help-seeking as signs of weakness, vulnerability or fear. These barriers to HCT uptake may render men vulnerable to HIV infection. Therefore, there is a need for a thorough investigation of relevant gender issues that have been overlooked and that impede the effectiveness of HIV prevention strategies (Mouch 2001:6).

Evidence suggests that South African middle-aged men are at risk of HIV infection because they often have unprotected sex with very young women under the illusion that these women might not be infected (Karim & Karim 2010:55). Furthermore, a review of available studies also suggests that a great deal of local research has been done on the vulnerability of women, girls and men who have sex with men (MSM) but that there is a paucity of research on older men.

Moreover SAFAIDS (2011:9) argues that HIV and AIDS programmes have always been ineffective because men do not fully participate in or support these programmes. This makes it difficult for women to either negotiate safer sexual practices or encourage their male partners to utilise HCT services. In support of this view,

Govender (2010:5) purports that people do not have adequate knowledge of their HIV status because HIV counselling and testing programmes are not tailored to local contexts and gender regimes.

Latif (2003:159) adds that myths and fears about HIV risks and prevention methods may make it difficult for men to access health care centres.

This may have a negative impact on the options available to reduce risky behaviours, including the importance of HCT utilisation. As noted above, a reduction in the transmission of HIV may largely depend on male involvement in HIV programmes and campaigns because they are often the primary decision-makers regarding health-seeking behaviours. In addition, with the male condom still being the main barrier method to prevent the sexual transmission of the HI-virus, male buy-in in prevention is a priority.

Other studies indicate that HIV and AIDS are not only medical issues, but are largely influenced by social issues such as poverty, gender inequality, gender norms and roles (Van Niekerk 1991:78). It is thus imperative to understand the impact of cultural, social and economic issues that may prevent middle-aged black men from utilising HCT services.

1.3 RATIONALE OR MOTIVATION OF THE STUDY

The researcher's interest in the topic stems from the preliminary interviews he conducted with the Engender Health HCT coordinators. Seeing that HIV/AIDS is an epidemic in our country, South Africa, and with the little exposure, he felt it was necessary to study the disease further so as to improve intervention skills and help both the infected and the affected people facing the challenges of living with HIV/AIDS. He studied a course in HIV/AIDS Care and Counselling to gather more knowledge on the fundamental facts of the disease, its prevention and counselling. This contributed immensely to his work and he was able to achieve satisfaction from providing quality social work services to patients, families and the community at large through the campaign to raise awareness regarding men as the driving force.

1.4 THE RESEARCH PROBLEM

Counselling and testing are the keys to HIV and AIDS management and universal access to treatment (WHO 2010). No cure is available for HIV and AIDS but they are preventable and can be managed through the enrolment of HIV and AIDS positive individuals for ART Care and treatment services provided free in all government and mission health facilities. Antiretroviral drugs (ARVs) can prolong the lives of HIV positive individuals for as long as 15 years. Research has demonstrated that over 230,000 lives were saved by increased enrolment of HIV positive people for care and treatment (WHO 2010).

HCT is based on the principle that tested clients who are HIV negative should receive counselling so that they maintain their HIV status. Those who test HIV positive should be assisted to obtain proper clinical care. HCT services are available free of charge at five sites in Ratanda, some of which are administered by non-governmental (NGOs) and faith-based organisations (FBOs). It has also been discovered that Ratanda has low HIV testing rates, especially among men with lower socio-economic status (SAFAIDS 2011:8).

Middle-aged black men may not perceive themselves to be at risk of HIV infections because they are married, cohabitating or in stable consensual relationships. They may thus develop a false sense of security that they will not be infected with HIV. In addition, older males may be less exposed to information about the importance of HIV counselling and testing (UNAIDS 2001:8).

In support of the above view, Swanepoel (2005:8) states that middle-aged men may not utilise HCT services if they do not show symptoms of HIV and AIDS or if they attribute HIV and AIDS symptoms to other illnesses or as part of the aging process. This means that the above research findings suggest that middle-aged men may unknowingly contribute to the spread of HIV and AIDS. The researcher has observed that traditional gender role expectations and male-dominant views on marriage are prevalent in Ratanda. Middle-aged black men may thus be more inclined than younger men to uphold traditional gender role expectations.

Views on what it means to be a black man stemming from this may make it unlikely that they would utilise HCT services. Seeley, Griller and Barnett (2004:95) state that a

black man's behaviour is shaped and influenced by social issues such as masculinity, culture and economic factors that define what it means to be a man.

Similarly, Peacock, Redpath, Weston, Evants, Daub and Greig (2008:5) state that South African men are far less likely than women to access HCT services. Furthermore, they are also less likely to be aware of their HIV status and thus may unintentionally infect their female partners. The *Household's Survey Results* by the United Nations General Assembly Special Session (UNGASS 2010:39) reveals that black men between the ages of 25 and 49 are at the highest risk of HIV infection in South Africa. Furthermore, UNGASS notes that 38% of men surveyed have never utilised HCT services. There is a need to investigate some of the reasons that contribute to this problem.

Therefore this qualitative study aimed to explore social contextual factors influencing the poor uptake of HIV Testing and Counselling (HCT) services by middle-aged black men in Ratanda, Heidelberg.

1.5 AIM OF THE STUDY

The aim of this study was to establish the influence of HIV and AIDs awareness levels, models of testing, access to testing sites and pre-test counselling on the uptake of HIV testing among middle-aged black men in Ratanda, South Africa.

1.6 OBJECTIVES OF THE STUDY

The main objective of the study was to reduce HIV infection and develop a framework of needed networking capabilities and inter-relationships to enable successful virtual organising intervention programmes to address adequately the benefits of male involvement in HIV prevention programmes.

The study aimed at achieving the following objectives:

- Determine middle-aged black men's knowledge of HIV/AIDS and HCT services.
- Identify factors that may act as barriers to middle-aged black men's use of HCT services.

- Determine challenges that men face when utilising HCT services in Ratanda.
- Establish ways to encourage middle-aged black men to utilise HCT services in Ratanda.

1.4 RESEARCH QUESTIONS

To facilitate the collection of information that would contribute towards understanding the social contextual factors that prevent middle-aged black men from utilising HCT services in Ratanda, the following research questions were answered:

- What do middle-aged black men know about HIV/AIDS and HCT?
- What social contextual factors contribute to middle-aged black men's reluctance to utilise HCT services?
- What social challenges do middle-aged black men face in utilising HCT services in Ratanda?
- What can be done to motivate middle-aged black men to utilise HCT services in Ratanda?

The researcher chose to look for concepts and constellations of factors that influence the uptake of health interventions in theories such as the Health Belief Model (HBM), the Theory of Reasoned Action (TRA) and the Social Ecological Theory (Decosas 2002; Van Dyk 2008). These theories are discussed in chapter two.

1.5 ASSUMPTIONS UNDERLYING THE STUDY

According to Polit and Beck (2004:13), an assumption is a basic principle that is believed to be true without a need for verification. The research study was based on the assumption that most middle-aged black men were reluctant to utilise HCT services and might not realise their possible contribution to the spread of HIV infection. It was also assumed that middle-aged black men might not perceive themselves to be at risk for HIV infection.

The researcher also assumed that current HIV prevention programmes and campaigns were not appropriately designed to cater for the needs of middle-aged black men. The researcher further assumed that middle-aged black men might have multiple sexual

partners owing to societal expectations of what it means to be a black man and the need to fulfil gender role expectations.

1.6 SIGNIFICANCE OF THE STUDY

The main objective of HCT is to reduce HIV infection by 50% as stated by the South African National AIDS Council (SANAC 2007:7). This objective may not be achieved since most HIV intervention programmes do not adequately address the benefits of male involvement in HIV prevention-programmes. This is contrary to the fact that middle-aged black men need adequate information on the importance of HCT utilisation so that they can protect themselves and their sexual partners from HIV infection.

The knowledge gained from the study may be useful to policy makers and HIV prevention programme developers in developing HIV campaigns that will address the needs of middle-aged black men. Furthermore, the results of the study will also help NGOs, FBOs and Ratanda Clinic HCT coordinators to revise their HIV and AIDS vision and mission statements.

1.7 DEFINITIONS OF KEY TERMS

Some key and recurrent terms used in the dissertation are defined below.

1.7.1 Voluntary Counselling and Testing (VCT)

VCT is a process whereby an individual undergoes counselling and testing for HIV to enable him or her to make an informed decision about being tested for HIV antibodies (Ross & Deverell 2007:213; Van Dyk 2008:138). The main purpose of VCT is to reduce the high risk of unsafe sexual practice, reduce HIV incidence and foster behaviour change.

1.7.2 HIV Counselling and Testing (HCT)

HCT can be defined as an umbrella term used to describe services that combine both HIV counselling and testing.

HCT distinguishes between two types of counselling and testing services that are client-initiated and those that are provider-initiated (National Department of Health 2009:9). The shift from VCT to HCT was introduced by the South African government in April 2011 as an attempt to get more people tested for HIV infection regardless of their health status (National Department of Health 2009:7). The difference between VCT and HCT is that HCT is aimed at encouraging people to go for HIV testing even though they do not show HIV and AIDS opportunistic infections relative to VCT.

In addition, HCT campaigns seek to encourage people to go for a routine HIV testing as part of a normal health seeking behaviour (National Department of Health 2009:18). Furthermore, the HCT campaign also aims at encouraging a multi-sectored approach in which the public, private and NGOs collaboratively provide HCT services so that there is an increased public awareness of HIV and AIDS.

1.7.3 Social contextual factors influencing male uptake of HCT

Social contextual factors refer to conceptions of masculinity and gender role expectations that may impede efforts to encourage black middle-aged men to access HCT services (Walker, Reid & Cornell 2004:62). These factors are regarded as social as they refer to shared belief systems and social circumstances that influence similar behavioural patterns (Van Niekerk 1991:16).

1.7.4 Socio-cultural factors influencing male uptake of HCT

The differentiation between social and cultural factors may be artificial, but under the rubric of socio-cultural factors the researcher included cultural norms and values that define what it means to be a man or woman in a particular society (Kleintjies, Cloete & Davids 2008:10). In this study, socio-cultural factors refer to beliefs, values and norms that are shared by middle-aged black men in Africa.

1.7.5 Middle-aged black men

In this study, middle-aged black men were individuals of male gender who were involved in a heterosexual relationship. For the purposes of the study, it referred to the age range of 30 to 58 years.

1.7.6 HCT utilisation

In this study HCT utilisation referred to people who made use of HCT services in order to know their HIV status (Peacock et al 2008:16).

1.8 THE CHOSEN STUDY SITE

The study was conducted in Ratanda because the researcher resides in the area and had observed that the majority of middle-aged black men still upheld traditional beliefs about masculinity. In addition, the researcher was known in the area because of his involvement in HIV and AIDS awareness campaigns that were conducted by faith-based organisations (FBOs). Furthermore, the researcher occasionally provided HIV care and counselling sessions to those infected and affected by HIV and AIDS. .

1.9 THE CHOSEN RESEARCH APPROACH

This chapter presented an overview of the research problem of poor HCT uptake by middle-aged black men, illustrating the need for more empirical research in this area. The identified research problem, objectives and questions that guided the study were given. The researcher detailed the rationale for the study in terms of its possible contribution to the scientific body of knowledge in understanding the social dynamics that might render HIV prevention programmes ineffective.

1.10 ORGANISATION OF THE DISSERTATION

The dissertation comprised the following chapters:

Chapter 1: The problem and its setting. This was an introductory orientation chapter aimed at familiarising the reader with the study, its central research problem, its objectives, rationale and orientation.

Chapter 2: Literature review of the social contextual factors that influence poor uptake of HCT services by middle-aged black men. This chapter provided a discussion of relevant literature on socio factors that influence HCT uptake by men. It detailed social challenges that prevent men from utilising HCT services as well as the impact on the spread of HIV infections. As noted above, relevant theories such as TRA, the Social Ecological Theory and the HBM were discussed in terms of sensitising concepts that formed the theoretical framework that guided the study.

Chapter 3: Methodology. This chapter dealt with the strategies that the researcher followed to gather data in order to answer the research questions. In addition, the research design used in the investigation of the research problem was discussed. Details were given of the ethical considerations of the study and of the data analysis strategies.

Chapter 4: Findings. In this chapter the researcher presented data vignettes according to the themes extracted via data analysis.

Chapter 5: Conclusion and recommendations. In this final chapter, the researcher summarised the findings and drew linkages to literature and the stated research objectives.

The strengths and limitations of the study were considered and recommendations were made for policy, programmes and suggestions for further research.

1.11 CONCLUSION

This chapter presented an overview of the research problem of poor HCT uptake by middle-aged black men, illustrating the need for more empirical research in this area. The identified research problem, objectives and questions that guided the study were given.

The researcher detailed the rationale for the study in terms of its possible contribution to the scientific body of knowledge in understanding the social dynamics that may render HIV prevention programmes ineffective

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In chapter 1 the researcher provided a background and orientation to the research problem, and also identified aspects of the problem to be investigated. In the present chapter, the researcher provides an overview of literature detailing social contextual factors that influence poor uptake of HCT services by men. In this chapter, general social challenges in health-seeking behaviour and their impact on HCT uptake by men are discussed. A few relevant theoretical frameworks are revisited to identify sensitising concepts central to the research problem.

2.2 HCT AND MEN

UNAIDS (2007) states that the largest share of new infections in many African countries occurs among older heterosexual couples. It has also been discovered that fewer men than women utilise HCT services (USAID 2009:7). Furthermore, studies show that men experience the highest levels of HIV-infection in their late 30s and 40s (UNAIDS 2009:22-23). It is against this background that the researcher reviewed literature to establish research findings on the social contextual factors that influence poor uptake of HCT services by middle-aged black men.

2.2.1 Reliance on a partner's HIV status or testing

One of the factors that may prevent middle-aged black men from utilising HCT services is their reliance on a partner's willingness to test and reveal her HIV status.

In a qualitative study on men's low utilisation of HIV Voluntary Counselling and Testing in Heidelberg, Levack et al (2006:2) comment that men usually rely on the HIV test results of their female partners as a test of their own HIV status. This concept is known as proxy testing.

The prevalence of proxy testing implies that there seems to be a lack of knowledge regarding the possibility of serodiscordant couples, that is, couples in the same relationship but with different HIV statuses. This may give recalcitrant males a false sense of security that they may not be infected with HIV and thus suppress their own

intention to utilise HCT services. It is worth noting that the current international HIV prevention programmes focus on couple testing in an attempt to alleviate the aforementioned problem; however, there is still low HCT uptake by middle-aged black men (USAID 2009:5).

According to Bunnell, Nassozi, Marum, Mubangizi, Malamba, Dillon, Kalule, Bahizi, Musoke & Mermin (2005:999), the prevalence of HIV-discordance among couples in Sub-Saharan Africa is high. This implies that many negative partners are at high risk of HIV infection. Middle-aged black men may be at high risk because they may be in stable, yet unsafe relationships. These men are more likely to have unsafe sex since they trust their female partners and regard their partner's HIV status as the same as theirs.

Recent studies in Sub-Saharan countries with mature epidemics show that two thirds of infected couples are discordant and that high infection rates are largely owing to heterosexual transmission (USAID 2009:3). This means that greater awareness has to be created about the importance of HIV testing regardless of one's partner's HIV status. One such strategy is to scale up health services by integrating broader HIV prevention programmes that target male involvement and support.

2.2.2 Socio-cultural factors influencing male health-seeking behaviour

Social agents are shaped by cultural, biographical and life experiences. According to Giddens (2001:22-28), all cultures have values that give meaning and provide guidance to humans as they interact with their social world. These values and beliefs may influence men and women to behave according to and conform to societal expectations with regard to what it means to be a man and woman in a particular culture. Socio-cultural factors may thus impede or facilitate HCT uptake.

Rutherford (cited in Ross & Deverell 2004:146) defines culture as the "shared experienced knowledge and values of a specific group". Ross and Deverell (2004) further state that culture plays a large part in determining whether or not people are willing to accept HIV prevention campaigns and utilise HCT services. Socio-cultural factors not only influence health-seeking behaviour, but also other behaviour such as adopting preventive health behaviour. In this regard, Taylor (cited in Woods 2008:54) notes that Rwandan males avoid condom use because of the belief that condoms

“block the gift of self”. They believe that if there is not a free flow of secretions between man and woman, then fertility will be compromised and illness will occur. A study conducted by Ngubane (cited in Woods 2008) indicates that South African isiZulu-speaking people share a similar belief that semen contains important nutrients essential for a woman’s health. Such beliefs may prevent men from practising safer sex.

Socio-cultural constructions of disease, illness and health also play a role as many traditional African beliefs link illness and especially sexually related illnesses to witchcraft (Woods 2008:52). Ancestors are thought to punish people by sending illnesses or misfortunes if the person does not conform to their counsel, or if certain social norms have been violated. Among some black Christians there is a belief that HIV and AIDS are punishment for immorality and sin (Van Dyk cited in Woods 2008: 52).

Many black men consult traditional healers or priests when they experience symptoms related to sexually transmitted infections (STIs) including HIV infection. This may also act as a barrier to using modern biomedical HCT services. Moreover, socio-cultural role expectations that regard men as self-reliant inhibit them from seeking treatment or information about protection against infections. These expectations may make men fearful that admitting a lack of knowledge about reproductive health issues will undermine their ascribed manliness (Cohen & Burger 2000; 2001).

Another cultural dimension that influences black men’s intentions to go for HIV testing is traditional socio-cultural constructions of masculinity and femininity as naturally stratified in a hierarchical order that confers greater decision-making freedom on males. Thus it may be considered as normal, acceptable and prestigious for men to have multiple concurrent sexual partners. Walker, Reid and Cornell (2004:24-35) argue that men’s greater social power places them in a position of vulnerability to HIV infection.

Middle-aged black men may choose not to act on information about HIV prevention because of particular social constructions of masculinity (Campbell 2009:336). Moreover, some middle-aged black men may have been socialised to behave in a domineering and aggressive manner that encourages them to equate risky behaviours

with manliness and to regard health-seeking behaviours as unmanly (Courtenay 1998). Moreover such socio-cultural constructions of aggressive masculinity may dictate that men should be knowledgeable and experienced in sex and demonstrate great sexual prowess (Levack et al 2005; Wood & Jewkes 2001).

Flint (2011:83) even goes as far as to argue that black culture must be blamed for the vulnerability of men to HIV and AIDS as the local epidemic is spread primarily by heterosexual sex that is spurred on by men's negative attitudes towards safer sexual practices.

Otaala (2003:134) states that in Africa sexual issues are traditionally not openly discussed between the sexes (even within marriage or between cohabitating partners). This may make it difficult for middle-aged black men to use HCT services since HIV testing is associated with promiscuity and testing may require open communication between sexual partners. Since open conversations between partners regarding reproductive health matters are not established as the norm, it becomes unlikely that a middle-aged black man would discuss testing as a joint undertaking with his female partner or spouse.

Furthermore, the payment of "lobola" was – and to some extent still is – perceived as giving black men the right to own a woman's body. According to the researcher's own experiences and observations, it is a common practice that safer sexual practices are no longer negotiable after the payment of lobola. This could be attributed to the fact that stable sexual partners are usually perceived to have a low risk of HIV infection. It should be pointed out, however, that Heeren, Jemmott, Tyler, Tshabe and Ngwane (2011) find no difference in husbands' tendencies to have extramarital sexual affairs according to whether they have paid lobola or not. In fact, in African culture, it is usually acceptable for a married man to have extra-marital affairs.

Thus middle-aged black men who uphold cultural beliefs and norms are more likely to engage in multiple sexual partners regardless of their marital status. Research reveals that women's low power in association with high male control in intimate relationships is correlated with increased HIV risk behaviours and HIV infection (Dunkle, Jewkes, Brown, McIntyre, Gray & Harlow 2004).

2.2.3 Current male prevention strategies

Perceived gender-appropriate preventive strategies may also inhibit or facilitate HCT uptake services by men. The South African government supports male circumcision as one of the additional HIV prevention strategies. There is a huge male circumcision campaign billboard in Ratanda that encourages men to go for circumcision at the clinic. The rationale behind this is to encourage more men to undergo male circumcision since it has been discovered that it can be difficult to motivate certain groups of people to use male or female condoms (Msomi 2010:11; Sawires, Dworkin, Fiamma, Peacock, Szekeres & Coates 2007:11).

Although this can be a positive gesture, it may fuel the spread of the epidemic since male circumcision offers only 60% odds of HIV prevention. It is worth noting that middle-aged black men may perceive and undergo male circumcision as an attempt at fulfilling their cultural expectations and gender roles rather than for HIV prevention purpose. This means that they may be less likely to adopt safer sexual practices after circumcision since male circumcision may be perceived as an alternative to condom use (or even as a cure for HIV infection).

The results of a qualitative study undertaken by Peltzer, Banyini, Simbayi and Kalichman (2009) reveal that circumcised black men are less likely to use condoms and utilise HCT services. Men usually believe that circumcision protects them from HIV infection and STIs. This may be because traditionally performed male circumcision seldom includes an extensive education on HIV and AIDS prevention.

It can be assumed that circumcised middle-aged black men may continue to uphold the belief that they are “real men” after circumcision and have to prove their manhood by not adopting safer sexual practices.

Connolly, Simbayi, Shanmugan and Nqeketo (2008:179) argue that circumcised males in some ethnic groups are encouraged to engage in unprotected pre-marital sex for sexual exploration. It can be argued that male circumcision offers only partial protection for only seronegative men from HIV infection. Men who are already infected with HIV and their partners cannot be protected through circumcision. Furthermore, male circumcision may make it even more difficult for women to

negotiate safer sex because circumcised men may refuse to use condoms consistently as a double protection strategy.

The Rakai Health Sciences Program (cited in the Meeting Report 2008:5) conducted a trial study on male circumcision and HIV positive men. It was discovered that there were more infections in women partners of circumcised men than in the female partners of uncircumcised men. The report further argues that male circumcision does not protect women from HIV infection and there is the possibility that women's vulnerability increases if men insist on resuming sex before their wounds have healed. Similarly, Alcorn (2011:5) states that male circumcision will not reduce the risk of infection for women and girls until it has delivered a long-term reduction in HIV prevalence for men.

2.2.4 Socio-economic factors

Studies reveal that economic factors have a strong influence on individual sexual behaviours, mostly through poverty and unemployment (UNAIDS 1999:11). A low socio-economic status resulting from unemployment may force men and women to opt for alternative means of survival which may include unhealthy sexual practices. The need to go for HIV testing becomes a last priority in this regard as they may fear a positive HIV test result.

The African continent and South Africa in particular have a well-established history of male labour migration and circular migration between urban centres that offer job opportunities and familial or spousal homes in rural areas.

Migrant men are likely to have casual sexual partners and limited knowledge of the importance of utilising HCT services because of their migrant status. However, Camlin, Hosegood, Newell, McGrath and Bärnighausen (2010) in a study in KwaZulu-Natal reveal that non-migrant women have a greater chance of becoming HIV-positive than male migrants and male non-migrants. Camlin et al (2010:6) conclude that high levels of mobility of both men and women may contribute to the sustained high HIV prevalence in the region of southern Africa. Frequent migrants may be important links to geographically-spread sexual networks, and high female mobility may be a factor enabling greater inter-connectedness of sexual networks beyond those created by male migrants alone, potentially contributing to the region's

exceptionally high and sustained HIV prevalence. The greater the inter-connectedness among sexual networks, the more quickly and broadly HIV circulates.

Cunha (2007) explains that transactional sex (not the same as commercial sex work) can limit South Africa's abilities to make healthy decisions concerning HIV and AIDS. In this regard, middle-aged black men who possess relatively better economic means than others are in a better position to dictate the terms and conditions of a relationship. In addition, they may also be able to afford to buy commercial sex (Engender Health 2010:10).

Tersbol (2006:405) offers a different point of view by stating that men who do not have the economic means to satisfy their basic needs may have multiple sexual partners with economically active women dictating the terms of sexual engagement. This practice may make men vulnerable to the risk of HIV infection since they may not be able to negotiate safer sex.

Setia, Vallee, Curtis and Lynch (2009:5) state that poverty increases the risk of HIV transmission by limiting access to information related to HIV prevention. It may be difficult for middle-aged black men with low economic backgrounds to utilise HCT services especially if they perceive themselves to be at high risk of infection and they do not have money for transport to visit HIV testing sites.

Mbilinyi and Kaihula (cited in Baylies & Bujra 2000:84) argue that changes in gender relations have a negative impact on men. These authors observe that women-traders who travel to distant urban centres to sell their goods may have unprotected sex with buyers who may be infected with HIV. The aforementioned issues put both women and their partners at risk of HIV infection.

2.2.5 Masculinity

Connell (cited in Skovdal, Campbell, Madanhire, Mupambirey, Nyamukapa & Gregson 2011:10) defines masculinity as an umbrella term denoting the multiple ways in which "manhood" is socially defined across different historical and cultural contexts. Such definitions have implied gender-based power differences related to specific versions of manhood. Moreover, gendered constructions affect attitudes and behaviour related to HIV prevention, treatment, reproductive health, gender-based violence and men's participation in maternal health (WHO 2007).

Studies show that men have different ideologies on how they express masculinity depending on the age, socio-economic class, racial and ethnic identity and geographic residence (Bowleg 2004:168; Skovdal et al 2011:19). These studies suggest that the notion of masculinity is not static because it depends on the men's contextual factors that may influence their expression of masculinity. Bowleg further argues that black men – particularly those who have a low income – have constructed alternatives of masculinity which are characterised by sexual promiscuity, aggressiveness, violence and denial of vulnerability. Furthermore, black men who have more traditional masculine ideologies are more likely to have more sexual partners, have negative attitudes towards condom usage and are less consistent in their use of condoms.

Therefore, the researcher can argue that these men are more likely to be the drivers of the epidemic because they may not see the need to utilise HCT services and adopt health-seeking behaviours. West (cited in Bowleg 2004:169-70) argues that black men who fail to meet the economic, socio-political and sexual requirements for ideal masculinity develop an incompetent gender identity. In turn, the latter manifest in a greater risk of HIV transmission and other health and social problems associated with sexual relationships and gender identity than men of higher economic status.

Woods (2008) suggests that the societal construction of masculinity in African culture fuels the spread of HIV and AIDS because it encourages men to have multiple, concurrent, unsafe sexual relationships. Therefore, a black man who does not uphold these rigid norms of masculinity may not be regarded as a “real” man and may be ostracised by the community. Pope, White and Malow (2009:63) argue that norms of masculinity that define men as being knowledgeable and experienced about sex put them at risk of infection. This may make it difficult for men to access health-seeking information especially if they feel they have to live up to the expectations of what it means to be a man (Cohen & Burger 2000; Pulerwitz & Barker 2008).

The aforementioned aspects suggest that the researcher must also focus on men's perceptions of the notion of hegemonic masculinity because it encourages men to have multiple sexual partners as a way to assert manliness in their society. Connell (cited in Skovdal et al 2011:2) defines hegemonic masculinity as an enactment of the idealised form of masculinity (being “the real man”) in a particular time and place. Connell (cited in Skovdal et al 2011:95) argues that hegemonic masculinity prevents

men from taking advantage of lifesaving HIV services. Black men who uphold the notion of hegemonic masculinity may be at risk of HIV infection since this may be accompanied by resistance to condom usage and access to health care centres.

UNAIDS (2001:17) argues that norms of masculinity may make it difficult for men to plead ignorance about sexual matters or reproductive health.

Most middle-aged black men in Ratanda associate masculinity with having multiple sexual partners – “*isoka*” (Casanova). Echoing the same sentiments, Rohleder, Swartz, Kalichman and Simbayi (2009:15) reveal in their study that male virility is often measured by the number of different sexual partners a man has. Similarly, Walker, Reid and Cornell (2004:35) argue that achieving masculinity is about commanding authority, and this may influence men to have multiple sexual partners and to have sex with other men.

Therefore, their endeavour to achieve a given masculinity (one that dictates that being a man means being tough, risk-taking, aggressive, abusing alcohol or other substances, having unsafe sex or driving dangerously to affirm one’s manhood) may have a negative impact on the spread of HIV infection and the impact on AIDS in Africa (WHO 2007).

It is worth noting that the notion of masculinity may also prevent men who have tested HIV positive to access early medical intervention as it may be perceived as a sign of weakness. Skovdal et al (2011:6-7) state that men perceive themselves as physically strong, tough, problem-solving and capable of withstanding “a little illness”. In addition, men may not utilise HCT services because being diagnosed with HIV infection may be perceived as a sign of weakness.

2.2.6 Social institutional factors

Factors operating at the level of institutions such as health care facilities can also influence men’s reluctance to use HCT services. On one occasion, the researcher visited the Ratanda Clinic and the local FBOs HCT services to observe how HIV testing and counselling were administered. He deduced from that observation that the available HCT services were not overtly male-friendly as the staff and lay counsellors were mostly female.

Furthermore, the researcher observed that HCT took only 10 minutes and that individual counselling could not be accommodated owing to time and staff constraints.

In this regard, WHO (2007:6) comments: “In addition, gender, interacting with poverty and other factors, directly affects how health systems and services are structured and organized and how and which individuals are able to access them”.

Research findings note similar observations. For instance, Levack et al (2006:28) assert that the men in their study expressed fear that breaches in confidentiality might occur when HCT staff, particularly those at NGOs, failed to observe strict confidentiality protocols. In the study by Levack et al (2006), the men mentioned that many of these sites were staffed by people from their communities and expressed concern that some of the staff members might disclose their HIV status.

Birdsall, Hadjiyiannis kosi and Parker (2004:24) argue that access to HCT services within the public sector is overly reliant on Primary Health Clinics which may discourage men from HIV testing. The hours of service at these centres are limited to standard working hours, making it difficult for employed men to utilise these services. Birdsall et al (2004) further argue that the lack of privacy, confidentiality and doubt in the accuracy of HIV results may further contribute to men’s reluctance to utilise HCT services.

Those who use the services at public health care facilities usually have to travel long distances and wait for extended periods before being attended to. In this regard, the Treatment Action Campaign (TAC 2011:2) conducted a door-to-door campaign in Khayelitsha about low HCT uptake by men and concluded that most men are not keen to test for TB or HIV because of long waiting hours associated with overcrowded conditions at local clinics. It can thus be argued that the aforementioned institutional factors may also contribute to middle-aged black men’s reluctance to utilise HIV testing sites.

2.2.7 The lack of male-oriented HIV prevention programmes

Waldo and Coates (cited in Campbell 2004:18) argue that HIV prevention programmes have been hindered by individual-level explanations of sexual behaviour which have led to individual-level interventions. These interventions fail to consider

the influence of the above-mentioned social factors in sexual behaviour change and men's reluctance to utilise HCT services. It is the researcher's contention that HIV prevention programmes do not adequately address the needs of middle-aged black men in terms of integrating cultural beliefs in prevention messages.

The use of pregnant women as the major sentinel groups for the epidemiological tracking of the local HIV and AIDS epidemic and the focus on the prevention of transmission from mother to child, discursively translate to a focus on women as responsible for accelerating the spread of HIV/AIDS. Campbell (2009:198) argues that prevention efforts that focus singly on women have been misguided and have served to undermine women by making them solely responsible for HIV risk reduction.

HIV intervention programmes may continue to be ineffective if the socio-cultural factors that define what it means to be a middle-aged black man are overlooked. In this regard Skovdal et al (2011:20) argue that there is a general tendency to neglect the socio-cultural and geographical factors that influence men's health-related behaviours. They maintain that such neglect often implies that men's poor health-services uptake is explained as matters of individual choice. Tersbol (2006:405) states that inadequate attention has been paid to the multiple factors that impact on people's lives and sexualities. This means that HIV/AIDS prevention programmes do not always consider the social contextual factors that may serve as barriers to HIV testing.

Middle-aged black men may not realise the importance of utilising HCT services if HIV prevention messages only emphasise individual circumstances and neglect other challenging multiple factors that can serve as barriers to HIV testing.

According to Namianzi et al (2009:151), society has been bombarded with safer sex messages that have pushed HIV intervention messages beyond saturation point. This may result in people becoming resistant to HIV-related health messages. In addition, the availability of antiretroviral drugs (ARVs) has implied that HIV infection is no longer a "death sentence". This may further make audiences resistant to appeals for testing.

Tersbol (2006:403-406) further argues that successful approaches to male-oriented intervention programmes in certain social contexts have been lacking and have

resulted in the social and symbolic exclusion of men. Middle-aged black men may thus continue to ignore HIV and AIDS messages as they do not target them specifically. To counter this, UNAIDS (2009:12) suggests a renewed consideration of the modes of HIV transmission and the drivers of the epidemic. This implies that HIV programme developers must have an in-depth understanding of the current mode of transmission so that relevant HIV prevention programmes are developed.

2.2.8 Stigma and discrimination

Stigma can be defined as the identification and recognition of a bad or negative characteristic in a person or group of persons and treating them with less respect than they deserve (Ross & Deverell 2004:206). Similarly, Alonzo and Reynolds (cited in Woods 2008:187) define stigma as a “powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons”.

This implies that stigma takes away the self-perceived value of a person loving his or her self-esteem as well as that person’s value in the eyes of others. On the other hand, discrimination refers to action based on stigma. UNAIDS (2008:77) defines discrimination as unfair treatment of an individual based on his or her real or perceived HIV status.

Stigma and discrimination remain central impediments in HIV prevention because fear of being labelled HIV positive may prevent people from utilising HCT centres. This is because the shame and embarrassment around HIV and AIDS come from their link to sex and unsafe sex. Meiberg, Bos, Onya and Schaalma (2008:49) describe the HIV and AIDS epidemic as an epidemic of ignorance, fear and denial leading to stigmatisation and discrimination against people living with HIV and AIDS and their families.

Ross and Deverell (2004:2007) argue that HIV/AIDS is considered to carry a double stigma – that of being both a terminal illness and a sexually transmitted disease. The researcher observed that at the Ratanda Clinic, the HCT centre is situated in an isolated far right corner of the consultation rooms. This gives the impression that HIV and AIDS are dangerous diseases and that their consultation rooms should be isolated from others.

In this regard Levack et al (2006:13) contend that fear and stigma remain the biggest barriers because HCT sites are associated with death. Furthermore, people who have tested HIV positive may not visit the health care centres again for treatment because of the fear that they may face discrimination by the community or loved ones (Meiberg et al 2008:55). Van Dyk (2008:412) argues that secondary stigma has a serious impact on the quality of care imparted by caregivers to people living with HIV and AIDS. This, in turn, impacts on the quality of life of those needing care as it deprives them of much needed support.

Owing to the stigmatisation of HIV as the slimming disease, communities may develop unhealthy attitudes about weight loss. For example, a widely accepted belief in Ratanda is that women or girls who gain weight are usually not HIV infected. Thus weight gain is perceived as a sign of being healthy regardless of one's sexual behaviour and HIV status.

The latter may give middle-aged black men who have gained weight a false sense of security that they are not infected and they may not see the need to utilise HCT services.

In addition to the aforementioned facts, stigma has a negative impact on male involvement in HIV prevention, care and support because this may create the perception that they themselves are HIV positive (Ross & Deverell 2004). The latter may be the reason for some middle-aged black men divorcing their sexual partners once they have tested as HIV positive because they fear that the community will stigmatise them.

2.2.9 Educational factors

Education plays an important role in understanding the importance of behaviour change and HCT utilisation. Avert (2011:3) argues that despite the improved reach of HIV awareness campaigns, accurate knowledge about HIV and AIDS is still poor. The latter may be attributed to lower levels of education accompanied by conservative social norms that hinder effective implementation of HIV prevention programmes and campaigns. These negative practices may render HIV prevention messages ineffective and often lead to people not being aware of the true facts of the disease and the manner in which it spreads (Woods 2008:60).

The afore-mentioned aspect is compounded by the fact that myths and misconceptions usually flourish when education levels are low. Furthermore, HIV and AIDS prevention campaigns and programmes seldom use indigenous languages as a medium of communication. Swanepoel (2005:3) argues that very little research has been forthcoming on the efficacy of the communication programmes that are needed to support VCT services in South Africa.

Visual information and demonstration that could cater for the needs of the middle-aged group are seldom used, making it difficult for people to develop an interest in HIV prevention messages. They may not fully comprehend the implication of these messages in terms of the importance of adopting safer behavioural practices. The need to utilise HCT services becomes a challenge under the foresaid circumstances.

USAID (2009) conducted a study on community perceptions of the risks and benefits of seeking Voluntary Counselling and Testing in China. It was discovered that it is difficult to persuade older men with low levels of education to go for HIV testing as they think that they are already old and that death is not a problem for them. The researcher can thus assume that the same perception may be applicable to middle-aged black men with low levels of education.

UNAIDS (2008) conducted a study in rural South Africa on VCT uptake and discovered that each additional year of educational attainment reduces the risk of HIV infection by 7%. Lack of education may also impact negatively on men's partners' decisions to utilise HCT services. On the other hand, it is important that the researcher acknowledge that adequate HIV knowledge may not always translate to behaviour change, but it may assist in reducing unsafe sexual behaviours and increasing HCT uptake. It is vital that HIV education be adjusted for different segments of the high risk group with an emphasis on outreach and face-to-face communication (USAID 2009:7).

2.2.10 Biomedical factors (treatment as prevention)

Alcorn (2011:2) says that early antiretroviral treatment reduces the risk of HIV transmission from treated partners to uninfected partners by 96%. This finding may be viewed as positive news not only for serodiscordant couples who are planning a

family but also in reducing the prevalence of HIV infection. However, there are challenges in this regard. First, it contradicts HIV prevention campaigns on the importance of safer sexual behaviours. The researcher argues that treatment as a prevention campaign may indirectly promote unhealthy behavioural practices especially if people are not well educated in understanding the implications of it.

Second, HIV positive people who are on early treatment may stop practising safer sex under the pretext that they will not infect their sexual partners.

Furthermore, they may re-infect themselves either with the same or different HIV strains owing to lack of an in-depth knowledge of how treatment works as HIV prevention. It is also assumed that treatment as prevention may reduce stigma and increase HCT uptake because people will be guaranteed of early treatment (Lancet 2011:1719).

This assumption does not seem to address strategies that will be put in place to minimise stigma and discrimination as the major barriers to HIV testing and adherence to treatment. Studies show that there is low HCT uptake in South Africa (UNAIDS 2009:25). Thus people who remain untested with early infection remain undetected and highly infectious, making the effects of treatment less profound (Alcorn 2011:3).

2.3 THEORETICAL FRAMEWORK

The Health Belief Model (HBM), the theory of Reasoned Action (TRA) and the Social Ecological model were adopted as the theoretical framework guiding this study. These theories take into consideration individual-level factors and socio-cultural factors in predicting and explaining health behaviours (Decosas 2002:15; Ross & Deverell 2004). It is vital that the researcher consider both the individual and environmental HIV risk factors that may influence poor HCT uptake services by middle-aged black men.

Swanepoel (2005:6) argues that problematic health-related behaviours are a function of a complex range of contextual and personal determinants. He further argues that attempts to change such behaviours should address both the contextual/ecological and personal determinants of the behaviour. Furthermore, it is useful to see theories as a

continuum of models moving from strictly individually-centred to macro-level and environmentally-focused (UNAIDS 1999:5).

2.3.1 The Health Belief Model

The Health Belief Model (HBM) attempts to explain and predict health behaviours by focusing on the role of perceptions in determining the attitudes and beliefs of the individuals. According to Munro, Lewin, Swart and Volmink (2007:6), a person's health-related behaviour depends on his or her susceptibility to that illness, the benefits of taking a prevention action and the barriers to taking action. This model assisted the researcher in establishing the social barriers and benefits that either motivate or discourage middle-aged black men from utilising HCT services.

Ross and Deverell (2004:214) maintain that the HBM has helped researchers in guiding the search for "why" these behaviours occur and to identify points for change. This model does not incorporate the influence of social and cultural norms on people's decisions regarding their health behaviours and there is also no evidence that belief formation always precedes behavioural change (AIDSCAP 2004:2).

However, this guided the researcher in assessing the middle-aged black men's perception of illness in terms of how they evaluate risk factors and their attitude on HCT utilisation as a point of entry to understanding their low HCT uptake. The researcher assumed that middle-aged black men with a low HIV risk perception were less likely to utilise HCT services as they might think that they would not be infected.

Swanepoel (2005:15) argues that a low risk perception is linked to the intention to go for HIV testing because if people believe that they are not at risk of HIV/AIDS, it makes no sense to go for VCT. Furthermore, Swanepoel (2005) believes that a high risk perception is one of the main motivators for people to go for VCT.

2.3.2 The Theory of Reasoned Action

The Theory of Reasoned Action (TRA) is conceptually similar to the HBM, but adds the constructs of behavioural intention as a determinant of health behaviour (UNAIDS 1999:7).

The TRA focuses on the individual's intention to perform a specific behaviour. The intention to enact a particular behaviour is shaped by the person's beliefs, attitudes and subjective norm (Van Dyk 2008:122-123). Here follows a brief explanation of attitude towards behaviour and subjective norms as major tenets of this theory.

2.3.2.1 Attitude towards behaviour

Attitude towards behaviour refers to the person's attitude towards enacting a particular behaviour. People are more likely to perform a particular behaviour if they have a positive attitude towards the specific behaviour and the belief that the enacted behaviour has more advantages than disadvantages (Van Dyk 2008:124). Middle-aged black men must believe that utilising HCT services has more advantages in terms of reducing the risk of infection and accessing early medical intervention if already infected.

On the other hand, behaviour change is less likely to take place if the specific behaviour has more cost than benefits, especially if it interferes with traditional norms and beliefs about sexuality. This tenet enabled the researcher first to establish middle-aged black men's attitudes and beliefs about HCT utilisation in order to determine their intention to go for HIV tests before assessing the beliefs of their subjective norms.

The researcher assumed that middle-aged black men who had a negative attitude towards HCT services and believed that the services had more disadvantages than advantages were less likely to utilise this service. It was imperative that the researcher establish middle-aged black men's attitudes and beliefs on HCT utilisation in order to assess the intention to perform the specific behaviour.

Ross and Deverell (2004:203) recommend that researchers determine and influence intentions so that behaviour becomes easy to predict and manipulate.

The TRA may be perceived as similar to Bandura's (1994) concept of self-efficacy that forms an integral part of a person's ability to function independently regardless of external influences. Bandura (1994:2) defines self-efficacy as an individual's beliefs in his or her ability to perform a particular behaviour under various conditions. This implies that middle-aged black men must be willing and self-motivated to go for HIV testing as an entry point to behaviour change regardless of external influence.

2.3.2.2 The subjective norm

The second determinant of behavioural intention is the subjective norm which refers to the person's perception of the significant other's beliefs and perceptions of the specific behaviour. AIDSCAP (2002:11) defines the subjective norm as a person's normative belief regarding other people's views of behaviour and the person's willingness to conform to those views. The influence of the subjective norm in either motivating or discouraging the individual to enact a specific behaviour plays an important role in understanding how middle-aged black men conform to the norms and beliefs of the subjective norms.

The researcher used this tenet in establishing the perceptions and beliefs of middle-aged black men's frames of reference about HCT utilisation. The subjective norm negative belief and attitude towards HIV testing may negatively influence an individual's willingness to utilise HCT services. The subjective norm's beliefs are perceived as part of the social contextual factors that may influence poor HCT uptake services by middle-aged black men.

According to UNAIDS (1999: 8), normative beliefs play a central role in the theory and generally focus on what an individual believes other people, especially influential people, will expect him or her to do.

The intention to go for an HIV test may largely depend on the middle-aged black men's subjective norms because conservative middle-aged black men are more likely to uphold collective decisions that are made by the community (Van Dyk 2008:206). Middle-aged black men's significant others play a vital role in either promoting or discouraging HCT utilisation.

Munro et al (2007:8) state that an intention to perform behaviour is influenced by the subjective norms that include the perceived expectations of the significant other. Thus, the TRA provided some guidelines in understanding behaviour change at an individual level and enhanced the researcher's perspective on some of the social contextual factors that had a negative impact on HCT uptake. Therefore, the TRA was used as a guideline to conduct a baseline risk assessment in investigating the social contextual factors that contributed to the problem statement.

2.3.3 The Social Ecological Model

The Social Ecological Model describes five levels of influence on behaviour including individual, interpersonal, institutional, community and policy (UNAIDS 1999:16).

This framework was used to examine contextual influences on the social contextual factors that influence poor HCT uptake services by middle-aged black men. As noted above, the researcher used both micro and macro theories as a guideline to explore the social contextual factors that may serve as barriers to HCT utilisation. The Social Ecology Model correlates with the HBM and the TRA because it takes into consideration the individual's risk perception and the influence of subjective norms in behaviour change.

Swanepoel (2005:11) maintains that contextual concerns will surface at individual level with regard to people's beliefs, attitudes and intentions to go for HIV testing.

He further argues that some individuals may already have developed a strong intention to go for HCT, but are deterred from doing so as a result of environmental barriers and beliefs about their skills to do so. Therefore, the social ecological model acknowledges the importance of the interplay between the individual and the environment and the influence it has on the individual's behaviour (Decosas 2002:13).

According to Grizzel (2007:10), social contextual factors such as culture, familial support and institutional factors provide a crucial framework for understanding an individual's risk behaviour. The latter has already been dealt with in the above literature review as factors that may prevent middle-aged black men from utilising HIV testing services. It is imperative that social contextual influences on behaviour are considered so that HIV prevention programmes yield positive results.

The Social Ecological Model enabled the researcher to identify possible challenges of the social factors that served as barriers for middle-aged black men to utilise HCT services. Therefore, the social ecology of middle-aged black men was considered and formed the basis of the researcher's recommendations on HIV prevention strategies that may increase HCT uptake services by middle-aged black men.

The use of this model may assist HIV programme developers to alleviate the overemphasis on individual factors as the main determinant of health behaviour

change. Middle-aged black men's sexual and health-seeking behaviours may be best understood with the social contextual factors that may govern a particular behaviour. Tersbol (2006:406) argues that inadequate attention has been paid to the multiple factors that impact on people's lives and sexualities.

From the above-mentioned argument it is clear that the Social Ecological Model provides a framework within which behaviour may be understood and predicted at different multiple levels of one's social encounter.

Decosas (2002:19) argues that people's social environment has an impact on their health and that it is imperative to recognise the dynamics of the population. It was of paramount importance that the researcher critically examined the social environmental factors that served as barriers for effective HIV prevention programmes and middle-aged black men's reluctance to utilise HCT services. The following aspects serve as major tenets of the Social Ecological Model:

2.3.3.1 Social ecology of HIV risk

Middle-aged black men may be exposed to multiple HIV risk factors and some of these risks may be more dominant than others. It was therefore necessary that the researcher investigated multiple risk factors that might have a negative impact on HCT uptake by middle-aged black men. The rationale behind this was to identify the dominant risk factors so that recommendations were based on well-researched findings.

In support of this view, Decosas (2002:10) states that the tools of epidemiological risk factor analysis allow the researcher to determine which among a number of chosen factors are significant. This guided the researcher in establishing significant multiple factors that played a leading role in preventing middle-aged black men from utilising HCT services. The researcher was able to identify prominent risk factors that exposed middle-aged black men to the risk of HIV infection through the selection of common social barriers that were identified by this target group.

2.3.3.2 Cumulative risk

According to Newman (1999:16), a social ecological model suggests that risks may cumulate both within and across individual, familial and community levels. It may be

beneficial to consider risk and its interaction across multiple levels as middle-aged black men's social ecology.

It is also hypothesised that cumulative risk will be associated with increased HIV-related sexual behaviour. This may imply that middle-aged black men who have multiple unsafe sexual partners may be at high risk of HIV infection and may be regarded as a high and vulnerable risk group.

Familial and community level risk factors may negatively affect HIV-related sexual behaviours thereby increasing the spread of HIV infection in a particular community and family. The researcher assumed that men's significant other and community members who did not advocate HIV testing might contribute to middle-aged black men's reluctance to go for HIV tests. Newman (1999) further states that this model may offer a viable method for incorporating social contextual factors in research on HIV-related sexual behaviours.

On the other hand, Swanepoel (2005:16) defines cumulative risk assessment as an assessment of one's own risk on the basis of the accumulation of own risk of acquiring HIV as a consequence of repeated episodes of unsafe sex. He argues that people have difficulty in judging their own accumulative risk and they typically underestimate their own accumulative risk for HIV but overestimate the accumulative risk of others. This tenet was used to establish middle-aged men's HIV risk perceptions and guided the researcher to use more probes in order to gain insight into their HIV risk perceptions compared with the HIV risk perceptions of younger men.

2.3.3.3 Social cohesion

Maxwell (cited in Decosas 2002:9) defines social cohesion as members of the community who share common challenges and are engaged in a common enterprise. Social cohesion shifts from being a determinant of individual's health to defining characteristics of a community's health.

The feeling of being supported by peers may be perceived as an expression of social cohesion especially if peers have a similar interest to utilise HCT services.

Therefore, the motivation to act on HIV prevention programmes and campaigns may be influenced by the presence of a social support system in the community. The latter

may play an important role in motivating middle-aged black men to utilise HCT services in Ratanda. The researcher could argue that middle-aged black men who receive a strong social support from their significant others and the communities are more likely to utilise HCT services.

These men may also support and encourage others to go for an HIV test thereby alleviating stigma and discrimination surrounding HIV testing and counselling. Moreover, it may also enable middle-aged black men to have a high HIV risk perception resulting in low HIV incidence in their communities. Tersbol (2006:405) states that research has sought to document how social exclusion affects men's sexuality and their relationship with women. This may affect men's ability to seek information about their health including the importance of taking an HIV test. It is, therefore, vital that the social ecology of middle-aged black men strive for social cohesion to fight against the spread of the epidemic and support the current national HIV Counselling and Testing campaign.

This calls for community and political leaders to lead from the front in utilising local HCT services so that middle-aged black men may also be motivated to go for HIV tests. The aforementioned theories were used as a framework in developing the research questions and objectives of the study. In addition, they were also used to develop the interview guide as a data collection instrument of this study and guided the research findings and conclusions.

2.4 SUMMARY

The literature review revealed that reliance on a partner's HIV status; current male prevention strategies; socio-economic factors; masculinity; social institutions; stigma and discrimination; lack of male-oriented HIV prevention programmes; and education are some of the social contextual factors influencing poor uptake of HCT services by middle-aged black men.

There was a need to conduct an in-depth research study on social contextual factors that might serve as a barrier for middle-aged men black to utilise HCT services in order to close the gaps that have been identified in the literature study. Social behaviour change theories provided a framework in which the middle-aged black men's sexual behaviour could be predicted and understood.

The social behaviour change theories such as the HBM, TRA and Social Ecological Model were selected to guide the research study in investigating the social factors influencing poor uptake of HCT services by middle-aged black men. Successful HIV prevention campaigns that targeted the needs of middle-aged black men largely depended on the application of the above-mentioned theories. Furthermore, these theories allowed the researcher to formulate and refine research questions in an attempt to test the applicability of the former in a natural setting. The HBM focuses on risk perceptions in determining healthy behaviour change while the TRA focuses on the individual's intention and the attitude of the significant other in performing a specific behaviour.

The Social Ecological Model focuses on the multiple factors that may put people at risk of HIV infection. This model was central to the research study as it enabled the researcher to explore the social contextual factors that serve as barriers to HIV testing by looking at men's social profiles, cultural beliefs, the accessibility of HCT centres and the availability of social support. The findings and recommendations of the study were thus guided by the aforementioned theories.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter focused on the research methods used in gathering data from the sampled participants and provided a detailed description of the rationale behind the methodology. The chosen research design, sampling procedures, data collection procedures, data analysis and ethical considerations were discussed.

3.2 THE CHOSEN RESEARCH ORIENTATION

The study adopted a qualitative research orientation to investigate the social contextual factors influencing poor HCT uptake services by middle-aged black men in Ratanda. The rationale behind the selection of a qualitative research orientation was to allow the researcher to develop rich insights into the phenomenon under investigation. In addition, it allowed the researcher to understand and interpret the meaning the participants gave to their everyday lives (De Vos, AS, Strydom et al 2009:270).

Furthermore, a qualitative orientation allowed the researcher to gain an in-depth understanding of the participants' HIV knowledge and perceptions of HCT utilisation through the use of face-to-face semi-structured interviews. The research topic demanded an exploration and discovery of context-bound social contextual factors that influenced poor uptake of HCT services by middle-aged black men in Ratanda. It was for this reason that the researcher opted for a qualitative approach as it enabled the exploration of different points of views and the emergence of different themes.

3.3 RESEARCH DESIGN

Burns and Grove (2003:195) define a research design as “a blueprint for conducting a study with maximum control over factors that may interfere with the validity of the findings” while Paratoo (1997:142) asserts that research design is “a plan that describes how, when and where data are to be collected and analysed”. In the same vein, Polit and Beck (2001:167) define research design as “the researcher’s plan overall for answering the research question or testing the research hypothesis”.

The study design was descriptive survey. Descriptive research design is a scientific method which involves collecting data in order to answer questions on the current status of subjects of the study (Kothari 2004). It involves gathering data that describes events and then organises, tabulates, depicts, and describes the data collection (Glass & Hopkins 1984). In this study, a descriptive research design was preferred because the nature of the research was a social study aimed at finding out “what, how and why” was observed in a completely natural and unchanged natural environment. Descriptive research is important because it acts as a precursor to a qualitative research design and the general overview gives some valuable pointers as to the variables that are worth testing qualitatively (Kothari 2004).

A survey is a method of sociological investigation that uses question-based or statistical surveys to collect information about how people think and act and is often used to assess thoughts, opinions and feelings. A survey design was adopted because the researcher wanted the respondents to express their views on the subject under discussion or investigation.

3.4.1 Sampling procedures

Sampling is the process of selection of the appropriate number of subjects from a defined population (Kothari 2004). A sample size of 10% for a social study is adequate for a study ((Mugenda & Mugenda 2003)

The researcher used non-probability sampling techniques to recruit ten heterosexual middle-aged black men from diverse socio-economic and educational backgrounds for face-to-face interviews. Three of the men were recruited at the researcher’s place of work (the Gauteng Department of Education). These three men were resident in Ratanda and were able to refer the researcher to three more men living in Ratanda. Each of these men referred the researcher to other Ratanda men who suited the inclusion criteria for selection as research participants in the study. Thus, after the initial purposive selection of the initial three participants, the snowball or referral sampling method was used to recruit the participants. As transcription and initial analysis of the data were conducted immediately following each interview, the researcher kept on following leads for recruitment of research participants until data saturation was reached.

The following inclusion criteria were used to select the participants:

1. The men had to be black, between 30 and 58 years of age.
2. Participants must not have gone for HIV testing in the past two years.
3. They had to reside in Ratanda for the duration of the study.
4. Only participants willing to participate voluntarily in the study and willing to have the interviews voice-recorded were selected.
5. The researcher tried to establish ethnic diversity by selecting volunteers who spoke IsiZulu, IsiXhosa, Sesotho sa Leboa (Sepedi), Tshivenda and IsiNdebele as home languages.
6. The researcher tried to obtain diversity in the educational background of the participants.
7. The two key informants, who were staff members of Engender Health, were purposefully selected to participate in the study to obtain views from a service-provider's perspective.

3.4.2 Data collection procedures

The study used qualitative data gathering methods to collect information on the social contextual factors influencing the poor uptake of HCT services by middle-aged black men. Semi-structured interviews and non-participants' observations were used to gather information on the participants' beliefs and perceptions about HCT services.

3.4.3 Pre-testing the data-gathering instruments

Reliability of the research is its level of internal consistency over time (Mugenda & Mugenda 1999). A reliable instrument, therefore, is one that constantly produces the

expected results when used more than once to collect data from two samples drawn from the same population.

Following the approval of the study by the ethics committee of the Higher Degrees Committee of the Department of Sociology at UNISA and the ethics committee of Engender Health, the interview schedule was tested. For this purpose, one key male informant from Engender Health and three middle-aged black men from diverse socio-economic and educational backgrounds were asked to participate. These interviews were conducted in these men's homes.

These four pre-test interviews were beneficial to the further development of the instrument. First, it allowed the researcher to test certain aspects of the questions, enabling him to make modifications in the wording.

Second, it enabled the researcher to check on possible omissions that she may have overlooked when framing the question items.

Third, the researcher found that the men did not express any difficulty in responding to a female interviewer.

The interviews from the pre-test were not included in the final data. The researcher did not re-interview the pre-test respondents in the final interview schedule, arguing that they were already familiar with some of the questions.

3.4.4 Face-to-face interviews conducted with the help of a semi-structured interview schedule

Face-to-face interviews were conducted with ten middle-aged black men from diverse socio-economic backgrounds and two key informants from Engender Health. The interview schedules were compiled in English, although most participants spoke different African languages. Most of the participants were comfortable speaking IsiZulu and IsiXhosa during the interviews.

All the interviews were conducted in private at the participants' homes. This arrangement was decided on after initial discussions with the participants revealed that they felt safer and more comfortable being interviewed in their homes rather than at the Ratanda Clinic. All the interviews lasted for an hour and were audio-taped and transcribed at the researcher's home immediately after each interview.

The researcher went to great pains to set the participants at ease, creating a good rapport so that they felt encouraged to speak freely. Face-to-face interviews were also conducted with two key informants from Engender Health. These key informants were both HCT coordinators whose duties at Engender Health focused on men as partners in the fight against HIV and AIDS

3.4 THE RESEARCH SITE

The study was conducted in Ratanda which is located on the periphery of Heidelberg, a modernised urban township, south-east of Johannesburg.

The rationale behind the selection of this site is that the researcher is familiar with it. As a resident in the area, I have observed how scores of middle-aged black men hang around in the local taverns and pubs and boast about their multiple sexual relationships. In addition, the researcher is well conversant with the spoken language, cultural and religious beliefs of the population. This made it easier for him to obtain access and convenient for him to visit the homes of the participants for conducting interviews.

3.5 TARGET POPULATION

The study was based on middle-aged men aged 30 to 58 in Ratanda, Heidelberg, South Africa. Ratanda was selected for this study because of its unique characteristics: middle-aged black men loiter in the local taverns and pubs and boast about their multiple sexual relationships.

3.6 Sampling technique and sample size

The researcher used non-probability sampling techniques to recruit ten heterosexual middle-aged black men from diverse socio-economic and educational backgrounds for face-to-face interviews. Three of the men were recruited at the researcher's place of work. These three men were resident in Ratanda and were able to refer the researcher

to three more men living in Ratanda. Each of these men referred the researcher to other Ratanda men who suited the inclusion criteria for selection as research participants in the study. Thus, after the initial purposive selection of the initial three participants, a snowball or referral sampling method was used to recruit the participants.

The following inclusion criteria were used to select the participants:

- The men had to be blacks between 30 and 58 years old.
- Participants must not have gone for HIV testing in the past two years.
- They had to reside in Ratanda for the duration of the study.
- Only participants willing to participate voluntarily in the study and willing to have the interviews voice-recorded were selected.
- The researcher tried to obtain diversity in ethnic groups by selecting volunteers who spoke IsiZulu, IsiXhosa, Sesotho sa Leboa (Sepedi), Tshivenda and IsiNdebele as home languages.
- The researcher tried to obtain diversity in the educational background of the participants.
- The two key informants, who were staff members of Engender Health, were purposefully selected to participate in the study in order to obtain views from a service-provider perspective.

3.7 DATA COLLECTION INSTRUMENT

Following the approval of the study by the ethics committee of the Higher Degrees Committee of the Department of Sociology at UNISA and the ethics committee of Engender Health, the interview schedule was tested. For this purpose, one key male informant from Engender Health and three middle-aged black men from diverse socio-economic and educational backgrounds were asked to participate. These interviews were conducted in the Ratanda community hall.

These four pre-test interviews were beneficial to the further development of the instrument. First, it allowed the researcher to test certain question items enabling him to make modifications in the wording.

Second, it enabled the researcher to check on possible omissions that he may have overlooked during the framing of the question items.

It is worth noting that the interviews from the pre-test were not included in the final data. The researcher did not re-interview the respondents for the pre-test using the final interview schedule as he argued that they were already familiar with some of the question items.

3.8 Interviews schedule

The semi-structured interview guide allowed for greater flexibility in adapting the questions according to the participants' needs (Saunders, Lewis & Thornhill 2007:312). In addition, the interview guide allowed the researcher to direct the interview questions so that the objectives and aims of the study were achieved. The researcher was well conversant with the interview guide. This enabled him to pay attention to details during the interview process.

Qualitative data gathering methods were used to collect information on the social contextual factors influencing poor uptake of HCT services by middle-aged black men. Semi-structured interviews were used to gather information on the participants' beliefs and perceptions of HCT services.

Face-to-face interviews were conducted with ten middle-aged black men from diverse socio-economic backgrounds and two key informants from Engender Health. The interview schedules were compiled in English although most participants spoke different African languages. Most of the participants were comfortable with speaking IsiZulu and IsiXhosa during the interviews.

All interviews were conducted in the Ratanda community hall. This arrangement was decided on after initial discussions with the participants revealed that they felt comfortable and safe if interviewed in the Ratanda community hall instead of at the Ratanda Clinic. All interviews lasted for an hour and were audio-taped and transcribed at the researcher's home immediately following each interview.

The researcher took great pains to set participants at ease and create rapport so that they felt encouraged to speak freely. Face-to-face interviews were also conducted

with two key informants from Engender Health. These key informants were both HCT coordinators whose duties at Engender Health included a focus on men as partners in the fight against HIV and AIDS.

The semi-structured interview guide allowed for greater flexibility in adapting the questions according to the participants' needs (Saunders, Lewis & Thornhill 2007:312). In addition, the interview guide allowed the researcher to direct the interview questions so that the objectives and aims of the study were achieved. The researcher was well conversant with the interview guide. This enabled him to pay attention to details during the interview process.

The interview schedules designed for the participants and key informants were developed on the basis of the aims of the study and the review of the literature. The main aim was to establish the social contextual factors influencing poor uptake of HCT services by middle-aged black men. The interview schedule for the participants obtained information on the following broad areas.

1. Involvement in multiple sexual partnerships
1. Knowledge of HIV/ AIDS and HCT
2. HCT perception between older and younger men
3. Perceived consequences of HIV testing
4. Cultural beliefs regarding HCT utilisation and multiple sexual partners
5. Views on dating younger girls
6. Perceptions of condom use
7. Perceptions of male circumcision
8. Views on the ideal middle-aged black man
9. Involvement in and intentions to become involved in HIV and AIDS programmes and campaigns

The interview schedule for the key informants consisted of the following question items:

1. The biographical characteristics of the men who access their services
2. The knowledge of male clients concerning HIV and AIDS and sources of information
3. Key informants' perceptions of the knowledge of HCT and of the sources of information for HIV/AIDS of middle-aged black men
4. Key informants' views of men's risk perceptions
5. Key informants' perceptions of barriers and challenges with regard to men's utilisation of HCT
6. Key informants' perceptions of the role of cultural beliefs in men's HCT utilisation
7. Key informants' perceptions of men's attitudes towards circumcision and condom use
8. Key informants' views of proxy testing
9. Key informants' perceptions of programmes aimed at men
10. Key informants' views of the role of income and education in HCT uptake
11. Organisational statistics and HCT motivational factors
12. Organisational HIV/AIDS prevention programmes and strategies
13. Suggested strategies to improve HCT uptake
14. Involvement in multiple sexual partnerships
15. Knowledge of HIV/AIDS and HCT
16. HCT utilisation and perceptions of men who go for HIV testing
17. Barriers and challenges in utilising HCT

18. Risk perceptions and comparison of risk perception between older and younger men
19. Perceived consequences of HIV testing
20. Cultural beliefs regarding HCT utilisation and multiple sexual partners
21. Views on dating younger girls
22. Perceptions of condom use
23. Perceptions of male circumcision
24. Views on the ideal middle-aged black man
25. Involvement in and intentions to become involved in HIV and AIDS programmes and campaigns
26. The biographical characteristics of the men who access their services
27. The knowledge of male clients concerning HIV and AIDS and sources of information
28. Key informants' perceptions of the knowledge of HCT and of the sources of information for HIV/AIDS of middle-aged black men
29. Key informants' views of men's risk perceptions
30. Key informants' perceptions of barriers and challenges with regard to men's utilisation of HCT
31. Key informants' perception of the role of cultural beliefs in men's HCT utilisation
32. Key informants' perception of men's attitudes towards circumcision and condom use
33. Key informants' views of proxy testing
34. Key informants' perceptions of programmes aimed at men
35. Key informants' views of the role of income and education in HCT uptake

36. Organisational statistics and HCT motivational factors
37. Organisational HIV/AIDS prevention programmes and strategies
38. Suggested strategies to improve HCT uptake

3.9 ETHICAL CONSIDERATIONS

The rights of the participants of any research process are of immense importance. The physical and emotional welfare of the participants and respect for their privacy were important considerations in this study.

The physical and emotional welfare of the participants and respect for the privacy of the research participants stress that all participants should be debriefed. The latter ensures that the truth and reasons for the research are communicated to all participants (Mouton 2009:245; Hogg & Vaughan 2005:18). It is imperative that the researcher acknowledge and observe the latter especially when dealing with sensitive issues such as HIV testing as part of a human rights issue.

The following aspects present the detailed description of the ethical issues that were taken into consideration:

3.9.1 The researcher's knowledge of ethics

The researcher was well conversant with the principles of ethics because the latter forms an integral part of the requirements for fulfilling a master's degree. The researcher also studied the ethical rules and guidelines of UNISA in great detail.

3.9.2 Institutional permission and ethical clearance

Permission to conduct interviews with key informants from Engender Health was granted by the management of the organisation.

The research proposal was submitted to the Department of Sociology's Ethical Review Committee. Ethical clearance was granted by this Committee in October 2013 following a critical scrutiny of the research proposal and interview schedules.

3.9.2.1 Informed consent

Informed consent requires the researcher to provide all the available information about a study so that an individual can make a rational, informed decision about participating in the study (Gravetter & Forzano 2009:108). Participants were requested to sign an informed consent form after the researcher had explained the purpose and benefits of participating in the study. The researcher informed the participants of the estimated time that the interview would take to complete, how the results from the interview would be used and of the availability of the summary of the findings of study if they so wished. Participants were informed of their right to withdraw from the study at any given time during the research project and that they could choose not to answer certain questions (Babbie 2007: 63-64).

Before signing the forms, the researcher asked each participant if they understood the contents of the informed consent and whether they had any questions regarding the purpose of the study and the interview process. The signed consent forms were securely locked away at the researcher's home.

3.9.2.2 Risks involved, debriefing and referrals

Prior to the commencement of data-gathering, the researcher was aware that the items in the interview schedule could potentially challenge the views of middle-aged black men on sexual issues. Mindful of this, the interview schedule was pre-tested. In addition, the researcher conducted a brief debriefing session for those participants who revealed to him that they feared that they might be at risk of HIV infection because of their involvement in unsafe multiple sexual partnerships. In such debriefing sessions, the participants were given information about HCT and referred for such services.

3.9.2.3 Confidentiality

All participants were assured that their responses were treated as highly confidential and that their true identities would never be revealed. Signed consent forms and all audio recordings and observational notes were securely locked away at the researcher's home. During the transcription of the audio recordings, the researcher assigned a pseudonym to each participant.

3.10 RELIABILITY AND VALIDITY

The researcher used the following four reliability and validity techniques for qualitative research as explained by Morse, Barrett, Mayan, Olson and Spiers (2002:11).

- *Methodological coherence*: The researcher aimed at establishing coherence between the data-gathering and data-analysis techniques and the stated research question. In addition, a careful deliberation of data collection and analysis took place between the supervisor (who acted as an external auditor) and the researcher. Common areas of consensus and disagreement were identified and recommendations made.
- *Sampling sufficiency*: Research participants who best represented the inclusion criteria and who were rich sources of data were recruited.
- *Developing a dynamic relationship between sampling, collecting and analysing data concurrently*: The researcher was mindful of safeguarding the credibility of his data through concurrent data collection and analysis.
- *Thinking theoretically*: The researcher used the tenets of the theories detailed in chapter 2 as sensitising concepts to ensure that “*ideas emerging from data are reconfirmed in new data; this gives rise to new ideas that, in turn, must be verified in data already collected*” (Morse et al 2002:13).

3.11 DATA ANALYSIS

The recorded interviews were transcribed verbatim personally by the interviewer after the completion of each interview. Each transcription was augmented with notes taken during the interview. The process of transcription included preliminary data analysis that resulted in the identification of emerging themes in the data. After completing the fieldwork, the researcher checked each transcription against the audio recording again to make sure that each transcription was correct and complete.

The list of emerging themes was used to code sections of transcript data. The researcher created separate word files for each theme and pasted the narrations in each file.

The initial themes were refined again and further codes were added. Coding enabled the researcher to discover patterns in the data. The aim was to identify critical information, key concepts and broad categories. The results obtained from open coding allowed the researcher to move to axial coding where core concepts and themes that addressed the research questions of the study were identified (Babbie 2007:385-386). The last phase of coding involved selective coding where data was revisited for information relevant to the major themes and a central code was identified.

3.12 CONCLUSION

In this chapter the researcher discussed the research methodology that was used in this study. Details on the chosen research design, sampling procedure, data collection procedure, reliability and validity, data analysis and, ethical considerations were given. The next chapter (chapter 4) presents data analysis along with a discussion.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

In this chapter the researcher presents the findings and analysis thereof. The chapter is organised as follows. In the first section, the biographical profiles of the research participants are described. To protect the participants' confidentiality, pseudonyms were allocated to each participant: namely, Themba, Tendani, Mzoxolo, Muzi, Nkosana, Thabo, Mandla, Tami, Sizwe and Teboho. This is followed by a discussion of the issues that emerged from the interviews with these ten men according to main themes. This is followed by background information concerning the key informants and a presentation of the findings that emerged from the analysis of the interviews with these informants.

Table 4.1: Selected biographical details of the research participants

Pseudonym	Age	Ethnicity	Employment status	Educational level	Marital status
Mandla	44	Sotho	Self-employed	Grade 12	Married
Thabo	38	Zulu	Unemployed	National diploma in engineering	Customary marriage
Sizwe	37	Zulu	Employed	Std 6/ Grade 8	Single
Tendani	40	Venda	Employed	Teaching diploma	Polygamous marriage
Tami	50	Ndebele	Employed	BA (Hons)	Married
Mzoxolo	36	Xhosa	Unemployed	Std 8/ Grade 10	Single
Muzi	40	Zulu	Unemployed	Grade 11	Single
Nkosana	49	Xhosa	Unemployed	Grade 12	Single
Teboho	43	Pedi	Employed	Laureates (Technology)	Married
Themba	46	Zulu	Employed	Std 1/ Grade 3	Married

EXPLAINATION OF THE ABOVE TABLE

Age in Years	Total	Employed		Unemployed		Educational Level				Marital Status	
		No.	%	No.	%	G	D	B	H	M	S
35 – 39	3	1	10	2	20	2	1	0	0	1	2
40 – 44	4	3	30	1	10	2	2	0	0	3	1
45 – 58	3	2	20	1	10	2	0	0	1	2	1
Total	10	6	60	4	40	6	3	0	1	6	4

Key

G	Grade 12 and below
D	Diploma
B	Bachelor's Degree
H	Honours
M	Married
S	Single

4.2 CHARACTERISTICS OF THE TEN MALE PARTICIPANTS

The participants were ten middle-aged black men from diverse ethnic backgrounds and socio-economic statuses. All of these men were involved in intimate heterosexual relationships and were residents of Ratanda. As shown in Table 4.1 (above), the participants ranged in age from 30 to 58 years.

At the time of the study, five participants were employed full-time, one was self-employed and four were unemployed. Although the researcher did not ask the respondents to tell him their incomes, he deduced that four of the ten participants belonged to middle to high income categories since they indicated that they held middle to senior management positions at their places of work. Only one participant had a low level of education and had been working for a newspaper for the past 15 years in a low-ranking job. Table 4.1 shows that the respondents' level of education ranged from Grade 3 to university level.

Concerning their marital status at the time of the interviews, three participants identified themselves as single, one as cohabitating, five as married in a monogamous marriage (here referring to marriage to one wife, but not to being monogamous in terms of sexual behaviour) and one as married in a polygamous marriage. Four participants were isiZulu-speaking; two participants were isiXhosa speaking; one spoke Sesotho sa Leboa (Sepedi); one Tshivenda and one IsiNdebele. Nine of the participants aligned themselves with Christianity and one was a practising Muslim.

4.3 THEMES EMERGING FROM THE ANALYSIS OF THE INTERVIEWS WITH THE TEN MALE PARTICIPANTS

Analysis of the transcribed audio-recordings of the ten men's face-to-face interviews uncovered the following 12 themes with some sub-themes themes: namely,

1. Involvement in multiple sexual partnerships
2. Knowledge of HIV/AIDS and HCT
3. HCT utilisation and perceptions of men who go for HIV testing
4. Barriers and challenges in utilising HCT consisting of the following sub-themes:
 - I. Fear of positive results and of rejection
 - II. Stigma and discrimination
 - III. Lack of adequate HIV information
 - IV. Clinic times and long queues
5. Risk perceptions and comparison of risk perceptions between older and younger men
6. Perceived consequences of HIV testing
7. Cultural beliefs influencing HCT utilisation and multiple sexual partnerships
8. Views on dating young girls
9. Perceptions of condom use

10. Perceptions of male circumcision
11. Views on the “ideal middle-aged man”
12. Involvement in (and intentions to become involved in) HIV/AIDS programmes and campaigns

These twelve main themes (and their sub-themes) are discussed in greater detail below.

4.3.1 Involvement in multiple sexual partnerships

Although half of the men were reportedly in committed relationships (five reportedly in monogamous marriages and one in a committed cohabiting relationship), a majority of half participants reported that they were involved in multiple sexual relationships at the time of the interviews. Only a few of the married men reported that they were faithful to their wives. All of the men in multiple sexual partnerships attributed this to fulfilling traditional gender roles and upholding traditional notions of masculinity. For instance Nkosana said: *“We as blacks, we are not supposed to have one partner, your menu must be different because you don’t eat meat every day, and I am ‘isoka’”* (Casanova). On the other hand Teboho said: *“According to us as blacks and as Pedi men you cannot have one partner. We even have our idiomatic expression in our idioms book that encourages us to explore sexual desires with different women.”* Some of the men explained that their forefathers were involved in multiple sexual relationships as a sign of manhood and that they were merely following examples set for them about how to express masculine ideologies.

This resonates with the findings by Skovdal et al (2011) that hegemonic masculinities encourage men to have multiple sexual partners. Themba argued: *“If your forefathers had polygamous marriages then chances are likely that you will follow in their footsteps and have a big family. We do not think about HIV and AIDS because it is just a new thing. In the olden days there was only an STD and that was curable.”*

Another justification for involvement in multiple sexual relationships that emerged from the interviews was that men need sexual intercourse because they are unable to control their sexual appetites. For example, Teboho said: *“As men we need to be serviced all the time hence we need to have sex with casual partners especially when*

our stable sexual partners are menstruating or sick.” Tendani, who held a similar view, elaborated that sexual intercourse with casual partners was more exciting. He said: *“Sex with casual partners is different from my wife because it is wild and that is what gives me satisfaction”*. Nkosana also held a similar view and said: *“I have four girlfriends because I love sex and I want more of it. My friends also have many girlfriends and we like to play with girls because we have casual sex with them.”* This finding resonates with the TRA’s treatment of the role of the individual’s intention to perform a specific behaviour as discussed in chapter 2.

The intention to enact a particular behaviour is shaped by the person’s beliefs, attitudes and subjective norms. These men showed the desire to be involved in multiple sexual partnerships because they either felt the need to enact the behaviour or they were influenced by their friends regardless of the risks involved in having multiple sexual partnerships.

The participants’ involvement in multiple sexual relationships affirms the Social Ecological Model which to Grizzel (2007:10) reinforces the notion that social contextual factors such as culture, familial support and institutional factors influence an individual’s risky behaviour.

4.3.2 Knowledge of HIV/AIDS and HCT

Nine of the research participants displayed sound general knowledge of HIV and AIDS. Only one (Themba) admitted to having absolutely no knowledge of the virus besides the fact that *“AIDS kills”*.

Themba’s low level of education relative to the other participants’ may be partly to blame for this. In terms of their knowledge, the nine participants were able to tell the researcher that HIV is a virus that attacks the human immune system and that AIDS represents the end stage of HIV infection. They also knew and were able to mention spontaneously modes of HIV transmission. Unprotected sexual intercourse with many different partners was mentioned as a mode of transmission by all nine men who were knowledgeable about HIV and AIDS.

Some of the participants were able to talk about treatments for HIV and AIDS. For example, Mzoxolo mentioned: *“an HIV positive person does not have to take ARVs because his CD4 count is still high but he has to start taking ARVs when it lowers to 350 although previously it used to be 200.”* He further mentioned that this was the reason for his always practising safer sex. He revealed to the researcher that he had received intensive HIV/AIDS awareness training when he served a prison sentence for 15 years.

Although one participant claimed that he was not knowledgeable about HIV and AIDS, all ten of the participants knew about HCT services. They mentioned that they knew about testing through information obtained from the radio, television, public campaigns and friends who had gone for HIV testing. However, knowing about testing and acting on the information were regarded as unrelated issues. Only one of the men was able to answer questions about the availability of HCT services in Ratanda.

The other nine participants did not actively seek information about the availability of testing services in their area of residence. For example, Sizwe said: *“I have heard of HCT services, but have not looked for such services around this area because I am not interested in HIV and AIDS issues.”* Nkosana shared similar views with Sizwe because he said: *“I am not interested in HIV and AIDS issues such that I avoid HIV and AIDS messages and even when I go to the clinic I don’t take any pamphlets.”*

In fact Sizwe and Nkosana displayed overtly negative attitudes regarding questions about the availability of HCT services in Ratanda. In this regard Swanepoel (2005) reports on studies that have found that public HIV testing campaigns may result in defensive denial of risk and the active avoidance of exposure to HIV and AIDS messaging.

Mzoxolo was interested in the availability of HCT services and had actively looked for services in Ratanda. However, he said that he was not aware of the availability of HCT services in Ratanda. When asked to mention places in Ratanda where he could look for HCT sites, he could not respond. This suggests that Mzoxolo may be too apprehensive to go for an HIV test. He suggested to the researcher that he was interested in accessing HCT services and yet said: *“I have discovered that we are still*

a bit ignorant about AIDS. People have their own reservations about HIV and AIDS because they are scared of being told they are HIV positive.”

The knowledge of HIV/AIDS and HCT displayed by the study participants agrees with the Health Belief Model (HBM) which attempts to explain and predict health behaviours by focusing on the role of perceptions in determining the attitudes and beliefs of the individuals. According to Munro et al (2007:6), a person's health-related behaviour depends on that person's susceptibility to an illness, the benefits of taking a preventive action and the barriers to taking action. The men seemed to feel susceptible to HIV and so they somehow retained the information they had about HIV/AIDS and HCT and thus they were fairly well-informed.

4.3.3 HCT utilisation and perceptions of men who go for HIV testing

When asked about their preferred source of information about HCT services, eight of the men responded that they preferred obtaining such information from the nearest clinic. The two men who did not prioritise the clinic as the preferred source of information held divergent views about their preferred sources of information. Muzi mentioned that he preferred door-to-door HIV campaigns such as those usually held during World AIDS Day. Tami said that he would rather visit a private clinic or health care practitioner as he regarded the quality of service offered by private health care practitioners superior to that of the public health care services. He also said that the staff at public health care facilities tended to be young men who were not part of his peer group.

Seven participants mentioned that they had gone for HIV testing in the past three years because they wanted to know their HIV status. However, when asked if they would consider going for testing again soon, all seven men were extremely reluctant to do so.

When asked what would prompt them to go for a test again, the resounding responses were that they would consider it only when they or any of their sexual partners started showing HIV-related symptoms. The three men who admitted that they had never gone for HIV testing said that they avoided it because they feared a positive result.

Nkosana intimated that he was fearful that he might already be infected because of his risky sexual behaviours. He said: *“I am not happy with my sexual behaviour. When I*

sometimes think about HIV, I get scared because I love sex and when I am with my girlfriends I feel like having sex and it is easy to get infected because I cheat a lot.”

Teboho, although fearful of testing, argued that he did not have to undertake an HIV test because his wife was tested during her last pregnancy and tested negative. His new-born baby boy was also HIV negative and for Teboho that implied that he was also HIV negative. In this regard Levack et al (2005) indicate that men usually use the HIV results of their female partners as a test of their own HIV status.

The researcher asked the participants to describe the characteristics of the “typical man who goes for HIV testing”. Seven men (all of whom had gone for testing in the past) mentioned that they respected a man who went for an HIV test. For example Teboho said: *“A man who goes for an HIV test is a brave and real man because he wants to protect himself and loved ones against HIV infection.”*

Four participants Mzoxolo, Tendani, Thabo and Muzi regarded men who went for HIV testing as real men who wanted to know their HIV status and planned for their future. Mzoxolo said: *“Every man needs to go for HIV testing, it is for your own benefit that you go.”* Whilst Tendani argued: *“If you want to take care of yourself and family then you will go for HIV testing.”* Thabo elaborated: *“A man who is health-conscious will go for an HIV test because knowing your status is the first step to becoming health-conscious.”*

Muzi seemed to have “normalised” HIV and AIDS because he said: *“Any man can go for an HIV test as long as you won’t be afraid to take a test. You will receive HIV counselling and treatment and live just like other people if you have tested HIV positive.”* To interpret this finding, cognisance should be taken of the HBM’s attempt to explain and predict health behaviours by focusing on the role played by perceptions in determining the attitudes and beliefs of the individuals (Munro et al 2007).

The three men, Themba, Sizwe and Mandla who had never gone for testing, expressed negative views of men who go for HIV testing. They regarded such men as “less manly”, arguing that was not manly to consult Western biomedical services. For example, Themba said: *“Tigers don’t cry. That is why we consult many traditional healers to show that we are real men and we are doing what is expected of us by the society.”*

It would thus appear that accessing health care services conflicted at least for some men with locally held versions of manhood. This finding was similar to the findings of the World Bank (cited in Skovdal et al 2011) highlighting that a common perception among men in Sub-Saharan Africa was that a real man did not fall ill. Therefore, such perceptions might prevent some men from accessing HCT services. However, seven of the ten male participants in this study were able to conquer these perceptions and go for testing.

According to UNAIDS (1999), normative beliefs play a central role in the theory and generally focus on what an individual believes other people, especially influential people, expect him/her to do. The Theory of Reasoned Action (TRA) is conceptually similar and adds the constructs of behavioural intention as a determinant of health behaviour (UNAIDS 1999:7).

The TRA focuses on the individual's intention to perform a specific behaviour. The intention to enact a particular behaviour is shaped by the person's beliefs, attitudes and subjective norms (Van Dyk 2008:122-123). The researcher briefly explained attitude towards behaviour and subjective norms as major tenets of this theory.

On the other hand, Sizwe and Mandla mentioned that a man may go for an HIV test because he may be forced by his sexual partner owing to infidelity and lack of trust. On this note, Mandla said: *"You can go for HIV test if your partner does not trust you, and then you do not have a choice but go for it."* Sizwe shared a similar view with Mandla and said: *"If your partner has caught you cheating, then you have no choice but to go for HIV testing to prove that you do not have AIDS."*

4.3.4 Barriers and challenges in utilising HCT

The researcher asked questions about perceived problems faced by middle-aged men should they use HCT services in Ratanda. Four sub-themes emerged in this regard: namely, fear of positive results and of rejection; stigma and discrimination; poor information about testing; and operational barriers when accessing reproductive health care services. These themes are discussed in detail below.

4.3.4.1 Fear of positive results and of rejection

Eight participants expressed the view that their own fear of testing HIV positive emanated from their (current and/or previous) risky sexual behaviours as the major barrier to HCT utilisation. Upon probing, the researcher discovered that it was not the fear of a positive test result that was the barrier, but rather the perceived consequences of such a result. The most feared consequence of a positive test result for all eight men was possible rejection by loved ones or by the community.

Teboho said: *“I have a cousin who is an attorney and HIV positive, he has disclosed his status but his community in the rural area is stigmatising him. So even when you disclose your status you will still be stigmatised.”* Thabo argued: *“When people know that you are HIV positive, they will start treating you differently because they know that you will soon be dying. You won’t live to the age of 80 years and communities won’t involve you in what they are doing.”* Tami held a similar view and elaborated: *“If you test positive, your partner will reject you because you got AIDS from other casual sexual partners.”*

Swanepoel (2005) refers to a study that shows that males are often more concerned than females that disclosure of a positive status will result in rejection by sexual partners and family members.

This framework was used to examine contextual influences on the social contextual factors that influence poor HCT uptake services by middle-aged black men. As noted above, the researcher used both micro and macro theories as guidelines to explore the social contextual factors that might serve as barriers to HCT utilisation. The Social Ecology Model correlates with the HBM and the TRA because it takes into consideration the individual’s risk perception and the influence of subjective norms in behaviour change.

Only two of the men linked fear of a positive test result with consequences to the HIV-positive person in terms of health status and lifestyle. Muzi argued: *“There is no cure of HIV or AIDS. Even if they [people living with HIV] take ARVs they will eventually succumb to the virus.”* Tendani said: *“If you test positive then you have to refrain from many activities. For example, you won’t have a baby and even enjoy unprotected sex. You also won’t be able to drink alcohol and smoke. You have to have a special diet and you won’t have fun.”*

4.3.4.2 Stigma and discrimination

Stigma and discrimination remain major barriers to HIV testing. All ten participants shared similar views on this, for example: *“As long as the nurses and community stigmatise HIV and AIDS men will not present themselves for HIV testing.”* (Thabo)

“Stigma is bad especially when you go to that counselling room. These are the things I do not like. The clinic is usually very full and that room has a sign that reads ‘VCT’. And there are many people who know me around the area. They will be saying I tested positive just because they saw me going there.” (Nkosana)

“When you go to the clinic, people will see you taking an HIV test and if you test positive you can’t hide your shock and anger. You will get out of that room looking very depressed and people will notice that and tell each other that you are infected and the whole world will know.” (Muzi)

“Even if people are sick they still will not go to the clinic because people will think they are already HIV positive and start stigmatising and discriminating against them.” (Mandla)

“Even if a person discloses his or her status, that person will still be stigmatised. Health care workers contribute to stigma and discrimination because they sometimes disclose patients’ status without their consent.”

“Even if you sign the consent form and they guarantee you that the results will be kept confidential, nurses will still disclose your status. If health care workers were professional in their conduct then everyone would go for HIV testing knowing that it is his business but our professionals take this outside our boundaries.” (Teboho)

In this regard Birdsall et al (2004) argue that the lack of privacy, confidentiality and accuracy of HIV test results may further contribute to men’s reluctance to utilise HCT services. Moreover, the Social Ecology Model correlates with the HBM and the TRA because it takes into consideration the individual’s risk perception and the influence of subjective norms in behaviour change.

Swanepoel (2005:11) maintains that contextual concerns surface at individual level with regard to people's beliefs, attitudes and intentions to go for HIV testing.

He further argues that some individuals may already have developed a strong intention to go for HCT, but are deterred from doing so as a result of environmental barriers and beliefs about their skills to do so. Therefore, the social ecological model acknowledges the importance of the interplay between the individual and the environment and the influence it has on the individual's behaviour (Decosas 2002:13). Social ecological models posit that individual-level beliefs are embedded in wider contextual concerns. For example, people who are concerned about the confidentiality of their test results usually link their concern to the stigmatisation and discrimination of people who are living with HIV in a society.

4.3.4.3 Lack of adequate HIV information

Nine of the participants maintained that they did not have relevant information on HIV or on HCT services. Mzoxolo argued: *"If people were well-informed about HIV and AIDS, then they would present themselves for HIV testing."*

Tami said: *"There is inadequate HIV information in the workplace and clinics. HIV testing is not reinforced and intensive HIV and AIDS awareness is only done on the 1st of December making it appear as if HIV and AIDS are festive season diseases."*

Only Tendani argued that information is available for everyone. He said: *"You go to your cell phone it is there, TV, billboards, Life Orientation as part of the school curriculum and newspapers. People are just ignorant."*

Nkosana and Sizwe justified their own ignorance about HIV/AIDS and HCT in terms of their active avoidance of messages and information in this regard. Nkosana said: *"I refuse to be informed about HIV and AIDS issues especially when they give you information about HIV and AIDS symptoms."*

"It really frustrates me. This is because I know that I am at risk so I do not want any information that will scare me." Sizwe argued: *"I am not interested in HIV and AIDS issues. Besides, I never get sick – so why should I bother 'Why fix it if it is not broken?'"*

The narrations above suggest that Nkosana and Sizwe were aware of the dangers of their unsafe sexual behaviours and were not showing any intention to change their behaviours. Instead they actively avoid HIV and AIDS information. Nkosana further stated: *“I like to have sex and when I am with my friends I feel like having sex and it easy to get it because you just cheat.”* Sizwe maintained: *“It is not clear to me how to identify an HIV positive person. So I won’t be sure whether I am infected or not. So I will only look for HIV and AIDS information if my partner starts showing HIV and AIDS symptoms.”*

4.3.4.4 Clinic times and long queues

Another concern raised by the research participants was the operating times of clinics and the long queues found at clinics. The participants argued that most employed men would regard the clinic times as inconvenient as they operated only from 7 am to 4 pm. In addition, they argued that it was impossible to book an appointment with HCT staff as public health care clinics did not operate like private clinics where bookings were possible or even essential.

According to Grizzel (2007:10), social contextual factors such as culture, familial support and institutional factors provide a crucial framework for understanding an individual’s risk behaviour. The latter has already been dealt with in the above literature review as factors that may prevent middle-aged black men from utilising HIV testing services. It is imperative that social contextual influences on behaviour be considered so that HIV prevention programmes yield positive results.

The Social Ecological Model enabled the researcher to identify possible challenges of the social factors that served as barriers for middle-aged black men to utilise HCT services. Therefore, the social ecology of middle-aged black men was considered and formed the basis of the researcher’s recommendations on HIV prevention strategies that might increase HCT uptake services by middle-aged black men.

The use of this model might assist HIV programme developers in alleviating the overemphasis of the individual factors as the main determinants of health behaviour change. Middle-aged black men’s sexual and health-seeking behaviours might be best understood with the social contextual factors that might govern a particular behaviour.

Thabo mentioned that visiting the clinic was time-consuming because of long queues. In this regard the TAC (2011) reveals that most men are not keen to test for TB or HIV because of long waiting hours associated with overcrowded conditions at local clinics. Beyond waiting times, Mandla mentioned that he found the lengthy duration of the counselling process off-putting as it was time-consuming. This could be attributed to the fact that Mandla had already gone for an HIV test three years prior to the interview and was thus familiar with the pre- and post-test counselling process. He asked: *“Why can’t they just do the test and counsel you after you have obtained the results?”*

4.3.5 Risk perceptions and comparison of risk perceptions between older and younger men

The researcher asked the participants if they considered themselves to be at risk of HIV infection. Seven participants considered themselves to be at risk of HIV infection. They attributed their risk to having multiple sexual partnerships, not using condoms consistently and irresponsible actions owing to alcohol consumption. Tami, despite being employed and having the highest level of education of all the respondents, acknowledged that he was at risk of HIV infection because he drank heavily and never used condoms despite having several sexual partners. He acknowledged that he was aware of the risks: *“Everyone is at risk of HIV infection regardless of their socio-economic status. For example it was publicly exposed that a police woman and a prison warden had unprotected sex and they were infected.”* Tami was thus able to repeat the messages of HIV-transmission risks, but could not put that knowledge into action by adopting less risky behaviour.

Nkosana said: *“I am at risk of HIV infection, but I still won’t use condoms or visit the clinic for HIV testing. If I die of AIDS, then let me get sick and die.”* Mzoxolo, who also regarded himself as being at risk, mentioned: *“I regard myself to be at risk because I am not immune to it. Even these condoms are not 100% safe. They can burst during sexual intercourse. So everybody is at risk of getting HIV and AIDS. HIV does not target a specific someone. For example this one is educated and that one not. Even if you are not sexually active, you are at risk because you are using machines or sharing needles.”*

Thabo said: *“I am at risk of HIV infection because at times I engage in sexual intercourse without a condom solely because I am under the influence of liquor.”* Tendani responded: *“I do not have one sexual partner and I do not use protection and I do not know what my partners are doing with other people.”* Sizwe argued: *“Women are beautiful and sexy so we have a notion that those kinds of ladies do not have AIDS and we sleep with them without using a condom.”*

Mandla said: *“HIV is like a prison, you can’t say you can never go to prison. There are many risks, you can meet an attractive woman and sleep with her without having gone for HIV testing then you can get HIV.”* Two men, Muzi and Teboho, regarded themselves as not at risk of HIV infection since they always took precautionary measures. Muzi said: *“I am not at risk of HIV infection because I make sure that I always use condoms.”* Teboho maintained: *“I take precautions because I use condoms consistently. I won’t touch anybody who is bleeding without gloves and I make sure I use quality gloves. In my car and house I always have a first aid kit, though I have never seen it at work.”* It is interesting to note that Teboho also argued that since he went for annual medical check-ups he was not at risk. Upon further probing, he said that he assumed that an HIV test was also included in these annual medical tests.

Themba was the only participant who was not able to respond to the question about own risk perceptions. He said: *“I would not know if I can get it or not because I can get it maybe from a woman that I can incidentally have unprotected sex with.”*

The researcher asked the respondents to compare the HIV risks faced by middle-aged men with those faced by younger men. Four participants argued that younger men were at greater risk of HIV infection than middle-aged men as young men were more attractive to women, tended to explore many different sexual relationships and tended to abuse alcohol and drugs. Themba said: *“Younger males are more at risk because they have a hectic life and party a lot. Middle-aged men have a low risk of HIV infection because they can control themselves and are mature.”* Thabo maintained: *“Men of younger ages are not informed. Or they might be informed, but there is a notion that they are still exploring and are exposed to a lot of temptations.”* Nkosana argued: *“Younger men are at risk because when they do things they overdo it. For example they don’t mind sleeping with ten girls and especially those that are 22 and*

below. They drink a lot. Middle-aged men are at minimum risk because they don't buy sex like younger males."

It was interesting to note that these men attributed risky sexual behaviours to immaturity, hectic lifestyles and having multiple sexual relationships. This suggests that although they also had other sexual partners, they still did not regard themselves as being at high risk of infection relative to younger men. In this regard, Swanepoel (2005) states that some people may have unrealistic views and overestimate the risk of HIV infection in others while at the same time underestimating their own risk.

The researcher found it interesting that five of the participants perceived middle-aged men to be at a greater risk of HIV infection than younger men. Reasons proffered for this assessment were that middle-aged men had young girlfriends or started looking for other sexual partners besides their spouses or regular partners. Tami argued: *"Middle-aged men are usually financially sound and can afford to buy expensive clothes for young girls. These men have sex with these young girls in exchange for expensive gifts because they think it is safe. But these young girls may have been exposed to HIV infection and would in turn infect these older men."*

In this regard, Engender Health (2010) states that men who possess relatively better economic means than others are in a better position to dictate the terms and conditions of a relationship. In addition, they may also be able afford to buy commercial sex. Teboho said that middle-aged men tended not to take their spouses or primary partners with them to parties and night clubs. He observed: *"The older men would rather take their casual partners to parties or night clubs and are more likely to have unprotected sex with them due to drinking alcohol."*

Muzi narrated: *"Middle aged men are more at risk because they go out with younger girls. You find that one has a problem, maybe he broke up with his stable partner because most middle-aged men that I meet say they just have relationships for its own sake after breaking up with their stable partners. They are no longer serious. They are just dating. That is why I say they are at risk."*

Sizwe reported: *"Our age group are at risk for HIV because they are not as informed as the younger ones. And we are still living according to the older days. We don't want to change."* This suggested that although Sizwe did not want to access health

information, he was aware of the importance of HIV and AIDS health messages in reducing risky sexual behaviours. Mzoxolo maintained: *“Young generations are more informed about HIV than middle-aged men and some middle-aged men deny that HIV exists so they do not want to act on the information they know.”*

One of the respondents, Tendani, said that all men were equally at risk of HIV infection as long as they were sexually active. He said: *“How you get infected may be a deciding factor. Unemployed young men are also at risk of HIV infection because they may visit cheap taverns and shebeens to find vulnerable sexual partners. Some young men are at risk of HIV infection because they have sex with older women for financial support and may have unprotected sex with these women. I am 30 years old and there is this woman who is working and her partner does not satisfy her sexually. Then she will go for this young one. You do not know their sexual history because you are dating them for money.”*

Tersbol (2006) states that men who do not have the economic means to satisfy their basic needs may have multiple sexual partnerships with economically active women who may dictate the terms of sexual engagement. It is also hypothesised that cumulative risk is associated with increased HIV-related sexual behaviour. This may imply that middle-aged black men who have multiple unsafe sexual partners may be at high risk of HIV infection and may be regarded as a high and vulnerable risk group.

Familial and community level risk factors may negatively affect HIV-related sexual behaviours thereby increasing the spread of HIV infection in a particular community and family. The researcher assumed that men’s significant others and community members who did not advocate HIV testing might contribute to middle-aged black men’s reluctance to go for HIV tests. Newman (1999) further states that this model may offer a viable method for incorporating social contextual factors in research on HIV-related sexual behaviours.

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4.3.6 Perceived consequences of HIV testing

The HBM posits that a person's health-related behaviour depends on that person's susceptibility to the illness in question, the perceived benefits of taking preventative action and the perceived barriers to taking action. The Health Belief Model (HBM) attempts to explain and predict health behaviours by focusing on the role of perceptions in determining the attitudes and beliefs of the individuals. According to Munro et al (2007:6), a person's health-related behaviour depends on his or her susceptibility to that illness, the benefits of taking a preventive action and the barriers to taking action. This model assisted the researcher in establishing the social barriers and benefits that either motivated or discouraged middle-aged black men from utilising HCT services

In terms of possible benefits, five men spoke about the health and behaviour benefits of testing and counselling, the benefits of general testing for the government's efforts to fight the epidemic and the benefit of being able to boast about a negative status. Two participants (Mandla and Nkosana) mentioned some benefits of HIV testing such as that knowing one's HIV status might lead to the reduction of risky sexual behaviours regardless of the outcome of the test. Nkosana said: *"If you are not infected, then you will reduce your risky sexual behaviours, because you would want to remain HIV negative."*

It would thus seem that at least two of the men saw some benefit in not only testing, but also in the counselling that went along with it. One participant, Teboho, suggested that the benefits of HIV testing went beyond the individual tester or even the tester's lovers as testing by many people might help the government plan for adequate health care services. He said: *"South Africa has facilities and resources but people still do not come forward for HIV testing. If more people tested, the government can plan for health care services."*

Two of the men, Tami and Muzi, regarded the benefits of knowing one's HIV status as unrelated to health and behaviour change. Instead they argued that a man would

celebrate his HIV negative status and boast to his friends that he was not infected. For example, Tami said: *“You will boast and throw a party that you are negative, you can even display your HIV results in your office and car.”*

The five men who thought HIV-testing might have potentially negative consequences regarded lack of behavioural change, self-blame, rejection and family breakdown as the main consequences. Two men, Sizwe and Thabo, argued that men who tested HIV positive might deny their HIV positive status, continue practising unsafe sex, and re-infect themselves and others. Sizwe argued that the very act of testing could appear to be a confession that the man had been sexually unfaithful and this might cause unnecessary conflict in a marriage or a relationship.

Tendani saw HIV-infection as a death sentence that would cause a man to stop enjoying sex because *“You will know that it is sex that brought on your HIV infection.”* On the other hand, Themba saw stigma and discrimination as negative consequences of HIV testing. He argued: *“When you tell one person that you are infected then he tells another one then people end up knowing your status and reject you. That is why people do not go for HIV testing.”* Mzoxolo shared similar views with Themba because he argued: *“We sometimes have informal conversations about people who are HIV positive. The things that are being said about them are bad. When it is you now that must go for HIV testing, then you start thinking about those things. Then you do not go for a test. Peer pressure is there and negative.”*

In this regard, Swanepoel (2005) states that the feeling of fatalism and helplessness that surrounds HIV and AIDS relates to the perception that HIV-infection is a death sentence. Some people will thus actively avoid HIV testing because they assume that a positive result will lead to major depression, which is thought to hasten the onset of AIDS and death.

4.3.7 Cultural beliefs regarding HCT utilisation and multiple sexual partnerships

In terms of the men’s understanding of the role of cultural beliefs in HCT utilisation on the one hand and about multiple sexual partnerships on the other hand, interesting findings emerged. Seven participants strongly felt that cultural beliefs contributed to poor HCT uptake regardless of the person’s ethnic and cultural background. The cultural beliefs that were seen as major barriers to HCT utilisation were traditionally

gendered notions of manhood that prescribed that men should model the sexual behaviours of their forefathers. Forefathers were believed to have had many wives and girlfriends, never to have used condoms and never to have gone for HIV testing.

Tendani reported: *“Our fathers, traditionally because of our customs, they were allowed to have many wives and there was nothing that was happening, they were not sick and dying from any disease.*

“So I am also from that land of upbringing then I will also have many partners why must I go for HIV testing and my father was never tested for HIV and is still alive so I cannot go.”

Teboho said: *“Yes, remember in our culture we do not do HIV testing because they will tell you that they used to have many wives and did not use condoms. Even our fathers say HIV is a new thing.”* Mzoxolo argued: *“Culture is still there for primitive men. They will say they are ‘isoka’ because they have many wives as a symbol of being real men.”*

In addition, the men recounted how they had been taught to consult traditional healers to treat any illness instead of visiting a clinic. For example Themba said: *“I cannot live in a new way when I am sick. I can go to the traditional healer and use traditional herbs. And if I am not getting better, I can go to another traditional healer. I will only go to the clinic after I have tried different traditional healers.”* Tendani said: *“If you go for HIV testing you are not men enough because it means you have become westernised and believe in Western medicine instead of in traditional healers.”*

Tami felt strongly about his cultural beliefs and argued: *“Culture says that men should be men. We use cultural herbs (muti) to prevent any disease including HIV and AIDS. That is why we won’t go for an HIV test because the muti makes us stronger not to get HIV.”* The researcher observed that Nkosana displayed a very negative attitude towards HIV testing and changed his facial expression when he spoke about culture and HIV testing. He said: *“On my side, when I am sick I don’t go to the clinic. I rather go to the traditional healer and drink their herbs. I don’t want to go to the clinic and test. If I am sick let me die. If they test me then it would mean I am very sick such that I cannot give consent to test. I am not going to test if I am still healthy.”*

Sizwe said: *“If you are a man, when you get sick you can ‘gabha, futha and chatha’ [Zulu traditional rituals] then you will get healed.*

“There is a wrong belief that when you sleep with a young girl, you will get healed from HIV and AIDS. That is why some of us don’t go for HIV testing.” Sizwe struggled with contradictory information. He was aware that the myth surrounding infected men having sex with virgins to cure HIV infection was incorrect; yet he also felt that HIV testing was uncalled for.

Mandla, Muzi and Thabo disagreed that cultural beliefs contributed to poor HCT uptake. It should be borne in mind that Mandla and Muzi had previously gone for HIV testing and might thus have been exposed to health messages about the risks involved in having multiple sexual partners. Thabo had a relatively high level of education. He argued that people used cultural beliefs as an excuse to have multiple sexual partnerships and to continue practising risky sexual behaviours. He said: *“People are aware of the impact HIV and AIDS. Even men from deep rural areas are aware of HIV and AIDS. Most maskandi groups [traditional artists] have songs that address HIV and AIDS issues.”* Muzi elaborated: *“Culture does not prevent men from taking an HIV test. We all know that HIV kills, you can go to the clinic for HIV testing free of charge. So people hide behind culture.”*

On the other hand, Mandla believed that the need to go for HIV testing depended on the person’s willingness to perform the desired behaviour. He said: *“Culture has nothing to do with this, it all depends on what you want and think about yourself.”* This finding can be explained in terms of the TRA which posits that the intention to enact a particular behaviour is shaped by the person’s beliefs, attitudes and subjective norms (Van Dyk 2008).

As far as the role of dominant cultural beliefs about men and multiple sexual relationships was concerned, all ten men felt that cultural beliefs supported multiple sexual partnerships as a sign of virile manhood. The men recounted how the community reinforced this idea by talking about men who had multiple sexual partners as *“isoka”* (Casanovas).

One man said that cultural beliefs supported the notion of men’s uncontrollable sexual desire; three related it to peer pressure. The other three believed that it was prescribed

behaviour and two said that they needed to explore their sexual appetites with different women.

Tendani expressed the view that traditionally male sexuality was characterised as a dominant force and an uncontrollable urge. He said: *“Sex [for a man] is a desire that can never be satisfied. If a man has only one sexual partner then that woman will become his sex slave. So if your woman is tired, you go to another one who is sexually hungry and craving for it. She will give you a better service than the one who is tired at home.”*

Echoing some of the same ideas, Themba and Teboho told the researcher that having more than one sexual partner was culturally admissible as acceptable behaviour allowing men to have sex with other women when their usual/regular partner was ill or menstruating. The cultural regulations of sexual intercourse were associated with beliefs about the health status of sexual partners. For example, menstruating women, women who had recently terminated a pregnancy, and widows (for a period after their bereavement) were deemed “dangerous” sexual partners. Beyond these cultural regulations, Teboho regarded multiple sexual partnerships as a powerful signal of male superiority. He said: *“If a man has many sexual partners then he has more stock and it is a sign of being a real man.”*

Tami shared a similar view with Teboho and argued: *“It is well accepted as a black man to have many girlfriends as it was done by our forefathers they used to have five wives and five girlfriends outside their marriages even the parliamentarians have many girlfriends.”* Echoing some of the same ideas, Nkosana said: *“We as blacks, we are not supposed to have one partner, your menu must be different because you don’t eat meat every day. I am ‘isoka’”.*

The narrations from the above research participants concurred with the findings by Rohleder et al (2009) that male virility is often measured by the number of different sexual partners a man has.

Similarly, Walker, L, Reid, G & Cornell et al (2004) state that achieving masculinity is about commanding authority, and this may influence men to have multiple sexual partners and to have sex with other men.

Mzoxolo, Muzi and Sizwe attributed the pressure to having multiple sexual partners to culturally-determined peer pressure and to the pervasiveness of multiple sexual partnerships. Mzoxolo explained this as follows: *“We men turn to have many sexual partners because our friends will laugh at us and say you are ‘isishimane’ [one man’s woman]. Anyway, it does not help to only have one sexual partner because you never know what that partner is doing behind your back. So you may be exposed to HIV infection even with only one partner.”*

Sizwe argued: *“If you have only one partner then your peers will refuse to be friends with you and may exclude you in decision-making. They will say that you cannot suggest anything because you only have one woman.”* Muzi said: *“Culturally it is acceptable because I am Zulu. If I have one girlfriend then people will laugh at me and say why do you stick to one partner, don’t you get tired of eating chicken all the time?”*

These views can be understood in terms of the TRA which posits that normative beliefs play a central role in health decision making. The TRA focuses on the individual’s intention to perform a specific behaviour. The intention to enact a particular behaviour is shaped by the person’s beliefs, attitudes and subjective norms (Van Dyk 2008:122-123). Thabo added that the pull of cultural beliefs might be stronger for some men than others. He said: *“Even if we are encouraged to have one sexual partner only, what about a man who comes from the deep rural areas to Johannesburg? This man is more likely to strongly uphold cultural beliefs that encourage multiple sexual partnerships and thus infect others because he may not use a condom in every sexual encounter.”*

It should be noted that whereas Thabo and Mandla reported that they preferred to have only one sexual partner in order to avoid HIV infection, both of them acknowledged the strong influence of cultural beliefs on multiple sexual partnerships.

4.3.8 Views on dating younger girls

The researcher questioned the participants about their views on dating young girls. Eight participants were against this and argued that a man who dated young girls was “*not man enough*” and “*scared of challenges*”. Four men out of eight felt that a middle-aged man should not discuss personal matters or share ideas with young girls. Mandla said: “*Us men, we go for younger girls just for power and dominance. Imagine sharing your problems with young girls. No! We don’t do that.*” Teboho argued: “*I don’t believe in young girlfriends because being a sugar daddy means I must support you. We are not helping each other. It is one-way traffic. Mentally we are not helping each other with ideas. My mental capacity will overpower that girl.*” Themba said: “*It’s a fake love. If you go out with a young girl, that is not a real man. He is actually a fool.*” While Thabo mentioned: “*According to me, a man who goes for younger women is scared of a challenge.*”

Four participants, Mzoxolo, Tendani, Nkosana and Sizwe, perceived a man who dated young girls as being irresponsible or as having a low sexual drive. Mzoxolo argued: “*Dating a younger girl is a sign of irresponsible behaviour. This was reinforced by a myth that an HIV positive man will be cured from HIV infection when he has sex with a virgin.*” Tendani said: “*Men who date younger girls are not benefiting from that relationship because these young girls do not give anything in return except sex. Older men are expected to financially support these young girls. But older men are not as sexually active as younger men. Hence older men do not benefit from such relationships.*” Sizwe said: “*There is something wrong with a man who dates younger girls. Maybe he cannot sexually satisfy older women. Or he does not have sexual experience. That is why he will rather date young women.*” Nkosana saw a man who dated young girls as an immature man who refused to become an adult. He said: “*Those are men who like things and their dignity is lowered when they date young girls.*”

It was interesting to note how the men’s narrations about the problems connected to sexual liaisons between older men and young girls related more to the unmet emotional needs of men or possible imbalances in the transactional arrangements in such liaisons than about the risk posed to the young girls.

Attitude towards behaviour refers to the person’s attitude towards enacting a particular behaviour. People are more likely to perform a particular behaviour if they

have a positive attitude towards the specific behaviour and the belief that the enacted behaviour has more advantages than disadvantages (Van Dyk 2008:124) Subsequently, behaviour change is less likely to take place if the specific behaviour has more cost than benefits, especially if it interferes with traditional norms and beliefs about sexuality.

On the other hand, two men, Tami and Muzi considered a man who dated young girls as “*manlier*” than other men because “*it makes him feel young and in control.*” Tami said: “*I can say to my friends: ‘Yes, I satisfy her because I made her cry and wet.’*” Muzi argued: “*Younger ones are fit and beautiful. The older ones grow and become fat. So it makes us lazy to date them. So the younger ones have beautiful bodies and are not nagging like the older ones. It also makes you feel young when dating young girls.*”

4.3.9 Perceptions of condom use

The researcher posed questions about the participants’ attitudes towards and perceptions of condom use. Seven participants supported condom use. The reasons for their support included views on responsible behaviour, the possible sensual enjoyment of condoms and the general acceptability of openly asking for or buying condoms. For example, Teboho said: “*I have seen an improvement where people are no longer afraid to buy condoms from retail shops like Pick-n-Pay or Shoprite. Whether it is a lady in the till it does not matter - people still buy. A man who uses condoms is man enough.*”

Thabo argued: “*Men who use condoms are actually real men because they protect themselves and loved ones from contracting HIV infection.*”

Tendani and Muzi revealed that they used condoms for health reasons. Muzi said: “*I use condoms consistently because I do not want to be infected with HIV. I am aware of the danger of HIV and AIDS because I receive HIV testing and counselling every year.*”

In this regard, Swanepoel (2005:14) states that VCT provides the opportunity for counsellors to assist high-risk individuals to assess their levels of risk, develop realistic plans to reduce their risk and to increase safer sex practices. However, Muzi revealed to the researcher that preventative messages confused him.

Ross and Deverell (2004:214) maintain that the HBM has helped researchers in guiding the search for “why” these behaviours occur and to identify points for change. However, this model does not incorporate the influence of social and cultural norms on people’s decisions regarding their health behaviours and there is also no evidence that belief formation always precedes behavioural change (AIDSCAP 2004:2).

Muzi said: *“I was advised by a Brazilian doctor that I must first do foreplay before sex so that my partner is wet then the chances of HIV infection will be reduced because I shall have avoided dry sex. The doctor said foreplay prevents vaginal cuts and bruises that make people vulnerable to HIV infection.”* Muzi’s account indicates that beyond some knowledge of condom use, some men lacked further information about HIV prevention methods.

Tendani argued: *“Men think that when they use condoms they are not feeling a right thing when they have sex. But if you are concerned about your health status, then using condoms is not something that is degrading. But it’s about the mentality of ‘I want a real thing’. Others do not want to use condoms, because they want to prove their love.”* Tami said: *“Men must use condoms because there are different types for different sensations such as condoms for sensitive skins. Neon is the best condom because it feels natural when you have sex and entices your partner. It also makes the room smell good.”*

The researcher found (through further probing intended to establish whether this general positive acceptance of condom use translated into general use) that the men held different views. All seven men who were in favour of condom use mentioned that (according to their own perceptions) the majority of their friends did not like using condoms or ignored using condoms under certain circumstances. Mzoxolo, for example, said: *“My friends do not use condoms when they have sex with girls who are fat or have a light complexion because these girls are perceived to be HIV negative.”*

Mandla observed: *“Men stop using condoms when they have developed trust in their relationships.”* This “development of trust”, however, was an ill-defined feeling and not based on going for an HIV test before commencing with unprotected sexual intercourse.

Three men, Nkosana, Themba and Sizwe were against condom use because they felt that men who used condoms were “*less manly*” as condom use was not “*part of our culture.*” Themba said: “*I love sex and I was advised to have many children as a sign of being a real man so I will not achieve my goal if I use condoms.*” Sizwe argued: “*God said people must make children and fill the earth. Using a condom is like masturbating. According to Zulu culture a man who uses a condom is actually not a real man.*”

Nkosana reported that he tended to use a condom at the first sexual encounter with a partner but ignored condom use when he did “*not feel like it*”. He also mentioned that his regular sexual partner (the woman he shared a dwelling with) was pregnant with their third baby and this would not have been possible had he used a condom. When asked by the researcher whether he was not concerned about impregnating his other sexual partners as a result of his inconsistent condom use, he responded: “*If you do not feel sex because of condoms then just throw it away. If she gets pregnant then it is unfortunate. What can you do?*”

Redpath et al (2008) and Bowleg (2004) state that men with patriarchal views on gender roles and relations are more likely to have negative attitudes towards condom use and will use condoms less consistently. Attitude towards behaviour refers to the person’s attitude towards enacting a particular behaviour. People are more likely to perform a particular behaviour if they have a positive attitude towards the specific behaviour and the belief that the enacted behaviour has more advantages than disadvantages (Van Dyk 2008:124). The findings of this study thus tended to support those of these authors.

4.3.10 Perceptions of male circumcision

Seven participants agreed that circumcised men must still use condoms because they could still be infected with HIV. Given their general level of information about HIV and AIDS, the researcher found it surprising that so many of the men knew about the possible link between male circumcision and HIV-transmission. Mandla mentioned that he had witnessed that friends who had been circumcised still became infected with HIV.

Tami said: *“I heard that male circumcision only reduces the HIV risk by 60%. What happens to the other 40%? This means that people can still be infected if they do not practise safe sex.”* Mzoxolo argued that male circumcision was not a cure for HIV/AIDS although most men were uninformed about this fact. Thabo said: *“Circumcisions only reduce risk of becoming infected but does not make one immune to be infected.”* Teboho maintained: *“A condom is not a protective for AIDS. It is for cleanliness not to protect any disease from any man. The foreskin does not protect you from any disease even when you are circumcised. You will still be infected if you do not use a condom.”* Tendani argued that men should use condoms *“because circumcision is not a protective mechanism.”*

It was interesting to note that although Muzi still upheld cultural beliefs regarding male circumcision, he felt that it was still imperative that men use condoms. He said: *“I don’t know about male circumcision because I am a Zulu man and I am not circumcised but I think men must still use condoms even if they are circumcised because they may still be infected.”*

Three men, Nkosana, Sizwe and Themba, argued that circumcised men should not use condoms because they were protected against HIV infection. They attributed their insights to governmental messages that encouraged men to go for circumcision as protection against HIV infection. Nkosana said: *“I sometimes used condoms before I was circumcised. But I have completely stopped using condoms after circumcision.”*

Peltzer et al (2009:47) also reveal that circumcised black men are less likely to use condoms and utilise HCT services. The TRA may be perceived as similar to Bandura’s (1994:44) concept of self-efficacy that forms an integral part of a person’s ability to function independently regardless of external influences. Bandura (1994:2) defines self-efficacy as an individual’s beliefs in his or her ability to perform a particular behaviour under various conditions. This implies that middle-aged black men must be willing and self-motivated to go for circumcision as an entry point to behaviour change regardless of external influence.

Sizwe attributed his aversion to condom use to his cultural beliefs and reported: *“I have no idea about the relationship between male circumcision and HIV/AIDS because King Shaka Zulu did not want Zulu men to undergo male circumcision. I am*

not even interested in undergoing male circumcision or using condoms because they go against my cultural beliefs.”

4.3.11 Views on “the ideal middle-aged man”

The aim of asking participants to describe the characteristics of the “ideal” middle-aged black man was to gauge those traits ascribed to maleness that they valued. Seven of the ten men suggested that the ideal middle-aged man was responsible, mature, had a family or if still unmarried, was in a stable relationship. Apart from that, the ideal man was faithful to his spouse, considerate towards his children and aspired to be a good role model to other (especially younger) men. The researcher found it interesting that as many as seven of the participants described healthy sexual behaviours (such as being faithful to a spouse or partner) as ideal behaviour as this was contrary to many of the men’s responses about multiple sexual partners. It was also possible that they interpreted the question to imply that they should describe characteristics that were ideal and sensible, yet not necessarily achievable or desirable.

However, five of the seven participants Themba, Mzoxolo, Muzi, Sizwe and Mandla shared similar views on the ideal middle-aged man. They argued that middle-aged men must be well behaved, good role models to young men and loyal to their spouses or stable sexual partners.

“He must be a family man and must have kids and house if married. If not, he must have a stable partner and behave well because he is already old and matured.”
(Muzi)

“People are looking up to you who might be doing what you used to do so you can correct that by acting responsible and have a good conduct since you are now old. You must have your wife and children.” (Mzoxolo)

“They must be well behaved because he has grown up and matured so he must protect his children.” (Themba)

“He must be well behaved and be a good parent.” (Mandla)

Teboho shared views similar to those of the above-mentioned participants. However, he suggested: *“You must set your goals straight and know what you want and where*

you are going. You must have a property and family. You can have girlfriends if your conditions at home are not good.”

Three participants offered different views on the ideal man. Two of them, Tami and Nkosana described irresponsible sexual behaviour as the type of conduct befitting the ideal middle-aged black man. The third participant, Tendani, felt that there should not be prescriptions for the “ideal” man.

Tami said: *“A middle-aged man must be a go-getter, a late explorer and have sex with young girls so that he knows what it feels like to have sex with a 25 year old.”*

Nkosana said: *“A middle-aged man must live his life precariously and date many attractive young girls.”*

Tendani argued: *“There really is no specific criterion for how a middle-aged man should live his life. It depends on how one views life. He believes that a person must enjoy everything. If you are married, then have fun with your family and if single, have fun with friends and girlfriends.”*

4.3.12 Involvement in and intentions to become involved in HIV/AIDS programmes and campaigns

The researcher questioned the participants about their exposure to HIV and AIDS programmes and campaigns as middle-aged black men. Six participants confirmed that they had been involved in HIV/AIDS awareness campaigns. All six of these men felt that they had benefited from such involvement as they acquired new knowledge about the basic facts of HIV and AIDS. Two of the six, namely Tami and Teboho, were able to recall vivid details about the most recent HIV and AIDS awareness events in which they had participated.

Tami pointed out that he had participated in a fun run. He recalled how the theme of the event was *“practise safer sex”* and that it aimed at motivating people to go for HIV testing. He mentioned that it inspired him to go for HIV testing. Teboho reported that he had attended an HIV/AIDS awareness campaign that was initiated by NICRO in Heidelberg. He felt strongly that the campaign was of value to him because he learnt how to openly discuss sexual issues with his children and with learners at

school. He further mentioned that he also learnt how to use a condom as the campaign included a demonstration of condom use.

Four participants, namely, Muzi, Nkosana, Sizwe and Themba, stated that they had never been involved in HIV and AIDS programmes or campaigns. The reasons for this ranged from active avoidance of such campaigns to restricted exposure. Muzi explained that his exposure to HIV and AIDS was restricted to the information he received whenever he went for routine HIV testing every year. This finding was similar to the findings of Tersbol et al (2006) that successful approaches to male-oriented intervention programmes in certain social contexts have been lacking and have resulted in the social and symbolic exclusion of men.

Themba said: *“I have never been involved in HIV and AIDS programmes because I don’t think that I have AIDS, maybe I will be interested in such programmes the day I get sick of AIDS.”*

Themba’s account suggested that he was either in fear control or had a low HIV risk perception. This also explained the reason for Themba’s uncertainty about his HIV risk perception as discussed in 4.3.5.

Nkosana and Sizwe said that the reason for their non-involvement in HIV and AIDS awareness campaigns was that they were not really interested in HIV and AIDS issues. This finding seemed to suggest that Nkosana and Muzi had a low HIV risk perception and tended to ignore health messages about HIV and AIDS. On closer inspection, however, it turned out that only Sizwe had a low HIV risk perception and that Nkosana felt fearful about his own status.

The researcher asked these two participants whether they would be willing to be involved in HIV and AIDS programmes and campaigns if they were given the opportunity to do so in the future. Only Nkosana said that he would continue avoiding HIV and AIDS programmes and campaigns because *“even when a person gives me an HIV and AIDS brochure or pamphlet, I just discard it. If I had it my way, I would not even listen to anything about HIV and AIDS because it really stresses me out.”* Sizwe was willing to become involved in the future if exposed to such an opportunity. Nkosana’s response could be explained in terms of Swanepoel’s (2005) conclusion

that HIV and AIDS can evoke high levels of fear in some individuals and that this may result in the active avoidance of exposure to HIV and AIDS messaging.

4.3.13 Strategies for becoming involved in HIV and AIDS programmes

The researcher wanted to know whether the participants ever considered ways of becoming involved in HIV and AIDS programmes. Nine of the men responded that the best way would be to volunteer their participation in locally organised HIV and AIDS programmes and campaigns. Many of them said that they had considered becoming informal educators in their community on the importance of behavioural change to prevent the spread of HIV infections. Muzi specifically mentioned that there was a need to conduct door-to-door campaigns so that men did not have to go to the clinic to obtain information. Thabo stated he would like to supply condoms at discos, taverns and night clubs because such venues presented opportunities for a high risk of HIV transmission owing to irresponsible alcohol consumption and risky sexual behaviours.

Tami reported that he would like to be involved by working with NGOs and by also targeting the patrons of bars and night clubs to discuss HIV and AIDS. He suggested: *“I would like to organise HIV and AIDS posters that can invite people living with HIV to be guest speakers at taverns. I will tell the NGOs that they must not only run HIV and AIDS campaigns during World AIDS day, but as often as possible.”*

“Let’s not hide HIV and AIDS issues. Let HIV and AIDS campaign be visible and not done only in December because this gives the impression that people only get infected with HIV in December during the festive season.”

4.4 RESULTS OF THE INTERVIEWS WITH THE KEY INFORMANTS

The data for this section was generated through face-to-face interviews with two HCT coordinators as key informants from Engender Health. To protect the key informants’ confidentiality, pseudonyms were allocated to each of them: namely, Bheki and Tshepo.

4.4.1 General background of the organisation

Engender Health is a Non-Governmental Organisation that aims to improve the health and well-being of people in the poorest communities by giving them information regarding sexual and reproductive health matters. It focuses on educating and informing the public about HCT, family planning, and gender-based violence, TB, STIs and Pap smears. In South Africa, Engender Health implements the Men as Partners (MAP) programme and provides a male-friendly mobile HCT service to disadvantaged communities with financial support from USAID/PEPFAR.

The key informants reported that they focused on men because they had noticed that more women than men were actively involved in their HIV and AIDS campaigns and in accessing their services. Their primary goal was to get more men involved in their HIV and AIDS programmes.

4.4.2 Themes emerging from the analysis of the interviews with the key informants

Analysis of the audio recorded transcripts of the two key informants' interviews uncovered the following themes:

- Perceptions of the typical characteristics of middle-aged black men accessing HCT services
- Key informants' perceptions of the knowledge of HCT and of the sources of information for HIV/AIDS of middle-aged black men
- Key informants' opinions of the attitudes and perceptions of men about HIV testing
- Key informants' views of men's risk perceptions
- Key informants' perceptions of barriers and challenges with regard to men's utilisation of HCT
- Key informants' perceptions of the role of cultural and religious beliefs in men's HCT utilisation
- Key informants' perceptions of men's attitudes towards circumcision and condom use
- Key informants' views of proxy testing
- Key informants' perceptions of programmes aimed at men
- Key informants' views of the role of income and education in HCT uptake

- Organisational statistics and HCT motivational factors
- Organisational HIV/AIDS prevention programmes and strategies
- Suggested strategies to improve HCT uptake

Each one of these themes is discussed in greater detail below.

4.4.2.1 Perceptions of the typical characteristics of middle-aged black men accessing HCT services

The two key informants mentioned that about one in four middle-aged men accessed their services. The majority of these male clients had low educational attainments and most of them were single. Only a small percentage of married middle-aged black men came forward for HIV testing and the informants suggested that such men usually claimed that their spouses insisted on their attending. This concurs with the findings as discussed in section 4.3.3 in which the male participants argued that they might present themselves for HIV testing if their partners allowed them to do so.

According to UNAIDS (1999), normative beliefs play a central role in the theory and generally focus on what an individual believes other people, especially influential people, expect him or her to do. The Theory of Reasoned Action (TRA) is conceptually similar and adds the constructs of behavioural intention as a determinant of health behaviour (UNAIDS 1999:7).

The TRA focuses on the individual's intention to perform a specific behaviour. The intention to enact a particular behaviour is shaped by the person's beliefs, attitude and subjective norm (Van Dyk 2008: 122-123). The researcher briefly explained attitude towards behaviour and subjective norms as major tenets of this theory

4.4.2.2 Key informants' perceptions of the knowledge of HCT and of the sources of information for HIV/AIDS of middle-aged black men

The two key informants were of the opinion that the majority of middle-aged black men did not have adequate knowledge of HIV and AIDS. They argued that most middle-aged men claimed to have such knowledge, but that when for example given a dildo to demonstrate the use of condoms, it became evident that they lacked practical

knowledge in this regard. They were of the opinion that the level of HIV knowledge was related to the socio-economic status of the men as they had perceived that men of middle to high levels of educational attainment were better informed about HIV and AIDS issues. This finding is contrary to the above research finding in section 4.3.2 because the researcher discovered that the participants who had previously gone for HIV testing were better informed about HIV and AIDS. This may be due to the fact that these participants were exposed to HIV counselling and testing sessions regardless of their educational attainment.

The key informants told the researcher that middle-aged black men preferred one-on-one contact sessions, HCT mobile services, information given to them at church or at the taxi rank as sources of information about HIV and AIDS. They also mentioned that middle-aged black men preferred to be given pamphlets that were written in the vernacular instead of in English. The knowledge of HIV/AIDS and HCT displayed by the study participants agrees with the Health Belief Model (HBM) which attempts to explain and predict health behaviours by focusing on the role of perceptions in determining the attitudes and beliefs of the individuals. According to Munro et al (2007:6), a person's health-related behaviour depends on his or her susceptibility to that illness, the benefits of taking a preventive action and the barriers to taking action. The men seemed to feel susceptible to HIV and so they somehow retained the information they had about HIV/AIDS and HCT and thus they were fairly well-informed

4.4.2.3 Key informants' opinions of the attitudes and perceptions of men about HIV testing

The key informants were requested to provide their opinions about middle-aged men's perceptions of HIV testing. They told the researcher that in their view, the majority of middle-aged black men did not access their HCT services for routine HIV testing. When such men accessed HCT services they did so for personal reasons such as that they had cheated, were drunk, had unprotected sex or no longer trusted their sexual partners.

This finding is similar to the TRA which focuses on the individual's intention to perform a specific behaviour. The intention to enact a particular behaviour is shaped by the person's beliefs, attitude and subjective norm (Van Dyk 2008:122-123). The

researcher briefly explained attitude towards behaviour and subjective norms as major tenets of this theory as it was discovered that seven participants had gone for HIV testing because they were either sick or suspected that their sexual partners were unfaithful to them. The key informants told the researcher that some men would drink excessively before accessing their services to have the courage to take an HIV test.

4.4.2.4 Key informants' views of men's risk perceptions

On the issue of middle-aged black men's HIV risk perceptions, the two key informants expressed different points of view. Tshepo argued: *"Middle-aged black men are aware that they are at risk of HIV infection because of their unsafe sexual behaviours."* On the other hand, Bheki argued that middle-aged black men usually had a low HIV risk perception. He said: *"When we conduct a door-to-door HIV campaign, middle-aged men usually say that they are too old and that the messages are therefore not meant for them. Or else the men would say that have had multiple sexual partners in the past, but that they currently are faithful to only one sexual partner or marriage partner and hence they cannot be infected with HIV."*

Tshepo's account of men's perceptions was similar to the cumulative risk associated with increased HIV-related sexual behaviour. This might imply that middle-aged black men who had multiple unsafe sexual partners might be at high risk of HIV infection and might be regarded as a high and vulnerable risk group.

Familial and community level risk factors might negatively affect HIV-related sexual behaviours thereby increasing the spread of HIV infection in a particular community and family. The researcher assumed that men's significant others and community members who did not advocate HIV testing might contribute to middle-aged black men's reluctance to go for an HIV test. Newman (1999) further states that this model may offer a viable method for incorporating social contextual factors in research on HIV-related sexual behaviours.

4.4.2.5 Key informants' perceptions of barriers and challenges with regard to men's utilisation of HCT

It is interesting to note that most of the barriers or challenges with regard to men's utilisation of HCT services as identified by the two key informants were service-related factors.

These factors included the paucity of male staff; perceptions of the professional conduct of staff; the lack of male-focused reproductive health messages; the draw of traditional healers; long queues and inconvenient clinic hours; and the stigma attached to the clinic. This finding concurs with the TRA which posits that the intention to enact a particular behaviour is shaped by the person's beliefs, attitude and subjective norm (Van Dyk 2008).

The two key informants argued that most middle-aged men did not want to visit HCT services because such services were usually offered by female personnel. Moreover, staff was often perceived as unprofessional or as insensitive to the needs of male clients. They further mentioned that owing to the lack of male-focused reproductive health messages, many middle-aged black men perceived themselves to be too old and mature to be at risk of HIV infection. They also reported that in their experience, many middle-aged men preferred to consult traditional healers for health and especially reproductive or sexual health problems. Based on this, Engender Health involves traditional healers in their HIV and AIDS programmes and campaigns.

4.4.2.6 Key informants' perceptions of the role of cultural beliefs in men's HCT utilisation

Both the key informants felt that cultural and religious beliefs had a negative impact on middle-aged black men's HCT uptake.

They justified this perception by referring to two issues: namely, cultural perceptions of male sexuality and a strong affinity to traditional medicine. The key informants argued that societal expectations that mark multiple sexual conquests as a sign of virility and masculinity fuelled the behaviour of many men. They told the researcher about many cases of middle-aged men that were referred to them by traditional healers. They felt that traditional healers were the first port of call for men in search of reproductive or sexual health services and that men trusted and believed in the services of traditional healers to a much greater extent than in Western biomedical services.

These findings are similar to those of the TRA which posits that the intention to enact a particular behaviour is shaped by the person's beliefs, attitude and subjective norm (Van Dyk 2008) as the male participants argued that they were expected to model the sexual behaviours of their forefathers who had multiple sexual partners. They also reported that they had been taught to consult traditional healers to treat any illnesses.

Other than in the interviews with the ten male participants, the two key informants mentioned religious beliefs as also influencing middle-aged black men's poor HCT uptake. They mentioned that some Christian churches discouraged their members from using condoms as this was associated with promiscuity regardless of one's HIV status. Tshepo added: *"HIV positive people sometimes stop taking ARVs because their priest has prayed for their healing. Some churches claim that they can cure AIDS by simply giving their members a special tea to drink."*

4.4.2.7 Key informants' perceptions of men's attitudes towards circumcision and condom use

The two key informants argued that the majority of middle-aged black men underwent male circumcision for cultural reasons and not specifically to limit the transmission of HIV. Tshepo said: *"You will hear them saying they must go to mountains to do male circumcision as part of their cultural practices and not to prevent STIs."*

The two key informants added that some men believed that male circumcision enhanced sexual performance. They also argued that a circumcised man found condoms more challenging than an uncircumcised man since condom use decreased sexual pleasure. Moreover, they also mentioned that some men were not aware that male circumcision reduced the risk of HIV infection.

The above findings should be contrasted with the findings of the TRA as well as with those perceived by Bandura's (1994) concept of self-efficacy that forms an integral part of a person's ability to function independently regardless of external influences. Bandura (1994:2) defines self-efficacy as an individual's beliefs in his or her ability to perform a particular behaviour under various conditions. This implies that middle-aged black men must be willing and self-motivated to go for circumcision as an entry point to behaviour change regardless of external influence.

It was reported that only two participants felt that circumcised men should not use condoms because they were already protected against HIV infection. Seven participants mentioned that circumcised men must still use condoms to minimise the risk of HIV infection. It would thus seem that the men showed greater awareness of the link between male circumcision and HIV protection than what the key informants believed. As only one of the ten male participants reported that his culture did not allow men to undergo male circumcision, it could be that the service providers (such as the two key informants) held untested views of what men actually knew, thought and felt about male circumcision. It is possible that strong anti-circumcision views existed that were informed by cultural or even political views, or that circumcision was falsely held to be a male cure for HIV infection.

The key informants provided additional information on men's perceptions of condom use. For example, they argued that middle-aged men did not know how to store and use condoms safely. They mentioned that many men who used condoms used Vaseline as a lubricant.

Bheki said: *“Some men tell me that it is not fair that they must use condoms with their stable sexual partners because they support them financially and want to establish a strong sexual bond with their partners.”* Tshepo responded: *“Middle-aged men would say that they cannot use condoms with their long-term sexual partners, because they trust them although they have not gone for an HIV test.”* These findings were similar to those reported in section 4.3.9 where seven participants mentioned that they stopped using condoms when they had developed trust in their relationships.

4.4.2. 8 Key informants' views of proxy testing

The key informants argued that the majority of men were not aware of sero-discordant couples because they were under the impression that if their sexual partners had tested HIV negative then they were also HIV negative.

They stated that those who presented themselves for HIV couple testing only got to know about discordant couples on site. They reported having witnessed how, when one partner had tested HIV positive and the other one negative, fights would ensue in which blame would be directed at the positive partner and in which there would be threat of divorce or abandonment.

According to UNAIDS (1999), normative beliefs play a central role in the theory and generally focus on what an individual believes other people, especially influential people, expect him or her to do. The Theory of Reasoned Action (TRA) is conceptually similar and adds the constructs of behavioural intention as a determinant of health behaviour (UNAIDS 1999:7).

The TRA focuses on the individual's intention to perform a specific behaviour. The intention to enact a particular behaviour is shaped by the person's beliefs, attitude and subjective norm (Van Dyk 2008: 122-123). It is reported that one participant argued that he did not see the need to present himself for HIV testing because his wife and baby had tested HIV negative. Therefore, he assumed that he was also HIV negative.

4.4.2.9 Key informants' perceptions of programmes aimed at men

The two key informants admitted that their HIV and AIDS programmes and campaigns had not focused on middle-aged men specifically. As noted above, the Social Ecology Model correlates with the HBM and the TRA because it takes into consideration the individual's risk perception and the influence of subjective norms in behaviour change. They mentioned that their HIV and AIDS programmes and campaigns tended to focus on the youth and women since they were perceived as the most vulnerable groups for HIV infection.

4.4.2.10 Key informants' views of the role of income and education in HCT uptake

The key informants opined that educated middle-aged men who earned high salaries did not come forward for HIV testing as they preferred to access private medical health services. In addition Tshepo argued: *“Educated and wealthy men are reluctant to go for HIV testing because they date young girls and buy commercial sex resulting in their high HIV risk exposure.”* Bheki said: *“The educated ones come to us just to challenge our HCT procedures and check if we know what we are doing, it is like they are quality assuring our HCT process. They also claim to have all the information about the basics of HIV and AIDS already, but when I interview them then I realise that they actually lack in-depth information.”*

4.4.2.11 Organisational statistics and HCT motivational factors

Despite the researcher allowing the two key informants the time and opportunity to verify their organisational statistics on client profiles, the two interviewees gave different figures regarding the organisational statistics of the middle-aged black men's HCT uptake. Tshepo said that 40% of their monthly clients were middle-aged black men, whereas Bheki said that 20% of their monthly clients were middle-aged black men, but that such figures tended to fluctuate in response to the effectiveness of their monthly HIV and AIDS campaigns.

It seemed to the researcher that this discrepancy could be attributed to lack of standardised metrics for the monthly monitoring and evaluation of the effectiveness of these campaigns. Both key informants, however, felt dissatisfied with these statistics and blamed poor awareness of the MAP programme.

The use of this model might assist HIV programme developers in alleviating the overemphasis on individual factors as the main determinants of health behaviour change. Middle-aged black men's sexual and health-seeking behaviours might be best understood with the social contextual factors that possibly govern particular behaviours.

Responding to the interview questions on the type of organisational strategies that could motivate more men to access their services, the two key informants mentioned that the HIV counselling sessions should be shortened. They felt that the duration of HCT sessions might be one of the factors that influenced poor uptake of HCT services. This finding is similar to Grizzel's contention (2007:10) that social contextual factors such as culture, familial support and institutional factors provide a crucial framework for understanding an individual's risk behaviour. The latter has already been dealt with in the above literature review as factors that may prevent middle-aged black men from utilising HIV testing services. It is imperative that social contextual influences on behaviour be considered so that HIV prevention programmes yield positive results.

The Social Ecological model enabled the researcher to identify possible challenges in the social factors that served as barriers for middle-aged black men to utilise HCT services. Social ecology of middle-aged black men was considered and formed the basis of the researcher's recommendations for HIV prevention strategies that might

increase HCT uptake services by middle-aged black men. One participant argued that the HCT process was time-consuming.

Another strategy mentioned by the two key informants was to emphasise the guarantees of confidentiality offered by their services.

They felt that this could be a matter that would attract more men to their services as they had heard from clients who were middle-aged black men that they distrusted the primary health care workers at public clinics and suspected that they would disclose their HIV status to other community members. Bheki said: *“We work with men from Soweto, Sedibeng and the Free State. They come here because we do not know them personally because we do not live there. We are based in Braamfontein.”* In this regard, the Social Ecological Model enabled the researcher to identify possible challenges in the social factors that served as barriers for middle-aged black men to utilise HCT services. The social ecology of middle-aged black men was considered and formed the basis of the researcher’s recommendations for HIV prevention strategies that might increase HCT uptake by middle-aged black men.

The use of this model might assist HIV programme developers in alleviating the overemphasis on individual factors as the main determinants of health behaviour change. Middle-aged black men’s sexual and health-seeking behaviours might be best understood with the social contextual factors that possibly govern a particular behaviour.

4.4.2.12 Organisational HIV/AIDS prevention programmes and strategies

The researcher asked the two key informants to list the Engender Health HIV and AIDS programme that specifically targeted middle-aged black men. They mentioned that the MAP or “men as partners programme” was their flagship as it targeted men from different socio-economic levels and ethnic backgrounds. They maintained that the programme was structured in such a way that it catered for the needs of different types of men. They also mentioned that they engaged the “Induna” (traditional community leaders) and priests to be part of their programmes so that they could advocate HIV and AIDS awareness and prevention to their members.

Furthermore, they mentioned that the organisation’s door-to-door campaigns and the involvement of NGOs lent greater strength to their HIV and AIDS prevention

campaigns. This finding was similar to the research finding in section 4.3.13 where the majority of the participants suggested that door-to-door HIV campaigns must be intensified as an alternative to the utilisation of the clinic HCT services. In addition, The Theory of Reasoned Action (TRA) is conceptually similar but adds the constructs of behavioural intention as a determinant of health behaviour (UNAIDS 1999:7).

The TRA focuses on the individual's intention to perform a specific behaviour. The intention to enact a particular behaviour is shaped by the person's beliefs, attitude and subjective norm (Van Dyk 2008:122-123). The researcher briefly explained attitude towards behaviour and subjective norms as a major tenet of this theory. Participants also mentioned that they usually consulted traditional healers instead of utilising HCT centres.

4.4.2.13 Suggested strategies to improve HCT uptake

The two key informants suggested additional HIV and AIDS campaigns such as the use of cars with loud speakers to encourage men to go for HIV testing. They argued that the organisation had previously employed the latter and that this had yielded increased HCT uptake. Bheki said: *“The car with a loud speaker remains our most powerful HCT campaign because it plays music that makes the campaign appear to be a kind of educational entertainment. We found that people initially went to the HCT mobiles only to listen to the music, and then end up presenting themselves for HIV testing.”*

Tshepo responded: *“We have partnered with local NGOs who undertake door-to-door campaigns targeting men to do HIV testing and this makes it convenient for us to speak directly to men. But Engender Health needs to intensify its existing HIV and AIDS strategies by targeting factories or other workplaces that employ lots of men. It has always been a challenge for us to target these workplaces as the management say that we interfere with the production system.”* This finding indicated the lack of commitment and partnership among stakeholders to mitigate the spread of HIV infection in South Africa. Attitude towards behaviour refers to the person's attitude towards enacting a particular behaviour. People are more likely to perform a particular behaviour if they have a positive attitude towards the specific behaviour and the belief that the enacted behaviour has more advantages than disadvantages (Van Dyk 2008:124). Middle-aged black men must believe that utilising HCT services is

advantageous in terms of reducing the risk of infection and accessing early medical intervention if already infected.

On the other hand, Ross and Deverell (2004:203) recommend that researchers should determine and influence intentions so that behaviour becomes easy to predict and manipulate. Behaviour change is less likely to take place if the specific behaviour has more cost than benefits, especially if it interferes with traditional norms and beliefs about sexuality. This tenet enabled the researcher to establish middle-aged black men's attitudes and beliefs about HCT utilisation in order to determine their intention to go for an HIV test before assessing the beliefs of their subjective norms.

A specific concern of both the key informants was the shortage of trained personnel to undertake community outreach programmes and to target men in such strategies. Tshepo argued; *“a decline in HIV prevalence of one age segment or gender group in the population must not result in the increased HIV incidence of other segments or groups.”*

4.5 CONCLUSION

Based on the analysis and interpretation of the participants' perceptions of HIV testing, it is clear from the research findings that social factors influenced poor HCT uptake by middle-aged black men. It was evident from the study that stigma and discrimination and cultural factors largely contributed to poor HCT uptake. The research findings also revealed that the majority of middle-aged black men had high HIV risk perceptions and yet behaviour change was still a challenge. Therefore, knowledge of HIV/AIDS is a critical factor that influences middle-aged black men in Ratanda with regard to testing for HIV/AIDS. It can also be concluded that the majority of middle-aged black men in Ratanda have used health facility testing and counselling models but they would prefer testing sites to be generally accessible and within reach of workplace and residential areas.

The latter could be attributed to socio-cultural factors and lack of HIV and AIDS behavioural interventions methods. Thus, the study postulated that there was a link between social factors and poor HCT uptake of services by middle-aged black men. In the next chapter (chapter 5), the researcher discusses the summary of the findings

based on the objectives of the study. Furthermore, general conclusions and recommendations for policy and programmes are provided.

CHAPTER 5

FINDINGS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In chapter 4 the researcher reported on the findings. As explained in chapter 1, the purpose of this study was to explore the social contextual factors influencing poor HCT uptake services by middle-aged black men in Ratanda (Heidelberg). In order to find answers to the research questions stated in chapter 1, the researcher used concepts and tenets from theories as discussed in chapter 2 and employed qualitative methods as described in chapter 3. This chapter is a summary of the findings in relation to the stated objectives, a review of the strengths and weaknesses of the study and recommendations based on the findings.

5.2 FINDINGS IN RESPECT OF OBJECTIVE 1

The first objective was to investigate middle-aged black men's knowledge of HIV and AIDS and of HCT services. Although all of the men were aware of the availability of HCT services, seven of them reported that they would not go for HIV testing because they feared a positive test result and that it would result in rejection by their loved ones or friends. Two of the men reported that they were not interested in accessing HCT services. For one of them the reason was that he perceived himself to be not at risk of HIV infection despite his involvement in multiple sexual partnerships. The other man indicated that he feared HIV and AIDS to such an extent that he rejected any health messages about the epidemic.

Three of the men told the researcher that it was customary to consult the services of traditional healers and to spurn Western health care including HCT services. The upholding of tradition by honouring the wisdom of traditional healers was regarded as a masculine duty.

This was supported by the views of the two key informants who confirmed that in their experience, black middle-aged men did not access HCT services because they preferred to consult traditional healers to treat opportunistic infections. Furthermore, the key informants reported that middle-aged black men did not go for HIV testing

because they tended to rely on the HIV test results of their female partners to test their own HIV status.

5.3 FINDINGS IN RESPECT OF OBJECTIVE 2

The second objective was to explore factors that might act as barriers to middle-aged black men's use of HCT services. This objective was achieved as the researcher was able to uncover many factors that acted as barriers to HCT utilisation. These factors included cultural beliefs; notions of masculinity; fear of stigma and discrimination; lack of adequate HIV information; and confusion about the role of male circumcision as a preventive method. Seven of the ten male participants reported that they feared a positive HIV test result because of their own risky sexual behaviour and inconsistent condom use. Furthermore eight men perceived themselves to be at high risk of HIV infection because of unsafe sexual practices. However, they did not show any intention of adapting to safer sexual behaviours owing to cultural beliefs and their own inculcated notions of masculinity. Three of the men held very strong traditional beliefs and showed negative attitudes towards condom use. In this regard Bowleg (2004) argues that black men who have more traditional masculine ideologies are more likely to have more sexual partners, have negative attitudes towards condom use and be less consistent in their use of condoms.

With regard to male circumcision, seven men maintained that circumcised men must still use condoms as protection against HIV infection. In contrast the two key informants reported that the majority of their middle-aged male clients were ignorant about condom use and regarded male circumcision as sufficient protection against HIV infection. It could be that the service providers underestimated the level of accurate knowledge among the general population about male circumcision.

The researcher found it alarming that three decades into the HIV and AIDS pandemic, fear of stigma and discrimination still played such a powerful role in the men's talk about the barriers to HCT uptake. The men revealed how merely being seen at the HCT site would result in a person being labelled by others as HIV positive. The men also expressed concerns about the conduct of nurses and other staff at public health care facilities and suggested that the staff were inclined to disclose the status of individuals without their consent.

5.4 FINDINGS IN RESPECT OF OBJECTIVE 3

The third objective was to uncover challenges that men faced when utilising HCT services in Ratanda. This objective was achieved because the researcher found that fears of a breakdown in relationships or marriages; resistance to lifestyles changes; self-blame; inculcated views of masculinity; inconvenient clinic times; and long queues were important challenges for men. One man reported that the very act of testing could appear to be a confession that the man had been sexually unfaithful and this might cause unnecessary conflict in a marriage or a relationship. Some of the men saw HIV infection as a death sentence that would cause men to stop enjoying sex.

Three men reported that clinic times were unsuitable for employed men and that the queues at the clinic were too long. One man regarded the lengthy duration of the counselling process as off-putting as it was time-consuming. One key informant suggested that the fact that HCT services were usually provided by female personnel posed a challenge for middle-aged men to visit HCT services.

5.5 FINDINGS IN RESPECT OF OBJECTIVE 4

The fourth objective was to investigate ways to encourage middle-aged black men to utilise HCT services in Ratanda. In this regard nine participants mentioned that they would like to be involved in HIV and AIDS programmes and campaigns if given adequate information. The two key informants reported that men preferred to visit HCT mobile units for HIV testing.

In this regard, USAID (2009) suggests that it is vital that HIV education be adjusted for different segments of the population with an emphasis on outreach and face-to-face communication. Some of the research participants declared a keenness to take active roles in HIV and AIDS campaigns in their communities. They suggested strategies such as supplying condoms to taverns and night clubs or partnering with local NGOs and FBO to conduct HIV and AIDS campaigns.

5.6 STRENGTHS OF THE STUDY

The study employed a qualitative approach that enabled the researcher to discover how difficult it was to speak for others, but at the same time how rich data could be uncovered through less structured means. The interview schedules allowed the researcher to use probes and rephrase the questions to find answers to the research questions. This level of depth could not have been attained in a quantitative survey.

5.7 WEAKNESSES OF THE STUDY

The researcher identified the following limitations:

5.7.1 Limitations related to the chosen study site

The study was conducted in the community of Ratanda (Heidelberg) and was therefore, context-specific. The findings of the study should not be generalized to other sites in South Africa without great circumspection.

5.7.2 Limitations presented by the sampling technique and the sample size

The study used purposive and snowball sampling techniques to recruit participants for the investigation. The researcher might have missed some data-rich individuals in the process. Moreover, the information obtained might not be representative of all middle-aged black men in Ratanda. This might also be the case because of the small sample size and the fact that the researcher requested the participants to recruit their friends or acquaintances who might therefore have shared similar characteristics, views and behaviours.

5.8 SUGGESTIONS FOR FURTHER RESEARCH

This study highlighted that social contextual factors influenced poor HCT uptake services by middle-aged black men. The researcher proposed that further studies be undertaken in the following areas:

1. A comprehensive study of the influence of religious beliefs as part of the social contextual factors that may prevent middle-aged black men from utilising HCT services

2. Research on ways to scale up male involvement in HIV and AIDS programmes and campaigns
3. A formative assessment of needs-driven, male-friendly HCT campaigns and programmes

5.9 RECOMMENDATIONS

In addressing the above findings, the following recommendations can be made to the following people for policy and programme purposes:

5.9.1 Recommendations for possible HIV and AIDS interventions in Ratanda

Public health care workers in Ratanda should work with local NGOs and FBOs in mobilising community members to participate in HIV and AIDS prevention campaigns and programmes. HCT sites should be integrated with other consultation services to minimise the impact of stigma and discrimination.

Efforts should be made to establish a local men's forum to discuss and reflect on cultural practices that expose men and their families to the risk of HIV infection. Furthermore, men should be given the opportunity to be at the forefront of HIV and AIDS prevention programmes and campaigns so that they can take ownership of such health messages. This may enable men to discover their own fears and vulnerability to HIV and AIDS. Creating forums for men to share, discuss and agree on action may be an effective way to alleviate fears of HIV testing. HCT coordinators and staff should create supportive peer structures to educate men about risky sexual behaviours and ways to take actions that promote healthy behaviours. Traditional healers should be regarded as important stakeholders in this regard. Furthermore, male-friendly HCT sites that are administered by trained male HCT coordinators and lay counsellors must be established. Greater dissemination of information about the availability of HCT services offered by NGOs and FBOs is recommended.

5.9.2 Recommendations for changes at the national level

At the national level it is recommended that long-term goals that are aimed at creating a movement of men who support HIV and AIDS programmes and campaigns must be established in South Africa. Programme developers at national level must ensure that all stakeholders involved in long-term HIV and AIDS strategic planning must also be

involved in monitoring and evaluating the effectiveness of HIV and AIDS programmes and campaigns.

Lastly, programme and policy developers at national level should adopt a multi-sectored approach to HIV and AIDS interventions so that clear and well-defined goals are put in place to educate not only unemployed men in communities but also those that are currently employed. This will also ensure that NGOs also access men in the workplace to conduct HIV and AIDS campaigns. Furthermore, the latter requires advocacy, continuous education and capacity building workshops to place men in a better position to reduce risky sexual behaviours.

5.9.3 Recommendations at the provincial level

At provincial level, it is recommended that intervention programmes be tailored to the specific risk factors of a community and these programmes be accessible to everyone. Provinces should implement HIV and AIDS intervention programmes and campaigns that are theory-based so that they become relevant to the needs of communities and middle-aged black men in particular (Swanepoel 2005).

HIV and AIDS programme developers should also make efforts to identify and address the drivers of stigma and discrimination in different communities. Furthermore, government should remove environmental constraints by scaling up male-friendly testing facilities and clinics. Finally, men as partners in the national fight against HIV and AIDS should be involved in confronting those beliefs and notions of masculinity that put men at risk of HIV infection.

5.10 CONCLUSION

The study explored the social contextual factors influencing HCT uptake by middle-aged black men. All participants in the study reported that social contextual factors such as stigma and discrimination, masculinity and socio-cultural factors largely contributed to their reluctance to utilise HCT services. Participants further reported that they did not have the necessary HIV/AIDS knowledge for adopting healthy sexual behaviours coupled with the fact that HCT sites were not male friendly and were highly stigmatising.

The findings of this study showed that some middle-aged black men did not perceive themselves to be at risk of HIV infection hence they were reluctant to go for HIV testing. On the other hand, those who had a high HIV risk perception reported that they would not adopt safer sexual practices owing to cultural beliefs and peer pressure influences.

The researcher concluded his study with an understanding gained from both the perceptions and experiences of the participants and the results of other researchers (Seeley *et al* (2004) that state that a black man's behaviour is shaped and influenced by social issues such as masculinity and culture and economic factors that define what it means to be a man. This study was an attempt to successfully address the aforementioned social issues that seem to be central to poor HCT uptake by middle-aged black men.

The researcher in agreement with previous research would like to advocate that a range of contextual variables at the interpersonal, communal and societal level be framed and determined by the specific cultural and socio-economic contexts of a specific target audience (Swanepoel 2005). It is thus imperative that HIV policy and programme developers at all levels take into consideration the social and environmental factors that influence middle-aged men's decisions whether or not to present themselves for HIV testing.

The findings should then be used to design HIV and AIDS intervention programmes and campaigns that would specifically increase the HCT uptake of middle-aged men.

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APPENDIX A: UNISA ETHICAL APPROVAL

Department of Sociology
College of Human Sciences

2013/MASBS/08/Student
2013/MASBS/08/Staff

17 October 2013

Proposed Title: An investigation into social contextual factors discouraging middle-aged men age (30-58 years) to attend HIV Counselling and Testing (HCT) in Ratanda Location, South Africa.

Principle investigator: Mageto FG (Student number 45970203)

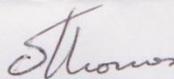
Reviewed and processed as: Class approval (see paragraph 10.7 of the Unisa Guidelines for Ethics Review).
Approval status recommended by reviewers: Approved

The Higher Degrees Committee of the Department of Sociology in the College of Human Sciences at the University of South Africa has reviewed the proposal and considers the methodological, technical and ethical aspects of the proposal to be appropriate to the tasks proposed. Approval is hereby granted for the candidate to proceed with the study in strict accordance with the approved proposal and the ethics policy of the University of South Africa.

In addition, the candidate should heed the following guidelines,

- To complete and sign a Supervisor-Student Agreement form, which is a code of conduct guiding the research process,
- To start the research study only after obtaining the necessary Informed Consent,
- To carry out your research according to good research practices and in an ethical manner,
- To maintain the confidentiality of all data collected from or about research participants, and maintain safe procedures for the protection of privacy and when storing such data,
- To work in close collaboration with the assigned Supervisor and to ensure the way in which the ethical guidelines as suggested in the reviewed proposal has been implemented in your research,
- To notify the Committee immediately in writing if any change/s is proposed to the study and await approval before proceeding with the proposed change,
- To immediately notify the Committee in writing if any adverse event occurs.

Regards,



01/11/13

Dr. Chris Thomas
Chair: Department of Sociology
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APPENDIX C: CONSENT FORM

INFORMED CONSENT FORM

My name is Mageto Fred Gichana and I am currently completing a Master's degree in Social Behaviour Studies in HIV/AIDS at the University of South Africa (UNISA). As a requirement for the degree, I plan to investigate the social contextual factors influencing poor uptake of HCT services by middle-aged African men (30 – 58 years) in Ratanda (Heidelberg). You will be requested to respond to questions about your experience and knowledge with regard to HTC services in Ratanda. The interview will last one hour.

Your participation is voluntary and you will not be penalised in any way should you decide not to participate. Your kind cooperation will enable me to gather scientific data that will assist in making recommendations to increase HTC uptake by middle-aged African men in Ratanda. This is therefore an urgent appeal to you to please participate. Let me assure you about the extent of your participation.

I will not ask for your name during the interview and this will ensure confidentiality. Everything you discuss during the interview will be kept confidential; please feel free to answer the questions as honestly as possible without fear that someone will know what you said. You will be requested to sign the consent form and it will be kept separate from the interview schedule in a locked safe and destroyed three years after the study has been completed.

1. Please note that you can opt out or you can refrain from participation at any time if you feel that you do not want to be part of the study any more. If, however, you agree to be part of the study, the interviewer will discuss a possible date and time for the interview and ask you to sign this document in two copies: one will remain with you and the other one will be kept by the interviewer.

I have read and understood this consent form, and I agree to participate in this study.

Participant's signature:

Interviewer's name

Signature

Signature

Date

Date

APPENDIX D: INTERVIEW SCHEDULE

Dear participant

I am currently completing my Master's degree in Social Behaviour Studies in HIV/AIDS at the University of South Africa (UNISA). The purpose of the study is to investigate social factors contributing to poor uptake of HIV Counselling and Testing (HCT) among middle-aged black men (30 – 58 years) in Ratanda. Please allow me to use a tape recorder so that all responses are correctly captured during the interview process.

1. How old are you?
2. What is your highest level of education?
3. Are you currently employed?
 - 3.1 If YES – what is your occupation?
 - 3.2 If NO – how long have you been unemployed?
4. What is your ethnic group?
5. What is your religion?
6. Are you currently married?
 - 6.1 If YES, are you in a monogamous or a polygamous union? Do you have girlfriend(s) or other sexual partners beside your wife/wives?
 - 6.2 If NO, are you single, living with a female partner, dating, divorced, separated or a widower?
7. Do you currently have more than one sexual partner? Please tell me more.
8. What are HIV and AIDS?
9. Have you ever heard of HIV Counselling and Testing (HCT)?
10. Where would you go for information about HCT in Ratanda?
11. Have you ever gone for HCT services?

- 11.1 If YES, where did you use HTC?
- 11.2 If YES, what was the last date on which you used HTC?
- 11.3 if YES, why did you go for an HIV test?
- 11.4 If NO, why have you never used HTC?
- 11.5 If NO, would you consider going for HTC some time in the future? Why do you say so?
- 11.6 What would make you change your mind and go for HTC?
12. In general, what challenges would a man of your age encounter should he want to use HCT services in Ratanda?
- 12.1 Probe: Access problems (transport, clinic times, etc.)
- 12.2 Probe: Fear of testing positive; fear of stigma if seen at the clinic
- 12.3 Probe: Information problems (do not know how or where to test)
13. In your opinion, what kind of a man would use HTC? Why do you say so?
14. What in your opinion are the consequences for men who use HCT services? (Probe: benefits, risks, peer pressure, pressure from sexual partners)
15. Do you regard yourself as at risk of HIV infection? Why or why not?
16. I want you to compare men in the age group 30 to 58 with younger males. In your opinion, are men in the 30+ age groups at greater risk than younger men for HIV infection? Why do you say so?
17. In your opinion, do cultural beliefs hinder men's uptake of HCT? Why do you say so?
18. What are the dominant cultural beliefs about men having more than one sexual partner? Why do you say so?
19. Do you think that people would think that a man who has many sexual partners is more manly than a man who has only one partner? Why do you say so?

20. Do you think that people would think that a man who goes for HCT is less of a man? Why do you say so?
21. Do you think that people would think that a man who has a young girlfriend (sugar daddy) is more manly than other men? Why do you say so?
22. Do you think that men who use condoms are regarded as less manly? Why do you say so?
23. Do you think a man who has been circumcised must still use a condom? Why do you say so?
24. What, in your opinion, are the characteristics of an ideal 35+ man today?
25. Have you ever been exposed to programmes or campaigns about HIV, AIDS or HTC? Please tell me about them. (Probe: Dates, focus, where accessed, value, etc.)
26. Is it possible for you to personally get involved in HIV prevention campaigns in Ratanda? If not, why?
27. If possible, how would you get involved?

APPENDIX E: KEY INFORMANT INTERVIEW SCHEDULE

Dear participant

I am currently completing my Master's degree in Social Behaviour Studies in HIV/AIDS at the University of South Africa (UNISA). The purpose of the research project is to investigate the social contextual factors influencing poor uptake of HIV Counselling and Testing (HCT) services by middle-aged black men (30 – 58) in Ratanda.

I have selected you as my key informant, because your organisation focuses mainly on men as partners in HIV and AIDS prevention and because you coordinate HCT services in your organisation. Please note that participation is voluntary and anonymous. Your name will not be recorded anywhere and cannot be attached to any of your responses. All information provided will be treated confidentially. Please allow me to use a tape recorder so that all responses are correctly captured during the interview process.

Date: October

Time:

1. What kind of HIV/AIDS activities does your organisation offer?
2. Why are men the focus?
3. In your own perception, do middle-aged (30 – 58 years) black men have adequate knowledge of HIV/AIDS? Why do you say so?
4. Do middle-aged black men face different challenges in terms of accessing HTC as compared to other target groups? Please elaborate.
5. In your opinion, what are middle-aged black men's preferred sources of information about HIV/AIDS?
6. Do you see many middle-aged men accessing your organisation's services?

7. Can you tell me from your monthly statistics what the actual percentages of clients are that represent middle-aged black men in terms of monthly HTC uptake in your organisation?

7.1. Are you satisfied with the figure?

7.2 What in your opinion motivates these men to utilise your services?

7.3. What can be done to increase these men's use of your services?

8. Do middle-aged men talk to you about the challenges they encounter in utilising other HTC services? What are they?

9. Could you give me stats on the educational level and marital status of the middle-aged men who use your services?

10. In your opinion, how do middle-aged black men view HIV testing?

10.1. If positive, what could be the reasons?

10.2. If negative, why is this so?

11. In your opinion, do middle-aged black men accurately assess their own HIV/AIDS risks? Why do you say so?

12. Would you say that traditional cultural notions of masculinity influence HCT uptake by middle-aged black men? Why do you say so?

13? Do concurrent multiple sexual relationships influence poor HCT uptake by middle-aged black men?

14.1 If yes, why?

14.2 If no, why not?

14. What, in your opinion, are middle-aged black men's perceptions of male circumcision?

15.1 Do they regard male circumcision as an HIV/AIDS double defensive strategy?

5.2 Is it only done for cultural reasons?

- 15.3 Do they still use condoms after male circumcision?
15. How do income and education influence HCT uptake by middle-aged black men?
16. What in your opinion are middle-aged black men's perceptions of proxy testing?
- 17.1 Do you think that they are adequately aware of sero-discordant couples?
17. What, in your experience, are middle-aged black men's attitudes toward condom use?
- 18.1. If positive, what are the reasons?
- 18.2 If negative, what are the reasons?
18. Which HIV/AIDS intervention programmes and strategies do you have in place to motivate middle-aged black men to utilise your services?
19. What is your opinion regarding the HTC provided to middle-aged black men by your organisation?
- 19.1 Suggested improvements?
- 19.2 Other comments

Thank you very much for your assistance!