



Men Health & Gender Equality



A report on the National Men's Imbizo
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Contents

BACKGROUND	4
Men, gender and sexual and reproductive health	4
Men, gender and other health issues	5
Men, gender equality and health policy	6
OBJECTIVES, FRAMEWORK AND OPENING	9
PRESENTATIONS	11
Men and women: Partners in health	11
Sexual and reproductive health and men	13
Men and health: Attitudes and behaviours	13
Men, health and gender equality	15
Men and health policy: Experiences from the Eastern Cape	18
COMMISSIONS	20
Introduction	21
Overview of Commissions' concerns	23
Men's experience of health and health services	24
Suggested improvements at the Policy level	26
Suggested improvements at the Service Delivery level	27
Suggested improvements at the Programming level	28
Men and gender-based violence: Responses	29
Men and gender-based violence: Why men do not respond	30
Men and gender-based violence: Improving the response	31
Fatherhood: What to change	
Fatherhood: Supporting men to be better fathers	32
Fatherhood: Role of Government	33
CONCLUSIONS AND NEXT STEPS	34
APPENDIX ONE: AGENDA	34
APPENDIX TWO: MEETING PARTICIPANTS	35

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Background

Men, gender and sexual and reproductive health

As HIV/AIDS continues to be a serious challenge in South Africa, it is now well documented that the sexual and reproductive health and well-being of not only women, but also of men are highly compromised. Whilst more coordinated strategies to improve women's health have been developed in South Africa, comprehensive national guidelines and policies to improve the health, and especially the sexual and reproductive health, of men and boys are still sorely lacking.

Gender norms and inequalities play a crucial role in fuelling the HIV/AIDS epidemic, by condoning men's violence against women, granting men the power to initiate and dictate the terms of sex, and making it extremely difficult for women to protect themselves from either HIV or violence or to access critical health and education services. By equating masculinity with sexual conquest, gender roles also contribute to what research suggests is the most significant factor driving the spread of HIV across sub-Saharan Africa – multiple concurrent sexual partnerships.¹

Studies also show that men with more traditional attitudes toward gender roles and relations are also more likely to have more negative attitudes toward condoms and to use condoms less consistently.² Men are also far more likely to drink more heavily than women and more likely to be habitual heavy drinkers according to the 2002 World Health Report.³ Alcohol consumption is a risk factor for gender based violence and for the sexual disinhibition that contributes to the spread of HIV/AIDS.⁴ Further research reveals that men are significantly less likely than women to utilise voluntary counselling and testing (VCT) services. A recent national study of VCT services found that men accounted for only 21 per cent of all clients receiving VCT.⁵ Research on the uptake of antiretroviral therapy (ART) in Khayelitsha reveals that 70 per cent of those accessing treatment were women.⁶ In Johannesburg General Hospital, one study found that women accessing ARVs “outnumbered men by a ratio of 2 to 1.”⁷

Men are also likely to access antiretroviral therapy (ART) later in the disease progression than women, and consequently access care with more compromised immune systems.⁸ In part these findings reveal the effects of male socialisation, in which health seeking behaviours can be taken to be a sign of weakness. However they also reflect the fact that many reproductive health services do not address men's HIV, STI and other sexual and reproductive health needs. Most VCT services, for instance, are offered in ante-natal clinics which often are not welcoming or equipped to deal with men.⁹ Similarly, many ante-natal clinics do not attempt to reach male partners with VCT services.

Men, gender and other health issues

There is a growing recognition that gender norms, and the violence that is used to maintain gender inequalities, harms more than men's sexual and reproductive health. 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/violence was the second most common cause of premature mortality for men (and the seventh for women). As has been noted, "this, too, constitutes a form of gender-based violence; much of the violence carried out by men against other men serves as a way to assert male dominance."

Such assertions of male dominance are evident in the sexual violence that men do to other men and boys. A lack of research makes it hard to ascertain an accurate picture of boys' experience of child sexual abuse in this country, yet a review of studies from 20 countries, including ten national representative surveys, has shown rates of childhood sexual abuse of 3–29 per cent for boys (compared to 7–36 per cent for girls).¹⁰ There is a growing recognition of the epidemic of male-on-male rape in prisons in South Africa; the 2001 Jali Commission of Inquiry into prison conditions found evidence that such rape was rampant.

The association between notions of masculinity and men's risk-taking behaviour has been noted with respect to sexual risk-taking. But such an association also has other implications for men's health; road traffic accidents are listed as the fourth most common cause of premature mortality for men (compared to eighth for women). Men's vulnerability to chronic disease is significantly worsened by their level of alcohol and tobacco consumption. In most societies, both smoking and drinking are heavily gendered behaviours, as is evident from the messages about and images of masculinity that are used to market alcohol and tobacco. More than 25 per cent of all South African men currently smoke. Smoking alone may account for more than 30 per cent of deaths as a result of coronary heart disease.

It is also important to recognize the relationship between gender norms and occupational health. Worldwide, men are over-represented in nearly all forms of injury. This is related to both to their gender and their class position, given the relationship between the gendered division of labour and occupational risk of injury, as in; men and road traffic accidents (truck drivers, taxi drivers), men and falls (construction industry), and men and other accidents at work (the more serious injuries happen in more industrial settings). It is also about the gendering of occupations, such that masculinity becomes equated with a willingness to do the dangerous jobs that 'lesser' men would be afraid of doing.

“The impact of gender norms on men’s health-seeking behaviour must be an important focus of policy on men, health and gender equality”

Gender norms of masculinity are also implicated in men’s reluctance to seek medical care. Men’s low use of HIV services in South Africa has already been noted and is a serious cause for concern. Cross-cultural evidence suggests that, in many societies, masculinity is associated with a sense of invulnerability, and with men being socialized to be self-reliant, not to show their emotions, and not to seek assistance in times of need. This reluctance to seek health advice and health care has been noted in the accounts of men with prostate cancer¹¹ and severe chest pain.¹² It has been suggested that delays in seeking and using health care may be related to men’s beliefs about masculinity.^{13,14} A UK study of men with testicular cancer found that men regarded help-seeking as not masculine and defined the “male” approach as being independent and being able to deal with problems on one’s own.¹⁵ The impact of gender norms on men’s health-seeking behaviour must be an important focus of policy on men, health and gender equality.

Men, gender equality and health policy

Gender inequalities that privilege men damage women’s health, at the same time as the norms associated with masculinity harm men’s health as well. The challenge for health policy, then, that is directed at men is to address both gender inequalities and gender norms. The evidence presented above suggests that developing such policy in South Africa is an urgent priority.

Since 1994 a number of important policies and legislative frameworks have been put into effect to promote gender equality in South Africa. The National Policy Framework for Women’s Empowerment and Gender Equality was approved by Cabinet in 2002 and defines roles and responsibilities related to gender for government representatives at all levels of government at the national, provincial and local level. In addition to constitutional commitments and legal rights, a number of important mechanisms have been put in place to facilitate civil society participation and government accountability. The Municipal Structures Act of 1998 mandates municipalities to establish ward committees, so that people can participate fully in local government issues and have input in affairs that affect them.¹⁶ AIDS councils have similarly been established in most municipalities across the country to encourage citizen participation. The National Crime Prevention Strategy emphasised the development of Community Policing such that by 2003 nearly every police station in the country had a Community Policing Forum or CPF.¹⁷

Reflecting this, many government departments have made efforts to engage men in efforts to achieve gender equality. The Department of Health launched the Men in Partnership Against AIDS initiative in 2002. The Commission on Gender Equality together with the South African Council of Churches and the South African Men’s Forum conducted a series of Men’s Dialogues in each province. The Department of Social Development

in partnership with the National Network on Violence Against Women launched the the Men in Action Campaign, and the Human Sciences Research Council has established the Fatherhood Project.

Over the past few years, civil society and government in South Africa have acknowledged and supported interventions that address gender inequalities and work towards scaling up and improving a change in gender roles. Indeed, there have been a number of programmes which seek to engage men and bring about significant changes in their attitudes and practices towards sex, women and their own reproductive health. Within civil society in particular, interventions such as Stepping Stones are widely described in international public health literature as best practices. As new programmes have been implemented, a body of effective evidence-based programming has emerged and confirmed that men and boys are willing to change their attitudes and practices in relation to their own behaviour that affects both their own sexual and reproductive health and that of their partners.

The international community has made a number of commitments in recent years that are directed toward engaging men in efforts to change both gender inequalities and gender norms, in part to improve the health of both women and men. The 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing provided a foundation for including men in efforts to improve the status of women, including their sexual and reproductive health. UNAIDS focused its 2000–01 World AIDS Campaign on men and boys, recognizing that their behavior puts themselves and their partners at risk of HIV infection. The Cairo Programme of Action (1994) and its 1999 review highlighted the need to encourage men to take responsibility with respect to child-rearing and housework, family life as well as parenthood and sexual and reproductive behaviour.¹⁸ In 2003, the Commission on the Status of Women organized an Experts Committee on Engaging Boys and Men in Gender Equality in preparation for the 2004 UN Commission on the Status of Women which focused on men's roles in achieving gender equality.

South Africa has been among the leaders worldwide in these efforts to engage men in work on gender and health. But whilst a number of interventions working with men continue to be implemented, research in South Africa shows that there is a critical need for greater clarity of purpose about the goals of work with men, improved guidance, as well as better coordination and planning.¹⁹

National guidelines on men, health and gender equality would not only provide an opportunity to build the capacity of programmers and policy makers, but would also facilitate better cohesion and collaboration across government and civil society in their work with men. Crucially, these guidelines would go far towards outlining strategies to increase men's utilisation of sexual and reproductive services – especially STI treatment,

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HIV testing, ARV uptake and circumcision. In the knowledge that male circumcision reduces the risk of heterosexually acquired HIV infection in men by between 51-60 per cent,²⁰ guidelines which focus on this particular prevention strategy will be extremely valuable.

An important component of these guidelines would be to ensure that the sexual and reproductive health of more marginalised groups of men gain greater attention: migrant workers, men who have sex with men, male sex workers, refugees and prisoners, for example. Providing strategies which incorporate the needs of these vulnerable groups would facilitate the development of better designed programmes, particularly those which address issues such as high turnover of sexual partners, high risk of sexually transmitted infections, non-use/inconsistent/incorrect condom use, lack of knowledge of HIV status and substance abuse. After these guidelines have been successfully developed, they will become a vital resource for training government and civil society on the different approaches outlined. As a result, more comprehensive and cohesive programmes will be rolled out which address the health needs and rights of different groups of men in South Africa.

Objectives, Framework and Opening

A **At the beginning of the meeting, participants were presented with the objectives of this National Men's Imbizo. These objectives of the meeting were described to the participants as being to:**

- Develop an understanding of men's sexual and reproductive health experiences, needs and recommendations for policy and training, especially but not exclusively related to maternal and child health and HIV/AIDS;
- Identify ways in which men can support their partner's participation in maternal and child health and sexual and reproductive health services, especially HIV/AIDS; and
- Increase men's skills, knowledge and motivation related to their and their partners' utilisation of sexual and reproductive health services.

While the framework of ideas and assumptions that underpinned the objectives and agenda for the meeting were not presented explicitly, they could be summarized as follows:

- The importance of thinking about policy and associated guidelines in terms of improving men's health and working toward greater gender equality;
- The importance of distinguishing between the impact of gender inequalities on health, and what this implies in terms of work with men, and the impact of gender identities on health, and what this implies in terms of work with men;
- The need to recognize the tension between appealing to men to use the gender power and privilege they have more responsibly, for the sake of their own and women's health, and challenging the gender power and privilege that men have in order to promote greater gender equality and better health outcomes, for both women and men; and
- The need to recognize that many men do not feel powerful in their lives, not only because they take for granted the gender privilege that they have but also because they are disempowered by larger social and economic forces - thus health policy on men and gender equality must also be developed within a broader commitment to social justice.

The meeting was opened by Dr. SA Amos who was followed by the moderator, Ms Esther Maluleke, both from the National Department of Health. Both noted that work on sexual and reproductive health in South Africa has almost exclusively focused on women and children, to the neglect of men's own health and a clearer understanding of the work needed with men to challenge the gender inequalities that harm women's health. The message was clear; it is time to start seeing men as equal partners in the solution, and not simply the problem. Both speakers also urged that we look beyond the "zero sum" game in which the empowerment of women is equated with the disempowerment of men, and recognize that men have a

lot to gain from greater gender equality, not least in terms of improvements in their own health, reductions in violence and closer relationships with their wives and children.

However, the beginning of the meeting also revealed the continuing tensions at the heart of this work with men on health and gender equality. Several participants questioned Ms. Maluleke's role as Moderator of the first day's deliberations, appearing to believe that a men's imbizo should only be led by a man. This served as a reminder of the importance of framing discussions of men, health and gender equality as not simply being about men by and for themselves, for this would be to continue the gender separation that maintains gender inequalities. Instead, the process of developing policy in this area must be about looking at gender relations between women and men, and what these relations mean in terms of work with men on health. The meeting also opened with a song, but the choice of Umshini Wami was also revealing of the tension between finding ways to engage with men, by using a liberation song that celebrates strength and power in the face of apartheid oppression, at the same time as not reaffirming gender inequality, by using a song that has since come to be associated with discrediting survivors of men's sexual violence.

Presentations

M

Men and Women: Partners in Health

Women and men must work together to promote the better health of all. In his presentation on “Men as Partners in Reproductive Health”, Dr. Hyera of the United Nations Population Fund made clear that a proper understanding of reproductive health implies involvement of both men and women as partners in reproduction and sexuality because:

- Men's reproductive health and behaviour impacts women's reproductive health and behaviour; and
- Men's reproductive health and behaviour impacts that of their children and society at large.

This interdependence suggests that efforts to engage men as partners in efforts to secure reproductive health must both encourage men to become more involved and supportive of women's needs, choices and rights in sexual and reproductive health and address men's own sexual and reproductive health needs and behaviours. The international community has backed this twin-track approach to engaging men as partners in securing reproductive health. The International Conference on Population and Development in 1994 called for men's support in the struggle for gender equality and encouraged their involvement and shared responsibility in all areas of family life and reproductive health. While not explicitly stated, the need for male involvement in reproductive health is apparent in the Millennium Development Goals.

The recognition of the need to engage men more actively in work on sexual and reproductive health within a gender equality framework has arisen in response to analyses of the shortcomings of reproductive health and family planning services, which include the:

- Uncritical acceptance of reproduction as women's responsibility - programmes on reproductive health have focused on women, creating an impression that it was solely a woman's responsibility;
- Lack of a clear focus on gender equality and of an understanding of the structural determinants of gender equality, and thus confusing the question of what it means to work with men on their individual experiences of power and privilege with the question of what it means to work with men on challenging structures of male power;
- Framing of men as simply the problem not as a potential partner in working for better sexual and reproductive health as well as greater gender equality;
- Lack of attention to men as sexual beings, with their own sexual and reproductive needs and interests;
- Lack of specially trained counselors to address male reproductive health issues; and
- Limited options for male contraceptive methods.



Not only is this work with men needed; the evidence is there that it is feasible:

- Research shows that men want to be more involved in sexual and reproductive health activities.
- Where men have been more involved with their partners in using health services, there have been positive health outcomes e.g. in terms of ante-natal care.
- Men have also been valuable advocates for change with regards to some issues such as genital mutilation.

At the same time as recognizing the feasibility of engaging men more actively in work on sexual and reproductive health within a gender equality framework, Dr. Hyera emphasized the need to be clear about the challenges, including:

- Men's low levels of knowledge about sexual and reproductive health;
- Poor partner communication e.g. STI notification
- Men's current lack of involvement in ante-natal and post-natal care;
- Men's marginalization by reproductive health services;
- Lack of information in mainstream media on reproductive health for men;
- Lack of training programmes addressing reproductive health and male responsibility; and
- Cultural taboos in talking more openly about sex and sexuality.

Overcoming these challenges means recognizing that sexual and reproductive health matters are entwined with gender norms and inequalities, general levels of education as well as issues of economic deprivation. We all have a responsibility to ensure that these issues are addressed. The way forward must be to:

- Use a multi pronged approach;
- Consult widely with stake-holders in developing appropriate policies on men's engagement in sexual and reproductive health within a gender equality framework;
- Address cultural barriers and educate men and boys in sexual and reproductive health, in terms of both rights and responsibilities;
- Target influential opinion leaders, especially the 'guardians' of tradition, including traditional leaders, religious leaders and faith based organizations;
- Work through the media to promote men's demand for engagement in sexual and reproductive health within a gender equality framework;
- Train health care workers to facilitate such engagement; and

“We must see our men as equal partners, not as our enemies”

- Esther Maluleke

Sexual and reproductive health and men

Dr. Mhlanga, of the Nelson R Mandela School of Medicine, University of KwaZulu-Natal, looked more closely at men and reproductive health, noting both men's influence over women's health and their own needs and concerns. Over 1500 women die every year from pregnancy related conditions; many rely on men's cooperation and permission to obtain medical help. For many women, pregnancy can be the result of their lack of control in their sexual lives. Men need to recognize their responsibilities for this.

Dr. Mhlanga stressed the need to understand the psychological and social preparation that men undergo that helps to explain their attitudes and behaviour. Men in South Africa are still raised to believe that manhood is related to the number of their children rather than the amount of caring they provide for their children. Any efforts to engage men in work on sexual and reproductive health must pay attention to these issues of gender socialization.

Such efforts must also take a broad view of men and sexual and reproductive health, including a focus on:

- Not just STIs but also on the quality of personal relationships;
- Men's violence against women as a central feature of sexual and reproductive health problems, not least the problem of marital rape;
- Concerns about how to enhance sexual pleasure;
- Body awareness: e.g. understanding male versus female anatomy, infertility (congenital vs. acquired);
- Cancer (prostatic and testicular); and
- Sexual dysfunction (e.g. premature ejaculation, priapism).

Dr. Mhlanga recommended that work with men:

- Educate men on sexual and reproductive health;
- Provide health education for both family and individual health;
- Access men in churches, taverns, workplaces and recreational facilities;
- Promote gender equitable attitudes within the home and the community;
- Promote men's active participation in governance of health institutions; and
- Promote responsible sexual activities, emphasizing the need for men to be accountable for their role in the prevention of HIV transmission.

Men and health: Attitudes and behaviours

Dr. Mhlako of the Health Promotion Directorate in the National Department of Health used his presentation to put the foregoing issues of sexual and reproductive health in the context of healthy lifestyles, and the attitudes and behaviours that promote health. A healthy lifestyle can be



Erectile Dysfunction

Dr. Madlala provided a more in-depth look at Erectile Dysfunction (ED) and its relationship to chronic disease. He defined ED as: “recurrent or persistent inability to achieve and/or maintain an erection appropriate for satisfactory sexual intercourse.” Research suggests an inverse relationship between ED and education levels and physical activity, and a link between the risk of ED and the risk of Cardiovascular Disease. Indeed, there is evidence that Erectile Dysfunction may be a sentinel alarm for Cardiovascular Disease. One study showed that 70 per cent of angina patients had ED prior to the onset of angina. European research has found associations between coronary risk and ED, namely:

- 44–66 per cent of Coronary Artery Disease male patients had prior ED
- 57 per cent of male patients undergoing heart bypass surgery had prior ED

Dr. Madlala stressed that ED is a medical as well as a sexual problem. There is a clear rationale for ED screening, as Erectile Dysfunction may indicate diabetes, hypertension and coronary heart disease, among others. The role of doctors must be to ensure early diagnosis and to regard ED as a significant medical condition that be treated as such in the medical training curriculum. Men must pay attention to a low fat diet and keeping up physical exercise. Research also suggests that there is an important role for medication, early intervention with which can lead to better treatment outcomes, in terms of reduced morbidity and mortality from cardiovascular diseases.

defined as a way of living that lowers the risk of being seriously ill or early dying, while helping oneself and one’s whole family to live a full life.

Chronic disease threatens the health of many South Africans. Lifestyle choices such as smoking, inactivity and incorrect eating habits significantly increase the chances of developing a chronic disease, which might be fatal. According to the Heart Foundation, 40 per cent of the people in ‘westernized’ South Africa that die in the age group of 25 – 64 years old, die from chronic disease. Over 50 per cent of all adult South Africans have at least one risk factor for chronic disease. At least 30 per cent of all South Africans are sedentary in their work and leisure time, while more than 25 per cent of all South African men currently smoke. Smoking alone may account for more than 30 per cent of deaths as a result of coronary heart disease.

Addressing chronic disease, and in this context, men’s vulnerability to chronic disease, involves paying attention to both social determinants and behavioural risk factors, and the relationships between them. Social determinants and risk factors are shaped by gender norms and inequalities. Men’s drinking and smoking behaviour is influenced by alcohol and tobacco marketing which equates substance use with masculine prowess and success. Men are also over-represented in certain occupationally-related cancers, such as lung cancer linked to the mining industry. Dr. Mahlako identified four priorities to address the threat of chronic disease to the health of people in South Africa. While these priorities do not explicitly take account of gender, it will be important to address the gender dimensions in developing action on them.

Nutrition: Action is needed on diets, to reduce the risks of being overweight to oneself (coronary heart diseases, non-insulin dependent diabetes mellitus, constipation, joint pain) and to one’s family (coronary heart diseases, bad eating habits, poor life expectancy).

Physical activity: Health education and investment in sports and recreation facilities is needed in order to improve levels of physical activity, which is important for immune functioning.

Tobacco use: Health education and tobacco control policies are needed in order to reduce levels of tobacco use, and its associated risks of premature mortality and high morbidity.

Alcohol use: While low alcohol use may be health-protective, immoderate alcohol use is a source of premature mortality and high morbidity. Health education and alcohol control policies are needed to reduce levels of alcohol use, especially among men.

Social determinants	Risk factors
<ul style="list-style-type: none"> • Unsafe water, sanitation and hygiene • Available food and food marketing • Climate change • Urban outdoor air pollution (airborne particulates) • Indoor smoke from solid fuels • Lead exposure • Alcohol/tobacco industries and marketing • Physical security issues that deter exercise • Lack of investment in recreation facilities • Selected occupational risks factors to injuries 	<ul style="list-style-type: none"> • Substance misuse • Diet (underweight, low fruit and vegetable intake, high cholesterol intake, overweight, deficiencies in iron, vitamin and zinc) • Alcohol use • Tobacco use • Physical inactivity • Unsafe sexual practices

Dr. Mahlako concluded by emphasizing the importance of men taking individual action and responsibility, for both themselves and their families, and in particular with respect to educating boys and younger men on healthy lifestyles.

Men, health and gender equality

The foregoing presentations on different aspects of men's experiences of and responsibilities for health were also placed in the context of the goal of gender equality, and its implications for health work with men. Dean Peacock, co-Director of Sonke Gender Justice, presented highlights from the 2007 South Africa Country Report to the UN Commission on the Status of Women. This was a report, commissioned by the Office on the Status of Women within the Presidency, on progress made by South Africa in terms of its commitments on involving men and boys in achieving gender equality.

The report makes clear the strong rationale for working with men in South Africa:

- Violence and unequal power between men and women is one of the root causes of the rapid spread of HIV in Southern Africa.
- South Africa has amongst the highest levels of domestic violence and rape of any country in the world.
- Across the region conviction rates for domestic and sexual violence are amongst the worst in the world.
- Men are not using HIV services—VCT, ART, support groups.
- Growing numbers of men want to be a part of the solution.

“The question should not be, “can men change?” We change all the time. The question is, “what can we do to accelerate this?”

- Dean Peacock

The report highlights the clear relationship between gender inequalities and HIV prevalence. Women make up 77 per cent of the ten per cent of South African youth between the ages of 15-24 who are infected with HIV. Men's violence contributes to women's vulnerability to infection. Almost one-third of sexually experienced women (31 per cent) reported that they did not want to have their first sexual encounter and that they were coerced into sex.²¹ One researcher has noted that, “Women with violent or controlling male partners are at increased risk of HIV infection.”²²

Conviction rates for domestic and sexual violence are amongst the worst in the world. Only one in nine victims reports rape and fewer than ten per cent of reported rapes lead to conviction. Post-exposure prophylaxis is available in less than half of all public clinics and staff are poorly trained on how to deal with rape.

But gender also shapes men's experience of AIDS, not least with respect to the use of HIV services. Women accessing ARVs outnumber men by a ratio of at least two to one and VCT by three to one.²³ Women's CD4 count at initiation of treatment in clinics in Johannesburg and Cape Town was also significantly higher than men's.²⁴

The report emphasizes that programmes working with men on gender norms and inequalities can make a difference in relation to some of the problems specified above. It looks at the evidence of some of this impact and cites the following evaluation studies to make this case:

- A 2007 evaluation of the Stepping Stones training and mobilization package found that men reported fewer partners at both 12 months and 24 months of follow-up and were more likely to report correct condom use “at last sex” and reduced rates of violence.
- An Instituto Promundo/Population Council study of Promundo's work with young men in Brazil found that participants were between four and eight times less likely to report STI symptoms and 2.4 times as likely to use condoms with primary partner.

In terms of the situation in South Africa with respect to men and gender equality, the findings of the research undertaken for the report offer some encouragement but also a reminder at the scale of the problems being confronted:

- Growing numbers of men are taking a stand for gender equality.
- Groundbreaking work with men is occurring across South Africa
- There is widespread adoption of work with men within gov't departments.
- Men's violence against women remains unacceptably pervasive.
- There is a need for greater clarity of purpose about the goals of work with men, as well as increased coordination and planning.
- Dialogue and accountability between organisations working with men

“As we engaged in struggle to end racist domination, we also said that we could not speak of genuine liberation without integrating within that the emancipation of women... No government in South Africa could ever claim to represent the will of the people if it failed to address the central task of the emancipation of women in all its elements, and that includes the government we are privileged to lead.”

- President Thabo Mbeki on the Occasion of his Inauguration and the 10th Anniversary of Freedom, Pretoria, 27th April 2004

and women's rights organisations is needed.

- Current efforts rely too heavily on workshops and community outreach.
- South African funding is insufficient and some international funding comes with strings attached.
- Not enough work with men taking place in rural parts of the country or with traditional leaders.
- Very little work with men addresses broader socio-economic conditions exacerbating gender inequalities.

On the basis of these findings, the report makes the following recommendations:

- Intensify efforts to involve men in achieving gender equality.
- Use existing policy frameworks—NSP, NAP, OVC Plan, Corrections Services Act.
- Foster collaboration between women's organisations and those working with men.
- Tailor interventions to address different groups of men.
- Employ a broader range of social change strategies including rights based advocacy, community mobilisation and policy approaches.
- Provide consistent, reliable and coordinated funding that promotes sustainable approaches and organisations.
- Build capacity with the public sector to engage men and boys in achieving gender equality.
- Take work to scale and expand efforts to engage boys and young men in achieving gender equality.
- Launch a “Men and HIV Services campaign” to increase men's use of HIV services.
- Increase men and gender equality work in rural areas—especially with traditional leaders.
- Develop a clear set of principles for this work (see box on the next page).

Mbuyiselo Botha, of the South African Men's Forum, spoke very movingly about the urgent need for men to get involved in the struggle for gender equality. He noted that men's violence against women also harms men, and not just because in their roles as fathers, brothers, sons and friends of women, men can be affected by the violence done to the women that they love; men's violence also reduces men to “just violent unthinking beings.” Gender equality can restore some of the humanity that men have lost in a world dominated by the brutality of men's violence.

But to recover their humanity, Mr. Botha stressed, it is essential that men understand the roots of male violence. Such roots lie deep in the way that boys are raised to believe in male superiority. This belief is bolstered by the very real gender privilege that men do have in this society, which “makes us bosses always giving out instructions and not expecting resistance from women because we argue that it is what God wants of us.”

Mr. Botha posed this question to the participants: What can we do as men to mobilize and galvanize other men in the struggle for gender equality? The first step is to become conscious of the unequal power and unfair privileges that we have as men compared to women. Only then can we begin to think differently and in the process show other men how debilitating and unjust the power that we have is. It is clear that this acknowledgment will not be easy because it will challenge the comfort zone that the majority of us men have considered to be the correct order of things in the universe.

A second step is to challenge the cultural practices that in many ways seek to entrench our privileges in society. Speaking out against such practices will upset a lot of people. Men who do so will be labeled as confused, Eurocentric, colonized and serving the white master's interest or agenda. In countering this labeling, Mr. Botha argued, it is essential to understand that the religious arguments that are used to justify men's power over women not only come from the Bible of the colonizers themselves but also reflect the fact that most religions in the world discriminate against women even though the majority of their members are women. In most religious institutions women are not in leadership positions. Thus, changing cultural practices in this religious sector will meet with much resistance because men in these institutions will reject any move that appears to threaten their leadership.

Mr. Botha stressed that acknowledging their privilege and challenging the practices and institutions that entrench this privilege is not only the right thing for men to do; it is in their interests as well. He urged that: "Our challenge as men therefore is to realize that there is a need for us to embrace change especially in our relationships with women and not view or think of change as something that we should fear or reject. Change brings opportunities for us as men too, in that when we embrace equality we also deal with a lot of societal pressures that are in most cases unhealthy for us men as well."

Gender equality not only liberates women; it liberates men from the dehumanization wrought by male violence. Mr. Botha closed with this final appeal to the men in the room:

"It is in our interest as men to create such a society, especially for our girl children so that they do not grow up in a society in which they will always have to look over their shoulders every time they walk in the streets. Justice must be the reason for all of us to want to embrace gender equality."

Men and health policy: Experiences from the Eastern Cape

Prince Langa Mavuso described the experience of developing a men's HIV/AIDS programme in the Eastern Cape. He noted that the genesis of the programme lay in the observation by the Deputy President Ms. Phumzile Mlambo-Ngcuka, at the launch of SANAC on 30 April 2007, that men were

not involved enough in the fight against HIV/AIDS. It was then that the Eastern Cape Department of Health took an undertaking that the Eastern Cape Province would hold a Men's Summit in order to discuss how best to improve men's participation in responding to the HIV epidemic. On this basis, a Memo was submitted to Cabinet through the Department of Health, the cabinet approved the request and ECAC, ECDOH and MEMSA formed a partnership for the implementation of the cabinet resolution. The securing of this high-level support, and the sense that there is a "burning platform" around men's involvement in sexual and reproductive health, has ensured that this initiative in the Eastern Cape has a significant level of political support.

The Eastern Cape Men's Summit developed the following resolutions, which significantly were understood to be informed by the priorities and targets of the Millenium Development Goals:

- Address the harmful socialization of Men
- Establish men's support groups
- Respond to the current challenges facing men
- Support men as positive role models
- Ensure the proper management of circumcision
- Embark on a vigorous drive against domestic violence
- Engage Traditional Health Practitioners for collaboration
- Promote messages about responsible alcohol use and no drug use
- Work with religious leaders to lead moral regeneration
- Develop a programme for men having sex with men especially in prisons
- Work with Traditional Leaders to make available land for poverty alleviation programmes for men

The summit also considered barriers to the implementation of these resolutions and what will be needed to overcome such barriers (see box).

Prince Langa Mavuso ended his presentation with the following messages:

- Maternal health is not for women only.
- Men should participate more as partners in maternal health in order to reduce the number of women who die every day in childbirth.
- Women cannot be emancipated until they are able to control their own fertility.
- Men and reproductive health are interdependent.
- Gender equality can only be achieved by bringing men into the picture.

Commissions

Introduction

Participants divided into separate Commissions on the afternoon of the first day to look more closely at men and gender equality in relation to different health and social issues. There were a total of ten Commissions, whose focus was as follows:

- Buffalo Group: **Sexual & Reproductive Health for Men**
- Chameleon Group: **Men and VCT**
- Tiger Group: **Men and Family Planning**
- Rabbit Group: **Prevention for Positives**
- Snake Group: **Men and ART**
- Lion Group: **Men and Maternal Child Health**
- Springbok Group: **Men and Male Circumcision**
- Zebra Group: **Men and PMTCT**
- Monkey Group: **Gender Based Violence**
- Rhino Group: **Fatherhood**

Each Commission was tasked with discussing a set of questions (see the box). The work of the Commissions was led by a team of facilitators, and the highlights and recommendations from each Commission was recorded by a rapporteur attached to each Commission.

Overview of Commissions' concerns

While most groups immediately began work on their issue of focus, the Chameleon group, looking at issue of men and VCT, took a few minutes to discuss the overall objectives of the Imbizo and to identify the broad set of issues pertaining to men, gender and health. This discussion provided not only a useful context for their work on VCT but, more generally, offers a valuable starting point for considering the deliberations and recommendations of the Commissions as a whole.

The group identified the following objectives for this work with men on health and gender equality:

- Men's empowerment and gender equality
- Focus on men's sexuality and reproductive health
- Focus on men's wellness
- Encourage men to speak up on health and to prevent violence and abuse

The group also discussed the general issues that must be addressed in work with men on health and gender equality and identified them as follows:

- Taboo of talking openly and honestly about sexuality
- Men don't open up
- Stress of men's lives
- Men's lack of help/health seeking
- Silence on men's experience of abuse
- Need to challenge cultural stereotypes

Questions for the Commissions

Questions for all the Commissions, except Gender Based Violence and Fatherhood:

What have been your experiences as users and as providers of health services? Specifically:

- What are the services available?
- What are your experiences with these services?
- What makes it difficult for you or other men to use these services?
- What would make it easier for you to use or participate in these services?
- How would you encourage other men to use or participate in these services?
- What changes need to be made to how health services are delivered to involve men more?

Questions for the Gender Based Violence Commission:

- What have you done or wanted to do to prevent violence against women and girls?
- What makes it difficult for you to be involved in preventing violence against women and girls?
- How could you or other men prevent violence more effectively?
- How could government support men to take action against violence against women and girls?

Questions for the Fatherhood Commission:

- What roles should men play in the lives of their children?
- What makes it difficult for men to be good fathers?
- What needs to change in terms of how men raise our children?
- How can we support men to be good fathers?
- What can government do to support men to be the best fathers possible?

- Women's rights and men's fears
- Men's relationship to women's leadership

Men's experiences of health and health services

Services benefit women: There was a sense among the Commissions that health services are 'female spaces' that primarily benefit women and that there is a failure to target health services at men and a lack of resources devoted to the health of men.

Service provider attitudes: The attitude of female health sector staff toward men was seen as playing a significant role in deterring men from using government health facilities and in reinforcing the impression that clinics were for women. Commission members shared stories of men being made to feel unwelcome, not least in MCH services when men are trying to get more involved in ante-natal and post-natal care. It was suggested that more men than ever before want to be present at the birth of their children, but that this was still not possible for many men, in part because of the attitudes of nurses and midwives whose traditional gender attitudes consider men's presence at childbirth to be inappropriate.

Accessibility issues: Another common finding across the different Commissions was that the location and opening times of health services, at least in the state sector, did not facilitate men's use of such services. Locating services nearer the sites of men's work and leisure time, and opening at times that meet the needs of men (e.g. employed men often cannot access health clinics unless they are open after work hours), were identified as important first steps in improving accessibility.

Limited service options for men: Some Commissions also felt that there was a lack of health service options for men, not least in terms of male contraceptives.

Neglect of men's broader health issues: A concern raised by Commissions was that current efforts to address men's health had too narrow a focus on HIV and STIs to the neglect of broader sexual health concerns, let alone problems of chronic disease. The positive response of participants to the medical presentations earlier in the meeting was another indication that men's need for information about their bodies and their health has hitherto been neglected.

Lack of confidentiality: This was reported across several Commissions as a cause for concern, and one that deterred men from seeking help from the government health sector. The VCT Commission emphasized that this was not simply a matter of inadequate training or a failure to follow proper procedures; more fundamentally, it is also a problem of inadequate health infrastructure, for example a lack of private space within clinics in which confidential consultations, such as VCT, could be carried out. Clearly this infrastructure problem affects both women and men, so it will be important

to tease out further the gender aspects of this issue. Further research is needed to clarify the barriers to confidentiality and how these affect men's use of VCT services.

Myths about services inhibit men: There were a couple of references within the Commissions to myths about condoms continuing to deter men from seeking and using them, notwithstanding the condom promotion campaigns that have been undertaken.

Economic issues inhibit men: This was identified explicitly by the VCT Commission as a deterrence for men in terms of testing and coming back for their results; a fear of getting a positive result and the consequent pressure to change diet and lifestyle, and the assumption that this would be more expensive. In general, the Commissions recognized the impacts of socio-economic inequalities in shaping both men's and women's health, and that major improvements in health would not be achieved without a public policy response to poverty and economic inequality in South Africa.

Socialization prevents help seeking: The Commissions also noted the effects of gender socialization in terms of men's lack of help-seeking and were clear that norms of masculinity, which equate seeking medical help and using health services with appearing weak and vulnerable (and being 'like women'), were a significant barrier to men's use of health clinics.

Fear and denial: The pressure to maintain the invulnerability of masculinity also plays out in men's fear of learning about ill-health and their denial of vulnerability to ill-health. Many Commissions felt that many men's fear and denial when it comes to health must be an important target of intervention in the health sector response to concerns about men, health and gender equality.

Lack of cultural and regional relevance: Many Commissions noted the insensitivity to cultural traditions and beliefs in the delivery of health services and the design of health promotion campaigns. This had a regional aspect too; in general, there was a feeling that too little effort was given to tailoring health service delivery and interventions to the particular cultural histories and conditions of specific communities.

Lack of follow up support: This noted particularly in relation to the lack of support groups for men after HIV testing. In general, Commissions were concerned that men lacked access to formal support services beyond the delivery of immediate health services. The absence of formal mechanisms for providing follow up support affects both women and men, but Commissions felt that this of particular concern for men because they were less likely than women to create and use their own informal support networks.

Lack of respect for sexual diversity: At least one Commission made the point that different groups of men have different needs with respect to health services, and that the stigma that still surrounds homosexuality



means that men who have sex with men are especially badly served by the health sector, in which homophobic attitudes are still common.

Suggested improvements at the Policy level

Health systems improvement: An overarching recommendation from the Commissions was that an improved response to concerns about men, health and gender equality must be enacted in the context of investment and improvement in health systems as a whole, in terms of infrastructure capacity and staffing levels. For example, Commissions were clear that improvements in confidentiality, for example in VCT, depended on investments in more trained counselors and greater provision of space for confidential counseling and testing.

Government structures for men's health?: A number of Commissions considered the question of how to structure the institutional response of government to these issues of men, health and gender equality. Some recommended that a separate structure for men's health be created within the Department of Health to move policy forward. On the other hand, there was some concern that setting up a parallel structure could inhibit effective gender-based work with men on health by creating a bureaucratic rivalry with those responsible for women's health, detracting from the priority which is to develop public policy on health within a gender relations framework that takes account of the gender dimensions of both women's and men's health. It was agreed that a more immediate step would be the creation of a Task Force on Men, Health and Gender Equality, charged with a more thorough consideration of government's leadership on these issues.

Separate or integrated health services?: Similarly to the above discussion, the question of how best to deliver health services in a way that addresses the needs and interests of different groups of men, within the broader goal of gender equality for health equity, was also considered. Some participants felt that the best way to respond to men's health issues was the creation of separate services for men; but the more widely held view was that better integrating men within existing health services was not only a more efficient use of resources but also a more effective way to address the impact of gender relations on health. Commissions also emphasized that such integrated services needed to be responsive to specific needs of particular constituencies of men, taking account of significant differences between men of different socio-economic strata, urban/rural location, age and sexual orientation.

Importance of Primary Health Care: In relation to the concern about the narrow view of men's sexual health issues, it was recommended that policy responses to men, health and gender equality be understood as a component of health and gender work within the framework of Primary Health Care.



Constitutional protections on Rights: Several Commissions noted that the Constitution and its framework of rights must underpin any policy response to concerns about men, health and gender equality. For example, the Commission on Men and VCT noted the importance of rights-based framework in considering policy on HIV testing. But it was also clear from the discussion that the question of whose rights needs to be considered more closely, especially in terms of the rights of the individual vis a vis the rights of the community/society.

Policy enforcement on confidentiality: Some of the concerns about confidentiality were related to a failure to enforce existing policies. Beyond the issue of infrastructure capacity discussed above, this was also seen as a matter of training for health providers and having good systems in place for monitoring policy implementation and for holding accountable those responsible for failures of implementation.

Policy engagement: Several Commissions noted the importance of continuing to engage different constituencies of men as well as organizations working with men on health and gender equality in this evolving policy dialog. The Commission on Men and VCT made particular mention of the importance of policy engagement with respect to the issue of provider-initiated HIV testing.

Policy review and accountability: While South Africa has many good policies, both on gender and health, it is widely acknowledged that policy implementation can fall short. Commissions called for a strengthening of processes of policy review in order to ensure accountability for the enactment of policy mandates. This clearly goes beyond questions of men's health but there are specific gender issues to consider in relation to policy review and accountability, not least with regard to the enactment of policies on gender-based violence.

Suggested improvements at the Service Delivery level

Community-based services: A key to increasing men's use of health services was to take such services to where men are, and expand health service outreach through the use of community-based outlets, such as taverns, soccer clubs etc. This kind of outreach was seen as being especially important in relation to increasing men's uptake of VCT and in targeting health promotion campaigns at men.

More male staff: Many Commissions described health services as 'female spaces' and felt that increasing the proportion of male staff would help to correct this perception, the assumption being that this would make clinics more welcoming to men. It was recognized that this was in part a matter of government policy but in part it was a matter of collective responsibility, in that parents and families needed to be encouraging young men to become health workers.

“Some participants felt that the best way to respond to men’s health issues was the creation of separate services for men”

Training for staff in working with men: Several Commissions heard reports of men being disrespected and mistreated in health service settings and felt that staff training must be an important element of making health services more responsive to men, especially with respect to men’s sexual and reproductive health needs. While not mentioned explicitly by the Commissions, it is important to note in this regard the diversity of these needs for different men, such as the problem of anal STIs faced by men who have sex with men. Another staff training issue relates to screening and referrals for violence, as experienced not only by women but also by men.

Male-friendly services: Based on the youth-friendly model, Commissions recommended that all aspects of health service delivery be reviewed to ensure that they are male-friendly. In addition to the issues raised above, this would include consideration of opening times to ensure that men can access services after work hours, as well as the location of services. In this regard, several Commissions noted the importance of a focus on the workplace as a site for health promotion and health service delivery, and the consequent need for closer partnerships with the private sector.

Issues of stigma in service delivery: HIV stigma remains a huge issue for both women and men, but for men who have sex with men who test positive it is exacerbated by homophobia. Some Commissions noted the importance of policies on stigma taking account of the multiple forms of stigma and discrimination that particular groups of men face.

Task shifting to expand service delivery: A general recommendation was made on the need for a policy on task shifting, for example to increase the range of staff tasked and trained to provide VCT. Any effort to increase men’s uptake of VCT must address this issue of task shifting in order to expand the number of VCT providers.

Work with religious and traditional leaders to expand services in rural areas: Commissions noted that religious and traditional leaders were important stake-holders in any effort to expand health services in rural areas, especially in community-based settings. Work with such stake-holders was seen as another aspect of work with men on health and gender equality; the need to work with men in positions of power and influence to promote norms of gender equality and to support health interventions with men.

Suggested improvements at the Programming level

Cultural traditions, beliefs and practices: Discussion of culture, in terms of traditions, beliefs and practices, was a prominent feature of all of the Commissions. Within this discussion there were different understandings of what “culture” meant, ranging from a view of culture that saw it as the unchanging foundation of society to a definition of culture as norms and ways of life that are always evolving in relation to the changing circumstances facing a given society. There was also some tension in



formulating policy on men, health and gender equality in relation to culture; the tension between the need to work 'with the grain' of culture in order to work with men on health and the need to challenge those aspects of 'culture' that are harmful to health.

Discussions of what culture means and how it should be addressed will continue to be a feature of work with men on health and gender equality.

Promote dialogue among men: There was a clear recommendation that programmes targeting men with interventions on health and gender equality must outreach to men where they are, to male-dominated spaces in order to encourage dialogue among men about these issues of health and gender equality, especially given the finding that men do not tend to open up about what is going on for them.

Use men to reach men: Commissions urged the importance of peer-to-peer approaches, based on the understanding that many men are more responsive to messages and approaches from other men. One participant emphasized the importance of using "men to fish men."

Rural focus: Many Commissions emphasized the importance of expanding health work in the rural areas. Clearly a rural focus in health delivery will benefit both men and women, and it will be important to think through the particular challenges of developing health interventions targeting men (of different ages) in rural areas.

Workplace focus: As noted already, the workplace was identified as a critical site for reaching men not only with specific health services (VCT) but with health and gender equality programming more generally. There are lessons that can be learned from engaging the private sector in HIV programming in high-risk occupational settings (e.g. the mining and transport sectors) that could be applied more broadly.

Men's health IEC materials and campaigns: Many Commissions had noted the lack of health promotion interventions targeting men and recommended that specific IEC materials and campaigns be developed targeting men in relation to particular health concerns.

Given the significance of AIDS as the leading cause of premature mortality for men, and the evidence of men's poor uptake of HIV services (VCT, ART), it was suggested that there was an urgent need for a "Men and HIV Services" Campaign.

Group-work: Some Commissions highlighted the importance of moving beyond mass-targeted campaigns and one-on-one health education approaches and using more intensive group-work in order to both support and challenge men around the impact of their attitudes and behaviours on their own health and the health of women and children. Such group-work could provide the space in which to help and push men to be honest with themselves and each other about health issues, to overcome the fear and

denial that has been identified as a problem for men, as well as to hold men to account for the choices that they make that impact on their health and the health of women and children in their lives.

Work on broader social norms: Many Commissions felt that it was critical to put this work with men on health in the context of efforts to change broader social norms of gender and sexuality, and thus to think in terms of a spectrum of action, whose goals would range from individual to policy change.

Mobilize the media: There was a general feeling that the media did little to provide a more positive image of men, for example by reporting on the initiatives that men are taking to change their attitudes and behaviours, but instead tended to perpetuate the stereotype of the reckless and feckless male. Thus, there was a need to involve media to promote positive messages and images about men's engagement in promoting better health and greater gender equality.

Address economic inequality: Importantly, some Commissions noted that this work with men on health and gender equality must also take account of significant differences between men, not least in terms of access to and control over economic resources, especially given the clear connection between economic inequality and ill-health. Thus, public policy on men, health and gender equality must be framed within a broader commitment to social justice that addressed economic inequalities.

Men and gender-based violence: Responses

The Commission on Men and Gender-Based Violence discussed current responses of men to such violence. These included:

Education for violence prevention: Men are involved in educating other men, especially young men, about the nature and impacts of gender based violence, and what they can do to prevent such violence.

Self-reflection and personal change: Change 'begins at home'. Commission members shared their own and others' experiences of the kind of self-reflection that had led to personal change in their own attitudes and behaviour with regard to gender-based violence. The Commission stressed the importance of publicizing these stories in order to promote such self-reflection among other men.

Being a positive role model: Related to the above, the Commission acknowledged the value of men being positive role models for other men, especially in terms of not being complicit with the gender attitudes and practices that allow such violence to continue and doing what they can in their own lives to challenge these attitudes and practices. This is especially important given the prevailing stereotype of the violent male; it is vital to model other, gender-equitable ways of being a man.

Promoting non-violent conflict resolution: Commission members also discussed the importance of giving young men the practical skills they need to reduce the violence; for example, skills in negotiating conflicts, at home, work and in relationships, that promote non-violence.

Mobilizing community leaders: Men as community leaders have a key leadership role to play in relation to norms around gender and violence. Commission members shared experiences of community leaders speaking out against violence and the impact that this can have at the local level. Community leaders are also key to energizing alternative community justice processes for holding men accountable for their violence and providing support to female survivors, in situations where the police and the courts are failing to respond adequately.

Offering recreation/diversion for at-risk men: High levels of unemployment and related drink and drug use have some connection with the high levels of men's violence in our communities. Commission members agreed that providing recreational alternatives for men in these situations, and using sports as an entry point for work with men around their gender attitudes and behaviours, are very practical ways that men can respond to gender based violence.

Holding men accountable: Above all, it is essential that men are held accountable for the violence that they do perpetrate. All men have a role to play as "active bystanders" in helping to ensure that incidents of violence are brought to justice, whether through formal state mechanisms or through alternative community processes. The men who staff and manage these mechanisms and processes clearly have a special responsibility in this regard.

Men and gender-based violence: Why men do not respond

The Commission discussed the various reasons why men do not get involved, or involved enough, in responding to gender based violence. These included:

"It's not my business": The widely held view that gender based violence is a 'private' affair, other people's business, is a significant reason why more men don't get involved in taking action on violence. This is especially the case in relation to violence in the home (domestic violence) but also in relation to violence in the street.

Some men's feeling that men are stereotyped as perpetrators: Some Commission members reported that some men do not get involved in responding to gender based violence because they resent what they see as the stereotyping of men as perpetrators.

Fear of getting involved: Men also have a fear of being targeted by violence themselves if they try to intervene. Commission members also reported some men's fear of getting involved with the police/courts if they

report the violence, especially in communities which themselves experience police violence and thus regard the police with suspicion rather than trust.

Lack of services for male survivors: There is a real lack of services for male survivors, especially in relation to child sexual abuse; the few survivor services that do exist are geared toward women. This lack of services inhibits men's response to violence both directly and indirectly; without support and healing, male survivors may be more likely to commit violence against others and even more unwilling to get involved in taking a stand against other men's violence. The Commission was clear that male survivor services should not be at the expense of women's and should not be taken to imply an equivalence in terms of experiences of violence, but felt that it was important to recognize that men are targeted by different forms of violence.

Men and gender-based violence: Improving the response

The Commission made several recommendations for improving the response to gender based violence and men's roles within such a response. These included:

Encourage and demand better police response: More men must be involved in efforts to hold the police accountable for their failures to take adequate action against gender based violence. Too often such efforts are left to women.

Encourage and demand better social work response: The Commission acknowledged the lack of services for survivors of different forms of violence and suggested that one role men can play in responding to violence is to be involved in efforts to demand more resources for social services and their support to survivors. Men are also under-represented as social workers themselves. The recruitment of more male social workers would send a strong message about men's willingness to be part of the solution to gender based violence.

Become an active bystander: As already noted, too many men are complicit in allowing violence to continue. The Commission urged that men must get involved in reporting incidents of violence and be willing to offer support to survivors as well as to challenge those men whom they know may be involved in perpetrating violence.

Develop services for male survivors: As noted above, there is a dearth of services for male survivors of violence, whether as adults or children. Providing such services is an important step in breaking 'cycles of violence' and in addressing the trauma that, in part, allows gender based violence to continue.



Fatherhood: What to change?

The Commission on Men and Fatherhood discussed what needs to change in terms of men's relationship to and experience of fatherhood. Several themes emerged from this discussion, as follows:

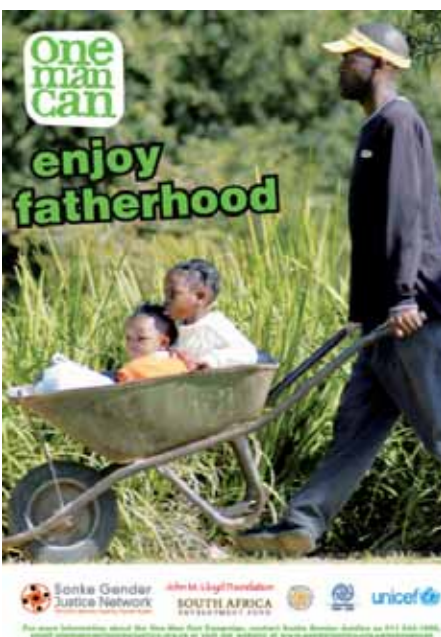
More engagement with families: There was a widespread feeling among Commission members that initiatives were needed to promote men's greater engagement with their families, beyond merely providing for them economically. Several participants spoke of their lack of relationship with their own fathers, and the efforts they were making to be a different kind of father for their children. At the same time, the Commission acknowledged that economic pressures, as well as gender expectations of men as the family breadwinner, do put a lot of pressure on men to prioritize work over spending time with their families.

More value on the family: However, the Commission also acknowledged that there was also a need for a change of attitude among many men toward their families, which they summed up in terms of the need for men to place more value on the family.

More communication with family: Related to the above, the Commission agreed that one of the major obstacles to men engaging more with their families and placing more values on time spent with their families was the issue of communication within families. In particular, Commission members felt that gender socialization, which often trains men to contain their emotions and not talk about their feelings, was to blame for many men's inability or unwillingness to talk freely with their wives and children.

Use the Constitution to promote gender equality in families: There was some discussion within the Commission about the need to promote greater gender equality within families, especially in terms of sharing the responsibilities of parenting and having an equal share in decision-making. By no means was there agreement on this, and a number of Commission members maintained that while women should have a greater say in family decisions and men should play a greater role in child rearing, it was still important that the man be the head of the household. However, those Commission members who argued that gender equality should be the goal felt that the Constitution had a critical role to play, as a statement of rights that should apply to the family as to any other form or level of social formation.

Changing context, changing culture?: There was debate about the changing nature of men's parenting given the changing nature of South Africa; significant changes in family size and attitudes toward the roles of mothers and fathers as well as the extended family were noted but there was discussion about whether these changes constituted simply a different context for the traditional culture of fatherhood, or whether these changes amounted to a cultural change in the way that family life is lived, and thus



necessitated a change in the roles of men and fathers within this new culture of the family. These tensions between continuity and change, tradition and modernity, were a feature of the Commission's discussion.

Father: Supporting men to be better fathers

The Commission made a number of recommendations for supporting men to be better fathers, including:

Restore cultural foundation: In relation to the discussion of changes in context and culture, there was a feeling among some Commission members that a good way to support men to be good fathers would be to restore the foundation of traditional culture that they saw as being undermined by modern social and economic trends. It was less clear what this meant in terms of changing or preserving current gender relations and practices within families.

Positive reinforcement for good parenting: There was a general feeling that portrayals of bad fathering dominated the media, and that there was a need to publicize examples of men as good fathers, in part as a way of providing positive reinforcement for men's good parenting.

Accountability for bad parenting: At the same time, the group was clear that men should be held accountable, not least by their peers, when they failed to meet the standards of good fatherhood. This accountability is both formal, in terms of child support and maintenance for example, and informal, in terms of men within the extended family and networks of friends helping each other and where necessary challenging each other to do a better job as fathers.

Fathers taking community responsibility: It was also suggested that men need to look beyond their immediate families and roles as fathers and take more responsibility, together with women, for addressing problems being faced by the community, problems that affect all the families in the community.

Support groups, training and mentoring: The Commission identified a clear need for support to fathers and potential fathers in terms of the skills and attitudes that men need to be good fathers. There was agreement that government needed to invest in parenting support programmes for men, that could include support groups, skills training and mentoring of younger fathers by older men. It was stressed that the focus should be on strengthening parenting and not just fathering; hence, a focus on the partnership between mothers and fathers was seen as important.

Supporting the extended family: Several Commission members lamented the decline of the extended family as a result of social and economic changes in society and called for efforts to support the extended family, with implications for the roles of men within extended families in

fulfilling parental responsibilities. This served as a useful reminder that the fatherhood discussion should not just be about men as biological fathers, but about the different roles that men can play in the lives of children within the extended family.

Fatherhood: Role of Government

Some specific recommendations on the role of government were made, including the need to:

- Develop fatherhood promotion campaigns
- Provide funding for fatherhood initiatives
- Review law and policy on maintenance issues
- Use the media to promote positive messages and images on fatherhood

Conclusions and next steps

This Men's Imbizo successfully brought together stake-holders from eight provinces to discuss and recommend policy responses to the related challenges of improving men's health and promoting gender equality. The mix of presentations on bio-medical and psycho-social aspects of gender and health in the lives of men raised key issues for discussion, and in the process revealed not only a deep hunger among men for more information on their health and their bodies, but also some of the key tensions that policy must address. The meeting made clear that policy on men, health and gender equality must address both male power, and its influence on women's health, and gender norms, and their influence on men's health, in a twin-track approach.

The Imbizo marked an important first step in a process of elaborating and translating such an approach into policy guidance that will be issued by the National Department of Health. It was followed one week later by a smaller meeting of policy experts and researchers, who considered more specifically the policy implications of the issues raised at the Imbizo. A separate report on this meeting is forthcoming. With the foundation laid by these two consultations, Sonke Gender Justice is now undertaking a desk review of the:

- Status of men's health in South Africa, with a particular focus on reproductive health and HIV and AIDS, and of men's rights vis a vis access to prevention and treatment information and services, as well as of the impact of men on women's health
- Range of evidence-based health interventions with men currently being carried out by civil society, and will consider the extent to which these interventions are guided by a commitment to gender equality; and
- Policies and guidelines that currently exist in South Africa, which address both the health needs and rights of men and men's roles in women's health.

On the basis of the gaps and challenges identified by the desk review, Sonke Gender Justice will prepare a report for the National Department of Health outlining a policy framework on Men, Health and Gender Equality, to be submitted toward the end of the fourth quarter of 2007.

Appendix One: Agenda

Thursday, Sept 06th Programme Director: Ms. Esther Maluleke		
Time	Activity	Facilitator
08:00 – 09:00	Registrations	
09:00 – 09:15	Welcome and Introduction	Dr Amos
09:15 – 10:00	Digital Stories	Nyanda
10:00 – 10:30	Men and Maternal Health	Dr Hyera
10:30 – 11:00	Country Report	Dean Peacock
11:00 – 11:30	Tea	
11:30 – 12:00		
12:00 – 12:30	Presentation on Men's Sexual Health	
Presentation on Men and Healthy Habits	Dr Madlala	
Dr. Mahlako		
12:30 – 13:30	Lunch	
13:30 – 17:10	Commissions	Rapporteur per commission
17:10 – 17:45	Action steps and formation of national task force on men, health and gender equality	Sonke
17:45	End of the day	NDOH
Evening	Reflection Survey	Sonke

Friday 07th, 2007 Programme Director: Sikhonjiwe Masilela		
Time	Activity	Facilitator
08:30 – 09:00	Welcome and Re-Cap	Bafana Khumalo
09:00 – 09:30	Presentation on Lesson from Eastern Cape Summit	
09:30 – 10:00	Men and Reproductive Health	Dr Mhlanga
10:00 – 10:30	Men and Gender Based Violence	Mbuyiselo Botha
10:30 – 11:00	Tea	
11:00 – 11:30	Commissions report	Bafana Khumalo
11:30 – 12:45	Commissions: Way forward	
12:45 – 13:30	Action steps and formation of national task force on men, health and gender equality.	
13:00 –	Lunch and Closure	

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