



Literature Review on Men, Gender, Health and HIV and AIDS in South Africa

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Executive Summary

Social constructions of manhood have strong effects on men's and women's health. They affect women directly, for example, via male violence against them causing physical and psychological harm, and indirectly through men's risky behaviour increasing their female partners' vulnerability to sexually transmitted diseases. And they also affect men, for whom expectations of risk-taking and taboos around health seeking heighten exposure to injury and illness.

South Africa is far from immune to such impacts. Although attitudes are changing, many South Africans of both sexes see men as superior to women and believe that men should dictate many decisions that affect health, including sexual decisions. Almost one-third of South African women are forced into their first sexual encounter - HIV infection rates are higher among women with violent husbands.

A growing body of evidence also suggests that men are far less likely than women to access HIV services including testing, treatment and other care and support services. Men's under-utilisation of HIV services significantly undermines prevention and treatment efforts. However, it is seldom recognized as a priority and few initiatives are in place to address this.

Gender roles are not set in stone, however, and there is evidence from South Africa and other countries that efforts to increase gender equality can have significant effects on health by promoting more gender-equitable attitudes. Involving men in such programmes is now seen as vital to success, as recognized in several key international agreements.

HIV/AIDS poses a greater burden for women than men in South Africa. Infection rates are higher among women, in part due to gender-driven behaviour. Gender norms allow men to dictate the terms of sex, including whether or not to use condoms. Levels of rape are among the highest in the world (and conviction rates among the lowest), while domestic violence is widespread. Post-exposure prophylaxis, which can prevent HIV infection, is available to few rape survivors, and the attitudes of health care providers deter many women who have been raped from seeking treatment. Constructions of masculinity also encourage men to have multiple concurrent sexual partners, which increases the risk of HIV infection both for their casual and long-term partners as well as for men themselves.

While condom use has become more common in South Africa in response to the AIDS epidemic, gender norms continue to limit their use among some men who see health seeking as weak, and among women who may be seen as "easy" and unfaithful if they carry condoms. South African men are also much less likely than women to present for HIV testing, and therefore less likely to be aware of their status, and to access antiretroviral treatment for AIDS. This greatly increases men's risk of death from AIDS, and it also imperils their female partners, who may be less likely to use HIV prevention methods if unaware that their partners are HIV-positive.

Women also carry by far the greater burden of care and support for those with AIDS-related illnesses. Gender expectations mean wives, mothers, daughters and sisters serve as primary care-givers, which reduces their own economic opportunities and ability to attend school, as well as causing great emotional stress. Moreover, women in many South African families are expected to remain quiet about their own health problems, which of course means their own health needs are less likely to be met.

Some groups of South African men are especially vulnerable to HIV and other health threats. Men in prisons, for example, receive inadequate nutrition and health care and

are at high risk of violence (including sexual assaults) at the hands of other prisoners or staff. HIV prevalence is higher among offenders, the vast majority of whom are male, than the population as a whole. Men outside prison are also often victims of violence, with the country having one of the highest homicide rates in the world. Men are more likely than women to be victims of such violence, although women are more likely to suffer sexual abuse. Gender norms that condone male violence are largely responsible for its perpetuation, and they are also a cause of higher rates of alcohol and tobacco consumption among men, which have multiple negative health impacts.

Much innovative work has been done in South Africa and elsewhere to shift these gender norms and thereby improve the health of men and women. 'Stepping Stones,' a community training and dialogue programme, has worked in multiple countries to reduce the acceptability of violence and promote discussion and awareness of HIV/AIDS. Sonke Gender Justice Networks' 'One Man Can' campaign uses a human rights framework to help men and boys take action to stop domestic and sexual violence, halt the spread of HIV/AIDS and promote healthy, equitable relationships. These programmes have had significant impacts on behaviour and attitudes, with men becoming more involved in family health care and parenting as well as less likely to commit violence and more likely to protect themselves from health threats. They have found men willing to become more gender-equitable and to share the health care burden with women. Much of the work with men on gender and health has been small-scale, however; expanding it will have large benefits for the health of all members of society.



Introduction

This literature review on men, gender and HIV and AIDS has been carried out in conjunction with a number of policy initiatives that Sonke Gender Justice Network has been involved in over the last 18 months. These include the development of the South Africa Country Report to the UN Commission on the Status of Women on Involving Men and Boys in Achieving Gender Equality; a multi-country research project on policy approaches to working with men for gender equality and improved men's health, coordinated by Instituto Promundo; the development of national guidelines on men and sexual and reproductive health in collaboration with South Africa's National Department of Health and Constella Futures; and a briefing for the WHO on policy approaches to working with men for gender equality. The literature review was conducted by Sonke staff, interns and consultants including Andrew Daub, Kieran Evans, Alan Greig, Eleanor McNab, Dean Peacock, Jean Redpath and Mark Weston.

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Men, gender and health

Social constructions of manhood shape men and women's health outcomes in important ways. In South Africa, 31 per cent of sexually active women reported that they had not wanted their first sexual encounter and that they were coerced into sex.¹ As well as the psychological effects of violence, it also harms physical health - a recent study of over 1,500 women in South Africa indicates that, "women with violent or controlling male partners are at increased risk of HIV infection."²

There are also negative health consequences for men. Men in many societies adhere to rigid notions of manhood and equate manhood with risk taking, dominance and sexual conquest; they view health seeking behaviors, moreover, as a sign of weakness. These attitudes put men at risk from both natural and non-natural causes. Men are more likely to view sexual relationships as adversarial, have more negative attitudes toward condoms and use condoms less consistently.³ This behaviour increases their risk of HIV infection and other sexually transmitted diseases. Young men are more likely than women to drive recklessly, including speeding, drinking and driving, tailgating and running red lights, which together with their far lower rates of seatbelt use result in young men dying in car accidents at far higher rates than women.⁴ Worldwide, almost three times as many males die from road traffic injuries as compared to females.⁵

A reluctance to access health services is also damaging. Data from South Africa indicate that men are significantly less likely than women to use voluntary counseling and testing (VCT) services and account for only 21 per cent of all clients receiving VCT.⁶

Only 45 per cent of those accessing antiretroviral therapy for AIDS are men, despite roughly equal HIV prevalence rates among men and women.⁷ In some regions the differences are much starker. These gender discrepancies in ART uptake reflect men's beliefs that seeking health services is a sign of weakness.⁸ In South Africa, men's low utilisation of HIV services mirrors their low use of all health services.⁹

Men's gendered practices are constantly changing, however, sometimes as a result of public health interventions and sometimes because of broader socio-cultural changes. In a study in Mexico, for example, middle class and younger men reported changes in "how they view gender roles, including domestic tasks,"¹⁰ while in another study almost half of the men interviewed reported being very different kinds of fathers than their own fathers were.¹¹ In South Africa, meanwhile, a survey of 3,500 men and women by the Unilever Institute (2005) found that attitudes to gender are changing: 61 per cent of respondents believe men and women are equal; 66 per cent that men and women should earn the same amount; and 50 per cent that women are treated unfairly. There is still some way to go, however; 73 per cent of respondents still believe that men should be the head of households and 64 per cent that they should be the primary breadwinner in the family.¹²



Evaluation data on the efficacy of men and gender equality programs

The question then is not whether men can change, but rather whether policies and programs accelerate and influence that change. Recent research suggests that carefully designed policies and interventions can bring about changes that improve men and women's health and that they can achieve this change in relatively short time periods. As new programs engaging men and boys have been implemented, a body of effective evidence-based programming has emerged and confirmed that men and boys are willing to change their attitudes and practices and, sometimes, to take a stand for greater gender equality.

Gender transformative work with men is occurring across the world. In Nicaragua, the Men's Group of Managua has implemented an ongoing national campaign to prevent male violence against women with the theme, "Violence Against Women: A Disaster that Men CAN Do Something About." In India, the Bhoruka AIDS Prevention Project has developed strategies to change attitudes and behaviors amongst truck drivers working on the routes between Calcutta and Katmandu.¹³ Across Latin America, Instituto Promundo coordinates the Program H Alliance and engages men and boys in gender transformative work. In South Africa, a number of "Men's Marches" to end violence against women and children have been held since 1997, which have drawn thousands of men out onto the streets in a public repudiation of male violence.¹⁴

The World Health Organisation and Instituto Promundo recently released a report reviewing 57 interventions with men in the areas of sexual and reproductive health, maternal and child health, gender based violence, fatherhood and HIV/AIDS prevention. Their analysis has confirmed that such programs, while generally of short duration, have brought about important changes in men's attitudes and behaviors.¹⁵ Of the 57 studies included in the analysis:

- 24.5 per cent were assessed as *effective* in leading to attitude or behavior change;
- 38.5 per cent were assessed as promising; and
- 36.8 per cent were assessed as *unclear*.

Programs were classified based on their degree of attention to gender and orientation towards change in gender roles.¹⁶ Programs that took an approach of addressing gender norms – within their messages, staff training, and educational sessions with men – were more likely to show an impact in changing attitudes and behavior.

A study of nearly 150 Nicaraguan men who participated in workshops on masculinity and gender equity revealed significant positive attitudinal and behavioral changes according to both partner reports and self evaluations in a wide range of indicators including use of psychological and physical violence, sexual relations, shared decision making, paternal responsibility and domestic activities.¹⁷

In Brazil, Instituto Promundo's intervention with young men on promoting healthy relationships and preventing HIV/STIs, showed significant shifts in gender norms at six months and twelve months. Young men with more equitable norms were between four and eight times less likely to report STI symptoms.¹⁸

The South African Medical Research Council's evaluation of the Stepping Stones initiative implemented in the Eastern Cape also showed significant changes in men's attitudes and practices. With two years follow up, men who participated in the intervention reported fewer partners, higher condom use, less transactional sex, less substance abuse and less intimate-partner violence.^{19,20}

Barker (2005) has outlined several key factors that are associated with gender-equitable attitudes and practices in men. As well as situational factors, such as men's temporary unemployment or illness that encourages some to undertake domestic tasks, the influence of peers and community leaders who have gender-equitable views is also important, as is the impact of community-based intervention programs that encourage discussion and reflection about gender norms and male identities.²¹

International Commitments to Working with Men

Informed by and lending momentum to the many programs working with men and boys across the world, a growing international consensus has emerged over the last ten years about the need to include boys and men in the promotion of gender equality. This is reflected in a number of international commitments:

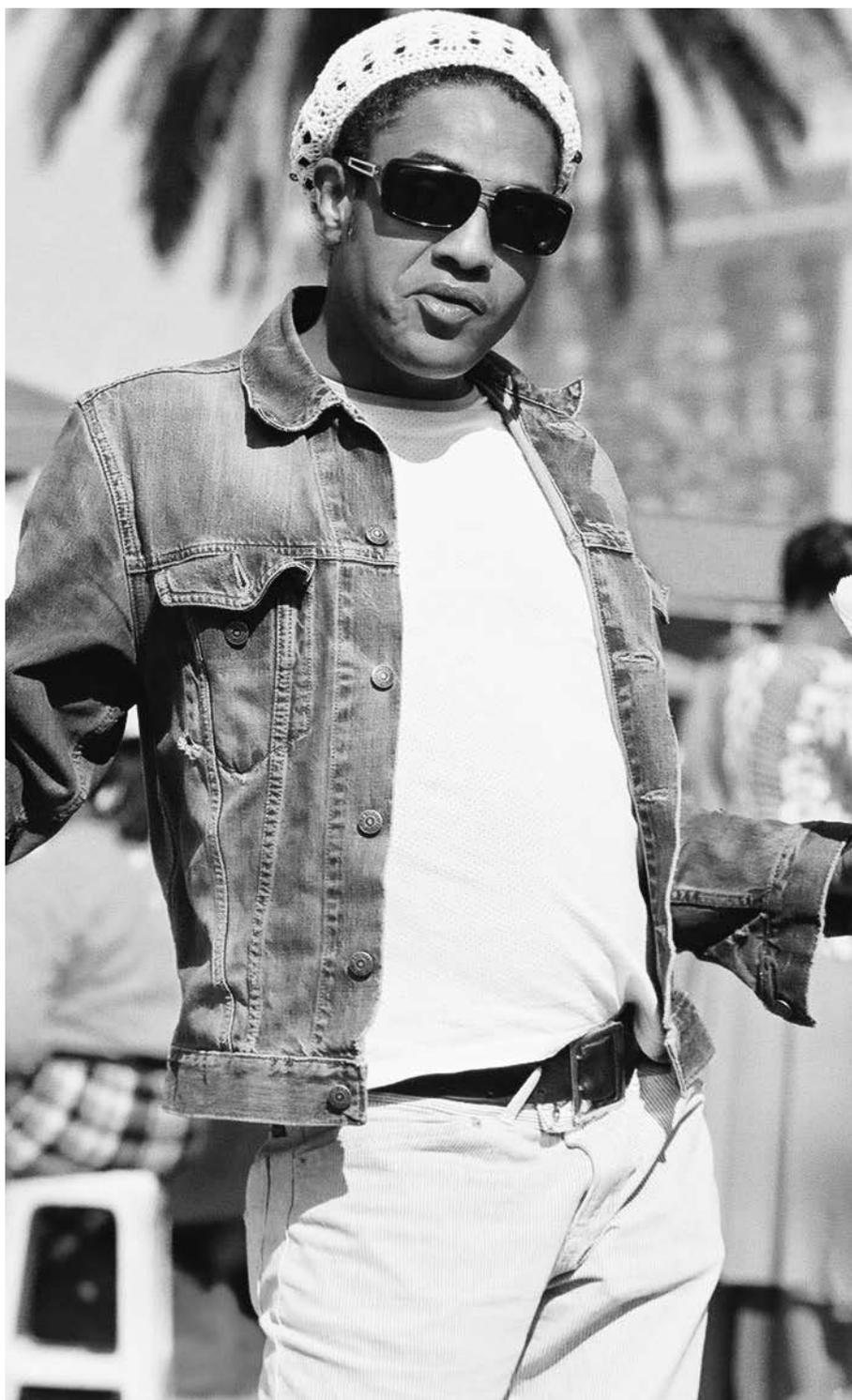
- The 1994 International Conference on Population and Development affirm the need to “promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles.”²²
- The Beijing Platform for Action (1995) restated the principle of shared responsibility and argued that women's concerns could only be addressed “in partnership with men.”²³
- The twenty-sixth special session of the General Assembly on HIV/AIDS (2001) recognised the need to challenge gender stereotypes and attitudes and gender inequalities in relation to HIV/AIDS through the active involvement of men and boys.²⁴
- At the 48th session, the UN Commission on the Status of Women adopted conclusions calling on governments, entities of the United Nations system and other stakeholders to encourage the active involvement of men and boys in eliminating gender stereotypes; encourage men to participate in preventing and treating HIV/AIDS; implement programs to enable men to adopt safe and responsible sexual behavior; support men and boys to prevent gender-based violence; implement programs in schools to accelerate socio-cultural change towards gender equality.

This brief introduction to men, gender and health in South Africa demonstrates three important points:

1. Men's behavior can and has changed in some contexts, sometimes as a result of program interventions, sometimes as a result of policies, and in other cases as a result of social trends and individual and local circumstances.
2. Men's behaviors related to sexual and reproductive health are directly related to a constellation of overall views about gender norms.
3. Program and policy interventions to engage men and truly transform gender norms that disadvantage women and girls (and at the same time leave men vulnerable) have largely been small-scale or have not been documented. However, many of them show tremendous potential.

Men's behaviors related to sexual and reproductive health are directly related to a constellation of overall views about gender norms.

The main focus of the literature review is on how gender interacts with HIV/AIDS. Part one addresses the various risk factors for HIV infection as well as gender issues in relation to testing, treatment and care. Part two looks at other health issues that are affected by gender, again with a focus on HIV/AIDS. Where available and useful, we have included international data for comparison purposes with South African data.



One: Gender, HIV/AIDS and Sexual and Reproductive Health

Sexual and Reproductive Health Rights in South Africa

The World Health Organisation (WHO) defines health as “A state of complete physical, mental and social well-being.” The recognition of health as a human right took a great step forward in 1948 when the newly formed United Nations adopted the Universal Declaration of Human Rights (UDHR), which states that everyone “has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.”

The International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1966 made the right to health even more specific by mandating governments ratifying the agreement to take steps to prevent, treat and control epidemic, endemic, occupational and other diseases, and to create conditions which would assure medical service and medical attention to all in the event of sickness. South Africa has signed but not yet ratified the ICESCR; however its provisions may be employed in interpreting the South African Bill of Rights.

Sexual and reproductive health is a key component of health. The 1994 International Conference on Population and Development in Cairo defined reproductive health as:

“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.”

Thus encompassed in reproductive rights are the rights of men and women to be informed about and to have access to safe, effective, affordable and acceptable legal methods of contraception and fertility regulation of their choice, and the right of access to appropriate health care services that enable women to go safely through pregnancy and child birth and provide couples with the best chance of having healthy infants.

Women and men should also be entitled to sexual rights, which are distinct from reproductive rights. The Aids Law Project has articulated sexual rights in the following way: “All women and men are entitled to:

- Control over their own bodies
- Only have sex when, with whom and how they want to
- Live out their sexual orientation
- Not be forced to have sex through the use of violence or coercion
- Have sexual enjoyment
- Be protected from diseases such as HIV and STIs
- Exercise the responsibilities that go with sexual rights.”

“The realisation of sexual and reproductive rights,” it adds, “is essential to the full well-being of men and women.”²⁵

The exact ambit of sexual and reproductive rights is open to some interpretation by the courts. In South Africa, these rights may come under the ambit of international law such as the ICESCR as well as the rights contained in the Bill of Rights of the Constitution, such as the rights to equality, dignity, life, privacy, access to health care and emergency medical treatment, children's right to health care, access to information, and just administrative action.

Both the Constitution and the South African National Health Act provide that no one may be refused emergency medical treatment. In the 1998 case of *Soobramoney*²⁶ the Constitutional Court confirmed that social rights, such as the rights of access to health care and housing, are dependant upon resources available for such purposes and the right may be limited by lack of resources. Thus in defining the ambit of "emergency medical treatment" the court was not prepared to accept that this would include ongoing treatment of chronic illness (in this case kidney failure) for the purpose of prolonging life. Such treatment is to be classified as "health care" and may thus be limited by lack of available resources and progressive realisation of the right. The case has particular implications for the treatment of chronic life-threatening illnesses such as HIV/AIDS.



In 2002, on the other hand, the *TAC*²⁷ case established that children's rights to health care (section 28 of the Constitution) and the general right of access to health care (section 27) obliged government to make Nevirapine available for the prevention of mother to child transmission of HIV. The case involved an appeal against High Court findings that the government had acted unreasonably in refusing to make an antiretroviral drug available in the public health sector, and in not setting out a timeframe for a national program to prevent mother-to-child transmission of HIV. The respondents argued that the government's actions amounted to a breach of the duty imposed on all State organs to give effect to rights guaranteed in the Constitution.

The provisions of sections 27 and 28 led to the question of whether government is constitutionally obliged to plan and implement a program for the prevention of mother-to-child transmission of HIV. The court found that the administration of the drug would be a simple matter. It issued another order against the government in slightly different terms from the lower court order by declaring that sections 27(1) and (2) of the Constitution require the government to devise and implement within its available resources a comprehensive and coordinated program to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV. The program must include reasonable measures for counseling and testing pregnant women for HIV, counseling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment available to them for such purposes.

The court found that the policy for reducing the risk of mother-to-child transmission of HIV as formulated and implemented by government fell short of compliance with these requirements in that doctors at public hospitals and clinics other than the research and training sites were not enabled to prescribe Nevirapine to reduce the risk of mother-to-child transmission of HIV even where it was medically indicated and adequate facilities existed for the testing and counseling of the pregnant women concerned. The policy also failed to make provision for counselors at hospitals and clinics other than at research and training sites to be trained in counseling for the use of Nevirapine as a means of reducing the risk of mother-to-child transmission of HIV.

Government was ordered without delay to remove the restrictions that prevent Nevirapine from being made available at public hospitals and clinics that are not research and training sites, to permit and facilitate the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this is medically indicated.

Government was also ordered to make provision if necessary for counselors based at public hospitals and clinics other than the research and training sites to be trained for the counseling necessary for the use of Nevirapine and to take reasonable measures to extend the testing and counseling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of the drug.

The court noted that these orders did not preclude government from adapting its policy in a manner consistent with the Constitution if equally appropriate or better methods become available to it for the prevention of mother-to-child transmission. The TAC case has obvious implications for the rights of those infected by HIV/AIDS and consequently sexual and reproductive health rights.

It is not just at government level that such rights need to be protected and promoted. POLICY Project's work with traditional leaders on HIV/AIDS advocacy and human rights has been one of the most notable projects working towards changing attitudes and strengthening rights at community level. 16.5 million rural people in South Africa live under the authority of traditional leaders, indicating that the latter are well placed to address issues related to HIV/AIDS in rural communities across the country.

Thirteen three-day workshops were carried out between June and September 2004, training 520 traditional leaders. The workshops aimed to increase traditional leaders' capacity to carry out HIV/AIDS advocacy work in their communities as well as enabling them to establish networks with local AIDS service organisations and local government structures.

In 2005, the POLICY Project carried out an evaluation of these workshops (interviewing 30 of those who had gone through the workshop process), looking at the impact on the traditional leaders themselves and the effectiveness of the work they have since carried out in their communities. As a result of the workshops, leaders' knowledge about HIV/AIDS increased significantly and in turn this broadened their capacity and commitment to addressing the epidemic in their communities. Almost all of the traditional leaders interviewed for the evaluation had engaged in some type of activity after the workshop, "ranging from calling community meetings to talk about HIV/AIDS, to talking at funerals, running workshops for other traditional leaders and even opening their houses to provide counselling and advice to those in need. About 21,100 people were reached through these activities."²⁸

Sexual and Reproductive Health in South Africa

At the end of 2007 it was estimated that 33 million people worldwide were infected with HIV.²⁹ The burden of infection is particularly high in developing countries, and specifically in the sub-Saharan African region. South Africa has one of the most severe HIV epidemics in the world. The country has 5.5 million people living with HIV/AIDS – an adult prevalence rate of 18.3 per cent.³⁰ Levels of HIV infection were found to be significantly higher among women at younger ages, with male prevalence exceeding female prevalence after age 35-39 years.³¹

Gender roles and relations are increasingly recognised as one of the fundamental forces driving the rapid spread of HIV and exacerbating the impact of AIDS. Across the sub-Saharan African region, gender related norms all too often condone men's violence against women, grant men the power to initiate and dictate the terms of sex, and make it extremely difficult for women to protect themselves from either HIV or violence.

As a result, the HIV/AIDS epidemic disproportionately affects women's lives both in terms of rates of infection and the burden of care and support they carry for those with AIDS-related illnesses. In many countries HIV prevalence among girls under the age of eighteen is four to seven times higher than among boys.³² A study from South Africa revealed that young women are much more likely to be infected than men, with women accounting for 77 per cent of infections among South African youth between the ages of 15-24.³³

There is increasing evidence that abuses of the human rights of girls, especially through sexual violence and other sexual abuse committed by men, contribute directly to this disparity in infection and mortality.³⁴ Indeed, Southern Africa has some of the highest reported levels of sexual and domestic violence in the world.³⁵ A 2006 SADC Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa called for HIV prevention efforts to "address gender issues especially from the perspective of male involvement and responsibility for sexual and reproductive health and HIV prevention and support, and specifically to reduce multiple, concurrent partnerships, intergenerational/age-disparate sex and sexual violence."³⁶

In a survey of 435 men in a Cape Town township, more than one in five reported that they had, "either threatened to use force or used force to gain sexual access to a woman in their lifetime."

Gender based violence and AIDS

South Africa has among the highest rates of violence against women in the world.³⁷ The 1998 South Africa Demographic and Health Survey found that ten per cent of women had experienced physical assault at the hands of men in the past twelve months. Seven per cent reported having ever been forced to have sex, and a further 4.4 per cent that they had been raped.³⁸ Levels of violence vary by location. A 2006 Medical Research Council survey of 1370 male volunteers recruited from 70 rural South African villages indicated that, "16.3 per cent had raped a non-partner, or participated in a form of gang rape; 8.4 per cent had been sexually violent towards an intimate partner; and 79.1 per cent had done neither."³⁹ A survey of young men in Eastern Cape found that 41 per cent reported having used physical violence against a female partner in the past twelve months.⁴⁰ In a survey of 435 men in a Cape Town township, more than one in five reported that they had, "either threatened to use force or used force to gain sexual access to a woman in their lifetime."⁴¹ And in Mpumalanga and Northern (Limpopo) Province, 12 per cent and 5 per cent of women, respectively, reported having been physically abused by a sexual partner.⁴² Globally, WHO reports that between 10 and 69 per cent of women in 48 population-based surveys reported being the victim of physical assault by an intimate male partner.⁴³

Conviction rates for domestic and sexual violence are amongst the lowest on the planet. In South Africa only one in nine victims reports rape and fewer than ten per cent of reported rapes lead to conviction. Inadequate recording of statistics makes it impossible to determine conviction rates for domestic violence but a recent study of domestic violence homicides in South Africa showed conviction rates no higher than 37 per cent.⁴⁴ This sends a clear message to perpetrators that they are unlikely to be apprehended or convicted and gives women little reason to believe that they can safely leave abusive relationships - even if they suspect their partner is putting them at risk of exposure to HIV/AIDS. The South African Law Commission's proposed alterations

of the definition of rape are a response to this situation. Such changes would mean that the state will not be required to prove absence of consent on the part of the person who has been raped. In the proposed legislation marriage is not regarded as an impediment to rape, which means that a husband can be convicted for raping his wife.

Violence against women increases their risk of HIV infection. Sexual abuse during childhood and forced sexual initiation during adolescence are associated with increased HIV risk-taking among women. In Nicaragua, one study found that women who were severely sexually abused in their childhood and adolescent years made their sexual debut more than two years earlier and reported a higher number of sexual partners than those who had experienced moderate or no sexual abuse.⁴⁵ The latter are key predictors of HIV vulnerability. Studies in the USA have found that among women living with HIV infection, nearly half report forced sexual experiences in childhood or teenage years.⁴⁶

Women who experience sexual assault in South Africa are at greater risk of HIV/AIDS infection than other women.⁴⁷ While the evidence is not conclusive, research suggests that men's violence limits women's ability to affect the use of condoms in their sexual relationships. A South African study found that women who experienced forced sex were nearly six times more likely to use condoms inconsistently than those who did not experience coercion. In turn, women with inconsistent condom use were 1.6 times more likely to be HIV infected than those who used condoms consistently.⁴⁸

Despite the alarmingly high levels of rape and HIV/AIDS, post exposure prophylaxis (PEP) is not available to many rape survivors. A recent study found PEP readily available in 84 per cent of hospitals but only 15 per cent of clinics. This has serious implications given that many women have limited access to hospitals and given the rapid reaction time that is required for PEP to be effective.⁴⁹

This deficiency is largely the result of negative attitudes towards rape survivors. The same study revealed that only 56 per cent of staff had received specialised training for addressing survivors of gender violence. A report by the National Working Group on Sexual Offences found that "almost a third of government health practitioners at 31 national rape centers said they did not consider rape to be a serious medical condition."⁵⁰ Staff at many health centers "refused to provide medical treatment in the form of antiretroviral drugs, taken as post-exposure prophylaxis to prevent HIV infection, if the rape had not been reported at a police station." Some women become victims of violence while attending health centers, moreover; WHO reports that, worldwide, tens of thousands of women each year are subjected to sexual violence in health care settings, including sexual harassment by providers, genital mutilation, forced gynaecological examinations and obligatory inspections of virginity.⁵¹

A number of studies have been conducted to determine South African men's and boy's attitudes to sexual violence.⁵² According to the authors of a 2004 report based on a survey of over 250,000 school aged youth, "In South Africa, several studies have shown that youth are affected by sexual violence, that there is a high prevalence of misconceptions about sexual violence and about the risk of HIV infection and AIDS, and that responses to communication about behavior change may be less positive than expected." The authors reveal that males were more likely than females to have misconceptions about sexual violence and were more likely to believe that "a person has to have sex to show love; [that] sexual violence does not include touching; sexual violence does not include forcing sex with someone you know; girls have no right to refuse sex with their boyfriends; girls mean yes when they say no; girls like sexually violent guys; girls who are raped ask for it; and girls enjoy being raped."⁵³



Some men are keen to see reduced gender inequality, however, and reduced gender-based violence. A 2006 Sonke Gender Justice survey of 1000 men in the greater Johannesburg area suggested that about equal numbers of men support and oppose government efforts to promote gender equality, with 41 per cent of men surveyed saying that the government is doing too much to end violence against women and 38 per cent saying that government is not doing enough. At the same time, 50 per cent of all men surveyed felt that they themselves should be doing more to end violence against women.⁵⁴

A study in sub-Saharan Africa of young men and violence in conflict settings identified several factors that facilitated more gender-equitable attitudes and less violent behavior by men, including:⁵⁵

- A high degree of self-reflection and space to rehearse new behaviors
- Having witnessed the impact of violence on their own families and constructed a positive lesson out of these experiences
- Tapping into men's sense of responsibility and positive engagement as fathers
- Rites of passage and traditions that have served as positive forms of social control and which have incorporated new information and ideals
- Family members who model more equitable or non-violent behaviors
- Employment and school enrolment (for some forms of violence and conflict)
- Community mobilisation around the vulnerabilities of young men

There have been a number of HIV-related initiatives seeking to mobilise men's support for gender equality through work on community norms. Perhaps the best known is the Stepping Stones community training and dialogue package. By fostering greater community dialogue, Stepping Stones workshops in 29 countries have helped to reduce the acceptability and prevalence of violence and to promote discussion and awareness about HIV. By changing attitudes and behavior related to violence against women and reducing stigma and discrimination in the community, these programs work to lower HIV vulnerability for women.

In South Africa, the Men as Partners program uses community-based workshops to challenge the attitudes and behaviors that perpetuate violence against women and increase their vulnerability to HIV. Through frank discussions of gender stereotypes and power dynamics, the program engages men and boys as positive forces for change in reducing violence, particularly as it contributes to the spread of HIV. A preliminary evaluation showed that workshop participants had become more likely to believe that men and women should have equal rights and that wife-beating was wrong.

Sonke Gender Justice implements its *One Man Can* Campaign in all South Africa's nine provinces and in a number of Southern African countries. The campaign "supports men and boys to take action to end domestic and sexual violence, reduce the spread and impact of HIV and AIDS and promote healthy, equitable relationships that men and women can enjoy - passionately, respectfully and fully". The campaign utilises a clear human rights framework and educates men and women about existing gender and AIDS related laws and policies that can be used to ensure government lives up to its commitments. Core to the campaign is an "action kit" developed to provide men with resources to act on their concerns about domestic and sexual violence and about HIV/AIDS.

An evaluation conducted by the Centre for AIDS Development, Research and Evaluation (CADRE) of the One Man Can initiative implemented with migrant farmworkers in Limpopo indicates that the workshops, “had a very high impact resulting in reported behavior change. Statements like: ‘people have changed their high risk behaviors’ and ‘the gender component has taken off amazingly’ are evident of the difference this component has had in the community. There is high dynamism as participants develop community action teams on how to put the training into action. The farmers are passionate about addressing gender and there is a need to build on this response... There have been major changes reported on reduction of sexual partners and increased demand for VCT.”

Multiple and concurrent partners

By equating masculinity with sexual conquest, gender roles also contribute to one of the most significant factors driving the spread of HIV across sub-Saharan Africa – multiple and concurrent sexual partnerships.⁵⁶ Having more than one sexual partner at the same time is a strong predictor of HIV infection.⁵⁷ Multiple partnering is closely tied to constructions of masculinity, which define them as the norm for men. Ideas and beliefs about male sexuality create expectations among men that having ‘main’ and ‘other’ sexual partners is both natural and central to their gender identity. Relative to women, men are more likely to have multiple partners simultaneously, more likely to be unfaithful to their regular sexual partner, and more likely to buy sex.

In many cultures, variety in sexual partners is seen as essential to men’s nature.⁵⁸ However, men are more likely to hold these views than women; in community surveys in Swaziland and Botswana, 12 per cent of men and just 3 per cent of women agreed that, “it is OK to have more than one partner at the same time.” In Swaziland, 36 per cent of men and 17 per cent of women thought it acceptable for a man to find another wife if his current wife does not bear children.⁵⁹ Sexual behavior studies globally indicate that heterosexual men, both married and single, as well as homosexual and bisexual men, have higher reported rates of partner change than women.⁶⁰

A quantitative and qualitative study of young people’s (18–30) sexual behavior, undertaken by CADRE in South Africa, concluded that cultural beliefs and ideas about masculinity and femininity interacted with underlying socio-economic contexts and individual psychological factors related to self-esteem and fatalism, to produce patterns of sexual relationships that can facilitate the spread of HIV.⁶¹ A South African study found that 13.5 per cent of men who had had sex within the past twelve months and 3.9 per cent of women had had more than one sexual partner. Younger people were more likely to have more than one partner.⁶²

Qualitative research has demonstrated that men are more likely to practice safer sex with casual sexual partners than they are with their regular partners. This is supported by findings showing that the longer partnerships progress the less condom use will be sustained and consistent over time.⁶³

Men and condom use

Condom distribution in South Africa has increased steadily each year. In 2005, HSRC reported, “clear evidence of excellent condom distribution systems in the country and of the successful implementation of condom use as an HIV prevention strategy,” and that “male condom distribution by the Department of Health has increased markedly – from 267 million in 2001 to 346 million in 2004.”⁶⁴

Other sources report that condom availability has continued to increase over the last two years, with 367 million available in 2006 and 401 million in 2007.⁶⁵

However, condom availability per person remains relatively low. In 2005, the male condom distribution rate was 8.8 per man per year.⁶⁶ The 2007-2011 South African National Strategic Plan draws attention to the need to improve condom distribution: “Male condom accessibility, judged according to the quantity of condoms procured and distributed, has significantly improved. Condoms are being distributed increasingly via non-traditional outlets, but the number of condoms handed out at these venues remains low compared to overall distribution.” A study by Weir et al of drinking venues in Khayelitsha supports this contention. Visits to the sites indicated that more than 90 per cent did not have condoms or any other AIDS prevention materials available despite the fact that more than 80 per cent of the men and women there reported “fishing” at the sites for new sexual partners.⁶⁷

The South African government has made clear its commitment to increasing condom availability. The National Strategic Plan (NSP) proposes to increase significantly the availability of condoms to 100 condoms per male over the age of 15 by 2011. In addition, it lists specific groups to be reached. These include “higher risk occupational groups including uniformed services, mining industry, long distance transport services, agriculture industry and the hospitality industry.” It also commits to ensuring that men in prisons should have access to VCT, male condoms, lubricants, STI symptom recognition and PEP and STI treatment, and draws attention to the condom needs of men who have sex with men, transsexuals, and sex workers and their clients.

A 2001 study of men’s attitudes towards condom use in South Africa reported that some men associate male condoms with discomfort, distrust in relationships, undesired interruption of sexual intercourse, and death of female sexual partners.⁶⁸ More recently, a study of men and women in Soweto by the Men as Partners programme found that 36 per cent of men thought women who carried condoms were “easy”, and that 24 per cent of women agreed.⁶⁹ In a community survey in Swaziland, meanwhile, 35 per cent of men and 27 per cent of women believe that “women should not insist on condoms if their partner refuses.”⁷⁰ These attitudes are somewhat reflected in actual condom use by men and women. A Centre for AIDS Development Research & Evaluation (CADRE) study of 10,000 South African adults found that 22 per cent of men but only 15 per cent of women reported having used condoms the first time they had sex.⁷¹

As noted above, men’s attitudes towards women also influence condom use. Women who experienced forced sex were much more likely to use condoms inconsistently than other women, and those with inconsistent condom use were 1.6 times more likely to be HIV infected.⁷² Qualitative data from studies in Uganda suggest that women find it difficult to suggest or insist on condom use in face of a threat of violence.⁷³

There is also some evidence of a link between men’s use of violence and their own sexual risk-taking. Studies show that men with more traditional attitudes toward gender roles and relations are also more likely to have negative attitudes toward condoms and to use them less consistently.⁷⁴

There is an extensive literature on lessons learned from condom promotion, marketing and distribution and, despite challenges to condom policy on ideological grounds, condoms are widely acknowledged to be a central tool in the public health response to STIs, including HIV. Condom policy should be explicitly linked to gender equity, and initiatives and messages used to promote condoms must also promote equitable sexual relations between women and men and not reinforce negative images of women and female sexuality.⁷⁵



Men and HIV testing

Men in South Africa are significantly less likely than women to use voluntary counseling and testing (VCT) services for HIV/AIDS. A recent national study of VCT services found that men accounted for only 21 per cent of all clients receiving VCT.⁷⁶ A study of over 2,500 men and women in Soweto found that 54 per cent of women and only 29 per cent of men had presented for an HIV test.⁷⁷ Countries such as Namibia, Swaziland and Zambia have similar gender gaps in HIV testing, but in Uganda and Zimbabwe testing rates are more equal, albeit at low levels.⁷⁸

The HSRC’s 2005 South African National HIV Prevalence, HIV Incidence, Behavior and Communication Survey indicates that people who know their status are more likely to use condoms. This remained true regardless of HIV status. Those who knew they were HIV positive used condoms two thirds of the time the last time they had sex compared to only a quarter of the time for those who did not know they were positive. Amongst those who knew that they were negative, half used condoms at last sex compared to only a third of those who did not know their negative status.⁷⁹

While these data show an association between knowing one’s status and increased condom use, many studies show that the relationship between VCT and behavior change depends in significant ways on whether the test results are positive or negative. A randomised trial with 3120 individuals and 586 couples conducted in Kenya, Tanzania and Trinidad found that “the proportion of individuals reporting unprotected intercourse with non-primary partners declined significantly more for those receiving VCT than those receiving health information, and these results were maintained at the second follow-up.”⁸⁰ Weinhardt et al’s meta-analysis of 27 studies on sexual behavior outcome data reported that, “after counseling and testing, HIV-positive participants and HIV-serodiscordant couples reduced unprotected intercourse and increased condom use more than HIV-negative and untested participants. HIV-negative participants did not modify their behavior more than untested participants.”⁸¹

In other words, testing has been shown to reduce unprotected intercourse amongst those who test positive. This is, of course, an important prevention goal. Testing also serves as the gateway to a range of HIV services including treatment. It is, therefore, critical that more men access HIV testing.

3.1. Gender and HIV testing

Country	Ever tested, received results (%)	
	Women	Men
Benin	6.5	4.8
Mali	6.5	2.7
Namibia	28.6	17.6
Niger	0.9	1.6
Uganda	12.0	10.4
Dom Rep	20.5	18.6
DR Congo	4.1	3.8
Swaziland	21.9	8.9
Ukraine	12.3	7.2
Zambia	18.5	11.7
India	1.2	1.4
Zimbabwe	7.0	7.0
Ghana	3.9	2.9



Men's violence and women's experiences of testing and disclosure

In countries with high rates of HIV, VCT services are now routinely being incorporated into antenatal care services, which are important opportunities to provide comprehensive HIV prevention counseling and services, including those related to the prevention of mother to child transmission of HIV. Women, however, are often reluctant to participate in these programs because of fear of abuse from their male partners if they test positive. In many cases, even if women do participate in VCT programs, they will not inform their partners or will not share their HIV status with their partner because of fear of blame or abandonment.⁸² Failure to utilise VCT services during the antenatal and pregnancy period, however, is an important missed opportunity. If a woman does not get tested and is positive, she may miss the chance to receive ARVs that can prevent HIV transmission to her child. She may not receive comprehensive counseling related to breastfeeding options, safe delivery recommendations, and linkages to care and support programs – all important ways for her to ensure a healthy outcome for her child and support for herself. Counseling is also essential for women who test negative because it can reinforce information about ways they can maintain their negative status.



Women's fears of violence upon disclosure are not unfounded; many women have experienced violence or relationship break-up following disclosure.⁸³ It is worth noting, however, that a ten-country study on VCT and disclosure published by the WHO in 2004 found that only 3-15 per cent of women reported violence as a reaction to disclosure of HIV-positive status. Although many studies show that women are fearful of such reactions, "these fears were seldom realised among women who chose to disclose their status."⁸⁴

Assuming most men will be violent even when the data suggest the reality is more complicated and includes a significant number of supportive men decreases the likelihood that service providers will encourage women to bring in their partner for testing and education. As a result, in South Africa and across the world, important opportunities to reach men with VCT services are being lost. In 2005, for example, the Perinatal HIV Research Unit (PHRU) in South Africa provided VCT to 29,333 women through its PMTCT program; however, only 64 men accessed these services in association with their female partners.

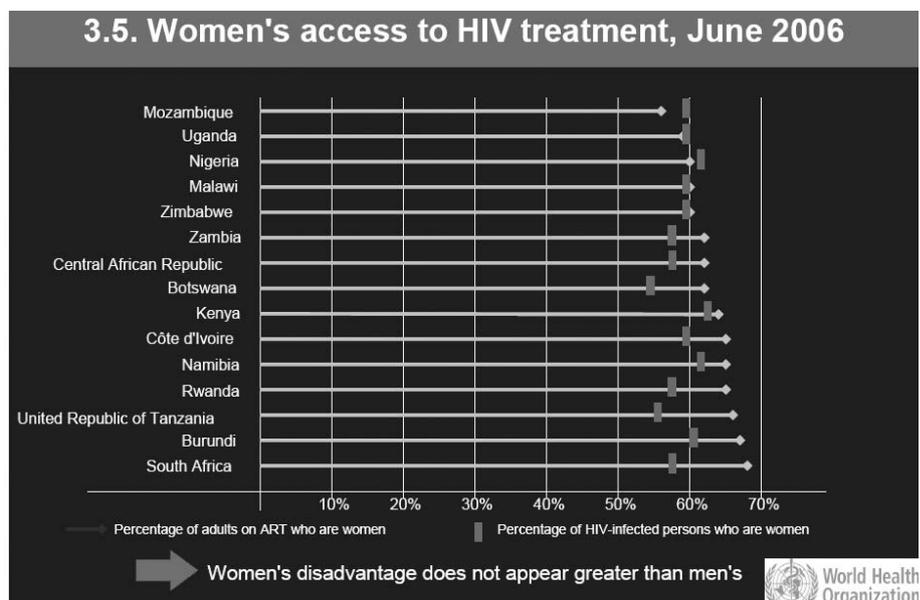
Men and treatment uptake

The South African government lacks accurate data on how many people are receiving antiretroviral therapy for AIDS. Although it claims that 42 per cent of those in need are receiving treatment, independent data gathered by civil society groups suggests this is an overestimate.⁸⁵ Men are less likely than women to access antiretroviral treatment (ART) for AIDS. Nationally, according to the World Health Organisation, 68 per cent of those on the ART program are women (a higher proportion than in all other high prevalence countries), despite roughly equal proportions of men and women needing treatment.⁸⁶ In some parts of the country the discrepancies are sharper still. Research on the uptake of ART in Khayelitsha reveals that 70 per cent of those accessing treatment were women.⁸⁷ In Johannesburg General Hospital, one study found that women accessing ART "outnumbered men by a ratio of 2 to 1."⁸⁸ A similar ratio was reported in a survey of 5,750 patients accessing a wellness clinic in North West Province.⁸⁹ Men are also likely to access antiretroviral therapy later in the disease progression than women, and consequently access care with more compromised immune systems.⁹⁰

Studies show that these gender discrepancies in ART uptake are not a function of the higher infection rates amongst women. An analysis of the Actuarial Society of South Africa's 2003 survey found that, although 43 per cent of ART-eligible patients were expected to be male, based on epidemiological estimates, only about 36 per cent of patients accessing ART turned out to be men.⁹¹

These findings suggest the effects of male socialisation, in which health seeking behaviors are often taken to be a sign of weakness. Natrass cites the result of a 2004 survey of 566 Khayelitsha residents that showed that two-thirds of respondents agreed or agreed strongly with the statement that, "men think of ill-health as a sign of weakness which is why they go to a doctor less often than women."⁹² Men's low utilisation of HIV services mirrors their low utilisation of all health services. Data from the most recent Demographic and Health Survey (DHS) carried out in 1998 show statistically significant differences between men and women's use of all health services across all racial groups.⁹³ Men's lower than expected use of ART also reflects the fact that many reproductive health services do not address men's HIV, STI and other sexual and reproductive health needs. Most VCT services, for instance, are offered in antenatal clinics which often are not welcoming to or equipped to deal with men.⁹⁴ Similarly, many antenatal clinics do not attempt to reach male partners with VCT services.

Dr Francois Venter, head of the South African HIV/AIDS Clinician's Society, makes the point that government has a critical role to play in increasing men's use of HIV services: "The work being done by NGOs... is making a difference in terms of how men now relate to the pandemic, but this exercise should not fall squarely on the shoulders of civil society groups," Venter said. "The government seriously needs to consider new approaches if it is to attract more men to its ARV program."⁹⁵



Men and women living with HIV and AIDS

The recent availability of antiretroviral treatment (ARVs) will allow HIV infected individuals in South Africa to live longer and to remain healthy. With increased levels of health and well-being, many will continue to be sexually active for longer periods of time than was previously the case. Research in the US has demonstrated that a substantial proportion of those infected with HIV continue to practice unsafe sex, despite knowing their HIV status.⁹⁶ Published studies estimate that between 18 and 70 per cent of HIV infected individuals will continue to practice sexual behaviors that may place their partners at risk of infection.⁹⁷ In developing countries such as South Africa, a higher percentage may continue to practice unsafe sex because they are unaware of their HIV status.⁹⁸ Little is known about the sexual behavior of HIV-infected individuals in South Africa, but a single study has noted that 54 per cent of sexually active HIV-positive adults reported unprotected sex in the six months prior to the research interview.⁹⁹

In a study of individuals either on or awaiting enrolment in ART, Eisele et al report that about half of both the men and women had had unprotected sex with a casual partner or a partner whose status was unknown to them and that individuals who were uncertain about whether ART reduced risk of transmission were twice as likely to have had unprotected sex as those who understood that ART does not eliminate the risk of HIV transmission. Importantly, the study also makes clear the gender dynamics informing decisions to have unprotected sex. In explaining their reasons, just over half the men indicated that, “they did not feel it was necessary” to use condoms and just under a quarter reported partner refusal. Of the women who had unprotected sex, just under half reported partner refusal as the reason and just under a third felt using a condom was not necessary. The authors conclude:

“These data reinforce the underlying inequity within this setting where men are typically in control of negotiating condom use during sex and when they deem it unnecessary, women typically comply. Secondary prevention interventions for men within this setting should therefore focus on increasing the awareness and motivation around the need to use a condom during sex, regardless of the availability of ART...Prevention interventions among HIV positive men and women should focus on increasing awareness that ART does not eliminate the risk of transmitting HIV and thus condoms should be consistently be used to reduce such risk.”¹⁰⁰

Male circumcision

Recent improvements in antiretroviral treatment coverage for people living with AIDS have not been replicated in the area of HIV prevention. While surveys across the region show substantial increases in knowledge about the causes of HIV infection and improvements in condom use, a number of countries continue to experience escalating numbers of new HIV infections, with South African studies reporting 1500 new infections a day or nearly 500,000 new infections a year.¹⁰¹ The April 2006 editorial of the South African Medical Journal provides a snapshot of how this context shapes perceptions and expectations related to male circumcision:

“We need some brave thinking on prevention – conventional approaches alone do not seem to work, and acknowledgment of this is long overdue... We need massive and creative interventions, including looking at controversial but seemingly effective interventions such as male circumcision.”¹⁰²

With two decades of observational studies and meta-analyses suggesting a link between male circumcision and increased protection against HIV transmission,^{103,104} and a number of studies indicating high levels of potential acceptability,^{105,106,107,108} three experimental studies on male circumcision were undertaken in Orange Farm, South Africa, Rakai, Uganda and Kisumu, Kenya.^{109,110} The results of the first randomised control trial carried out in Orange Farm were released in June 2005. The study of 3,274 men was stopped at the interim analysis stage due to compelling evidence that men in the intervention arm were 61 per cent less likely to have become infected with HIV. The investigators concluded that male circumcision “provides a degree of protection against acquiring HIV infection, equivalent to what a vaccine of high efficacy would have achieved. Male circumcision may provide an important way of reducing the spread of HIV infection in sub-Saharan Africa.”¹¹¹

Given the limited impact of other HIV prevention methods across the region, these findings led to considerable excitement about the potential for male circumcision to reduce new infections. Dynamic simulation models indicate that full roll-out of male circumcision would lead to dramatic reductions in HIV infection rates and associated mortality. Assuming full coverage of MC is achieved over the next ten years, Williams et al report that:

“Male circumcision could avert 2.0 million new HIV infections and 0.3 million deaths over the next ten years in sub-Saharan Africa. In the ten years after that, it could avert a further 3.7 million new HIV infections and 2.7 million deaths, with about one quarter of all the incident cases prevented and the deaths averted occurring in South Africa.”¹¹²

In some countries, news of the probable protective effect of circumcision combined with donor and NGO advocacy led to sudden waiting lists for the procedure.¹¹³ At the same time, concern was raised about whether publicity about the results might lead to “disinhibition”, with men misinterpreting the results and reaching the conclusion that the increased protection offered by circumcision allowed for more risky sexual behavior, such as less consistent condom use and more concurrent partners.¹¹⁴

Analyses and studies of disinhibition amongst circumcised men are inconclusive. In the Kisumu study, individuals in the control group were found to practise safer sexual behaviors: “Notably greater proportions of circumcised men reported riskier behaviors, although the differences were small and not significant.”¹¹⁵ Agot et al report on a study of 648 men and find, “no excess of reported risky sex acts among circumcised men. Similar results were observed for risky unprotected sex acts, number of risky sex partners, and condom use.”¹¹⁶

In March 2007, the WHO and UNAIDS jointly issued a set of recommendations on male circumcision which included guidance on how best to integrate male circumcision into other HIV services. The relevant section reads:

The investigators concluded that male circumcision “provides a degree of protection against acquiring HIV infection, equivalent to what a vaccine of high efficacy would have achieved.”

“Male circumcision should never replace other known methods of HIV prevention and should always be considered as part of a comprehensive HIV prevention package, which includes: promoting delay in the onset of sexual relations, abstinence from penetrative sex and reduction in the number of sexual partners; providing and promoting correct and consistent use of male and female condoms; providing HIV testing and counseling services; and providing services for the treatment of sexually transmitted infections.”¹¹⁷

Despite the compelling evidence that male circumcision provides significant levels of protection against HIV infection, the South African National Department of Health is yet to develop policies that could take male circumcision to scale. It has only recently begun consultations on circumcision policy. In Swaziland, Lesotho and Zambia, senior health ministry officials coordinate national taskforces on male circumcision.

Men, care and support in the context of AIDS

Lack of access to AIDS treatment has especially disastrous consequences for women and girls in terms of the burden of care and support it forces them to carry. As the epidemic progresses and as more and more people become seriously ill, the impact on women and girls in South and Southern Africa becomes more apparent and the consequences more devastating.¹¹⁸

Cross-cultural research makes clear that women are more likely than men to serve as the primary caretakers of sick relatives and to remain silent about their own health problems when other family members are in need of caring. Women frequently provide this care for people living with HIV/AIDS, although they are not assured of care to the same extent.¹¹⁹ In Africa, there is widespread evidence that men leave the burden of caring for the sick and dying at household and community levels to women, and that this is regarded as a female role.¹²⁰

Taking on this socially prescribed female role of caring often has a serious impact on women's lives. Carers report that looking after people living with HIV/AIDS has drained them both economically and emotionally.¹²¹ For women living with HIV or AIDS, the time and resources they spend taking care of a sick male partner typically means being unable to meet their own health needs, thus creating additional vulnerabilities to opportunistic infections.

A national survey in South Africa of how 8,500 households divide their time showed that women perform eight times more care work than men.¹²² School-aged girls are increasingly pulled out of school to take care of the sick and to assume household responsibilities previously carried out by their mothers. In Swaziland, for instance, school enrolment has fallen by 36 per cent with girls more affected than boys.¹²³ Carers report that looking after people living with HIV/AIDS has drained them both economically and emotionally.¹²⁴

Desmond and Desmond (2005) argue that high HIV/AIDS related mortality amongst women requires that men play a more active role in meeting the psychosocial needs of AIDS-affected children. They provide an analysis of parental presence when one parent has died and show that where the mother is not alive only 30 per cent of surviving fathers are present, but when the father is not alive 71 per cent of surviving mothers are present.¹²⁵

Not all care is provided by women and girls, however. A Kaiser Foundation survey

found that 32 per cent of care in South Africa is provided by men.¹²⁶ Other literature reveals that at least some men want to be more involved in providing care and support to those infected and affected by HIV/AIDS, but are prevented from doing so by cultural pressures. In 1998, a UNAIDS study conducted with men in Tanzania found that some men were willing to do more to support their partners when they fell ill, but were inhibited by culturally prescribed gender roles and expectations.¹²⁷ An evaluation of the Men as Partners program in South Africa bears this out. The program reports that:

“In focus groups conducted in Soweto in March 2003, many men identified traditional gender roles and the fear of losing respect from their peers as a significant deterrent to participating in care and support activities. When asked what might prevent other men from playing a more active role, men identified a number of obstacles. In one group, men answered that some men would see doing work traditionally performed by women as an “affront to their dignity”. Others answered that many men simply did not have the knowledge or skills necessary to provide support or to be more involved in domestic activities and would not want to risk being seen as ignorant or incompetent. Additionally, some men discussed being afraid that their involvement in care and support activities might create the perception that they themselves were HIV positive, which they feared might lead to stigma and social exclusion.”¹²⁸

Montgomery et al’s qualitative study of households affected by HIV/AIDS in KwaZulu-Natal describes a “disjuncture” between “how men’s activities are *talked about* and what some men are observed to be *doing* for their own or other households” (italics in original text). They argue that whilst there is a “linguistic and conceptual locus for the discussion of ‘deficient’ men, no such language appears to exist to talk about men who are positively involved in their families.” Their study revealed that men were involved in care giving activities. However, these activities were seldom acknowledged by community members or by the field workers conducting research who continue to hold the perception that “men are not caring for their families because they are irresponsible and profligate.” The authors call for more research on men’s roles in the family and argue that this has the potential to “inform the development of new programmatic approaches that might feasibly engage men’s concerns and needs, and more effectively involve men as actors in community coping strategies.”¹²⁹

Men, maternal health and family planning

Most men in South Africa are not actively involved in the reproductive health care of their partners and do not typically participate in family planning or antenatal care consultations with them. Most are also absent during labor and delivery.¹³⁰ This has negative consequences for men and women. It decreases the likelihood that men will know how to provide support and reduces the chances that men will learn of health care services that they might benefit from themselves. In the context of sexual and reproductive health, some analysts have argued that men are “the forgotten clients.”¹³¹

When given the opportunity, many men wish to be positively involved in reproductive health decision-making, including in the use of services, to contribute to positive health outcomes not only for themselves but also for their families and communities.

In a study conducted in South Africa on men's attitudes to care and support, findings illustrated that men were willing to participate in antenatal care but felt they did not have the necessary skills.

In a pilot PMTCT program implemented by the Horizons project in Kenya that sought to increase partner involvement in PMTCT, the proportion of male partners who used VCT services as a result of being involved in the program doubled in one site and increased by 50 per cent at another site.¹³² In a study conducted in South Africa on men's attitudes to care and support, findings illustrated that men were willing to participate in antenatal care but felt they did not have the necessary skills. Focus group discussions held with urban and rural men in KwaZulu-Natal in 2001 indicated that men had an interest in using family planning to avoid unwanted pregnancies and control the future. They also expressed a desire for low family sizes and the responsibility of procuring contraceptives for their sexual partners.¹³³

Reporting on the findings from their "Men in Maternity" study carried out in KwaZulu-Natal, Mullick et al argue that it is "indeed acceptable and feasible to involve men in the reproductive health care of their partners." After interviewing and following over 2000 women and more than 500 men, the investigators reported that "the intervention was feasible, relevant and effective in significantly changing communication patterns, encouraging partner assistance during emergency, and highlighting condoms as a dual protection method." They suggest that, "had the intervention been in place for a longer period and supported by mass communication efforts to encourage men to come to the clinic, we may have seen a much bigger impact."¹³⁴ "In order for male involvement in the maternity care of their partners to be successful," the authors argue, "the following challenges need to be addressed:

- Undertaking wider community education so that more men can be persuaded to participate in their partners' maternity care;
- Addressing infrastructural health service issues and timings of services to facilitate the involvement of working men;
- Training more health providers to serve couples, conduct couples counseling and provide male-friendly reproductive health services;
- Integrating other reproductive health services such as STI, family planning, voluntary counseling and testing, and prevention of mother-to-child transmission with antenatal and postnatal care."

Men in prisons

Some men are particularly vulnerable to HIV infection because of the circumstances of their lives. As of 2007, South Africa is home to over 160,000 offenders and an overcrowding rate of approximately 140 per cent.¹³⁵ Men make up nearly 70 per cent of the incarcerated population.¹³⁶ Overcrowding in correctional facilities is an especially worrisome issue when viewed in relation to South Africa's health challenges. In the prison setting, HIV transmission and vulnerability are exacerbated by poor nutrition, inadequate condom provision, and little to no distribution of disinfectant products or condom lubrication.¹³⁷ It is widely acknowledged that: "The quality of prison health care, compared to that available to the general public, is deplorable, and there is little reason to assume that the care specifically for those who are HIV positive is an exception."¹³⁸

A National Inmate Survey of 146 State and Federal Prisons carried out in 2007 found that 4.5 per cent of inmates reported sexual victimisation while in prison. This translates into a nationwide estimate of 141 incidents of sexual victimisation per 1,000 inmates. Over half of this victimisation was carried out by members of staff. In some correctional facilities, the proportion of inmates reporting abuse exceeded 10 per cent.¹³⁹

Chapter 8 of the Jali Commission presents evidence that rape is widespread in prison and calls for action from Government:

“If the Department [of Correctional Services] keeps on ignoring the fact that sexual abuse is rife in our Prisons and that there is an extreme likelihood that prisoners who are exposed to violent unprotected sex will in all likelihood contract AIDS, then it is effectively, by omission, imposing a death sentence on vulnerable prisoners.”¹⁴⁰

HIV infection rates among offenders are higher than those among the general population. A study of over 10,000 prisoners nationwide found HIV prevalence of 19.8 per cent (the national HIV population average is 16.3 per cent). 94 per cent of infections were found among men, and just 6 per cent among women - this despite men making up just 70 per cent of those in correctional facilities.¹⁴¹ A country profile on drugs and crime recorded a 484 per cent increase in deaths in South African prisons between 1995 and 2000. According to post-mortems conducted, most of those deaths are believed to have been the result of HIV/AIDS.¹⁴²



Two: Men, gender and other health issues

There is a growing recognition that gender norms, and the violence that is used to maintain gender inequalities, harms more than men's sexual and reproductive health.

Men's violence against other men and boys

Both worldwide and in South Africa, male-on-male violence is widespread. For males aged 15-29 years old, interpersonal violence (most of it at the hands of other men) is the third leading cause of death worldwide.¹⁴³

In 2003, the National Injury Mortality Surveillance System found that roughly seven times as many South African men as women died as a result of homicide. The South African Health Review reports that in the year 2000, homicide was the second most common cause of premature mortality for men (and the seventh for women). It is important to understand such male-on-male violence as a form of gender-based violence; much of the violence carried out by men against other men serves as a way to assert male dominance.

Violence is not just a matter of individual acts and behavior, however. Violence is institutionalised and rooted in histories and structures of inequality and oppression, including patriarchy, colonialism, racism, and economic exploitation. Some commentators have described the suffering caused and inequalities maintained by public policy and the institutions that make such policy as forms of structural violence.¹⁴⁴ The violence of individual men must be understood and addressed in this broader context of the violence used by dominant groups to maintain their power over subordinate groups, and the institutions through which this violence is exercised - schools, the health system, the workplace, the military and law enforcement systems.

Such assertions of dominance are evident in the sexual violence that men do to other men and boys. A lack of research makes it hard to ascertain an accurate picture of boys' experience of child sexual abuse in this country, yet a review of studies from twenty countries, including ten national representative surveys, has shown rates of childhood sexual abuse of 3-29 per cent for boys (compared to 7-36 per cent for girls).¹⁴⁵ An analysis of the Stepping Stones dataset of 1368 men shows that 3 per cent had been "persuaded or forced to have sex when they did not want to" by a man and 10 per cent had experienced this abuse by a woman. In total 21 per cent of men reported sexual coercion in response to either of these questions or one that asked whether before the age of 18 they had had sex with someone (gender unspecified) because they were threatened or frightened or forced (unpublished data)."

Men, alcohol and risk

Patterns of drinking are embedded in the social, cultural and gender relations of a society. Historically, drinking has been socially acceptable primarily for men. In some societies, alcohol use has taken on a symbolic role as a marker of gender difference. Alcohol use is linked to social reputation, for both men and women, and in some societies is associated with the gender regulation of the public face of people's lives. Men can drink in public, but women more often drink in private. Drinking behavior can also be gendered in relation not only to where drinking takes place, but how much is drunk. Binge drinking that leads to drunkenness is much more common and acceptable for men. The reasons that people drink can also be distinctly gendered.

Alcohol consumption has long been used by men as a way of expressing masculinity. Drinking alcohol is a practice that not only reflects gender norms about appropriate and desired male behavior, but also produces and reproduces those norms.

According to the 2002 World Health Report, men are likely to drink more heavily than women and more likely to be habitual heavy drinkers¹⁴⁶ In South Africa, 40 per cent of men and 15 per cent of women consume alcohol. This widespread alcohol consumption is rising, especially in the adolescent community. It has been noted that adolescents who consume alcohol are prone to “violence, vehicular accidents, uncontrolled sexual behavior and its consequences and drinking to stupor/coma.”¹⁴⁷

The table below shows the tendency to drink or engage in risky drinking is also gendered in South Africa (risky drinking is defined as 5 or more standard drinks per day for men and 3 or more for women). In all age groups, all provinces and all population groups, a much higher proportion of men than women drink. Among drinkers, however, the gender gap is narrower in terms of risky drinking, with roughly equal proportions of male and female drinkers engaging in risky drinking. Rural African women with little education are the riskiest drinkers.

Table 1: Percentage of males and females (=15 years) reporting current use of alcohol, and percentage of current drinkers engaging in risky drinking

Background characteristics	Total sample (5 574 males and 7 962 females)		Current drinkers (2 478 males and 1 321 females)			
	Drink now (Current drinking)		Risky drinking - weekdays ^a		Risky drinking -weekends ^a	
Age	Males	Females	Males	Females	Males	Females
15-24	23.5	8.5	3.1	1.2	29.3	30.1
25-34	51.8	15.6	8.4	9.1	37.2	33.4
35-44	61.1	21.0	7.5	7.4	39.0	32.4
45-54	60.1	23.5	8.1	14.0	31.7	35.3
55-64	54.2	20.4	7.6	12.5	27.2	31.8
65+	45.8	20.3	6.6	7.0	21.0	30.2
Residence						
Urban	46.7	19.2	6.4	7.1	30.0	29.5
Non-urban	41.4	13.2	8.3	12.9	38.0	39.3
Province						
Eastern Cape	47.5	16.2	6.5	9.8	31.4	33.6
Free State	56.2	24.5	5.6	5.6	27.3	30.0
Gauteng	49.7	20.6	6.1	4.7	24.0	22.1
KwaZulu-Natal	39.8	11.5	8.5	14.2	31.7	37.8
Mpumalanga	45.9	14.2	5.8	8.6	49.4	46.4
Northern Cape	48.5	23.1	6.2	7.7	38.1	48.7
Northern Province	28.3	8.6	11.1	18.1	41.1	45.2
North West	46.6	17.0	9.1	14.9	42.9	43.0
Western Cape	43.6	24.2	6.1	5.4	33.4	30.2

Education						
No education	54.6	22.9	6.9	14.6	36.0	38.6
Sub A - Std 3	50.7	16.3	12.1	11.3	40.3	44.6
Std 4 - Std 5	42.0	13.2	10.5	9.5	42.9	44.9
Std 6 - Std 9	39.6	12.7	4.7	7.6	30.4	32.5
Std 10	46.7	18.5	6.9	5.9	24.4	18.3
Higher	57.8	33.4	2.0	1.9	24.0	12.6
Population group						
African	41.5	12.3	7.7	13.3	35.7	42.1
Afr. Urban	43.6	12.8	6.6	11.3	32.5	40.7
Afr. Non-urban	38.8	11.8	9.2	15.3	40.2	43.5
Coloured	44.8	23.2	9.3	4.3	39.2	34.2
White	71.4	50.5	3.4	2.7	18.7	14.0
Indian	37.4	9.0	1.5	0.0	6.1	0.0
Total	44.7	16.9	7	8.8	32.8	32.4

Source: Department of Health 's 1998 South African Demographic & Health Survey

Alcohol consumption is a risk factor for gender-based violence and for the sexual disinhibition that contributes to the spread of HIV/AIDS.¹⁴⁸ The Medical Research Council's National Trauma Research Program reported that 67 per cent of domestic violence in the Cape Metropolitan area was alcohol related. In another study of women abused by their spouses, 69 per cent identified alcohol or drug abuse as the main cause of conflict leading to the violence.¹⁴⁹ Further studies in South Africa have drawn a correlation between alcohol consumption and the likelihood of men and women engaging in unprotected casual sex, particularly in spaces associated with alcohol consumption such as shebeens or taverns.¹⁵⁰ A qualitative study by Morajele et al in taverns and bars in Gauteng suggests a relationship between the use of alcohol and risky sex, especially among casual sexual partners.¹⁵¹ In studies conducted in Cape Town and Durban secondary schools, 66 per cent of male students and 48 per cent of female students in Grade 11 reported binge-drinking.¹⁵² The link with HIV infection, moreover, is strong – a CADRE study in South Africa found that people who regularly had five or more drinks at a time were more likely to be HIV-positive.¹⁵³

Efforts to reduce alcohol consumption have spanned behavioural and structural approaches. Behavioural approaches attempt to help people understand the links between alcohol and health, but in general, structural approaches have proven more effective. These include those related directly to alcohol and those aimed at changing people's environment so that drinking will be a less attractive option.

Taxes on alcohol are a widely used structural deterrent. Tax increases do reduce consumption,¹⁵⁴ but in countries where the rule of law is weak the availability of cheap illicit alcohol reduces the scope for raising tax. Fiscal policies therefore need to be accompanied by effective targeting of illegal vendors.

Legal constraints are a further structural tool. Raising the minimum legal drinking age,¹⁵⁵ reducing legal blood alcohol concentration limits for drivers, installing breath testing checkpoints and banning alcohol advertising have been among the most cost-effective legal measures.¹⁵⁶ Reducing the availability of alcohol also has a significant effect on consumption. A high density of outlets is associated with increased drinking and negative alcohol-related behaviors such as violence.¹⁵⁷

Training those who serve alcoholic drinks has been shown to help tackle both excessive consumption and underage drinking.¹⁵⁸

Perhaps the most radical structural option is nationalisation of alcohol sales. Nationalisation is unpopular with international financial institutions such as the International Monetary Fund (IMF), but it has proven effective in curbing consumption and reducing alcohol-related problems.¹⁵⁹ State monopolies allow governments more easily to restrict outlet numbers and hours of sales, and by reducing the profit motive and removing competition they eliminate the need for advertising and other forms of marketing, which have been shown to encourage consumption.¹⁶⁰

It is not only governments that can address excessive alcohol consumption. Community mobilisation, according to the World Health Organisation, is “among the most powerful catalysts in developing societies, as in the developed world, in reducing rates of alcohol-related problems.”¹⁶¹ The Communities Mobilising for Change on Alcohol (CMCA) project in the US, for example, helped cut consumption among young people and reduced drinking and driving arrests and disorderly conduct violations. The project was run by communities, and included alcohol-free events, monitoring of alcohol outlets that sold to young people, training for servers and reductions in hours of alcohol sales.¹⁶²

Men, chronic disease and tobacco use

Men’s vulnerability to chronic disease is significantly worsened by their level of alcohol and tobacco consumption. Men lose many more disability-adjusted life years than women to chronic diseases related to such behaviors.¹⁶³ There is some evidence to suggest that men and women experience cancer differently, for example.¹⁶⁴ More men than women get cancer, more men than women die from cancer, and men usually adapt less well than women after a cancer diagnosis.¹⁶⁵

These outcomes have been linked to the pressures that men face to adhere to notions of gender difference, and the impact of these on men’s risk behaviors, screening, early detection, symptom recognition, and help seeking and psychosocial adaptation.¹⁶⁶ In most societies, both smoking and drinking are heavily gendered behaviors, as is evident from the messages about and images of masculinity that are used to market alcohol and tobacco. As with alcohol advertising, tobacco use is portrayed as a manly habit linked to happiness, fitness, wealth, power and sexual success. Advertisements often show men in rough terrain, undertaking risky sports (sometimes in industry-sponsored competitions).¹⁶⁷ Tobacco use in many cultures marks the transition to manhood.¹⁶⁸ Globally, over 80 per cent of smokers are men.¹⁶⁹

More than 25 per cent of all South African men currently smoke. In most countries, the poor are more likely to smoke than the wealthy. Those who are less educated are also more inclined to smoke.¹⁷⁰ As well as the health risks, the opportunity costs of tobacco use can be very high for poor people. Household expenditure surveys in countries such as Bulgaria, Egypt, Indonesia, Myanmar and Nepal, show that low-income households spend 5–15 per cent of their disposable income on tobacco, with many poor households spending more on tobacco than on health care or education.¹⁷¹

Tobacco kills one in two long-term users.¹⁷² It is responsible for more deaths worldwide than any other risk factor bar high blood pressure. Consumption of cigarettes trebled in the developing world between 1970 and 2000. Some of the problems caused by tobacco affect men and women equally, including lung cancer, upper aerodigestive cancer, several other cancers, heart disease, stroke, chronic bronchitis and emphysema.

Other problems, such as reduced fertility and sexual potency, are specific to men, while smoking causes pregnancy-related problems in women.

Profound legislative changes have occurred since 1994 in relation to tobacco. Amendments to the Tobacco Products Control Act 83 of 1993 have resulted in the prohibition and restriction of smoking in public places, the prohibition of the advertising and promotion of tobacco products; the prohibition of advertising and promotion of tobacco products in relation to sponsored events; and the prohibition of the free distribution of tobacco products.¹⁷³

Another strategy used by the government to control the use of tobacco and indirectly raise revenue to meet some of the social costs associated with tobacco use is that of excise taxes on tobacco products (Customs and Excise Act 91 of 1964).

These twin strategies of tobacco control legislation and rapidly increasing excise taxes have been remarkably successful. As van Walbeek notes:

“Between the early 1990s and 2004 aggregate cigarette consumption in South Africa decreased by more than a third and per capita cigarette consumption decreased by about half. Smoking prevalence decreased from 32 per cent in 1993 to 24 per cent in 2003. The average number of cigarettes smoked by smokers decreased from 229 packs in 1993 to 163 packs in 2003. Africans, males, young adults and poorer people experienced the most rapid decreases in smoking prevalence, while the decrease was less pronounced among whites, females, and older and more affluent people.”¹⁷⁴

A recent WHO meeting¹⁷⁵ considered the WHO Framework Convention on Tobacco Control (FCTC) in the context of gender. It made the following recommendations for governments:

- Establish national focal point(s) for gender in multi-sectoral tobacco control committees
- Involve NGO groups, especially women’s groups
- Develop and include indicators to measure the gender-responsiveness of national plans of action
- Include Ministries that work on women’s affairs in national planning for tobacco control
- Include gender components and sex-disaggregated data in Conference of the Parties (COP) reports
- Carry out a gender-specific tobacco control situation analysis every 2-3 years
- Establish a gender-responsive infrastructure
- Appoint gender focal points within COP Committees and committees monitoring the WHO FCTC
- Ensure the presence of women’s groups, youth groups and health professionals in national coordinating mechanisms

Action at many other levels is also needed to reduce tobacco consumption. In the health sector, gender-sensitive smoking cessation advice should be included in other health promotion campaigns. In the education sector, gender-sensitive tobacco education should be incorporated in life skills and gender awareness training for young people. Banning tobacco advertising, meanwhile, has been found to reduce tobacco use,¹⁷⁶ and policies to ban smoking in the workplace and other public buildings have also proved effective.¹⁷⁷

In the education sector, gender-sensitive tobacco education should be incorporated in life skills and gender awareness training for young people.

Men and occupational health

It is also important to recognise the relationship between gender norms and occupational health. Worldwide, men are over-represented in nearly all forms of injury. This is related both to their gender and their class position, given the relationship between the gendered division of labor and occupational risk of injury, as men account for the majority of morbidity and mortality from road traffic accidents (including among truck and taxi drivers), falls (men make up most of the construction workforce) and other accidents at work. It is also about the gendering of occupations, such that masculinity becomes equated with a willingness to do the dangerous jobs that 'lesser' men would be afraid of doing.¹⁷⁸ In South Africa, for example, miners, the vast majority of whom are men, are at risk of pulmonary tuberculosis, whose prevalence has doubled since 1989, and silicosis, which affects 247 in every 1000 miners each year and is becoming increasingly widespread.¹⁷⁹

Globally, there are many examples of policies and programs to reduce road traffic injuries, including driver education programs; limiting the number of hours truck drivers can drive to reduce driver fatigue; drinking and driving laws and laws to promote seatbelt wearing. However, there is still little regulation of driving practices in most countries (whether occupational or domestic). Where regulations do exist, enforcement remains weak.

Men and care seeking

Gender norms of masculinity are also implicated in men's reluctance to seek medical care. Men's low use of HIV services in South Africa has already been noted and is a serious cause for concern. Cross-cultural evidence suggests that, in many societies, masculinity is associated with a sense of invulnerability, and with men being socialised to be self-reliant, not to show their emotions, and not to seek assistance in times of need. This reluctance to seek health advice and health care has been noted in the accounts of men with prostate cancer¹⁸⁰ and severe chest pain¹⁸¹. It has been suggested that delays in seeking and using health care may be related to men's beliefs about masculinity.^{182, 183} A UK study of men with testicular cancer found that men regarded help-seeking as not masculine and defined the "male" approach as being independent and being able to deal with problems on one's own.¹⁸⁴ The impact of gender norms on men's health-seeking behavior must be an important focus of policy on men, health and gender equality.

Some of this reluctance is spurred by the fact that health services are often not set up to cater to men's needs. Reproductive health services continue to be provided for and by women, and men often report difficulty in accessing such services. Even those services that are most directly targeted at men, namely STI services, often fail to respond adequately to men's own expressed needs and concerns. Psychosocial issues often predominate when men are asked about their sexual health concerns, yet they are rarely addressed by sexual health services. Analyses of large numbers of studies carried out in Europe and the USA among community and clinic-based samples found a consistent proportion of men who self-report psychosexual concerns of premature ejaculation (35–38 per cent), male erectile dysfunction (4–9 per cent), and inhibited male orgasm (4–10 per cent).^{185, 186}

Certain groups of men may find it particularly hard to access health services, and especially sexual and reproductive health services. Men from poor communities that are underserved by clinical health services often lack the means to pay for transport to clinics and hospitals.¹⁸⁷



Men who have sex with men face both stigma and a lack of knowledge among health care providers of how to treat infections associated with male-to-male sex.¹⁸⁸ Young men often face stigma and censure at the hands of service providers,¹⁸⁹ and men in prisons often receive weaker health care than their free counterparts.

Men and education

Education reduces women and girls' risk of HIV infection, decreases the likelihood that they will engage in risky sexual behaviors, and enhances their ability to discuss HIV and condom use with a partner and negotiate sex.^{190,191,192,193} Gupta et al's analysis of eight sub-Saharan African countries indicates that women with eight or more years of schooling were 47-87 per cent less likely to have sex before the age of 18 than women with no schooling.¹⁹⁴ Similarly, Hargreave and Glynn's review of educational attainment and HIV infection in developing countries revealed reduced HIV prevalence amongst individuals with more education in Uganda, Zambia and Thailand.¹⁹⁵ Education has the potential to play a critical role in reducing women's vulnerability to gender-based violence.^{196,197} The WHO's multi-country study on women's health and domestic violence against women indicates that the strongest evidence for a link between young women's education and their reduced vulnerability to intimate partner violence is to be found among those who have attained post-school leaving qualifications.¹⁹⁸ Higher educational attainment is also associated with women's greater ability to leave abusive relationships.^{199,200,201}

Across Sub-Saharan Africa, school-aged girls have worse educational outcomes than their male counterparts. They also have fewer educational opportunities, with many girls remaining at home to help out with domestic tasks, and priority to receive an education given to boys. South Africa has made great strides in focusing education policy on increasing female outcomes and creating more parity amongst boys and girls within the schooling system. As a result, more women are joining the labor force and entering male-dominated fields.

The Department of Education Gender Parity Index (GPI) shows a GPI in 2001 of 1.00 indicating that school-aged boys and girls have equal access to the school system.²⁰² All provinces within South Africa had a GPI close to 1.00 with only KwaZulu-Natal and Mpumalanga showing ratios less than 1.00, meaning more boys have access to the education system than girls in these provinces. There are other educational outcomes which have not been similar for boys and girls. The National Department of Education revealed that although fewer girls are enrolled in primary school, there were 10 per cent more female learners than male learners at the secondary level,²⁰³ with 93 per cent of girls transferring to secondary school, compared to only 90 per cent of boys.²⁰⁴

However, there are several issues that continue to undermine efforts to create equality in education. Women and girls face more discrimination in school and within the work environment, with sexual violence in school settings a problem. Unterhalter notes that, "the high levels of sexual violence reported in schools is one feature of ways in which participation in education is not a simple process of enrolment and retention and passing exams. Sexual violence in school intersects with political and cultural forms of subordination." A recent national survey in South Africa that included questions about experience of rape before the age of 15 years found that schoolteachers were responsible for 32 percent of disclosed child rapes.²⁰⁵ Human Rights Watch has documented extensive sexual abuse and harassment of girls by both teachers and other students. In each of three South African provinces they visited, they documented cases of rape, assault, and sexual harassment of girls committed by both teachers and

male students. Girls who encountered sexual violence at school were raped in school toilets, empty classrooms and hallways, and hostels and dormitories. Girls were also fondled, subjected to aggressive sexual advances, and verbally degraded at school.²⁰⁶ A 1998 Medical Research Council survey found that among those rape victims who specified their relationship to the perpetrator, 38 per cent said their schoolteacher or principal had raped them.²⁰⁷ A report released by the South African Human Rights Commission on violence in schools indicated that, “schools have become unsafe places for substantial numbers of learners.”²⁰⁸

The report also suggested that schools were the most likely place where children would become victims of crime, including crimes of sexual violence, assault and robberies. In a study conducted to examine the prevalence of bullying behavior in adolescents from Cape Town and Durban it was found that 36 per cent of students were involved in bullying behavior, 8 per cent as bullies, 19 per cent as victims and 9 per cent as bully-victims (those that are both bullied and bully others). Male students were most at risk of both perpetration and victimisation, with younger boys more vulnerable to victimisation.²⁰⁹

Policies related to teen pregnancy are often a further problem. Teen pregnancy has proven to disrupt school-going girls’ education. Nationally, the proportion of women aged 15-19 who are mothers or who have ever been pregnant is 39 per cent.²¹⁰ A study using 2001 data from KwaZulu-Natal found that 32 per cent of 14-19-year-olds who had ever been pregnant were currently attending school.²¹¹ In several qualitative studies, it was also found that girls who had dropped out of school due to pregnancy were less likely to return to complete their matriculation.²¹²

In South Africa evidence suggests youth begin sexual relationships with limited health knowledge and insufficient access to health services. The 2005 HSRC survey indicated that the median age for sexual debut for male and female youths is 17,²¹³ with about 10 per cent more female youths under 25 engaging in sexual activity than males. In a large study that examined knowledge of HIV/AIDS and sexual risks amongst school-going adolescents, 49 per cent of nearly 18,500 learners from across South Africa indicated that they were sexually experienced. Only half indicated that they had used a condom during their last sexual experience.²¹⁴ Evaluations of life skills programs implemented collaboratively by the Department of Health and the Department of Education indicate that these are not well implemented and have little effect on behavior. Describing an outcome evaluation conducted in 24 schools in Gauteng province, Visser reports:

“Learners’ knowledge of HIV/AIDS increased and their attitudes were more positive although the changes may not be attributed to the program alone. In the post-test more learners were sexually active, although preventive behavior did not increase... Results showed that the program was not implemented as planned in schools due to organisational problems in the schools, lack of commitment of the teachers and the principal, non-trusting relationships between teachers and learners, lack of resources and conflicting goals in the educational system”.²¹⁵

Although efforts have been made to use education to prevent violence, there is as yet little conclusive evidence that this approach works.²¹⁶ Developing and implementing violence prevention curricula, whether as a formal part of the mainstream curriculum or an extra-curricula activity, is a common strategy. Evaluations of such curricula suggest that experiential learning is vital, in order to move beyond the transfer of knowledge to focus on attitudes and skills as well. Programs are most effective when

they begin early, involve both girls and boys, and seek to create an alternative peer environment supportive of gender equity and non-violence.

Among limited examples of successful educational programs in South Africa is the program developed by Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) for young boys aged 12-15 to develop resilience in them in order that they can play a positive and meaningful role as men in society. The program used psycho-educational group work to target boys within the school system. The program challenged learners to look at their behavior in relation to the rest of the world. They were encouraged to consider whether this behavior was a strength or a weakness, and thereby engage with the cause and effect of their actions. A program evaluation showed that girls were appreciative of the different way in which boys who had gone through the program responded to them, and that boys generally showed greater empathy for others.²¹⁷



Men and fatherhood

Richter identifies a number of direct and indirect ways in which father involvement improves health outcomes for children. Men are better paid than women and bring more income into the family. Men's status in the community allows them to access and share resources and protects their children. When fathers live with their children, "it confers social value on the children," especially in societies like South Africa where most children grow up without a father in the home. Fathers and step-fathers who live with their children are also likely to spend more money on them than they would if they lived apart.²¹⁸ In healthy relationships, women who live with partners "report being less stressed about childcare." Richter points out that men's involvement is not automatically positive, however. Many men commit violence against women. There is also an urgent need for men to become more involved in childcare activities. Time-use studies show men spend only "a tenth of the time, compared to women, performing childcare tasks for children under seven years of age."²¹⁹

There is a large body of research showing the positive impacts of men's involvement as parents on the development of their children. The engagement or presence of a father or father figure in their life is said to positively affect children's life prospects, academic achievement,²²⁰ physical and emotional health²²¹ and linguistic, literacy and cognitive development.²²² Children's psychological, social and cognitive development, moreover, has been hampered by paternal abandonment and a lack of emotional and material support.²²³

Studies in Central America and the United States have found that paternal abandonment or neglect can result in poor educational performance and school drop out (including early entry into the labour market to help families financially), teen pregnancy, and drug and alcohol abuse. Fatherless children in the US are more prone to suicide.²²⁴

Fathers' negative behaviors have further impacts. Men who are violent, aggressive or alcoholic are more likely to have children, particularly boys, who behave in a similar way.²²⁵ Conversely, fathers with gender-equitable attitudes to childrearing are more likely to pass on those values to their sons and daughters and to spend more time with them.²²⁶

Men's participation as parents can also be positive for the health and well-being of women. It may lead to men assuming more responsibility for child care and domestic tasks, which would be in women's interest as fathers currently only contribute about one-third or one-fourth of the time that mothers contribute to the care of children.²²⁷

Active fathers also provide financial support to their families. Women with children are more vulnerable to poverty if fathers neglect their financial responsibilities.²²⁸ Some mothers are forced to remove their children from school and send them to work.²²⁹ Taking children out of school, of course, may harm the long-term economic prospects of both the children and their mothers.

Fathering can be a useful entry point for working with men on gender equality. In contexts where men have scant engagement with childrearing, expanding and increasing their involvement in the lives of their families can change gender behaviors and attitudes more generally.²³⁰ As the awareness of men's needs in relation to their wives and children increases, traditional ideas about men's role and behaviors are being challenged.²³¹

Research conducted in Sweden and the UK found that as men participate more in sharing domestic work and involve themselves more with children their ideas of masculinity and childcare change, along with their view of their role as fathers.²³² In India and Pakistan a study of how men have changed through becoming fathers (particularly of girls) found that men became more aware of gender issues such as sexual harassment and inheritance law, and that they tried to shift the laws, policies and social pressures that enforced gender inequity.²³³

Desmond and Desmond (2005) estimate that only 48 per cent of fathers in South Africa are present in the homes of children under the age of 18 compared with 80 per cent of mothers. They add that, "in 96 per cent of households headed by men, a female spouse of the head was also present, compared to only 21 per cent of female-headed households that had a male partner of the head present." Their data also indicate a strong relationship between household expenditure and father involvement irrespective of racial group with fathers present in only 38 per cent of households spending less R 400 per month compared with 93 per cent father presence in households with a monthly expenditure totaling over R 10,000.²³⁴

Richter concludes, "Despite widespread father absence and neglect, we should not make the mistake of underestimating the actual and potential contribution, interest and impact of non-resident and low-income or unemployed fathers and, in doing so, marginalise them further...The concept needs to be fostered that increasing men's exposure to children, and encouraging their involvement in the care of children, may facilitate their own growth, bring them happiness and gratification, and foster a more nurturing orientation in general."²³⁵

Research also suggests that health services are not well attuned to the roles that men can play in maternal and child health. A study in the UK has noted the range of and potential conflicts between male roles in antenatal screening, diagnosis and subsequent decision-making. The research found that men can play inter-linked roles: as parents, bystanders, protectors and supporters, gatherers and guardians of fact, and deciders or enforcers. These may be roles they have chosen or which are assigned to them intentionally or unintentionally by others (their female partner or health professionals). Men's status and feelings as fathers are sometimes overlooked or suppressed, or may conflict with their other roles, particularly when screening detects possible physical or mental problems with the baby.²³⁶

Men often welcome opportunities to learn more about the importance of fathers to children, and to discuss how they would like to interact with children and the ways in which, in being more attentive parents, they can promote gender equality.²³⁷ If given the necessary support and opportunities, there is evidence that many men can play a greater role in more gender equitable parenting.

However, many men lack the skills, knowledge and opportunity to change how they



act as parents. They lack positive role models and support in adjusting to a new role as fathers. Their negative experiences with their own fathers can make it hard for them to talk about fatherhood.²³⁸ Programs working with fathers often begin from women's perspectives about what men should be doing, rather than from men's self defined role as fathers.²³⁹ Women may perpetuate behavioral patterns that marginalise men from full participation with their children.²⁴⁰ Activities such as breast feeding, for example, can affect fathers' positive feelings towards infants unless they are able to have exclusive time with babies and, where possible, open and honest discussion with their partners about parenting processes.²⁴¹

Social structures may also prevent men from taking a more active role as fathers, including work practices and the gendered distribution of labor and remuneration, as well as an absence of social support.²⁴² The economic security of families often dictates who stays at home to look after children and whether men take parental leave.²⁴³ This can cause difficulties for fathers as they struggle to balance home and work commitments.

Peer education programs to promote men's role as parents have achieved some success. For example, the Society for the Integrated Development of the Himalayas in India has attempted to bring about changes in fathering by working with men who are the exceptions to the uninvolved norm. It attempts to find those men who assist their wives and can be called upon to speak up about their alternative points of view.²⁴⁴

A few impact evaluation studies have been conducted of programs seeking to increase father involvement. They have shown improved service satisfaction by fathers, greater assistance by fathers of mothers in breast-feeding, and improvements in child-father relationships based on father self-reports.²⁴⁵ Among the indicators of effective work with men on fatherhood, the following appear to be most useful:

- Preventing negative behaviors by fathers (such as abandonment and alcohol use)
- Knowledge (about childbirth, early childhood development, child health)
- Sense of preparedness for fatherhood and perceived paternal competence
- Process indicators (levels of participation)
- Presence and involvement at birth
- Impact on children (cognitive development, school readiness, school performance)
- Paternity establishment
- Time spent interacting with and caring for children.

Health systems constraints

In developing policy that addresses the gender determinants of men's health-seeking behavior, including men's use of health care services, it is important to locate such policy initiatives within the broader context of severe health systems capacity constraints. Studies show that health systems in Southern Africa are "buckling" due to a range of factors, including a dramatically increased workload due to AIDS; AIDS related morbidity and mortality amongst health care workers; emigration of nurses and doctors due to poor pay and difficult working conditions; national policy barriers that prevent task shifting; inadequate national and international attention to the health care worker crisis; and a lack of donor funding for recurrent human resource costs. These problems have been reflected in the failure to expand sufficiently HIV testing and to provide antiretroviral therapy for AIDS to more than a small fraction of those who need it. Findings from a recent report from Medecins Sans Frontieres (MSF) make clear the health systems capacity limitations across Southern Africa. The study shows that whereas the US and the UK have 247 and 222 doctors per 100,000 inhabitants respectively, South Africa has on average 74 doctors per 100,000 inhabitants. The number of nurses per 100,000 in the UK is 1,170, in the US 901, and in South Africa 393.²⁴⁶

These deficiencies highlight the need to prevent rather than cure health problems that arise because of gender differences. As many of the examples presented above show, civil society, communities and businesses can do much to relieve the pressure on public health services. By working with men and boys to tackle harmful gender norms and attitudes, such work can have positive impacts on the health of all South Africans, male and female.

Conclusions

Although much good work has been done to engage men in efforts to reduce gender inequality, most programs have been small in scale and had limited sustainability. Most have focused on running workshops and community education events. Rare exceptions like Soul City in South Africa have been national in scale or reached large numbers of men. Indeed, few program coordinators and staff engaged in such programs are thinking beyond small-scale public health interventions to the larger scale of policy levers and initiatives that lead to larger, faster and broader change in men's behavior.

There is potential for far deeper and more wide-ranging change if existing efforts are scaled up and replicated in more sites. Measurement of impact is crucial to effective rollout – in a field where few initiatives have a long history, it will be important to establish which methods work and which do not in order to design successful scale-up strategies and tailor programmes to different environments. Those campaigns that have achieved results so far have shown that many men are willing to help promote gender equality and that this in turn can improve women's and men's health. If South Africa wishes to stop the spread of HIV/AIDS and enhance the physical and psychological health of all its people, it is time to bring men on board.



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