



Sonke Gender Justice Project

HIV/AIDS, Gender Equality, Human Rights

Men for Change, Health for All:
A Policy Discussion Paper on Men, Health and Gender Equity

Prepared for the
National Department of Health
by Sonke Gender Justice
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Introduction

This discussion paper, *Men for Change, Health for All*, forms part of series of processes toward the finalisation of health policy which engages with men. The aim is to provide a brief gender analysis of men's responsibilities and needs while proposing policy responses in the health arena.

Commitment to gender equality has been a defining feature of South Africa's transition to democracy. Gender has a profound impact on who gets sick, why they get sick and whether they recover. As the World Health Organisation's Commission on the Social Determinants of Health has recently emphasised:¹

"Gender biases in power, resources, entitlements, norms and values, and the way in which organizations are structured and programmes are run damage the health of millions of girls and women."

The Commission concludes that the "[e]mpowerment of women is key to achieving fair distribution of health." Absent, however, in the WHO Commission work is any discussion of men's roles or of the impact of gender on men's own health.

By contrast, the processes of which this discussion paper forms part embrace the notion that the rights, responsibilities and needs of men must be addressed in working toward gender equity in health.² This builds upon the pioneering work on gender equality by government and civil society within South Africa that both calls on men to change and supports men to change, with positive implications for themselves as well as for the women and children in their lives.³

The urgency for such change is clear. Violence, usually perpetrated by men, damages and destroys the lives of both women and men. Risky sexual behaviour by men, encouraged by violent notions of masculinity, increases women's vulnerability to HIV infection and other sexually transmitted diseases. At the same time, social expectations and pressures around masculinity also operate to worsen men's own health. As the Gender Guidelines note:⁴

"[T]he social expectation of young men to have sexual experience and prove prowess may push them into unsafe sexual practices. The social expectation of men to be tough, coupled with the increasing economic vulnerability of young men as they face a future without a job, increases the acceptability of violence as a means of resolving conflict and insecurity."

Men for Change, Health for All is guided by a commitment to develop policy for gender equity in health that both engages men and works for women and men. In doing so, the paper seeks also to reflect the range of lives of men. While all men may enjoy male privilege, this privilege is deeply shaped by other factors and forces, such as class, race, age, nationality and sexuality. "Men" are not an homogenous group and nor is "masculinity" a monolithic concept, and men's diverse experiences of health reflect this. Engaging men in work for gender equity in health must also necessarily be work that is guided by a broader agenda for social justice in health.

This process toward health policy engaging with men for gender equity in health originated in the Gender Guidelines developed by the National Department of Health in 2002, which guidelines

1 WHO CSDH ref "Closing the gap in a generation: health equity through action on the social determinants of health" World Health Organization: Commission on Social Determinants of Health 2008

2 Gender Policy Guidelines for the Public Health Sector, 2002 available on <http://www.doh.gov.za/docs/factsheets/guidelines/gender/>

3 Ambe, D. Karth, V. Khumalo, B. McNab, E. Peacock D., and Redpath, J. *South Africa Country Report to the UN Commission on the Status of Women* Sonke Gender Justice February 2007 by Donald Ambe, Vanja Karth, Bafana Khumalo, Eleanor McNab, Dean Peacock, and Jean Redpath, Feb 2007

4 Gender Policy Guidelines for the Public Health Sector, 2002 available on <http://www.doh.gov.za/docs/factsheets/guidelines/gender/>

acknowledged the rights, responsibilities and needs of men in health policy.⁵ More recently, the South Africa Country Report (2007) to the UN Commission on the Status of Women on *progress made in involving men and boys in achieving gender equality* made clear the need to develop a coherent national policy with regard to engaging men in work for gender equality. In particular, the report noted the importance of health, as both a critical entry point and focus for such policy.

This was followed in September 2007 by a broad consultative forum held with 300 men, drawn from all provinces of South Africa and a range of government and civil society entities, to explore their experiences with sexual and reproductive health services and their perspectives on appropriate policies. This was followed in the same month by a series of National Consultative Meetings convened by the Department of Health in Gauteng, on 17-18 September 2007, which explored policy approaches to working with men to improve men's health and achieve greater gender equality.

The input from these meetings was incorporated into a report on policy approaches to working with men on sexual and reproductive health and rights and gender equality. This report, completed by Sonke Gender Justice for the Department of Health with funding from USAID in December 2007, concluded that the development of health policy engaging with men should be an urgent priority.

Men for Change, Health for All is thus a discussion paper which builds on these processes and forms part of the commitment by the Department of Health to develop national policy guidelines on men, health and gender equality, with a specific emphasis on sexual and reproductive health and rights. Integral are recommendations for policy action which can engage men in efforts to improve the health of both women and men. The recommendations are primarily but not exclusively located in the health sector and have clear implications for action by government and civil society within health and other sectors.

⁵ Gender Policy Guidelines for the Public Health Sector, 2002 available on <http://www.doh.gov.za/docs/factsheets/guidelines/gender/>

1. Sexual Attitudes and Practices

Problem analysis

The vision of gender equality to which the Constitution commits South Africa, and toward which the Department of Health's Gender Guidelines are oriented, is a vision of gender equitable sexual attitudes and practices.

The reality is that sexual attitudes and practices stemming from constructions of masculinity in South Africa underpin two of the gravest crises confronting South Africa, namely HIV/AIDS and sexual violence. A culture of sexual entitlement associated with constructions of masculinity, combined with gendered power and control disparities in relationships, create a context for men to have multiple concurrent partners and fuels a reluctance to use condoms. Men are more likely than women to have multiple partners simultaneously, more likely to be unfaithful to their regular sexual partner, and more likely to buy sex. Women with little power in their relationships are at the highest risk for both sexual assault and HIV infection.⁶

The 2007 National Strategic Plan on HIV /AIDS (2007 NSP) notes that “*qualitative studies in South Africa consistently show that men believe they are more powerful than women and that men are expected to control women in their relationships.*”⁷ Negative attitudes toward women among men are widespread and consequently normalised, so much so that there is evidence that these attitudes are often held by women themselves.⁸ Such beliefs are held by men irrespective of any history of violence. Indeed, it has been observed that:⁹

“The acts of gang rape and forcing by strangers are extreme manifestations of a general culture of male sexual entitlement. This is reinforced in multiple ways by institutions of society, one of which is customary marriage, and dating relationships.”

Sexual attitudes and practices with links to gender which have important health consequences include:

- Multiple sexual partners
- Early sexual debut
- Unequal power in relationships
- Risky sexual practices

Multiple Partners

The available evidence suggests men in South Africa are more likely than women to have more than one sexual partner. A South African study found that among those who had sex within the past 12 months, 13.5% of men and only 3.9% of women, had more than one sexual partner. The same study found that younger people were also more likely than older people to have more than one partner.¹⁰ This is in line with the 2005 HSRC survey, which found that 28% of females aged 15-19 reported having more than one sexual partner in the last year compared to 45.2% of male youths, although the

6 Kalichman, S.C., & Simbayi, L. (2004c). Sexual assault history and risks for sexually transmitted infections among women in an African township in Cape Town, South Africa. *AIDS Care*, 16, 681-689

7 HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (12 March 2007) available on <http://www.info.gov.za/otherdocs/2007/aidsplan2007/index.html>

8 Kalichman, S.C., & Simbayi, L.C (2005). Genital Bleeding During Sex among Sexually Transmitted Infection Clinic Patients in Cape Town, South Africa. *Sexual Health*, 2, 85-88.

9 Jewkes. R. and N. Abrahams, 2002, *The epidemiology of rape and sexual coercion in South Africa: an overview*, *Social Science and Medicine*, Oct; 55(7).

¹⁰ Nelson Mandela/HSRC Study of HIV/AIDS: *South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey*, 2002.

danger of gendered reporting bias (women under-reporting and men over-reporting) should not be discounted.¹¹

Men's practice of having multiple and concurrent partners is closely tied to notions of masculinity which define these sexual partnerships as desirable for men. Beliefs about male sexuality at the heart of these notions of masculinity create expectations among men that having 'main' and 'other' sexual partners is both natural and central to their identity as men. The close connections between men's sexual attitudes and practices and their sense of themselves as men has a long history.¹²

Early sexual debut

Both young men and women face pressure to be sexual in South African society. An indication of the pressure on young men to be sexual to demonstrate their masculinity is evident from a recent national youth survey, which found that 12% of young men report sexual debut at the age of 14 years or younger.¹³ In a study in KwaZulu/Natal, such early sexual debut for men was strongly associated with multiple sexual partnerships in the later teen and young adult years.¹⁴ This association is borne out by other research on men in Africa, suggesting that early sexual behaviours are linked to risk throughout the life course.¹⁵

The implications of this are however highly gendered. Young women are much more likely than young men to be HIV positive: women comprise 77% of the 10% of South African youth between the ages of 15-24 who are infected with HIV/AIDS.¹⁶ This disparity has many causes beyond the biological, including gendered power relations and an associated high rate of sexual violence.¹⁷

At the same time, sexual relationships amongst young people must be understood in the context of prevailing social and economic conditions. These include a more openly sexual youth culture, for both young women and men, and an economic situation in which sex for young women becomes a means for material support as well as emotional connection.

A recent quantitative and qualitative study of young people's (18–30) sexual behaviours concluded that cultural beliefs and ideas about masculinity and femininity interacted with underlying socioeconomic contexts and individual psychological factors related to self-esteem and fatalism, to produce patterns of sexual relationships that can facilitate the spread of HIV.¹⁸

Ethnographic research is showing how unemployment, poverty and sex/money exchanges can fuel multiple-sexual-partners, sometimes across large age gaps, with younger women having sexual relationships with older, often richer, men.¹⁹ Sexual relationships between younger women and older

¹¹ Shisana, O, Rehle T, Simbayi LC, Parker W, Zuma K, Bhana A, Connolly C, Jooste S, Pillay V et al. (2005) South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005 Cape Town: HSRC Press, pp.1-156.

¹² Hunter, M. (2005b). Cultural politics and masculinities: Multiple-partners in historical perspective in KwaZulu-Natal. *Culture, Health, and Sexuality*, 7(4), 389–403.

¹³ Pettifor A, Rees H, Kleinschmidt I, Steffenson A, MacPhail C, Hlongwa-Madikizela L, Vermaak K. Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey. *AIDS* 2005; 19:1525–1534.

¹⁴ Harrison A, Cleland J, Gouws E, Frohlich J. Early sexual debut among young men in rural South Africa: heightened vulnerability to sexual risk? *Sex Transm Infect* 2005; 81:259–261.

¹⁵ White R, Cleland J, Carael M. Links between premarital sexual behaviour and extramarital intercourse: a multi-site analysis. *AIDS* 2000; 14:2323–2331.

¹⁶ Pettifor A, Rees H, Stevens A (2004) HIV & Sexual Behaviour Among Young South Africans: A National Survey of 15-24 Year Olds, University of the Witwatersrand.

¹⁷ Pettifor et al, op cit.

¹⁸ Parker W, Makhubele B, Ntlabati P, Connolly C. Concurrent sexual partnerships amongst young adults in South Africa: Challenges for HIV prevention communication. Johannesburg: CADRE, 2007.

¹⁹ Selikow, T., Zulu, B., & Cedras, E. (2002). The ingagara, the regte and the cherry. HIV/AIDS and youth culture in contemporary urban townships. *Agenda*, 53, 22–32.

men may not only further disempower women because of their youth as well as gender, but also expose such women to greater likelihood of infection from more sexually experienced men.

Rapidly expanding informal settlements, where HIV rates are reported to be almost twice as high as they are in rural and urban areas, are also the areas of highest reported rates of multiple-partnered-relationships.²⁰

High risk sexual practices

Although vaginal sexual intercourse is the predominant mode of HIV transmission in South Africa, as in the rest of sub-Saharan Africa, there is little data on the prevalence of anal sex practices in South Africa, and this is of concern given the increased risks of HIV transmission associated with anal sex.²¹ Research with female sex workers on a national trucking route found that 42.8% had had anal sex with their clients and that this group was more than twice as likely to be HIV positive than those who had only vaginal sex.²² In comparison research based on an analysis of data from a nationally representative household survey of youth aged 15-24 found that amongst those who were sexually experienced, 5.5% of men and 5.3% of women had ever had anal sex. Notably, men reporting anal intercourse were more likely to be HIV positive and younger men aged 15–19 years were more than four times more likely to be HIV infected than those reporting only vaginal intercourse.²³ Yet there appears to be little consciousness that unprotected anal sex is potentially more risky for HIV than vaginal sex in popular understanding.²⁴ There are even indications that anal sex may be perceived as an HIV risk reduction strategy among youth who are avoiding the known risks associated with vaginal intercourse.

Men who have sex with men

Whilst HIV infection amongst men who have sex with men (MSM) was a focus in the early phases of the HIV epidemic in South Africa, very little is currently known about the HIV vulnerabilities and experiences of such men. Small-scale, qualitative studies of self-identified gay men reveal multiple determinants of vulnerability, including homophobic stigma as a barrier to accessing HIV-related services, exacerbated by the familiar factors of class and race.²⁵ There is a growing research interest in “*the sexual aspects of various homo-social situations and settings, such as among mineworkers, prisoners, soldiers, boys living on the streets, and in the context of certain initiation rituals.*”²⁶ The availability of condoms in prisons signals an official recognition that sex between men takes place ‘inside’, and there has been widespread publicity about coerced sex between men in correctional settings. Yet this relative visibility of male-on-male rape has obscured the fact that consensual sex between men also takes place in prison. There is as yet no clear policy that differentiates between

20 Human Science Research Council. (2005). South African national HIV prevalence, HIV incidence, behaviour and communication survey. Cape Town: HSRC Press.

21 Padian, N., Marquis, L., Francis, D.P., Anderson, R.E., Rutherford, G.W., O'Malley, P.M., & Winkelstein W. (1987). Male-to-Female Transmission of Human Immunodeficiency Virus *Journal of the American Medical Association*, 258(6) 788-790.

Varghese, B., Maher, J., Peterman, T.A., Branson, B.M., & Steketee, R.W. (2002). Reducing the Risk of Sexual HIV Transmission: Quantifying the Per-Act Risk for HIV on the Basis of Choice of Partner, Sex Act, and Condom Use. *Sexually Transmitted Diseases*, 29(1), 38-43

22 Karim, S.S., & Ramjee, G. (1998). Anal sex and HIV transmission in women. *American Journal of Public Health*, 88(8), 1265-1266.

23 Lane, T., Pettifor, A., Pascoe, S., Fiamma, A., & Rees, H. (2006). Heterosexual anal intercourse increases risk of HIV infection among young South African men. *AIDS*, 20(1), 123-125.

24 Makhubele B & Parker W. Heterosexual anal sex amongst young adults in South Africa: Risks and perspectives: CADRE, 2007.

25 “PRISM Project: Needs Assessment Report” OUT Lesbian/Gay/Bisexual/Transgender (LGBT) WELL-BEING, 2008

26 “Off the Map: How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa” 2007 International Gay and Lesbian Human Rights Commission

coerced and consensual sex between men in prison, and that seeks to reduce the incidence of the former while reducing the health risks of the latter.

Policy situation

The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (2007 NSP) recommends that there be a greater emphasis on strategies designed to influence behaviour rather than simply raise awareness, and to emphasize positive messaging that it is possible to live a fulfilled life with HIV/AIDS. At the same time, the plan emphasizes to a greater degree the importance of gender issues:²⁷

“There is some evidence that cultural attitudes and practices expose South Africans to HIV infections.

First, gender inequalities inherent in most patriarchal cultures where women are accorded a lower status than men impact significantly on the choices that women can make in their lives especially with regards to when, with whom and how sexual intercourse takes place. Such decisions are frequently constrained by coercion and violence in the women’s relationships with men. In particular, male partners either have sex with sex workers or engage in multiple relationships, and their female partners or spouses are unable to insist on the use of condoms during sexual intercourse for fear of losing their main source of livelihood.

“Second, there are several sex-related cultural beliefs and behavioural practices such as rites of passage to adulthood especially among male youth, rites of marriage such as premarital sex, virginity testing, fertility and virility testing, early or arranged marriages, fertility obligations, polygamy, and prohibition of post-partum sex and also during breastfeeding, and rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of a barren woman marries his wife’s sister) are also believed to spread HIV infection.”

The NSP does not discuss the content of strategies designed to address these attitudes and practices have yet to be clarified.

Policy recommendations to change sexual attitudes and practices

Health programmes and interventions

Policy should seek to ensure that appropriate programmes and interventions which achieve the following are mandated:

Expand masculinities work with men and boys: There is now a body of international and national evidence pointing to the efficacy of gender-based work with men and boys in shaping attitudes and practices around gender and sexuality. Investment is required to scale up these efforts, and in particular to fund the training and compensating of an increased number of male peer educators who can lead this work. As this work is scaled up, it will be important to put training, support and monitoring systems in place to ensure the quality of work done, and to maintain a focus on male power and privilege, and their impact on women’s lives, as well as notions and practices of masculinity, and their impact on men’s lives.

Use peer-based masculinities projects as a pathway to increasing the number of men in the caring professions: While the high level of male unemployment is a significant social and economic challenge facing society, it does present an opportunity to mobilize a significant number of young men in public works initiatives that could include peer-based gender interventions with men and boys. As more men are drawn into this work through the ‘volunteer’ economy, attention should be given to developing pathways between such volunteerism and entry into health and social welfare professions, to increase the number of men in traditionally ‘feminine’ work of social reproduction.

²⁷HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (12 March 2007) p34-35

Health communication

Policy should seek to ensure the following communication strategies are employed:

Target messaging for vulnerable boys and young men: There is some evidence pointing to the efficacy of developing specifically-targeted HIV prevention interventions which address partner concurrency, inconsistent condom use, excessive alcohol consumption, and intimate partner violence among men who live in urban, informal settings. Individually-targeted and small, peer group interventions aiming to support self-defined behavioural change and shift social norms may be appropriate for this population. Venues other than formal education and health care institutions must be utilised for HIV preventive messaging. An example would be venues used for recreation, like shebeens and taverns as well as sports clubs and events.²⁸ Policy must mandate these alternative modes of communication.

Combine mass media with community-based initiatives to promote gender relational approaches to gender equity: Evaluations point to the effectiveness of community-based gender interventions (such as Stepping Stones) that promote dialogue between women and men and joint action toward gender equity. Such interventions, effective across a range of health outcomes, not only require investment for scale-up but also coordination with mass media efforts to promote messaging around equitable gender relations.

Give voice and visibility to alternative masculinities and male sexualities: Part of this expanded agenda must be to give voice and visibility to men, whose gender identities and sexual practices do not conform to the dominant heterosexual norm. While the South African constitution recognizes the sexual rights of people within LGBTI communities, homophobia remains widespread, blighting the lives of men who have sex with men and women who have sex with women. Such homophobia is also an important component of patriarchal relations of power. Challenging this homophobia is thus not only essential to efforts to secure the rights of women and men within LGBTI communities, but also to address the harms of gender inequalities more broadly.

Health research

Policy should mandate the following research:

Further research to better understand the complexities of men's sexualities and vulnerabilities: Recent research has drawn attention to hitherto neglected issues, such as the extent to which male-female anal sex constitutes a significant HIV risk for men and women,²⁹ and the extent of coerced sex experienced by boys and young men, and how this affects their sexual health, practices and lives – and also those of their sexual partners.³⁰ There is still much that is unknown or poorly understood about the complexities of men's sexualities and vulnerabilities, and how these relate to women's sexualities and vulnerabilities, that requires more ethnographically sophisticated research.

Policies in related sectors

These issues should also be addressed in other sectors and while taking cognizance of the intersection with other social inequalities:

28 "Sexual Risk Behaviour Among Men With Multiple, Concurrent Female Sexual Partners in an Informal Settlement on the Outskirts of Cape Town", MRC Policy Brief, April 2008

29 "Heterosexual anal sex amongst young adults in South Africa: Risks and perspectives", CADRE, 2007

30 "13,915 reasons for equity in sexual offences legislation: a national school-based survey in South Africa", Neil Andersson and Ari Ho Foster, International Journal for Equity in Health 2008, 7:20

Address masculinities and social inequalities: A large and growing body of research highlights the complex relationships between masculinities and social inequalities in driving not only men's patriarchal attitudes and behaviours, but also the masculine attitudes and practices that harm men's health and lives. At the level of both direct work with men and at the level of public policy, it is important to address issues of masculinity and their impact on women's and men's health cognizant of the context of social inequalities. More equitable gender relations in part depend on the social, economic and political changes that are needed to bring about greater social justice more broadly. Policy should support such social, economic and political changes.

Target schools as a critical site for gender and sexuality work with young men and boys: The education sector is a critical partner for the health sector in addressing the harmful gender attitudes and practices that produce a range of health problems. There are huge resource issues within the education sector, but there are some steps that can be taken to address the challenge of gender and sexuality work with young men and boys in the school setting, including:

- Fostering partnerships between health and education staff at the district and local level to support the implementation of the Life Orientation curriculum
- More work with peer gender groups in schools, including the DoE's boys and girls clubs initiative
- More emphasis on gender training in teacher training curricula
- More use of Sports as a venue to challenge constructions of masculinity and femininity, including links between DoE and civil society efforts to link gender work with young men and the 2010 soccer World Cup.
- Exploring ways to ensure more women in leadership positions (as Principals and Vice-Principals) and more men in teaching younger grades.

2. Condom Use

Problem analysis

The accessibility of the male condom, according to the quantity of condoms procured and distributed, has improved over recent years. [C]lear evidence of excellent condom distribution systems in the country and of the successful implementation of condom use as an HIV prevention strategy," was highlighted in a 2005 study.³¹ However, condom availability per person remains relatively low. Some 428 million male condoms were distributed in 2007, the equivalent of 17 per person in the 15-49 age group. South Africa's female condom programme has become one of the largest in the world, with a procurement of 2.4 million female condoms in 2005. But a lack of research makes it hard to gauge the gap between supply and demand; the evidence that exists suggests that supply is failing to keep pace with a growing demand.³²

Beside availability, other obstacles to condom use persist. A recent study in North West province commissioned by the provincial Department of Health found positive results regarding accessibility and awareness, but that the majority of respondents still resisted condom usage, used condoms inconsistently, or were not in a position to negotiate their use. The main reasons reported for this were: "reduced pleasure, perceived and real physical side-effects, myths, lack of information, status, financial reasons, distrust in the efficacy of condoms, family planning, cultural reasons, gender-related reasons and trust."³³

Research in South Africa suggests that some men associate male condoms with discomfort, distrust in relationships and undesired interruption of sexual intercourse.³⁴ Furthermore, studies show that men with more patriarchal attitudes toward gender roles and relations are more likely to have more negative attitudes toward condoms and to use condoms less consistently.³⁵ It is important to note that men's attitudes towards women also influence condom use: women who experienced forced sex were nearly six times more likely to use condoms inconsistently than those who did not while women with inconsistent condom use were 1.6 times more likely to be HIV infected than those who used condoms consistently.³⁶

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.³⁷

These attitudes are reflected in actual condom use by men and women. Household surveys suggest that condom use among the 15-24 age group is increasing, but not among other age groups.³⁸ In a large study that examined knowledge of HIV/AIDS and sexual risks amongst school-going

³¹ Human Science Research Council. (2005). South African national HIV prevalence, HIV incidence, behaviour and communication survey. Cape Town: HSRC Press.

³² *Female Condom Research Briefs*, Family Health International available on <http://www.fhi.org/en/RH/Pubs/Briefs/FemCondom/southafrica.htm>

³³ Versteeg M, Murray M. Condom use as part of the wider HIV prevention strategy: experiences from communities in the North West Province, South Africa. *SAHARA J.* 2008 Jul;5(2):83-93.

³⁴ Maharaj, P. (2001). "Male Attitudes to Family Planning in the Era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa. *Journal of Southern African Studies*, 27(2), pp.252-254.

³⁵ Noar SM, Morokoff PJ. The Relationship between Masculinity Ideology, Condom Attitudes, and Condom Use Stage of Change: A Structural Equation Modeling Approach. *International Journal of Men's Health*, 2001; 1(1).

³⁶ Pettifor A E, Measham D, Rees H V and Padian N S. 2004. Sexual power and HIV risk, South Africa. *Emerging Infectious Diseases*. 10 (11): 1996-2004.

³⁷ Parker et al 2007.

³⁸ Shisana, O., Rehle, T., Simbayi, L.C., Parker, W., Zuma, K., Bhana, A., Connolly, C., Jooste, C., Pillay, V. et al. (2005). *South African national HIV prevalence, national incidence, behaviour and communication survey, 2005*. Cape Town: Human Sciences Research Council Press.

adolescents, 49% 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.³⁹ One study of 10,000 South African adults found that 22% of men but only 15% of women reported having used condoms the first time they had sex.⁴⁰

In the two South African sites (Vulindlela in KwaZulu-Natal and Soweto in Gauteng) of a recent baseline study for a community-randomized controlled trial to determine the effectiveness of community-based VCT, men reported higher consistent condom use with both regular and non-regular partners than females, but the levels of consistent use among males in regular partnerships were less than 50%. The study found increased condom use by men with non-regular partners, but cautioned that “*these data may be limited due to smaller sample sizes reporting sexual activity in the prior 30 days.*”⁴¹

The limited research on condom use by men within LGBT communities and other men who have sex with men echo the findings above. A study by OUT found that only 27% of respondents used condoms most of the time and 24% indicated that they did not use condoms, citing their relationship as a reason.⁴² In a sexual health needs assessment with 36 self-identified gay, white males, “*it became clear that the more familiar the sexual partner is the less likely it is that protection will be used.*”⁴³

Condom use in sex between men is also related to power in sexual relationships. Poor, young, homeless male sex workers, for example, seldom have the power in their transactions to demand that their clients wear a condom.⁴⁴ The lack of availability of appropriate lubricant has also impaired the effective use of condoms in anal sex.

The little research that has been done in correctional settings bears this out. HIV transmission and vulnerability are exacerbated in prison by inadequate condom provision, and little to no distribution of disinfectant products or condom lubrication.⁴⁵ Condoms are officially available, but in reality, inmate access to condoms varies markedly, depending on the attitudes of particular staff and the cultures of particular institutions. A survey of male youths’ experiences in the Boksburg Youth Correctional Centre found that those who had succeed in obtaining a condom had most commonly sourced the condoms from another offender (28%), while 24% had received it from a medical member of staff.⁴⁶ However, lubricant is not available in correctional settings, thus undermining the efficacy of the condom use, particularly when other forms of lubrication are used that damage the integrity of the condom. The Boksburg study found that over 60% of the young men were either unsure about the effect of Vaseline on condoms, or wrongly believed it not to damage condoms.

³⁹ Kushlick, A. & Rapholo, G. (1998). Baseline survey into HIV/AIDS knowledge, attitudes and related life skills. Researched for the National Life Skills Task Team. Braamfontein: Community Agency for Social Enquiry.

⁴⁰ Kincaid, DL, Parker, W (2008): National AIDS Communication Programmes, HIV Prevention Behaviour, and HIV Infections Averted in South Africa, 2005. Pretoria, JHHESA.

⁴¹ “HIV Risk Behaviors in Sub-Saharan Africa and Northern Thailand: Baseline Behavioral Data From Project Accept”, Becky L. Genberg, Michal Kulich, Surinda Kawichai, Precious Modiba, Alfred Chingono, Gad P. Kilonzo, Linda Richter, Audrey Pettifor, Michael Sweat and David D. Celentano, (J Acquir Immune Defic Syndr 2008; Volume 49, Number 3:309–319

⁴² OUT. (2005). *Results of the Young Gay Men’s Study*. Pretoria: OUT LGBT Well-being Research Report.

⁴³ “PRISM Project: Needs Assessment Report” OUT Lesbian/Gay/Bisexual/Transgender (LGBT) WELL-BEING, 2008

⁴⁴ “Opportunities for LGB-Research Collaborations in South Africa: Report about an exploratory work visit”, Theo Sandfort and Robert Sember, (unpublished) 2006?

⁴⁵ Goyer KC, Gow J. Alternatives to Current HIV/AIDS Policies and Practices in South African Prisons. *Journal of Public Health Policy*, 2002; 23(3): 308-310.

⁴⁶ “Doing Time in a Gauteng Juvenile Correctional Centre for Males”, CSVr Criminal Justice Programme, Briefing Report No. 01, September 2007

Policy situation

Policy has thus far emphasized ensuring access and increasing distribution of condoms. The *Sterilisation Act 44 of 1998* recognises that “women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation”. The *National Contraception Policy Guidelines (2003)* provide that male condoms should always be in stock at all health facilities, and that effective, safe, permanent male sterilisation procedures should be made accessible to and promoted for men who are certain that they do not wish to have more children.⁴⁷ In 2000, the National Education Department published *Guidelines for Educators on the HIV/AIDS Emergency* that encourage condom availability in schools and encourage educators to talk to learners about sexuality. The *Children’s Act (2005)* goes further in stating that any child from the age of 12 who requests condoms should be given them and is entitled to confidentiality.

The *National HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011* (NSP) draws attention to the need to improve condom distribution, in particular via non-traditional outlets. The NSP proposes to significantly increase the availability of condoms to 100 condoms per male over the age of 15 by 2011. In addition, the NSP 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 “access to VCT and access to male condoms, lubricants, STI symptom recognition and access to PEP and STI treatment,” for men in prisons and draws attention to the condom needs of “men who have sex with men and transsexuals”, and “sex workers and their clients” and to workplaces in general.

Policy recommendations to expand condom use

Health programmes and interventions

Use non-traditional condom outlets as opportunities for gender equity education: The acknowledged shortfall in condom distribution will only be met by significantly expanding the use of non-traditional condom distribution outlets. It is important that condom distributors in such outlets are not only trained and supported to provide basic information on correct condom usage, but also equipped to do basic work on gender equity education, using materials developed by civil society groups, such as the One Man Can campaign.

Increase the emphasis on provision of female condoms: The condom shortfall is most marked in relation to the female condom, whose level of distribution remains significantly below that of the male condom. Cost considerations have inhibited efforts to promote the female condom more widely. But given a commitment to link the protection afforded by condoms with the effort to promote greater gender equity, it is clear that female condoms, as a female-controlled method, should be given greater attention in condom promotion strategies. Further research is needed on men’s attitudes toward the use of the female condom, but there is anecdotal evidence that some of the factors that inhibit men’s use of the male condom, such as anxieties about correct use and loss of spontaneity, would be addressed by the female condom.

Address the needs of men who have sex with men via provision of lubricant: Organisations representing gay men and other men who have sex with men have long called for increased investment in the distribution of appropriate lubrication to accompany condom distribution targeted at men who have sex with men. Current policy, as stated in the NSP, reflects this need but

⁴⁷ HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (12 March 2007) p27

implementation is lacking. Making lubricant available in community and correctional settings is an urgent priority, together with education on currently used forms of lubrication that damage condoms and increase risk of infection.⁴⁸

Health communication

Link condom promotion explicitly with gender equity education: 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.⁴⁹

Link condom distribution and promotion with work on sexual violence and coercion: Condom distribution and promotion are potentially valuable opportunities to educate men about issues of communication and coercion within sexual relationships.

Develop condom promotion campaigns that emphasise family planning and dual protection: While some evidence points to increasing use of condoms in ‘casual’ relationships, there is considerable evidence suggesting that condom use in relationships is associated with lack of intimacy and lack of trust. Such associations constitute major barriers to increasing the use of condoms. Reframing condoms as a family planning method and emphasising their role in dual protection is one way to minimize such associations, at the same time as increasing men’s engagement in family planning itself.

Policies in related sectors

Review current policy on condom availability in schools: Current policy prohibits condom distribution in schools and emphasises the teaching of abstinence to learners. In light of international evidence on the efficacy of age-appropriate, comprehensive sex education and of increasing young people’s access to condoms, as well as the body of national research pointing to high levels of sexual activity among school-going young people, it is important that current policy be reviewed.

⁴⁸ *Policy approaches to working with men to achieve gender equality:* National Consultative Meeting, September 17-18, 2007, Birchwood Conference Centre, Gauteng

⁴⁹ “Men’s influences on women’s reproductive health: medical anthropological perspectives”, Matthew R Dudgeon and Marcia C Inhorn, *Social Science & Medicine*, 2004 vol. 59 pp. 1379-1395

3. Male Circumcision

Problem analysis

Dramatic results from three experimental studies on male circumcision undertaken in Orange Farm, South Africa, Rakai, Uganda and Kisumu, Kenya have provoked intense interest in and debate about the need to scale up male circumcision as a powerful tool for HIV prevention.^{50,51} Investigators from the Orange Farm study concluded that circumcision:⁵²

“[P]rovides 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.”

Mathematical modeling supports this prediction. It has been estimated that large-scale implementation of male circumcision has the potential to avert about 2 million new HIV infections and 300 000 deaths over the next 10 years in southern Africa. Over the subsequent 10 years, an additional 3.7 million HIV infections and 2.7 million deaths could be averted.⁵³ A WHO/UNAIDS Technical Consultation concluded that the *“[e]vidence is compelling. Promoting male circumcision should be recognized as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men.”*⁵⁴

The challenges of and concerns about translating these experimental studies into policies and programmes in the ‘real world’ has generated much debate. Concern has been 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.⁵⁵ 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.”*⁵⁶ 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.”*⁵⁷

Concern has also been raised about the benefits of male circumcision to women. A recent meeting of civil society representatives, predominantly women living with HIV in sub-Saharan Africa, concluded

⁵⁰ Scott BE, Weiss HA, Viljoen JI. The acceptability of male circumcision as an HIV intervention among a rural Zulu population, KwaZulu-Natal, South Africa. *AIDS Care*, 2005; 17(3): 304.

⁵¹ Mattson CL, Bailey RC, Muga R, Poulussen R, Onyango T. Acceptability of male circumcision and predictors of circumcision preference among men and women in Nyanza Province, Kenya. *AIDS Care*, 2005; 17(2): 182.

⁵² Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, et al. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. *PLoS Med*, 2005; 2(11): e298. [PLoS Medicine (eISSN 1549-1676; ISSN-1549-1277) is an open-access, peer-reviewed medical journal published monthly online by the Public Library of Science (PLoS), a nonprofit organization.]

⁵³ Williams BG, Lloyd-Smith JO, Gouws E, et al. The potential impact of male circumcision on HIV in Sub-Saharan Africa. *PLoS Med* 2006; 3: e262.37

⁵⁴ WHO/UNAIDS Technical Consultation Male Circumcision and HIV Prevention: Research Implications for Policy and Programming, Montreux, 6- 8 March 2007.

⁵⁵ Cassell M, Halperin D, Shelton J, Stanton D. HIV and risk behavior: Risk compensation: the Achilles’ heel of innovations in HIV prevention? *BMJ*, 2005; 332(11).

⁵⁶ Bailey RC, Moses S, Parker CV, Agot K, Maclean I, Krieger JN, Williams CM, Campbell RT, Ndinya-Achola J, (2007) Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial www.thelancet.com Vol 369 February 24, 2007 643

⁵⁷ Agot, KE; Kiarie, J, Nguyen, H, Odhiambo, J; Onyango, T; Weiss, N (2007) Male Circumcision in Siaya and Bondo Districts, Kenya: Prospective Cohort Study to Assess Behavioral Disinhibition Following Circumcision. *Journal of Acquired Immune Deficiency Syndromes*. 44(1):66-70, January 1, 2007.

that: “*Modeling studies suggest indirect protection will eventually accrue to women but that in the short term increased feminisation of the epidemic is likely.*”⁵⁸ While women will benefit from circumcision via men’s lowered likelihood of genital ulcer disease and human papilloma virus infection (causative agent of cancer of the cervix), the meeting urged that the focus on male circumcision not divert attention and resources away from prevention and treatment programmes that work for women (such as the female condom, microbicides, pre-exposure prophylaxis and vaccines, as well as structural and behavioral interventions that will reduce women’s risk). It is in part in response to these concerns that the WHO/UNAIDS Technical Consultation affirmed that:⁵⁹

“*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.*”

Such a package must pay attention to the particular challenges of circumcision for HIV positive men.

The need to develop a policy position on male circumcision within a broader package of HIV prevention and framework of sexual and reproductive health is made more urgent by a recent study that links circumcision with increased rates of HIV infection, in connection with circumcision-related blood exposures.⁶⁰ While the methodology of this study has been questioned by other researchers, there are a number of concerns relating to circumcision and HIV risk that policy needs to address. These include setting standards for circumcision procedures that ensure their HIV protective effect, given that many different practices are included within the rubric of “circumcision”, as well as ensuring that the procedure is accompanied by education and services for risk reduction, not least with respect to abstaining from sex for at least 6 weeks after the procedure.

Current policy (discussed below) addresses the safety of traditional circumcision and issues of consent, and enforcement of these policy provisions remains a priority, given what is known about the health complications arising from poorly performed procedures.⁶¹ However, developing a legal, regulatory and policy framework that ensures accessibility, acceptability, quality, and safety for male circumcision in South Africa must involve a fuller dialogue with traditional leaders and healers, given the likely role that traditional circumcision will play in any significant roll out of a male circumcision service in the context of an over-burdened and under-resourced public health sector.

Policy situation

Male circumcision was not addressed in the 2000-2005 NSP. The 2007-2011 NSP notes only that a mechanism is needed to determine how best to translate recent evidence about the impact of circumcision on prevention into policy and programmes.

Current policy is consequently focused on ensuring that circumcision is carried out ethically and with minimum harm to those being circumcised, particularly in respect of traditional circumcision. For example the *Children’s Act 38 of 2005* provides that circumcision of male children under the age of

58 Stevens, Marion. Civil Society Report-back on dialogue on Male Circumcision: Implications for Women. Democratic Nursing Organisation of South Africa: *Nursing Update*. August 2008, p39-41

59 New Data on Male Circumcision and HIV Prevention: Policy and Program Implications. WHO/UNAIDS Technical Consultation Male Circumcision and HIV Prevention: Research Implications for Policy and Programming, Montreux, 6- 8 March 2007.

60 Brewer, D. D., Potterat, J. J., Roberts, J. M., Jr., & Brody, S. (2007). Male and female circumcision associated with prevalent HIV infection in virgins and adolescents in Kenya, Lesotho, and Tanzania. *Annals of Epidemiology*, 17: 217-226.

61 Speech by MEC for Eastern Cape Department of Health, Ms Nomsa Jajula at the 2nd Initiation Schools Conference held at Griffiths Mxenge College of Education, Zwelitsha from 24 - 27 October 2006.

16 is prohibited, except when circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the “manner prescribed”; or circumcision is performed for medical reasons on the recommendation of a medical practitioner.⁶² The “manner prescribed” is not yet known as the regulations to the Act have not yet been promulgated. Taking into consideration the child’s age, maturity and stage of development, every male child⁶³ has the right to refuse circumcision.⁶⁴

In terms of the *Regulations governing private hospitals and unattached operating theatre units* promulgated in terms of this Act, circumcision is a prescribed procedure which may also be carried out in unattached operating theatre units.⁶⁵

The *National Health Act 61 of 2003* provides that the Minister may, in the interests of the health and well-being of persons attending an initiation school and subject to the provisions of any other law, prescribe conditions under which the circumcision of a person as part of an initiation ceremony may be carried out.⁶⁶ The date of commencement has yet to be proclaimed and the Minister has yet to prescribe such conditions.

However provincial legislation on traditional male circumcision exists in some provinces. The *Free State Initiation School Health Act 1 of 2004*, the *Application of Health Standards in Traditional Circumcision Act 6 of 2001* (Eastern Cape) and the *Northern Province Circumcision Schools Act of 1996* all provide inter alia for registration of traditional circumcision practitioners. This is an arena of struggle concerning the status and powers of traditional authorities. Despite such regulation, boys continue to die or be hospitalised as a result of inappropriately administered traditional circumcision practices.⁶⁷

Policy recommendations on male circumcision

Health structures

Establish a national task force: Given the evidence pointing to the efficacy of male circumcision as an HIV prevention method and the controversies surrounding the optimal ways in which to expand the use of this method, as a first step, the Department of Health should follow the example set by Swaziland, Lesotho and Zambia, amongst others in the region, who have set up national task forces on male circumcision led by senior government officials. Such a task force should include, amongst others, representatives from the traditional sector.

Work with traditional authorities to ensure traditional circumcision is both complete and safe: As news of the HIV protective effects of male circumcision spreads, it is unlikely that the public health system will be able to meet the increased demand. One clear priority for a national task force on male circumcision will be to work with traditional authorities to ensure that traditional circumcisions are not only safe but complete, in order to ensure their HIV protective effect. As has been noted, there is already evidence that traditional leaders are eager to ensure the safety of

⁶² Section 12 (8), Children’s Act 38 of 2005

⁶³ Genital mutilation or the circumcision of female children is prohibited in terms of s12(3) Children’s Act 38 of 2005.

⁶⁴ Section 10, Children’s Act 38 of 2005

⁶⁵ Annexure A, GNR.158 of 1 February 1980

⁶⁶ Section 43, National Health Act 61 of 2003

⁶⁷ See e.g. Daily Dispatch *Boy, 16, dies after botched circumcision*
<http://www.dispatch.co.za/article.aspx?id=219565>

traditional circumcision practices and male circumcision offers the opportunity to re-engage with religious and ethnic groups in HIV prevention.⁶⁸

Health policy

Develop a regulatory framework: Current policy focuses on reducing the harms of traditional circumcision (discussed below). But a broader regulatory framework is required to ensure that the anticipated increase in demand for male circumcision can be met in a way that ensures accessibility, acceptability, quality, and safety, and that male circumcision never replace other known methods of HIV prevention and be always considered as part of a comprehensive HIV prevention package.

Address the needs of HIV-positive men: In developing a national policy framework, the task force should also take account of the following UNAIDS guidance with respect to HIV positive men:

- Not recommended for HIV-positive men as an intervention to reduce HIV transmission to women.
- Provide to all men irrespective of HIV status, if medically indicated
- If male circumcision is requested by men with HIV infection following in-depth counselling on the known risks & benefits, it should not be withheld unless it is medically contraindicated.
- HIV testing should be recommended for all men seeking male circumcision, but should not be mandatory.

Health services

Invest in health sector capacity: Another priority for the task group will be to develop and cost plans for strengthening the capacity of the public health system, including changing policies to allow surgical nurses to perform male circumcision and expanding provision of neo-natal circumcision.

Health communication

Ensure HIV prevention and gender equity education: Circumcision providers, whether in the traditional or formal health sector, require training, resourcing and monitoring to ensure that a package of HIV prevention and gender equity education accompany the circumcision procedure. This is essential in order to address the acknowledged risk of sexual disinhibition and to use the opportunity to promote messages around shared sexual decision-making, gender equality, and improved health of both women and men. This education package should also include condom distribution and promotion, as well as VCT and STI treatment referral.

Health research

Support further research needed to guide implementation: There is still much that we do not know in relation to male circumcision. It is important that the national task force consider ways in which South Africa can participate in international efforts to:

68 Working with traditional leaders and circumcisors critical to effective role out of male circumcision as an HIV prevention strategy. Dean Peacock and Bafana Khumalo (unpublished)

- Clarify the risks and benefits re HIV transmission from HIV-positive men to women, for men who have sex with men and in the context of heterosexual anal sex.
- Further study safety in HIV-positive men.
- Conduct operations research during scale-up to determine: best models & packages for service delivery in different epidemic settings, for different population groups & at different ages; how to achieve optimum quality services, including effective counselling methods; document changes in HIV-related individual and community perceptions and behaviours.

4. HIV Testing and PMTCT

Problem Analysis

HIV testing is an important component of prevention as well as treatment. People who know their HIV status are more likely to use condoms.⁶⁹ HIV testing has been shown to reduce unprotected intercourse amongst those who test positive, an important HIV prevention goal.⁷⁰ Testing also serves as the gateway to a range of HIV services, including treatment.

Men are much less likely than women to know their HIV status as a result of getting an HIV test. A recent national study of VCT services found that men accounted for only 21% of all clients receiving VCT.⁷¹ A baseline household study for a community-randomized controlled trial to determine the effectiveness of community-based VCT found that around half of females in Soweto reported ever having had an HIV test, whereas only one third of males reported a lifetime HIV test; in Vulindlela (KwaZulu-Natal) approximately 40% of women had ever had an HIV test, compared to only 16% of men.⁷² Little is known about the effect of age, ethnicity or economic status on men's testing behaviour. The findings from small scale, qualitative studies of men who have sex with men echo those above in terms of low levels of VCT uptake.⁷³

Explanations of this gender difference highlight several factors. Women and men appear to be similarly knowledgeable about HIV testing services,⁷⁴ but women are more likely to be tested as part of their uptake of ante-natal care in public health clinics. It is easier for men to avoid the test because of their low utilization of public health facilities. It has been suggested that men's low uptake is a specific example of a more general problem; men are less ready than women to seek treatment for poor health as a result of "gendered norms which make it difficult for men to admit any health-related weakness and seek medical attention."⁷⁵

At the same time as men are less likely to test, they also influence women's testing behaviour. Research suggests that the fear and fact of men's violence can deter women from taking an HIV test or disclosing an HIV positive result. In studies from Tanzania, South Africa and Kenya, 16-51% of women who did not disclose their status cited fear of men's violence as a major reason.⁷⁶ A study of PMTCT programmes in sub-Saharan Africa found that fear of ostracism and domestic violence led to pregnant women refusing to get tested for HIV or to return for their test results.⁷⁷ In developing policy

⁶⁹ Shisana, O, Rehle T, Simbayi LC, Parker W, Zuma K, Bhana A, Connolly C, Jooste S, Pillay V et al. (2005) South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005 Cape Town: HSRC Press, pp.1-156.

⁷⁰ L S Weinhardt, M P Carey, B T Johnson and N L Bickha (1999); Effects of HIV counseling and testing on sexual risk behavior: a meta-analytic review of published research, 1985-1997. *American Journal of Public Health*, Vol. 89, Issue 9 1397-1405.

⁷¹ Magongo B, Magwaza S, Mathambo V, Makhanya N. *National Report on the Assessment of the Public Sector's Voluntary Counselling and Testing programme*. Durban: Health Systems Trust, 2002.

⁷² "HIV Risk Behaviors in Sub-Saharan Africa and Northern Thailand: Baseline Behavioral Data From Project Accept", Becky L. Genberg, Michal Kulich, Surinda Kawichai, Precious Modiba, Alfred Chingono, Gad P. Kilonzo, Linda Richter, Audrey Pettifor, Michael Sweat and David D. Celentano, (J Acquir Immune Defic Syndr 2008; Volume 49, Number 3:309-319

⁷³ Tim Lane, J. McIntyre, and S. Morin, "HIV Testing and Stigma among Black South African MSM," Center for AIDS Prevention Studies (CAPS) poster presentation at the 2006 International AIDS Conference Toronto, Canada.

⁷⁴ Shisana, Olive; Rehle, Thomas; Simbayi, Likeness; Parker, Warren; Zuma, Khangelani, Bhana, Arvin; Connolly, Cathy; Jooste Sean, and Victoria. Pillay. 2005. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Human Sciences Research Council, Pretoria.

⁷⁵ "Gender and Access to Antiretroviral Treatment in South Africa", Nicoli Natrass, *Feminist Economics*, Volume 14, Number 4, October 2008, pp. 19-36(18)

⁷⁶ Medley A, Garcia-Moreno C, McGill S and Maman S. 2004. Rates, barriers and outcomes of HIV sero-disclosure among women in developing countries: Implications for prevention of mother-to-child transmission programmes. *Bulletin of the World Health Organization*. 82 (4): 299-307.

⁷⁷ Nyblade, Laura and Mary Lyn Field-Nguer (2000). "Women, Communities, and the

responses to the reality of this fear, however, it is important to take account of other research which points to the gap between this level of fear and lower levels of reported violence; a ten-country World Health Organisation study in 2004 found that between 4-15% of women actually reported violence after disclosure.⁷⁸

Prevention of mother-to-child transmission is a critical component of South Africa's response to the HIV epidemic. Goal 3 of the NSP commits the government to reducing such transmission to less than 5% by 2011. Men's lack of involvement in PMTCT programming, and in antenatal and postnatal care more generally, is a barrier to the achievement of this target. Yet there are indications that appropriate strategies can mobilise greater male engagement. Supporting women to talk to their partners about PMTCT and HIV testing can significantly increase men's involvement.⁷⁹ This may also motivate more men to know their status. In a pilot PMTCT programme implemented by the Horizons project in Kenya that sought to increase partner involvement, the proportion of male partners who used VCT services as a result of being involved in the programme doubled in one site and increased by 50% at another site.⁸⁰

Policy Situation

The policy approach towards prevention and VCT highlighted in the 2007 NSP includes Information, Education and Communication (IEC), VCT, treatment-related preventions e.g. treatment of sexually transmitted infections (STIs) and the use of barrier methods. Voluntary Counselling and Testing (VCT) was one of the key prevention strategies used in 2000 - 2005 period. But the 2007 NSP notes that the implementation of these programmes tended to be vertical, with capacity deficits evident in their implementation, which it maintains is reflective of the health system or lead agency's weaknesses rather than a weakness in the strategic framework.

Thus the 2007 NSP notes that a "supportive policy framework is critical for programme development in this regard." [page ref?] The NSP notes that a policy and legal issue requiring attention in HIV prevention is in "establishing a national culture in which people regularly seek voluntary testing and counselling for HIV" which will require a "paradigm shift in the traditional approach to VCT". In particular it requires a policy where HIV testing is offered by health providers to specified groups of people attending health services, as well as the identification of new strategies for the provision of counselling and testing outside of health facilities.

The NSP does not stipulate in detail what form VCT should take, for example, whether it should be completely voluntary and/or whether there should be incentivised testing. The NSP calls for mother-to-child transmission services to be broadened to include other related services and target groups, and specifies the need to implement responsible fatherhood programmes in health districts and in the community.

It has recently been argued that there should be an international reorientation of HIV testing policies based on the realities that more than one person is engaged in a sexual encounter, and that sexual

vention of Mother-to-Child Transmission of HIV: Issues and Findings from Community Research in Botswana and Zambia". Washington, DC, International Center for Research on Women.

⁷⁸ Maman S, and Medley A, (2004) *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes*. World Health Organisation: Geneva.

⁷⁹ UNICEF. *Evaluation of United Nations-supported pilot projects for the prevention of mother-to-child transmission of HIV*. New York: United Nations Children's Fund, August 2003.

⁸⁰ Rutenberg, Naomi et al. 2003. *Evaluation of United Nations Supported Pilot Projects for the Prevention of Mother to Child Transmission of HIV: An Overview of Findings*. UNICEF, NY, New York.

rights are realized only if each person respects and protects the rights of the other.⁸¹ The core premise is that everyone needs to know his or her own HIV status to protect the health and rights of the partner(s) in order to make informed sexual and reproductive decisions. Everyone has a corresponding obligation to respect his or her partner's need to know and right to decide. There have therefore been calls for better health sector support for disclosure and expanded actions to achieve gender equality and protect human rights, in order to create an environment in which more and more people respect the mutual rights and responsibilities of sexual partners.⁸² As there are divergent views on the issue, it is recommended that further research and consultation on the issue in the South Africa context should be pursued.

Policy recommendations on HIV testing and PMTCT

Health programmes and interventions

Include VCT promotion in masculinities work with men: There is some evidence to suggest that men's sense of invulnerability and fear of appearing weak deter them from using VCT services specifically, and health services more generally. It is important, then, that VCT promotion and referrals be included as part of any effort to expand masculinities work with men, whether through community interventions or mass media campaigns.

Link VCT with anti-violence work: Efforts to increase men's uptake of VCT should also include attention to issues of men's violence, and the role it plays in deterring women's use of testing and treatment services. Unless these issues are addressed in VCT services, women will be much less able to protect themselves from adverse consequences of disclosure (or having their status revealed) and less able to live positively with HIV. Those who are negative will be less able to protect themselves. *Vezimfihlo!* is a training program for VCT counselors developed in South Africa that aims to equip counselors who work in VCT settings to address gender issues and particularly gender-based violence. The programme explores why gender-based violence is a public health concern, what health workers can do to help abused patients and builds identification, consultation, communication and response skills.⁸³ Training of this nature should be mainstreamed into programs training VCT counselors in all settings. Counselors should be encouraged to provide care in a way that maximizes protection for women and assists in processes that encourage men to test, including couple counseling.

Involve men in PMTCT programming: The lack of male involvement in PMTCT programming is a missed opportunity, not only to engage men in HIV prevention and testing but also, more broadly, to engage them as partners and fathers. It is important to increase men's involvement in PMTCT programs by supporting women to talk to their partners about PMTCT and HIV testing. Greater male involvement in PMTCT has also been a priority for PMTCT-plus programming, such as the MTCT-Plus Initiative of the International Center for AIDS Care and Treatment Programs at Columbia University in New York City which aims to meet the needs of every family member infected or affected by HIV/AIDS in resource-limited settings by extending all HIV services, including

⁸¹ Ruth Dixon-Mueller and Adrienne Germain *HIV Testing and the Mutual Rights and Responsibilities of Partners* Lancet 1 December 2007

⁸² Ruth Dixon-Mueller and Adrienne Germain *HIV Testing and the Mutual Rights and Responsibilities of Partners* Lancet 1 December 2007

⁸³ Jewkes R, Christofides N, Mooideen V, Ngobeni R. *Vezimfihlo! A training manual for addressing gender-based violence in VCT*. Pretoria: Medical Research Council, 2007.

antiretroviral therapy (ART), to each mother's HIV-infected children, partners, and other family members.⁸⁴

Health services

Take VCT to men: Men are under-represented in VCT services because they are reluctant to use public health clinics (for reasons discussed below). When VCT is taken to where men are, whether through mobile testing sites or workplace testing programmes, the evidence suggests that men are willing to get tested. One early conclusion to be drawn from a large-scale mobile testing intervention is the importance of investing in community preparedness work with male leaders and opinion formers to ensure a rapid uptake of testing by men when services are made available.⁸⁵

Make public health clinics more male ‘friendly’: While the over-burdened and under-resourced public health service is not necessarily ‘friendly’ to women, it is widely acknowledged that health clinics are perceived by men and women alike as primarily female spaces, both in terms of who goes there and who staffs them. Efforts to make clinics more male friendly (through extending opening times to accommodate working men, employing more male staff, and improving privacy within clinic settings) have shown some success in attracting more men into VCT.⁸⁶ The development of male-only centres has also been piloted with some success, but the cost implications of parallel services for men make it unlikely that this is a viable option to be taken to scale.⁸⁷

Address problems of disclosure: Research suggests that disclosure of positive status remains a significant challenge for many men, for a variety of reasons, some of which are to do with masculine fears of weakness and anxieties over inability to perform the male ‘provider’ role. This suggests a need not only for increased attention to masculinity issues in pre- and post-test counseling, but also to ensuring that men have access to appropriate male-sensitive support groups, whether single or mixed gender, to help them in dealing with issues of disclosure and healthy living, as well as preparing them for treatment through treatment literacy programmes.

Meet the needs of marginal men: There is some evidence to suggest that certain groups of men who have sex with men, and particularly those who identify as gay, may face particular barriers to accessing testing services, related to widespread homophobic attitudes within society. This points to the need to develop VCT services within dedicated interventions for men within LGBTI communities. The NSP states that prisoners, the vast majority of them men, should have access to VCT but once again, implementation is lacking. Attention should be given to the investments in training and services that are required in order to ensure that prisoners have access to VCT and appropriate follow-up services.

⁸⁴ International Center for AIDS Care and Treatment Programs - www.columbia-icap.org/

⁸⁵ “HIV Risk Behaviors in Sub-Saharan Africa and Northern Thailand: Baseline Behavioral Data From Project Accept”, Becky L. Genberg, Michal Kulich, Surinda Kawichai, Precious Modiba, Alfred Chingono, Gad P. Kilonzo, Linda Richter, Audrey Pettifor, Michael Sweat and David D. Celentano, (*J Acquir Immune Defic Syndr* 2008; Volume 49, Number 3:309–319)

⁸⁶ “THE CLINIC AS A GENDERED SPACE: An exploratory study examining men’s access to and uptake of voluntary counselling and testing services (VCT) in the context of a male-friendly health facility”, Maria Faull, A minor dissertation submitted in partial fulfilment of the requirements for the award of the degree of Masters in HIV/AIDS and Society, Faculty of the Humanities, University of Cape Town, 2008

⁸⁷ HIVSA, 2006, *Community Projects: Men’s Health*, [Online] Accessible: http://www.phru.co.za/hivsa/projects/community_menshealth.stm, updated 4 August 2006, [Accessed 25th July 2008].

5. AIDS Treatment and Care

Problem Analysis

Treatment uptake is highly gendered. Fewer men than women are seeking and sustaining AIDS treatment. Research on the uptake of antiretroviral therapy (ART) in Khayelitsha found that 70% of those accessing treatment were women.⁸⁸ This is not solely the result of higher infection rates among women. A recent study of 16 ART sites (in Gauteng, Free State, Western Cape and Mpumalanga) reports that one-quarter (25%) of patients in the 16 sites were male, compared to 75% female, while the study estimated that men represented 45% of need, yet formed only 25% of the patient populations, and were under-represented in all age groups.⁸⁹ Other studies confirm 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 even though 43% of HAART eligible patients were expected to be male, based on epidemiological estimates, only about 36% of the patients accessing HAART turned out to be men.⁹⁰ A similar under-representation of men is evident in AIDS treatment provided by medical scheme beneficiaries (approximately 15% of the population), workplace treatment programmes, community treatment programmes (funded by donors) and private doctors.⁹¹ Dr Francois Venter, head of the South African HIV/AIDS Clinician's Society, emphasises that the "government seriously needs to consider new approaches if it is to attract more men to its ARV programme."⁹²

Not only are fewer men coming for treatment, but men are likely to access ART later in the disease progression than women, and consequently access care with more compromised immune systems.⁹³ A study of non-state sector ART services also found that men were less adherent than women.⁹⁴ Reviewing the available data, it has been concluded that:⁹⁵

The key reason why men are accessing HAART in disproportionate numbers to women is that men, in general, seek treatment for poor health less readily than women. Although there are some indications that men are more suspicious than women about the relative merits of HAART versus alternative treatments, these were not found to be statistically significant and it appears that having visited a traditional healer is complementary to, rather than a substitute for, accessing HAART.

Demographic and Health Surveys reveal statistically significant differences between men and women's utilization of all health services across all racial groups. Less is known about the impact of socio-economic status on men's uptake of ART services, and health services more generally, though international evidence suggests a relationship between lower socio-economic status and less uptake.

⁸⁸ Coetzee D, Hildebrand K, Boule A et al. Outcomes after two years of providing antiretroviral treatment in Khayelitsha, South Africa. *AIDS*, 2004;18(6): 887-95

⁸⁹ Helen Schneider, Dingie van Rensburg, David Coetzee. *Health systems and antiretroviral access: Key findings and policy recommendations*. Electronic version available at: <http://www.ufs.ac.za/faculties/content.php?id=5709&FCcode=01&DCcode=161>

⁹⁰ Natrass N. *AIDS, Gender and Access to Antiretroviral Treatment in South Africa*. Centre for Social Science Research Working Paper No.178, University of Cape Town, 2006.

⁹¹ Nachege, Jeab; Hislop, Michael; Dowdy, David; Lo, Melanie; Omer, Saad; Regensberg, Leon; Chaisson, Richard and Gary Maartens. 2006. "Adherence to Highly Active Antiretroviral Therapy Assessed by Pharmacy Claims Predicts Survival in HIV-Infected South African Adults", in *Journal of Acquired Immune Deficiency Syndromes*, 43(1) September 2006 pp 78-84

⁹² "South Africa: A battle of the sexes over national ARV programme." *PlusNews Special*, 2006, UN Office for the Coordination of Humanitarian Affairs.

⁹³ Hudspeth, J., W.D.F. Venter, A. Van Rie, J. Wing and C. Feldman. 2004. "Access to and early outcomes of a public South African antiretroviral clinic". *The Southern African Journal of Epidemiology and Infection* 19(2): 48-51.

⁹⁴ "Health systems and antiretroviral access: key findings and policy recommendations", Helen Schneider, Dingie van Rensburg, David Coetzee, Round-table conference, 22 and 23 October 2007, University of the Free State, Bloemfontein, South Africa

⁹⁵ "Gender and Access to Antiretroviral Treatment in South Africa", Nicoli Natrass, *Feminist Economics*, Volume 14, Number 4, October 2008, pp. 19-36(18)

Little is known about the effects of homophobic stigma in impeding men from LGBT communities from accessing treatment services, though anecdotal evidence highlights the significance once again of socio-economic status for men from these communities. Not only do poorer men have fewer options than richer men when it comes to health care; they are also much more likely to be incarcerated.

Men in prison face particular challenges in accessing ART services. Men make up nearly 70% of the incarcerated population,⁹⁶ and 94% of the HIV infected prison population. 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% (the national HIV population average is 16.3%).⁹⁷ A country profile on drugs and crime recorded a 484% 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.⁹⁸ It is widely acknowledged that “[t]he 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.”⁹⁹

Poor and working class men are also at increased risk of being co-infected with HIV and tuberculosis, whether because of incarceration, employment and/or residence in overcrowded living conditions. Tuberculosis has historically been one of South Africa's largest health problems, especially in the mines and within poor and working class communities.¹⁰⁰ The prevalence and impact of TB has been exacerbated by the HIV epidemic. HIV-related TB is the leading cause of death in South Africa. Recorded TB deaths have increased from 25,640 in 1997 to 73,903 in 2005. The risk of developing active TB is increased tenfold by HIV.¹⁰¹ Of particular concern is drug-resistant TB. The incidence rate of TB on South African gold mines is among the highest in the world, and up to ten times the national incidence rate. The increased risk of occupational TB disease in miners is largely a result of exposure to silica dust and cramped, poorly ventilated working and living conditions, and is aggravated by high HIV prevalence in the communities from which miners come. Regulations for TB control on mines and compensation of workers with occupational TB are inadequate, poorly adhered to by mining companies and poorly supported by government at the national and provincial level.¹⁰²

Men are not only missing from treatment services; they are also under-represented in the provision of care. A survey conducted by the Kaiser Foundation in HIV positive households reports that “*in more than two thirds of households women or girls were the primary caregivers. Almost a quarter of caregivers were over the age of 60 and just over two thirds of these were women.*”¹⁰³ This burden of care has devastating consequences for women, as has been noted:¹⁰⁴

The quadruple burden placed by AIDS care on women – weaker health, social exclusion, lack of education and reduced economic power - makes it more difficult for them to advocate for change and engage in efforts to transform their lives and communities.

⁹⁶ South African Department of Correctional Services Basic Information. “Inmates Gender Breakdown.” 2007.

⁹⁷ Lim’uvune Consulting (2007): Report on Provision of Unlinked, Anonymous HIV and syphilis prevalence study to the Department of Correctional Services. February.

⁹⁸ CADRE, 2003, *Gender-Based Violence and HIV/AIDS in South Africa: A Literature Review*.

⁹⁹ Goyer KC, Gow J (2002). Alternatives to current HIV/AIDS policies and practices in South African prisons. *J Public Health Policy* 23(3): 307-323 p308

¹⁰⁰ *TB: Confronting the Crisis of TB and HIV in Southern Africa, An Advocacy Agenda for governments, health care workers, researchers, civil society, regional and international agencies.* ARASA, TAC and SATAMO. 2007. Available at http://www.arasa.info/files/tb_summit_report.pdf

¹⁰¹ World Health Organization. *TB/HIV: A Clinical Manual*. (2nd Edition) Geneva: WHO; 2004., p.37. Available at <http://libdoc.who.int/publications/2004/9241546344.pdf>

¹⁰² “THE MINING SECTOR, TUBERCULOSIS AND MIGRANT LABOUR IN SOUTHERN AFRICA: Policy and Programmatic Interventions for the Cross-Border Control of Tuberculosis between Lesotho and South Africa, Focusing on Miners, Ex-Miners and Their Families”, AIDS and Rights Alliance for Southern Africa, 2008

¹⁰³ Henry Kaiser Family Foundation (2002) *Hitting Home, How Households Cope with the Impact of the HIV/AIDS Epidemic. A Survey of Households Affected by HIV/AIDS in South Africa*. The Henry Kaiser Family Foundation, Social Surveys, Memory Box Project

¹⁰⁴ Peacock and Weston, *Care Economy*

Given this, it is essential to build on the care activities that men already provide. According to the Kaiser Foundation study cited above, men and boys are playing some role in care in about one out of every three households in South Africa. A barrier to their greater involvement in care appears to be the widely-held and, it seems, self-fulfilling stereotype of the irresponsible man. Research in KwaZulu-Natal has revealed that men are involved in a range of care giving activities, and that they “*care for patients and children, financially support immediate and extended family members and are present at home, thereby enabling women to work or support other households.*”¹⁰⁵ However, the study found that “*these activities were seldom acknowledged by community members or by the field workers conducting research*” because of the stereotype of the irresponsible male. Effective policy to address the disproportionate burden of care borne by women depends, in part, on a better understanding of the different ways in which men are involved in the care economy, and the barriers to greater involvement. Not only does unemployment impair men’s ability to contribute financially to their families, but gender norms that associate care activities with ‘women’s work’ deter men from getting involved. A survey in Soweto found that men lacked the knowledge and skills to take part in caring activities, and that they worried that their consequent inadequacy might expose them to ridicule.¹⁰⁶

Policy Situation

Current policy in the form of the Primary Health Care Package provides only that “The staff are adolescent friendly with friendly communication so as to be accessible and acceptable to shy patients whether male or female.” There are specific references to men’s sexual and reproductive health in terms of testicular and prostate cancers. The current NSP makes no specific mention of gender issues in its analysis of gaps in and goals for antiretroviral therapy, management of TB and community and home-based care.

Policy Recommendations on AIDS treatment and care

Health services

Address men’s poor health-seeking behaviour: Research suggests that men’s under-representation in AIDS treatment services is related to their under-representation within health services more generally.¹⁰⁷ Efforts to increase men’s uptake of ARV treatment should be understood as part of efforts to improve men’s health-seeking behaviour. The gendered stigma that deters men from seeking treatment must be an important focus of masculinities work with men, both intensive group-work and extensive media work, as well as being integrated into community preparedness work for testing and treatment services.

Provide male-sensitive support to engage and maintain men in treatment: As part of the testing-treatment continuum, consideration should be given to the role that single-gender as well as mixed gender treatment literacy/preparedness and support groups can play in helping men to both engage with and stay on treatment. The value of such male-only spaces can be seen from the experience of support groups for HIV positive men that offer advice on health matters, HIV testing and counselling, sexual dysfunction and other services in an all-male milieu, as for example run by HIV South Africa,

¹⁰⁵ Montgomery, CM, V Hosegood, J Busza, & IM Timaeus. (2006). “Men’s involvement in the South African family: Engendering change in the AIDS era.” *Social Science and Medicine*, 62, p.2415.

¹⁰⁶ V Kruger (2003): Being willing to love and support them. An EngenderHealth report on focus group discussions held in Soweto by the HOPE Worldwide Men as Partners staff.

¹⁰⁷ “Gender and Access to Antiretroviral Treatment in South Africa”, Nicolli Natrass, *Feminist Economics*, Volume 14, Number 4, October 2008, pp. 19-36(18)

the psychosocial support arm of the Perinatal HIV Research Unit, at Chris Hani Baragwanath Hospital in Soweto.¹⁰⁸

Partner with the private sector to expand treatment services for men: There is a growing recognition within both government and the private sector, that public-private partnerships have a role to play in expanding access to HIV treatment services. Both good business practice and corporate social responsibility dictate that the private sector must increase its efforts to meet the health needs of its workforce, including HIV treatment.

Ensure integration of TB and AIDS treatment: This issue of corporate social responsibility has surfaced particularly with regard to TB and AIDS co-infections, especially in the mining industry. A recent report, noting the inadequate response of the mining industry to the twin and mutually reinforcing epidemics of AIDS and TB affecting its workforce, makes several recommendations in this regard. It calls for the establishment of systems for better prevention, diagnosis and treatment of TB and HIV for miners, ex-miners and their families in Lesotho and South Africa, as well as the strengthening of linkages between TB and HIV programmes in Lesotho and South Africa, and between the public and private sectors – including the establishment of bi-national information and administrative systems to support continuity in TB prevention, diagnosis, treatment and care for miners, ex-miners and their families.¹⁰⁹

Address reproductive health issues in AIDS treatment: Recent research highlights the need to better integrate reproductive health issues within AIDS treatment services, and that the reproductive rights and interests of people living with HIV are poorly addressed.¹¹⁰ Within this, the role of men in supporting their female partners' reproductive choices and decisions as well as articulating and addressing their own reproductive desires, in the context of both discordant and concordant relationships, needs increased attention.

Address the treatment needs of marginal men: As already noted with testing, certain groups of marginal men, including men who have sex with men and prisoners, face particular challenges in accessing AIDS treatment services. Improving such access is a priority.

Policies in related sectors

Engaging men in the care economy: While the overwhelming burden of AIDS care continues to be borne by women, there are signs of increasing male involvement and willingness to be involved. Efforts must continue to be made to recruit men into home-based care programmes, especially in areas of high male unemployment, where stipended work in home-based care services can provide men not only with a very minimal income but also a potential route back to employment. The impact of involving men in traditionally female caring roles will not only be to share the burden of care with women, but also to begin to challenge deeply held beliefs about appropriate gender roles for women and men.

108 South Africa: *HIV-positive men come to terms with their status*. IRIN Plus News, HIV/AIDS New Service for Africa. 7 June 2005. At: www.plusnews.org/pnprint.asp?ReportID=4895

109 "THE MINING SECTOR, TUBERCULOSIS AND MIGRANT LABOUR IN SOUTHERN AFRICA: Policy and Programmatic Interventions for the Cross-Border Control of Tuberculosis between Lesotho and South Africa, Focusing on Miners, Ex-Miners and Their Families", AIDS and Rights Alliance for Southern Africa, 2008

110 "Policy maker and health care provider perspectives on reproductive decision-making amongst HIV-infected individuals in South Africa", Jane Harries, Diane Cooper, Landon Myer, Hillary Bracken, Virginia Zweigenthal, Phyllis Orner, BMC Public Health 2007, 7:282

6. Reproductive Health

Problem Analysis

Most men in South Africa are not actively involved in the reproductive health care of their female partners and do not typically participate in family planning or antenatal care consultations with them. Most are also absent during labour and delivery.¹¹¹ This lack of male involvement has negative consequences for the health and well-being of women and children, as well as men themselves.

When given the opportunity, some men wish to be more involved. A study of men's attitudes to care and support found that men were willing to participate in antenatal care but felt they did not have the necessary skills. The "Men in Maternity" study, looking at an intervention to involve men in maternal care in KwaZulu-Natal, found that the intervention had been effective in promoting men's assistance during health emergencies and changing men's attitudes toward condoms as a dual protection method. The study concluded that it is "*indeed acceptable and feasible to involve men in the reproductive health care of their partners.*"¹¹² Focus group discussions held with urban and rural men in KwaZulu-Natal in 2001 indicated that men had an interest in using family planning methods to avoid unwanted pregnancies and in procuring contraceptives for their sexual partners.¹¹³

Men are not more involved in reproductive decisions and services because of a range of factors. Social expectations and pressures around femininity and masculinity assign reproductive responsibilities to women. These expectations find concrete expression in the attitude of health care providers, many of whom do not welcome the presence of men in antenatal, delivery and postnatal services. Young men are largely invisible in policy responses to the problem of teen pregnancy, and specifically the education sector's response to learner pregnancy. Similarly, men are largely missing from the emerging discussion of the reproductive health needs, desires and rights of people living with HIV. A recent study concludes that:¹¹⁴

Understanding HIV positive men's reproductive intentions are important in their own right as well as for the influence they are likely to have on their female partners' reproductive intentions.

Even as the procedures and practices of over-burdened public health facilities deter men's involvement in RH and MCH care, economic conditions, including the rise in both male unemployment and female employment outside the home, are pushing more men to take up family responsibilities that were previously the domain of women. This has been further fueled by a growing public interest in, and discussion of, men's roles as fathers, and the benefits of engaged fatherhood for women, children and men themselves. In this changing context, it remains true, however, that many men continue to choose not to be more involved in reproductive health decisions and services.

Efforts within the health sector to encourage more male involvement must begin with the design and delivery of sexual and reproductive health services themselves. In relation to these services, some analysts have argued that men are "*the forgotten clients*".¹¹⁵ Not only are public health clinics widely perceived as services 'for women'; 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. Psychosexual issues, such as concerns about premature ejaculation and male erectile dysfunction, often feature when men are asked about their sexual health concerns, yet they are rarely addressed by

¹¹¹ Mullick, S, B Kunene, & M Wanjiru. (2005), "Involving men in maternity care: health service delivery issues." Agenda Special Focus, p.126.

¹¹² Mullick op cit.

¹¹³ Maharaj, P. (2001). "Male Attitudes to Family Planning in the Era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa. Journal of Southern African Studies, 27(2), p.251.

¹¹⁴ Diane Cooper, Jane Harries, Landon Myer, Phyllis Orner, Hillary Bracken. "Life is still going on": Reproductive intentions among HIV-positive women and men in South Africa. Social Science & Medicine 65 (2007) 274–283

¹¹⁵ Mehta, M; Peacock, D; Bernal, L (2004). "Men As Partners: Lessons Learned from Engaging Men in Clinics and Communities." in Ruxton, S (ed) *Gender Equality and Men*. Oxfam: Oxford.

sexual health services. At the same time, concern has been expressed about the efficacy of STI treatment in the private sector, which it is estimated accounts for half or more of all cases.¹¹⁶ While the NSP notes that the introduction of syndromic management of STIs in 1995 has proven effective, for instance in reversing the prevalence of syphilis among pregnant women, a recent report notes the body of research pointing to:¹¹⁷

[S]ignificant limitations in the extent to which STI syndromic management has been implemented in the private sector. STI management does not appear to be a priority for GPs and this may be undermining national efforts to control STIs especially among the poor.

Policy Situation

With regard to involving men in family planning, the *National Contraception Policy Guidelines (2003)* provide the policy framework for the provision and use of contraception, and in the foreword, the Minister of Health remarks that, “For the first time this policy recognises the importance of involving men in this critical area.”¹¹⁸ The guiding principles of the guidelines include a commitment that contraceptive services should be made available to all who need them, including adolescents and men, as well as people with disabilities and special needs. Significantly, the guidelines provide that curricula for service provider training and retraining should include, “Values clarification, anti-bias training and the development of client centred approaches of care, to help ensure that providers uphold clients’ rights, and provide services to all people, irrespective of age, race, sex, social status and disability, in a respectful, understanding, and non-judgmental manner.”¹¹⁹ Furthermore, the guidelines provide that periodic studies should be conducted to evaluate the impact of services.

With regard to involving men in maternal and child health services, the *Maternal, Child and Women’s Health (MCWH) Committee Policy Proposals (1995)* stipulate that the goal for maternal, child and women’s health policy should be, inter alia, to “achieve optimal reproductive and sexual health (mental, physical and social) for all women and men across the life-span of individuals.” In the underlying philosophy statement, the policy acknowledges that, “Men also have a particular role to play in women’s reproductive health because in many cultures they are the decision-makers and they control access to resource needed for health-care.” Promotion of gender equity is listed as one of the principles on which provision of services should be based. The *Kangaroo Mother Care (KMC) Policy and Guidelines for the Western Cape Province (2003)* marks one attempt to focus on the role of men, in this case with respect to low birth weight infants. The policy encourages the role of fathers in caring for the infant by providing that “support KMC givers, especially the father, should be involved in KMC training as early as possible, together with the mother, while the infant is still in the Neonatal Unit.”

In terms of male involvement in preventing and responding to teen pregnancy, the National Education Department has published *Guidelines for Educators on the HIV/AIDS Emergency (2000)* that state that male educators have a particular responsibility to end the practice of demanding sex with female educators or learners. On the other hand, the *Health Policy Guidelines for Youth and Adolescent Health (2001)* do not include specific reference to gender issues which should be addressed nor to particular strategies for men and boys but do acknowledge that the elimination of domestic and sexual violence is a priority.

In 2007 the Department published the *Measures for the Prevention and Management of Learner Pregnancy* that focus on encouraging abstinence in learners under the age of 16 and on managing

116 Schneider H, Blaauw D, Dartnell E, Coetzee DJ, Ballard. STI Care in the South African Private Sector. SAMJ 2001; 91(2): 17-20.

117 “HIV and AIDS, STI and TB in the Private Sector” Marion Stevens, Edina Sinanovic, Leon Regensberg, Michael Hislop, in *The Role of the Private Sector within the South African Health System*, South African Health Review, 2007 pp201-211

¹¹⁸ *National Contraception Policy Guidelines (2003)* p1

¹¹⁹ *National Contraception Policy Guidelines (2003)* p29

pregnancy where it does occur among learners, including ensuring that pregnant learners are not expelled or discriminated against and receive adequate care and support. Once again, there is no specific mention of the roles and responsibilities of men and boys. In general, young fathers remain almost invisible in school policy and practice, in part because fathers of children born to school-going girls are often a lot older.

Policy Recommendations on reproductive health

Health policy

Address men's absence from sexual and reproductive health policy: Policies that promote health and equitable models of masculinity and which enhance gender equality in the field of sexual and reproductive health would include those which involve men in contraceptive decision-making, family-planning and maternity services. Such policies would encourage men to take responsibility for planning their families or for choosing not to have children, as well as involving them at the earliest stages of their children's lives.

Health services

Promote changes in health service protocols to engage more men in women's sexual and reproductive health: This should include training (and monitoring) to address provider barriers to involving men in family planning, by training more health providers to serve couples, conducting couples counseling and providing male-friendly reproductive health services. Where feasible, this should also include protocols, training and monitoring to encourage men to be present at birth and in neo/post-natal care. Lessons can also be learned from international experience with involving men in maternal and child health services, for example through campaigns and interventions to involve men in recognising and responding to obstetric emergencies.¹²⁰

Develop more integrated services to meet needs of both women and men: Notwithstanding the challenges facing already overburdened the public health sector, international experience suggests that 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 can facilitate greater male involvement.

Health communication

Greater promotion of STI treatment: While the NSP notes progress made in STI management and treatment, much greater investment in health promotion communications around STI help-seeking is needed to ensure greater coverage of men. Given men's recourse to both the private and traditional health sector for STI treatment, both sectors should be drawn into initiatives to expand effective STI case detection and treatment. For the traditional sector, this should include training and support to make appropriate referrals. For the private sector, this should include training and support to adopt syndromic treatment. Anecdotal evidence points to inadequate diagnosis and treatment of anal STIs, and a need for greater attention to be given to the STI treatment needs of men who have sex with men.

Policies in related departments

Give greater attention to men's roles in preventing and managing teen pregnancy: While there is well-established policy on the prevention and management of teen pregnancy, education policy says

120 Shefner-Rogers CL and Sood S, "Suami Siaga (Alert Husband) Campaign in Indonesia", *Journal of Health Communication*, JHUCCP, 9, pp 233-258, 2004

little about the roles of men and boys in teen pregnancy, or about the importance of using the Life Orientation curriculum and other means to address the pressures of both masculinity and femininity that result in teen pregnancy. There is a need to:

- Strengthen gender and sexuality education in schools in order to prevent teen pregnancy
- Develop protocols and programmes for young fathers, to assist them in becoming an engaged parent at the same time as completing their education

7. Violence

Problem Analysis

Men's violence against women has reached epidemic proportions in South Africa; between a quarter and a two thirds of women in different studies report ever having experienced physical or sexual intimate partner violence.¹²¹ A recent survey of 435 men in a Cape Town township revealed that "more than one in five men ...reported that they had either threatened to use force or used force to gain sexual access to a woman in their lifetime."¹²² In a 2006 Medical Research Council survey of 1370 male volunteers recruited from 70 rural South African villages, one in six men reported that they had raped a non-partner, or participated in a form of gang rape and about one in twelve said they had been sexually violent towards an intimate partner.¹²³

Such violence begins early in girls' lives. Human Rights Watch has documented extensive sexual abuse and harassment of girls by both teachers and other students.¹²⁴ 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% of disclosed child rapes.¹²⁵ 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."¹²⁶

Firearms are frequently used to force sexual violence and their availability greatly increases the likelihood of an incident of intimate partner violence resulting in homicide. According to a 2004 Medical Research Council (MRC), the number of women fatally shot by her current or former partner rose by 78% between 1990 and 1999.¹²⁷ Among all the female victims of homicide in South Africa in 1999, the MRC found that one in three had been killed with the use of firearm and of those, half were shot by their intimate partner and 71% were shot in their own homes. The study also found that in 20% of cases, the women were shot with a legally owned weapon.

Little of this violence is ever reported and when it is, convictions are difficult to secure. At most one in nine victims report rape, and of these reported cases, only one in twenty lead to conviction of the perpetrator.¹²⁸ Inadequate recording of statistics makes it impossible to determine conviction rates for physical violence against intimate partners but a recent study of intimate partner homicides showed conviction rates no higher than 37%.¹²⁹ This failure of justice ensures that the violence continues with

121 Jewkes R, Penn-Kekana L, Levin J. Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine* 2002; 55, 1603-1618; Dunkle KL, Jewkes RK, Brown HC, et al. Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. *American Journal of Epidemiology* 160, 230-9;

Jewkes R, Vundule C, Maforah F, Jordaan E (2001) Relationship dynamics and adolescent pregnancy in South Africa. *Social Science and Medicine* 52 (5), 733-744.

¹²² S. C. Kalichman, L. C. Simbayi, D. Cain, C. Cherry, N. Henda, A. Cloete (2007) Sexual assault, sexual risks and gender attitudes in a community sample of South African men; *AIDS Care*, Jan. 2007, Vol. 19,1, pages 20 – 27.

¹²³ Vetten L, Jewkes R, Fuller R, Christofides N (2008) Tracking Justice: The attrition of rape cases through the criminal justice system in Gauteng. Tshwaranang Legal Advocacy Centre, Johannesburg.

¹²⁴ Human Rights Watch, (March 2001). Scared at School: Sexual Violence Against Girls in South African Schools. New York: Human Rights Watch.

¹²⁵ Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science and Medicine*(in press).

¹²⁶ http://www.sahrc.org.za/sahrc_cms/downloads/Background%20Info_Violence_Schools.pdf

¹²⁷ Mathews S, Abrahams N, Martin LJ, Vetten L van der Merwe L & Jewkes R. "Every six hours a woman is killed by her intimate partner": A National Study of Female homicide in South Africa (June 2004)

¹²⁸ Vetten L, Jewkes R, Fuller R, Christofides N (2008) *Tracking Justice: The attrition of rape cases through the criminal justice system in Gauteng*. Tshwaranang Legal Advocacy Centre, Johannesburg.

¹²⁹ Mathews, S. Abrahams, N. Martin, L. Vetten, L. van der Merwe, L. & Jewkes, R. (2004). "Every six hours a woman is killed by her intimate partner": A National Study of Female Homicide in South Africa. Gender and Health Research Group, Medical Research Council, Tygerberg, 7505.

impunity. Notwithstanding widespread public concern about men's violence against women, such violence is in part sustained by male attitudes, including sexual entitlement and victim blaming. A 2004 survey of over 250,000 school aged youth found that males were more likely than females to agree with statements that included:¹³⁰

“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.”

Limited research among LGBT communities also highlights concerns about men's violence against lesbian women. As one report has commented: *“Rape of lesbians, often expressed by perpetrators as a means of making these women straight, is another form of the oppression of South African women.”*¹³¹

Women who experience sexual assault in are at greater risk of HIV/AIDS infection than other women.¹³² 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. One 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.¹³³ A study of over 1,350 women across South Africa found that their risk of HIV infection was significantly related to the degree of violent or controlling behaviour of their male partners (an important feature of the control related to non-condom use).¹³⁴ There is some evidence to suggest that the fear and fact of men's violence affects women's use of HIV testing and treatment services.

Men are not only perpetrators of violence; they are also profoundly affected violence. 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). Much of this violence is gang-related, yet public debate of and policy responses to the gang phenomenon consistently misperceives its gendered nature. Gangs are a place where an exaggerated form of masculinity is produced and performed, one that is based on dramatic displays of power and violence, often against women, but also other men. Gangs provide sources of income and dignity, as well as companionship and support, for men who have limited access to more traditional means of asserting manhood.

Public policy responses to male-on-male violence, and its links with the culture and economy of gangs, must also take account of violence against men in prison. There is a growing recognition of rape of men in correctional settings in South Africa. A National Inmate Survey of 146 State and Federal Prisons carried out in 2007 found that 4.5% of inmates reported sexual victimisation while in prison. This translates into a nationwide estimate of 141 incidents of sexual victimisation per 1,000

¹³⁰ Andersson N, Ho-Foster A, Matthis J, Marokoane N, Mashiane V, Mhatre S, Mitchell S, Mokoena T, Monasta L, Ngxowa N, Salcedo MP and Sonnekus H (2004). National cross sectional study of views on AIDS among South African school pupils sexual violence and risk of HIV infection and AIDS among South African School Pupils, *BMJ*;329;952; originally published online 14 Oct 2004

¹³¹ “Opportunities for LGB-Research Collaborations in South Africa: Report about an exploratory work visit”, Theo Sandfort and Robert Sember, (unpublished)

¹³² Kalichman SC, Simbayi L. Sexual assault history and risks for sexually transmitted infections among women in an African township in Cape Town, South Africa. *AIDS Care*, 2004; 16: 681-689.

¹³³ Pettifor A E, Measham D, Rees H V and Padian N S. 2004. Sexual power and HIV risk, South Africa. *Emerging Infectious Diseases*. 10 (11): 1996-2004.

¹³⁴ Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntyre JA, Harlow SD (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*. 2004 May 1;363(9419):1410-1.

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%.¹³⁵

Indeed, prisons reinforce some of the most harmful notions and practices of oppressive masculinity and submissive femininity when more powerful inmates take other inmates as their “wives” and routinely rape them.¹³⁶ Consequently the ability of prisons to engage positively with men is severely compromised, and many men leave prison victimised or with harmful practices reinforced rather than corrected. This suggests that alternatives to incarceration are urgently required in South Africa, alongside the challenge of making prisons more humane. Whether in prison or community, little is known about the extent of physical and sexual violence against men within LGBT communities.

Boys may also experience violence early in their lives. There is a dearth of research on the prevalence and impacts of child sexual abuse in South Africa, especially with regard to the experience of boys. But an analysis of the Stepping Stones dataset of 1368 men shows that 3% had been “persuaded or forced to have sex when they did not want to” by a man and 10% had experienced this abuse by a woman. In total 21% 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”.¹³⁷ A recent large-scale national study of 269,705 learners aged 10-19 years in grades 6-11 found that 44% of males aged 18 years at the time of the survey said they had been forced to have sex in their lives. Male abuse of schoolboys was more common in rural areas while female perpetration was more an urban phenomenon.¹³⁸ Many studies show that violence and abuse in the home – witnessed and experienced by children – is a cause of later violence by men both against women and other men, as well as increasing the likelihood that girls will subsequently become victims.¹³⁹

Policy Situation

Changes to the law on rape with important implications for gender have been introduced by the *Criminal Law (Sexual Offences and Related Matters) Act 32 of 2007*. This law changes the definition of rape so that it is gender-neutral (it recognises that both men and women can be raped) and so that any form of non-consensual penetration of the vagina, anus or mouth (i.e. not only penetration of a vagina by a penis) can constitute rape.

Furthermore, the definition of consent has now been changed to “voluntary and un-coerced agreement”: the Act sets out circumstances where consent is understood to be lacking, including situations where the perpetrator abuses a position of power, thus acknowledging the gendered power dynamics under which rape can occur. The law confirms earlier legislation¹⁴⁰ which established that a husband can rape a wife but expands the provision gender-neutrally so that any spouse can be raped by his or her spouse. The law also provides for HIV testing of perpetrators and state care for rape survivors and lays an obligation on health care providers and the Department of Health to provide

¹³⁵ Beck, A., and P. Harrison, *Sexual Victimization in State and Federal Prisons Reported by Inmates*, 2007, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 2007, available at <http://www.ojp.usdoj.gov/bjs/abstract/svsfpri07.htm>.

¹³⁶ Sasha Gear and Kindiza Ngubeni, *Daai Ding: Sex, Sexual Violence and Coercion in Men's Prisons* (Johannesburg, Centre for the Study of Violence and Reconciliation, 2002)

Sasha Gear, Behind the bars of masculinity: disappearing victims, disqualifying desire and prefiguring perpetrators in South African men's prisons, *Sexualities*, 10, 2, 2007.

¹³⁷ Jewkes R, Wood K, Duvvury N. **‘I woke up after I joined Stepping Stones’: meanings of a HIV behavioural intervention in rural South African young people's lives.** *Social Science & Medicine* (submitted)

¹³⁸ Neil Andersson & Ari Ho Foster. 13,915 reasons for equity in sexual offences legislation: a national school-based survey in South Africa. *International Journal for Equity in Health* 2008, 7:20

¹³⁹ Abrahams N, Jewkes R. What is the impact of witnessing mother abuse during childhood on South African men's violence as adults? *American Journal of Public Health* 2005;95:1811-1816

Jewkes R. Intimate partner violence: causation and primary prevention. *The Lancet* 2002;359:1423-29

¹⁴⁰ Prevention of Family Violence Act 133 of 193

post-exposure prophylaxis (PEP) and health care to survivors of sexual offences; and to provide such care in designated facilities and to have approved training courses.

The national *Sexual Assault Care Policy (2005)* seeks to ensure that victims of sexual violence receive appropriate treatment and are not subject to further victimisation when seeking medical attention. This Department of Health Policy outlines the responsibilities of the health sector on rape including the need to provide support for survivors, to meet their medical needs of pregnancy and STI prevention (including providing HIV post-exposure prophylaxis) and the documentation of findings on examination and collection of evidence to assist the courts in the case.

The *Domestic Violence Act 116 of 1998* provides for a broad definition of domestic violence and creates protection orders for which victims of domestic violence can apply.¹⁴¹ Such an order interdicts the abuser from carrying out certain acts and may also provide police with a firearm confiscation order. Police are obliged to arrest perpetrators who fail to comply. Research in 2001 however showed that attitudes and perceptions regarding domestic violence continue to affect the extent to which the police are effective in carrying these out.¹⁴² Subsequently, a Domestic Violence Training Manual was launched in 2004 by the Sexual Offences and Community Affairs Unit of the National Prosecuting Authority. It is unclear whether this manual has yet had an impact.

The *Firearms Control Act 60 of 2000* imposes limits on the number of firearms and rounds of ammunition that may be possessed legally.¹⁴³ The law also creates different categories of firearms licenses based on the reason provided by the licensee for needing a firearm. For example, only one handgun or manually operated shotgun is permitted in terms of a self-defence licence. Whereas firearms licences were previously issued for life, now they are issued for a limited period of five years only. Licences may only be issued to people in possession of a valid competency certificate, and owners must keep their firearms in a safe at home. Those convicted of offences can be declared by a court to be unfit to possess a firearm. Police can also hold a hearing and remove a firearm from someone is posing a danger or against whom a protection order has been issued. However these provisions appear to be under-utilised, except in the Western Cape province.¹⁴⁴ An amnesty for the surrender of firearms was also provided for in the Act, and implemented over a three month period in 2005.¹⁴⁵ By the end of February 2005 more than 16 000 firearms and 300 000 rounds of ammunition had been confiscated or handed in to the South African Police Service.¹⁴⁶

Policy recommendations to prevent and respond to violence

Health sector leadership

Support and expect male leadership in the implementation of health sector response to sexual violence: The national *Sexual Assault Care Policy (2005)* and the *Criminal Law (Sexual Offences and Related Matters) Act 32 of 2007* mark significant progress in the recognition of and response to sexual violence. Both the law and the policy lay new responsibilities on the health sector to respond more comprehensively and effectively to the rights and needs of survivors. Men in leadership positions

¹⁴¹ Or anyone with a material interest

¹⁴² Mathews S, Abrahams N. (2001). *Combining stories and numbers. An Analysis of the Impact of the Domestic Violence Act (No.116 of 1998) on Women*. Gender Advocacy Programme & Medical Research Council.

¹⁴³ Commenced July 2004.

¹⁴⁴ Mistry, D et.al. *The role of the CJS in excluding unfit persons from firearm ownership* Gunfree SA and OSF-SA (2002)

¹⁴⁵ Declaration of amnesty in terms of section 139 of the Firearms Control Act 2000, 26 November 2004.

¹⁴⁶ Firearms Amnesty Update, 1 March 2005,

http://www.saps.gov.za/crime_prevention/firearms/media/01032005.htm

within the health sector have a critical role to play in ensuring the translation of law and policy into practice, implying a need for both gender training and performance appraisal to ensure the implementation of that role.

Health services

Improve health sector response to other forms of men’s violence against women: Research suggests that a range of men’s controlling and violent behaviours, rather than just sexual violence itself, that is responsible for women’s increased vulnerability to HIV, as well as for other a range of other health impacts. This highlights the need to improve the health sector response to multiple forms of men’s violence against women, which could include protocols, training and monitoring systems for improved case detection, management and referral. Once again, male leaders within the health sector have a critical role to play together with their female colleagues in developing this improved response.

Respond to men’s experiences of sexual violence:¹⁴⁷ Recent studies have also highlighted disturbing levels of male-on-male sexual violence in prison and in other forms of detention and the extent to which this violence both results from and reinforces male-on-female sexual violence in the community. The rights and needs of male survivors of sexual violence are explicitly addressed in the national Sexual Assault Care policy and it will be important to monitor the roll-out of this policy to determine its impact on health sector responses to male survivors, given the aforementioned societal denial and minimization. This implies an urgent need to develop training and support for medical and corrections staff in basic sex health education as well as post-assault care, as well as developing protocols for defining consensual and non-consensual sexual contact and preventing and addressing the latter within correctional settings.

Health communication

Integrate a focus on sexual violence into condom education and distribution strategies: Condom promotion provides an important opportunity to educate men about sexual violence and challenge widespread misconceptions about what constitutes sexual consent. It is important to fund and replicate interventions like Instituto Promundo’s Program H Alliance and Sonke Gender Justice’s One Man Can campaign that use condom education as a vehicle to educate and empower men to take a stand against sexual violence.¹⁴⁸

Health programmes and interventions

Expand masculinities work with men to address roots of violence: Both international and national experience points to the role that intensive masculinities work with men and boys can play in mobilizing them to take action against violence in their communities and social networks. Expanding such work is an urgent priority.

147 “Rules of engagement: structuring sex and damage in men’s prisons and beyond”, Sasha Gear, Culture, Health & Sexuality, 2005, pp1-14

148 See, for instance, www.promundo.org.br or www.genderjustice.org.za/onemancan.

Health research

Understand boy's experiences of sexual violence: Recent research has revealed unexpectedly high levels of sexual violence against boys and young men.¹⁴⁹ More research on child sexual abuse and its complicated gendered dynamics is needed, especially to understand its impacts on boys' and men's sexual attitudes and behaviours, and how these affect their own and women's sexual health. The role of sexual trauma in men's sexualities remains poorly understood.

Policies in related departments

Identify and assist boys who are victims of sexual violence

Better collaborations between health, education and social welfare sectors is needed to ensure that schools are better able to identify and address boys' experience of sexual violence.

Work to improve the response of the criminal justice system: While current policy provides for criminal justice responses to men's intimate partner violence, implementation of such policy is inhibited by the institutional cultures of male-dominated systems. The health sector has a role to play in partnering with law enforcement and judicial institutions to ensure that men are held accountable for the violence they commit. Such a partnership will include working with police and prosecutors to ensure they have the evidence to prosecute and regarding good practices in working with witnesses and victims including suspect interviews and confessions.

Address the culture of impunity: In tandem with efforts to improve criminal justice system responses to men's violence against women, there must be a multi-sectoral initiatives to challenge the broader culture of impunity and acceptance of such violence.

Promote harm reduction through gun control: Given the role that gun violence plays in violence between men and men's violence against women, it is important that the health sector collaborate with others in advocating for improved implementation of the *Firearms Control Act*, including understanding and addressing the barriers to implementation.

Collaborate in developing targeted violence prevention initiatives with at-risk young men: A recent study reports that 3,478 children are in pre-sentence and post-sentence detention and that the the top six crimes committed by these children are murder, rape, serious and violent assault, robbery aggravated, house breaking and theft. The study recommends targeted support to the households from which these children come, including "sending public health nurses or equivalent professionals to visit the homes of high-risk families, such as low-income families, and those with teenage or unmarried first-time mothers to help them with parenting practices, mental-health problems and to address the use of tobacco and alcohol" and " providing adult mentors to provide a sustained caring relationship and role models to youths aged 6-18 who live in single-parent families below the poverty line."¹⁵⁰ Such targeted interventions are also required to address the nexus of masculinities and inequalities issues that surround young men's involvement in gangs and the violence they perpetrate.

Collaborate in expanding safer schools initiatives: Research continues to highlight alarming levels of physical and sexual violence in schools. The health sector has an important role to play in partnering with the education sector to support safer schools initiatives, including doing more work with district education officials, principals and governing bodies to address complicity in tolerating and not reporting such violence.

149 Neil Andersson & Ari Ho Foster. 13,915 reasons for equity in sexual offences legislation: a national school-based survey in South Africa. *International Journal for Equity in Health* 2008, 7:20

150 See http://www.csvr.org.za/index.php?option=com_content&task=blogsection&id=4&Itemid=21

8. Other Health Issues

Problem Analysis

Social expectations and pressures around masculinity affect men's and women's health in many ways. In South Africa, the association between alcohol use and masculinity is particularly troubling. It is estimated that R16 of every R100 spent in South Africa is spent on alcohol.¹⁵¹ A much higher proportion of men than women drink, across all age groups, all provinces and all population groups.¹⁵² Alcohol consumption is rising, especially in the adolescent community.¹⁵³

Patterns of drinking are embedded in the social, cultural and gender relations of a given 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. It is also the 'social grease' of male-only cultures in, for example, bars and shebeens. The reasons that people drink can also be distinctly gendered. Alcohol consumption has long been used by men as a way of expressing masculinity and as a coping mechanism for dealing with emotional distress.

Alcohol consumption is a risk factor for many health problems. Violence and the sexual disinhibition that contributes to the spread of HIV/AIDS have both been linked to alcohol use.¹⁵⁴ In a study of women abused by their spouses, 69% identified alcohol/drug abuse as the main cause of conflict leading to the abuse.¹⁵⁵ Research also shows that about 47% of murder victims tested positive for alcohol at the time of death, as did 66% of trauma victims.¹⁵⁶ Research highlights a correlation between alcohol consumption and unprotected casual sex, particularly in spaces associated with alcohol consumption such as shebeens or taverns.¹⁵⁷ ¹⁵⁸ One study in South Africa found that people who regularly had five or more drinks at a time were more likely to be HIV-positive.¹⁵⁹ Adolescents who do consume alcohol are more prone to "violence, vehicular accidents, uncontrolled sexual behavior and its consequences and drinking to stupor/coma."¹⁶⁰ The consequences of young men 'performing' their masculinity through both excessive drinking and reckless driving are evident in the statistics for road traffic accidents; such accidents are the fourth most common cause of premature mortality for men in South Africa (while being the eighth for women).

151 www.csvr.org.za/ - accessed Sept 5, 2008

152 Department of Health's 1998 South African Demographic & Health Survey

153 Parry CDH, Myers B, Morojele NK, Flisher AJ, Bhana A, Donson H, Plüddemann A.. Trends in adolescent alcohol and other drug use: findings from three sentinel sites in South Africa (1997-2001). *Journal of Adolescence*, 2004; 27(4): 429-440.

154 Shisana O, Simbayi L. Nelson Mandela/HSRC study of HIV/AIDS: *South African national HIV prevalence, behavioral risks, and mass media household survey 2002*. Cape Town: Human Sciences Research Council, 2002.

155 WHO. *Global Alcohol Consumption*.

http://www.who.int/substance_abuse/publications/en/GlobalAlcoholafro.pdf. Accessed on November 2nd, 2007.

156 Council for Scientific and Industrial Research researcher Barbara Holtmann, speaking at the Safe South Africa conference, facilitated by the Institute for Democracy in South Africa (Idasa) - reported on CSVr website - accessed Sept 5, 2008

157 CADRE. *Concurrent Sexual Partnerships Amongst Young Adults in South Africa: Challenges for HIV prevention communication*. Johannesburg: CADRE, 2007.

158 Morojele NK, Kachieng'a MA, Mokoko E, Nkoko MA, Parry CDH, Nkowane AM, Moshia KM & Saxena S. Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science and Medicine*, 2006a, 62, 217-227.

159 Kincaid, DL, Parker, W (2008): op cit.

160 Odejide, AO. 2006. Status of Drug Use/Abuse in Africa: A Review *International Journal of Mental Health Addiction*, 4, p.91.

Furthermore, 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 behaviours.¹⁶¹ More than 25% of all South African men currently smoke. Smoking alone may account for more than 30% of deaths as a result of coronary heart disease in South Africa. Globally, tobacco kills one in two long-term users.¹⁶² It is responsible for more deaths worldwide than any other risk factor bar high blood pressure. 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.

In most societies, smoking, like drinking, is a heavily gendered behaviour, as is evident from the messages about and images of masculinity that are used to market alcohol and tobacco. Similarly to 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).

Tobacco use in many cultures marks the transition to manhood.¹⁶³ Globally, over 80 per cent of smokers are men.¹⁶⁴

In most countries, the poor are more likely to smoke than the wealthy. Those who are less educated are also more inclined to smoke.¹⁶⁵ 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% of their disposable income on tobacco, with many poor households spending more on tobacco than on health care or education.¹⁶⁶

Lower socio-economic status in combination with gender also explains the higher prevalence of occupational health problems, including workplace injuries, experienced by poor and working class men. In South Africa men are clearly over-represented in employment sectors where injury and disease are likely e.g. construction and mining. Mining in particular, which is 95% dominated by men, is a particularly risky occupation, encompassing diseases risks (silicosis, tuberculosis) as well as high risk of injury. Dangerous, poorly paid working conditions are concentrated among those with the least access to power and resources, linked to economic, educational and immigration status.

In general, little work has been done in South Africa on the connections between gender and mental health. Internationally, a consistent finding from research is that more women experience depression and anxiety disorders than men, with ratios varying from 1.5:1 to 2:1, whilst men experience more

¹⁶¹ WHO (2002): *World Health Report 2002*. WHO, Geneva.

¹⁶² Source: the fact sheet on gender, health and tobacco developed at the request of the WHO department of Gender, Women and Health (GWH) by the WHO Tobacco Free Initiative (TFI) together with Dr Martha Morrow of the University of Melbourne, Australia

¹⁶³ Robb, J.H. 1986. Smoking as an Anticipatory Rite of Passage: Some Sociological Hypotheses on Health-Related Behavior. *Social Science and Medicine*. 23(6):621-627

¹⁶⁴ Gajalakshmi CK et al. Global patterns of smoking and smoking-attributable mortality. In: Jha P & Chaloupka F, eds. *Tobacco control in developing countries*. Oxford University Press, 2000:11–39 (<http://www1.worldbank.org/tobacco/tcdc/009TO040.PDF>, accessed 17 December 2004).

¹⁶⁵ Gajalakshmi CK & Peto R. *Studies on tobacco in Chennai, India*. Presented at the 10th World Conference on Tobacco or Health, Chinese Medical Association, Beijing, 1997. Cited in Jha P & Chaloupka F, eds. *Tobacco control in developing countries*, Ch. 3: Poverty and smoking. Oxford University Press, 2000 (<http://www1.worldbank.org/tobacco/tcdc/041TO062.PDF>, accessed 17 December 2004).

¹⁶⁶ Source: the fact sheet on gender, health and tobacco developed at the request of the WHO department of Gender, Women and Health (GWH) by the WHO Tobacco Free Initiative (TFI) together with Dr Martha Morrow of the University of Melbourne, Australia

alcohol use disorders.¹⁶⁷ A recent study of 900 HIV positive people in 18 recruitment sites across 5 provinces in South Africa found that people living with HIV/AIDS have high rates of mental disorder; substantially higher than previous general population or clinic based studies in South Africa (including studies of populations with similar socio-economic status).¹⁶⁸ However, in contrast to the prevailing global pattern, men indeed had significantly more alcohol related problems than women, but their levels of depression and anxiety were not significantly different. The authors suggest that one explanation may lie in men's gendered fears of illness as 'unmasculine', making it more difficult for men living with HIV to cope with deteriorating physical health leading to heightened susceptibility to depression. They conclude that more research is needed to explain this uncharacteristic finding.

This explanation is supported by findings from research elsewhere in the world on men's relationship to ill-health. There is some evidence to suggest that men and women experience cancer differently, for example.¹⁶⁹ More men than women die from cancer, and men usually adapt less well than women after a cancer diagnosis.¹⁷⁰ These outcomes have been linked to the pressures that men face to adhere to notions of masculine invulnerability, and the impact of these on men's symptom recognition, help seeking and psychosocial adaptation.¹⁷¹

Policy Situation

Current policy responses to alcohol use focus on controlling, regulating and disincentivising use and treating alcohol abuse, but do not address gender issues specifically. The current *National Drug Master Plan 2006 – 2011* recommends community-based prevention of substance abuse programmes which focus both on supply and demand. Specific interventions by sector departments include, for example, implementing the *Policy Framework on the Management of Drug Abuse in all Public Schools and Further Education and Training Institutions*, which provides that substance abuse should form part of the Life Orientation Curriculum. There is no specific policy on regulating the use of gender imagery and messages in alcohol and tobacco advertising. Current policy on mental health makes no specific reference to the gender dimensions of mental health problems experienced by women or men.

Policy Recommendations on other health issues

Health Services

Invest in alcohol treatment services: Both government and civil society have a role to play in expanding the availability and accessibility of alcohol treatment. Efforts should be made to support conventional and traditional health providers in making appropriate referrals to alcohol treatment services in health sector and community settings.

Address the links between mental health problems and harmful alcohol consumption: A significant international literature points to the links between depression and harmful drinking, especially among men. More research is needed to tease out the specifics of these links in the South

¹⁶⁷ World Health Organisation. (2001). *The World Health Report 2001. Mental Health: New Understanding, New Hope*. Geneva: World Health Organisation.

¹⁶⁸ M Freeman, N Nkomo, Z Kafaar and K Kelly. Mental Disorder in People Living with HIV/AIDS in South Africa. *SA Journal of Psychology* 2008 vol? no?

¹⁶⁹ Nicholas DR. (2000) Men, masculinity, and cancer: risk-factor behaviors, early detection, and psychosocial adaptation. *Journal of American College Health*, Jul;49(1):27-33.

¹⁷⁰ Nicholas DR. (2000) Men, masculinity, and cancer: risk-factor behaviors, early detection, and psychosocial adaptation. *Journal of American College Health*, Jul;49(1):27-33.

¹⁷¹ Nicholas DR. (2000) Men, masculinity, and cancer: risk-factor behaviors, early detection, and psychosocial adaptation. *Journal of American College Health*, Jul;49(1):27-33.

African context but it seems clear that many forms of harmful substance use are related to the social and economic problems faced by men, and consequent mental health problems.

Address the links between mental health, alcohol use and HIV status: Recent research has highlighted unexpectedly high levels of depression amongst men living with HIV as well as high levels of harmful alcohol use. There is a need to:

- Recognize the mental health challenges facing men who are living with HIV, linked to the gendered stigma associated with HIV as a source of un-masculine weakness and a lack of support and other coping mechanisms
- Integrate mental health work into AIDS services to address the mental health needs of people living with HIV
- Develop tools and curricula to equip treatment support groups (single and mixed gender) to address issues of depression and alcohol use
- Develop referral mechanisms to ensure appropriate referrals for people living with HIV to mental health services where they are available
- Address the needs of HIV positive men who have sex with men, who face additional stigma and discrimination that may increase their vulnerability to mental health problems, especially for those men who lack access to LGBTI community resources and spaces

Health communication

Develop community-wide campaigns to reduce the levels and harms of drinking: Alcohol consumption is a significant, arguably defining, feature of male recreational culture across different racial groups in South Africa, while selling alcohol constitutes a significant feature of the informal economy. Attempts to reduce the levels and harms of alcohol use thus confront deeply entrenched patterns of behaviour and belief as well as vested economic interests. Challenging such patterns and re-directing such interests is a long-term project, but a start can be made through funding community-led campaigns and programmes on safer drinking. International experience points to the efficacy of such efforts, including organising alcohol-free events, monitoring of alcohol outlets that sell to young people and training for servers to help tackle both excessive consumption and underage drinking.¹⁷² Prominent male leadership and role-modeling from national and community leaders will be crucial to the effectiveness of such efforts.

Develop national health and well-being campaigns for men on drinking and smoking: Men's vulnerability to chronic disease is significantly worsened by their level of alcohol and tobacco consumption. As part of a broader effort to change men's relationship to their health and their attitudes toward health seeking behaviour, much greater investment is needed in health promotion initiatives to educate men on the links between smoking, drinking and chronic disease and on practical options for healthier lifestyles. Such initiatives must be accompanied by efforts to address the structural inequalities that constrain people's lifestyle options; as a priority, this should include efforts to address issues of nutrition and exercise.

Policies in related sectors

Address the links between masculinity and alcohol marketing: Current policy on reducing harmful levels of drinking within society is focused on the regulation of outlets selling alcohol to the public and excise taxes on alcohol products. As yet, little effort has been made to challenge the gendered

¹⁷² HD Holder (2002): The role and effectiveness of alcohol policy at the local level: international experiences. Presented at "Debating Public Policies on Drugs and Alcohol", Trinity College, Dublin, Ireland, 26 September.

nature of alcohol advertising and the use made of conventional and patriarchal images and messages of masculinity together with sexist portrayals of women. A partnership between government and the alcohol and advertising industries is needed to review, set and enforce standards in alcohol marketing that proscribe sexist and patriarchal messaging and that use representations of masculinity and femininity that associate safe and pleasurable alcohol consumption with positive and respectful relations between women and men.

Explore other structural approaches to reduce the harms of alcohol consumption: Structural approaches have proven more effective, in general, than behavioural approaches to reducing the harms of alcohol consumption. While not gender-specific, the use of such structural approaches could have a significant impact on men's drinking patterns and its impacts. Such approaches could include raising the minimum legal drinking age,¹⁷³ reducing legal blood alcohol concentration limits for drivers and stepping up penalties for and policing of drink-driving offences.

¹⁷³ CS Carpenter et al (2007): Alcohol control policies and youth alcohol consumption: evidence from 28 years of monitoring the future. *BE Journal of Economic Analysis and Policy*, 7(1), Article 25; P O'Malley and A Wagenaar (1991): Effects of minimum age drinking laws on alcohol use, related behaviors and traffic crash involvement among American youth: 1976-1987. *Journal of Studies on Alcohol*, 52: 478-91; RB Voas and AS Tippetts (1999): *The relationship of alcohol safety laws to drinking drivers in fatal crashes*. National Highway Traffic Safety Administration, Washington DC.