

**AN INVESTIGATION INTO SOCIAL FACTORS
INFLUENCING POOR UPTAKE OF HIV COUNSELLING
AND TESTING (HCT) SERVICES BY MIDDLE-AGED
BLACK MEN (35- 49 YEARS OF AGE) IN PIMVILLE,
SOWETO**

by

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DECLARATION

I, N. S Mdunge, (student no: 44243367), declare that ***AN INVESTIGATION INTO SOCIAL FACTORS INFLUENCING POOR UPTAKE OF HIV TESTING AND COUNSELLING (HTC) SERVICES BY MIDDLE-AGED BLACK MEN (35- TO 49-YEARS) IN PIMVILLE, SOWETO*** 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

(NS MDUNGE)

30 NOVEMBER2011

DATE

SUMMARY

This study investigated the social factors influencing the poor uptake of HIV Testing and Counselling (HCT) services by middle-aged black men in Pimville, Soweto. A qualitative research approach was used for this study 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, male circumcision, and challenges in using HCT services. Various social behaviour change theories formed the theoretical framework guiding this study. It was found that fear, stigma and cultural factors are major reasons for the poor HCT uptake. 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 Pimville are 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	Antiretrovirals
FBOs	Faith-based organisations
HBM	Health Belief Model
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
MAP	Men as Partners
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 TO THE RESEARCH PROBLEM

1.1 INTRODUCTION

South Africa reportedly has the highest HIV prevalence in the world, but 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 the unacceptable rate of 5,7 million in the global burden of HIV infection (Karim, Churchyard, Karim & Lawn 2009:921).

Karim *et al* (2009) further argue that heterosexual transmission is the dominant mode of HIV infection between adults in South Africa. The role of gender and power relations is usually not counted among the factors that could render HIV and AIDS prevention programmes ineffective, as well as contributing to the spread of the epidemic. The researcher argues that HIV intervention programmes have tended to focus on women and girls in mitigating the spread and impact of AIDS. Men's reproductive health needs have not received adequate attention (UNAIDS 2001:5).

Similarly, Swanepoel (2005:3) argues that HIV intervention programmes do not empower men, because they do not speak directly to the male audience. This lack of attention to a male audience reinforces the traditional views of male roles, resulting in minimal behavioural change in respect of HIV infection. It is therefore necessary to investigate men's roles in contributing to the spread of HIV infection.

This study has sought to explore the social factors that impede black men in the age group 35-49years from using HIV Counselling and Testing (HCT), previously known as Voluntary Counselling and Testing (VCT) in Pimville (Soweto).

HCT provides a framework within which HIV prevention and treatment can be understood. Individuals have the opportunity of knowing their HIV status in order to protect them against HIV infection if they are as yet free, and to access early medical intervention if they are already infected (Tlou 2009:20).

The researcher's interest in the topic stems from the preliminary interviews she conducted with the Engender Health HCT coordinators. The interviews revealed that black women are more inclined to use HCT services than are middle-aged black men. Similar conclusions were drawn by Bourne, Bourne and Francis (2010:3). In addition, Levack, Raletsemo, Budaza, Hugoplan and Gonzales (2006:2) found 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. There is thus a need for a thorough investigation of relevant gender issues which have been overlooked and which impede the effectiveness of HIV prevention strategies (Mouch 2001:6).

Evidence suggests that South African middle-aged black 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). A review of available studies also suggests that a great deal of local research has been carried out 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.

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 use HCT services. In support of this view, Govender (2010:5) maintains 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 using HCT. As noted above, reducing the transmission of HIV may be largely dependent on male involvement in HIV programmes and campaigns, because they are often the primary decision-makers when it comes to health-seeking behaviours. In addition, with the male condom still being the main barrier method of preventing sexual transmission of the HI-virus, male buy-in to prevention is a top priority.

Other studies indicate that not only are HIV and AIDS medical issues, but they are also largely influenced by social issues like 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 might prevent middle-aged black men from using HCT services.

1.2 THE RESEARCH PROBLEM

HCT is based on the principle that clients who have been tested and are HIV negative should receive counselling so that they can maintain their HIV negative status and those who test HIV positive should be helped to obtain proper clinical care (Meiberg, Bos, Onya & Schaalma 2008:49). HCT services are available free of charge at ten sites in Pimville, some of which are administered by nongovernmental (NGOs) and faith-based organisations (FBOs). It has also been discovered that Soweto has low HIV testing rates, especially among men with lower socio-economic status (SAFAIDS 2011:8).

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

In corroboration of the above view, Swanepoel (2005:8) states that middle-aged men may not use HCT services if they do not show symptoms of HIV and AIDS or if they attribute HIV and AIDS symptoms to other illnesses or part of the aging process. The above research findings thus 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 Pimville. Middle-aged black men may thus be more inclined than younger men would be to uphold traditional gender role expectations.

Consequently, views on what it means to be a black man may make it unlikely that they would use HCT services. Seeley, Griller and Barnett (2004:95) maintain that a black man's behaviour is shaped and influenced by social issues such as masculinity, culture and economic factors, which 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, so they might unintentionally infect their female partners. The *Household's Survey Results* by the United Nations General Assembly Special Session (UNGASS 2010:39) revealed that black men between the ages of 25 and 49 are at the greatest risk of HIV infection in South Africa. Furthermore, UNGASS found that 38% of men surveyed had never used HCT services. At least some of the reasons that contribute to this problem must be investigated.

The research problem driving this study is:

What are the social factors that influence the low uptake of HCT services by middle-aged black men (35-49 years of age) in Pimville?

1.3 OBJECTIVES OF THE STUDY

The research question stated above which gave rise to the research objectives guiding this study are:

1. to investigate middle-aged black men's knowledge of HIV/AIDS and HCT services;
2. to explore factors that may act as barriers to middle-aged black men's use of HCT services;
3. to expose the challenges that men face when using HCT services in Pimville;
4. to investigate ways of encouraging middle-aged black men to use the HCT services in Pimville.

1.4 RESEARCH QUESTIONS

To facilitate gathering the information that will contribute towards understanding the social factors that prevent middle-aged black men from using HCT services in Pimville, the following research questions must be answered:

1. What do middle-aged black men know about HIV/AIDS and HCT?
2. What are the nature and types of social factors that contribute to middle-aged black men's reluctance to use HCT services?
3. What social challenges do they face in using HCT services in Pimville?
4. What can be done to motivate middle-aged black men to use HCT services in Pimville?

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 will be discussed in Chapter 2.

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 any need for verification. This research study is based on the assumption that most middle-aged black men are reluctant to use HCT services and might not realise their possible contribution to the spread of the HIV infection. It is also assumed that middle-aged black men may not perceive themselves to be at risk of HIV infection.

The researcher also assumes that current HIV prevention programmes and campaigns are not appropriately designed to cater for the needs of middle-aged black men. The researcher further assumes that middle-aged black men might have multiple sexual partners owing to societal expectations of what it means to be a black man. The need to fulfil the gender role expectations is also assumed.

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, as most HIV intervention programmes do not adequately address the benefits of male involvement in HIV prevention-programmes. This contradicts the fact that middle-aged black men need adequate information on the importance of using HCT in order to protect themselves and their sexual partners against 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. The results of the study will also help NGOs, FBOs and the Pimville 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 practices, 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 - those that are client-initiated and those that are provider-initiated (National Department of Health 2009:9). The shift from VCT to HCT was initiated by the South African government in April 2011 in 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 if they do not show HIV and AIDS opportunistic infections relative to VCT.

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

1.7.3 Social factors influencing male uptake of HCT

Social 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

Differentiating between social and cultural factors may be artificial, but under the rubric of socio-cultural factors the researcher includes cultural norms and values that define what it means to be a man or woman in a particular society (Kleintjies 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 are individuals of the male gender who are involved in a heterosexual relationship. For the purposes of the study, it refers to the age range of 35- 49years.

1.7.6 HCT use

In this study HCT use refers to people who make use of HCT services so that they know their HIV status (Peacock *et al* 2008:16).

1.8 THE CHOSEN STUDY SITE

The study was conducted in Pimville because the researcher resides in the area and has observed that the majority of middle-aged black men still uphold traditional beliefs about masculinity.

The researcher is known in the area because of her involvement in HIV and AIDS awareness campaigns conducted by faith-based organisations (FBOs).

Further, the researcher occasionally provides HIV care and counselling sessions for those who are infected and affected by HIV and AIDS.

1.9 THE CHOSEN RESEARCH APPROACH

To find answers to the stated objectives, the researcher opted for a qualitative approach using face-to-face interviews and non-participant observations as the primary data-generation tools. Face-to-face interviews based on a semi-structured interview schedule were conducted with Engender Health HCT coordinators. The Engender Health was used to recruit volunteer middle-aged black men who had never used HCT services in Pimville. Face-to-face interviews with the volunteers were conducted according to a semi-structured interview schedule.

Purposive and snowball sampling techniques were used to select the interviewees from among the volunteers. These techniques were chosen because it was not easy to recruit and identify middle-aged black men who had never gone for HIV testing. For this reason, the researcher had to select participants who were likely to be ‘information rich’ with respect to the researcher’s purpose for in-depth study. The participants were in turn requested to recruit their peers, with whom they shared similar characteristics. Further details on the chosen methodology are given in Chapter 3 of this dissertation.

1.10 ORGANISATION OF THE DISSERTATION

The dissertation is comprised of the following chapters:

Chapter 1: The problem and its setting: This is 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 factors that influence the poor uptake of HCT services by middle-aged black men: This chapter provides a discussion of relevant literature on the socio factors that influence HCT uptake by men. It details the social challenges that prevent men from using HCT services as well as the impact on the spread of HIV infections. As noted above, relevant theories such as TRA, Social Ecological theory and the HBM are discussed in terms of sensitising concepts that formed the theoretical framework guiding the study.

Chapter 3: Methodology: This chapter deals with the strategies that the researcher followed to gather data for answering the research questions. In addition, the research design used in the investigation of the research problem is discussed. Details are given of the ethical considerations for the study and of the data analysis strategies.

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

Chapter 5: Conclusion and recommendations: In this last chapter, the researcher summarises the findings and points out links to literature and the stated research objectives.

The strengths and limitations of the study are considered and recommendations are 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 2: 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 factors that influence poor uptake of HCT services by middle-aged black men. In this chapter, some general social challenges pertaining to 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 highest number of new infections in many African countries is comprised of older heterosexual couples, it has also been discovered that fewer men than women use HCT services (USAID 2009a:7). Furthermore, studies have shown that men experience the highest levels of HIV-infection in their late 30s and 40s (UNAIDS 2009a: 22-23). It is against this background that the researcher reviews literature to establish research findings on the social 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 using 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 use of HIV Voluntary Counselling and Testing in Soweto, Levack *et al* (2006:2) found that men usually rely on the HIV test results of their female partners as a test of their own HIV status. This is known as proxy testing.

The prevalence of proxy testing implies that there is a lack of knowledge about the existence of sero-discordant couples, i.e. couples in the same relationship but with different HIV status. This might give recalcitrant males a false sense of security, thinking that they may not be infected with HIV. They consequently discard their intention to use HCT services themselves. It is worth noting that the current international HIV prevention programmes focus on couple testing in an attempt to dispel this misconception. Nevertheless, the problem of low HCT uptake by middle-aged black men (USAID 2009a:5) persists.

According to Bunnel, Nassozi, Marum, Mubangizi, Malamba, Dillon, Kalule, Bahizi, Musoke and 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 presume their HIV status to be the same as their own.

Recent studies in Sub-Saharan countries with mature epidemics show that up to two thirds of infected couples are discordant and that high infection rates are largely due to heterosexual transmission (USAID 2009a:3). This means that greater awareness of the importance of HIV testing regardless of one's partner's HIV status has to be created. 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 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 for humans as they interact with their social world.

These values and beliefs may influence men and woman to behave and conform to societal expectations as far as what it means to be a man and woman in a particular culture is concerned. 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 use HCT services. Socio-cultural factors influence health-seeking behaviour, as well as other behaviour, such as adopting preventive health behaviour. In this regard, Taylor (cited in Woods 2008:54) found that Rwandan males avoided using condoms because of the belief that condoms “*block the gift of self*”. They believe that if there is no free flow of secretions between a man and woman fertility will be compromised and they will become ill. 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, 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. Some black Christians believe that HIV and AIDS are a 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 create a barrier against 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).

Another cultural dimension that influences black men's intentions to go for HIV testing is traditional socio-cultural constructions of masculinity and femininity, which are naturally stratified in a hierarchical order that confers greater decision-making freedom to males. Thus it may be considered 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 owing to 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 might 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 so far as to argue that black culture must be blamed for the vulnerability of men to HIV and AIDS, because the local epidemic is spread primarily by heterosexual sex, spurred on by men's negative attitudes to safer sexual practices.

Otaala (2003:134) states that, in Africa, sexual issues are traditionally not openly discussed between the sexes (even within marriage or among cohabitating partners). This might make it difficult for middle-aged black men to use HCT services, as HIV testing is associated with promiscuity and testing might require open communication between sexual partners.

Since open conversations between partners about reproductive health matters are not thought of 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 commonly accepted 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) found that whether they had paid *lobola* or not made no difference to husbands' tendencies to have extramarital sexual affairs. In fact, in African culture, it is usually acceptable for a married man to have such affairs.

Thus middle-aged black men who uphold cultural beliefs and norms are more likely to engage with multiple sexual partners regardless of their marital status. Research has found that women's low power in comparison with high male control in intimate relationships correlates 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 could inhibit or facilitate men's uptake of HCT services. The South African government supports male circumcision as one of the additional HIV prevention strategies. There is a huge billboard in Soweto advertising the male circumcision campaign, encouraging men to go for circumcision at the Zola clinic.

The rationale behind this is that more men should be exhorted to undergo male circumcision, following the realisation 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 could be a positive move, it could fuel the spread of the epidemic, as 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 to fulfil their cultural expectations and gender roles rather than for preventing HIV. 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) revealed that circumcised black men are less likely to use condoms or HCT services. Men usually believe that circumcision protects them from HIV infection and STIs. This could 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 hold on to the belief that they are “real men” after circumcision and have to prove their manhood by eschewing safer sexual practices. Connolly, Simbayi, Shanmugan and Nqeketo (2008:179) argue that in certain ethnic groups circumcised males are encouraged to engage in unprotected pre-marital sex for the sake of sexual exploration. It can be argued that male circumcision offers only partial protection for only the sero-negative men in those ethnic groups. Men who are already infected with HIV and their partners cannot be protected by circumcision.

Furthermore, male circumcision could make it even more difficult for women to negotiate safer sex because circumcised men might consistently refuse to use condoms as a double protective strategy. The Rakai Health Sciences Program (cited in the Meeting Report 2008:5) conducted a trial study of male circumcision and HIV positive men.

It was discovered that there were more infections among the female partners of circumcised men than among those of uncircumcised men.

The report also argued that male circumcision did not protect women against HIV infection and there was the possibility that women's vulnerability would increase if men insisted on resuming sex before their wounds had 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 have shown that economic factors have a strong influence on individual sexual behaviours, mostly through poverty and unemployment (UNAIDS 1999:11). 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. HIV testing is a low priority for these people, as they may fear a positive HIV test result.

The African continent and South Africa in particular, has a well-established history of male labour migration and circular migration among urban centres offering job opportunities and familial or spousal homes in rural areas. On account of their status, migrant men are likely to have casual sexual partners and possess limited knowledge of the importance of using HCT migrancy status. However, Camlin, Hosegood, Newell, McGrath and Bärnighausen (2010), in a study in KwaZulu-Natal, found that non-migrant women had a greater chance of becoming HIV-positive than male migrants and male non-migrants.

Camlin *et al* (2010:6) conclude that the high levels of mobility of both men and women may contribute to the consistently high HIV prevalence in the southern African region. Frequent migrants may be important links with geographically-spread sexual networks, while high female mobility may be an enabling factor in the greater inter-connectedness of sexual networks beyond those created

by male migrants alone. This is a potential contribution to the region's exceptionally high and sustained HIV prevalence. The greater the interconnectedness among sexual networks, the more quickly and widely HIV will circulate.

Cunha (2007) explains how transactional sex (not the same as commercial sex work) could limit South African's ability to make healthy decisions regarding HIV and AIDS. Transactional sex in this regard can be defined as sex that is predicated on actual or anticipated material gain as stated by Jewkes, Morrell, Sikweyiya and Penn-Kekana (2012). This may expose both men and women to the risk of HIV infection because they may not be in a position to negotiate safer sex. This being the case, 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 sexual relationship. In addition, they can possibly afford to pay for commercial sex (Engender Health 2010:10).

Commercial sex takes place when women and men pay for or sell sex for cash (Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow 2004:1588). Exchanging sexual favours for money (or any other forms of payments) commercial sex therefore excludes other types of benefits (such as partnership, protection, the promise of a stable relationship in the future) that are linked to transactional sex. Transactional sex, therefore, may take place in stable consensual relationships and serve as a strong motivation for people to get married. Furthermore, African men may be motivated to engage in such relationships so that they may fulfil traditional male gender norms of being providers. Dunkle *et al* (2004) further argues that in Sub-Saharan Africa gifts often forms an integral part of transactional sexual relationships. Commercial sex differs from transactional sex in that the former always involves the exchange of sex for material gain (USAID 2009b:3).

Tersbol (2006:405) offers a different point of view, 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 might make men vulnerable to the risk of HIV infection, since they might not be able to negotiate safer sex. Although cultural norms may prescribe that men should dictate the terms of sexual engagement regardless of their socio-economic status, men who do not possess economic means may fail to do so especially if they have sexual relationships with economically active women who do not want their male partners to use condoms. Furthermore, these men may not even consider having stable sexual partners because they may not foresee the possibility that they might offer their sexual partners financial and material stability. .Jewkes *et al* (2012) found that men believe that the realm of sexual relationships is governed by a cash economy. This implies that men with little or no money may mistrust the motivation and commitment of female sexual partners. These men are more likely to engage in transactional relationships with wealthy women.

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

Mbilinyi and Kaihula (cited in Baylies & Bujra 2000:84) argue that changes in gender relations have had a negative impact on men. These authors observed that women-traders who travel to distant urban centres to sell their goods might have unprotected sex with buyers who in turn might be infected with HIV. This suggests that although men are perceived to be the drivers of the epidemic, women (particularly women of a lower-socio-economic status) may contribute to the spread of the epidemic because they may engage in unsafe transactional sex with non-marital sexual partners. Halperin and Epstein (2007:22) state that women in Africa, especially poor women, may be compelled to rely on multiple partners for support and often have little power to negotiate with partners about the timing of sex or the use of condoms.

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 have shown that men have different ideas on how they express masculinity depending on their 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 contextual factors that may influence their expression of masculinity. Bowleg further argues that black men, particularly those with a low income, have constructed alternative versions of masculinity, which are characterised by sexual promiscuity, aggressiveness, violence and the denial of vulnerability. The researcher assumes that these men may have low level of education including poor knowledge of HIV prevention methods hence they are more likely to engage in unsafe sexual relationships and have low HIV/AIDS risk perception.

Gillespie, Kadiyala and Greener (2007:10) argue that although wealthy individuals are also at risk of HIV infection due to multiple sexual partners, they tend to be better educated with better knowledge of HIV prevention methods and are more likely to use condoms. Furthermore, the researcher has observed that men with little or no income tend to be less attractive to women. These men are more likely to sexually assault and rape women due to anger and frustration resulting from the inability to establish stable and healthy sexual relationships.

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 incomplete gender identity. Therefore, based on the above views, 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 use HCT services and adopt health-seeking behaviours. In turn, the latter manifests in a greater risk of HIV transmission and other health and social problems associated with sexual relationships and gender identity than those same related to 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. Thus 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 points suggest that the researcher has to focus on men’s perceptions relating to the notion of hegemonic masculinity because it encourages men to have multiple sexual partners as a way of asserting their masculinity in their particular 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”) at a particular time and place. Connell (cited in Skovdal *et al* 2011) argues that hegemonic masculinity prevents men from taking advantage of life-saving HIV services. Black men who uphold the notion of hegemonic masculinity may be at risk of HIV infection; this may be because of a refusal to use condoms and access health-care centres.

UNAIDS (2001:17) argues that norms of masculinity may make it difficult for men to plead ignorance about sexual matters of reproductive health. Most middle-aged black men in Pimville associate masculinity with having multiple sexual partners-“*isoka*” (Casanova). Rohleder, Swartz, Kalichman and Simbayi (2009:15) have found 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. Their endeavour to achieve a given masculinity (one dictating 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 could also deter men who have tested HIV positive from accessing early medical intervention as it might be perceived as a sign of weakness. Skovdal *et al* (2011:6-7) states that men perceive themselves as physically strong, tough, analytical and able to endure “a little illness”. Because HIV infection is seen as a sign of weakness men might not use services provided by the HTC.

2.2.6 Social institutional factors

Factors operating at the level of institutions like health-care facilities can also influence men’s reluctance to use HCT services. It was observed by the researcher when visiting the Pimville Clinic and the local FBOs’ HCT services to observe how HIV testing and counselling were administered. It was deduced from that observation that the available HCT services were not overly male-friendly as the staff and the lay counsellors were for the most part female.

The researcher also observed that HCT took a mere 10 minutes and individual counselling could not be accommodated owing to constraints in time and staff workload.

In this regard, the 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 have made similar observations. For instance, Levack *et al* (2006:28) discovered that the men in their study expressed fear that breaches of confidentiality may occur when HCT staff, particularly those at NGOs, fail to observe strict confidentiality protocols. In the study by Levack *et al* (2006), the men pointed out that many of these sites are staffed by people from their communities and expressed concern that some of the staff members would disclose their HIV status.

Birdsall, Hajjiannis, Nkosi and Parker (2004:24) argue that access to HCT services within the public sector is over-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 use them. Birdsall *et al* (2004) further argue that the lack of privacy, confidentiality and doubt about the accuracy of HIV results may further contribute to men’s reluctance to use the HCT services.

Those who use the services at public health care facilities usually have to travel long distances and have a long wait before being attended to. With this in mind, the Treatment Action Campaign (TAC 2011:2) conducted a door-to-door campaign in Khayelitsha about low HCT uptake by men. They concluded that most men are not keen to test for TB or HIV because of the long hours of waiting 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 use 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 has led to individual-level interventions. These interventions fail to consider the influence of the above-mentioned social factors in sexual behavioural change and men's reluctance to use HCT services.

It is the researcher's contention that HIV prevention programmes do not adequately address the needs of middle-age black men in terms of integrating cultural beliefs into 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 translates discursively 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. The writers maintain that such neglect often implies that men's poor uptake of health-services is explained as a matter 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 using HCT services if HIV prevention messages emphasise individual circumstances exclusively and neglect other challenging multiple factors that could be acting as barriers to HIV testing.

According to Nanin *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 Antiretrovirals (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, which do not target them specifically. To counter this, the 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 can be 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 personally-perceived value of a person's 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 the unfair treatment of an individual based on his or her real perceived HIV status.

Stigma and discrimination remain a central impediment to HIV prevention because fear of being labelled HIV positive may prevent people from using

HCT centres. The shame and embarrassment associated with HIV and AIDS come from their obvious link with sex and unsafe sex. Meiberg, *et al* (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 thought to carry a double stigma, that of being both a terminal illness and a sexually-transmitted disease. The researcher observed that, at the Pimville Clinic, the HCT centre is situated in the isolated far-right corner of the consultation rooms, giving the impression that HIV/AIDS are dangerous diseases so the consultation rooms should be isolated from others.

Levack *et al* (2006:13) contend that fear and stigma remain the greatest 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 for fear of discrimination by the community or their loved ones (Meiberg *et al* 2008:55). Van Dyk (2008:412) argues that secondary stigma has a serious impact on the quality of care given 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 might develop unhealthy attitudes about weight loss. For example, a widely-accepted belief in Pimville 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. This could also give middle-aged black men who have gained weight a false sense of security that they are not infected and they might not need to use the HCT services.

In addition to the above, stigma has a negative impact on male involvement in HIV prevention, care and support, because this might create the impression that they themselves are HIV positive (Ross & Deverell 2004).

The latter might be the reason why some middle-aged black men divorce their sexual partners once they have tested 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 use. Avert (2011: 3) argues that, despite the improved reach of HIV awareness campaigns, accurate knowledge about HIV and AIDS is still minimal. This could 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 how it spreads (Woods 2008: 60).

This 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 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 use HCT services becomes a challenge under these circumstances.

USAID (2009a) conducted a study on community perceptions of the risks and benefits of seeking Voluntary Counselling and Testing in China. It was discovered that it was difficult to persuade older men with low levels of education to go for HIV testing as they take the view that they are already old

and that death does not matter to them. The researcher can thus assume that the same perception may also be applicable to middle-aged black men in South Africa with low levels of education.

UNAIDS (2008) conducted a study on VCT uptake in rural South Africa 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 the decisions by men's partners to use HCT services. On the other hand, it is important for the researcher to acknowledge that adequate HIV knowledge does not always translate to behaviour change, but it may help reduce unsafe sexual behaviours and increasing HCT uptake. It is vital for HIV education to be adjusted for different segments of the high-risk group, with an emphasis on outreach and face-to-face communication (USAID 2009a:7).

2.2.10 Biomedical factors (Treatment as prevention)

Alcorn (2011:2) maintains 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 for sero-discordant couples who are planning a family, as well as reducing the risk of HIV infection. However, there are challenges. In the first place, it contradicts the HIV prevention campaigns on the importance of safer sexual behaviours. The researcher argues that treatment as a prevention campaign might indirectly promote unhealthy behavioural practices, especially if people are not well educated in understanding its implications. Secondly, HIV positive people who are on early treatment might stop practising safer sex on the pretext that they will not infect their sexual partners.

Furthermore, they could re-infect themselves with either the same or different HIV strains, owing to lack of in-depth knowledge of how treatment works as HIV prevention. It is also assumed that treatment as prevention might 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 to be put in place to minimise stigma and discrimination as the major impediments to HIV testing and adherence to treatment. Studies have shown that there is low HCT uptake in South Africa (UNAIDS 2009:25).

Thus people with early infection who remain untested remain undetected and highly infectious, making the effects of treatment less profound (Alcorn 2011:3).

2.3 THEORETICAL FRAMEWORKS

The Health Belief Model (HBM), the theory of Reasoned Action (TRA) and the Social Ecological model were adopted as the theoretical frameworks 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 for the researcher to consider both the individual and the 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 the personal determinants of the behaviour.

Further, it is useful to see theories as a continuum of models moving from strictly individually-centred, the macro-level and the 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 their susceptibility to that illness, the benefits of taking 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 using HCT services.

Ross and Deverell (2004:214) maintain that the HBM has helped researchers in guiding the search for "why" these behaviours occur and identifying points for change. This model does not incorporate the influence of social and cultural norms on people's decisions on 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 and how they evaluate risk factors and their attitude to HCT use as a point of entry to understanding their low HCT uptake. The researcher assumes that middle-aged black men with a low HIV risk perception are less likely to use HCT services, as they might be under the impression that they will not be infected.

Swanepoel (2005:15) argues that a low risk perception is linked to the intention or otherwise of going 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) found 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, attitude and subjective norm (Van Dyk

2008: 122-123). The researcher will briefly explain attitudes to behaviour and subjective norms as major tenets of this theory.

2.3.2.1. Attitude towards behaviour

Attitude toward 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 using HCT services is more advantageous in terms of reducing the risk of infection and accessing early medical intervention if they are already infected.

On the other hand, behaviour change is less likely to take place if the specific behaviour costs more than it benefits, especially if it interferes with traditional norms and beliefs about sexuality. This realisation enabled the researcher to first establish the attitude and belief of middle-aged black men when it came to HCT use, in order to determine their intention to go for an HIV test before assessing their subjective norms.

The researcher assumes that middle-aged black men who have a negative attitude towards HCT services and believe that they offer more disadvantages than advantages are less likely to use the services. It was imperative that the researcher establish middle-aged black men's attitudes to and beliefs about HCT use in order to assess their 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 the Bandura's (1994) concept of self-efficacy, which 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/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 their significant other's beliefs and perceptions on 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 the individual or discouraging them from enacting a specific behaviour played an important role in understanding how middle-aged black men conform to the norms and beliefs of the subjective norms.

The researcher used this in establishing the perceptions and beliefs in the frame of reference of middle-aged black men about the use of HCT. The subjective norm of negative belief and attitude towards HIV testing may negatively influence an individual's willingness to use HCT services. The beliefs endemic to the subjective norm are perceived to be some of the social 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/her to do. The intention to go for an HIV test may depend largely on the middle-aged black men's subjective norms, because conservative middle-aged black men are more likely to uphold collective decisions 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 use.

Munro *et al* (2007:8) state that the 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 for understanding behaviour change at an individual level and enhanced the researcher's perspectives on some of the social contextual factors that had a negative impact on HCT uptake. The TRA was therefore used as a guideline to conduct a baseline risk assessment in investigating the social factors that contributed to the problem statement.

2.3.3 The Social Ecology 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 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 for exploring the social factors that may serve as barriers to the use of HCT. 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 the individual level relating 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 ability to do so. The social ecological model acknowledges the importance of the interplay between the individual and the environment and the influence they have 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 individual risk behaviour. The latter has already been dealt with above as factors that may prevent middle-aged black men from using 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 the possible challenges in the social factors that served as barriers to the use of HCT services by middle-aged black men. The social ecology of middle-aged black men was therefore considered, and formed the basis of the researcher's recommendations on HIV prevention strategies that may increase HCT services uptake by middle-aged black men.

The use of this model might assist HIV programme developers in alleviating the overemphasis on the individual factors as the main determinant of health behaviour change. Middle-aged black men's sexual and health-seeking behaviours might be best understood along with the social contextual factors that may govern a particular behaviour. Tersbol (2006:406) argues that too little attention has been paid to the multiple factors that impact on people's lives and sexuality.

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 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 to effective HIV prevention programmes and middle-aged black men's reluctance to use 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 for the researcher to investigate multiple risk factors that may 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 would be 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 using 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 accumulate 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 might 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 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 assumes that men's significant other and community members who do not advocate HIV testing may 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.

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 perception, and guided the researcher to use more probes in order to gain insight into their HIV risk perception and comparing it with the HIV risk perception by 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 an individual's health to becoming a defining characteristic 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 in using HCT services. The motivation to act on HIV prevention programmes and campaigns may therefore be influenced by evidence of the community's social support system. The latter may play an important role in motivating middle-aged black men to use HCT services in Pimville. The researcher could argue that middle-aged black men who receive strong social support from their significant others and the community are more likely to use HCT services.

These men may also support and encourage others to go for an HIV test, thereby alleviating the 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 might 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 using local HCT services, so that middle-aged black men may also be motivated to go for an HIV test. The above theories were used as a framework in developing the research questions and objectives of the study. In addition, they were also be used to develop the interview guide as a data collection instrument of this study as well as guiding the research findings and conclusions.

2.4 CONCLUSION

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 factors influencing the poor uptake of HCT services by middle-aged black men.

It would be helpful to conduct an in-depth research study on the social factors that might serve as a barrier for middle-aged men black to use 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 like the HBM, TRA and Social Ecological Model were selected to guide the research study in investigating the social factors that influence the poor uptake of HCT services by middle-aged black men. Successful HIV prevention campaigns that target the needs of these men depend largely on the application of the theories discussed above. Further, 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 whilst 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 might put people at risk of HIV infection. This model was central to the research study, as it enabled the researcher to explore the social factors that served as barriers to HIV testing by looking at men's social profile, 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 3: METHODOLOGY

3.1 INTRODUCTION

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

3.2 THE CHOSEN RESEARCH ORIENTATION

The study has adopted a qualitative research orientation to investigate the social factors influencing poor uptake of HCT services by middle-aged black men in Pimville. 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 give to their everyday lives (De Vos *et al* 2009:270).

In addition, a qualitative orientation allowed the researcher to gain an in-depth understanding of the participants' HIV knowledge and perceptions of HCT use by means of the face-to-face semi-structured interviews. The research topic demanded an exploration and discovery of context-bound social factors that influence poor uptake of HCT services by middle-aged black men in Pimville. The researcher opted for a qualitative approach, as it enabled the exploration of different points of view and the emergence of different themes.

3.3 THE RESEARCH SITE

The study was conducted in Pimville which is located on the periphery of Soweto, a modernised urban township, south-west of Johannesburg.

The people of Pimville are predominantly black and the area is divided into seven sections known as (Zones). People in the area are a mixture of almost tribal groups found in South Africa. These groups comprises of Sesotho, IsiZulu, Tshivenda, Ndebele, IsiXhosa, Sepedi, Setswana and Swazi speaking people. However, the predominant ethnic group is IsiZulu speaking people because they occupy four sections in the area. Furthermore IsiZulu and IsiXhosa are common languages spoken in the area.

The majority of the household come from a low socio-economic status characterised by high rate of unemployment and low level of education. The majority of people in the area live in low cost houses, while some of the poor live in squatter camps. 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 incomplete gender identity. In addition, there are seven bars (township shebeens) that are frequently visited by the residents. This led to a high level of substance abuse. It has been observed by the researcher that there is a high level of mortality resulting from HIV and AIDS related symptoms.

Because of the researcher's familiarity with the site, it was a rational choice. As a resident in the area, she has observed how scores of middle-aged black men loiter in the local taverns and pubs and boast about their multiple sexual relationships. In addition, the researcher is familiar with the spoken language, as well as the cultural and religious beliefs of the population. This made it easier for her to obtain access to, and convenient for visiting the participants' homes to conduct interviews.

3.4 THE RESEARCH DESIGN

3.4.1 Sampling procedures

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 are resident in Pimville and were able to refer the researcher to three more men living in Pimville. Each of these men referred the researcher to other men in Pimville 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 35 and 49 years of age;
2. Participants must not have gone for HIV testing in the last two years;
3. They had to reside in Pimville for the duration of the study;
4. Only participants willing to voluntarily participate 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

Qualitative data gathering methods were used to collect information on the social factors influencing the poor uptake of HCT services by middle-aged black men.

Semi-structured interviews and the observations of non-participants' were used to gather information on the' beliefs and opinions of participants on the services provided by the HTC.

3.4.3 Pre-testing the data-gathering instruments

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. Firstly, it allowed the researcher to test certain aspects of the questions, enabling her to make modifications in the wording.

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

Thirdly, 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 question.

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

During the pre-testing interview session, it became apparent that men did not regard it strange to talk about their reproductive health issues with a woman, as they may not always be attended to by male nurses, doctors or counsellors

in a clinical setting. Lyons and Willott cited in Sloan, Gough and Conner (2010:789) suggest that the presence of a female researcher would facilitate men to talk about health issues since women have traditionally played a significant role in enabling men to confront physical and mental health problems. On the other hand, it is worth noting that due to gender differences, some men probably did not provide honest responses impacting negatively on the validity of the data collected.

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 Pimville Clinic. All the interviews lasted for an hour and were audio-taped and transcribed at the researcher's home after each interview.

The researcher went to great lengths to put 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 informants were both HCT coordinators whose duties at Engender Health focused on men as partners in the fight against HIV and AIDS.

3.4.5 Non-participant observation

Non-participant observation occurs when the researcher is not involved in the activities of the group, but remains a passive observer (Kumar 2005:120).

The advantage of non-participant observation is that it enables the researcher to observe the participants' facial expression, tone and language during the interview process. Although observations are not recorded in Chapter 4, non-participant observation was used to give the content of the transcriptions. The researcher used non-participant observation to make astute observations during her interviews in the ten participants' homes. Moreover, since the researcher is herself middle-aged and black, it created some common ground for establishing rapport with her interviewees. The researcher made extensive notes detailing the participants' anxiety and discomfort when responding to some of the questions in the interview schedule. These notes were taken up in a reflective account written after each interview.

3.4.6 Interview 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 could be achieved. The researcher was thoroughly conversant with the interview guide, which enabled her to pay attention to details during the interview process.

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

1. Involvement in multiple sexual partnerships;
2. Knowledge of HIV/ AIDS and HCT;
3. HCT use and perceptions by men who go for HIV testing;
4. Barriers and challenges in using HCT;

5. Risk perceptions and comparison of risk perception between older and younger men;
6. Perceived consequences of HIV testing;
7. Cultural beliefs regarding HCT use and multiple sexual partners;
8. Views on dating younger girls;
9. Perceptions of using condoms;
10. Perceptions of male circumcision;
11. Views on the ideal middle-aged black man;
12. 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 on HIV/AIDS;
4. Key informants' views on men's risk perceptions;
5. Key informants' perceptions of barriers and challenges to men's use of HCT;
6. Key informants' perception of the role of cultural beliefs in men's use of HCT;
7. Key informants' perception of men's attitudes towards circumcision and use of condoms;
8. Key informants' views on proxy-testing;
9. Key informants' perceptions of programmes aimed at men;
10. Key informants' views on 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 for improving HCT uptake.

3.5 ETHICAL CONSIDERATIONS

The rights of the participants in any research process are of immense importance. The participants' physical and emotional welfare and respect for their privacy were important considerations in this study. This means that all the participants should be debriefed, ensuring that the true reasons for the research are communicated to all participants (Mouton 2009:245; Hogg & Vaughan 2005:18). It is imperative that the researcher acknowledges and observes the latter, especially when dealing with sensitive issues such as HIV testing as part of a human rights issue.

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

3.5.1 The researcher's knowledge of ethics

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

3.5.2 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 Ethical Review Committee of Department of Sociology. Ethical clearance was granted by this Committee in October 2011 following a critical scrutiny of the research proposal and interview schedules.

3.5.2.1 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 to participate in the study (Gravetter & Forzano 2009: 108). Participants were requested to sign an informed consent form after the purpose and benefits of participating in the study were explained to them by the researcher. The researcher informed the participants of the estimated time it would take to complete the interview, how the results from the interview would be used and how to access 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 were told that they may choose not to answer certain questions (Babbie 2007: 63-64).

Before the participants signed the forms, the researcher asked each of them 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.

3.5.2.2 Risk 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. Given this, the interview schedule was pre-tested. In addition, the researcher conducted a brief debriefing session for those participants who told her of their fear 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 to such services.

3.5.2.3 Confidentiality

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

3.6 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).

1. *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.
2. *Sampling sufficiency*: research participants who best represented the inclusion criteria and who were sources of rich data were recruited.
3. *Developing a dynamic relationship between sampling, collecting and analysing data concurrently*: The researcher was mindful of safeguarding the credibility of her data through concurrent data collection and analysis.
4. *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).

3.7 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 themes emerging from 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 transcribed data. The researcher created separate word files for each theme and pasted the narrations into 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 whereby data was revisited for information relevant to the major themes and a central code was identified. This final set of themes was sent to the supervisor for her guidance and approval.

3.8 CONCLUSION

In this chapter the researcher discussed the research methodology used in this study. Details of the chosen research design, sampling procedure, data collection procedure, reliability and validity, data analysis and ethical considerations were given. In Chapter 4 the analysis of the data is presented, along with a discussion of the research results.

CHAPTER 4: 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 confidentiality for the participants, a pseudonym has been allocated to each participant: 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 the main themes. This is followed by background information on the key informants and a presentation of the findings that emerged from the analysis of the interviews.

4.2 CHARACTERISTICS OF PARTICIPANTS

The ten participants were middle-aged black men from diverse ethnic backgrounds and socio-economic status. All of these men were involved in intimate heterosexual relationships and were residents of Pimville. Although the intended age range was from 35, the youngest male participant to be recruited was 37 years of age as shown in Table 4.1 (below).

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 disclose their incomes, she deduced that four out of ten participants belonged in the middle to high income category, as 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 has been working for a newspaper for the past 15 years in a low-ranking job. Table 4.1 shows that the respondents' educational background ranged from Grade 3 to university.

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 were isiXhosa-speaking, one spoke Sesotho sa Leboa (Sepedi), one spoke Tshivenda and one IsiNdebele. Nine of the participants allied themselves with the Christian religion and one was a practising Muslim.

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	49	Ndebele	Employed	BA (Hons)	Married
Mzoxolo	36	Xhosa	Unemployed	Std 8/ Grade 10	Single
Muzi	40	Zulu	Unemployed	Grade 11	Single
Nkosana	42	Xhosa	Unemployed	Grade 12	Single
Teboho	43	Pedi	Employed	Laureates(Technology)	Married
Themba	46	Zulu	Employed	Std 1/ Grade 3	Married

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, along with some of the sub-themes:

1. Involvement in multiple sexual partnerships;
2. Knowledge of HIV/AIDS and HCT;
3. HCT use and perceptions of men who go for HIV testing;
4. Barriers and challenges in using HCT consisting on the following sub-themes;
 - I. Fear of positive results and of rejection;
 - II. Stigmatisation 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 use and multiple sexual partnerships;
- 8. Views on dating young girls;
- 9. Perceptions of using condoms;
- 10. Perceptions of male circumcision;
- 11. Views on the “ideal of the middle-aged men”;
- 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 six of the men were reportedly in committed relationships (five reportedly in monogamous marriages and one in a committed cohabiting relationship), eight participants reported that they were involved in multiple sexual relationships at the time of the interviews. Only two 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. Nkosana, for instance, 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 that *“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 had been involved in multiple sexual relationships as a sign of manhood and that they were merely following examples set for them on 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 that: *“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 appetite. 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, explained 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 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 finds resonance in 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, attitude and subjective norms. These men show the desire to be involved in multiple sexual partnerships because they either feel the need to enact the behaviour or they are influenced by their friends regardless of the risks involved in having multiple sexual partnerships.

4.3.2 HIV/AIDS knowledge and HCT

Nine of the research participants displayed sound general knowledge of HIV and AIDS. Only one (Themba) admitted to knowing absolutely nothing other than the fact that *“AIDS kills”*.

Themba’s low level of education relative to that of the other participants might 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 spontaneously name modes of HIV transmission. Unprotected sexual intercourse with many different partners was mentioned as a mode of transmission by all the 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 that *“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 admitted that this was the reason why he always practised safer sex. He disclosed to the researcher that he had received intensive HIV/AIDS awareness training when serving a prison sentence for 15 years. This finding suggests that men who have received adequate HIV education are more likely to have a low risk of HIV infection. UNAIDS (2008) found that each additional year of educational attainment reduces the risk of HIV infection by 7%.

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

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 views similar to Sizwe’s, 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 to questions about the availability of HCT services in Pimville. On this point, Swanepoel (2005) reports on studies that have found that public HIV testing campaigns may result in the 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 Soweto. However, he said that he was not aware of the availability of HCT services in Pimville. When asked to name places in Soweto where he had looked for HCT sites, he could not give an answer. 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.”*

4.3.3 HCT use 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 on their preferred sources of information. Muzi mentioned that he preferred door-to-door HIV campaigns such as those usually held on 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 as superior to that offered by public health care services. Tami's perception about poor services rendered by public clinics suggests that these clinics may also serve as a barrier for men to go for HIV testing and adopt health seeking behaviour. 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 said that they had previously gone for HIV testing in the last 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 response was that they would consider it only when they or any of their sexual partners started showing HIV-related symptoms. This finding is similar to Swanepoel's argument that middle-aged men may not use HCT services if they do not show symptoms of HIV and AIDS(2005:8).The three men who admitted that they had never gone for HIV testing said that they avoided it because they were afraid of getting a positive result.

Nkosana intimated that he was afraid 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 afraid of being tested, argued that he did not have to undertake an HIV test because his wife was tested during her last pregnancy and was negative. His newborn baby boy was also HIV negative and, for Teboho, that implied that he was also HIV negative. Levack *et al* (2005) found 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 have gone for testing in the past) answered that they respected a man who goes 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 go for HIV testing as real men who want to know their HIV status and plan for their future. Mzoxolo said: *“Every man needs to go for HIV testing, it is for your own benefit that you go”*. While Tendani argued that: *“If you want to take care of yourself and family then you will go for HIV testing.”* Thabo elaborated that: *“A man who is health-conscious will go for an HIV test because knowing your status is the first step to becoming health-conscious.”* This finding suggests that HIV/AIDS pre and post counselling process are somehow effective because all the men who had gone for HIV testing seem to comprehend the importance of HIV testing

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, Lewin, Swart & Volmink 2007).

The three who had never gone for testing, Themba, Sizwe and Mandla, all expressed negative opinions of men who do so. They regarded men like that as “less manly”, arguing that is 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 conflicts, at least for some men, with locally-held versions of manhood.

The above finding is similar to those by the World Bank (cited in Skovdal *et al* 2011), highlighting that a common perception among men in Sub-Saharan Africa is that a real man does not fall ill. Such perceptions may therefore prevent certain men from accessing HCT services. However, seven out of the ten male participants in this study were able to conquer these perceptions and did go for testing.

On the other hand, Sizwe and Mandla said that a man could go for an HIV test because he was forced to do so by his sexual partner on grounds of 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.”* 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, would expect him/her to do.

4.3.4 Barriers and challenges in using HCT

The researcher asked questions about perceived problems faced by middle-aged men should they use HCT services in Pimville. Four sub-themes emerged: fear of positive results and of rejection, stigmatisation 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 and that these act as the major barrier to using HCT. Upon probing, the researcher discovered that it was not the fear of a positive test-result *per se* 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 that: *“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 explained that: *“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 found that males are often more concerned than females that disclosure of their positive status would result in rejection by sexual partners and family members.

Only two of the men linked fear of a positive test result with consequences for the HIV-positive person in terms of health status and lifestyle. Muzi argued that: *“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 that: *“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.”*

This finding supports the TRA’s argument that people are more likely to behave a particular way if they have a positive attitude towards the specific behaviour and the belief that that behaviour has more advantages than disadvantages (Van Dyk 2008:124). In this regard Tendani seems to have a negative attitude towards HIV testing and is more likely to continue engaging in risky sexual behaviours that may expose himself to HIV infection.

4.3.4.2 Stigmatisation and discrimination

Stigmatisation 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).

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 use HCT

services. Moreover, the social ecological model posits that individual 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 against people who are living with HIV in that particular society.

4.3.4.3 Lack of adequate HIV information

Nine of the participants maintained that they had no 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.”* This finding suggests that the public and workplace HIV/AIDS prevention campaigns and programmes do not advocate HIV awareness and prevention as well as it should have and might not be targeting middle-aged men. Tersbol (2006:403-406) 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.

Only Tendani argued that information is available to 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?’ ”*

These narrations suggest that Nkosana and Sizwe are aware of the dangers in their unsafe sexual behaviours and show no intention of changing 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 is easy to get it because you just cheat.”* Sizwe maintained that: *“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 clinics hours and the long queues. The participants argued that most employed men would regard the clinic times as inconvenient, as they operated only from 7am- 4pm. In addition, they argued that it is impossible to book an appointment with HCT staff as public health care clinics do not operate like private clinics, where bookings are possible or even essential.

Thabo pointed out that visiting the clinic was time-consuming because of the long queues. The TAC (2011) found that most men were not keen on testing for TB or HIV because of the long 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. This could be because 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 perception between older and younger men

The researcher asked the participants if they considered themselves to be at risk of HIV infection. Seven participants agreed with this, attributing the risk to their having multiple sexual partners, not using condoms consistently and irresponsible actions owing to alcohol consumption. Tami, even though he was employed, and had more education than all the respondents, acknowledged that he was at risk of HIV infection. He drank heavily and never used condoms, despite having several sexual partners. He acknowledged that he was aware of the risks by saying: *“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 about HIV-transmission risks, but could not put that knowledge into practice by adopting less risky behaviour. This suggests that having adequate HIV/AIDS knowledge ensure safer behavioural practices.

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, said: *“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 that: *“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 of the men, Muzi and Teboho, regarded themselves as not being 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 that: *“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 goes for annual medical check-ups and that he is 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 unable to respond to the question about his 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 and those faced by younger men. Four participants argued that younger men are at greater risk of HIV infection than middle-aged men, as they are more attractive to women, tend to explore many different sexual relationships and tend 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 that: *“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 that: *“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 is interesting to note that these men equate risky sexual behaviours with immaturity, hectic lifestyles and having multiple sexual relationships. This suggests that although they also have other sexual partners, they still do not see themselves as being at high risk of infection in comparison with younger men. In this regard, Swanepoel (2005) states that some people may have unrealistic views and overestimate the risk for HIV infection in others whilst 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 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. The 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.”*

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 tend 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 that: *“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 suggests that although Sizwe did not want to access health information, he was nevertheless aware of the importance of HIV and AIDS health messages in reducing risky sexual behaviours. Mzoxolo maintained that: *“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.”*

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.

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.

For this reason, the researcher asked the men to reflect on the possible consequences should a man decide to present himself for HIV testing. Five men recounted possible benefits of such a step, whereas five said that testing might hold negative consequences.

In terms of possible benefits, the five men spoke about the health and behavioural benefits of testing and counselling, the benefits of general testing in 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 to HIV testing, such as that knowing one's HIV status could 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 not only in the test, but also in the counselling that went along with it. One participant, Teboho, suggested that the benefits of HIV testing exceeded the individual tester or even the tester's lovers, because if more people went for the test it could 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 being 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. 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 saw HIV-testing as having 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 test HIV positive may 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 may cause unnecessary conflict in a marriage or a relationship.

Tendani saw HIV-infection as a death sentence that would make a man 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 that: *“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 that: *“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 feelings of fatalism and helplessness that surround HIV and AIDS relate 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 use and multiple sexual partnerships

In terms of the men’s understanding of the role of cultural beliefs in HCT use 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 use were the traditional gendered notions of manhood that prescribed that men should emulate the sexual behaviours of their forefathers. Forefathers are believed to have had many wives and girlfriends, to never have used condoms and to never have gone for HIV testing.

Tendani reported that: *“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 that: *“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.”*

The above findings are similar to the findings by Heeren, Jemmott, Tyler, Tshabe and Ngwenya (2011) who found that whether men had paid lobola or not, made no difference to husbands' tendencies to have extramarital sexual affairs. In fact, in African culture, it is usually acceptable for a married man to have such affairs.

In addition, the men recounted how they had been taught to consult traditional healers to treat 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 man 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 that: *“Culture says that men should be men. We use cultural herbs (muti) to prevent any disease including HIV and AIDS. That is we won’t go for an HIV test because the muti makes us stronger not to get HIV.”* The researcher has observed that Nkosana displayed a very negative attitude towards HIV testing and his facial expression changed 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 may 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 and said: *“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 going 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, attitude and subjective norm (Van Dyk 2008).

As far as the role of dominant cultural beliefs about men and multiple sexual relationships were 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”* (Casanova).

One man said that cultural beliefs supported the notion of men’s uncontrollable sexual desire; three said it related to peer-pressure, three said 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 is 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 is culturally admissible as it is acceptable for men to have sex with other women when their usual/regular partner is ill or menstruating. The cultural regulations of sexual intercourse are associated with beliefs about the health status of sexual partners. For example, menstruating women, women who have recently terminated a pregnancy and widows (for a period after their bereavement) are 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 that: *“It is well accepted as an 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 concur 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 *et al* (2004) state that achieving masculinity is about commanding authority, and this may influence men to have multiple sexual partners as well as to have sex with other men.

Mzoxolo, Muzi and Sizwe attributed the pressure to have multiple sexual partners to culturally-determined peer pressure and to the pervasiveness of having 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 woman’s man]. 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.” Mzoxolo response is similar to Oster (2007:10) who argued that women tend to exhibit different sexual behaviours because if their spouses are travelling they tend to have sexual partners and if their spouses are at home then they may have non-marital partners.

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. Thabo added that the pull of cultural beliefs might be stronger for some men than for 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 when it came to 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 dates young girls is *“not man enough”* and *“scared of challenges”*. Four men out of eight felt that a middle-aged man could 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 that: *“According to me, a man who goes for younger women is scared of a challenge.”*

On the other hand, 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 dates young girls as immature, refusing to become an adult. He said: *“Those are men who like things and their dignity is lowered when they date young girls.”*

It is 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 the possible imbalances in the transactional arrangements in such liaisons than about the risk posed to the young girls.

On the other hand, 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 that: *“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 that: *"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."*

Swanepoel (2005) states that VCT provides the opportunity for counsellors to assist high-risk individuals to assess their level of risk develop realistic plans to reduce their risk and to increase safer sex practices. However, Muzi told the researcher that preventative messages confused him. He 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 that: *"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 who were in favour of using condoms mentioned that (according to their own perceptions) the majority of their friends do not like using them or ignore them in 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 has observed that: *“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 participants, Nkosana, Themba and Sizwe, were against condoms because they felt that men who used them were *“less manly”*, as using condoms is 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 tends to use a condom at the first sexual encounter with a partner but ignores it when he *“does not feel like it.”* He also mentioned that his regular sexual partner (the woman he shares a dwelling with) is 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 owing to his inconsistent use of condoms, 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?”*

Peacock *et al* (2008) and Bowleg (2004) state that men with patriarchal views on gender roles and relations are more likely to have negative attitudes to condoms and will use them less consistently. The findings of this study thus tend to support the views of these authors.

4.3.10 Perceptions of male circumcision

Seven participants agreed that circumcised men must continue to 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 seen friends who had been circumcised still become 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 is not a cure for HIV/AIDS, although most men are uninformed about this. Thabo said: *“Circumcisions only reduce risk of becoming infected but does not make one immune to be infected.”* Teboho maintained that: *“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 is interesting to note that, although Muzi still upholds cultural beliefs regarding male circumcision, he feels that it is 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 are protected against HIV infection. They attributed their insights to governmental messages that encourage 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) also found that circumcised black men are less likely to use condoms but use HCT services.

Sizwe attributed his aversion to condoms 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.”*

4.2.11 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 is 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 that were similar to those of the above-mentioned participants. However, he suggested that: *"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 be no 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 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 organised by the Bethesda home for orphans. 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 initiated by NICRO in Soweto.

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, 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 how his exposure to HIV and AIDS was restricted to the information he received whenever he went for routine HIV testing every year. This finding is similar to those of Tersbol *et al* (2006) that successful approaches to male-oriented intervention programmes in certain social contexts have been lacking and this has 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 suggests that he is either controlled by fear or has a low HIV risk perception. This also explains why Themba is uncertain 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 seems to suggest that Nkosana and Muzi have a low HIV risk perception and tend 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 nervous 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.

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 can be explained in terms of Swanepoel's (2005) conclusions 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 had 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 behaviour.

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 were generated through face-to-face interviews with two HCT coordinators as key informants from Engender Health.

To protect the key informants' confidentiality, pseudonyms have been 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 at improving the health and wellbeing of people in the poorest communities by giving them information on sexual and reproductive health matters. They focus 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:

1. Perceptions of the typical characteristics of middle-aged black men accessing HCT services;
2. Key informants' perceptions of the knowledge of HCT and of the sources of information for HIV/AIDS for middle-aged black men;
3. Key informants' opinions of the attitudes and perceptions by men about HIV testing;

4. Key informants' views of men's risk perceptions;
5. Key informants' perceptions of barriers and challenges to men's use of HCT;
6. Key informants' perception of the role of cultural and religious beliefs in men's use of HCT;
7. Key informants' perception of men's attitudes towards circumcision and use of condoms;
8. Key informants' views on proxy testing;
9. Key informants' perceptions of programmes aimed at men;
10. Key informants' views on 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 for improving 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 access their services. The majority of these male clients have low levels of education and the majority of them are single.

Only a small percentage of married middle-aged black men come forward for HIV testing and the informants suggested that such men usually claim that their spouses insisted on them 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.

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

The two key informants were of the opinion that the majority of middle-aged black men do not have adequate knowledge of HIV and AIDS.

They argued that most middle-aged men claimed to have such knowledge, but when, for example, they were given a dildo to demonstrate the use of condoms, it became evident that they lacked practical knowledge. They were of the opinion that the level of HIV knowledge is related to men's socio-economic status, as they had perceived that men of middle to high levels of educational attainment were better informed on 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 because these participants had been 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 being 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 written in the vernacular rather than in English.

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

The key informants were requested to give 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 they had cheated on their wives, were drunk, had had unprotected sex or no longer trusted their sexual partners.

This finding is similar to that by the researcher in section 4.3.3, where 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 find 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 they 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 is similar to the findings discussed in section 4.3.5, where eight participants considered themselves to be at risk of HIV infection because of their involvement in concurrent multiple sexual relationships and inconsistent condom use when they were under the influence of alcohol.

4.4.2.5 Key informants' perceptions of barriers and challenges to men's using of HCT

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

These factors included the paucity of male staff, perceptions about 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 per se.

The two key informants argued that most middle-aged men do not want to visit HCT services because they are usually offered by female personnel. Moreover, the staff is often perceived as unprofessional or as insensitive to the needs of male clients.

They further pointed out that owing to the lack of male-focused reproductive health messages, many middle-aged black men perceive themselves as being too old or mature to be at risk of HIV infection. They also reported that, in their experience, many middle-aged men preferred to consult traditional healers on health, especially reproductive or sexual health problems. Based on this, Engender Health involves traditional healers in their HIV and AIDS programmes and campaigns.

The key informants told the researcher that according to their own research, many middle-aged men do not want to use HCT services because of the long queues at the clinic. Further, they are aware of perceptions in the community and that to be seen at the clinic is to be stigmatised immediately. Bheki said: *“At Chris Hani (Baragwanath Hospital) there is a bridge that leads to the nurses’ home where a variety of services such as HIV testing, male circumcision and support groups are offered. This bridge itself is highly stigmatised such that people do not want to be seen crossing it because they will be perceived to be HIV positive.”*

This finding also confirms the responses obtained from the ten male participants in section 4.3.4, in which they revealed that they would not present themselves for HIV testing because of stigma and discrimination.

4.4.2.6 Key informants' perception of the role of cultural beliefs in men's HCT use

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, cultural perceptions of male sexuality and a strong affinity with traditional medicine. The key informants argued that societal expectations that mark multiple sexual conquests as a sign of virility and masculinity fuel the behaviour of many men. They told the researcher about many cases of middle-aged men who 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 trust and believe in the services of traditional healers to a far greater extent than in Western biomedical services.

These findings are similar to those discussed in section 4.3.7, where the male participants argued that they were expected to emulate the sexual behaviour of their forefathers, who had multiple sexual partners. They also reported that they had been taught to consult traditional healers to treat illnesses.

Other than the aspects 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' perception of men's attitudes towards circumcision and condom use

The two key informants argued that the majority of middle-aged black men undergo 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 believe that male circumcision enhances sexual performance. They also argued that a circumcised man finds condoms more challenging than an uncircumcised man, since condoms decrease sexual pleasure. They also said that some men were not aware that that male circumcision lowered the risk of HIV infection.

The above findings should be contrasted with the findings described in section 4.3.10. 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 said 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 the key informants might believe. As only one of the ten male participants reported that his culture did not allow men to undergo male circumcision, it was possible that the service providers (such as the two key informants) held untested views of what men actually know, think and feel about male circumcision. It is possible that there were strong anti-circumcision views 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 using condoms. For example, they argued that middle-aged men do not know how to safely store and use condoms. They mentioned that many men who use them use 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 are similar to those reported in section 4.3.9, where seven participants maintained that they would stop using condoms when they had developed some 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 during which blame would be directed at the positive partner and there would be the threat of divorce or abandonment.

In section 4.3.3, it is reported how 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. He therefore assumed that 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 specifically on middle-aged men.

They admitted that their HIV and AIDS programmes and campaigns tended to focus on the youth and women, as they were perceived to be the groups most vulnerable to HIV infection.

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

The key informants were of the opinion 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 factors

Despite the researcher allowing the two key informants the time and opportunity to verify their organisational statistics on client profiles, the two informants gave different figures for the organisational statistics for 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 them on poor awareness of the MAP programme.

Responding to the interview questions on the type of organisational strategies that could motivate more men to access their services, the two key informants said that their HIV counselling sessions should be shortened. They felt that the duration of HCT sessions may be one of the factors influencing the poor uptake of HCT services. This finding is similar to one of the participants' argument in 4.3.4.4 stating that the HCT counselling process is 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 attract more men to their services, as they had been told by middle-aged black male clients 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."*

It was reported in section 4.2.4.2 that one participant claimed that health care workers sometimes disclosed someone's HIV status without his or her consent.

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 programmes that specifically targeted middle-aged black men. They mentioned that the MAP or "Men as Partners programme" is their flagship, as it targets men of different socio-economic levels and ethnic backgrounds. They maintained that the programme is structured in such a way that it caters 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.

In addition, 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 is 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 use of the clinic's HCT services. In addition, participants also mentioned that they usually consulted traditional healers instead of using 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 loudspeakers to encourage men to go for HIV testing. They argued that the organisation had previously employed the latter and that it 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 indicates the lack of commitment and partnership among stakeholders to mitigating the spread of HIV infection in South Africa.

A specific concern for both the key informants was the shortage of trained personnel to undertake community outreach programmes and to target men in such strategies.

Tshepo argued that *“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 on HIV testing, it is clear from the research findings that social factors influence poor HCT uptake by middle-aged black men. It is evident from the study that stigma, discrimination and cultural factors largely contribute to poor HCT uptake.

The research findings also revealed that the majority of middle-aged black men have a high HIV risk perception, but behaviour change is still a challenge. The latter could be attributed to socio-cultural factors and lack of HIV and AIDS behavioural intervention methods. Thus, the study postulates that there is a link between social factors and poor HCT uptake of services by middle-aged black men.

In the next chapter (Chapter 5), the researcher will discuss the summary of the findings based on the objectives of the study. General conclusions and recommendations of the study for policy and programmes will also be discussed.

CHAPTER 5: SUMMARY OF 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 factors influencing poor HCT uptake services by middle-aged black men in Pimville (Soweto). 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 it was because he did not think he was 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. Upholding tradition by honouring the wisdom of traditional healers was narrated as a male duty.

This was supported by the views of the two key informants, who confirmed that in their experience middle-aged black men did not access HCT services because they preferred to consult with traditional healers for treating opportunistic infections. The key informants also 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 gauge their own HIV status.

5.3 FINDINGS IN RESPECT OF OBJECTIVE 2

The second objective was to explore factors that could act as barriers to the use of HCT services by middle-aged black men. This objective was achieved, as the researcher was able to uncover many factors that acted as barriers to HCT use. These factors included cultural beliefs, the notion of masculinity, the fear of stigma and discrimination, the lack of adequate HIV information, and confusion about the role of male circumcision as a prevention method. Seven out of the ten male participants reported that they were afraid of a positive HIV test result because of their own risky sexual behaviours and inconsistent use of condoms.

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 adopting safer sexual behaviours, because of cultural beliefs and their own inculcated notions of masculinity. Three of the men held very strong traditional beliefs and displayed a negative attitude to condoms. Bowleg (2004) argues that black men who adhere to more traditional masculine ideologies are more likely to have more sexual partners and negative attitudes to condoms, and to be less consistent in their use of condoms.

When it came to male circumcision, seven participants maintained that circumcised men should still use condoms as a protection against HIV infection. In contrast, the two key informants reported that the majority of their middle-aged male clients were ignorant about using condoms and regarded male circumcision as sufficient protection against HIV infection.

The service providers had possibly underestimated the level of accurate knowledge about male circumcision among the general population. 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 the 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 they were inclined to disclose individuals' status without their consent.

5.4 FINDINGS IN RESPECT OF OBJECTIVE 3

The third objective was to uncover challenges that men faced when using HCT services in Pimville. This objective was achieved, because the researcher found that fears of a breakdown in relationships or marriages, resistance to lifestyle changes, self-blame, inculcated views of masculinity and inconvenient clinic times and long queues were important challenges for men. One man reported that that the very act of testing could appear to be a confession that the man had been sexually unfaithful, and this may cause unnecessary conflict in a marriage or a relationship. Some of the men saw HIV-infection as a death sentence that would mean they had 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 counselling process as off-putting. One key informant suggested that the fact that HCT services were usually provided by female personnel posed a challenge for middle-aged men if they were to use HCT services.

5.5 FINDINGS IN RESPECT OF OBJECTIVE 4

The fourth objective was to investigate ways of encouraging middle-aged black men to use the HCT services in Pimville.

Nine participants mentioned that they would like to be involved in HIV and AIDS programmes and campaigns if they were given adequate information about them. The two key informants reported that men preferred to visit HCT mobile units for HIV testing.

USAID (2009a) suggests that it is vital for HIV education to be adjusted for different segments of the population with an emphasis on outreach and face-to-face communication. Some of the research participants declared an interest in taking 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 FBOs 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 is to speak for others, but at the same time how rich data can be uncovered through less structured means. The interview schedules allowed the researcher to use probes and rephrase the questions to find answers to her research questions. This depth could not have been achieved in a quantitative survey.

5.7 WEAKNESSES OF THE STUDY

The researcher identified the following limitations, which are discussed below.

5.7.1 Limitations related to the chosen study site

The study was conducted in the community of Pimville (Soweto) and is therefore context-specific. The findings of the study should not be generalised to other sites in South Africa without great circumspection.

5.7.2 Limitations presented by the gender difference between the researcher and the research participants

All the participants were male and the researcher is a woman. She overcame this challenge by making the participants feel at ease in the interviews. However, some participants might not have provided completely honest responses. The researcher would like to follow up her study with one that includes heterosexual couples.

5.7.3 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 may not be representative of all middle-aged black men in Pimville, which could be owing to the small sample size and the fact that the researcher requested the participants to recruit their friends or acquaintances, who might therefore share similar characteristics, views and behaviours.

5.8 SUGGESTIONS FOR FURTHER RESEARCH

This study has highlighted social factors as influencing poor uptake of HCT services by middle-aged black men. The researcher proposes that further studies be undertaken in the following areas:

1. A comprehensive study of the influence of religious beliefs as one of the social factors that may prevent middle-aged black men from using HCT services.
2. Research on ways to upscale 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 are being made to the following people for policy and programme purposes:

5.9.1 Recommendations for possible HIV and AIDS interventions in Pimville

Public health care workers in Pimville should work with local NGOs and FBOs in mobilising community members to participate in HIV and AIDS prevention campaigns and programmes. The HCT site 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. Men should also be given the opportunity of being at the forefront of HIV and AIDS prevention programmes and campaigns so that they could take ownership of such health messages. This might enable men to discover their own fears and vulnerability to HIV and AIDS. Creating forums for men to share, discuss and agree on action might be an effective way of alleviating fear 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 national level

It is recommended that at the national level, long-term goals aimed at creating a men's movement to support HIV and AIDS programmes and campaigns must be established.

Programme developers at the national level should ensure that all stakeholders involved in long-term HIV and AIDS strategic planning are also to be involved in monitoring and evaluating the effectiveness of HIV and AIDS programmes and campaigns.

Programme and policy developers at the national level should adopt a multi-sectoral approach to HIV and AIDS interventions so that clear and well-defined goals can be put in place to educate unemployed men in communities and those that are currently employed. This will also ensure that NGOs also access men in the workplace to conduct HIV and AIDS campaigns. Further, the latter requires advocacy, continuing 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 the provincial level, it is recommended that intervention programmes be tailored to the specific risk factors of a community and that 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, particularly to middle-aged black men (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 up scaling male-friendly testing facilities and clinics. Finally, men as partners in the national fights 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 factors influencing HCT uptake by middle-aged black men.

All the participants in the study reported that social factors such as stigma and discrimination, masculinity and socio-cultural factors largely contributed to their reluctance to use HCT services. Participants further reported that they had limited HIV/AIDS knowledge, which is necessary to adapt healthy sexual behaviours, coupled by the fact that HCT sites are not male-friendly and are highly stigmatising.

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

The researcher concludes her study with an understanding gained from the perceptions and experience of the participants, which concur with the results of other researchers. Seeley *et al* (2004) state that a black man's behaviour is shaped and influenced by social issues such as masculinity, culture and economic factors, all of which define what it means to be a man. This study has been an attempt to successfully address these social issues, which seem to be central to the consideration of the poor uptake of HCT by middle-aged black men.

The researcher agrees with previous researchers in advocating that a range of contextual variables at the interpersonal, communal and societal levels should 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 black men's decision on 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 by middle-aged black men.

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APPENDIX A: ENGENDER HEALTH PERMISSION LETTER



EngenderHealth
for a better life

07th October 2011

To whom it may concern

Permission is granted to Nomsombuluko Sybil Mdunge (Student no: 44243367) to conduct interviews with outgoing EH HCT staff members: Papiso Marago and David Damane.

This letter therefore serves as authorization for the above candidate to interview EH staff on the research subject: Social Factor in the poor uptake of HIV testing among middle –aged African men (35-49 years): a qualitative study in Pimville; Soweto.

EngenderHealth works to improve the health and well-being of people in the poorest communities of the world by sharing expertise in sexual and reproductive health and transforming the quality of health care, promoting gender equity, advocating for sound practices and policies, and inspiring people to assert their rights to better, healthier lives, and working in partnership with local organizations.

In South Africa, we implement the Men as Partners® (MAP) program and provide male friendly mobile HIV Counseling and Testing (HCT) in disadvantaged communities with support from USAID/PEPFAR. We work with the South African Police Services in Sedibeng district, to implement an intergrated MAP and HCT service.

Please do not hesitate to contact Ms Caroline Mbi-njifor on 011 403 4625 or cmbinjifo@engenderhealth.org

Sincerely,

Caroline Z.A. Mbi-njifor
Engenderhealth, South Africa
Country Representative

APPENDIX B: UNISA ETHICAL APPROVAL



Department of Sociology
College of Human Sciences
05 October 2011

Proposed title: SOCIAL FACTORS IN THE POOR UPTAKE OF HIV TESTING AMONG MIDDLE-AGED AFRICAN MEN (35-49 years): A QUALITATIVE STUDY IN PIMVILLE, SOWETO

Principal investigator: NS Mdunge (student number 44243367)

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 Ms. Mdunge 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 only start this research study after obtaining informed consent from the interviewees
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To notify the committee in writing immediately if any adverse event occurs.

Kind regards

SIGNED

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APPENDIX C: CONSENT FORM

INFORMED CONSENT FORM

My name is Nomsombuluko Sybil Mdunge 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 factors influencing poor uptake of HCT services by middle-aged African men (35-49 years) in Pimville (Soweto). You will be requested to respond to questions about your experience and knowledge with regards to HTC services in Pimville. The interview will last for one hour.

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

I will not ask your name during the interview and this will ensure confidentiality. Everything you will 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 3 years after the study has been completed.

- **Please note** that you can opt out or you can refrain from participation at any time if you feel like you do not want to be part of the study anymore. 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 (35-49 years) in Pimville. 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" – for 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 partner 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 (HTC)?
10. Where would you go for information about HCT in Pimville?
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 sometime 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 Pimville?

- 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 35 to 49 with younger males – in your opinion, are men in the 35+ 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 manlier 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 manlier 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 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 Pimville? 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 factors influencing poor uptake of HIV Counselling and Testing (HCT) services by middle-aged black men (35- to 49-years) in Pimville.

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 (those aged 35- to 49 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 use 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 using 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? Does concurrent multiple sexual relationships influence poor HCT uptake by middle age black men?
- 14.1 If yes, why?
- 14.2 If no, why?
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 reason?
 - 15.3 Do they still use condoms after male circumcision?
15. How does 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 use 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!